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Health Information Technology: *The Changes and The Promises*



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Health Information Technology: The Changes and The Promises



Paul M. Steen, MD

Now that we have an Office of the National Coordinator for Health Information Technology in Washington signaling the start of the national effort on electronic records, we felt it was time to take a look at some of the issues involved. The best conceptual statement of Health Information Technology (Health IT) is: it allows comprehensive management of medical information and its secure exchange between health care consumers and providers. Its proponents hope that it will improve health care quality, prevent medical errors, increase the efficiency of care and reduce unnecessary health care costs, increase administrative efficiencies, decrease paperwork, expand access to affordable care, and improve population

health. It is very idealistic to think all of this will happen on the first efforts, but with good input from health care professions it is a vision to shoot for.

George Abraham's article on the value of the electronic record is a great primer on how we got here and what the issues are in more depth. Larry Garber's article shows one institution's implementation of Health IT. There are three major types of Health IT: 1) consumer-usage via personal health records (PHR), 2) physician-usage via electronic health records (EHR) and 3) electronic prescribing (e-Rx). These are thoroughly explored in Deb Drexler's article and should be your starting point in understanding these types of electronic transmissions.

Those concerned about Health IT center their issues on security and privacy issues. As this process moves forward nationally, all personal health information will be available electronically to your doctor and other health care providers and health plans as well. In the past few years, there have been security breaches in hospitals and doctors' offices. As Health IT becomes more prevalent, these will become more common occurrences. Jeffrey Geller discusses these issues from the viewpoint of psychiatry. Psychiatry was chosen as the area where the greatest concern has been expressed over privacy issues. This issue covers just the tip of the iceberg in Health IT. But we need to raise awareness as this new national effort to expand and ~ we hope ~ standardize Health IT takes off. There needs to be input from health professionals as the rules and regulations are being prepared, not after they are announced and are almost impossible to change. This process can do very good things for medicine if we are involved ~ or bad things if we don't keep our vigilance up.

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contents

Vol. 74, No. 5

SEPT./OCT. 2010



On the cover:
Health Information Technology:
The Changes and The Promises

- | | | | |
|-----------|--|-----------|---|
| 6 | Editorial
Paul M. Steen, MD | 18 | Legal Consult
Peter Martin, Esq. |
| 8 | Personal Health
Records: A Primer
Deborah L. Drexler, JD | 20 | As I See It
Joel H. Popkin, MD |
| 12 | Electronic Medical
Records (EMRs): Boon
or Bane?
George Abraham, MD, MPH, FACP | 22 | As I See It
Larry Garber, MD |
| 14 | Panacea or Pandora's
Box: Electronic Health
Record in Psychiatry
Jeffrey Geller, MD, MPH | 24 | Financial Advice For
Physicians
Greg Thomas |
| 16 | History of Medicine
Sande Bishop | 27 | In Memoriam
Robert A. Bolduc, MD
Paul A. Ricciardi, MD
James P. Walsh, MD |
| | | 30 | Society Snippets |

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Personal Health Records: A Primer

Deborah L. Drexler JD

Most health care providers are familiar with Electronic Medical Records (EMRs), either because they have an EMR system in their practices or are in the process of implementing one. Most health care providers have also accepted that EMRs are here to stay.

But these same health care providers often have questions about Personal Health Records (PHRs). Some wonder how PHRs are different from the more familiar EMR. Some wonder what to say to their patients about PHRs. Others wonder if they should offer a PHR to their patients through their practice's website. And some wonder if they should start a PHR for their own personal use.

This article will answer these and other questions about PHRs.

What is a PHR?

Like an EMR, a PHR is a record of a patient's medical information. But unlike an EMR, a PHR is under the individual's control, not the provider's. This defining characteristic was affirmed legislatively by the HI-Tech Act of 2009 which contains the following definition of a PHR:

"...electronic record of ...identifiable health information... about an individual that can be drawn from multiple sources and that is managed, shared, and controlled by or primarily for the individual."



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In summary, patient control is what makes a PHR different from an EMR. An EMR is a legally mandated record of the services provided to a patient during a particular patient visit. While the information contained in an EMR is highly regulated by federal privacy and security regulations, and while patients retain certain rights with respect to that information (such as a right to access the information or to request that it be amended), the EMR itself remains under the control of the provider who created it.

In contrast, a PHR is created, managed, and controlled by the patient. A provider treating that patient has no right to see that PHR and can do so only if the patient allows it.

What types of PHR exist?

There are three types of PHRs: paper based, application-based, and internet-based.

The earliest PHRs were paper-based (many providers will remember the diminutive blue booklet which pediatricians gave to new mothers to track their infants' immunizations). Paper PHRs still exist today. They can be unstructured and informal: notes kept by a patient in a blank journal can serve the function of a PHR. But paper PHRs can also be kept in a structured format. For example, the American Health Information Management Association (AHIMA) posts free PHR forms on its website.¹ The PHR form for adults is 15 pages long, with 19 separate sections!

Paper PHRs are easy to use, secure, and low cost. However paper PHRs can sometimes be hard to read, and they are subject to loss, theft or destruction. More significantly, as medical care gets more complex, and as patients live longer, a paper PHR often becomes unwieldy and disorganized.

In recent years, vendors have begun offering electronic PHRs² which make it easier to read and organize large amounts of medical information. An electronic PHR can be either application-based or internet based:

- An application-based PHR is a software program. Using the program, a patient enters medical information into a computer and then stores that information either on that computer or on an associated device (i.e. CD, flash drive, or smart card) ~ or both. Some application-based PHRs available today are Med-InfoChip, the World Medical Card, and CheckUp.
- An internet-based PHR is a web service under which a patient enters medical information into the PHR vendor's computers using a web browser. The PHR information is stored on the PHR vendor's computers in the PHR vendor's data center.

Well-known examples of internet-based PHRs are Google Health, WebMD Health Manager, and Microsoft Health Vault.

An application-based PHR allows patients to have sole physical control over their medical information. The medical information created with an application-based PHR never has to leave the patient's possession. The patient can easily choose who can have access to the PHR by simply handing or not handing over the associated storage device.

In contrast, patients using an internet-based PHR do not have physical control of their information ~ since that information is stored on the PHR vendor's computers. But internet-based PHRs can provide more advanced features and more convenience than an application-based PHR. Internet-based PHRs can allow patients to provide their family members, their health care providers, and others with convenient access to the PHR. Internet-based PHRs can be accessed from any computer with internet access. Internet-based PHRs can set up a mechanism to allow a patient's health care providers to download data directly into that patient's PHR, thus sparing the patient the inconvenience of typing it in directly. Some internet-based PHRs maintain direct relationships with health care providers, thus allowing patients to use their PHR to communicate and schedule appointments with their doctors.

Who offers PHRs?

PHRs are often marketed directly to patients. But increasing numbers of patients are also able to obtain an internet-based PHR service through a third party ~ typically the patient's health care provider, employer, or health insurer. In these situations, the provider, employer or health insurer contracts directly with the PHR vendor to offer the service. The provider, employer or health insurer keeps the PHR service separate from other systems containing information about the patient, has no access to the PHR unless the individual grants it, and maintains no control over its content and use.

