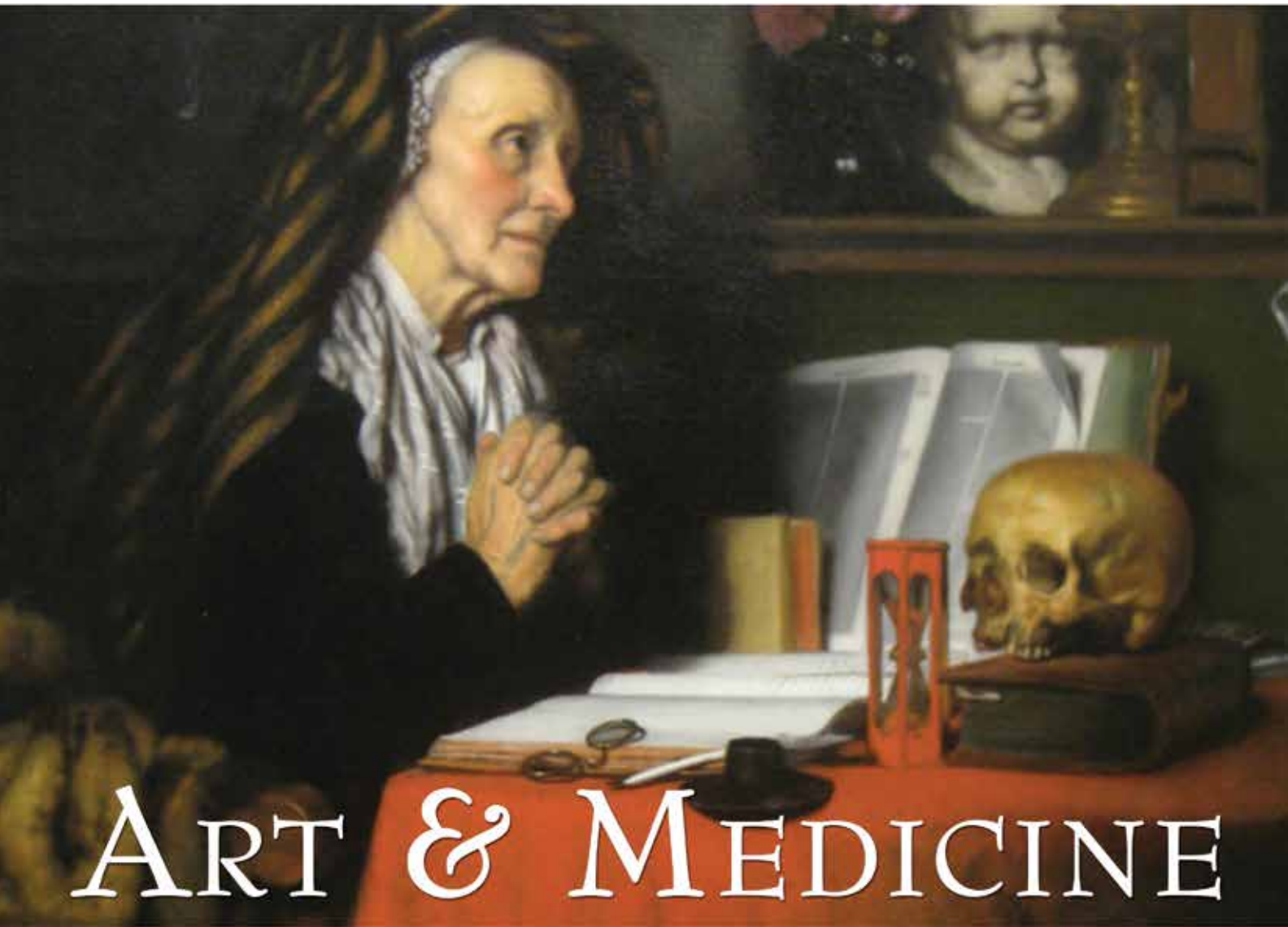


WORCESTER **medicine**

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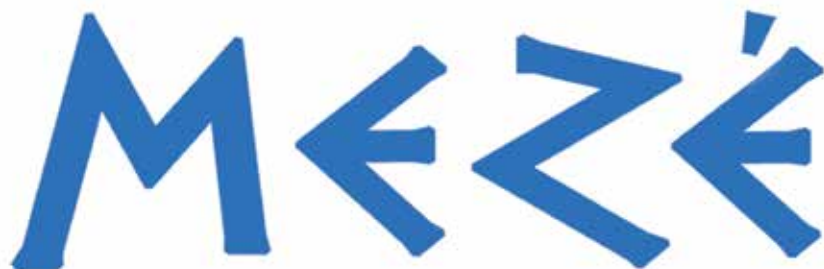
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contents

Vol. 79, No. 2

On the Cover: Art & Medicine

Old Woman Praying, 1655, by Nicolas Maes (Dutch 1634-93).

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- | | |
|---|---|
| <p>6 Editorial
Jane Lochrie, M.D.</p> <p>9 President's Message
Frederic Baker, M.D.</p> <p>10 219th Annual Oration: Art and Medicine
Paul M. Steen, M.D.</p> <p>13 Art & Medicine:
Imagine a Closer Connection
Joel T. Katz, M.D., MACP</p> <p>14 The Arts, Humanities, and Medicine:
What has one got to do with the other?
David Hatem, M.D.</p> <p>16 Reflective Writing in Family Medicine
Hugh Silk, M.D., MPH, FAAFP and Joanne Dannehofer, PGY 2</p> <p>17 Music Therapy:
Answering <i>Why</i> Rather Than <i>What</i>
Cara Brindisi, MT-BC</p> | <p>19 Art for Healing:
Inspiration in the Therapy Room
Anne Kane, RN, Ph.D.</p> <p>20 UMMS Family Medicine Worcester Art
Museum/Medical Humanities Curriculum
Sherrilyn M. Sethi, D.MH</p> <p>20 Past the Pink Horse
Martha Duffy, M.D.</p> <p>21 The Storm
Mary G. Cooper, M.D.</p> <p>22 As I See It: Facts Matter
Frederic Baker, M.D.</p> <p>23 Legal Consult:
Coordinated Care Versus Market Power
Peter J. Martin, Esq.</p> <p>24 Society Snippets</p> |
|---|---|

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Editorial

Jane Lochrie, M.D.



Jane Lochrie, M.D.

Can studying art make you a better physician? Apparently, it can. In previous years, medical students' admission committees selected students for "left brain characteristics." Today, these committees are considering a background in the humanities that emphasizes "right brain" qualities a lot more positively. There is a growing body of literature that describes how the arts allow physicians to pick up more physical findings on examination of a patient. The idea is not to teach art history but increase the physicians' powers of observation.

This issue of *Worcester Medicine* starts with the 219th Oration. Dr. Paul Steen discusses the growing relationship between medical schools and art museums to improve their students' observation skills. Art is inherently complex and ambiguous, leading to endless analytical opportunities. He describes his involvement with the University of Massachusetts medical students and family practice residents and the four stages involved in each painting that they scrutinize.

Dr. Joel Katz has a similar program that he performs with the Harvard medical students and internal medicine and dermatology residents. He asks three key questions: 1.) What's going on with this picture/patient? 2.) What do you see that makes you conclude that? 3.) What else do you find? He uses art not only to improve the power of observation but also to improve multidisciplinary teamwork.

Dr. David Hatem has extensive experience in the humanities in medicine. He explains that reading can help us understand problems from multiple perspectives that we might otherwise not appreciate. Reflective writing has some important benefits, both physical and psychological, especially when dealing with stress and change. Reflection has been shown to be the foundation of clinical learning, and the humanities are a good way of stimulating reflection.

Drs. Silk and Dannehofer describe a forum to celebrate the accomplishments of the UMass Department of Family Medicine, the Thursday Morning Memo. This is reflective writing that describes

their successes in patient care and teaching. A recent survey showed that this weekly story improves empathy and patient-centeredness and, in addition, benefited the writer.

Cara Brindisi, a music therapist, tells us not to ask what music therapy is, but rather, why music therapy is important. Each patient requires customized music dependent upon the assessment of his/her varying needs. She gives us several illustrative examples of how this is accomplished and how this is important to the patient.

Dr. Anne Kane relates an inspiring story of how music is important to the art of healing. A friend's mother with dementia was admitted to a rehabilitation hospital after a devastating fracture. The therapist investigated what she did at home on a daily basis and found out that she played the piano. The therapist went the extra mile and found a piano so the patient would feel at home and not be afraid of therapy. The patient was then able to cooperate with therapy and eventually return home.

