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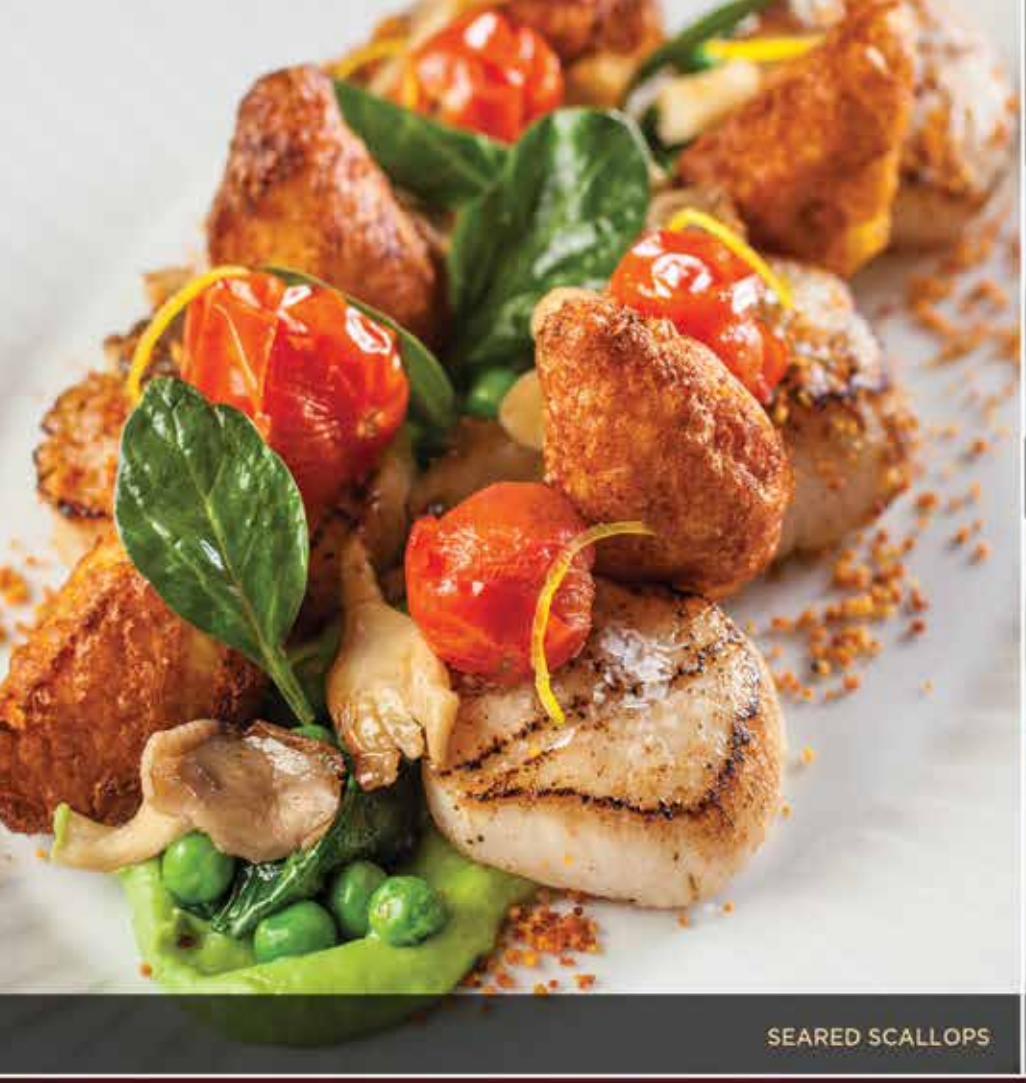

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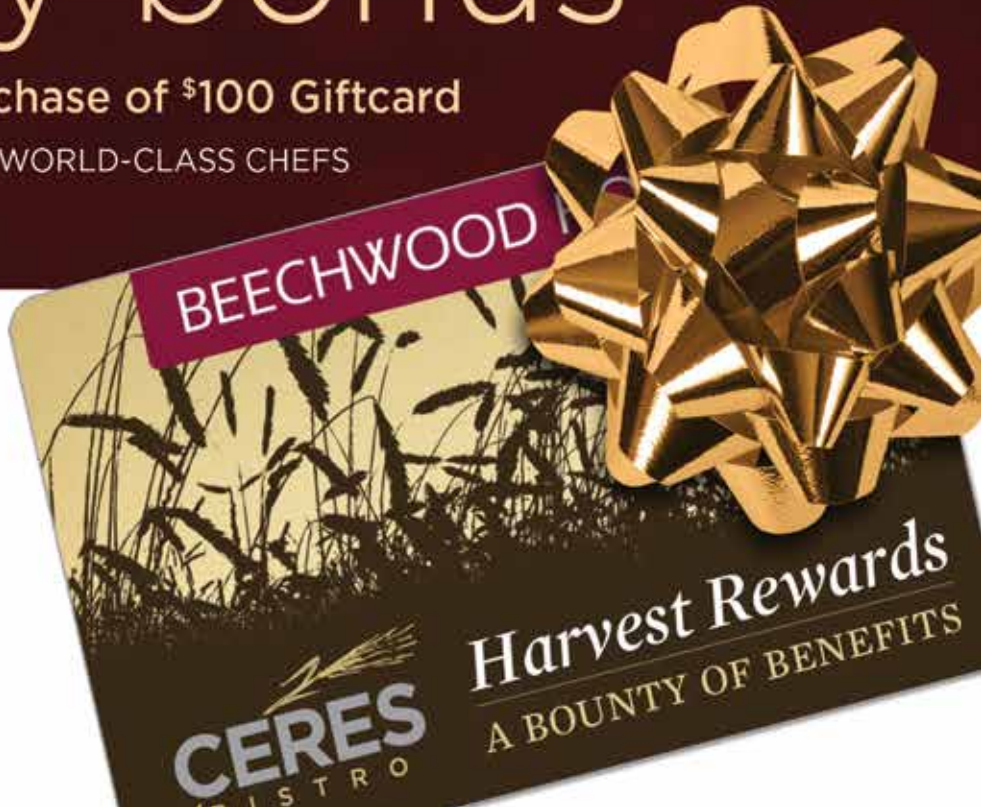

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Vol. 79, No. 6

ON THE COVER:
UMass Memorial Children's Medical Center Child Protection Program (CPP)

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

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Editorial

Jane Lochrie, M.D.

Jane Lochrie, M.D.

Her headstone reads "Our Special Angel." Who can live in Massachusetts and not be touched by the tragedy of Bella Bond? Advocates who spent the summer helping search for Bella's identity are now trying to make sure that she will be enveloped in the love that she should have received while she was alive. Not as widely publicized, but equally disturbing, is the death of the 22-month-old child from Auburn who died while under foster care.

Just how bad is the epidemic of child abuse in the United States? The U.S. has one of the worst records among industrialized nations, with 6 million reports of child abuse every year and, on average, five deaths from child abuse and neglect every day. More than 80 percent of deaths are children not old enough to attend kindergarten. This issue of *Worcester Medicine* looks at what is being done in Worcester to help victims of child abuse and to help prevent it.

In the first article, Dr. Sell reviews the role of the Child Protection Program (CPP). This program, under the auspices of UMass Memorial Medical Center, is exclusively involved with the medical care of the child. The CPP's role is to make sure that the child is safe, but it does not have any legal authority and does not investigate any allegations. CPP advocates for the child and the family as a whole. This article gives a lot of tips on the practitioner's role in child abuse.

The concept of "toxic stress" is introduced in Dr. Forkey's article. This constant stress triggers dysregulation of the hypothalamic-pituitary-adrenal axis, reticular activating system and the inflammatory response system. Consequently, the trauma experienced in childhood impacts the child's physical and mental health in adulthood.

