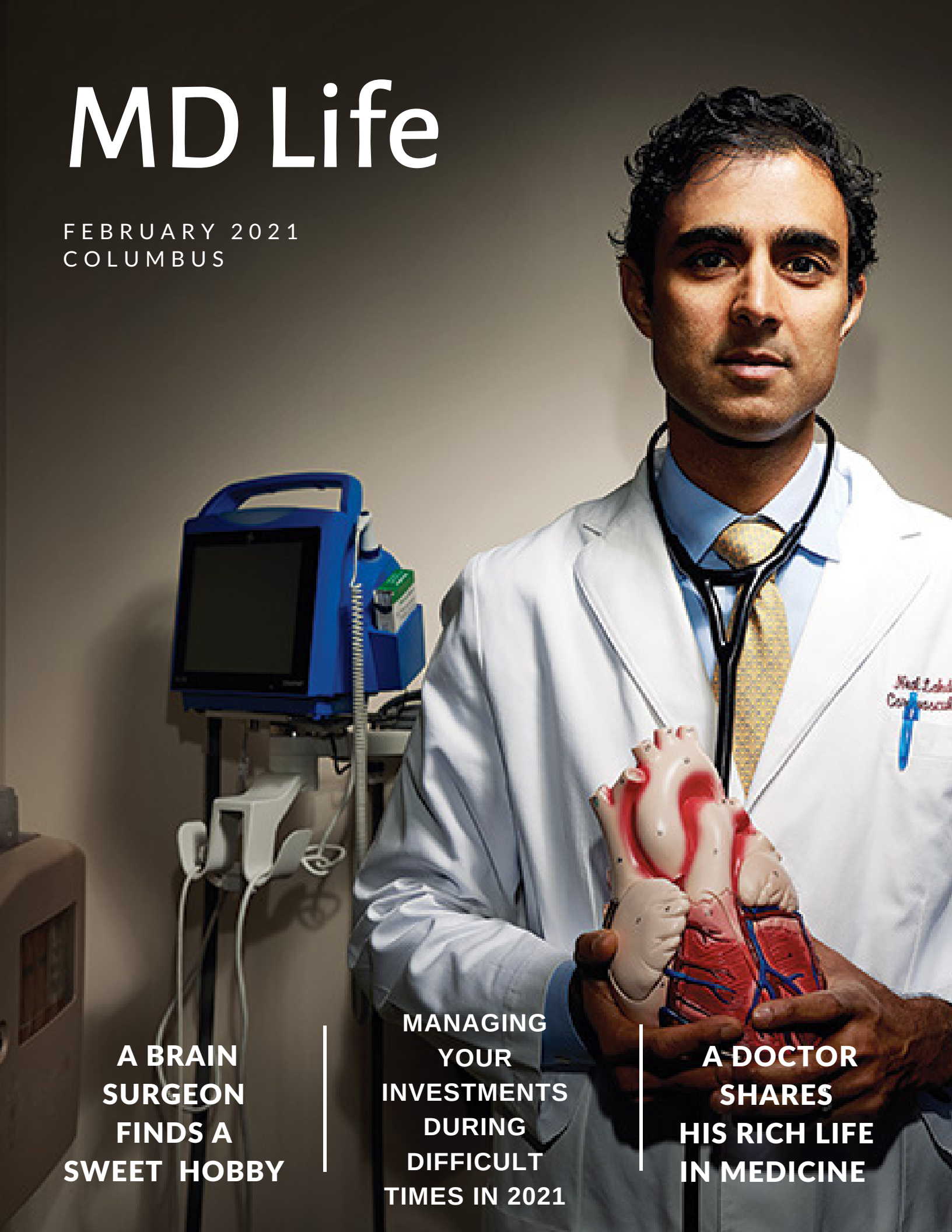
MD Life

FEBRUARY 2021
COLUMBUS



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Contents in This Issue

EXPERT on CALL
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Physician Burnout: *Relieving Some of the Stresses of Our Job with RPM*

By Frank Astor, MD, MBA, FACS
Chief Medical Officer, WITHmyDOC

As physicians, most of us can relate on some level to provider burnout. Long hours often due to inefficiencies in the work environment, electronic health record (EHR) stress, complicated patients, poor work-home balance and more…we've all probably experienced some it and all of it can lead to burnout. Add to that a high volume of patient visits on a daily basis and not enough time to spend with each patient, as well as a high percentage of either cancelled appointments or patient no shows.

We have to factor in the pandemic as well. With the advent of COVID-19 last year, burnout accelerated significantly. According to Physicians Foundation research in September 2020, 58% of physicians said they often have feelings of burnout, compared to 40% in 2018.

Burnout is more than routine stress. It is a legitimate medical diagnosis according to World Health Organization (WHO)'s ICD-11 adopted in May 2019. WHO defines burnout as a medical syndrome "resulting from chronic workplace stress that has not been successfully managed."

Healthcare providers are experiencing new stressors as a result of the pandemic.

The list includes fear of contracting COVID-19 and taking it home to their family, social isolation, salary reduction due to decreased hours or furloughs, the emotional impact of taking care of COVID patients, lack of hospital bed and resource capacity, and more.

A Cleveland Clinic Journal of Medicine article points out that the pandemic is accelerating the many negative repercussions of uncertainty and inadequate support, and the consequences are being felt by patients, physicians and healthcare systems. Studies have shown that burnout is associated with negative clinical outcomes; decreased quality of patient care; increased number of medical errors; and higher rates of addiction, depression and suicide among physicians.

The COVID-19 pandemic has presented unprecented challenges for healthcare workers, highlighting critical vulnerabilities in the ability to manage the mental health consequences. This could have long-term ramifications for those affected.

Increased errors can be a sign of burnout. U.S. clinicians spend 50% more time in the EHR than those in other countries. A 2019 JAMA study found that clinicians spend 90.2 minutes a day using the EHR, including 26.5 minutes per day after hours.

Among the tangible solutions that have been enlisted in the past several months to deal with increased provider burnout are providing mental health support and reducing administrative burden including prior authorizations, disability paperwork and EHR inefficiencies. Some hospitals have hired chief wellness officers.

Many of the inefficiencies in the workplace can be mitigated through remote patient monitoring (RPM) as a tool. Providers can increase their care footprint through the use of RPM, relieving some of their time stress and yielding more job satisfaction.

WITHmyDOC's RPM@Home kit offers many advantages using the latest breakthrough in medical technology to monitor chronically ill patients that typically require more attention. Proactively reducing ER visits and readmissions minimizes emergent situations which could help to alleviate provider burnout. Our platform allows providers to receive real-time patient information on at-a-glance patient cards to quickly and efficiently review a large number of monitored patients. It has a notes functionality so providers can input notes from patient communications and track the amount of time spent on a monthly basis with each patient in order to facilitate billing. Its reporting functionality supports summarized billing reports that can be submitted for reimbursement. RPM@Home also has one-click telehealth capability while simultaneously viewing a patient's historical record.

