

WORCESTER **medicine**

Volume 82 • Number 2

Published by Worcester District Medical Society

March/April 2018



CORRECTIONAL MEDICINE

Presorted Standard
US Postage
PAID
Worcester, MA
Permit No. 467

wdms.org

UMass Memorial Medical Center

DIVISION OF COLON AND RECTAL SURGERY

Providing exceptional minimally invasive surgical care for patients struggling with colon and rectal disease.



Our fellowship-trained, board-certified surgeons offer treatment and procedures supported by the latest clinical trials and research breakthroughs.

Offering minimally invasive treatment options for:

- Colon Cancer
- Rectal Cancer
- Ulcerative colitis
- Diverticulitis
- Hemorrhoids
- Crohn's Disease
- Rectal Prolapse
- Fissures
- Fistulas

Leading the Medical Community with taTME

taTME is a ground-breaking, minimally invasive surgical treatment for rectal cancer. Justin Maykel, MD, division chief, and his team have pioneered the procedure and now provide instruction and training to surgeons worldwide. As one of the few centers to offer taTME, we are leading the way to improved outcomes for patients. Learn more at www.umassmemorial.org/taTME



For more information, call Physician Referral Services Center at **1-800-431-5151** or visit www.umassmemorial.org/colorectal to learn more about the Division of Colon and Rectal Surgery.



UMassMemorial
Health Care



University of
Massachusetts
UMASS Medical School

CELEBRATE NATIONAL NURSES DAY



**SATURDAY
MAY 12
2:00PM**

EAT, DRINK AND PUB CRAWL DOWN SHREWSBURY STREET!

JOIN US TO CELEBRATE NATIONAL NURSES DAY WITH A PUB CRAWL FOR THE HEALTH CARE PROFESSIONALS OF WORCESTER. PARTICIPATION IS OPEN TO THE PUBLIC **(21+)**. EACH GROUP WILL VISIT AROUND 7 BARS.

TICKETS INCLUDE ONE BEER TICKET (VALID AT A SPECIFIED LOCATION),
SNACKS AT EACH LOCATION, AND CUSTOM EVENT SHIRT!
A PORTION OF EACH TICKET WILL BE DONATED TO A LOCAL CHARITY.

AFTERPARTY AT 4TH AND 1 SOCIAL CLUB
7 MUSKOGEE AVE, WORCESTER, MA

PULSE
A lifestyle & entertainment magazine www.thepulsemag.com

SHREWSBURYSTREETPUBCRAWL.COM

contents

Vol. 82, No. 2

on the cover: correctional medicine

- | | | | |
|-----------|--|-----------|---|
| 6 | Editorial
Jane Lochrie, MD | 13 | UMass Medical School Correctional Health Optional Elective
Colleen Flanagan, UMass Med '20,
Ivana De Lucia, UMass Med '21,
Keaton Cameron-Burr, UMass Med '21 |
| 8 | Mass Incarceration in the U.S.: An Epidemic and its Impact on Health
Warren Ferguson, MD | 14 | The Touch
Lisa Simon, DMD |
| 9 | Doin' My Time in Correctional Medicine
Patricia Ruze, MD, CCHP-P | 15 | As I See It: Substance Use Disorder in our Community
Matilde Castiel, MD, Commissioner of Health and Human Services |
| 10 | The Power of a Handshake
Hugh Silk, MD | 16 | As I See It: Jargon 101
Gerard Aurigemma, MD |
| 11 | Opening Doors
Luke Latario | 18 | Society Snippets: Annual Business Meeting |
| 12 | Patient or Prisoner: When Cultures Collide
Stephanie Rondeau, ACNP/CNP, CCRN | 19 | Society Snippets: 222nd Annual Oration |
| | | 20 | Society Snippets: Pre-Concert Reception |

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

UMass Memorial Health Care
Reliant Medical Group
The Louis Albert Cottle, MD Trust Fund

WORCESTER

medicine

Worcester Medicine is published by
the Worcester District Medical Society
321 Main Street, Worcester, MA 01608
e-mail: wdms@massmed.org
web: www.wdms.org
phone: (508) 753-1579

WDMS Officers

President: James Broadhurst, MD
Vice President: Sahdev Passey, MD
Secretary: Spiro Spanakis, DO
Treasurer: Robert Lebow, MD

Joyce Cariglia, Executive Director
Martha Wright, Assistant Director
Melissa Boucher,
Administrative Assistant

WDMS Editorial Board
Jane Lochrie, MD, Editor

Lisa Beittel, MBA
Anthony Esposito, MD
Michael Hirsh, MD
Anna Morin, PharmD
Nancy S. Morris, PhD, ANP
Thoru Pederson, PhD
Joel Popkin, MD
Robert Sorrenti, MD
Peter Zacharia, MD

Alex Newbury, Student Representative



**Production and advertising sales
by Pagio Inc.**

88 Winter Street, Worcester, MA 01604
(508) 756-5006
sales@pagioinc.com

Paul Giorgio, President
Donna Roberson, Editor
Vanessa Herbold, Art Director
Chris Reddy, Account Executives
Kati Nalbandian, Event Manager
David Simone, Vice President/Sales

Worcester Medicine does not hold itself responsible for statements made by any contributor. Statements or opinions expressed in Worcester Medicine reflect the views of the author(s) and not the official policy of the Worcester District Medical Society unless so stated. Although all advertising material is expected to conform to ethical standards, acceptance does not imply endorsement by Worcester Medicine unless stated. Material printed in Worcester Medicine is covered by copyright. No copyright is claimed to any work of the U.S. government. No part of this publication may be reproduced or transmitted in any form without written permission. For information on subscriptions, permissions, reprints and other services contact the Worcester District Medical Society.

Old World Charm, New World Cuisine

piccolo's
157 Shrewsbury Street
Worcester

GIFT CARDS AVAILABLE –
perfect for any occasion

Tuesday - Thursday 5-10 p.m. • Friday & Saturday 5-11 p.m.
157 Shrewsbury St., Worcester • (508) 754-1057 • Piccolos157.com

AUTHENTIC GREEK TAPAS • FULL BAR • DINE-IN • TAKE-OUT • CATERING

MEZE
GREEK TAPAS BAR & GRILLE

**SPRING TIME IS
GREEK TAPAS TIME!**

MEZEGREEKTAPAS.COM • 508-926-8115
156 SHREWSBURY STREET, WORCESTER, MA

Editorial

Jane Lochrie, MD



Jane Lochrie, MD

When I tell friends and family that I am leaving for Haiti next week, their reaction is invariably very positive. They know that I am passionate about caring for the underserved. I wonder if they would have the same reaction if I told them that I was going to work in a prison. Regrettably, incarcerated individuals do not engender the same compassion as other disadvantaged populations. The United States has the largest

prison population in the world, approximately one in 31 adults in the U.S. are under criminal justice supervision (prison, jail or parole). The U.S. prison population has quadrupled since 1980, partially as a result of mandatory sentencing that came about during the “War on Drugs.” This year, 700,000 prisoners are expected to be released from prison. If our justice system fails to rehabilitate, then our communities are locked in a cycle of crime and incarceration. The nation’s recidivism rate currently sees two out of three former prisoners rearrested.