Melissa Angiolillo describes the function of the Children's Advocacy Center (CAC) of Worcester County. The CAC works collaboratively with the Child Protection Program and provides a multidisciplinary response to alleged victims of child abuse. One of the most important roles of CAC is the forensic interview, most often consisting of law enforcement, the Department of Children and Families and the District Attorney's Office. The forensic interviewer gathers the information in a child-friendly and non-leading manner while the team watches from an observation area.

The Massachusetts Sexual Assault Nurse Examiner (SANE) Program is described By Ms. Hazard and Ms. Marchant. This program provides compassionate, forensic nursing care to sexual assault victims. Recognizing that patients at different stages in their lives have unique needs, these nurses are specially trained to care for adults, adolescents and children, and they provide individualized care and forensic evidence collection to all age groups. If law enforcement has not been involved, SANE will notify the proper authorities if the victim is agreeable.

Drs. Damle and Hirsh give us the perspective of trauma surgeons. Approximately 10 percent of patients at a Level 1 trauma center are victims of non-accidental trauma (NAT). If the NAT is not identified, 25 percent of these children will return with more serious injuries. Studies show that race and economic status directly affect the suspicion of child abuse. In order to address these concerns, UMass introduced a protocol that refers all children with traumatic injuries who are nonverbal to the Child Protection Program (sited above).

In response to the unique needs of children in foster care, UMass Medical Center founded Foster Children Evaluation Services (FaCES) in 2003 to ensure that all children entering foster care would have appropriate care adapted to their special needs. Dr. Sagor states that these children have a higher prevalence of both medical and mental health issues and a greater incidence of developmental delay and behavioral problems. The objective of FaCES is to perform a comprehensive evaluation of the child and send all pertinent data to the child's primary care provider.

This issue contains two very important As I See It commentaries. The first message is from the social workers at the Child Protection Program, opining that it is everyone's responsibility to protect the children under our care. The second is a message from the WDMS Public Health Committee regarding the opioid crisis. As always, our president, Dr. Baker, has an important message for us – it is our privilege to inspire and share our knowledge with students and residents. Last, but not least, don't forget to read Legal Consult by Peter Martin, Esq., and Joyce Cariglia's Society Snippets.

letter to the editor

To the Worcester District Medical Society:

I just wanted to update you on the response the Child Protection Program (CPP) has been receiving after the Annual Cottle Lecture held on October 6th. We have received phone calls from physicians and from the City of Worcester to provide trainings for staff. The response in general has been so well received from those in attendance and regret from those that couldn't attend! We at CPP thank the Worcester District Medical Society for this opportunity to provide information and resources for the health care providers in our area. As you know, the subject of child abuse and neglect is a difficult topic for many. In recognizing this need at this time, the Worcester District Medical Society Board has allowed CPP to reach out, and, in time, together we will make our community safer for children and families.

I really can't imagine what will happen after the publication! It has been such a pleasure to work with you.

Thank you,

Patricia A. Vanasse, LICSW

Licensed Independent Clinical Social Worker for UMass Memorial Children's Medical Center, Child Protection Program

correction

In the September/October issue of *Worcester Medicine* (Vol. 75, No. 5), the title of Esquire was mistakenly omitted from the byline of Attorney Libbie Howley, co-author of Legal Consult, "The apparent authority of a doctor in hospital clothing."

Inspiring a future generation: All it takes is you!

Frederic Baker, M.D.

Frederic Baker, M.D.

As a physician, it is a joy and a privilege to fulfill a calling of serving others, utilizing the skills, resources and training unique to this profession. Likewise, it is also a privilege and a joy to share that experience, knowledge and that passion with medical students and residents. As an attending physician, I often precept students in their first, second and third years in my office. I always appreciated the opportunity to work with attending physicians who welcomed me to their busy practices, sharing not only their patients, but their wisdom and passion. Many of us feel a similar obligation to give back and inspire a future generation. Much is learned in the classroom, the labs and, of course, on the wards. However, it is often in the outpatient setting where students get to apply all that knowledge and where they witness the undifferentiated patients in their presentation. It is always exciting to see the enthusiasm of students who experience their patient encounters for the first time. As others note, the experience of precepting can present some unique challenges, particularly when students ask how we justify certain treatments and conclusions. But the experience can be quite invigorating, allowing us to reflect and rethink situations that we may often take for granted, to refine our communication skills and expand our knowledge.

If one is sincere and determined to make precepting a truly positive learning experience, it demands an extra commitment of time and energy from a preceptor to engage, instruct and give constructive feedback to students. These demands might discourage some who already find the workflow of medicine challenging, particularly with the ever-growing regulations and administrative burdens. However, precepting offers the potential for a greater return with many positive consequences. An article from *Family Practice Management* by Sally P. Weaver, Ph.D., M.D., et. al., best summarizes the benefits of precepting: "We have found that precepting improves relationships with patients. Residents and students are often able to devote more time to patient interviews than practicing physicians can, and patients appreciate this attention. Residents and students can also handle many aspects of patient education, freeing up physician time for more complex issues. ... Students and residents can be valuable team members. In addition to taking comprehensive patient histories, they can help with nonclinical tasks, such as filling out lab requests, coordinating referrals, updating problem lists, and making calls to patients. With their technical skills, they can even research and download information the physician may need. Students and residents also ask good questions, so preceptors often find themselves updating their own knowledge about trends in medicine and clinical practice guidelines."[1] Many physicians would agree that it is well worth it. Perhaps patients capture it best when they also share the sentiment that if we don't welcome students, "How will they learn?"

The WDMS is blessed to have in its ranks a diverse membership of students, residents and attending and retired physicians with disparate experiences united in a shared vision of delivering the best health care for our community. For those who choose to teach and precept students, I say thank you for inspiring and mentoring a future generation. For those who are hesitant about precepting students or wondering if it's the right thing to do, I would strongly encourage you to welcome and embrace this outstanding opportunity to inspire and teach a future generation, as the positive returns for the students, patients and preceptors consistently seem to surpass the demands.

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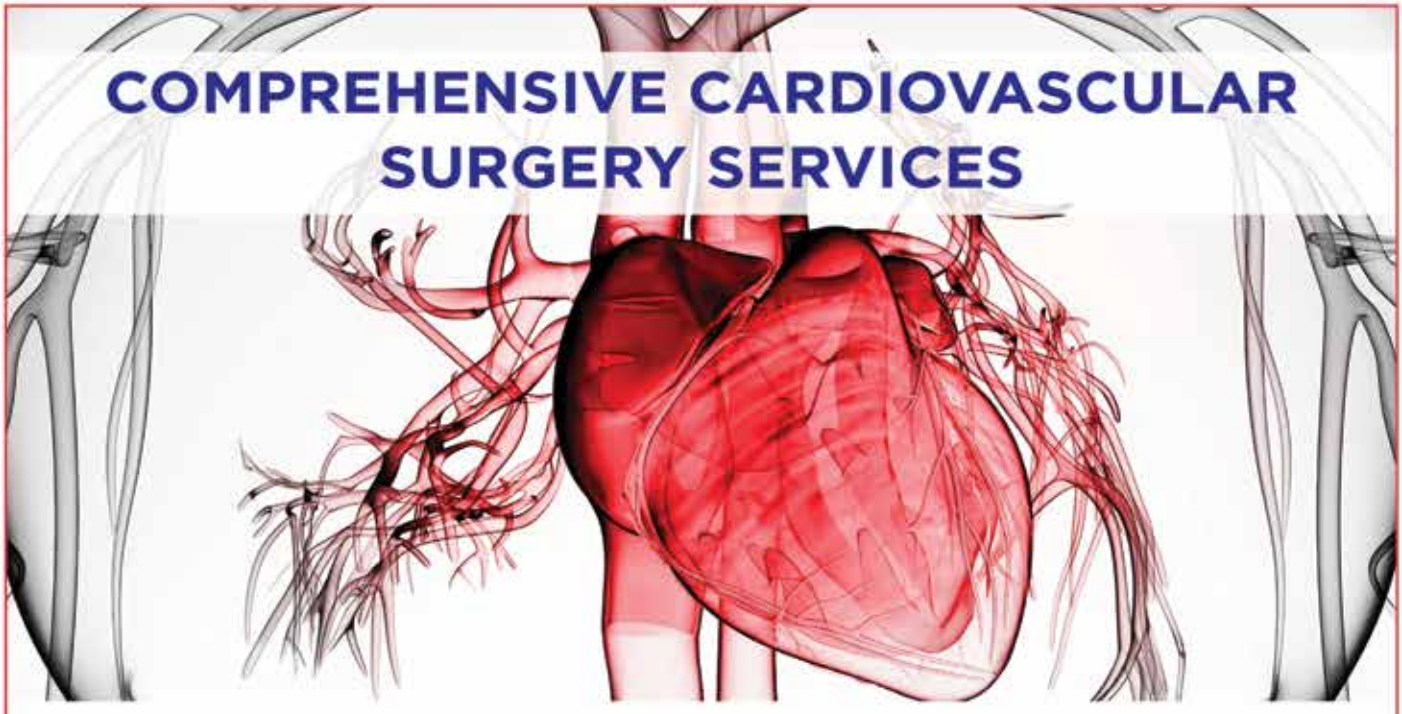

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Child Protection 101

Peter Sell, D.O.