Why use a PHR?

Experts advocate that individuals use PHRs for the following reasons:

- To become more involved in their care
- To consolidate many different sets of medical records into one document
- To save the cost and inconvenience of unnecessarily repeating diagnostic tests
- To efficiently communicate allergies, medications and medical histories to their health care providers
- To help detect errors in other medical records

- To keep track of other important health related information such as health care proxy information, donor status, and insurance account numbers.

In addition to the above benefits to the individuals, health care providers offer patients a PHR for several additional reasons: to more conveniently obtain information about the patient's other medical visits, to decrease the administrative burden of appointment scheduling and reminders, to easily distribute clinically relevant educational materials, and to create a mechanism to monitor patient compliance.

There are also reasons why employers and insurers offer PHRs: to provide a benefit to the individual, to support overall health and wellness, and to simplify certain administrative transactions.

What are PHR vendors allowed to do with patient data?

Some patients are uneasy about the fact that internet-based PHR vendors store PHR information on their own computers. These patients may wonder how the PHR vendor will use their data.

The Hi TECH Act of 2009 states that any vendor providing a PHR to individuals through a contract with a HIPAA-covered health care provider or health insurer is a business associate of that entity. This essentially makes the PHR vendor subject to all HIPAA requirements. In these cases, potential PHR users may be comforted to know that the PHR vendors are subject to the same HIPAA regulations as the provider or health insurer offering the PHR.

But neither the HIPAA requirements nor any other health care law applies to vendors that provide PHRs directly to patients. Rather, these vendors are subject to the Federal Trade Commission (FTC) Act prohibiting

companies from engaging in fraudulent or deceptive trade practices. The FTC has taken the position that a company must abide by the statements it makes in its privacy notices. Failure to do is in itself an unfair and deceptive trade practice.

Virtually all internet-based PHR vendors post a privacy notice on their web pages stating what they will do with the information in their possession. Since companies are required to abide by these statements, it is important for potential PHR users to review them carefully. PHR vendors vary widely in the level of detail that they provide in their privacy notices. In general, all of them promise that they will not use a patient's medical information for any purposes unrelated to the PHR.

What happens if an internet-based PHR vendor experiences a security breach?

The Hi-TECH Act of 2009 requires all vendors of internet-based PHRs, regardless of whether they provide their services directly to patients or through a provider, employer or health insurer, to notify individual PHR users if any of the security of any of the identifiable information in their possession is breached. This will allow a patient to take any steps necessary to lessen the chance of financial or medical identity theft pursuant to the breach.

How should a health care provider use a PHR?

PHRs have an important place in the increasing complex health care field. Until EMRs are as ubiquitous and interoperable as ATM machines (a prospect which is not likely to happen soon), PHRs provide a convenient way to accumulate all medical information in one place. A provider who can access a patient's PHR will often be able to discern clinically relevant information about a patient much more quickly than

would be possible by talking to the patient. Because of this, providers might welcome the chance to review a patient's PHR during the course of clinical care.

One caveat, however: it is important for providers never to assume that the information in a PHR is 100% complete or accurate. By definition, a PHR allows an individual to choose which information to include in the PHR and which information to omit. Some patients might choose to omit information about conditions often referred to as "sensitive:" information relating to HIV status, substance abuse diagnoses, or mental illness. Other patients might choose to omit completely different categories of information. It is also possible that, either by accident or design, information in the PHR is inaccurate. Providers will get greatest benefit from PHRs by considering the information in there helpful, but not the final word.

Health care providers might also consider starting their own personal PHR. This will allow a provider to become familiar with the benefits and problems of PHRs and to speak more knowledgeably about the subject with patients. It is also possible that providers who do so will benefit personally in their own health care experiences.

Deborah Drexler is a health care attorney. She is currently the Chief Compliance Officer for the Caritas Christi Health Care System.

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(Footnotes)

1 Available at http://www.myphr.com/index.php/start_a_phr/choose_a_phr/. Retrieved July 23, 2010

2 The remainder of this article will focus on electronic PHRs only.

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Electronic Medical Records (EMRs): Boon or Bane?

George Abraham, MD, MPH, FACP



George Abraham, MD

Today's "buzz" in the healthcare field is all about electronic health/medical records (EHRs/EMRs) and how they have "revolutionized" the delivery of healthcare today.

In the 1960s, a physician named Lawrence L. Weed first described a system to automate and reorganize patient medical records to improve their functionality and, consequently, patient care. His work formed the basis of the

PROMIS project at the University of Vermont, a collaborative effort between physicians and information technology experts started in 1967 to develop an automated electronic medical record system. The group's efforts led to the development of the problem-oriented medical record, or POMR. Also in the 1960s, the Mayo Clinic began developing electronic medical record systems.¹

In 1970, the POMR was used in a medical ward of the Medical Center Hospital of Vermont for the first time. Over the subsequent few years, drug information elements were added to the core program, allowing physicians to check for drug actions, dosages, side effects, allergies and interactions. At the same time, diagnostic and treatment plans for over 600 common medical problems were devised.

Since these initial steps, EMRs have come a long way, and with the passage of the 2010 Healthcare Reform Bill², there are Federal monies being offered to all physician practices to transition from paper to electronic records.

In weighing the pros and cons of such a transition, several advantages to having an EMR come to mind:

At the outset, the efficiency of not having to retrieve records to file and refile sheets of paper with lab tests, communication sheets, consult notes, etc. creates huge annual savings in both time and cost of personnel. Couple that with the added advantage of not having to worry about loss of documents or misfiling, and the advantages mount.

For individual patients, care becomes safer when important information such as current prescriptions, allergies, medical conditions and other aspects of their medical history are accessible quickly at the point of care or during a telephone encounter. Further, such information can be appropriately shared with other providers or facilities, improving communication and decreasing overall healthcare costs by avoiding duplication of tests due to inaccessibility of information.

Electronic records require minimal storage space, can be "backed up" remotely to prevent complete loss of information, exactly what has happened to hospitals in New Orleans during Hurricane Katrina.

Other safety benefits include being able to perform "real-time" drug-drug interactions, the use of "clinical decision support" systems to guide appropriate testing and treatment, and access to current information via the web.

However, all is not "motherhood and apple pie" as is made out to be, above. Physicians are creatures of habit and are loathe to make changes, especially something as dramatic as a transition to EMRs. Experience from the Massachusetts E-Health Collaborative (MAeHC) has demonstrated that physician adoption of EMRs has been sub-optimal even when they are given the EMR free of charge.

That said and done, costs of transitioning are not inconsequential; they include the cost of software, hardware, additional equipment

such as digital scanners, wireless routers, a computer server, etc., all of which quickly add to the cost. Studies and experience with EMRs have demonstrated the most value for physician practices with 5 or more members; smaller practices spend more per capita and take longer to realize the gain.

