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Bullying

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president's message

Jane Lochrie, MD

Much has been written about bullying in schools since the tragic suicides of two Massachusetts children. Eleven year old Carl Walker-Hoover hanged himself April 9, 2009 after enduring bullying at school including daily taunts of being gay, despite his mother's weekly pleas to the school to address the problem. Fifteen year old Phoebe Prince committed suicide September 14, 2009 after enduring months of constant torment by classmates in person and online. These actions occurred on school grounds during school hours; again, school officials knew about the bullying.

In this month's issue, Judith Vessey, PhD, RN, PNP, FAAN discusses the long term effects of bullying on individuals and society. In most cases, an individual is targeted because he or she displays characteristics different from the group norm. This can be offset by an individual's personality and resilience, in addition to a community standard that condemns bullying behavior.

Until recently, Massachusetts has been one of seven states without a specific law targeting school bullying. Senator Harriette L. Chandler describes the legislation that prohibits any actions that could cause emotional or physical harm, including text messages and taunting over the Internet. The law requires every school employee, including custodians, bus drivers and cafeteria workers to report incidents of suspected bullying Schools must investigate each occurrence and take disciplinary actions when necessary. Local law enforcement agencies must be notified when criminal charges may be pursued. Furthermore, schools must offer information to parents, age appropriate instruction to children and ongoing professional development for teachers and other.

Dr. Mariann Manno gives us the perspective from the emergency room. She presents some amazing ~ albeit discouraging ~ statistics. Many children who present repeatedly to the ER are labeled as accident prone. She makes a plea for health care providers to keep this in the differential diagnosis for all children presenting to the ER with injuries or vague complaints.

Dr. Massiello's article underscores the importance of community involvement in prevention of bullying. He outlines the Olweus Bullying Prevention Program. Equally important to the implementation of the program is the evaluation and monitoring of the curriculum.

Dr. Beheshti outlines information regarding signs and symptoms that bullies and victims of bullying might display. She discusses practical tips for parents of bullies and their victims and relates the long term consequences of this behavior.

The article by Dr. Dierer Wolke reviews the different kinds of bullies and victims of bullying. He makes the very interesting observation that bullying is not related to the affluence of the school but rather to the economic inequality of adolescents in the school.

Dr. Hirsh and Sgt. Steve Roche point out how blessed we are to live in Worcester where the Police Department has taken a strong interest in our youth. They have started "good gangs" that provide healthy activities, such as boxing, as an alternative to joining a "street gang." The Worcester police are wonderful role models for children at an age when peer pressure is significant and at a time when their influence can make an immense difference in the children's lives.

And finally, eleven year old Elizabeth George (the daughter of Drs. George Abraham and Susan George) has written a most compelling and riveting poem for a school assignment after reading the book *The Misfits* by James Howe. Her eloquent and well-expressed poem underscores the fact that we need to address this problem immediately.

I hope you enjoy this issue of Worcester Medicine. The topic has been discussed by authors who are well known both locally and nationally and working in varying professions.

Jane Lochrie, MD

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Bullying

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No name calling
Often causes self-denial

Bullies want power over you
Understand that you are just as good as the bully
Let someone know if you're being bullied
Let's work together to stop name calling and bullying
You need to stand up for yourself
Important to be respectful of others
No control of your life when being bullied
Get help from friends and adults to back you up

By: Elizabeth George
Grade 6, Shrewsbury

Aiming to End Bullying in Schools

Senator Harriette L. Chandler

Senator Harriette L. Chandler

A topic that has not received much public attention until recent years, often due to shame and embarrassment from targeted youth, bullying has now become prevalent in the media. In particular, cyberbullying has become an issue as more youth interact socially online. Recently, a young woman in South Hadley took her own life after being relentlessly bullied at school and online. Currently, five of her peers from school are being charged in the case.

Bullying affects many school-aged children in Massachusetts, causing them undue physical and emotional pain. Thankfully, Massachusetts legislators took action this spring to pass An Act Relative to Bullying in Schools, which creates more positive school climates and age-appropriate instruction on bullying prevention for students in each grade. In addition, schools must offer information to parents about bullying prevention. Ongoing professional development for teachers and other staff will also be required to help them prevent, identify, and respond to bullying, beginning in the 2010-2011 school year. Furthermore, children with a disability that affects social skills development must have provisions in their Individualized Education Programs (IEPs) to ensure they obtain the skills to avoid and respond to bullying, an especially challenging task for such children.

Our children are the future of the Commonwealth and they should feel comfortable going to school every day to learn and grow without fearing their peers.

In this Act, bullying is defined as the repeated use by one or more students of a written, verbal, or electronic expression, or a physical act or gesture, or any combination thereof, directed at a victim that: causes physical or emotional harm to the victim or damage to the victim's property, places the victim in reasonable fear of harm to himself or of damage to his property, creates a hostile environment at school for the victim, infringes on the rights of the victim at school, or materially and substantially disrupts the education process or the orderly operation of a school. Cyberbullying is also defined in this Act as the use of technology or any electronic means, including both the creation of a web page or blog in which the creator impersonates another person, or the distribution or posting of information online if these acts create any of the conditions listed above.

In order to stop bullying as soon as it occurs, school staff members (including teachers, cafeteria workers, bus drivers, athletic coaches, and advisors to extracurricular activities) are required to immediately report instances of bullying or retaliation. The school must promptly investigate reports of bullying and take disciplinary action when appropriate. In addition, principals must notify the local law enforcement agency when criminal charges may be pursued against a student. The Department of Elementary and Secondary Education is required to promulgate regulations to assist principals with the fulfillment of this duty. Non-public schools must develop their own procedures for principals to immediately notify local law enforcement when criminal charges may be pursued..

To help local schools, The Department of Elementary and Secondary Education will develop a model bullying prevention and intervention plan and compile a list of bullying prevention and intervention resources. The Department will also periodically review school programs to ensure that they are within compliance.

Our children are the future of the Commonwealth and they should feel comfortable going to school every day to learn and grow without fearing their peers. This act will help foster understanding among youth in order to curb bullying and teach them that bullying is not to be tolerated.

A Public Health Approach to School Based Bullying

Matthew Masiello, MD, MPH

We are quite aware of the statistics. Bullies in middle school, without intervention, are three times as likely to have at least one criminal conviction by the age of 24. Seventy percent of attackers in school shootings were somehow involved in bullying incidents as children. Every day, 160,000 children miss school because of fear of being bullied and every seven minutes a child is bullied at school. These and other concerning bullying-related facts continue to be a focus of attention after each tragic bullying-related incident brought to our attention by the media. And the most humbling data point is that thousands of children sit in a classroom every day and feel that they do not have one friend.

