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Introduction



Robert Sorrenti, MD

If you search on “physician writers” within Wikipedia, a multiple page entry comes up, listing the names of physicians from the Middle Ages through the 21st century who have also been writers. For the 20th century alone, there are over 100 physicians listed. This issue of Worcester Medicine offers you the opportunity to sample the work of our own physician authors ~ members of the Massachusetts Medical Society who have participated in our Creative Writing Exposition and have been selected as the blue-ribbon best.

The Creative Writing Exposition is sponsored by the MMS Arts, History, Humanism & Culture Member Interest Network (Arts MIN). This MIN provides a forum for our members to explore, develop and participate in non-medical activities that range from bird watching to bonsai planting, from art exhibition to astronomical viewing. We invite MMS and MMS Alliance members to take part in some of the activities and events the Arts MIN sponsors and to join us on the executive council to promote new areas of interest.

This year, there were a record number of submissions for our Creative Writing Exposition. A creative writing workshop, sponsored by the MIN and led by Dr. Julie Stiles, helped to spur interest in this event. We plan to offer other workshops of this type in the future.

The physician authors who participated in our exposition, like other physicians, fill many roles in their day to day careers. This exposition highlights what they do in their spare time as they master the written word. Join me in congratulating our winners for this year’s Creative Writing Exposition and enjoy their work in this special issue of Worcester Medicine.

Robert Sorrenti, MD, is Chair, MMS Arts, History, Humanism & Culture Member Interest Network (Arts MIN)

Robert Sorrenti, MD

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The Piano Competition

Pei-Li Huang, MD

“There are no competitions in medicine.” This thought comforts me as I pace back and forth in the vestibule of the Western Presbyterian Church in Washington, D.C. one humid July morning, waiting to walk “on stage” as the first performer in the 2009 Washington International Piano Amateurs Competition.

It doesn't take exceptional talent to practice medicine. I have fine motor skills that allow me to handle delicate surgical instruments, and a talent for being a good listener, but I have never deluded myself that I was the best doctor in my field. For me it's enough to be the best doctor I know how to be, the kind of doctor that patients like and colleagues respect. Why then would I and my fellow performers ~ who are doctors, engineers, lawyers, financial analysts, professors and software programmers, but definitely not professional pianists ~ voluntarily subject ourselves to a competition in which there are only a few winners and many losers?

I suspect that it is the same reason why every year there are thousands of runners in the Boston Marathon. There are the elite runners and there are all the rest of us. I've seen many of these runners toiling up the concrete hills by my house every chilly, freezing weekend in the winter months before the marathon. Some of them run during the week in the darkest hours before sunrise or after sunset. Most of these “amateur” athletes will never win any medals. Why do they do this, train all winter to run 26.2 draining, exhausting miles? What will they have to show for it after they cross the finish line besides a silver Mylar blanket and perhaps a free water bottle? I believe that these runners train for the same reason that I have practiced my piano nearly every day for the past nine years ~ to get a little stronger and go a little further every day. And sometimes, the training is its own reward, allowing us to improve our personal best. We amateurs dream ~ not about winning the race, because that is impossible ~ but about just reaching the finish line, even several hours later, friends and thousands of strangers cheering us on.

Meanwhile, I am nervous as I stride into the church sanctuary to sit at the piano, and I have never, ever been nervous before when playing in front of an audience. I have faced situations far more horrific

without flinching ~ like staunching an unexpected hemorrhage in the operating room, blood soaking my shoes. “Nobody dies, nobody dies,” I chant silently to myself as a mantra to remember that, unlike surgery, nobody will die if I make a mistake at the piano. What is the worst that can happen? But my heart is pounding out of my chest and my fingers are trembling as I sit down to play. I am trying to play with as much nuance and beauty as I can, despite fingers that feel numb, as if the notes are slipping through them like the reins of a panicked horse. Then it happens! In the middle of a run of octaves, suddenly my mind is blank and I cannot remember what to play next. I stare at my hands in horrified panic. I start playing the passage again. Again my memory fails and the music grinds to a halt. The silence feels like an eternity as time expands and contracts with my heartbeat. Finally I manage to start playing somewhere beyond the frozen landscape of blank space in my mind and grimly limp towards the ending, knowing that my dream of playing my very best and making it into the next round of the competition has just imploded.

I get up from the piano, take a bow, and collapse ~ shaken ~ in a nearby pew. I can't believe I spent the last nine years taking piano lessons and practicing thousands of hours to suffer a performer's worst nightmare: a mind-numbing memory lapse so obvious that it can't be covered up by quick improvisation. The doctor in me, ever clinical, wonders if this is a sign of early Alzheimer's. To add to my humiliation, I know that in my panic I played terribly, without a glimmer of musical feeling. I am distraught but somehow I manage to pull myself together and applaud when the next performer walks to the grand piano and sits down. I slouch down as far as possible in my hard wooden pew to avoid the pitying glances coming my way. Phil, a kindly elderly volunteer “stage hand” who ushered me through the side door to the piano, gives my arm a squeeze and says, “Better luck next year, huh?”

The next day I do my best imitation of being a good sport and cheer for my new friend Robin (a tall, elegant woman too young to be a retired lawyer) as she makes it into the semi final round and eventually wins an award for best performance by an American composer.

As the competition progresses, I tell myself the entire traumatic, humiliating experience was worth it because I am invited to swanky receptions at several Washington embassies and because I will leave with several new friends: Robin, Judy, a retired music teacher and equestrian, Neil, a retired chemistry professor, and Andrew, an on-line marketing specialist.

I return to my “day job” as a physician who helps infertile couples conceive, usually a very gratifying job. None of my patients are even aware that I have stolen time away from practicing medicine. But I feel like a failure: depressed, listless, and unable to touch the piano. A month goes by and I am finding it impossible to make myself to start playing the piano. Robin is worried and sends me a Youtube video in which Jon Nakamatsu, the 1997 Van Cliburn piano competition winner, gives a speech to the Van Cliburn amateur piano contestants in 2007. “My name is Jon Nakamatsu, and I am a loser,” he announces with a charming smirk. In a self-deprecating yet hilarious manner he lists every single competition he lost on his way to the Van Cliburn gold medal ~ recounting the advice he was given by a well-meaning judge that he would never have a career in music so he should try something easier. We show courage, he says, “... every time we expose ourselves to public judgment of something intensely personal, all for the promise of nothing.”

I promptly fall in love with Mr. Nakamatsu and decide that if he is a loser, then being a loser is a badge I can wear with honor. It takes a long time, but slowly I start taking an interest in music again, forming an internet chat group made up of my new piano friends, all of us competition losers, but the richer for having met one another. One month after the debacle that was the competition, I sit down at the piano and start playing again, once more resolved to enter a piano competition and next time to “fail better.”

One day in August shortly after my return from Washington, one of my patients ~ extremely anxious and deathly afraid of anesthesia ~ refuses to have her egg retrieval surgery unless her husband or “someone she knows” is in the operating room with her. Her husband is not allowed to be in the O.R., so it left to me to cajole and convince her to have the surgery by promising to be in the operating room with her. I come in on my day off to hold her hand while her IV is placed and to perform her surgery. There is no CPT billing code for “TLC,” but I come in anyway, on a perfect summer day, because this is what I do as a doctor. I care for my patients even when there is no reward, sometimes not even a thank you, “...all for the promise of nothing.”

My patient is crying and shaking. “Please don’t let me die. It wouldn’t ruin your day if I die, but think of my husband....” “Believe me,” I say with all seriousness, “It would ruin my day. I won’t let anything happen to you.” Eventually she lets us wheel her, heavily sedated but still crying, into the operating room. When she awakens dazed from the anesthesia, her face is still wet with tears, but this time they are tears of relief. “Thank you,” she says hoarsely, as if barely aroused from sleep. “Thank you so much for being here for me.” For a moment, I feel like a hero. Three days later, I transfer a single perfect embryo into her uterus. Twelve days later she finds out she is pregnant.

