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Jane Lochrie, MD

I am very grateful to Emily Tsanotellis for agreeing to serve on the Editorial Board. She has done an outstanding job as the guest editor of this issue. Likewise, I'd like to thank all the students who participated by writing articles. We are very fortunate to have such wonderful participation from the University of Massachusetts Medical School. Students serve on several WDMS committees: Philip Aurigemma and Gillian Griffith on the Executive Committee, Matthew Bartek on the Public Health Committee, and of course Emily Tsanotellis on the Editorial Board. The students bring a lot of enthusiasm and energy to these committees. In addition, many students participate in our public outreach programs.

This edition of *Worcester Medicine* includes the Gerald F. Berlin Creative Writing Award that was established to encourage creative writing in biomedical and nursing students and residents. This year's award was presented to Noah Rosenberg, a fourth year medical student, for his poem "Coming of Age in Baghdad." Please take time to read this moving piece.

Dr. Sanghavi has some very interesting insight into the new resident work hours. He points out that originally these rules were instituted to prevent medical errors made by residents who were fatigued but, disappointingly, the restrictions did not improve the medical error rate. This does not mean that we should go back to the "old ways," but rather look to new ways to improve patient safety.

The spoken history project was written by fourth year medical student Philip Aurigemma. He recounts the long and distinguished career of Dr. Arthur Pappas, the founding Chair of the Department of Orthopedics at U Mass. He describes Dr. Pappas as "…a role model for any aspiring physician, and a key figure in the emergence of the UMass hospital and medical school."

Dr. Sandy Marks' wife, Julia, wrote a wonderful reflection of her husband's philosophy of teaching Gross Anatomy. Dr. Marks was the founding father of the Cell Biology Department at U Mass in 1970 and created a respect for the dignity of what was once a fellow human being that reflects his belief in the value of every human life. The first Memorial Service for the cadavers was held in 1980 at a time when this was not common practice.

Again, I'd like to thank all the students at UMass for their superb participation in the WDMS.

Jane Lochrie, MD
Editor

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Guest Editorial

Emily Tsanotelis, 2nd year medical student,
University of Massachusetts Medical School

This issue of *Worcester Medicine* addresses salient topics of the medical school experience, ranging from morning rounds on the wards to volunteerism abroad. At the University of Massachusetts Medical School, students learn about the intricacies of the human body and the privilege of caring for "a fellow creature in pain," as Maimonides appreciated so long ago. With the passing of each "first" ~ the first cut into a cadaver, the first nasogastric tube into a patient ~ we become indoctrinated into the world of doctoring. Yet we are not so far removed from that other world, the one before medical school. From the anatomy lab to the operating room, we explore and absorb and try to find our place.

As a second year medical student, I view medicine with equal amounts of awe and consternation. On the difficult days, when the brain devotes itself to rote memorization and task-oriented to-dos, leaving little room for the freedom of thought, let alone an hour in the sun, I remind myself that I wouldn't want to be doing anything else. I am continually impressed by the energy and grace and talent of my classmates. I feel fortunate to be surrounded by such motivated and compassionate peers, who will (soon enough) be motivated and compassionate physicians. The following articles offer a window into the ideas, adventures, uncertainties and small triumphs of its authors, providing insight apropos both formal and informal components of medical school education. With pride for UMass and gratitude for those willing to share their stories, I happily present this issue of *Worcester Medicine*.

President's Message

Michael Hirsh, MD


Michael Hirsh, MD

This edition of the *Worcester Medicine* has been completely designed by Emily Tsanotelis, the Medical School representative on the editorial board. The wonderful submissions as accrued are a reflection of the amazing medical community represented by the medical school. Whether it is contributing to free care clinics throughout the city or international health efforts around the globe, the Medical School students continue to astound all of us involved with their education with their passion, their compassion, their dedication, and their social conscience. Their outstanding performance was also reflected in the Commencement Exercises of this past June 3. The honorary doctoral candidates included President Ellen Johnson Sirleaf, Nobel prize winner and the President of Liberia. President Sirleaf addressed the class in her hushed but passionate way, chronicling her personal journey from prison to post-civil war reconciliation to triumph in politics as the twice elected president of Liberia (the first female president in Africa), and then as Nobel Laureate. She also relayed in somber tones the tremendous challenges her country has faced and in many areas have begun to overcome.

After absorbing her amazing tale, the graduates and their families heard Madame President make the analogy of the long and arduous journeys that these scientists, advanced practice nurses and med students have made to reach their goals. She implied that if she and her country could triumph over adversity, so to could these graduates reach their goals with perseverance, tenacity, and hope. She ended her address by imploring the grads to go out and "Save the world." Seeing the thoughtfulness and empathy embodied in this edition's entries, I am confident the readers of *Worcester Medicine* will agree with me that these authors are all doing their part. Hope you enjoy the issue as much as I have.

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The Limit of Good Intentions

Caleb Dresser, University of Massachusetts Medical School, Class of 2015

Caleb Dresser

A few years ago, I did a very foolish thing. The Times of India was covering a flood in the eastern part of the country and, against my better judgment, I went to see things for myself. Sporting a third-class rail ticket and a page torn from a friend's elementary school atlas of India, I headed east. In Patna, the capital of Bihar, I stopped to rest and pick up what scattered information I could. My only plan was to make friends, keep my valuables close, and see where things led.

That evening, I bought a new ticket on the provincial railway. As I watched squads of khaki-clad soldiers draped with duffel bags and assault rifles forming up on the platform to board my train, I began to wonder if I were making a mistake. At dusk, we began to snake our way into the flood zone.

A smiling relief worker in a brown sari saved my bacon. She spoke good English and couldn't stop herself from asking why a scruffy-looking American was taking a train into the middle of a crisis. I didn't have a good answer, but when tracks ran out and the train could go no further, her friends invited me to join them in the back of their NGO's ambulance. A few hours later, I fell asleep under a pink mosquito net between the camp cook and a grizzled schoolteacher named Jitu. I woke up to a world gone mad.

Breakfast was puffed rice without water. Lines of shelters stretched for miles; IDP camps had sprung up on patches of flat land beside drowned villages. Floodwaters had blown right through railroad embankments, leaving the track hanging in U-shaped bridges of rusted steel. We crossed by walking next to each other, one on each rail, holding hands.

In the camps, the doctors and volunteers set up mobile clinics and food distribution points and tried to help people get organized. At one of the feeding stations, I watched as a man snatched the high-energy biscuits out of a hungry child's hand and ran off before anyone could stop him. In the only concrete structure for miles, soldiers in white undershirts lounged in the sun playing cards.

