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

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Editorial

Jane Lochrie, MD

Perinatology, sometimes referred to as maternal-fetal medicine began to emerge as a discipline in the 1960s when advances in research and technology allowed physicians to diagnose and treat fetal complications in utero. It is one of the most rapidly evolving fields of medicine, especially with regards to the fetus. Fetal gene and stem cell research are making progress in offering early treatment of genetic disorders, open fetal surgery for the correction of birth defects, such as congenital heart disease and the prevention of preeclampsia.

Perinatologists provide care for pregnant women who have a chronic illness (e.g. heart or renal disease, hypertension, diabetes and thrombophilia), patients who are at risk for pregnancy-related complications (e.g. pre-term labor, pre-eclampsia, or multifetal pregnancy) and women with fetuses at risk (chromosomal or congenital abnormalities, maternal disease, infections, and growth restrictions. They may also act as a consultant for expectant mothers with chronic conditions, drug use during or before pregnancy, or women who experience difficulty conceiving a baby. This issue of Worcester Medicine explores perinatology in Worcester.

In the first article, Lawrence Rhein, MD, MPH, explains the extraordinary improvements that have occurred in caring for premature infants, even infants born as early as 23 weeks. Survival rates have significantly improved while morbidity has decreased dramatically. Surfactant and noninvasive ventilation have revolutionized the treatment of respiratory distress syndrome. Cerebral palsy has decreased with judicious use of steroids and whole-body cooling. Similarly, improvements in nutrition and treatment of narcotic abstinence syndrome have also helped transform neonatal medicine.

Ellen DelPapa, MD opines that Maternal Fetal medicine has made a lot of progress over the past 30 years yet there is still a lot that we still don’t know about the pathophysiology of preeclampsia and preterm labor. Patients today are sicker, and have more chronic illness, are more obese and are older. Advances have been made in evidence-based interventions that have reduced morbidity and mortality. Rapid DNA sequencing allows screening for the most common chromosomal abnormalities without an invasive procedure. Muriel Cleary, MD, FACS, FAAP discussed the ability to detect fetal anomalies in utero that leads to 20% of neonatal mortality. Once a diagnosis is made or is suspected, families are referred to the Fetal Specialties Clinic (FSC) where multispecialized care providers work together to formulate a cohesive plan. The FSC focuses on providing a positive experience despite an upsetting or potentially devastating diagnosis. Parents are able to process this information and are able to ask questions in a calm, supportive environment before the baby is born. Parent are informed of what to expect post-delivery. Pediatric surgeons are now able to intervene early and prevent or minimize poor outcomes once the prenatal diagnosis is made.

Cheryl Killoran, MS, RNC–NIC describes the Perinatal Bereavement Program in the Neonatal Intensive Care Unit (NICU) at U Mass Memorial Medical Center. The team includes: social workers, pastoral care, child life, March of Dimes, nurses, respiratory therapists, physicians and other providers. Social workers help the family through the grieving process and child life helps build memories for the family by creating handprints family pictures and, most recently heartbeat songs. Nurses who care for a baby who has died or is dying include the family in all aspects of care. A yearly Memorial Service is held for families of babies who have died through miscarriage, stillbirth or neonatal death.

The student perspective is provided by a University of Massachusetts second-year medical student, Vanessa Villamarin, et. al. She tells us that the infant mortality rate (IMR) in Worcester is higher than the Massachusetts overall rate and has been for years. She describes the significant racial disparities that is alarmingly high among the Hispanic population. The Worcester Health Baby Collaborative (WHBC) was started to respond to the disparities in IMR. This is a coalition of health professionals, students, community leaders who volunteer their time and skills to address this issue. They have partnered with the Worcester Department of Public Health and the Baby Box Company to provide new parents with a safe sleep space, educational materials and other supplies to care for their newborn. Medical and nursing students take a leadership role in this wonderful project.

As always, please read the President’s Message, Legal Consult, As I See It and Society Snippets before you leave this issue.
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President's Message

I cannot believe that two years have already passed since I was named President of the WDMS. It has been a great honor and privilege for me to serve the Society. The last two years have seen change and celebration. As you know, during the years 2018 and 2019, we had a changing of the guards with a new Executive Director and Treasurer positions and a period of transition. With the help and hard work of Dr. Dale McGee and Martha Wright, the changes we were able to make will, hopefully, be long lasting and put our Society on a strong footing for the future. There is still more work that needs to be done and I hope we will have your support and approval to accomplish it.

I am very proud of the 225th Anniversary Gala we were able to put together in September 2019 to celebrate this historical milestone of our Society and to raise funds for our Scholarship Fund. There were over 250 attendees at the Gala, and we were able to raise over $70,000. After expenses, we donated $25,000! My heartfelt thanks to Martha, Melissa, Katrin and Francine for their hard work in putting the Gala together. I am also so grateful to Dale and his team for producing the history of the WDMS video which will be something our members will be able to enjoy for many years to come.

I know it is not easy for many of you to volunteer for the Society but I am very grateful to all those who are able to volunteer and fill the roles of Chair or being members of our committees and serve as delegates to the MMS. It takes a lot of personal and professional time on your part and we are grateful that you consider doing this.

These last two years had been a wonderful experience for me to learn and understand the inner workings of both the WDMS and the MMS. I am very grateful for all the help and support so many of you have given to me. I take with me the kindness I have received and the friendships I have made during the last two years.

I leave the Society in a strong position and in good hands. I wish Dr. Spiro Spanakis and his team and Martha all the best in the coming years.

Thank you very much for giving me this opportunity to serve.

Sahdev Passey, MD
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Update in Neonatology

Lawrence Rhein, MD, MPH

Neonatal medicine has made incredible advances over the last few decades. Survival rates, even for babies born as early as 23 to 25 weeks of gestation are significantly improved. Through scientific discovery, implementation of best practices, and focus on measurable improvements using quality improvement methods, rates of most of the other key morbidities of prematurity (chronic lung disease, late-onset infection, necrotizing enterocolitis [NEC], intraventricular hemorrhage, and retinopathy of prematurity) have also all decreased dramatically.

This review aims to provide a brief update on the most important recent changes in neonatal medicine.

