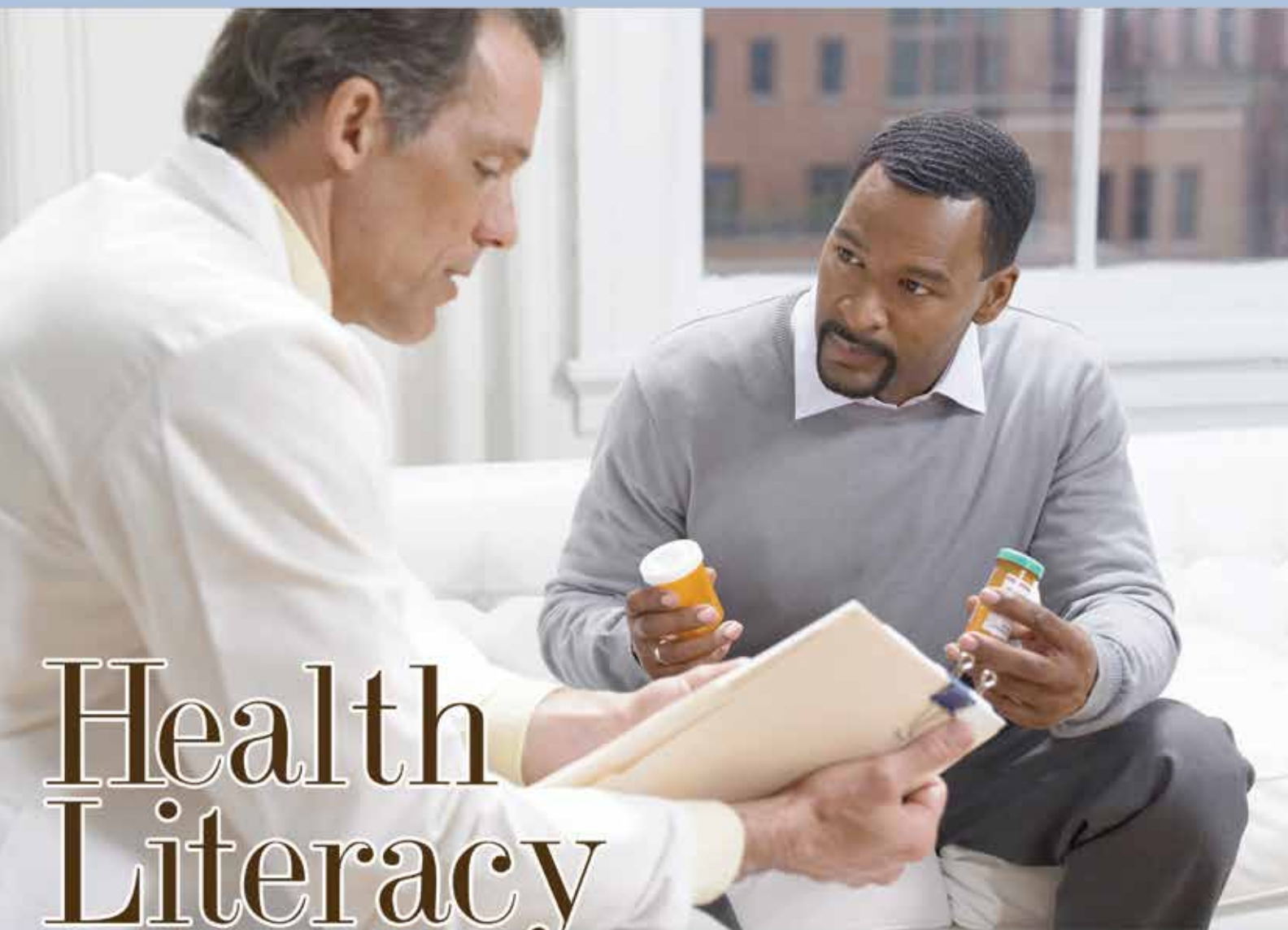


WORCESTER medicine

Volume 77 • Number 1 Published by the Worcester District Medical Society Jan./Feb. 2013



Health Literacy

www.wdms.org

Presorted Standard
US Postage
PAID
Worcester, MA
Permit No. 467



Delivers Hope



Our cancer care is designated as high performing in the Worcester region by *U.S. News* best Hospitals

The UMass Memorial Health Care Cancer Center of Excellence delivers hope ...

- ... Through research and clinical trials
- ... Through a multidisciplinary team approach where doctors, researchers and staff discuss each cancer patient
- ... Through a system of care provided at UMass Memorial hospitals throughout Central Massachusetts



Scan the QR code to learn more about cancer care.
Call: 866-597-HOPE (4673)
www.umassmemorial.org/cancer

Cancer
CENTER OF EXCELLENCE





academics

arts

athletics

technology



Educating college-bound students Pre-K through Grade 12

Bancroft students discover themselves as leaders, learners, and global citizens, developing the skills to succeed in the world's top colleges and beyond.

Learn More
admission@bancroftschool.org
508.854.9227



**BANCROFT
SCHOOL**

Lower, Middle, & Upper Schools

110 Shore Drive
Worcester, MA 01605
508.854.9227
www.bancroftschool.org



Jane Lochrie, MD

Health literacy is defined in the Institute of Medicine report as "...the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions." Health literacy is not simply the ability to read. It requires a complex group of reading, listening, analytical, and decision-making skills, and the ability to apply these skills to health situations. This issue of *Worcester Medicine* looks at different perspectives of health literacy.

In the first article, Drs. Kathleen Mazor and Sarah Cutrona look at health literacy in the elderly. The physician is often the most important source of information for the geriatric population. Spoken health literacy has not received the attention that written literacy has been given. Even patients who have English as their native language struggle to comprehend what the physician is telling them, especially if the news is not good. They have some wonderful suggestions to improve health literacy. Be sure to read this article to the very end.

Dr. Katherine Barnard gives the viewpoint from a primary care physician caring for the underserved population. Unfortunately, these patients have poor health care literacy and studies have shown worse health care outcomes for this population. They are more likely to be admitted to the hospital and have longer lengths of stay. They are more likely to miss appointments, confuse their medications, and not comply with their plan of care.

The nursing perspective is provided by Dr. Nancy Morris. She points out that studies have shown that almost one third of the adult population do not have the skills to cope with their health care requirements. The populations at risk for limited health care literacy are often the patients in the most need of health care.

The pharmacist plays a critical role in educating patients regarding their medications. Dr. Monina Lahoz reports that the prescription label is often the only source of information that patients receive on how to take their medication. She reports that a study suggests that only twelve percent of the U.S. adult population has the proficiency to determine what time to take their medication based on reading the label on their prescription bottle.

Dr. Robert Sorrenti invites us to enjoy this year's creative writing contest winners. Please take a moment to enjoy the two poems and one memoir contributed by our colleagues.

Now that the election is over, "As I See It" received contributions from Drs. Leonard Morse and Jay Broadhurst with their thoughts on the narrow defeat of physician-assisted suicide and the overwhelming ratification of medical marijuana. Dr. Joel Popkin surveyed multinational professionals regarding their opinion and the opinion of their country's citizens on medical marijuana.

Worcester Medicine is published by the Worcester District Medical Society
321 Main Street, Worcester, MA 01608
e-mail: wdms@massmed.org
web: www.wdms.org
phone: 508.753.1579

WDMS Officers

President: Michael Hirsh
Vice President: Peter Lindblad
Secretary: Dennis Dimitri
Treasurer: Robert Lebow

Joyce Cariglia, Executive Director
Melissa Boucher, Administrative Assistant
Francine Vakil, WDMS Alliance

WDMS Editorial Board

Jane Lochrie, MD, Editor
Lisa Beittel, MBA
Anthony Esposito, MD
Michael Hirsh, MD
Anne Kane, RN, PhD
Peter Lindblad, MD
Michael Malloy, PharmD
Thoru Pederson, PhD
Joel Popkin, MD
Robert Sorrenti, MD
Peter Zacharia, MD
Emily Tsanotelis, Student Representative



Publishing, Design, Event Planning, & Web Development

Production and advertising sales by Pagio Inc.
88 Winter St., Worcester, MA 01604
508.756.5006

Paul Giorgio, President
Lara Dean, VP, Editorial Division
Justin Perry, Art Director
Chris Reddy, Account Executive
Mike Moore, Account Executive
Erik Carlson, Account Executive

Worcester Medicine does not hold itself responsible for statements made by any contributor. Statements or opinions expressed in *Worcester Medicine* reflect the views of the author(s) and not the official policy of the Worcester District Medical Society unless so stated. Although all advertising material is expected to conform to ethical standards, acceptance does not imply endorsement by *Worcester Medicine* unless stated. Material printed in *Worcester Medicine* is covered by copyright. No copyright is claimed to any work of the U.S. government. No part of this publication may be reproduced or transmitted in any form without written permission. For information on subscriptions, permissions, reprints and other services contact the Worcester District Medical Society.

contents

Vol. 77, No. 1

JAN./FEB. 2013

4 Editorial

Jane Lochrie, MD

6 “Helping older patients understand health information”

Kathleen Mazor, EdD
and Sarah Cutrona, MD, MPH

9 Health Literacy:
A Family Doctor’s
Perspective

Katharine Barnard, MD

12 Health Literacy:
A Nursing Perspective

Nancy S. Morris, PhD, ANP-BC

14 Pharmacy Health
Literacy

Monina R. Lahoz, PhD

16 Annual Creative
Writing Contest

Robert Sorrenti, MD
Deb Carter (Alliance)
Sarithchandra Reddy, MD
Ronald Pies, MD

22 Legal Consult

Peter J. Martin, Esq.

