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RIMS thanks Pfizer for supporting the transformation of the 96-year-old Rhode Island Medical Journal into a 21st-century vehicle to serve the health care community in Rhode Island. A grant from Pfizer enabled the Rhode Island Medical Society to redesign the Journal for electronic distribution to a much wider audience, endowing it with an attractive new design and more diverse content, while making more efficient use of RIMS’ resources and sparing the environment.

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The Rhode Island Medical Society has challenged, on both state and federal levels, United Healthcare’s abrupt de-selection of hundreds of physicians from its Medicare Advantage network in Rhode Island. The medical societies of Connecticut, New York, New Jersey, Florida and Indiana, with support from the AMA, have also swung into action in response to United’s threat to disrupt hundreds of thousands of patient-doctor relationships in those states – an event that should provide an epiphany to anyone who still thinks that having insurance means having access.

Thanks to RIMS’ effective advocacy back in the 1990s, Rhode Island has some of the nation’s best managed-care legislation, including requirements for network adequacy and for advance notice of insurers’ plans to implement “material modifications” in their networks. For its part, the Centers for Medicare and Medicaid Services now also require Medicare Advantage plans to maintain responsible networks. Those legal and regulatory requirements are some of the tools at our disposal in responding to United’s sudden move against a significant segment of our Rhode Island community, including both doctors and patients.

Network adequacy is just one of many questions raised by United’s unheralded action. RIMS will be looking for answers face to face with United’s leadership in a few days, hopefully even before you read this letter.

One question is why United is cutting its Medicare Advantage network so brutally right now. The company’s reticence about its rationale leaves plenty of room for speculation. United’s full-page ad in the October 19 Providence Journal says the issue is money (surprise!); specifically, it is the federal government’s “severe funding reductions for Medicare Advantage plans.” Now, it is true that Medicare Advantage plans have been targeted for cuts ever since it has become common knowledge that they cost the government more per beneficiary than standard Medicare. In fact, much of the cost of expanding Medicaid under the Affordable Care Act was always supposed to be offset by cuts to the Medicare Advantage program (officially known as Medicare Part C). But those cuts were famously postponed during the last presidential election campaign, and they still haven’t really happened. Still, over the next ten years the government does intend to nudge Medicare Advantage plans toward per-capita parity with regular Medicare, and next year an effective cut of about two percent will begin to take effect.

When I compare that two percent with the absurd cuts Medicare’s SGR formula has routinely threatened for doctors’ fees (most recently in the range of 30%), I find it hard to take seriously the industry apologists who predict that Medicare Advantage insurers will be forced from the market en masse. Do they really have so little confidence in their vaunted ability to manage cost and care at least as well as standard Medicare? (Incidentally, in 2013 for the third quarter alone, UnitedHealthcare Group netted profits of $1.6 billion.)

Perhaps cutthroat market competition is a more plausible explanation for United’s move. The ultimate objective may be to stick the competition with the poorer risks. United is highly sophisticated in managing data, and they know their bottom line. While they are now barred from dropping expensive patients or denying coverage to those with pre-existing conditions, they can still achieve the same effect by dropping doctors who care for expensive panels of patients. Granted, we do not know what algorithm United is using to cull 15 to 30 percent of its Medicare Advantage physician panel, but they have at least made it clear that money is the leading criterion.

We do not know what algorithm United is using to cull 15 to 30 percent of its Medicare Advantage physician panel, but they have at least made it clear that money is the leading criterion.
Medicare Advantage physician panel, but they have at least made it clear that money is the leading criterion.

Given that patients (especially older patients) are known to be far more attached to their physician(s) than to their health plan, and given the fact that Medicare Advantage subscribers are mostly free agents, it seems likely that many United insureds will jump ship before December 7, the date when Medicare open enrollment closes, in order to stay with their doctors. United subscribers who happen to like the format of Medicare Advantage do have one other option in the Rhode Island market, and that option [still] has a robust physician network. But do the Blues really want these particular patients, who may represent so many high-cost Trojan horses?

Incidentally, one factor that may inhibit some patients from leaving United is AARP’s national seal of approval for United’s Medicare Advantage plan. As recently as October 15, AARP’s embarrassment (if any) over their business partner’s aggressive dumping of doctors and patients was apparently not great enough to inhibit AARP from entering into a new agreement with United [in return for still more of the insurer’s undisclosed largess] for co-branding a new portfolio of UnitedHealthcare products through the year 2020.

