WESTCHESTER PHYSICIAN

January 2019 **Volume 35, Issue 1**

PRESIDENT'S MESSAGE
THE BENEFITS OF THE INTANGIBLE

How do you quantify and measure the impact of an extra ten minutes spent talking with a patient and his family? A follow-up phone call to check in? Holding a patient's hand? Asking a patient how their grandchild is doing? Filling up some ice at the bedside so a patient does not need to wait for someone else to do so? Washing and combing a patient's hair in the operating room so it will look and feel nice when they wake up? Medicine is science, medicine is business, but most importantly, medicine is humanity. I would assume that most of us were drawn to medicine and pursued this career path, going through many long difficult years, in large part driven by the motivation to help people, sometimes when they are most in need and vulnerable.

If I think back to my late-teen self and why I wanted to "be a doctor" – it revolved around wanting to be able to "help people." I did not have an idea at that time what type of medicine I wanted to practice but simply to do good and help people. After years of training and practicing and the day-to-day grind and struggles, it's easy to become jaded. On many days, I certainly feel the weight of a patient being unstable, so many dictations to finish, so many calls to return, a forty minute conversation where I feel like I have said the same thing multiple times more than feeling the gift of doing good and well by people.

A recent pediatric study published by Patel, et al. followed over 1000 patients with serious illnesses and the results showed that children who had a wish granted by the Make-A-Wish foundation were less likely to visit an emergency room or have an unplanned hospital admission for the next two years when compared to those that did not have a wish granted. Other studies have similarly shown the role hope, optimism and positive emotions on health outcomes. It is hard to quantify how and what having the granted wish experiences did for these patients but the lifting of their spirits likely was at the crux. A patient's feelings have a real, and often undervalued, influence on their health outcomes.

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OMAR SYED, MD
President, WCMS

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UPCOMING EVENTS

WCMS/WAM Annual Meeting
Thursday, June 13, 2019
Westchester Country Club
Rye, NY

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FROM THE EDITOR…
PETER J. ACKER, MD
TRIP TO INDIA—PART 1

I have just returned from Southern India. I intended to write about it but am too jetlagged to meet the deadline. Instead is a previous column about my trip to Northern India and next month I will have my column on Southern India.

Peter

It came in the mail last September in a glossy envelope looking like a lot of the various things I get from pharmacological companies and various purveyors of CME programs from around the country. Usually I shift through it quickly with the paper recycling bin near by, but a picture of an Indian Temple caught my eye and I opened it. It was a very official looking invitation from a board member of the AAP (American Academy of Pediatrics) asking me to join a delegation of pediatricians to India. I didn't take it quite seriously, it just seemed too exotic and I almost wondered if it was some sort a scam. But a short google session put that fear to rest and I put the letter on my desk rather than consigning it to the trash.

To make a long story short, I decided that perhaps life for me had been a bit too tame recently (having sent the third of our three kids off to college) and perhaps an Asian adventure would be just the ticket to lift me out of my empty nest malaise. So with my wife's blessing, I boarded a non stop flight out of Newark over the pole to Delhi (15 hours!). I was met just out of customs by a young Indian man named Shiv who placed his hands together in front of his chest in greeting. He led me to where various other members of our group were waiting. In all it was ten pediatricians representing states from Texas to Michigan and North Carolina to Oregon.

The ten of us were thick as thieves for the next eight days as we traveled from Delhi, to Jaipur and to Agra. The trip was sponsored by an organization called People to People Ambassadors, started during the Eisenhower administration with the goal of promoting better international understanding by sending small groups of professionals abroad to various other countries to meet with colleagues. The cynic in me caused me to silently doubt the efficacy of such a seemingly Polly Anna like endeavor started during the cold war era, but I have to say as we toured hospitals and met with groups of health professionals in all three of three cities, I was impressed with how quickly the dialogue became stimulating, thoughtful and meaningful. A highlight was a visit to a school started by an NGO in the middle of a sprawling Delhi slum. The building was in a word, ramshackle, and the classrooms were crowded with kids. Rather than separate desks per student, there were long benches along a narrow long table, with the kids packed together, shoulder to shoulder, each with a reader and notebook in front of them. But, remarkably, they seemed incredibly focused on the teacher and their work and probably not a one of them on Ritalin!

