

WORCESTER medicine

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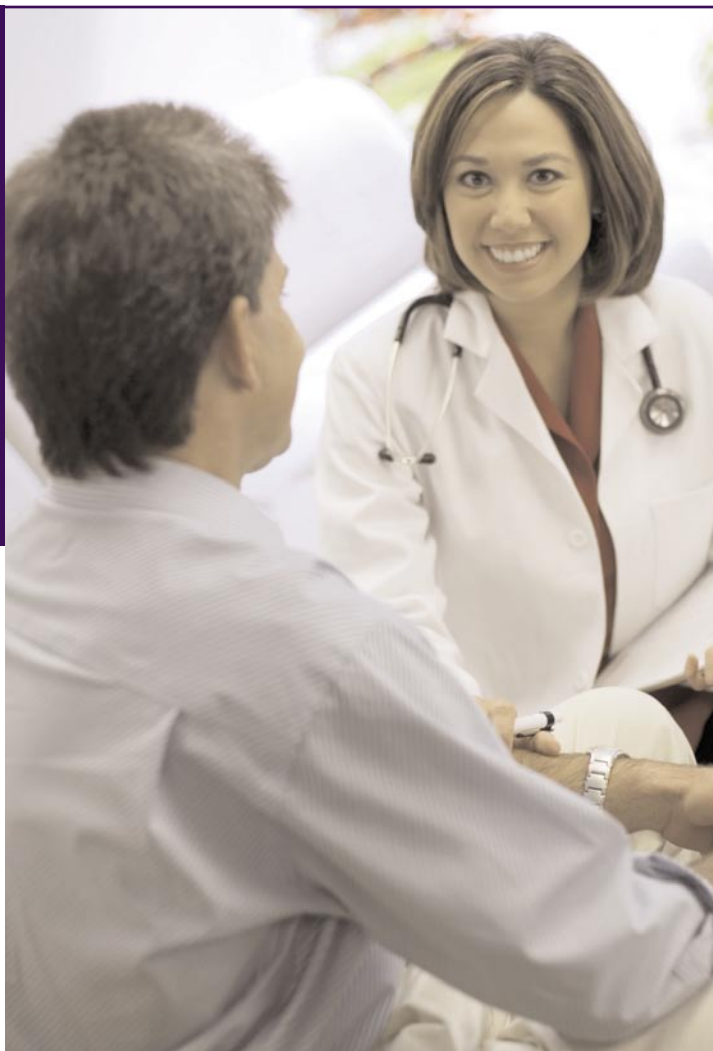
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**Jane Lochrie, MD**

The Institute of Medicine's report "To Err is Human: Building a Safer Health System" focused public attention on patient safety. The report was based on two studies from the 1980s that showed that 2.9% of hospitalized patients experienced an adverse event and 8.8% of these events were fatal. These findings have galvanized hospital systems, policy makers, training programs, and technology to change the culture in order to improve patient safety.

In this issue of *Worcester Medicine*, we learn how the healthcare systems in Worcester are working to make healthcare safer through technology, teaching and innovative patient safety programs. All three systems have received awards for patient safety.

Sophisticated technology has played an important role in the improvement of patient safety. Drs. Klugman and Tosi describe two programs at U Mass Memorial Medical Center that allows monitoring of patients miles away from the physician. The Telestroke program allows neurologists to examine and speak with the patients and their families in real-time. The eICU program uses high resolution video and audio technology to examine patients. The program can also monitor for developing problems and alert the intensivist of potentially life-threatening issues. Patients no longer need to be transferred to a major teaching hospital to receive expert care.

The ACGME new 2011 Program Requirements have a major focus on patient safety. There are new standards for limited duty hours, patient transitions of care, supervision, for professionalism that addresses fitness for duty, and alertness management and promotion of patient safety. Drs. George and Abraham depict several programs at St. Vincent Hospital that teach patient safety to the internal medicine residents in a non-threatening and supportive environment.

Dr. Kelleher explains the major upgrade in Fallon Clinic's state-mandated Patient Care Assessment Program. The Clinic implemented an integrated tracking tool to assess the impact of ten interventions ~ including patient complaints, both minor and major adverse clinical events, claims and law suits ~ to improve patient safety. They have demonstrated a significant improvement for their global risk score and a comparable decrease in malpractice cost.

The culture of safety at U Mass Memorial Healthcare Center is discussed by Melissa O'Malley Tuomi, BS, RNC. In her role as Regulatory Clinical Quality Project Manager, she feels it is critical to respect everyone and to learn from mistakes.

Fifty-two percent of all serious reportable events are from falls in the hospital. Patricia Dykes, DNS, RN, FAAN and Diane Carroll, PhD, RN, FAAN report on a software toolkit that tailors fall prevention interventions to address determinants of identified risks. Use of this toolkit in acute short stay hospitals has been associated with a significant reduction in patient falls in the older population.

Patty Ellis, MPH explains the "Safety for Life" program at St. Vincent Hospital. She describes a journey that began 2 years ago for the purpose of learning from past errors so that they could purposely plan a strategy to eliminate events that result in patient harm.

Finally, Dr. Dufault, Jr.'s Letter to the Editor highlights another important patient safety hazard in Worcester: the lack of acute care bed causing overcrowding in the Emergency Department.

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Correction: In the July/Aug issue of Worcester Medicine, we mistakenly printed the by-line "Stephen Doxsey, MD;" the correct by-line is Stephen Doxsey, PhD. We apologize for the error.

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letter to the editors

In the most recent Worcester Medicine, President Hirsh documented a resolution submitted to the Massachusetts Medical Society in May that should make all of our members proud of this district's appropriate advocacy position.

Please allow me to introduce a topic that would seem to have important relevance for our own community. It may warrant study and similar advocacy.

At about the time that our medical school decided to come to Worcester and build a teaching hospital, regional planners reached the conclusion that this area had an unjustifiable surplus of inpatient general medical and surgical beds. Subsequently, a major reduction occurred with two hospitals closing (Worcester City and Holden), one (St. Vincent's) reducing its size by about 50%, and three undergoing significant curtailment and reorientation (Doctors, Fairlawn and Hahnemann). Within the past year or so, an inpatient ward was closed at Memorial.

In early June, a tornado ravaged Central Massachusetts. If it had landed just a few miles north and east (Petersham to Worcester), as did its 1953 predecessor, the destruction, morbidity and mortality figures would have skyrocketed. The impact on our health care facilities cannot be fully imagined.

About one week later, and again in mid July, on a nice, sunny summer day, with no epidemic, major accident or climate catastrophe anywhere around, UMass Memorial Medical Center found it necessary to implement their "Emergency Operation Plan" because of an inpatient bed shortage on its Worcester campuses.

Many patients have had the challenge of trying to sleep in an emergency room holding area while waiting for "a bed to open up." Did that benefit their medical condition?

It's acknowledged that our hospitals are struggling in a very difficult squeeze between trying to improve quality of care while reducing costs.

The question should be raised as to whether our area has adequate medical facilities, and plans, to serve our population if a major, never mind cataclysmic, event occurred.

Francis X. Dufault, Jr., MD

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Integrating Technology and Expertise for Increased Safety

Robert A. Klugman, MD, FACP and Stephen E. Tosi, MD, FACS



Robert A. Klugman, MD, FACP



Stephen E. Tosi, MD, FACS

As providers and patients, we are fortunate to live and practice in a state where the quality of health care ~ and the outcomes of safe care initiatives ~ exceed national standards. In fact, work to increase patient safety at our UMass Memorial hospitals earned our system the Betsy Lehman Patient Safety Recognition Award not once, but three times.

Our five UMass Memorial hospitals are actively working to eliminate hospital-acquired infections and injuries related to procedures. We are also standardizing care to provide the best, most consistent treatments. However, it is perhaps our investment in new technologies that sets UMass Memorial apart as a national leader in pioneering patient safety initiatives.

Across Central Massachusetts, a number of critically ill patients who may have succumbed are now at home with their loved ones. They lived thanks to sophisticated technology ~ and highly trained staff ~ that are partnered in our UMass Memorial Telestroke Program and eICU Program.

The Telestroke Program

The videoconferencing Telestroke Program enables UMass Memorial Medical Center neurologists with expertise in stroke care to examine patients and speak with them, their families and physicians in real-time from miles away. The neurologist can also view CT scans and work collaboratively with physicians through the patient care process.

“Once a diagnosis is made, we can decide the most effective treatment plan to quickly lessen the symptoms and outcomes of the stroke,” said Wiley Hall, MD, director of the Telestroke Program. “Our ex-

perts are examining patients via audio and video feeds to eliminate the need to spend precious time transferring them to our academic medical center.” Dr. Hall noted that the Telestroke Program links his team to patients at Clinton, Day Kimball, Harrington, Heywood, HealthAlliance, Hubbard and Wing Memorial hospitals, significantly reducing the impact of stroke on patients throughout Central Massachusetts.

And the outcome of this investment in technology is being noted. UMass Memorial Medical Center recently received the American Heart Association/American Stroke Association’s Get With The Guidelines® ~ Stroke Gold Plus Quality Achievement Award, an honor, we believe, bestowed largely because of the implementation of the Telestroke Program.