After this heart warming experience, you might think that I would need no further validation. But surprisingly, such moments of grace are few and far between. Is it so hard to understand why I play the piano and enter piano competitions? It’s not because I have any delusions of winning prizes or becoming a concert pianist late in life.. All I wanted to do in Washington was to play my very best and sadly, I did not even do that. No, I entered the piano competition because I wanted to play for an appreciative audience ~ even if it meant facing a panel of intimidating judges and playing for a “jury” of my peers, every one of them serious music lovers. Listening is an act of love which longs to be reciprocated. Those of us whose vocation is listening do realize that love ~ romantic or platonic ~ is often unrequited. But sometimes we need ~ and indeed even crave ~ a little love, a burst of applause, a single, heart-felt thank you.

Pei-Li Huang, MD is a board-certified reproductive endocrinologist at Fertility Solutions, a new IVF center in Dedham, MA, as well as an amateur pianist.

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Clean Your Belly Button!

Claire Cronin MD, MBA

Since the origin of the loincloth 7,000 years ago, mothers have been telling their children (husbands implied) to wear clean underwear when going to see the doctor. The underlying assumption is that the physician is trained to notice and record the condition of a patient's undergarments and that there will be a lasting documentation of it in the medical chart:

Physical Exam

Cardiovascular System: regular rhythm and rate.

Respiratory System: clear to auscultation.

Abdomen: soft, non tender, no hepatosplenomegaly, no masses.

Underwear: neglected appearance with abnormal pink overtones and severe loss of elasticity.

In reality, most physician appointments are elective, which allows patients the opportunity to discreetly hide their knickers beneath their pile of clothes when undressing. With the evidence concealed, doctors rarely have the opportunity to judge the state of a patient's undergarments. The younger generation avoids commentary on their under-things by going "commando" and through the adoption of the thong. The thong, even when worn, provides precious little material for evaluation.

If on the other hand the visit to the hospital is an emergency, then usually the underwear is either not present, having been left behind at the scene of the accident, or already soiled from the trauma, which makes the clean underwear issue moot on arrival. If there is any undergarment remaining, it is cut off with shears and placed in a plastic bag that will be returned to the patient at the time of discharge.

The necessity of having to wear clean underwear when going out of the house, just in case you're involved in an accident, has gone the way of waiting 30 minutes after eating to go swimming just in case

you get a cramp. It has been replaced by a new edict that is far more relevant:, "Clean your belly button!"

This new concern to all is important due to the advent of laparoscopic surgery. Gynecologists and surgeons are using small incisions that are guided by a camera placed through the umbilicus to perform both elective and emergency surgeries. In order to gain access to the belly button, the surgeon spends the first few minutes of the operation cleaning the lint and other concretions out of the navel. This preparatory step is occasionally accompanied by gagging noises which are comical coming from professionals who aren't fazed in the slightest by the two main byproducts of general surgery, pus and poop. Unlike the underwear situation where very little judgment occurs, comments such as "...and she seemed like such a nice girl..." are frequently heard in the operating room.

There is a surprising lack of awareness on the public's part as to what can accumulate in a belly button and therefore what must be removed. These collections can take the form of a hair ball or a blackened wax cast of the umbilicus. Lint from clothes can accumulate just as it does in the dryer. Some entrepreneurialfolk actually save and display their navel lint in jars. Unfortunately, the volume of material increases as the patient ages and, just like their arteries, can harden. I like to think of it as a cache of a lifetime of little treasures.

The anatomy of the belly button obviously plays a role in these matters. This is primarily ~ but not exclusively ~ a disease associated with "innies.". Some "outies" have folds that can collect a dark grime in the hard to see areas. Women with belly button rings usually have extremely clean navels as the purpose of the ring is to show off this titillating body part. After pregnancies, when the piercing is stretched out along with the rest of the abdominal wall, the upkeep of the navel is usually abandoned as woman no longer wish to draw attention to this area.

Most patients have not received adequate instruction on proper

umbilical hygiene. It has not received the same level of attention that the area behind the ears has. I remember driving in a car as a child with my parents and in front of us was a sedan with two children and a plant in the backseat. My parents told my sisters and me that the plant was coming out of the ears of a third unseen child who didn't clean her ears properly. I had nightmares for a while but that was good parenting. I still search for the beginnings of potato buds in the shower.

There is a technique to cleaning the belly button. It involves soap and water and gentle probing. Care must be taken not to scratch the inside of the skin, which can cause infections. Apparently alcohol should not be used in order not to disturb the delicate pH balance of the area. Who knew the umbilicus had an acid-base issue?

I once met a patient who flew from Bermuda to Boston for a weeping, foul-smelling discharge that was emanating from his button. He came with computed tomography (CT) scans and other official reports from all the physicians that he had seen on the island. The surgeon that I was working with took one look at the patient's hirsute abdomen, glanced at the films and asked for a Kelly hemostat. Without uttering a word he plunged it into the patient's navel and pulled out a wad of old hair and muck that was wedged deep into the crevice. It was one of the most successful surgeries that I have ever witnessed.

Another woman whom I think of with fondness prior to any laparoscopic procedure that I am performing came in as an emergency patient to my office because she had been cleaning her belly button with a Q-tip and when she pulled out the stick the cotton tip was missing. She was attractive but very obese and clearly very hygienic. I didn't mind one bit fitting her in between patients to extract the prodigal "Q." She understands what is important.

So until the next edition of the mother's handbook is released, do not feel obligated to throw away your favorite pair of old boxers ~ but do pay attention to the maintenance of your belly button. It is the window into your abdomen that must be kept free of clutter in case you need your appendix out. Next time you visit grandma, bring along some cotton applicators and tweezers and help her navel out, too. Try not to pass judgment if you find that missing Lego piece from your childhood, as she grew up in the pre-laparoscopic era. She seems like such a nice lady.

Claire Cronin MD, MBA is a general surgeon at Newton-Wellesley Hospital and an Assistant Clinical Professor at Tufts University School of Medicine.



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Canadian Medicine: A Model for the USA!

Gerald P. Corcoran MD

It is unusual to see a US doctor extolling the virtues of Canadian medicine! My exposure to it was over 40 years ago and was not in any of the big cities of the Canadian provinces, but rather in Argentia, Newfoundland while I was stationed at the 80 bed Naval Hospital at the US Naval Air Station there. In one of the neighboring towns was a “cottage hospital,” one of many which were located around the province of Newfoundland and Labrador, mostly in the larger outport villages. The doctor stationed at that hospital was excellent, expert and efficient. He practiced a style of medicine not seen for many years elsewhere in North America. We could use some of that style today.

The doctor, John Ross M.B., was originally from Scotland, I think; at least he had a soft burr in his speech. He went on to live in Australia and then did some surgical training in London. He was the chief (and only) medical officer at the hospital in Placentia, just outside the Main Gate of my base, and my brief acquaintance with him was a milestone in my training and allowed me at a young age to reach an advanced level of medical maturity.

Shortly after my arrival to take command of the hospital on the naval base, I was at the Officers’ Club and was told by someone that there was a Canadian doctor there from the Placentia Hospital whom I simply HAD to meet. I assumed he would be a poorly trained doctor stuck in this outport because he was not sharp enough to be working in a big city hospital. I was young enough and cocky enough to be sure that all of the talented doctors were over at Memorial Hospital in St. John’s. He was quite gracious, and I was pleased to hear that he had served some mini-residencies of sorts, and apparently had the minimum training for this posting. How much I had to learn!

He seemed anxious to show this Yank doctor what his shop was like and, in the interest of community relations, I arranged to meet him and tour his little hospital the next week. I didn’t think it would take long as there would not be much to see.

No directions were needed to find the hospital; the town square consisted of Sacred Heart Church, the Trading Post, the gas station and the hospital. All other structures were homes. There was no industry, no workshops. Opposite to the church was a two story building, the size of a New England four bedroom colonial. Its identity was marked by a Pontiac ambulance (recognized by the big Red Cross) that was parked outside.