Neonatal Respiratory Disease

Decades ago, the discovery of the role of surfactant revolutionized neonatology, and subsequently made respiratory distress syndrome a non-lethal disease. More recently, the widespread initiation and optimization of noninvasive ventilation (through continuous positive airway pressure [CPAP] and non-invasive positive pressure ventilation [NIPPV]) now allow many infants to avoid mechanical ventilation completely. When surfactant is delivered selectively, many neonatal intensive care units (NICUs) can deliver without intubation (Less Invasive Surfactant Administration or LISA) or can immediately take out the breathing tube after surfactant delivery (the INSURE method). Noninvasive methods of assessing oxygenation and carbon dioxide provide thousands of data points to allow optimal respiratory management. Tighter management of oxygen target saturations has helped to decrease rates of retinopathy of prematurity without adversely affecting neurodevelopment. Similarly, more judicious use of corticosteroids, which were once ubiquitously provided to most premature infants, has helped decrease rates of cerebral palsy. While some of the most dramatic improvements in care have related to lung disease in premature infants, other advances have helped term infants. For example, inhaled nitric oxide has now become a standard-of-care therapy to decrease mortality for infants with neonatal pulmonary hypertension. Improved technology and the availability of focused follow-up programs now allow infants to be discharged home much earlier through safe home oxygen weaning protocols. Efforts at the level 3 NICU at UMASS regarding the development, optimization and implementation of various respiratory care guidelines in both the inpatient and outpatient settings have led to some of the best respiratory outcomes in the country.

Surgical Advances

Improvement in surgical techniques now allow pediatric surgeons to place abdominal drains at the bedside in the tiniest of NICU patients. Laparoscopic techniques allow infants to undergo procedures with shorter recovery, minimizing the effects of ventilator injury and large fluid shifts, resulting in better outcomes.

Nutritional Advances

Evolving evidence has helped NICUs to move away from prolonged periods of fasting due to concern for NEC. This practice had resulted in a catabolic state of unintended starvation. Instead, early total parenteral nutrition and sub-nutritional trophic feedings have now become the standard of care. Preferential use of mother’s own milk, as well as donor breast milk, in conjunction with standardized feeding regimens have both reduced NEC rates and reduced rates of growth failure. In addition, an explosion of research into the neonatal microbiome and the effects of different medications has led to more judicious use of medications, including antibiotics and pharmacologic treatment of gastroesophageal reflux.

Hypoxic Ischemic Encephalopathy

For term infants who experience perinatal deficiencies of oxygen (hypoxic ischemic encephalopathy), large randomized controlled trials have demonstrated the neuroprotective effects of initiating whole-body cooling, resulting in decreased rates of brain injury for these infants. To be effective in its neuroprotective benefits, cooling must be initiated within hours of the perinatal insult, highlighting the need for regional level 3 centers to serve infants throughout the state.

Narcotic Abstinence Syndrome

Neonatal caregivers across the country have been more recently facing a growing epidemic of substance use in pregnancy, affecting both mothers and their infants, many of whom experience active withdrawal. Most recent evidence suggests that emphasis on nurturing the mother and ensuring her comprehensive treatment and ability to support the infant through a focus on feeding, sleep optimization and consolation (Eat/Sleep/Console) results in best outcomes. These outcomes include timely and safe discharge of infants to home, decreased length of stay, and decreased days exposed to pharmacologic narcotic treatment.

Family-Centered Care

The modern NICU now encourages family participation on rounds and facilitates parent involvement in care, including kangaroo care (the practice of skin-to-skin contact between parents and infant).

In summary, dramatic progress in neonatal intensive care continues to be made. The regional network of neonatal units in Central Massachusetts are helping to contribute to the growing body of knowledge in this area, to optimize outcomes for the infants in our region and throughout the country.

Lawrence Rhein, MD MPH is an Associate Professor of Pediatrics and the Division Chief of Neonatology, Director of the Center for Healthy Infant Lung Development, and Chair of the Department of Pediatrics at the UMass Memorial Medical Center. Lawrence.Rhein@umassmemorial.org
A Paleontologist’s View of Thirty Years of Maternal Fetal Medicine

Ellen Delpapa, MD

Are you the paleontologist on call? Asked a physician, in 1989, looking to transfer a patient with a complicated pregnancy to the University Hospital where I was a fellow. I paused - what was the right answer to that question! I shrugged, Paleontologist/Perinatology all the same, I listened to the patient’s history and the referring physician’s concerns.

Perinatology is a complicated word which has gradually transitioned to the more descriptive title of our specialty, Maternal Fetal Medicine. Besides the name, what else has changed in the thirty years I have been at UMassMemorial?

First, I would say the increased visibility of Maternal Fetal Medicine within the medical system and public discourse of both infant and maternal outcomes. Patients and medical providers more often seek the input of a Maternal Fetal Medicine specialist when they recognize a complicated pregnancy. Along with an increase of awareness for our subspecialty, is the acuity of patients we are asked to see. We all see and hear it every day, the patients are sicker and have more chronic illness, added to obesity and delayed childbearing, this makes for more challenging obstetrical cases.

Unfortunately, our field has not had as many eureka moments as I would have hoped. Thirty years ago, I would have said, the three biggest challenges in obstetrics were the etiology of preeclampsia, the underlying mechanism of the initiation of labor and determining genetic conditions of the fetus without an invasive and potentially harmful amniocentesis. The first two, sadly, have remained an enigma; there has been great progress on the pathophysiology of both preeclampsia and preterm labor but the final pathway to each disease remains a black box on any algorithm. After theories that have included a parasitic worm (artifact) and angiogenic imbalance, we have landed on preeclampsia as an endothelial disorder caused by placental hypoperfusion. It has been known for years, in patients destined to develop preeclampsia the remodeling of the maternal uterine spiral arteries is defective; But what causes the abnormal placental development? Simply stated, we are still looking for the toxin in the black box that causes toxemia.

The physiology of the initiation of human labor whether preterm or term also remains elusive. We know prostaglandins, inflammation, and activation of the fetal hypothalamic-pituitary-adrenal axis all play a role but again there is a frustrating black box at the top of the algorithm.

Aspirin for preeclampsia and supplemental progesterone for preterm labor reduce the risk of these conditions, in high risk populations, by about a third. Not a cure by any means but in large populations it decreases the disease burden. I am holding out for game-changing breakthroughs which will allow us to develop preventions for preeclampsia and preterm labor, along with a reliable means of induction of labor. Greedy, perhaps, but we owe it to the brave women (our patients and those around the world) who submit themselves to the uncertain process that assures the continuation of our species.

The statistics of maternal mortality in the USA is nothing our specialty or our country can be proud of. WHO reports the maternal death rate in the USA has increased from 2000-2017 from 12-19 /100,000 live births. Our specialty has recently been a leader in developing standards and educational materials of evidence-based interventions that are distributed widely as “toolkits”. Toolkits for postpartum hemorrhage and severe hypertension in pregnancy have proven to be effective in decreasing maternal morbidity and mortality.

Genetics has been the big win for Maternal Fetal Medicine. The ability to rapidly sequence DNA and the finding of circulating cell free placental DNA in mother’s blood has allowed us to screen with high certainty the most common chromosomal abnormalities of sex chromosomes and Trisomy 21,13 and 18 without an invasive procedure. We are just at the beginning of the use of this technology. Everyday another application is available. It is being used to determine if the fetus is RH positive or negative, important in RH negative women with antibodies. The technology also allows for screening for an increasing number of microdeletions such as 22q known as DiGeorge syndrome. This revolutionizing technology provides access to fetal genetic material and gives parents more information about their unborn child without invasive procedures.

