

# WORCESTER **medicine**

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## MENTAL HEALTH PART 1



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# Editorial

Jane Lochrie, MD



Jane Lochrie, MD

All you need to do is tune into any news broadcast or read any newspaper to appreciate that mental health disorders are on the rise. Recent mass school shootings and the stabbing death of a medical student have been attributed to mental illness. Recently, we lost two high-profile celebrities to suicide – Kate Spade and Anthony Bourdain.

One in every five adults has a mental health condition, and nearly half have a coexisting substance abuse disorder. Rates

of youth with severe depression has increased from 5.9 percent in 2012 to 8.2 percent in 2015, yet 76 percent of youth are left with no or insufficient treatment. The statistics are even more staggering for the minority population. According to Mental Health America, Massachusetts has the highest prevalence of mental illness in both the adult and youth populations; however, the state ranks 33<sup>rd</sup> in access to mental health care. This issue of *Worcester Medicine* focuses on the mental health crisis.

The response for articles on the topic of mental health has been immense, and we received twice as many articles as we expected. Therefore, we will be covering this topic in two issues. I have published the articles in the order that we received them. I want to thank all the authors who have submitted articles, and I apologize for the delay to those of you whose articles will be in Part 2.

This is a very special edition of *Worcester Medicine*. Not only do we have the Oration but also a wonderful update on Worcester by City Manager Ed Augustus and a Book Review of Ellen More's book, *Beating the Odds: The University of Massachusetts Medical School, A History 1962-2012*.

The 222nd WDMS Annual Oration was delivered by Dr. Marianne Felice on May 9, 2018. For those of you who missed Dr. Felice's oration, you are in for a treat when you read the summary of her oration. Those of you who were there will want to review her "lessons learned."

In the first article, Dr. Peter Metz reminds us of the importance of attachments in childhood and how adversity in this age group negatively affects individuals as adults. Unfortunately, recurring adverse childhood experiences seem to be the rule, rather than the exception, particularly for those living in poverty. Science has proved

that "toxic stress" in the fetus and young child can dramatically alter brain development and affects the maturation of the prefrontal cortex.

Dr. Matilde Castiel states that substance misuse is still the largest public health and public safety crisis in this country; nonetheless, there is a severe shortage of social workers, psychologists, primary care physicians who prescribe Suboxone/Vivitrol and psychiatrists due to low reimbursement rates. She reminds us that addiction starts in childhood; children start to use marijuana, cigarettes and alcohol at the age of 8, often related to difficult experiences. Worcester has launched a pilot program in five schools to evaluate and treat children who have had adverse childhood experiences.

Dr. Nandana Kansara asserts that the most frequent concern she encounters in her primary care practice is stress and anxiety. U.S. teens and those in their 20s have become progressively more anxious over the past decades due to hypervigilance and FOMO (fear of missing out). She relates this to overscheduling the work day, over-parenting, lack of sleep, improper diet and poor sleep habits.

Our attention to the devastating effects of unrecognized depression during pregnancy on both the mother and her children is described by Dr. Nancy Byatt. One in seven women suffer from depression during pregnancy, yet most women do not receive treatment. In 2011, state lawmakers established the Massachusetts Legislative Commission on Postpartum Depression to provide consultation to providers for screening and treatment of this disorder. The author is the medical director of the statewide program MCPAP for Moms and has drawn national attention and accolades for this program.

A heart-wrenching account of her own anguish with perinatal mood and anxiety disorder (PMAD) is given by Bridget Croteau, who is raising awareness and breaking the stigma surrounding mental health issues during pregnancy. Instead of this being the happiest time in her life, she felt exhausted, scared and a failure. She suggests that all providers should ask mothers and fathers how they are doing and screen for PMAD at all visits and know local resources available.

From reading his article, new medical school graduate Raghu Appasani has a bright future in psychiatry. He explains his work developing and delivering mental health education and access to care for those in rural India. He maintains that social support and alleviation of the stigma around mental health is more important than medication. Listening, observing and, most importantly, respecting cultural backgrounds and their influence on perceptions of mental health help to develop trust. He wants all physicians to advocate for policies for mental health that focus on prevention.

As always, don't close this issue of *Worcester Medicine* without reading The President's Message, Legal Consult, As I See It and Society Snippets.

# President's Message

Sahdev R. Passey, MD



Sahdev R. Passey, MD

I would like to take this opportunity to thank the Committee on Nominations and the membership of the Worcester District Medical Society for the privilege and honor you have bestowed upon me to serve as your new president. Our society has always been a well-run organization over the years under the stewardship of our past presidents and the dedicated work of Joyce, Martha and Melissa, and I thank them for this.

The Committee on Publication deserves our gratitude and appreciation, as well, for their dedication and hard work in bringing us inspiring, current and relevant topics for discussion. It is always a pleasure to read the well-written articles contained within.

As a physician, we are always involved in the lives of our patients. Sometimes, this can come at the expense of our personal and family time. When I was in medical school 50 years ago, we were taught the art of healing, some understanding of the disease process and the importance of taking care of the patients and their families. No one taught us the business of medicine. That we learned as we practiced our profession. Unfortunately, in the current health care environment, we are constantly reminded of not only how to practice, but much focus has also been placed on the business and management end of health care. I agree we need to know more about the science behind the disease process and more efficient and effective treatments, but somehow, this has made us distant from our patients and the families for which we care. Maybe this is the new way to practice medicine, but it is not the way I was trained.

Current regulations, administrative tasks and the intrusion of technology within the practice of medicine has frustrated many of our seasoned colleagues and discouraged many more qualified

candidates from making medicine first choice for their careers. It happened, starting with EMRs, meaningful use, MACRA, private insurance and Medicare audits, the ICD-10, attestations, CMEs, requirements for BORM, PQRS, QAPI, the ACA, MOC and all the other alphabet soup that has been pushed down the throats of our physicians. It is our responsibility to get more actively involved in the governance of our profession and make sure that patient care and the physician/patient relationship stays the main focus of future policies affecting the practice of medicine. We ALL need to be involved in our local, state and federal politics to make sure the future of our profession stays intact.

We are very fortunate to be part of such a dynamic local and state medical organization, which has made tremendous contributions to correct and monitor the regulatory policies at the state and federal levels. We must continue to support organized medicine and stay involved to make a difference. If we do not, we will have no one to blame but ourselves for frustrated physicians and failed health care.

As you know, next year (2019), our Worcester District Medical Society will be celebrating its 225th anniversary. This is certainly an occasion for celebration. I will keep you posted as we make the plans for the upcoming festivities. I hope you will plan to join us to make it a most memorable year.

I thank you all for your support and your continued participation in our society's programs and governance. I wish you and your family a wonderful, safe and enjoyable summer.



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# 12 Lessons Learned About Leadership

Marianne E. Felice, MD



Marianne E. Felice, MD

Thank you for the honor of being a Worcester District Medical Society orator. Several previous orators are in this audience. Their presentations raised the bar for everyone coming after them, and I am well aware of the challenge I face, as the most recent orator, in reaching that bar. I also want to thank Joyce Cariglia and Melissa Boucher for their assistance as I prepared for this presentation. And I want to recognize Maribel Gonzalez, administrative assistant for the Division of Adolescent Medicine, for her expertise in preparing the PowerPoint slides for this presentation.

When I was asked to give the WDMS office a title for the presentation, I used “Ten Lessons Learned About Leadership.” Ten was a nice round number. But, when I began to write the talk, I realized that there were about 20 lessons I had learned, not 10. But 20 lessons were too many and would take too much time, so I carefully considered what to cut and what to keep. Eventually, I settled on the **12** lessons I considered most important.

I learn best by reading, and I have read many books and articles on leadership over the years. With this presentation, I have included an annotated bibliography that may be helpful to individuals who wish to pursue some aspects of leadership that I do not address as part of this presentation.

So, here are the lessons that I have learned.

## **Lesson #1: We all have “baggage” and “halos” in our past.**

This baggage and these halos may influence how we lead and how we deal with difficult situations. Our backgrounds may determine how we face adversity. This does not mean that how we react or handle challenges will be right or wrong, but rather that we need to be aware of how our past may shape our future.

In the spirit of full disclosure, I think that there are six factors on my baggage and halo list, and these six factors have probably influenced my current leadership style.

- I was born prematurely before there were Neonatal Intensive Care Units and before there were neonatologists. Based on family

folklore, I think I weighed about 4 pounds and was born at 32 weeks gestation. In today’s world, 32-weekers generally do very well. But, in the 1940s, when I was born, many babies died at 32 weeks. I think the fact that I survived means that I was a fighter and a survivor from birth.

- My mother died when I was 10 years old and my brother was age 7. I lost my mother to congestive heart failure just as I was entering puberty. I did not have her guidance and wisdom to help me through my adolescence, but most importantly, she was my biggest cheerleader and my biggest support. She told me I was smart and I could be anything I wanted to be if I just studied and got good grades. My father, on the other hand, was a barber and did not see a need for girls to have anything more than a high school education. He never praised me, nor even acknowledged my academic success. I think I was a challenge for my dad. He simply did not understand why I could not be satisfied with the choices that his own sisters had made or my girl cousins had made. For example, I did not want to attend the local public high school (where everyone else in the family had attended) and wanted to go to a private girls’ academy run by the Sisters of Mercy. He rightfully told me that we could not afford for me to go to the academy. So, I took the entrance examination anyhow and applied for a scholarship, which I obtained.
- I grew up in a large extended Italian-American family. My grandparents had been immigrants from Italy and Sicily. My father was one of 13 siblings, and my mother had three siblings. My father remarried when I was 13 years old, and my Italian-American stepmother was one of eight siblings. So, I had lots of aunts and uncles and cousins. We were a loud, raucous group. I love my Italian roots, but my adolescence had a lot of turmoil. My father, brother and I moved from the house in which my brother and I grew up to my stepmother’s house, where she lived with her elderly mother and older brother who never married. She was responsible for caring for them. My brother and I lost our own rooms and our privacy. I had to share a bedroom with my elderly grandmother, and Johnny had to share a room with our elderly uncle. On either side of my stepmother’s house lived one of her siblings and their children. My brother and I were the interlopers in this arrangement, and I did not always feel welcomed. To be fair, it would be difficult for anyone to have to accommodate a mouthy, know-it-all 13-year-old girl and a poorly disciplined 10-year-old boy into a household. I ran away from home a lot as a teenager. I was fortunate that I was never harmed as a runaway, but I did learn resilience at that time and I still graduated at the top of my class. To be clear, my father, stepmother and I all reconciled our differences when I was a young adult and I was mature enough to realize that my teen years were difficult for all of us, not just me.