The eICU Program

The eICU Program partners bedside ICU providers with a team of intensivists and critical care-trained affiliated practitioners who provide 24/7 patient monitoring from a remote eICU support center located on our Hahnemann Campus.

Here board-certified intensivists use high-resolution video and audio technology, enabling virtual rounds to conduct examinations and see patients’ vital signs such as blood pressure, oxygen saturation, and heart rate. The intensivists can also view care plans, physician notes, current medications, X-rays and recent test results. “Smart alerts,” programmed to alert eICU providers to developing problems, aid them in addressing potential life-threatening issues sooner than would otherwise happen.

It’s important to note that these remote intensivists do not replace ICU staff; they support them. An eICU intensivist may receive an alert that a patient is experiencing elevated blood pressure and heart rate. The intensivist immediately alerts the ICU bedside staff and works together with them to quickly evaluate and stabilize the situation, avoiding a serious turn for the worse.

“The system allows the eICU experts to help the bedside providers monitor the patients and detect evolving deterioration before the patient becomes unstable. This supplemental attention places critical care at UMass Memorial Medical Center and our community hospitals ahead of institutions using older technology,” said Craig Lilly, MD, medical director, eICU Program. The UMass Memorial team ~ bedside and support center ~ has consistently earned number one ranking for overall quality of ICU care from the national Quality Consortium of VISICU eICUs, consisting of 40 health care systems in 35 states.

The commitment to increased safety and surveillance of ICU patients extends beyond critically ill patients at the Medical Center as we've also invested in the same technology for our ICUs at HealthAlliance Hospital, Marlborough Hospital, and Wing Memorial Hospital. We have also extended the monitoring to non-UMass Memorial hospitals, including Harington, with others expected to join the system this fall.

Studies show that this constant surveillance and immediate physician access can reduce ICU mortality by 25 percent. While safety is the overriding concern in implementing eICU care, a study published in 2009 in the Journal of Postgraduate Medicine noted that tele-ICU systems can save about \$8 million a year by reducing length of stays. In addition, it's estimated by the New England Healthcare Institute that an annual 350 lives and \$122 million could be saved if all Massachusetts' hospitals adopted an eICU program. We have shown that our eICU program has decreased the cost of caring for critically ill patients with cost savings exceeding the initial investment in the technology and ongoing costs of running it.

One criticism of these programs is that most of the benefit is the result of new efficiencies implemented along with the new technology. However, in our case, we have shown that only part of these associations could be attributed to following best practice guidelines. This suggests that there are benefits of these programs beyond what is provided by daytime bedside intensivist staffing and traditional approaches to high-quality care.

In Conclusion


As our region continues to pioneer initiatives to increase patient safety, the use of technology will increasingly support the work of skilled health care experts. Safer care falls, however, not only to the experts. We need caregivers, support staff and patients to all adopt best practices and vigilance in order to prevent errors. The commitment of UMass Memorial to the use of technology augments this effort, supporting expanded care at the community hospital level.

(Editor's note: For more information on reducing mortality, length of stay and preventable complications using tele-ICU technology see article authored by Dr. Craig Lilly and the UMass Memorial critical care team in JAMA, June 1, 2011—Vol 305, No. 21.)

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Promoting a Culture of Safety in the Hospital: Training the Trainee

George M. Abraham, MD, MPH
and Susan V. George, MD, FHM



**George M. Abraham,
MD, MPH**



**Susan V. George, MD,
FHM**

Prevention of errors in the setting of a hospital has become one of the foremost priorities in the healthcare environment of today. The gold standard for safety is the “airline industry” where the highest level of safety “six-sigma,” is achieved on a consistent basis. While healthcare may never achieve that level of safety given that the human body is not a consistently reproducible environment, achieving a goal as close to that is the aim.

It is not only important to inculcate a culture of patient safety in the hospital environment among practicing physicians, it is also important to teach trainees about concepts of patient safety so that they in turn practice these same principles when they are in their respective workplaces. This article briefly serves to focus on areas of patient and medication safety that are critical to the practice of medicine today, with all its complications and information overload, as incorporated into the training program of the internal medicine residency at Saint Vincent Hospital, Worcester.

While patient safety is a vast topic, due to space constraints we aim to focus on some key areas that are of more singular importance and form an integral part of our training curriculum. These could be broadly divided under two heads, medication safety and patient care safety.

Medication Safety

In today’s complex healthcare delivery environment, the number of medications available and administered to patients are ever increasing, be it drugs, intravenous fluids, parenteral nutrition, etc. Thus, as the prescriber of most of these medications, the physician needs not only to know enough about each of these agents, but also to order them in a safe and standardized manner so that the implementation of these orders leads to a safe delivery of these medications to the patient.

Some of the initiatives implemented that are part of our educational program are:

1. Before they begin their formal training, during their week of orientation, a formal medication safety lecture is held where, in collaboration with faculty from the Massachusetts College of Pharmacy and Health Sciences (MCPHS), residents are taught about how to write a prescription correctly, medication errors, schedules of drugs, etc. Further, they are strongly discouraged from using abbreviations, are educated about a list of prohibited abbreviations, are shown examples of real-life situations where errors have occurred as a result of the use of abbreviations, and are taught how to correctly give a telephonic order of a prescription. Such education prior to their starting their training helps reduce the number of potential errors that could occur in the first 2-3 months, when trainees are new on the job.
2. One of our chief residents is a member of the Pharmacy and Therapeutics Committee, where new medication safety programs that are launched are vetted and receive resident input. These include increasing medication adverse event reporting in a non-punitive manner, being a part of a “Medication Error Root Cause Investigation (MERCi)” team that develops systemic improvements to prevent future such occurrences, and developing standard drug order forms that prompt the prescriber to go through a series of preconditions to ensure not only safe and appropriate prescribing,

but also appropriate monitoring of the patient while on the medication.

3. Lectures are given on a monthly basis and address medication safety, high-risk medications, newer agents added to the hospital formulary that require education around their use as well as some basic information around pharmacology. Further, a comprehensive pharmacology resource is available online at every terminal in the hospital as well as externally, which serves as a reference prior to prescription, if needed.

Overall, the education of residents in the culture of medication safety is a dynamic process, constantly updated to reflect the ever-changing needs of today's healthcare environment..

Patient Safety

"Why are we so reluctant to own up to errors in medicine? If we expect perfection, error is humiliating and potentially costly. But expecting perfection is foolish; we must move away from this false and unattainable standard. If we don't accept the inevitability of our own errors and those of everyone on the healthcare team we cannot honestly put patients first. We also risk becoming the villains in the growing "patient safety movement" instead of leaders in it." (Pietro DA et al).

A recent review published in the Annals of Internal Medicine suggests that mortality increases and efficiency decreases in hospitals because of year-end turnover of residents. This is attributed to both the drop in clinical experience of the physicians in the system and a decrease in the number of physicians who are familiar with the clinical system. To mitigate this effect, the incoming interns receive several lectures, at orientation, on the Joint Commission patient safety standards with discussion of common mistakes. They are also introduced to the Institute of Health Improvement's 100,000 Lives Campaign as well as the 5 Million Lives Initiative..

During the course of training, the various causes of errors are discussed and include:

1. Physician Stressors

- Feeling hurried or distracted, usually because other patients were waiting to be seen or because the time of the visit was stressful (e.g., night, weekend, off-duty hours, quitting time) ~ Feeling fatigued
- Being misled by advice or anticipated advice from other physicians
- Avoiding a medical intervention because of its cost

2. Process-of-Care Factors

- Being too focused on one diagnosis or treatment plan
- Not being aggressive enough in diagnosing or treating (e.g., didn't diagnose cancer because of the patient's young age)
- Lacking an adequate follow-up plan
- Not asking advice

3. Patient-Related Factors

- Being misled by a normal or negative history, physical examination, laboratory result, or imaging study, which overshadowed other signs that the patient had a significant illness
- Not responding with aggressive treatment because the patient either underreported symptoms or insisted on an inappropriately conservative treatment
- Having an attitude of dislike or unusual fondness toward the patient that hinders objectivity

4. Physician Characteristics

- Lacking knowledge about the medical aspects of the case because of inexperience
- Having too much pride in his or her own abilities which leads to a wrong decision

(When Good Doctors Err. Steven S)

Residents are taught to successfully identify and report errors within a supportive environment by making sure that everyone in the hospital, including residents, feel empowered to point out errors they feel have jeopardized patient safety. Discussions are held on how to error-proof the system and residents are strongly encouraged to come up with error prevention measures and ideas on how to improve the safety of the system. They are also required to review and present guidelines on standards of care.

Monthly Patient Safety Rounds are held with the residents and medical students during which errors or near-misses are discussed. These cases are identified through the hospital incident-reporting system as well as through self-reporting by the residents. The aim of these sessions is to promote competency-based education as well as to have the residents come up with solutions to systematic and process-related challenges. The residents are also made familiar with Root cause analysis.

We also utilize role-playing amongst other methods to teach the residents how to communicate a medical error to a patient with honesty and empathy, and also discuss methods of how to cope with feelings following a medical error.