Further, adoption of an EMR is more than merely dictating or typing up a note that was formerly handwritten. Intelligent use of an EMR, which the federal government through the Office of the National Coordinator has termed “meaningful use” and for which alone it is willing to incentivize adoption of an EMR, involves performing a number of additional tasks. These tasks include but are not limited to maintaining active medical problem and medication lists, tracking and updating those lists at every encounter (medication reconciliation), being able to develop “disease registries” whereby patients in a practice with a particular disease state can be tracked for overall compliance and adherence to prescribed goals, etc.; all are integral to enhancing the quality of care and consequent outcomes in a particular patient population.

EMR vendors have mushroomed in number, each promising to deliver everything that “meaningful use” requires and to provide dazzling demonstrations of all that their EMR can do. The unknowing

customer (the physician) falls for some of this showmanship and buys one of these bundles, only soon to realize that there a number of “unspoken” caveats during implementation that often lead to added costs and suboptimal functionality. Additionally, one soon realizes that it is not easy to switch vendors or applications, given that no product talks to another and there is no common platform that ensures that information can flow seamlessly from one product to another.

In summary, it is an exciting time of transition in the healthcare landscape, but one also fraught with challenges. Among the most significant of them is the fact that we are in our “infancy” when it comes to EMR use; the challenges and anxiety of a new “mindset” is probably the biggest barrier to successful implementation of an EMR in a practice.

George Abraham, MD is Medical Director of Central Massachusetts Independent Physician Association, LLC and in independent practice in Worcester. He is also Past President of WDMS.

(Endnotes)

1 Pinkerton, K. EzineArticles.com

2 Patient Protection and Affordable Care Act, 2010

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Panacea or Pandora's Box: Electronic Health Record in Psychiatry

Jeffrey Geller, MD, MPH



Jeffrey Geller, MD, MPH

In psychiatry, the use of the electronic health record (EHR) and related computer-driven medical communications, e.g. e-prescribing and psychiatric-patient emails, may be higher stakes innovations than in other fields of medicine. Like all areas of medical practice, psychiatry has a significant percentage of its focus on chronic diseases. But psychiatry is the contemporary home of the most stigmatized disorders. This fact

casts a shadow over psychiatric, electronic communications distinct from other medical fields.

This paper examines observations and quandaries about the EHR in psychiatry from the perspectives of: 1) confidentiality/privacy, 2) quality of psychiatrist-patient contact, 3) quality of the treatment, 4) quality of the records, 5) safety, 6) stigma, and 7) work flow. It is worth noting at the outset that the jury is still out on all of these.

Confidentiality/Privacy is the major concern about the EHR in psychiatry. Unauthorized access, with information used to the patient's disadvantage, is a fear expressed by patients and psychiatrists who are for or against using the EHR now. One suggested method to address this concern is to apply the restrictions used to protect the records of persons involved in drug and alcohol treatment (42 CFR Part 2) to all electronic psychiatric records. This regulation requires, with very few exceptions, a person's signed release explicitly for any information in the record

that would identify an individual as a drug and alcohol abuser. A useful resource here is Frequently Asked Questions: Applying the Substance Abuse Confidentiality Regulations to Health Information Exchange, available on the Substance Abuse and Mental Health Services Administration's (SAMHSA) website.

Psychiatry is dependent upon and exquisitely sensitive to the physician-patient relationship. Will this relationship be tampered with, or even profoundly interfered with, when a laptop is interposed between doctor and patient? Even with paper records, a patient will say to her psychiatrist during an appointment, "Close my medical record and look at me."

A major impediment to the efficacious treatment of persons with chronic mental illness (CMI) is fragmentation of care. The greater the degree to which the EHR allows information to flow throughout

Confidentiality/Privacy is the major concern about the EHR in psychiatry. Unauthorized access, with information used to the patient's disadvantage, is a fear expressed by patients and psychiatrists who are for or against using the EHR now.

a network of practitioners who share in caring for an individual with CMI, the greater will be the potential for any one person's treatment to be more effective, safer, and more comprehensible to the patient. But if the patient holds back, or fabricates data for fear of breach of confidentiality, all gains are in peril.

The quality of the psychiatric record is not necessarily improved by an EHR. This has already been shown, but seems to escape practitioners' comprehension. Repeatedly, we hear how a hospital or clinic's treatment planning, for example, will improve "as soon as we get an EHR." If only this were true. A poor treatment plan done with pen and paper will be the same as a poor treatment plan done electronically, only now it will be easier to read and just how poor it is will be more evident.

The EHR has the potential to improve patient safety. All loci of treatment can access a common crisis plan. A patient's warning signs of decompensation can be assessed by all providers. Current medications can be known, thus decreasing medication errors such as continuing discontinued medications. The risk to the patient, however, is that all manner of information not required to be known for his/her safety travels with that which needs to be known.

The bedrock of the Pandora's Box aspect of the EHR in psychiatry is stigma. That chronic mental illness remains the leprosy of our era will not be solved ~ not even addressed ~ by the EHR. The campaign against stigma must be won if the EHR is to be a viable tool in psychiatry.

One aspect of the EHR that only indirectly affects the patient is workflow. Many psychiatrists have opined that the EHR "just takes longer than doing it by hand." This may well be a transition issue. Certainly the next generation of physicians will not struggle with computer literacy and facility.


Of related interest, e-prescribing may be a bigger burden for psychiatry than other fields of medicine due to psychiatry's disproportionate prescribing of controlled substances (see the DEA's interim final rule). E-mailing between patient and psychiatrist is more muddled than most other areas of medicine, due to the very content of the e-mails.

The EHR holds promise for the patient with a psychiatric disorder to be more a part of her treatment. She could, for example, make direct entries into her own medical record. Who, if anyone, monitors that?

A patient once said to me, "I have schizophrenia, you have snoophrenia." Will the EHR exacerbate that feeling? Or will a shared set of information allow the patient and psychiatrist to feel more like we are partners in this together? Tune in between 2015 and 2020 and we'll find out.

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Stalking the Doctors of the Full Moon

Sande Bishop

This article is excerpted from the presentation given by Sande Bishop on March 27, 2010, at the Worcester Historical Museum for Doctors' Day.

What started as a little jaunt into local medical history became a major excursion when Joyce Cariglia introduced me to a small wooden box filled with handwritten medical papers, penned between 1834 and about 1845. The carefully folded papers were tied into bundles with faded red ribbons.

From the contents of the box, a collection of more than 400 papers, I learned that a group of physicians met regularly to discuss medicine in general and their own cases in particular. Today, I will share some of the fun I've had ~ my journey acquired aspects of a treasure hunt, trying to figure out where to go and what to do with each clue. There were a lot of dead ends, but also some unexpected and intriguing finds....

First, the doctors penned a constitution and rules for their society, the Union Medical Association. They agreed that attendance was mandatory, with a fine of 25 cents for tardiness or absence. They also charged 25 cents to anyone who failed to deliver a paper. Rule #3 specified that the Association meet on the Monday closest to the full moon. I puzzled over this. Why would the doctors choose to meet at the full moon, instead of, for example, the third Monday of the month? After some research, I learned they simply appreciated the extra moonlight for the buggy ride home!

