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From the Editor:  
A Forum in Central Massachusetts

The New Year’s season is a time to look back and evaluate progress. Last year we set out to achieve the following goal: Worcester Medicine’s mission is to provide a forum in Central Massachusetts to promote commentary on health care. Our vision of this forum was as a public meeting place for open discussion. The public meeting place we intended was the pages of Worcester Medicine. “Open discussion” has two important meanings to me: 1) the discussion that takes place by and between authors and 2) readership response to the topics we report to them.

To steer the magazine in this direction, the Editorial Board has selected themes that are controversial and thought-provoking. For this issue’s topic, we selected collaborative drug therapy management presented in a point-counterpoint format. The authors were asked to present their viewpoint on the subject with no requirement that it be balanced with opposing viewpoints. In addition, we have expanded the range of topics covered so that it is of interest to a broader audience; we have added articles on science and literature and have a new Off Call section that covers some of our non-professional lives and interests.

To successfully become a true forum, we need to receive thoughtful and insightful letters to the Editor that reflect your thoughts on the topics and articles. This will be our final measure of whether we have achieved the mission set in motion six months ago. So, how much progress have we made? To quote a famous motivational cliché, “We’re still not where we’re going, but we’re not where we were.”

Paul M. Steen, MD  
Editor  
Worcester Medicine
Medicare D and Collaborative Drug Therapy Management: 
DOES CHANGE NECESSARILY NEED TO CAUSE CONFUSION AND CONTROVERSY? 

By Michael Malloy, PharmD, Associate Editor

Medicare D and Collaborative Drug Therapy Management will both likely be front and center in the minds of many Central Massachusetts health care providers in the coming year. Though these two topics encompass two distinctively separate issues, they do have two areas of commonality. Both are being or will be implemented by governmental action and the health care community will be responsible for ensuring that both benefit our patients.

It is our hope that the articles by Dr. Gurwitz and Dr. Sullivan and by Ms. Massey will help ease some of the confusion created by the rapid implementation of the Medicare D Prescription Drug Plan. The articles address some of the immediate and future concerns and questions surrounding the plan while offering health care providers a basic understanding of how the plan is intended to work. In addition, they present a local resource, MassMedLine, which health care providers can use to help patients maximize utilization of the plan.

The articles concerning Collaborative Drug Therapy Management are sure to create controversy and provoke thought amongst most health care providers in Central Massachusetts. It is important that our health care community be aware of potential legislative action that will impact the delivery of health care in Central Massachusetts.

I am sure this issue will challenge our readers to decide how they want to embrace changes that will effect how health care is administered in Central Massachusetts. We at the journal hope that we our living up to our mission “To provide a forum in Central Massachusetts to promote commentary on health care.”
The new Medicare drug benefit officially starts January 1, 2006. The federal cost of the new benefit is projected at $37.4 billion in 2006 and $724 billion from 2006 to 2015. Recent polls show that most seniors are planning to turn to their doctors for help in deciding whether to enroll. Since 60% of beneficiaries say that they do not have a good understanding of the new drug benefit nor comprehend how the program will impact them personally (see Figure 1), it will be essential for physicians to know both the basics of the Medicare drug benefit and how to guide patients asking for help. The purpose of this article is to provide an overview of the new Medicare drug benefit and to discuss some of the implications of this substantial change in Medicare policy.

Overview

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) grants access to drug coverage for the nearly 40 million elderly and disabled people in the Medicare program. The new drug program, called Medicare Part D, is the largest expansion to the Medicare program since its inception in 1965. The program provides beneficiaries with the option to enroll into private health plans that have contracts with Medicare to provide drug coverage. The drug benefit is technically voluntary, although some individuals (those who have both Medicare and Medicaid benefits and who were previously called the “dual-eligibles”) will be enrolled automatically, as their former source of drug coverage will be eliminated under the MMA. The benefit is voluntary; however, there is a substantial penalty for not signing up within the initial enrollment period. For example, a person who signs up 12 months after the enrollment period ends will pay 12% more in premiums than the person who signs up right away.

Benefits will be able to select from at least two drug benefit plans, although most will have many more choices. The drug benefit plans include: 1) Stand-alone prescription drug plans that offer only drug coverage and 2) Medicare Advantage plans such as HMOs or regional PPOs which cover all Medicare benefits including the medical benefit Parts A and B as well as Part D, which covers prescription drugs. Enrollment in the Part D benefit will cost about $34 in premiums per month (this is the national average) in 2006, although premium and cost-sharing subsidies are available to low-income beneficiaries who meet the certain thresholds of income and asset tests. Beneficiaries who may qualify for the low-income subsidies must apply at local Social Security or state Medicaid offices for the subsidies.

What Does the Coverage Look Like?

The Medicare Part D benefit has a complex structure with a mix of some familiar and some unusual features (see Table 1). Features that look familiar include a $250 deductible and 25% patient cost-sharing arrangement for drug costs up to $2,249. However, once medication costs reach $2,250, the drug benefit has an unusual 100% cost-sharing corridor known as the “doughnut-hole.” The doughnut-hole is a $2,850 gap in coverage during which beneficiaries are responsible for all of their medication bills. The doughnut-hole lasts for a third time. For medication costs over $5,100, individuals will pay for only 5% until the
2006 Medicare Part D Benefit Cost-sharing Rules
(for enrollees without low-income subsidies)

<table>
<thead>
<tr>
<th>Total Drug Expenditures</th>
<th>Patient Contribution</th>
<th>Total Out-of-pocket Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0 - $250 ($250 deductible)</td>
<td>Patient pays 100%</td>
<td>$250</td>
</tr>
<tr>
<td>$250 - $2,250</td>
<td>25% coinsurance or copay</td>
<td>$750</td>
</tr>
<tr>
<td>$2,250 - $5,100</td>
<td>Patient pays 100% (doughnut-hole)</td>
<td>$3600</td>
</tr>
<tr>
<td>$5,100 - and up</td>
<td>Patient pays $5 or 5%, whichever is greater</td>
<td>unlimited</td>
</tr>
</tbody>
</table>

Table 1

To illustrate the average experience under the Part D benefit, consider a beneficiary who spends approximately $3,000 (or $250 per month) on medications each year. In 2006, our hypothetical beneficiary will have 1 month without coverage until meeting the Part D deductible ($250), 8 months of paying for 25% of his/her medications ($62.50 per month), and then 3 months of paying 100% of drug costs while in the doughnut-hole ($250 per month). The monthly fluctuations become even larger for individuals with more costly medications. A hypothetical Medicare beneficiary with $5,000 in annual drug expenditures in 2006 will spend $292 in January, $104 per month for the next 5 months, and then $417 per month for the last 6 months. Our hypothetical person with $5,000 in annual medication costs will spend nearly 60% of the year (7 months) paying for 100% of their drug costs.

