OCTOBER/NOVEMBER/DECEMBER 2012

Maine medicine

MAINE MEDICAL ASSOCIATION

IN THIS ISSUE

Party Control of Maine Legislature Shifts Again; 4 Physicians Among Apparent Winners

Demonstrating just how volatile the electorate continues to be, at press time Maine voters in the 2012 General Election appear to have restored Democratic control of both chambers of the 126th Maine Legislature. Among the apparent Democratic winners are four physicians: Representative Linda F. Sanborn, M.D. (District 130, parts of Buxton and Gorham), Senator-elect Geoffrey M. Gratwick, M.D. (District 32, Bangor and Hermon), Representative-elect Ann E. Dorney, M.D. (District 86, Madison, Norridgewock, and Solon), and Representative Jane P. Pringle, M.D. (District 111, part of Windham). The MMA congratulates these successful physician candidates! They will bring great credibility to the continuing debate about health care reform and other important health policy matters in the Maine legislature.

With the election now over, the MMA leadership and staff are busy preparing for the First Regular Session of the 126th Legislature. The new legislature is scheduled to convene on December 6th for swearing in ceremonies and the election of leadership and constitutional officers. The deadline for legislators to file bill requests is December 21st and the MMA expects hundreds of bills impacting on medical practice and public health to be considered in 2013. Budget crises continue, both in Augusta and Washington, D.C. with continuing uncertainty about federal approval of 2012 MaineCare cuts and the so-called "fiscal cliff" facing President Obama and the Congress on January 1st. Among the federal fiscal problems is the 27% Medicare SGR cut that would be devastating to both physicians and patients, but the AMA, MMA, and other medical societies are working hard to achieve another short-term patch during the lame duck session. The new Congress must, however, work toward a permanent solution to the Medicare SGR problem.

The MMA Legislative Committee, now chaired by Amy Madden, M.D., a family physician practicing in Belgrade, will meet on December 12th to review the composition of the new legislature and to finalize the Association's legislative agenda for 2013-2014. Dr. Madden invites any interested physician and medical specialty society representative to the meeting to discuss policy priorities for the medical community.

So, please join the MMA leadership and staff in advocating for the interests of your patients, public health, and responsible professional regulation. Serve as Doctor of the Day, participate in Physicians' Day at the Legislature on March 19th, and join the weekly Legislative Committee conference calls when you can. Democracy is a participatory sport and we need your help!

MMA's Legal and Advocacy Team
From left: Gordon H. Smith, J.D., Jessa Barnard, J.D., and Andrew MacLean, J.D.

MMA Concludes Successful 159th Annual Meeting

Members and guests of the Maine Medical Association met for the 159th time this past September in Bar Harbor. Over 250 people attended some or all of the meeting, which featured CME sessions on aging with the theme of "Caring for Our Elders." Keynote Speaker Dennis McCullough, M.D. set a serious tone for the weekend discussions. At the annual business meeting on Saturday morning, the members passed six resolutions and adopted a balanced budget for 2013. Dieter Kreckel, M.D., a family physician practicing in Rumford, was installed as President of MMA for the next year, following Nancy M Cummings, M.D. Guy Raymond, M.D. of Fort Kent was elected as President-elect. Lisa Ryan, D.O. of Bridgton, was elected by the Board of Directors as Chair of the Board.

The six resolutions were passed as presented and can be found on the MMA website at **www.mainemed.com**. Following are the titles of each of the Resolutions:

1. Appropriate Use of Antibiotics
2. Support for our Public Health Infrastructure
3. Limits on the Possession of Dangerous Weapons
4. Taxes on Beverages with Added Sweeteners
5. Operation of Maine's Pre-litigation Screening Panels
6. Maintenance and Expansion of Health Care Coverage in Maine

Resolution #6 was a late resolution presented by the Board of Directors that calls on the Association to reaffirm its support for universal health care coverage and oppose reductions to MaineCare eligibility enacted by the 125th Maine Legislature, as well as support the expansion of MaineCare to all eligible individuals up to 133% of the federal poverty level in 2014.

Presentations were made at the Saturday morning session by Terrance Sheehan, M.D, President of Medical Mutual Insurance Company of Maine, Michael Sherman, M.D., MBA, Chief Medical Officer of Harvard Pilgrim Health Care and James Harnar, Executive Director of the Hanley Center for Health Leadership.

On Sunday morning, several practicing physicians shared with attendees their experiences in different types of practice models.

Other highlights of the meeting included the presentation of the Annual Award for Distinguished Service to Charles "Tom" McHugh, M.D. of Baileyville and a special presentation to Patricia Bergeron who began work at MMA 50 years ago, in 1962.

Three senior physicians attended to be presented with 50 year pins recognizing the 50th anniversary of their graduation from medical schools. John Serrage, M.D., John Van Pelt, M.D. and Eric Nicholas, M.D., all made brief remarks expressing their appreciation for having had the opportunity to practice in Maine.

The 2013 Annual Meeting, celebrating the Association's 160th anniversary, will be held in Portland, Maine at the Holiday Inn by the Bay October 4-6th. We hope to see you there!

Dieter Kreckel, M.D. having just been handed the gavel from outgoing President Nancy Cummings, M.D.

Distinguished group of Past Presidents.

Honoree Patricia Bergeron with John Makin, M.D. and his wife Nancy. Dr. Makin is a former MMA President.

Fifty year pin recipient Eric Nicholas, M.D. and his wife Georgia with Ohio State Medical Association President Deepak Kumar, M.D. and his wife Sureka.

Outgoing MMA President, Nancy Cummings, M.D., presents the Distinguished Service Award to Charles "Tom" McHugh, M.D. of Baileyville.

More photos of Annual Meeting on page 4

SAVE THE DATE

FINAL 2012 MMA FIRST FRIDAYS EDUCATION SEMINAR

Scheduled for December 7, 2012

The Affordable Care Act (ACA) Post-Election

Register for this seminar at **www.mainemed.com**

All First Friday seminars take place at the MMA Headquarters in Manchester, Maine with Registration and Breakfast at 8:30am and the Session from 9:00am – 12:00pm.

Driving Safety for Older Patients

In partnership with the National Highway Traffic Safety Administration, the AMA offers a free educational course to help you identify medical conditions that can impair a patient's ability to drive.

The online course, "Medical Fitness to Drive" provides assessment tools, case studies and additional resources to help you better evaluate and counsel older drivers.

The course provides continuing medical education credit. Find it at **www.ama-assn.org/go/olderdrivers.**

Invite a Physician to Join MMA

Encourage your colleagues to become an MMA member and take advantage of the benefits of membership.

Contact Lisa in the MMA Membership Department at 622-3374 ext 221 or email lmartin@mainemed.com

Dieter Kreckel, M.D.
President, MMA

President's Corner

Greetings to all the physicians of Maine. My name is Dieter Kreckel and I have the honor of being the President of the Maine Medical Association for the next year. The year started at our annual session held in Bar Harbor, Maine. Our theme this year was 'Elder Care' and the session was well attended by physicians from around the state.

I would first like to thank Nancy Cummings, M.D., for her exceptional leadership as president this past year. She continues to be active in the Association and we appreciate all the time and effort she has committed on behalf of Maine physicians.

Your association continues to be active in many areas on your behalf. Certainly each year brings its challenges at both the state and national level. This year has been particularly challenging and with the upcoming elections, the coming year promises to be equally interesting. The Medicare SGR problem and general reimbursement for service at all levels, continue to avoid a long term solution. Meaningful use and changes in medicaid/medicare payments will need to be taken into account. Your association will help you navigate your practice through those minefields.