"Reforms based on the naming, blaming and shaming of individual practitioners may fail to engage with the 94-98% of physicians who cause the majority of errors, because they do not reflect the collegial culture and working practices of the medical profession. A more theoretically informed and longitudinal approach might be to address the genesis of medical thinking about error through reforms to the aspects of medical education and professional socialization that help to create and perpetuate the existence of avoidable error, and reinforce medical collusion of error. Further changes in the curriculum, to emphasize team work, communication skills, evidence-based practice and strategies for managing uncertainty, are therefore potentially key components in helping tomorrow's doctors to discuss and cope with medical errors and to commit fewer of them." (Lester H and Tritter JQ)

We can only hope to bring about real change in creating a safer environment for our patients to heal in if we first eliminate the shame and blame that has traditionally been associated with medical errors.

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Safety for Life at Saint Vincent Hospital

Patricia Ellis, MPH and Octavio Diaz, MD

At Saint Vincent Hospital we are fully committed to eliminating safety events that cause harm to our patients. The negative impact of patient safety events is significant on many fronts. First and foremost, the result may be serious, permanent, and devastating harm to a patient, his or her family, and the care provider who made an error. The national statistics are frightening: 1 in 7 Medicare patients experience a medical error while at a hospital and the annual cost of caring for patients who have experienced an error is \$4.4 billion.

Safety is our top core value and priority for all stakeholders from our Board of Trustees, leadership team, front line staff, and medical staff. Patient safety doesn't happen by accident. No one of us alone is able to create a safe environment for our patients ~ it takes all of us together as a team. To be effective, our team needs to be focused. We began a journey 2 years ago to help us learn about the errors we've made so that we could purposely plan a strategy to eliminate safety events that result in patient harm. Our steps to a safer hospital include:

1. Learning from our past
2. Aligning and engaging all stakeholders
3. Communicating transparently
4. Identifying best practices
5. Developing safety skills and habits
6. Analyzing errors to improve problem solving
7. Reinforcing new habits
8. Celebrating successes

Learning: Our journey began with a detailed cause analysis of our past safety events. It included:

- Identifying inappropriate actions
- Determining who, where, why and when we make mistakes
- Discovering contributing process problems and system failures which may reach a patient

The reality is that although we are focused on high reliability and standardizing care processes, the literature demonstrates that on any

given day humans make 10-15 mistakes. Some of these have no consequences. Others we catch ourselves and correct before there is a problem. The most concerning are the ones we are never aware of as they may have a negative impact that is often left to chance. The result of this analysis helped us identify our biggest opportunities for improvement so that we could have the biggest impact.

Alignment & Communication: Every stakeholder at Saint Vincent Hospital understands that we have a collective team responsibility to our patients to protect them from harm. Open communication is critical and includes:

- Safety as the first topic of every agenda
- We report daily how many days it has been since our last serious safety event
- We share safety success stories at a daily hospital wide huddle
- We publish Safety Alerts as a means of sharing critical immediate action needed
- We engage our patients and their families as part of our safety team – encouraging them to speak up and to let us know when something is not right.

When a serious safety event occurs, we carefully analyze the situation from the perspective of our patient and share the story of what happened to them with as many stakeholders as possible. We use a “stop the line” approach to immediately assess if any other patients are at risk and take immediate action when necessary.

Best Practices and Developing Skills: we have worked with Health Care Performance Improvement to focus our safety strategies in 2 critical areas:

1. To decrease the number of errors we make
2. To ensure that we have effective barriers in place that will intercept an error before it reaches a patient or colleague.

During the past year, we have been teaching our employees and medical staff twelve safety behaviors and error prevention techniques that have been proven to decrease medical errors. These techniques fall into 4 general categories of Patient, Personal, and Team Safety; Clear and Concise Communication; Having a Questioning Attitude, and Paying Attention to Detail.

Developing Analytical & Problem Solving Skills: You can't fix a problem you don't know about, therefore a critical element of our safety journey is to improve real time reporting of errors, whether they reach a patient or not. In fact our best opportunity to learn and fix problems happens when we hear about a near miss or great catch. We have the chance to identify the root cause and also to learn about (and promote) the successful barrier that caught the error before it reached a patient. Having detailed information about errors provides us with the opportunity to do common cause analyses, which helps us to fix processes and systems. It also shows us that the error prevention techniques are being used.

Reinforcement and Accountability: All leaders play a critical role in helping to coach their teams on the use of the error prevention tools. They accomplish this by:

- Keeping patient safety in the forefront of all communications
- Holding daily safety huddles
- Rounding with staff to provide positive feedback
- Identifying and fixing problems as they occur
- Holding all members of the team accountable to the policies and procedures that govern safe care

Celebrating Successes: Everyone loves a winner, especially when it's one of our patients. We recognize and reward employees who report great catches. We share safety success stories and highlight the successful use of our error prevention tools.

Patient safety only happens when every member of the team is accountable to each other; when each team member understands that we are all vulnerable to make mistakes and therefore need to be vigilant, help each other, correct each other, speak

up when we have concerns, and when in doubt stop all action and figure it out.

Our focus on Patient safety is not an initiative – it's a fundamental, systematic way of providing patient care. We call it Safety for Life because it's mission critical for us and we know there is no end-point. We are committed to continuous learning and implementation of standardized safety practices that will ensure patient safety in a complex health care environment. Our safety journey has been exciting, rewarding, and successful and we've only just begun.

Patricia Ellis, MPH is Vice President of Quality and Patient Safety at Saint Vincent Hospital

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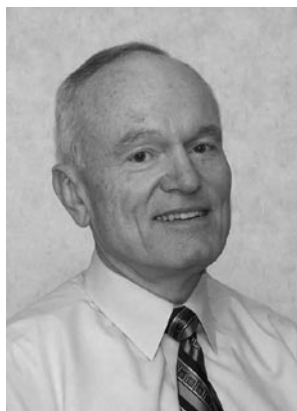
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Patient Safety at Fallon Clinic

Michael Kelleher, MD



Michael Kelleher, MD

Background Information

Fallon Clinic has a long history of dedication to the quality and safety of care delivered to our patients, with particular focus and energy subsequent to the in-house migration of our malpractice insurance coverage in 2003. In concert with the creation of our captive insurance company, we implemented a major upgrade of our state-mandated Patient Care Assessment (PCA) Program, staffing our

new risk management department with four FTEs. At that time, we also formally merged our peer review, quality improvement, and risk management functions, moving to a combined database for all related clinical events.

All of these performance improvement functions were also restructured to report up to our Medical Director for Quality and Patient Safety, helping to ensure tighter integration for these closely-related activities.

This model has proved to be very successful for our organization, which was recognized in 2007 by the American Medical Group Association with its prestigious "Acclaim Award" for patient safety.

The following sections summarize the major tracking/reporting tools and interventions that have substantially improved patient safety at Fallon Clinic over the last seven years, while at the same time promoting a culture of safety and trust, essential for the engagement of our medical staff.

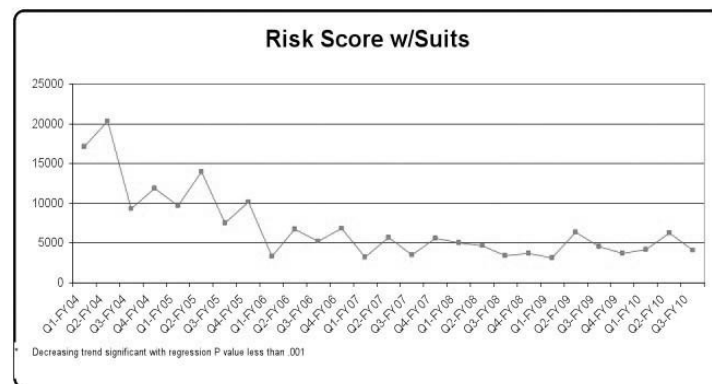
Global Risk Score Tracking

By 2004 we recognized the need for a tracking tool to assess the impact of our interventions across multiple categories of events including patient complaints, minor adverse clinical events, major events, claims, and lawsuits. We performed detailed analysis to de-

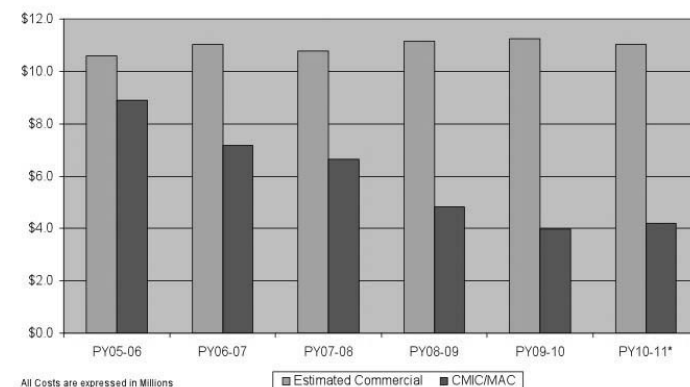
termine the average dollar cost for each of these event categories as determined by our actual experience. For complaints this was challenging, but we were able to determine the likelihood of losing a capitated patient because of a complaint, enabling a reliable estimate of that cost.

Subsequently, we have been able to demonstrate a significant improvement trend for our global risk score, as depicted below. We have also seen a comparable decline in our malpractice premium costs, saving the organization more than \$20 million over the past six years.