24 As I See It
Physician Assisted Suicide

Leonard J. Morse, MD

25 As I See It
Medical Marijuana in MA

James B. Broadhurst, MD, MHA

26 As I See It
International Views on
Medical Marijuana
Legalization

Joel Popkin, MD
and Karthik Gnanapandithan, MD



On the Cover:
Health Literacy

28 As I See It
Engaging Medical
Clinicians in Oral Health

The WDMS Editorial Board and Publications Committee gratefully
acknowledge the support of the following sponsors:

UMass Memorial Health Care

Reliant Medical Group

The Louis Albert Cottle, MD Trust Fund

“Helping older patients understand health information”

Kathleen Mazor, EdD and Sarah Cutrona, MD, MPH



Kathleen Mazor, EdD



Sarah Cutrona, MD, MPH

Physicians are not usually the ones struggling to comprehend basic health information. This is why the story I was told last week at a conference on cancer communication was particularly striking. A national leader in oncology with years of experience delivering bad news, a physician described to us what he heard the day his wife was diagnosed with cancer: almost nothing. He had conducted similar conversations countless times, but sitting next to his wife, he understood almost none of what he was told.

The Institute of Medicine defines health literacy as the ability to obtain, process, and understand the basic health information and services needed to make appropriate health decisions. This includes spoken information as well as written information. Spoken health literacy has received less attention than written, but as any physician who has sat in an office face-to-face with a patient can tell you, it is vitally important.

Chatting during an exam, explaining the need for a test, engaging in complex medical decision-making or delivering bad news, a physician is the most important source of health information for many patients, particularly for older patients who are less comfortable going online to access alternate sources of health or medical information. Patients who, despite fluency in English, struggle to process and understand what is being said to them in a healthcare environment are considered to have low health literacy.

Reasons for low health literacy vary. As this oncologist’s story demonstrates, emotional distress can be a barrier to health literacy. Physical impairments such as difficulty hearing can also affect a patient’s ability to understand and process information. While hearing deficits can be a particular challenge for older patients, real or perceived stigmas attached to such impairments may make a struggling person reluctant to call attention to the problem. Cognitive deficits, diagnosed or unrecognized, can also make it hard for some elderly patients to follow and to remember complex conversations. Barriers extend well beyond those with emotional distress, hearing or cognitive impairments. Challenges abound: shortened office visits, noisy emergency rooms, physicians and staff with diverse accents, and the ubiquitous computer screen toward which speakers’ faces are too often directed, to name just a few. In a recent study, we found that 60% of participants over age 70 felt that they had a hard time understanding when people speak quickly, compared to only 37% of those aged 40 to 49.

Activities aimed at identifying and addressing barriers to health literacy are often framed as patient-centered, but the patient is only part of the story. A patient’s ability to function effectively depends not only on his or her background and immediate emotional factors, but also on the nature of the task, the setting, and the available supports. Recognition of this has led to calls for healthcare organizations to “become health literate.” Health literate organizations work to make it easier for patients to navigate, understand and use health information and services. These organizations make health literacy a priority, provide resources and training for clinicians and staff, and support better spoken and written communication. Some organizations assign staff to review and revise written materials. Other organizations are conducting internal walk-throughs, assessing signage and other environmental supports or impediments. Still others are involving patients as advisors, soliciting their input on how to facilitate navigation.

In summary, patients of any age may have difficulty processing and understanding written and spoken health information. As people age, changes in hearing, cognitive processing, and memory may make these activities even more difficult. Emotional distress and distracting environmental influences undermine even the most medically fluent. Each of us may one day be in the same position as the patient in front of us. It's simple, really. Let's speak as we hope someday to be spoken to. And let's help our organizations do the same.

Supporting spoken health literacy: What can you do?

- **Speak clearly and slowly.**
- **Be audible.**
- **Break your information into chunks.**
Start each "chunk" with an orienting sentence. For example: "Now let's talk about what might be causing this. It could be due to your blood pressure medication."
- **Use plain language.**
- **Explain any medical terms that the patient should know.**
- **Check for understanding. Ask a question that gets you real answers.** Simply saying, "Do you understand?" or "Ok?" is likely to elicit a "yes" whether or not the patient truly understands. Try: "So, if you wanted to tell your wife what we decided on today, what would you tell her?"
- **Sit down. Look at the patient (not the computer screen).**
When patients think physicians are in a hurry, or don't care about them, they usually won't speak up.
- **Make it comfortable for patients to voice questions, doubts and concerns.** Asking "What questions do you have?" is much more likely to encourage a patient to speak up than the short-hand phrase "Any questions?"
- **Be explicit about what is important and why.**
Patients can't always tell what is important, and what is optional. Make this clear. For example: "It's very important that you go to the lab and get this test done today. If you wait until next week, it will be harder for us to treat you."
- **Put your most important points in writing.**
Doing so helps in three ways: 1) clarifying what is most important, 2) serving as a memory aid, and 3) facilitating communication with family and caregivers who help the patient manage his or her health.

Kathleen Mazor, EdD is Assistant Director, Meyers Primary Care Institute, and Associate Professor, University of Massachusetts Medical School. She can be reached at Kathy.Mazor@meyersprimary.org

Sarah Cutrona, MD, MPH is a general internist and Assistant Professor, University of Massachusetts Medical School/Meyers Primary Care Institute. She can be reached at Sarah.Cutrona@umassmemorial.org



As you get older, your health care needs can be hard to manage on your own. Now there's a program that brings the pieces of your health care together:

NaviCare®

NaviCare HMO SNP personalizes care for seniors 65 and older with MassHealth Standard.

You get all of the covered Medicare and MassHealth Standard benefits and services. Coverage and care with NaviCare includes:

- a Navigator and care team to coordinate your health care needs.
- your choice of primary care physicians from our network.
- transportation to medical appointments when authorized.
- support 24 hours a day by phone.


All at no cost to you!

**Call us at 1-866-427-8892
(TDD/TTY: 1-877-795-6526)**

Monday through Friday, 8 a.m. to 8 p.m.
(From October 15–February 14, we're available seven days a week.)

www.navigare.org

navigare®
HMO SNP

 **fallon community health plan**

A Coordinated Care plan with a Medicare Advantage contract and a contract with the Massachusetts Medicaid program. NaviCare HMO SNP is a voluntary program in association with MassHealth/EOHHS and CMS. The benefit information provided herein is a brief summary, not a comprehensive description of benefits. For more information contact the plan. Your benefits may change on January 1 each year. 12-676-019 Rev. 00 1/12 H9001_N_2012_193 File&Use 09172011

autumn village



enhancing *life with peace of mind*

Long Term Care Center

When you are in need of long term care or short term rehabilitation consider Notre Dame's reputation for excellence.

A team of dedicated professionals is ready to provide compassionate and skilled care to chronic or acutely ill residents.

When you are in need, we are ready to serve you.

Call 508.852.3011



Notre Dame
Health Care Center, Inc.
www.notredamehealthcare.org

Health Literacy: A Family Doctor's Perspective

Katharine Barnard, MD



Katharine Barnard, MD

Imagine that you are discharging a patient from the hospital, a middle-aged man who considered himself healthy until an episode of cough, progressive shortness of breath and chest tightness which brought him to the hospital five days ago, at which time he was diagnosed with bronchitis triggering a COPD exacerbation. Your discharge plan includes standard care for this condition: medications (a regimen of antibiotics for his infection, a 10-day tapering dose of steroid, an inhaled bronchodilator for symptoms and a twice-daily inhaler for control, both to be used with a spacer), instructions to call his primary care provider and the pulmonologist for follow-up appointments, avoidance of allergens, and information so he may contact the QuitWorks program for assistance with smoking cessation if he desires. He agrees to follow through diligently with these recommendations.

Now imagine that this patient completed 10th grade but reads at a 5th grade level. He never did well in math and always struggled with telling time. He grew up outside the US and does not speak English at home. He has attended few medical appointments in the US. He thinks he may need reading glasses, but he hasn't seen the eye doctor.

It goes without saying that these factors will collectively affect your patient's ability to understand and implement the plan of care. Formally, we call this "health literacy:" the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.¹ On the most basic level, patients need to have what is termed "functional health literacy," enabling them to navigate the health care system, but ideally they will also have "interactive" and "critical" health literacy, which

allow them to be activated decision-makers about their own health and engaged in self-management.²

Unfortunately for our patient, multiple studies have shown worse health outcomes for patients with poor health literacy. Even if he is provided with educational activities, this patient would be less likely to gain a thorough understanding of his disease. His disease control will likely be poorer, as has been shown for patients with chronic conditions such as diabetes^{3,4} and asthma.⁵ It is more likely that he will be readmitted to the hospital, and for longer-than-average stays.⁶

But how likely is this scenario? Actually, it is much more common than we may think. Low health literacy is remarkably prevalent. It is estimated that 88% of US adults do not have a level of health literacy that enables critical decision-making about health issues, and 14% do not have even basic literacy.¹

As I think about my typical day, I realize that every interaction with a patient is affected by the patient's level of health literacy. I hope and expect that patients will take their regimen of medications correctly, but that requires them to be able to identify pills accurately, understand and remember instructions, and follow a schedule. I may prescribe a specific diet that requires the patient to measure ingredients or read labels. For a parent to appreciate a child's growth chart means having a basic understanding of percentiles and graphing. A major challenge is explaining aneuploidy screening (testing for Down Syndrome and other fetal anomalies) to expectant parents such that they understand the epidemiological concepts of risk stratification and false positive test results. I may choose to give a patient written instructions for any number of conditions, but should not assume that all patients can read. When I refer a patient to a specialist, he or she will have to navigate our disparate and sometimes confusing health care system.

