

# WORCESTER medicine

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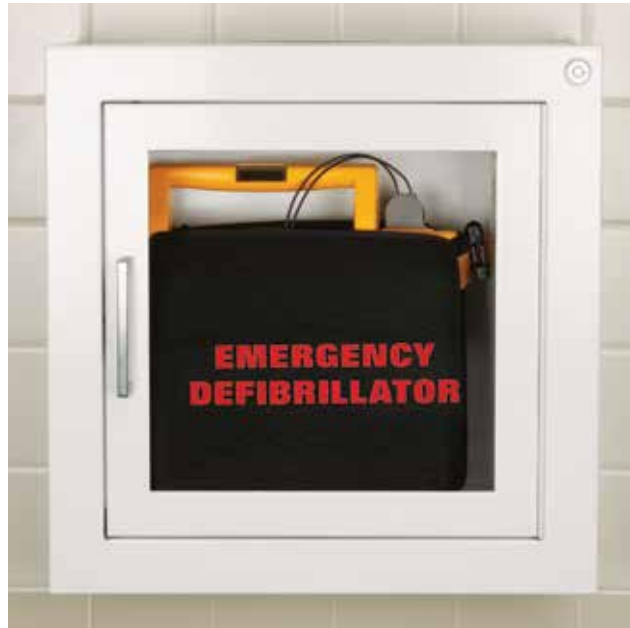
## THE IMPACT OF DIRECT CONSUMER MARKETING ON THE DELIVERY OF HEALTHCARE

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# Direct Consumer Marketing and Health Care

Michael Malloy, PharmD



**Michael Malloy,  
PharmD**

The question “What effect does direct consumer marketing have on health care?” will elicit a response that is dependent upon to whom the question is posed. Ask a representative from a pharmaceutical company, and you will hear that it helps educate the patient about what drugs are available to treat various disease states. A physician may respond in terms questioning the ethics of direct consumer mar-

keting or speak about the amount of time it takes to respond to questions about the value of the latest new test or drug. If you ask a pharmacist, he or she may question the effect it may have on the safe and effective use of medications. This issue of

*Worcester Medicine* attempts to challenge the reader to explore his or her own opinions on this controversial topic.

In Dr. Leonard J. Morse’s article, he presents the ethical side of the issue and asks the reader to reflect on physicians promoting themselves through advertising. He asks us to read the AMA Code of Medical Ethics and the 218 published opinions to help guide us in making sense of how to utilize all the information in the best interest of our patients.

Dr. Ronald Dunlap challenges us to “vigorously examine the effects of direct-to-consumer marketing on physicians and patients.” He also informs us that we, as health care providers, will be required to take time to answer patients’ questions about ads concerning medications and medical devices and support our answers with data from long-term research concerning their safety and efficacy.

In the third article, Dr. Mimi Mukherjee focuses on the direct-to-consumer (DTC) marketing of pharmaceuticals. She presents arguments for both proponents and opponents to DTC marketing and points out that there is only self-regulation of the practice by pharmaceutical firms. She suggests that the patient-provider relationship will be central to maintaining safe medication use by the patient.

Regardless of where you, as a provider, stand on direct-to-consumer marketing of health care, the primary objective of all providers is the safe and effective use of any product. I believe these three articles provide the reader a sound starting point to develop an opinion regarding direct-to-consumer marketing of health care.

*Michael Malloy, PharmD is Professor and Dean School of Pharmacy-Worcester/Manchester MCPHS University and a member of the Editorial Board*

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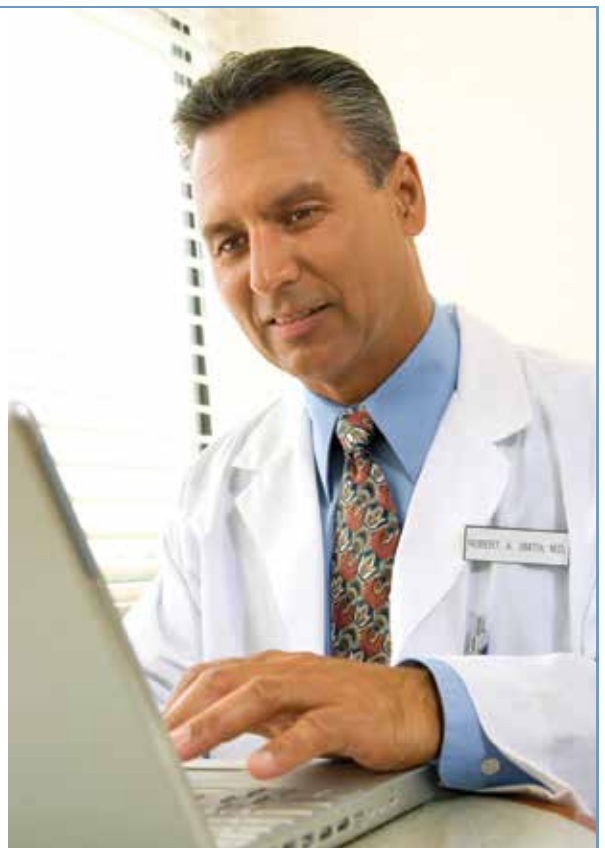


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# Message from the President

Michael Hirsh, MD



Michael Hirsh, MD

The Earth shook on Friday, Aug. 9, 2013, or so I am told. This was not your standard tectonic plate upheaval or a volcanic eruption. No, this was a cataclysm of human making. Dr. Sanjay Gupta ~ America's Doctor (with apologies to Dr. Oz) ~ came out in favor of the legalization of medical marijuana. He did it to coincide with the premiere of his documentary,

*Weed*, which aired over the weekend on CNN, Dr. Gupta's home away from his neurosurgery practice. The calls to the state legislatures and departments of public health started coming in around the country, with Worcester being no exception. Massachusetts had, in fact, already had a 2012 referendum on the legalization of medical marijuana, and the Commonwealth had voted by a wide margin to proceed with this process.