In the first article, Dr. Warren Ferguson discusses his role in developing comprehensive health services for individuals incarcerated in Massachusetts. He describes some shocking statistics of the over-representation of minorities, especially those without a high school diploma. Once released from prison, things do not get any easier. The mortality is 12 times greater than that of the community in the first two weeks, and the relative risk of overdose is 128.

Dr. Patricia Ruze states that she believes that correctional medicine is the antidote to many of the problems facing physicians today and may actually prevent burnout. “This is primary care at its best,” she says. She works long hours but has the freedom to spend as much time as necessary with her patients. She feels privileged to care for the neediest population the state, and the ability to make a difference in their lives is worth the challenge.

Dr. Hugh Silk describes the power of a handshake and how it is evaluated differently in the correctional health system. This simple gesture shows respect and sets the tone for partnership and friendliness. It simply says, “I care, but don’t plan on taking advantage of that caring.”

The nursing perspective is provided by Stephanie Rondeau, ACP/CNP and CCRN. She explains how emotionally draining and difficult it is caring for these patients in the hospital. Impediments to care include the presence of the guards, obtaining consent for procedures, finding past medical records and determining who can legally obtain and provide medical information. Because of this, care is often delayed and may cause complications and impede recovery.

As always, the medical students have written very thoughtful articles. Luke Latario looks back three years when he was a first-year student and participated in the elective to introduce students to correctional medicine. He describes being able to understand the patient’s sense of vulnerability, even though he did not yet understand the medicine. He appreciated how the physician was able to offer comfort and dignity just by listening. This therapeutic relationship was able to transcend the societal barriers and, in itself, begin to alleviate the suffering.

In the next article, we have a fresh look at the same elective by three first-year students, Colleen Flanagan, Ivana De Lucia and Keaton Cameron-Burr. They point out that many providers may not realize that their patients have been justice-involved because of the stigma. They had the opportunity not just to attend lectures about correctional research and health care policies but also to teach justice-involved youth about health topics and where to receive non-judgmental care when they are released. They describe their faculty as “inspirational.”

In the final article, Lisa Simon, DMD, tells a poignant story about one of her patients who required a tooth extraction and, while she was working on him, asked her if she felt safe with him. She describes being transformed from being the caregiver to being the one who is cared for and how this made her feel.

As always, please do not close the cover on this issue until you have read *As I See It* and *Society Snippets*.

JOIN US IN CELEBRATING OUR 20TH ANNIVERSARY

ElderCare 2018

FREE EVENT
FOR SENIORS &
CAREGIVERS

OLDER
AMERICANS
MONTH



ENGAGE AT EVERY AGE: MAY 2018

Wednesday, May 16, 2017 • 9:30 a.m. - 1:30 p.m.

Leicester Country Club • 1430 Main Street, Leicester, MA



50 Exhibiting Companies • Informative Seminars
Live Entertainment • Giveaways & Raffles
Health Screenings & Information • Refreshments



Central Massachusetts
Agency on Aging, Inc.

www.SeniorConnection.org



For more information:

Central Massachusetts Agency on Aging, Inc. • (508) 852-5539 or VRamos@seniorconnection.org

Mass Incarceration in the U.S.: An Epidemic and its Impact on Health

Warren Ferguson, MD



Warren Ferguson, MD

In 2002, I was asked to help develop a proposal by UMass Medical School to provide comprehensive health services for individuals incarcerated in Massachusetts prisons. I knew nothing about prisons or the incarcerated population or about the provision of health care in such settings. The learning curve was steep; I was shocked by the facts, and ever since, my career has been transformed.

The United States incarcerates seven times more people than other developed Western countries and leads the world with an incarceration rate of 700/100,000.^{1,2}

Men, especially black and brown men, and people living in poverty are dramatically over-represented.^{3,4} One in three black men have a lifetime risk of incarceration, and black men without a high school diploma have a 70 percent chance of incarceration by age 40.⁵ Due to longer mandatory sentences, the population is becoming older, and the number of women is on the rise. Sadly, being a veteran carries independent risk for incarceration. But these statistics don't tell the whole story.

One in 34 Americans are under criminal justice supervision if you include probation and parole, and there are an astounding 10 million people cycling through jails, with 700,000 people released from prison annually. Recidivism rates hover at 75 percent after five years, thus implying that your sentence does not end when you finish your time. The hurdles facing those released are overwhelming. Individuals with felony convictions are often refused employment and are legally barred from public housing in many states. In states without Medicaid expansion, individuals are uninsured. Even with health insurance, access can be very challenging. I've become convinced that these social determinants of health intimate that criminal justice involvement is a leading cause of health disparities. The immediate two weeks post-release is particularly dangerous, with mortality risk 12 times that of the community, with relative risk of overdose death at 128.⁷

I have several formerly justice-involved persons in my panel of patients as a family physician at the Family Health Center of Worcester, where I've practiced for 29 years. Two are particularly special because they have beaten the recidivism odds despite these obstacles. I am inspired by these individuals because of their resilience.

I have known Joanne since she was a little girl, having been her family physician when she was a child. She began to go to another doctor at some point, but her mother remained my patient for 28 years. Through Joanne's teens, I counseled her mom as she described her daughter's reckless behavior and diagnosis of bipolar disease. Joanne developed an opioid addiction and got into a lot of trouble, landing her a long prison sentence. It tore her mother apart. Upon her release, I agreed to be her family physician. Almost immediately, she let me know of cravings for opioids, and I quickly started her on buprenorphine. For several years, her criminal record prevented her from finding housing and, like many others, she had to rely on family members for a place to sleep. Her record also made it difficult for her to find

a job until a retailer took a risk and hired her. She succeeded and recently was promoted to store manager; with her work success and my letters of advocacy, she was able to find housing and now has an apartment.

Willy has been out of prison for six years. Sexually abused and raped by a trusted adult, Willy later turned to opioids and became addicted to heroin. Through treatment, he developed great insight into his addiction and has been helped by buprenorphine to avoid a return to drug abuse. During his six post-prison years, he has had two relapses but has otherwise been stable in recovery. Very recently, he texted me, "SOS, I need to talk to you."

Willy had awoken a week earlier to a barely breathing, comatose girlfriend; she died in the hospital later the same day. Willy knew that she also had opioid addiction problems but believed her to be in recovery. Willy immediately relapsed but thought to seek my help after a week. Through a team effort involving behavioral health, nursing and me, we were able to get him into a short-term rehabilitation facility for stabilization and then re-engage in outpatient treatment.