The situation seems daunting. Our days are busy and full. Many patients with low literacy may feel ashamed to self-identify as needing assistance and therefore go unrecognized. Tools have been developed to aid us in assessing our patients' level of health literacy, but they are not universally applied. How is a provider to proceed?

We can start by remembering not to make assumptions. We can consider the possibility of low health literacy in those patients who miss appointments, or confuse their medicines, or do not conform to our standard modes of accessing health care. We can ask questions. We can "close the loop" by reassessing patients' understanding of information. We can ensure that our office distributes written material that is targeted to a 5th grade reading level. We can ask patients how they prefer to receive information about their health. We can keep our messages simple and limit instructions to the two or three most important per visit.⁷ We can advocate for our health care system to support care managers to assist our most complex patients in accessing the right health care for their conditions. We can create an environment in which patients feel confident to ask for the

assistance, accommodations, and explanations that they need. The above interventions not only improve safety, but also improve health outcomes.⁸ The Joint Commission recognized this fact in their 2001 Public Policy Initiative, which sets forth standards for providing safe care accessible to all patients regardless of level of literacy.⁹ In addition to the health system's attention to this topic, though, we can also address health literacy on an individual level, remembering that an informed patient will be an activated and healthier patient.

REFERENCES:

- 1 U.S. Department of Health and Human Services. 2000. *Healthy People 2010*. Washington, DC: U.S. Government Printing Office.
- 2 Nutbeam D, "Health literacy as a public health goal: a challenge for contemporary health education and communication strategies into the 21st century," *Health Promotion Intl*. 2000; 15:259-267
- 3 Williams MV, Baker DW, Parker RM, Nurss JR, "Relationship of Functional Health Literacy to Patients' Knowledge of Their Chronic Disease: A Study of Patients With Hypertension and Diabetes," *Arch Intern Med*. 1998; 158:166-172.
- 4 Schillinger D, Grumbach, K, et al, "Association of health literacy with diabetes outcomes," *JAMA* 2002; 288:475-482
- 5 Williams MV, Baker DW, Honig EG, et al., "Inadequate Literacy Is a Barrier to Asthma Knowledge and Self-Care," *Chest* 1998; 114:1008-1015
- 6 Baker DW, Gazmararian JA, et al, "Functional health literacy and the risk of hospital admission among Medicare managed care enrollees," *Am J Public Health*, 2002;92: 1278-1283
- 7 Safer RS, Keenan J, "Health Literacy: The Gap Between Physicians and Patients," *Am Fam Physician* 2005; 72:463-468.
- 8 Schillinger D, Piette J, Grumbach K, et al, "Closing the Loop: Physician Communication With Diabetic Patients Who Have Low Health Literacy," *Arch Intern Med*. 2003; 163:83-90
- 9 "What Did the Doctor Say?: Improving Health Literacy to Protect Patient Safety", Joint Commission publication 2007

A New Place to Call Home in a Community that Cares



Heywood Wakefield Commons is an affordable rental community in historic downtown Gardner for adults 62+ offering private apartments with assisted living services in beautiful home-like settings.

An Assisted Living Residence

Assisted Living Services Include:

- ◆ A full social & activity calendar
- ◆ Assistance with personal care needs
- ◆ Daily chef-prepared meals
- ◆ Medication reminders & safety checks
- ◆ Laundry & housekeeping services

Apartment Amenities Include:

- ◆ Kitchenettes
- ◆ Private bathrooms
- ◆ Built-in safety features
- ◆ Walk-in closets in some apartments!



Dr. Barnard is an Assistant Professor of Family Medicine and Community Health at UMass Medical School, and the medical director and a clinician at Plumley Village Health Services, a small family medicine clinic serving the primary care needs of Plumley Village and Bell Hill neighborhoods in Worcester.

NOW ACCEPTING APPLICATIONS!

To schedule a tour or to learn more about Heywood Wakefield Commons, please call Kristy Clark at (978) 632-8292.

50 Pine Street, Gardner, MA 01440 | (978) 632-8292 | hwcommons.com





7 NANA

JAPANESE STEAKHOUSE

Japanese Steakhouse • Sushi • Hibachi

Experience Worcester's
Hottest New Restaurant!



Open Christmas Day at 4pm!

Now Booking Holiday Party's - Call for Reservations!
Gift Cards Available



Open 7 Days a Week!
Mon. - Sat. 11:30am - 1am
Sunday 12pm - 1am



Private Function Rooms Available.

www.7nanasteakhouseworchester.com

60 Shrewsbury Street - Worcester, MA 508-755-8888

Health Literacy: A Nursing Perspective

Nancy S. Morris, PhD, ANP-BC



**Nancy S. Morris,
PhD, ANP-BC**

“How am I ever going to learn to give myself insulin?” “What immunizations do my children need?” “How do I change my colostomy bag?” “How do I care for my baby’s umbilical cord?” “How do I find a good surgeon?” Questions like these are asked of nurses each and every day. In all settings ~ hospitals, emergency departments, clinics, schools, and in patients’

homes, nurses work with adults and children to help them understand how to access care and manage their health. Public health nurses work outside of clinics with a focus on getting health care information to the general public. Educating people has been central to nursing’s philosophy of practice for many years (Redman, 2011). In working as patient advocates, nurses strive to help patients clarify their values and health goals and intervene to facilitate successful outcomes. The recent increase in research related to health literacy has established the widespread prevalence of limited health literacy (Kutner et al., 2006). It has also focused attention on the importance of educating the public about health related matters and the necessity of examining our communication patterns and our health care systems that are more complex than need be.

Over the last 15 years, health literacy ~ “...the degree to which individuals can obtain, process, understand, and communicate about health-related information needed to make informed health decisions...” (Berkman et al. 2010, p. 16) has surfaced as a concern for the health of our nation. The 2003 National Assessment of Adult Literacy (NAAL) incorporated the initial and only national assessment of adults’ health literacy that has been done. Results of the NAAL identified that 90 million Americans, almost one third of the adult population, do not have the knowledge and skill necessary to manage their health (Kutner et al., 2006). A number of studies have shown that limited health literacy is associated with decreased use of preventive services (Davis et al., 2001; White et al. 2008), worse outcomes in managing chronic disease (Cavanaugh et al., 2008; Murray

et al., 2009), increased use of emergency services (Olives et al. 2010), higher hospitalization (Baker et al. 2002; Kollipara et al., 2008) and rehospitalization (Mitchell et al., 2012), and overall increased mortality (Baker et al., 2007; Bostock & Steptoe, 2012; Sudore et al., 2006). Populations at higher risk for limited health literacy include older adults, minorities, adults with less than a high school education, adults who spoke a language other than English before starting school and people living in poverty (Kutner et al., 2006). The populations with limited health literacy are often those most in need of health care.

Although patient education has a long history in nursing, our engagement in the health literacy field is relatively recent. The interdisciplinary approach to research on health literacy is expanding and nurses are getting involved in studies addressing the conceptualization of health literacy, clarification of causal and contributing factors, prevalence among specific populations, cultural issues, measurement of health literacy, associations with health outcomes, and innovative interventions to mitigate limited health literacy. As well, nurses are engaged in efforts to make health care settings health literate by decreasing the demands and complexities of the health care system. With the increasing understanding of the role that health literacy plays in the health of our country educational efforts are underway to introduce and educate nursing students and practicing nurses about health literacy.

There are several initiatives underway that are useful to nurses in trying to better communication with patients. Working with the University of North Carolina at Chapel Hill, the Agency for Health Care Research and Quality (AHRQ) published a “Health Literacy Universal Precautions Toolkit” designed to help health care practices create systems that support clear communication (www.ahrq.gov/qual/literacy/healthliteracytoolkit.pdf). Another useful resource is “Taking Care of Myself: A Guide for When I Leave the Hospital,” adapted from Project RED (Re-Engineered Discharge), which was funded by the AHRQ and the National Heart, Lung, and Blood Institute and operated by the Boston University Medical Center (www.ahrq.gov/qual/goinghomeguide.htm). It is an easy-to-read guide designed to

help patients meet their health care needs after hospitalization. Rima Rudd and colleagues (2010) developed “The Health Literacy Environment Activity Packet” as a starting point for hospitals and clinics to assess the health literacy environment and to identify ways to reduce the demands on people seeking care (www.hsph.harvard.edu/healthliteracy/files/activitypacket.pdf).

Nurses focus on helping patients assume self-management of their health if interested and capable, considering their preferences and competencies (Redman, 2011). This emphasis on patient-centered care is consistent with an environment in which patients are comfortable asking questions and sharing their concerns. Comprehending health related information can be challenging and the stress and anxiety that sometimes accompanies encounters with the health care system may limit one’s ability to hear, understand, process and remember information. Multiple strategies tailored to the individual can be useful in facilitating comprehension. Many people with limited health literacy rely on verbal communication; this reliance speaks to the need to simplify language, avoid jargon, and speak slowly and clearly (Castro et al., 2007; Doak et al., 1998). The “teach-back” technique, in which the patient is asked to explain and/or demonstrate an instruction that was just taught, is an effective way to evaluate comprehension (Schillinger et al., 2003). Matching word choice with the terms that patients use has been shown to be helpful and improve outcomes (Castro et al., 2007; Williams & Ogden, 2004). Limiting the number of key points discussed to a maximum of three at any one time is also recommended. Communicating clearly is one requirement for patient-centered care.

It’s also important to create an environment that encourages questions. Since a large segment of the population has limited health literacy, it’s likely that there are many questions that people have about their health and how to manage it that go unasked and thus unanswered. Experts recommend that we communicate an expectation of questions and instead of asking, “Do you have any questions?” we should invite a response by asking, “What questions do you have?” (Dewalt et al., 2010). The goal is to indicate interest and ensure understanding. This is one of many strategies that nurses are using to help patients feel empowered to clarify and ensure comprehension of health related information.