The challenge to schools, communities and the nation is to find a way to address this public health epidemic. We have evidence-based bullying prevention programs available to us, but unfortunately at a cost that is often prohibitive to many schools. All too often, many of these programs are implemented without the highest degree of fidelity to the program content and often without the appropriate monitoring and evaluation of the program components, implementation process, cost and impact. Several countries have approached school-based bullying as a national crisis, with a national mandate to reduce the incidence of the activity. This has not occurred in the United States despite the frequency and degree of violence associated with bullying. Though we have come to realize the critical importance of sustainable funding for health promotion initiatives, the success rate for schools maintaining such funding for ongoing implementation, monitoring and continuing education is, at best, satisfactory.

In 2007, the Highmark Foundation, created in 2000 with funding from Highmark Inc., Pennsylvania's largest health insurer based on membership, initiated a bold and innovative bullying prevention program throughout western Pennsylvania. Over 200,000 children, their parents and teachers will have participated in what has now become the largest implementation and evaluation of the evidence-based Olweus Bullying Prevention Program (OBPP) in the U.S. Most importantly, a coalition consisting of programmatic and evaluation experts from the Foundation, educators, and public health professionals worked strategically and collaboratively to maximize fidelity to the program, implement appropriately and monitor and evaluate the initiative with direct and ongoing support from the Pennsylvania Secretary of Education. Clemson University, the national site for the OBPP, as well as Professor Dan Olweus serve as members of an established expert panel.

As we have successfully addressed other concerning epidemics throughout history, this Pennsylvania- based effort identified key stakeholders who realized the benefit of and need for developing a public health approach to address a national health crisis. There was a considerable amount of effort applied to coalition building, as there was to program implementation. Monitoring and evaluation were key components of the initiative, as were the actual program components. Positive changes in bullying rates occurred; the student bystander issue was significantly addressed as was the role of the teacher as an involved and active bystander. And, most importantly, we were able to document that many more children can now say that they have a friend. Moreover, the strategies and processes developed for this large population-based health promotion initiative can very well be used to facilitate the process of addressing other child and adolescent health issues such as childhood obesity. To date, local, regional, and statewide attempts to address this specific health epidemic have not been adequately demonstrated.

In summary, we need to realize that though funding and the identification of an evidence-based program, is critical to a successful, sustainable health promotion initiative, so too is the process of coalition building, monitoring, evaluation and program enhancement. Large population-based health promotion initiatives exist in the programmatic, research and evaluation domain of public health professionals. The Center for Health Promotion at the Windber Research Institute is actively working with other states to form that larger national coalition. The goal of this effort is to strategically march through the country with a cost effective, evidence-based initiative to effectively address this epidemic of child and adolescent bullying. In the 2003 Institute of Medicine report "Who Will Keep the Public Healthy," the importance of collaboration between health care and public health professionals is nicely documented and should serve as a reference for how to best obtain maximum health benefits for our citizens and, most importantly, for our children.

Matthew Masiello, M.D, MPH is Director of the Center for Health Promotion and Disease Prevention at the Windber Research Institute, Windber, PA

Childhood Bullying:
Awareness, Interventions, and a Model for Change

Negar Beheshti, MD

Negar Beheshti, MD

The topic of bullying has been the focus of recent news headlines and local legislation. The repetitive verbal and/or physical abuse from bullies can wreak havoc on their victims. Making it worse, the bullies themselves may not even know the extent to which they are inflicting so much physical and/or emotional trauma.

Bullying involves repeated and deliberate verbal and/or physical harassment, as well as social exclusion over time toward another who has difficulty defending him or herself from a person or group of people perceived to be stronger or dominant.[1-4] In youth, bullies tend to choose peers who are easily intimidated. Bullying by girls tends to be verbal and usually targets another girl, whereas bullying by boys tends to be physical intimidation or threats, regardless of the gender of their victim.[1-3]

Recent studies show that in the United States, 30 percent of 6th to 10th graders were a bully, a target of bullying, or both.[3-4] On any given day, as many as 160,000 students nationwide may stay home because they are afraid of being bullied.[5] Victims of bullies can develop low self-esteem, depression and anxiety that may subsequently interfere with their social and emotional development as well as their academic performance.[6-7] Some victims may also develop suicidal thoughts.[6] In Massachusetts, there have been two reports of completed suicide in which the youths were chronically bullied and were no longer able to deal with the harassing behavior from their peers.

Cyberbullying is a relatively new phenomenon where bullies use electronic means such as e-mail, texting and social networking sites to send mean or threatening messages or images to or about someone, send disparaging information anonymously, or even worse, pretend to be someone else when sending it.[3, 5, 8] Through cyberbullying, the teasing and taunting of one is spread quickly and easily with a few simple clicks of a mouse. In some cases, cyberbullying is worse than bullying because of the ability for embarrassing or disparaging information to be sent well beyond the victim's school, town, or even state, to virtually anyone around the globe.

It is important to recognize signs that a youth may be the victim of bullying. Some common signs are withdrawal and/or apprehension over going to school, riding the school bus, or taking part in organized activities with peers.[5, 9] Youth may develop physical symptoms as well, including: headaches, abdominal pain, poor appetite, sleep disturbance, and cold-like symptoms.[6-7, 9]

It is important to let victims of bullying know that it is not their fault. Rather, empower them by teaching them to take an assertive stance with bullies, such as ignoring them, walking away and seeking help from a teacher or staff member at their school. Explain to them that the true goal of the bully is to get a response and it is best that the bully get a consequential response from an authoritative figure at the school rather than the satisfaction of seeing his/her victims continue to suffer and feel helpless.

The Olweus Bullying Prevention Program (BPP), developed in Norway, reduced bullying incidents up to 50 percent.[10] The program, which aims to change the social norms that promote passive acceptance of bullying behavior, made a flexible model of the program to allow adaptability to different cultures.[11] Pilot studies of Olweus BPP implemented in the United States have demonstrated some degree of effectiveness, showing decreased bullying incidents anywhere from 20 - 45 percent.[1, 12-14] The more robust decreases were noted when there was stronger parent/family and community involvement, as seen in Norway.