The two scenarios described above are only hypothetical, as each Medicare drug plan may offer different features as long as the benefit is actuarially equivalent to the basic Medicare drug benefit. For instance, some Medicare drug plans may waive the deductible or make the doughnut-hole smaller to entice greater enrollment. For beneficiaries who do enroll, a new term will become familiar: True-out-of-pocket costs, or TrOOP. All deductibles, co-payments, co-insurance or other beneficiary cost sharing are considered out-of-pocket costs and will be tracked by the Medicare therapeutic classes or therapeutic categories defined by the United States Pharmacopeial Convention, Inc. for Medicare Part D coverage (the list is available on their website at http://www.usp.org/healthcareInfo/mmg/). Part D plans can also establish formularies and tiered cost-sharing amounts as long as they do not substantially discourage enrollment. The MMA also excludes certain drugs or drug classes from Medicare reimbursement, but some Part D plans may still offer to cover them in order to gain a marketing edge. The list of excluded drugs includes: Anti-anorectic agents, barbiturates, benzodiazepines, cosmetic medications, and over-the-counter medications. Drugs will not be covered under Part D if they can be paid for under Parts A or B (such as pneumococcal pneumonia vaccines and influenza virus vaccines). State Medicaid programs may also elect to cover drugs that are not covered under Part D.

Is Medicare Part D a Good Deal?

Estimates of the drug spending under the Medicare Part D predict financial relief for most people; however, one in four Part D participants will likely spend more rather than less under the new program. Medicare Part D will represent a clear improvement over what many individuals have now, especially the estimated 10 million beneficiaries who have no drug coverage or the beneficiaries who qualify for the low income subsidies but who were not eligible for the Medicaid program. The basic Part D benefit is also a better deal than the standard Medigap policies H, I, and J or the Medicare-Choice plans with low drug benefit caps. On the other hand, the very poorest of Medicare beneficiaries will likely pay higher out-of-pocket drug costs under Medicare Part D than before. These individuals currently pay little or nothing for prescription drugs under their state Medicaid program and the new Medicare drug benefit will not be as generous or comprehensive. Others who will not fare well under Medicare Part D are individuals with low medication costs and individuals who will lose their rich prescription drug coverage from employer-sponsored retiree plans that are discontinued or scaled back.

continued on page 8
Conclusion

In summary, there are three important things to know about the new Medicare drug benefit. First, the typical beneficiary will face out-of-pocket cost obligations that fluctuate throughout the year and become especially high while in the benefit’s doughnut-hole. The second is that a substantial portion of the average drug bill will not be paid for by Part D. The third thing to know is that premium and cost-sharing subsidies will be available for low-income individuals, but they must apply to receive assistance. There are nearly 8 million non-dually eligible beneficiaries (i.e., not on Medicaid) with incomes below 150% of the federal poverty level ($14,355 for an individual in 2005), who will qualify for Medicare Part D assistance in 2006. Low-income Medicare beneficiaries who sign up for the new Part D drug plans and apply for the additional subsidies are projected to pay 83 percent less for prescription drugs in 2006 than they would have spent if the Medicare drug law had not been enacted.

Many important questions relating to the Medicare Part D benefit remain, such as how many individuals will sign up, how many drug plans will participate, and what will the benefit really cost taxpayers. Of special concern is how the benefit’s extended periods without any coverage may adversely affect patient compliance with chronic medication regimens. This impact is especially difficult to predict as the Part D doughnut-hole is a new structure in health benefit design that has no direct precedent. It will be important in the first evaluations of the Part D program to consider the perspective of beneficiaries and their ability to manage wide fluctuations in monthly drug costs while remaining compliant with their prescribed drug regimens.

References

Resources
Centers for Medicare and Medicaid Services’ Information on Medicare Prescription Drug Coverage http://www.medicare.gov/medicarebenefitasp
The Henry J. Kaiser Family Foundation Resources on the Medicare Rx Drug Benefit http://www.kff.org/medicare/rxdrugs.cfm
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The Facts About Collaborative Drug Therapy Management

By Katherine Keough, MS, Executive Director, Government Affairs & Cont. Education, Mass. College of Pharmacy and Health Sciences, and Ronald A. DeBellis, EdD, RPh, Assoc. Prof. of Pharmacy Practice & Asst. to the Dean, Mass. College of Pharmacy and Health Sciences

The Massachusetts Legislature is currently considering legislation that would allow pharmacists to engage in voluntary collaborative drug therapy management (CDTM) practice under the supervision and direction of a physician or group of physicians. Should legislation pass, Massachusetts would join 41 other states in the country that have some form of collaborative drug therapy management. There are two identical pieces of legislation pending in the Legislature, Senate Bill 408, introduced by Senator Richard Moore (D-Uxbridge) and House Bill 2689, filed by Representative Peter Koutoujian (D-Waltham), both of which contain identical language. Recently, Senate Bill 408 passed its first hurdle in the Legislature, receiving a favorable report from the Committee on Health Care Financing, where it is expected to be referred to Senate Ways and Means for further action.

It is important to note that if the legislation is enacted, physicians would ultimately determine A) whether or not they wish to participate in a CDTM model, B) the practice setting, C) the types of diseases they wish to manage drug therapy under collaborative (protocol) agreements, and D) with whom they wish to collaborate. Participation in collaborative drug therapy management practice would be voluntary and this model does not allow independent prescriptive authority for pharmacists.

Based upon the written protocol with the physician, the activities of the pharmacist may include the authorization to implement, modify, discontinue or administer drug therapy and to order the appropriate laboratory tests necessary to monitor the drug therapy.

CDTM combines the skill and expertise of physicians and pharmacists to improve pharmaceutical care for patients. Under CDTM, the pharmacist’s role could include the following, subject to approval by a supervising physician:

- Assisting physicians with improving medication management and continuity of care by initiating, modifying, continuing, discontinuing, and monitoring a patient’s drug therapy
- Ordering, performing, and interpreting medication-related laboratory tests
- Assessing patient response to therapy
- Counseling and educating a patient on medications and medical devices
- Administering certain medications such as vaccines
- Improving drug therapy outcomes
- Improving patient quality of life
- Reducing delay in modifying drug regimens
- Increasing patient adherence to drug therapy plans
- Reducing adverse drug reactions through early detection
- Reducing health care costs by improving medication utilization and positive patient outcomes

Benefits to the public:
- Improved access to healthcare through pharmacists
- Enhanced patient care through optimized drug therapy management
- Decreased drug related problems (adverse drug reactions, drug interactions, poor compliance, etc.) through the use of scientifically designed drug therapy protocols management
- Reduced costs through optimal use of medications and minimization of drug related problems
- Pharmacists’ identification of individuals who require the care of a physician

Benefits to physicians:
- Reduced costs of care
- Reduced visits for chronic disease patients, freeing up more time for acute care visits
- Delegation of medication management to the pharmacist who has the skills and the knowledge that can be used to support the physician’s therapy strategies

Examples of CDTM agreements that are being used successfully:
- Immunizations
- Emergency contraception
- Asthma therapy management
- Dyslipidemia Therapy Management
- Warfarin Anticoagulant Therapy Management
- Diabetic Therapy Management
- Smoking cessation Therapy
- Flu/antiviral therapy

CDTM has been well studied and the results of many trials clearly demonstrate that patient outcomes are improved and health care costs are reduced or avoided. In addition, numerous studies have shown that CDTM protocols can reduce medication errors and save significant time for clinicians who have to manage their patients’ medications. In addition, The Centers for Medicare and Medicaid Services estimates that net savings from Pharmaceutical Care Services in Massachusetts could reach $179,849,444.