REFERENCES:

Baker, D.W., Gazmararian, J. A., Williams, M.W., Scott, T., Parker, R. M., Green, D.Ren, J., & Peel, J. (2002). Functional health literacy and the risk of hospital admission among Medicare managed enrollees. *Am J Pub Health*, 92, 1278-1283.
Baker, D. W., Wolf, M. S., Feinglass, J., Thompson, J. A., Gazmararian, J. A., & Huang, J. (2007). Health literacy and mortality among elderly persons. *Arch Intern Med*. 167, 1503-1509.

Berkman, N. D., Davis, T. C., & McCormack, L. (2010). Health literacy: What is it? *J Health Commun*, 15Suppl 2, 9-19. doi:10.1080/10810730.2010.499985.
Bostock, S., & Steptoe, A. (2012). Association between low functional health literacy and mortality in older adults: longitudinal cohort study *BMJ*, 34410.1136/bmj.e1602
Castro, C. M., Wilson, C., Wang, F., & Schillinger, D. (2007). Babel babble: physician’s use of unclarified medical jargon with patients. *Am J Health Behav* 31(S1), 85-95.
Cavanaugh, K., Huizinga, M. M., Wallston, K.A., Gebretsadik, T., Shintani, A., Davis, D., Gregory, R. P, fuchs, L., Malone, R., Cherrington, A., Pignone, M., DeWalt, D. A., Elasy, T. A., & Rothman, R. L. (2008). Association of numeracy and diabetes control. *Ann Intern Med.*,148, 737-746.
Davis, T.C., Dolan, N.C., Ferreira, M.R., Tomori, C., Green, D. W., Sipler, A. M., & Bennett, C. L. (2001). The role of inadequate health literacy skills in colorectal cancer screening. *Cancer Invest*. 19,193-200.
DeWalt, D. A., Callahan, L. F., Hawk, V.H., Brouckson, K.A., Hink, A., Rudd, R., & Brach, C. (2010) Health Literacy Universal Precautions Toolkit. (Prepared by North Carolina Network Consortium, The Cecil G. Sheps Center for Health Services Research, The University of North Carolina at Chapel Hill, under Contract No. HHS290200710014.) AHRQ Publication No. 10-0046-EF) Rockville, MD. Agency for Healthcare Research and Quality.
Doak, C. C., Doak, L. G., Friedell, G. H., & Meade, C.D. (1998). Improving comprehension for cancer patients with low literacy skills: strategies for clinicians. *CA Cancer J Clin*.48,151-162.
Kollipara, U.K., Jaffer, O., Amin, A., Toto, K. H., Nelson, L. L., Schneider, R., Markham, D., & Drazner, M. H. (2008). Relation of lack of knowledge about dietary sodium to hospital readmission in patients with heart failure. *Am J Cardiol*.102, 1212-1215. doi: 10.1016/j.amjcard.2008.06.047
Kutner, M., Greenberg, E., Jin, Y., & Paulsen, C. (2006). The Health Literacy of America’s Adults: Results From the 2003 National Assessment of Adult Literacy (NCES 2006-483). U. S. Department of Education. Washington, DC: National Center for Education Statistics.
Mitchell, S. E., Sadikova, E., Jack, B. W., & Paasche-Orlow, M. K. (2012). Health literacy and 30-day postdischarge hospital utilization. *Journal of Health Communication*, 17, 325-38. doi:10.1080/10810730.2012.715233
Murray, M. D., Tu, W., Wu, J., Morrow, D., Smith, F., & Brater, D. C. (2009). Factors associated with exacerbation of heart failure include treatment adherence and health literacy skills. *ClinPharmacolTher*, 85, 651-658. doi: 10.1038/clpt.2009.7
Olives, T., Patel, R., Patel, S., Hottinger, J., & Miner, J. R. (2010). Health literacy of adults presenting to an urban ED. *Am J Emerg Med*, 29(8), 875-882.. doi:10.1016/j.ajem.2010.03.031
Redman, B. (2011). Ethics of patient education and how do we make it everyone’s ethics. *Nursing Clinics of North American*,46(3), 283-289.
Rudd, R. E. (2010). The Health Literacy Environment Activity Packet: First Impressions & Walking Interview. On-line tools. *Health Literacy Studies*. hsph.harvard.edu/healthliteracy
Schillinger, D., Piette, J., Grumbach, K., Wang, F., Wilson, C., Daher, C., Leong-Grotz, K., Castro, C. & Bindman, A. B. (2003). Closing the loop: physician communication with diabetic patients who have low health literacy. *Arch Intern Med*, 163 (1), 83-90.
Sudore, R. L., Yaffe, K., Satterfield, S., Harris, T. B., Mehta, K. M., Simonsick, E. M.,...Schillinger, D. (2006). Limited literacy and mortality in the elderly: The health, aging, and body composition study. *J Gen Intern Med*, 21, 806-812. doi:10.1111/j.1525-1497.2006.00539.x
White, S., Chen, J., & Atchison, R. (2008). Relationship of preventive health practices and health literacy: A national study. *Am J Health Behav*. 32, 227-242.

Williams, N. & Ogden, J. (2004). The impact of matching the patient’s vocabulary: a randomized control trial. *Journal of Family Practice*, 6, 630-635.

Nancy S. Morris, PhD, ANP-BC is Associate Professor UMass Worcester Graduate School of Nursing and an Adult Nurse Practitioner at UMass Memorial Health Care. She can be reached at nancy.morris@umassmed.edu.

Pharmacy Health Literacy

Monina R. Lahoz, PhD

In 2009, the U.S. Department of Health and Human Services Agency for Healthcare Research and Quality (AHRQ) launched the AHRQ Pharmacy Health Literacy Center website (www.ahrq.gov/pharmhealthlit/).¹ The website was created "...to help retail pharmacists meet the needs of customers with low or limited health literacy."¹ It provides tools and resources to engage pharmacists in recognizing and responding to the health literacy problem. It is evident that AHRQ acknowledges pharmacy's critical role in addressing health literacy and has made resources available to the profession. In February 2012, AHRQ added to the website a set of modules with slide decks and activities for pharmacy faculty, students, and residents to learn techniques to help patients with limited health literacy.²

AHRQ defines pharmacy health literacy as the degree to which individuals are able to obtain, process, and understand basic health and medication information, and pharmacy services needed to make appropriate health decisions.³ This is the same definition adopted by the Institute of Medicine in its 2004 report titled "Health Literacy: A Prescription to End Confusion" and Healthy People, except for the words "medication" and "pharmacy."^{4,5} In this article, I will focus on "medication information," particularly on prescription drug labels and auxiliary (or warning) labels. Oftentimes, the prescription drug label is the only source of print information a patient has on how to take a drug prescribed by his physician. Are patients able to process and understand the information on prescription drug labels? How basic is the information? How understandable is the information? How accurate is the information?

The first ever study of the nation's health literacy, an assessment of adults' ability to use their literacy skills in understanding health-related materials and forms, suggests that only 12 percent of U.S. adults have "proficient" health literacy;⁶ that is, someone who has proficient health literacy is able to determine what time a person can take a medication, based on information on the prescription drug label that relates the timing of medication to eating.⁶ Over a third of U.S. adults, those with "below basic" or "basic" health literacy, have difficulty following direc-

tions on a prescription drug label.⁶ Limited health literacy leads to medication errors.⁷

The link between health literacy and the ability to correctly interpret the information on prescription drug labels and auxiliary labels has been a subject of several research studies. It has been shown that patients with lower health literacy are more likely to misinterpret dosage instructions placed on labels of five common prescription medications.^{8,9} The rates of misunderstanding of individual dosage instructions ranged from 8% for the instruction "Take one tablet by mouth once each day" to 33% for the instruction "Take one tablet by mouth twice daily for 7 days." Other factors that contributed to incorrect interpretation of the dosage instructions were greater number of prescription regimens⁸ and the dosage instructions themselves; they were phrased awkwardly, vague, and difficult to read.⁹

Even simple words, when used in an unfamiliar context such as those that are printed on auxiliary labels, may be difficult to grasp. In one study, except for the auxiliary label "Take with food," the other seven auxiliary labels that were tested proved difficult for patients across all literacy levels.^{10,11} The auxiliary label "Do not take dairy products, antacids, or iron preparations within 1 hour of this medication" proved to be the most difficult. Patients with lower health literacy were less likely to interpret the eight auxiliary labels correctly.

Nowadays, pharmacy computer programs can translate dosage instructions to other languages. However, one study has shown a 50 percent error rate in computer-generated Spanish-language prescription drug labels.¹² A common source of error was when English and Spanish words were combined in a dosage instruction. One of the phrases that was not translated at all in Spanish was "once a day." In English, "once" means "one time," while in Spanish it stands for the number 11. Such errors can have hazardous consequences.

AHRQ has been calling for universal medication labeling standards. Groups of researchers who have heeded the call have

been using a patient-centered approach to investigate the effect of using different features on a prescription drug label or warning label on patient comprehension of the labels. The results have been promising. When compared to the typical dosage instructions written as times per day (e.g., once, twice, 3 times per day), instructions on a standardized, patient-centered label that specify explicit timing with standard intervals (morning, noon, evening, bedtime) were more likely to be correctly interpreted by patients, including patients with limited health literacy.^{13,14} Likewise, when the text on nine warning labels was simplified and rewritten in plain language, patients were better able to correctly interpret it.^{15,16}

What has arisen from the IOM-led initiatives to improve health literacy has been the release in October 2012 of the United States Pharmacopeia (USP) standards that provide, for the first time, a universal approach to the format, appearance, content and language of instructions for medicines in containers dispensed by pharmacists.¹⁷ One of the elements of the new USP standards requires that instructions for use should clearly separate the dose itself from the timing of each dose. Further, alphabetic characters should not be used for numbers. Thus, “Take 2 tablets in the morning and 2 tablets in the evening” should replace “Take 2 tablets twice daily.”