- I entered the convent of the Pittsburgh Sisters of Mercy when I graduated from high school. The Sisters of Mercy were a well-educated group of women who ran a hospital (Mercy Hospital in Pittsburgh) and a college (Mt. Mercy College, now known as Carlow University), as well as several high schools and grade schools in the Pittsburgh area, including St. Xavier Academy, where I had attended high school. It was natural that I would identify with these nuns who praised me and encouraged me in my studies. To this day, I value the years that I spent in the convent. It is where I learned forgiveness, where I learned the positive aspects of silence, where I learned my values. Most importantly, if it were not for the Sisters of Mercy, I would not be standing here before you as a physician.
- I attended medical school when only 10 percent of the classes were women. As a young nun, I was attending college with a chemistry major with the intent of obtaining my Ph.D. in chemistry at an outside university and returning to Mt. Mercy College to teach chemistry. But those times were interesting times. It was the 1960s. It was the era of Women's Lib, the Civil Rights Movement, the Vietnam War. Pope John XXIII had "thrown open the windows of the church," and there were dramatic changes in the Catholic Church. Priests were leaving the priesthood, nuns were leaving the convent, and both former priests and former nuns were finding other ways to serve their communities without vows of celibacy, poverty and obedience. Nuns were leaving the order of the Sisters of Mercy. My mother superior was concerned about the nuns leaving the convent with conflict and guilt in their hearts. She consulted with her brother, a psychiatrist on the faculty of the University of Pittsburgh Medical School, and he advised her to grow her own psychiatrist in the order by sending someone to medical school. My mother superior thought I would make a good doctor, and she suggested that I take the MCAT exam and apply to medical school. I did apply, and I did not get in .... for good reasons. When I was asked why I wanted to become a doctor, I dutifully responded, "Because my mother superior would like me to become a doctor..." I would not accept someone into medical school who gave me that answer, so I am not surprised that no one else accepted me either. So, I taught high school for two years and then reapplied to medical school with much more knowledge about medical school and what it required, and I was accepted at Penn State Medical School at Hershey, Penn. By then, I was having doubts about my own religious vocation and talked to my mother superior about it, but she told me to pursue medicine and even if I dropped out of the convent, I would still be a good doctor. Halfway through medical school, I decided to leave the convent. When I drove back to Pittsburgh to tell my mother superior, she encouraged me to stay in medical school and gave me a check for \$200 to help with my expenses. I had no money, and I had to apply for loans and scholarships to finish medical school. What I am most proud of, however, is that when I graduated from medical school, nine nuns showed up at my medical school graduation. Of the 39 graduates, only two of us were women. (Two other women had dropped out.)
- I was the only woman chair at UMass Medical School for over 10 years. It is strange for me to write this fact. I never thought of myself as the only woman chair; I was simply another chair. It was not until there were other woman chairs that I realized how much I missed having another woman peer. The other interesting fact is that after I was chair for three years, I was asked to be the interim CEO of UMass Memorial Health Care when the current CEO stepped down. This meant that I was now over all the men

chairs. The men chairs were always good to me, I might add, with very few exceptions. I held the interim CEO position for nearly one year. I learned more then about leadership than I ever learned before being CEO.

## **Lesson #2: The word administrator comes from the Latin root words "ad" and "ministrare" and means to serve or take care of.**

We leaders take care of those we lead. They do not take care of us. In human resource manuals, there is an axiom that goes something like this: Administration takes care of the workforce; the workforce takes care of the product; the product takes care of the bottom line. This is not completely true in health care, but the concept is a good one.

I once heard Dr. Eric Dickson, the current CEO of UMass Memorial Health Care, speak of his observations about dog sledding when he was visiting Alaska with his family. He said that the dog sled racers never went to sleep at night until they had checked every dog on the team. The dogs were checked for illness or cuts on their paws or other problems. The teams could only go as fast as their weakest dog. I am not comparing our workforce with dogs in a race, but I am saying that, as leaders, we need to be concerned about those who work under our leadership.

## **Lesson #3: When a person moves into a position of power, s/he gets a bigger head or a bigger heart; s/he rarely remains the same.**

I learned this lesson when I was a young nun in the convent. As a senior novice, I attended college and lived at the motherhouse in Pittsburgh with about 200 other Sisters of Mercy. Besides our regular jobs (in my case, a student at the college with a major in chemistry), we all had assignments at the motherhouse. I was the chief server, or, in laymen terms, the chief waiter over 11 other young novices, and I was responsible for making sure that all the nuns were served their meals promptly and efficiently and sometimes in silence when prayers took place during meals. In some ways, I was like a chief resident making out a call schedule. One Sunday afternoon, I was summoned to the Mother Superior's office and informed that one of the nuns at an outlying grade school had taken ill and was admitted to the hospital. I was expected to replace her while she was ill, and I was told to pack my suitcase for at least a one week stay at the local convent. I would be teaching 35 fifth-graders, and Sister Josephine (not her real name) had left her lesson plans for the week. I was ecstatic! I was being groomed to be a teacher and educator and here was my chance to prove that I could do that. And I would get out of the motherhouse and be in a real convent among God's people, and I would be in charge of a group of 10-year-olds.

As I packed my bag, I remembered that I had chief server responsibilities. So, I ran down to the refectory (dining hall for laymen) to inform Sister Alma (the chef) that I would not be organizing the servers for dinner. When I arrived in the kitchen, she was kneading bread and praying. I shouted, "Sister Alma, Sister Alma, I have something to tell you!" And she held up her hand indicating that I was to be silent while she prayed. After what felt like 10 minutes, but was probably only one minute, I interrupted again. "Sister Alma, I have something important to tell you!" I stated. "Sister Josephine has taken ill, and I am going to St. Peter's Convent to take over her class of fifth-graders. I am leaving in a short time. I am so excited. Oh, Sister Alma, I can't wait to teach

those 10-year-olds. They are going to learn so much this week, and Sister Josephine is going to be so surprised at how much they will have learned. And they will learn discipline and will behave. I will not tolerate misbehavior. So, I will not be here this evening to organize the servers. Do you want me to assign someone, or do you want to assign someone to be in charge?" Sister Alma stopped kneading the bread dough and looked at me. She did not answer my question. Instead, she stated: "When a person moves into a position of power, whether it is being in charge of General Motors or teaching fifth-graders, she gets a bigger head or a bigger heart. She rarely remains the same." I was 19 years old, and I had no idea what she was talking about. In fact, I wondered if she was starting to have dementia since she was quite old, at least 60 years old (at 19, I thought 60 was ancient; today, I would not mind being 60 again). I looked at Sister Alma for a moment and then said, "So....do you want me to assign someone or will you do it?" She looked at me and sighed and said, "I will take care of it. Be gone, my child."

About 10 years later, I finally realized what Sister Alma was trying to teach me. And I have never forgotten it.

#### **Lesson #4: Managers do things right; leaders do the right thing.**

There is a difference between being a manager and being a leader. Managers manage; leaders lead. In the process of leading, leaders are forced to make decisions for the institution all the time. Some decisions are easy, like choosing between right and wrong, but often, leaders have to choose between two rights or two wrongs. For example, most institutions have a limited amount of money to invest back into the institution. Which program or department or clinical unit receives the money?

One of my most difficult decisions occurred when I was the interim CEO. As luck would have it, there were seven union contracts up for negotiations during my term as CEO. When the first union contract was being negotiated, we knew that salary increases would be a major issue. The administrative team determined that we could only afford a small percentage increase, if any at all. Negotiations continued for over two weeks and were not going well. The COO agreed to participate in the negotiations to see if he could help the union understand our financial situation and move the discussions forward.

On a Friday evening at about 8 p.m., on my way home from work, I stopped to pick up a pizza and a salad at a local pizzeria for dinner with my husband, who was waiting at home for me. I called him at home and told him I had the pizza and was on my way. He said that he would open a bottle of red wine and let it breathe, so it would be ready when I arrived home, and he had a DVD for us to watch. Great, I thought. Then, my phone rang, and the COO told me that the union negotiators were on a quick break and I had to make some decisions. First, they were going to serve me a notice that they were going to strike the following week if I did not agree to their terms. Second, they wanted a raise higher than we had planned. How much will it cost if we give them the raise, I asked? And how much will it cost us to bring in replacement workers if they strike? I was on the phone in a pizzeria parking lot trying to write down numbers on the pizza box. But the pizza box was oily, and my pen would not work, so I was using my lipstick to write as the COO and I tried to figure out rough costs and a plan before the break was over. My husband was beeping me on

my beeper because he could not get through on the phone. The pizza was getting cold. Finally, we came up with a plan, but I was worried about three things: 1) could we really afford the compromised raise I was agreeing to do; 2) all the union negotiations coming after this one would expect the same percentage of raise; and 3) I would be considered a wimp and a weak CEO for giving in to the union. But the COO and I also talked about the morale of the institution if we had a strike, and that worried me even more, so I agreed to a pay raise just a little lower than they were requesting but higher than the one we originally planned. Frankly, I did not feel good about the whole thing.