Dr. Sethi introduces us to the UMMS Family Medicine Residency Program's Medical Humanities curriculum, which is designed to integrate compassion, humanism, empathy, professionalism and effective communication through reflective writing. The curriculum encourages physician wellness, mindfulness and strategies to foster a healthy work-life balance. Two of her residents relate their experiences at the Worcester Art Museum.

Dr. Duffy contemplates a painting and is reminded that there may not always be a right answer in medicine. The trip to the museum helped her reignite the creative human part of her and put the patient back into the equation.

In contrast, Dr. Mary Cooper's article is a perfect example of reflective writing and illustrates the benefits of this as mentioned in the article by Dr. Hatem. She mentions that it is very important to listen to our patients during times of crisis and stress – exactly, as Dr. Hatem states, the time when reflective writing has the most benefit.

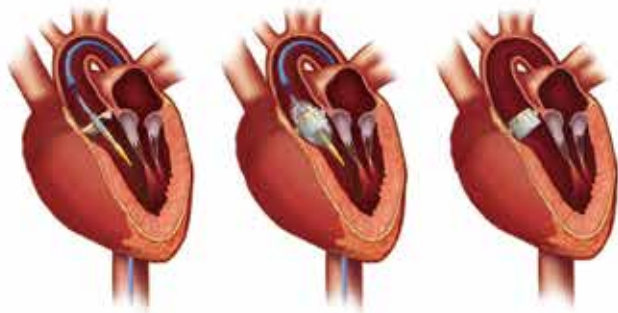
Before you leave this issue, please read our feature articles. Dr. Baker brings up the timely topic of immunizations in *As I See It*. You will be reading more about vaccines in a future publication. As always, Peter Martin, Esq., writes about another significant topic, *Coordinated Care Versus Market Power*. And finally, Joyce Cariglia's *Society Snippets* informs us about some wonderful upcoming events.

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Art and Medicine

Frederic Baker, M.D.



Frederic Baker, M.D.

Our current issue pays homage to the arts. Medicine is often described as a science and an art. *The New Oxford Dictionary* defines art in various ways. Many would associate medicine with the definition of art as a skill at doing a specified thing, typically one acquired through practice. However, I would also offer that medicine is an art in the sense that physicians apply and express creative skills and imagination in a manner that reinforces the beauty and emotional power of our patients. Whether it is restoring the inner or outer beauty or function to a person who has been ill or injured or emotionally traumatized, physicians can empower patients with the strength and resources to pursue more meaningful lives.

We physicians are very fortunate to have the privilege of practicing our art. We are even more fortunate to be inspired by the arts. I recently had the pleasure of attending a great oration, presented by Dr. Paul Steen, on the use of art as a teaching tool for medical students and residents, particularly in its application in enhancing the skills of observation.

Perhaps my first introduction to medicine and appreciation for the powers of observation was in the artwork of the great Dr. Frank Netter, a surgeon who was also a masterful medical illustrator. A biography written by his daughter refers to him as *Medicine's Michelangelo*. My father, a physician, kept the collection of *CIBA Geigy Netter Medical Illustrations*. Even as a child, I found the images fascinating. Dr. Netter's artwork is universally admired. His anatomic illustrations, with meticulous attention to detail and clarity, seem so lifelike, they often rival or even surpass the experiences that one might have from witnessing "the real thing." His images convey a narrative in a way that is often far more powerful than text. One image, in particular, depicts a moderately overweight man leaving a restaurant. As he is climbing the stairs, he clutches his chest while his face harbors an expression of pain and horror. He is turning blue with a cigarette having fallen out of his mouth. How brilliant, I thought, that no words had to be expressed to convey the tension and meaning of angina. The reader could connect intellectually and emotionally with such a powerful image without having to be physically present.

Art can move us in a way no other medium can. It can expand our imagination, broaden our horizons and introduce us to places not easily accessible. Art can inspire us to rethink our world and our biases. I hope you enjoy this issue and find it very meaningful.

219th Annual Oration: Art and Medicine

Paul M. Steen, M.D.



Paul M. Steen, M.D.

Dr. Paul Steen delivered the 219th Annual Oration on Wednesday, Feb. 11, 2015, to a captive audience of more than 100 physicians, guests and members of the community. This memorable event was held at The Beechwood Hotel.

Shortly after completing my art docent training at Worcester Art Museum (WAM), I noticed visits by medical students and family practice residents. My curiosity was triggered. Why would medical students and residents take a field trip to an art museum? I discovered that over the past 17 years, an unusual partnership has been developing between medical schools, hospitals and art museums to teach medical

students, residents and even practicing physicians how to improve their observational skills. To quote William Osler: “There is no more difficult art to acquire than the art of observation...”

The first mention in the literature of the concept of using art to teach health care providers was in 1981 in Ohio, but no actual program was instituted. The first formal program began at Yale Medical School in 1997, when Dr. Irwin Braverman, a dermatology professor, was unhappy with the way his residents presented descriptions of their patients on rounds. He believed that visual training would improve their observational skills and partnered with the Yale Center for British Art to develop a program to accomplish this goal. It seemed logical that visual skills could be improved, but would it be transferable to medical observation? In 2001, Dr. Braverman published in *JAMA* the first controlled study on this process, showing a 10 percent improvement in medical observation skills. This was a fairly small, but encouraging, finding, and other medical schools began to adopt the system. In 2008, in the *Journal of General Internal Medicine*, Dr. Joel Katz, of Harvard University, published a study that incorporated both a clinical and more intensive visual training component that resulted in a 38 percent improvement in medical observations over the control group.

Thanks in part to these studies, the program has spread to at least 27 medical schools and community hospitals in 25 states and internationally. In studying these programs, I found that most have altered the program to meet local goals and needs. Most of the programs fall into two groups: 1.) humanities workshops and 2.) observation workshops. Both have art museum visits about two to three hours in duration. The humanities workshops have one to two sessions, whereas the observation workshops have four to 13 sessions. The humanities workshops use literature, reflective writing, film and plays to educate on patient-physician interactions, as well as how people face disease and difficult health decisions.

Their goals are directed toward personal balance and well-being of physicians. Some also work on teaching medical team dynamics and physician leadership, areas of rapidly growing importance in today's team-oriented care delivery. Most of the programs we see at WAM fall into the humanities group. The observation workshops are frequently combined with clinical teaching focused on medical observation. Even though I have separated them into two neat divisions, each group borrows components from the other. Observation is at the very heart of the “Art of Medicine,” and experts have stated that it takes 10 years to become accomplished at any skill. At the very least, these workshops aspire to shorten this time.

Let me tell you about an experience I had as an intern at Kings County Hospital in New York City, the second largest hospital in the world at the time, with 3,600 beds. I was handling 20 patients, of which five were called “placement patients,” meaning they were waiting for a nursing home, which in those days, could keep them in the hospital for one to two years! Time was short and the time per patient even shorter, especially the “placement patients.” On my third day, I noticed something odd about one of the placement patients. She had been diagnosed with pneumonia when admitted 10 months ago and was doing well other than her dementia. To me, she looked jaundiced. My resident was doubtful but agreed that I should order testing. As he predicted, the tests were negative. I researched what causes the combination of yellow discoloration of skin and dementia and came up with a differential diagnosis list that included pernicious anemia. This time, her lab tests confirmed the diagnosis. After treating her with B12 and folic acid, she began to recover and she left the hospital fully functioning. This type of observation error is called Inattention Blindness, defined as: “Failure to notice a finding that is in plain sight because it wasn't expected or looked for and because our attention was distracted.” This is a good clinical example: The yellow skin was in plain sight, was not expected with dementia and not noticed because of distraction from time pressure.

So don't we teach observation in medical school? The answer is yes. We teach pattern recognition, which is essential to making diagnoses in all branches of medicine. We learn by rote memorization that findings A and B mean the patient has a specific disease (e.g., cough and fever in January could be flu). Over many years of practicing medicine, we learn to see details and patterns we didn't see before. I refer to this as “analytic observation.” A good analogy is how we learn to read, memorizing words at first and later using phonics to sound out new words. This analytic process doesn't lend itself to lecturing; we actually have to train ourselves. As Sherlock Holmes said to Watson, “*I see no more than you, but I have trained myself to notice what I see.*”

Why are art museums so well suited to teach observation skills? Art is inherently complex and ambiguous, leading to endless analytic opportunities. Artwork selection can focus on specific needs like social or emotional issues. Analytical observation is encouraged over pattern recognition. A not-so-hidden benefit in taking students and residents out of the high-pressure clinical setting into a less-pressured environment encourages participation and risk-taking. Lastly, patients change; art doesn't. This allows us a consistency from visit-to-visit, knowing what to expect and instruct.