The association has worked hard with Dr. Kevin Flanigan and MaineCare to develop a reasonable set of guidelines for prescriptions for controlled substances. We continue to work on the changes that the Affordable Care Act (ACA) will bring and how we can help you and your practice get ready for those changes. Other changes include the upcoming change in CPT coding and how that will affect your practices. The association will be offering First Fridays where many of these issues and others are discussed/presented. A list of all the 2013 presentations are included as an insert with this issue of *Maine Medicine*.

The practice of medicine continues to change and we must adapt and in fact be the leaders of that change. Whether you are in a group practice, solo practice, or in a hospital owned practice, all of these changes and more will affect the way you take care of your patients today and tomorrow.

Your team at the association continues to work hard for you and represent you at all levels, including working on contracts, peer review, and voicing your concerns in the state and national legislative arenas. To continue to do so, we need your input and help. You can inform us of issues or problems and can even add your expertise to help us solve some of these issues. Come to our seminars or send your staff. Serve as 'Doctor of the Day' at the state legislature and see how things work in Augusta, come down and testify before the different committees on the various legislative proposals. The point is, we need your active involvement if we are to be successful in representing you and your patients.

The practice of medicine will continue to evolve and through it all, **we** must remember the most important aspect, the health of our patients and community. I ask that you join the association and its efforts to enhance the practice of medicine for you and your patients in the state of Maine.

Thank you for allowing me to serve as your president of the MMA. I look forward to working with all of you. Please contact me at any time at 369-0146 or president@mainemed.com.

Gordon H. Smith, Esq.

Notes from the EVP

The fall is always a busy time for MMA staff and I know for our members as well. The summer is short and we do catch a little break. But with September comes our Annual Session and every two years, an election. As advocacy is a critical part of the MMA mission (advocacy for physicians, patients and public health), we have to be cognizant of the election and its impact, both in Augusta and Washington. I will not repeat the points made in the article on the cover page of this issue of *Maine Medicine*. Suffice it to say, it is a busy election season as I write this column and I suspect we will all be glad to have it over with. Then the even more difficult task of governing will begin and we will be back at the State House with a mix of veteran and new legislators. I look forward to it.

Our Legislative Committee, chaired now by Amy Madden, M.D., anticipates an extremely busy session. Budget issues will still be front and center, but during the two-year session of the 126th Legislature, hundreds of bills will be introduced and considered that impact directly or indirectly on medical practice. Public health, scope of practice, professional standards, prescription drugs, health insurance, the costs of healthcare, the Affordable Care Act, all of these will be considered and more. We will need your help and I hope you will consider serving as our Doctor of the Day and attending the Physicians' Day at the Legislature on March 19th.

I hope that you and your family members all voted. As messy and nasty as this election cycle was, and as insane as the total advertising spend was, at the end of the day, the voters got to make their decision. I particularly regret all the negative ads. It is difficult to find good people to run and serve when half-truths, flat out lies and intentional distortions are utilized. Perhaps that is what the First Amendment requires. But it sure is painful to watch.

It has been a good year at MMA. We have met our goal for the year of 2200 active members and 3600 members overall. We are on track to meet most of our budget goals. By year-end, we will have launched the re-designed website and implemented a pilot membership project for small federally qualified health centers. We have presented over a dozen educational programs and done nearly fifty individual presentations. We have even greater goals for 2013 and I will share those with members in the next issue. None of our successes would be possible without the support of you, the members, a great team of voluntary leaders and an excellent and dedicated staff. Thank you all for what you do for patients and for MMA. I hope you all have a happy and healthy holiday season and an exceptional 2013!

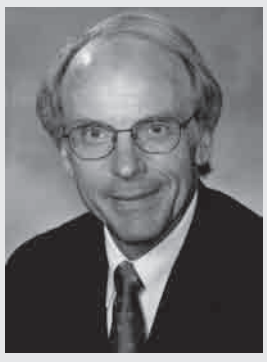
SAVE THE DATE

Physicians' Day at the Legislature
State House, Hall of Flags, Second Floor
March 19, 2013 • 8:00am – 4:00pm

Visit the MMA website at: www.mainemed.com

Promoting the Physician-Led Team for Patient Care: *AMA Fights FTC Overreach*

By Jeremy A. Lazarus, M.D., President, American Medical Association (AMA)



Jeremy A. Lazarus, M.D.
Photo courtesy of the American Medical Association

The pace of innovation in the practice of medicine is moving rapidly forward, and interest from the public and private sector in achieving high quality, cost efficient patient outcomes through coordinated care has never been greater. With rapid changes afoot, it is critical to promote the physician-led team model as the means to ensure high quality patient care.

Physicians have raised concerns that the physician-led team model of care is being undermined by the Federal Trade Commission (FTC) through its recent aggressive advocacy on behalf of the independent practice of non-physician health care professionals, such as nurse practitioners.

In recent letters to Missouri and Tennessee legislators, the FTC stated that nurse anesthetists can safely provide chronic interventional pain management services without physician supervision. The FTC has similarly opined on Advanced Practice Registered Nurse (APRN) supervisory arrangements, stating that "available empirical evidence indicates that APRN-delivered care across settings is at least equivalent to that of physician-delivered care as regards safety and quality." In FTC letters to medical boards and state legislators, the FTC relies on "available evidence" to make clinical judgments on complex medical issues that have an impact on patient health and safety.

The FTC's focus on health care professionals is not limited to physicians. It has also taken an enforcement action against the North Carolina State Board of Dental Examiners. Through this case, the FTC has suggested that state professional boards—such as state boards of medicine or dentistry—that are comprised primarily of the members they regulate (e.g., physicians or dentists) are private actors, not subject to the protection from federal antitrust laws. The AMA disagrees. And we're concerned that fear of antitrust enforcement action by the FTC can have a chilling effect on state medical boards' efforts to protect the public health and safety.

The AMA is working to protect patient safety by ensuring that the role of states and medical licensing boards to define appropriate medical standards at the state level is not undermined by federal overreach. AMA has met directly with FTC commissioners to share its position that the FTC does not have the clinical expertise to make judgments regarding the competency of health care professionals to perform medical procedures. We urged them to reexamine their ability to advocate on the complex medical issues involved in state scope of practice activities and medical licensure.

Our advocacy is paying off: FTC letters released since our meetings no longer include misleading clinical judgments. Disclaimers have been added stating that "FTC staff are not experts in patient care or safety," and do not offer advice on such matters. For the first time in its letters, the FTC also acknowledged that "certain professional licensure requirements are necessary to protect patients," and that "in particular, special practice requirements may be recommended or required for certain chronic or acute pain indications or treatments that may present heightened consumer risks." The FTC has also agreed to reach out to medical associations before drafting their letters in the future, and recently acknowledged in a letter to the Colorado Medical Society (CMS) that meetings with the AMA led to changes in the language and tone of subsequent FTC advocacy letters.

The AMA is also weighing in on the antitrust court case regarding the North Carolina Dental Board. The Litigation Center of the AMA and State Medical Societies filed an amicus brief challenging the Federal Trade Commission's (FTC) antitrust enforcement action against the North Carolina State Board of Dental Examiners for attempting to fulfill its statutory mandate to regulate public health and safety.