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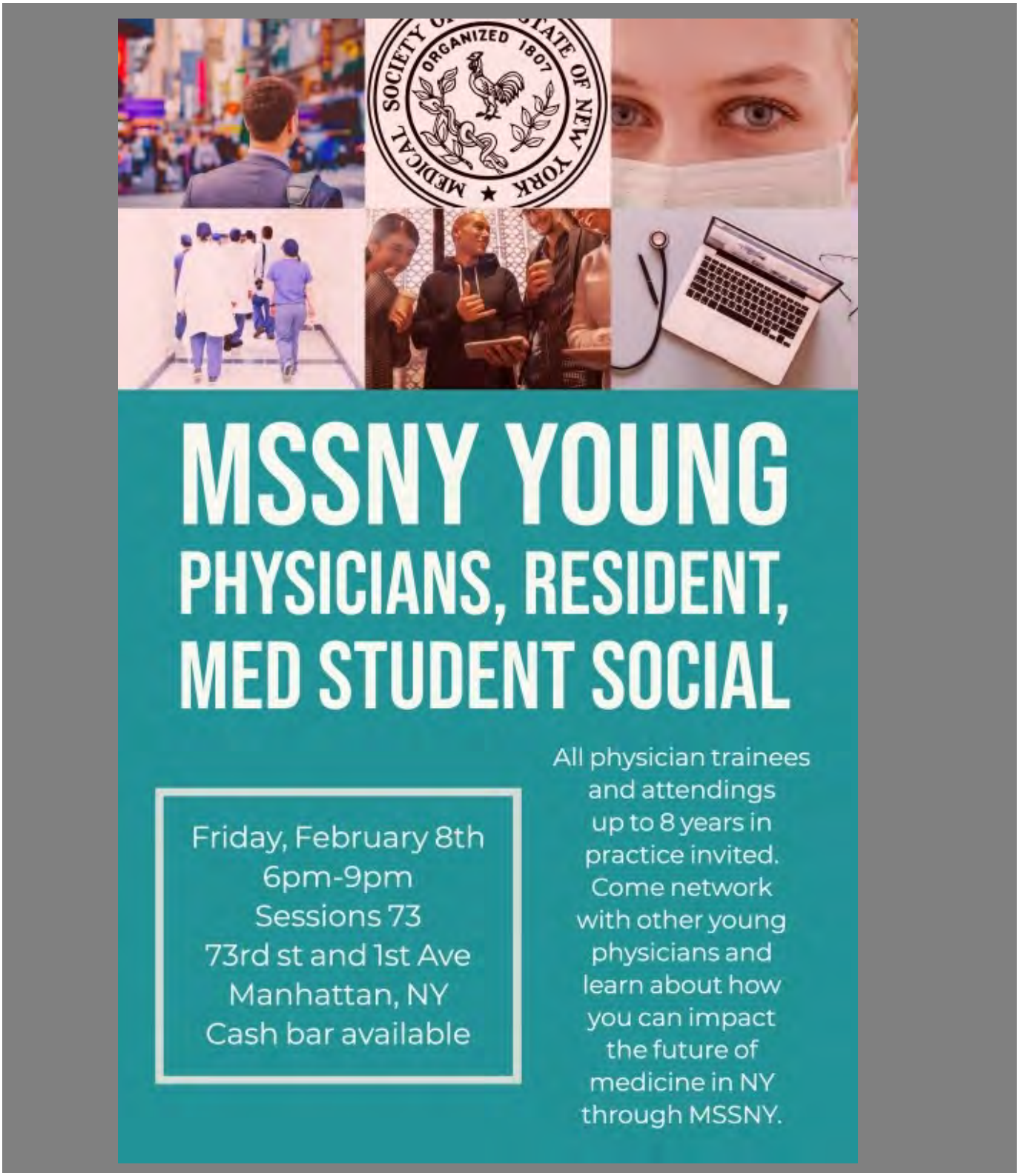
Medical Society of the State of New York
Young Physicians, Resident/Fellow, Medical Students Social

Come network with other young physicians and physician trainees and learn about how you can impact the future of medicine in NY through MSSNY. All physicians trainees and attendings up to 8 years in practice invited. MSSNY membership not required.

RSVP here



PRESIDENT'S MESSAGE
THE BENEFITS OF THE INTANGIBLE
(Continued from page 1)

We have very sophisticated ways to make a diagnosis as well as measure and quantify how our medical interventions may be working, from fetal blood sampling to awake craniotomy surgery. We do not have printed "lab" results of how our actions and interactions with patients and their families affect their outcomes and we don't need to. It's about humanity, kindness, and "Do unto others as you would have them do unto you." Most of our patients will not have a "wish granted" that may influence, in ways we may never fully understand, their clinical course. The take home, however, is the impact lifting the spirit can have in health outcomes. I think we all experience, in things big and small, if you feel good, you do 'good'. While we may be limited in what we can medically do for our patients at times, those limits do not apply when it comes to influencing and helping try to make a patient ***feel*** better.