As the acting commissioner of public health for Worcester, as well as the president of the Worcester District Medical Society (WDMS), I had to appear at several public listening sessions commissioned by the Massachusetts Department of Public Health (WDPH) to learn about the needs of the citizenry with regards to the prescription, distribution and cultivation of this newly approved herbal remedy.

I was not the most popular commissioner in the Commonwealth for stating publically that, just as the Mass Medical Society and the WDMS had previously espoused before the vote, it is difficult to "prescribe" a medication that has never been randomly tested, never had its active ingredients "dosed" and comes in a popular delivery system ~ smoking ~ that we know has health risks of its own. I am also concerned that the great

demand for marijuana will promote unscrupulous price gouging from physicians for the permit certificates to use "medical marijuana." The difficulty with establishing safe community guidelines for dispensaries also will encourage unscrupulous growing/distribution practices and potentially expose youth to more opportunities to experiment earlier with the drug. Opportunities for crime, fraud and traffic-related injuries can all rise under these circumstances.

I am not opposed to states proceeding with the legalization of marijuana. I trust the people to make their choices on that. That said, I continue to feel the term "medical marijuana" puts the physician in the awkward position of prescribing something that has no dose schedule, delivery system or controlled studies to support its safe prescription. If the Federal Food and Drug Administration or the Drug Enforcement Agency released the restriction on research in this area and dosing of active ingredients not delivered by smoke could be achieved, then I would be on board with treating marijuana like a drug. But until that day, despite Sanjay Gupta's endorsement, I stand by my opinion (that of the AMA/MMS and WDMS, as well) that this is an herbal remedy that should not involve physicians in its distribution.

I hope that those unfortunate patients who have come to see marijuana as their only relief from post-chemotherapy nausea, seizures, chronic pain and other ailments can help work with the medical community and the greater community at large to push to get means to distribute the active ingredients of the plant in a smokeless form that has met safety standards of testing and production quality control that will satisfy their medical needs and reduce the need for physicians to be put in the awkward position of prescribing "a nebulous number of joints/day."



# Impact of Direct Consumer Marketing on the Delivery of Health Care

Ronald Dunlap, MD



**Ronald Dunlap, MD**

Every time I see an advertisement exhorting a patient to “Ask your doctor about Plavix,” I know that my fellow physicians and I will probably spend a significant amount of time grappling with that question.

Direct-to-consumer marketing in health care has always been a presence in newspaper, radio and television. Today, just about all popular websites feature flashy banner ads for popular, and usually pricey, name-brand drugs. These ads enthrall our patients and frequently provoke phone calls asking whether they should switch ~ or even start ~ medications.

Of course, we want patients to be active participants in their own health. I feel that patient education is a very important part of my job, and I willingly spend hours each week on the phone answering questions about new drugs and treatments.

But this becomes a challenge when the ads are touting an expensive medication where the benefits, in many applications, are minimal. Many times, the patient asking about such a drug is already on a drug in the class being advertised.

In my field of cardiology, we recently saw a blitz of advertising for a new anticoagulant in an attempt to gain market share before several other drugs, which are better tolerated, were approved.

I also have ethical concerns about advertising that communicates benefits but downplays serious side effects. Studies have

shown that patients retain the purported benefits of drug advertising but often don’t remember the side effects, which are often rattled off in rapid-fire speech or included in tiny fine print.

On a more practical level, the effect of direct-to-consumer marketing is that physicians now need to spend significant amounts of time explaining why a patient should or should not use a given medication.

I also feel that direct-to-consumer advertising can have some great public health benefits.

For example, Bayer aspirin has run a campaign encouraging at-risk consumers to take an aspirin daily for cardiovascular health. The ads did promote the brand name, but it also was a public service to alert the public to the benefits of taking aspirin during a suspected heart attack or to reduce the likelihood of a repeat stroke or heart attack.

I asked MMS leaders their experience with direct-to-consumer advertising.

My colleague Dennis Dimitri, MD, MMS, vice president and vice chairman of the Department of Family Medicine & Community Health at UMass Memorial Medical Center and UMass Medical School, said that the most common effect on his practice has also been a demand for certain pharmaceuticals.

But a more recent trend has been increased advertising for diagnostic services such as MRI and cardiovascular screening tests, he said.

“This creates an expectation that every painful joint or back needs to be evaluated with MRI or that everyone should be screened for cardiovascular disease, even in the absence of any



symptoms or significant risk factors. This can lead to unnecessary testing that is not supported by the medical evidence,” said Dr. Dimitri.

Another colleague, James Feldman, MD, MPH, FACE., said that in his capacity as an emergency department physician at Boston Medical Center, he less frequently encounters patients seeking medical treatments they have seen advertised directly. However, he said, the media can play a very important role in informing the public about health care.

“I have had several patients who have seen a TV show such as *The Today Show* and recognized that they had similar or concerning symptoms, such as a threatened heart attack,” said Dr. Feldman.

“One woman I recall who came to the Emergency Department with a heart attack said that she watched a show about heart disease in women; that one might only have fatigue or weakness and came for help,” said Dr. Feldman, who is also a Boston University School of Medicine professor. “Campaigns about public health concerns, such as heat illnesses and prevention, appear to have had an important impact on reducing serious health problems like heat stroke and death during heat waves.”

Sharon Marable, MD, MPH, medical director of the Harvard Street Neighborhood Health Center in Boston, said she does not field many questions about specific medications, but has noticed a growing popularity of television health shows. One of the most influential media sources on patients is *The Dr. Oz Show*, she said.

“In that sense, the media is a positive force,” said Dr. Marable, a member of the MMS House of Delegates and its Committee on Diversity in Medicine. “My patients are certainly watching Dr. Oz, and it has triggered a lot of questions and

conversations about nutrition and other topics.”

The MMS has for years been aware of the importance of direct-to-consumer marketing issue. In 2009, we passed a policy that encourages all Massachusetts medical schools and residency programs to educate their students and resident physicians on the possible effects of pharmaceutical, device and equipment marketing and advertising on care of patients.