With the new USP prescription medication labeling standards and the tools and resources available in the AHRQ Pharmacy Health Literacy Center, pharmacists should make a concerted effort to give their patients, especially those with limited health literacy, the most essential information so that their patients are better able to understand how to safely and appropriately use their medications and adhere to their prescribed medication regimens.

REFERENCES:

1. Meet the AHRQ Pharmacy Health Literacy Center, AHRQ Electronic Newsletter, Issue No. #285, January 6, 2010. Available from www.ahrq.gov/news/enews/enews285.htm.
2. AHRQ Releases Web-based Modules to Help Pharmacy Faculty and Pharmacists Implement Health Literacy Concepts, AHRQ Electronic Newsletter, Issue No. #335. February 8, 2012. Available from www.ahrq.gov/news/enews/enews335.htm.
3. U.S. Department of Health and Human Services Agency for Healthcare Research and Quality. AHRQ Pharmacy Health Literacy Center. Available from www.ahrq.gov/pharmhealthlit/.
4. Nielsen-Bohlman L, Panzer AM, Kindig DA. 2004. *Health literacy: A Prescription to End Confusion*. Washington, DC: National Academies Press.
5. U.S. Department of Health and Human Services. *Healthy People 2020*. Available from <http://healthypeople.gov/2020/default.aspx>.
6. Kutner M, Greenberg E, Jin Y, Paulsen C. 2006. *The health literacy of America's adults: Results from the 2003 National Assessment of Adult Literacy (NCES 2006-483)*. Washington, DC: U.S. Department of Education, National Center for Education Statistics.
7. Aspden P. 2007. *Preventing medication errors*. Washington, DC: National Academy Press.
8. Wolf MS, Davis TC, Shrank W, Rapp DN, Bass PF, Clayman M, Parker RM. To err is human: Patient misinterpretations of prescription drug label instructions. *Patient Education and Counseling* 2007; 67:293–300.
9. Davis TC, Wolf MS, Bass PF, Tilson H, Neuberger M, Parker RM. Literacy and misunderstanding of prescription drug labels. *Ann Intern Med* 2006; 145:887–94.
10. Davis TC, Wolf MS, Bass PF, Middlebrooks M, Kennan E, Baker DW, Bennett CL, Durazo-Arvizu R, Savory S, Parker RM. Low literacy impairs comprehension of prescription drug warning labels. *J Gen Intern Med* 2006; 21:847–51.
11. Wolf MS, Davis TC, Bass PF, Tilson H, Parker RM. Misunderstanding prescription drug warning labels among patients with low literacy. *Am J Health System Pharm* 2006; 63:1048–55.
12. Sharif I, Tse J. Accuracy of a computer-generated, Spanish-language medicine labels. *Pediatrics* 2010; 125:960–965.
13. Wolf MS, Davis TC, Curtis LM, Webb JA, Bailey SC, Shrank WH, Lindquist L, Ruo B, Bocchini MV, Parker RM, Wood AJ. Effect of standardized, patient-centered label instructions to improve comprehension of prescription drug use. *Medical Care* 2011; 49(1):96–100.
14. Wolf MS, Curtis LM, Waite K, Bailey SC, Hedlund LA, Davis TC, Shrank WH, Parker RM, Wood AJ. Helping patients simplify and safely use complex prescription regimens. *Arch Intern Med* 2011; 171(4):300–305.
15. Webb J, Davis TC, Bernadella P, Clayman ML, Parker RM, Adler D, Wolf MS. Patient-centered approach for improving prescription drug warning labels. *Patient Education and Counseling* 2008; 72(3):443–449.
16. Wolf MS, Davis TC, Bass PF, Curtis LM, Lindquist LA, Webb JA, Bocchini MV, Bailey SC, Parker RM. Improving prescription drug warnings to promote patient comprehension. *Arch Intern Med* 2010; 170(1): 50–56.
17. U.S. Pharmacopeial Convention. 2012. *First Universal Standards Guiding Content, Appearance of Prescription Container Labels to Promote Patient Understanding of Medication Instructions* [Press Release]. Retrieved from www.usp.org/usp-nf/key-issues/usp-nf-general-chapter-prescription-container-labeling.

Monina R. Lahoz, PhD is Associate Professor of Pharmacy Administration, School of Pharmacy – Worcester/Manchester, Massachusetts College of Pharmacy and Health Sciences. She can be reached at Monina.Lahoz@mcphs.edu.

Introduction: Annual Creative Writing Exposition

Robert Sorrenti, MD

As you leaf through this issue of *Worcester Medicine*, we invite you to enjoy several contributions from the annual Creative Writing Exposition, sponsored by the MMS Arts, History, Humanism & Culture Member Interest Network (Arts MIN). We selected these contributions as the blue-ribbon best from a number of submissions representing a variety of writing styles and formats. We offer for your enjoyment two poems ~ one by a physician and one by an Alliance member ~ and a memoir by another of our physician members.

The Arts MIN Creative Writing Exposition allows us to learn a little more about the members of MMS and their spouses. We already knew they are dedicated to serving the practice of medicine; now, through this Exposition, we get some insight into other talents they have and that they are willing to share with us. We appreciate their participation in this event.

The Arts MIN provides other opportunities, besides the written word, for members of MMS and of its Alliance to explore, develop and participate in non-medical activities that range from bird watching to bonsai planting and from art exhibitions to astronomical viewing. We invite MMS and MMS Alliance members to take part in the activities and events the Arts MIN sponsors and to join us on the executive council to promote new areas of interest.

I want to thank all the participants in this year's Exposition. I hope as you read the work of our talented colleagues you will think about contributing next year.

Robert Sorrenti, MD, is Chair, of the Arts, History, Humanism & Culture Member Interest Network, Massachusetts Medical Society.



**Treating
Cancer.**
*Repairing
Hope.*

The
CANCER CENTER
at Harrington

For information
Call 508-764-2400
55 Sayles St., Southbridge, MA

Harrington
HOSPITAL
Total Local Care

www.harringtonhospital.org

The Ride Home

Deb Carter (Alliance)

The car dealership billboard
tells me on their big clock that it's 4:30
But it's really 2:15
Why do they want to take
two hours and change
Away from me.

The radio sings a song
it says I need to control
My pests
But why would they want to
Take them
Away from me.

Blue Oyster Cult
Tells me not to fear the reaper
But I know
He's out there
even though the melody is sweet.

Studies show that those with no regard
For nature and who destroy our environment
Have no regard
For human life and those
Who are suffering.

Hydrolize will erase the dark circles under your eyes.

Guns N' Roses
Wonders
Where do we go
Sweet child of mine.

Deep Purple knows
Swiss time is running out.

Debbie Carter is an artist and teaches art to children in Lenox, MA. She is the President of the Berkshire West chapter of the Alliance.

Superhero

Sarathchandra Reddy, MD

My son has just finished listening
to his favorite bedtime story once
again - asks the same questions,
accepts the same answers,
falls asleep comfortably
in predictable endings.

He dreams of being that slayer
of black dragons, a prince on a white horse,
a universe light years from
my world of in-betweens.

He declares he will be
just like me one day riding off into the night,
masquerading as God in a white coat.
How long will it be before he discovers
I have saved
no one? only pushed off the inevitable
to the next shift.

I teach him we can keep things in motion
for only so long

before they come to rest -
that is the nature of the body
and other worldly things.

The spinning top slows, stumbles.
Each bounce of a ball shallows in succession.
The bicycle tilts when the peddling
has stopped.

And when I have exhausted my pills and potions,
all that remain are pre-packaged
condolences then -
awkward silence.

But I vow to keep his fantasy alive
an extra minute
let his head sink deeper into the pillow,
settle into his kingdom,
eyelids quivering
as he prepares to battle the dragon
and save his world
from us.

Sarath Reddy MD, MPH is a gastroenterologist at Harbor Medical Associates in Braintree, MA.

Let the Small Clocks Run Wild: A Meditation

Ronald Pies, MD

The great clock of your life
is slowing down,
and the small clocks run wild.
For this you were born.

—Stanley Kunitz, “King of the River”

So now the woods have opened up a bit, even as they have darkened, and I am just past my sixtieth year. Wisdom gained? It’s hard to say. Looking back at my teenage and college years, I can see that I’ve let go of some of my youthful grandiosity and sense of entitlement ~ the demon-sprite that told me I’d certainly win the Nobel Prize in science, a second one in literature, and maybe cure cancer along the way. Sometimes I miss that demon, though, and I wonder if the “realistic” expectations of my later years are really a kind of surrender ~ settling into old age, rather than raging against its limitations.

In my sixth decade, intimations of mortality are never far from me, and I can now read Robert Frost’s deeply-felt poem “Nothing Gold Can Stay” with an understanding I never had in my college literature course:

Nature’s first green is gold
Her hardest hue to hold.
Her early leaf’s a flower;
But only so an hour.
Then leaf subsides to leaf.
So Eden sank to grief,
So dawn goes down to day.
Nothing gold can stay.

I was raised in the Jewish faith, but ~ like many American Jews ~ I have found much wisdom in the Buddhist tradition. In his book *Everything Arises, Everything Falls Away*, the Thai meditation master Ajahn Chah teaches us “...to look in the present and see the impermanence of body and mind.” He speaks of the peace that comes from “letting go” of attachment ~ whether to the newest electronic gadget, a rigidly-held belief, or even

a beloved friend or family member. When he was five, Ajahn Chah’s father died suddenly, and this left a deep wound in the young boy ~ one that prompted him to meditate on the fragility and transience of human life. I lost my father to cancer when I was 17, and the loss surely shaped my sense of the world as a place where nothing could be taken for granted.