I was warmly greeted although he apologized for it not being very busy, but that did give me the opportunity to see almost everything there. There was a clinic on the first floor with waiting room and two exam rooms, one of which served as a trauma room. There was also a full OR just inside the ambulance entrance. We chatted about the commonality of our specialties and he was very interested in the care of the servicemen. I explained that I was doing Obstetrics and some Pediatrics, thereby treating mostly dependents.

John treated me to a cup of delicious soup (fish-based of course and NOT “fried in maggoty butter”) and a sandwich served in the small kitchen with the nurses and other attendants joining us, and he invited me back the next week to assist him in a hysterectomy. (I had asked him quite pointedly how he got along with no assistant at his surgeries.)

When I asked him how he felt about where he was, he said he was very happy. I could see the nurses and other personnel treated him like a God and each one had a story about some family member whose life he had saved.. He wanted for nothing. The fees were set by the government, but all the food and bakery goods and presents left on his doorstep were not included in the compensation. If he wanted anything (except some time off), he had only to ask and his patients would see that it was supplied

That visit began my real medical education. Medical School was busy and thorough, and we learned a lot, some of which was even pertinent to treating patients, but it was a very rudimentary education.

I arrived slightly early a week later, not wanting to interfere with any of the routine. I changed into scrubs and soon thereafter John arrived. He changed, but didn't scrub, instead going into the OR and proceeding to induce the anesthesia. When the machine was set to his liking and the gases were flowing through the mask, he joined me at the scrub sinks. He explained that if this were anything longer than 30 or 40 minutes, he would have incubated the patient. The nurse, although not certified as a nurse-anesthetist as ours was on base, was very competent and he had trained her himself. And so we began.

I did assist him in painting the operative area with betadine and in arranging the drapes, but as God as my witness, that was the last thing I did to assist. John used the self-retaining retractors and he did everything else. Oh, I held a couple of Kellys and he was never impolite, but every time I went to get a bleeder or expose some tissue plane, he was there ahead of me. About the only thing you can do in the presence of such competence and skill is to be humbled... and I was --not humiliated, but humbled. We finished about 29 minutes after induction without rushing and without incident. The patient's anesthesia was lightened for the last five minutes and so she was able to talk to him and thank him before we left the room,

I tried to tell him how impressed I was, but he would have none of it and said that any competent physician could do what he did. He had some patients to see in the clinic and I stayed a while and talked with the nurses, trying to probe into this set-up and find out how risky it really was. They didn't defend him, but matter-of-factly told me, "No, [we can't] recall any operative or post-operative death, no, we haven't lost any babies at all, no, the infection rate [is] non-existent". It was clear to me that the care was excellent ~ as good as, if not better than, any in the "big city."

Things got very busy at the base after that, as we had to move the Navy hospital from one side of the base to the other and that consumed most of my time. I did see him at the club from time to time, but then he wasn't there and I understood he had contracted some hepatitis and returned to England for a while. His replacement was a shadow of what John had been and spent most of his time packing people into ambulances to travel to St. John's.

About a month before my tour was over, I learned that John was back and true to his character, he amazed me again. As I said, he had access to basic equipment but not to some of the disposable set-ups that we had. If a case came in, he could make up a kit and sterilize it, but it took extra time and just wasn't the same. So it was

not unusual for our on-call doctor to field some requests for equipment. I was on the weekend I learned he was back.

Friday evening, a request was received for a chest tube set. It seemed that two cousins were out duck hunting in a dory, and the shotgun went off, hitting the patient obliquely but causing considerable loss of tissue and a collapsed lung. John put in the chest tube and patched him up but had to send him off to St. John's for some extensive skin grafting.

On Saturday afternoon, we got a call that he had a baby with a dangerously high bilirubin and would we mind loaning them an Exchange Transfusion set. I learned later that one set of transfusions did it and the baby was fine.

And the final touch was the call at 2am Sunday morning; they had just brought a fellow in from a car accident on the Trans-Canada Highway with one pupil dilating and so they needed a burr-hole set. The patient had his intracranial pressure relieved and did fine. Obviously John Ross was back. No other doctor could do so much so well.

So, if Canadian Medicine were populated by John Ross's ilk, the US would do well to imitate it. At one time we did have it all in the United States. We had a country where 75% of the doctors were generalists, handling most complaints and referring to specialists only when needed. Now the ratio is the reverse, with 75% of doctors specializing in some field or other and only 25% in Primary Care.

Where is the balance? For all their dedication and hard work, these Primary Care doctors received the lowest recompense. But the rewards of a career in true primary care transcend mere money. In "De Senectute," Cicero tells us that looking back on a life well spent in "...seeking knowledge, practicing virtue and performing right actions, brings unspeakable comfort to the soul." That satisfaction is priceless.

Gerald P. Corcoran MD is an assistant Professor of Family and Community Medicine at UMASS Medical School and has been a Family Practitioner in Needham for 40 years.

Where Is Jane?

Laura M. Prager MD

My father and I stand on Wellfleet's Indian Neck Heights gazing across the bay to Lieutenant's Island. My mother had taken her camera and disappeared down the rough stairway that leads from the house to the beach. Less than a minute passes before my father asks me, "Where is Jane?"

"Mom went down to the beach to take some pictures. She is worried about possible erosion from last night's storm," I tell him.

"She should not be gone so long," he says. "Where is she?"

"Dad, a minute ago she left us and began walking down to the beach to take some pictures. She is just over the cliff and out of sight."

"But I can't see her. How do you know she is down there?" he demands, his voice starting to quiver and betray his anxiety and fear. "She doesn't need to take any pictures. We can see the view from right here. It's the same as it has always been."

"She will be right back," I say.

A few moments pass.

"Where is Jane?" he asks again, as if that question were the only question in the world worth asking. Yet because it had to be asked at all, there would never be a truly acceptable answer.

It was not always like this. My child psychiatrist father had been the master of the right question. He taught me early on that there was no question too small or mundane. He encouraged me to be curious and unafraid ~ to ask the question to which I wanted to know

the answer. Questions were like the curved line that approaches an asymptote but never quite meets it. The final answer should remain tantalizing and always just out of reach.

I was too young to understand how time can sneak up on you when you're not looking, too young to appreciate that these might have been questions my father was asking himself.

His favorite greeting was, "How are things in Glocca Morra?" a line he lifted from the song of that name in the Broadway musical, Finian's Rainbow. He just assumed that everyone, no matter his or her age, could imagine a world outside the confines of the present where memory and desire lay waiting. It was his job to help you to tell him about that place.

His questions were not meant to be intrusive; rather they reflected his total absorption in the other person. The answers

to each question, now shared details, become a foundation for the path toward insight and understanding that therapist and patient can travel together.

This is not to say that some questions of his questions were not insensitive or unwelcome. Certainly, sometimes we, his children, experienced them as simple meddling or even, particularly in our teenage years, as invasive. He was fond of asking us to interpret his favorite popular songs. Driving somewhere with him was often frustrating. When the Talking Heads blared, he turned the volume up.

"Tell me what the song means," he would ask as he sang along with David Byrne, "You may tell yourself, this is not my beautiful house/ You may tell yourself, this is not my beautiful wife."¹ I would stammer out an answer about the singer's surprise at finding himself trapped by his choices. I was too young to understand how time

can sneak up on you when you're is not looking, too young to appreciate that these might have been questions my father was asking himself.

But in his role as a therapist, he understood the need to strike the necessary balance between curiosity and coercion. He taught me that a psychiatrist should think carefully before asking a patient with an eating disorder any questions about food. He particularly admired and often quoted his teacher, Elvin Semrad, MD, a psychoanalyst renowned for his ability to elicit answers to his questions from psychotic patients, somehow giving them permission to talk about their feelings in a non-psychotic, coherent fashion.