I can say confidently that there are many physicians who know little about the impact of criminal justice involvement on the lives of their patients and their patients' families. The associated stigma either leads to avoidance of the health care system or non-disclosure for fear of substandard treatment. In consideration of the prevalence, I guarantee you that you have many patients who have been touched by this epidemic and whose health has been affected. The following are a few actions you can take to make a difference:

- While yet unproven, screening for justice involvement in a non-judgmental way provides you an opportunity to help.
- If you learn that someone was incarcerated, don't ask about the crime. It's none of your business.
- Advocate for those patients who are trying to re-engage with life as a member of the community. They have paid their debt to society. Write letters of support for housing or work.
- Help with access to substance abuse treatment when needed. For those with opioid addiction, encourage medication-assisted treatment.
- For those with histories of learning disorders, trauma, anxiety or depression, help them to gain access to treatment. This is particularly true for children.
- If you learn that a patient has an immediate family member who is incarcerated, explore how they are coping and offer empathy and support. The emotional trauma can be as intense as the death of a family member or a divorce.

Dr. Warren Ferguson, is a professor and vice chairman of the Department of Family Medicine and Community Health and director of Academic Programs, Health and Criminal Justice Program at the University of Massachusetts Medical School.

References:

- ¹ Drucker E. A different kind of epidemic. In: Drucker E. A Plague of Prisons: The Epidemiology of Mass Incarceration in America. New York, The New Press, 2011.
- ² Bureau of Justice Statistics, Survey of State Criminal History Information Systems, 2012 (U.S. Department of Justice, 2014) available at <https://www.ncjrs.gov/pdffiles1/bjs/grants/244563.pdf>
- ³ Pettit B, Western B. Mass incarceration and the life course: race and class inequality in U.S. incarceration. *Am Sociol Rev*. 2004 Apr;69:151-69.
- ⁴ ADAM II. Arrestee Drug Abuse Monitoring Program. Office of National Drug Control Policy. April, 2009. Available at: <http://www.whitehousedrugpolicy.gov/publications/pdf/adam2008.pdf>
- ⁵ Western B, Pettit B. Incarceration and social inequality. *Daedalus*. 2010;139(3):8-19.
- ⁶ Freudenberg N, Daniels J, Crum M, et al. Coming home from jail: the social and health consequences of community reentry for women, male adolescents and families and communities. *Am J Pub Health*. 2005 Oct;95(10):1725-36.
- ⁷ Binswanger IA et al. Release from prison. A high risk of death for former inmates. *N Engl J Med* 2007; 356:157-165. DOI: 10.1056/NEJMs064115

Doin' My Time in Correctional Medicine

Patricia Ruze, MD, CCHP-P



Patricia Ruze, MD, CCHP-P

A recent issue of this magazine was focused on health care provider burnout and compassion fatigue. I read about emotional exhaustion, depersonalization and low sense of personal accomplishment. So, job satisfaction is what I want to share regarding my eight years behind bars as prison doctor. Am I emotionally exhausted and professionally burned out? Of course, I am at times. However, a career in correctional medicine may be an antidote to many of the problems my more traditional medical practice colleagues are facing.

I hear from physician friends and read often about frustrations with “up or down coding,” EMRs, haggling with insurance providers and hospital administrations. I hear about physicians coming home from eight hours with patients to do three or four hours of electronic charting from home after finally putting their kids to bed. As a correctional health provider, I don’t have those headaches. Medical care is “free,” and I get a fair salary from my employer that isn’t linked to volume of patients or procedures. My meaningful use criteria: “Is it medically necessary?” I don’t get distracted during work hours by my cell phone, as I am not permitted to bring it to work. I document patient encounters with a black ballpoint pen in a paper chart. Does this sound old-fashioned? Maybe it is, but from what I hear from senior colleagues, those were the joyous days of doctoring.

Clinically, correctional medicine may be primary care medicine at its best. I am faced daily with a wide variety of clinical concerns – alcohol and drug detox and overdose, hyperthyroidism, diabetes, HCV treatment, latent TB, myasthenia gravis, endocarditis and hunger strikes. The variety and extent of disease is vast. Unlike what I observe when my own family goes to the family doctor, I manage my patients through these challenges. I have been amazed when a primary care provider for my own family member refers uncomplicated back pain to an orthopedist, seizure management to a neurologist or osteoporosis to an endocrinologist. Perhaps I live too close to Boston and too far from Worcester?

At the same time, I have close daily communication with specialty and subspecialty providers by phone call, telemedicine or videoconferencing and, of course, in person for patients I feel believe need specialty care. This approach cuts down on the fragmentation of care, which can be confusing for patients and frustrating for providers.

Because my patients live at my office, I don’t feel the same pressure to sweat through a harrowing appointment schedule. I do work long hours and I work hard, but if I need to spend an extra hour with a difficult, angry, confused or just plain complicated patient, I just do. I ask my correctional officer not to call down my next patient and reschedule for tomorrow. When I go home, I am finished with work. While I have scheduled after-hours duties, for the most part, I can’t take any work home with me.

Our patient care approach is a team one, with capable nursing staff central to the overall operations of our medical system. I mentor nurse practitioners, PAs, medical students and residents, as well as RNs, LPNs and CNAs. Correctional officers are essential colleagues who facilitate access to care and keep everyone safe. Clinical learning opportunities abound, and I have found prisons an optimal setting for clinicians in training to learn not only from patients’ disease process but also from patients’ life experiences in a profound way.

What about personal safety at work? My current job in the Massachusetts prison system is probably the safest job of my career. Competent and dedicated correctional officers are entrusted with making sure that my nurses and I can practice medicine in a safe and respectful environment. This is sadly in contrast to work done previously in ER and urgent care settings, where violent or intoxicated patients with concealed weapons could walk through the front door at any time.

So, what are the down sides? My office has no windows and is sometimes just too hot or too cold. Some might call it claustrophobic. Frivolous lawsuits are a fact of life, and I arouse patient ire daily by denying requests such as moisturizer, medical shampoo, extra pillows, medical shoes and bottom bunks. I have a strict drug formulary, and at times, my utilization reviewer (a fellow physician and friend) chafes about whether certain services for my patients are truly medically necessary. Appropriate medical resource allocation affects my day-to-day work, but I believe that we have an evidence-based, rational system, which should be adopted beyond correctional medicine.

Many of us went into medicine to make a difference in the lives of individuals who are marginalized. Our prison and jail population are arguably the neediest population in the state. While my patients may be robbers, murderers or sex offenders, they are entitled to community standard medical care. For me, the privilege of caring for a needy and vulnerable population and the ability to make a difference in their lives is well worth the challenges.

Dr. Patricia Ruze is the medical director of a maximum-security prison in Massachusetts. She is a fellow of The American College of Physicians and an assistant professor of Community and Family Medicine at University of Massachusetts Medical School.