I arrived home to an angry and frantic husband (who did not know why I was not home when I said I would be), who had drunk most of the wine already and made himself a junk food sandwich. The pizza was cold and unappetizing, and I was not in the mood to watch a movie when I did not know if I was going to have a strike on my hands in a few days. It was not a good evening.

At about 1 a.m., the COO called me with good news: Strike averted. The union agreed to a raise increase that was between our suggested percentage and their percentage. Life was good, right? I was relieved that we would not have a strike, but I wondered if I would be crucified for not being strong enough to hold out on the negotiations and stay within the confines of our finances. I still felt uneasy. The next morning, the *Telegram & Gazette* had a front-page article about the negotiations and praised the new CEO for agreeing to the deal that was cut. I was being praised! I was shocked. I learned from this experience that decisions are not always easy, but if we truly try to do what is best for the institution, we will at least have that on our side. (The true hero in this story is the COO who worked so hard to avert a strike.)

#### **Lesson #5: Get the right people on the bus and the wrong people off the bus and the right people in the right position on the bus ... and you can take the bus anywhere.**

This statement is the major premise of the book *Good to Great* by James Collins. Having the right team of people around the leader is essential for any leader to be effective. It is also important that team members have the freedom to be honest and direct with the leader. Team members must be able to tell the leader that s/he is wrong or full of hot air or going out on a limb or anything else that the leader should hear. Team members cannot be afraid to tell the leader what needs to be said.

#### **Lesson #6: Learn how to get the wrong people off the bus with tact, respect and dignity.**

In other words, leaders need to learn how to fire people or how to let people go. And we need to do it with compassion. This is a good time to remember that we all need to treat people like we would want to be treated in the same situation. I often use a "poor fit" analogy. An individual may be a poor fit for a specific position in the institution but be fine in another institution. I sometimes say that one can see a beautiful pair of shoes at DSW or Nordstrom's and desperately want them, but when you try them on, they hurt your feet. Poor fit. It would not be a good idea to buy those shoes. And if you already have such a pair of shoes and you never wear them, it would be a good idea to get rid of them. When you let someone go, that individual should not feel shamed or humiliated, but rather, they should feel respect.

**Lesson #7: In today's corporate milieu, leaders must understand the finances of their units to be effective.**

A former colleague, Bruce Meyer, MD, stated during a talk he was giving on the economics of medicine that "...healing is an art; medicine is a science; and health care is a business." To be leaders in the health care business, we must be knowledgeable of the income and costs of the units we run. If we don't know this information and depend fully upon others to know it, we could be unknowing victims of fraud. When I was a junior faculty member at another institution, the chair of a major department was asked to step down. There were rumors that he had committed fraud. I asked a more senior member of the faculty to explain what was happening. He told me that money had been siphoned out of the department by the department administrator, and it was accidentally discovered through a bank error because the administrator's name was similar to the name of the son of a senior faculty member. "Well, it wasn't the chair's fault, then, so why is he being asked to leave?" I asked. The senior faculty member responded, "Because he should have known!"

When it comes to finances, there are five issues we need to consider.

- Money is not a dirty word. Most of us did not become doctors for the money. We became doctors to take care of patients. We wanted to do good in the world. But sometimes, we physicians act as if money is beneath us and we should not have to worry about it. Others not as well-trained as we are can get their hands dirty, but we are above that. I think of this as physician naiveté; others call it physician arrogance.
- No money (or no margin) = No mission. If our institutions cannot make money, we cannot invest in capital to improve the physical plant, nor invest in our people by giving raises or bonuses. Many of us work for nonprofit organizations. That does not mean that we cannot make a profit. What we do with the profit is how we define nonprofit.
- Reimbursement inequity is not fair but a given. It is true that insurance companies reimburse some disciplines more than others, and it may not seem fair. We have to change the inequity or work within its constraints. Whining about it will not help us.
- Money often equals power. The individuals or disciplines that make the most money often feel that they should be the ones who decide how the money is spent. People who determine how money is spent have power.
- Understand your funding streams. In academic medicine, we have many different funding streams: reimbursement from patient care, education funds, research grants, clinical service contracts and philanthropy, to name a few. Understand how each funding stream contributes to your bottom line.

Most importantly, if you are the one who controls the purse strings for your unit, be fair in the allocation of resources and dollars. Being fair does not necessarily mean giving everyone an equal share.

**Lesson #8: Everyone is on the team and everyone is important to the mission.**

I read a story once about the early years when the United States was trying to put a man on the moon. A group of senators was touring the Houston space station and had met all the important people stationed down there: the astronauts, the scientists, the technicians and others. As they were preparing to leave the grounds, they walked through a hangar and saw a man sweeping. Apparently, he was a janitor. Being politicians, they stopped to speak to him. "What is your name?" one asked, and the man gave his name. "And what is your job here?" another asked. The man replied, "My job is to get a man on the moon. That is everyone's job here." Clearly, the leadership in Houston made sure that everyone knew that every job was important to the mission.

Closer to home, I have another example. Every year at the time of the UMass Medical School graduation, there is a big dinner for donors, dignitaries, senior officials and others on the evening before graduation, and there is a party for the graduates. Dr. Michael Collins, chancellor of UMass Worcester campus, always reminds the students and the guests to remember to thank the many janitors and environmental workers who would be around making sure that the place is clean and tidy for the students and their families. Dr. Collins always reminds us that these folks take great pride in seeing the students graduate.

Taking this one step further, I would ask each of you if you know the name of the person who cleans your office every day? If you do, wonderful. If you don't, find out and call that person by name. Your office will always be the cleanest one.

**Lesson #9: Listening to people is more important than talking to people.**

I learned this lesson when I was interim CEO. Because morale was low, I decided to meet as many of the UMass Memorial workforce as I could. I visited all three clinical campuses (University, Memorial, Hahnemann), including all three shifts, when applicable. I visited billing areas and administrative areas and cooking areas and other places I did not know existed. I thought I had seen it all. Then, Dr. Dan Lasser, chair of Family and Community Medicine, reminded me, "You haven't seen Barre, yet." "Who is Barry?" I asked him. "Why do I have to go to him?" "Barre is not a person but a place, and Family Medicine has a clinic there. The people in Barre think you are going to close that clinic." "But I am not going to close the clinic there; no one has even mentioned that to me," I told him. But rumors persisted, and Dr. Lasser invited me to visit Barre.

Barre is a lovely little town. I loved it. It was like stepping back in time. The clinic was lovely. It was well run, and it was obvious that patients enjoyed going there and the staff liked working there. I reassured all the staff members I met that I was not going to close the Barre Clinic. I thought my work was done, but Dr. Lasser told me I had to speak to the townspeople who were waiting for me in the town hall. I went to the town hall and was surprised to see that the room was filled and that there was a podium for me to use and a microphone set up for the townspeople to use. I was invited to the podium, where I introduced myself. I told them how happy I was to be visiting their charming city. I told them how impressed I was with the Barre Clinic. I told them that it was obvious to me that the Barre Clinic was very important to the town. I told them that I was not going to close the Barre Clinic. At that



point, I expected all to start clapping, but there was silence. So, I said, "Would anyone like to speak about the Barre Clinic?" People started coming up to the microphone. One lady stood at the microphone and said, "Dr. Felice, it is very important that you not close our clinic. It is the only health care facility we have here, and we need it." I replied, "I am not going to close the clinic." Then a man stood up at the microphone, and he said, "Dr. Felice, please don't close our clinic. My children go to that clinic, and they know all the staff and like them." I replied, "I am not going to close the clinic." After the third person spoke, I did not speak. I just listened as about 15 people spoke about the need to keep the clinic in their town. I realized that it was more important for them to speak and be heard than it was for me to speak and be heard.

#### **Lesson #10: Communicate, communicate, communicate. Have clarity and consistency in your message.**

If we don't tell the folks who work for us where we are going and what we are doing, why should they follow us? I once read an article written by an Army general who said that it was important to tell the troops what the mission is and what they must do. Then, it was important to remind them what the mission is and what they must do. And then tell them again. Some experts in communication state that a message must be given at least five times before enough individuals in a group hear the message and retain the information given. I think of this as similar to "herd immunity" in infectious disease.

#### **Lesson #11: Everyone thinks that s/he could do your job better than you ... don't take it personally.**

It is quite possible that many people could do our jobs better than we do. But, it is not THEIR job; it is our job, and we are the ones who have the responsibilities that go with the job. Most of the time, if your critics are offered your job, they won't take it.

#### **Lesson #12: It is lonely at the top ... even if the service is better. (Told to me by Dr. Aaron Lazare, former dean of UMass Medical School).**

The higher position we hold, the lonelier it may be. We cannot be friends with the people who work under us. We can be and must be friendly, but not close social friends. This is favoritism, and everyone will recognize it for what that is. Leaders must be perceived as fair in every respect. This is sometimes difficult for new leaders who are chosen from within. One day, they are peers with others; the next day, they are over their peers. The relationship shifts and changes.

I want to end this talk with a quote from Albert Schweitzer, who wrote: "I don't know what your destiny will be, but one thing I do know: The only ones among you who will be really happy are those who have sought and found how to serve"

Good leaders serve others. I hope that you embrace the leadership role you have and that you find the same amount of joy and happiness that I have been fortunate to experience in my own leadership positions.

*Marianne E. Felice, MD, is a professor of Pediatrics and Obstetrics/Gynecology at the University of Massachusetts Medical School and is a former chairperson of the Department of Pediatrics. She was interim chief executive officer of UMass Memorial Health Care for about one year in 2001-2002.*

## **Books on Leadership:**

**Brook, Robert H.: *Redefining Health Care Systems*. Santa Monica, CA. Rand Corporation, 2015.**

This book is not about leadership, per se, but has several chapters on leadership in a time of great change in the health care industry. It is a must-read for all medical leaders today. It is easy reading and only 136 pages long. Chapters are short and to the point.