Did my presence benefit anyone? Not really. I took some pictures, I spoke with some survivors, I wrote some blog posts that eventually made it onto the internet. I took a few blood pressures. I carried some boxes to distribution points. Nothing the Indian volunteers couldn't have done.

Was my presence a burden to those around me? Definitely. I ate greedy handfuls of food every evening with the volunteers, food that they had painstakingly arranged to transport into the province along a supply line hundreds of miles long. I took up space in one of their canvas shelters. I added complexity to an already difficult job.

Were people glad I was there? The ones I talked to seemed to be. The relief workers went out of their way to help explain the situation and took pleasure in including me in their routine. Many said they approved of my decision to join them. People in the camps were usually excited to say hello ~ I was the first foreigner many of them had met. Others looked at me pointedly and told me to show the outside world what had happened. One man took the time to show me a safe barefoot route through the muddy, thigh-deep waters of what had been his village. That said, there were many who watched without expression as I passed, and I can't claim to know what they were thinking.

In the end, the person who got the most out of my presence was me. I expanded my world view and opened my eyes to realities I had only read about. I started down a path that would eventually land me in medical school. From this perspective, it was a valuable experience.

In the big picture, however, I had no business being there. Medical work in developing countries is a serious, professional business, doubly so in a disaster. The Indians working in the camps were well qualified and didn't need me. I was an amateur. We are all amateurs, even once we have an M.D. after our names, if we don't understand the people and places and systems with which we work. This is a process that begins with listening to others, no matter their position, and that never really ends.

For students who spend a few days or weeks or months in a new place, medical volunteerism is at its best a thought-provoking moment of human connection, a Technicolor experience that spurs us toward meaningful engagement and greater sensitivity. For the people in the communities where we work, it's their lives.

This isn't to say we shouldn't go ~ far from it ~ but it is to say that we need to be honest about what we are doing. We cannot become tourists in search of the biggest tumor, the most aggressive procedure, the prettiest self-portrait holding someone else's baby. We must recognize that service work which makes us feel good about ourselves can sometimes be harmful to the communities we profess to be helping. None of us is perfect, but it is our responsibility to ask ourselves what we really are trying to do, who really benefits, and whether we are treating those who have allowed us the privilege of entering their lives with the respect and dignity that they deserve.

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Back in the Day and Today

David Clive, MD

David Clive, MD

Nothing will make someone's eyes glaze over more quickly than if you start talking about your medical training. And should you begin more than a few sentences with the phrase "In my day…," your listener may actually become fixed and dilated. So, imagine my surprise when I was veritably invited ~ by one of our students, yet ~ to contrast my medical school experience with that of today.

Fortuitously, this year marks the 40th anniversary of my starting medical school at Case Western Reserve, a great institution renowned for innovation in medical education. Even Case's admissions office was avant garde. Our Dean of Admissions, the legendary Dr. John L. Caughey, took an adventurous approach (as you might guess, given his having accepted the likes of me). My class was an eclectic group, its members having arrived via many paths. Dr. Caughey fondly referred to his non-traditional selections as "bent arrows" to differentiate them from the classic, 4-year, straight-arrow premed. Today, unconventional medical students have become quite conventional.

Case Western pioneered the now popular concept of an integrated, organ-system-based curriculum. We learned the pharmacology, biochemistry, physiology and anatomy of each system in sequence, the normal stuff in Year One, the pathologic in Year Two. I was an art major in college, and one of the rare medical students who might now be called a "right-brain" type. Somehow, the integrated approach proved such a good fit for my artsy-fartsy cognitive processes that I bet a friend I could pass Part One of the National Boards (equivalent to today's USMLE Step 1) in June of my first year ~ and won!

1970s educational technology was, at best, primitive. There were no simulation labs, audience response systems, or videotaping. Frankly, I'm glad I was never videotaped, as I'd have to locate all those tapes and burn them, lest they fall into the hands of anyone who knows me today. Lacking PowerPoint, our profs showed at most 20 Kodachromes during a one-hour lecture, in contrast to the 6,000 images that today's students suffer through. OK, so I exaggerate ~ 3000 images.

There was also no internet, and no personal computers. Imagine that! But at the risk of sounding retro, let me say that there were some advantages to that lack of technology. We actually attended lectures. We got to know our professors. In fact, we were curious to meet them, since we would encounter many of them later in the clinical setting. And going to morning classes allowed students to meet each other, have breakfast together, learn together. We had a cohesive class identity. We didn't have a class show, but we had plenty of unrehearsed yucks in class.

The great Dr. Benjamin Spock was on the Western Reserve faculty during the '60s and he masterminded yet another innovative concept, early clinical exposure. As soon as students arrived on campus, we were assigned to follow an expectant mother, typically single, adolescent, and living in the inner city. In theory, this program was a win-win: the patient gained a liaison with the medical establishment while the student periodically got to escape the tedium of the lecture hall and play doctor. Looking back, I suspect its major effect was to demonstrate how totally clueless we were, no doubt to the occasional amusement of those poor young women. With four more decades of collective experience under their belts, all U.S. medical schools offer early clinical exposure to their students, and the programs are quite effective.

Once a week, we engaged in precepted small-group discussions called T groups or sensitivity groups, a taste of West Coast cul-

ture right there in Cleveland. There was still no overarching, longitudinal course in which to learn communication skills, medical ethics, cultural diversity, health care policy, and other "non-core" aspects of the modern medical curriculum. At UMass, our version of such a course, eventually called "PPS," was developed in the early '90s under the leadership of the late Dr. Sarah Stone. These courses are now a vital part of every school's curriculum. I'm sure my cohort could have benefited from one. However, I believe we received better training in physical diagnosis, no surprise considering that bedside diagnosis was more heavily relied upon back then.

For all its novel ideas, the Case medical education followed the standard time line of two years preclinical, two years clinical. Our third year was comprised of five core clerkships (Medicine, OB-GYN, Pediatrics, Psychiatry, and Surgery), each of two months' duration. There were no introductory clerkships and no bridging experiences. Since there were no academic departments of family medicine, there were no family medicine clerkships. Our core clerkships were loosely structured. It was up to us to figure out what hospital life was about and what was expected of us. I can't imagine our teaching attendings received any substantive faculty development. We had no standardized evaluative experiences, OSCEs, web-based learning tools, or shelf exams. To this day, I have no idea how they evaluated us.