Other fields breakthroughs have made a positive impact on high risk obstetrics. Our friends in the NICU continue to make us look good. The outcomes of increasing small neonates is improving. HIV just a generation ago had a perinatal transmission rate of 25%; now it is less than 1% in the USA with antivirals during pregnancy.

Thankfully, the joy of Maternal Fetal Medicine has not changed in thirty years; it continues to be a privilege to share a woman’s journey through the intense, intimate process of pregnancy and birth.

Ellen Delpapa MD is a Professor Obstetrics and Gynecology at the University of Massachusetts Medical School and Division Chief of Maternal Fetal Medicine.
The CDC estimates that congenital malformations and chromosomal abnormalities affect about 3% of all newborns in the United States and account for nearly 1/5th of neonatal mortality (1). With the advent of prenatal screening protocols and the ability to identify both structural and gene defects, parents are now able to plan for their child’s first foray into the world. The role of both parent and physician has been greatly influenced by this ever-evolving ability to detect fetal anomalies in utero. Through the use of fetal ultrasound, many congenital diagnoses are now known long before delivery. Tracing the natural history of certain structural anomalies has greatly enhanced our understanding of many of these diagnoses and has also enabled us to potentially intervene to improve outcomes. This imparts great responsibility upon the medical team to reliably predict how ultrasound findings translate into postnatal outcomes. It has guided the development of ultrasonographic criteria that have been rigorously studied to determine how certain features may predict prognosis. The prognosis may range from a good outcome to an outcome that can be optimized by certain treatments or delivery environments to very poor outcomes that might prompt individualized palliative care plans. The ultimate goal is to empower families with the ability to make the wisest and most informed decisions.

Our UMass Fetal Specialties Clinic (FSC) under the leadership of Dr. Julianne Lawring and Dr. Petra Belady, focuses on providing thoughtful and individualized multidisciplinary care to families faced with fetal diagnoses ranging from Chromosomal, Genitourinary, Neuroanatomical, Cardiovascular, Gastrointestinal, Craniofacial, Skeletal, and Abdominal Wall congenital anomalies. Once a diagnosis has been made or is suspected, referral to this clinic places families in contact with multiple specialized care providers who work together to formulate a cohesive plan. Additional imaging such as more detailed ultrasounds, echocardiograms (ECHO) or magnetic resonance imaging (MRIs) are coordinated such that results can be reviewed by specialists and discussed with families in a single setting. The goal of this clinic is to streamline care and provide counseling to families in a forum where all their questions can be accurately addressed. Depending upon the severity of the diagnosis, this counseling can range from reassurance to recommendations regarding delivery timing/location to, in tragic cases of a lethal anomaly, consideration of termination or a postnatal palliative care plan based on a family’s wishes. The focus remains on optimizing the care of both mom and fetus and providing a positive experience during the pregnancy despite an upsetting or potentially devastating diagnosis.

In 2019, the UMass FSC cared for 65 patients with our Maternal Fetal Medicine team leading and coordinating care with many specialty providers: Neonatology, Pediatric Cardiology, Pediatric Urology, Pediatric Otolaryngology, Pediatric Orthopedic Surgery, Pediatric Plastic Surgery, Pediatric Neurosurgery and Pediatric General Surgery. Within the realm of General Pediatric Surgery, we see many patients with congenital lung lesions, abdominal wall defects, intra-abdominal masses or hernias and abnormal gastrointestinal anatomy. We have found that most families find tremendous reassurance in simply being able to sit down and discuss what the ultrasound finding actually means. In cases of a Congenital Pulmonary Airway Malformation (CPAM), for example, we are able to review why this occurs and how we can track its growth in utero. Special measurements that calculate the size of the lesion relative to the size of the baby allow us to prognosticate the likelihood of needing an earlier intervention. In many cases, the fetus is able to progress to term and delivery is uneventful. During the prenatal consultation we discuss with families the indications for, and timing of, elective resection of the lung so that they have a good sense of what to expect should everything proceed smoothly following delivery.

"PARENTS OFTEN EXPRESS THAT PROCESSING THIS INFORMATION AND BEING ABLE TO ASK QUESTIONS IN A CALM ENVIRONMENT BEFORE THE BABY COMES, IS EXTREMELY HELPFUL."

Parents often express that processing this information and being able to ask questions in a calm environment before the baby comes, is extremely helpful. This is particularly true in cases of abdominal wall defects or gastrointestinal anomalies where surgical intervention is nearly always indicated in the immediate post-natal period. All parents desire a clear sense of what is going to happen in the delivery room, where their baby goes after birth, whether or not they will be able to hold their child, how soon after birth a surgery is necessary, how dangerous the surgery is, what the recovery looks like and how long their baby might be in the hospital. While there is certainly a wide range of questions to these questions which may depend on several individual factors, we are typically able to provide the reasonable spectrum of outcomes such that families can mentally and emotionally prepare for their child’s arrival.
While patients and families have undoubtedly benefited from our ability to make prenatal diagnoses, it has also had tremendous impact on the field of pediatric surgery. It has contributed greatly to our understanding of disease processes and embryologic development and more importantly, has given us a window to potentially intervene to prevent or minimize poor outcomes. For many of these congenital anomalies, this simply means safe delivery in an appropriate setting where specialty care is immediately available. For others, the timing or method of delivery may be adjusted to optimize outcome. For example, fetuses who may require extracorporeal membrane oxygenation (ECMO), are referred to a center where this is provided and consultation can be completed prior to delivery. In other situations, medical treatment such as the administration of steroids or less commonly, fetal surgical intervention may be considered, and appropriate referrals made. Our UMass FSC creates a truly multidisciplinary approach to making these sometimes-challenging decisions, always placing our patient and family at the center. As the ability to detect prenatal diagnoses continues to advance, we will need to keep pace and develop strategies to interpret these findings and appropriately translate them into thoughtful and comprehensive care plans. Through these collaborative efforts, we strive to start caring for our patients long before they exit the womb.

References


Muriel A. Cleary MD, FACS, FAAP is an Assistant Professor of Pediatric Surgery at UMass Medical School
A Perinatal Bereavement Program

Cheryl Killoran, MS, RNC-NIC

Babies are not supposed to die. Unfortunately, some do. I have worked in the Neonatal Intensive Care Unit (NICU) at UMass Memorial Medical Center, the only level 3 NICU in Central Massachusetts, for almost 40 years. We care for babies who sometimes don’t make it home. Even though the number of deaths in our NICU is low, about 10 to 12 per year, every loss is hard for the NICU staff who help not only the baby, but the family as well, through an extremely difficult time.

UMass Memorial – Memorial Campus delivers more than 4,000 babies a year at its high-risk Maternity Center. It is not easy for anyone when birth and death happen within the same time frame. Some babies are stillborn, others die shortly after birth, and some babies, after spending months in our NICU lose their struggle to survive. NICU and Maternity staff build close bonds as they work closely to take care of the baby and the family during the intimate time before, during, and after birth.