Like the Olweus BPP model, anti-bullying programs need clear learning objectives and effective implantation guidelines as a foundation in order for the program to be successful. Critical to the foundation is redefining the role of "the bystander".[10, 15]

Teachers, parents, and the community at large, via anti-bullying campaigns, should teach youth what they should do if they witness a peer being bullied.[2] They should be taught that it is not OK to be a bystander or an instigator and not to encourage the bully by making comments or laughing. Instead, they should report the bully to a supervising adult. In cases of cyberbullying, youth should be instructed not to respond to any posted messages and report the incident to their parents or teachers. Their kind actions could very well mean the world to their peers.

Parents, teachers, and physicians should also look for signs that a youth might be a bully. If the youth gets into frequent fights or destroys, steals, or vandalizes property, it might be a sign of bullying.[1, 13] Let youth know in no uncertain terms that bullying will not be tolerated. Some tips for parents if they suspect their child is a bully are:

- Spending more time with their child and carefully supervising and monitoring their activities
- Making it a point to find out who their friends are, and how and where they spend their free time
- Sharing their concerns with their child's teacher, counselor or principal, and physician.[2]

If it is clear a youth is bullying others, a referral to a mental health professional for a comprehensive evaluation may also be helpful to understand what is causing the bullying and to develop a plan to stop the destructive behavior.

Bullying also has long-term consequences. Research shows that bullies are at a higher risk of dropping out of school, getting into fights, vandalizing, shoplifting, as well as becoming substance users.[4-5, 13] If there is no intervention, they are also four to six times more likely than their non-bullying peers to have at least one criminal conviction by age 24.[4-5, 16]

Bullying is an individual and societal problem. With the passage of the Anti-Bullying Act in Massachusetts, it is urgent that all those who work with youth work together to corroborate for the future well being of our nation's youth.

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Bullying: Facts and Processes

Dieter Wolke, PhD

Dieter Wolke, PhD

North America is still shocked by the revelations of how bullying drove 15 year old Phoebe Prince, a pupil at South Hadley High School, to hang herself in January this year. Sadly, the intensive research on bullying over the last 3 decades can be traced to 1982 when three young boys killed themselves in short succession in Norway, all leaving notes that they had been whipping boys, bullied by their peers [1]. Many more suicides attributed to bullying have occurred worldwide since then [2 3]. In addition to suicide, being a victim of bullying increases the risk of a range of adverse outcomes including increased physical health problems [4-5], more behavior and emotional problems and depression [6-7 8], and a higher risk for psychotic symptoms [9] and poorer school performance [10]. The effects of victimization are unique and occur over and above any pre-existing behavior or emotional problems [11-12].

What makes bullying different from normal conflicts or arguments? Occasional conflict between peers of the same social stature is adaptive; it helps children to resolve disagreement and to acquire skills of negotiation. In contrast, bullying victimization refers to children being exposed repeatedly and over time, to negative actions on the part of one or more other students who are or perceived to be stronger [13]. It is systematic abuse of power [14] with three crucial elements: repetition, intention to harm, and unequal power. Bullying can be direct and include verbal abuse, hitting, kicking, beating, destroying others belongings or blackmail. In contrast, relational bullying refers to deliberate social exclusion of children by ignoring, excluding them from games or parties, spreading gossip or framing them to be humiliated [6]. Traditional bullying has expanded by "cyber" bullying techniques such as emailing, text messaging and social networking ranging from e-threats to spreading rumors or posting embarrassing pictures or videos. Victims are not even safe in their own homes anymore. Cyber bullying is possible 24/7 and can reach an audience of millions of people at a press of a button. Direct bullying is more frequent at a young age and decreases with age while relational and cyber bullying increases in adolescence. However, bullies usually employ multiple methods of bullying with girls favoring relational to direct bullying strategies more often than boys.

Not all bullies are the same [15] and individual differences matter. There is a small group of so-called "pure bullies" (prevalence: 2-5%). These bully others but never become victims themselves. They are usually confident individuals with good social understanding and skills and manipulate others to act as their henchmen or enforcers. Their approach is labeled 'cool cognition' due to their lack of empathy for others [16]. Some have suggested that these "pure bullies" may be the managers of the future, hiring and firing without moral concerns. Other bullies are called "Bully-victims" because they get victimized themselves and at other times bully others (5-10%). They are more often hyperactive, easily provoked, aggressive, have low self-esteem, poor in understanding social cues and often break rules in games. They are often the supporters and henchmen for the pure bullies and get often caught. Any child can become a victim (12-30%) but those who remain victims are often more anxious, submissive, withdrawn or physically weak, show easily a reaction (e.g. run away, start crying, scream for help), have poor social understanding [17] and coping skills and have no or only few friends who can stand up for them [18].

Why do children bully? Bullying is one way to gain social status and a powerful dominant position in the peer group. Individuals who are dominant have better access to material and social resources (the most wanted toy, best role in a game, sexual attention) [19 20]. Bullying, to enhance social status, requires witnesses and is most prevalent at times when peer status is most valued, i.e. in adolescence. Bullying

is a group process. Pure bullies try out different peers and home in on those who have victim characteristics (see above). Although pure bullies are disliked by some peers, they are also perceived as cool and popular. They are socially central to lots of peers, visible and have a high impact. For example, while boys targeting boys in the same class were disliked by boys they were actually highly regarded by the girls. In contrast to these pure bullies who are highly strategic and skilful, bully-victims are hot-tempered and dysregulated and quite a different group: they are the least liked in school. The bully-victims are at risk for all adverse outcome of victims and bullies, i.e. they have the highest rate of psychiatric problems and involvement in crime [21].

Apart from individual differences among victims, bullies and bully-victims, there are differences in their family upbringing, social support, school environment, neighborhoods and the countries in which they grow up.[22-24 25]. For example, both protective parenting (i.e. managing all conflicts and thereby depriving their child of learning coping skills) or the opposite, ignoring constant sibling bullying, have been found to increase the risk of victimization in school [26 1 27]. The ethos of the school and how teachers, parents and pupils deal with bullying are highly relevant to the prevalence of bullying. Contrary to common belief, bullying is not more frequent in large or inner-city schools; rather, it has been found as or even more often in small schools in rural areas. Once a child has become a victim in a small school, there a few alternative peers to make friends in or outside school – the hierarchy is more fixed than in a large school or community [28]. Similarly, victimization or bullying is generally not related to the general affluence of the school or country but rather determined by the degree of economic inequality of adolescents in schools or between countries. Adolescents who attend schools with larger economic inequality among students, and adolescents who live in countries with larger economic inequality, are at elevated risk of being victims of bullying [29]. It has been speculated that societies that accept large socio-economic inequality may approve behaviors associated with hierarchies and status differences such as bullying more readily.