Wishing you and your families a very happy and healthy 2019!

Impact of a Make-A-**Wish** experience on healthcare utilization.
Patel AD, Glynn P, Falke AM, Reynolds M, Hoyt R, Hoynes A, Moore-Clingenpeel M, Salvator A, Moreland JJ.
Pediatr Res. 2018 Oct 18. doi: 10.1038/s41390-018-0207-5.

♦

Save the Date

WCMS/WAM ANNUAL MEETING
THURSDAY, JUNE 13, 2019
Westchester Country Club
Rye, NY

We are now accepting nominations for the "Friend of Medicine" Award
Please contact Janine Miller—jmiller@wcms.org for more information.

STOP THE TRAIN

Elliot Barsh, MD

Happy New Year everyone!

How do you feel when you are waiting? Is it inconvenient? Is it annoying?

How do our patients feel when they have to wait to see us?

Do we ever look forward to waiting, and do our patients ever look forward to waiting to see us?

In Maria Popova's most recent *Brain Pickings* she takes a philosophical approach to waiting.

She introduces us to Jason Farman's book, ***Delayed Response: The Art of Waiting from the Ancient to the Instant World.***

In it, we are taught to see waiting as, "a gift that can free us from our fast-paced, restless lives."

Farman looks at the times we spend waiting as time we can, "think, create, and imagine."

He proposes that we "shift our focus from the negative feelings of waiting, such as boredom, helplessness, and anger, to a focus on

the positive object of what we are waiting for."

He proposes something brilliant when he suggests that... "***we view time not as individual but as collective, which is inherently an act of empathy, the willingness to accept***

another's time as just as valuable as our own, however different our circumstances may be."

If we can look at each other's waiting time with empathy, then the time we will spend together is off to a great start!

Thanks for reading.

♦

V.O.M.I.T. IN THE ER

Rada Jones, MD

This article was originally published January 29, 2019 on KevinMD.com

First came the SOAP notes. They've nothing to do with cleanliness, just the opposite. SOAP stands for: Subjective, Objective, Assessment and Plan.

S: "Patient states that pain is 16/10, sharp, unremitting. Feeling like a crocodile is eating insides every 10 minutes, after sprinkling them with Frank's hot sauce."

O: On entering the room, patient is eating Cheetos and drinking Mountain Dew while texting. Abdomen is soft and nontender.

A: Abdominal pain, probably gastritis.

P: Remove Cheetos, offer Maalox, follow up with PCP.

Tsheets came next. Things changed a bit. Instead of my deciding what to write, the form prompted me through questions. Some were relevant. Some were not.

"Tell me about your shortness of breath," I'd ask.

"I'm not short of breath. I'm here for a penile discharge, but I didn't want to tell them in triage."

Unrelenting progress brought us electronic health records (EHRs). Now my computer harasses me into documenting everything — relevant or not. That allows the hospital to charge for it. Money? Always relevant.

The EHR system rules my life, eats my lunch and inhabits my nightmares. It's a match made in hell. Like a nagging partner, it incessantly spits nasty little comments to stop me in my tracks.

"Temperature."

"103."

EHR turns pink, ignoring my efforts to save the chart.

I may notice it. I may not.

If I don't, I'm screwed. I get to start over.

If I do, I go back. I find the pink box.

103. C/F.

C is Celsius. I know Celsius. I love Celsius. I lived in Celsius. It's a wonderful system with crystal clear limits. Water freezes at zero. Water boils at 100.

Easy, no?

I don't know about you, but I have a short supply of boiled patients. Mine come raw.

At 103, they'd be seriously overcooked.

I know that. My nurses know that. My stethoscope knows that.

My computer doesn't. It forces me back through documenting senseless boxes.

Patients wait. Patients leave. Patients die.

Without me.

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WCMS Board Meeting Schedule

2018-2019

February 7

March 7

April 4

May 9

V.O.M.I.T. IN THE ER

Rada Jones, MD

This article was originally published January 29, 2019 on KevinMD.com

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I'm busy, spending quality time with EHR.

103. C/F.

F.

Moving on.

Next: Pain.

Continuous? Intermittent? Fluctuant? Radiating? Waxing? Waning? Occasional? Sharp? Dull? Achy? Burning? Crampy?

Like, really?