Child abuse is not a topic that anyone likes to think about, let alone discuss. However, there are a number of important issues our Child Protection Program (CPP) feels everyone should know:

Abuse presents in many ways. There are three main types of abuse: physical, sexual and neglect. Neglect is by far the most common form of abuse (present in greater than 50 percent of child abuse cases), but the majority of the cases we are consulted on involve questions of physical or sexual abuse.

… and in many settings. Abuse is present throughout our community, in all aspects of cultural, ethnic, religious, social and economic settings. Our CPP team relies on vigilance by all our referral sources to ensure child safety and access to care.

Risk factors. There are a number of factors that increase the risk of abuse or neglect. Basically, anything that affects a family or caregiver in such a way that adds stress or decreases their coping skills will increase the risks for children in that environment to be abused or neglected. Common risks are: teen pregnancy, presence of drug/alcohol abuse in the home, children with developmental delays or chronic medical conditions, mental health issues, unstable social situations (poverty, unemployment or homelessness), domestic violence or prior DCF involvement with the family.

But they are such a nice family! CPP makes no judgments about anyone; we only want to ensure the child is safe. We advocate for the family as a whole and the children in particular. Children who are abused are often not physically harmed intentionally but rather in a moment of frustration. Health care workers can help alleviate some of these frustrations by giving parents realistic expectations about their child's developmental abilities at various stages of childhood (i.e., a 9-month-old is not being "spiteful" when he refuses to eat his baby food).

We are not DCF. Our team consists of two social workers, a nurse specialist, a nurse practitioner, a trauma educator and several pediatricians. We are tasked with evaluating the medical and psychosocial health of children in our care. The Child Protection Program is employed by UMass Memorial Medical Center and is only involved in the medical care of children who may have been abused or neglected. We do not investigate allegations of abuse and have no legal authority to remove children from custody – those powers lie with the Department of Children and Families (DCF).

We don't forensically interview children. Our CPP office receives lots of referrals for families who have concerns about abuse and want their children examined and interviewed to find out more. We are always happy to examine children for concerns about abuse or neglect. As part of our medical histories, we gather a great deal of information about the patient and family, just like when you go to your primary care doctor. Unfortunately, we are unable to ask the children many detailed or specific questions about allegations of abuse or neglect since that may influence later court testimony or legal deposition. We refer those cases on to DCF or to the Worcester County Child Advocacy Center (CAC), where there are trained personnel who employ forensic interview techniques.

Not all bruises are created equal. Kids are active, and they bruise during the course of learning to walk, play or other energetic activities of childhood. However, not all bruises are created equal, and our team examines and photo documents a great number of skin markings in order to help determine if there are concerns for abuse or neglect. We expect children who walk around to bruise on common sites: forehead, elbows, knees, shins, etc. Kids will commonly bruise along bony surfaces, but far less often will they bruise over soft tissues, such as the thighs, buttocks, belly and (rarely) the ears. Young infants are an entirely different story altogether. We have a saying in the child protection world: "Those who don't cruise rarely bruise."[1] Infants should not bruise on their own because they are not able to generate enough force or momentum to physically cause the marks.

What lies beneath? When we do see bruises in young infants or atypical skin markings in older children, we may employ a series of tests to determine if there are other injuries that cannot be seen on the surface. These may include head CT scans, skeletal surveys (i.e., specialized full-body X-rays), blood work and urine studies. Studies have shown that even one bruise may be a red flag to alert medical professionals to underlying injuries.[2] The younger the child, the more concerned we all should be for occult injury.[3]

When should I consider abuse?

- If a child discloses abuse.
- No history to explain injury (especially in a non-ambulatory child).
- Stated history does not explain the injury.
- Changing history.
- Any bruise in a young infant.
- Delay in seeking medical care.

How can I be sure? You can't. If you have concerns, then you should file a protective concern (i.e., a "51A"). You can also contact our office, and we will be happy to talk to you at any time to offer advice and discuss the case. We can be reached from 8:30 a.m.-5 p.m. Monday through Friday at 774-442-6629. At all other times, you can contact UMass at 508-334-1000 and ask to speak with Child Protection.

How do I file? Contact the DCF hotline at 1-800-792-5200. Ask for intake and give them as much information as you can. Remember, all health care personnel, teachers and anyone that works with or cares for children regularly are mandated reporters in Massachusetts.

Peter Sell, D.O., is an associate professor of Pediatrics in the Divisions of Critical Care Medicine and Child Protection at UMass Medical School.

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Ten reasons why child adversity matters to every clinician

Heather Forkey, M.D.

Heather Forkey, M.D.

Toxic stress and trauma in childhood have become buzz words lately, but what if all this impacts patient care into adulthood? Had David Letterman used his talents in medicine instead of broadcasting, a Top Ten list of why a history of adversity matters to our patients' health might look like this:

10. ACEs high? Intrigued when he realized that many of his obese patients who could not lose weight seemed to have had difficult lives, a preventive medicine physician wondered if this was significant. To further investigate the association, he paired up with a Centers for Disease Control (CDC) researcher and had more than 17,000 adult primary care patients complete questionnaires about their experiences of 10 types of abuse and household dysfunction when they were young. With each type of trauma counting as one, collecting the number of Adverse Childhood Experiences (ACEs) reported by each patient allowed the researchers to give every one of these middle class, (mostly) white, employed, insured, middle-aged adults an ACE score between 0 and 10. Surprisingly, two-thirds had experienced one or more ACE, and for those who had experienced one ACE, 87 percent were likely to have experienced two or more. Twelve percent (one in eight) had experienced four or more ACEs.[1]

9. Bad to worse. What's more, there was a direct link found between the experience of these childhood traumas and adult onset of chronic disease. ACEs were linked to the risk of cardiovascular disease, diabetes, cancer and poor pregnancy outcome. Mental illness, likelihood of incarceration and absenteeism and poor productivity also were correlated with ACEs.

8. Dose dependent. More adverse childhood experiences results in higher risk of medical, mental and social problems as an adult. Compared with people with a 0 ACE score, those with an ACE score of 4 or more have a 240 percent higher risk of hepatitis, 390 percent higher risk of COPD and 240 percent higher risk of sexually transmitted infections. Likelihood of depression increases 460 percent and suicide 1,220 percent, yet many physicians still do not even ask their patients about ACEs.

7. Again and again. These results have been replicated in tens of studies, and results are the same no matter the population, region or ethnicity of the patients. This means that every day, in every practice, we see patients significantly impacted by ACEs, no matter where or how we practice.

6. Toxic stress. Neuroscience, genetics and epidemiology have helped us to uncover some of the causality of these correlations. Repeated activation of the hypothalamic-pituitary-adrenal (HPA) axis leads to a hormonal and immunologic cascade, which has long-lasting effects on the body. Brains and bodies developing in the milieu of fear and threat mature in ways that promote protection over skill acquisition and long-term health.