The box contains only medical cases and dissertations, with no clues about the writers. The stories you hear today are what I have learned about the twenty-two doctors who wrote the reports. Some, like Nathan Adams, contributed only once, but six attended fairly regularly throughout the decade ~ from Rhode Island, Drs. Hiram Allen of Woonsocket and Metcalf Marsh of Slatersville, and from

Massachusetts, Drs. Ariel Ballou of Blackstone, John Metcalf and Abel Wilder, both of Mendon, and Moses Southwick of Millville....

The most striking fact is how well educated most of these doctors were. In an age when anyone could hang a shingle and call himself a doctor, it is impressive that many of the doctors of the Union

Medical Association not only went to college, but also attended medical school....

Of the six I mentioned, four graduated from medical school and two went to both college and medical school. The records are tricky ~ let me

give you an example. The family genealogy claims that Dr. Wilder "attended medical lectures at Dartmouth;" however, the Dartmouth Directory lists non-graduates as well as graduates and they have no record for Dr. Wilder.

If the family records are wrong about Dartmouth, the question remains whether Dr. Wilder graduated from a different medical school. Probably he did not, and I say that because he was accepted into the Worcester and Massachusetts Medical Societies without a record of passing the censors' entrance exams or presenting any papers. He was admitted simultaneously to both organizations in 1824 with the comment that he had been in practice already for 12 years. He was probably grandfathered....

Dr. Southwick applied for membership in the Worcester Medical Society in 1830 and was refused entry until "...he shall produce evidence of having studied medicine at least three years before he was examined for his Degree." That refusal must have distressed him, because after a short practice in Millville, according to the family genealogy, he spent three years in Wellfleet, probably doing an apprenticeship.

The box contains only medical cases and dissertations, with no clues about the writers. The stories you hear today are what I have learned about the twenty-two doctors who wrote the reports... The most striking fact is how well educated most of these doctors were.

After considerable time at the Historical Society and the Library in Wellfleet, I have been unable to find evidence that Dr. Southwick was there. However, a graduate of Bowdoin Medical College practiced in Wellfleet and Eastham at that time and it is reasonable to suppose that Bowdoin was the connection between the two. In any case, Dr. Southwick, in 1834, on presentation of both his medical diploma and evidence of an apprenticeship, was granted membership in the Worcester Society, of which, in the 1860s, he served as president.

I think the doctors were all Protestant, temperance supporters as well as ardent abolitionists. Most were considered Reformers. Several Association doctors served in their respective state legislatures, both in Massachusetts and Rhode Island. One introduced the bill that abolished capital punishment in Rhode Island. Through Probate Court records it is clear they did not die wealthy. In fact, at least one of the doctors of the group died bankrupt.

One of the more interesting chronicles concerned two physicians of the organization who testified in court about the mental status of a patient. It was an ugly family battle, where the father was represented as a nasty old man and was probably demented.

Most of the physicians moved around during their careers, which made tracing them difficult. For example, one was born in Winchendon, married in Swanzy, and had children born in Bristol, Walpole, Blackstone and Mendon before moving to Rochester, N.Y., and dying in New York City. Some of the members of the Association have been impossible to trace.

I have spent a long time stalking these doctors, who met at the full of the moon, and have become very fond of them. Some left such a legacy that I have gotten to know them well ~ they feel like friends. We should be thankful they bequeathed to us the remarkable treasure stored in the little box, which now resides at the Worcester District Medical Society, and I am appreciative of the freedom and support the Society has given me to delve into the rich legacy of the Union Medical Association.

Sande Bishop is a local historian.

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The Hitech Act and the Continuing Expansion of HIPAA

Peter Martin, Esq.



Peter Martin, Esq.

Within the space of a few days this July, the federal government issued two different sets of rules promulgated under the American Recovery and Reinvestment Act of 2009, popularly known as the “stimulus bill.” Whereas one set of regulations promises financial assistance for adopting and using EHRs, the other set of rules imposes additional regulatory burdens on providers relating to

the privacy and security of the information found in such EHRs.

The first set of rules were final regulations that among other things define “meaningful use” by health care institutions and practitioners of EHRs for purposes of qualifying for some \$20 billion in stimulus funds intended to foster the development and adoption of EHRs. The second set of rules, issued pursuant to the Health Information Technology for Economic and Clinical Health, or HITECH, Act (which is a part of ARRA) propose long-promised expansions to the scope of HIPAA. While the “meaningful use” regulations are important, the stimulus funding available to “meaningful users” of EHRs will not be available until the beginning of 2011; in contrast, the HITECH Act regulations will likely be finalized before then and will have an impact broader than the likely number of “meaningful users” of EHRs.

The HITECH Act regulations expand on the definition of “business associates” to include patient safety organizations and data transmission entities such as health information exchanges, as well as vendors of personal health records. It also makes the sub-contractors of business associates, and those sub-contractors’ own sub-contractors, “business associates” as well, each of whom must have a business associate agreement or other reasonable written assurance that the entity or individual will adhere to applicable HIPAA rules. The practical consequence of this is that business associates, and covered entities which may be acting as business

The new regulations also enhance the enforcement of the HIPAA privacy and security rules. HIPAA is going from a complaint-driven enforcement scheme to one in which the government may initiate compliance reviews entirely apart from a complaint.

associates, will have to examine their sub-contractor relationships to determine if even more business associate agreements need to be negotiated and signed.

Another related change brought by these new rules has already been widely discussed ~ the need to amend the many thousands of business associate agreements already in place. The new rules require that these agreements contain provisions stating that the business associate will: comply with the security rule, report breaches of unsecured protected health information to the covered entity, ensure that its subcontractors apply the same restrictions and conditions on the use of PHI as apply to the business associate, and comply with the same privacy rule requirements as does the covered entity. The government does not estimate the costs of re-negotiating and re-executing business associate agreements, in part because it promises to provide its own sample contractual provisions in the final rule, thereby allegedly minimizing the costs to the provider community. This of course does not address the costs in both time and money of reviewing and administering this massive re-contracting effort, some of which has already occurred. Providers are, however, given an additional year after the final regulations’ compliance date in order to accomplish this task.

Another potential paperwork nightmare created by the new regulations is the need to revise providers’ Notices of Privacy Practices. These documents must now contain a disclosure that

most uses and disclosures of psychotherapy notes and for marketing purposes will require a patient authorization, as will any disclosures of PHI for which the provider receives any remuneration. In addition, if the provider anticipates receiving any remuneration from a third party for making written communications regarding treatment with his/her patient, then the Notice of Privacy Practices must notify the patient of a right to opt out of receiving such communications. The government anticipates that over 700,000 separate entities will be affected by this requirement, and that it will cost the private sector over \$118 million, based on an official estimate that revising the Notices of Privacy Practices will take each provider twenty minutes.