The Power of a Handshake

Hugh Silk, MD



Hugh Silk, MD

The story was previously published in Intima: A Journal of Narrative Medicine (2015) and Bodies of Truth: Personal Narratives on Illness, Disability, and Medicine (to be published 2019 University of Nebraska).

I offer a simple enough gesture – a handshake. I have been told that my shake is weak and does not denote confidence, a “wet fish” kind of shake. I am not concerned with how I convey power or strength, as my confidence brews deeper than my handshake. But in this clinical setting – correctional health – the handshake is evaluated differently. I am offering it to an inmate, even

though we were instructed repeatedly during our orientation to avoid shaking hands with inmates. He looks up at me in astonishment as we briefly join hands.

Inmates are very careful not to come in contact with staff as this can result in disciplinary action. As I walk down the hallway, inmates will move to the side to let me pass and are careful that our sleeves do not touch by mistake, which can be misconstrued as an act of aggression.

Some have downplayed the handshake in the medical setting for other reasons. With the transmission of infections on the rise, studies have shown a fist bump may be a wiser choice for physicians to do with patients. There is certainly a place for the fist bump, but can we realistically train all patients to embrace it? And what will we lose with the omission of the handshake?

A wise old sage I worked with in medical school, who was a product of the generation where the physical exam was everything, would take each patient's hand and make at least 10 observations from that handshake. How was their strength, their temperature, their ability to coordinate a handshake, etc? Additionally, he explained how that simple gesture showed respect, initiated physical contact in a non-intrusive manner and set a tone of partnership and friendliness. Bates and DeGowin could not have said it better!

Not long ago, a retired warden came to speak to our medical team to be sure we were being mindful of the rules. On occasion, a staff member has crossed a professional line, resulting in a breach of security. She was on message to remind us to be careful, to be cautious and to be professional. However, she felt it was okay to shake hands. She told us: The handshake is a controlled act initiated by the provider and therefore will not be misconstrued; it can simply say, “I care, but don't plan on taking advantage of that caring.” It also conveys respect.

Medical care can never seriously be offered without a foundation in mutual respect. All too often that respect, unfortunately, flows only in one direction – towards the doctor. My best moments with patients are when they feel I am interested in them, when I am complimenting them on their efforts and outcomes. Respect is a potent motivational tool. I learn so much when I just stop and listen. Every person has a story to tell.

And so here I am, sitting with a man who has cancer. He is very aware of his options and has decided not to take the medical treatments that he sees as having too many potential side effects and too many potential shortcomings. He is choosing not to engage in false hope, and I find his reasoning sound. He clearly has done his homework, listened well, consulted with family (including medical types) and is confident in his decision. The conversation is not an easy one. I explain how I will care for him here, like I would care for someone in the community or my own family member.

I explain there are limits to what we can get approved, but I will push for all the options at our disposal for maintaining his quality of life. I will see his pain meds are appropriately adjusted, that he has an extra pillow (a big deal in a prison setting), and I will pay attention to the little things we think will make a meaningful difference for him.

A family medicine colleague and friend of mine from Maine, David Loxterkamp, often paraphrases a thought from those who have come before us: We should be judged by the care we offer to the least of our patients. The words haunt me as I navigate care for the prisoners.

Am I measuring up?

We stand to conclude the visit and shake hands for the second time today. This time his look of astonishment has changed to a look of admiration.

“Thanks for listening and for understanding. Nice explanations, doc.”

We are eye-to-eye for a moment. The embrace is firmer now, and we are both offering more through this symbolic contact. Today, I feel I have measured up. Tomorrow, we shall see.

At a recent national medical conference, Eric Topol announced that the stethoscope was obsolete. Another low-tech tool that connects us to patients – gone. Let's hope the handshake stays with us as long as we are called upon to join with patients in a profession founded on caring.

Hugh Silk, MD, MPH, is a professor in the Department of Family Medicine and Community Health at the University of Massachusetts Medical School and cares for patients at Community Healthlink in Leominster

Opening Doors

Luke Latario



Luke Latario

It was spring during my first year of medical school, and as I followed the armed guard through layer after layer of locked iron doors, I felt like I was, yet again, in way over my head. That year, I participated in an elective class designed to introduce medical students to the United States correctional system and the challenges in providing health care for the more than 2 million incarcerated Americans. This course offered an opportunity to work with physicians who care for patients living behind bars

and see firsthand what we discussed in class. So, that morning, I left behind a sunny spring day in March and entered a local medium-security correctional facility, passing through metal detectors, walking by towers and through huge concrete walls topped with razor wire. I wondered how doctors could work somewhere so different from the hospitals and clinics I was used to. How could they relate to patients who I thought must carry such a deep-seated mistrust of authority? And what on earth did I get myself into?

That last question had run through my mind so many times over the last year of medical school. I had felt like I was in over my head many times: on the first day of class, my first pharmacology exam and while meeting so many intelligent and accomplished classmates and teachers. I feared I did not fully understand what I had committed to as I became buried in a busy schedule of class, lab and reading assignments and intimidated by the long years that stretched ahead.

While I often felt like a foreigner in a new country that first year, immersing myself in the unique language and customs of medicine, behind the walls of this correctional facility was a whole different and strange world. Here, there are rigid rules about what to wear, where you can go, what you can do. At least for me, this created a terrible sense of uncertainty about whom I could trust and anxiety about the possible consequences of an innocent mistake. In contrast, I was impressed by the providers who greeted me and guided me the rest of that day. They were comfortable and seemed at home as they showed me around and brought me to the medical clinic.

In this clinic as a first-year medical student, I did not understand most of the medicines the providers prescribed or even the conditions they were treating. But meeting with our first patient, a middle-aged man, I did understand the patient's sense of vulnerability as he discussed his symptoms. He had suddenly and inexplicably suffered terrible pain in his foot that made it excruciatingly painful for him to walk. I saw the anxiety he had about how this represented aging and the onset of a physical vulnerability he feared. As the doctor conversed with the patient and explained how this condition was likely gout, it was apparent the relief the man experienced by sharing his concerns with his doctor when frailty was something he felt he must hide from everyone else around him.

Another patient was brought to the exam room from a higher-security part of the prison and remained handcuffed and chained with a guard during the visit. I began to appreciate how the doctor restored some of the patients' dignity and humanity in this difficult circumstance, simply by respectfully listening and acting as an advocate. I was inspired to see the trust these men placed in their doctor and how the physician offered comfort and helped them cope with many of the hardships of their daily life.

At the end of that day, walking out of the correctional facility, I felt a renewed wonder and appreciation for the special profession I saw physicians practicing behind those walls. Here was a dramatic example of the great privilege of medicine – to be able to go anywhere and to care for anyone, regardless of their character, wealth or status. The patient-doctor relationship is a connection that transcends so many societal barriers and, in itself, begins to alleviate human suffering. Moving forward in my career, I told myself even though I may not always have the answers or know exactly how to help, I can always listen, care and advocate for patients who may not be able to advocate for themselves. I was grateful that my future profession afforded opportunities to create these interactions and could open so many doors to serve others that would otherwise remain closed. I also felt reassured that becoming a physician was a meaningful goal, worth every sacrifice to overcome the many obstacles in the marathon of medical training to come.