How do typical programs work at WAM? Most of the programs involve University of Massachusetts Medical School fourth-year students and family practice residents. Most of the programs fall in the humanities category, with groups of four to six participants. The sessions are two to four hours long and involve four to five works of art, mainly paintings or sculptures, but prints and photos can be used. I like to choose paintings that have numerous details, portraits, symbolism and are ambiguous or mysterious.

There are four stages involved in each painting: 1.) Observation, 2.) Description of details, 3.) Analysis, and 4.) Interpretation. Often we add a fifth stage if art appreciation is the goal – Judgment – which asks the participants for a personal opinion of the painting.

Old Woman Praying

1655, by Nicolaes Maes (Dutch, 1634-93)

This painting is the easiest of the four, as it is loaded with detail that is easily recognizable but is harder to interpret because of the symbolism that was intended for a 17th century audience.

Step 1 – Observation: Students are told to study this painting for five minutes, getting an overview first and then focusing on sections. Our goal is to slow the students down to focus thoroughly on the picture. We remind them that the artist puts every item in the painting for a reason, and they are to find them all and eventually decipher their meanings.

Step 2 – Description: Our goals are to get a complete list of items in the painting. Think of this as similar to signs and symptoms in medicine. After five minutes, the participants are asked to name what they see. In this picture, the most common first response is, "It's an old woman praying." We ask them how do you know it is a woman, that she's old and that she's praying? We want them to report only what they actually see, not interpret. This is followed by naming the obvious: hourglass, glasses, books, flowers, baby porcelain figure, candle, inkwell, ink quill. They usually miss the small details. We guide them along by asking, "What else is there in this picture?"

Step 3 – Analysis: We want the students to figure out the techniques the artist uses. This is really advanced description, and they need some guidance from us in the form of questions. Typical questions are: "What was the first thing you noticed when looking at the painting?" "What did the artist do to achieve this?" In this case, most start with the woman's face because it is the brightest or the table because of the bright-colored tablecloth. Light and dark contrast, color, texture, shapes, composition are common techniques to emphasize the subject or to tell a story. Our goal is not to teach art appreciation, although this is a nice by-product.

Step 4 – Interpretation: What is the artist trying to tell his target audience? This is where group discussion takes place, and students learn problem-solving and teamwork. There are frequently two to three different interpretations, and we try to get the team to come to a mutually acceptable one. Think of this as similar to a differential diagnosis in medicine. We hope doctors arrive at a single working diagnosis. Generally, the students read the painting this way: a frail elderly woman is praying. There are symbols of the shortness of life (hour glass, faded flowers and the unlit candle). This is usually where we come in with relevant art history information. This type of painting is called *vanitas* (Latin for vanity). It is about the transience and meaninglessness of life and would have been readily understood by its 17th century Dutch audience.



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The remaining two paintings will not be discussed in the same detail. I will tell why I selected each artwork. They are, in my opinion, increasingly difficult as they are increasingly ambiguous and require deeper intellectual analysis.

Portrait of the Artist's Daughters

1763-4, Thomas Gainsborough (English, 1727-88)

Portrait paintings are mainly about personality, mood, social environment and occupation. What makes this painting so interesting is that it has been changed several times relative to the sisters' positions. We can see a second image of the standing daughter originally facing her sister. Later, she was repainted to be next to her. The discussion with the students is how this changes the perceived relationship between the sisters and their personalities?

The Brooding Woman

1891, Paul Gauguin (French, 1848-1903)

In this painting, there are only a few objects, and the students usually find them all. Gauguin is famous for unusual colors. The rug's color and the grass create two focal points. The big question is what is the relationship between the woman and the man on horseback? What role did the artist intend for the dog? In this case, even experts don't know the answers, so the discussion is always spirited.

What are the challenges? At present, even with a growing use of art for improving observation, there are only a small percentage of students and residents involved. The challenges to expand this involvement include an already crowded curriculum, time availability of faculty and students and skepticism. Many of the skeptics at Yale and Harvard were won over after the studies were published and the program became a requirement. It seems to me that this is an area ripe for more research to optimize the program.

What I hope you take away from this presentation is that observation in medicine is a skill that can be improved by using fine art as a supplement to the patient learning experience. The bottom line is that I believe this process works, both in improving medical observation skills and as part of a broader student education in the humanities. I leave you with this final quote:

"The trouble with many doctors is not that they don't know enough, but that they don't see enough."

– Sir Dominic Corrigan, 1853

Paul Steen, M.D. was in the private practice of internal medicine in Southbridge, where he served as president of the medical staff. He then joined the corporate world as vice president of clinical development for McKesson Corporation until his retirement in 2005. He served as WDMS president from 1981-82 and as editor of Worcester Medicine from 2005-12. Currently Dr. Steen is an art docent at the Worcester Art Museum with an interest in art as applied to medical student and resident training.

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Art & Medicine: Imagine a Closer Connection

Joel T. Katz, M.D., MACP



Joel T. Katz, M.D., MACP

As first glance, art (highly emotional, evocative, inspired and individual) and medicine (precise, scientific, evidence-based, protocol-driven and collaborative) seem to be not just different, but diametrically opposed. Artwork marks a moment in time, often hangs statically on a wall and, whether ancient or modern, is inextricably linked to and enriched by its (often bygone) historical context. Medicine, on the other hand, is focused on the one accurate diagnosis and most effective treatment, which evolves and invariably improves over time; old theories and methods are abandoned and replaced by new, more refined paradigms.

My own journey took me through what, in retrospect, were the extremes of art school (subjective portfolio critiques) and medical school (memorizing seemingly endless facts proscribed by my professors), and while I had faith that they would come together, I did not foresee how close the links would prove to be or how valuable the methods of art would be in teaching medicine. For the last decade, I have enjoyed working with a truly multidisciplinary team of arts educators, artists, nurses and medical educators who have helped create the connecting experiences below.

Observation of artworks in a museum is an ideal setting to teach fundamental approaches to physical examination, including, but not limited to, the very first skill of careful and accurate inspection. Art museums allow participants to explore one's observational style, articulate these observations and build meaning collaboratively among a group of learners. Key prompting questions (based on the Visual Thinking Strategies methodology) shared by art and medicine are: "What's going on with this picture/patient?" and "What do you see that makes you conclude that?" A third, valuable follow-up question is: "What else can you find?" recognizing the nearly infinite possibilities in both fields. Recently, we have expanded these methods from medical students (early learners) to dermatology residents (advanced learners) with excellent results.

We also use the art museum as a site for improving multidisciplinary teamwork – a skill that is woefully lacking in too many care settings. On selected general medicine inpatient teams, we provide coverage so that the whole team – students, trainees, attending physicians, nurses, physical therapists, social workers, care coordinators, ward clerks, etc. – can participate in an "Evening at the Museum." The event begins with a light dinner and wine and is followed by a series of carefully crafted arts-based exercises in the Museum of Fine Art, Boston galleries, which explore communication, collaboration and hierarchy. The exercises are fun, flexible and accessible to all team members, regardless of one's prior arts experience. The exercises progress from straight-forward to complex, in which teams are asked to build meaning about a seemingly impenetrable piece of abstract art for the last exercise. Finally, the participants share their thoughts on the evening from the perspective of a team member, and leaders reflect on the teamwork style (strengths and challenges) of the group. At the very least, everyone knows each other's names and something about their lives by the end of the evening. Almost every group appreciates improved levels of respect and efficiency (shared values and methods) that extend to rounds the next day and beyond.

We have a required curriculum at the MFA, Boston for our often-beleaguered interns, which focuses on humanism, empathy, professional balance and career sustenance. In this curriculum, all interns come to the art museum in small groups and participate in a series of exercises that require them to reflect on the extraordinary demands of medical care and the reasons that they each chose to go into the field of medicine. One exercise, often surrounding the MFA's beautiful Etruscan sarcophagus, focuses on difficult conversations about death and dying. The evening's final exercise is a guided meditation held in the calming shadows of the beautiful Buddhist temple display.

Medical educators do not need to be artists or arts experts to take full advantage of these methods. All participants can start with what they know; no one needs to be an expert. Furthermore, in my experience, art museum education departments are eager to partner with teachers from a wide range of fields and offer outstanding curricular guidance and partnerships, which are at the root of all of our programs.