My first clerkship was Medicine. It's probably the most difficult to lead off with, and the fact that I started it in July simultaneous with the new group of interns made it particularly stressful. There was, however, one distraction from the stress: Watergate. TVs ran ceaselessly throughout the hospital as the Nixon administration plunged itself inexorably into ruin. On August 9, 1974, I interrupted my blood-drawing rounds on a group of patients in one of the large male wards and joined them to watch a smiling Nixon stride up a helicopter ramp and disappear into posterity.

I enjoyed the entire third year except for my brief stint in the neonatal ICU. Sticking needles into tiny, fragile creatures isn't my thing. I'd had an insect collection as a kid which satisfied that yen for good. My OB-GYN clerkship was very weird. I liked OB and remember wishing I didn't have to switch to GYN midway through clerkship. Oddly, that wish came true; due to a fluky and undiscovered scheduling glitch, I was assigned a second month on the OB service instead of GYN. By the end of the clerkship, I had delivered 40 babies myself!

Fourth year back then resembled fourth year today: a subinternship, electives, and residency interviews. My fourth year was marked by two pivotal events. First was a terrific medical subinternship, which triggered a spur-of-the-moment decision to drop my plans for surgical training in favor of a medicine residency. The other was my "away" elective, a pulmonary rotation in a London hospital. Several of my classmates were also doing electives in London. At a prearranged time one evening, we convened at the international post office in Trafalgar Square to call our school registrar and learn where we had each matched for residency. I was both thrilled and terrified with my result, medicine at Bellevue. Afterwards, we celebrated with roast beef and Yorkshire pudding, washed down with liberal drafts of warm British beer. Now that the Match was behind us, it seemed too anticlimactic to continue our electives. My buddy and I bolted and spent the next few weeks meandering through France and Spain before returning to the States to graduate and begin internship.

How would the medical school of my day stack up against the current one? Face it: medical school has never been easy. It was nearly impossible to get into medical school in the early '70s, and it still is. The learning environment we faced was more hierarchical and less nurturing than today's. However, the exponential expansion in biomedical knowledge places a much greater learning burden on today's student. Our education was loosely structured and largely experiential. Today's is more carefully regulated and sturdily buttressed with modern educational theory. Today we have competency-based goals and assessment methodologies. Back then, we had ~ well ~ I'm not sure what we had.

The one constant through the years is the medical profession itself. It was, and will always be, a great privilege to be part of it.

David Clive, MD is a Clinical Nephrologist and Professor of Medicine at University of Massachusetts Medical School.

Lessons from the Anatomy Lab

Jennifer Perez and Matthew Sloan, University of Massachusetts Medical School, Class of 2015

Jennifer Perez

Matthew Sloan

Just a year ago, we impatiently looked forward to the start of our journey into the medical profession. After spending our first month of medical school in biochemistry and genetics lectures, we were welcomed into the medical community with our White Coat Ceremony in mid-September. During the ceremony, the keynote speaker, Darrell G. Kirch, MD, president and chief executive officer of the Association of American Medical Colleges, told our class that during our medical training, it would "…take quite a bit of time to fill [our coats] with substance."

The white coat, a derivative of the scientist's lab coat, reflects the foundation of medicine, a field firmly rooted in science. Science is a study that, by definition, divorces itself from emotion. A genuine scientist bases his or her work not on his or her beliefs, but on data and facts. And it is true, we have spent a lot of time in medical school learning facts: which gene causes a particular disease, or how a drug leads to a specific outcome. In between learning these facts, though, we are reminded that our future profession is not only about becoming an expert on disease, but on becoming an expert at caring for others. Here lies the difference between the scientist's lab coat and the doctor's white coat, as medicine is not a field that can be practiced without emotion. So far, we've learned this lesson best from our first patients, our cadavers in anatomy lab.

On the day prior to the start of the anatomy course, there was an introduction explaining that what we were about to begin would be an unusual and emotionally challenging endeavor. We were told that some people would be uncomfortable. Some were. We were told that the smell of formalin used to preserve the bodies would be difficult to get used to. It was. We were also told that the next five months we would spend down in anatomy lab opening a dead body would mark an initiation and a transformation in each of us. We'd join an exclusive collection of individuals before us who have had the experience of looking within and closely studying another human body. But at the time, we did not know just how intimate the experience would be and how etched these months would become in our minds.

We were introduced to our cadavers in early October. We were told only a little about them: gender, age and cause of death. Four or five students were assigned to each table. As we began our first dissection,

we tentatively and nervously unzipped the white bags that sheathed our lifeless teachers. Silence filled the lab space as each group saw their cadavers for the first time. They were once living people. They were mothers and fathers, husbands and wives, grandmothers and grandfathers. But to us, they were strangers: lifeless, draped with dark blue towels. We didn't even know their names.

Some of us dared not step close to the stainless steel anatomy table for weeks. Others took rather naturally to the process of dissection. After the first couple of days, during which we studied the superficial muscles of the back, we became more comfortable with the scalpel and the language of anatomy and began to realize just how much we had to learn. We continued in subsequent laboratories to unveil the secrets behind the ribcage, the soft organs within the belly, the swirling muscles and vessels wrapped about the limbs, and the intricacies of the brain buried underneath an unyielding skull. During our studies, we learned all at once the complexity and fragility of the human body. We observed the unique pathologies ~ cancers, strokes, enlarged hearts ~ that afflicted these people in life. As we touched their hands and held their hearts, we began to garner the clinical knowledge and skills we'll use for years to come.

We were at different points amazed, saddened, inspired, and uncertain, but always grateful. It was these emotional hurdles that helped to make the experience so meaningful and memorable. Because our cadavers, who in death were now teaching us so much about life, had so selflessly given us this opportunity, we were inspired to appreciate the human body far beyond the capacity of learning through books and computers. And the lessons that they taught us remain deeply engrained within our minds. When trying to understand the physiology or pathology of the heart, it's not a picture of the heart in a textbook that we see. We go back to the anatomy lab and remember theirs.

Undoubtedly, the most unique and outstanding lessons we have had in caring for another person took place in the anatomy lab. We were provided the rare opportunity to study anatomy because of the remarkable donations made by so many generous individuals to medical students they had never even known. So great was their faith in our abilities, our future profession, and our potential to care for others that they gave us their final gifts ~ their bodies. This, possibly, is the greatest beauty of their gift: that it has given us a glimpse into just how much one can give, even to a stranger, with the hope that that gift might make the world a better place.