While FTC engagement and court cases are necessary, our primary goal is to foster collaboration and coordination among health care professionals to create positive health outcomes for patients. To that end, a recent Virginia law shows a way forward. The Medical Society of Virginia and the Virginia Council of Nurse Practitioners worked together, at the behest of the Virginia General Assembly, to develop legislation on team-based care. As reported in *American Medical News*, the law calls for nurse practitioners to consult and collaborate with physicians, while defining the physician as the leader of the health care team. The AMA supports the legislation, and believes it can serve as a model for other states as health care professionals work together in a physician-led team to help patients.

It is only through the support of our members that this work from the AMA is possible. Help sustain our advocacy efforts on issues of importance to you and your patients. Please activate your 2013 AMA membership by visiting www.ama-assn.org or contacting AMA Member Relations at (800) 262-3211.

Common Sense Compliance

Lessons from the Wall of Shame

By Stacey Mondschein Katz, Esq.

Stacey Mondschein Katz, Esq.

Have you ever looked at the federal Department of Health and Human Services (HHS) Breach Notification page, also known as the "Wall of Shame?" If you haven't, you should. Where a breach of unsecured protected health information (PHI) impacts 500 or more individuals, and no "safe harbor" or exception applies after an investigation, a report to HHS is mandated within 60 days of when the breach was, or reasonably should have been discovered. That information is posted to the HHS website for the world to see.

As of this writing, 498 organizations, including individual medical practices and mammoth healthcare entities, have made such reports. The reports range from an impact on 500 individuals' records to a mind-boggling 4,901,432 patients' PHI affected by a breach at TRICARE Management Activity, when EHR back-up tapes were lost.

The vast majority of breaches appear to be caused by theft or loss of unencrypted desktop or laptop computers or other electronics, including servers and portable devices. Other reasons for posting include lost, stolen or unauthorized access to paper documents and improper disposal of PHI. The sinister hacking scenario appears to be a rare cause of breach. A number of these breaches have occurred at the hands of business associates.

This data can be very useful in informing your overall breach protection and compliance strategies and steps, as there is almost always a place where security or privacy practices can be strengthened. How do you prevent those events posted on the Wall of Shame from being repeated in your practice?

Along with having understandable written policies and strong business associate agreements, consider low tech fundamentals such as locking paper charts away when not in use, and storing tablets and laptops in a secure cabinet after hours. Physical security, such as window and office door locks, an alarm system, and anti-theft devices may help prevent the loss of a desktop computer or server that hosts patient data.

Appropriate encryption of electronic PHI would keep your organization from having to publically post a sizeable breach to the Wall of Shame, and is high on the list of considerations in the Stage 2 Meaningful Use criteria.

Don't forget regular education on these issues. The Office of the National Coordinator recently posted a training "game" at www.healthit.gov that may help support your privacy and security efforts. While not a substitute for in-person education that allows for questions and responses applicable to your practice, the free training is another tool in your compliance toolbox. Be sure to document any training to demonstrate your good faith compliance efforts in the event of a regulatory review.

And if you feel like you are falling behind, you are not alone. Even CMS and its contractors were recently found to have missed several HITECH requirements in reporting numerous breaches of PHI, which included mailings to wrong addresses, loss of documents in transit, and erroneously posting patient PHI online. CMS agreed that it needed to improve its breach notification measures.

But while CMS won't be subject to enforcement and financial penalties, your practice could be. That is why putting common sense safeguards into place may be the key to your compliance success.

Stacey Mondschein Katz, Esq. is the founder and president of SMK Consulting Services, LLC, a healthcare compliance and education company. She may be reached at stacey@smkconsultingservices.com or visit her website at www.smkconsultingservices.com.

Upcoming Specialty Society Meetings

DECEMBER 5, 2012 *Dry Dock Restaurant & Tavern – Portland, ME*
Maine Chapter, American College of Emergency Physicians Chapter Meeting
MMA Contact: Maureen Elwell 622-3374 x219 or melwell@mainemed.com

DECEMBER 19, 2012 *Maine Medical Association – Manchester, ME*
Maine Chapter, American College of Physicians GAC & Chairs Meeting
Contact: Warene Eldridge 207-215-7118 or warene54@yahoo.com

FEBRUARY 2-3, 2013 *Sugarloaf Mountain Hotel & Conference Center*
Maine Urological Association Annual Winter Conference
MMA Contact: Dianna Poulin 207-622-3374, x223 or dpoulin@mainemed.com

FEBRUARY 9-10, 2013 *Sugarloaf Mountain Hotel & Conference Center*
Maine Society of Anesthesiologists Winter Meeting
Contact: Anna Bragdon 207-441-5989 or mesahq@gmail.com

MARCH 6, 2013 *Exact location TBA – Lewiston, ME*
Maine Chapter, American College of Emergency Physicians Spring Business Meeting
MMA Contact: Maureen Elwell 622-3374 x219 or melwell@mainemed.com

APRIL 18-19, 2013 *Marriott Portland at Sable Oaks*
Maine Association of Psychiatric Physicians Spring General Membership Meeting & Clinical Conference
MMA Contact: Dianna Poulin 207-622-3374, x223 or dpoulin@mainemed.com

MAY 3, 2013 *Harraseeket Inn – Freeport, ME*
Maine Society of Eye Physicians and Surgeons Spring Business Meeting
MMA Contact: Shirley Goggin 207-445-2260 or sgoggin@mainemed.com

MAY 4-5, 2013 *Harborside Hotel & Marina – Bar Harbor, ME*
Maine Chapter, American Academy of Pediatrics Spring Educational Conference – Theme: Pediatric Hospital Medicine
Contact: Leslie Goode 207-782-0856 or ldgoode@aap.net

JUNE 27, 2013 *Fisherman's Wharf – Boothbay Harbor, ME*
Maine Chapter, American College of Emergency Physicians Lobster & Clam Bake on Cabbage Island
Contact: Maureen Elwell 622-3374 x219 or melwell@mainemed.com

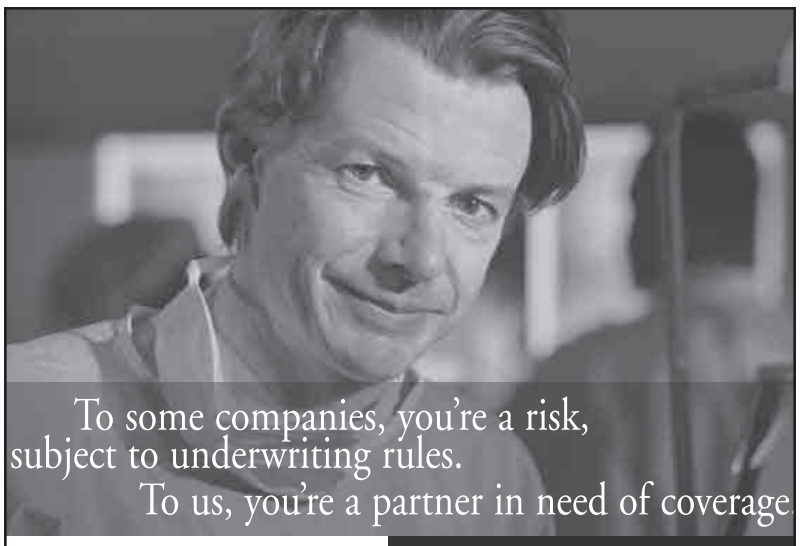
SEPTEMBER 4, 2013 *MMA Headquarters – Manchester, ME*
Maine Chapter, American College of Emergency Physicians Fall Business Meeting
Contact: Maureen Elwell 622-3374 x219 or melwell@mainemed.com

SEPTEMBER 20, 2013 *Harborside Hotel & Marina – Bar Harbor, ME*
Maine Society of Eye Physicians and Surgeons Fall Business Meeting
(To be held in conjunction with the 12th Annual Downeast Ophthalmology Symposium)
MMA Contact: Shirley Goggin 207-445-2260 or sgoggin@mainemed.com

SEPTEMBER 20-22, 2013 *Harborside Hotel & Marina – Bar Harbor, ME*
12th Annual Downeast Ophthalmology Symposium
(Presented by the Maine Society of Eye Physicians and Surgeons)
MMA Contact: Shirley Goggin 207-445-2260 or sgoggin@mainemed.com

Maine Primary Care Association Annual Meeting

Norman Fournier, retiring CEO at Fish River Rural Health of Eagle Lake and Fort Kent and his wife Anne with Holly Gartmayer-DeYoung, CEO of Eastport Health Care, Inc. Mr. Fournier received the MPCA President's Award at the Maine Primary Care Association meeting.