**Kouzes, James M. and Posner, Barry Z: *The Truth About Leadership: The no-fads, heart-of-the matter facts you need to know*. San Francisco, CA. Jossey-Bass, 2010.**

The authors have researched exemplary leadership and list 10 "truths" that are foundations for great leadership. For example, Truth No. 8 is: You either lead by example or you don't lead at all. Gives lots of examples.

**Collins, Jim: *Good to Great*. New York, NY. Harper Business, 2001.**

A best-seller. Compares 11 companies that became great with 11 in the same industry that did not become great and explains why. Key concepts: Get the right people on the bus and the wrong people off the bus. Get the right people in the right position on the bus.

**Hertling, Mark. *Growing Physician Leaders*. New York, NY. Rosetta Books, 2016.**

The author is a retired Lieutenant General from the Army who became the CEO of a large health care system in Florida. He compares leading a group of physicians on the front lines of healthcare to leading soldiers in battle. Interesting comparisons. Great examples.

**Philips, Donald T.: *Lincoln on Leadership: Executive Strategies for Tough Times*. New York, NY. Warner Books, 1992.**

My favorite book on leadership. Lincoln became president days after the South seceded. He was elected to office by a minority of the popular vote. Some people thought he would simply be a puppet to his advisors because he was just a "country lawyer." He understood the issues on both sides of the war and always kept his eyes on what was best for the country as a whole, even when this did not please those around him.

**Lazare, Aaron: *On Apology*. New York, NY. Oxford University Press. 2004.**

We are all human, and we make mistakes. Sometimes, we hurt other people and do not mean to do that. If so, we need to know how to apologize.

**Zemke, Ron; Raines, Claire; Filipczak, Bob: *Generations at Work*. New York, NY. Amacom, 2000.**

This is a good book to understand the different characteristics of the four age groups in all of our departments and divisions: Veterans, Baby Boomers, Generation X and Generation Y. For me, this gave me insight into myself and why I react in a certain way in my interactions with certain faculty members.

# Reflections on Child and Adolescent Mental Health

Peter Metz, MD



Peter Metz, MD

Our current health and human services delivery system does not adequately serve the developmental – and especially attachment – needs of many vulnerable children and their parents. There is evidence that children and adolescents are demonstrating increasing levels of mental health symptoms over the past 25 years. The recent Centers for Disease Control and Prevention report of an overall 30 percent increase in suicide rates from 1999–2016 underscores this increasing problem. Children's mental health, resting on the interwoven strands of secure attachments to caregivers and safety from overwhelming adversity, is a key predictor of children's future overall physical and mental health status as adults,

importantly including their functioning as parents themselves.

Secure attachment experienced by the child is supported by the predictable, compassionate availability and attuned responsiveness of the parent/caregiver to the child. Conversely, there is also strong and ever-increasing evidence, supported by the CDC, that adversity in childhood, especially when recurrent, results in marked increase in the rates of major medical sequelae, including early death from obesity, smoking, alcoholism and substance use, which impacts cardiovascular, pulmonary and other end organ functioning (ACES study). With respect to behavioral health, risk of suicide attempts in people with six or more adverse childhood events (ACES) is 30 to 50 times that of people with no ACES, according to the CDC.

Statistics prove that a history of recurring adverse childhood experiences (trauma and disrupted attachments), particularly in children living in poverty, is the rule rather than the exception. This is NOT to say that all children who experience adversity suffer from this as adults. Remarkable resiliency and recovery are possible, especially now that we are starting to ask "What happened to you?" instead of just "What is wrong with you?" While heredity counts and biological psychiatric disorders like Autism Spectrum Disorder absolutely do exist, the importance of epigenetics and gene-environment interaction in brain development is scientifically well-established.

The role of childhood adversity in effecting adult outcomes is reinforced by the evidence that "toxic stress" (Center on the Developing Child, Harvard) in the fetus and young child can dramatically alter brain development due to the effects of chronically high levels of circulating glucocorticoids and inflammatory cytokines on neuronal development on an epigenetic basis. Significant in this regard is the adverse impact of toxic stress on maturation of the prefrontal cortex (PFC) and neural networks that support integration of PFC activities – including reflection, inhibition of impulse expression and problem-solving – to buffer the more limited and primitive fight, flight or freeze responses to threat available to an unbridled limbic system.

Secure attachment is a critical support needed to prevent and ameliorate the experience of trauma. Every time a child is maltreated, there is a caregiver who was unable to recognize and/or respond to the child's need for protection. A parent may be unable to appreciate the child's risk for trauma because the parent is unavailable due to barriers such as depression, dissociation, intoxication and/or simply the stress and distraction that poverty can create. The fact that more than 50 percent of children live in

poverty implies that more than 50 percent of their parents also are living in poverty. These barriers to good enough parenting to prevent harm to the child frequently are related to the parent's own history of trauma and insecure and/or disrupted attachments. The power and frequency of multigenerational transmission of trauma is well appreciated by mental health providers.

Sadly, after the child has been traumatized, the same initial inability of the parent to anticipate and prevent maltreatment frequently results in the parent's subsequent inability to provide adequate comfort and support to the child at a time when the child is in greatest need.

There is strong evidence that early supports for the development and maintenance of secure attachments between young children and their parents, especially in high-risk populations, can have a far-reaching impact on the child's development and adult functioning. One long-term prospective study that has been replicated in multiple settings is the Nurse-Family Partnership, created by David Olds. This intervention began during pregnancy as early as possible and continued through the child's second birthday. Nurses worked with low-income pregnant mothers bearing their first child to improve the outcomes of pregnancy, improve infant health and development and improve the mother's own personal life-course development through instruction and observation embedded over time in the supportive relationships developed during home visits. These visits generally occurred every other week and lasted 60–90 minutes.

A 15-year follow-up in this prospective study revealed that the rates of maltreatment in families where the program was received was less than half the rate in a matched control population. Child functioning was enhanced in multiple ways, including significantly fewer youth arrests. Over the 15-year follow-up with a matched control group, the program more than paid for itself in cost savings achieved by adolescence, not counting future cost savings achieved by youth who do not develop serious lifestyle illnesses and/or end up in prison.

The tragedy of our current situation is that we have both the scientific knowledge and financial resources to address early childhood risks to healthy development that, when unaddressed, lead not only to adult medical and mental health illness, but also to increased developmental risk in the children of the index child after he or she has become an adult.

If just a fraction of what is spent on health care in the last six months of life were spent on supporting mothers and fathers of young children starting at pregnancy, particularly those at risk by virtue of poverty and/or traumatic histories, we could avoid much chasing of our tails with expensive technical interventions at the end of life, not to mention limiting the additional huge and increasing costs to our society of incarceration, unemployment and homelessness.

Children are our future. We must advocate, as my guild, the American Academy of Child and Adolescent Psychiatry, does in concert with the American Academy of Pediatrics and many other groups, including those representing family voices. Advocacy, especially at the youth level, to fight the stigma of mental illness is key to helping decrease the risk of shameful isolation and additional burdens. And we continue to work to help one family at a time within the framework of a seriously flawed and under-resourced system. However, until we can address how to pay physicians and other providers to talk more and do technology less (including pharmacology) and unless we can get to a single federal payer that has an investment in lifespan costs, I fear we will continue to be stuck with trying to address downstream costs and suffering that could very often have been prevented or ameliorated.

*W. Peter Metz, MD, is a professor of Psychiatry and Pediatrics at UMass Medical School and director of Community Child Psychiatry at UMass Memorial Medical Center.*

# Mental Health, The Adverse Childhood Experiences and Addiction

Matilde Castiel, MD



Matilde Castiel, MD

Addiction is the largest public health and public safety crisis in this country. Nationally, more than 64,000 drug overdose deaths were estimated in 2016. The opioid-related death rate in Massachusetts has surpassed the national average, with an especially sharp rise in 2015 and 2016, at a cost of \$700 billion. In 2017, Massachusetts had 1,874 overdose deaths, 76 percent of which were males and 24 percent of which were females, which was a 10 percent decrease from the previous year. In Worcester, we

had 1,238 fatal and non-fatal overdose 911 calls recorded by our police department in 2017, which was a 7 percent increase from 2016 (1,156 fatal and non-fatal overdose 911 calls). There were 70 confirmed and suspected overdose deaths in 2017, a scant 4 percent decrease from 73 overdose deaths reported in 2016.

This disease has been devastating, not only due to deaths and non-fatal overdoses, but also because of the loss of relationships, marriages, families and neighborhoods and disruption of jobs, which affects the mental health of our entire community. Although progress in overcoming this epidemic has been slow, we have seen changes, but there is much more work to be done, specifically in the realm of treatment. One of the biggest challenges is getting primary care providers to provide Suboxone and/or Vivitrol. According to the American Society of Addiction Medicine, only 1 percent of primary care providers are certified for Suboxone treatment. Mental health treatment goes together with MAT (Medical Assistive Treatment), yet we have a shortage of social workers, psychologists and psychiatrists due to low reimbursement rates. Furthermore, we tend to focus on the middle-aged person who is overdosing in our community and fail to realize that those we are seeing actually began using drugs when they were adolescents. Addiction, in the majority of cases, is a childhood disease. Worcester Department of Public Health's data demonstrates that kids start using marijuana, cigarettes and alcohol at the age of 8 and use starts to peak at 13-16. Early use, along with trauma and genetics, predispose kids to addiction.

Based on dialogues with youth from the Worcester Recovery High School, we know they began to use drugs because of distressful

experiences such as bullying, low self-esteem and a long history of trauma. The study of Adverse Childhood Experiences (ACES), published in 1990 by Kaiser Permanente in California, has now been used as supporting evidence to show ACES to be a predisposing factor to addiction. These ACES include having a parent who has been incarcerated or divorced and mental illness and substance misuse in the family, along with abuse and neglect, just to name a few. Sixty-four percent of families across the U.S. have one ACE, and they occur in all races and ethnicities in the same proportion. Therefore, starting treatment in school with adjustment counselors, social workers and therapists, along with home visits, needs to begin in elementary school and continue through high school in order to prevent the effects of these ACES. In Worcester, we have launched a pilot program, through the Health Foundation of Central Massachusetts, working with four elementary schools and one middle school to evaluate and treat children as an avenue to prevent the adverse effects of ACES.