When I started in my own practice of child psychiatry, I tried to remember what I had learned from my father and shape my own questions accordingly. Sometimes I still hear his voice in my ear murmuring, "What does the song mean?" I have become well known by my own residents and medical students as the supervisor who can be relied upon to ask three things about a child patient: Where does the patient live? Who has custody? And the question to which the resident doesn't know the answer. The first two are pragmatic and predictable; the answer to the third is designed to prompt new questions and, I hope, guide further inquiry.

I should have known several years ago that something was amiss. My father stopped in after work, pulling up to the house in his Buick, dashing in through the rain, forgetting his umbrella in the car. He had agreed to comment on a complicated play therapy case with a medically ill child that I was writing up for possible publication. He sat at my kitchen table thumbing through each page. When he finished, he said, "I like how you chose to use a paper-mâché volcano as a way of helping this child adjust to her colostomy. Good work." That was all. No questions. I had expected that he would push me further along by asking me to condense, clarify, or elaborate. I had hoped that he would ask me questions about the patient to which I did not know the answer and, in that way, force me to look at the material in a different light.

Now, as time goes by, my father's seemingly inexhaustible source of questions has been slowly but irrevocably reduced to that singular question, "Where is Jane?" It is a question that carries with it the love, need, dependence, anger and resentment that fifty years of marriage has wrought. Jane is the

woman he pursued and won, the woman he left and returned to, the woman he loved, admired, and took for granted. Yet the question of where she is has become rhetorical, a tragic coda to his life's work. My father would have been the first to remind me that when memory fades, life is never the "...same as it ever was." In the present, "Where is Jane?" has become a mantra with only one possible response: "She will be right back," both a statement of truth and a lie.

He and I remain watching and waiting. Jane slowly rounds the bend and climbs the staircase in the sand, coming closer and closer to where we stand on the top of the dune.

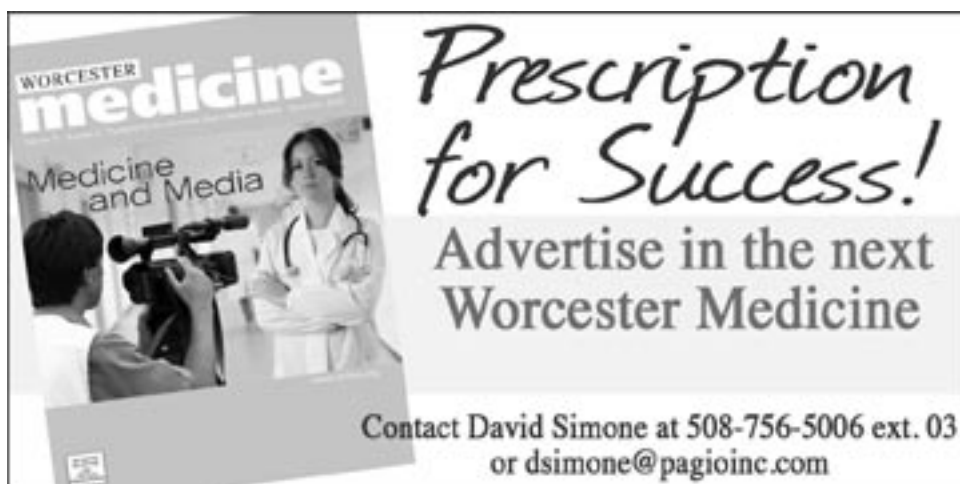
"Here she is," my father says triumphantly.

My mother offers a sad smile. She did not take any pictures, she tells us. Ironically, my father was correct; there is no need for photographs. The erosion is plain to see from any vantage point.

Laura M. Prager MD is an Assistant Professor of Psychiatry at Harvard Medical School and Director of the Child Psychiatry Emergency Service at Massachusetts General Hospital.

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1. *Talking Heads, "Once in a Lifetime," from Remain in Light, 1980. http://www.lyricsfreak.com/t/talking+heads/once+in+a+lifetime_20135070.html (accessed September, 2010).*



The advertisement is a rectangular graphic. On the left side, there is a black and white photograph of a female doctor in a white lab coat with a stethoscope around her neck, standing next to a male patient who is holding a video camera and filming her. Above the photo, the text "WORCESTER medicine" is written in a bold, sans-serif font. Below the photo, the text "Medicine and Media" is written in a smaller, italicized font. To the right of the photo, the text "Prescription for Success!" is written in a large, elegant script font. Below that, "Advertise in the next Worcester Medicine" is written in a bold, sans-serif font. At the bottom right, the contact information "Contact David Simone at 508-756-5006 ext. 03 or dsimone@pagoinc.com" is written in a bold, sans-serif font.

The Con Artist

Submission for MMS 8th Creative Writing Expo

Leana S. Wen, MD, M.Sc.

“He’s baaaack!”

I looked up as a skinny man in an orange jumpsuit was wheeled from triage. Metal clattered as he strained against the handcuffs, yelling, “Picasso! Rembrandt! The artist is here, mon!” He stopped hollering long enough to flash a toothless grin at a young nurse’s assistant, who pressed herself against the wall in shock. “Calm it down,” snapped his companions, three large well-armed police officers. “Can’t you see that everyone around here is looking at you?”

Indeed, the noise in the Emergency Department (ED) had fallen several decibels as patients and staff alike strained to see the commotion. I sighed. This was Jake. Jake was a 30-something Jamaican man who had been in the Boston penal system for some time. He tended to create quite a stir whenever he came to the ED, with his colorful dreadlocks and even more colorful language and stories. What he was in jail for, I didn’t know, or ever want to know. It must have been something pretty bad, since he always had three officers with him while most other prisoners came with a complement of one or two.

I didn’t want to know what he did because Jake was, frankly, rather entertaining. He came frequently to the ED with lame attempts at being hospitalized because, compared to the prison, our hospital had “hotter food and hotter women, mon.” In my short time in residency, I had seen him twice already. The first time, a couple of months back, he claimed that an errant cactus pot fell from a shelf and hit his face while he was sleeping. “Doc, you gotta rescue my beautiful face!” he pleaded with me. He had a tiny lip laceration and a few cactus spines stuck in his cheeks; judicious use of forceps and he was good as new. He managed to sing all the way through my spine-extraction, and remains the only person to have serenaded me on his knees with shackles on both ankles.

The second time, he seemed to have learned that certain symptoms bought him a longer length of stay. He came in complaining of crushing chest pain that began while he was raking leaves. The

symptoms, in combination with his history of diabetes, meant he would receive a much longer workup. He cackled when I told him that, indeed, we had to wait for a second set of labs to come back. “High-five, doc, high five!” he cried, throwing up both arms as far as they would go and shaking his full head of locks for emphasis. Whenever I came in to check on him during that shift, he would provide me with some amazing medical aphorisms, such as “The worst kind of pain is a screwdriver through the right eyeball” and “The cure for a stroke is pineapple skunk.” One of the guards muttered under his breath, “Con artist,” and Jake latched on to the latter part of the phrase. That last time, Jake signed his discharge paperwork “Jake, the arteest” with a flourish.

This time, the chief complaint on the triage note was “Altered mental status.” This will be fun, I thought. Jake at baseline was pretty out there; Jake altered should be something else to behold. The note that accompanied him was from the prison nurse, and stated that he had been in isolation for a week after a fight with fellow inmates. Two days ago, his guards noticed “bizarre behavior” that consisted of not responding to his name. The nurse saw him today because he refused to eat. A urine tox there was negative; his fingerstick was 150; he had no documented trauma, and his physical exam only commented on intermittent lethargy and manic behavior. QUESTION MALINGERING was written in large letters at the bottom of the prison note.

The noises had died down in the exam room by the time I walked in. From the door, I could see that Jake was lying on his back, hands stiffly folded across his chest, eyes squeezed shut. The nurse had unsuccessfully attempted an IV; one of Jake’s hands would shoot out and smack the nurse whenever she came close. The three guards collectively rolled their eyes at me as I walked into his room. “Can you believe this joker? First he’s yelling like a banshee. Then he’s some mute pretending to lie in a coffin,” one of them jeered. Another grumbled, “No offense doc, but this is such a waste of our time.”