By the end of the anatomy course, we had to find peace and say goodbye to the people who had become so much a part of our daily routine. In May, our class celebrated the lives and generosity of these people and their families with a largely student-organized Memorial Service. Though perhaps the greatest thing that we can do to honor our first patients and generous teachers is to learn to give as they have given. It is by giving to our fullest capacity during our medical careers and our lives that we might follow in their noble footsteps. With that inspiration, we can keep their gifts alive throughout our careers, sharing the lessons they have taught us with our colleagues, our future patients, and even complete strangers along the way. In that manner, we might continue to fill our white coats with "substance."

Old Elevators, Cheap Vodka, and Context

Laura Dezieck, University of Massachusetts Medical School, Class of 2015

Laura Dezieck

Home visits, the hallmark of the traditional allegoric physician with his black case and stoic demeanor, seem largely to have become an idealistic legend from past, simpler times. I would argue, however, that they play an enormously valuable role in the education of any medical student lucky enough to tag along on one. Home visits confront practitioners not just with a person, but with a person in his or her own environment. The patient's reality, which is so often wiped away by a sterile exam room, becomes your reality. Suddenly there is context with the character. It adds a unique flavor to the patient encounter and wipes away the uniform routine a clinic can present. As a trainee, this encounter affords you a new sort of experience, the ability to anticipate the world of the little old lady who steps into your office; it provides a new sketch of her life, adding an increment of empathy and comprehension of, literally, where she's coming from.

My first home visit experience was deep in the upper Bronx. We took a yellow cab to a spray-painted housing project, and then an elevator up twenty floors to a dank, cramped apartment where we met an elderly woman with an unrelentingly cheerful countenance. She had big dimples at the corner of her mouth and offered us tea even though she could barely stand upright without help. As we refilled her pill cases and checked her feet, she chattered on about her grandson's football game and a great-niece's wedding. Her aide doesn't come quite often enough and sometimes her children are too busy with their kids to stop by and check on her, but she gets by. "Jeopardy" was on the TV and it was easy to imagine that this woman has a difficult life. The nurse with me was thorough and nurturing, and she resolved to follow up on increasing the woman's home help. The hardening in her eyes was the only indication of her distress at her patient's living conditions.

Now, the apartment changed to a squat trailer, red dust coating the contents ~ from frayed rugs to torn furniture. A blinding sun streamed in from all the windows, shining a harsh light on the beadwork the old woman held tightly and on the empty bottles of vodka sitting on a table that has seen better days. The woman was speaking in soft, lilting Apache instead of in the mushed New York accent, but the smile and the dimples were the same. So were the hard eyes of her nurse, who couldn't help but be dismayed by the frail woman in her equally frail house. Her children weren't working, and much of her aid checks go to feeding the family. Her son and daughter-in-law were drinking again, but they got on OK. We were in Whiteriver, Arizona, the reservation that houses the White Mountain Apache tribe. It also houses their alcoholism and their poverty. The woman moved obediently as the nurse checked her feet for ulcers and listened to her heart, but she remained quiet, as is customary for someone her age.

The stories are different, but the similarities are striking and they both yield so much more information than one could obtain in a clinic visit. Home visits bring patients to life and force the practitioner to envision a three dimensional image of the person, making him or her more whole, sending an enduring message.

Seven Days

Anne Barnard, 3rd year medical student, University of Massachusetts Medical School

Seven days into my surgery rotation and I feel like I've learned more than in the past two years combined. Seven days into my surgery rotation and I can finally find my way to the OR, ER, and cafeteria. Seven days into my surgery rotation and I've learned only the tip of the surgery shorthand iceberg. While I'm still a novice in surgeon speak and technique, I'm privileged to have a unique perspective on the patient experience. I am not yet a doctor with the stresses of paperwork, dictations, and discharge summaries. Nor am I a family member, suffering vicariously with a loved one during an NG tube placement. I am a medical student, subject to, but not yet blinded by, the systems and traditions of the hospital, ranging from effective, tried and true practices to inefficient and potentially inhumane dogmatic routines. I am stuck in a strange dichotomy between the eagerness to learn and internalize the system and the desire to analyze and challenge the system, to listen longer to patients, to avoid treating them like zoo animals, to do something "out of the ordinary" on their behalf.

Of course, all this cognitive dissonance makes for rather belabored learning. So on most days, I have sidelined my analytic internal monologue and given priority to integrating myself into the hospital culture and maximizing my productivity, thinking that maybe with more experience I will start to understand why this is the way things are. With each day, I gain confidence on the floors and have even started to help rather than hinder the streamline efficiency of the surgical team. But even in my moments of glory (such as driving the laparoscope in a gallbladder resection, or getting a "Great job!" from a resident), I can't help but remember the moments that make me truly happy: a big smile from one of my post-op patients, a handshake from a grateful spouse, a long conversation with a patient relegated to his bed and usually subjected to hurried snippets of one-way communication from the medical team.

My feeling of ambivalence is most pervasive during morning rounds, a tradition that is ubiquitous and amazingly similar in hospitals around the world. For an exercise that should be focused exclusively on patient care, rounds ~ at least from the medical student perspective ~ are a lesson in conformity, obedience, and cutting to the chase, both in walking and talking. As an unfortunate by-product of this efficiency, patients are treated as a menagerie of oddities ~ poked, prodded, and, when finally left alone, awoken before dawn by a tourist group of white-coated residents and wordless students scurrying to keep up with their leader. Despite our best efforts, time on rounds is limited, and therefore communicationand compassion are as well.

There has to be a better way. Don't get me wrong ~ everyone I have worked with thus far is fantastic. I just know that the system is stifling much of what made us come to medical school in the first place, and much of what allows patients to retain their humanity. Perhaps we can build on the momentum of the evidence-based medicine movement, making aneffort to quantify the benefits of patient-centered care. Patients' opinions, thoughts, preferences ~ to scientifically analyze such subjective information may seem like a daunting task. Research protocols and biostatistics can navigate the realm of doses and outcomes; however, medicine is, after all, for the patients, and our research must support this mission, keeping political, financial, and even scientific considerations secondary to patient care.But all that is for another essay. For now, I know I'm young ~ I'm just starting my long journey of training and there is a lot for me to learn. Maybe my attitude will change, but I hope that my passion never will. I owe it to the medical system, to my patients, and ultimately to myself to make sure that I maintain that skepticism, cultivate that need to analyze and challenge the norm, and remember that medicine is more than the sum of diagnoses and procedures. Ultimately, I will strive to preserve the mindset granted to me so graciously by these first seven days.