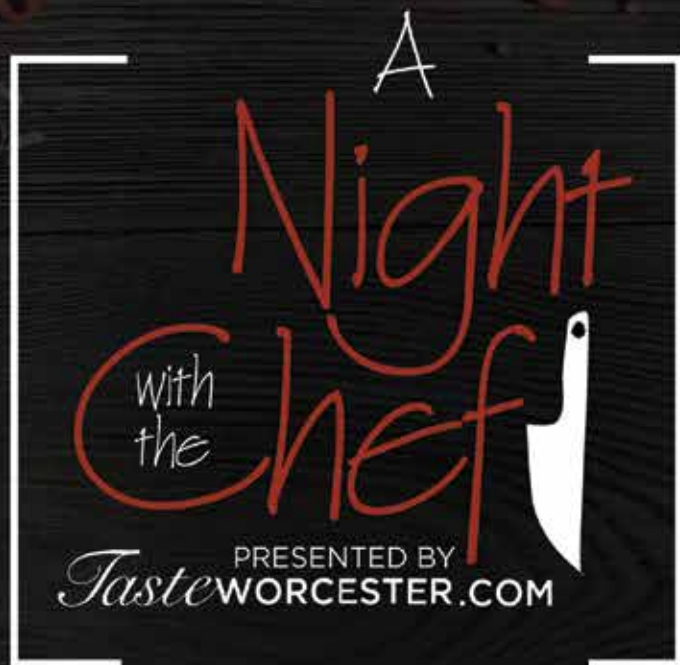
We also need to look at mental health treatment in the adult population, and a large emphasis has to be placed in making sure that clients are referred to treatment with a clinician and/or psychiatrist. Most patients have significant PTSD and depression, among other mental health issues, and treatment with CBT (cognitive behavioral therapy), psychotherapy and medical treatment with medication is essential. Understanding that these issues have been longstanding since childhood means that treatment needs to be long-term also. Due to the effects of stigma, clients themselves do not understand the correlation between mental health disease and addiction, and therefore, a thorough explanation is required. The effects of stigma will not change until people understand the physiology of addiction and how the ACES and continued trauma from toxic stress, such as incarceration, racism, homelessness and other adversities, continue to affect their mental health.

Unfortunately, at a time when mental health treatment is so crucial, we see problems in access to care for our patients and long wait lists. We need to advocate for increased mental health beds and an increase in providers, with a corresponding increase in reimbursements.

Meanwhile, as a community, we need to all reach out and help those suffering with addiction get into treatment and support them through the process of recovery and relapse. Our compassion is the beginning of treatment.

*Matilde Castiel, MD, is the commissioner of Health and Human Services for the City of Worcester.*





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# OB/GYNs and Primary Care Providers Can Help Suffering from Perinatal Depression with MCPAP for Moms

Nancy Byatt, DO, MS, MBA



Nancy Byatt, DO, MS, MBA

An expectant mom is looking forward to having a first baby with a planned pregnancy. But halfway through the pregnancy, something changes. She begins to feel down and bad about herself, has less energy and struggles to concentrate. Thinking this is a normal part of pregnancy, she ignores it. But it gets worse after her delivery. Feeling as if she is in a black hole of sadness, she often has her mother care for the baby, thinking the baby is better off without her.

This woman is a composite figure, based on the thousands of women for whom we have cared or met during our clinical work and research. Her story demonstrates the profound impact that

depression can have on mothers and their children.

One in seven women suffers from depression during or after pregnancy. Although it is twice as common as diabetes during pregnancy, it is often unrecognized. The unmet mental health needs of new and expectant mothers have rendered a public health crisis that impacts children, families and communities, as well as the affected women.

Despite the potentially devastating consequences of undiagnosed and untreated depression, most women do not receive treatment. Perinatal depression is often not diagnosed, and even when it is, providers may be at a loss as to how to best treat it. Obstetric and primary care providers are not trained to manage psychiatric illness and may lack confidence in their ability to talk to their patients about depression, assess it and offer suggestions about the various treatment and support options, including medication, therapy and lifestyle changes.

Fortunately, help is available, which we are proud to have launched right here in Central Massachusetts.

Recognizing a serious public health threat, in 2011, state lawmakers established the Massachusetts Legislative Commission on Postpartum Depression to create and fund screening and treatment initiatives statewide. Soon after, I was honored to be appointed medical director of a statewide program to better identify and treat depression in mothers during and after pregnancy.

With MCPAP for Moms, expert psychiatric advice is a phone call away for obstetric, pediatric, family medicine and psychiatric providers who are on the front line serving pregnant and postpartum women. It is funded by the Massachusetts Department of Mental Health as an expansion of the Massachusetts Child Psychiatry Access Program, which, since 2005, has provided rapid access to psychiatric expertise and mental health resources for pediatricians treating children with mental and behavioral health care needs.

Similarly, MCPAP for Moms ([www.mcpapformoms.org](http://www.mcpapformoms.org)) provides telephone consultation and liaison services for providers whose patients may be suffering from perinatal and postpartum depression. A perinatal psychiatrist is on call to answer questions about assessment, diagnosis, treatment and community resources from 9 a.m.-5 p.m. Monday through Friday. Providers can also talk with a care coordinator who can help identify and access mental health supports for women in their local communities. These and other supports are building the capacity

of front-line providers for pregnant and postpartum women to screen, refer and treat them for perinatal mood disorders.

Every provider in Massachusetts can access MCPAP for Moms services free of charge. Since its inception in 2014, it has helped more than 4,400 women across Massachusetts while drawing national attention and accolades.

Here in Worcester, the establishment of the new Division of Women's Mental Health by the UMass Medical School and UMass Memorial Health Care Department of Psychiatry underscores growing recognition of – and a growing response to – perinatal depression and other mental health issues affecting women across the lifespan. And now a new program, also developed here at UMass Medical School, is taking the MCPAP for Moms model nationwide.

Lifeline4Moms is focused on helping the health care community optimize maternal mental health and aims to cultivate local, national and international collaborations and partnerships that bring innovative ideas to scale. Washington and Wisconsin are starting programs, and 17 others are seeking federal grants, which are now available for other states to establish such programs.

In conclusion, we envision a health care system where we have the resources we need so that we can care for pregnant and postpartum women holistically by integrating obstetric and mental health care. Women need to know they live in a culture that supports them, listens to them and remains with them as they take on an extraordinarily challenging role. And providers need to feel comfortable broaching the subject with patients and following up with appropriate referral and treatment.

With MCPAP for Moms (855-MOM-MCPAP) in place, you can do more than just want to help your patients who may be suffering from perinatal depression. Now, you actually can.

*Nancy Byatt, DO, MS, MBA, FACP, is a graduate of the UMass Psychiatry Residency Program and the Harvard/Brigham and Women's Hospital Fellowship Program in consultation-liaison psychiatry. She is the founding medical director of MCPAP for Moms, a statewide program that has impacted state and national policies and funding for perinatal mental health care; executive director of Lifeline4Moms; associate professor of Psychiatry, OB/GYN and Quantitative Health Sciences and director of the Division of Women's Mental Health in the Department of Psychiatry at the University of Massachusetts Medical School, where her federally funded research focuses on developing and testing scalable interventions for addressing depression in obstetric settings. Dr. Byatt frequently serves on national advisory boards and expert work groups focused on perinatal mental health. She has more than 100 peer-reviewed publications, book chapters and national presentations to her credit and has been recognized with numerous national awards.*

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# Myths and Realities of Motherhood: My Experience with Postpartum Depression and Anxiety

Bridget Croteau



Bridget Croteau

This is the happiest time of your life. You'll be filled with such joy. Breastfeeding is easy and "natural." Motherhood will come "naturally." These are just some of the motherhood myths circulating society. Fact is, they aren't true for all – myself included. Being a new mom was far from the "happiest time of my life." I was one of the one in five mothers who suffered from a perinatal mood and anxiety disorder.

Before having my girls, I believed these myths despite the fact that I knew I was at high risk for having a PMAD. I have a personal history of depression and anxiety,

and I lost my teaching job prior to having my first daughter.

My first pregnancy was uneventful; my nurse practitioner called it "textbook." But, at our last visit, I began to leak fluid (which was tested in the office and the hospital and wasn't amniotic fluid). I was sent for a sonogram to make sure everything was okay. The sonogram technician found that my "fluid level" was slightly lower than normal. She left the room briefly to call our OB/GYN office and returned with congratulations – we were being sent to the hospital to have our baby. My husband and I were stunned, scared and nervous, to say the least.

At the hospital, I was given Cervadil with the plan of repeating it or using Pitocin after 12 hours, depending on how my body reacted. The plans failed. I had to have the Cervadil removed after nine hours because my daughter's heart rate declined. I was given oxygen and closely monitored.

After a total of more than 30 hours of labor, my daughter was born. I had a fever during delivery, and my daughter had a fever at birth. After a few pictures and a brief cuddle, she was brought to the NICU. I never felt the "motherly love and euphoria" I had expected to feel – I was exhausted and scared.

While my baby was in the NICU, I cried all the time. I felt like a failure as a mom already, and my daughter was only hours old. Breastfeeding did not come naturally to us; we struggled at each feeding. I was desperate to succeed at breastfeeding, as I felt I failed at everything related to motherhood already. I truly believe my postpartum depression began at this time. While in the hospital, I was never asked if I was okay or how I was feeling.

After a week, she was able to go home, but we still struggled with breastfeeding. I still had immense feelings of guilt, shame and failure. I continued to cry almost daily. There were many occasions I wanted to "run away" because I thought my family would be better off without me.