As mentioned, with the addition of West Virginia, the latest state to enact CDTM, there are currently 41 states with specific laws that authorize CDTM. State policy makers across the country have embraced CDTM because data have shown that CDTM provides the best outcome for patients by increasing patient safety, reducing medication errors and health care costs associated with such errors, and improving patients’ quality of life. The few remaining states are either developing or reviewing proposed legislation or regulations that would allow pharmacists to participate in CDTM.

As a recognized leader in the provision of quality health care, it is time for Massachusetts to adopt this well-established and successful pharmaceutical care initiative.
It's a Question of Patient Safety

By Alan M. Harvey, MD, MBA

Pharmacists have an important role in our health care system, but giving them authority to prescribe medications as outlined in House Bill 2689 is a bad idea for one critical reason: it undermines patient safety.

In 1999, the Institute of Medicine published its landmark report *To Err is Human*, calling attention to thousands of medical errors that occur each year in our health care system. IOM estimated that up to 98,000 Americans die every year from mistakes, 7,000 of those from medication errors. The report was a clarion call for patient safety.

Patient safety programs and systems improvements have since become a health care priority, especially in Massachusetts. Some examples:

Mass Health Data Consortium's MedsInfo-Ed is a pioneering project for emergency departments, specifically for prescription drugs. My own hospital, Brigham and Women's, committed millions of dollars to set up a bar coding system to reduce overdoses and other medication errors. The Massachusetts Coalition for the Prevention of Medical Errors and the Cambridge-based Institute for Healthcare Improvement have both advanced the cause of patient safety for more than 15 years. The State Department of Public Health (DPH) conducted a first-in-the-nation study on weight loss surgery, examining patient safety aspects of bariatric surgery, an effort which I was honored to chair. The Massachusetts Medical Society has become a leading advocate for electronic health records and, along with the state’s major health plans, has led the charge in electronic prescribing programs for physicians.

Massachusetts’ progress on patient safety is admirable. But we need more attention to safety, more checks and balances in patient care, not fewer.

That’s why passage of House 2689 would be a huge step backward. Quality health care requires a trusting relationship between physician and patient, and this bill would erode, if not erase, that relationship.

Consider how “collaborative drug therapy” is defined in the bill: “The initiating, monitoring, and discontinuing of a patient’s drug therapy by pharmacist.” Thus, the legislation would allow pharmacists to prescribe, dispense, and administer drugs subject only to the constraints of as yet un-drafted regulations and written guidelines of one or more supervising physicians who may not know or ever have seen the patient.

Further, the legislation sets no limits on the kinds of drugs prescribed, on how many pharmacists one physician may supervise, or on how many supervising physicians one pharmacist may have. It sets no limits on preventing pharmacists from selling drugs or lab tests directly to patients, and it does not prohibit pharmacists from soliciting new patients in stores or treating patients without a physician referral.

The bill cites no educational or training standards for pharmacists and ignores ethical issues in allowing pharmacists who dispense and sell medications to choose a medication most appropriate for a patient. Finally, it does not require patient consent.

Is this the kind of protection we want for our patients?

Proponents of the bill say it’s modeled on existing laws governing the prescribing authority of nurses in an expanded role. But nurses and physicians’ assistants have both educational backgrounds consistent with direct patient care and histories of working with physicians and patients.

Pharmacists have no such model of collaborative practice. In hospital settings, pharmacists often work effectively as part of a team to review medication orders and collaborate on treatment plans. These programs have been well established for many years and operate within current laws. They have nothing in common with the excesses that House 2689 allows.

Proponents also argue that 41 other states now have such collaborative drug therapy management. But a close examination of this argument reveals that collaborative care is not the norm in the US.

The progress we’re making in patient safety is clouded by a disturbing increase in pharmacy prescription errors. As of mid-July, 84 formal complaints against pharmacies were registered with DPH this year. In all of 2004, there were 82. We don’t know how many go unreported.

No profession is perfect, but this dramatic rise in pharmacy errors should make us think long and hard before establishing a patient care model as proposed by House 2649, especially when the state faces a shortage of pharmacists and an aging population. Health experts agree — and Massachusetts Pharmacists Association officials admit — that prescription volume will far exceed the number of pharmacists in the years ahead. This situation may well lead to more errors.

The desire of pharmacists to increase their responsibilities is laudable. But I believe they need to address the obligations and challenges of their own profession before seeking new and unwarranted responsibilities, especially those as undefined in legislation as flawed as House 2649.

Alan M. Harvey, MD, MBA is president of the Massachusetts Medical Society and Director of Quality Assurance and Quality Improvement, Department of Anesthesiology, Perioperative and Pain Medicine, Brigham and Women’s Hospital/Harvard Medical School.

Jan./Feb. 2006 • WORCESTER MEDICINE 11
High-Deductable Health Plans

Traps for the Unwary

By Peter Martin, Esquire

Although most of the attention paid to the Medicare modernization act properly focuses on the new Medicare Part D prescription drug benefit, that act contains another provision that may have a significant and growing impact on physicians for years to come. That provision is the creation of “high-deductible health plans” (HDHP) and their associated “health savings accounts” (HSA). HDHPs are an expression of the “consumer-driven health care” notion which argues that if individual consumers of health care are responsible for a greater proportion of the costs of the health care they consume, they will make more rational and cost-effective decisions, thereby reducing overall health care costs. The danger for providers is that at least some consumers will drive their health care costs far beyond their ability to pay, placing physicians in a difficult position.

The Medicare modernization act created a new tax deduction for contributions to HSAs. HSAs are to be used to pay the deductible and other co-insurance amounts due under an HDHP; although there is no requirement that an HDHP participant also have an HSA. The deduction is limited in 2005 to $2,650 for individual-only HDHP coverage and to $5,250 for family HDHP coverage (there are higher limits for persons at least 55 years old). Maximum monthly contributions to an HSA eligible for the tax deduction are limited to 1/12 of these annual limits.