Fallon Clinic Malpractice Premium Trend \$2M/\$6M Coverage, \$25M Aggregate Limit



*not including premium rebate for 2011



By 2008 we had sufficient data in our registry to enable reporting of this innovative risk score for our clinical departments and for individual physicians, using 95% confidence intervals to identify outlier performance. This has been a valuable tool for our department chairs to use in monitoring performance in the patient safety category, and we have also incorporated this data into our recredentialing process to ensure that those important decisions are driven by objective data.

System Interventions to Promote Patient Safety

The list which follows summarizes the top 10 interventions that we have launched over the past six years in support of our patient safety goals. The impetus for most of these interventions came from our peer review program, where we invariably identify system drivers as well as individual performance issues when we investigate significant adverse events.

(1) **Clinical Guidelines.** Our clinical guidelines committee has posted more than 30 guidelines on our Intranet, and we have embedded these guidelines as appropriate into our chronic disease management programs and our electronic record decision support systems.

(2) **Anticoagulation Clinic.** Our peer review process identified performance gaps when the management of these patients was delegated to site staff members who had many other duties. Accordingly, we have established a dedicated anticoagulation clinic with nine nurses who have substantially reduced the frequency of adverse events related to this high-risk treatment.

(3) **EMR Decision Support.** Our informatics team has embedded into our EMR Best Practice Alerts for drug monitoring with real-time feedback to clinicians, as well as drug interaction alerts and health maintenance alerts. The system identifies patients who are past their due date for important preventive services, pegged to their age, sex, and chronic medical problems.

(4) **Medication Error Tracking.** Our dedicated Pharm-D works with our P&T Committee to identify medication errors, relaying them to our peer review program for investigation and for planning of system interventions. The Pharm-D also sends out monthly prescriber alerts regarding new interaction warnings and “black box” PDR alerts.

(5) **Chronic Disease Management Programs.** We have internally implemented disease management programs for diabetes, COPD, CHF, and HIV. All these programs incorporate our updated

clinical guidelines and serve to prevent errors of omission, while at the same time engaging patients to be more compliant with their treatment program. We have been able to demonstrate substantially improved quality performance through these programs.

(6) **High-Risk Patient Registries.** We created tracking registries for patients with prior colon polyps and lung nodules to ensure that they are tested at the appropriate follow-up interval. In addition, we have created formal registries for our primary care staff to manage patients with diabetes, hypertension, and hyperlipidemia, as part of our Patient-Centered Medical Home.

(7) **Staff Safety Alert Reporting.** In June of 2010, we implemented an electronic staff safety alert reporting system. This rollout included focus on reporting near misses and patient adverse events, and we did see an increase in reporting of such events following implementation of the tool.

(8) **Patient Safety Related Policies.** We continue to create and update related policies, including our time-out policy for outpatient procedures and, more recently, a policy regarding tracking of “no shows.”

(9) **Specialty Quality Measures.** We have created customized quality measures for each of our 25 specialty divisions. Most of these do focus on patient safety issues such as high-risk drug monitoring for the cardiology, GI, and neurology divisions, and procedure complications for our surgical and GI divisions.

(10) **Narcotic Profiling.** Recognizing the growing risk of overdose and death with high-dose narcotics, we have implemented tracking of narcotic prescribing profiles for our primary care physicians, identifying outliers using 95% confidence intervals for prescriptions per 1000 visits. This program has been effective, initiating appropriate coaching to ensure safer approaches to pain therapy.

We are encouraged by the results to date for our patient safety programs, but realize that much remains to be done to achieve our ambitious goal of defect-free care.

Dr. Michael Kelleher is the Medical Director for Quality and Patient Safety at Fallon Clinic, a multispecialty group practice serving 200,000 patients in Central MA. Prior to his arrival at Fallon Clinic in 1995, he served as Associate Medical Director for the Scott and White Clinic in Texas.

Fall Prevention in Acute Care Hospitals: The Fall TIPS Toolkit

Patricia C. Dykes, DNS, RN, FAAN and Diane L. Carroll, PhD, RN, FAAN



Patricia C. Dykes, DNS, RN, FAAN



Diane L. Carroll, PhD, RN, FAAN

Patient falls and falls with injury are serious and preventable problems in hospitals.^{1, 2} Injuries and death related to patient falls are classified by the National Quality Forum (NQF) as “serious reportable events.” As of October 2008, costs associated with fall-related injuries in US hospitals are no longer reimbursable under Medicare.³ In the state of Massachusetts, nurse-sensitive measures, such as patient falls, are publicly reported and disseminated through the Patient Care Link initiative (www.patientcarelink.org/), a website that aims to establish transparency related to hospital-based care. In the Commonwealth of Massachusetts, 52% of all serious reportable events in hospitals were patient falls, underscoring the significance of the problem for health care organizations.⁴

These startling statistics make it clear that simply being hospitalized places a patient at risk for falls and fall related injury. The unfamiliar environment, acute illness, sur-

gery, bed rest, medications, treatments and the placement of various tubes and catheters are common challenges that place patients at risk. Even when no injury is apparent, a single fall may result in a fear of falling that can begin a downward spiral of reduced mobility, leading to loss of function and further risk for falls.⁵ The majority of published studies are in the area of fall risk assessment. The risk factors associated with patient falls are well established, but until recently,⁶ the linkage between nursing assessment of fall risk status and interventions to prevent falls in hospitalized patients was not established.^{7, 8}

The Fall TIPS study was conducted at Partners HealthCare System (PHS) in eastern Massachusetts from 2007-2009 and funded by the Robert Wood Johnson Foundation. In the first phase of the Fall TIPS study, focus group interviews of professional and paraprofessional caregivers were conducted to explore existing barriers, facilitators and interventions used to prevent falls in hospitals.⁹ In addition, interviews were conducted with patients who had fallen while in the hospital.¹⁰ A content analysis of the resulting transcripts was used to inform system requirements.

The Fall TIPS toolkit leverages existing practices and workflows (e.g., routine nursing fall risk assessment, the use of signs to alert caregivers to fall risk status) and makes use of information technology to decrease barriers to fall prevention. The Fall TIPS toolkit software automatically tailors fall prevention interventions to address patient-specific determinants of risk identified through assessment using the Morse Fall Scale (MFS).^{11, 12} The toolkit is aimed at providing a workflow-friendly solution that overcomes the usual silos associated with communication of fall risk status and fea-



Figure 1: Bed poster tailored to patient-specific determinants of fall risk and associated evidence interventions to prevent falls

sible, evidence-based interventions to prevent patient falls. Using the Fall TIPS toolkit, nurses complete a fall risk assessment scale using the Morse Fall Scale online. The evidence-based toolkit logic automatically selects a core set of interventions directly linked to patient-specific areas of risk. The nurse has the ability to further tailor the interventions based on his/her knowledge of the patient. The nursing assessment data and the associated tailored interventions are then processed by the Fall TIPS software to generate three patient-specific fall prevention tools: a bed poster, a plan of care, and an educational handout for patient and family members. Figure 1 is an example of a tailored bed poster from a patient who is at high risk for falls. Note that in addition to conveying risk status, the bed poster includes actionable alerts related to patient toileting status, assistance required to get the patient out of bed, and patient mental status (e.g., bed alarm is needed).

Use of the Fall TIPS toolkit in acute short stay hospitals is associated with a significant reduction in patient falls in patients over age 64 years.⁶ Older patients on control units were more than twice as likely to fall as those on experimental units where the Fall TIPS toolkit was in place (adjusted rate difference 2.08 [95% CI.61-3.56] per 1000 patient days. While fewer older patients were injured on intervention than control units, this difference was not significant [$p=.66$]).⁶

The next steps for the Fall TIPS research team are to use data mining techniques to refine the Fall TIPS toolkit logic to improve effectiveness across age groups and types of patients. The refined Fall TIPS toolkit will be tested for effectiveness for preventing falls and injurious falls in hospitalized adult patients of all ages. Additional information about the Fall TIPS toolkit and associated resources can be found from the Brigham and Women's Hospital Center for Nursing Excellence (www.brighamandwomens.org/Patients_Visitors/pcs/nursing/nursing/FALLS.aspx) and the Agency for Healthcare Research Quality (www.innovations.ahrq.gov/content.aspx?id=3094) websites.

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Quality Care at UMass Memorial Medical Center: A Culture of Safety

Melissa O'Malley Tuomi, BS, RNC



**Melissa O'Malley
Tuomi, BS, RNC**

Patient safety is hard to “see.” Often measured by adverse events or outcomes measures, when people say they are working to improve safety it may mean several things. Patient safety incorporates much more than simply the principle of nonmaleficence (“First, Do No Harm”). Safe care thrives when everyone can report safety concerns or unanticipated/adverse events without fear of reprimand. We must take what is learned to improve care and help individuals appreciate the value of their

reports, moving from a place of “Tell me what I need to do” to “Let me see what I can do to make this better.” While I have learned a lot about quality and patient

safety in my current role, most of my knowledge about spreading a message of change was learned from nursing.

I have worked at UMassMemorial since I was a student. After working at the bedside for six years, two as a nurse educator, I took a non-clinical position involving my two favorite things: staff development and quality improvement. I struggled to leave direct care, but was excited at the opportunity. Now, as a quality project manager, I see improvement throughout the organization. I also see organizational support for improvement. Departments experiencing successes share them across the organization; departments experiencing challenges tell us what they need and we work to make improvements, incorporating staff and patient suggestions. Every day is an opportunity.