My Job Does Not Define Me…Anymore

By Dr. Christy Pearce MD

We have all answered the question "What do you do?" with "I'm a physician." There is nothing wrong with that response. But why do we change it from *what* we do to *who* we are? Everyone does it, not just physicians. Equating our profession with our identity over and over changes how we view ourselves. If we are defined by our work as a physician, then our self worth is held captive in the performance of that work, or patient satisfaction surveys, or how efficient or inefficient our charting is, etc.

While I am deeply proud of my education, training, and skills as a physician, this is not who I am. So I thought I would write a post inspired by who I am – outside of medicine. My original vision for this was to have a post filled with pictures describing who else I am.

But I am not those things either.
Posting pictures of all the other things I love to do with my time serves the purpose of showing that there is so much more life to be lived than our work. It was for me a way to push back at all I felt I let medicine take from me. And show myself and you guys that you can get it back. Life as a whole person with interests and passions outside of medicine.But it can also just make some folks that read it feel like crap. For not doing more in life than they currently are, for not being enough.

Then I got all deep and thoughtful. Warning, deep thoughts ahead. (Anyone remember that SNL skit? Deep thoughts by Jack Handey. He's actually a real guy!) Sorry – squirrel – moving on.

I realized my problem in composing this post was a microcosm of a larger, dare I say existential, life struggle we all have. My value, my worth is not even the sum of all I do, or want to do, and certainly not how I compare to others out there.
Brene Brown alludes to it in her books, particularly *The Gifts of Imperfection: "*Some of us spend most of our lives trying to outrun vulnerability and uncertainty. We weren't raised with the skills and emotional practice to 'lean into vulnerability.' Do our numbing activities get in the way of our authenticity? Do they stop us from being emotionally honest and feeling like we are enough? (Perfectionism, work, planning, saving the world)."

For many medical professionals the "saving the world" activity rings true. For this post, the "numbing activity" of having lots of other (non-medical) activities may be a way I am trying to prove myself, trying to be good enough, worthy, rather than just loving myself as is and presenting my authentic self for others to see, accept, love. I don't want to do the former. I want to do the latter. For myself but also so as not to mislead anyone reading this. I count just for being me. So do you. And because we count, we can go and do so many many amazing things not to make ourselves worthy but to fully live life.

(and now I'm thinking of another SNL skit – Daily Affirmation with Stuart Smalley. That guy was played by Al Franken, who is now a US senator!) Side tracked again – super squirrel! Back to my deep thoughts.

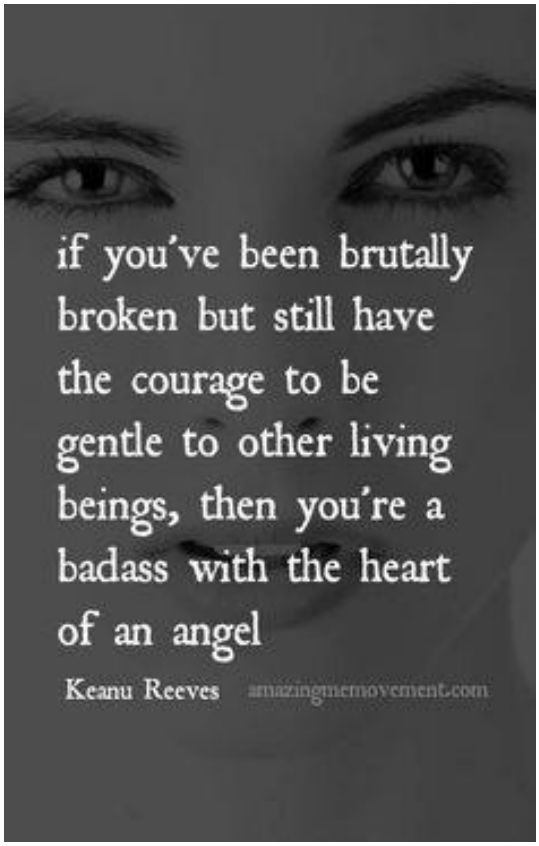
In my original listing of all the things that make me who I am (which we have just discussed – see above – that those activities and roles don't actually define me either) I knew I would need to list my spirituality. Because who I am lies there. But as deeply meaningful and satisfying as it is for me to know that I am a child of God and that this faith is all I truly need, I debated even placing that aspect of my life in this post. Because I didn't want to alienate anyone, and I acknowledge that this is not everyone's belief, I wanted to stay "spiritually neutral." But that didn't quite feel authentic either. And then pg 73 of Brene Brown's *The Gifts of Imperfection* validated what I was struggling to articulate: "The most difficult thing about what I'm proposing in this chapter is captured by a question that I get a lot (especially by my colleagues in the academic world): Is spirituality a necessary component for resilience? The answer is *yes.* Feelings of hopelessness, fear, blame, pain, discomfort, vulnerability and disconnection sabotage resilience. The only experience that seems broad and fierce enough to combat a list like this is the belief that were all in this together and that something greater than us has the capacity to bring love and compassion into our lives."

So below is my list of activities and roles in my life as it currently stands, with medicine being but a part of it. It is not a list that makes me enough or accepted. It does not define me. I will not use it or my busyness with life to run away from vulnerability and the authenticity of being enough just as I am. But I will use it to celebrate life and remind me of the goodness outside of medicine there is to experience. May the perspective that being in medicine has given us help us to experience this world more fully and deeply.

Child of God :: Daughter, Granddaughter, Sister, Wife, Mother :: Friend :: Ballet Dancer :: SUP Paddleboarder :: Sorta Mountain Biker :: Skier, 3 year old ski instructor :: (Likely ADHD) I mentioned to a Nurse once that I was probably ADD, but didn't have the hyperactivity component. She gave me an incredulous stare. Fine then (not confirmed by pyschiatrist but self diagnosed with the aid of my co-workers) ADHD :: Hiker :: Nature lover :: Beach and water lover :: Physician :: Blogger and Physician advocate :: Book lover :: Snuggler :: Dance Mom :: Soccer Mom :: Gym Mom :: Educator :: Not really a cook, but can make a mean cheese platter :: Cake (real and diaper) decorator :: Board breaker :: Leader

To Quote Howard Thurman (a quote I read in *The Gifts of Imperfection*) "Ask what makes you come alive and go do it. Because what the world needs is people who have come alive."

Christy Pearce is a board-certified maternal fetal medicine physician.