If they can speak, and if they have their hearing aids on, and if they are neither drunk, nor obtunded, or on the phone with somebody more important than me, our conversation goes something like this:

"When you got dizzy, how did that feel?"

Suspicion ensues. For full disclosure: I have an accent. I sound like Dracula. My friends call it a Beekmantown accent.

"Like, dizzy."

"Say I never heard the word 'dizzy' before. How would you explain it to me?"

They look at their spouse. They consider bolting.

"I was, like, dizzy."

"Dizzy like passing out, or dizzy like the room is spinning?"

"Dizzy like dizzy."

Take that, EHR. Pain, like, pain. It hurts.

Moving on. Physical exam.

"The abdomen is: Soft? Hard? Tympanitic? Obese? Scaphoid? Distended?

The discharge is: Clear? Serosanguinolent? Bloody? Purulent? Scant? Abundant?

I spend three-quarters of my shift on the computer. Another 10 percent communicating with the staff. Another 10 percent on the phone advertising my patients to consultants as if I'm trying to sell them a used car.

Everything else is direct patient care. How's your math?

To be fair, I do type like a Neanderthal—I hope that's not a racist comment, yet. My younger colleagues have nimble fingers. They dance on the keyboard like ballerinas performing "Swan Lake." Mine are like two old stiff drunks trying to waltz.

Time for orders. EHR is there, standing right between my patients and my care.

"Aspirin, 325," I order.

EHR turns deep pink and balks. "Allergy to aspirin."

I click on it. "Stomach upset."

I click the next button, looking for: "That's not a f-ing allergy." Not there.

I click "medically necessary."

Next: "Ciprofloxacin."

EHR gets really upset. "Not indicated in pregnancy."

Pregnancy?! She's 55! Really?

I log out. I go back to my patient.

"Any chance you may be pregnant?"

She looks at me like I've lost it.

"I'm 55. I had a hysterectomy 12 years ago."

I nod. I go back to EHR. I scan in my ID, then type in my username, my password, my PIN.

No good.

I start over.

I get it right this time. I login. I look for: "not pregnant."

Not there. I shrug and move on.

"Medically indicated."

Same with lactation. EHR must think that, humans, since they are mammals (unlike factory-built computers) once pregnant, stay pregnant. Indefinitely. Unless they start lactating. Then they lactate forever, like goats.

I disagree. EHR doesn't care.

"Medically indicated."

Done with the orders.

I finally get to medical decision making, the most important part of the chart.

The part that really matters.

That I can input as I choose.

I skip it.

I've been fighting EHR for an hour now for this one patient. Many others are waiting.

Here's to V.O.M.I.T.—Victims of Modern Information Technology in the ER.

Rada Jones is an emergency physician and can be reached at her self-titled site, RadaJonesMD, and on Twitter @jonesrada. She is the author of Overdose.

FROM THE EDITOR…

PETER J. ACKER, MD

TRIP TO INDIA—PART 1

(Continued from page 2)

India is a remarkable country with an amazing array of strengths and weaknesses. Take their demographics, for example. Their population is huge and unlike the US, it is concentrated in the younger ages. As one Indian told me, it is itself their greatest strength and weakness – social and infrastructure problems abound, but it also is a tremendous well of intellectual talent and energy which is being increasingly harnessed by their rapidly improving educational system.

TRIP TO INDIA—PART 2

In Part 1 of my column I wrote about my trip to India. I would now like to focus more specifically on what I learned about India's healthcare system. First off, a few introductory words about India: it is a huge sprawling country that encompasses a growing population which is expected to surpass that of China by 2030. It has an economy that is growing by leaps and bounds. Unlike China, it is a democracy. It is a country of enormous contrasts: opulence of an unbelievable degree exists literally next to slums of abject poverty. The challenges facing the country, I think it is fair to say, dwarfs anything we are facing in the USA – to wit: infrastructure underdevelopment, lack of sanitation, malnutrition just to name a few. Diseases such as tuberculosis, HIV, malaria and dengue exact a huge toll, especially upon the large rural population. In addition, ironically for a country that battles malnutrition, it is also facing a burgeoning epidemic of Type 2 diabetes, a consequence of a genetic predisposition combined with the increasing adoption of Western style eating habits.

The whole panorama of India's challenges is evident during even a very short trip through Delhi. Traffic is a constant snarl and the cacophony of horns is deafening as drivers attempt to wend their way through the chaos without colliding with one another. A ubiquitous sight is men urinating at the side of the road. Traveling from city to city takes easily twice as long as similar distance in the US. Instead of overpasses, there are speed bumps – so every ten miles or so everyone slows down to 3 mph. The roadsides are populated with camels, elephants, peacocks and even monkeys.