Teaching medical skills in an art museum is an uncommon activity that falls within the broader and growing field of medical humanities, which includes the use of poetry, literature, theater, music and other humanities to address some of the most challenging aspects of health care provider competence. These tangential methods allow the participants to escape the paralysis of ingrained habits, biases and high expectations by approaching truths on what noted educator Parker Palmer calls "the slant." The value of art as an educational prompt is that...

"Works of art [can be] 'third things' because they ... have voices of their own, voices that tell the truth about a topic but, in the manner of metaphors, tell it on the slant. Mediated by a third thing, truth can emerge from, and return to, our awareness at whatever pace and depth we are able to handle."

– From *A Hidden Wholeness: The Journey Toward an Undivided Life*, 2004

Broader still are the opportunities to use the arts to engage patients of all ages in their own health care and health promotion. Our programs would not be possible without the valuable feedback of our students and the generous support of Mrs. Estrellita Karsh, who was an inspirational early adaptor of the value of transdisciplinary approaches to education. Dr. Shahram Khoshbin is a gifted neurologist, artist, teacher and dear friend, whose partnership and kindness have greatly contributed to my own professional sustenance. More details on our work and collaborators can be found at: Katz JT, Khoshbin S. "Can Visual arts training improve physician performance?" *Trans Am Clin Climatol Assoc*; 2014; 125:331-42. Finally, I am indebted to leadership of the St. Vincent Hospital's Department of Medicine for inviting me to share this work and my passion for art and medicine with them at medical grand rounds.

Dr. Katz is the Marshall A. Wolf Chair of Medical Education at the Brigham and Women's Hospital, where he is program director of the internal medicine residency and vice chairman for Education of the Department of Medicine. He is an associate professor of medicine at Harvard Medical School.

The Arts, Humanities, and Medicine: What has one got to do with the other?

David Hatem, M.D.



David Hatem, M.D.

As I began to write this piece, I thought that it would be easy. My involvement in initiatives in humanities in medicine has been generous and generative. I have had the privilege to teach an undergraduate college course, Medicine and Literature: The Human Experience, for nearly a decade at Boston College, a generous request from Joseph Alpert, M.D. I have partnered with Emily Ferrara, MS, to teach reflective writing to numerous medical students at our University of Massachusetts Medical School and bring

a Massachusetts Humanities Council course, Literature and Medicine: Humanities at the Heart of Healthcare, to the medical center, collaborating with visiting scholars from both Worcester Polytechnic Institute and, later, The College of the Holy Cross. I have been co-chairing the Humanities in Medicine Committee of the UMass Medical School Library with Peter Schneider, M.D., and have been the beneficiary of the extraordinary generosity of Brownie Wheeler's invitation to take on this role after his departure. I have benefited from the steady contributions of Ellen More, Joyce Cariglia, Emily Ferrara, Elaine Martin, Hugh Silk, Terry Reed, numerous students and the expert aid of Nancy Linnehan and Kristine Sjosted.

So, what is there to say about the benefits of the arts and humanities on medical education? Early work focused on the great books or great works of art where medicine was a focus and led to the publication of an extensive bibliography in book form by Banks and Pollard,¹ and later, Aull has maintained an extensive Literature, Arts, and Medicine database housed as part of New York University's website.² Many of these works looked at the role of medicine and medical care in society and the portrayal of "the good doctor."³⁻⁶ Any person interested can search this extensive bibliography of art, literature and the performing arts. More recently, physician authors (Sherwin Nuland, Jerome Groopman, Rafael Campo, Atul Gawande and Rita Charon, to name just a few) have demonstrated the extent of peoples' interest in reading about medicine as subject. Art has

often had medicine as its subject. Sir Luke Fildes' famous image of *The Doctor* portrays a doctor sitting at the bedside of a dying child at home in an age when efforts to care were common, given more limited tools to cure. Many point to this as something that is lost in medicine today in an era where technology has emerged as a significant part of care, referred to as "high-tech and low touch."⁷

What does reading a novel or poetry or looking at a painting have to do with being a doctor or helping one to become a good doctor? This has been a vexing question for medical humanities scholars. T.S. Eliot once said, "We read many books because we cannot know enough people." The implication of this is that reading and exposing yourself to multiple viewpoints that extend beyond what you have been exposed to might be a foundation for understanding a patient's viewpoint or even teach you empathy. Reading Raymond Carver's *What the Doctor Said*⁸ allows us to experience a first-hand account of hearing bad news, and this account illustrates well that patients often do not hear what physicians say after the news is delivered. Similarly, reading Mark Haddon's *The Curious Incident of the Dog in the Night-Time* allows a reader to experience the disappearance of a dog and the divorce of Christopher Boone's parents as a detective story written from the perspective of a person with Asperger's Syndrome. Trying to make sense of the emotional impact of the events through Christopher's more objective methods of observation and logic gives the reader an extraordinary portrait of the experience of Asperger's Syndrome. Yet, it is not certain that these well-written, clear and beautiful accounts lead to any change when physicians are with patients.

Yet the humanities are not without demonstrated benefits. Recently, there have been efforts to tie the art of observation in the art museum to physical exam skills, and the course in formal art observation improved numbers and sophistication of observations using both artistic and clinical imagery for an intervention group when compared to controls.¹⁰ There are some interesting benefits that have been demonstrated by reflective writing exercises. The extensive work of Pennebaker and his colleagues demonstrates multiple physical and psychological benefits among varied populations dealing with significant transitions or stress.¹¹⁻¹⁵ Writing about prior trauma was shown to boost immune response to Hepatitis B vaccinations among a sub-group of New Zealand medical students.¹⁶ A relatively recent report demonstrated clinical improvement in lung function (increased FEV1) in patients with asthma and a reduction in

disease activity (measured by disease severity score) in patients with rheumatoid arthritis who wrote about stressful experiences when compared to matched controls who wrote about neutral topics.¹⁷

The skill of reflection (and the humanities are one way to stimulate reflection) has been shown to be foundational for clinical learning,¹⁸ is a way to understand multiple perspectives and is a metacognitive skill essential to patient communication and clinical problem-solving.¹⁹ Interest in hearing the patient's story offers an opportunity to bridge cultures, allay patient fears and concerns, hear patient explanatory models, share uncertainty and aid in adaptation to chronic illness.²⁰ While we await further outcome studies, we hope that this issue of *Worcester Medicine* engages your interest and your imagination.

David Hatem, M.D., is professor of medicine, a doctor of general medicine and primary care and co-director of Learning Communities at University of Massachusetts Medical School.

References:

1. Banks JT, Pollard C. *Literature and Medicine: An Annotated Bibliography*. Univ of Pittsburgh Pr. 1982
2. NYU Literature, Arts, and Medicine Database. <http://medhum.med.nyu.edu> accessed 2/22/15
3. Camus A. *The Plague*. Harmondsworth. Penguin; 1970.
4. Chekhov A. *A Doctor's Visit: Short Stories*. New York. Bantam Classics; 1988
5. Eliot G. *Middlemarch*. London. Penguin Books; 1994.
6. Mann T. *The Magic Mountain*. New York. Random House; 1969.
7. Verghese A. "Culture Shock – A Patient as Icon, Icon as Patient." *N Engl J Med* 2008; 359:2748-2751.
8. Carver R. "What the Doctor Said" in *A New Path to the Waterfall*. New York. Atlantic Monthly; 1989.
9. Haddon M. *The Curious Incident of the Dog in the Night-Time*. New York. Random House; 2003
10. Naghshineh S, Hafler JP, Miller AR, et al. "Formal art observation training improves medical students' visual diagnostic skills." *J Gen Intern Med* 2008; 23:991-7.
11. Pennebaker JW. "Telling stories: the health benefits of narrative." *Lit Med* 2000;19:3-18.
12. Pennebaker JW. "Opening up: the healing power of expressing emotions." New York: Guilford Press; 1997.
13. Spera SP, Buhrfeind ED, Pennebaker JW. "Expressive writing and coping with job loss." *Acad Manage J* 1994; 37:722-33.
14. Richards JM, Beal WE, Seagal JD, Pennebaker JW. "Effects of disclosure of traumatic events on illness behavior among psychiatric prison inmates." *J Abnormal Psychol* 2000; 109:156-60.
15. Rime B. "Mental rumination, social sharing, and the recovery from emotional exposure." In: Pennebaker JW, editor. *Emotion, disclosure, and health*. Washington, DC: American Psychological Association; 1995.
16. Keith J, Petrie KJ. "Disclosure of trauma and immune response to hepatitis B vaccination program." *J Consulting Clin Psychol* 1995; 63:187-92.
17. Smyth JM, Stone AA, Hurewitz A, Kaell A. "Effects of writing about stressful experiences on symptom reduction in patients with asthma or rheumatoid arthritis." *JAMA* 1999; 281:1304-9.
18. Greenberg L, Blatt B. "Perspective: successfully negotiating the clerkship years of medical school: a guide for medical students, implications for residents and faculty." *Acad Med*. 2010; 85:706-9.
19. Quirk M. *Intuition and Metacognition in Medical Education*. New York. Springer; 2006.
20. Kleinman A. *The Illness Narratives*. New York: Basic Books; 1988.