HDHPs are defined in the new tax law as having a minimum annual deductible of $1,000 for individual coverage and $2,000 for family coverage, and maximum annual out-of-pocket expenses (the deductible and other expenses, but not including premiums) of $5,100 for individuals and $10,200 for families. A study published in September of this year found the average HDHP deductible to be $1,900 for individual and $4,070 for family coverage; at the same time, the average employer contribution to HSAs was $533. One-third of employers who offer a HSA-HDHP do not contribute at all to their employees’ HSAs.

From these numbers it is clear that the expenses under a HDHP that can be paid out of a HSA may quickly outstrip the amounts actually contributed to the HSA. There is no legal requirement that a HSA be funded to cover all of the individual’s or family’s out-of-pocket responsibilities under the HDHP. What does the practitioner do when the patient covered by a HDHP doesn’t have HSA funds sufficient to cover the costs of care that are within the plan’s deductible?

If the physician waives the deductible, the HDHP might claim that its obligation to pay for services rendered has not been triggered because the deductible amount has not yet been paid. The HDHP might also claim that its agreement with the physician requires collection of the deductible amount. This is a typical contractual provision in most third-party payor contracts, but given the much greater amounts that are patient-payable under HDHPs, plans may be more aggressive in enforcing these provisions against physicians.

Practitioners are well advised to carefully review HDHP insurance programs and think about their exposure if they participate in such plans that either do not offer an HSA linked to the HDHP or that do not provide a way for the practitioner to immediately verify the funding level of the HSA and the amount remaining under the HDHP’s deductible. If the physician decides to enter into a contract with HDHP payors, she should carefully train her staff to identify HDHP patients and to quickly determine HSA balances and whether the patient has satisfied the HDHP deductible. The physician will want to know whether and how she can waive the deductible in a way so as to permit payment by the plan after the deductible amount has been exceeded. The physician may want to consider charging higher rates for such patients given the increased risk that deductibles will not be paid.

With the percentage of employers offering HDHPs growing from 5% in 2003 to 20% in 2005, this is a growing trend and one that will pose challenges for physicians’ relationships with their patients. The issue of under-funded or unfunded HSAs will increasingly require physicians to determine whether to vigorously pursue collection actions against patients, dismiss (after proper and ethical notice) patients unable to pay, or seek to mitigate the risks by negotiating changes to HDHP payor contracts.

(The author would like to thank Robin Fisk, Esq., of Plymouth, NH, for graciously allowing use of her analysis contained in a recent New Hampshire Bar Association presentation.)
“Do No Harm”
Hippocrates to the I.O.M.

Orator: Harvey Kowaloff, MD,
Chief Medical Officer,
Jordan Hospital, Plymouth, MA
Finding Access to Affordable Prescription Medication

By Mary Sullivan, PharmD

Affordable health care, especially prescription coverage, has been at the forefront of political and consumer concern. A survey comparing uninsured to insured individuals, ages 18–64, showed that of those uninsured with two or more chronic conditions, 61% did not obtain prescription medication due to the cost. Recognizing the impact on overall health care that results from this statistic, actions were pursued by key Massachusetts legislators. In 2001, the Massachusetts Legislature created a safety net – a unique program designed to assist Massachusetts residents in working through the options available for low or no cost prescription medications. This concept developed into the MassMedLine Pharmacy Outreach Program. MassMedLine is a collaborative partnership between the Massachusetts College of Pharmacy and Health Sciences and the Massachusetts Executive Office of Elder Affairs. The free service, located at the Worcester campus of the College of Pharmacy, provides information and referrals to programs for Massachusetts residents, regardless of age or income. MassMedLine's free services are available Monday – Friday through a toll free help line (1-866-633-1617). There is also a walk-in center located at the MassMedLine office at 25 Foster Street, Worcester, MA. MassMedLine provides TTY and interpretive services to assist callers. Interpretation of the MassMedLine informational brochure is also available in multiple languages including English, Spanish, Portuguese, Chinese, and Vietnamese.

MassMedline assists callers through two components, case management and clinical pharmacist intervention. Case management staff screen callers and assess them for eligibility for the many available state, federal, and local programs. These may include various insurance options such as Prescription Advantage (the state pharmacy assistance plan), discount options, and new benefits such as the Medicare Drug Benefit. Eligibility is also determined for the many discounted and free programs available from the pharmaceutical manufacturers. After assessment, the case managers work collaboratively with the patients and their providers, facilitating necessary paperwork and offering technical assistance to expedite completion of the applications.

The staff of MassMedLine is comprised of pharmacists, students and faculty of the College. Medication profiles of the callers are reviewed to evaluate for potential drug interactions and are assessed for therapeutic alternatives and generic equivalents. This clinical staff also monitors for compliance issues. Community outreach programs are provided statewide, offering prescription-related educational services and promoting awareness of programs available to the general public and healthcare practitioners.

Since taking the first call in 2001, MassMedLine has logged over 40,000 contacts with those seeking assistance. Most recently, MassMedLine has gained national exposure and recognition as an outstanding resource for the developments surrounding Medicare Modernization Act of 2003 and the resulting Medicare Discount Card and Drug Benefit Program. The Centers for Medicare and Medicaid Services have requested that MassMedLine function as the New England Coalition Network Leader for Worcester County, serving as the liaison between this federal agency and other community partners throughout the county. MassMedLine will continue to provide support and resources to state agencies such as the Executive Office of Elder Affairs’ SHINE program, Prescription Advantage, and MassHealth.

How can MassMedLine help you help your patients? MassMedLine will assist with the application process for the free programs offered by the pharmaceutical manufacturers. Case managers will coordinate all the paperwork and work collaboratively with your office to streamline the process. Once the application has been processed, MassMedLine will provide follow-up with you and your patient to assure the medications were received. For more information, or to make a referral, call 1-866-633-1617.

In December of 2003, Congress passed the Medicare Prescription Drug, Improvement, and Modernization Act. This legislation provides all Medicare beneficiaries with a prescription drug benefit known as Medicare Part D or Medicare Prescription Drug Coverage. The prescription drug benefit begins January 1, 2006. Participation is voluntary and enrollment began on November 15, 2005. In Massachusetts, beneficiaries with both Medicare and MassHealth, referred to as dual eligibles, are automatically enrolled in a prescription plan. Copays for the prescriptions are $1 and $3 or $2 and $5. MassHealth beneficiaries will have an opportunity to change plans if they are in a program which does not completely cover their medications. Additionally, in an effort to ensure that the members benefit from the cost savings, the Centers for Medicare & Medicaid Services (CMS) are providing a facilitated enrollment beginning May 15, 2006 for Medicare Savings Program members and all other individuals determined eligible for Extra Help.