A range of intervention approaches have been proposed and some have been tested. The introduction of legislation or school policies by themselves are unlikely to make any difference to bullying [30 31]. Rather, changes have to start at home with appropriate parenting, no tolerance for sibling bullying, training of teachers and consistent implementation of rules to deal with bullying in school. In particular, positive modeling and teaching alternatives to reaching high peer status is required. This can include collaborative working and compassionate leadership while being allowed to compete in other settings (sport, music) or rewarding support to other students, befriending and peer counseling schemes [32]. Furthermore, recent technology advances may not just be exploited by cyber bullies but may help victims to practice and learn ways of combating bullying in a safe virtual environment [33].

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Bullying – One Pediatric Perspective

Mariann Manno, MD

Bullying is a form of violence. It is repetitive, aggressive behavior where there is an imbalance of power and the intent to harm. Bullying has proven long-term consequences for the victim and the perpetrator, and perhaps for children who are peripheral observers. A longitudinal study looked for the link between bullying and victimization at the age of 8 and psychiatric diagnoses 10 to 15 years later in a cohort of approximately 2400 boys born in 1981. At age eight, 6% of these boys frequently bullied, 6% were frequently victims and 3% were both bullied and were victims. As young men between 18 and 23 years of age, psychiatric disorders were present in 30% of the bully-victim group, in 18% of the frequent victims and 17% of the frequent bulliers. Psychiatric disorders were seen in 9% of the reference group of boys who did not experience bullying at age eight. The authors conclude that particular attention should be focused on boys who are frequent bulliers, especially bully-victims, since they seem to be at risk for developing psychiatric disorders in early adulthood. (1)

Bulling, like injuries from "accidents," has been accepted as a cultural norm. As a culture we have accepted, for example, a driving-rite-of-passage among high school students. Young teens who are inexperienced drivers are routinely given access to cars after Drivers' Education. Not surprisingly, inexperience, poor judgment and other factors conspire to result in the death of over four thousand teens in motor vehicle crashes every year. (2) So too, bullying behaviors have been tolerated by parents, teachers, community leaders and health care practitioners as normal in the course of child development. Injury is the leading cause of death in children over the age of one year and most of these deaths can be prevented. So too, the immediate and long term negative outcomes from bullying can be prevented. This thinking represents a departure from my childhood memories and a paradigm shift from my training in pediatrics. The recognition that bullying need not remain the cultural norm comes with a new responsibility for professionals who are charged with ensuring the heath and well being of children.

When I reflect on my practice as a Pediatric Emergency Physician, several themes come to mind. The first is that headache, abdominal pain, back ache and fatigue are common complaints among children and teens who present to the Emergency Department. These clinical entities are associated with a long list of differential possibilities. Since some of these diagnoses are serious, these patients' evaluations often involve extensive laboratory and radiographic tests. Most of the time, the cause of a headache is not precisely determined, but a brain tumor is excluded with a CT scan. Most children with abdominal pain have normal laboratory tests and x-ray results and will be assigned a useful label ~ gastritis, constipation, reflux. However, headache, abdominal pain and listlessness are complaints that are three times more common among children who are bullied than their nonbullied peers. (3)

How carefully do pediatricians and pediatric health care providers ~ in any venue, from the office to the ED to the inpatient service ~ consider violence and bulling as root cause for their patients' symptoms? How carefully do Emergency Physicians consider a psychosomatic etiology before embarking on a time consuming and expensive work up? Perhaps not carefully enough. The cursory "How are things at home?" or "Everything OK in school?" are hardly specific enough to be useful. In a hurried clinical environment, patients ~ and teens especially ~may not have the opportunity or inclination to explore the connection between bullying experienced at school and their clinical symptoms. Indeed, this link may not be clear to children or their parents.

Although we have become more sophisticated in our understanding that many injuries in children are not simply unavoidable accidents, children who present repeatedly to the ED with injuries are still commonly labeled as simply being injury prone. Yet, just as children with nonspecific abdominal pain or a benign pattern of headache may be over-evaluated for their complaints, I worry about what is missed in the case of a child with repetitive concussion or fractures when his evaluation is focused on the current injury without a more holistic perspective. How often do we counter a parent's claim that "He is just a wild man" with the concern about risk taking behavior and explore the reason for this?

What hope exists that things can be different? 1) Age ~ Bullying behaviors are most intense between 8 and 14 years old and the formation of bully-victim relationships develop before that. At these ages, children still live under the relatively close scrutiny of teacher and parents. Additionally, during this time, children still have a lot of learning, growing and development left. This should give

us hope that early recognition and intervention will produce dramatically better outcomes for teenagers and young adults. 2) Awareness ~ There are hopeful signs that bullying has become a mainstream concern and no longer tolerated as an accepted developmental process. In a 2009 policy statement, Role of the Pediatrician in Youth Violence Prevention, the AAP challenges pediatricians to tackle the issue of violence prevention within four domains: Clinical Practice (anticipate and effectively address issues of youth violence in the course of health maintenance visits), Advocacy (educate leaders in politics, education and community education about bullying and youth violence), Education (become/remain informed about issues related to violence and bullying and resources that are helpful to children and families, and Research (participate in practice based research and injury surveillance databases).

The true impact of a serious disease or injury to a child ripples forth in a circle that includes many: his siblings and parents, his extended family, his school and community. In the same way, I think of bullying as a disease state that involves not only the bully and victim, but those children who immediately observe this form of violence, their parents, families, classmates and communities.

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Bullying:
Sticks, Stones, and Names Can All Hurt You

Judith A. Vessey, PhD, RN, PNP, FAAN

Judith A. Vessey, PhD, RN, PNP, FAAN

Think back to when you were a child. Most adults can remember instances when they have been bullied, observed bullies, or bullied themselves. Despite having the potential to significantly disrupt the health of those who are targeted, bullying is a pervasive problem. In fact, it is estimated that between 15 and 25% of American students are bullied with some frequency (Nansel et al., 2001). These oppressive behaviors occur among children, within families, and in the workplace. In today's society, bullying has been allowed to flourish, in part because individual achievement and personal recognition have become increasingly valued over community harmony.