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"Jake, can you hear me?" I called. No response. I shook his shoulder gently. "It's Dr. Wen, remember me?" No response. I tried again. "Hey artist man! Got some pineapple?"

This time he stirred. He sat bolt upright and stared at me, rattling on his chains loudly with both arms and legs. "Get me the f*** out of here! I'm the ARTEEST! ARTEESTS do not belong in the jail, mon!" As the guards stood to restrain him, he crashed down loudly on his back again, squeezed his eyes shut, and folded his arms tightly over his chest.

To the snickering of the guards, I tried, unsuccessfully, to elicit further words or a cooperative exam from Jake. Though I couldn't assess orientation, and he certainly was not behaving normally, I thought his neuro exam, in addition to the rest of the physical, was fairly unremarkable. His cranial nerves appeared intact, he could move all extremities, and he had no abrasions or contusions or any tenderness to palpation.

What to do with the artist? The guards had their own idea: send Jake straight back into isolation and call it a day. They had their own incentives, but also some legitimate reasoning. One of the guards claimed to have known Jake for the entire five years he had been incarcerated, and said that this was a twice-monthly occurrence; apparently we were not the only ED they brought him to. Besides, he had been in isolation with a 24/7 guard duty for a week. If his blood glucose was fine, and he couldn't have gotten any drugs or been in any trauma, what could he have?

The nurses were similarly inclined. "The artist is back?" they chuckled. Some had much longer histories with Jake than I did. One nurse told us that he had come in last year alleging that he had excruciating testicular pain. On exam, they found that he had painted his scrotum green, black and gold—the colors of the Jamaican flag. It was Jamaican Independence Day after all, and he wanted to celebrate it in the company of women. This nurse threw up her hands when she found out that Jake was back. "It's not Independence Day again, is it?"

The other members of the medical team, too, expressed ambivalence about getting labs and imaging studies. They thought that letting Jake "settle out" for a few hours was the way to go. I was not as convinced. His strange neuro exam and multiple past admissions certainly suggested malingering, but every time before, his strangeness manifested itself in an entertaining, flamboyant way. Something wasn't right this time.

In fact, as I went in to convince Jake to let the nurses draw blood, I found him moaning, barely able to open his eyes. A STAT CT of his head showed bilateral acute on chronic subdural hematomas, with evidence of midline shift and cerebral edema. Finally that got people's attention! The guards finally snorted their defeat. They still muttered, though, that the con artist finally found a way to do this to himself. The nurses shook their heads and said, who knew, one day when the boy cried wolf there actually was a wolf. I remember feeling vindicated on Jake's behalf. Ha! This is why we should avoid prejudging our patients!

Alas, I never got to preach my lesson. The night of presentation, Jake was admitted to the neurosurgical ICU. He was intubated for airway protection, and the guards were sent away in anticipation of a long hospital course. The ICU team weaned his sedation to better follow his neurological status. A few hours later, Jake's bed was empty and he was nowhere to be found. The artist had finally fled the coop.

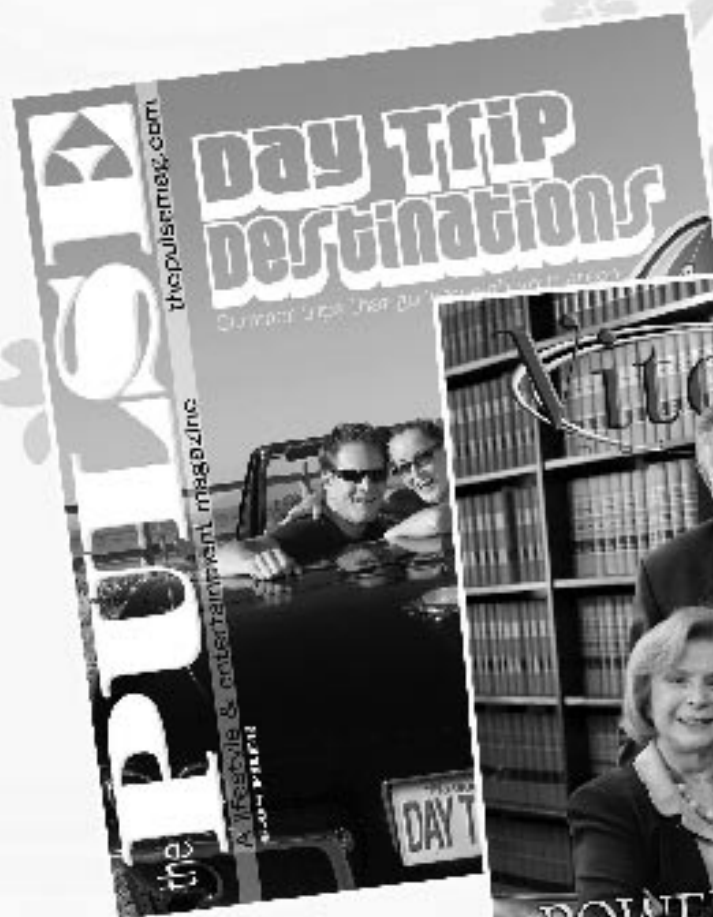
One thing about Jake's stories is that they always had a good punchline. So it's a fitting end that perhaps Jake was malingering after all. Maybe he didn't even know about his expanding brain bleeds; maybe he had just wanted to come to the hospital to get out of jail for a bit, then saw his opportunity and took it. Maybe he really was unwell, and left in a state of delirium.

We'll never know. Once Jake was reported missing, police were dispatched to search for him. According to their reports, he was found dancing in a bar a few miles from the hospital, draped in a flag of green, black, and gold. As the police were arresting him, he collapsed; by the time EMS arrived, he had died. The artist was gone, leaving us in as colorful of a way as he had lived.

Leana S. Wen, MD M.Sc. is a resident physician at the Harvard Affiliated Emergency Medicine Residency, a combined training program of the Brigham & Women's Hospital/Massachusetts General Hospital.

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Book Review of Genius on the Edge

Giles Whalen, MD

This book tells the story of William Stewart Halsted (1852 -1922) and how he midwifed the modern field of surgery on the North American continent at the turn of the last century. He is usually known to contemporary professional audiences as the first Chief of Surgery at the then brand new Johns Hopkins Hospital and Medical School ~ an institution which opened in 1898 on the principles that medicine needed to change and be based on science and evidence. The best “new men” that Medicine had to offer were recruited to Johns Hopkins and were eager to come. The founding Chairs of the other departments at this brand new institution, William Osler (Medicine), Howard Kelly (OB-Gynecology), and William Welch (Pathology) were already legends in their own time and have remained giants even through the lens of history.

Halsted's personal surgical accomplishments during this time were extraordinary by the standards of any era. He developed the radical mastectomy for breast cancer and new operations for the repair of groin hernias, both of which dramatically changed the ancient natural history of these problems and which persisted as the surgical standard of care for seventy five years. He made fundamental contributions to the study of wound healing, formation of intestinal anastomoses, and arterial occlusions and aneurysms. He introduced the use of rubber gloves in surgery, ushering in the the age of aseptic surgery. His own infection rates were orders of magnitude better than his contemporaries' ~ probably because of his attention to precise anatomic and relatively atraumatic dissection and the use of fine artery forceps and fine silk to tie vessels only and not devitalize wads of tissues in the ligatures. This was a relatively new surgical virtue since, in the absence of good anesthesia, speed and strength had been more prized in surgeons up to this point in time. Still, what really set Halsted apart was his ability to teach his techniques and thoughtful scientific approaches to the patho-physiology of disease to his trainees. As importantly, he had an uncanny ability to identify who those trainees should be. His residents became the founding fathers of neurosurgery, urology, ENT, and so forth. His method of training surgeons (“residents” who lived in the hospital and used the wards as their laboratories, caring for patients 24/7) established the patterns, culture and expectations of surgical training which are changing only now, more than 100 years later.