Other beneficiaries with limited income and resources may qualify for Extra Help that can significantly reduce the cost-sharing associated with the program. Individuals with income less than $14,355 and resources less than $11,500 and couples with income less than $19,245 and resources less than $23,000 should complete the Application for Help with Medicare Prescription Drug Plan Costs, obtained by calling Social Security at 1-800-772-1213 (www.socialsecurity.gov). The Medicare drug insurance benefit is administered by private plans and most Medicare beneficiaries will choose a plan according to their individual needs. CMS has contracted with Medicare Advantage Plans and stand-alone Prescription Drug Plans. Medicare Advantage Plans offer a comprehensive medical benefit with added prescription coverage. Stand-alone Prescription Drug Plans can be added to traditional Medicare or to traditional Medicare with a medigap plan. Each plan must offer a drug benefit that is at least equal in value to the standard benefit outlined in the federal regulation.

The standard benefit offers prescription coverage after a $250 deductible. Once the deductible has been met, beneficiaries pay a 25% coinsurance until drug costs exceed $2,250. When drug costs are between $2,250 and $5,100, beneficiaries have reached a gap in coverage, or “donut hole,” where they pay 100% of the cost of their medications. After exceeding $5,100 in drug expenses, the member will be responsible for 5% of the drug costs.

With the marketing of drug plans in full swing, we have seen many variations in benefits. Seventeen Prescription Drug Plans have over forty different plan options, many offering a tiered co-payment structure based on a formulary of medications, a mail order service, and a zero deductible. Plan formularies cover 74 to 99% of the Top 100 drugs. Premiums vary from $7.32 up to $65.58.

With a plethora of variables to consider, many Medicare beneficiaries and health care professionals turn to MassMedLine for personalized assistance. The following are examples of how MassMedLine can help patients:

A patient with MassHealth and Medicare is concerned with the Medicare Drug Benefit Program they have been assigned. Will it cover all my medications and what if some are not covered? What are the costs? MassMedLine can check coverage, suggest alternative medications, or help the patient enroll in a more appropriate insurance plan.

MassMedLine is available Monday through Friday from 8am-6pm by calling 1-866-633-1617.

Introduction to the 6th Annual Creative Writing Contest of the Massachusetts Medical Society Members Interest Network for Arts, History, Humanism and Culture

Dear Readers,

For the sixth consecutive year, we are pleased to announce the finalists of our writing contest. We were fortunate to receive submissions from our faithful writers who had never disappointed us in the past; we were equally happy to see several new names, and we congratulate those who submitted their work for the first time.

As was the case last year, we did not assign a topic to our writers. We thought it might be too restrictive and hoped for a greater number of participants if all means of literary expression and all topics were accepted. And it does seem like our hypothesis was proven correct!

Our winning pieces this year are:
1. The Grace-Walk
   Robin Schoenthaler, MD
2. Poems
   Katherine Phaneuf, MD
3. Equilibrium
   Denise Millstine, MD
4. Finding St. Elsewhere
   James Chengelis, MD
5. Déjà vu
   Jack Randall

Unlike in previous years, this year we will not be publishing all the pieces in the same issue of the Worcester Medicine. Now that the magazine is published six times per year as opposed to four, we and the editorial board have decided to spread out the five winning submissions amongst the next five issues. This way, readers will be able to enjoy each piece separately, and each issue of Worcester Medicine will be enhanced by the presence of the literary bit. Our Writing Contest is now a “year-round” event!

We applaud this year’s contributors and encourage all of you to start thinking about next year’s contest. I would like to take the opportunity to thank our reviewers for their dedication and their time. Please contact us with any questions at 1-800-322-2303 x7715 or email Cathy Salas at csalas@mms.org.

Sincerely,
Maciej M. Mrugala, MD, PhD
Mass. Medical Society, Members Interest Network, Arts, History, Humanism and Culture

The Grace-Walk

By Robin Schoenthaler, MD

Over time she’s become accustomed, in a bemused sort of way, to the slam-shut silence that descends when she mentions to new acquaintances that she’s an oncologist. It seems it’s an occupational hazard for a lot of physicians; certainly gastroenterologists and urologists come in for it, too. It’s just a fact that nothing dims a cocktail party’s volume setting like the casual comment that you specialize in anal surgery or leukemic kids.

So over time she’s come up with an acceptable sound byte that rapidly reassures new acquaintances that she’s just a regular gal who happened to get involved with nether regions and unspeakable tragedy for all the right reasons.

She has a little template of sorts, a quick response to the quasi-horrified, so when laypeople ask her, “But how can you bear to be a cancer doctor?” she can chat for a moment about the steady pace of oncologic advances, the satisfaction of having a measurable impact, and the honor of witnessing total strangers coping with the big issues. And then she changes the subject.

But she’s getting older, and more and more she’s tempted to add, “Because cancer opens doors that dropping dead simply doesn’t allow.”

Thus far she’s resisted the temptation to debate the merits of different demise-modes at dinner parties, but increasingly she contemplates the pros and cons of known-impending-cancer deaths vs. out-of-the-blue sudden deaths.

She finds herself wondering if cancer might not just be the answer.

She pulls the car over on a highway, intently listening to an NPR story reporting that more than eighty percent of oncology nurses would choose to die of cancer. Not heart attacks, not car accidents: Cancer.

Increasingly, she can see the nurses’ point. Every year that she deals with the dying she becomes more aware of the “silver side” of cancer, reasons to prefer slow death from cancer to sudden death via blood clot or car wreck or an unannounced MI while on a boat all alone.

On the other hand, she’s had a couple of brushes with a cancer diagnosis herself (that terrifying mammogram call-back springs to mind) and the mere thought of a mutating heat-seeking missile in her blood led to hyperventilation and night sweats. And yet increasingly she believes she would vote “cancer” if her deathbed had multiple choice.

She knows part of her reasoning is that she gets to see the “good” cancer deaths. The continued on page 18
Creative Writing

ending doesn't terrorize her the way it did twenty years ago, knowing that nowadays cancer deaths can be painless and peaceful, accompanied by the magic of the morphine drip and the godliness of a good hospice nurse.

And she's learned from her patients that a cancer diagnosis can give people time to tidy up life's loose ends, putting one's proverbial affairs in order. But she's learned from other patients (mostly those horrible unexpected deaths via pulmonary emboli) that sudden deaths can leave a family gaping, gasping for more, grasping for the words they would have could have should have said if only, only they had known.

But lately (probably because she's getting older), she's been learning from her friends, and most of it has been from individual friends and individual moments. It's been seeing up close and personal the moments of presence and transcendence the terminal diagnosis seems to allow. Lately she's been seeing them as moments of a grace-walk.

She remembers her first friend walking the grace-walk. A thirty five year old mother of toddlers, Stage II breast cancer, she went from shaking and shrieking to arranging a “Say Good-bye To My Hair” party. She provided the venue, her friends provided the purple wigs; and her village was transformed from terrified bystanders wringing their hands to a cadre of clowns,-tools they'll use again to prop each other up during the aftermath. It's become clear to her that cancer simply by grace-walking into the grocery store, tall and bald and fully alive. Or when they sit and talk and rock and gaze out kindly at a future wildly different than anything any of them had imagined before and that all of them try to picture now. Or while they keep journals or essays or send out weekly emails, giving a clear-eyed view of each rocket-fueled step along the path.