Unfortunately, if staff members never see the bird's-eye view, quality improvement may not feel collaborative. It is a constant struggle to address concerns without making the staff feel as though they have made a mistake or are being told what to do. To guide my practice, I developed some strategies to help make the work of safe care accessible, valuable, and appreciated by all staff.

Make it Clear

Most healthcare professionals didn't learn about improvement in school. While nursing and medical education have evolved, gaps persist in education about quality improvement and the science of safety. Addressing these gaps, the Institute for Healthcare Improvement (IHI) launched the IHI Open School for Health Professions in 2008 (www.ihi.org/offering/IHIOpenSchool/Pages/default.aspx). This program of online courses allows students worldwide to learn collaboratively about quality and process improvement. Recently, the Institute of Medicine (IOM) issued a challenge to nursing schools in the 2010 report “The Future of Nursing: Leading Change, Advancing Health” (<http://thefutureofnursing.org/>) to incorporate inter-professional quality and patient safety training into already-packed curriculums.¹

In order to make quality improvement initiatives successful, we cannot assume understanding of colloquial terms across all staff as technical terms can be very confusing. Consider as the term “SRE.” Serious reportable events (SRE) are the specific classification of “largely preventable, grave errors” also referred to as “never events.”² Some events that are reported, while serious, are not on the SRE list. Without background information, the distinction is impossible to make. In addition to clinical knowledge, a basic knowledge of patient safety and quality improvement processes can be helpful. In the absence of formal training for many staff on these topics, I have learned that it is my job to make sure that I am explicitly clear.

Make it Relevant

In his commentary to the IOM report, Dr. Donald Berwick outlines the importance of nurses' involvement in systems improvement. Quoting health care improvement guru Dr. Paul Batalden, Dr. Berwick retells a comment from a nurse about improvement.

“I see.” said the nurse. “You're saying that I have two jobs: doing my job, and making my job better³.”

This is a huge challenge to nursing staff, but it has never been more important. The expectation is to do more with what you have. It can be hard for staff to see that improvement strategies, some involving cuts, are about eliminating waste and effectively utilizing resources, making room for more. More patient interaction. More teaching. More care.

Adding to the confusion, regulatory and accrediting bodies may have different terminology and, occasionally, different requirements. While they have set standards, the organization determines the processes to meet those standards, considering the regulations. It can be frustrating for clinicians who feel they are being told to change if they cannot see the rationale for the change.

Improvement initiatives involving those directly impacted (as much as possible) are most successful. If changes are made, it is important for staff to know why. Even the most complex change has a basic rationale. If a new process is implemented, I have learned to identify potential consequences of not following the process. An explanation helps achieve collaboration needed to perform safe care.

Identify Champions of Change

I have learned that those with an interest seek opportunities to participate in improvement. As a survival strategy to educate nearly 250 nurses and aides, I utilized all the help I could get. While individuals can make a difference, doing the work of safe care takes an army. Identifying key contacts throughout the organization can make all the difference in promoting the spread of an improvement initiative. Each member of the care team is valued, but individuals who are ready and willing to work on improving quality of care and patient safety can be utilized as key contacts.

Final Thoughts

Blame and fear can erode a safety culture. When unanticipated outcomes occur, everyone handles them differently and some may internalize even the most benign remark. It is critical that we respect each other and learn from our mistakes. We all have the same goal and when blame is introduced and people become defensive, reaching that goal becomes more difficult.

Trust is vital to the work done by nursing. Patients trust that we have their best interests at heart. The organization's leadership feels the same about the work done by the hospital. Sometimes tough decisions must be made, but relationships with patients, staff, and the community are paramount. The best interests of the system, of the community, and of the individual really are considered. At the end of the day, with a focus on improving quality and patient safety, there really is an army doing the work of safe care.

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the gerald f. berlin award

My Beautiful Boy

Noah Rosenberg

The Gerald F Berlin Prize is awarded for an essay, a poem or series of poems, or a work of short fiction. The annual contest is open to UMass medical students, residents, and fellows affiliated with UMass Memorial, Berkshire Medical Center and Worcester Medical Center/St. Vincent Hospital. It is named in honor of Dr. Richard Berlin, a poet and psychiatrist in private practice in Lenox, MA, and an associate professor of psychiatry at the University of Massachusetts Medical School's Berkshire campus in Pittsfield. For additional information about the Berlin Awards and to read previous winning submissions, visit Dr. Berlin's website at www.richardmberlin.com/creative.html.

My Beautiful Boy

Mrs. Mehnde watches him go,
her husband of 62 years.
The doctor kneels in front of her.
"It's time, Mrs. Mehnde."
The physician hates this the most,
these moments
when he must be the voice
of death and not life.
"Have you done all you could?"
A nod.
Their life together
pours from her eyes.

At the foot of his bed,
he no longer looks old.
He is young and beautiful,
the Middle Eastern boy
who shared her life.
What a thing, to share a life,
she thinks and cries harder yet.
The children, the secrets,
the fears, the laughter.
What a thing to ask "remember when?"
and be told not only "yes,"
but spend the entire day
recalling just that moment.

Noah Rosenberg is a third year medical student, class of 2012

The Affordable Care Act — The Battle is Joined

Vincent F. O'Rourke, Jr., Esq. and Peter J. Martin, Esq.



Peter Martin, Esq.

Although the Patient Protection and Affordable Care Act (PPACA) does not become effective until January 1, 2014, there have been numerous challenges to its constitutionality in Federal Courts across the country. On June 29, 2011, a divided panel of the Sixth Circuit Court of Appeals issued its opinion in *Thomas More Law Center, et al v. Barack Hussein Obama, et al*, rejecting claims that the mini-

imum coverage provision of the Act (the "Individual Mandate") is unconstitutional because it exceeds Congress's powers under the Commerce Clause.¹ On August 12, 2011, a divided panel of the Eleventh Circuit Court of Appeals issued its opinion in *State of Florida, et al v. U.S. Department of Health and Human Services, et al* addressing the claims of 26 States' Attorneys General, and affirmed a lower court ruling that the Individual Mandate exceeded Congress' powers under the Commerce Clause but reversed the lower court's ruling finding the entire Health Care legislation unconstitutional.

The stage is now set for a Supreme Court decision on the PPACA's Individual Mandate. It appears clear from the two Court of Appeals decisions that critical to the Supreme Court's analysis will be how to describe the Individual Mandate ~ as a regulation of economic decisions regarding the consumption of health care services, with substantial effects on interstate commerce, or as a means of coercing participation in the health insurance market to support a larger regulatory scheme. The anticipated Supreme Court resolution of this conflict may be a classic case of dissolving a problem by re-framing it ~ with potentially epic consequences for the federal government's regulation of the marketplace.

The Sixth Circuit Opinion

The Individual Mandate requires most citizens to obtain "minimum essential coverage" for themselves and their families if financially able to do so. The Sixth Circuit majority opinion addressed the

question whether the Individual Mandate is consistent with the Commerce Clause of the United States Constitution. The majority recognized that the Individual Mandate, "like all Congressional enactments, is entitled to a presumption of constitutionality and will be invalidated only upon a plain showing that Congress has exceeded its Constitutional bounds" and reviewed the precedents defining Congress's power "to regulate activities that substantially affect interstate commerce, [and] even non-economic intrastate activity if doing so is essential to a larger scheme that regulates economic activity." In a 2-1 decision, the Sixth Circuit found that the Individual Mandate was constitutionally authorized by the Commerce Clause because: (1) it regulates economic decisions regarding how to pay for health care that have substantial affects on the interstate health care market, and (2) it is essential to PPACA's larger regulation of the interstate market for health insurance.

The majority rejected the plaintiffs' argument that the Individual Mandate regulated activities that are beyond the power of Congress to regulate because it deprives the plaintiffs of their right to in effect self-insure by making an assessment of their own risk and to make an individual determination as to what extent they must set aside funds or arrange their affairs to compensate for probable future health care needs. The majority rejected this challenge to Congress' power under the Commerce Clause claims for two independent reasons. First, the Individual Mandate regulates economic activity that Congress had a rational basis to believe has substantial effects on interstate commerce. Second, Congress had a rational basis to believe that the Individual Mandate was essential to its larger economic scheme reforming the interstate markets in health care and health insurance.

The majority noted that it is well established that "Congress may regulate economic activity, even if wholly intrastate, that substantially affects interstate commerce," and held that the Individual Mandate regulates activity that is "decidedly economic." In mandating that individuals maintain a certain level of coverage, "the minimum coverage provision regulates the financing of health care services and specifically the practice of self-insuring for the cost of care." The majority held that self-insurance is economic activity

because the “activity of foregoing health insurance and attempting to cover the cost of health care needs by self-insuring is no less economic than...purchasing an insurance plan. Thus...the practice of self-insuring is economic activity” and within the reach of the Commerce Clause.