I have been a part of perinatal bereavement, which also includes maternity, for more than 30 years with past support from the late Dr. Frank Bednarek. Dr. Bednarek's compassion and empathy for grieving families led the way for much of what we do today. Members of our team include social workers, pastoral care, child life, March of Dimes, nurses, respiratory therapists, and providers. Team members are dedicated to helping make the bereavement process a little easier for families and staff. Social workers help support families through the grieving process and offer resources that might be helpful including a monthly bereavement support group. Child life helps build memories for families, including siblings, by creating handprints, family pictures, and most recently heartbeat songs. The nurse at the bedside who cares for the baby who has died or is dying includes the family in all aspects of the baby's care. With the help of the maternity staff bereavement team, a CuddleCot was donated by Amy and Joseph Loud in August 2018. The CuddleCot is a special bassinet with cooling components that allows grieving parents to spend more time with their deceased baby. Members of the team also help gather mementos, so the family has something to take home with them. Bereavement pictures are also part of the process.

UMass Memorial Medical Center started taking perinatal bereavement pictures in 1989 before it became a standard of care. Perinatal bereavement photography became an accepted practice in most hospitals in the 1990s. Literature was available explaining how to take respectful and compassionate pictures of babies who had died. In 2006, I presented a poster at the National Association of Neonatal Nurses Annual Education Conference in Nashville highlighting UMass's Perinatal Bereavement Program including bereavement pictures. We were one of the only programs that were doing black and white photographs of non-living babies swaddled in a natural position. These photographs are important to families as they provide a lasting memory of the baby. Today, there are many resources related to bereavement photography on the internet, in the literature, and from many organizations.

Some people question why we take bereavement photos. They can provide families with a tangible memory of their baby. Pictures help confirm the baby’s existence. A picture shows what the baby looked like and lets families share the picture with others and show for whom they are grieving. For siblings who were too young or not yet born, it is important to have a picture so they can see their brother or sister. The pictures can be viewed years after they were taken. Pictures, along with other mementos, prevent families from leaving the hospital empty-handed.

A yearly Memorial Service is held at the Memorial campus for families of babies who have died through miscarriage, stillbirth, or neonatal death. The service includes readings and songs relevant to the event. Each year a parent reads “In Parents Words,” an opportunity for parents to talk about their personal loss. The service helps families know that they are not alone. Part of the service is a reading of the baby’s names and a white rose is given to the families for each baby who was lost.

Perinatal bereavement has changed over the years. We are currently creating a Palliative Care/Bereavement Committee to help facilitate these aspects of neonatal care. One example is a sign to identify loss. The Maternity Center hangs a leaf with a teardrop on the hospital room door to alert staff a death has occurred. The picture of the leaf and teardrop serves as a visual reminder of the need for sensitivity when entering the room. The NICU started displaying a candle and placing the name of the baby who died that week under the purple butterfly on our huddle board. The candle and name of the baby provides acknowledgment of the loss of life.

Death isn’t easy, especially the death of a baby. For many parents, grief lasts a lifetime and they may always grieve for the life their child never had. With the extraordinary efforts of staff taking care of bereaved families, together we help them get through it and help validate the meaning of their baby's life. The Palliative Care/Bereavement Committee will continue to look at ways to ease the process of coping with the loss of a baby, it is important for all.

Cheryl Killoran, MS, RNC-NIC is a Nurse Education Safety Specialist in the NICU at UMass Memorial Medical Center. Chair of the NICU Palliative Care/Bereavement Committee. May be contacted at: cheryl.killoran@umassmemorial.org
CELEBRATE NATIONAL NURSES DAY!

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As Worcester’s former Commissioner of Public Health, Dr. Leonard Morse best said: “A Baby’s Health is a City’s Wealth”. This quote guides the work done by the Worcester Healthy Baby Collaborative (WHBC) to address infant health in our city.

Worcester’s infant mortality rate (IMR) has been higher than the Massachusetts overall rate for decades. Furthermore, Worcester’s Black and Hispanic/Latino infant mortality rates have been higher than the state’s since at least 2000.

**Diving into the numbers**
The infant mortality rate (IMR) is the number of infant deaths under one year of age per 1,000 live births. The most recent data from the state show an IMR of 4.3 for 2014-2016 in Massachusetts, when Worcester’s IMR for that time period was 7.3. While preliminary numbers for Worcester for 2016-2018 show an average IMR in that time period of 4.6, the lowest number in decades, significant racial disparities are seen, not just between different races in Worcester, but also comparing Worcester’s Black and Hispanic IMR to those of the state as a whole. For example, Worcester’s White IMR from 2014-2016 was 4.3, while the city’s Black IMR was 8.6. The Hispanic IMR in Massachusetts from 2014-2016 was 5.5, but Worcester’s Hispanic IMR was 11.9.

**The impact of social determinants of health**
“Social determinants of health” are factors impacting one’s health that arise from economic and social issues in an individual’s life. These factors include access to healthcare, education, racism, and economic stability. Stressors like discrimination, poor health care access, debt, and hunger are correlated with poor health outcomes. Mapping of IMR in Worcester shows infant mortality is concentrated in areas with low income, racial minority populations, and high English isolation. In the last five years that such data have been available, a majority of infant deaths over that period were to mothers born outside the continental US. Worcester mothers living in higher-risk areas may have poor access to transportation, which may contribute to difficulty accessing prenatal care. Most of Worcester’s infant deaths are due to extreme prematurity; the causes of premature birth are multifactorial however often reflect the mother’s underlying health as well as the impact of social determinants of health.

**A call to action**
The WHBC began in the mid-1990’s to respond to the disparities in IMR within Worcester. The WHBC is a coalition of health professionals, students, and community leaders who volunteer their skills to address this public health issue. The WHBC collaborates with community groups, churches, health centers, and other Worcester volunteers to develop community-driven solutions to better understand and work to reduce the city’s IMR. In September 2016, the WHBC proposed several different projects/interventions in a Community Baby Forum at City Hall, in which members of the community voted for the WHBC to pursue the Baby Box Project to address the IMR disparities.

**The Baby Box Project**
The Baby Box Project is inspired by a tradition in Finland where new parents are provided with a ‘baby box’ which serves as a safe sleep space for an infant, along with supplies to care for their newborn. The WHBC and Worcester Division of Public Health partnered with the Baby Box Company to distribute free baby boxes and educational resources/infant supplies to Worcester’s needy families.