Until recently, reports of bullying were met with an overwhelming tendency to 'blame the victim,' further marginalizing the victim in the face of their attackers and bystanders. It has only been in the last decade, when the long-term effects of bullying on individuals and society have been recognized, that bullying has been declared a significant public health problem. Public policies and legislation now emphasize the prevention of bullying, and when bullying does occur, the initiation of interventions designed to minimize its impact.

Defining Bullying and Its Consequences

It has been said that the more a word is used, the less precision it has. And so is the case with bullying. Widely accepted definitions of bullying require the following features: 1) patterns of verbal, non-verbal, or virtual (cyber) behaviors directed by one or more individuals toward another individual with the intent to deliberately inflict psychological or physical abuse; 2) the presence of a real or perceived power differential; and 3) behaviors that are repeated over time. Bullies, victims, and victim-bullies come from all socio-economic backgrounds, from all ethnic/racial groups, are of both genders, and can be either children or adults. Physical bullying occurs more frequently among males while females generally engage in relational bullying (aka 'social toxicity'), however, neither type is gender-specific. Cyber-bullying occurs equally across genders.

Some individuals are targeted by bullies for no apparent reason although, far more commonly, targets display characteristics different from those of the group norm. Risk factors include dissimilar behaviors, mannerisms, physical traits, and/or family characteristics. Children perceived as 'vulnerable' by their parents and those with insecure parental attachment also are at greater risk for victimization. The presence of risk factors, however, does not mean bullying will occur. Protective factors include an individual's personality and resilience in addition to community norms that decry bullying behaviors. Because bullying involves multiple encounters, the downward cycle of increasingly poor interactions between bullies and victims inflates the bully's perceived power while simultaneously exacerbating the victim's vulnerability. Most victims become increasingly insecure and begin limiting their activities to situations where they feel safe. They often are submissive and do not readily defend themselves when threatened. Over time, many become anxious, depressed, and in the worst cases, exhibit suicidal ideation. A smaller group of victim-bullies are provocative, with their behaviors serving as catalysts for attacks. Victim-bullies are frequently hyperactive/impulsive, aggressive, and may exhibit conduct problems or other forms of undesirable social interactions. All recipients may exhibit impaired self-esteem, increased psychosomatic complaints, and poorer attendance and performance at school or work. The stresses associated with being bullied diminish the quality of personal and family life.

Prevention Strategies

A nexus of interventions is needed to effectively address bullying, with significant attention paid to prevention strategies. Individuals of all ages must be educated about bullying through media

campaigns and other venues. For schoolyard bullying, primary prevention programs that include teaching social competence and conflict resolution, creating a safe environment, and establishing and enforcing codes of conduct should be incorporated into school curricula. The U.S. Department of Health Resources Services Administration sponsors the website www.stopbullyingnow.hrsa.gov, a social media campaign directed at reducing peer bullying. The youth portion of this website features 'webisodes' and other activities designed to help 'tweens'--youths between 8 and 13 years of age--deal with bullying situations. In addition, evidence-based resources are available in the area labeled "What Adults Can Do." Of specific note are the numerous Tip Sheets, each addressing a specific aspect of bullying. These can be readily copied and disseminated at primary care visits or parent-teacher meetings.

Primary Care Providers can Help

Bullying and its consequences diminish well-being for targeted individuals, and by extension, the welfare of entire families. Bullying should be discussed during all primary healthcare visits. Through careful assessment, primary care providers (PCPs) can determine whether children or other family members are at risk for or are actively being bullied. If a child is at risk, teaching parents the warning signs of bullying is paramount as victims are often reluctant to confide in others. If specific characteristics that heighten a child's risk are identified, for example, an ADHD hyperactive/impulsive diagnosis or unusual physiognomy associated with a chronic condition, the PCP can assist in helping families to recognize these differences and strategize around how to handle uncomfortable peer teasing so that it does not deteriorate into bullying.

If bullying has occurred, every effort must be made stop its progression before frank bullying and attendant suffering have ensued. Interventions must be tailored to the targeted individual and the situations in which the bullying has occurred. Specific strategies (e.g., personal empowerment, help-seeking) can be useful for avoiding or deflecting future attacks. Working with schools to provide safe zones and helping to modify bystander behavior are also critical components of bullying prevention as bystanders can interrupt or exacerbate bullying through their actions or inactions. Given the important health consequences of bullying, helping prevent bullying and addressing it and its sequelae are essential roles for all of us; primary care providers can begin leading the way.

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Thinking Outside the Box But Inside the Boxing Ring

Worcester Police Department and Worcester Physicians Collaborate to Reduce Youth Violence and Gang Activity through Innovative Youth Programming

Michael Hirsh, MD, and Sgt. Steve Roche

Michael Hirsh, MD

This month's *Worcester Medicine* is devoted to the topic of bullying. Bullying has long been a key tactic of gang recruiters and enforcers who picked out vulnerable children as targets for recruitment into gang membership ~ kids who were victims of bullying were actively pursued. These kids sought refuge as members of a gang where they would be respected, protected, even feared while hanging with their fellow gang members. Bullying also allowed gang members to establish their turf, shake down local kids, and intimidate neighbors from turning them in to the police when illegal activities (drug trafficking, illegal gun sales, and prostitution) were being conducted in the neighborhood and investigated by police.

The gang dynamic was not always well understood by police agencies. Shows of force and muscle by the police frequently hardened the gangs to even more violence and criminal activity. We are very fortunate in Worcester that our extremely progressive police department, with its strong commitment to "community policing" techniques, recognized that gangs could be contained and to some degree stifled by channeling resources into an elite group of streetwise policemen who recognized where and when gang activities were happening and could insinuate themselves into the community is such a way as to thwart or deter these activities.

Thus the Worcester Police Department Gang Task Force (WGTF) was created in 1998 through the efforts of then Worcester Police Chief James Gallagher. By 2001, it became apparent that one of the best ways that the WGTF could do its job was to supply to kids membership in a "good gang" ~ one dedicated to healthy activities and offering mentored by caring adults who respected the kids ~ and in turn earn the kids' respect and trust. Basketball, softball, summer camps, after school community centers that were safe havens from gang activity were developed under the watchful direction of the WGTF founders and Sgt. Steve Roche.