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MICIS Offers CME on Evidence-based Prescribing

MICIS, the Maine Independent Clinical Information Service, a program of the Maine Medical Association, offers high quality, no cost CME on the evidence-based use of prescription drugs. Our "academic detailers" visit practice sites throughout the state to speak with individuals, small or large groups.

York County Practitioners, Schedule Your Visit for 2013 Now

Though any practitioner can request a visit from one of our academic detailers at any time, MICIS is currently scheduling a "York County Tour" to reach out to York County practitioners. To that end, MICIS academic detailers will be present throughout York County in March 2013, offering educational modules on the following topics:

1. Restrained use of antipsychotics
2. Management of chronic pain
3. Management of atrial fibrillation

Please contact Jennifer Reck, MICIS Program Manager, at jreck@mainemed.com or 632-5806 if you would like further information or to request a visit on a specific topic. Not in York County, but still interested? Please contact Jennifer Reck with any questions or to schedule a visit at your practice site.

Maine Independent Clinical Information Service (MICIS)
Academic Detailers:
Erika Pierce, MMSc, PA-C
Elisabeth Fowlie Mock, MD, MPH, FAAFP

Advisory Committee Chairperson:
Noah Nesin, MD

More information can be found on the Academic Detailing page of the MMA website:
www.mainemed.com

Andrew MacLean, Esq.

Legislative Update

MMA Legislative Committee Prepares for 126th Maine Legislature

The 126th Maine Legislature will be seated in early December and will begin the work of its First Regular Session in early January 2013. The MMA Legislative Committee, now chaired by Amy Madden, M.D., has scheduled an organizational meeting in anticipation of the new legislature on Wednesday, December 12, 2012 at the MMA headquarters in Manchester and any interested member is welcome to attend.

With the election of Lisa Ryan, D.O. as Chair of the MMA Board of Directors, the Legislative Committee members thank her for her service to the Committee and welcome Amy Madden, M.D. as the incoming Chair. Dr. Madden is board certified in family medicine and practices at the Belgrade Regional Health Center. As mentioned above, the organizational meeting of the MMA Legislative Committee will take place on Wednesday, December 12, 2012 from 6:00 to approximately 8:30 p.m. at the Frank O. Stred Building, 30 Association Drive in Manchester. Because the Committee will be discussing the MMA's legislative agenda for the new legislature, medical specialty societies are strongly encouraged to have one or more representatives at the meeting. Any interested member also is welcome. Please RSVP to Maureen Elwell, Legislative Assistant, at melwell@mainemed.com or 622-3374, ext. 219.

The MMA staff has prepared a comprehensive summary of the health care legislation considered by the outgoing legislature that is now available in printed form from the MMA office and is available on the MMA web site, www.mainemed.com. Also, you can find the 2012 Annual Report of the Legislative Committee, presented to the membership at the Annual Session in Bar Harbor in early September, on the web at: http://www.mainemed.com/annual/2012/2012AnnualReport_LegislativeCommittee.pdf.

During the legislative session, the MMA staff provides links to bills for review and comment, updates on the legislature's work, and calls-to-action through our weekly electronic newsletter, *Maine Medicine Weekly Update*. Also, the MMA Legislative Committee holds a weekly conference call to review bills and brief members on legislative action. The conference call information is published each week in the *Maine Medicine Weekly Update*. Look for these calls to begin again in mid-January 2013.

To find more information about the MMA's advocacy activities, visit the Legislative & Regulatory Advocacy section of the MMA web site, www.mainemed.com/legislation/index.php. You will find more information about the Maine Legislature, including schedules, committee assignments, legislator contact information, audio coverage of legislative work, and newly enacted laws on the web at: http://www.maine.gov/legis/.

The MMA welcomes your participation in our legislative advocacy activities. For more information, please contact Andrew MacLean, Deputy Executive Vice President, at amaclean@mainemed.com.

Thank You!

The second-session of the 125th Legislative Session is now behind us. The MMA would like to acknowledge all members who assisted in the legislative process to advocate for patients and fellow physicians during the session. We appreciate the time that these physicians took out of their busy schedules to come to the State House and participate in the Doctor of the Day Program and those who testified in person or submitted testimony for public hearings. Testimony at public hearings and participation in the Doctor of the Day Program are essential elements of MMA's role in promoting a good practice environment for physicians in the State of Maine and quality healthcare for Maine citizens. The MMA would also like to thank the children of our Doctor of the Day participants who served as honorary pages in the House of Representatives. We have done our very best to include all participants in the following lists and we apologize if we have omitted anyone. If your name was omitted, please contact Maureen Elwell at melwell@mainemed.com.

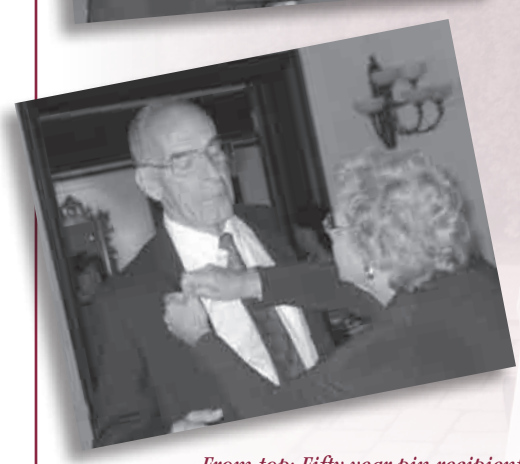
Doctor of the Day 2012 Participants:
William Atlee, Jr., MD
Michael Bell, MD
A. Jan Berlin, MD
Carla Burkley, MD
Rebecca Chagrasulis, MD, FACEP
Judith Chamberlain, MD
Kenneth Christian, MD
Barbara Covey, MD
Nancy Cummings, MD
Russell DeJong, MD
Richard Fein, DO
Richard Flowerdew, MD
Janet Fowle, MD, FACEP
Jonathan Gasper, MD
Maroulla Gleaton, MD
Lani Graham, MD, MPH
Daniel Hammond, DO
Sue-Anne Hammond, DO
Andrew Iverson, MD
David Jones, MD
Scott Kemmerer, MD, FACEP
Peter Leighton, MD
Lisa Letourneau, MD, MPH
David McDermott, MD
Dylan McKenney, MD
Elisabeth Mock, MD, MPH, FAAFP
Barbara Moss, DO
Tim Nuce, MD
Thomas Page, DO
Charles Pattavina, MD, FACEP
Janis Petzel, MD
Chris Pezzullo, DO
Melanie Rand, DO
Lisa Ryan, DO
Sydney Sewall, MD, MPH
Daniel Stanhiser, MD
Donald Strickland, MD
Robert Struba, MD, MPH, PhD
William Tapley Jr., MD
Emily Trask-Eaton , MD
Robert Weiss, MD
Gary Winn, DO, MPH

Honorary Pages:
Luke Gerard Moss Bartol
Katie Boston
Gabriel Fein
Jakob & Alexandra Hammond
Rayanne Harris
Cole & Lauren Jakobs
Laura & Emily Mock
Alex, Henry & Josephine Nuce
Caleb Rand
Susie Strickland
Emily & Benjamin Talpey

Public Testimony:
Paul Berkner, DO
Steve Diaz, MD, FACEP
Steven Feder, MD
Lani Graham, MD, MPH
James Maier, MD
Tamas Peredy, MD, FACEP
Jeffrey Young, MD

We look forward to seeing you at the Statehouse in 2013!