She sees her friends transform her views of the disease simply by grace-walking, she saw cancer deaths can be painless and peaceful, accompanied by the magic of the morphine drip and the godliness of a good hospice nurse.

A few days before the end, her son brought her his copy of Make Way for Ducklings. She told him that reading that book to him as a toddler was one of her most precious memories, and she held him where they had sat, and in which chair, and what the light had been like, and how when he sat on her lap he rubbed her arm over and over, her left arm, while she read.

She is now convinced that the words of Mr. Mallard may well have been the last words her friend heard. Certainly the last thing she felt was her ten-year-old son rubbing her arm, her left arm, over and over.

This must be why she's with the nurses. “Everybody dies,” her kidney-cancer friend had said the bleak black day when he was given half a year to live. “Everybody dies.” So if she has to die but got to choose, she thinks now that she'd take the one where you have half a chance to wear a crazy wig or tie the shoelaces up snug, where you can write emails and sermons and know that people will be listening with broken but wide-open hearts, where you have time to let your children know every little thing you ever loved about them, where you can maybe follow in the footsteps of her patients and her friends and leave behind a transforming legacy of walking talking grace, and where you might get to sail away with your son rubbing your arm, your left arm, over and over, until the book is done.
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Treating Depression in the Primary Care Setting
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Hoggland-Pincus Conference Center, Shrewsbury, MA

Hand-Assisted Laparoscopic Intestinal Surgery Workshop
April 1, 2006
Umass Endosurgery Conference Room, Worcester, MA

9th Congress of Chest Pain Centers Acute Coronary Syndromes: Expanding the Continuum of Care
May 3-5, 2006
Boston Park Plaza and Towers Registration:
www.scppc.org/congress

Early Screening for Autism
and Other Developmental Disabilities
May 24, 2006
Hoggland-Pincus Conference Center, Shrewsbury, MA

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Introduction

Central Massachusetts is home to a remarkable number of dedicated and accomplished individuals involved in biomedical research and other scholarly activities. Through this new section, "Science Corner," the Editorial Board hopes to highlight some of the vibrant and creative programs designed to expand knowledge and to enhance the health and well-being of people everywhere. The primary focus of these feature articles will be, at least initially, on the objectives, outcomes and implications of basic science or clinical investigations in medicine and its related disciplines.

The Editors encourage individuals to submit manuscripts summarizing the scholarly activities that they or their colleagues are performing, with an emphasis on the broad avenues paved by such work. Submissions from seasoned investigators, residents, and students in any medical, nursing or related discipline will be welcomed. Submitted manuscripts should be 500 - 750 words in length and should be forwarded to the Worcester District Medical Society for review and consideration.

Feature Editors: Anthony Espisito, MD and Michael Malloy, DPharm

Research and Critical Thinking:
A Modest Contribution and Caution from Worcester Medicine

By Joel Popkin, MD, Program Director for Medicine, St. Vincent Hospital

For several ruinous decades General Motors has modeled its incapacity to think beyond three months (aka, the quarterly statement), presumably sensitive to stockholder belief that progress simply "happens" as a function of time. It looks like Middle Ages Research and Development mentality still holds sway in the security of the mothership, where top brass wring their hands as Toyota prepares to obliterate GM's once invincible position as the world's largest automaker. Where someone in the bunker has maybe by now fearfully whispered to the vested Hummer community: "Hybrid," a technology which archival Ford has reluctantly started leasing – from Toyota.

Are we in Medicine doing better with our own R&D? Certainly far better than GM's visionless wallowing, but on the horizon aren't we facing our own leasing, in this case stem cell technology – from Korea? So where we are depends in part upon how one reads the all-telling water glass level.

Undoubtedly there is much good news: We have come to take science seriously. "Evidence Based Medicine" is officially in; "In My Experience" is officially out. After years of doing what seemed right, we have bought into doing what is scientifically best, although quoting that science doesn't yet guarantee its transfer to our individual patients.

But our insistence on living by scientific principles has also generated some subtleties. Far from perfect EBM guidelines have coalesced, non-stop, into medical "cookbooks" – paradoxically the result of a new level of scientific hauteur capable of intimidating those who think independently. The Bible of Medicine has defaulted to UpToDate®, an elegant, continuously updated electronic textbook that more than guides a generation of residents and students – often to the exclusion of almost everything else. To be sure, UpToDate is phenomenally better than "In My Experience," but how it seduces us to sneak around critical reading of the literature!

What other issues are affecting research? A factor that has made UpToDate indispensible is the crush of productivity standards and documentation. Who has the time to read? Will you make it to the last paragraph of this editorial?

Respect for research comes mainly from its undisputed fans – those of us in the medical field. In the real world the media and, yes, grammar schools, paint scientists as geeks. Does anyone speak of Einstein as a "hero"? In a multiple choice test would your average high school student pick Jonas Salk as an old-time third baseman for the Pittsburgh Pirates?

Can we depend upon the checkbook balancing to continue indefinite underwriting of the cost of research? It was not until the early 1980s that biomedical research funding exceeded that of other technologies, and in the past decade biomedical research funding has doubled, adjusted for inflation.¹ Yet when comparing the cost of today's MRIs and DNA sequencing to yesterday's beakers and pipettes, it is hard to quantify what a doubling of support actually represents in terms of current needs. And most research support goes to investigators and programs, rather than the buildings and other critical laboratory infrastructure.¹

Nevertheless, the dollars are real, undoubtedly a result of stimulating the public's imagination and expectations for many more of the last generation's astounding medical breakthroughs. Surprisingly, we are spending seven times more per capita on cancer research than the 25 members of the EU, leading to worry among EU members about a brain drain to the US.² Although Europe is spending more on the "R" of Research and Development, we are spending a great deal more on the "D."² This may be problematic in the long term, probably explaining the pattern of FDA approval of new drugs: 24 in 1998, decreased on average by 2 per year since, with 11 approved in 2004.¹

Finally, what about the funding of medical education research, which tells us, after all,
if the technology we develop is truly meaningful. While most tech companies spend 15-20% on R&D, federal spending on health professions education research has been less than 0.001% of direct federal spending on graduate medical education. In a recent study private foundation grants made up 42% of the funding, the most common sources for study of medical education research. Most of this research is funded informally, and that which receives support is mostly underfunded.

So on the whole, the cup sort of looks half full. But we had better be smart enough to keep it there, perhaps in part by being mindful of the following:

1. Massive medical research funding can and has led to striking inefficiencies and ineffectiveness, a condition ripe for society to frown upon in very tangible ways. (Witness the rises and falls of NASA, and this prior to the financial pressures yet to come from a federal make-believe budget.) We had better avoid embarrassments.