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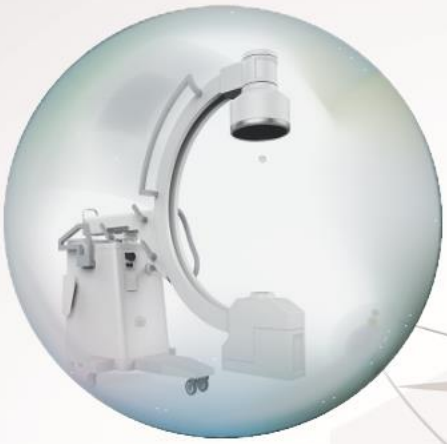

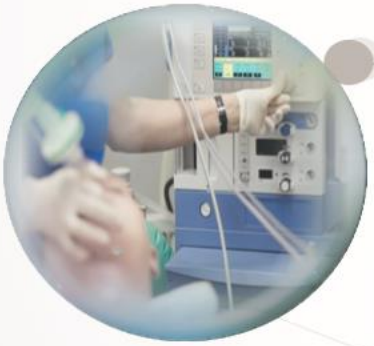

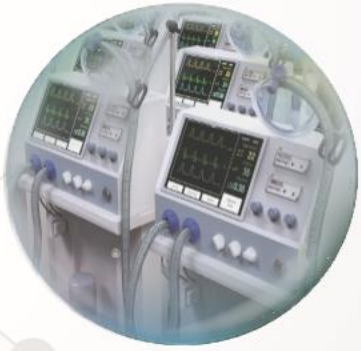

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Is Now a Good Time to Invest in Rental Property?

By Ari Rastegar, rastagarproprty.com/blog

Between civil unrest, unemployment, heightened financial tensions with other countries… I feel like I'm missing something… oh yes, a global pandemic, it's hard to resist the urge to squirrel away every dollar in a mattress. But for those who resist, the rewards may far outweigh the risk.

As Warren Buffet's longtime investing partner, Charlie Munger, puts it, "A lot of people with high IQs are terrible investors because they've got terrible temperaments. You need to keep raw, irrational emotion under control."

You'll have no trouble finding opinions on how to manage your funds during an economic downturn, but here are a few reasons why investing in rental property continues to present itself as a noteworthy option.

Economic Uncertainty Due to COVID-19

A lot of people have made a tremendous amount of money in the stock market. Besides the odd scatter point, most of those people are excruciatingly patient. They are also very well funded, which means they have the luxury of weathering any storm. They can push all their chips into the pot when things look bad, knowing if they wait long enough, and if they have enough money spread out across different areas, eventually it will shake out in their favor.

Not many Average Joes enjoy that luxury.

There's a good chance your 401K, IRA, or any individual stocks you're into at the moment are a source of frequent heartburn as you watch them dip into the red, then jump back to green with startling speed. Even when things are good they are apparently still not good, according to the Jim Cramers of the world.

Rental property, by comparison, could always be considered valuable as long as a human being requires a place to lay their head at night. There are no dividends to concern yourself with. And over time, investing in rental property tends to yield better returns than stocks.

Unemployment May Drive the Demand for Multi-Family Housing

Although the American Dream is still alive and well, the state of the economy makes it awfully difficult to achieve. Unemployment and reduced income for thousands upon thousands of people means less money in the bank to cover mortgages. That also means the hunt will soon be on for more inexpensive living options.

Investing in rental property now could not only put you in a position to capitalize on your investment strategy, but also provide low-cost housing for people desperately in need.

Resist the Urge to Time the Market

We've already determined it takes lots of time and lots of money to come out ahead of the stock market. If "buy low and sell high" was all there is to it, we'd all be filthy rich. If you think the real estate market is any easier, ask the many young families who "sold high," then moved into their mom and dad's basement until they could "buy low."

For example, it certainly seems like the middle of a global pandemic might be a good time to buy, doesn't it? There's got to be some deals out there. In reality, home prices are up 45% since 2012... with no down years.

"OK. I get it," I can hear you say. "Jump in as soon as you can."

Further down in the same New York Times article, you'll find a warning that harkens back to a 75% rise from 1997 to 2005 – an era in which, "delusions of eternal price increases for houses" sprouted. After 7 years and a 36% dip in home prices, some Americans are just now starting to get back the value they lost if they held on.

"OK. So... wait?"

Maybe. It depends on your long-term and/or short-term goals and the amount of capital you have ready to invest. The ball is in your court, but one thing is clear, those who attempt to time the real estate market end up reducing their overall return when compared to those who invest without regard for economic cycles.

The "Value" of a Home

You'd have been hard-pressed to find anyone who could have predicted the situation our nation would be in just 6 months ago, but one thing is certain–home is now a lot more than that place you go after work. More than likely, it is now *where* you work. When government officials gave the word, it was the only place you could go and it's the only respite you have when civil unrest and a rapidly spreading virus waits just outside your door.

Investing in rental property is much more than a chance to expand a portfolio. It's a chance to provide affordable safety and security for people whose lives have changed forever.

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How Do They Hack Hospitals? – Cyberthreats in the Digital Health Era

Bertalan Meskó, MD, medicalfuturist.com

While we were battling the COVID-19 virus in 2020, other infections were also happening, albeit in other, digital systems. We are, of course, talking about cyberattacks. These involve digital viruses infecting IT systems and disrupting potentially life-saving processes until after paying a ransom. No honor among thieves, goes the saying; not even during a pandemic.

Indeed, as global technology company Acronis noted, there was a rise in ransomware cases at the start of the COVID-19 outbreak. A ransomware attack in mid-2020 on Blackbaud, cloud computing vendor, compromised sensitive data of over 10 million patients, including health details and social security numbers. In late 2020, several healthcare institutions in the U.S. faced a wave of such attacks; a wave which *Wired* termed as "*unprecedented.*"

"*The ransomware problem is bad, it was bad years ago, it was worse months ago, then untenable a few weeks ago, and unfortunately it just got worse over the last few days,*" said Charles Carmakal, senior vice president and chief technical officer of the cybersecurity firm Mandiant, following the wave of attacks. "*We have to create awareness of this problem*."

As a matter of fact, we must. Discussion about cyberthreats is and will increasingly be crucial in the medical field so as to better address and prevent them. This issue is particularly concerning as the world is increasingly turning to digital solutions to access healthcare while we must limit physical visits.

However, these discussions should not revolve only around strengthening the IT infrastructure with anti-malwares. This won't cut it as, in addition to the technological component, there's very much a social component in hacking into healthcare facilities. Let's decrypt how this is the case; and consider additional measures that all of us can take to further secure our healthcare institutions and their precious data.

The larger trend in ransomware in healthcare

When talking about cyberthreats in healthcare, the most common ones are ransomwares. These involve infections happening not through pathogens but rather by hackers. The latter infect IT systems with malwares or digital viruses to encrypt crucial files. These paralyze whole infrastructures as that information is inaccessible until after paying the required demands, usually through cryptocurrency.