Through partnership with the Family Health Center of Worcester, Edward M. Kennedy Community Health Center, Pernet Family Health, and Head Start, the WHBC is able to reach Worcester’s most vulnerable communities. In addition, the WHBC hosts Baby Box distribution days at churches and community centers. The project emphasizes the use of the Baby Box as a tool to provide education to mothers and families about safe sleep, breastfeeding, postpartum depression, contraception, and substance use in pregnancy. In addition to the box, families receive a bag full of community resource contact information, educational pamphlets, diapers, onesies, books to promote early literacy, and other infant materials. Parents watch educational videos featuring local healthcare professionals offering health education. Currently in English and Spanish, the videos will soon be available in Arabic, Portuguese, and Vietnamese. By
providing the information in more languages, the WHBC can reach more of Worcester’s diverse population.

Parents receiving a baby box complete three surveys to gather demographic data and to assess the likelihood of engaging in healthy behaviors. The surveys are given before and after viewing the educational videos and six weeks after the child is born. The surveys are used to gauge likelihood of engaging in healthy behaviors like speaking to a WIC counselor, speaking to their healthcare provider about important postpartum issues, breastfeeding, room-sharing (but not bed sharing), and baby box use. Thus far, with demographic data showing that 83% of baby box recipients are non-white, the project has been successful in reaching communities most at risk for infant mortality. In the post-education and follow up surveys, recipients report increases in their self-reported likelihood of engaging in healthy behaviors compared to the pre-educational surveys.

Student involvement

Over the years, the passion for caring for Worcester’s most vulnerable and the desire to improve the overall health of the community has led both medical and nursing students to take on various leadership roles to support the work of WHBC. Students volunteer to organize Baby Box distribution days, conduct follow-up calls, facilitate baby box distribution to individual families who do not have a place for their infant to sleep safely, actively participate in data analysis and meetings, follow up with community partners, and help to create language-accessible educational materials and videos.

Baby box distribution serves as an opportunity to address the health needs of mothers and infants, many of whom come from disadvantaged and underserved backgrounds. Together, the components of this project have the goal of improving maternal and child health in the perinatal period in order to reduce Worcester’s high IMR and the disparities among the Black and Latina community. To date, the Worcester Baby Box Project has provided baby boxes to over 100 families. The WHBC will continue its mission to involve the community in projects to improve every infant’s health.

Special Acknowledgements to Dr. Heather-Lyn Haley, Marislena Amezquita B.S, Pernet, FHCW, EMK, Worcester DPH, and Nursing and Medical students of UMMS

Alexandre J. Wenk-Bodenmiller, MD Candidate Class of 2022, University of Massachusetts Medical School; Vanessa Villamarin, MD Candidate Class of 2021, University of Massachusetts Medical School; Emily Nuss, MD Candidate Class of 2021, University of Massachusetts Medical School; Sara G Shields, MD, M.S., FAAFP, Professor of Family Medicine and Community Health, University of Massachusetts, Family Health Center of Worcester.
Amelia Walters
Central Massachusetts Agency on Aging, Inc. (CMAA), located in Worcester, MA, is the leader in Central Massachusetts in providing information and resources to older adults and their caregivers.

CMAA is happy to announce the 22nd celebration of the annual ElderCare event, on Tuesday, May 5, 2020, at The Manor in West Boylston held in collaboration with the Worcester County Sheriff’s Office. ElderCare is a yearly event for seniors in the Central Massachusetts area (including Tri-Valley and Montachusett areas).

Every May, the Administration for Community Living (ACL) leads our nation’s observance of Older Americans Month. This year’s theme is Make Your Mark. "ACL selected this theme to encourage and celebrate countless contributions that older adults make to our communities. Their time, experience, and talents benefit families, peers, and neighbors every day. Communities, organizations, and individuals of all ages are also making their marks. This year’s theme highlights the difference everyone can make – in the lives of older adults, in support of caregivers, and to strengthen communities" (From the Administration of Community Living announcement).

Education, outreach, and strengthening communities are all important goals of ElderCare 2020. Hundreds of older adults and caregivers will be in attendance. There will be over 60 vendors and sponsors from different organizations from Central Massachusetts that serve seniors and caregivers. Vendors will provide health and wellness resources and inform the attendees of services they provide to improve or keep up their quality of life and health. There are so many resources out there to help seniors and caregivers, this event is a way to spread the word and get those resources to the people who need them most.

Some vendors and sponsors in attendance include: Elder Services of the Worcester Area (ESWA), Tri-Valley, Inc., Montachusett Home Care, the Executive Office of Elder Affairs, RSVP and Senior Companions of Worcester, Community Legal Aid of Worcester, District Attorney Joe Early, UMass Memorial Health Care, UMass Medical School, Vitality Magazine, YMCA of Central Massachusetts, Reliant Medical Group, Harvard Pilgrim Healthcare, and many more.

If you are interested in becoming a vendor or sponsor for this event, please contact Amelia Walters at awalters@seniorconnection.org or via phone at 508-852-5539.

Amelia Walters is the Director of Public Engagement and Marketing at Central Massachusetts Agency on Aging, Inc. Amelia can be reached at awalters@seniorconnection.org
From the Archives

Note: Infant mortality in Massachusetts in 1939 was approximately 50 per thousand live births, today it is about 4 with about 2/3 being neonatal deaths. The committee suggested in this article was established

- B. Dale Magee, MD, WDMS curator

Worcester Medical News, Vol 3, 4, 1939

Would a study of our 1939 neo-natal mortality be profitable for the Worcester district?

While general infant mortality rates had steadily receded during recent years, the neonatal rate has remained practically at a standstill. This fact has challenged a great deal of serious thought. Recent interest has centered largely around a masterly study of neonatal mortality in Chicago carried on by Dr. Herman Bundensen, Chicago Commissioner of Health. Other groups have also surveyed their mortality during this period and have submitted analyses that have shown suggestive variations from Chicago figures. Would Worcester profit by such a study? Medical news has asked Dr. James P. Beck, Pathologist at Memorial Hospital, to discuss this question for us. Dr. Beck has been deeply interested in this subject and has already submitted a report on a small series of cases at our October meeting. Dr. Beck's discussion follows:

Editor

A study of the neonatal mortality would unquestionably be profitable to the Worcester District from both clinical and pathological points of view. We have all realized that while a steady advance has been made in nearly all phases of medical science, knowledge regarding the death of the newly born has lagged. This lack of knowledge is referable especially to those infants whose death is related, in a way poorly understood, to the functional and pathological processes of the parents or of the infant while in utero or in the birth canal. The death rate in infants in which the cause of death is clearly postnatal is steadily being lowered by advances in bacteriology, immunology, serology, hygiene and feeding of infants. Such advances have been made at the hands of specially trained men in institutions equipped with the proper armamentarium for investigation. Being related to the intriguing clinical pathological aspects of pregnancy itself, the causes of death in the newborn are now in the light and should be lowered by the application of the same diligence that has lowered the causes of postnatal deaths. Shall the Worcester District take its part in this advance? I feel that a greater profit would be realized by a cooperative effort between clinician and pathologist than by individual effort. The fact that results were pooled and studied by a central group would in no way detract from the benefits derived by each individual hospital and community participating in this study. These and other reasons indicate that Worcester would benefit by such an enterprise. Since other communities and institutions have recently made such surveys, I believe that the Worcester District should not wait and thereby incur the obvious inference did we are either disinterested or unable.