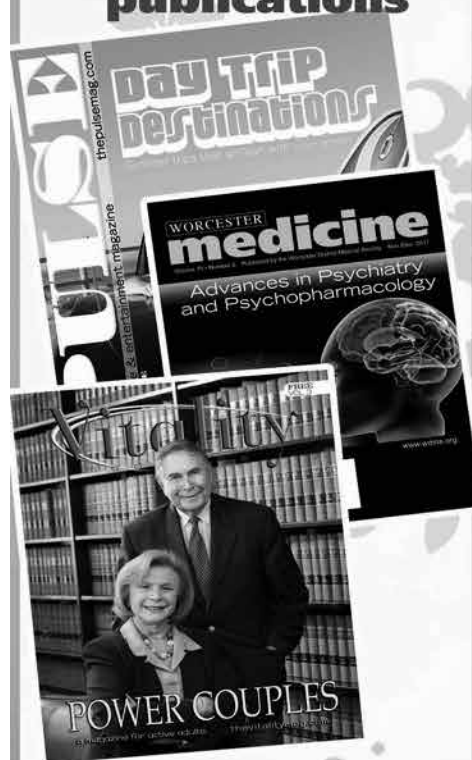
I hope we will continue to vigorously examine the effects of direct-to-consumer marketing on physicians and patients. Responding to patient questions about these ads requires physician time to thoroughly compare drugs and/or devices and seek out long-term data on safety and efficacy.

In addition, the pressure to contain costs in alternative payment plans is in direct conflict with direct-to-consumer marketing. Sooner or later, we will need to address the long-term issue of whether certain types of direct-to-consumer advertising are contributing the high cost of care.

*Dr. Ronald Dunlap is a cardiologist at South Shore Hospital and the president of the Massachusetts Medical Society.*

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# Direct Marketing of Medications to Patients ~ Helpful or Harmful?

S. Mimi Mukherjee, PharmD, BCPS



**S. Mimi Mukherjee,  
PharmD, BCPS**

Over the years, *Saturday Night Live* (SNL) has produced several mock commercials for medications. One of my favorites is a parody of a commercial for Boniva, a medication for osteoporosis. The original commercial starred Sally Field. The parody began with a SNL cast member, dressed to look like Sally Field, promoting a medication called Preniva. She states, “Women are inherently weak and fragile. You get this one body and this one life.”

She touches a skeleton next to her, and it crumbles to smithereens. She then faces the audience and asks, “Are you bummed yet?” She concludes, “Preniva ~ your weakness is our strength.”<sup>1</sup>

This parody exemplifies some of the controversies surrounding direct-to-consumer (DTC) marketing of pharmaceuticals. Opponents of DTC marketing believe that the advertisements prey on patients’ fears, which results in patients approaching providers with inappropriate medication requests. These requests then consume appointment time as providers try to educate patients on alternative treatments with greater benefits than the advertised drug. Some data indicates that the advertisements and resultant discussion lead to the development of distrust between providers and patients.<sup>2,3</sup>

Other patients become so fearful of the adverse effects of medications that they fail to consider the risks of not taking the medication. Many patients lack the expertise to comprehend the risks and benefits of the medications described. Much of the content in DTC advertisements is presented at greater than an eighth-grade reading level,

which is typically the level at which public documents should be written.<sup>4</sup> Certain medications categorized as lifestyle drugs are promoted for non-health reasons, such as improvements in lifestyle and improved appearance. Critics charge that the advertisements for these products emphasize the benefits while glossing over the potential side effects. These medications include the oral contraceptive Yaz, the wrinkle reducer Botox and the eyelash growth stimulator Latisse. Bayer, the company that manufactures Yaz, was reprimanded by the Food and Drug Administration (FDA) in 2008 for advertisements that promoted Yaz as an oral contraceptive that goes beyond the rest, implying that it eliminated acne and other symptoms of premenstrual syndrome.

The promotion of new medications presents another problem, since adverse effects are often not discovered until several years of use. By promoting new medications heavily before adverse effects are fully known, critics argue that more patients are unnecessarily exposed to potential harm. For example, the medication Vioxx was marketed to consumers as a pain medication that minimized ulcer risk but was later found to increase the risk of stroke or heart attack. Due to public pressure and pressure from the FDA, Merck, the manufacturer of Vioxx, voluntarily withdrew it from the market.

Proponents of DTC marketing believe that advertisements for pharmaceuticals assist in reducing the stigma that surrounds many disease states and avert the underuse of medications for these conditions. For example, exposure to television advertising in one study increased antidepressant use by about 8 percent.<sup>5</sup> Due to the proliferation of advertisements for erectile dysfunction and urinary incontinence, the discussion of these issues has become more commonplace. Additionally, health care in



the United States is increasingly shifting from a physician-centered decision system to a more patient-oriented decision system.

In accordance with this shift, DTC marketing is thought to empower patients by providing information that they can then share with their care providers to initiate discussion. This discussion does not necessarily result in the advertised medication being prescribed but can lead to improved adherence.<sup>4</sup> One study found that patients who requested a medication after seeing an advertisement were the most adherent, even if the medication requested was not prescribed. The authors speculated that the knowledge gained from the advertisements resulted in patients that were more vested in their health. However, the possibility exists that patients who request medications are already more health conscious and the knowledge gained from the advertisement could have been acquired from a less biased source.

Of note, expenditures for DTC advertising have been decreasing over the past six years due to several factors.<sup>6</sup> This decrease in spending is not solely due to the recent recession. Many lawsuits have been filed against pharmaceutical companies for misrepresentation of efficacy information and minimization of adverse effects, leading to increased expenditures and bad press. For example, many lawsuits have been filed against Bayer for failing to warn patients adequately about the risk of blood clots with the oral contraceptive Yaz. Additionally, more biologics and targeted drugs, which are not indicated for the general public, are in the pipeline. These medications are used for specific indications and specific populations, making DTC marketing less lucrative.