Finding Health with Integrative Medicine

Vincent J. Minichiello, 4th year medical student, University of Massachusetts Medical School

Vincent J. Minichiello

"What am I supposed to eat?! How do I make the pain go away?!" An exasperated 41-year-old man with Crohn's disease spoke to me in confidence upon his second hospital admission in two weeks for flare-ups of his inflammatory bowel disease. He had been diagnosed with Crohn's disease nearly 10 years ago and, up to this point, the only form of treatment he had been given was a single prophylactic pill that he took daily to hold the flares at bay. Unfortunately, it was no longer working and he yearned to stay out of the hospital ~ to spend pain-free time with his wife and two children.

The World Health Organization defines "health" as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." As a fourth year medical student looking back on my education, I cannot help but notice the focus on making sure there is an "absence of disease." We devour books on the bugs that make us sick and the drugs that eliminate these infections. However, whether it is due to the time constraints of our current medical education or our health care system's desire to cling to conventional medical practices, we rarely focus on the true meaning of "health:" social, emotional, spiritual health and healing of the whole person.

Here enters the field of "integrative medicine," defined broadly as "the practice of medicine that reaffirms the importance of the relationship between practitioner and patient, focuses on the whole person, is informed by evidence, and makes use of all appropriate therapeutic approaches, healthcare professionals and

disciplines to achieve optimal health and healing." This definition comes from the Consortium of Academic Health Centers for Integrative Medicine, which includes 50 academic medical institutions throughout the country, including UMass Medical School. Integrative medicine is not a new term for so-called "alternative medicine," but instead it represents an innovative approach to patient care that advocates for an individualized treatment plan combining our traditional Western medicine with the most effective non-conventional therapies available.

By utilizing the philosophy of integrative medicine, the hospital residency team and I came up with a comprehensive treatment plan for my 41-year-old patient with Crohn's disease. To answer his first question, we researched and found the Anti-Inflammatory Diet, which consists of common foods known to decrease inflammatory markers throughout the body. In addition, we spoke to him about lifestyle modifications such as exercise, quitting smoking, and avoiding caffeine and alcohol. We were able to identify various vitamins and minerals frequently deficient in Crohn's patients. And lastly, we referred him to a local community acupuncture clinic, since this form of traditional Chinese medicine has been shown to be effective in people with mild to moderate inflammatory bowel disease. Our patient was discharged from the hospital, empowered by the knowledge he had received the complete care that he had been seeking.

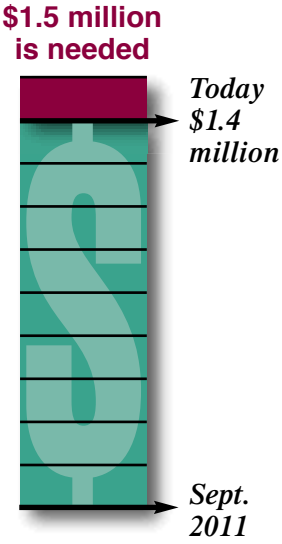
As medicine in the 21st century progresses, the practice of integrative medicine will grow to simply become "good medicine:" individualized care that uses the best possible treatments to promote whole person health.

You can make a difference to help feed the hungry.

Buy your ticket today!

Help Father John F. Madden close the gap on the funds needed to begin construction on the new St. John's Food for the Poor Center before winter sets in.

And . . . meet Wally the Green Monster, official mascot of the Boston Red Sox, in the lobby of The Hanover Theatre.



Thanks for making it all possible.

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The Gerald F. Berlin Creative Writing Award

Noah Rosenberg

Noah Rosenberg

The Gerald F. Berlin Creative Writing Award was established in 2005 by Richard M. Berlin, MD, a poet and Associate Professor of Psychiatry at the University of Massachusetts Medical School. Berlin established the award to encourage creative writing in biomedical and nursing students and residents and to honor his father, who struggled with a severe chronic illness.

Noah Rosenberg, a medical student in the Class of 2012, has been chosen as the grand prize winner of the Gerald F. Berlin Creative Writing Award at the University of Massachusetts Medical School. In July, he began his Family Medicine training at the University of Massachusetts Family Medicine Residency.

Coming of Age in Baghdad

His father had always risen before him,
so early that it seemed like he never slept.
That morning, he kissed his father goodbye,
feeling the familiar rasp of his dark beard.
The streets lay still, a lull in the march
of empire after empire conquering the city.
The sun awakened sleepy street children,
who slinked like stray cats into shadows.
Already, patients gathered at the mouth
of the hospital, seeking succor and shade.
First came those with the severest debility,
and second, he saw those who were poorest.
The assistant boy ran toward him.
"Please, there's been a stroke, sir."
So early in his training, it was his first,
but he showed confidence, as he was taught.
The boy quickly wheeled the patient to him,
his uneven face framed by thick black hair.
Closed eyes, still lips, silent plea:
It was his father's face in prayer.
Fear grew in him like the swiftest cancer.
Until now, he had been a young boy,
stitching wounds and setting fractures
for an endless army of broken men.
The boy had stayed with him, helped him
avoid becoming a wracked man.
Now, his father's face appeared changed,
like a newborn, unused to gravity's pull.
The son knew he must save his father,
and the man believed he would.

Phantom of the Sleep Deprived Doctor

Darshak Sanghavi, MD

Darshak Sanghavi, MD

In 2011, something extraordinary happened at teaching hospitals around the country: young interns worked for 16 hours straight ~ and then they went home to sleep. After years of debate and over the opposition of nearly every major medical organization and 86 percent of residency program directors, new rules that abolished 30-hour overnight shifts for brand new doctors.went into effect.

The overworked, sleep-deprived doctor valiantly saving lives is an archetype that is deeply rooted in the culture of medical training, not to mention television hospital dramas. But over the last three decades, a counterpoint archetype has been constructed: the sleep-deprived, judgment-impaired young doctor-in-training who commits a serious medical error. A large body of research on the hazards of sleeplessness ultimately led to the new rule on overnight shifts by the Accreditation Council for Graduate Medical Education, the independent non-profit that regulates the medical residency programs. "Doctors think they're a special class and not subject to normal limitations of physiology," says Dr. Christopher Landrigan, an associate professor at Harvard Medical School and one of the most influential researchers calling for work-hour reform.