The new regulations also enhance the enforcement of the HIPAA privacy and security rules. HIPAA is going from a complaint-driven enforcement scheme to one in which the government may initiate compliance reviews entirely apart from a complaint. Penalties are greatly enhanced and in determining the amount of the penalty, the government is now allowed to take into account the extent of the violation, in terms of both the time period and the number of people affected. Moreover, covered entities will now be liable potentially for their business associates' violations of HIPAA, even if the covered entity was not aware of any pattern or practice by the business associate that violates HIPAA. This will increase the incentives for covered entities to monitor more closely the activities of their business associates.

The new regulations contain other new requirements, pertaining to, among other things, patient authorizations where the provider receives remuneration related to a disclosure of PHI, or with respect to certain research projects, and the authority of family members to authorize disclosures of a decedent's PHI. However, the major focus of the newly-issued rules is on the continuing expansion of the HIPAA universe to include new regulated entities, new enforcement weapons, and new unfunded regulatory mandates on health care providers. As the movement toward wider adoption of EHRs gathers steam, the privacy and security concerns associated with the increasing ubiquity and accessibility of those records will likewise grow and may motivate the imposition of more bureaucratic requirements on providers.

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.

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A HIPAA's Thick Hide

Joel H. Popkin, MD



Joel H. Popkin, MD

HIPAA, the Health Insurance Portability and Accountability Act, was created by Congress to regulate against inappropriate use of protected health information. Although laudable in principle, the National Committee on Vital Health Statistics in 1997 had found no evidence of significant medical or health research threats to privacy and confidentiality ~ i.e., no rational justification for its creation.

As best as I can tell, we have

done no better in justifying its existence. Meanwhile, the cost and complexity of this act has become incalculable: exactly how much, no one can fathom, but we do know it is staggering ~ at least tens of billions of dollars ~ without demonstrable benefit.

Anyone even remotely connected to medical work must regularly take inane, instantly forgettable courses regarding privacy. Electronic records are now sometimes dangerously difficult to access, compromising the exchange of vital medical information and negatively impacting on patient care. HIPAA has also frequently led to the abandonment of exceptionally important research studies, simply because of the expense and frustration in meeting the regulations.

If the law requires us to keep confidentiality paramount ~ and certainly that should be our goal ~ every health care worker could simply sign a document annually attesting to having read and understood the concepts of privacy and consequences of non-compliance. We don't specifically need to instruct the public that robbing banks is against the law. There are bad guys who will rob banks anyway, just as there are bad guys in health care who will challenge any system, no matter what we do. But for bank robberies we assume

a general understanding of the law and focus on the consequences of breaking it; with HIPAA, we consume ourselves on "education" about the law, while, ironically, consequences are nil. Were simple privacy laws responsibly applied, our patients would be protected as adequately as the HIPAA bureaucracy has done, without the squandering of resources that could otherwise provide immunizations, nutritional resources, and education to every child in the country, while saving trees, carbon footprints, and what's left of sanity in the health care system.

HIPAA, like many other laws, was well intended at its inception. But it is time to admit that the implementation has gone amuck, to say the least. Unfortunately, the job of modulation is daunting ~ especially when non-regulated regulators are generally allowed to operate at will and since most can effectively convince our citizenry that they act in the public interest. HIPAA has metastasized widely, and our leaders may not have the gumption to treat responsibly or even the knowledge that they should do so. In this time of economic crisis and only stalemates to deal with it, maybe someday a bipartisan bulb will light up, and responsible leaders will analyze what has actually been done. Maybe they will even act on that information.

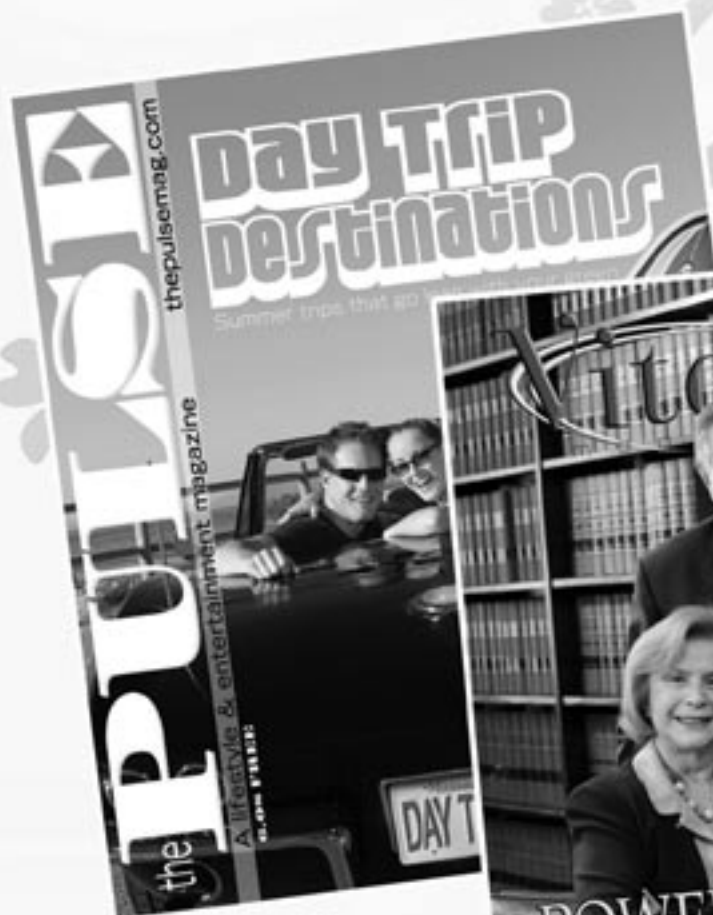
Joel H. Popkin, MD, is Associate Professor of Medicine, University of Massachusetts Medical School, Staff Physician, Fallon Clinic, and Director of Special Services, St. Vincent Hospital.

An advertisement for Worcester Medicine. On the left, there is a photograph of a female doctor in a white lab coat standing next to a male cameraman who is filming her. The text "WORCESTER medicine" is overlaid on the top of the photo, and "Medicine and Media" is written below it. To the right of the photo, the text reads: "Prescription for Success!" in a large, handwritten-style font. Below that, it says "Advertise in the next Worcester Medicine space deadline is September 3rd". At the bottom, it provides contact information: "Contact David Simone at 508-756-5006 or dsimone@pagoinc.com".

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The Future of Healthcare Has Been Alive and Well for Years in Central Massachusetts

Larry Garber, MD

Fallon Clinic, a 250-physician multispecialty group practice, over the past 18 years developed interfaces to 5 regional hospitals, a reference lab, an imaging center, a Quality Data Center, a home health agency, and a health plan. These interfaces pass discrete test results as well as textual documents directly into Fallon Clinic's EHR in a seamless manner. For instance, mammograms performed at one of the interfaced hospitals will appear on the imaging tab in the EHR

right next to imaging studies done at other facilities. This mammogram also automatically satisfies health maintenance reminders so no unnecessary alerts appear. Similarly, claims data from the health plan for a Hemoglobin A1C done outside of Fallon Clinic's interfaced systems appear on the lab tab next to other labs performed on that patient, and satisfy EHR disease management reminders as well as Massachusetts eHealth Collaborative/Massachusetts

Medical Society Quality Data Center reports. Claims from visits to an Emergency Room for a laceration while a patient is away on vacation create an ER Encounter in our EHR and automatically update the patient's tetanus immunization status. For the past 18 years, Fallon Clinic has similarly been loading medication claims data into the patient's medication list where it is possible to view medication compliance and the number of refills remaining on a patient's prescription, regardless of prescriber or the pharmacy that they used to fill it.