2. We must stimulate our young physicians to think critically and responsibly, so that they can utilize meaningful developments and trash the many “new and improved” claims that are in reality much more expensive but no better. This extends to all of us, who in the next iteration of Medicine simply must be given some kind of break, so we can think about what we do.

3. We must refocus our even younger high school and college students to view research as a bold venture, and do so by talking with our children, participating in career nights, and pushing our educators back toward the sciences. And let’s recognize Paul Farmer for the hero he is.

4. We must put the fun of learning and discovery back into science. To start, we must think of it in that way.

Toward these goals we begin “The Science Corner” in this issue of Worcester Medicine. We open with a couple of posters (linked to our WDMS website—www.wdms.org/publications.htm) culled from many authored by the medical residents of St. Vincent Hospital, who habitually stimulate and challenge our medical staff and me to think anew. But for our next “corner” we look to the rest of our readers to provide the decorations. Share with us your own research or ideas for research and tell us what has stimulated you to think creatively. Tell us what’s meaningful, and what we can use to fire up the next generation. And sometimes very different: Tell us what’s going on that is pointless – a waste of resources that might be putting the whole system at risk. The kind of fun I mean is what comes directly from our imaginations, unencumbered by managed care, the government, and even political correctness. We look forward to hearing from you!

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5. Charlton BG, Andras P. Medical research funding may have over-expanded and be due for collapse. QJM. 98(1):53-5, 2005 Jan.
What Do You Do When You Are Not at the Office?

This issue marks the debut of our Off Call column. It will become a regular feature of Worcester Medicine, highlighting your personal interests. We invite readers to submit ideas on their areas of expertise on a variety of leisure activities and hobbies, including but not limited to the following topics:

Art
Book Reviews
Collecting

Cuisine
Golf Tips
History

Horticulture
Music Reviews
Self-Help

Spirituality
Sports
Theatre Reviews

Travel
Wine & Brew

I am grateful to Drs. Mark Kranis and Laurie Marin, both of whom are third year residents at St. Vincent Hospital, for writing the first article.

Feature Editors: Jane Lochrie, MD and George Brinnig, MD

Visiting Switzerland

By Mark Kranis, DO and Laurie Marin, DO

Switzerland, a small land-locked nation in Europe, is best known for its cheese, watches and, of course, chocolate. For such a small nation, it offers diverse landscapes ranging from snow peaked mountains to green pastures filled with cows to large metropolises with world-class shopping. Additionally, it may be one of the few countries to have three official languages - French, German and Italian, depending on the region. My wife and I had the pleasure of visiting this country in early September.

We started our trip in Lausanne, Switzerland. After landing in Geneva airport in the early morning, we took a quiet 45 minute train ride to Lausanne. Looking out the window of the train we were treated to some truly picturesque views of the banks of Lake Geneva and of the grape vineyards which adorn those banks. In case you were wondering, the trains in Switzerland do run like a Swiss watch and are always on time.

Lausanne, a city on a hill on the edge of Lake Geneva in the French part of the country, is the home to the International Olympic Committee and the International Olympic Museum. Surrounding the city are the eternally snow-capped mountain peaks of the Swiss and French Alps, including Europe’s tallest peak, Mount Blanc. An underground metro connects the two halves of the city. The upper part on the hill is comprised of the businesses and stores typical of a French city while the lower half, Ouchy, is the lakeside area which is home to many resort and lake activities.

Because Lausanne is located on the bank of Lake Geneva, Europe’s largest lake, one can spend time relaxing on the beach, taking a pedal boat ride on the lake, having a crepe at any of the outdoor cafes, or taking a steamer ship across the lake to Evian, France. Yes, this is the same town from which the famous Evian water comes to us.

After a few days in Lausanne, it was off to the mountains. A two and a half hour train ride took us into the valley to the town of Sierre. Then a funicular, a train pulled up the mountain by a cable, brought us up to the town of Crans-Montana, located on a plateau at an altitude of about 4,500 feet. During the winter, this is one of the premier ski areas for Europe and is home to the 1987 World Cup Ski Championship. During the summertime, it is filled with miles of trails which make it a haven for hikers. One of the favorite routes is called the Bisse de Zitterot, a trail which takes you along the mountain, following a small stream supplied by the melting glacier above. Along the way we saw many of those famous Swiss cows as they grazed in the pastures. When in any of the pastures is takes a lot of restraint to refrain from singing tunes from the Sound of Music.

From whichever city or town you are in, the Swiss rail system makes it easy to take a number of day trips to numerous desti-
nations. We were able to visit Gruyere, home to one of Switzerland’s most famous medieval castles and the place where gruyere cheese is made.

One of our favorite day trips took us to the town of Zermatt. Over the years, this town has become one of the premier tourist attractions because of the world-famous Matterhorn peak, visible from the town. Zermatt remains the only town in Switzerland that does not have gas cars; all the transportation is either by foot, horse drawn carriages, or electric cars which resemble oversized golf carts.

Climbing the Matterhorn requires a level of technical skill that most of us visiting do not possess. Luckily, we can still visit the peak of the Klein Matterhorn (Little Matterhorn in German). A gondola cable car, like the one you see at ski resorts, connects you to the larger cable cars that hold up to 50 people. Now you are suspended well above the Alps, glistening glaciers below you. From here you need to transfer to yet another cable car which eventually brings its passengers inside the base of the mountain. At this altitude, the air is much thinner and you can feel a little lightheaded. Finally, an elevator brings you up through the mountain to an outside staircase which you can climb to a platform built right on top of this peak. You are now at an altitude of over 12,200 feet, getting an eye level view of the surrounding Alps - and depending on the weather, you may even be looking down at a few clouds.

For lunch, we wanted to have a traditional Swiss meal. We opted for cheese fondue, a meal consisting of melted gruyere and emmenthaler cheeses into which you dip French bread, and raclette cheese. Raclette is a melted raw milk soft cheese which is eaten with bread, potatoes and very small pickles. A brick of this raclette is brought to the table along with a cheese melter so that you can melt your own cheese onto the bread.

Zurich, Switzerland’s largest city and business center of the country, was the last city we visited. This is the city where the infamous Swiss banks all have their headquarters. The shopping is also world-class along the Swiss version of Rodeo Drive or Madison Ave., The Bahnhofstrasse. One of our favorite places to stop is Café Sprungli. This café and patisserie is part of the chocolate company Lindt and Sprungli, the same company that makes those delicious Lindt chocolate truffles.

Getting around the city is easy especially if you know Boston since these two cities share a similar tram service. The Swiss version is identical to Boston’s Green Line except that it happens to be blue and is numbered.

With what seemed like a ton of chocolate, a few cuckoo clocks, and well-defined calf muscles from all the hiking, we departed Zurich Airport bound back to Boston.

If you are interested in more info on visiting Switzerland, check out www.suiterlandtourism.com.