One of the most successful programs that WGTF established was their boxing program; it allowed the kids to get into shape, learn some techniques of self-defense, and earn the respect of their peers in a safe, competitive environment. The kids, girls and boys alike, responded with such enthusiasm that over the years, the WGTF started a boxing promotional event, Worcester's "Give Kids a Fighting Chance." Since its inception in 2003, there have been 8 events that have helped to raise over $625,000 to offset the costs of gym space, equipment, travel and instruction. There has from the beginning been a partnership with community physicians in the area, all volunteers, with a strong commitment to youth and sports. Dr. Brian Busconi, Chief of Sports Medicine at the UMass Memorial Medical Center, and Dr. Jeffrey Cukor, Director of the Emergency Medicine Training Program at the UMass Medical School, have served as medical providers for these events for the past 10 years, staffing boxing matches between gang task force participants. Sgt. Roche has also tried to work closely with the Trauma Center at UMass Memorial Medical Center, imparting to its Trauma Team of physicians, nurses, and paramedics knowledge about the recognition of gang related injuries that may otherwise have arrived unnoticed. When such gang activity does result in a gang victim or member being hospitalized, it is very important for the security of hospital personnel and patients and their families that extra security

measures are taken to ensure everyone's safety.

Sgt. Roche is pictured 5th from left

Under Sgt. Roche's tutelage, the Trauma Center has been able to flag the onset of gang-related trauma back to the WGTF so that they in turn can hit the streets to try to head off escalation of further violence or revenge. This partnership has also extended to helping ex-gang members or their girlfriends who wish to make their homes safer turn in firearms to the annual Goods for Guns Gun Buyback held at Christmas time and co-sponsored by the UMass Medical Center Injury Prevention and Trauma Program and supported by the Worcester District Medical Society, Worcester Police Department, Worcester Department of Public Health, The Worcester Office of the District Attorney and WalMart.

In summary, the WGTF and its many outstanding community activities have sought to keep a lid on the violence that can stem from the systematic bullying activities of gangs and reduce the gangs' influence on the youth of our community by giving them an alternative to life on the street. This is a partnership between the medical community, the Worcester Police Department, and the young people of Worcester that we all hope continues to thrive. Where such partnerships are missing, such as in the cities of Lawrence, Lowell, Fall River, Springfield, and Hartford, the cities deteriorate, violence escalates, and everyone loses.

Michael Hirsh, MD, is Vice President of the Worcester District Medical Society and Sgt. Steve Roche is Director of the Worcester Gang Task Force.

Prize Winning Author Tracy Kidder Urges Medical School Audience to Find "Strength in What Remains"

Harvey Fenigsohn

On May 19, 2010, Pulitzer Prize winning author Tracy Kidder addressed an appreciative audience of 200 at the University of Massachusetts Medical School. His appearance was co-sponsored by the Worcester District Medical Society and the UMass Medical School Lamar Soutter Library's Humanities in Medicine committee.

Kidder signed copies of his latest work of non-fiction, Strength in What Remains, the story of a medical student who escaped genocide in the south central African nation of Burundi to make a new life in American and establish a desperately needed clinic in his native land. Before talking about his latest book, the author spoke of Paul Farmer, MD, the subject of his earlier work, Mountain upon Mountains (2003), a much acclaimed account of a charismatic physician determined to heal underserved populations around the world.

Kidder praised the significant achievements of Partners in Health, the international organization of health care workers founded by Dr. Farmer. Accompanying his remarks with a slide show of moving photographs, the author demonstrated how Partners in Health surmounts seemingly insurmountable economic and political barriers, relieving suffering from the slums of Peru to the squatter settlements of rural Haiti.

Speaking about his latest book, Kidder noted this same compassion motivated Deogratias Niyizonkiza, the subject of Strength in What Remains. Escaping an African holocaust, the youth arrived in the U.S. with just $200, speaking only French and knowing no one. Nevertheless, with hard work, luck, and diligent study, he overcame penury, mastered the language, and ~ aided by dedicated new friends ~ graduated from Columbia University. Inspired by Paul Farmer, Deogratias joined Partners in Health and, despite agonizingly painful memories, returned to Burundi, determined to better the life of his people.

Kidder developed a close relationship with Deogratias as they revisited the places in Rwanda and Burundi where Deo, on the run for six months, had bravely dodged the machetes of Hutu tribesmen. A fugitive during a brutal civil war in 1993 between rival tribes, the young Tutsi witnessed unspeakable atrocities. Finally safe in the USA, yet hauntingly traumatized, Deo at first remained mute about his horrific experiences, but later compulsively retold his story to any who would listen. Kidder revealed that his friend resisted psychological counseling, yet helped himself heal through selfless forgiveness, dedicating his life to building a village hospital serving Tutsi and Hutu alike.

Throughout his talk, the Northampton author emphasized that despite the ravages of war, the destruction of natural disasters, and the scourge of poverty, individual courage and community good will can prevail. Though subjected to savage cruelty, Deogratias benefited in Burundi from a complete stranger risking her life to save him, from family friends funding his flight to the USA, and from kindly New Yorkers offering financial support and a warm home. These gestures of generosity led Deo to respond in kind, establishing Village Health Works, a not-for-profit enterprise serving over 350,000 Burundian villagers lacking any other medical care.

Kidder stressed that, like Deogratias, we must respond to the challenge of overcoming man-made and natural adversities from geno-

cide to disease. He told the medical school audience that such tragedies as the earthquake in Haiti, HIV/AIDs in Africa, and famine around the world serve to unite all humankind, bringing out the best in all who respond. Conversely, when we fail to act, all of us suffer, and all are diminished, not merely the victims.

Appropriately enough, among the many standing in line to have Strength in What Remains signed by the author was Dr. Christine Purington, whose group of UMMHC health care workers recently visited Haiti and returned earlier in July. Later, Kidder was gratified to learn that the day after the Worcester Telegram ran a front page article on his appearance at UMass, the same newspaper reported the medical school had sent 500,000 doses of tetanus/diphtheria vaccine to Haiti.

Dr. Michael F. Collins, the chancellor of the Medical School, stated, "After seeing the devastation in Haiti firsthand, with our medical teams on the ground helping in the days after the earthquake, we realized we were in a unique position to reach out to the people of Haiti and help with this life-saving vaccine. Our mission has always been focused on public health, and today, that means taking a global view."

Tracy Kidder acknowledged that many despair at the futility of relieving the misery of the millions of third world people ravaged by disease and poverty. "It's just too easy to say, 'Oh, this has failed' and write the Haitians off and say 'It's just a nightmarish mess.' ...I understand it. I feel that way sometimes, certainly. I don't think anybody who works in a place like Haiti or Burundi doesn't feel that way sometimes. But the standard you might apply would be, say, if it were your own family, your own kids. Would you take that position regarding them? Probably not!"