Although pharmaceutical companies have been spending relatively less on advertisements targeting the general public, the advertisements continue to impact patient care and health care costs. DTC marketing remains controversial. Some have tried to advocate for tighter regulatory control by the FDA, but the costs associated with increased staffing needed to ensure compliance has limited this idea as a feasible strategy. In response to the concerns about DTC marketing, pharmaceutical companies have attempted to self-regulate. The Pharmaceutical Research and Manufacturers of America (PhRMA) developed a voluntary set of guidelines, consisting of 15 principles that companies should follow when designing DTC ads.<sup>7</sup> Central concepts within the guideline include ensuring that medication advertisements portray risks and benefits accurately and specify that actors are being used to promote the drug. Unfortunately, there is no consequence for not following these guidelines.

Although there may be some benefits to DTC marketing as far as reducing stigma, in the end, DTC marketing is more harmful than helpful. This is why in most of the world, pharmaceutical companies can not market directly to patients. The U.S. and New Zealand are the only two countries where DTC marketing of pharmaceuticals is allowed. Patients need assistance interpreting the complex data presented in many of the advertisements. The patient-provider relationship is central to maintaining medication safety. DTC marketing only confuses patients.

S. Mimi Mukherjee, PharmD, is an assistant professor of pharmacy practice at MCPHS University ~ Worcester and a clinical pharmacist at Edward M. Kennedy Community Health Center ~ Framingham.

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# Engaging the Public

Leonard J. Morse, MD



Leonard J. Morse, MD

In 1961, when I entered medical practice in Worcester, a small announcement in the *Worcester Telegram & Gazette*, and perhaps a name shingle in front of one's office, was the extent of advertising your wares at the time, with the exception of the Yellow Pages in the telephone directory. I remember opting only to have my name listed in the alphabetical section

and requested conventional print rather than a bold or upper-case font. Times have changed. The public is deluged with all sorts of advertising within the full spectrum of media by physicians, hospitals, group clinics, health insurance companies and especially pharmaceutical companies, most often promoting very personal health considerations during prime-time television with the bottom line caveat always being "Ask your doctor if you have any questions."

The American Medical Association was established in 1847, when a group of physicians first met in Philadelphia to discuss professionalism and ethics. Currently the AMA publishes a Code of Medical Ethics based on the deliberations of AMA's Council on Ethical and Judicial Affairs.<sup>1</sup> The Code is updated every two years and includes 218 opinions. It is a most useful resource, heralded by the nine Principles of Medical Ethics, which were adopted in 1957 and last revised in 2001. Principle II states, "A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities."

Currently, Opinion 5.02, titled "Advertising and Publicity," states, "There are no restrictions on advertising by physicians except those that can be specifically justified to protect the public from deceptive practices. A physician may publicize himself or herself as a physician through any commercial publicity or other form of public communication (including newspaper, magazine, telephone directory, radio, television, direct mail, or other advertising) provided that the communication shall not be misleading because of omission of necessary material information, shall not contain any false or misleading statement, or shall not otherwise operate to deceive.

"Because the public can sometimes be deceived by the use of medical terms or illustrations that are difficult to understand, physicians should design the form of communication ... to the public in a readily comprehensible manner. Aggressive, high pressure advertising and publicity should be avoided if they create unjustified medical expectations or are accompanied by deceptive claims. The key issue, however, is whether advertising or publicity, regardless of format or content, is true and not materially misleading.

"The communication may include (1) the educational background of the physician, (2) the basis on which fees are determined (including charges for specific services), (3) available credit or other methods of payment, and (4) any other non-deceptive information."

Examples of deceptive forms of advertising include individual patient testimonials and a physician's claim to have an exclusive or unique skill or remedy. I believe the unrelenting rise in the cost of healthcare relates, in part, to the patient and the physician provider not knowing or weighing the value of the cost of any test, service or consulta-



tion in advance of it being rendered. There is no other product in our society offered or purchased without the recipient (patient) knowing the cost in advance! I believe physicians should begin to lead the way by publicizing their charges.<sup>2-4</sup>

Unfortunately, physician advertising may often stimulate competition. Physicians ideally should be colleagues, not competitors! It is impossible to know everything, and the first thing a physician should know is what she or he does not know! In the best interest of patient safety, the physician should recognize a colleague to whom a patient with an enigmatic situation should be referred in consultation.

A community of medical doctors, clinics and hospitals then serve as a resource for unraveling puzzling situations, clarifying uncertain diagnosis, suggesting complicated diagnostic study, formulating complex pharmacotherapy and providing medical follow-up and co-management, with ultimate referral back to the referring physician, all with harmonious communication.

The Council on Ethical and Judicial Affairs of the AMA holds authorship of the splendid Code of Medical Ethics, and I strongly recommend every physician have a copy upon entering practice as a reference guide.

Leonard J. Morse, MD, retired, is Worcester's former commissioner of public health. He is a professor of clinical medicine, family medicine and community health and University of Massachusetts Medical School and Graduate School of Nursing. He was past president of the Worcester District and the Massachusetts medical societies.

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3. Morse, L.J. "The Disclosure of Prices for all Drugs and Pharmaceuticals." Resolution: 510. Proceedings, American Medical Association. House of Delegates (A-93). June 1993.
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# Payment Transparency Rules From The Physician's Perspective

Peter Martin, Esquire



**Peter Martin, Esq.**

Section 6002 of the Affordable Care Act requires certain drug and device manufacturers and group purchasing organizations to report to the Centers for Medicare and Medicaid Services payments to physicians and teaching hospitals and ownership/investment interests held by physicians. The intent of

the law is to stop conflicts of interest that can harm patient care and dishonest influence on research, education and clinical decision-making. The effect of the law is to increase awareness and understanding of industry-physician financial relationships. Physicians with such relationships should take the opportunity to make sure the information disclosed is accurate and presented in the proper context.

Regulations and other materials issued earlier this year by CMS describe how this is going to work. The reporting obligations lie with GPOs that purchase or arrange for purchases of drugs, devices and biological or medical supplies and manufacturers of the same items. It does not pertain to wholesalers or distributors that do not own drugs, devices or biological or medical supplies, but it does to entities related to manufacturers that engage in the marketing, promotion, sale or distribution of those items. The regulations do not impose any obligations directly on physicians or other covered recipients.