The undisputed catalyst to this long-term change was the death of Libby Zion on March 5, 1984. Reforms followed, albeit slowly: in 1989, New York state cut the number of hours that doctors in training could work, setting the limit at 80 hours per week. In 2003, the ACGME imposed the 80-hour limit on all U.S. training programs, prohibiting trainees from direct patient care after 24 hours of continuous duty and mandating at least one day off per week.

In a landmark 2004 study, interns working the traditional 30-hour shifts made 36 percent more serious medical errors. These included ordering drug overdoses, missing a key diagnosis of Lyme disease, attempting to drain fluid from the wrong lung on a patient, and administering drugs known to provoke an allergy. Thomas Nazca, the director of the ACGME, cites this data as the single strongest argument for limiting doctors' work hours.

But this is where the neat narrative ~ how work hour reduction solves the medical error problem ~ hits a wall. The 2004 research was compelling, but the study was small and controlled. In normal, day-to-day practice in hospitals across the country, nothing changed. A massive national study of 14 million veterans and Medicare patients, published in 2009, showed no major improvement in safety after the 2003 work-hour reforms. The researchers scrupulously parsed the data to see whether even a subset of hospitals improved, but the disappointing results appeared in hospitals of all sizes and all levels of academic rigor.

In retrospect, medical errors result from many layers of flawed health care practices, of which work hours were only the most apparent. What the persistence of errors tells us is not that we should repeal the trainee restrictions and return to a state of sleep deprivation, which is what most of the nation's residency directors would have us believe, but instead suggests that we should redouble efforts to fix the remaining problems.

This leads to what may be the biggest problem in physician training today. Defenders of the old-school way argue that the demands of medical practice justify the brutal training hours. But after their residencies, most doctors practice in outpatient settings and work regular daytime hours as members of large groups. They treat chronic problems that need weeks or months of periodic outpatient follow-up, not high-intensity hospital-based care lasting only a few days.

"For people who came out of the old training system, it may be hard to imagine one that works better," says Donald Berwick, the director of the Centers for Medicare and Medicaid Services and former president of the Institute for Healthcare Improvement. "The point is, it's all about design, and coming up with optimizing models."

Darshak Sanghavi, MD is an associate professor of pediatrics and chief of pediatric cardiology at the University of Massachusetts Medical School.

An extended version of this essay by Darshak Sanghavi, MD appeared in The New York Times Magazine in August 2011.

Spoken History Project

Philip Aurigemma, 4th year medical student at the University of Massachusetts Medical School

This is a summary of an interview with Dr. Pappas in 2002, conducted as part of the Spoken History Project, a series of interviews with practicing physicians.

The name Dr. Arthur Pappas is synonymous with UMass Orthopedics. During a long and distinguished career, Dr. Pappas treated countless children and helped build the University of Massachusetts Medical Center into what it is today. Although medicine has undergone revolutionary changes during his career, Dr. Pappas preaches the principles of diligence, compassion, and lifelong learning that have always defined the profession.

Dr. Pappas grew up in Auburn, MA, and went on to Harvard University. Participating in athletics helped spark his interest in the mechanics of the musculoskeletal system and a ultimately let to a career in medicine. He attended the University of Rochester School of Medicine, where he paid tuition of $600 a year, an incredible bargain by today's standards!

In 1975, he became the founding chair of the Department of Orthopedics at the University of Massachusetts Medical Center. He has the honor and distinction of admitting and operating on the first patient in the history of the UMass Medical Center. The allure of returning home to UMass was a combination of the opportunity to practice medicine and also become involved in the academic and community aspects of a brand new medical center.

Over the next 40 years, the landscape of medicine changed dramatically. Dr. Pappas paints a picture of Worcester in the mid 1970s consisting of 8 hospitals which treated patients who were mostly 2nd and 3rd generation immigrants from European and Irish backgrounds. He recalls long hospital stays for relatively uncomplicated injuries. At the outset of his career, the most commonly treated orthopedic ailment was poliomyelitis, a disease virtually unseen today.

At the beginning of his career, health care insurance was a rare commodity. More commonly, health care was either paid for out of pocket or patients without insurance were seen in subsidized clinics. Dr. Pappas laments the increasing governmental regulations in health care and the increasing liability and malpractice threats borne by physicians. At the same time, he marvels at the revolutionary changes, including MRI technology and arthroscopic surgery.

Perhaps the greatest change during Dr. Pappas's career has been the increase in female physicians. He notes that the substantial increase in female practitioners has helped raise awareness of issues surrounding women's health. Similarly, Dr. Pappas also speaks proudly of the health care improvements for children, such as vaccinations, and increasing focus on children's nutritional, mental, and physical health.

Dr. Pappas, a role model for any aspiring physician and a key figure in the emergence of the UMass hospital and medical school, proudly mentions that the personal rewards of medicine are outstanding and are an important aspect of the career. He reiterates that although technology and delivery of health care may change, the core principles of medicine will always remain important.

Reflections

Julia Marks, on her husband's philosophy of teaching Gross Anatomy.

Sandy C. Marks Jr., DDS, PhD, was a founding faculty member of the Cell Biology Department at the University of Massachusetts Medical School in 1970. The first class consisted of only 16 students. The faculty was small in number and developed close relationships. No precedent had been set so they were free to be creative in their thinking and approach to teaching. They had fun. The following thoughts were often with Sandy:

"Put it before them
briefly
so they will read it,
clearly
so they will appreciate it,
picturesquely
so they will remember it,
and above all,
accurately,
so they will be guided by the light."
~ Joseph Pulitzer

In the early '70s, bodies for the anatomy labs were obtained from either Harvard or Boston University Medical Schools. Sandy initiated the body donor program at UMass, which was established gradually over the first few years. Educating the public was an essential first step. Sandy organized seminars on Death and Dying in conjunction with other professionals: attorneys, a funeral home director, and a psychologist. These were held in local venues for many organizations in the greater Worcester area as a way to "get the word out."

As interest and awareness spread, he was able to formalize the process of the donor program. Thoughtfully, the faculty guided the students in their approach to the body. For many young people,it is their first actual experience with coming this close to death; at the same time, they are learning to deal with their own feelings about and fear of death. In the later '70s, Sandy began to collaborate with Dr. Sandra Bertman, a medical humanities specialist. They began working with students who hadn't yet met their first cadaver. In these sessions, students are asked to reflect on their feelings, to write about them, draw pictures, and share with peers and mentors in anticipation of what is to come. These exercises inevitably elicit many complicated emotions. Gross Anatomy becomes a rite of passage.