Luke Latario is a fourth-year medical student at the University of Massachusetts Medical School, where he participated in the Correctional Health Optional Enrichment Elective as a first-year student and then acted as the student coordinator for the elective in his second year.



**120 STAFFORD STREET
SUITE 206
WORCESTER, MA 01603
(508) 459-6937
ACCLAIMWORCESTER.COM**

- HIGHLY TRAINED PROFESSIONALS
- NO DELAYS IN SN, PT, OT, ST, SW, OR HHA
- MULTILINGUAL CLINICAL STAFF
- CLOSE WORKING RELATIONSHIP WITH PHYSICIANS
- SKILLED NURSING

Insurances include Medicare, MassHealth, Fallon, Summit, ElderPlan, Evercare and Network Health.
Towns include Auburn, Berlin, Boylston, Brookfield, Clinton, Charlton, Dudley, East Brookfield, Grafton, Holden, Leicester, Millbury, Marlborough, Northborough, Northbridge, Oxford, Paxton, Rutland, Shrewsbury, Spencer, Sutton, Webster, West Boylston, Westborough and Worcester.



Patient or Prisoner: When Cultures Collide

Stephanie Rondeau, ACNP/CNP, CCRN



Stephanie Rondeau, ACNP/
CNP, CCRN

The following account is based on an actual patient experience and reflects the true opinions expressed by the nurses and health care providers that cared for her. All names and details have been altered for the sake of protecting the identities of those involved.

The snow had been falling for at least two hours. Sarah had been working in the medical ICU of a suburban tertiary care center for a year and enjoyed her overnight shifts. Although her 12-hour shift did not start until 7 p.m., as a RN, Sarah knew that she was required to report to work regardless of weather conditions.

She arrived at the hospital and reported to the charge nurse to start her assignment early. “The devil you know is better than the devil you don’t,” she thought to herself.

Sarah’s early arrival was welcomed. She assumed care of a 22-year-old female prisoner, who attempted to hang herself from the top bunk in her prison cell, being admitted from the emergency room. Sarah’s heart sank. She knew that prisoners deserved the same care as everyone else, but these cases were always emotionally draining and difficult. Obstacles included guards, obtaining consent for procedures, finding past medical records and determining who could legally obtain and provide medical information. Sarah was very quickly regretting her offer to start early!

The prisoner patient was admitted to the ICU in critical condition. She was intubated for acute respiratory failure related to a cervical spine injury and remained on cervical spine precautions. She required central line placement for blood pressure support. The ICU providers were unable to obtain consent for ICU-related procedures because this prisoner was newly incarcerated and not fully processed. The procedures were performed at risk for being held liable. The providers were advised to document thoroughly that procedures were required for stabilization. “But is this the best way?” Sarah couldn’t help but wonder.

The patient’s ICU course was complicated by Acute Respiratory Distress Syndrome, requiring paralytics and nitrous oxide. MRI revealed C-4 fractures that could be stabilized with surgery; however, since the patient was stable, the operation required consent. The hospital had initiated court proceedings to appoint a guardian; however, after six weeks, there was still no appointment.

Sarah had been the primary nurse for the patient during the first four weeks of ICU care. But she then requested to be reassigned due to the emotional strain. She watched a 22-year-old, who could have had corrective surgery, been weaned off mechanical ventilation and transferred to the medical surgical floor, instead suffer the sequelae of the long-term effects of intubation without tracheostomy and no definitive treatment for her cervical fracture. She also experienced the daily stress of two guards and visitors who were forbidden to see their loved one due to her incarcerated state.

After three months, the patient was transferred to the medical-surgical floor. She underwent neurosurgery; however, surgeons were unable to completely re-establish function below C-4 because of scar tissue due to the extensive length of time from injury. She had severe deconditioning, requiring long-term rehabilitation. This necessitated coordination on the state level to find the appropriate rehabilitation facility, possibly escalating to the federal level with transfer out of area.

Kyle cared for the patient on the medical-surgical floor. He knew that many prisoners had poor or no health care prior to being incarcerated and appreciated the attention they received during their hospital treatment. This patient, however, had a depressed affect and refused to participate in her care. The only time she seemed to be interested was when the guards were not around, which was not very often. She had been diagnosed with severe depressive disorder, and Kyle couldn’t help but think this unsurprising, given the circumstances of her incarcerated state and now-chronic health conditions. He also noted that while most patients received gifts, flowers and companionship of friends and family, being a prisoner deprived this patient from these comforts.

Kyle had recently graduated and remembered his nursing theory instructor’s lecture on incarcerated patients. Most salient was the feelings of friction between the prison culture of custody and the nursing culture of care. He recalled the explanation that imprisonment imposes deliberate harm, while health care aims to prevent harm and improve well-being – a direct oxymoron if Kyle had ever heard one! No wonder he was running into barriers when it came to advocating for this patient. But Kyle was also warned against providing reactive care, especially in the setting of emotionally draining situations. When he found that his response to the patient depended on the guards, and that he second-guessed the need for pain medications because she had a history of drug abuse, he knew he was succumbing to the notion of reactive care.

Kyle would often rely on the charge nurse, Fabiola, who would tell him that caring for a prisoner was actually easier because guards kept them from acting out and allowed an excuse for nurses to spend less time conversing. Kyle, however, felt that the normal care he would provide for his patients was disrupted by the guards and made it more difficult to advocate for progressing the patient’s plan of care. For instance, he was only allowed to ambulate the patient in the hallway when other patients were in their rooms, so that the shackles/restraints and guards did not scare anyone.

The emotional drain from caring for prisoners is best attributed to the fact that providing care may not come with the same ease or as instinctively as with caring for other patients. It is hard to handle the gamut of emotions that inevitably haunts the health care professional. Often, the thought of the crime is worse than the reality, and it is hard to stay non-judgmental and objective. The prisoner population is a defined culture that is not included in many nursing and medical school curriculums. Nurses and health care providers make choices about the level of engagement they embrace with prisoners; more support must be provided to this under-recognized culture, beginning with nursing and medical school curriculum.

Stephanie Rondeau, ACNP/CNP, CCRN, is the Acute & Chronic Theory course coordinator and nursing instructor at UMass Medical School’s Graduate School of Nursing, as well as a nurse practitioner in Pulmonary Critical Care and Hospital Medicine at Lahey Hospital and Medical Center in Burlington.