What kind of paragon of medical/surgical energy could pull all this off? What experiences developed his emotional intelligence to the degree that allowed him to make such astute human selections and inspire his mentees to carry on? How did he manage the tensions between scientific research and clinical instruction which were nascent even at the beginning of this prototypical academic medical center? As often seems to be the case in stories of medical greatness and achievement, the truth is not what you might expect. Halsted was born to the upper echelons of merchant society in New York City. There is a Worcester ~ or at least Central Massachusetts ~ connection in this story since he was sent off to boarding school at age 11 to the Monson Academy, which is still open for educational business in Wilbraham, Massachusetts. He did not like it there and literally escaped, but was apprehended in Springfield and sent back to school. He apparently did not demonstrate any specific traits that marked him for greatness. In fact, he seemed a fairly indifferent student who went to Yale and towards the end of his senior year found Gray's Anatomy. He shortly informed his father that he was going into medicine and not the family business. Interestingly, memorizing and understanding Gray's Anatomy text appears to have been a touchstone for him throughout his career, as there are anecdotes of him disputing what fine points were printed in which edition. He went on to be a good medical student and then teacher in New York medical circles and developed a tight cadre of like-minded medical friends. This group lived or convened at the house Halsted kept in New York City and was dedicated to the new scientific approaches to medicine and disease.

By the time he turned up at Johns Hopkins there was more to write about, but at this point in the book he sounds like a fairly odd human being with significant obsessive compulsive tendencies whom you would never predict would be capable of accomplishing what he did. The Halsted in these pages is a fairly shy or remote individual who apparently rarely talked with his residents; he was caustic when they did not measure up but otherwise left them to their own devices. He was regularly derelict in his teaching duties; for example, he never turned up to teach his assigned medical school lectures and never actually delegated the task. He worked hard in his laboratory during the day and performed operations several

days a week, but often turned up late or didn't bother to turn up at all and instead worked from home. He also would regularly leave Baltimore; some summers he could be found staying for four or five months in rural North Carolina or traveling anonymously through Europe. These habits understandably drove the trustees of Johns Hopkins to distraction and it seems a wonder that he was not fired. Of course, this behavior makes more sense once one learns something else about the man. Remarkably, even given his extraordinary success as both a surgeon and a new light in medical training, plus his apparent unimpaired, energetic faculties, Halsted had a problem. He was a junkie.

Indeed, Halsted's ongoing addiction, which only came to light in the 1960s, is now a well known part of the tale. He became addicted to cocaine while experimenting with it as a local anesthetic during the early part of his career at New York's Roosevelt Hospital. He had been successfully injecting it into particular peripheral nerves to block them and produce safe regional anesthesia. He was writing about this and as was the scientific custom of the time, testing it on himself and friends as well as on patients. These experiments spilled over into more social uses of the drug and ultimately nearly destroyed Halsted as man and as a physician. He was treated in one of the leading asylums of the day ~ nearby in Rhode Island ~ where the cure at the time involved replacing the cocaine addiction with another one ~ morphine. There is some evidence and suggestion in the book that all this really produced was an addiction to morphine in addition to an ongoing one to cocaine. Halsted was ultimately rescued from his fate by his own willpower and by the influence and intercession of his very close friend William Welch, who had been one of his chums in those heady early days in New York City. Welch got him off to the asylum, then secured his appointment to the job at Johns Hopkins and finally protected him during his life there. The story of how he managed and concealed his addictions and still carried on with his life's work is certainly worthy and even heroic. However, after reading this book, one wonders whether he was more lucky than he was a genius. He certainly had talent and tastes. He was drawn to the field of surgery as it was entering a phase of explosive advances (following the discovery of anesthesia and the appreciation of the role of bacteria in infections) and the advent of Listerian antiseptic

surgery. Indeed, an interesting question is whether Halsted would choose to become a surgeon if he appeared in medical school today. There is reason to think that he might not. The frontpiece of the book is a quote from him: "Surgery would be a wonderful field if you did not have to operate." Nevertheless, he did become a surgeon and landed in a supportive institution with a cast of colleagues who would be in any Medical Hall of Fame at a time when the major opportunities for medical advance were in surgery ~ and the rest, as they say, is history.

Indeed, an interesting question is whether Halsted would choose to become a surgeon if he appeared in medical school today. There is reason to think that he might not.

This book overall is an instructive and enjoyable read. However, the personality traits which Halsted must have demonstrated to inspire such loyalty and devotion from his friends and trainees remain veiled in these pages. It is equally unsatisfying in its presentation of his character development and formative experiences. There simply is not enough here to help the reader understand the man or find inspiration. Never-

theless, this may be a function of Halsted's private and secretive nature ~ a nature which is blamed on his addiction but which one suspects may have been innate. The book's strength lies in its depictions of the circumstances of the hospitals where he worked, his patients and their diseases and the customs and flavor of the times. It also refreshes the memory of some of the other men and women who helped construct the greenhouse in which Halsted flourished. For example, it leads the reader to appreciate more clearly the character and talents of his good friend William Welch, without whom things may well have turned out differently for him and for Johns Hopkins Hospital. Halsted's personal and domestic idiosyncrasies are both many and fascinating even if they don't necessarily help us understand his genius or his achievements. The prologue to the book is simply a spectacular piece of story-telling that really sets the stage for all that is contained between the covers and demands that you read on.

Squeezing the Balloon

Peter Martin, Esq.

Recently issued federal regulations regarding health insurance premium rate increases and insurers' medical loss ratios are just the latest examples of regulatory pressures on the health care industry. In this case, the pressures will be felt by the health care provider community initially as an increased emphasis by health insurers on quality improvement measures and data reporting obligations. As these new rules demonstrate, the insurers are now being squeezed by the regulators in a way that can only lead to increased pressure on providers to restrain costs, whether that eventually takes the form of global payment systems, direct price competition, "top-down" price and benefit mandates, or some combination thereof.

Early in December 2010, the federal Department of Health and Human Services issued an interim final rule implementing medical loss ratio requirements under the Affordable Care Act, effective January 1, 2011. Those requirements are that the proportion of an insurer's premium revenue devoted to payment for clinical services and activities that improve health care quality be no less than 85% for large group health plans, and 80% for individual or small group plans. Insurers whose medical loss ratios fall below these thresholds are required to provide rebates to enrollees, either in the form of a premium credit or a lump-sum payment.

Near the end of that month, HHS also issued proposed regulations requiring health insurers in the individual and small group markets to report information to HHS regarding "unreasonable rate increases" filed on or after July 1, 2011. Under the proposed rule, a rate increase would be subject to review if it exceeds 10%, or some other threshold established by a State regulator. Such rates would be determined to be "unreasonable" if they are found to be excessive, unjustified, or unfairly discriminatory.

A rate increase is excessive if it is "unreasonably high in relation to the benefits provided under the coverage" and one of the criteria used for making that determination is whether the increase would result in a medical loss ratio below the federal standard established by the other recently-issued rule.

Together, these new rules focus primarily on the internal operations of health insurers, not on the activities of health care providers. Nevertheless, they imply some important forthcoming changes for providers, both in the near and long terms.

For example, the medical loss ratio regulation allows health insurers to include in the numerator of that ratio not just incurred claims for medical services rendered, but also "expenditures for activities that improve health care quality." In order to meet the new federal standards, insurers will surely look to increase those expenditures.

That means insurers will spend more money on the specific activities cited in the new rule, such as: case management, care coordination, chronic disease management, quality reporting, hospital discharge planning, patient education and counseling, efforts to encourage evidence-based medicine, prospective prescription drug utilization review, and wellness assessments, coaching programs and education. Common to all of these initiatives is quality reporting and documentation of care, which to a large extent

means providers generating, collating and reporting such data to the insurer.