We are all responsible for reducing human misery caused by natural disasters wherever they occur, Kidder stressed. "Human beings didn't create the earthquake, but the terrible vulnerability to earthquakes, the terrible vulnerability to flooding ... those are human creations and it has a history and the history didn't begin five minutes ago." For Tracy Kidder, Paul Farmer said it best: "The only real nation is humanity."

A "Black Swan" Dive

Greg Thomas, ThomasPartners, Inc

Predictably random…

The stock markets are unique among games of chance; there are an infinite number of possible outcomes. Yet, investors consistently think its price movements are predictable and then seem so surprised when stock prices "misbehave."

Usually, the market's unpredictable movements fall within acceptable norms. While unpleasant, a 10% market decline seems reasonably manageable because investors know that, historically, the necessary 11% (or more) correction to get back to even has happened over 50% of the time.

Occasionally, however, the markets move in unacceptable patterns; share prices experience extreme and seemingly "unfair" downdrafts for which most investors are unprepared. "How could I have seen that coming?" is the common response.

That random event probably won't happen again. But, some other random event surely will, and most investors will be just as unprepared for the next random shock as for the last.

Marketplace meltdown…

A case in point happened on May 6, 2010 when the Dow fell 998 points during the day. This was the largest point drop in history and seemed to have no immediate explanation.

At first, it was thought that the market feared a repeat of the last damaging random event, the bankruptcy of Lehman; only this time it would be the bankruptcy of Greece that would bring global markets to their knees.

While that fear may have contributed to investors' reactions and other explanations may emerge, the current thinking is that the initial trigger might have been a sale of a futures contract by a hedge fund advised by Nassim Taleb, author of the book Black Swan: The Impact of the Highly Improbable, that put in motion an improbable sequence.

According to most reports, this sale of a futures contract on an options exchange inspired others to sell stocks on the New York Stock Exchange which, in turn, caused the broad market indexes to fall which, in turn, triggered selling by the exchange-related funds which…well, you get the drift. Eventually, the markets seized and liquidity was gone; one large company's share price fell to $.01/share from about $42.00/share then recovered to about $41.00/share!

The irony…

The irony is that it was Nassim Taleb who introduced the notion that the stock market movements are far more influenced by unpredictable and random events than most realize. He called these random events "Black Swans," a reference to how an American could spend his whole life observing only white swans and, therefore, assume and even wager that the next swan to pass by would be white too. Imagine his shock (and lost wager) when a black swan from Australia flew into the pond.

The significance of "Black Swan" events is broad, but not fully appreciated because they are unpredictable. The only way for an investor to protect against a "Black Swan" is to assume that one will happen and prepare accordingly; advice that is germane to market risk protection, in general.

"Black Swan" defense…

Almost every financial plan created by a financial services person makes two assumptions: 1) that stocks will go up, over time,and 2) that investors will be able to spend those gains in retirement.

Almost every financial plan that fails does so because of those same two assumptions. It fails when stock prices do not go up for extended periods of time. It fails when the lack of spendable capital gains forces the distribution and consumption of principal.

A good financial plan, therefore, is positioned to enjoy rising markets; however, it does not require them. A good financial plan does not require capital gains because it generates significant levels of recurring portfolio income from dividends, interest, and rents.

The income can be spent or reinvested when "Black Swans" wreak havoc with share prices and when capital gains are still a planning assumption but not a portfolio reality.

Income growth…

It would be a mistake to think a portfolio income stream inhibits growth. Over the last 40 years, the share price appreciation, on average, of all stocks that paid dividends exceeded the price appreciation, on average, of all stocks that did not pay dividends.

Dividends can grow, too, even if share prices do not. There are currently over 250 domestic stocks that have increased their dividends each year for ten years. Some have increased them every year for over 25 and even 50 consecutive years.

In other words, the "Black Swan" insurance offered by owning dividend-growing common stocks has historically come without additional cost. Who says there's no such thing as a free lunch?

PIAM, a subsidiary of the Massachusetts Medical Society, has selected ThomasPartners to be their designated provider of financial planning and investment management services to MMS members at discounted fee arrangements. If you would like additional information, please contact Amos Robinson at amos@thomaspartnersinc.com or at 888-431-1430.

For more information, please contact Amos Robinson at ThomasPartners, Inc.

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WDMS Remembers Its Colleagues

David J. Cavan, MD
1920-2010

David J. Cavan, MD, radiologist, died Saturday, January 9, 2010. He graduated from Boston College, and Tufts University Medical School and interned at Brighton Marine Hospital. He served as a Lieutenant at Cushing Veteran Administration Hospital. He leaves his wife of 64 years, Mildred, and his six children and grandchildren. A son predeceased him.

Dr. Cavan was the president of Radiology Clinics Inc, which was one of the three prominent groups providing radiology services to the greater Worcester area from 1950 to 1990. Radiology Clinics' flagship hospital was the Worcester City Hospital, where Dr. Cavan served as Chief of Radiology until 1975 and remained on its staff until its closure in 1991. He was also the Chief of Radiology at Fairlawn Hospital until his retirement in 1991.

Radiology Clinics provided diagnostic radiology services at Milford Hospital, Holden Hospital, Clinton Hospital, Harrington Hospital, Doctors' Hospital, Fairlawn Hospital, Hubbard Regional Hospital, and the Worcester City Hospital.

His professional career spanned four decades at a time when radiology underwent astounding technological change, a transition from wet processing of plain films by hand and mirror imaged fluoroscopic radiology to the comprehensive computerized modern departments providing nuclear medicine, ultrasound, mammography, CAT scanning, and angiographic and interventional radiology that are the mainstay of today's medicine. Dr. Cavan embraced these changes and was responsible for implementing them in the several hospitals that he served.

I first met Dr. Cavan as a student at the University of Massachusetts Medical School at the Worcester City Hospital. He always had time to discuss a case. He had a calm and patient yet disciplined demeanor. He was very approachable, would take the time to review a case, address my concerns and teach me a little about reading x-rays. One never had the feeling that he was rushed or inconvenienced or that he had better things to do or smarter people with whom to speak. I found this informal, congenial, and non-intimidating approach a refreshing contrast to much of what I had experienced in my training, so much so that I returned and took several radiology electives at the Worcester City Hospital with Dr. Cavan and his associates at the Radiology Clinics. Their encouragement and support resulted in my specialty choice of radiology.