What must be reported are any transfers of value or payments made to, and ownership or investment interests held by, physicians. This latter category includes stock; stock options other than received as compensation; partnership and LLC interests; and loans. Also, it includes ownership and investment interests held by a physician's immediate family members. For purposes of these regulations, the term "physicians" includes dentists, osteopaths, podiatrists, optometrists and chiropractors, regardless of whether they participate in Medicare or Medicaid, but excludes residents.

Reports include the name and address of the covered recipient, the amount and date of payment and the form of payment. Payment can be described as cash, in-kind items or services, stock or stock options, other ownership interests or dividends, profit or other return on investment. The nature of the payment must also be reported, such as consulting fees, compensation for services rendered, honoraria, gifts, entertainment, food and beverage, travel and lodging, education, royalties or grants. Reports during the initial compliance year must be submitted by the manufacturers and GPOs by March 31, 2014, and pertain to payments made and interests in existence on or after Aug. 1, 2013. CMS will post the reported data on a website no later than Sept. 30, 2014.

Certain payments need not be disclosed. For example, compensation for speaking at a continuing education program need not be reported if the event is accredited or certified by certain professional organizations or the



manufacturer does not pay the speaker directly and does not select the recipient speaker. For calendar year 2013, payments of less than \$10 do not have to be reported unless multiple payments exceed \$100 in a calendar year; in subsequent years, these amounts will be increased by the rate of inflation. Product samples, educational materials that directly benefit patients, in-kind items used for charity care or dividends from a publicly traded security or mutual fund do not need to be reported. Food and drink provided at an event where the average cost per person is lower than the \$10 threshold does not need to be reported. Food and beverage provided in "settings where it would be difficult to establish the identities of people partaking in the food" also need not be reported.

Physicians and others will have the opportunity to review the information reported by manufacturers and GPOs. They will be notified by CMS through online postings and notifications on listserves. CMS strongly suggests potential recipients register with CMS and indicates that further information about the registration process will be forthcoming. Once notified, the physician will have 45 days within which to resolve any disputes with the reporting entity. If a resolution is arrived at, the reporting entity must notify CMS of the changes to the reported information no later than 60 days after the review period begins. If the dispute is not resolved, the report will be posted without change, but with a notation that the information is disputed. Disputes may be initiated after the 45-day period, but any changes to the reported information will not be corrected until the next time the data is refreshed.

Public reports as to some payments or transfers of value under a product research or development agreement may be delayed. The information must be reported by the manufacturer to CMS, but CMS will not publicly post the information until the drug, device, biological or medical supply has been given FDA approval or four calendar years after the date of payment, whichever occurs first.

Manufacturers and GPOs who fail to report or report inaccurately or in an untimely manner are subject to civil monetary penalties. These range from \$1,000 to \$10,000 for each such failure. The penalties are enhanced if such failure is "knowing," that is, the reporter acts in deliberate ignorance or in reckless disregard for the truth or falsity of the information. In these cases, the penalties range from \$10,000 to \$100,000 for each such report. The maximum combined annual penalty per reporting entity is \$1.15 million.

Practitioners who have compensation or ownership relationships with applicable manufacturers and GPOs would be well advised to register with CMS to maximize their ability to review and possibly dispute information that may be reported about those relationships.

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

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# Spoken History Project

Dale Magee, MD, MS



**Dale Magee, MD, MS**

What we need today is a compass. The world around us is changing. Our science is evolving, but what is going on in health care delivery is nothing short of revolutionary. Our judgments are challenged on a daily basis. Our very role in the delivery of health care is being questioned. Now more than ever, we need the calm sense of purpose and direction that comes with experience. Our colleagues who have come before us have lived a profession defined as much by change as it is by the bond between the doctor and the patient. Their experiences and their vision are vital to the evolution of our profession.

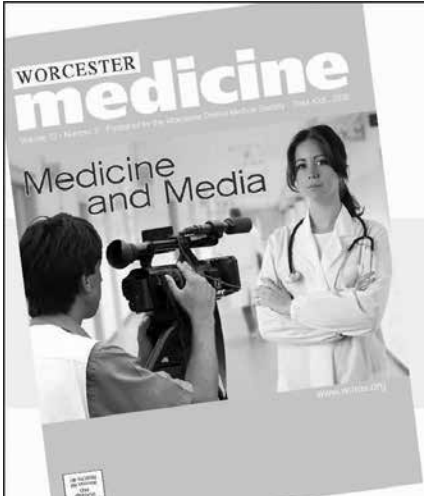
Imagine how good it would be to hear about the day-to-day practice of medicine from not only the icons such as Holmes and Osler but also the rank and file physicians practicing every day medicine. What did they see? How did they treat patients? What were their worries and successes? What was their life like outside of their practice?

The Worcester District Medical Society began a Spoken History Project in 1995, and over the past few decades, we have compiled dozens of interviews. This project is overseen by Dale Magee, but the interviews are being performed by medical students. Currently, Miriam O'Neil, a second-year medical student at UMass Medical School, is conducting the interviews and doing an excellent job. We are also indexing the interviews to better make them available to researchers, as well as allowing those who want to browse our collection to more easily find what they are looking for.

We are in the process of developing a lending library. Members will be able to view a list of videotaped interviews available on DVD and request a copy by visiting our website [www.wdms.org](http://www.wdms.org).

*Worcester Medicine*, our journal, is also providing a regular series based on reviews of interviews.

So as a member, I encourage you to take advantage of the perspective that our senior colleagues have so generously provided us. If you are a senior, please know that we want to hear about your career and contact Joyce Cariglia, executive director of the Medical Society, at (508) 753-1579.



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Our history is vital to our future. Join us as we listen to the stories and let the lives of our colleagues become a part of us.