Dr. Robert J. Silkman, 93, of East Dennis, Mass., died on Jan. 24, 2015, at the Cape Cod Hospital. The family is planning a memorial service to be held in early summer. More information is available from his son, Jeffrey Silkman at jsilk1212@gmail.com.

Dr. Silkman's obituary can be found at <http://www.capecodtimes.com/article/20150201/OBITUARIES/150209977/101031>.

Reflective Writing in Family Medicine

Hugh Silk, M.D., MPH, FAAFP and Joanne Dannehoff, PGY 2



Hugh Silk, M.D., MPH, FAAFP **Joanne Dannehoff, PGY 2**

Eight years ago, the UMass Department of Family Medicine and Community Health created a forum for reflective writing to celebrate our daily clinical and teaching successes. For decades, our department was emailed a memo of academic accomplishments every Monday – grants, publications, presentations, etc. This was very impressive; however, some of us thought we should also celebrate our accomplishments of patient care! So we created the Thursday Morning Memo (TMM), which is sent out every Thursday to more than 400 department members, including residents, faculty, alumni, community doctors, administrative staff, medical students and others.

We recently evaluated the TMM through a survey done by a UMMS medical student (Meghan Veno, MS2, funded by AHEC and HRSA). Results include that more than 80 percent of readers of the TMM agree or strongly agree that reading the weekly story improves empathy and patient-centeredness. Three-quarters of readers found that the TMM helped them feel more connected to colleagues. Writers also found additional benefits, including having better perspective about a patient experience, through the reflective writing process.

The writing comes in the form of poems, stories, 55-word essays and even haiku! Below is a poem written by Joanne Dannenhoffer, a PGY2 in the UMass Family Medicine Residency Program.

Her poem speaks volumes about caring with and for patients in moments of need. For context, Dannenhoffer wrote, “This is a short poem I wrote as a reflection on a moment I shared with a patient not too long ago, as I had to tell her that her breast mass biopsy had revealed breast cancer.”

Motion In Stillness

Her eyes intent on mine are rimmed with tears
I meet her gaze, wondering if my own fear shines through.

Breath

My words hang heavy in the air
And in the silence of my office I can hear the tiny crack in her world.

Breath

I lay my hand on hers, and she squeezes my fingers gently
The clock ticks loud in the silence.

Breath

In the silence, in the stillness, we two sit
My heart open and pouring out
Her whole world tips upside down.

Breath

The world clicks back into place and time moves again.
Laughter in the hall, her phone buzzes
And the stillness is broken
But the motion persists

And still we breathed.

Hugh Silk, M.D., MPH, FAAFP, is an associate clinical professor at UMass Medical School and part of Reliant Medical Group and the Massachusetts Partnership for Correctional Health. Joanne Dannenhoffer, PGY 2, is part of Barre Family Health Center and is completing a UMass family medicine residency.

Music Therapy: Answering *Why* Rather Than *What*

Cara Brindisi, MT-BC



Cara Brindisi, MT-BC

What is music therapy? This question is posed to me almost every day as a board certified music therapist working in Central Massachusetts. Some days, I find myself gently describing my role to a doubtful, but curious, caregiver of a hospice patient. Other days, I am advocating for the field to a doctor in an elevator of UMass Medical Center. Over time, I have found that I have changed my response from *what* is music therapy to *why* is music therapy important? *Why* is music therapy relevant as an interdisciplinary role on

the hospice team to support patient satisfaction? *Why* is music therapy beneficial for pre- and post-operative pediatric patients and can assist in reduction of medication?¹ *Why* is music therapy essential in the overall progress of humanities in medicine?

To better understand these questions, it is helpful to recognize the ways in which music serves as an intrinsic connection, association and reality to the human experience. We can feel the value of music during aerobic exercise as our increasing heartbeat synchronizes with the rhythmic stimulation from our headphones. We can observe the sedative qualities in a soft, melodic lullaby as it evokes the relaxation response in an infant. Millions find joy in the countless YouTube videos that reveal a child's natural reaction to music or the extraordinary memory recall in a patient with Alzheimer's disease.

Based on the most current research of how music is processed in the brain, we can further explore these physiological responses, whether identifying "the chills response" as an effect of our autonomic nervous system to music² or affirming, through the use of functional magnetic resonance imaging (fMRI),³ the "biological relevance of music" in our innate neuroanatomy.

Even with this widely accepted concept of the nature of music, the question can still remain: *Why* music therapy?

Quantitative and evidence-based research is commonly met with

qualitative and anecdotal accounts of patient/client satisfaction. The dynamic nature of music therapy is dependent upon the needs of the person(s) within the therapeutic relationship. Board-certified music therapists continue to saturate a multitude of interdisciplinary settings, including, but not limited to, prenatal care, Neonatal Intensive Care Unit (NICU), Early Intervention, schools, hospitals, substance abuse programs, psychiatric settings, nursing homes and hospice organizations. Each person within these varying populations requires customized music dependent upon assessment of physiological, psychological and spiritual needs. In other words, one song does not fit all.

As expressed by Kenneth E. Bruscia in his publication, *Defining Music Therapy*, a music therapist must be transdisciplinary in order to appropriately, safely and successfully respond to the unforeseen associations a person may have with music. Music therapy is "at once an art, a science and an interpersonal process."⁴

In helping illustrate this transdisciplinary nature, I reflect on a case in which music triggered an adverse reaction for a woman in hospice care. A significant goal within the setting of hospice music therapy is to facilitate life legacy and celebration through song review. In facilitating this process, the patient initially suggested music she once enjoyed from the 1960s, music she admittedly had not listened to in years. As I led with a song by Peter, Paul and Mary, the patient was overcome with emotions of high-intensity. I continued to provide guitar music by shifting the audible sounds into an ambiguous series of notes so that the music was present and safe but not associable. Together, we explored her overwhelming regrets as a young mother during this time period. The music did not serve as a positive experience, but one of complexity and pain. All subsequent sessions were filled with almost complete improvisatory music-making, allowing for the creation of new associations through original songwriting. The songwriting concurrently served as an expressive life legacy-leaving tool for her family. As I shared these experiences and developments within the protection of the hospice care team, the other disciplines were able to better understand the patient as a whole person nearing the end of her life.

The inpatient pediatric department setting calls for a less predictable approach to using music therapy techniques. This is due to multiple factors, such as the nature of rapid patient turnaround, varying procedures and the delicacy of childhood development between age groups. While simultaneously creating safety and trust through music to promote overall patient and family satisfaction, music therapy serves as a beneficial tool in redirecting pain and anxiety awareness, thus leading to a decrease in difficulty during procedures⁵ and a potential decrease in medication pre- and post-procedure. Even the least invasive procedures prove to be an effective time for redirective music therapy techniques.

I recall a session with a timid 18-month-old who displayed distress and anxiety upon initial introduction. After approximately 15 minutes of developing rapport through music, a certified nursing assistant (CNA) entered the room to measure his vitals. At first, his expression was fearful, but with the use of intentional redirective music and instrument playing, the CNA successfully completed her necessary task. The young child was so physically and cognitively engrossed in the therapeutic process that it appeared he was almost completely unaware of the CNA's presence. The CNA later expressed appreciation for the use of music therapy and made note of the efficiency in reaching her goals.

As the medical field continues to place relevance on the humanities of medicine, it is advantageous to include the use of music therapy as an allied profession within the interdisciplinary context. Though research provides current substantiation for the physiological effects of music, it is more often than not the personal testimonies of patients, families and fellow professionals that speak to the significance of music therapy. It can be heard in the

expressions of a long-term pediatric patient emoting newfound autonomy and strength on a drum. It can be seen in the teary smile of a wife as her husband with dementia sings "Let Me Call You Sweetheart" for the last time. It can be felt as the culture of care shifts with the evolving interdisciplinary paradigm. In asking *what* music therapy is, one needs to illustrate *why* music therapy?