The majority reviewed the legislative history of PPACA and determined that Congress had a rational basis to believe that the practice of self-insuring for the cost of health care in the aggregate substantially affects interstate commerce. In doing so, the majority recognized that nearly everyone requires health care services at some point, but unlike nearly all other industries, the health care market is governed by Federal and State laws requiring institutions to provide services regardless of a patient’s ability to pay. In his concurring opinion, Judge Sutton noted that the uninsured consume over \$1 billion in health care services annually and that Congress determined that the cost of uncompensated care is passed on from providers “to private insurers which pass on the cost to families” and that this cost shifting “inflates the premiums a family must pay for health insurance by on average over \$1,000 a year.” Thus, the majority concluded, the Individual Mandate is a valid exercise of the Commerce power because the legislative record established that Congress had a rational basis for concluding that the practice of self-insuring for the cost of health care substantially affects interstate commerce by driving up the cost of health care and by shifting the cost to third parties.

After reviewing the legislative history of the Individual Mandate, the majority further found that Congress had a rational basis for concluding that leaving those individuals who self-insure for health care outside Federal control would undercut Congress’ underlying economic regulatory scheme. Congress had found that in the absence of the Individual Mandate, PPACA’s other provisions on guaranteed issue and community rating would increase existing incentives for individuals to delay purchasing health insurance until they actually require care. The legislative record before Congress demonstrated that the seven states that had enacted guaranteed issue reforms without minimum coverage provisions encountered escalating costs and insurance companies exiting the market. In contrast, Congress had found that in Massachusetts, a minimum coverage requirement strengthened private employer based coverage and that despite the economic downturn, the number of workers offered employer based coverage actually increased. Relying in part on these Congressional findings, the majority concluded that Congress had a rational basis for concluding that the Individual Mandate is essential to a broader reform of the national markets for health care delivery and health insurance and is a valid exercise of Congress’ power under the Commerce Clause.

Finally, the majority rejected the argument that Congress did not have the constitutional authority to regulate “inactivity” ~ that is, the failure to purchase insurance. The majority re-characterized this alleged “inactivity” as the practice of self-insuring for the cost of health care. It held that “Congress had a rational basis for concluding that the practice of self-insuring for the cost of health care has a substantial effect on interstate commerce and that the minimum coverage provision is an essential part of a broader economic regulatory scheme. Thus, the [Individual Mandate] is constitutional notwithstanding the fact that it could be labeled as regulating inactivity.” Moreover, the statute could not properly be classified as regulating inactivity as “virtually everyone will need health care services at some point, including in the aggregate those without health insurance.”

Senior District Judge James Graham (sitting by designation) dissented from the majority’s holding that the Provision is authorized by Congress’ power under the Commerce Clause. In his view, the provision “does not regulate the commercial activity of obtaining health care. It regulated the status of being uninsured” and is not within Congress’ power under the Commerce Clause. Relying on *United States v. Lopez*², which struck down a federal statute establishing gun-free school zones because the statute had an insufficient nexus to interstate commerce, Judge Graham dissented because the challengers had not bought or sold a good or service and were “strangers to the health insurance market,” and in his view their conduct in not purchasing health insurance does not affect interstate commerce.

The Eleventh Circuit Opinion

The Eleventh Circuit panel issued a lengthy divided opinion in which the majority ruled that the Individual Mandate violated the Commerce Clause. The majority conducted a lengthy exegesis of Supreme Court Commerce Clause precedent. Relying on principles articulated in the decisions in *United States v. Lopez* and *United States v. Morrison*³, which struck down a portion of the Violence Against Women Act of 1994, the Court concluded that the Individual Mandate was both an over-expansive and an over-inclusive exercise of Congress’ powers under the Commerce Clause.

In so holding, the majority ruled that the Individual Mandate impinged upon areas of traditional state concern and exceeded powers of Congress established by the Commerce Clause. The Court observed that Congress had exceeded its powers because the Act improperly “applied across-the-board without regard to whether the regulated individuals receive, or have ever received, uncompensated care ~ or indeed, seek any care at all, either now or in the future” and that “[a]lthough health care consumption is pervasive...

participation in the market for health care is far less inevitable than participation in markets for basic necessities like food or clothing.” The Eleventh Circuit majority also disagreed with and rejected the argument that the Individual Mandate was a valid exercise of the power to tax, ruling that it was a civil regulatory penalty and not a permissible tax.

The majority explicitly rejected the description of the Individual Mandate as a regulation of an individual’s decision on how to pay for the consumption of health care, with its attendant cost-shifting effects on the interstate market for health care services. Instead, the Eleventh Circuit majority described the Individual Mandate as dealing with an individual’s decision to forego health insurance. As such, the Individual Mandate lacks any limiting principle to its application of Commerce Clause power, since a similar rationale could apply to decisions to forego life, disability, liability and other types of insurance. “Properly formulated, we perceive the question before us to be whether the federal government can issue a mandate that Americans purchase and maintain health insurance from a private company for the entirety of their lives. . . . Under this theory, because Americans have money to spend and must inevitably make decisions on where to spend it, the Commerce Clause gives Congress the power to direct and compel an individual’s spending in order to further its overarching regulatory goals”

The majority also described the Individual Mandate as an unprecedented “economic mandate” forcing individuals to enter a market they might otherwise avoid, through choosing to self-pay for health care. The majority contrasted the Individual Mandate with the National Flood Insurance Act of 1968 which does not include a personal mandate to purchase insurance, even though persons who purchase homes in flood plains face the inevitability of flooding and their failure to purchase insurance results in cost-shifting through seeking disaster relief funds. The inevitability of an individual’s use of health care and the cost-shifting resulting from delivery of health care to the uninsured are characteristics of the health care marketplace cited by Congress to justify the Individual Mandate. The majority cited other “individual mandates” such as jury duty, registration for the draft, and the filing of tax returns, and noted that in each case the mandate involved an individual’s dealings with the government. In contrast, the Individual Mandate is unprecedented in that it requires an individual to engage in a commercial transaction with a private insurance company.

Finally, the majority reversed the lower court insofar as it had ruled the entire PPACA unconstitutional. The majority ruled that there were hundreds of other sections of PPACA, such as the guaranteed issue and ban on pre-existing conditions provisions, which were

totally separate from the Individual Mandate and were within the enumerated powers of Congress.

Circuit Judge Marcus joined in the majority opinion to the extent it reversed the lower court’s holding that the entire PPACA was unconstitutional. However, he dissented from the majority’s ruling that the Individual Mandate was unconstitutional. He found, based on numerous Commerce Clause decisions over the last several years, that the Individual Mandate was authorized by the Commerce Clause because it was enacted as part of an extensive program regulating health care and insurance, areas already heavily regulated by Congress and was proper under the Necessary and Proper Clause because it furthered the regulatory aspects of PPACA’s insurance reform.

How will the Supreme Court view the Individual Mandate? Will the Supreme Court regard it as an essential part of a regulatory scheme of an industry representing nearly a fifth of the American economy that Congress could rationally adopt under its constitutionally enumerated power over interstate commerce? Or will it characterize it as an unconstitutional attempt to mandate an individual’s participation in a market that damages principles of federalism and asserts a general police power reserved by the Constitution to the states? A choice by the Supreme Courts to strike down the Individual Mandate could radically change not only the fate of PPACA, but also the course of nearly seventy years of Commerce Clause jurisprudence.

(Footnotes)

¹ On July 26, 2011, the plaintiffs filed a petition for certiorari in the United States Supreme Court seeking review of the Sixth Circuit’s decision. In their Petition, the plaintiffs strenuously argue that the Commerce Clause does not give Congress the power to regulate economic inactivity. In light of the Eleventh Circuit decision discussed below which creates a split in the Circuits by finding the Individual Mandate unconstitutional, it is very likely that the Supreme Court will accept this case for review sometime in early 2012.

² 514 U.S. 549 (1995)

³ 529 U.S. 528 (2000)

Peter J. Martin, Esquire, is a partner in the Worcester office of Bowditch & Dewey, LLP, whose practice concentrates on health care and non-profit law.

Vincent F. O’Rourke, Jr. is a Partner in and General Counsel of the firm of Bowditch & Dewey. He is a member of the Massachusetts and United States Supreme Court Bars and specializes in trial and appellate litigation.

“Playing By the Rules”

Michael Hirsh, MD



Michael Hirsh, MD

Modern day medicine as practiced today is a complex ballet that involves the interaction of patient, pathophysiology, the medical team, the hospital infrastructure and the third party payor. As a practicing pediatric trauma surgeon, I participate in this dance on a daily basis, and I wish I could say that the medical system comes off like the Bolshoi. More often than not, we appear to be stumblebums rather

than “Dancing with the Stars” material. Let me give you a recent example.

Central MA recently hosted a state baseball tournament. A team from out of town came to participate. In the course of a few days, this team of out of town teens saw themselves getting thrown at, cleated, and bullied by local teams from Central MA. This infuriated their coaches. Then, in an ultimate act of unsportsmanlike conduct, a local team’s base-runner who was going to be easily thrown out at home during a game chose to bowl over the defenseless catcher of the visiting team, a la Pete Rose vs. Ray Fosse in the infamous play from the 1970 All-Star game. The runner was out, but the poor catcher sustained a serious blunt liver injury requiring transfer to our trauma center.

The catcher was fortunate ~ his injury responded to non-operative management and he stabilized in about 24 hours. At that point, realizing that the patient was over an hour away from home and that he and his poor coach/dad were experiencing the hardship of being away from both home and their team, I attempted to have the patient transferred to a level 2 pediatric trauma center near their home. The transfer was accepted by the pediatric trauma surgeon and the pediatric intensivist, and all seemed to be in order.