UMass Medical School Correctional Health Optional Elective

Colleen Flanagan, UMass Med '20, Ivana De Lucia, UMass Med '21, Keaton Cameron-Burr, UMass Med '21



Colleen Flanagan, MD



Ivana De Lucia, MD



Keaton Cameron-Burr, MD

The Correctional Health Optional Enrichment Elective at UMass Medical School aims to give students an understanding of the health concerns facing justice-involved populations. The Bureau of Justice Statistics estimates that, as of 2015, almost 7 million adults, or 2.7 percent of the U.S. adult population, is justice-involved,¹ and in Massachusetts, as of 2016, there is an average daily adult prisoner population of almost 10,000.² The correctional health elective seeks to improve outcomes for justice-involved populations by decreasing stigma and increasing future providers' comfort with this group. The elective also explores issues that many justice-involved individuals face following release, including the need for transitional care, and calls attention to opportunities to offer preventative health services, provide health education and address some of the health issues individuals may experience while incarcerated.

During one of our elective sessions, we learned that the overwhelming majority of providers will, at some point, care for an individual that is justice-involved. As a native New Yorker, I, Ivana, worked with a number of psychiatrists that spent part of their professional careers at Rikers Island, New York City's main jail complex, which manages approximately 100,000 admissions annually. This volume of individuals demonstrates a core lesson of the correctional health elective: People who are justice-involved represent a greater portion of those accessing health care than we acknowledge. Providers may not realize how many of their patients are justice involved, due to stigma, which prevents disclosure. It is critical, therefore, for medical students to acknowledge that, regardless of specialty, we will likely serve individuals that are either currently incarcerated or have recently disengaged from the justice system. A few weeks after starting the correctional health elective, I, Keaton, had the opportunity to take a history from a patient who came into the emergency room in handcuffs with a police officer watching closely. Having just listened to a lecture on the power dynamics of incarceration in the context of health care, I felt I could have a more informed and empathetic conversation with that patient.

In addition to attending lectures, students have the opportunity to volunteer as Correctional Health Educators (CHEs). CHEs teach justice-involved youth workshops on anatomy, harm reduction practices

and healthy relationships at multiple Department of Youth Services sites in Central Massachusetts. Serving as a CHE while participating in the elective offers students an opportunity to take what they learn in the classroom and translate that knowledge into the real world in a way that can positively impact the justice-involved population. I, Keaton, while serving as a CHE, emphasized what resources are available for young people looking to receive competent, non-judgmental care following release. The lectures we received on the importance of transitional care solidified for me how important

it is for people exiting the justice system to connect with providers and services after disengaging from the correctional system.

The faculty that led lectures included academics, policy advocates and clinicians. During presentations, these faculty frequently remarked that they wished a similar course existed during their time in training and were eager to encourage interest in the subject. In this way, the faculty provide inspiration for students interested in research and policy. By having the opportunity to connect with this group of professionals, I, Colleen, was able to find a mentor to pursue a research project combining two topics I am passionate about in medicine – cancer prevention and caring for justice-involved individuals. Specifically, I will be investigating HPV vaccination and cervical pap smear policies and practices in the Commonwealth's women's facilities and possible barriers to care. I am very passionate about preventative cancer care in a correctional setting because incarcerated women are four to five times more likely to have cervical cancer as non-incarcerated women, a relative risk higher than that for diabetes, obesity or heart disease.³ I feel that my time in the correctional health elective has provided me with a solid foundation to explore the policy dynamics of correctional health.

As students at UMass Medical School, we are taught to serve individuals from all walks of life with compassion, care and respect. We are passionate about health disparities, activism and education, and we hope to use the skills and information we've learned in this elective to be better providers for our future patients.

References:

¹ Kable, D. and L. Glaze. (2016). Correctional Populations in the United States, 2015. U.S. Department of Justice, Bureau of Justice Statistics, 1-20. Retrieved from <https://www.bjs.gov/content/pub/pdf/cpus15.pdf>.

² Kohl, R, et.al (2016). Massachusetts Department of Correction Prison Population Trends Report, 2016. <http://www.mass.gov/eopss/docs/doc/research-reports/pop-trends/prisonpop-trends-2016-final.pdf>.

³ Binswanger IA, Krueger PM, Steiner JF. Prevalence of chronic medical conditions among jail and prison inmates in the USA compared with the general population. *J Epidemiol Community Health* 2009;63:912-919.

The Touch

Lisa Simon, DMD



Lisa Simon, DMD

The medical interviewing class I help teach recently held a group discussion. It was on the subject of touching. I don't teach the class alone – I share a small group of first-year medical and dental students with two other faculty members from different specialties. It's an intimate group with insightful students, and our conversations often meander to unexpected places. Even so, I was surprised when both my colleagues took a reserved and cautionary tone when we talked about how we touch our patients.

"Think twice before you touch a patient," one exhorted. "You never

know if they might respond badly, so it's a risk you might not want to take."

The other nodded in agreement. "It can land you in deep trouble," she said.

I don't want to put my students at risk, and it is important to read an intimate situation before acting. Both my co-teachers are older and more experienced. They have been in practice much longer than me, fresh out of residency. I felt worried and confused. Were they right? Was I doing something wrong?

Because I work as a dentist in a jail, and I touch my patients all the time.

When I first started my job, I confess I expected to find it a little glamorous, or at least a little exciting. But for all the video cameras and alarm bells and 3-foot-thick concrete walls, the dental clinic is actually a completely normal-looking room. The dental chair is even a cheery shade of blue. Unfortunately, it's a chair it takes far too long to get into for those in need. There are about 600 men in the jail where I work, and last time I checked, the list of people in urgent need of a dentist was nearing 200.

All of my patients are in pain, and usually, they are terrified. They have waited patiently for months because they have no choice. Sometimes, this is the first time in their lives that they have visited a dentist. I spend most of the day pulling teeth and cleaning infection out of gums. Sometimes, I can devote some time to explaining how a patient can find a dentist to treat him when he is released. Many of my patients are eligible for free dental care because the state, the same one that has put them in the jail, still considers them, for health insurance, to be children.

My fourth patient of the day, like the others before him, needs to have a tooth extracted. The antibiotics given to him by a nurse have brought the swelling down, but his eyes are red from lack of sleep and his hand tightly cups his chin. It is obvious that he is suffering. He is quiet when

I ask to examine his mouth and even more quiet when explain what I will do. When I ask if this is alright, he simply nods.

As I attend to his infected teeth, I hear a wordless lilt that I know is a question. "I'm sorry, what?" I remove my tools from his mouth to hear him better.

"Do you feel safe here with me?"

Everyone entering the building goes through a metal detector. The elevators don't work without a special badge. There is always a correctional officer standing at the open door leading into the dental clinic. I am far safer here than I will be on my bicycle, coming home at the end of the day. But that is not what he means.

Lots of people are afraid of dentists. I'm used to that; actually, I'm pretty good at working with patients who have dental anxiety. But when I walk down the street, no one is afraid of me. I exist in a body that guarantees I will always have that luxury. I can only imagine how painful that must be, like the constant dull ache of a bad tooth. And yet, the man before me wants to make sure I'm comfortable. My patient, a person it is my job to care for, is caring for me.