Cara Brindisi, MT-BC, is a board-certified music therapist at the VNA Care Network & Hospice, the Pediatric Department at UMass Medical Center, and provides private one-on-one and group music therapy in a private practice setting.

References:

1. Walworth, D. D. (2005). Procedural-support music therapy in the healthcare setting: A cost-effectiveness analysis. *Journal of Pediatric Nursing*, 20(4), 276-284.
- 2.
3. Blood, A. J., & Zatorre, R. J. (2001). Intensely pleasurable responses to music correlate with activity in brain regions implicated in reward and emotion. *Proceedings of the National Academy of Sciences*, 98(20), 11818-11823.
- 4.
5. Koelsch, S., Fritz, T., Schulze, K., Alsop, D., & Schlaug, G. (2005). Adults and children processing music: an fMRI study. *Neuroimage*, 25(4), 1068-1076.
- 6.
7. Bruscia, K. E. (1998). *Defining Music Therapy* (2nd ed.). Gilsum, NH: Barcelona Publishers.
- 8.
- 9.
10. Nguyen, T. N., Nilsson, S., Hellström, A. L., & Bengtson, A. (2010). Music therapy to reduce pain and anxiety in children with cancer undergoing lumbar puncture: a randomized clinical trial. *Journal of Pediatric Oncology Nursing*, 27(3), 146-155. doi:10.1177/1043454209355983.

akwaaba medical director needed

Akwaaba Health Initiative, a free clinic that seeks to enhance access to health care and improve health outcomes for vulnerable populations in the city of Worcester, is in search of a volunteer medical director for its weekly clinic. The medical director will be licensed to practice medicine in the Commonwealth of Massachusetts and will have full and sole authority to make medical decisions, direct medical care and supervise other doctors, nurses, nursing assistants, medical technical personnel and all others providing medical services to the corporation's patients and clientele.

The position involves a commitment of 2.5-4 hours per week, typically on Thursday nights from 6:00-8:30 p.m., and other duties as needed.

For additional information, please contact Akwaaba.Health@gmail.com.

Art for Healing: Inspiration in the Therapy Room

Anne Kane, RN, Ph.D.



Anne Kane, RN, Ph.D

A friend whose elderly mother had been admitted to a rehabilitation hospital told an inspiring story about her care. His mother – let's call her Michelle – had fallen and suffered a debilitating fracture. The fracture was such that it could not be set. It would heal slowly, somewhat painfully, as she learned how to stay mobile through the healing process. Michelle's care in the rehabilitation hospital was designed to reduce her pain while increasing her mobility. But she could not grasp that because her other conditions,

including dementia and anxiety, affected her cognition. In the hospital, Michelle had some episodes of intense fear and confusion that caused her to resist the skilled care she was there to receive. Engaging Michelle in physical and occupational therapy required particular skill. With admiration and appreciation, my friend told of the afternoon a therapist artfully met his mother where healing could begin.

They were in the therapy room, a large space with low padded benches, colorful exercise balls, a kitchen and other equipment physical and occupational therapists use to help people reclaim their normal function after debilitating illness or injury. Although the therapy room is a place where people can practice the things they routinely do at home and work, it doesn't look like home. This was Michelle's first time in a therapy room, a strange environment to her. A family member was with her because the staff had asked him to accompany Michelle this first time to ease her anxiety and help her transition to therapy.

Michelle was always a petite woman. She had raised a family and kept the books for a successful business. In her wheelchair in the therapy room, she was very frail, a bent wisp of person, unsure of what was happening.

The therapist introduced Michelle to the idea of therapy sessions by asking about an ordinary day at home: What did Michelle typically do? Therapy might then reasonably begin with teaching Michelle how to accomplish daily tasks, such as dressing, bathing or using a walker, with minimal pain. Michelle was unsure of how to answer, and her son answered for her: "She plays the piano." Setting aside more typical functional activities for the moment, the therapist worked with that answer, and her response transformed the situation.

Somehow – I can't imagine how – a piano was found, and the therapist positioned Michelle in front of the keyboard. Without the sheet music she used at home to dabble in show tunes, Michelle began to play and to sing softly. Hearing the piano, other people stopped what they were doing and gathered around. Some sang along. When the song was over, Michelle was more herself and more at home than she'd been in days. She was no longer afraid of the therapy that would eventually enable her to return home again.

As stories go, this is a small one that only hints at the big place we know art has in healing. It's not a story about "music therapy" the way music therapists use carefully selected musical experiences, often at precise times, to soothe or stimulate patients. For me, it's a story about how what we call art (in this case, music played by a little old lady in a wheelchair) has the power for transcendence. Art calls us beyond our limits to teach us more about who we are and about our world.

In that spontaneous musical moment, and not only for that moment, Michelle and her family learned she could rise above disability and disorientation to play show tunes still and she could play from memory, though she was having trouble recalling people's names. She could be herself in a strange environment. She could use music to relate to others when holding a conversation seemed beyond her. Through this somewhat pedestrian art form, when words failed her, she could help her therapist know her.

I like to think it was a transcendent experience for the therapist, too. The therapist extended herself to find a keyboard *in a hospital* to find a way to get to know and heal Michelle. She couldn't have known what would unfold, but she must have hoped for something more than what she could see, something good. She must have hoped that giving Michelle the opportunity to make music would create the opportunity for them to work together toward healing. Therapy began that day.

This is more than a little story about an old woman's introduction to rehabilitation therapy at the hands of a skilled therapist or about people standing around a pianist at play. It's about something we humans already know but can never fully appreciate: Art is in play in healing. My friend's family inspires me to look for it, even when it's least expected.

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UMMS Family Medicine

Worcester Art Museum/Medical Humanities Curriculum

Sherrilyn M. Sethi, D.MH

The longitudinal medical humanities experience in the University of Massachusetts Worcester Family Medicine Residency is provided through a diverse curriculum at the each of the three health centers (Hahnemann Family Health Center, Barre Family Health Center and the Family Health Center Worcester) and the central residency located at Memorial Hospital. As an interdisciplinary field, the medical humanities curriculum is designed to integrate compassion (compassionate care), humanism (humanistic interaction), empathy (empathic conduct), professionalism and effective communication through the use of reflective writing, narrative medicine and the arts in residency education. In collaboration with the longitudinal behavioral science curriculum, it is also designed to encourage physician wellness, mindfulness and

strategies to foster a healthy, work-life balance. Led by multi-disciplinary faculty and educators at each health center and the central residency, the medical humanities curriculum is implemented across a series of diverse settings (such as the Worcester Art Museum and the Boston Museum of Fine Arts) and through a variety of different modalities (such as Balint sessions and didactic workshops).

To learn more about the medical humanities experience in the University of Massachusetts Worcester Family Medicine Residency at the University of Massachusetts Medical School, please contact Sherrilyn Sethi, D.MH, assistant residency director at Sherrilyn.Sethi@UMassMemorial.org.

Past the Pink Horse

Martha Duffy, M.D.



Martha Duffy, M.D.

I had no idea what to expect; I only knew I was excited. In a small group, we wound our way up the stairs, past a life-sized, bright-pink horse and knight, past strollers, past running 5-year-olds and past grandmothers on their canes. We arrived at a large smattering of paint on canvas. We were invited to view it from all angles, to get up close (not too close!) and admire it from afar. We did this silently, observing our patient. When I found myself wondering, "What is this artist trying to say to me?"

I actively shut down that part of my brain. No, I told myself. This is an exercise for my creative brain.

There was no right answer to that painting. The artist made it for herself and invited others to experience something in themselves by viewing it. So often in medicine, this is not the case. There is

a right answer. There *is* a protocol for that. There *is* a process for how to do this.

The museum trip was a breath of fresh air for the part of me that used to be. For the part of me that used to voraciously read English literature and pick out my own meanings from it. To look at something and decide what I wanted to do with it. It was also a reminder that there are occasionally times in medicine when there is not a single right answer. When there is an opportunity to step back and say, "Well, there are a few things we could do. We could approach this from here, or here, or even this way. ..." There is more than one way to answer this question. I had forgotten that. I was so focused on starting residency and getting the right answer, not making any mistakes and doing the right thing for my patient that I had actually removed the patient entirely from the equation. The trip reignited that creative, human part of me and warned me to not get stuck in processed, pre-packaged thinking. There is always room for discussion.