Our group had the opportunity to visit six hospitals, two of each in Delhi, Jaipur and Agra. India has a two tier system: private and public and we sampled one of each in the three cities. The private hospitals are generally run by large healthcare conglomerates that each own many hospitals. The facilities are top of the line: every possible technological advance is available and they have robust programs in transplantation, joint replacement and advance cancer treatment modalities. India, by virtue of their huge population, has a tremendous pool of human capital to draw on. In the last ten years or so, there have been advances in educational opportunities, particularly in high technology, and the sciences including medicine. Reversing a trend of many years, many Indian physicians have opted to complete their training in India and remain rather than pursue opportunities in the United States.

The public hospitals, on the other hand, are more utilitarian and simple in the services they provide. The hospital beds are crammed into large open rooms. A neonatal unit I visited was wall to wall preemies. Yet I detected a real spirit de corps and dedication among the physician and non physician staff. Also I got the impression that the Indian government is increasingly active in pursuing a broad preventative medicine strategy. One physician connected with the polio immunization program spoke with pride that so far in 2012, there had been no new cases of polio. The public hospitals are mandated to provide care for all comers, which is important since only about 5% of the population has health insurance. At the private hospitals, fee for service rules the day and therefore close to 80 % of the health care dollar goes there. Yet despite this, it is far cheaper than the United States both as a percentage of gross national product as well as in absolute dollars. For example, the total cost for a hip replacement is about a tenth of what it is in the United States. As a consequence, medical tourism has be come a huge industry.

All in all, it was a fascinating experience to view another health care system up close. I'm already thinking seriously about another trip, this time to Mumbai and Southern environs of India. We can all learn from each other.

Next month, when I'll be completely recovered from what has proven to be a crippling jet lag, I will discuss the Indian healthcare system and other lessons I gleaned from what was an awe inspiring trip.

♦

MSSNY'S ANNUAL

PHYSICIAN ADVOCACY DAY

WEDNESDAY, MARCH 6TH, 2019
LEWIS SWYER THEATER
"THE EGG," ALBANY'S EMPIRE PLAZA
8AM-12PM

CLICK HERE TO REGISTER

Join your colleagues from all around New York State to speak with your legislators and communicate the right health policy solutions for you and your patients!

A luncheon will follow the morning program. Legislators and their staff are invited to join their constituents.

PRIORITY ISSUES:

- **Shape the discussion surrounding Single Payor Healthcare**
- **Discuss health concerns associated with legalizing recreational marijuana**
- **Prevent inappropriate scope of practice expansions**
- **Reducing prior authorization hassles**
- **Rejecting burdensome mandates**
- **Preserving opportunities for NY's medical students and residents**

For More Information Contact:
CARRIE HARRING
CHARRING@MSSNY.ORG

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The Medical Society of the State of New York designates this live activity for a maximum of 3.0 AMA PRA Category 1 Credits™ Physicians should claim only the credits commensurate with the extent of their participation in the activity.

THE MEDICAL SOCIETY OF THE STATE OF NEW YORK
WWW.MSSNY.ORG

Make the most of your membership

Join your colleagues from all around New York State and come to MSSNY's Physician Advocacy Day to speak with your legislators and key policymakers to ensure they're making the right choices for New York's physicians and their patients.

Join us to urge your legislators to:

- Proceed very cautiously on paradigm shifting proposals such as legalization of recreational marijuana (proposed in the State Budget) and creating a single payor health insurance structure.
- Reject proposed unfair cuts to physicians treating patients covered by both Medicare and Medicaid;
- Reject proposals that would add prior authorization burdens for care provided to Medicaid patients;
- Support legislation to reduce excessive health insurer prior authorization hassles that delay patient care.
- Reduce the high cost of medical liability insurance through comprehensive reforms.
- Preserve opportunities for medical students and residents to become New York's future health care leaders.

A brief informal luncheon to which members of each House are invited to speak with their constituents will follow the morning program. County Medical Societies will be scheduling afternoon appointments for physicians to meet with their elected representatives.

If you have any questions/comments, please contact Carrie Harring at charring@mssny.org. **(HARRING)**

2019 MSSNY Young Physicians Section Annual Meeting and Educational Symposium
REGISTER HERE

Presentations from national leaders in **medical toxicology** and **social media in medicine**. CME* credits provided. Webex available. We look forward to seeing you!