After four months, I realized I had postpartum depression. I reached out to my obstetrician's office and to a local support group for help. The nurse practitioner was sympathetic to how I felt and offered me a list of therapists to call. However, this list was outdated; it led me to numbers that were out of service or had no answer and no way to leave a message. This was very discouraging, and there was no follow-up from my doctor's office. I did begin attending a support group the following week and was able to find a therapist through my insurance. Many mothers (and fathers) are not as lucky as I was. With this help, I eventually became "myself" again.

When my daughter was 18 months old, I became pregnant with my second daughter. Again, the pregnancy was "uneventful," but we decided to change offices and use midwives instead. I made my midwives very aware of my history. They asked me almost every visit how I was feeling and genuinely sounded concerned about how I was doing, both physically and emotionally.

One snowy night in January, my second baby was born after a quick labor and delivery. She was healthy, happy and we were able to go home the following day. Breastfeeding was much easier this time. While in the hospital, we received a visit from the social worker, who talked to us for almost an hour. She made sure we had resources and help arranged for when we went home. I felt cared for and really appreciated the effort. This should be the case with all new moms and dads.

At home, I had help from my parents and a postpartum doula. Despite our preparation, after a few months, I began to feel very anxious. I was sleep deprived and stressed. Luckily, I had my support group and knew where to turn to for help.

The medical system could have easily failed me had I not been somewhat educated in the topic and self-aware enough to know I was in need of help. Because of what I went through, it is my goal to raise awareness for perinatal mood and anxiety disorders and help to break the stigma surrounding maternal mental health by sharing my story.

Perinatal mood and anxiety disorders are very common and absolutely treatable. However, most mothers and fathers do not get the help they need. As members of the medical community, you are vital to helping pregnant mothers and new parents.

- Ask mothers and fathers how they are doing and screen them at all visits.
- Know resources in your area where you can refer patients who are in need of help.
- Take classes and seminars on this topic; the more you know, the better you can help your patients.

For more information about resources in Massachusetts, visit <https://www.mass.gov/service-details/postpartum-depression-support>.

*Bridget Croteau is a stay-at-home mother and author, serving as Mrs. Suffolk County America 2018-2019 and a volunteer for the Postpartum Resource Center of New York. She can be contacted at [MrsSuffolkCounty2015@gmail.com](mailto:MrsSuffolkCounty2015@gmail.com).*



# No Hablo Ingles

Nandana Kansra, MD, MPH



Nandana Kansra, MD, MPH

My medical assistant walks into my office and states, “He is doing a lot better than the last time he was here.” I pause typing my notes for a moment and let the information settle in.

I think back to the numerous visits we have shared, trying to understand where his anxiety stems from and making changes to his lifestyle and medications. As I walk into the room, he greets me with a smile – a smile that for the first time reaches his eyes – and as he animatedly pulls out his diary to detail his progress, I know that, finally, his healing has begun.

As a primary care physician, the chief concern I encounter most frequently with my patients is “stress and anxiety.”

Today, 450 million people in the world live with mental illness. Forty million adults in the U.S. suffer from anxiety. Only 39.7 percent of those who suffer from anxiety actually receive treatment. There has been a significant increase in the number of teens and young adults with anxiety in U.S. since the 1940s. Twenty-five percent of teens in the U.S. will fit the criteria for an anxiety disorder at some time, and anxiety is the most common mental disorder in adults (according to the NIH). The U.S. (and other western countries) have a higher incidence of anxiety than the rest of the world, where the global prevalence of anxiety is only 7 percent. U.S. teens and 20-somethings have become progressively more anxious over the last 60 years, are the most anxious age range in our society, and are more anxious than their peers in the rest of the world. What is going on in our culture and environment that is making our 21st-century young people so anxious?

Well, for one, our youth live in a constant state of hypervigilance and FOMO (fear of missing out) – a term I heard for the first time from my young adult patient – a condition in which one will go to great lengths to stay connected with one’s peers and end up with anxiety when he or she loses the connection, even though he or she may not particularly like the peer group. Ironically, today we are connected digitally more than ever and disconnected from each other more than we have ever been.

It doesn’t get any easier for us adults by any means. Between juggling a rushed morning routine, brutal commute time, deadlines at work, running back home to after-school activities for children and getting dinner on the table, there is sometimes no time left to exhale.

For our mind, body and soul to be at peace, there has to be a pause. A pause that allows us to reflect, absorb and make conscious decisions. Some days, we completely miss the pause. How many of us actually take a few moments to reflect on our day before we fall asleep? Our minds are so busy thinking ahead to the next step that we lose what is currently around us.

A young patient I see in the office has a blood pressure of 160/90, and she is only 19. She asks for an urgent visit because she cannot keep up with her school grades, her part-time job and her volunteer work at her church.

Her social anxiety has caused her severe somatic symptoms, and she has had multiple ER visits for abdominal pain, all of which have yielded a negative workup. Overscheduling our work days to be ahead of the curve and to stay on top of a class is one thing, but when it starts to come at the expense of our health, we need to step back and re-evaluate our ability to balance our work with our emotional health. At our visit, we decide that it may be best for her to focus on the two things that give her most joy – her school and her church work – and she elects to take a leave from her part-time job.

Another reason for anxiety is over-parenting. A patient I saw a few years ago suffered from lifelong anxiety, alternating between severe bulimia and anorexia. Several visits went into us trying to figure out what was the trigger, and then she finally revealed she had been forced by her mom as a child.

Her mother, in her misguided attempts to be a good parent, had inadvertently caused severe emotional conflict in her feedback loop. The deep-rooted stress in not knowing how much food her body actually needed led her to alternate between periods of severe anxiety, anorexia and bulimia. It took us several years of working together to finally get her anxiety under control.

A common manifestation of anxiety is a panic attack. A middle-aged gentleman greets me with a sweaty handshake. “It is constant,” he states. “I cannot go to work like this. Every time my boss comes to me with a deadline, I get a panic attack.”

“Tell me more,” I say. “How many hours of sleep are you getting?”

“Five,” he states. “I get home around 7 p.m., eat dinner around 10, catch up on emails for an hour or two and go to bed around midnight.”

What time do you wake up? “I wake up at 5 am ...always a morning person.” Is your sleep restful? “No. Mornings are tough, and I usually drag in the morning, but I grab a Dunkin’ coffee on my way in ... I don’t usually eat breakfast...I have another coffee or two at work, which keeps me going till noon, and then I grab some soda and chips.” And what about any hydration? “No, I don’t like water ...It’s too bland.” As I delve further into this patient’s lifestyle, it becomes clear to me that his over-caffeinated, over-processed diet is offering him nothing of value in terms of good, wholesome nutrition, and part of his anxiety is stemming from that.

We sit down together and chalk out a lifestyle plan, and he agrees to start melatonin at bedtime to help him get at least seven hours of sleep. We discuss his diet, and we make a simple meal plan for him for the next few weeks. We discuss medication...at this time, he wishes to try lifestyle first.

As I leave his room, I cannot help but feel a little sad that when we talk about stress and anxiety how narrow the armamentarium of our treatment plan is in primary care. “Take this prescription and see the therapist” is not an approach that works or one that helps. The lack of access in primary care to mental health providers is an ever-

widening chasm. This, coupled with a health system that is already burdened with an epidemic of anxiety, leaves it pretty much up to the primary care provider to diagnose and treat mental health disorders like anxiety and depression.

I truly believe that no medicine can fix mental health issues unless a concerted approach is made towards wellness from healthy eating habits, exercise, hydration, emotional support and getting restful sleep. We are what we eat, and scientific studies are now revealing that the gut microbiome and mental health are intricately interconnected. Recent research validates that poor dietary habits can produce “dysbiosis” in the gut, which can cause a paucity of tryptophan, the building block for serotonin, i.e., “the happy hormone.”

If we simplify this, the research is following the ancient wisdom: “Don’t eat anything your grandmother wouldn’t call food.” Back in the day, when lives were uncomplicated, we ate real food, we had stronger family ties, there was no social media, we moved more, we slept soundly, we interacted a lot more socially, children played together for hours in the neighborhood, multigenerational families lived together, and stress and anxiety were rare disorders.

Another significant issue that affects our anxiety barometer is our inability to let go of our day-to-day stress. “Let’s work on our breathing,” I tell my patient, and we sit down, and for two minutes, we inhale and exhale, allowing our breaths to synchronize. At the end of the two minutes, both of us are relatively calmer and more focused. “Five minutes when you wake up, and five minutes before you fall asleep,” I tell her as she leaves.

“And I will see you on the weekend,” she states, as she smiles and I watch her take her walker and slowly walk down the hall.

On the weekend, I will meet the same patient at my weekly wellness walks with the community. Three months ago, she lost her husband of 49 years. Her children, busy in their lives, have done what they can and moved back into their respective roles of spouse and parent, and she is left alone to deal with the emptiness of her life.

A few months later, she is still walking with us, now every weekend. Now, having made friends with other walkers, she has started seeing a physical therapist because she wants to get rid of her walker and get stronger. She has started going to classes at the senior center, and last week, she decided to take a step-dancing class with encouragement from some of the other walkers.

An oft-missing part of our stressed-out lives is the beauty of humor, which is a powerful emotional coping tool. A line from comedian Ronnie Shakes comes to mind that always makes me smile: “After 12 years of seeing me, my psychiatrist finally said something that brought tears to my eyes,” he said. “No hablo ingles.”

Yes, anxiety is the most common disorder we see in primary care, but over the years, I have learnt that love, humor, empathy and medication (when needed) can be powerful tools that we can use to help our patients lead healthier, less stressful lives.