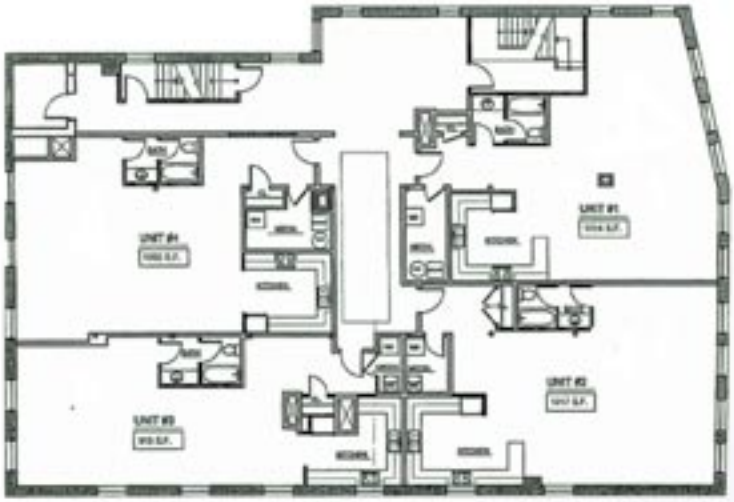
When I completed my residency, I called Dr. Cavan, asked if any jobs were available, and was hired immediately. That was the entire extent of my job search. I worked for the Radiology Clinics for eleven years until the dissolution of Worcester City Hospital and Dr. Cavan's retirement. There was nothing he asked of us that he didn't do more of himself…with perfect equanimity. The experience I gained at the Worcester City Hospital in his employ was invaluable to my career; the true value of his guidance, knowledge, experience and instruction was only fully appreciated in retrospect after having had to assume responsibility for many of these roles myself as he delegated them with a parental-like oversight.

When one takes inventory of one's career, indeed one's life, there are inevitably a few names that stand out on the plus side of the ledger as having been extraordinarily helpful, kind, and influential. Dr. David Cavan, whose expertise contributed greatly to the provision and evolution of Central Massachusetts' radiology services, figures very highly on my list. Thank you, Doctor David, rest in peace.

Robert D. Chiulli M.D.
Dartmouth Hitchcock Medical Center

The Lofts at Winter Place

Just minutes from St. Vincent's Hospital and MCPHS



Enjoy city living at its best. Tour these beautiful, luxurious units and see for yourself how convenient and elegant city living can be!

The Lofts at Winter Place are located above Bocado Tapas Wine Bar on the corner of Winter & Water Streets in Worcester's new Canal District. The neighborhood is surrounded by restaurants, shops, clubs & cafes. This convenient location is a short walk to downtown & just steps to the commuter rail at historic Union Station.

Each unit features 1,000+ square feet of open living space framed by high ceilings, architectural arches, exposed brick walls, hardwood floors, central air, marble bathrooms, sound-proofing & oversized windows. Gourmet kitchen provides granite counter tops, breakfast bar, gas cooking & stainless steel appliances. A large utility closet accommodates in-unit laundry. Well appointed common area lobby & off-street parking. Still time to pick your own light fixtures & colors.

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2010 Community Clinician of the Year Award Presented to James B. Broadhurst, MD, MHA at the WDMS Annual Business Meeting on April 10th

Dr. Broadhurst is Assistant Professor, Department of Family Medicine and Community Health and Associate Director, Family Practice Residency at the University of Massachusetts Medical School.

In addition to his many other current positions, 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 Health Awareness Services of Central MA.

Dr. Broadhurst has been an active teacher and role model, teaching in the medical school's Longitudinal Preceptorship Program and in the Physician, Patient and Society course. He has taken a leadership role in a variety of programs for third year medical students focusing on community health issues, including programs devoted to domestic violence, health policy, oral health, pain management, and care of the disabled.

Dr. Broadhurst has served on a variety of committees at the WDMS, the Massachusetts Medical Society, MassPro, community agencies, and other organizations. He currently serves as a member of Board of Trustees for the Massachusetts Medical Society. Since 1993, he has served as a member of the Worcester District Medical Society Public Health Committee and as its Chair since 1998. Under his leadership, he has collaborated with the Worcester Division of Public Health on several programs including the development of a community immunization program, disaster preparedness, and designation of the city of Worcester as a "heart healthy community."

He was an active leader in the community's oral health initiative, raising physician awareness of the importance of oral health issues in practice and advocating for public policies. He devoted his time and energy toward the establishment of smoke free environments, developed the WDMS Rx Fund to support patients lacing insurance to obtain prescription medication, and collaborated with the Injury Free Coalition for Kids to promote the Goods for Guns Program, reducing the number of firearms within the community.

Annual Business Meeting 2010
Dr. George Abraham, chair, Awards Committee, presented the 2010 Worcester District Medical Society, Massachusetts Medical Society Community Clinician of the Year Award to Dr. Jay Broadhurst in recognition of his outstanding contributions to his patients, those in need, and the community. (pictured left to right: Drs. Warren Ferguson, Jay Broadhurst, Jane Lochrie, George Abraham)

His activities have been recognized with many honors, including the "Advocacy for Primary Care Award" from the UMass Generalist Physician Initiative, an "Appreciation Award" from Health Awareness of Central Massachusetts, the "Citizen Award" of the Horace Mann Educational Association, an "Appreciation Award" from FAITH, Inc., a "Service Award" from New England Residential Services, a "Citizenship Award" from the South Central Massachusetts Rehabilitative Resources, Inc., and the "Partnership in Healthcare Award" from Rehabilitative Resources, Inc.

Dr. Broadhurst's contributions have been essential in building a framework for physician involvement in the health of our community, and have led to substantive improvements in the health of the people whom we serve. WDMS honored Dr. Broadhurst for his significant contributions to patients and the community with the "2010 Community Clinician of the Year Award" at the Annual Business Meeting on April 10th.

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2010
CALL FOR NOMINATIONS

AWARDS

Take a moment to recognize a deserving colleague

20TH ANNUAL DR. A. JANE FITZPATRICK COMMUNITY SERVICE AWARD

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

2010 WDMS CAREER ACHIEVEMENT AWARD

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

TO NOMINATE AN INDIVIDUAL PLEASE INCLUDE:

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

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

Fax, Phone or E-Mail
Fax 508-754-6246
E-Mail: wdms@massmed.org
Phone: 508-753-1579

EXTENDED DEADLINE:
August 10, 2010

Please print all information

Nominator _____ Phone _____

Email _____ Fax _____

Award _____

Name of Nominee _____

Email _____ Hospital Affiliation _____

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