In my teens and twenties, I saw mortality as something to defeat ~ there’s that cure for cancer again ~ but lately, I have to come to see death in somewhat more conciliatory terms. No, I don’t welcome the idea of personal oblivion. But having imbibed the teachings of the Buddhists and their Greco-Roman cousins, the Stoics, I now try to see death as one of the necessary processes of Nature. The late Steve Jobs reflected a bit of this Stoic wisdom in his 2005 Stanford commencement speech. “No one wants to die,” Jobs said. “Even people who want to go to heaven don’t want to die to get there. And yet death is the destination we all share. No one has ever escaped it. And that is as it should be, because Death is very likely the single best invention of Life. It is Life’s change agent.”

Now, I don’t want to convey the mistaken impression that I spend all day contemplating the prospect of death! My life is packed with the blessings of a wonderful marriage, a challenging career and ~ more recently ~ the indolent pleasures of semi-retirement. In fact, I’ve been thinking a great deal lately about gratitude, and how fundamental it is to what the ancient Greeks called *eudaimonia* ~ “the flourishing life.” First, of course, is gratitude for life. How many people in the history of the world have lived beyond 60 years? (In 1900, life expectancy at birth in the U.S. was about 50 years ~ now it is over 77.) In the Jewish faith, we are instructed to begin each day with a prayer of thankfulness, known as the *Modeh Ani*. In English, the prayer goes, “Thankful am I before you, living and eternal King, that you have returned my soul within me with compassion; abundant is Your faithfulness.” The Rabbis tell us that we return God’s faithfulness with our own by expressing a prayer of thanksgiving each day.

I have to admit, I don't say the exact words of this prayer, but each day, I do find a way of thanking God for life and health ~ and for the innumerable blessings in my life. When I think of the woes I have witnessed over the last 30 years—the sorrows and sickness of friends and loved ones, the suffering of so many of my patients ~I would count myself a fool if I didn't feel immense gratitude for my life. I am especially fond of a Buddhist teaching, which I have taped to my computer monitor: "Let us rise up and be thankful, for if we didn't learn a lot today, at least we learned a little; and if we didn't learn a little, at least we didn't get sick; and if we got sick, at least we didn't die; so let us all be thankful."

And, with the advancing years, I have lost patience with a certain type of intellectual virtuosity. As a college student, and even as young physician, I devoted a good deal of time to esoteric subjects in philosophy and theology ~ I can still spout off St. Anselm's "ontological argument" proving the existence of God! In my later years, I have become much more interested in personal ethics ~ not so much the theor, as the everyday practice. In my book *Becoming a Mensch*, I tried to develop the idea that each of us can become a better person by practicing a few simple habits in our daily lives ~ for example, civility, honesty, and kindness. I am guided by a wonderful teaching from Rabbi Abraham Joshua Heschel, who said, "When I was young I admired clever people. Now that I am old, I admire kind people." Indeed, kindness is arguably the core value within all the major faiths. When the Dalai Lama was asked to explain his religion, he replied, "My religion is very simple. My religion is kindness." Imagine what the world would be like if each of us were to put that teaching into practice! I fall short of the mark every day, but I find that my life is greatly enriched by the mere effort of practicing kindness.

And yet, and yet: I come full circle to the epigram that begins this essay, from the late Stanley Kunitz's poem "King of the River." (Kunitz died in 2006, at the age of 101). Ostensibly a poem about salmon, "King of the River" is of course much more than that. When he was in his 70s, Kunitz was interviewed by Chris Busa for the *Paris Review*. Kunitz said of this poem, "It may be pertinent that I experienced a curious elation while confronting the unpleasant reality of being mortal, the inexorable process of my own decay. Perhaps I had managed to "distance" my fate ~ the salmon was doing my dying for me."

But the lines from "King of the River" that have always stuck with me are these: "The great clock of your life/is slowing down,/and the small clocks run wild." What did Kunitz mean by this? I don't know, and maybe Kunitz didn't, either. (In his interview, he made the point that "A poem has secrets that the poet knows nothing of. It takes on a life and a will of its own.") Yes ~ and a poem holds meanings for its readers that often go well beyond the intention of the poem's author. I understand the "great clock" of my life as simply my own limited "biological" time as a human being. But what of "the small clocks" that "run wild"? For me, these are the myriad plans, hopes, desires, projects and passions that I may never realize, but which are an unkillable part of my nature and being. They are the beneficent remains of that demon-sprite that possessed me and drove me in my youth. And while I honor the emotional "equanimity" the Stoics called *ataraxia*, I find it a bit too staid for my later years. I pray that the small clocks of my life run wild, for whatever time I have been granted.

Ronald Pies MD is Professor of Psychiatry and Lecturer on Bioethics & Humanities at SUNY Upstate Medical University and Clinical Professor of Psychiatry at Tufts University School of Medicine. He is the author of several books on philosophy and ethics, as well as several collections of poems and short stories.



What do you want for your son's high school experience?

Challenging Academics:

- Named by the Siemens Foundation and the CollegeBoard as leading Massachusetts in AP Math, Science, and Technology

Formation of Values:

- 110 year tradition of intellectual, moral, and spiritual education

Transformational Experience:

- 18 varsity sports and 50 clubs for a well-prepared and well-rounded young man

For Information Regarding Admission and Financial Aid Contact:

ST. JOHN'S HIGH SCHOOL

Admissions Office: 508-842-8934, ext. 266/230

Visit our website: www.stjohnshigh.org



**"Working to keep you
in your home."**



acclaim

Home Health Care Inc.

- Highly trained professionals.
- No delays in SN, PT, OT, ST, SW, or HHA.
- Multilingual Clinical Staff.
- Close working relationship with Physicians.

120 Stafford St., Suite 206
Worcester, MA 01603
Ph#: 508-459-6937
Fax: 508-459-4154
www.acclaimworcester.com

Insurances include: Medicare, Blue Cross Blue Shield, MassHealth, Fallon Summit, ElderPlan, Senior Whole Health, Evercare, Neighborhood Health Plan, Network Health, BMC Healthnet, and Fallon Navicare.

Towns include: Worcester, Shrewsbury, Millbury, Paxton, Holden, Grafton, West Boylston, Leicester, Auburn, Oxford, Webster, Westboro, and Northboro.

Commonwealth
of Massachusetts

Justice of the Peace

Open a world of possibilities with an M.S. in Nursing from **Worcester State University**



Community/Public Health Nursing Specialty Nurse Educator Specialty*

- Blended courses combining the best of face-to-face and online learning
- World class faculty from diverse disciplines
- Affordable tuition
- Traditional Entry: For students with a BS in nursing
- Bridge Program: For RNs with a non-nursing BA or BS degree
- RN-to-MS Fast Track: For associate-degree or diploma-prepared RNs seeking to proceed directly to the MS in nursing degree

The teachers are incredibly knowledgeable and passionate about what they're doing. They make you feel that you're in the right place.

- Gina Marie Fleury, R.N.

*Supported by the Greater Worcester Community Foundation.

The 
Graduate School
WORCESTER STATE UNIVERSITY

For more information call **508-929-8680**
or contact Dr. Stephanie Chalupka at
Stephanie.Chalupka@worcester.edu

www.worcester.edu/gradnursing

*"For
everyone's
wedding
needs"*

Paul Giorgio
508-414-4454
pgiorgio@pagioinc.com



EASTERN ORTHODOX MANAGEMENT CORPORATION
Holy Trinity Nursing & Rehabilitation Center
Holy Trinity Hospice
Ichabod Washburn Hospice Residence



1183 Main St. 300 Barber Ave.
Worcester, MA 01603 Worcester, MA 01606

www.htnr.net

Virtual Tour available of Ichabod Washburn Hospice Residence



*A Non-Profit Organization
Dedicated to Quality Care
and Christian Love*

HOLY TRINITY NURSING & REHAB CENTER
508-852-1000
ICHABOG WASHBURN HOSPICE RESIDENCE
508-791-8200



*“State of the Art
Healthcare
Environment”*

We offer:

- Long-term and short-term care
- Ancillary Services: dental, eye, podiatry provided at the nursing center.
- Respite and Hospice Care
- PT/OT/ST Rehab services; 7 days a week
- Full time Physician Assistant
- Continuing care community

- Restaurant-style dining room
- Bright and airy rooms • Activities; 7 days a week
- Cable TV and telephones available in each room
- Resident computer with free access to internet
- Pet therapy through Tufts Veterinary Program



Schedule a tour today
with Tracey King,
Hospital Liaison
call 508-853-6910

***Knollwood
Nursing Center***
YOUR PARTNERS IN CARE

“A part of Briarwood Continuing Care Retirement Community”

87 Briarwood Circle, Worcester, MA 01606
508-853-6910
www.knollwoodnursingcenter.com

What's The Benefit In a Benefit Corporation?

Peter J. Martin, Esq.



Peter Martin, Esq.

Massachusetts recently joined eleven other states in creating a new form of for-profit corporation, a so-called “benefit corporation,” under new Chapter 156E of the Massachusetts General Laws. Designed to be attractive to socially-conscious entrepreneurs and investors, this law, unlike some other states’ laws, applies to professional corporations such as medical

practices. Why would a medical practice organized as a professional corporation consider revising its charter to become a benefit corporation?