Another question: Why is United doing this so precipitously right now? Limited networks per se are nothing new. They grew out of the insight that it is possible to have any two, but never all three, of healthcare’s trifecta: affordability, quality and choice. Conventional wisdom says we haven’t seen anything yet, that the transformation of healthcare will bring a proliferation of new products built on limited networks. But note that what United is doing is radically different: it is pruning the network of an existing product. How many subscribers will notice that the value of what they bought is being substantially diminished by United’s action?

Several years ago, the American Medical Association established policies on limited networks. Those AMA policies include:

- Payers should disclose in plain language the criteria by which they construct tiered, narrow or restricted networks.
- Law and/or regulation should require that before plans establish new networks, they must disclose the criteria for participating in those networks and afford physicians sufficient advance notice to permit them to satisfy the criteria.
- Patient access to care should not be unduly limited by the confines of a network.
- Limited networks should not be inappropriately driven by economic criteria.
- Law and/or regulation should prohibit the formation and operation of networks based solely on economic criteria.

Clearly, United is transgressing egregiously against at least some, and perhaps all, of these well-considered national standards. ❖
I have been impressed many times by a discrepancy between some neurological drugs’ commercial success and their actual clinical efficacy. I occasionally consult for venture capital funds interested in investing in companies that appear poised for a major killing. What is the market for a drug that is supposed to have this effect? They want to know. What if the effect is smaller or larger? What side-effect profile would make the drug more or less likely to be effective? How much better/worse would the intervention have to be compared to the drugs already on the market?

I am not allowed to share inside information, and I have none anyway, so it’s all on the up and up. When asked about marketability, I always point out that in most cases marketing determines sales. Some crummy drugs are big hits and some good drugs go down the drain. Although my doctor colleagues won’t want to read this, it’s the free dinners, the coffee and donuts for the secretary, the wining and dining of KOL’s (“Key Opinion Leaders” in the lingua franca of the drug reps) and the solicitous opinion-seeking that help drive sales, at least for the average neurological drugs.

I got to thinking about this as I prepare for a paid consultation with a drug company interested in choosing a scale for a study in Parkinson’s disease (PD). This is, of course, an important part of the methodology of any study, but as I thought about it, I recalled a statement made by a biotech company executive I also consulted for, many years ago, when the discussion turned to how likely the product was to be a commercial success as a function of various possible reasonable trial outcomes. Obviously if the product was a failure it would never even be approved for sale by the FDA. But what if it just worked a little, like the dementia drugs? How much improvement in a test score would assure commercial success? What would insurers be willing to pay? He noted that when dialysis was first begun, the results weren’t great but people lined up to have it done. Dialysis results improved and it became standard treatment. If the biotech product was as good as its theoretical promise, it shouldn’t matter much how we measured the outcome. It should speak for itself. He wasn’t worried about what measures we used for evaluating his product. In his mind, it either “worked,” in which case it was a slam-dunk, or it didn’t, and the business folded.

I’ve given a lot of thought to this. In contemporary FDA policy, a lot of credence is given to small gains. We see cancer drugs approved that provide a very modest benefit over existing treatments. Dementia drugs, used in widespread fashion in the United States, aren’t thought sufficiently worthwhile to enter the British national formulary. What does it mean if a drug produces a “statistically significant” benefit over placebo, and, hopefully over currently existing treatments, on some measure but not others? I was the principal investigator for the first multi-center trial for the treatment of any behavioral problem in PD, completed many years ago. Having no accepted, validated measure for assessing psychosis in PD, we used four different measures, two of which were aimed at schizophrenia, a very different entity, hoping that we’d see improvement in all. And we did. Recently, another study in PD also used four distinct measures, also achieving uniform success. This can be a risky business. What if two measures are successes and two are not? This had, in fact, been the problem with a previous trial of this new drug.

It is obvious that choosing an appropriate metric is crucial for any study. But it’s not always so easy to decide what represents a good measure. In the last decade, the development of new assessment tools and sophisticated validation techniques has become a cottage industry, with publications reporting the validity of Test X in Norway, Test Y in Japan, etc. While boring to read, these are, in fact, important. For example, how should one “measure” PD? Unlike
amyotrophic lateral sclerosis (ALS), where there are clear-cut markers like death or time until ventilator dependency, PD is a disorder that affects different motor, behavioral and autonomic functions in very variable ways that progress at very variable rates. We can use objective measures of motor function: how long it takes to walk a certain distance; how much tremor occurs in a limb over 30 minutes using accelerometers; how fast a task can be performed, etc. PD not only varies among individuals, it varies in the same patient from minute to minute, hour to hour and day to day. The assessment of activities of daily life, quality of life, mood, which are more meaningful problems, unfortunately is highly subject to bias.