But enter another precinct that as of yet had not been heard from ~ the insurance company. Request for transfer denied; this request was considered to be only for the patient’s convenience and not out of medical necessity. The ambulance transfer would not be covered.

The admit to the other facility was also going to lead to an extra level 1 day, whereas subsequent inpatient days at my hospital would all be level 2. Therefore, the facility to our west could no longer accept the patient unless the patient’s family assumed those costs. I was incensed that the medical providers could be overruled, but not surprised. It happens all too frequently these days.

So I went to the court of last resort ~ I called the medical director of the insurance company to express my disagreement and plead my case for transfer. I spoke to the physician, who very calmly reiterated the gobbledygook that our discharge planner had previously explained to me. “Of course, you understand how our company would have a responsibility in representing an insurance product for the commonwealth of MA that we must protect against an outlay of funds only for the convenience of the parent.”

I did not respond impolitely, only firmly. I said, “In this case the convenience of the family was a big part of the patient’s ability to heal. With friends and family around him, who is to say that this patient’s healing wouldn’t be accelerated. Instead, he has to watch his dad fret over the work absence and being far from home. So convenience in this case might be the exact correct medical move for us all to make.”

The physician reviewer wasn’t buying this and reiterated her stance that this was for the good of the Commonwealth. I respectfully said that one of the least pleasant things about dealing with MDs who do insurance work is that they spend their day justifying rules that are arbitrary, capricious and work against the patient ~ exactly the opposite of practitioners of medical science who follow biologic laws and work FOR the patient at all times. So I explained my position and also added my intent to report this episode to the Board of Insurance. The reviewer said she regretted I felt this way. I said I regretted that no one from the insurer would tell the father directly of the rationale behind their decision. The reviewer said she would make sure that explanation did occur.


So, dejectedly, I went back to the patient’s room to explain the outcome. To my great pleasure, both the patient and the father

expressed their willingness to stay in Worcester and thanked me for my advocacy. Just then, the door of the room opened and in strode the rest of the patient's baseball team. They were still in uniform and had come straight from the field to tell the patient they had won the state championship and to bring him the game ball.

The moral of the story is that if your team is good and you play by the rules in baseball, your team will usually prevail. In medicine, if your team is good and you play by the rules, your patients will generally thrive. If you are an insurance company, your rules are not valid and your motives are profit driven, so the only ones who thrive are the stockholders, NOT the stakeholders (patients, families, medical teams). Such is life in medicine, circa 2011.

I am submitting this frustrating tale to stimulate our readers' thoughts and comments. Must physicians accede to this construct without so much as a whimper of protest? Please send your thoughts and comments to me at hirshman54@gmail.com and perhaps together we will come up with the correct type of grievance process to pursue this type of issue.

Thanks for listening.
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Professionalism and the Internet Curriculum at UMass

Sheldon Benjamin, MD

The pace of emerging Internet technologies has exceeded by far the speed with which medicine has been able to evolve principles, boundaries and guidelines for their ethical use. Medical educators in the age of Web 2.0 must create ways of helping trainees understand the ethical and boundary issues raised by new technologies and help them consider the challenges posed to existing values. In 2010, the American Association of Directors of Psychiatry Residency Training (AADPRT) created a taskforce² to review available educational resources and create a curriculum to help psychiatry trainees anticipate the various professionalism issues that arise as physicians develop an online presence. The curriculum is being edited for use by general physicians as well.

It has become commonplace to read in the news media of the damage that can be caused by failing to consider the boundary and ethics issues raised by on-line behavior. In a recent extreme case, Rutgers University freshman Tyler Clementi committed suicide after his roommate posted online a clandestine video of Tyler's private sexual behavior. While such cases may not seem to apply to medicine, there have now been many cases of healthcare professionals being disciplined for posting identifiable patient information on social media sites. Earlier this year, the Rhode Island Board of Medical Licensure and Discipline reprimanded and fined a physician who posted on her Facebook page what she believed to be unidentifiable patient information relating to her emergency room experiences. Despite what she felt was adequate anonymity, it was possible to deduce the identity of the patient from her description of the injuries and knowledge of where the physician worked.

The current generation of trainees, who grew up treating the Internet as an appliance, may need help in considering their online personas as they transition to professional roles. Since 2009, for example, new UMass Psychiatry interns have been asked during orientation to consider the implications of physicians utilizing social media, posting identifiable photos, blogging, participating in online dating sites, etc. Rather than issuing guidelines that forbid the use of these sites, we have asked these newly minted physicians to think aloud together about the ethical and boundary issues that could arise in the routine use of these technologies. The discussions allow them to consider the ramifications for their professional identities of decisions they make in posting various types of information. In most cases, residents say they had not thought of it quite this way before and the discussion helped them consider how they want to shape their online professional identi-

ties. Many decide to maintain completely separate online professional and personal identities. Others decide to avoid certain types of online technology altogether. Inevitably, some will say that they've already set their privacy preferences to protect their information. Others will counter that Facebook's default settings favor public access and it's easy to miss a privacy setting. Animated discussion of "what-if" scenarios typically follows. A 2008 study showing that only 37.5% of 813 University of Florida medical students and residents had opted to make their personal social networking pages private³ lends support to the notion that medical trainees may not adequately consider online professional boundary issues.

The AADPRT curriculum, also being implemented in the UMass Psychiatry Program, utilizes 36 vignettes as stimuli for discussion of issues related to physician online behavior, online professional liability, mandated reporting requirements, slander, "netiquette," conflict of interest, academic honesty, confidentiality, psychotherapy, and remediation for professionalism breaches. Discussion points and key references are provided.

It is time for physicians to become more aware of the ramifications of their online behavior and for medical schools and residency training programs to include this in their curricula.

References:

1. *Web 2.0 refers to the evolution of the internet from a mode of accessing static information stored on servers around the world to an interactive system involving information sharing, collaboration, interoperability (across platforms), and user-centered design.*
2. *The author was president of AADPRT in 2010-2011 and both commissioned and served on the AADPRT Taskforce on Professionalism and the Internet.*
3. *J Gen Intern Med. 2008 July; 23(7): 954-957*

Dr. Benjamin is Professor of Psychiatry and Neurology and Vice Chair for Education in Psychiatry at UMass Medical School. He can be reached at Sheldon.benjamin@umassmed.edu.

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Cutting for Stone

by Abraham Verghese

Sidney P. Kadish, MD

Even the title *Cutting for Stone* is loaded with meaning. The words are familiar, because they appear in the Hippocratic Oath. But in order to deliver the identical and conjoined twins, sons of the surgeon Thomas Stone, from the uterus of the pregnant Indian Sister Mary Praise Joseph, a caesarian section must be performed. The setting for this drama, which intensely grips the reader for the first third of the book, is a small hospital on the outskirts of Addis Ababa, Ethiopia, called the Missing (read Mission) Hospital. The story of the extracted and separated twins is narrated by Marion, the first,

and relates the growth and development of the boys, the daily vicissitudes in the hospital, and the political ebb and flow of Ethiopia in the 1950s and 1960s.

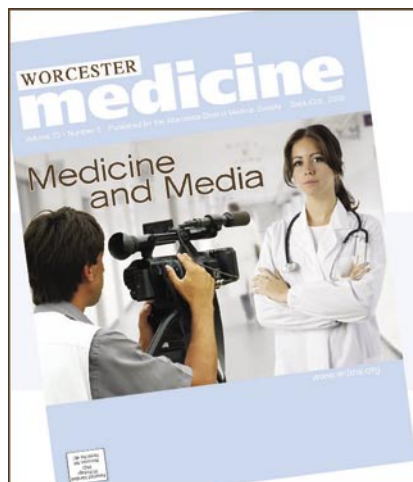
This book has a strong medical, nay surgical flavor, but it has remained at the top of the New York Times best seller charts for over a year, a testimony to the universal appeal of the story. Author Verghese is a Professor and Senior Associate Chair for the Theory and Practice of Medicine at Stanford University and thus has a rich medical background, but he is also a brilliant novelist. I found the

book hard to put down as the narrative flows from the initial excitement in the Labor & Delivery Room at the Missing Hospital to surgical training and practice for Marion at an obscure but busy hospital in Brooklyn, Our Lady of Perpetual Succor.

One can summarize the plot as an exercise in fixing up what was broken: limbs, family ties, trusting relationships. Of course, that is what doctors do on a daily basis. Yet the exotic characters and locations, the fast-paced action of the story line, and the sheer joy one feels in reading this uplifting and illuminating story explains the great popularity of this book.

In short, this is a MUST READ for anyone engaged in the healing process. And although we may see healing as our exclusive province, the story illustrates how healing is a unique and universal human exercise.

Sidney P. Kadish, MD is Professor and Clinical Director, Department of Radiation Oncology, University of Massachusetts Medical Center.