While we started this article with examples from 2020, such cyberthreats were commonplace well before the pandemic. One of the high-profile ones happened back in 2017 with the WannaCry attacks on 61 NHS institutions. It led to the cancellation of operations and clinical appointments, loss of internet connection in hospitals and diverted patients from emergency departments even one week after the incident. But the trend persisted in the following years.

Towards the end of 2020, in November and December, there was a 45% increase in cyberattacks on healthcare organizations globally, reports HIPAA Journal. This was more than twice the percentage rise in cybercrime across all industry sectors globally during the same period. To put it in context, there were 430 attacks in October 2020 globally on healthcare organizations; but November and December saw an average of 626 cyberattacks weekly.

Some of these cyberhreats from 2020 could have long-term consequences. One example is that of the ransomware attack on Rangely District Hospital, a nonprofit critical access hospital. It left 5 years of patient records inaccessible.

And it's not just cases that have been on the rise but the demands as well. Antivirus firm Emsisoft found that average ransomware demands increased from about $5,000 in 2018 to about $200,000 in 2020; with demands for multimillion-dollar ransoms becoming more and more common. As these concerning trends amplify, the managements of healthcare institutions should better equip themselves to avert cybercrime. And for that, we have to understand that it does not only rely on the technological aspect but also on the social one.

Social hacking as the access key

Now, when thinking about a cyber attack, the image that might come to mind might be about tech-savvy hackers as depicted in *Mr. Robot* or *The Matrix*. However, this notion popularized in pop culture is not the whole part of the equation. In fact, there is very much a "social hacking" component in cyberattacks.

Rather than exploiting technical vulnerabilities, social hacking or social engineering involves exploiting those vulnerabilities in human psychology to circumvent security technology. Famous hacker Kevin Mitnick terms humans as "*the weakest link in any security system*."

Mitnick popularized the term 'social engineering' in the '90s; and his scams exemplify how breaching into tech systems is possible with this method. One example is when he accessed the OS development servers of Digital Equipment Corporation in 1979. He did so by posing as one of the lead developers over a phone call. Claiming that he couldn't log in, he was immediately given new credentials to do just that.

Not much has changed since then as a similar method was used to control a U.S. Department of Justice (DoJ) email address in 2016. A hacker, postulating as a new employee, gently persuaded a help desk colleague to provide an access token for the DoJ intranet.

As such, when considering methods to curb cyberthreats, it's also paramount to educate personnel about ways they can be duped. In the next section, we'll take a look at the measures that can be taken in this regard.

Adequate protection lies in humans, not just technology

Sure, securing computerized systems in healthcare organizations will require investing in proper technological tools. We previously talked to Istvan Lam, Founder and CEO of Hungarian data privacy company Tresorit, who emphasized this. "*Two things are key in prevention*," Lam explained. "*First, healthcare institutions and organizations should use anti-virus software with anti-ransomware protection to protect themselves. Second, it is crucial for everyone to update operating systems and software applications.*"

Tens of billions are already spent annually on cybersecurity globally on such tools. But spending a fraction of these on educating employees about social hacking should also be an imperative. Indeed, even CEOs aren't impervious to such cyberthreats as security company Rapid7 showed. In a simulated phishing attack by the company, 45 CEOs, or 75% of the total group in attendance, fell for at least one phishing campaign.

Thankfully, there are some ways to counter social hacking and here are a few examples:

1. Increase exposure to cyberthreats
One way to increase awareness of cybersecurity is to increase exposure to those threats via frequent simulations. During its cybersecurity events, Rapid7 noticed that people exposed to a suspicious activity had a strong instinct to report subsequent ones they came across.

2. Familiarize staff with each other
Other experts recommend including everyone from top management to new recruits in training and awareness sessions about cyberthreats. That's because it's often newcomers to an organization that get tricked into thinking they are conversing with an executive about an urgent issue that requires bypassing normal protocols.

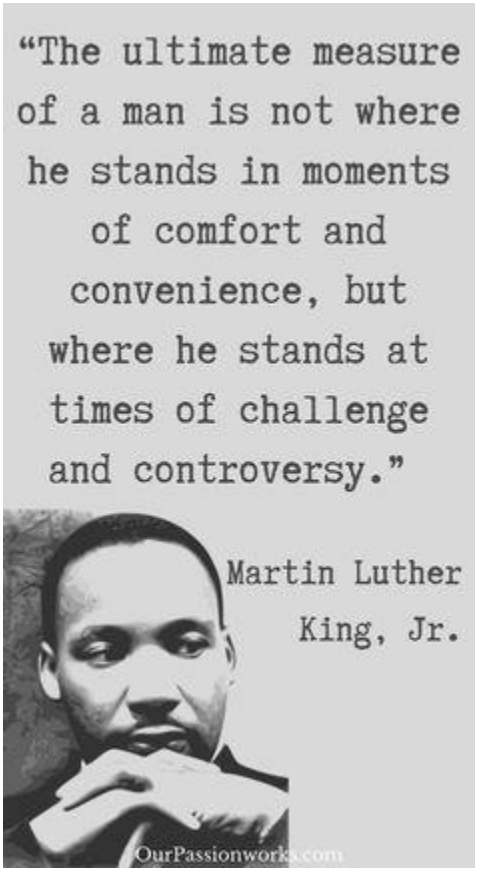
3. Raise red flags about suspicious activity
Another easy method to counter cyber attackers hacking into the social component is to train employees to identify and report red flags. Some methods used by attackers such as an email from a CEO's personal email address should immediately be flagged.

Cautious cybersecurity measures
Cybersecurity firms will of course tell you the worst horror stories in the industry to sell their products. One of the most tragic ones was about a reported case of a ransomware attack in September 2020 on the Duesseldorf University Hospital in Germany. Due to the attack, a woman was redirected to another healthcare facility around 20 miles away. But the ensuing delay in life-saving treatment led to her demise.
This was widely reported as the first reported death caused directly by a cyberattack. The story could serve as an incentive to invest heavily in pricey cybersecurity tools.

However, a few months later, an investigation found that she had died due to her poor health, which had been "*entirely independent from the cyberattack.*" As such, we have to take these threats and attacks with a pinch of salt.

Nevertheless, German law enforcement and many cybersecurity experts believe that it's only a matter of time before a cyberattack causes such an actual demise of a patient. "*There is a moral line that every person, just as a human being, recognizes exists—when you do something knowing that you are potentially impacting somebody's life you've crossed the line,*" Mandiant's Charles Carmakal said. "*So there's a very clear crossing of the line by this threat actor. This group is incredibly brazen, heartless, relentless*."