Creating an atmosphere of respect for the students and respect for the dignity of what once was a fellow human being reflected Sandy's belief in the value of each human life. Students begin to wonder what each person's life had been like. What could be learned about how they lived, from the details of their hands and face, injuries, disease processes and the condition of their internal organs? All of these questions bring to life something more than just a body that will impart scientific knowledge.

Approaching their "first patient" with respect for the whole person is communicated clearly. All physicians want to be able to diagnose, relieve pain, cure, and help patients manage health issues. The hope is that many will also become healers, which demands a holistic approach that not always easy to accomplish in this age of specialization and constraints of time. The holistic approach is nurtured in the anatomy lab with the teaching of dignity and respect, where science meets mystery.

With all the attention given to respect and dignity in the lab, students and faculty came to realize that something was missing in the way of closure, that a more significant statement was needed to honor what was a gift to medical education. Thus was born in 1980 the first Memorial Service at UMass. Nationwide this kind of service was not a common practice as a part of medical education. Sandy was sometimes derided by colleagues at other universities. Now these commemorations are widely held at the end of the Gross Anatomy class. The ceremony here has grown tremendously over the last 32 years and has been moved to an off-campus site to accommodate attendance. Family is invited and they often participate with humorous or poignant stories. It is a non-religious expression of thanks carefully planned by the students, with music, both choral and instrumental, and the lighting of candles and reflections by the students. There is power to heal in the students' gratitude expressed to the grieving family!

Sandy's statement of purpose at the first Memorial Service reads as follows: "We gather today to celebrate and honor the human gift provided this year by the 38 individuals who took deliberate steps

to contribute their bodies after death for our education. Why do people make these kinds of gifts? An almost universal concern is expressed in one of my favorite poems:"

To a Medical Student, by Claire Small

This is my body
The shell of my being
Which is given to you
In a final offering
To the world.
I share the elements of life
From these old bones
These ligaments
My sinews and my nerves.
May the life force
That ran in me
Shine forth once more
And pass to you
The knowledge and the power
That helps sustain
The miracle of life.

Health Care Reform, Part 2:
New Terms for a New Era

Peter Martin, Esq.

Peter Martin, Esq.

"An Act improving the quality of health care and reducing costs through increased transparency, efficiency and innovation," all 345 pages of it, was recently signed by the Governor as the second major piece in Massachusetts' ongoing health care reform efforts. This cost-control bill now joins the 2006 access-expansion statute and adds to the Massachusetts health care landscape a wide range of new government agencies, regulatory requirements, and health care terminology. The statute is massive and wide-ranging, and no attempt is made here to describe it in its entirety. However, some of the new language of Massachusetts health care reform is described below.

Health Planning Council This new body is within the Executive Office of Health and Human Services and consists of government officials and three outside experts appointed by the Governor. The Council will have an advisory committee of representatives of providers, payors, consumers and labor organizations. The Council will conduct at least five public hearings on a proposed state health plan, which shall "…identify needs of the commonwealth in health care services, providers, programs and facilities; the resources available to meet those needs; and the priorities for addressing those needs." The plan is to be presented to the Governor by January 1, 2014, and is to make recommendations for the appropriate supply and distribution of health care resources, programs and services for a five year period. These recommendations will include as goals the following: reduction of unnecessary duplication, encouragement of universal access to community based preventative and primary care, meeting the health care cost growth benchmark, reduction in health disparities, and rational distribution of health care resources across the Commonwealth. These provisions regarding distribution of health care resources would not apply to applications for determination of need filed prior to December 31, 2013.

Health Policy Commission This body, established under a new Chapter 6D of the Massachusetts General Laws, has an eleven-member board consisting of state officials and appointees of the Governor, Attorney General and Auditor. This is the body which establishes an annual health care cost growth benchmark figure which, from 2013 through 2017, will be equal to

the growth rate of the gross state product and from 2018 through 2022 will be that gross state product growth rate minus 0.5 percent. If the average percentage change in total health care expenditures for a given year exceeds the benchmark for that year, certain "health care entities" may be required by the Commission to implement a "…performance improvement plan." If the entity fails to file or implement the plan, it can be fined a civil penalty of up to $500,000. "Health care entities" subject to this provision are clinics, hospitals, ASCs, physician organizations, ACOs or payers, provided that physician contracting units must have a patient panel of at least 15,000 patients and other providers must have at least $25 million in annual patient service revenues.

The Commission also registers "provider organizations," which are defined as an entity, of any size, that delivers or manages health care. Provider organizations must register with the Commission every two years and provide information regarding the ownership, governance and operations structure of the provider organization as well as the number of health care professionals affiliated with or employed by the organization. No provider organization may negotiate a network contract with a carrier or third-party administrator without being registered with the Commission, and provider organizations that assume downside risk in such contracts must provide an "insurance risk certificate" to the Commission (about which, more below).

Every provider organization, prior to "…making any material change to its operations or governance structure," must provide notice to the Commission, the Center for Health Information and Analysis, and the Attorney General. If the Commission determines that the change is likely to have a significant impact on the commonwealth's ability to meet the health care cost growth benchmark, or on the competitive market, the Commission may conduct a "cost and market impact review." If this review concludes that the provider organization has dominant market share, charges prices for services that are materially higher than the median, and has total medical expenses materially higher than the median, then the matter shall be referred to the Attorney General, who may take action under the consumer protection statute against the provider organization to protect health care consumers. This provision regarding the review of "material changes" is effective January 1, 2013.

Center for Health Information and Analysis This new entity (sporting an entertaining acronym), established under new Chapter 12C of the Massachusetts General Laws, has the responsibility for ensuring the "…uniform reporting of revenues, charges, costs, prices, and utilization of health care services" by providers, and for requiring providers to report any agreements between providers involving rebates, discounts or any other remuneration in any way related to the provision of health care services. The statute says that the Center may establish reporting thresholds through regulation, so it is not clear at this time whether all providers will have these reporting obligations. Another responsibility of the Center is to monitor the financial condition of acute hospitals by, among other things, requiring hospitals to report payroll as a percent of operating expenses as well as the salary and benefits of the top ten most highly compensated hospital employees. Registered provider organizations must report to the Center such information as realized capital gains and losses, accumulated surpluses and reserves,

and information regarding charitable care and community benefit programs. All licensed providers will be required to report to the Center as a condition of licensure.