*Dale Magee, MD, MS, is a practicing physician in Shrewsbury, Mass., past president of the Massachusetts Medical Society and the Worcester District Medical Society. He has led the Spoken History Project since 1995.*





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**Francis J. Bednarek, MD**  
1944-2013

Francis J. Bednarek, MD, 68, chief of neonatology at UMass Memorial Healthcare, died unexpectedly on Monday, July 15, 2013, while vacationing at his summer home in Harwich. Frank was born and raised in Wilkes-Barre, Pa., graduated cum laude from King's College in Wilkes-Barre and received his medical degree from the Stritch School of Medicine at Loyola University in Chicago. He did both his pediatrics residency and neonatology fellowship at Mott Children's Hospital in Ann Arbor, Mich.

Frank came to Worcester in 1975, one year after Dr. Brad Griffin had opened the first neonatal intensive care unit in Central Massachusetts at the Worcester Memorial Hospital, quickly establishing a training program in neonatology for the UMass pediatric residency, as well as a fellowship in neonatology. The NICU has grown from its initial eight beds to the current 49-bed unit.

They became true pioneers in the field. They gathered patient data early on for later annual reviews of the regional neonatal and high-risk perinatal population. When the Vermont Oxford Network of neonatal intensive care units was established in the late 1980s, the concept of reviewing patient quality and outcomes had already been well-established in Worcester. They instituted quarterly outreach for patient review and teaching at the Central Massachusetts regional delivery hospitals. This established a quality improvement program, resulting in the NICU having some of the best outcomes for its infants, in comparison to NICUs in this international network. In addition, Frank assisted in the establishment of the Level 2 Special Care Nursery at St. Vincent Hospital.

Frank's career in neonatology spanned 38 years; he was still practicing neonatology at the time of his unexpected passing. He was involved in the care of nearly every sick or premature infant born in Central Massachusetts. In recent years, he also cared for a second generation of babies, the children of his former patients. He was an integral part of the Massachusetts and New England neonatology community and was well known nationally for his research. His academic and professional interests varied, but they were always centered on the subject of newborn medicine and how to improve the care delivered to the newborns and their families. Having parents participate in daily rounds and instituting 24/7 in-house neonatal attend-

ing coverage were precursors to the concept of family-centered care, years before this became routine in medicine.

Frank authored a multitude of works on newborn medicine topics, which included more than 100 academic papers. As an educator, he participated in and organized hundreds of lectures at local, regional and national conferences. Frank mentored hundreds of college, nursing, nurse practitioner and medical students; pediatric residents; and neonatal fellows. His dedication to the families under his care inspired many to choose a similar path. As the neonatal-perinatal fellowship director and professor of pediatrics at the University of Massachusetts Medical School, he trained several generations of neonatologists and pediatricians who continue his legacy in their practices throughout the country.

Frank was a humble man, but his many accomplishments were noted by others. He was recognized by the Worcester District Medical Society in 2006 with its Career Achievement Award. In 1999, the Diocese of Worcester conferred upon him the St. Luke Physician's Award, which represents medical excellence combined with a caring attitude ~ qualities that enabled him to help families dealing with traumatic situations.

Frank enjoyed relaxing and spending time at his summer home with his family and friends. He was an avid sports fan and an accomplished athlete who played semi-pro baseball in his 20s. He was a member of Cranberry Valley Golf Course in Harwich and was a former member at the Worcester Country Club. He will always be remembered for his gentle, kind and compassionate nature and his many contributions to the Worcester medical community and beyond.

**Stuart Weisberger, MD**



**Gary Tanguay, MD.**

1951-2013

Dr. Gary Tanguay, of Chadwick Medical Associates, died suddenly on Sunday, April 21, 2013. Like everyone who knew him, I was shocked by the news, particularly because he was so physically fit and a role model of good health practices to us all.

He was, of course, grateful for the esteem in which he was held by his professional colleagues, but he valued the confidence of his patients just as highly.

Dr. Tanguay was my primary care physician for more than 35 years, beginning when he was at Memorial Hospital. Like all of his patients, I benefited from his insightful and empathic care, but I also had the privilege of him taking time out from each visit to share his thoughts, and seek mine, on trends in health care ~ his domain and, in biomedical science, mine. These exchanges brought me into a confluence with this fine man that went beyond the typical doctor-patient axis.

After he left Memorial, I became a great advocate of Chadwick Medical Associates, it being the perfect size of practice ~ somewhere between a sole practitioner and cavernous large-scale operations that can be so user-unfriendly (without meaning to be). There were so many times over the years when the office would get me in the same day to be seen for an acute situation, e.g., poison ivy, an earache and the like (things certainly not for the ER). One time in such a visit, he saw me himself. I had been pruning shrubbery and had accidentally excised a nice little wedge from the side of a finger. Always armed with a keen sense of humor and also always knowing his patients' quirks, he asked me "Were you looking up in the clouds, thinking up some complicated DNA experiment in your lab when you did this?" Then, turning from playful to serious, he added, "For your well-being, when you use sharp instruments, pay attention!"

In so many exchanges we had over the years, his instructions were so firmly conveyed and had such gravitas that we, his patients, always did our best to follow through. We didn't want to disappoint him. That is among the many legacies of this fine physician and, in so many, many respects, I think his practice of medicine could have been a platinum standard for training the next generations, and indeed, it was with the medical students and fellows fortunate enough to work at his side.

He even taught a hapless "student" like me. One time, as he was pushing down on my abdomen like a 10-ton gorilla, I asked him, "What is that physical diagnosis technique for anyway?" He replied, "Many things, including an enlarged aorta." I replied confidently (recalling faint memories of a rat I dissected in a college biology course ~ like this meant I was on a same plane as the author of *Grey's Anatomy* or something), "You can't feel my aorta under my liver!" His sage answer: "I can if it's enlarged." He also shared with me his admiration for the teacher who taught him that. He was not one to claim knowledge *ab initio* but consistently credited mentors in all our conversations over the years.

Another time, I told him I was changing my daily 81 mg. of aspirin from the coated tablet to the chewable because I had read a study that claimed the coated tablets can get through the stomach without completely uncoating. Once again, there came his Solomonic reply: "Talk to me when you see these publications and don't believe everything you read."