5. A tiger in the house. We humans are animals designed to survive in the wilderness, and the HPA axis, cortisol and adrenaline are critical to allowing us to run, fight or hide when the predatory tiger attacks. This response should last about 20 minutes – time for us to fight, flee or … be eaten. Indeed, the cortisol and adrenaline should feed back to the receptors in the brain to turn the system off. But when the "tiger" lives in the home or neighborhood, the response gets put into overdrive and epigenetic changes alter our ability to shut the response off. The child thus exposed to domestic violence, abuse or a parent who is unpredictable due to substance abuse or mental illness can have constant stimulation of the HPA axis.

4. Wear and tear. While short-lived increases in stress hormones can be critical for survival, prolonged exposure and the consequent dysregulation of the co-involved inflammatory response, including cytokines and the sympathetic and parasympathetic nervous system, take a cumulative toll on the body, leading to effects on multiple organ systems.[2]

3. Not little adults. For children, the presentation of trauma exposure may not look like trauma does in adults and may be missed by those not familiar with it. Brain regions responsible for complex thought are suppressed as the brain areas responsible for quick response and safety get bigger. The amygdala, the body's alarm system, gets bigger, while the frontal cortex and hippocampus, important for executive function and impulse control, are disengaged. Children may be misidentified at school as having ADHD or anger issues when actually the body is responding to a threat at home.

2. Sleepless in Seattle (and everywhere else). Many exposed to trauma have difficulty falling and staying asleep, and sleep issues may by your first clue that a child and family are being impacted by trauma. The reticular activating system, which is responsible for wakefulness, is turned on with stress. Bodies managing stress are getting messages from the brain that it is too dangerous to sleep, even when the threat is resolved and the body is no longer in immediate danger. Asking open-ended questions about prior or recent exposure to threat may help you uncover what the child and family may be reacting to.

1. Not, "What's wrong with you?" but "What happened to you?" Traditionally, we have focused our medical care on figuring out "What is wrong with you?" instead of "What happened to you?" Observing health and behavior through the trauma lens allows us and our patients to view these brain and body responses as predictable adaptations to unhealthy situations, rather than only as disorders and infirmity. By asking about trauma and referring patients for evidence-based trauma therapies available in our community, we validate the patients and begin to address some of their most significant health risks. We and the patients can then move forward with a better understanding of behavior, healthy responses and, ultimately, improved health.

Heather Forkey, M.D., is an associate professor of Pediatrics at UMass Medical School and the division director of the Child Protection Program and the medical director of the Foster Children Evaluation Service at UMass Memorial Children's Medical Center.

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The Children's Advocacy Center and the Child Protection Program: Working as a multi-disciplinary team

Melissa Angiolillo, MS

Melissa Angiolillio, MS

The Children's Advocacy Center (CAC) of Worcester County is part of the Child Abuse Unit in the Office of District Attorney Joseph Early, Jr. In 2014, the CAC received full accreditation from the National Children's Alliance. Also in 2014, more than 350 children received a forensic interview at the CAC. That same year, the CAC worked collaboratively with a team that included the Child Protection Program (CPP), a division of the Pediatric Department at UMass Memorial Children's Medical Center (CMC), to provide a multi-disciplinary response to more than 500 allegations of child abuse in Worcester County alone.

Child abuse affects almost 6 million children across the United States every year, and the need for multi-disciplinary collaboration is imperative to ensure that children who have been victims of abuse receive a comprehensive and coordinated response. The CAC of Worcester County works with more than 60 state and local law enforcement agencies, the District Attorney's Victim Witness Program, forensic interviewers, prosecutors, the Department of Children and Families, mental health professionals and the Child Protection Program. This team, referred to from here on as the Multi-Disciplinary Team (MDT), works collaboratively to lessen the trauma to child abuse victims and their non-offending caregivers and to ensure each case receives the appropriate social, medical and investigative services.

Identification and handling of child maltreatment, from the discovery of abuse through investigation and potential prosecution, is a complex, multi-faceted issue that has many legal, medical and social layers. By working hand in hand with the Child Protection Program and other disciplines on the MDT, cases are examined through the eyes of numerous professionals having different areas of expertise. Alone, one indicator of child maltreatment may not raise a red flag, but when multiple indicators are examined as a collective whole, it allows the team to better identify, treat and investigate the allegation of abuse.

Because child maltreatment often presents itself through a multitude of physical, behavioral and emotional indicators, medical professionals should be mindful of the numerous signs, symptoms and injuries that may be indicative of child abuse. While these indicators may not definitively conclude that abuse is taking place, it is important to have an understanding of the multi-disciplinary investigation process so that there is true appreciation for the importance of mandated reporting, linguistics (when asking questions) and allowing for a collaborative-care effort from appropriate agencies.

Part of this collaborative care is the forensic interview, which occurs at the CAC. It is one of the first and most important steps of any child abuse investigation. An MDT – most often consisting of law enforcement, the Department of Children and Families and the District Attorney's Office – is present while a trained forensic interviewer gathers information from the child in a non-leading, child-friendly manner. The MDT watches from an observation room while the interviewer and the child discuss the allegation that brought them to the center. Interviewers at the CAC are trained to follow specific protocols and guidelines based on the child's age, developmental ability, type of disclosure and many other factors. The forensic interviewers have knowledge of each discipline's investigative needs, and their training is such that they are able to elicit information in a way that is not suggestive and is legally sound.

It is of utmost importance that, whenever possible, medical and other community professionals avoid conducting lengthy interviews when child abuse is suspected. Ideally, the forensic interview should be the place where focused questions are asked and detailed information is gathered. The reason for this is to ensure that questions are being posed in a way that is legally sound and to avoid the child having to be asked the same questions multiple times by multiple different agencies. When children are interviewed excessively by multiple professionals, it adds to the trauma that the child may be experiencing. Also, when these interviews are being conducted by professionals who are not trained in forensic interviewing, it may compromise the investigation. However, if the child's safety is in question, gathering the necessary information to keep that child safe is paramount.

Many child abuse investigations require a child to be seen and/or examined medically by the team of doctors, social workers, advocates and nurses at the Child Protection Program. The team at CPP works closely with the MDT in Worcester County to provide its medical expertise throughout the investigation and at case reviews. The collaboration between the CAC, CPP and the MDT is imperative in making certain that children who are victims of child abuse are responded to in a way that meets their needs, both physically and psychologically. Because we have worked together for decades, CPP has an intimate understanding of the CAC's fundamental principles and guidelines and works as an integral part of our investigative team. This partnership is imperative to ensuring that the children of Worcester County receive the most comprehensive and well-coordinated system of care that they deserve.

The Children's Advocacy Center of Worcester County is committed to educating medical and community professionals on the CAC/MDT process and philosophy and would be happy to provide free training upon request.

Melissa Angiolillo, MS, is the director of the Children's Advocacy Center of Worcester County and a forensic interviewer in the Middle District Attorney's Office.

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The Massachusetts Sexual Assault Nurse Examiner (SANE) Program: A critical service for sexual assault patients

Karen Hazard, RN, BS, SANE, and Anne Parsons Marchant, RN, MS, CNS, PediSANE

Celia, 14, goes to a party, is given a drink and remembers little until she wakes naked. Celia tells no one. The following morning, a smartphone is passed around school with pictures of Celia being sexually assaulted. Celia's parents and the police respond to her school, and Celia is transported to a UMASS system hospital.

Stories like these, and those of many other males and females of all ages, were the catalyst for the creation of the Massachusetts Sexual Assault Nurse Examiner Program (SANE) – a program of the Massachusetts Department of Public Health (DPH) – initiated in 1995. The MA SANE Program is a model of quality, compassionate forensic nursing care providing services for sexually assaulted and abused patients of all ages.