More Photos of Annual Meeting



From top: Fifty year pin recipients John Serrage, M.D.; John Van Pelt, M.D.; and Eric Nicholas, M.D. Patricia Bergeron does the honors.

Lani Graham, M.D. presents report of Medical Professional Health Program.

From left: Janet Smith, Margaret Kenney, and Katherine Ayer at Annual Meeting reception.

AMA Delegate Richard A. Evans, M.D. moderated the Saturday morning business meeting.

Lisa M. Letourneau, M.D., MPH

Quality Counts

By Lisa M. Letourneau, M.D., MPH, Executive Director, Quality Counts

Shared Decision-Making: From Concept to Reality

Surveys continue to support the good news that most patients report a high level of trust with their health care providers and want to get their health care information from their doctor more than any other source. At the same time, recent data suggests that patients are sometimes reluctant to engage in collaborative discussions with physicians about their choices in health care. While patients consistently voice a strong desire to engage in shared decision-making about treatment options, we need to learn more about why patients are often reluctant to actively engage in a collaborative discussion with their physician about their health care choices.

For over a generation, efforts to make health care more patient-friendly have focused on getting patients and doctors to work together to make decisions about care and treatment. Numerous research papers, conferences and advocacy organizations have been devoted to the topic of "shared decision-making." In just the past two years, the United States Congress incorporated shared decision making into the Affordable Care Act of 2010. A number of states, including Washington, Connecticut, Minnesota, and Oklahoma, have adopted policies directed at placing patients at the center of shared decision making. (for referenced articles, see www.mainequalitycounts.org)

Yet despite those efforts, more recent research shows we have a long way to go to effectively implement shared decision making in practice. In a 2012 research study led by Dominick L. Frosch, PhD, [1] *"Communicating With Physicians About Medical Decisions: A Reluctance to Disagree,"* results from focus-group sessions with health care consumers, showed that nearly all patients could envision asking questions (93%) and discussing preferences (94%) with their doctor, but few individuals felt they would actually voice a disagreement with their physician if their preferences conflicted with physician recommendations. While most felt that they had the ability to disagree (79% reported self-efficacy for disagreeing), few thought that disagreement with their physician was socially acceptable (14%) or would lead to good outcomes. **Among participants who would not disagree with their physician, 47% feared being seen as a difficult patient; 40% thought that disagreement would damage their relationship with their physician; and 51% worried that it might interfere with getting the care that they wanted.** Patients reported feeling they couldn't disagree because doctors often acted authoritarian, rather than authoritative. The findings present an interesting challenge to previous optimistic assumptions about patients' willingness to engage in shared decision-making - conclusions that in retrospect were based mostly on studies that examined physicians' intent, but not patient perceptions.

What can we as physicians do to help patients get more engaged? Results of the above study suggest that significant changes need to occur if we truly want patients to get more engaged in making their own health care decisions. First of all, we must take a look at ourselves and how we interact with our patients. Are there words, actions, or attitudes we are projecting that are perceived by our patients as authoritarian? Given the time constraints we as providers often face today, do we sometimes provide a quick, "rapid-fire" response, rather than create time and space for questions? Are our non-verbal cues giving off messages that it's better for patients not to ask questions? Do we interact with our patients in a way that actively encourages them to feel comfortable asking questions about the information presented to them? While challenging, the data would suggest that it's time to start assessing our own actions, and begin to take the necessary steps towards personal change.

So what's a busy doctor to do? Given the very understandable constraints of time and resources that physicians face in today's busy health care environment, it can be challenging to know how to help patients feel more comfortable making health care choices. As we strive to learn how best to support these changes, Maine Quality Counts has been working with consumers and experts around the country, and offers some specific suggestions for changes that could help:

1) **Create a safe space:** The first step in helping patients become more engaged in these important discussions is to realize they often may not feel safe or encouraged to do so. Recognizing that, providers need to actively encourage patients to become engaged. We need to actively persuade patients that it is not only okay to ask questions or challenge recommendations, but that we actually encourage it. Making statements such as, "I know it can sometimes be hard to ask doctors questions, but it would be very helpful to me if you'd share some of your questions," can be hugely helpful to change perceptions and create space for collaborative discussions.

2) **Use your team!** While patients trust their doctors, studies show that patients also have great trust in nurses and other members of the health care team, especially when their physician expresses confidence in that team. Given the busy pace of practices, physicians need to empower, train, and use their staff team to be part of the process of educating and engaging patients in shared decision making. By delegating and distributing tasks across the team, physicians will be better able to ensure that our patients can get their needs met during a busy visit.

3) **Use the tools:** There are a growing number of well-developed decision support tools that providers can use to introduce the concepts of shared decision making, and provide patients with more information on their treatment choices for specific conditions. Locally, MaineHealth is currently leading an effort to promote shared decision making (http://www.mainehealth.org/mh_body.cfm?id=7848).

Providers can also find resources at other trusted organizations such as:

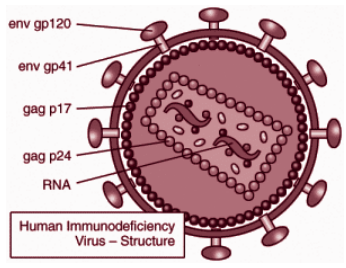
- ABIM's "Choosing Wisely": www.choosingwisely.org
- AHRQ decision aids: www.effectivehealthcare.ahrq.gov/ehc/decisionaids/prostate-cancer
- Center for Advancing Care: cfah.org/
- National Patient Safety Foundation's "Ask Me 3": www.npsf.org/for-the-healthcare-professionals/programs/ask-me-3/
- Mayo Clinic: shareddecisions.mayoclinic.org/decision-aids-for-diabetes
- Foundation for Informed Decision Making: informedmedicaldecisions.org/shared-decision-making-in-practice/decision-aids

Additionally, Maine Quality Counts (QC) launched the "Better Health. Better ME!" (BHBM) patient engagement campaign to help patients and care-givers to become more confident participants in their care. The goal of this effort is to empower patients to engage in a dialog with their physician, ask questions to better understand their options, and take accountability for their own health and health care. The BHBM initiative seeks to reduce communication barriers between patients and their physicians, and assist in creating an effective dialog that can lead to more meaningful partnerships (shared decision-making) to improve the quality of health and health care.

As part of this effort, QC has developed a patient brochure titled ***"It's All About ME!"*** that offers patients specific steps to partner in their health care. The brochure encourages patients to take four steps to become more active partners in their care: (1) visit your primary care provider; (2) ask questions; (3) know your (health-related) numbers; and (4) use community resources to help reach health goals. For more information, contact kslatemiller@mainequalitycounts.org.