If this proposal has merit, I believe that the problem should be considered seriously by the physicians interested and discussed at the January meeting. Certainly, every pediatrician, obstetrician, general practitioner doing pediatrics and obstetrics and pathologist should make up his mind as to the merits of such an organized effort and come prepared to discuss it. Should this proposal be accepted by the society, a managing committee would have to be appointed by the president. This committee should be empowered to establish uniform records in pathological procedures, authorize the local subcommittees in the various hospitals and communities participating, select cases for special consideration and call on the advice of other physicians. The results of such a study could well serve as the basis of a symposium at one of the district meetings in 1940. In order to bring the matter up for consideration I therefore, suggest that a motion be made that such a committee be appointed.

Dr. Jas P. Beck
Legal Consult: “Stop” Signs and Medical Battery

It is commonly understood that medical treatment of a competent patient without the patient’s informed consent constitutes a battery. What happens when during a medical procedure the patient withdraws her consent, but the treatment continues? This is the question posed in a case recently decided by the Massachusetts Court of Appeals. In Zaleskas v. Brigham and Women’s Hospital, the Court of Appeals held that continued treatment in that circumstance may also constitute a battery, provided certain conditions are met.

The case involved a terminally cancer patient who was experiencing pain in her left leg and knee. Her doctor ordered X-rays. Prior to the exam, the lead radiology technologist told the patient’s mother and sister that if the patient experienced too much pain, he would stop the examination. The relatives were not permitted to remain in the X-ray room and remained just outside. During the exam, the relatives claimed to hear the patient “pleading and begging” but subsequently could not remember whether the patient ever said “stop.” Although there was some factual dispute, it appeared that the series of X-rays was not terminated prior to their completion.

The relatives brought a lawsuit against the hospital and the radiology technicians. One of the causes of action stated was a claim of battery under a theory of withdrawal of consent. All parties moved for summary judgment, the trial court judge ruled in favor of the defendants, and the plaintiffs appealed. The standard for review of summary judgments is that there are no genuine issues of material fact and the moving party is entitled to judgment as a matter of law. Because the Court of Appeals found that there were factual disputes as to whether the patient withdrew her consent during the exam, the trial court judgment as to the battery claim, as well as some other claims, was reversed. The Court of Appeals noted that Massachusetts courts had “not previously considered a claim of battery on the basis of withdrawal of consent in the medical context” but that other courts had done so. In particular, the Court cited a 1964 Georgia decision upholding a medical provider’s liability for battery when the patient withdraws consent during a treatment in progress. The Georgia court’s decision imposed two conditions on this liability. First, the patient must act or use language which “can be subject to no other inference and which must be unquestioned responses from a clear and rational mind. These actions and utterances of the patient must be such as to leave no room for doubt in the minds of reasonable men that in view of all the circumstances consent was actually withdrawn.” Second, when treatment or examination involving bodily contact is proceeding when consent is withdrawn, “it must be medically feasible for the doctor to desist in the treatment or examination at that point without the cessation being detrimental to the patient’s health or life from a medical viewpoint.”

The Massachusetts Court adopted the Georgia court’s analysis, holding that “if a patient unambiguously withdraws consent after medical treatment has begun, and if it is medically feasible to discontinue treatment, continued treatment following such a withdrawal may give rise to a medical battery claim.” The Court’s decision went on to advise that “complaints of pain and discomfort are not sufficient.”

As to proving the claim, the Court said that expert testimony is not required to establish that a patient had withdrawn her consent, although whether cessation of treatment is feasible may require expert testimony. In this case, there were questions about the admissibility of evidence at the trial as to whether the patient said “stop” but the Court of Appeals ruled that summary judgment was inappropriate even if that evidence was not admitted, and remanded the case to the trial court for determinations of the admissibility of that evidence. Thus, as of this writing, it is unclear whether the plaintiffs in this case will be able to prove that the patient unambiguously withdrew her consent so as to support a claim of battery against the defendants. However future proceedings in this particular case unfold, and bearing in mind that the question has not yet been ruled upon by the Massachusetts Supreme Judicial Court, it is still worth noting this development in the law. Should this holding become established law, clinicians will have to be careful to monitor the actions and words of the patient during treatment and examination to try to determine if the patient continues to consent. This will involve deciding when “complaints of pain and discomfort” become more than complaints and amount to commands. This might pose a real challenge for a provider evaluating the words and actions of a patient who is considered to be a “complainer.”

Then, if the provider determines that a request to stop has been made, she must also consider the feasibility of discontinuing the treatment or examination. Providers would then be faced with making a judgment that, notwithstanding an unambiguous “stop” from the patient, the treatment must nevertheless continue because stopping would be detrimental to the patient’s health or life. One can easily imagine many practitioners choosing instead to discontinue treatment. In any event, practicing under this holding would require practitioners to continuously monitor actions and statements that may reflect the state of the patient’s consent.
In Memoriam

Dr. Alicja Rudnicka-MacGillivray

Alicja Rudnicka, M.D. passed away on January 5, 2020, at home, surrounded by her family, after a courageous battle with cancer.

Alicja was born in Krakow, Poland on April 11, 1942. She graduated from Warsaw Medical Academy before emigrating to the United States in 1968. After moving to Massachusetts, she continued her medical education at Brown University, where she was Chief Resident and Teaching Fellow in Medical Science at Brown Medical School. She then became a Diplomat of the American Board of Dermatology and Fellow of the American Academy of Dermatology.

Alicja worked for 48 years as a physician, opening her private practice in Dermatology in 1975 in Webster, Massachusetts. She worked for 24 years at Fallon Clinic/Reliant Medical Group before retiring in April 2019. Innumerable patients benefited from her medical care and many patients have fond memories of seeing her as a patient decades ago, as well as recently.

Alicja was the daughter of the late Polish architect, Zbigniew Rudnicki, and lawyer and writer Aleksandra Rudnicka (Homme). She was married to William MacGillivray M.D. from 1968 until his death in 1996. In 2003, she married Piotr Ferensowicz, a musician with whom she shared her life until her untimely death.

Throughout the years, she was active in local organizations. She was a member of the Massachusetts Medical Society, Worcester District Medical Society, Rhode Island Dermatological Society, International Center of Worcester, Massachusetts Horticultural Society and Polish Heritage Foundation.

Alicja was a loving and passionate gardener (she finished the course of Master Gardener) and loved to take care of her beautiful gardens in Douglas, Massachusetts. After moving to Sutton, she became president of the Villas Pleasant Valley Garden Club and volunteered at Tower Hill Botanical Garden. She also loved animals, especially dogs. For the last five years, she rediscovered her passion for watercolor painting, creating beautiful artistic works. She also enjoyed traveling with her husband Piotr, visiting multiple countries around the world.