Fallon Clinic is nationally recognized for this and other innovative interface work. Indeed, Fallon Clinic is the recipient of the 2009 Association of Medical Directors of Information Systems (AMDIS) Award. For example, significant surgical procedures and diagnoses from billing and claims are reloaded back into the EHR

to automatically populate the Past Surgical Hx and Past Medical Hx respectively. This, and the fact that 15 years of historical notes, test results, medications, allergies, and immunizations were loaded through interfaces into Fallon Clinics EHR when it went paperless 3 years ago, have led to the extraordinarily successful implementation of this EHR from Epic Systems Corporation. As a result of this electronic "abstracting," it appeared to the user when the system

went live, as if the EHR had been in use for 15 years, with encounters from 1992 showing the transcribed notes, billing diagnoses, prescriptions, and test results all linked together. Combining this robust EHR with a carefully staged rollout plan and Nuance's Dragon Medical Speech Recognition software has allowed Fallon Clinic to meet the needs, skill sets, and comfort levels of all of its physicians. In fact, Fallon Clinic only experienced a minor drop in productivity that

lasted two weeks during each EHR site go-live.

Patients have access to their Epic EHR using a tethered Personal Health Record (PHR) where they automatically receive their test results, can view most of their electronic record, have instant access to a linked medical encyclopedia, and can send secure emails to their Fallon Clinic physicians. This not only provides more convenient service to patients, but also empowers them to participate in their care with tools to make that possible.

Fallon Clinic continues to advance healthcare with SAFEHealth.org, a live and sustainable federated Health Information Exchange written by the Fallon Clinic IT Department with the assistance of a \$1.5 million AHRQ grant, designed to simplify the patient consent process and to integrate clinical data directly into other EHRs.

Fallon Clinic continues to advance healthcare with SAFEHealth.org, a live and sustainable federated Health Information Exchange written by the Fallon Clinic IT Department with the assistance of a \$1.5 million AHRQ grant, designed to simplify the patient consent process and to integrate clinical data directly into other EHRs.

Emergency Room physicians feel that clinical data easily obtained through SAFEHealth has resulted in fewer hospital admissions, fewer tests ordered, and safer medical care.

Fallon Clinic has been able to provide exceptionally high quality care to their patients as a result of this Health Information Technology. For instance, in 2009 Fallon Clinic exceeded the 90th percentile nationally for 22 of the 36 Commercial HEDIS Quality Measures for which comparisons are available, and is the benchmark for the state of Massachusetts in 8 of these. At the same time, Fallon Clinic has a reputation for providing highly efficient, cost effective care to a large degree as a result of health information technology. And since SAFEHealth went live in June of 2009, other healthcare providers are now experiencing the same incredible capabilities that physicians at Fallon Clinic have enjoyed for years: only having to look in their own EHR in order to know everything about their patients.

The future is here today, and it's wonderful!

Related links/publications:

Garber, LD. Building an EHR at Fallon Clinic: The Art and Science of Seamless Transition. Group Practice Journal 2008;57(5):38-43

Breaking Into Electronic Medical Records. Worcester Business Journal 11/9/2009 <http://www.wbjournal.com/news44941.html>

MyChart: Fallon Patients Go Online For Medical Records. Worcester Telegram and Gazette 9/20/2009 <http://www.telegram.com/article/20090920/NEWS/909200392/1116>

Fallon Clinic's Dr. Larry Garber on EHR + Voice Recognition. David Williams - Health Business Blog 3/22/2010 <http://www.healthbusinessblog.com/?p=3238>

Is the Stock Market Broken?

Greg Thomas, ThomasPartners, Inc

Recently, companies' earnings have been up very nicely; however, stock prices have gone down. Is the stock market broken?

The stock market “capitalizes” companies' expected future earnings; i.e., it multiplies expected earnings by risk-adjusted price/earnings ratios to arrive at today's share prices – then it does it all over again tomorrow.

During the first quarter, a recovering economy caused expectations of future earnings to rise; so, share prices went up. In the second quarter, investors grew fearful of the impact that deficits, debts, taxes, etc., might have on expected earnings; so, even though actual earnings were up, share prices went down. At the start of the third quarter, expectations changed again; so, share prices changed again.

This is what the stock market does: it rewards changes in future earnings expectations ~ not the current earnings themselves ~ then multiplies the impact. As such, stock market prices are necessarily and normally more volatile than companies' current earnings.

So, there isn't a connection between stock prices and companies' actual earnings?

On the contrary, the market's expectations are continually “corrected” by reality. Eventually, therefore, portfolios' capital gains should approximate their companies' earnings growth rates. Sometimes that happens quickly; other times, it takes years, even decades.

Can investors take action to reduce this “logical,” though unnerving, volatility without sacrificing long-term capital gains potential?

Yes...and no. If portfolio investments have low price correlations, volatility can be somewhat lower much of the time. Unfortunately, during severe market crises, when investors most need lower volatility, the benefits of diversification often break down.

Diversification, however, has no effect on potential rewards. Portfolios' rewards, over time, will be mathematically exactly equal to the weighted average rewards of what the portfolios own ~ nothing more and nothing less.

Is there something investors can do to increase long-term rewards without increasing risk?

Mark Twain once said that “History doesn't repeat itself ~ at best it sometimes rhymes.” Assuming the market's future patterns rhyme with those of the past, there are several steps investors can take to improve rewards.

Since the market punishes stock prices when earnings expectations are not met, investors have historically done better by avoiding stocks with high built-in earnings expectations.

Many studies have shown that the natural inclination of investors is to expect too much from fast-growing companies and too little from slow or non-growing companies. When those expectations are corrected to meet reality, the stocks of the lesser-growers have generally done better. It seems a paradox, but history has shown that “value” stocks have significantly outperformed “growth” stocks.

Dividends have been in the news a lot, lately. Do they increase or decrease volatility or expected rewards?

Because the market “capitalizes” expected earnings, it cannot effectively “de-capitalize” expected dividends; it only subtracts the value of the current dividends. The result is that future dividends are not fully discounted in current share prices; so, future dividends become something of a “free lunch” for investors who collect them.

Though disputed by conventional wisdom and some “efficient” market theorists, the empirical evidence of this “dividend effect” on investors' total returns has been quite compelling.

Over the 40 years through 2009, for example, the companies in the S&P 500 enjoyed average annual earnings growth of 5.6%.

Not surprisingly, the S&P 500 delivered reasonably similar average annual share price growth of 6.4%.