Ultimately, changing these behaviors is nothing less than changing the culture of health care in this country. While challenging, it *is* possible. Let this be the legacy of our generation that will change the culture of health care as we know it.

[1] Frosch, D., Suepattra G.M., Rendle K.A.S., Tietbohl C., Elwyn G. Archives of Internal Medicine. July 9,2012; doi:10.1001 http://archinte.jamanetwork.com/article.aspx?articleid=1212630



New HIV Testing Law Now in Effect

The MeCDC is reminding clinicians that 5 MRSA §19203-A, Maine's HIV testing and consent law, was amended last year to include a sixth subsection on the "protection of newborn infants," which went into effect on September 28, 2011.

The amended section of the law requires healthcare providers caring for pregnant women to include HIV tests in the standard set of medical tests performed, subject to the consent and procedure requirements of 5 MRSA §19203-A, Sub § 1. That section requires that a patient must be informed orally or in writing that an HIV test will be performed, unless the patient declines.

Under the new law, healthcare providers caring for newborn infants are also required to test the infant for HIV and ensure that the results are available within 12 hours of birth if the healthcare provider does not know the HIV status of the mother or the healthcare provider believes that HIV testing is medically necessary. There is an exception if a parent objects to the test on the grounds that it conflicts with the sincere religious or conscientious beliefs and practices of the parent.

The amendments to the law are intended to make HIV testing routine and standard for all pregnant women, and to make paramount the interest of the infant. While consent of the patient is still required, the law now requires that every pregnant woman be offered HIV testing and further requires that the infant be tested if the HIV status of the mother is unknown (but either parent has the right to object). Attorneys at the Maine Medical Association are able to provide general advice on the intent of the law and its practical implications. Hospital-based physicians should also look to their institutional health lawyers to assist with some of the more difficult questions about this change in practice.

Save the Date: MMA's 160th Annual Session October 4-6, 2013 at the Holiday Inn by the Bay

UPCOMING AT MMA

NOVEMBER 21
9:00am - 11:00am
Coalition for the Advancement of Primary Care

1:00pm - 4:00pm
Aligning Forces for Quality, Patient Family Leadership Team

NOVEMBER 28
11:00am - 1:00pm
Patient Centered Medical Home, Working Group

DECEMBER 4
8:00am - 3:30pm
APIC – Pine Tree Chapter

4:00pm - 6:00pm
Committee on Physician Quality

DECEMBER 5
8:00am - 12:30pm
Maine Health Management Coalition

9:00am - 12:00pm
Maine Independent Clinical Information Service (MICIS)

1:00pm - 2:00pm
Aligning Forces for Quality, Executive Leadership Team

2:00pm - 3:00pm
Quality Counts, Executive Committee

3:30pm - 5:00pm
Behavior Health Committee

4:00pm - 6:00pm
MMA Board of Directors

DECEMBER 7
9:00am - 12:00pm
First Fridays Seminar

DECEMBER 12
4:00pm - 6:00pm
MMA Public Health Committee

6:00pm - 8:30pm
MMA Legislative Committee

DECEMBER 13
1:00pm - 3:00pm
OSC HIT Steering Committee

DECEMBER 19
9:00am -11:00am
Patient Centered Medical Home - Conveners

11:00am - 1:00pm
Patient Centered Medical Home - Working Group

1:00pm - 4:00pm
Aligning Forces for Quality, Patient Family Leadership Team

6:00pm - 9:00pm
American College of Physicians GAC

DECEMBER 20
6:00pm - 8:00pm
Maine Association of Psychiatric Physicians Executive Committee

JANUARY 2
8:00am - 12:30pm
Maine Health Management Coalition

1:00pm - 2:00pm
Aligning Forces for Quality, Executive Leadership Team

continued on next page

Stephen D. Sears, M.D.

From the State Epidemiologist

By Stephen D. Sears, M.D., M.P.H., State Epidemiologist, Maine Center for Disease Control and Prevention

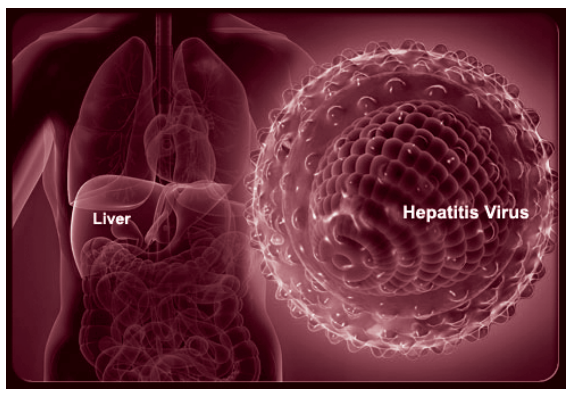
Hepatitis C – New Guidelines

Why baby boomers should get tested for Hepatitis C Virus Infection (And Yes I am a Boomer):

Hepatitis C virus (HCV) infection is an increasing cause of morbidity and mortality in the United States. Many of the 2.7-3.9 millions persons living with HCV infection are unaware they are infected and do not seek care or treatment. The most recent data show that an estimated 17,000 persons were newly infected in 2010. Maine Center for Disease Control and Prevention (Maine CDC) estimates there are 21,000-26,000 persons living with chronic HCV infection in the State. Over 16,000 reports of chronic HCV infection have been made since reporting began in 1997.

U.S. CDC estimates that although persons born during 1945–1965 make up about only 27% of the population, they account for approximately three fourths of all HCV infections in the United States, 73% of HCV-associated mortality, and are at greatest risk for hepatocellular carcinoma and other HCV-related liver disease.

With the development of new therapies, we can stop disease progression and provide a virologic cure in most persons. With targeted testing and linkage to care for infected persons in this birth cohort, it is likely we can reduce HCV-related morbidity and mortality.



Why baby boomers?

We don't completely understand why baby boomers have the highest rates of chronic hepatitis C. Most are believed to have become infected in the 1970s and 1980s when rates of the disease were the highest. Since chronic hepatitis C can go unnoticed for up to several decades, it is possible that baby boomers could be living with an infection that occurred many years ago.

Hepatitis C is primarily spread through contact with blood from an infected person. This may have been the cause of infection in this boomer population before widespread screening of the blood supply began in 1992 and universal precautions were adopted. Others may have become infected from injecting drugs, even if only once in the past. To many, the source of infection remains a mystery.

Why test?

We know that early diagnosis and treatment of hepatitis C can help prevent liver damage, cirrhosis, and even liver cancer. The sooner a person is aware of his/her infection, the sooner he/she can take steps to seek care and treatment and learn how to prevent the spread of infection to others.

Testing is particularly important because people living with chronic hepatitis C:

- Often have no symptoms
- Can live with an infection for decades without feeling sick
- Can be successfully treated with medications
- Can learn how to prevent spreading the infection to others

Recommendations for the Identification of Chronic Hepatitis C Virus Infection Among Persons Born during 1945–1965:

- Adults born during 1945–1965 should receive one-time testing for HCV without prior ascertainment of HCV risk.
- All persons with identified HCV infection should receive a brief alcohol screening and intervention as clinically indicated, followed by referral to appropriate care and treatment services for HCV infection and related conditions.

As providers, we can discuss HCV testing as part of each individual's preventive health care. For persons identified with HCV infection, U.S. CDC recommends they receive appropriate care, including HCV-directed clinical preventive services such as screening for alcohol use, hepatitis A and hepatitis B vaccination as appropriate, and medical monitoring of disease.