Alicja was a great hostess and cook and loved receiving guests, including family and many interesting visitors from various foreign countries. She was also a connoisseur of music, attending many musical performances, including Music Worcester, Boston Symphony Orchestra, New York City Broadway Shows, the New York Metropolitan Opera, and the International Chopin Piano Competitions in Warsaw, Poland.

Alicja will be remembered as having a charming and gracious personality. She was a very beloved colleague in Dermatology. During her long career in medicine she touched and benefited the lives of many others, both professionally and personally. She will be greatly missed by all who were lucky enough to know and work with her.

David Snook, MD, Former Chief of Dermatology, Reliant Medical Group.

Dr. J. Barry Hanshaw

We will miss the warm smile, gentlemanly manner, skilled leadership and artistic talents of J. Barry Hanshaw, pediatrician extraordinaire who died December 19, 2019.

After an exemplary career at the University of Rochester, Dr. Hanshaw became the founding Chairman of the Department of Pediatrics at the University of Massachusetts Medical School. His commitment to providing high quality health care to the children of Central Massachusetts led to the expansion of pediatrics and the subspecialties in the region.

A dedicated leader, committed to medical education subsequently, he served as Dean, Provost and Interim Chancellor. In 1991, he was awarded an honorary doctorate by his alma mater. Dr. Hanshaw served on the editorial committee of the Massachusetts Medical Society.

A graduate of Syracuse University and its medical school, Dr. Hanshaw served as a Medical Officer in the United States Airforce. Following a residency at Strong Memorial Hospital of the University of Rochester, he became a postdoctoral fellow in virology at the Harvard School of Public Health focusing his research on congenital cytomegalovirus (CMV). Returning to the University of Rochester he worked on a ten-year NIH grant studying the effect of CMV. Following a Visiting Professorship at The Hospital for Sick Children in London, he coauthored Viral Diseases of the Fetus and Newborn.

Post-retirement, he devoted his energy and talents to painting, presenting his work at 17 shows and the Guild of Boston Artists Juried Competition in 2009.

Dr. Hanshaw’s beloved wife, Chris, passed away nine days after his death. The Henshaw’s are survived by five children; Thomas, Lee, Liza, John and Margaret, a son in law Pedro Andre’ and three grandchildren; Sarah, Margaret and Isabel.

Thank you, J. Barry Hanshaw, for a life well lived and well shared with family, professional colleagues, friends and the community.

Lynn Eckert, MD, Former Chair, Family and Community Medicine, University of Massachusetts Medical School

Marianne Felice, MD, Former Chair, Pediatrics, University of Massachusetts Medical School
Herbie’s is Worcester.

Pre-Renaissance Worcester, that is. Herbie’s is a living artifact of the city’s Medieval age: the town I first encountered decades ago. A place where thrift trumped trendy and townsfolk pinched pennies so hard that only Spag’s Supply had figured out how to pry them loose. Anything new and shiny was automatically suspect.

Lest I sound as if I’m setting the stage for negativity; Relax! Dinner at Herbie’s is as comfortable and welcoming as your favorite pair of jeans and those sneakers that fit perfectly. The staff are begrudgingly friendly in a way that makes you seek their approval; seat yourself! I know what you want to drink… enough with all the questions!

The place is divided into bar and dinner tables. The décor is kind of roadhouse, but without the sinister milieu; no one seems to have the energy left for acting up. Smokers form a queue on the shallow ramp leading to the front door. Inside, an honor system prevails that anticipates the next available table and who’s in place to get it.

Once seated, it’s time to scan the tri-fold menu that’s laminated so stiff it slaps closed like a trap when you let go of it. It mostly lists salads, burgers and sandwiches. What’s really interesting is the full-page, single-spaced sheet of the day’s dinner specials – tilted toward seafood dishes. While prices aren’t crazy-cheap, they’re low enough that it’s natural to suspect an onslaught of high school cafeteria fishstick dinners. But as any customer knows, that’s not Herbie’s.
Traditionally, chowder in Worcester was creamy-thick; so thick that if you stuck your spoon into it and let go it would stand there in defiance of gravity. Herbie’s is more to my liking; my friend’s cup of Seafood Chowder was creamy but in a flavorful, seafood-brothy way that permeated right into the soft cubes of potato. With bits of sweet corn niblets, clam and other seafood it was a promising start to the meal.

The menu lists plenty of carnivore options, but a commonly held belief is that Herbie’s = Fried Fish. In adherence to that, I ordered the ultimate, their Fisherman’s Platter entrée. Admittedly, the expectation of ingesting all that grease made me apprehensive, but when I sampled my first bite, I was relieved to discover fresh seafood not thickly cloaked in breading, not over-fried, and not oily!

Indeed, there was a scattering of whole-belly clams – no sand, just sweet clam flavor; a half-dozen juicy jumbo sea scallops; a few large shrimp and a couple filets of flaky-moist white fish. Many restaurants fluff up their fried seafood dinners over a big pile of boring French fries; Herbie’s platter was a generous portion (plenty for sharing) set over a barely visible layer of tasty fries. No deception.

But wait a minute! I matched my meal up with a tall glass of Wormtown’s Be Hoppy IPA. For just Four Bucks! When I went to Herbie’s with the neighbors last summer, we shared a huge pitcher of Be Hoppy for the same money some places charge for two glasses. Not bad, Renaissance Worcester at Medieval prices.

"THREE (NO, COULD THAT BE FOUR?) FULL CLAWS OF FRESH SWEET LOBSTER MEAT TOSSED WITH A BUCKET OF CHunks OF KNUCKLE AND TAIL MEAT. AND NOT SOAKED IN HELLMAN’S; JUST LIGHTLY COATED WITH FRESH DRESSING. ”

Meanwhile, my friend had chosen Herbie’s Lobster Roll. The industry’s standard format for this dish is to cram a toasted hotdog bun with lobster meat drenched in mayonnaise. Herbie’s, in contrast, looked like an avalanche of lobster meat had buried the bun and crowded out a pile of French fries and cup of coleslaw. Three (no, could that be four?) full claws of fresh sweet lobster meat tossed with a bucket of chunks of knuckle and tail meat. And not soaked in Hellman’s; just lightly coated with fresh dressing.

In old Worcester, if some hotshot suggested, “How about going to Maine for lobster dinners?” any real Worcesterite would reply scornfully, “And pay double the price?” For our cheap twin lobster dinners, we’d queue up at Barber’s Crossing or a place on Lincoln Street where they’d seat you in what felt like a caged-in dog run.

That’s all fading memories. But we still have Herbie’s.
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- Search by Cuisine, Location, Price or Rating
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TASTEWORCESTER.COM
Health Matters

Health Matters is a television program produced in collaboration with The Worcester District Medical Society and WCCA TV in Worcester. Offering valuable information on disease prevention, treatment options, current public health issues and more, Health Matters is produced in a ½ hour interview format and the program airs on WCCA TV Cable Channel 194: Wednesday- Noon and 7:30 pm, Thursday– 7:00 pm and Friday – 9:30 am.