MA Adult/Adolescent SANE Program

For patients 12 and older, specially trained forensic clinicians (Adult/Adolescent SANEs) respond to 29 hospitals to provide individualized care and forensic evidence collection to sexual assault patients in emergency departments, intensive care units or operating rooms. Adult/Adolescent SANEs care for sexual assault patients in DPH-designated hospitals when the patient meets the following criteria:

- The patient is medically cleared.
- The assault took place within 120 hours or five days.
- The patient is able to consent and consents to the exam by a MA SANE.[1]

If a patient meets these criteria, the SANE is paged and will respond to the hospital within 60 minutes. A SANE exam consists of documentation of the patient's account of the assault, a head-to-toe exam, documentation of physical injuries, photo-documentation of non-genital injuries, evidence collection using the Massachusetts Sexual Assault Evidence Collection Kit (MSAECK), recommendations for post-assault medications (emergency contraception and medications to reduce the risk of an assault-related sexually transmitted infection or HIV), and development of a follow-up plan for the patient. In Central Massachusetts, MA SANEs respond to five hospitals: Harrington Memorial, Milford Regional Medical Center, St. Vincent Hospital and the University and Memorial campuses of UMass Medical Center (UMMC).

Recognizing young adolescent patients (ages 12-17) as a very vulnerable patient population, a unique follow-up care process was developed for this age group in Worcester County, utilizing available Child Protection Program (CPP) and Infection Disease resources at UMMC. This process allows the Adult/Adolescent SANE to call in a referral directly to a UMMC CPP clinician or a Pediatric Infectious Disease clinician if the patient is started on HIV preventive medication (HIV PEP). This follow-up protocol requires that the patient give both verbal and written consent for the CPP team to make a follow-up call. This CPP follow up is invaluable to these young patients, as their questions and their guardians' questions can be answered and their care can be guided based on individualized needs.

MA Pediatric SANE Program

In 2004, recognizing the unique needs of children younger than 12 who are victims of sexual abuse, the Massachusetts Pediatric SANE program was launched. Child sexual abuse is more commonly a chronic experience and frequently involves a person a child knows and trusts. In response to those dynamics, the majority of children cared for – about 700-800 per year – receive care in a Children's Advocacy Center (CAC) setting, where Multi-Disciplinary Team (MDT) sexual abuse investigations are conducted and children and families receive supportive services. PediSANEs are advance practice nurses, certified and employed by the Massachusetts Department of Public Health, who serve as the health care provider in seven of the 11 county-based CACs in Massachusetts. In the CAC setting, PediSANEs partner with the child's caregivers to identify health/medical interventions suited for each child/family. These range from supportive phone calls and/or face-to-face meetings for anticipatory guidance, health recommendations, support and teaching to technology-assisted, child-friendly, non-invasive forensic examinations and, when indicated, evidence collection. CAC-based PediSANEs participate as integral members of MDTs, providing team health/medical consultations and links to community-based services. In addition, they provide outreach and education to community medical providers and agencies. Like Adult/Adolescent SANEs, PediSANEs are often called on to act as factual or expert courtroom testimony.

Acute Assault Pediatric SANE Care

In addition to the CAC-based Pediatric SANE services, cross-trained Adult/Adolescent SANEs currently provide evidence collection when indicated for children younger than 12 and within 72 hours of abuse at Lawrence General Hospital, Cape Cod Hospital, Falmouth Hospital and Nantucket Cottage Hospital. Evidence is collected using the Massachusetts Pediatric Evidence Collection Kit (MA PEDI Kit), the first of its kind and developed by the MA SANE program. Every hospital in Massachusetts has MA PEDI Kits and accompanying training DVDs on site, as well as access to training provided by MA SANE in the collection of evidence with patients across the lifespan. Regardless of setting, MA SANE is committed to a philosophy of "do no harm" and believes every child for whom there is concern about sexual abuse deserves a health intervention.

Developmentally Appropriate Care

For patients like Celia, a SANE would listen to Celia's account and be able to determine what evidence collection steps should be taken and also offer a toxicology screening, based on the fact that she has little memory of her assault. Following a patient-empowerment model, Celia is able to decline any portion of the exam and/or evidence collection, and the SANE is able to adapt the exam based on Celia's level of development and comfort. If Celia had not yet spoken to law enforcement investigators and would like to, the SANE would notify law enforcement, which will respond to the hospital and take her statement, working collectively with the SANE. Another important part of Celia's care includes a response by a local Rape Crisis Center (RCC) advocate. A RCC advocate will respond to the emergency department, along with the SANE, to provide immediate crisis intervention, support and ongoing counseling for Celia and her family.

In Central Massachusetts, the innovative follow-up program created by the UMMC Child Protection Program allowed for Celia's seamless referral from SANE's emergency response to connection with CPP and Infectious Disease follow-up. SANE is honored to partner with UMMC Child Protection Program in this comprehensive care model designed to address the unique needs of this young adolescent patient population.

Karen Hazard, RN, BS, SANE, is the training and outreach coordinator for the Massachusetts Sexual Assault Nurse Examiner Program. Anne Marchant, RN, MS, CNS, PediSANE, is the pediatric clinical coordinator of the Massachusetts Sexual Assault Nurse Examiner Program.

[1] If a patient is unable to give consent, MA SANE has specific protocols in place to permit a forensic examination.

Protocol for physical child abuse screening at the UMass Memorial Children's Medical Center

Rachelle Damle, M.D., MS, and Michael Hirsh, M.D., FACS, FAAP

Rachelle Damle, M.D., MS **Michael Hirsh, M.D., FACS, FAAP**

Providing care for pediatric patients is one of the greatest privileges of surgical residency. Children are cared for with various ailments, from hernias to appendicitis to bowel obstructions. Most of the time, we perform a simple procedure, fix the problem, make them feel better, and they are off to recover and get back to their childhood. Management of traumatic injuries, such as those sustained during sports accidents or motor vehicle crashes, are also within the scope of pediatric surgery. However, non-accidental traumatic injuries also occur. Children are frequently brought into the emergency department with bumps on their heads, unable to use an arm or no longer walking and crawling like they used to. In some instances, a seemingly reasonable explanation is given by the parent or caretaker: "I was holding her in my arms when I tripped over the curb, and we both fell down," or "He was going to run out into the street, and I grabbed his arm quickly to pull him back." When the patient is of an age or level of mental development that they cannot tell the story for themselves, how can we know what really happened?

Physical child abuse, or non-accidental trauma (NAT), represents the leading cause of childhood injury and death in the United States.[1] Approximately 10 percent of trauma patients at Level 1 trauma centers are victims of NAT.[2] Anecdotally, this percentage is actually on the rise. While many cases of NAT are identified at the time of evaluation, 25 percent of children with missed cases present with more severe injuries the next time.[3,4] The most devastating consequence is a head injury resulting in severe neurologic sequelae or even death.[1] These head injuries are associated with occult fractures in otherwise well-appearing children. Guidelines from the AAP recommend a skeletal survey (a series of plain radiographs to encompass the entire skeleton) to evaluate suspicious injuries in patients who cannot provide an accurate history.[5]

As providers, we can each remember instances when we believed the history and times when we did not. What factors contributed to our belief? It seemed like a plausible story? We had personal experience with a similar situation? Our perceptions of parents or families as "good people"? Well, studies report that racial bias certainly factors into our suspicion. Minority and low-education families are more likely to be suspected of NAT.[6,7]A survey of primary care practitioners revealed that patient race and socioeconomic status directly affected their suspicion of abuse.[8] Even without taking into account racial biases in suspicion of NAT, disparities in outcomes of traumatic injuries are well-described.[9]

In order to eliminate known disparities at their own institution, Dr. Richard Falcone's group at Cincinnati Children's Hospital developed an algorithm to screen all patients less than 12 months old with unwitnessed head injuries with skeletal surveys.[10] In their algorithm, if their evaluation of a patient resulted in an abnormal head CT, showing either a skull fracture or intracranial bleeding, and the event was not witnessed in a public setting (such as a motor vehicle crash or fall in a store), a skeletal survey was performed, social services were consulted and, as indicated, a referral to the child abuse team was made. Prior to implementing these screening guidelines, the authors' noted significant disparities in the rates of screening between African-American and white patients (91 percent vs. 70 percent, p=0.01). Following implementation, there was no difference between the rates of surveying between African Americans and whites (92 percent vs. 85 percent, p=1.0). The authors concluded the success of such a policy in eliminating disparities, as well as in identifying additional cases of NAT.