But, the total returns of the S&P 500 over the period were, on average, 9.9% per year, fully 77% higher than underlying earnings growth rate and 55% higher than share price appreciation. That is dramatic outperformance.

That substantial outperformance can be attributed entirely to dividends, specifically 3.5% per year, on average, in dividend income paid directly by the dividend-paying companies in the S&P 500, not by the stock market.

Wow! That's a lot of "alpha" without a lot of risk or effort. Is there some secret imbedded in the process of enhancing rewards through dividends?

Again, yes...and no. It helps to pick companies that consistently pay and grow their dividends. During the 40 years referenced above, if investors had owned only the dividend-payers in the S&P 500, their average annual returns would have been 11.5%, not the 9.9% for the index as a whole.

It also helps to favor "value" stocks. If investors owning only the dividend-payers had also excluded stocks with P/E ratios more than 50% above average, their average annual total returns would have been 12.5%; not the 11.5% for the dividend-payers, not the 9.9% for the whole index, and not the 6.4% for the capital gains of the whole index.

Of course, that's the past. But, our portfolios own only dividend-paying stocks with "value" pricing metrics; so, obviously, we think they will deliver in the future, as well.

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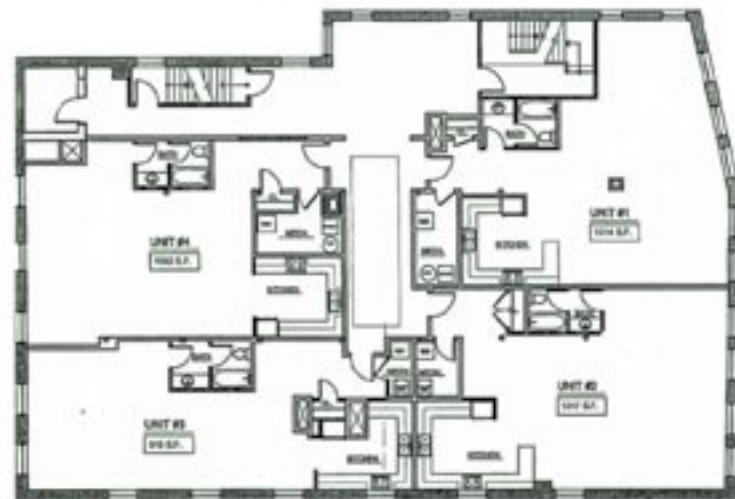
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WDMS Remembers Its Colleagues

Robert A. Bolduc, MD 1913-2009

Dr. Robert A. Bolduc died peacefully at the Rose Monahan Hospice in Worcester on November 16, 2009, from complications of renal failure. He was 96 years young, having lived independently and with great élan until several months before his death. He was born in Worcester, the third of five living children, and except for his years of medical school, training, and military service during WWII, lived his entire life in Worcester. He was the son of French Canadian immigrants, and always remained proud of his Franco-American heritage. In his retirement, he became fascinated with his genealogy, and spent several years completing an elaborate family tree.

He graduated from North High School and received his undergraduate education at Clark University. He often referred to this experience as the launching pad for his medical career. Ever appreciative of this life-defining opportunity, he established an endowed scholarship in his name at Clark. He graduated cum laude from Tufts University School of Medicine in 1939, did his internship at Beverly Hospital, and his surgical residency at Boston University Medical Center. He served as major in the U.S. Army medical Corps, treating the wounded on a ship in the Southwest Pacific from 1942-1946.

He opened his surgical practice in Worcester in 1949 and practiced mainly at Worcester Hahnemann Hospital until he retired in 1984. He served as Chief of Staff from 1963-1964. He was a busy general surgeon. I have many recollections as a young child of Uncle Robert no sooner arriving at our home for an event than he would place a call to the telephone operator at Hahnemann to leave a number where he could be reached. (It is difficult to remember practice without pagers and cell phones!) He would frequently be called away for an emergency. He was dedicated to his patients, and I never stopped hearing compliments from physicians and nurses with whom he worked about his pleasant manner and dapper sense of style.

Although he never married, I knew him best as a family man. He had 15 nieces and nephews, all of whom were equally special to him. He took an avid interest in each of our lives, loved bragging about his grand nieces and nephews and another generation beyond. As the last survivor of his generation, he established his rights as family patriarch, a position he thoroughly enjoyed until his death. I treasure the memory of my Thursday afternoon visits with him as had become my custom. I never stopped by without learning something new. He was a well-read lover of classical music, especially the opera, and would always bring me up to date on news of the Boston Symphony Orchestra or the Metropolitan Opera in New York.

It has been my privilege to share these thoughts with the Worcester medical community and to celebrate this long well-lived life.

Elise A. Jacques, MD

Paul A. Ricciardi, MD 1953-2010

Dr. Paul A. Ricciardi passed away from brain cancer on Sunday, April 18, 2010, at his home in Holden, with his family at his side.

Paul was born in Medford, Massachusetts, and graduated from Medford High School. He attended Boston College, where he met his future wife Kathy, and he graduated from BC in 1975 with a degree in chemistry. He graduated from UMass Medical School in 1979, a member of the first full sized class of 100. He completed residency in internal medicine at St. Vincent Hospital, and returned to UMass for his oncology fellowship.

After qualifying as an oncologist, Paul initially set up practice at St. Vincent Hospital, where he remained for several years. Subsequently, he returned to UMass as an Assistant Professor of Medicine. He was instrumental in setting up a system of decentralized UMass Memorial affiliated clinics at area hospitals including Day Kimball Hospital in Putnam, CT and Harrington Hospital in Southbridge, where Paul was an integral member of the medical staff for almost twenty years. Paul also developed the first guidelines for the diagnosis, staging, and treatment of lung cancer at UMass. In recognition of this work, Paul was promoted to Associate Professor of Clinical Medicine in 2001.

I came to know Paul well when, for five years, he and I attended and roomed together at the American Society of Clinical Oncology meeting, the annual,

Continued on next page

James P. Walsh, MD
1930-2010

premier meeting for clinical oncologists in the world. At those meetings Paul would exhaust himself, attending as many sessions as he could squeeze in, trying to maximize his knowledge. He would also meet and reminisce with many old friends from his fellowship or early years of practice.

Paul's primary concerns were his family, especially his youngest son, and his patients. He was active in charitable work, especially for the Autism Society of Massachusetts.

Paul was a rabid golfer with an impressive handicap and he was active in many area medical staff golf tournaments. He loved to talk golf.

Paul was diagnosed with a glioma almost fifteen years ago when he had a seizure while at work at Harrington Hospital. Within weeks he had returned to his medical practice, and continued to practice (rarely missing a day) throughout years of chemotherapy and radiation treatment. I am certain his illness only increased his compassion for and identification with his patients. After many years, however, his disease began to exact its toll: when I asked him one day why he didn't retire (or move on to part-time, non-patient care medical work), he said it was because he loved his patients and because he felt he "hadn't contributed enough" as an oncologist. It was no surprise to those who knew him that Paul continued to work as a clinical research supervisor, even while partially paralyzed, until a month before his death.