*Nandana Kansra MD, MPH, is an assistant professor in the Department of Medicine at UMass Medical School and a member of Saint Vincent Medical Group.*

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# The Time Is Now – Shifting the Landscape of Global Mental Health

Raghu Kiran Appasani, MD



Raghu Kiran Appasani, MD

Mental health, mental illness, mental disorders, psychiatric illness – whatever you want to call it – is on the rise. According to the World Health Organization, depression alone will be the leading cause of disability worldwide by 2020. I have been fortunate enough to join the growing movement in global mental health. Since 2010, my work has primarily been focused in India, developing and delivering mental health education and access to care for those in rural communities. Over the past four years, I have been able to build upon my foundation of knowledge as a medical student at UMASS Medical

School and quickly learned that mental health is a human condition that far exceeds geographical, cultural or socioeconomic boundaries. As an example, just look at the numbers around youth suicide – they are shameful! There is one suicide occurring about every 40 seconds across the globe. What are the causes behind this striking rise in mental health issues and how can we do better?

These are the questions that continue to motivate me to pursue working in the field of mental health. During my time working with communities, families and patients in India, I learned the importance of social structural support in recovery. Yes, pharmacological and western medicine are useful in psychiatry, but what appears to be even more important in the long run is social support and alleviation of stigma around mental health. Through my organization, The MINDS Foundation, we have been able to provide mental health educational workshops in villages in Gujarat, India, and provide mental health training for front-line community health workers and schoolteachers. Through this approach, we have already seen a dramatic increase in well-being in communities and an increase in resource utilization. Specifically, the interactions between community members and those undergoing treatment has increased to a point where previously excluded individuals are now welcomed into social gatherings. In the coming year, we are scaling to other geographic regions throughout India.

My clinical experiences in the United States have highlighted one major important piece that is often lost in the one-way street approach to global health. Traditionally, the field of global health has been an almost parachute-like approach to bringing western ideals and methods to “developing nations.” Instead, we should embrace lessons learned from other countries. The successful implementation of task-shifting models, train-the-trainer and community-based health education are working quite well in these developing nations, and they are key methods that we must begin to embrace in the United States, because when it comes to mental health, we are all living in a developing country. Due to this current global state of mental health and the intrinsic nature of mental illness not discriminating its patient population, I encourage of those in the field to expose themselves to a population consisting of all

socioeconomic classes coming from a diverse array of backgrounds. I never thought that my experiences working in rural India would align with and provide me necessary skills for working with patients in urban America.

During my inpatient psychiatry rotation at UMASS Medical School, I admitted a 30-year-old gentleman who moved from India in 2015 to complete his master’s degree. He recently lost his job and, after what appeared to be dissociative fugue and a state of psychosis, ended up in Massachusetts from California. Prior to admission, he was found having overdosed on sleeping pills in a motel room. This man had no family in the United States; he had some friends; he was in a new culture, far away from home. He was having auditory hallucinations for days, had not slept, was not eating and now found himself in a locked psychiatric unit. By observing the interview as my attending asked questions, it became clear from his body language that he was terrified of the whole situation. He was normally a high-functioning individual, but he was having significant word-finding difficulty. The occupational therapist kept saying that he was not doing well on their tests. I realized that this individual did not have the understanding about mental health the staff on the unit assumed he had. They did not understand his cultural framework or upbringing, which had led to his lack of mental health literacy. Due to my experience in the mental health system in India, as well as my research in stigma, I was able to connect with this patient in his native language, answer his questions, clear his confusion and even speak to his worried family overseas. I continue to learn from each and every patient encounter; this particular one taught me the importance of listening, observing and, most importantly, respecting cultural background and its influence on perceptions of mental health, which all helped to accelerate the development of trust. For those that may not have yet had such exposure, it becomes vital to listen to the patient and try to understand their background and culture, in turn, working as a team to come up with a mutual treatment plan.

Psychiatry has traditionally dealt more with mental illness than mental health, putting it at odds with the culture of global health. Mental health professionals have a tendency to help those seeking help, causing reactive behavior versus active – and perhaps this is part of the nature of the profession, to sit back, observe and listen. This leads to a culture of treatment, instead of focusing on prevention, possibly caused by the lack of professionals in the field and minimal financial support for such efforts. But despite all this, some in the field are beginning to take an active role in leadership to shift the world’s stage on mental health. Hence, a specialized breed of psychiatrists, known as community or public psychiatrists, are left with the responsibility to reach out to the world beyond clinics, inpatient wards and outpatient rooms.

Therefore, I would like to leave you, the reader, with a call to action. Together, we must all stand up, speak up and advocate for better policies and implementation of resources for mental health that focus on prevention. For those of you entering the field of mental health, I encourage you engage with your patients to understand their culture, social status, economic status and overall background, as this will help you to understand the origins of their definition of mental health.

*Raghu Kiran Appasani, MD, is the founder and CEO of The MINDS Foundation and a 2018 graduate of UMass Medical School.*



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# Worcester's Time Is Now – One Year Later

City Manager Edward M. Augustus Jr.



City Manager Edward M. Augustus Jr.

It is a truly remarkable time in the City of Worcester's history.

As in the field of medicine, sometimes progress is quick, sometimes it is slow, but it never stops.

That's what we are seeing in Worcester. There is an undeniable energy in our city right now, and it shows no signs of slowing down.

Worcester is ranked the second-largest city in New England, but that's just a number. The size of our population does not define us – the people themselves do. The

people of our city have passion. A passion to excel, a passion to make this the best city it can be.

I believe that what we are accomplishing in Worcester is the result of partnerships, collaboration and unrivaled dedication.

Call it what you want – a renaissance, a renewal, a revitalization, a city on the move.

Over the past year, there has been an explosion of development in downtown Worcester and the surrounding area as part of a 20-year, \$90 million Urban Revitalization Plan.

We are experiencing a great period in Worcester, but our work is far from over. We are not slowing down. Good times and success shouldn't be limited to short spans of time or experienced on occasion. It should be consistent. Here, in Worcester, we have even more on the horizon.

I invite everyone in the city to join us as we continue making Worcester a dynamic and safe destination, where people want to live, work and play.

We are diverse, we are inclusive, and we are progressive. The sense of community here is contagious. It will take all of us working together to keep moving Worcester forward.



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# The Uncooperative Patient and the Least-Restrictive Protection Approach

Peter J. Martin, Esq.



Peter J. Martin, Esq.

It is a dilemma inherent in caregiving: what to do when a patient disagrees with what appears to be the obviously correct treatment decision? Inpatient facilities can suffer significant financial losses when a patient refuses care but cannot legally be transferred to another facility. One Massachusetts hospital faced this issue in a case decided by the Massachusetts Supreme Judicial Court on May 11, 2018, *Guardianship of D.C.*, which offers helpful guidance on the scope of authority of both courts and guardians.

In January of 2016, the 79-year-old D.C. was admitted to the hospital with a hip fracture but refused to have corrective surgery or to take any medications. D.C. also presented with acute renal failure, pancreatitis and cardiac issues; she underwent a coronary bypass and a mechanical heart valve replacement. At the end of January 2016, the hospital petitioned the court for appointment of a guardian with specific authority to admit D.C. to a nursing facility. A temporary guardian was appointed in February and extended in March, but the guardianship lapsed in June. The hospital then went back into court in July with a new guardianship petition, stating that, in the SJC's words, "D.C. was an incapacitated person in need of guardianship based on her insistent refusal of medical care." A different judge held a trial at the hospital in September of 2016 and issued an opinion in November of 2016 that D.C. was not incapacitated. The judge wrote that D.C. was "demanding, difficult, obstreperous and plainly refused to assist or participate with various medical care personnel" but was not incapacitated, and therefore, a guardian could not be appointed for her. Nevertheless, the judge allowed the hospital's request that D.C. be transferred to a skilled nursing facility, finding that an acute setting was no longer required for her.

Presumably at this point, the hospital, armed with the judge's ruling about a SNF transfer, contacted appropriate facilities. One can only wonder what those facilities made of the judge's ruling, which fell short both of an appointment of a guardian with authority to consent to a transfer and of a direct order that such a transfer take place. Now, some 10 months after D.C. was admitted to the hospital, it moved for clarification of the judge's order.

The judge reiterated the finding that D.C. was not incapacitated. He also denied the hospital's requests that the judge appoint a guardian with authority limited to consenting to a SNF, or alternatively, that the judge issue an order regarding the hospital's authority to transfer D.C. to a SNF. Instead, the judge reported three questions to the Appeals Court. Before that appeal was heard, the hospital filed yet another petition for guardianship, and on Nov. 8, 2017, the judge found D.C. to be incapacitated and appointed a guardian with authority to admit D.C. to a nursing facility. One can presume that D.C. was then transferred to

a suitable facility, some 21 months after being admitted to the hospital.

This sad saga left the hospital struggling to find recourse to get its patient the appropriate care in the right setting, with the patient being uncooperative but not legally incompetent. The three questions posed to the Appeals Court reflect three alternative forms of recourse. First, should a finding of incapacity be made, can a guardian without specific authority to do so admit the patient to a nursing facility? Second, can a limited guardian be appointed with authority to admit to a nursing facility if the patient is not deemed incapacitated? Third, can a probate court order a patient who is not incapacitated to be transferred to a nursing facility?

The SJC answered all three questions in the negative. However, with respect to the first question, the court stated that once there is a judicial finding of incapacity and a further finding that transfer to a nursing facility is in the patient's best interest, then a guardian can admit the patient to the nursing facility, even if the patient objects. (The best interest finding can be omitted for short-term nursing facility admissions, but only if the incapacitated person does not object.) This answer clarifies what had apparently not been entirely clear under the new Massachusetts Uniform Probate Code (MUPC), which went into effect in 2009. The need for such clarification is suggested by the fact that the SJC took the initiative to consider the questions posed to the Appeals Court. The Court stated that there had been little opportunity to provide guidance on the new statute and a matter of "significant public importance." While the SJC did consider the particular questions posed, it is significant that it did not consider "the legal options available to an acute care hospital where a patient who is not incapacitated fails to leave upon discharge."