Recommendations are available to guide treatment decisions. Treatment decisions should be made by the patient and provider after several factors are considered, including stage of disease, hepatitis C genotype, comorbidities, therapy-related adverse events, and benefits of treatment.

Hepatitis C is a reportable condition:

Persons testing positive for anti-HCV and/or who have detectable HCV RNA should be reported 24/7 to Maine CDC at 1-800-821-5821.

Remember, not all boomers have hepatitis C. It just turns out that they are at increased risk. So let's add another screening test to our preventive strategies.

Resources:

- CDC. Recommendations for the identification of chronic hepatitis C virus infection among persons born during 1945-1965. MMWR 2012; 61 (No. RR-4). http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6104a1.htm
- CDC Viral Hepatitis Website: http://www.cdc.gov/knowmorehepatitis/index.htm
- Maine CDC Viral Hepatitis Program: www.mainepublichealth.gov/hep (includes places in Maine where persons at risk for HCV can get free screening).

What the CME Accreditation Statement Means for You

By Murray Kopelow, MD, President and CEO, Accreditation Council for Continuing Medical Education and MMA Co-author Gail Begin, CME Director

When you review announcements of continuing medical education (CME) activities, you may notice an accreditation statement, which tells you that the education provider is accredited by the Accreditation Council for Continuing Medical Education (ACCME®) or by the Maine Medical Association (MMA) to provide CME for physicians. What is the meaning of that statement? What is its value and benefit for you?

The statement tells you that the CME provider is part of a community of more than 2,000 accredited organizations across the country that offer more than 130,000 educational activities each year, addressing national, regional, and community-based health care improvement priorities. ACCME accreditation assures physicians and other health care professionals that CME is designed to be relevant, effective, and independent. The ACCME accredits organizations that offer CME primarily to national or international audiences and also recognizes state and territory medical societies, including the MMA, as accreditors for organizations that offer CME primarily to learners from their state or contiguous states. All CME programs within the ACCME system are held to the same high standards. The accreditation statement means that the CME provider has met those standards.

The ACCME accreditation requirements are a roadmap for producing effective education that supports health care professionals' commitment to lifelong learning and practice improvement. The ACCME Accreditation Criteria call on accredited providers to develop CME activities that address the real-world problems that physicians and other health care professionals encounter in their practice, whether they work in clinical care, research, administration, executive leadership, or other areas of medicine. CME providers explore why these problems exist, identify the changes that need to be made, and determine the educational support that physicians need in order to effect those changes. Each activity is focused on a specific goal of teaching participants strategies for translating new knowledge into action, improving performance in practice, and/or for improving patient outcomes. Accredited providers use their educational expertise to choose the format that is most appropriate for the activity, selecting from a range of face-to-face and online approaches such as journal clubs, lectures, point-of-care, one-on-one training, simulations, performance improvement, or team-based learning.

The ACCME accreditation system is based on goal-setting, measurement, and continuous improvement. CME providers are expected to analyze educational outcomes, to see whether their CME programs are effective in producing change, and if not, to find out why. Physician learners are expected to engage in ongoing learning, change, and improvement—and to support that process, accredited providers are held to the same expectations. Accredited providers reflect on their own success at meeting their CME program's mission, and identify plans for improvement.

The ACCME Standards for Commercial Support create a framework for ensuring that CME is accountable to participants, the profession of medicine, and to the public for promoting health care quality improvement. The Standards require CME providers to design activities that are independent, free from commercial bias, and based on valid content. Providers must identify and resolve conflicts of interest, and disclose to learners the relevant financial relationships of all those in control of CME content. The ACCME's objective is to support the free flow of scientific exchange while safeguarding accredited CME from commercial influence.

The accreditation statement is brief, but it stands for a voluntary, self-regulatory system that has been in place for more than three decades and has become a national model. Since its founding in 1981, the ACCME has focused on setting and maintaining accreditation requirements that are relevant to physicians' lifelong learning needs and responsive to changes in the health care environment. The ACCME accreditation system is *your* accreditation system, ensuring that accredited CME is of, by, and for the profession of medicine.

The ACCME Accreditation Statement

The Accreditation Council for Continuing Medical Education accreditation statement must appear on all CME activity materials or brochures.

For directly sponsored activities: "The (name of accredited provider) is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians."

For jointly sponsored activities: "This activity has been planned and implemented in accordance with the Essential Areas and policies of the Accreditation Council for Continuing Medical Education through the joint sponsorship of (name of accredited provider) and (name of non-accredited provider). The (name of accredited provider) is accredited by the ACCME to provide continuing medical education for physicians."

The MMA Accreditation Statement

The (name of accredited provider) is accredited by the Maine Medical Association's Committee on Continuing Medical Education to provide Continuing Medical Education (CME) to physicians.

The AMA Designation of Credit Statement

The (name of accredited provider) designates this activity for a maximum of ____ AMA PRA Category 1 Credit(s)™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

Jessa Barnard, J.D.,

Public Health Spotlight

By Jessa Barnard, J.D.,
Director of Public Health Policy, MMA

Antimicrobial Resistance Posing Growing Health Threat: *MMA, MeCDC and Partners Join Get Smart About Antibiotics Week to Draw Attention to the Issue*

Millions of Americans take antimicrobial drugs each year to fight illness, trusting they will work. However, the bacteria, viruses and other pathogens are fighting back. Within the past couple of years alone, new drug-resistant patterns have emerged and resistance has increased – a trend that demands urgent action to preserve the last lines of defense against many of these germs. This year, the Maine Medical Association and Maine Center for Disease Control and Prevention join with the US CDC and other health partners in recognizing Get Smart About Antibiotics Week, November 12-18th.

"People assume that antibiotics will always be there to fight the worst infections, but antimicrobial resistance is robbing us of that certainty and new drug-resistant pathogens are emerging," said MeCDC State Epidemiologist and MMA Member Stephen Sears, MD, MPH. "It's not enough to hope that we'll have effective drugs to combat these infections. We must all act now to safeguard this important resource."

Antimicrobial resistance—when germs change in a way that reduces or eliminates the effectiveness of drugs to treat them—is a growing global problem. Sporadic cases of pandemic H1N1 flu have shown resistance to oseltamivir, one of only two antivirals that work against it. In the United States, *methicillin-resistant Staphylococcus aureus*, known as MRSA, remains a problem in many health care settings. Drug-resistant *Klebsiella pneumoniae,* previously seen in a limited number of hospitals, has now been reported in at least 36 states. Gonorrhea is now showing potential for resistance to cephalosporins, the only recommended antibiotic left to treat this common sexually transmitted infection.

Antibiotic resistance increases the economic burden on the entire health care system. Resistant infections are often more severe, leading to longer hospital stays and increased costs for treatment. According to the latest available data, antibiotic resistance in the United States costs an estimated $20 billion a year in excess health care costs, $35 million in other societal costs and more than 8 million additional days that people spend in the hospital.

As part of the effort to address this concerning trend, US CDC, FDA, and an alliance of partners including national health organizations, state and local health departments, non-profits, managed care organizations, pharmaceutical companies, and other groups concerned about this problem, hope to reverse the public perception that 'antibiotics cure everything' through their Get Smart campaign. The campaign relies on featuring a series of television, radio, and print public service announcements and comprehensive national, state, and local outreach. The campaign aims to better inform the public and prescribers about when antibiotic treatment is warranted.