Risk-Bearing Provider Organizations New Massachusetts General Law Chapter 176T establishes this type of provider organization (defined above) as one that manages the treatment of a group of patients and bears the downside risk for the care of those patients under an alternate payment contract. Downside risk is the risk of exceeding contracted budgets for the care of patients, and alternate payment contracts include methodologies such as shared savings arrangements, bundled or global payments or fee-for-service payments that are reconciled with a bundled or global payment. Registered provider organizations that enter into such alternative payment contracts must apply for a "risk certificate" from the Division of Insurance. That application must include, among other things, a financial plan describing how the risk-bearing provider organization will establish and maintain sufficient reserves or other resources to protect it from downside risks, an actuarial certification that all of its alternate payment contracts collectively will not threaten the solvency of the risk-bearing provider organization, and a detailed description of how that organization will monitor the financial solvency of its sub-contractors who also assume downside risk.

These are just some of the new entities that will populate the Massachusetts health care landscape under this statute. The themes of coordination, "transparency" and market regulation run through these parts of the statute. Providers should be aware of new reporting and other regulatory requirements that very soon will be imposed upon them as part of this next phase of health care reform.

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.

Worcester District Medical Society

Calendar of Events

2012

September 14
Friday
9 a.m. to 3 p.m.
(By Appointment)
WDMS Headquarters, Mechanics Hall

INDIVIDUAL CLAIMS CONSULTATIONS

Problem-solving workshops designed to allow physician members and their office staff to schedule 30-minute appointments with health plans to assist with troublesome medical claims

Workshops cosponsored by the Massachusetts Medical Society

September 28
Friday
7:30 a.m.
Beechwood Hotel

21ST ANNUAL WOMEN IN MEDICINE BREAKFAST

"Is Work-Life Balance Possible?"

Julia V. Johnson, MD, professor and chair of obstetrics and gynecology, University of Massachusetts Medical School

Cosponsored by the Physicians Insurance Agency of Massachusetts

October 11
Thursday
5:30 p.m.
Mechanics Hall

NEW ENGLAND JOURNAL OF MEDICINE NEJM200

"Two Hundred Years of Medical Advances"

Speaker: Jeffrey M. Drazen, MD, editor-in-chief, New England Journal of Medicine

Sponsored by the WDMS Public Relations Committee

October 20
Saturday
6 p.m.
Catered Cocktail Reception
Tower Hill Botanic Garden in Boylston

MUSIC, ART, AND A GARDEN TOUR

Enjoy beautiful artwork and a music program by our talented MMS members. Ongoing tours of the Orangerie, a large conservatory that houses temperate and subtropical plants, will also be available throughout the evening. This is an extraordinary location with beautiful vistas and gardens!

Sponsored by the Massachusetts Medical Society Art, History, Humanism, and Culture Member Interest Network

October 23
Tuesday
5:30 p.m.
Beechwood Hotel

MEDICAL EDUCATION PROGRAM

"Update in Obesity Management"

Speaker: Florencia Halperin, MD, medical director, Program for Weight Management, Brigham and Women's Hospital, Boston, MA, instructor in Medicine, Harvard Medical School

This live activity is supported by a grant from Guenter L. Spanknebel, MD, given to him by The Health Foundation upon his retirement from service as a founding Director of the Foundation.

November 14
Wednesday
5:30 p.m.
Beechwood Hotel

FALL DISTRICT MEETING

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

November & December 30 & 1
Friday & Saturday
9 a.m.
MMS Headquarters & Westin Hotel, Waltham

2012 INTERIM MEETING & MEETING OF THE MMS HOUSE OF DELEGATES

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

2013

January 23
Wednesday
7 p.m.
Mechanics Hall

A NIGHT AT THE MOVIES

The Hospital

A classic film of Paddy Chayefsky depicting a bleak 24-hour day in the life of a public hospital in Brooklyn, New York, and the travails of its chief of medicine, played by George C. Scott. The depiction was meant to be an indictment of the inequity, disparity, inadequacy, and insanity within the American medical system. Come, watch the movie, and see if you think things have changed 40 years later.

Cosponsored by the Worcester District Medical Society Alliance

February 13
Wednesday
5:30 p.m.
Beechwood Hotel

217TH ANNUAL ORATION

Orator: Michael F. Collins, MD, senior vice president for the Health Sciences, University of Massachusetts, chancellor and professor of quantitative health sciences and medicine, University of Massachusetts Medical School

February 15
Friday
7 p.m. Reception;
8 p.m. Program
Mechanics Hall

CHINA NATIONAL SYMPHONY ORCHESTRA

The China National Symphony Orchestra is one of the most outstanding professional orchestras in China. Previously known as the Central Philharmonic Society.

March 13
Wednesday
5:30 p.m.
Beechwood Hotel

7TH ANNUAL LOUIS A. COTTLE MEDICAL EDUCATION CONFERENCE

March 20
Wednesday
5:30 p.m.
Beechwood Hotel

WOMEN IN MEDICINE LEADERSHIP FORUM

April 10
Wednesday
5:30 p.m.
Beechwood Hotel

ANNUAL BUSINESS MEETING

Meeting includes presentation of the 2013 Community Clinician of the Year Award.

May 9 & 11
Thursday & Saturday
9 a.m.
MMS Headquarters, Waltham, and the Seaport Hotel & World Trade Center, Boston

2013 MMS ANNUAL MEETING AND MEETING OF HOUSE OF DELEGATES

All WDMS members are invited to attend guests and may submit resolutions to the Massachusetts Medical Society.

May
Date to be announced
University of Massachusetts Medical School

MEET THE AUTHOR SERIES

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

May 22
Wednesday
5:30 p.m.
Mechanics Hall

140TH YEAR ANNIVERSARY OF CLARA BARTON AND THE FOUNDING OF THE AMERICAN RED CROSS

Speakers: Paulette Seymour Route, PhD, RN, MS, dean, Graduate School of Nursing, and associate dean for Practice, University of Massachusetts Medical School; Emily F. Thomas, tour guide, Clara Barton Birthplace Museum, Oxford, MA, adjunct professor of history, Nichols College

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- One of the most recognized and trusted real estate firms in all of Worcester County.

- LOOKING TO SELL?
More exposure and more experience means more calls from more qualified and motivated buyers. We'll help get you the maximum amount for your home.

- PERSONALIZED HELP IN BUYING A PROPERTY
We understand the complicated and stressful buying process. We'll sit down with you and find out your needs and budget and make the process a more simple and fun experience.

- FINANCING AND INSURANCE
We have dozens of financing programs designed around your needs and our insurance ARM will get you a policy at a price you can afford.