I believe that if the treatment benefit will only show up on the “right” measuring instrument, assuming there are choices that, a priori, seem to be measuring the same thing, then there is a problem. For example, there are several measures of schizophrenia, depression, fatigue, apathy, anxiety, etc. Obviously one wouldn’t use a schizophrenia scale in a study of depression, but of the many depression scales, what would it mean if a drug was successful with one scale but not with another? Does it mean that the study should be repeated using only the “correct” scale so the results support efficacy? Or does it mean simply that biodiversity is great enough to have produced a faulty positive outcome, p<.05? We clinicians, who are encouraged to rely increasingly on evidence-based medicine, need to understand the quality of the evidence we base our decisions on. In this age of increasingly sophisticated statistical analyses, it has, unfortunately, become more, rather than less difficult, at least for this physician.

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Dr. Aronson in 2007 receiving Doctor of Medical Science (DMS) at Brown in 2007.

Stan Aronson, MD, in the early years in the 1950s at Downstate Medical Center in NYC.
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As islands go, Kos is little more than a small, inconspicuous piece of land in the eastern Aegean Sea, perhaps 110 square miles in area and with a resident population of about 33,000. And yet, in a curious way, it has a tenuous connection, perhaps only botanical, with Providence, Rhode Island.

Kos, a living history-book of successive invasions, is part of an archipelago populated since prehistoric times and consisting of twelve major islands (the Dodecanese) as well as about 150 minor islets. These islands are in the midst of the eastern Mediterranean trade paths and hence have been fought over repeatedly during the last three millennia. The dominion over these islands has passed, successively, to Minoan Crete; then to Mycenian Greece; to the Anatolian mainland; to the Dorians; then, briefly, to the Persian Empire; then to the Macedonians under Alexander the Great; then to the Ptolemy Dynasty of Egypt; then the Constantinople-based Byzantine Empire; then the Ottoman Empire; thence to the Italians, especially the mariners from Genoa; briefly the British; then back to Greece; and all of these episodes of suzerainty intermixed with intervals when the islands ruled themselves. As entrepots in the eastern Mediterranean Sea, and despite their succession of foreign rules, the islands prospered as major cultural and mercantile centers.

Nor have these many islands been ignored by history. The largest, Rhodes, was taken over by the Knights Hospitallers during the Crusades beginning in the 11th Century. And even idyllic Patmos, a small island at the northern extremity of the Dodecanese, populated by some 3,000 folk, is famous for its Byzantine seminary, with Greek Orthodox scholars, and for the Cave of the Apocalypse, said to have been the sanctuary of John the Apostle where he wrote the Biblical Book of Revelation.

Kos is best known, however, as the likely birthplace and certainly the site where Hippocrates (c.460–370 BCE) educated young physicians in a secular cult usually called Asklepian. Medicine, in the Hippocratic school, became an independent profession, with its own prescribed education, regulations, discipline and prevailing philosophy.

The Tree of Hippocrates is the plane tree under which, according to the legend, Hippocrates of Kos taught his pupils the art of medicine. Photos show the Hippocratic tree on the island of Kos in Greece and one nurtured from a seedling in front of Brown University’s Arnold Laboratory on Waterman Street.
Hippocrates is said to have educated a generation of young physicians in a newly contrived form of the healing arts, now separated from religion, and based on careful diagnosis, minimal use of herbals, reliance upon natural healing forces and the underlying belief that illness was not divinely fashioned but represented, rather, the manifold forces of the environment, improper sanitation, dietary indiscretions, excessive wines and imprudent living. In Hippocrates’ words when referring to epilepsy: “Men believe only that it is a divine disease because of their ignorance and amazement.”

Hippocratic medicine relied heavily upon the art of foretelling, distilled from careful observation and the outcomes of prior patients with similar histories, what today is called prognosis. And in one of the books ascribed to Hippocrates, we read: “He will carry out the treatment best if he knows beforehand from the present symptoms what will take place later.” Much of what we know of Hippocrates today is derived from the later writings of Aristotle, Plato, Soranus of Ephesus, Polybus and Galen.