The public can play a role in reducing the threat of antimicrobial resistance by not pressuring their health care providers for antibiotics, not sharing or saving antibiotics, and taking antibiotics exactly as prescribed, including taking the entire amount prescribed.

Health care providers can prevent antimicrobial resistance by ensuring prompt diagnosis and treatment of infections, prescribing antibiotics appropriately, and following infection prevention techniques to prevent the spread of drug-resistant infections in health care facilities. According to the CDC, tens of millions of the antibiotics are prescribed in doctors' offices for viral infections that are not treatable with antibiotics. Doctors cite diagnostic uncertainty, time pressure, and patient demand as the primary reasons for their tendency to over-prescribe antibiotics. Appropriate use of existing antibiotics can limit the spread of antibiotic resistance, preserving antibiotics for the future.

For treatment guidelines for Upper Respiratory Tract Infections, see:
http://www.cdc.gov/getsmart/campaign-materials/treatment-guidelines.html

For more information about antimicrobial resistance, including background articles, patient materials and continuing education programs, see:
http://www.cdc.gov/getsmart/specific-groups/hcp/

Medical Mutual Insurance Company of Maine Risk Management Practice Tip: *Communication: Managing Conflict*

Effective communication is a two-way process that involves sending the right message in the right way that is correctly received and understood. It sounds like an easy process and in fact people communicate everyday in many ways. But is this communication always effective?

Providers and staff members who feel increasing pressure to do more with less resources may wonder how they can find time in their busy schedules to improve patient communications. Studies have shown that when communications are effective, patients are more likely to follow their provider's recommendations.

At times communications will run smoothly. Far too often however, there are breakdowns in communication which often lead to conflict and defensiveness. When people encounter conflict they typically respond in one of two ways, they will either defend themselves or find a way to escape from the situation. Neither of these is an effective method for dealing with conflict.

When encountering conflict consider the following steps:

Build Skills:
First ask:
- What is my conflict style?
- How adept am I at communication?
- What are my triggers and beliefs that might interfere with the way I handle conflict?

Evaluate:
When conflict arises do a quick "self-assessment."
- What am I bringing to the discussion?
- Does my background affect how I communicate?
- Am I making assumptions about the person or situation?
- What else is influencing the situation?

Determine what you want from this discussion, e.g., a resolution with a win-win outcome.

Engage:
Once you are prepared to interact:
- Acknowledge the patient and elicit their concern.
- Remember to remain calm, respectful and professional.

Empathize:
Employing empathy can help to diffuse situations. One article notes that "extending empathy, by focusing on the patient's emotions and being firm but compassionate… can return a difficult encounter to success."
When interacting:
- Actively listen with a posture signaling openness, make good eye contact and use a non-threatening tone of voice.
- Remember to accept the patient and not judge them.
- Acknowledge their feelings and reflect on your understanding using statements such as:
  - Let's see if I have this right.
  - I can understand why you might be feeling angry.
  - I'm sorry that you had to go through that.

Educate:
Take steps to educate the patient:
- Explain the situation as you understand it.
- Answer any questions and confirm that the patient understands what you have discussed.

Enlist:
At this point:
- Discuss solutions with the patient.
- Allow the patient to have input into the outcome.
- Reach an agreement about what will happen if the solution doesn't work.

End:
Conclude the interaction by:
- Verifying the plan with the patient.
- Committing to continually communicate expectations.
- Confirming that the patient feels the conflict has been resolved.

Effective communication is not always easy. Taking the time to assess our communication skills and then working on techniques to improve our skills will greatly enhance our chances of communicating effectively with not only our patients, but also fellow employees and colleagues.

Medical Mutual Insurance Company of Maine offers this tip as reference information only. It is not intended to establish practice standards or serve as legal advice. Please obtain a legal opinion from a qualified attorney for any specific application to your practice.

UPCOMING AT MMA

JANUARY 2
2:00pm - 3:00pm
Quality Counts, Board

JANUARY 4
9:00am - 12:00pm
First Fridays Seminar

JANUARY 16
9:00am - 11:00am
Coalition for the Advancement of Primary Care

11:00am - 1:00pm
Patient Centered Medical Home, Working Group

1:00pm - 4:00pm
Aligning Forces for Quality, Patient Family Leadership Team

JANUARY 22
3:00pm - 5:00pm
Maine Independent Clinical Information Service (MICIS)

5:00pm - 9:00pm
Maine Chapte,r American Academy of Pediatrics

JANUARY 23
11:30am - 2:00pm
Senior Section

FEBRUARY 1
9:00am - 12:00pm
First Fridays Seminar

FEBRUARY 6
8:00am - 12:30pm
Maine Health Management Coalition

1:00pm - 2:00pm
Aligning Forces for Quality, Executive Leadership Team

2:00pm - 3:00pm
Quality Counts, Executive Committee

3:30pm - 5:00pm
Behavior Health Committee

FEBRUARY 20
9:00am - 11:00am
Patient Centered Medical Home - Conveners

11:00am - 1:00pm
Patient Centered Medical Home - Working Group

1:00pm - 4:00pm
Aligning Forces for Quality, Patient Family Leadership Team

MARCH 1
9:00am - 12:00pm
First Fridays Seminar

MARCH 5
1:00pm - 4:00pm
Maine Council on Aging

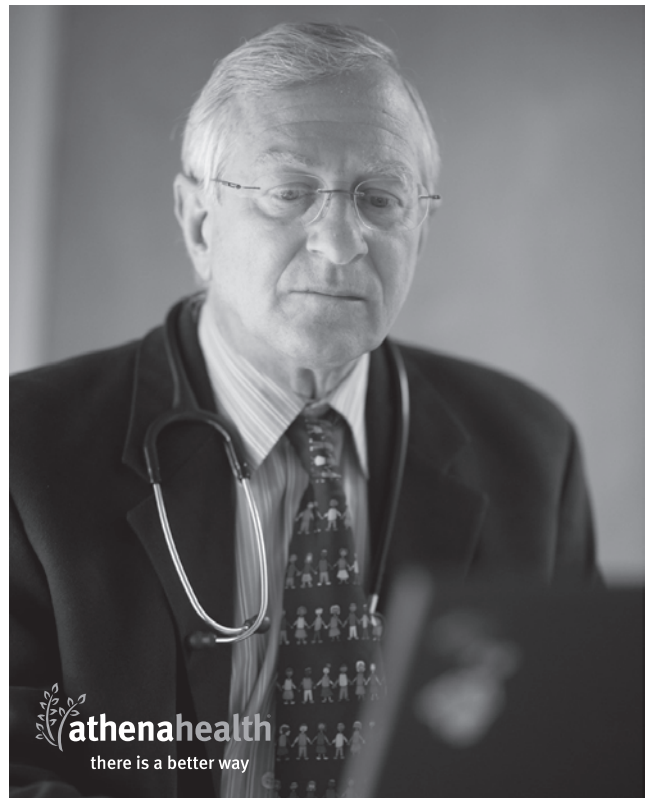
MARCH 6
8:00am - 12:30pm
Maine Health Management Coalition

1:00pm - 2:00pm
Aligning Forces for Quality, Executive Leadership Team

2:00pm - 3:00pm
Quality Counts, Board

**All MMA Committee Meetings are now being offered through WEBEX

Maine medicine
Maine Medical Association
30 Association Drive • P.O. Box 190
Manchester, ME 04351



Visit us on the web at **www.mainemed.com**

Save the Date: MMA's 160th Annual Session
October 4-6, 2013 at the Holiday Inn by the Bay, Portland, ME