Martha Duffy, M.D., is a first-year resident of family medicine and community health at University of Massachusetts Medical School, Worcester. She can be reached at Martha.Duffy@umassmemorial.org.

The Storm

Mary G. Cooper, M.D.



Mary G. Cooper, M.D.

Gold, blue, green, purple – chaos. A ship rising from splotches of bold color; the hint of a serpent from the depths of a turbulent sea. Yet, there is a determined brightness: a frame providing direction, a window on a moment, a perspective. We are outsiders looking in. Or a person observing a former self – an alternate state of mind. Harsh fabric textures, barely hidden beneath the choppy, thick application of paint – the turmoil made patent, palpable. A gold, square legend to guide the way – an escape? Or just the wisdom that with time comes transition, healing, a new way of looking at the world? Or the self and the chaos that therein resides?

Such are my memories and impressions of the painting “Dark Release” by Joan Snyder at the Worcester Art Museum, which I visited with my fellow family medicine residents. This provocative piece kept us guessing and discussing its possible meanings and its relevance to our practice as physicians. The abstract nature of the piece makes it broadly interpretable. We discussed conceptions of artistic intention that could be applied. There were no wrong answers in this safe space of reflection, a place imbued with so much humanity – humanity presented differently than in our offices every day, yet so very similar at its core.

I interpret this piece as a powerful expression of suffering, which nearly radiates from the paint. I see patients living the realities of difficult lives every day, and all have different ways of presenting it and experiencing it. There are times of acute change in life due to illness or circumstance, unexpected difficulties that can be hard to manage. What can we give our patients at these times of crisis, uncertainty or turmoil like the one in the painting? Often, we providers can feel overwhelmed and helpless ourselves when such patients bring their storms through the door.

Around this image are a shining gold frame and a rectangle in the top right corner. Per the artist, they are allusions to the hope that helped her through a difficult time in her life. I see them as a way to provide perspective on the suffering when those within the storm cannot. It reminds me that there are some days, some crises, in which we providers need to be that steady presence. When there is little else we can provide, this perspective can be the most powerful therapeutic tool. The role of quiet listener, rather than problem-solver, gives us the opportunity to be a reflective frame like the one in the painting, which can help our patients see their own strengths in the storm. Family medicine is about forming relationships, being with people at important, formative moments in their lives – even the ones they’d rather forget. It is a privilege to be there in the storm, to be a guide. Just as importantly, it lets our patients know they are not alone ... and that this, too, shall pass.

Mary G. Cooper, M.D., is chief resident at Hahnemann Family Health Center in the University of Massachusetts Medical School Worcester Family Medicine Residency Program. Her academic interests include the medical humanities, and she has undergraduate training in art history and a master’s degree in bioethics.

Facts Matter

Frederic Baker, M.D.

The recent increase in measles cases has sparked a spirited dialogue regarding the importance of public health policies, particularly the merits of universal vaccination and the dangers of misinformed celebrity proclamations on health matters.

According to a Pew Research Survey, the vast majority of Americans across the political spectrum agree with scientists on the merits of mandatory childhood immunizations. In 2000, there were no cases of measles were diagnosed in the country. As of Feb 20, 2015, the *Los Angeles Times* noted the number of measles cases in the U.S. in the first two months of this year is at least 149 patients, with 123 cases in California, felt to have started in Disneyland. The irony of it all is that measles was declared eliminated in the U.S. in 2000. Many have observed that the rise in measles cases parallels the rising trend of people who choose to decline vaccination. The reasons for not vaccinating are varied and include religious objections, overreliance on “herd immunity,” lack of access for some, unjustified fears, misinformation and/or a distrust of government.

However, as many experts and pundits have noted, the merits of vaccination programs remain irrefutable. The Centers for Disease Control notes public health policies are credited with adding 25 years to the life expectancy of people in the United States from 1900-99. The impact of vaccines is cited as one of the 10 greatest public health achievements in the 20th century. Per *The Economist*, among children born between 1994-2013, vaccinations prevented 730,000 deaths and netted societal savings of \$1.38 trillion.

The World Health Organization notes the following: Measles is one of two of the most contagious illnesses; one or two in every 1,000 infected by the disease will die; without the vaccine there is 90 percent chance of being infected if exposed to measles; one sick person will infect 12-18 other people; and it is estimated that to establish protection from herd immunity (the concept that vaccinating the individual also protects a community), measles immunization rates must reach 92 percent to 95 percent. The CDC notes 92 percent of measles cases in 2013 were in unvaccinated people. The World Bank noted that from 2010-13, countries like Belize, Greece, China, Brazil and Cuba had 99 percent measles immunization rates for kids between 12 months-23 months compared to the U.S. rate of 91 percent.

The economic and societal costs of not immunizing are equally staggering. *The Journal of Infectious Diseases* noted that in 2008, an infected Swiss traveler visited a hospital in Tucson, Ariz., and initiated a predominantly health care-associated measles outbreak involving 14 cases at a cost of \$799,136, which was incurred by two hospitals and spent on responding to and containing cases in these

facilities. It costs approximately \$1 to immunize a child against measles. A series of two vaccines confers 97 percent effectiveness in immunity. With communities and municipalities struggling to increase revenue, reduce health care costs and provide for other resources such as education, infrastructure and security, can anyone justify what some would argue as a hidden and astronomical tax in the form of not vaccinating?

From 1989–91, a resurgence of measles in the United States resulted in 55,622 reported cases, with approximately 11,000 reported hospitalizations and 123 reported deaths that disproportionately affected inner city and racial/ethnic minority children, who were at 3 to 16 times greater risk for measles than were non-Hispanic white children. In response, the United States created the Vaccines for Children (VFC) program in 1994, with the strategic goal of reducing disparities by eliminating the cost of vaccines as a barrier to vaccination, whereby the CDC purchases vaccines at a discount and distributes them at no charge to private physicians’ offices and public health clinics registered as providers for VFC.

Many societies have come to embrace the many merits of vaccination over the risks. Consider the ambitious goals of the Bill and Melinda Gates Foundation, which has chosen to invest heavily in global vaccination, citing, “Nearly 200 countries around the globe have endorsed a shared vision – known as the Decade of Vaccines – to equitably extend the benefits of vaccines to every person by 2020 and thereby save more than 20 million lives through the Global Vaccine Action Plan (GVAP).”

What about arguments citing mandatory vaccination as infringing upon personal choice and freedoms? In 1905, a legal precedent was established by *Jacobson v. Massachusetts*, in which the Supreme Court upheld state rights to enforce compulsory vaccination laws. The court argued that personal liberties could be suspended given external circumstances, noting that a community has the right to protect itself, both from disease and from military invasion. The acceptance of the concept that personal freedoms are not absolute and may be restricted for the societal good or public safety is also evident in laws mandating that physicians report patients with tuberculosis, gunshot wounds or suspected child abuse to appropriate authorities without fear of sanctions. People who opt not to have vaccinations may mistakenly claim they are making a personal choice that has no impact on others. The reality is that these individuals do not live in silos and ultimately interact with society, whether it is Disneyland, a doctor’s office, maternity ward or school. Populations especially vulnerable to measles complications who cannot get vaccinated, such as pregnant women, young children and immunosuppressed individuals, now face substantial life and

Continued on page 25

Coordinated Care Versus Market Power

Peter J. Martin, Esq.



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A recurring theme of health care reform is the need to move away from uncoordinated, fee-for-service, siloed care toward integrated, population health-focused care paid for on the basis of quality outcomes. For example, the Affordable Care Act specifically fosters the development of Accountable Care Organizations to coordinate care among a variety of providers and suppliers and, if quality and cost benchmarks are met, become eligible for additional payments under the Medicare Shared Savings Program. In order to deliver that transformed

health care, providers have naturally formed collaborations, affiliations and mergers that enable the delivery of seamless care across the continuum of caregivers, empowered by quality and utilization data that is obtained from a variety of providers, all part of a single system. One of the leaders in this effort has been Partners Health Care, which has engaged in a long series of acquisitions, innovative reimbursement arrangements and health information system innovations.

The stated purpose of these efforts has been to provide high-quality, cost-effective care in the most appropriate setting while positioning the entire system to take on risk and succeed in value-based purchasing arrangements. That may continue to be the ultimate purpose, but the actual effect, as demonstrated by the annual Cost Trend Reports issued by the Health Policy Commission, was that Partners dwarfed the competition, with twice the number of commercial insurance hospital discharges than the next four largest systems combined. The HPC also found that this market power led to consistently higher prices charged by Partners' hospitals and physicians.