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Paul Gardner, MD
1922 - 2005

Dr. Paul Gardner died peacefully on September 30, 2005. He was a Worcester resident all of his life except for time spent in military service and graduated from South High School and Clark University. From 1943-1947, while a private in the Army, he attended and completed medical school at Boston University.

Following graduation from medical school, he interned and was a resident in Internal Medicine at Worcester City Hospital. During the Korean War, he was commissioned a First Lieutenant and served in Germany, where Churchill’s “Iron Curtain” was in place.

Upon discharge, Paul returned and became a Worcester City Hospital staff member and eventually joined the staffs of Fairlawn and Memorial Hospitals. He maintained a private practice, taught interns and medical residents, and did his share of serving the indigent at Worcester City Hospital clinics. Dr. Gardner practiced Internal Medicine for 35 years before retiring and was a member of the Worcester District and Massachusetts Medical Societies.

His wonderful wife Anne, a Worcester City Hospital Nursing School graduate and the mother of their six children, died in 1995. They were great neighbors and some of our children formed lasting friendships that continue today.

Golf was Paul’s greatest sports interest, with the Boston Red Sox a close second. He played in a foursome with Drs. Bob Kelly, Felix Cataldo and me for many years at the Wachusett Country Club. In later years at Holden Country Club, he played with the late Dr. George Joseph, another valued friend. He loved golf and played it very well.

In later years, The Gardners, by this time empty nesters, moved out of our neighborhood and into a smaller home. The annual Coolidge Road cookout, an area celebration, was held this year in early September. A new young couple showed up and announced that they lived in the “Gardner House” and all understood. A case of gone but not forgotten, these special friends were one of a kind. Dr. Gardner will be remembered by his children, many grandchildren, friends, medical confreres, and former patients.

John Riordan, MD

Felix Cataldo, MD
1923 - 2005

Dr. Felix Cataldo died on September 22, 2005 at his home on Salisbury Street in Worcester at age 81.

Dr. Cataldo graduated from the College of the Holy Cross and Tufts University Medical School. He served in the US Navy in WW II and was awarded the Bronze Star for his service as a surgeon with the US forces in Korea. He was Chief of Surgery and Chief of Staff at Worcester City Hospital, Associate Clinical Professor of Surgery at University of Massachusetts Medical School, and a member of the Ethics and Library Committees of the Worcester District Medical Society, the President’s Council of Holy Cross, the Board of Trustees of Worcester City Hospital, and the Massachusetts Medical Society.

Felix was a talented surgeon and teacher, training hundreds of residents throughout his career and being selected “Teacher of the Year” in 1983 by his residents. But more than that, his kindly, reassuring manner epitomized the Art of Medicine.

Throughout his fifty-two year career at Worcester City Hospital and subsequently at the Family Health Center of Worcester (where he worked until shortly before his death), he devoted much time to the care of the underserved families of the community.

On September 6, 2005, in recognition of his years of dedication, the Family Health Center established the Annual Dr. Felix G. Cataldo Lifetime Achievement Award in his honor.

Felix was an avid reader, liked golf, fishing, birding, cooking, and skiing, and adored the outdoors and nature. Above all, he loved his wife and family.

He is survived by his wife, Anne O’Sullivan Cataldo, and seven children: Maria, Lisa, Paul F., Dr. Peter and his wife Melanie, Eileen Cataldo Kneeland and her husband Dr. Thomas and his wife Lisa, and twelve grandchildren of whom he was very proud.

There were many who are blessed to have known him, and I am one of them.

Robert Kelly, MD
Ed Prunier
1929 - 2005

Ed Prunier died on August 24th, 2005 at the home of his daughter Margaret, where he and his wife, Corinne, to whom he had been married for fifty-eight years, had been living.

Ed was first and foremost a man of family and faith. For many years, he and Corinne lived in the big, gracious house on William St. in Worcester. The family with one daughter and four sons grew and flourished at that address, a place not far from Elm Park where they could be seen strolling as a family on any pleasant evening. Ed was proud of his family and those of us who worked with him could hear his enormous pride in his children and his deep and loving devotion to his beloved Corinne. They shared fifty-eight years of a warm and deep but quiet love. No one in the Prunier family was ostentatious; their lives were lived modestly and quietly, following the example of their father.

Ed Prunier lived a Roman Catholic life. His education had been in Catholic schools and his behavior, both personally and professionally, demonstrated the ethical teachings of his faith. Nonetheless, Ed never wore his religion on his sleeve. With his non-Catholic colleagues and with those who shared his beliefs, Ed could share a good joke, even ones that occasionally came close to being risqué. He was a man of deep religious faith and an individual who was able to combine the teachings of his religion and his studies of psychoanalysis in a manner that made him an effective psychiatrist and a fine human being. He practiced psychiatry for fifty years to the enormous benefit of countless patients.

Ed was also a devoted teacher. He shared his knowledge and insights with many grateful students at all levels. He taught at Assumption College and the University of Massachusetts Medical School and instructed many post-graduate psychiatric residents. He practiced the art of teaching as well as the art of medicine.

Ed lived a full, good life and those of us who were fortunate to have been touched by him share his family’s loss. He was “a really nice guy.”

Edward Mason, MD
“Literature and Medicine: Humanities at the Heart of Healthcare” is a unique book-discussion seminar series that has been offered since 2003 to health care providers, faculty, administrators and students from the University of Massachusetts Medical School and the UMass Memorial Health System. The program is part of a statewide effort spearheaded by the Massachusetts Foundation for the Humanities to provide a hospital-based forum for discussion of literary works – fiction, poetry, and nonfiction – with the goal of exploring such complex themes as the role of the care giver, illness, death and dying, cultural considerations in healthcare, the patient’s perspective, and relationships between healers and patients.

In 2006’s upcoming session at UMass, the program will meet monthly from January through May for five 2.5 hour sessions that include dinner and discussion led by Joseph Cady, PhD, Adjunct Associate Professor of Medicine (Literature) at New York University Medical School. In addition to the foundation, which provides the books on loan and the trained facilitator, crucial institutional support is provided by both the medical school and clinical system.

Literary works to be studied at UMass during the 2006 seminar series include: Tolstoy’s *The Death of Ivan Ilyich*, Kay Redfield Jamison’s *An Unquiet Mind*, and David Hilfiker’s *Not All of Us Are Saints*, as well as poetry by Raymond Carver, Paul Monette and Veneta Masson.

Participants enthusiastically laud the program’s merits, offering a variety of perspectives on the richness of the experience. In evaluating the program, a past participant articulated the spirit and intent of the program: “These seminars provided the opportunity to meet, listen to and have my thinking questioned and influenced by men and women who are deeply committed to patients and who have rich experiences to share from caring about and for other people with health problems.”

Emily Ferrara, MA is Assistant Professor of Family Medicine and Community Health, and Director, Grants and Special Projects in the Office of Medical Education, UMass Medical School.
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