As the saying goes, "Kids are only 20 percent of our population but 100 percent of our future." This is reflected in the Children's Medical Center's response to Dr. Falcone's results of adopting a similar protocol. Starting in 2009, any patient with traumatic injuries who is preverbal and unable to explain what happened automatically receives a consultation by the Child Protection Program (CPP). The CPP is composed of pediatricians who have undergone fellowship training in NAT. Importantly, this is not a governing authority with the ability to revoke custody or enforce law; it is a group of medical providers who evaluate the patient and make further recommendations for evaluation and reporting to the Department of Children and Families (DCF). Different than Falcone's protocol, the skeletal survey is not automatically performed, it is recommended after review by CPP.

We looked back at our results for the two years before the policy and the two years afterwards. Over the four-year period, 146 patients that received CPP consults were identified. During the study period, there were 344 pediatric trauma patients younger than age 2, 211 of which suffered head injuries. On average, the population was comprised of white (63 percent) males (59 percent) less than 1 year of age (67 percent) who resided in an urban region (70

percent). Falls were the most frequent injury mechanism at 82 percent. Interestingly, we found no difference in the demographics of the "pre-policy" group (n=78) and the "post- policy" group (n=68) that underwent CPP consultation. There was, however, an increase in the number of CPP consults following the implementation of the policy (76 percent vs. 65 percent; $p<0.05$). Further investigation is required to determine if our recognition of NAT cases has improved with the implementation of our protocol.

Certainly, this instituted protocol cannot prevent all cases of NAT, but it can protect the patient with occult injuries from being a victim in the future. Additionally, early identification may also protect siblings or relatives at risk for abuse from the same perpetrator. Until child abuse is eliminated, there is more work to be done, but at least we can make a small impact in the prevention efforts by minimizing judgmental bias and applying a systematic child abuse evaluation to all. Especially at a time when DCF is overwhelmed and understaffed, health care providers like us need to step up to the plate and take action to protect our future.

Email questions/comments to: rachelledamle@gmail.com.

Rachelle Damle, M.D., MS, is a senior surgical resident in the Department of Surgery at the University of Massachusetts Medical Center.

Michael Hirsh, M.D., FACS, FAAP, is the surgeon-in-chief of UMass Memorial Children's Medical Center, chief of the Division of Pediatric Surgery and Trauma at UMass Memorial Health Care System, medical director of the Worcester Department of Public Health and co-principal investigator of the Injury Free Coalition for Kids of Worcester.

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Advocating for the health needs of children in foster care: The FaCES Model

Linda Sagor, M.D., MPH

Linda Sagor, M.D., MPH

About 12 years ago, two little girls arrived at my office for an evaluation after having been placed with a foster family a few days before. At six weeks of age, Emma weighed less than her birth weight, and Maya, at 2 years old, weighed 2½ half pounds less than she had at her 18-month visit. After their appointment with their doctor at a local community health center the previous week, he had filed a report with the Department of Children and Families, and the children were removed from their home and put in foster care. Their medical evaluation in our FaCES Clinic indicated that they were both basically healthy – they had just been starved by their mentally ill and substance-abusing mother.

The FaCES (Foster Children Evaluation Services) Clinic was founded at UMass Medical Center to ensure that all children entering foster care in our Central Massachusetts area would have access to medical care, adapted to their specific health issues, whenever they needed it. There was much urgency on our initial planning committee for many reasons. We understood that children in foster care generally come from impoverished families who have experienced multiple social stressors, such as family violence, mental illness, substance abuse and homelessness. Although Emma and Maya were found to have no underlying health problems despite their starvation, we realized that was often not the case with children entering foster care. We knew that they were, in general, sicker than other children living in poverty who were not in foster care. We recognized that they had a higher prevalence of chronic illnesses such as asthma, obesity and dental caries; that they had a greater incidence of developmental delay; and that mental health and behavioral problems were ubiquitous and severe – no surprise, given the amount of trauma in their young lives.

We were also aware that, despite these health concerns, many children in foster care throughout the country were not receiving the care that was recommended by the American Academy of Pediatrics and the Child Welfare League of America. Our statistics in Massachusetts were no better. In addition, when we did see these children in our primary care offices, we found that we often had no information about their medical problems, allergies, medications and immunizations.

A call was put out to our community to come together to solve this problem. A group of people – a juvenile judge, doctors and representatives from DCF and MassHealth – met frequently over 18 months and created the template for an evaluation clinic for children entering foster care. Although funding seemed like a huge hurdle initially, the United Way of Central Massachusetts, Fallon Foundation and Hanover Insurance provided seed money to get the doors opened.

So FaCES began, with little fanfare but much optimism, in November 2003. Since that time, we have seen more than 3,000 children in our clinic. Our goal is to schedule them for an initial screening within days after they enter foster care. Within a few weeks, we try to get all their past medical records; complete a comprehensive medical evaluation and trauma inventory; update their immunizations and necessary lab tests; and refer them as needed to pediatric subspecialists, psychiatrists, Early Intervention, and dentists. We always make sure that we identify a specific primary care provider who will follow the child after he or she completes an assessment in FaCES. We then send a summary of all relevant data to that PCP so that follow-up care can be seamless and informed.

I followed Emma and Maya during their full evaluations in FaCES and have been in touch with their family since then. They were adopted by their foster mother, who has provided a loving and warm and safe home for them. They are flourishing – growing into healthy adolescents, playing soccer, taking ballet and hip hop lessons and talking about their future.

We know that life for a child in foster care is often one of upheaval and uncertainty. Dr. Abraham Bergman noted in his "call to arms" in 2000 that, although these children are the most vulnerable children in our country, the health care services they receive are often delayed, fragmented and wholly inadequate.[1] Our decision to create FaCES, and the community and state response that we have received in the subsequent 12 years, has led to an ongoing effort to ensure that all children in our Central Massachusetts area, especially the most vulnerable, receive the health care that they need and deserve.

Linda Sagor, M.D., MPH, is a professor of Clinical Pediatrics at the University of Massachusetts Medical School and founder and director of the FaCES Clinic.

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WORCESTER ACADEMY

ACHIEVE THE HONORABLE

Better together – social workers team up for child protection

Michelle Abdelnour, LSW, and Patricia A. Vanasse, LICSW

Michelle Abdelnour, LSW, and Patricia A. Vanasse, LICSW

"I know I need to file this 51A with DCF, but I still have three patients waiting to be seen, and the office is due to close shortly!"

In a busy physician practice, finding sufficient time to fully explore a child's concerning dental caries, bruises, behaviors, etc., often seems overwhelming. Yet, we know that asking about, caring for and acting upon these concerns can be life-changing (or saving) for this vulnerable population. The prevalence of child abuse in our community is no secret, and our professional response is a work in progress. As Child Protection Program (CPP) social workers, we often assume the role of first responder. Whether contacted by a parent, caregiver or provider, angst often accompanies having to make the call to report concerns of abuse or neglect of a child.

Health care providers seek to establish trust with families in their practices. However, raising concerns about caregiving that seems "not quite right" or asking questions regarding a child's safety may challenge that trust. As CPP social workers, we strive to educate and support medical providers navigating the sensitive and heartbreaking process of ensuring child protection. Many medical professionals are unfamiliar with well-established child protection systems and procedures, which creates alarm for those acutely confronted with child physical or sexual abuse or neglect.

At CPP, we believe education and support is best delivered before crisis occurs. Education includes dispelling child maltreatment myths. One such myth is that of "stranger danger." Child maltreatment more often occurs at the hands of someone the child knows and loves rather than at the hands of a stranger. As medical providers, we must find time to see what is often concealed and listen for what is often unspoken if we hope to minimize threats hiding in plain sight – within the child's social circle. As We See It, responsibility for protecting the beautiful, brave, resilient and vulnerable children under our care and ensuring their voices are heard is a multi-disciplinary responsibility.