"Do you feel safe here with me?"

I think of the concerns my colleagues voiced, and I think of the times my patient has been touched. There is the jostling of the correctional officers who escorted him to the clinic. There are my own rough, clinical manipulations in his mouth. Perhaps, if he is lucky, he has felt a furtive pat on the arm from a visiting family member. My hand goes immediately to his shoulder and gives a warm squeeze. I leave it there for a while before I resume my work.

My day at the jail is also visiting day. As I leave, I grab my backpack and bicycle helmet and slip past the lines of people here to see their incarcerated loved ones. Some are gray-haired; some look like they have come here straight from their high school classroom; some hold newborns. I do not know how long they have been waiting. Before being granted entrance, they are heavily scrutinized, yield their driver's licenses and deposit all their belongings in lockers. They wait in small groups to pass through the jail's hulking doors, holding laminated visitors' passes up to the officer, who frowns at them behind a thick pane of bulletproof glass. I don't have to do any of that. For me, the doors just open.

Biking through the crisp fall air, I reflect on the day – on what went well, on what I can do better. My mind snags on my patient's words, and they echo back to me. "Do you feel safe here?" There are so many things I wanted to say in response. I'm sorry you're in pain. I am sad things are so unfair. I am so touched you are concerned about me. I want you to have the dignity and respect you deserve.

A touch, I know, can't say all that. But what I hope it manages to say is simply, "I'm here."

Lisa Simon, DMD, is a fellow in Oral Health and Medicine Integration at the Harvard School of Dental Medicine and a medical student at Harvard Medical School.

Substance Use Disorder in our Community

Matilde Castiel, MD, Commissioner of Health and Human Services



Matilde Castiel, MD

My work as a primary care physician has been dedicated to substance use and opioid addiction, particularly in communities of color. In 2009, we established a treatment facility called Hector Reyes House, which includes primary care, psychiatry and infectious disease physicians and a clinical director, in hopes of changing the mindset about incarceration.... It is not a "treatment."

Today, I sit as commissioner of Health and Human Services for the city of Worcester, trying to recreate the same treatment for everyone suffering with opioid addiction. We have done some

great work at the city level by having all police and firefighters trained in opiates and to carry Narcan. We have gone into the community and

trained our nonprofits and for-profits, along with our city employees. We developed a quality of life task force to help those with addiction, homelessness and mental health, which all go hand in hand. We partnered with APW to bring needle exchange in Worcester. We have opened kiosks to return drugs in the community; we have advocated for more treatment beds, recovery coaches, and the lists goes on.

But I have one dream I would like to see fulfilled to save our community from this opioid epidemic. I would like to see every physician, whether in a hospital setting or private practice, help us combat this epidemic. I would love to see every physician, no matter what specialty, see some of the patients who are suffering with addiction, to be trained in MAT (medically assisted treatment). I would like to see all residents and students being trained in addiction and to also be certified in Suboxone. Suboxone is a simple eight-hour course, and then you are able to prescribe.

Please help our community by all of us taking patients and giving them the help they need. If each one of us took five patients who are suffering with this disease and extended our expertise to them, maybe we would see our numbers of overdose and mortality decrease. This is my dream, and I hope everyone can help end this epidemic.



Spring is in the Air

*with our fresh
seasonal menu
and unparalleled
outdoor dining*



The Only AAA Four
Diamond Hotel in
Central Massachusetts

BEECHWOOD
HOTEL

sonoma
RESTAURANT

363 PLANTATION STREET
WORCESTER, MA 01605
BEECHWOODHOTEL.COM





Gerard Aurigemma, MD

Jargon 101

Gerard Aurigemma, MD

Like many in my medical school class of 1979, I aspired to become a 'triple threat' academic physician: to be outstanding in the areas of teaching, research and patient care. In 2018, there is a fourth area to be mastered by medical students: jargon. It may be difficult to survive, let alone thrive, in the current medical environment without becoming a skilled jargonista.

Current medical jargon is a language that would not have not been recognizable to my medical school self. It borrows from a variety of sources: business meeting patois. Popular culture. Psychobabble. Orwellian

double-speak. It follows the general non-medical use English trend of adding words superfluously, possibly to soften their impact by implying volition. Thus, we used to say, "You have to do this," we now say, "You need to do this." Likewise, "Why don't you come in to work this weekend?" has become "Why don't you go ahead and come in to work this weekend?" A sociologist or psychologist might be able to explain why language has taken this non-confrontational turn at a time when people seem angrier than ever.

What follows is a short list of terms in common medical parlance, along with a libretto, broken down by categories.

	What is said	Translation
Scientific	"There's a signal...."	"We think...."
	"The consensus is...."	"A couple of us think..."
	"Clinical phenotype"	"A guy with..."
	"Not high enough priority to warrant publication"	"Junk"
	"Hypothesis generating"	"p value somewhere between 0.09 and 0.19 and/or n=7"; on occasion can mean "junk"
Clinical	"In my experience...."	"I once had a patient with...."
	"In my series...."	"I had 2 patients with...."
	"In case after case after case..."	"I had 3 patients with"....*
	"Shared decision-making"	"Don't blame me if this doesn't work out so well."
	"From a -- standpoint, we would be discharging him/her"***	"Please take this patient off our hands."
	"That's interesting"	"That's not interesting."
	"The data are conflicting."****	"To be honest, I don't know the data but don't want to sound stupid," or "The last time I read about this was during the Clinton administration."
Administrative	"Scalable"	"More"
	"Let's circle back"	"Let's return"
	"Take a deep dive" also add "granularity"	"We've got another 15 minutes allotted to this meeting."
	"Current state"	"How we do it now"
	"Future state"	"You wish"
	"We want to empower you."	"We wish to give you more work."
	"You will have the opportunity."	"We wish to give you more work."
	"Transparent"	"Opaque"
Miscellaneous	"Did you try rebooting?"	"You fat-cat physicians, unlike those of here in the call center, know nothing about computers."
	"I see."	"Wait....what?"
	"Send me an email about this."	"I don't want to be bothered by this; I am betting heavily that you will forget about this between now and next time you log on to your computer."
	"Around"	"About"
	"I have to jump on a conference call (WebEx)."	"Don't let the door hit you on the way out," or "Please get lost."

Note that use of jargon is scalable. Multiple jargon building blocks may be used in the same sentence.

As a training exercise, I sometimes try to stuff as much jargon as I can into one sentence. With a little practice, one can generate a three-minute discussion which conveys little to no information: "Why don't we go ahead and circle back and get more granular around this discussion of physician

empowerment and examine the current state workflow." That is, of course, unless you have a WebEx to jump on to....

*Note that this is subject to economy sizing. When one has a series of patients with a similar condition, a third is often thrown in at no extra charge.