To view past shows, please view our video library: www.wdms.org.

Show Number 198:
“An Update From UMass Medical School’s Chancellor”

Guest: Chancellor Michael F. Collins
Host: Bruce Karlin, MD

Show Number 199:
“225th Anniversary of the Worcester District Medical Society”

Guest: Dale Magee, MD, Curator of WDMS
Host: Bruce Karlin, MD

Our Hosts

James Broadhurst, MD
Michael Hirsh, MD
Bruce Karlin, MD
Lynda Young, MD

If you have an idea for a topic or guest, or wish to be a guest, please contact wordmsa@massmed.org or call 508-753-1579.
WORCESTER - Praised as a “living hero” for his surgical skills, dedication to the Goods for Guns program and public health advocacy, Dr. Michael P. Hirsh was honored with a Team Excellence and Merit Award in a ceremony at the Worcester County Courthouse on Wednesday.

“I’m totally verklempt,” Hirsh said, using the Yiddish word meaning overcome with emotion, as he received the award from Worcester District Attorney Joseph D. Early Jr. “This is such a wonderful event.”

Early created the TEAM Award last year to recognize outstanding achievements and service in public safety.

Hirsh is director of pediatric surgery at UMass Memorial Medical Center and co-director of the Injury Free Coalition for Kids. He was promoted last year to assistant vice provost for wellness and health promotion at UMass Memorial and is also medical director of the Worcester Department of Public Health.

Hirsh is perhaps best known locally for co-founding the annual Goods for Guns buyback program, which officials said has collected nearly 4,000 unwanted guns in communities from Worcester to Springfield.

“He sees a problem and makes it his mission to fix it,” said Early. “He embodies a passion, a passion for saving lives.”

Worcester Health Commissioner Dr. Mattie Castiel and City Manager Edward M. Augustus Jr. both referenced Hirsh’s “delicate touch” in approaching both public health and surgical matters.

“He never makes you feel like you’re being lectured to ... he speaks to you as an equal,” Augustus said. “Having that voice and delicate touch is such an asset for the community ... he is a leader in so many ways and does it quietly and gently, and we thank you for it.”

Castiel teared up as she talked about emulating Hirsh.

“I thought I would like to grow up to be like you,” Castiel said. Worcester Deputy Police Chief Ed McGinn called Hirsh a “living hero” for working with police to help make the city safer. “Your passion is so clearly evident in everything you do,” McGinn said. “Worcester is a safe place ... you have to give it to people like Dr. Hirsh.”

Cyrus Moulton, Telegram & Gazette Staff

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Photo provided by Worcester Telegram & Gazette Photo
The Worcester District Medical Society’s Annual Holiday Celebration and Movie Night
Thursday, December 19, 2019

Dr. Sahdev Passey, President of WDMS, presented Jean McMurray, Director, Worcester County Food Bank, with a donation from the medical society.

Many thanks to those who contributed. We collected $615 and 22 pounds of food.
On February 13, 2020, one-hundred ten Society members and their guests enjoyed the captivating keynote speech by our 224th Orator, Dr. Sanjiv Chopra. Below are a few slides from his speech.

**My Purpose in Life**

To fulfill my Dharma to teach Medicine, about Leadership and Happiness.

To do it grounded in humility, and with an ardent desire to learn every single day.

To express gratitude to my family, friends, colleagues, students and patients who inspire me in countless ways.

And in some small measure inspire everyone I meet on this amazing life journey.

I invite you to reflect on what gives you the greatest joy and resonates for you.

Take a few minutes now, or later, and reflect on Your Purpose and write it down.

You may wish to share it with your closest family members and your closest friends.

It is my fervent hope that you will find lasting happiness and it will light up every day of your life.

**Happiness**: The sensation of feeling good, being pleased, an internal experience in which the goodwill is expressed outwardly, extending the positive feeling towards others.

**Joy**: Experience of extreme happiness, euphoria, a temporary but intense and exuberant sensation.

**Bliss**: The experience of intense joy, anchored by a sense of connectedness with others and with nature (perfect happiness, great joy)

The Two Most Important Days

What are the two most important days in your life? “The day you are born and the day you find out why,” Mark Twain famously wrote.

For more information visit: https://sanjivchopra.com/
VOTE!

Best R&B
Tony Soul Project
We and the Dawg
Big Jon Short
Ton of Blues

Best CD
Silent Bravery - Holding Out for Hope
Stan Matthew - You and Me
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Pete Blaze
Dj Jack Frost
Chuck Chillin
Dj Tec Threat

Best Country
Ashley Jordan
Tequila Bonfire
Lexi Zarozny
Backyard Swagger

Best Americana
Mark Mandeville & Riaianne Richards
The Promise of Hope
Boogie Chillin
Hip Swavers

Best Cover
He Said She Said
Band Inc
Boombox
Annie Brobst Band

Best Tribute
Fellowship of the King
Burning Sky
Great Escape
Dirty Deeds
Petty Larceny

Best Female Vocals
Chloe Belsito
Ashley Jordan
Lexi Zarozny
Cara Brindisi

Best Male Vocals
Dan Decristofaro
Ricky Duran
Jason Paulino
Matt Wade

Best Metal/Hardcore
On Your Deathbed
Grey Curtain
White Lights
Whiskey Church

Best Jam/Groove
Clamdigger
New Pod
Fondle
Booty & The Jett
Certain Treble

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Little Black Dress
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Liam Coleman
Lexi Zarozny
Jim Weeks Band
Good Time

Best Pop
Good Time
Silent Bravery
Blue Light Bandits
The Verge

Best Electronica
Sunshine Nile
The Grey Curtain
Toreba
Spacedrift
The Deadlights

Best Punk
Sapling
Destruction
Michael Kane and the Morning Afters
Square Loop

Best Radio DJ
Mark Veau
Nick Noble
Jerry Robertson
Rick McCarthy

Best Rap/Hip Hop
Chracks Royalty
Janonymous
Boston Key
Genocide Geno

Best Rock
Jim Weeks Band
Dearbones
Grey Curtain
Bobbing for Apples

Best Solo
Cara Brindisi
Ilene Springer
Silent Bravery
Giuliano D’Orazio

Join Us:
Wednesday, April 15th!

At the Worcester Beer Garden and Pavilion!

Presented by:
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We offer unique meeting room designs with more than 8,000 square feet of flexible meeting space, custom audiovisual setups, and inspired banquet cuisine options. From the physical setup of the event venue to the finest catering detail, we take care of everything.

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Serving medical and life sciences professionals for more than three decades.

OpenTable Diners’ Choice Award Winner

DiRōNA (Distinguished Restaurants of North America) Awarded Restaurant

“It’s one of the best dining destinations anywhere in New England.”

Phantom Gourmet