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Tinkers By Paul Harding

Harvey Fenigsohn

Another Pulitzer Prize Winner at the Medical School

On May 18, at the University of Massachusetts Medical School, Pulitzer Prize winning author Paul Harding addressed an audience of students, staff, and visitors. The writer's appearance was sponsored by the Worcester District Medical Society and the Humanities in Medicine committee of the Lamar Soutter Library at the Medical School. A graduate of the University of Massachusetts at Amherst and until recently a writing teacher at Harvard University, Harding in 2010 won a Guggenheim fellowship and the Pulitzer for Fiction for *Tinkers*, his first novel.

The book takes place during the final eight days in the life of one of the tinkers of the novel, George Washington Crosby. Lying on his death bed, the old man vividly recalls his boyhood years with his family in the wilds of Maine early in the twentieth century. In flashbacks, George remembers his epileptic father, Howard Crosby, a dry goods salesman and a tinker who struggled to provide for his wife and children. Like the family in the novel, three generations of Harding's own New England family lived a hardscrabble life in the same dark woods as the setting of the novel, and like George's father, the author's great grandfather also suffered from epilepsy.

Today, epilepsy is considered a neurological disorder rather than a form of mental illness, but in the time period of the story, a desperate wife might conclude that her epileptic husband would be better off in a mental asylum. When Harding's great grandfather discovered his wife's plans to institutionalize him, he fled his family, as does his fictional counterpart, Howard Crosby. On the last day of George's life, after remembering his father's suffering, the son forgives his father for his desertion, and both are redeemed by the transformative power of love.

Reading aloud a passage depicting the shocking effects of Howard's epileptic convulsions, the author explained that he deliberately chose not to research the medical aspects of the disorder, avoiding too clinical an account, but also not sentimentalizing or romanticiz-

ing the illness. Untreated, Howard endured unpredictable seizures, and Harding's striking metaphor reveals the intensity of these attacks: "During his seizures ...his brain nearly fried in his skull." Harding's depiction of the seizures and his account of how the public once viewed epilepsy particularly resonated with the Medical School audience.

A virtuoso of style, Harding has a poet's gift for figurative language. He can evoke images of "splitting frozen wood so brittle it rang when you split it" and "the heartbreak of a cold sun." He describes wind "like the murmur of old men muttering" and a hermit "attended by a small but avid swarm of flies," selecting just the right details to change fact into fiction.

Harding noted that his work initially garnered only rejection letters from major publishers. The manuscript lay dormant in his desk drawer for three years until lesser known Bellevue Press recognized its merits. Rarely does a writer's first novel earn the Pulitzer Prize for Fiction, but this stylistic tour de force proved an exception. Following last year's appearance by Tracy Kidder, Paul Harding is the second Pulitzer winner to speak at the spring program jointly sponsored by the Humanities in Medicine committee and the Worcester District Medical Society.

Harvey Fenigsohn writes book reviews for the Humanities in Medicine website at the University of Massachusetts Medical School Library. His review of Tinkers is available at http://library.umassmed.edu/humanities_med/past_book_reviews.cfm. He can be reached at harvey.fenigsohn@umassmed.edu.

WDMS Remembers Its Colleagues

George E. Deering, Jr., MD 1917-2010

George E. Deering, Jr., MD died on December 6, 2010. He was a pioneer educator and clinician in the field of mental health. His contributions as a psychiatrist and physician role model in Worcester and beyond spanned over two generations.

Dr. Deering, born in Worcester, was a graduate of North High School and Clark University. After receiving his MD degree from Harvard Medical School in 1943, he began residency training in Internal Medicine at Worcester City Hospital followed by second residency program in Psychiatry at Worcester State Hospital. Both Worcester institutions were noted for their excellent post graduate programs. Dr. Deering then entered the US Army Medical Corps. and served in the Korean War. Following military discharge, he returned to Worcester to practice psychiatry with a special focus in alcoholism and addiction. He and the late Dr. James M. Morrison established the St. Vincent Hospital out-patient Clinic and in-patient treatment center for alcoholism. Their outreach led to the founding of the Worcester County Council on Alcoholism serving as a model for similar addictive disorders.

Dr. Deering was a founder of Faith House Recovery Home for Women (the third such institution for women in the country). He was an innovator who stressed prevention. Dr. Deering spoke widely to lay and professional assemblies and wrote extensively in general readership publications including Time Magazine and the AA Grapevine. Of special note was his travelling theater group, "Theater Six," which performed before high school and college populations and other adult audiences. His assemblies were ahead of their time and well beyond his primary clinical responsibilities. They reflected Dr. Deering's recognition for the need to inform the populace of the hazards of high risk behavior.

Dr. Deering was a member for over fifty years of the Worcester District Medical Society, the Massachusetts Medical Society and the American Psychiatric Association. He also was a member of the General Society of Mayflower Descendants.

Dr. Deering loved Worcester and Worcester loved him. His family of three children, two stepsons, eleven grandchildren and three great grandchildren stand very tall on the shoulders of a devoted physician who exemplified his ethical obligations by practicing compassionate and competent counsel and treatment for his patients and also worked for an improved community and the betterment of the public's health.

Leonard J. Morse, MD

Lucille Doris Pohley, MD 1946-2011

Dr. Lucille Pohley passed away in her sleep on Sunday, January 16, 2011. She is survived by her husband of 40 years, Dr. Paul Levine, two god-daughters, and her brother.

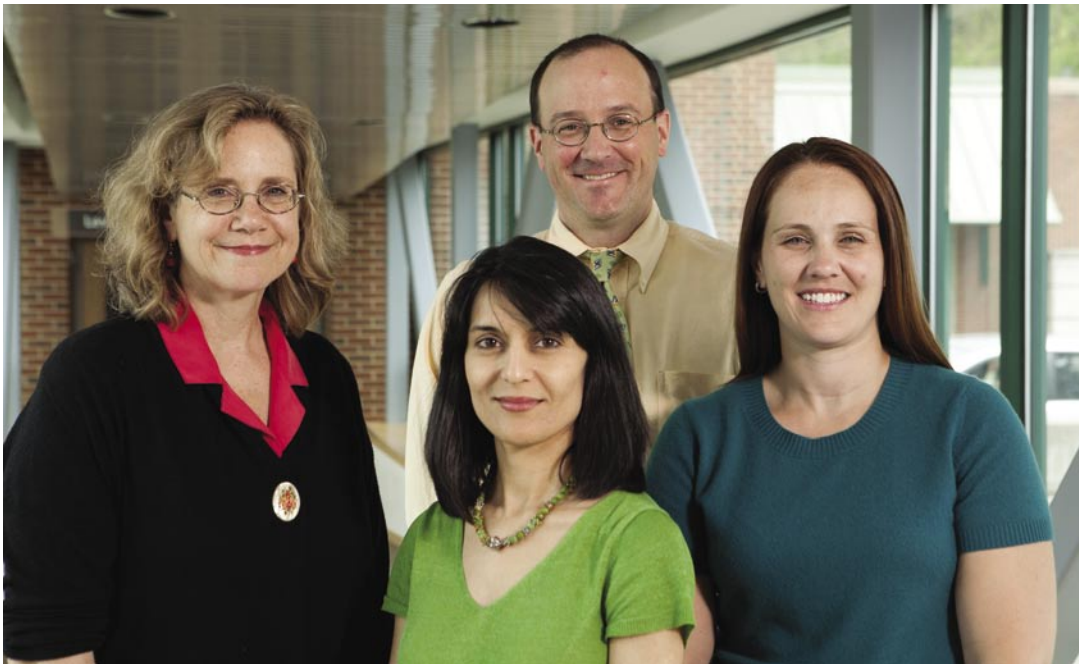
Dr. Pohley began her professional career as a physical therapist. Despite the enthusiasm and skill that led her to graduate first in her class at Ithaca College, Lucille looked at the challenges of Medicine, and with Paul's encouragement, moved on to Georgetown University School of Medicine, where she graduated with honors.

I met Lucille on July 1, 1974, the first day of our internship at St. Vincent Hospital, and the start of a co-working relationship that can only take place during the unique years of residency training. During those three years, my colleagues and I continually marveled at Lucille's dedication to her patients, the staff, the institution, and us ~ she devoted what seemed like endless energy to all of us. Aside from her medical skills, her mothering instinct was truly legendary. After her overnight calls, which rarely included any sleep, on the next morning's intake rounds she would characteristically tell us details about the medical and social histories of our own patients that even we had not known. If we had to dodge a gurney flying down the ward carrying a patient in extremis, IV poles swinging precariously, we knew that behind the panting nurses it would be Lucille pushing from behind, sometimes wheezing, but always at full throttle. On the wards, if a unit secretary stepped away from her post, Lucille would be answering the phones.

Lucille's passion for taking care of every aspect of her patients' needs continued without pause following her training. After ten years of group practice with the eminent physicians Morse, Bessette, and Kocot, she moved to Los Angeles, where Paul was to continue his complex and innovative work on pacemakers. Regretfully, I lost touch with her at that point, but Paul and others have related to me that, not surprisingly, her mission and her practice style remained steadfast, as did her devotion to family, friends, and community. It was also there that she left us terribly prematurely.

Even after more than twenty years of practice in California, Lucille had made it clear that Worcester was her home. Our memories of her compassion and dedication will now remain here with us.

Joel Popkin, MD



Meet our growing team (pictured from left): Katharine O'Dell, NP, PhD, Joy Saini, MD, Michael Flynn, MD, and Danielle Patterson, MD.

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