First off, it is important to emphasize what a benefit corporation is not. It is not a non-profit or tax-exempt organization: profits may still go to the shareholders of a benefit corporation, and it may still have a primary goal of maximizing shareholder value. It is also not a so-called “B Corp,” which is a private designation granted to certain organizations by the private non-profit firm B Labs. This organization reviews the operations of for-profit corporations in such areas as governance, workers’ relations, environmental impact, and other criteria. Corporations scoring above a threshold in these areas, as determined by B Labs, are designated a “B Corp.”

To become a benefit corporation under the new Massachusetts law, an existing business or professional corporation must amend its articles of organization by a two-thirds vote of all shareholders to state that the corporation is a benefit corporation. That amendment may but is not required to state a specific public benefit. The new law permits a professional corpora-

tion to have both the purpose of rendering professional services and creating a general public benefit (whether specified or not). The duties imposed on a benefit corporation by the statute can be enforced against the corporation, its directors and officers only in an action brought by a shareholder, director or owners of more than 5% of the corporation’s parent, if any.

One such duty is that a benefit corporation must have a “benefit director” who is required to prepare an annual report and provide it to each shareholder and post it on the corporation’s web site, if any. The report must also be filed with the Massachusetts Secretary of State’s office (for a \$75 filing fee). The report includes the benefit director’s opinion as to whether the benefit corporation acted in accordance with its declared public benefit purpose. In addition, the report must state the benefit director’s opinion as to whether the corporation considered the effect of its actions on its shareholders, employees and customers/clients, its community, the local, regional and global environment, the short-term and long-term interests of the corporation, and the ability of the corporation to accomplish its public benefit purpose. The corporation is not required to give priority to any of these considerations over any other consideration, unless its articles of organization so provides.

This annual report must also include an assessment of the “... overall social and environmental performance” of the corporation against an independent third-party standard. Currently, B Labs is the most prominent source of such a third-party standard. Its “Global Impact Investing Rating System” has become the de facto third-party standard used in other states with benefit corporation statutes. The annual report must also include the name of each person owning at least 5% of the shares and any compensation paid to any director for his/her duties as director. However, the copy of the annual report filed with the

Secretary of State need not include director's compensation or other financial, confidential or proprietary information.

Given all of these requirements, why would a health care practice organized as a professional corporation want to become a benefit corporation? On the one hand, the extra annual reporting and filing fee obligations, the requirement of conducting an annual evaluation of its pursuit of social goals and the need to designate a benefit director only add to the ongoing corporate maintenance burdens of the practice. As a new type of corporate entity under Massachusetts law, there is bound to be further development in case law and regulations of what the statute means, adding some uncertainty to the enterprise.

On the other hand, business corporation status might make it more likely to attract foundation support for the corporation's public benefit activities, subject to IRS restrictions. It is possible that younger practitioners might be attracted to a practice that has established a commitment to furthering social and environmental goals, so benefit corporation status may enhance the practice's reputation and aid in provider recruitment and retention. In general, benefit corporation status could differ-

entiate the practice from its competitors and burnish its image among existing and potential patients. Practices that already seek to pursue some of the social goals cited in the statute might want to be recognized for those efforts and enjoy the liability protections afforded by the new statute.

It has been widely noted how "business-like" some non-profit organizations have behaved in recent years. This new benefit corporation statute now gives legal status to some of the practices of socially-conscious business entities. Health care practices that consider themselves to have both "profit" and "mission" motives now have a new way to formalize the blended nature of their enterprise. Early adopters of this new corporate form may get the jump on their competitors, but take on some added burdens and risks in the process.

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.

worc academe-
my

Physician Assisted Suicide

Leonard J. Morse, MD

Suicide is defined as “the act or instance of intentionally killing oneself” (*The American Heritage Dictionary*, 4th edition). I believe the intent is contrary to the purpose of being a physician. Good medicine begins and endures with a trusting relationship between physician and patient and family embraced by an appreciation of the patient’s spiritual and cultural beliefs.

In the presence of an unrelenting, irreversible disease, process palliation (soothing in the absence of curing) becomes the goal of hospice care. Hospice care is “a program that provides palliative care and attends to the emotional and spiritual needs of terminally ill patients at an in-patient facility or at the patient’s home.” Hastening a patient’s death should preferably be called physician-assisted dying.

However, the intent is contrary to the purpose of being responsible for directing medical service (cure sometimes, relieve often, and comfort always).

The 2010-2011 edition of the *Code of Medical Ethics* prepared by the Council on Ethical and Judicial Affairs of the American Medical Association contains approximately 200 ethical Opinions. Opinion 2.211 ~ entitled “Physician Assisted Suicide” was last updated in 1996 and reads as follows:

“Physician assisted suicide occurs when a physician facilitates a patient’s death by providing the necessary means and/or information to enable the patient to perform the life-ending act (eg, the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide).

“It is understandable, though tragic, that some patients in extreme duress ~ such as those suffering from a terminal, painful, debilitating illness ~ may come to decide that death is preferable to life.

However, allowing physicians to participate in assisted suicide would cause more harm than good. Physician- assisted suicide

is fundamentally incompatible with the physician’s role as healer, would be difficult or impossible to control, and would pose serious societal risks.

“Instead of participating in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Patients should not be abandoned once it is determined that cure is impossible. Multidisciplinary interventions should be sought including specialty consultation, hospice care, pastoral support, family counseling, and other modalities. Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication.”

The Massachusetts Medical Society distributed to all of its members a most thorough “Overview” and an “Opposition” statement entitled “Question 2: Prescribing Medication to End Life” that concluded:

“...instead of participating in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life ... Patients must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication.”

The issue was put to a State vote on November 6, 2012 and Ballot Question 2 was very narrowly defeated (51 - 49 %)!

Leonard J. Morse, MD, is Professor of Clinical Medicine, Family Medicine and Community Health, University of Massachusetts Medical School and Graduate School of Nursing as well as a past member and Chair of the Council on Ethical and Judicial Affairs of the American Medical Association.

Medical Marijuana in Massachusetts

James B. Broadhurst, MD, MHA

On November 6, 2012, voters in Massachusetts approved a binding ballot initiative entitled “An Act for the Humanitarian Medical Use of Marijuana.” The initiative becomes law on January 1, 2013. Licensed physicians play a central role in this law as a physician must provide a document to a patient certifying that “...the potential benefits of the medical use of marijuana would likely outweigh the health risks for the qualifying patient...” as well as identifying the debilitating medical condition which is the basis for the certification.

Several areas of the law need to be clarified through enabling regulation involving both the Mass Department of Public Health and the Mass Board of Registration in Medicine. The Mass Medical Society House of Delegates adopted policies on December 1, 2012, identifying the areas of particular importance to physicians. They include:

Defining the required “bona fide” physician/patient relationship

Providing for patient re-evaluation and parent/guardian permission for minors

Clarifying that the physician must be licensed in Massachusetts

Integrating marijuana dispensing with the existing DPH Prescription Monitoring Program

Adopting guidelines for certification developed by the American Society of Addiction Medicine

Detailed information on these policies and on implementation of the medical marijuana law is available on the MMS website at: www.massmed.org/AM/Template.cfm?Sec-

[tion=MMS_News_Releases&CONTENTID=80963&TEMPLATE=/CM/ContentDisplay.cfm](#)

Please remember that while this new law makes possessing and using marijuana for medicinal purposes legal in Massachusetts, the federal Controlled Substances Act remains in full force and technically, a physician who signs a medical marijuana certification will be violating federal law. Physicians who choose to participate should consult with their malpractice carrier as to whether or not their professional liability policy will respond if a civil case arises related to providing medical marijuana certification.



DR. CHRISTOPHER VAN KLEECK
Licensed Psychologist

19 CEDAR ST.
WORCESTER, MA
01609

NOW ACCEPTING
NEW PSYCHOTHERAPY
PATIENTS

VANKLEECK@CHARTER.NET
508-612-6212

International Views on the Legalization of Medical Marijuana

Joel Popkin, MD and Karthik Gnanapandithan, MD

Although marijuana has been used for thousands of years, with documentation going back to ancient China, it wasn't faring nearly as well by the 20th century. Most countries had classified it as an illegal drug. In the past couple of decades, however, there has been a growing movement to legalize marijuana, primarily for medical purposes.

Opinions on legalization of recreational marijuana have been shifting dramatically from the 1980s and early 1990s, when public support was around 20%. Last year, for the first time, a Gallup poll reported 50% of Americans supporting and 46% opposing the legalization of marijuana.¹ Others have mildly disagreed,^{2,3} but almost every recent poll has been fairly close to an even split.

Support for legalized medical marijuana, on the other hand, is enormously widespread, and medical marijuana use has been soaring where legal: 77% of Americans are now in favor.³ This past November was a landmark in the marijuana movement

in the United States, as Massachusetts became the eighteenth state to approve its medical use. This same election has complicated the use of medical marijuana, following the legalization for recreational use by Colorado and Washington ~ laws which undoubtedly will head for national test cases.

While the mixed emotions and controversy in the American population have been well described, views about medical marijuana from the rest of the world are relatively unknown. We therefore thought it would be of interest to conduct a survey, voluntary and anonymous, spanning a group of multinational professionals. We sought opinions as to how their countries' citizens would view legalization of medical marijuana in the homeland, as well as their own reflections on the subject. The table summarizes the numerical responses.