This market concentration has drawn regulatory attention since at least 2009, when the Massachusetts Attorney General's Office began investigating Partners for anti-competitive practices. That investigation led to a complaint alleging that Partners violated the state Consumer Protection Act by engaging in unfair methods of competition and seeking to bar Partners from acquiring Hallmark Health Corporation and the parent of South Shore Hospital. That complaint was accompanied by a proposed Consent Judgment that placed certain restrictions on these acquisitions. Recently, a

Superior Court judge rejected the Consent Judgment; this decision was followed shortly by Partners' announcement that it would no longer seek to acquire the South Shore Hospital system.

A review of the measures negotiated by the Attorney General's Office and Partners into the Consent Judgment, and of their rejection by the Superior Court judge, highlights the uneasy relationship between the imperatives of consolidation and coordination fostered by health care reform and the antitrust laws' mandate to protect competition. This tension remains unresolved by the Superior Court's opinion and will likely remain part of the health care provider landscape for years to come.

The judge in the case posed two questions: Does the Consent Judgment reasonably and adequately address the harm to competition alleged in the complaint, and is the Consent Judgment enforceable? The negative answer to both questions is founded upon the judge's unfavorable assessment of the so-called conduct remedies embodied in the Consent Judgment. In the judge's view, those remedies would keep in place Partners' pre-existing market dominance and would involve the court in a lengthy and complicated regulatory oversight process.

In general, conduct remedies, such as price caps and contracting restrictions, are not favored by antitrust regulators, who prefer structural remedies such as divestitures of companies that reduce the anti-competitive effects of corporate mergers. Partners' decision to forego the South Shore Hospital acquisition might be an attempt to proactively provide this sort of structural remedy to alleviate antitrust concerns so that it might continue to pursue the Hallmark acquisition. As a matter of substance, conduct remedies do not reverse market dominance but seek to limit the impact of that dominance. As a matter of procedure, since the target of conduct remedies has incentives to act like a single integrated firm, maintaining those remedies requires ongoing and potentially complex oversight.

The conduct remedies in the Consent Judgment are certainly complex. They involve two kinds of price caps, rules permitting insurers to contract with only some parts of the Partners network, a ban on contracting on behalf of unaffiliated physicians, and a cap on the growth of Partners' physician network. All of the remedies are time-limited. The judge emphasized the complexity of the price cap remedies: They are contained in a 23-page attachment to the Consent Judgment, with 12 additional pages of examples; the opinion states that, having studied these materials, "this Court will admit quite candidly that the methodology remains a mystery to me at this point." Moreover, whoever monitors the remedies will

Continued on page 25

2015 Annual Business Meeting

Wednesday, April 8, 2015 – Beechwood Hotel

2015 Community Clinician of the Year Award



Matilde Castiel, M.D.

Dr. Castiel, an associate professor in the departments of Internal Medicine, Family and Community Medicine, and Psychiatry at the University of Massachusetts Medical School in Worcester, Massachusetts, will be presented with the 2015 Community Clinician of the Year Award at the Annual Business Meeting on April 8.

The Community Clinician of the Year Award was adopted at the Interim House of Delegates meeting in November 1998. It was established to recognize a practitioner from each district medical society who has made significant contributions to patients and the community.

Guest Speaker



Carol Ann Small – “From Wired & Tired to Inspired”

Carol Ann Small, founder and CEO of Laughter with a Lesson, is a nationally recognized motivational humorist and stress and work/life balance expert who imparts wisdom with a twist of real-life humor. As a consultant for Wiley Workplace Learning Solutions, Carol Ann teaches organizations how to boost morale, reduce stress and create a happier and healthier work force. Her customized, humorous presentations have entertained and educated Fortune 500 companies, health care workers, educators and the general public for almost two decades. She has appeared on *Good Morning America*, at the Majestic Theatre and Panache’ NYC and been featured in *Health Magazine*. She shows her purpose of finding more joy in your life in her book *HUMOR US - the Power of Laughter*.

25 & 50 Year Members will be Honored

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health risks that are entirely preventable at costs and burdens that far exceed individual and community resources and budgets.

Vaccines, like most medical interventions, carry some degree of risks, but their relative safety and overwhelming benefit is well researched and established. Dr. Anthony Fauci, director of the National Institute of Allergy and Infectious Diseases, was quoted by CBS News as stating, “In fact, all the scientific data that we’ve collected over a long period of time from multiple organizations indicate that the measles vaccine is safe and all of these connections to things like autism and things like that are just not true.” A 2007 British study estimated the vaccine-attributable risk of serious neurologic disease after the first dose of MMR vaccine as 1 in 365,000 doses. The U.S. Congress acknowledged the risk of vaccination but also reaffirmed its strong bipartisan support for the sustainability of vaccinations when it enacted the National Vaccine Injury Compensation Program in the early ’80s. This federal program was created to protect vaccine manufacturers from liability through no-fault tort laws that compensate victims of alleged vaccine harm.

As the CDC noted, “Vaccines are one of the greatest achievements of biomedical science and public health. Despite remarkable progress, several challenges face the U.S. vaccine-delivery system. The infrastructure of the system must be capable of successfully implementing an increasingly complex vaccination schedule.” Discussion about public health policies should always stick to the facts. As many pundits noted, vaccine safety and efficacy merits no debate. Let’s not give a platform or a pass to those who choose to distort, dismiss, deny or withhold facts, lest we undermine the great progress we have made in public health. The old saying that people are entitled to their own opinions, but not their own facts, is even more relevant in healthcare policy. We all deserve better, and we are all in this together.

Frederic Baker, M.D., a Board Certified Attending Physician in Family Medicine, has a full-time outpatient practice in Holden, MA, providing comprehensive care from newborn to advanced elderly serving Central Massachusetts. He is also an Instructor in Family Medicine and Community Health, University of Massachusetts Medical School. Dr. Baker is President of the Worcester District Medical Society.

Peter J. Martin, Esq., continued from page 23

require the use of proprietary data provided by Partners, thus being placed “in the difficult position of playing the role or [sic] regulator in a highly complex field where the party with superior knowledge (Partners) is the very entity being regulated.”

The remedies are also, in the judge’s view, ineffective at remedying the harm to competition alleged in the complaint. For example, the price caps limit increases in unit prices to an inflation rate but do not address Partners’ already “supra competitive prices” or the effect of the proposed consolidations driving patients to higher-priced Partners providers. The limit on the growth of Partners’ physician system uses a baseline that would permit Partners to grow its community physician network by one-third over five years. Partners may seek to be relieved of any provision of the Consent Judgment if a statutory or regulatory change increases its costs by more than 0.5 percent of its commercial revenue. The proposed component

contracting restriction has no record of success because in the one antitrust settlement where it was used, no payer utilized it.


The Partners decision is not the only instance in which courts or regulators have tried to balance the benefits of coordinated care versus the dangers of market dominance. In Idaho, a hospital acquired a physician practice as part of its efforts to create an ACO. Last year, a federal court judge required the hospital to divest itself of the practice because the combination likely would result in higher health care costs through its dominant market position. In 2011, the Federal Trade Commission and the Department of Justice jointly issued a policy statement on antitrust policy as applied to ACOs. That policy statement established an antitrust “safety zone” that is measured (simplifying greatly) as 30 percent of the market for particular services provided by two or more ACO participants. ACOs that fall outside the “safety zone” are subject to certain conduct rules concerning practices such as patient steering and exclusive contracting. Thus, both structural and conduct remedies are being applied.

Health care providers can be forgiven if they are confused about the legal “rules of the road” as they head down the path of health reform. They may even be convinced that the contradictory legal mandates may doom or greatly inhibit the effectiveness of reform efforts. What they should not doubt is that they must proceed with caution.

Peter J. Martin, Esquire, is a partner in the Worcester office of Bowditch & Dewey, LLP, his practice concentrating on health care and nonprofit law.

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Watering Hole

Mimosa

Prosecco with OJ and a splash of Triple Sec 8

Kir Royale

Prosecco and Chambord 8

Orange Sunrise

Prosecco, Tito's vodka and OJ 9

Pink Grayhound

Tito's vodka with pink grapefruit juice and a splash of prosecco 9

Surf & Turf Bloody Mary

Old Bay rimmed bloody with homemade beef jerky and a jumbo grilled shrimp 14

Hot Tamales

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Smokin' Maria

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