**Fill in blank with medical, surgical, etc (usually surgical).

***I have no personal experience with this phrase but have heard that others use it this way.

WORCESTER medicine

Interested in reaching a target market that includes over 4,200 physicians?



Advertise your business in Worcester Medicine!

Worcester Medicine, available six times per year, is published by the Worcester Medical Society, a professional organization and resource for physicians, medical personnel, and medical students in Central Massachusetts.

We invite you to partner with us and become a recognized presence in the medical community!

FOR ADVERTISING INFORMATION, CONTACT:

PAGIO INC.
PUBLISHING, DESIGN, EVENT PLANNING,
& WEB DEVELOPMENT
88 WINTER ST. 2D, WORCESTER, MA
978-771-1531
DSIMONE@PAGIOINC.COM

Kummerspeck
Making the Best of the Worst
A NEW AMERICAN BISTRO

118 WATER STREET, WORCESTER, MA 01604 • 774-243-7071 • KUMMERSPECKFOODS.COM
BUTCHER SHOP & DELICATESSEN HOURS: 10:30AM-6:30PM
RESTAURANT & BAR HOURS: LUNCH 11:30AM-3PM & DINNER 5-9PM • OPEN UNTIL 10PM ON FRIDAY & SATURDAY
CLOSED SUNDAY & TUESDAY

Commonwealth of Massachusetts Justice of the Peace

"For Everyone's Wedding Needs"



Contact Paul Giorgio
(508) 414-4454 • pgiorgio@pagioinc.com

Worcester District Medical Society

SAVE THE DATE ANNUAL BUSINESS MEETING

**WEDNESDAY, APRIL 11, 2018 • 5:30PM
BEECHWOOD HOTEL, WORCESTER**



“WORCESTER’S TIME IS NOW... ONE YEAR LATER”

SPEAKER:

CITY MANAGER EDWARD M. AUGUSTUS, JR.

AWARD PRESENTATIONS:

**2018 COMMUNITY CLINICIAN OF THE YEAR
RECIPIENT: FRANCISCO S. GIL, MD**

25 & 50 YEAR MEMBER AWARDS

Worcester District Medical Society

222ND ANNUAL ORATION

“TEN LESSONS LEARNED ABOUT LEADERSHIP”

RESCHEDULED DATE: WEDNESDAY, MAY 9, 2018 • 5:30PM
BEECHWOOD HOTEL, WORCESTER



ORATOR:
MARIANNE FELICE, MD

*Professor of Pediatrics and Obstetrics/Gynecology
Former Chair, Department of Pediatrics
University of Massachusetts Medical School*

**FOR MORE INFORMATION AND TO REGISTER VISIT:
WWW.WDMS.ORG**

THE WEIMAR SYMPHONY ORCHESTRA

On March 1, WDMS Members and guests enjoyed the electrifying performance of Strauss, Brahms, and Beethoven's Symphony No. 5 at Mechanics Hall.

PRE-CONCERT RECEPTION AT BOYDEN SALON



Join the Pagio Family

Advertise in one of our many publications!



We also offer special advertising rates for our websites:

THEPULSEMAG.COM
TASTEWORCESTER.COM
THEVITALITYMAG.COM

For advertising information contact:

DAVID SIMONE
DSIMONE@PAGIOINC.COM
OR 978-771-1531



Publishing, Design, Event Planning,
& Web Development
88 Winter St. 2D, Worcester, MA

El Basha

Voted Worcester's
Best Middle
Eastern Restaurant

Middle Eastern & American Cuisine



Serving the People of Central Mass Quality Food for 25 years!

INQUIRE ABOUT OUR BEAUTIFUL NEW FUNCTION ROOM AT OUR PARK AVE. LOCATION- ACCOMODATES UP TO 200 PEOPLE

OPEN MONDAY - SATURDAY
OPEN SUNDAYS ON BELMONT ST.
LUNCH 11:30AM - 3PM • DINNER 4:30PM - 10PM

424 BELMONT ST., WORCESTER - (508) 797-0884
256 PARK AVE., WORCESTER - (508) 795-0222
2 CONNECTOR RD., WESTBORD - (508) 366-2455

Leo's Ristorante

...the tradition continues.

OPEN 7 DAYS A WEEK

DINNER: 5PM TO CLOSING
LUNCH: MON-FRI 11:30AM TO 2PM

PRIVATE
FUNCTION ROOM
AVAILABLE

GIFT CARDS
AVAILABLE



JOIN US EVERY WEDNESDAY IN THE LOUNGE
FOR BUY 1 GET 1 PIZZA FREE (DINE-IN ONLY)

11 BRACKETT COURT, WORCESTER, MA 01604
OFF SHREWSBURY ST. AND MINUTES FROM THE DCU CENTER!
508-753-9490 / LEOSRISTORANTE.NET

TASTEWORCESTER.COM

FEATURES INCLUDE:

- INTERACTIVE MAP
- SEARCH BY CUISINE, LOCATION, PRICE OR RATING
- RESTAURANT LISTINGS
- DINING REVIEWS
- LATEST CULINARY NEWS, EVENTS & RESTAURANT OPENINGS
- SEASONAL FOOD & DRINK RECIPES



**INTERESTED IN ADVERTISING
ON TASTEWORCESTER.COM?**

CONTACT PAGIO INC.
DSIMONE@PAGIOINC.COM
978-771-1531

*Taste*WORCESTER.com
Explore Central Massachusetts' Cuisine



proudly presents:

**COMING SOON TO WORCESTER
SPRING 2018**

Buy Tickets & Learn More at
www.MusicWorcester.org
or call **508-754-3231**

**CAMERON
CARPENTER**

*The International
Touring Organ*

**Saturday, April 28 at 8:00 PM
Mechanics Hall**

**Chamber Music Society
of Lincoln Center**

*Wu-Han, piano
David Finckel, cello
Philip Setzer, violin*

**Thursday, May 10 at 7:30 PM
Tuckerman Hall**

Adult Primary Care Physicians: Is the grind of primary care practice getting you down?

We have a
prescription
for that...

R_x

DATE

PATIENT NAME

ADDRESS

Prescription

Join



RELIANT
MEDICAL GROUP

Reliant Medical Group offers:

- Highly competitive compensation – earn additional 10–20% for good medical management, patient satisfaction, and quality scores.
- Modest patient encounter expectations – 13 per day/65 per week
- Collegial, multi-specialty group practice where providers offer care across the continuum.
- A unique, team-based care practice model that gives you the support you need to succeed.
- Large, progressive practice with value-based payment models.
- New, state-of-the-art facilities to enhance care and efficiency and allow more time spent with patients.



RELIANT
MEDICAL GROUP

To learn more, visit practiceatreliant.org or contact:

Stephanie Jackson

Stephanie.Jackson@reliantmedicalgroup.org

(774) 261-1371