As such, cyberthreats in healthcare cannot be overlooked. And to protect our medical facilities and patients, both the social and technological components of this issue must be adequately reinforced. The average patient should demand more security over their data, and the medical staff and management should take these demands seriously and familiarize themselves with cybercrime methods in order to better counter them.



CURRIED CHICKEN SALAD RECIPE

Dr. Sonali Ruder, TheFoodiePhysician.com

My *Curried Chicken Salad* is the perfect light dish. It has a mixture of savory and sweet flavors and plenty of ingredients to add color and crunch. It's delicious on a sandwich or as a salad topper piled on a bed of crisp, spring greens.

The main ingredient that forms the base of the sauce for my *Curried Chicken Salad* is Greek yogurt. I like to use 2% plain Greek yogurt. Greek yogurt is one of my favorite ingredients to use in the kitchen, whether it's breakfast, lunch, dinner or dessert. Its distinctive rich taste and creamy texture make it amenable to a wide range of culinary applications. Made with only milk and live active cultures, this all-natural Greek yogurt is rich in protein and is also an excellent source of calcium.

My *Curried Chicken Salad* is a great way to use up leftover chicken that you have in your fridge or you can use rotisserie chicken from the grocery store. The tangy yogurt works really well with the savory curry powder in this dish. And to balance out the spices and add a touch of sweetness, I also stir a little mango chutney into the sauce. To add texture and color to the salad, I mix in a bunch of nutritious ingredients including red grapes, celery, scallions, and almonds. Feel free to mix it up and add your own favorite ingredients. Chopped apple, dried cranberries or raisins would work well. And instead of almonds, you could try cashews, pecans or walnuts.

Servings: 4
Calories: 332

Ingredients

½ cup 2% Plain Greek Yogurt
2 Tablespoons mayonnaise
1 teaspoon curry powder
1 ½ tablespoons mango chutney
2 teaspoons fresh lemon juice
Kosher salt and black pepper
3 cups cooked, shredded or diced chicken breast (can use rotisserie chicken)
¾ cup halved red grapes
1/3 cup chopped scallions
¼ cup sliced almonds
¼ cup chopped celery
1 head butter lettuce

Instructions

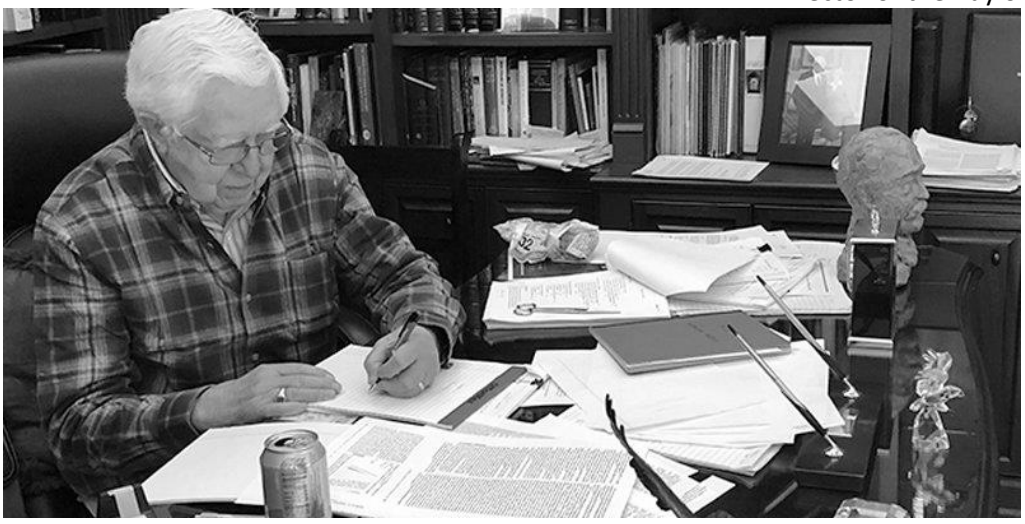
Mix the yogurt, mayonnaise, curry powder, chutney, and lemon juice together in a large bowl. Season the mixture with a pinch of salt and black pepper. Stir in the chicken, grapes, scallions, almonds and celery. Serve on a bed of lettuce or use to make sandwiches.

About Dr. Sonali Ruder

My name is Sonali- I'm a board-certified Emergency Medicine physician, trained chef, mom, recipe developer, and cookbook author. I want to help give you the tools to take control of your health, starting in the kitchen. Healthy food can and should be delicious!

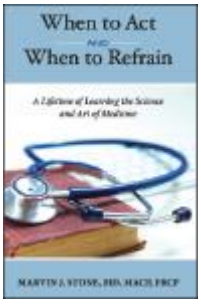
A Doctor Shares His Rich Life in Medicine and Cancer Research

By Ronald Piana



"The best doctor, like the successful general, is the one who makes the fewest mistakes." —William Osler, MD

"What am I doing here? This question kept running through my mind as the incoming freshman medical students at the University of Chicago assembled for the first time." The person asking the introspective question was Marvin Stone, fresh out of college, recently married to his wife, Jill, and now a nervous 21-year-old student at a renowned medical school in the nation's third largest city. Dr. Stone recalled the culture shock he and his young bride encountered.



Title:When to Act and When to Refrain: A Lifetime of Learning the Science and Art of Medicine
Authors: Marvin J. Stone, MD, MACP, FRCP
Publisher: Marvin Stone, MD
Publication Date: October 2018
Price: $32.95, hardcover, 284 pages

"Jill and I lived in a third-floor walkup apartment over a grocery store…. It was like a war zone. Many of my classmates were robbed at some time during medical school…. The unrest that occurred in many American cities in the 1960s was already prevalent on Chicago's South Side in the 1950s."

This kid from Bexley, a suburb of Columbus, Ohio, was justifiably overwhelmed. But, as they say, the rest is history, and it is told in clear, understated prose in When to Act and When to Refrain: A Lifetime of Learning the Science and Art of Medicine, a memoir by Marvin J. Stone, MD, MACP, FRCP, a venerable man of science and medicine. His story stretches over a 60-year career, much of it spent as a cancer researcher and Director of the Baylor Sammons Cancer Center, Dallas.

Mentors and Eye-Opening Discrimination

When to Act and When to Refrain is organized in four parts: Mentors and Training, Patients, Colleagues, and Summing Up. The narrative is spiced up with figures, pictures, and appendices, which include several tributes and extensive interviews with Dr. Stone. They drill deeper into the personal perspectives he shared in the body of the book.

In the opening section, Dr. Stone introduces several of his fondest mentors, each of whom helped shape different facets of his career path and general philosophy. "The profession of medicine involves caring, knowledge, skill, accountability, empathy, and lifelong learning," writes Dr. Stone. His passion for knowledge and learning was first nurtured by his close-knit family, which was led by his father, an attorney with a voracious appetite for scholarly reading. The dinner table was not only a gathering place to break bread, but a forum for shared ideas about current events and their effects on society.