Michelle Abdelnour, LSW, is a licensed social worker for UMass Memorial Children's Medical Center, Child Protection Program. Patricia A. Vanasse, LICSW, is a licensed independent clinical social worker for UMass Memorial Children's Medical Center, Child Protection Program.

The Opioid Crisis: A message from the Worcester District Medical Society Public Health Committee

Not a day goes by when a new governmental agency does not commission a task force to work on the opioid crisis. Governor Baker's got one, our District Attorney Early has one, and City Manager Augustus has one, too. The city data shows that we are hovering at about 125-150 overdoses per month, according to 911 data, which undercounts these events. Fortunately, with the first responder training that the Worcester Department of Public Health has facilitated, the lethality of these events has been greatly diminished and the death toll has been limited. Nonetheless, the problem is a multifaceted one, as it has spurred a sense that homelessness, crime and needle sticks are posing increasing dangers to public safety and health in our community.

We as physicians have an important load to bear in both the origin and the solution of this crisis. It was the recognition that medical providers were undertreating pain in patients that led to pain evaluation in every patient encounter being elevated to the "fifth vital sign." And with that new emphasis on pain status came the wave of prescription opioids, encouraged by the pharmaceutical companies, that has led to so many previously unaffected individuals becoming addicted to narcotics. Once the high cost and difficulty in obtaining prescription opioids overwhelms the user, illegal IV opioid use ensues. And the medicine chest at home has become a target for both drug-seeking burglars and family members and visitors looking for a financial killing by fencing unused prescription opioids on the street or, even worse, in our schools.

So the Worcester DPH will work hard in the next year with our medical providers, the WDMS Public Health Committee and our nursing, medical and pharmaceutical schools and institutions to educate physicians on what we can do to make things better. Could our medical clinics and pharmacies become places where unused drugs and needles could be disposed of? Could we be smarter about the way we prescribe and the amounts we dispense? Could we become more facile at using the prescription monitoring program? Could we educate our youth about the threat these drugs pose? Can physicians also advocate for more treatment facilities and to destigmatize addiction so it is treated and recognized as the disease it is?

It has taken 20 years for us to get into this position, so digging out of this will not happen overnight. But as Vice President Biden said about solving problems, "Just because it seems we have to do everything does not mean we should not do anything." Let's get to work.

Public Health Committee

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Legislation vs. Addiction

Peter Martin, Esq.

Peter Martin, Esq.

The opioid epidemic in Central Massachusetts is not news to readers of this publication, which devoted an entire issue (September/October 2014) to the problem. The variety of perspectives offered in that issue, from physicians, academics and law enforcement, suggests that there is no one way to address the crisis. Now, the Massachusetts Senate has stepped up to the table with a draft bill (Senate Number 2020), passed on Oct. 1, 2015, that similarly offers a wide variety of measures designed to attack the problem from a number of angles. What remains to be seen is whether public policy measures, individually or collectively, can make a dent in an intractable medical and psychosocial problem. Physicians should be alert to those measures that most directly affect their daily practice, which are described below.

The legislation seeks to assist practitioners with identifying non-opioid alternatives to pain management medications through the issuance of a list of such medications by the Drug Formulary Commission within the Department of Public Health. The list is to be updated annually with new, approved, non-opioid drug products. This provision is to take effect on March 1, 2016.

The proposed law tries to support patients in recovery by giving them a way to avoid further access to opioids. Physicians should be aware that patients of substance use disorder treatment programs are now to be offered the opportunity to execute a voluntary non-opiate directive "that shall indicate to all prescribers, health care providers and facilities that an individual shall not be administered or offered a prescription or medication order for an opiate." This directive can be overridden by the patient for any reason and by the treating practitioner based on documented medical judgment.

The bill tries to address the problem of leftover prescribed medications. It adds a requirement that prescribers, as a condition of obtaining or renewing their license, be given training regarding the appropriate prescription quantities for prescription medications "that have an increased risk of abuse." The various boards of registration are charged with developing standards for this additional training.
The proposed law seeks to formalize and make mandatory good clinical practices when prescribing an "extended-release long-acting opioid in a non-abuse deterrent form" for outpatient use for the first time. Prior to doing so, a physician must provide a statement in the clinical record that in the physician's medical opinion, the prescription is an appropriate course of treatment. The physician must also use the prescription drug monitoring program already in place. If the patient is being treated for long-term pain management, the physician and patient must enter into a pain management treatment agreement and include that agreement in the clinical record.

The proposal tries to educate prescribing providers about their opiate prescriptive practices, using peer pressure, and perhaps more stringent measures, on outliers. Beginning in 2017, the Department of Public Health will annually determine the practitioner's Schedule II and III opiate prescribing quantity and volume and report back to the practitioner where s/he falls among his/her peers using a percentile ranking. The rankings will compare physicians within particular specialties and practice types. This information will be provided only to the practitioner him/herself and shall not be a public record or be admissible in a civil or criminal proceeding. The proposed statute goes on to state that this information "shall not be the *sole* basis for investigation by a licensure board (emphasis added)." The proposal also promises to make resources available to providers to help them change their prescriptive practices and incorporate alternative pain management options. As a result of this reporting mechanism, physicians who prescribe these substances will have comparative peer information and assistance with their prescriptive practices, but they may also be subject to licensure board investigation should the prescribing information be combined with other information that might justify an investigation.

The proposed law seeks to alleviate liability concerns about emergency treatment of overdoses by specifically exempting from liability any person administering naloxone or another opioid antagonist to a person reasonably believed to be experiencing an opiate-related overdose. Such protections would not be available in the event of gross negligence or willful or wanton misconduct in the course of delivering this emergency care.

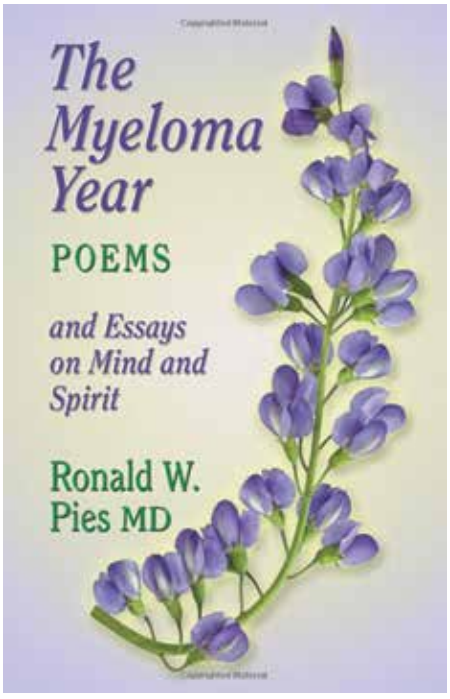
The proposal addresses the reluctance of some primary care providers to treat pain management patients. It holds open the possible future development of a pain management access program, which is a referral system to make pain management specialists available to primary care providers. The statute would create a commission to investigate ways to incorporate "a full spectrum" of pain management methods into provider practices, including acupuncture, exercise and non-pharmaceutical interventions.

At this writing, it appears that both the House and the Governor intend to file complementary bills addressing additional issues, including the sale of fentanyl and the hospital treatment of involuntarily committed women. Clearly there is momentum on this issue, and providers should be aware that there is the potential for significant mandated changes in their practices relatively quickly.

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

The Myeloma Year, Poems and Essays on Mind and Spirit

Jane Lochrie, M.D., FACP



I recently received a copy of Dr. Ronald Pies's book, *The Myeloma Year, Poems and Essays on Mind and Spirit*. Dr. Pies has generously contributed articles to *Worcester Medicine* in the past. Just reading his dedication will give you an idea of the content: "To Nancy, the love of my life, and the bravest one I know."