Much of the criticism of Hippocratic medicine, expressed centuries later, was its passive, nihilistic concept of how medicine should be practiced, demanding a respect for “the healing power of nature” rather than the intensive interventions invented by Hippocrates’ successors. In Latin, centuries later this fundamental Hippocratic doctrine was called, “vis medicatrix naturae.”

Where then, in all of this, is the tangible connection with Providence, Rhode Island?

Hippocrates was said, by tradition, to have taught his students beneath the branches of a great, spreading tree on the plains of the Dodecanese island called Kos. And indeed, there exists today an ancient tree sited approximately where this teaching had been undertaken. This tree, identified as Platanus orientalis, is botanically related to the London plane tree (which adorns countless American boulevards) and the American sycamore. It is a tree of incredible longevity and has been an integral part of the Hindu religion as the earthly representation of the Goddess Bhavani; and in Persian mythology the tree is known as Chenar.

In 1972, the inaugural year of Brown University’s school of medicine, a seedling from the Hippocratic tree on Kos was presented to the medical dean’s office wishing the newly opened school much prosperity and success in its educational and healing mission. The seedling was nurtured carefully and now stands proudly before the Arnold Laboratory Building, 97 Waterman St. Seeds from this secondary Platanus tree now grow in various places in Rhode Island and neighboring Massachusetts.

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The author has no financial interests to disclose.
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I’ve heard the expression “getting your bell rung” ever since I started playing football, in 3rd grade. It never struck me as a particularly ominous expression. The phrase, uttered by my coaches in a light-hearted tone, was often used to minimize the effects of a big hit. As a high school football coach in Florida, I clearly remember players and coaches alike using phrases like “he just got his bell rung; he’ll be fine.” It wasn’t until medical school and the more recent media attention on concussion that I started to think about what this phrase communicates.

Despite all of the current focus on concussion, I find that many of my patients and their families don’t know exactly what it means to have a concussion. Contrary to the harmless image of a ringing a bell, a concussion is a disturbance in brain function caused by direct or indirect forces to the head. Concussive forces disrupt neural processes in the brain and affect the way the brain functions.

That’s right, a concussion is a disturbance in the way the brain functions!

I spend hours each week trying to explain to frustrated athletes why it is important to rest and take time out of their sport. There are certainly more coaches, athletes, and parents who take concussion more seriously now than there were five years ago, but the continued use of phrases like “he just got his bell rung” really do make an impression on young athletes and minimize the seriousness of concussion.

Many states, including Rhode Island, have passed laws addressing concussion. Under the Rhode Island law, coaches must remove any player who exhibits signs or symptoms of a concussion from a game or practice. That player must obtain written medical authorization by a licensed physician before being allowed to return to play.

As a medical community we are doing a better job of recognizing and appropriately treating people with concussion than we have in the past. Nevertheless, athletes are still sometimes making it back to practices and games without resolution of their symptoms or a gradual return to activity protocol. According to the 2012 Zurich Consensus Statement on Concussion in Sport: “The cornerstone of concussion management is physical and cognitive rest until the acute symptoms resolve and then a graded program of exertion prior to medical clearance and return to play.”

The consensus statement goes on to recommend a sample graded program of exertion otherwise known as a “return to play protocol” as outlined in the table below. With the stepwise progression shown in the table below, the athlete should proceed to the next level only if he or she has NO symptoms at the current level. Generally each step should take 24 hours. Therefore, as long as an athlete remains symptom free he or she would take approximately 1 week to proceed through the protocol. If any post-concussion symptoms occur during the protocol the athlete should drop back to the level where there were no symptoms and discuss the protocol with their physician.

The next time you hear the words “he only got his bell rung,” think of the translation: “he only suffered a traumatic brain injury which has caused a disturbance in the way his brain functions” – sounds a little different that way, doesn’t it?

Editor’s note: Jeff Manning, MD, specializes in sports medicine and is the medical director of Affinity Sports Medicine, an affiliate of Kent Hospital, in East Greenwich. He is also a faculty member with the departments of Family Medicine at Brown University and the University of Massachusetts. In addition, Dr. Manning sits on the Sports Medicine Advisory Committee of the Rhode Island Interscholastic League.