"No other profession is like medicine…. What will not be altered by technology is the need for physicians to relieve suffering and embrace healing."

— Marvin J. Stone, MD, MACP, FRCP

The most poignant memory in the opening speaks volumes to the current zeitgeist that has taken hold of the nation. Dr. Stone had become intensely interested in pathology early in his studies at the University of Chicago Medical School. While working on a tumor immunology project, he met Lloyd N. Ferguson, a Black medical student 2 years ahead of Dr. Stone. He was "bright, stimulating to talk to, and fun to be around—I looked up to Lloyd and learned a lot from him," the author comments.

The two young medical students arranged to attend a course in the fundamentals of cancer at MD Anderson. It was the first trip to Texas for both men. Dr. Stone recalled: “Lloyd asked if I’d mind sharing a room, and I said, ‘Of course.’ We made reservations at the Shamrock Hotel, a first-class hotel near the medical center. As we stood on line to register for our room, the hotel manager asked us to step inside his office, where he told us, ‘Local custom does not permit us to take care of Dr. Ferguson, but we’d be glad to take care of you, Dr. Stone.’” The two friends shouldered the embarrassment and anger and spent the night together in a rooming house in the Black section of town. “That experience opened my eyes to the anger and pain Black Americans felt and the impact of blatant discrimination,” writes Dr. Stone.

Antiwar Protests and Medical Advances

Dr. Stone’s coming of age as a researcher at the National Institutes of Health was made memorable by his world-class mentors, such as pioneering immunologist Henry Metzger, MD, who not only mentored Dr. Stone in his laboratory, but also in antiwar protests. It was the height of the Vietnam War. Dr. Metzger was active in the Medical Committee for Human Rights (MCHR) and introduced Dr. Stone into the organization.

“Many of us in the MCHR provided medical support for the ‘March on the Pentagon,’ in October 1967. I participated in the event, mixing in with the crowd for about 6 hours…. It was very moving, especially to see veterans of Vietnam, some in wheelchairs, who were demonstrating against the war,” writes Dr. Stone. During this section, readers, especially those old enough to have been through those incredibly turbulent times, will marvel at how Dr. Stone faced the rigors of a burgeoning career and made his own contributions to social justice, along with being a young husband and father.

Dr. Stone does a good job of integrating his stories about treating patients with cancer and interweaving the medical advances that coincided with their treatment. Dr. Stone displays his prowess as a medical historian in this section, and, once again, readers will meet well-known oncology luminaries such as Drs. James and- -Jimmie Holland.

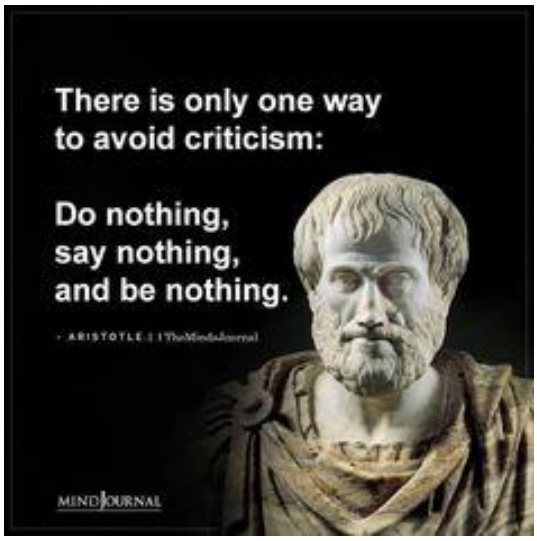
In addition, there is an especially lively and informative chapter on Judah Folkman, MD, who also graduated from Bexley, Dr. Stone’s high school alma mater. “Judah was 5 years ahead of me. His father was our rabbi…. I followed Judah’s career through the years,” notes Dr. Stone.

A Close Call and a Glimpse Into the Future

In Chapter 19, aptly titled “Derailment,” Dr. Stone offers a vivid description of his diagnosis of a serious heart condition that required surgery. However, persistent remnants of the condition forced him to give up his clinical practice, a devastating blow. “I knew it was the right thing to do, but, as anticipated, I missed my patients immensely.”

The last chapter is called “The Future of Medicine.” Here, Dr. Stone makes some bold predictions, among them: “Hospitals will decrease in number; many of those that remain will become giant intensive care units. Rehabilitation and assisted living units will proliferate. Telemedicine and virtual doctors’ visits will increase and expedite patient care. Whether quality of care will improve as a result remains to be seen. Concierge medicine will increase for those who can afford it.”

However, as medical technology races forward at dizzying speed, helping and sometimes displacing humans, Dr. Stone ended his fine memoir with a confident nod to the profession he cherished: “No other profession is like medicine…. What will not be altered by technology is the need for physicians to relieve suffering and embrace healing.”



How To Choose the Best Wine Glasses For You

By Madeline Puckette, winefolly.com

Certain wine glasses perform better than others (there's actually some science to back this up). That being said, what are the best wine glasses for you?

You can drink wine from whatever vessel you want, be it a wine glass, coffee mug, mason jar, or dixie cup. Heck, you can ditch the glass altogether and drink straight from the bottle for all I care.

However, using the right glass improves the taste of wine. And they won't cost you a fortune either.

The Importance of a Proper Glass

There are many different wine glasses to choose, but the fundamental shape is the same…
There is now there is a piece of scientific evidence that supports the importance of glass shape.

In 2015, a Japanese medical group used a special camera to record images of ethanol vapors in different glasses. In their study, the research group showed how different glass shapes affected the density and position of vapors at the openings of different glasses.

Why do vapors matter? Well, they carry aromatic compounds into your nose. Aromatic compounds are responsible for producing the vast majority of flavors in wine.

Why are there so many different glasses for wine?

Of the many different wine glasses available, you'll find that certain shapes are better for enjoying certain types of wine.

By the way, it doesn't really matter if your glass is stemmed or stemless. It's more about how the shape of the vessel collects aromas and deposits wine into your mouth. (I know some of you enthusiasts will strongly disagree! 😉 Below is a summary of the primary glass shapes and the wines that tend to perform well in these shapes.

Nope. This might look like a wine glass, but it really isn't. First things first. You know those stemmed glasses that you fill all the way to the top? Those aren't wine glasses. They're hipster cups.
In order to taste flavors in wine you really need ace above the wine to collect aromas.

One type of white wine glass is better at maintaining a cool temperature. The other is better at collecting aromas.

White Wine Glasses

White wines are typically served in smaller bowled glasses. Smaller glasses:

- Preserve floral aromas
- Maintain cooler temperature
- Express more acidity in wine
- Delivers more aromas (even at cooler temperatures) due to proximity to nose

You'll notice that full-bodied white wines like oak-aged Chardonnay, Viognier, White Rioja, and orange wines are better with a larger bowl.