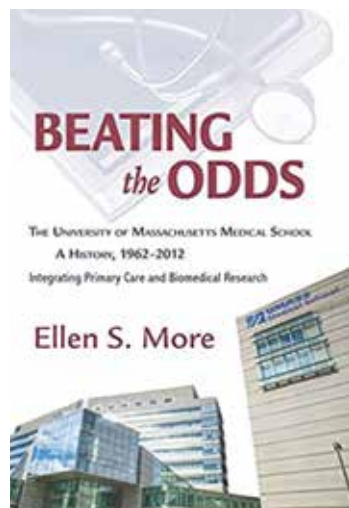
In addressing the three questions, the Court described the process of obtaining a general guardianship. That process includes consideration of the appropriateness of a limited guardianship in an effort to "encourage the development of maximum self-reliance and independence of the incapacitated person," in the words of the statute. In a Prefatory Note to the MUPC, this is called the "least-restrictive protection approach." Given this background, it is not at all surprising that the SJC would answer all three questions posed to the Appeals Court in the negative. In each case, the maximum feasible autonomy of the patient is furthered by requiring a best interest finding for an incapacitated person, and requiring in every case a finding of incapacity, prior to a nursing facility admission.

Inpatient facilities faced with situations such as D.C.'s might not, in appropriate cases, have to opt for the lengthy and frustrating guardianship process described above. There is still the option of discharging patients against medical advice, although that, too, can be troubling. In any event, caregivers need to remember that an "insistent refusal of medical care" does not mean that the patient is legally incapacitated. And, as much as caregivers want to provide care, even to the "demanding, difficult, obstreperous" and uncooperative patient, sometimes the legal system's insistence on the least-restrictive approach means caregivers have to let patients make bad decisions for themselves.

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

# Beating the Odds: The University of Massachusetts Medical School, A History 1962-2012. By Ellen S. More. Tide Pool Press, 2017.

Thoru Pederson, Ph.D.



In the 16th-19th centuries, at Heidelberg, Pavia and elsewhere on the continent, medicine had been taught in a standard model, with variation. In America, the two pioneer medical schools at Michigan and Johns Hopkins captured a new vision, embodied by the “two Williams” (Welch and Osler, respectively). It was a sincere start, but after the scathing

Simon Flexner report on how badly medicine was being taught virtually everywhere else in America, the time had come for a sea of change. It did not happen overnight, but by the post-World War II era, several of the largest U.S. universities fortified their medical schools (Harvard, Yale, Washington University, St. Louis – all strong from their outset but now rejuvenated) or launched new ones. By the 1960s, we saw the end of the pre-modern era of U.S. medical schools arising or strengthening, but with yet more to come as National Institutes of Health funding grew along with institutional aspirations. In this ascent, we saw the University of Washington, the University of California, San Francisco and the University of Texas Southwestern Medical Center as the most meteoric. A little later, the medical school at the University of California, San Diego, arose dramatically.

In her book, Ellen More sets forth the story of the University of Massachusetts Medical School, founded in 1962. It is an account that rivals the drama and rapidity of ascent of several of the aforementioned latter-day saints of U.S. medical schools. Dr. More wrote as an insider on the faculty of the institution, and yet, did so with a sober objectivity in keeping with her career as a historian of medicine. She develops the story of the University of Massachusetts Medical School in a steady march of facts, and even though there were moments of serendipity – and

indeed, momentary chaos – she resisted melodramatic treatment. There were many characters, medical and political, and they are all presented in accurate and dispassionate terms. An overarching theme the author vividly captures is the zeal felt by the founders of the institution that the Commonwealth of Massachusetts should not have its entire medical estate located east of the Charles River. She also poignantly conveys the mission of having a medical school train physicians who would stay and practice in the state.

As Dr. More relates, shortly after its first decade, the University of Massachusetts Medical School had attained national stature in the training of family practice physicians, consummating its charter. Then, quite suddenly in the 1980s, basic biomedical research arose on the campus and ascended in a league parallel with the increasing excellence in medical education. The author also presents a very insightful account of the University of Massachusetts Medical School’s controversial decision to sever its hospital. She avoids pointing fingers but presents the story in accurate terms. Happily, the school and the clinical system have now come to synergize in important ways.

This book has few parallels. Errol Friedberg’s *From Rags to Riches – The Phenomenal Rise of the University of Texas Southwestern Medical Center at Dallas* is a story almost out of a Hollywood script, and yet, even with such a great story, Friedberg can be faulted for often resorting to long tracts of institutional boilerplate text and is somewhat uncritical in some passages. Ellen More has written the story of the University of Massachusetts Medical School *ab initio*, as the true historian she is. The book is engaging, but not because of any hyperbole she created. It is engaging because the story itself is, and she has cast it accurately and with an engaging but sober style.

*Thoru Pederson, Ph.D., is an Arnett Professor of Cell Biology, professor of Biochemistry and Molecular Pharmacology and associate vice provost for Research at UMass Medical School.*





## Gateway to the Polio Vaccine

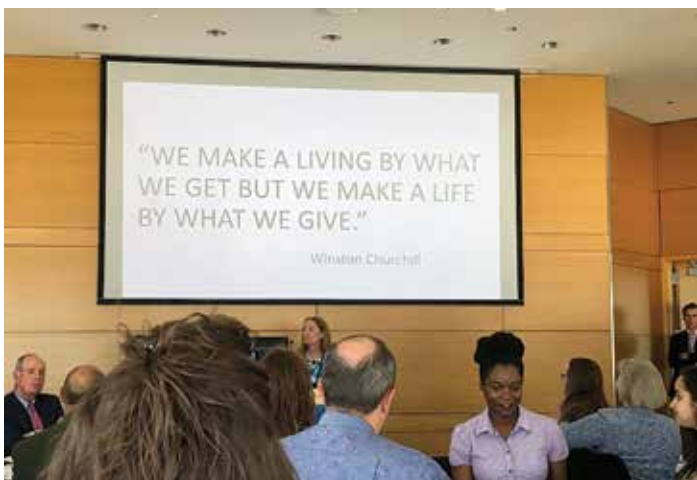
Alan Witschonke

The unveiling of the portrait, *Gateway to the Polio Vaccine*, took place on May 29, 2018, at the Lamar Soutter Library, University of Massachusetts Medical School.

The portrait celebrates an important, transformative and Nobel Prize-winning event in medical science, public health and the history of medicine by growing the polio virus for the first time in tissue culture, here in Massachusetts, which enabled the vaccine development. Dr. Leonard Morse, professor of Medicine at UMMS and commissioner of Public Health for the City of Worcester from 2002-2011, commissioned the portrait through the auspices of the Boston Medical Library (BML). In 1963, Dr. Morse also spearheaded the initial program for polio vaccination in Worcester through the sponsorship of the Worcester District Medical Society (WDMS).

With this background of partnerships and collaboration that spans the UMMS, WDMS, the BML, Worcester and our broader region, along with our shared commitment to public health, the history of medicine and the legacy of Dr. Leonard Morse as a physician, clinician scientist, leader, role model and champion of public health and the medical humanities, the BML is pleased to support the "on loan" display of the polio portrait at the UMMS campus.

A link to Tuesday's video of the unveiling of Gateway to the Polio Vaccine: [vimeo.com/272452623](https://vimeo.com/272452623).



## The Gold Humanism Honor Society Event May 29, 2018

Dr. Jane Lochrie was chosen by the Gold Humanism in Medicine Honor Society (GHHS) and the UMass Medical School to win the highest award in humanism for a physician – The Leonard Tow Award. Here, she delivers her response to the GHHS at the annual Induction Ceremony on May 29, 2018.



## Health Matters TV Program Celebrates Over 175 Programs Offering Valuable Health Care Information to the Community

The Worcester District Medical Society was recognized at the WCCA TV Annual Meeting on June 14, 2018, for producing more than 175 shows.

*Health Matters* may be viewed on WCCA TV Cable Access Channel 194.

Airing times: Wednesday at noon and 7:30 p.m., Thursday at 7 p.m., Friday at 9:30 p.m.

To view *Health Matters* anytime, visit the WDMS website: [wdms.org](http://wdms.org).

*Michael Hirsh, MD, and Bruce Karlin, MD (hosts of Health Matters), with Joyce Cariglia, Melissa Boucher and Martha Wright, MBA. (Hosts Jay Broadhurst, MD, and Lynda Young, MD, were unable to attend.)*

# WORCESTER DISTRICT MEDICAL SOCIETY

## 2018

# CALL FOR NOMINATIONS

### AWARDS

#### 28<sup>TH</sup> ANNUAL DR. A. JANE FITZPATRICK COMMUNITY SERVICE AWARD

Established by WDMS to recognize a member of the health care community for their contributions beyond professional duties, to improve the health and well-being of others and to commemorate the life-long community contributions and exemplary efforts of Dr. Fitzpatrick in the Worcester Community.

Return to:  
**Worcester District Medical Society**  
321 Main Street, Mechanics Hall  
Worcester, MA 01608

Take a moment to  
recognize a  
deserving colleague

#### TO NOMINATE AN INDIVIDUAL PLEASE INCLUDE:

- 1) A letter of nomination
- 2) A current curriculum vitae of the nominee
- 3) Letters of support are encouraged

#### 2018 WDMS CAREER ACHIEVEMENT AWARD

Established to honor a WDMS member who has demonstrated compassion and dedication to the medical needs of patients and/or the public, and has made significant contributions to the practice of medicine.

Fax, Phone or E-Mail  
Fax 508-754-6246  
E-Mail: [wdms@massmed.org](mailto:wdms@massmed.org)  
Phone: 508-753-1579

**DEADLINE:**  
**August 29, 2018**

*Please print all information*

Nominator \_\_\_\_\_ Phone \_\_\_\_\_

Email \_\_\_\_\_ Fax \_\_\_\_\_

Award \_\_\_\_\_

Name of Nominee \_\_\_\_\_

Email \_\_\_\_\_ Hospital Affiliation \_\_\_\_\_





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