Paul's wake at the Mercadante funeral home on April 2 was scheduled to run from 4-8pm, but lasted until 10. The line of mourners extended out the door, and included friends and former colleagues from UMass, the greater Worcester physician community, and from Harvard Medical School.

Paul will be sorely missed.

William V. Walsh, MD

Central Massachusetts notes with great sadness the passing of James Walsh, a principled and resolute man who recognized voids in his local and global communities and who quietly took action.

As an army doctor in Korea, James saw firsthand war's crushing burden on a vulnerable population. Moved, he interrupted his residency to staff the St. John of God Clinic in Kwang Ju, donating four years of his time. In an article published in *The Georgetown Medical Bulletin*, James explained his service in the following way: "We have obligations to fulfill, and for me, this urge to help our brothers and sisters in other parts of the world was one way of meeting those responsibilities." Not surprisingly, James gave financial support to the St. John of God Clinic for many years, and he made several trips back to Kwang Ju, returning for the last time in November 2008 in order to participate in the Clinic's 50th Anniversary celebration. His work at the Clinic was recognized by the Republic of Korea, and he was elected a member of the Korean Medical Society.

After completing his internal medicine residency at St. Vincent Hospital in 1966, James went into practice and served as a wonderful primary care physician in Worcester until his retirement this year. He was a founding member of Vernon Medical Center on Winthrop Street, and he maintained a private practice there for 35 years. His dedication to vulnerable patients, such as debilitated nursing home residents, was simply exemplary.

James' community-of-service included his alma mater, The College of the Holy Cross. For 40 years he served as physician to the school's athletic teams. Donating his time, he accompanied the football and basketball teams to venues sometimes exotic but more often quite modest, and he brought temperance in times of exhilarating victory, and solace on days of heartbreaking loss. In March 2010, James was inducted as an honorary member to the Holy Cross Varsity Hall of Fame.

His community-of-service extended beyond medicine. In 1974, he helped found Opera Worcester, and he served as treasurer or president on multiple occasions. Because of Opera Worcester, the citizens of Central Massachusetts have enjoyed stirring performances twice yearly for more than three decades. Members of the WDMS will recall receiving notices of upcoming Opera Worcester events in envelopes addressed in James' distinctive handwriting, a reflection of his love of music and his desire to ensure that great performances continued locally.

In recognition of his devotion to his fellow human beings ~ to frail patients and to robust athletes alike ~ and in appreciation of his work to bring the glory of opera and classical music to Central Massachusetts, the WDMS named James the recipient of the 2008 A. Jane Fitzpatrick Community Service Award at a ceremony attended by his devoted sisters, his admiring office staff, and his appreciative College of the Holy Cross friends. Forever humble, he accepted the award with trembling lips and teary eyes, not fully aware that those in attendance were as grateful for his exemplary service as he was for the recognition.

Anthony Esposito, MD

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Calendar of Events

Worcester District Medical Society

2010

2011

September 10
Friday
7:30 a.m.
Beechwood Hotel

19TH ANNUAL WOMEN IN MEDICINE BREAKFAST
"The Baby Experiences Reflections on Doctoring and the Privilege of Seeing"
Speaker: Michele Pagnaire, MD, professor of family medicine and community health and senior associate dean for educational affairs at the University of Massachusetts Medical School.
Supported by the Physicians Insurance Agency of Massachusetts

September 17
Friday
9 a.m. to 4 p.m.
(By Appointment)
Mechanics Hall

INDIVIDUAL CLAIMS CONSULTATIONS
Problem-solving workshops for Medicare, Medicaid, and DMO providers and their office staff to assist with medical claims processing. Workshops sponsored by the Massachusetts Medical Society.

October 6
Wednesday
5:30 p.m.
Beechwood Hotel

MEDICAL EDUCATION PROGRAM
"The Cornerstones of Health Reform: What Patients and Physicians Need"
Speaker: Lynda Young, MD, president-elect, Massachusetts Medical Society

October 16
Saturday
6 p.m.
Tower Hill
Botanic Garden

MUSIC, ART, AND A GARDEN TOUR
Enjoy works of art and a music program by talented MMS members.
Sponsored by the Massachusetts Medical Society Arts, History, Humanities, and Culture Member Interest Network

October 27
Wednesday
5:30 p.m.
Mechanics Hall

3RD ANNUAL HEALTH CARE FORUM
"Making Your EHR Work for Your Office"
Speaker: Denise Scott, manager, HIT Consulting, Mass.gov; HIT clinical consultant, CMIPA
Sponsored by the Public Relations Committee

November 10
Wednesday
5:30 p.m.
Beechwood Hotel

FALL DISTRICT MEETING
The dinner meeting includes presentation of the A. Jane Fitzpatrick Community Service Award, the WDMS Career Achievement Award, and scholarship awards.

November 18
Friday
7 p.m. Reception
8 p.m. Concert
Mechanics Hall

DAVE BRUBECK AND THE DAVID BRUBECK QUARTET
Music Worcester presents the legendary Dave Brubeck, one of the most active and popular musicians in the world today.

December 3 & 4
Friday & Saturday
9 a.m.
MMS Headquarters & the Westin Hotel, Waltham

2010 MMS INTERIM MEETING & MEETING OF THE HOUSE OF DELEGATES
All WDMS members are invited to attend as guests and can submit resolutions to the Massachusetts Medical Society.

February 9
Wednesday
5:30 p.m.
Beechwood Hotel

21STH ANNUAL ORATION
"That Which Ennobles: The Quiet Heroes of Medical Discovery"
Orator: Anthony Esposito, MD, FACP, chief of the department of medicine, Saint Vincent Hospital, and professor of medicine at University of Massachusetts Medical School

March 9
Wednesday
5:30 p.m.
Beechwood Hotel

5TH ANNUAL LOUIS A. COTTLE MEDICAL EDUCATION CONFERENCE

March 23
Wednesday
6 p.m.
Beechwood Hotel

WOMEN IN MEDICINE LEADERSHIP FORUM

April 13
Wednesday
5:30 p.m.
Beechwood Hotel

ANNUAL BUSINESS MEETING
The meeting includes presentation of the 2011 Community Clinician of the Year Award.

May 19 & 21
Thursday & Friday
9 a.m.
MMS Headquarters, Waltham, and the Seaport Hotel & World Trade Center, Boston

2011 MMS ANNUAL MEETING & MEETING OF THE HOUSE OF DELEGATES
All WDMS members are invited to attend as guests. Please submit resolutions to the Massachusetts Medical Society.

May 18
Wednesday
5:30 p.m.
Faculty Conference Room, University of Massachusetts Medical School

MEET THE AUTHOR SERIES
Sponsored by the WDMS and the Humanities in Medicine Committee of the Lamar Soutter Library at the University of Massachusetts Medical School

Have you visited www.wdms.org recently?

The WDMS website is your local connection to the WDMS/MMS membership application, membership benefits, online program registration, online scholarship applications, Worcester Medicine online, guidelines for the WDMS Rx Fund, "spotlight news," and the WDMS Calendar of Events.

sprint

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