The larger bowl, originally introduced by Riedel as a "Montrachet" glass , better emphasizes a creamy texture because of the wider mouth.

The 3 primary red wine glass shapes help moderate high tannin wines, deliver more aromas, or make spicy-tasting wines more rounded.

Red Wine Glasses

The choice of a red wine glass has a lot to do with mitigating the bitterness of tannin or spicy flavors to deliver a smoother tasting wine.

After a few years of tasting wines from different glasses, we've noticed that red wines tend to taste smoother from a glass with a wide opening. Of course, the distance to the actual fluid affects what you smell.

Large “Bordeaux” Glass

This glass shape is best with bolder red wines, such as Cabernet Sauvignon, Cabernet Franc, Alicante Bouschet or Bordeaux Blends.

- Delivers more aroma compounds vs. the burn of ethanol from being farther from nose
- Larger surface area to let ethanol evaporate
- Wider opening makes wines taste smoother

“Standard” Red Wine Glass

A great glass for medium- to full-bodied red wines with spicy notes and/or high alcohol.

Spice is softened because flavors hit your tongue more progressively from the smaller opening. Try wines like Zinfandel, Malbec, Syrah (Shiraz), and Petite Sirah with this glass.

Aroma Collector “Bourgogne” Glass

A great choice for lighter more delicate red wines with subtle aromas. The large round bowl helps collect all the aromas. Try this glass shape with Pinot Noir, Gamay, Zweigelt, St. Laurent, Schiava, Freisa, Valpolicella blends, and even Nebbiolo!

Specialty Wine Glasses

You may find a reason to pick up a few specialty wine glasses depending on what you tend to drink the most.

For example, we cannot live without our official Port glass (shown above on the right). It’s small size and narrow mouth reduces evaporation (it’s a high alcohol wine).

That said, I’ve broken almost every Champagne flute I’ve purchased. (flailing arm syndrome) We tested 5 Universal wine glasses and here’s what we learned.

What About “Universal” Glasses?

A few glass manufacturers including Zalto and Gabriel-Glas offer a “universal glass.”

This is a great idea for the space-saving, pragmatic enthusiast who doesn’t want to bother with all the different shapes. Both aforementioned glass brands are of exceptional quality (starting at $30 a stem!), so it’s hard to fuss over the subtle differences in taste delivery.

That said, if you're someone who "only drinks bold reds" you might be better served with a biggy-sized Bordeaux glass (like the one displayed above).

Questionnaire: Which Type of Wine Glasses Should I Buy?

Answer these questions *truthfully* to figure out what kind of stemware to buy.

1. Do you hand wash special kitchen tools such as knives?
2. Do you have places to store tall wine glasses?
3. Do you enjoy a glass of wine almost every night?
4. Do you wash your dishes after dinner?
5. Do you find pleasure in cleaning and organizing your kitchen or bathroom?
6. Do you have safe areas that are off-limits to kids?

If you answered mostly "No" Owning fine crystal stemware will drive you insane. Instead, get

glassware or stemless crystal glasses. These will be easier to maintain and won't give you a conniption if they break. You can also wash them in the dishwasher.

If you answered mostly "Yes" You are neurotic enough to keep crystal glassware clean and sparkly. (Yes!) You should look into getting a set of 6 matching crystal wine glasses that you can use for years to come.

About Madeline Puckette

James Beard Award-winning author and Wine Communicator of the Year. I co-founded Wine Folly to help people learn about wine. @WineFolly

A Brain Surgeon Finds a Sweet Hobby

Interview by Chiemela Ohanele | Photos by Graham Perry, *pennmedicine.org*

After scrubbing out of the OR, most surgeons don't trade their blue scrubs for a fresh white suit covering every inch from head to toe. But most surgeons aren't M. Sean Grady, MD, who uses that head-to-toe protection in pursuit of a sweet hobby. Outside of his work as chief of Neurosurgery at the Perelman School of Medicine, Grady is an amateur beekeeper who keeps bees and collects their honey in Chester County, Pa.

Chiemela Ohanele, a pre-medical student and biology major at the University of Pennsylvania, spoke with Grady about his beekeeping, his interest in ecology, and how these outside interests relate to his work as a surgeon.

What inspired you to start beekeeping?

I have been interested in beekeeping for many years. I never pursued it until about four years ago, when my daughter said that it is time to start doing instead of just talking. So she got me *Beekeeping for Dummies,* and that's what started it.

I like beekeeping for very practical reasons. As a neurosurgeon, I don't have a huge amount of free time. Beekeeping is not a huge time commitment. It's about an hour a week if you do it as a hobby. Secondly, I think the biology of bees is fascinating—from the workings of a beehive and how bees find nectar, to how they communicate with the rest of the beehive about where to go. Nobel prizes have been won for this. I am also an ecologically-oriented person and beekeeping fits into that. Lastly, I get honey out of it.

Do you ever sell your honey or have you ever thought about creating an online market? Or do you mainly see your beekeeping as a hobby?

I see it primarily as a hobby. In fact, I just harvested honey yesterday from my four beehives and I probably got about seventy pounds of honey. So I could sell it, but generally I just give it away to family and friends.

Tell me about your path to medicine. Were you always interested in becoming a doctor?

I first became interested in medicine in high school and kept that in the back of my mind in college. I majored in biology, and by the time I got to my junior year I realized that I did want to go to medical school.

I wasn't sure what I wanted to do when I went to medical school in terms of specialty. However, my exposure during medical school both in the preclinical and clinical years led me into neurosurgery. Most medical students to not know what to specialty to pick at first, but when they get exposed to certain elements during their education, they realize they find a specialty that reflects not only their personalities but also how they think.

What made you decide to specialize in neurosurgery?

During your medical school rotations, you realize that the problems that you encounter with a particular specialty and the people that you will work with may or may not fit your personality.

So, for example, you rotate in internal medicine. Within this specialty, the physicians are trying to put together the source of the problem for the

particular medical condition that the patient has. In the case of neurosurgery, on the other hand, generally you have already identified the problem, and your goal is to take the patient through the necessary operation.

Also, as a first year medical student, I was most fascinated by the brain compared to other organs. When I was rotating on other surgical specialties, I was just in awe of what could be done as a neurosurgeon. There is also so much that is unknown about the brain, which means that there will never be a time in my career where I will not be a student.

What would you say is the hardest and or the most rewarding aspect of being a surgeon?

To me, the hardest and most rewarding aspects come in one package. Sometimes you deal with very serious conditions for which there is no treatment. As a physician, you work with the patient and the family to provide comfort for them. While providing a cure is of course enormously rewarding, always being able to provide care and comfort and can be every bit as rewarding.

Is there a case that frequently returns to your memory?