The Myeloma Year is a collection of seven poems that he wrote while his wife was undergoing treatment for multiple myeloma. Beautifully written, the poems chronicle the everyday experiences of a couple facing the challenges of chemotherapy for a devastating diagnosis. The love for his wife and her brave spirit comes across in each poem.

Ron's essays are equally as well-written and focus on the correlation of psychology, spirituality, philosophy and ethical traditions. The essays explore the timely topics of moral responsibility, hope, extremism, anger, loneliness and gratitude.

WDMS Congratulates its 2015 Award Recipients

25th Annual Dr. A. Jane Fitzpatrick Community Service

Louis E. Fazen, III, M.D., MPH

Dr. Fazen's career exemplifies community service at all levels; local, regional, national and international. He worked as a pediatrician at UMass, Hahnemann and Saint Vincent Hospitals for many years. He went on to live in Africa with his family as a volunteer clinician educator and returned to work as a pediatrician at the Martha Elliott Health Center in Boston. In retirement, he returned to his roots caring for children of the Navaho Nations. For 12 years Dr. Fazen served as an elected member of the Board Health in Southborough. He continues to work with the Mass Medical Society on the Public Health Committee and the Alliance Foundation Board.

Twenty five years ago Dr. Fazen introduced the concept of honoring one of our own WDMS members, Jane Fitzpatrick, for her years of outstanding public service thus inaugurating the Dr. A. Jane Fitzpatrick Award.

Nominated by: James Broadhurst, M.D., MHA
Supported by: Alfred DeMaria, Jr., M.D. and Steve Holve, M.D.

This award commemorates the life-long contributions and exemplary efforts of Dr. Fitzpatrick. The award recognizes a member of the health care community for contributions beyond professional duties to improve the health and well-being of others.

2015 WDMS Career Achievement Award

Michele Pugnaire, M.D.

Senior Associate Dean, Office of Educational Affairs
Executive Director, iCELS (Interprofessional Center for Experimental Learning and Simulation)
Professor, Department of Family Medicine and Community Health

Dr. Pugnaire has devoted her career to service that has resulted in substantial and long-lasting contributions to the education and training of our future physicians, to WDMS, to the community at large, and to further medical education across the country. Dr. Pugnaire's CV enumerates an extensive series of initiatives which, under her leadership, have enhanced our community. She has been a valuable member of WDMS since 1987 and a long time chair of the Scholarship committee.

Nominated by: Terence R. Flotte, M.D. and Daniel Lasser, M.D., MPH

This award honors 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.

Awards presented at the Fall District Meeting – Monday, October 26, 2015

Congratulations 2015 Scholarship Award Recipients

Elizabeth Ackley-2017
Columbia University College of Physicians and Surgeons
The Dr. Julius Tegelberg Award

Peter Antkowiak-2016
Albany Medical College
The Dr. Sanfrey Lilyestrom Award

Corey Bradley-2016
Wake Forest University School of Medicine
The Worcester District Medical Society Award

Roderick Geer-2016
University of Massachusetts Medical School
The Worcester District Medical Society Award

Rashmi Jasrasaria-2016
Stanford University School of Medicine
The Dr. Burte Guterman Award

Christopher LaChapelle-2016
Boston University School of Medicine
The Worcester District Medical Society Award

Kara Lindquist-2016
University of Massachusetts Medical School
The Reliant Medical Group
Dr. M. Elizabeth Fletcher Award

Stephanie Ludy-2018
University of Massachusetts Medical School
The Saint Vincent Hospital
Dr. Gilbert E. Levinson Award

Sarah McGowan-2017
University of Massachusetts Medical School
The Milford Regional Medical Center
John A. Rauth Book Award

Jyotsna Mullur-2016
University of Massachusetts Medical School
The Worcester District Medical Society Award

Justin Spring-2018
Columbia University College of Physicians and Surgeons
The Amaral Family Book Award

Courtney Temple-2017
University of Massachusetts Medical School
The UMMHC Dr. Samuel Pickens Award

Worcester District Medical Society Alliance 2015 Nursing Scholarship Award Recipient

Alyssa Johnson-2015
Mass college of Pharmacy and Health Science
WDMSA BSN Nursing Scholarship Award
Co-Sponsored with the Worcester District Medical Society

SAVE THE DATE
220TH ANNUAL ORATION

SYMPHONY OF THE BRAIN

Wednesday, February 10, 2016 • 5:30 p.m.
Beechwood Hotel • Worcester, MA

Orator: Joel Popkin, M.D.

Director of Special Services at Saint Vincent Hospital
Professor of Clinical Medicine at the University of Massachusetts Medical School

Dr. Popkin will address how music is such a fundamental and universal aspect of humanity – and how processing by the brain has made it so. The relationship of music to learning, speech, and neurological growth has implications that go far beyond the powerful emotion it elicits, and he will look into some surprising therapeutic applications. Mozart and Beethoven should have only known what they did for us.

Romany Hakeem Girgis, M.D.

July 23, 1932 – May 24, 2015

Dr. Romany Hakeem Girgis died May 24, 2015, at 83 years old. He is survived by his wife, Dr. Faiza D. Kattan, and a son, Samuel Romany Girgis, and two grandchildren. He was predeceased by six sisters and a brother.

Dr. Girgis attended medical school in Egypt, where he was born, and later moved to England to complete his post-graduate training. In 1977, he came to Webster to work as an Emergency Room physician. He also participated at the St. Ann's Church evening clinic in Shrewsbury, where he taught medical students and residents. He was known as a physician who "always gave more than he received."

Dr. Girgis and his wife, Dr. Kattan, practiced medicine together in Dudley for 21 years. For eight years, he served as a consultant for the disabled for the Commonwealth of Massachusetts.

Dr. Girgis was a Fellow of the Royal College of Surgeons and a member of the Massachusetts Medical Society. He had almost perfect attendance at the meetings of the Worcester District Medical Society. It was at these meetings that we developed a warm friendship.

Romany had a most friendly, outgoing personality. Following a cordial welcome and comment about the weather, we would always pick up where we left off at our last meeting. I looked forward to seeing him and his wife and was always uplifted by his perpetual smile, warmth and sincere friendliness.

He will be missed.

– Leonard J. Morse, M.D.

Aaron Lazare, M.D.

February 14, 1936 – July 14, 2014

My time with Dr. Lazare was brief, yet his presence remains with me. We met in the parking lot by the Emergency Department. Sounds like a great first line of a spy novel, but I digress. He was taking his walker out of his vehicle and someone passing by offered assistance. I detected a subtle brisling at the suggestion, which he politely declined. Thinking of my own father, I smiled as our eyes met. As he got closer, I shrugged and said, "They meant well." We laughed and immediately hit it off. He introduced himself as Aaron Lazare. While the name was familiar, anything beyond that eluded me. Our chance encounter became an impromptu, several-hour conversation spanning my desire to become a psychiatrist, our mutual love of writing, my idea for a book (of course, after I made him swear not to steal it), his eight adopted children and life in general. I left his office that day feeling connected and inspired.

A perpetual student himself, Dr. Lazare seemingly turned everything into a teaching moment, artfully combining the eye of the beginner with a master's patience. He processed poignant and painful experiences through writing, working tirelessly to sift through self-imposed complications and arriving at the core simplicity of what it is to be human. Three examples come to mind. Out of his father's illness and death, he highlighted the importance of humanizing the doctor-patient relationship well before the idea was in vogue. Following the near loss of two sons in a plane crash, he delved into the process of grief and bereavement. Finally, drawing on his many years as a practicing psychiatrist, he explored suffering borne out of conflict and the power of true apology. This relentless curiosity, depth of kindness and generosity of spirit are no doubt why generations of students, patients and colleagues flocked to him.

Thank you for sharing yourself so courageously and selflessly with us. You are dearly missed, Dr. Lazare.

– Miriam P. O'Neil, JD, LL.M

Miriam P. O'Neil, JD, LL.M, is a fourth-year medical student at The University of Massachusetts Medical School.

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