Our international colleagues voiced a wide range of personal opinions, and not necessarily in conjunction with what they felt was the majority view at home: "... I definitely favor legaliza-

Summary of Legalization Views (Y=Yes, NS=Not Sure, N=No)

Country	Personally Favor	Country Would Favor	Total
India	Y-7 (18%), N-31 (82%)	Y-1 (3%), NS-6 (16%), N-31 (81%)	38
Pakistan	Y-3 (23%), N-10 (77%)	Y-0, NS-1 (8%), N-12 (92%)	13
Philippines	Y-5 (50%), N-5 (50%)	Y-0, NS-3 (30%), N-7 (70%)	10
Nepal	Y-5 (83%), N-1 (17%)	Y-1 (17%), NS-2 (33%), N-3 (50%)	6
China	Y-2 (40%), N-3 (60%)	Y-1 (20%), N-4 (80%)	5
UK	Y-1 (25%), N-3 (75%)	Y-2 (50%), N-2 (50%)	4
Thailand	N-3 (100%)	N-3 (100%)	3
Saudi Arabia	Y-2 (66%), N-1 (33%)	N-3 (100%)	3
South Africa	Y-1 (50%), N-1 (50%)	Y-1 (50%), N-1 (50%)	2
Italy, Malaysia, Egypt, Singapore, Romania, Tanzania, Lebanon, Poland, So.Korea, Kenya	N-11	Y-0 (0%), NS-2 (18%), N-9 (82%)	9
Switzerland, Taiwan, Vietnam, Iran, Canada, Russia	Y-6	Y-3 (50%), NS-3 (50%), N-0 (0%)	6
All	Y-32 (32%), N-69 (68%)	Y-9 (9%), NS-17 (17%), N-75 (74%)	101

tion of marijuana, as there are not many adverse effects from the medical standpoint.” “I disagree with making marijuana a legally prescribed drug. I feel that it will become a very significant abuse issue.” “I believe legalization will save us some tax dollars. Marijuana should be treated just like alcohol. Perhaps half of the jail population is related to this issue and it’s such a waste of our resources.”

Commentators, independently of their personal opinions, were quite consistent in their predictions of acceptance (or lack thereof) by their home nationals.

Undoubtedly, the debate over legalization of medical marijuana in the United States will continue for the foreseeable future. In a preliminary look, it seems that these discussions are not confined to our shores, and global repercussions are on their way.

REFERENCES:

Nate Silver. *Gallup Poll Is First to Find Plurality Support for Marijuana Legalization.* New York Times. Oct 18, 2011.

Ariel Edwards-Levy. *Voters Back Legal Marijuana Usage, Divided Over Gay Marriage: Poll* The Huffington Post Dec 5, 2012

Fred Backus. *Poll: Public supports medical marijuana, but not full pot legalization.* CBS News. November 18, 2011.

Joel Popkin is a staff physician at Reliant Medical Group and the Director of Special Services for the St. Vincent Hospital Internal Medicine Residency. He can be reached at joel.popkin@stvincenthospital.com.

Karthik Gnanapandithan is a second year resident in the St. Vincent Hospital Residency Program and can be reached at karthik.gnanapandithan@stvincenthospital.com.

Food With Bite



BEST OVERALL RESTAURANT
BEST PLACE TO BE SEEN *and* BEST VEGAN & ORGANIC FOOD
 LUNCH | DINNER | FULL BAR | WEEKEND BREAKFAST 8A-2P



234 Chandler St. Worcester. 508 . 459 . 4240 www.evodining.com

down to earth acupuncture

DOWN TO EARTH ACUPUNCTURE IS NOW ACCEPTING REFERRALS.

SEND US YOUR STUBBORN CASES:

- CHRONIC BACK PAIN
- SEVERE MIGRAINES
- FIBROMYALGIA
- IRRITABLE BOWEL
- UNEXPLAINED INFERTILITY



**ACUPUNCTURE YOUR PATIENTS CAN AFFORD:
\$20-\$40 PER TREATMENT.**

**DOWN TO EARTH ACUPUNCTURE - (508) 890-8899
 65 JAMES STREET, SUITE 207, WORCESTER, MA 01603
WWW.DOWNTOEARTHACUPUNCTURE.COM**

Engaging Medical Clinicians in Oral Health

A tri-state initiative partnering CT, MA & RI

Foundation for Children
104 Hungerford Street
Hartford, CT 06106
Tel: 860 525 9738
Email: oralhealth.ctaap@gmail.com
Web: www.ct-aap.org/oralhealth

Funded by: 

Pediatric Oral Health Services Medical Providers Billable Services

MassHealth is promoting oral health guidance and application of fluoride varnish by physicians, their nursing staff or MAs. The role of the physician's office in oral health has demonstrated promising results for decreasing the occurrence of early childhood tooth decay.

Oral health education and fluoride varnish application are reimbursed by MassHealth for children up to age 21 at \$26 per fluoride varnish application. **If you saw 10 Medicaid children per week, this would be \$13,520 in revenue per year** and you would be providing a very valuable service to these children who are at risk of pain and suffering from early tooth decay.

Providing oral health education, fluoride varnish and referral to a dental home takes little time yet is so important for MassHealth members who do not reach out to obtain dental care but will see a primary care physician.

How can I learn more about oral health and applying fluoride varnish for my office staff and myself?

In order to prepare your office for providing oral health services, a **FREE** lunch and learn CME/CNE program **in your office** will:

- train physicians, physician assistants, nursing staff and medical assistants through hands-on practice
- assist administrative/billing staff with reimbursement procedures
- transform office flow to make adding the service easy and profitable
- provide fluoride varnish start up kits to use in your office immediately

What makes this training unique?

A trained dental hygienist will "adopt" your practice to help you get started and provide personalized technical assistance until you are providing the Medicaid billable fluoride varnish to your patients. All we require is a commitment from you to get started. You will keep your patients healthier and add new reimbursement to your practice.

I'm worried applying fluoride varnish will take too long to provide during a well child visit.

Offering fluoride varnish adds very little time to a visit. Providers are already discussing diet and brushing, and looking in children's mouths (we hope!). Fluoride varnish can be done as part of the mouth examination and adds less than a minute to the process. Some practices have chosen to have the nursing or medical assistant staff provide the varnish just before the vaccines as part of the care provided after the physician sees the patient.

What if the patient is seeing a dentist already?

If the child is at risk of caries you can still apply the varnish. It is safe and beneficial for children at moderate and high caries risk to have multiple fluoride varnishes a year. Medicaid pays for the application regardless of whether the child has received the treatment from a dentist.

Who is providing this FREE training?

Supported by the DentaQuest Foundation, this training program utilizes the Smiles for Life curriculum developed by the Society of Teachers of Family Medicine Group on Oral Health.

For more information on how to schedule a training session at your office, contact:

Ellen Sachs Leicher at 978-371-8816 or eslassoc61@aol.com

OR Megan Mackin, MassHealth/DentaQuest at 607-886-1728 or megan.mackin@dentaquest.com

The
WOUND CARE CENTER
at Harrington

Somehow,
The Wound Care
Center at
Harrington found
a way to heal my
wound when
nobody else
could. The doctors
and nurses knew
just what to do.
And they had
wonderful
technology that
I can't even
pronounce, much
less explain.

But the best part
is they did it.
My wound
is healed.
Finally.

That's all that
matters to me.



Our medical experts provide you with the individualized treatment plans and the most advanced wound care therapies available. Our specialized approach offers treatments that radically speed the healing process. It's time to get your life back.

10 North Main Street,
Charlton, MA 01507
508-248-8126

The
WOUND CARE CENTER
at Harrington

The Wound Care Center at Harrington is part of Harrington HealthCare Systems.



**Now she has a helping hand,
even when we're not there.**

When Grandma showed some signs of dementia, we didn't know where to turn. We were trying to arrange care for her, losing time at work and wondering what to do. A nursing home seemed like our only choice. Then we found Summit ElderCare®, a Program of All-Inclusive Care for the Elderly that has been providing compassionate and cost-effective care to older adults for over a decade.

Summit ElderCare is an insurance, medical care and social services program all in one convenient package that includes home care, personal care and even prescription drugs, when approved. And all approved services are fully covered with no copayments or deductibles.*

To learn more, talk to one of our enrollment specialists or visit us on the Web.

summit
eldercare® 

 fallon community health plan

A Program of All-Inclusive Care for
the Elderly (PACE) offered by Fallon
Community Health Plan

1-800-698-7566 (TDD/TTY: 1-800-889-4106)
www.summiteldercare.org

** In some cases, there may be a monthly premium required based on your income or assets. All services must be provided by or authorized by the PACE Interdisciplinary Team (except emergency services). PACE participants may be held liable for costs for unauthorized or out of PACE program agreement services.*

09-626-129 Rev. 01 8/11 SEH2219_2007_29 06/25/07

eisenburg



embracing • enhancing • enriching • empowering

du Lac Assisted Living
508.852.5800

Long Term Care Center
508.852.3011

Hospice
508.852.5505

Educational Bridge Center
508.852.1589

Notre Dame Health Care Center provides exceptional care and service giving residents, families, and visitors the peace of mind they need and desire. At every level, we give renewed meaning to the words family and community. Each of our programs offers expertise with respect, love, and compassion.



Notre Dame
Health Care Center, Inc.
www.notredamehealthcare.org

HEAD, SHOULDERS, KNEES & TOES...

With over
100 medical specialists,
we have your patients
covered head to toe.



**Reliant
Medical Group**
Atrius Health

***We accept most major
health insurance plans.***



(800) 283-2556

www.reliantmedicalgroup.org/specialties





*Whether you're thinking of buying a property
or you have one you'd like to sell,
we're the right firm for the job.*

- #1 listing & selling office and company in Worcester, Worcester County, all of MA.
- We have the most innovative and far reaching marketing initiatives that are designed to attract the attention of the largest and most qualified buyers looking for property.
- Our remarkable tools and agent experience make the home buying process a successful and pleasing one.

*See why more people hire us to sell
their home or buy the next.*

COLDWELLBANKERWORCESTEROFFICE.COM



508.795.7500
196 Park Ave., Worcester, MA 01609

NEMOVES
MORTGAGE LLC
Call Chris Stelmach
508-635-6770
for financing options