He was just so perfect in combining light-hearted conversation ~ always delightful ~ with a resolute instruction to the patient, with the two not to be confused. He knew me so well, as he did all his patients, that he was able to clearly signal us when he was chatting vs. when he was giving orders. This was among his most sterling skills as a physician.

Dr. Tanguay's devotion to medicine was exceeded only by his devotion to his family. Photographs of his wife and children were always on proud display in the exam rooms, and I felt like I was watching the children grow up over the years, as new photos appeared from time to time. Every trip he told me about began with "We ...." He was a paragon of family feeling. A first grandchild arrived just weeks before his death, adding a most bittersweet element to his passing.

I was fortunate to have had such a fine physician for so long in my life. How much I admired him, benefitted from his wise care and, most of all, how greatly I enjoyed being in his good company created many very special encounters over the years. Sitting on the exam table, I was on a slightly elevated perch, but, needless to say, I was always looking up to him.

**Thoru Pederson**



## in memoriam

### Gerald Bowen, MD

1932-2011

Gerald Bowen died on May 6, 2011, and is survived by his wife, Norma; two children, David and Joan; their spouses; and five grandchildren.

He was born in Rollinsford, N.H., attended local schools and graduated from the University of New Hampshire (Phi Beta Kappa) in 1954. He graduated from Tufts Medical School (AOA) and served in the U.S. Navy Medical Corp from 1959-61. He completed his medical residency in internal medicine at the Mary Hitchcock Medical Center and his fellowship in gastroenterology at the University of Chicago Medical Center, where he conducted research on inflammatory bowel disease.

He joined the Fallon Clinic as the ninth physician in the group and was the first gastroenterologist on the staff at St. Vincent's Hospital. He was a fellow of the American Medical Society, American Society of Gastroenterology and a member of the Dartmouth-Hitchcock Pinnacle Society.

In his practice and in teaching, Gerry preached, "listen to the patient." Gerry retired in 1995 but continued to read medical journals and attended grand rounds at St. Vincent's up until his death. He was also active at the Shrewsbury Senior Center, the Knights of Columbus and his church.

Norma and Gerry enjoyed their second home in Waterville Valley, N.H., where Gerry enjoyed his hobbies, including painting, golf and gardening. He also enjoyed sailing with his family.

He will be remembered for his compassion and loyalty and as a role model by his patients, colleagues, friends and family.

**Herbert Dean, MD**

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# WORCESTER DISTRICT MEDICAL SOCIETY

8th Annual Louis A. Cottle  
Medical Education Conference

## CEO FORUM

HEALTH CARE IN  
CENTRAL MASSACHUSETTS

The Worcester District Medical Society is pleased to host this CEO Forum providing members with an opportunity to meet with chief executive officers to discuss the current healthcare situation in Worcester and in Massachusetts at an informal gathering.

### Discussion Topics:

- Current healthcare situation in Worcester and in Massachusetts
- Impact of the Affordable Care Act (ACA) on hospitals and physicians
- Future of hospitals/physician groups, their relationships in light of Accountable Care Organizations, (ACOs)

### Moderator:



**George M. Abraham, MD, MPH, FACP**  
Chair, Medical Education Committee, Associate Chief of Medicine, President of the Medical Staff, Saint Vincent Hospital and Associate Professor of Medicine, University of Massachusetts Medical School, Governor-Elect, MA Chapter American College of Physicians (ACP)

### Panel of CEOs :



#### **Eric Buehrens**

Chief Operating Officer / Executive Vice President, Reliant Medical Group, a multispecialty medical group practice employing over 2000 people and serving patients in 20 locations throughout Central MA

#### **Wayne B. Glazier, MD**

President, Central Massachusetts Independent Physicians Association (CMIPA), a 200 physician member organization of Independent Physicians in Central Massachusetts



#### **Patrick L. Muldoon, MBA, FACHE**

President, UMass Memorial Medical Center, the Academic Medical Center partner of UMass Medical School

#### **Eric G. Wexler, MBA**

President & CEO of the Chicago and New England Region for Vanguard Health Systems and CEO of Saint Vincent Hospital, Worcester, MA



**Wednesday, October 23, 2013**  
**Beechwood Hotel, Worcester**

**5:30pm Registration**

**6:00pm Panel Discussion**

**A light buffet will be available.**

**WDMS & Alliance members \$10**

**Non-members \$20**

**FOR MORE INFORMATION OR TO REGISTER, VISIT [www.wdms.org](http://www.wdms.org)**



# WDMS Congratulates its 2013 Award Recipients

## 23rd Annual Dr. A. Jane Fitzpatrick Community Service Award



### **W. Peter Metz, MD**

Clinical Professor of Psychiatry and Pediatrics, UMass Medical School and UMass Memorial Medical Center; Medical Student Learning Communities Mentor, UMass Medical School; and Director of Community Child Psychiatry, Dept. of Psychiatry, UMass Memorial Medical Center

This annual award commemorates the life-long community contributions and exemplary efforts of Dr. Fitzpatrick in the Worcester community. The award emphasizes the main purpose of WDMS: to promote the health, benefit, and welfare of our citizens, to highlight contributions that have been made to the global community, to encourage others to seek similar opportunities and to publicly recognize the role of a health professional for outstanding contributions made beyond their professional duties, to improve the health and well-being of others.

## 2013 WDMS Career Achievement Award



### **Stephen E. Tosi, MD, FACS**

Senior Vice President/Chief Physician Executive, Chief Medical Officer, UMMHC  
Interim President UMass Memorial Medical Group, Interim Chair, Department of Urology.

This annual award was established to honor a member of the Worcester District Medical Society 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.

## 2013 President's Award



### **James B. Broadhurst, MD, MHA**

Dr. Broadhurst is Assistant Professor, Department of Family Medicine and Community Health and Associate Director, Family Medicine Residency at the University of Massachusetts Medical School. He is also Associate Director, Sports Medicine Fellowship, Department of Family Medicine and Community Health, Fitchburg Family Practice Program, and Staff physician, Shrewsbury Family Practice, UMass Memorial Medical Group-Shrewsbury and Medical Director of the UMass Memorial Ronald McDonald Care Mobile.