Another example is how insurers may rely on providers to help them justify premium rate increases. The proposed federal rule says that a rate increase is unjustified if the data supporting it are

In order to meet the new federal standards, insurers will surely look to increase those expenditures. That means insurers will spend more money on the specific activities cited in the new rule...

incomplete or inadequate; a rate increase is unfairly discriminatory if it results in premium differences that do not reasonably correspond to differences in expected costs. The cost of providing health care services is of course an important factor in calculating premium rate increases. Insurers seeking to support those increases will, among other things, have to seek more, and more detailed, cost information from providers. Providers should also bear in mind that the proposed regulation provides that where an insurer proceeds with a rate increase that is deemed “unreasonable,” it will be required to post on its website not only HHS’s or the state’s final determination of unreasonableness, but also its own justification for the rate increase, including an “explanation of the most significant factors causing the rate increase.” This might contain information prejudicial to providers.

So, the federal government has begun to take steps in at least a portion of the health insurance market similar to those already taken here in Massachusetts, with respect to efforts to examine the market performance of insurers and curb health insurance premium increases. As in Massachusetts, the inquiry will not end with insurers’ excessive profits or executive compensation, but proceed to a greater emphasis on providers and the costs of providing health care goods and services. Squeezing one part of the health care balloon will increase pressure on the other parts.

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

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Common stock prices have historically been good inflation protectors, over time; inflation causes companies’ revenues and earnings to increase, which eventually drives their share prices higher as well. But, higher prices, over time, do not protect clients’ standards of living all the time; market prices do periodically go down. Therefore, we select only stocks that pay and grow their dividends each year and we specifically manage portfolios to deliver significant and annually-growing portfolio income streams. In essence, irregular price appreciation should benefit from inflation, but the growing dividend income streams provide the year-in-and-year out protection.

“Given that the stock market, as a whole, has not increased in value over the last 10 years, should I invest in stocks?”

Portfolios invested in common stocks, with dividends reinvested, have actually increased in value over the last ten years; only their share prices have not. In addition, a portfolio invested in the more-dividend-rich Dow, for example, would have experienced a significant increase in portfolio dividend income during the period, while investments in Treasuries would have experienced declining income, as maturing principal was reinvested at lower and lower interest rates. As to the future, we note that it costs about \$33.00 to

“buy” \$1.00 of interest income from a ten-year Treasury, but costs only about \$15.00 to “buy” \$1.00 of free cash flow from large-cap domestic stocks. For us, high quality stocks are, by far, the better value in the markets today.

“Shouldn’t I be investing in emerging economies like China and India? They look like they will be growing faster than the U.S. over the next ten years?”

Deflation worries me most. A little inflation is a good thing; it greases economic growth. Too much inflation is a bad thing but can, with pain, be fixed. Deflation is never good for anyone and, once well-rooted in consumers’ expectations, cannot be easily fixed, at any cost.

Elroy Dimson of the London Business School performed a 100 year study comparing the GDP growth of all countries with the share price growth of the companies domiciled there. Surprisingly, higher GDP growth did not deliver higher share price growth (in fact, there was an inverse correlation); the reason was that high-growth economies tend to attract too many overly-enthu-

siastic investors, causing their common stock prices to be too high. The better way to “play” faster emerging economy growth was to own the common stocks of those companies domiciled in well-developed countries that sold a lot of products and services into fast-growth emerging markets. That way, the investor gets all the growth potential of emerging markets without having to pay inflated prices. With share prices of companies in developed countries depressed and economic growth rates of emerging economies accelerating, we think it is a perfect time to buy stocks of companies from slow-growth countries that do business in emerging markets.

“How worried should I be about the U.S. debt load and currency?”

Very worried; but you should also have confidence in the American spirit to seek and embrace solutions to its problems. Who, a year ago, would have thought the national stage would be so dominated

by the same question you have posed? Who would have thought the electorate would try to take matters into its own hands rather than just depend on elected officials? Right now, these problems are fixable as long as we have the resolve and the patience to take the time to do it right. In general, it's not the problems we see that undermine equity values; it's the ones we don't see coming that really hurt.

"Which worries you more: inflation or deflation?"

Deflation worries me most. A little inflation is a good thing; it greases economic growth. Too much inflation is a bad thing but can, with pain, be fixed. Deflation is never good for anyone and, once well-rooted in consumers' expectations, cannot be easily fixed, at any cost.

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Central MA Awarded Regional Emergency Preparedness Partnership Grant

Colleen Turpin

The City of Worcester, Division of Public Health, along with all Central Massachusetts health and medical related organizations, was awarded a partnership grant from the Massachusetts Department of Public Health, Bureau of Emergency Preparedness in January 2009. This grant, known as the Partnership for the Enhancement of Regional Preparedness (PERP) grant, is designed to enhance regional collective capacity to share resources and respond to public health and medical threats and emergencies throughout Massachusetts Emergency Preparedness Region 2. PERP is governed by a ten person executive committee representing ten diverse health and medical disciplines including public health, the metropolitan medical response system (MMRS), hospitals, health centers, an ACS level 1 trauma center, a regional EMS agency, specialty care hospitals, long term care facilities, home health agencies, and local physicians. With the guidance of the executive committee and input from stakeholders throughout the region, this initiative will be accomplished through the development and implementation of plans, procedures and protocols on how best to manage the flow of information during an emergency, how best to develop and implement mutual aid plans and memoranda of understanding (MOUs), and how best to respond to the health and medical challenges presented by disasters and emergency situations.

The PERP grant has developed and made available to the region numerous planning and preparedness tools including a regional health & medical hazard vulnerability analysis and regional hazard geographic information system (GIS) maps. Both documents are valuable planning tools focused around identifying both man-made and natural hazards and the effect these hazards may have on a specific organization or community. These tools serve as a guide when

creating and updating emergency preparedness plans, procedures and protocols. In addition, the grant has fostered several mutual aid agreements already in process, including the statewide Long Term Care MassMAP initiative and the Region 2 Healthcare Mutual Aid Plan. Both plans were recently developed to establish a course of action and an agreed commitment among participating healthcare

facilities to assist each other as needed in the time of a disaster. PERP is also in the process of assisting in the ongoing development of a Region 2 Medical Coordination Center (RMCC). The RMCC was conceptualized several years ago to more efficiently and effectively coordinate the movement of medical surge patients, resources, and staff during a large emergency or

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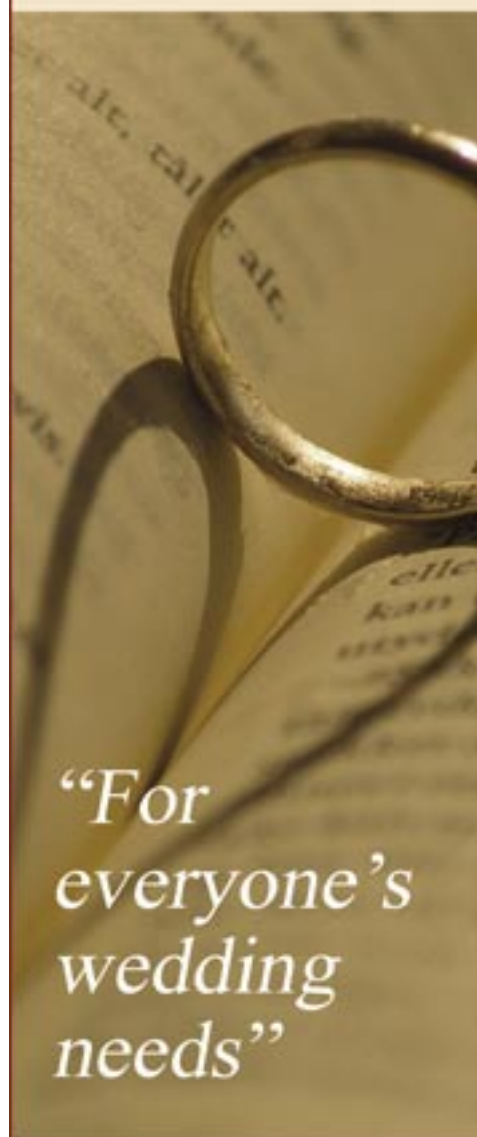
disaster. The RMCC, MassMAP and HMAP plans will work synergistically during a regional health or medical event to best manage the flow of information and response. This collaboration not only meets grant deliverables but is the essence of a partnership grant.