Established by the Awards Committee, the special award recognizes the recipient for his contributions to organized medicine and the health and well being of our community.

**Awards will be presented at the Fall District Meeting on Wednesday, November 13, 2013**



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# Calendar of Events

2013

**September 20**  
Friday  
7:30 a.m.  
Beechwood Hotel

**22ND ANNUAL WOMEN IN MEDICINE BREAKFAST**  
"Making a Difference"  
Speaker: Alex Calcagno, director of federal and community relations, Massachusetts Medical Society.  
*Cosponsored by Physicians Insurance Agency of Massachusetts (PIAM)*

**October 23**  
Wednesday  
5:30 p.m.  
Beechwood Hotel

**8TH ANNUAL LOUIS A. COTTLE MEDICAL EDUCATION CONFERENCE**  
CEO Forum: "Health Care in Central Massachusetts"

**October 1**  
Tuesday  
5:30 p.m.  
"The Cube," Albert Sherman Center, UMass Medical School Campus

**MENTORING RECEPTION FOR MEDICAL STUDENTS**  
*Cosponsored by the WDMS Women's Caucus and the American Medical Women's Association (AMWA)*

**November 13**  
Wednesday  
5:30 p.m.  
Beechwood Hotel

**FALL DISTRICT MEETING**  
The dinner meeting includes the A. Jane Fitzpatrick Community Service Award, the WDMS Career Achievement Award, and scholarship award presentations.

**December 6 & 7**  
Friday and Saturday  
9:00 a.m.  
MMS headquarters and Westin Hotel, Waltham

**2013 INTERIM MEETING AND MEETING OF THE MMS HOUSE OF DELEGATES**  
All WDMS members are invited to attend as guests and may submit a resolution to the Massachusetts Medical Society.

**December 12**  
Thursday  
5:30 p.m.  
Mechanics Hall

**A NIGHT AT THE MOVIES**  
*Escape Fire: The Fight to Rescue American Healthcare*  
Group discussion and holiday celebration will follow.

2014

**February 9**  
Sunday  
7:00 p.m. reception;  
8:00 p.m. program  
Mechanics Hall

**THE VIENNA CONCERT-VEREIN ORCHESTRA, PHILIPPE ENTREMONT, CONDUCTOR**  
"Strauss, Beethoven, Mozart"

**February 19**  
Wednesday  
5:30 p.m.  
Beechwood Hotel

**218TH ANNUAL ORATION**  
"From the Roadside to the Bedside: Following the Saint of the Gutters"  
Orator: George Abraham, MD, MPH, associate chief of medicine, president of the medical staff, Saint Vincent Hospital; associate professor of medicine, University of Massachusetts Medical School; governor-elect, MA Chapter, American College of Physicians (ACP)

**March 12**  
Wednesday  
5:30 p.m.  
Beechwood Hotel

**WOMEN IN MEDICINE LEADERSHIP FORUM**  
"Domestic Violence and Intervention in Our Community"  
Speakers: Ginger Navickas, former executive director, YWCA Daybreak, Worcester, Massachusetts.

**March 19**  
Wednesday  
5:30 p.m.  
Mechanics Hall

**A NIGHT AT THE MOVIES**  
*A Place at the Table*  
Hunger is a growing epidemic in the United States.

**March 30**

**DOCTORS' DAY**  
March 30 is National Doctors' Day, a day when patients, friends, family, and colleagues honor physicians and express their gratitude for physicians' continuing commitment to patients and exceptional medical care.  
*Sponsored by the Worcester District Medical Society Alliance*

**April 9**  
Wednesday  
5:30 p.m.  
Beechwood Hotel

**ANNUAL BUSINESS MEETING**  
"Massachusetts Health Reform, the ACA, and You"  
Speaker: Secretary John Polanowicz, secretary, Executive Office of Health and Human Services, Commonwealth of Massachusetts  
Meeting includes presentation of the 2014 Community Clinician of the Year Award.

**May 14**  
Wednesday  
University of Massachusetts Medical School

**MEET THE AUTHOR SERIES**  
*Cosponsored by WDMS and the Humanities in Medicine Committee of the Lamar Soutter Library at the University of Massachusetts Medical School*

**May 15 & 17**  
Thursday and Saturday  
9:00 a.m.  
MMS headquarters, Waltham, and the Seaport Hotel and World Trade Center, Boston

**2014 MMS ANNUAL MEETING AND HOUSE OF DELEGATES**  
All WDMS members are invited to attend as a guest and may submit a resolution to the Massachusetts Medical Society.

Have you visited  
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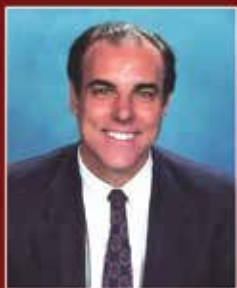


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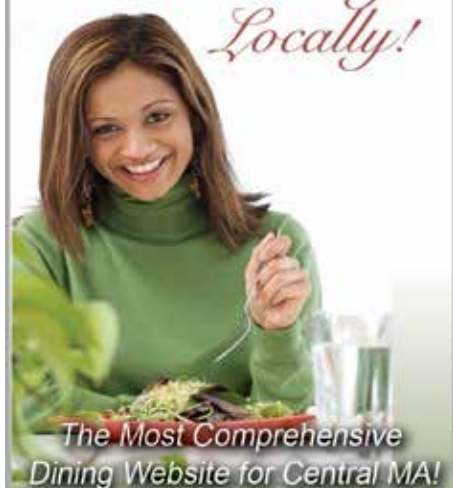
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Sun., Oct. 20, 2013  
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## *Is the Real Estate Market Starting to Change?*

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✓ # of closed homes - up 7.7%

✓ # of homes for sale - down 28.5%

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