As our past pandemic and weather emergencies have only reinforced, communities and their partners working collaboratively and communicating effectively have the best chance to successfully meet the needs of those served. Plans and procedures are only as effective as the awareness and education of those who will use them, and the executive committee welcomes participation and input from all who are interested. Please contact me at cturpin@worcesterma.gov to learn more.

Colleen Turpin is the Grant Coordinator of the Region 2 Partnership for the Enhancement of Regional Preparedness (PERP) Grant City of Worcester, Division of Public Health

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Week of Convocation Events Launches the New Academic Year at UMass Medical School

Kristen O'Reilly

The official launch of the new academic year at UMass Medical School was marked by a week of events that highlighted incoming students, celebrated new partnerships, reflected on recent accomplishments, and set the stage for the coming year.

The events, held during the second week of September, included a Convocation address by Chancellor Michael F. Collins, MD, who recognized outstanding faculty and noted the many recent and upcoming reasons to celebrate the institution. He also challenged the Medical School community to take a leadership role in health care reform initiatives.

Chancellor Collins presented the first Chancellor's Awards to recognize the significant contributions of the faculty. Susan Gagliardi, PhD, professor of cell biology and neurology, received the Chancellor's Medal for Distinguished Teaching. Michael P. Czech, PhD, the Isadore and Fannie Foxman Chair in Medical Research and chair and professor of molecular medicine and biochemistry & molecular pharmacology, received the Chancellor's Medal for Distinguished Research, and John L. Sullivan, MD, vice provost for research and professor of pediatrics and molecular medicine, received the Chancellor's Award for Service.

During his address, Collins told a poignant story of how, in the midst of a busy day and rushing off to a meeting, he passed an elderly couple having difficulty getting out of their car and into UMass Memorial Medical Center for an appointment. He considered rushing by without helping, mindful that he was late, but ended up stopping to help the grateful couple on their way. "The purpose of the story is to ask you not to walk by," he said. "Our health care system needs you. It needs each of us, working together to make a difference in the lives of patients around the world." [Read the full speech here: http://www.umassmed.edu/news/2010/chancellors_convocation_speech.aspx.]



Chancellor Michael F. Collins, MD, congratulates John L. Sullivan, MD, vice provost of research and professor of pediatrics and molecular medicine, who received the Chancellor's Award for Service at UMass Medical School's 2010 Convocation ceremony in September.

In the Convocation keynote address, author Charles Kenney, Sorrel King ~ the mother of an 18-month old girl who died as the result of a medical error ~ and pediatrician George Dover, MD, talked about how one family's story of tragedy led to a new one of hope. Kenney, King and Dr. Dover made a unified call to action: learn to communicate, take personal responsibility, and become leaders in avoiding preventable errors such as the one that cut young Josie King's life short.

"As doctors and nurses, you are special people doing special work," said Kenney, who recounted the Kings' loss and the subsequent quality and safety improvement efforts at Johns Hopkins Children's Center, where Josie died, in his book *The Best Practice*.

Also during the week of Convocation, six faculty members became named professors at the annual Investiture ceremony, a celebration of new philanthropic partnerships that provide essential funding for research and education. The Medical School and UMass Memorial also jointly hosted a ribbon-cutting ceremony to commemorate the opening of the Ambulatory Care Center, a new seven-story, 258,000-square-foot building that houses a mix of clinical care centers and clinical and translational research programs.

The final event of the week was the Medical School's first-ever White Coat Ceremony, where first-year medical students were welcomed into the medical community and presented with their white coats by their Learning Communities mentors.

Kristen O'Reilly is the managing editor at UMass Medical School.

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WDMS Remembers Its Colleagues

Peter H. Levine, MD 1938-2009

Dr. Peter H. Levine, a nationally prominent academic hematologist, medical educator, and investigator, died on December 15, 2009 at age 71.

Raised in Chelsea, Peter graduated from Tufts College (B.S., cum laude, 1960) and Tufts University School of Medicine (M.D., AOA, 1964). He completed internal medicine training at Bellevue Hospital Center, Cornell Medical Division, and Boston VA Hospital, then a fellowship in Hematology at Tufts-New England Medical Center. From 1969-1971, he was Chief of Hematology-Oncology at Andrews AFB Hospital. From 1971-1974, he was a hematologist and director of the Hemophilia Center at Tufts-NEMC.

In 1975, Peter became Chair of Medicine and Director of the Blood Research Laboratory at Worcester Memorial Hospital, a primary teaching hospital of UMass Medical School, where he was Professor of Medicine. In 1988, he became Physician-in-Chief of The Medical Center of Central Massachusetts, formed under his leadership by merger of three private hospitals; in 1990 he was appointed President and CEO. In 1998, Peter became the first President and CEO of UMass Memorial Health Care, created by merger of MCCM and UMass Medical Center.

Peter was a nationally regarded hematologist. His research led to over 150 articles and textbook chapters on thrombosis, bleeding disorders and atherosclerosis. He pioneered home-based, self-administered clotting factor therapy for patients with hemophilia; this innovation improved survival and quality of life for patients. He successfully lobbied in Washington to obtain federal funds to support hemophilia care. He served in leadership positions at the National Hemophilia Foundation and the World Federation of Hemophilia.

Peter was an outstanding educator, teaching via thought-provoking Socratic questioning. His concise, logical lectures were punctuated by tales of Bert-and-I. He garnered numerous medical education awards from UMMS students and residents, and many of his learners have gone on to careers in academic medicine and hematology-oncology.

Peter was a force in the cultural life of Worcester. From 1991-1993, he chaired the board of the Worcester County Music Association. He led the 1995 United Way campaign and chaired its Leadership Giving Committee. He served WPI as trustee and member of the President's Circle and President's Advisory Council. He was board member of the Greater Worcester Foundation.

Dr. Levine is survived by his wife of 47 years, Catherine, three sons and five grandchildren.

Richard Glew, MD

2011 WDMS Calendar Of Events

Wednesday, February 9th

5:30 pm

Beechwood Hotel

215TH ANNUAL ORATION

“That Which Endures: The Quiet Heroes of Medical Discovery”

Orator: Anthony Esposito, MD, FACP, chief of the department of medicine, Saint Vincent Hospital, and professor of medicine at University of Massachusetts Medical School

Wednesday, March 9th

5:30 pm

Beechwood Hotel

5TH ANNUAL LOUIS A. COTTLE MEDICAL EDUCATION CONFERENCE

Speaker: Luis T. Sanchez, MD, Director, Physician Health Services

Tuesday, March 15th

6:00 pm

Beechwood Hotel

WOMEN IN MEDICINE LEADERSHIP FORUM

Speaker: Luanne Thorndyke, MD, Vice Provost for Faculty Affairs, University of Massachusetts Medical School

Wednesday, April 13th

5:30 pm

Beechwood Hotel

ANNUAL BUSINESS MEETING

Meeting includes presentation of the 2011 Community Clinician of the Year Award

Thursday & Friday, May 19th & 20th

9:00 am

Seaport Hotel & World Trade Center, Boston

2011 MMS ANNUAL MEETING & MEETING OF THE HOUSE OF DELEGATES

All WDMS members are invited to attend as a guest and may submit resolutions to the Massachusetts Medical Society

Wednesday, May 18th

5:30 pm

Faculty Conference Room, University of Massachusetts Medical School

MEET THE AUTHOR SERIES

Co-sponsored by the WDMS and the Humanities in Medicine Committee of the Lamar Soutter Library at the University of Massachusetts Medical School

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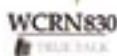
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