It is the failures that I remember. Should I have approached the problem differently to improve the outcome or even not operated at all—I'm trying to follow the "do no harm" rule in medicine.

Do you see any intersection between ecology and medicine?

I think ecology pushes me to think about what I can do to help our environment. I carry the same perspective in medicine. What kind of things can I do or what kind of influences can I exert on our medical environment? There may be some similarities there.

Do you think that beekeeping as a hobby can mitigate any of the effects of physician burnout?

Beekeeping is one of those activities that require a lot of focus. For example, when you open up a hive for inspection, you cannot disrupt the bees. Otherwise you might get seriously stung. So, you have to concentrate on what you're doing. I find this process meditative and can take my mind away from things at work that I may have been dwelling on.

What is one piece of advice that you would give to anyone pursuing medicine and has a passion outside of medicine?

Medicine is an all-consuming passion—it is much more than a job. The problem is that this passion can be overwhelming sometimes. So, it is important to find some other intellectually engaging pursuit to balance that passion, so that your whole identity is not subsumed into this one thing.

You have to pick something that accommodates the type of schedule that you have as a doctor. While some physicians pick a career that gives them a lot a free time to pursue many activities, most surgeons don't have a lot of free time. You have to figure out something that can be done within that framework. You could be an artist, write, or even beekeep. Whatever you choose has to fit in with the kind of specialty you have chosen.

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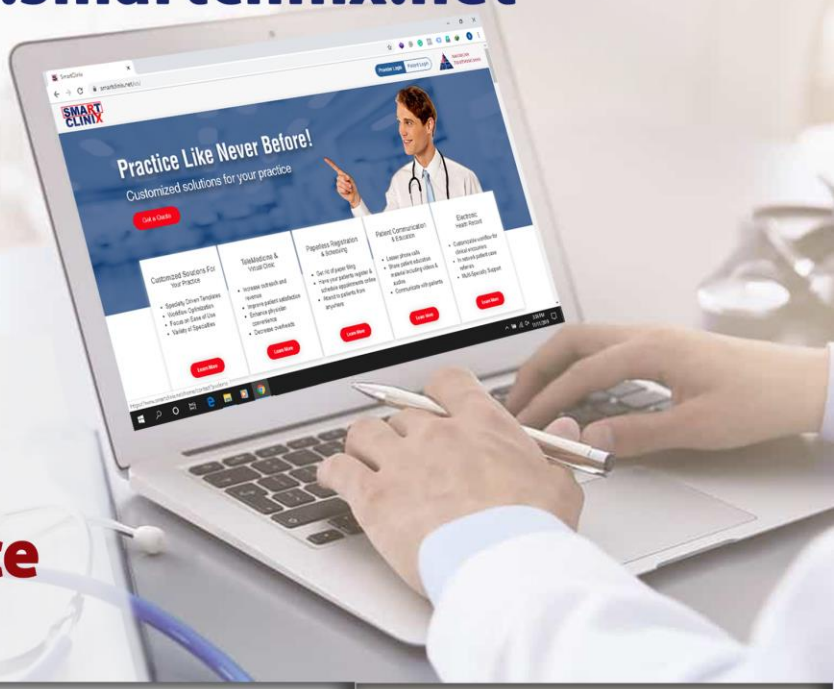

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Managing Your Investments During Difficult Times in 2021

In recent times, the combination of a pandemic, economic difficulties, political unrest, and natural disasters have all presented their respective challenges. Besides grappling with the near-term effects of these situations, investors may be wondering what effect these events could have on their investments. Which is why it's helpful for investors to focus on three fundamental actions that could help them work toward meeting their investment goals—know yourself, build a plan, and keep an eye on the long term.

Know Yourself

When stocks drop by 20% or more, some investors might ignore the drop, others might feel the urge to sell, while still others might see it as a good time to buy. This range of reactions illustrates different levels of risk tolerance, or how sensitive investors are to market volatility. Risk tolerance varies from one investor to another, and no level of tolerance is considered the "right" level—there's only the right risk tolerance for each investor. Talking with financial advisors or completing online questionnaires can help investors determine their risk tolerance.

While understanding your risk tolerance is essential, it should not be considered in isolation. Risk tolerance, goals, and time horizon all play a role in setting an investment plan.

Investing more aggressively may yield more rewards but the length of time available for investing also plays a part. A longer time horizon could give investors the potential for compound growth. And setting specific goals can help to determine how much an investor should accumulate to support their goals.

Build a plan

Dwight D. Eisenhower may have said it best—"Plans are worthless, but planning is everything." Even though a plan may need to be modified to adapt to changes, the very process of setting a plan will help investors to discover and focus on their most important investment goals.

For a plan to be useful, it's important for investors to clearly detail which goals they are trying to achieve. Some of an investor's goals will be shorter term, such as building a rainy day fund. Intermediate-term goals might include buying a house or paying for a child's education. Longer-term goals might include planning for retirement and potentially leaving a legacy for charities or family. Investor assets can then be matched to those various goals. For example, investors might own short-term bonds to meet a near-term expense, and a mixture of stocks and longer-term bonds to meet needs that are further in the future. The investor's risk tolerance will help determine the mix of more volatile assets—such as stocks—to less volatile assets such as bonds.

Keep an eye on the long term

Once a plan is in place, it's important to maintain it over the long term. This process includes regularly rebalancing the portfolio if allocations move too far away from targets, a task that in many cases can be automated. Maintenance also includes revisiting plans as investor goals or situations change. A plan is meant to be a living document.

While market drops can be troublesome, unpredictable economic events have presented challenges in the past. With resilience and creativity, America's businesses and households have managed to overcome them. While there are no guarantees that past performance will repeat itself, history has shown us that investors who reach their goals are often those who stick to their investment plans and take a long-term view of the markets.

This article was written by/for Wells Fargo Advisors and provided courtesy of Chris Thompson, CFP®, CRPC ®, First Vice President – Investment Officer, in Ponte Vedra, FL at 904-273-7956 or Christopher.thompson@wellsfargoadvisors.com or www.christophermthompson.com.

14 Tips When Negotiating a Physician Job

Christina Arnold, MD

Negotiations are not just for the job interview and annual review. We negotiate every day. Negotiating in place can be a powerful mechanism to make your current job a better fit.

The key to effective negotiations is to think like the boss. What are her concerns, goals, and interests? How can you align your goals with those of the boss and institution so that everyone wins?

At every point where you are asked to take on additional responsibilities or tasks, consider making an ask that will help you (and your institution) succeed. If your boss cannot adjust your salary, remember that salary is not the only adjustable factor. Negotiating for a title, off-service time, additional research funds, leadership position, or an accelerated promotion track could be at least as valuable as salary adjustments, for example.

When millions of dollars and opportunities are on the table, leverage these top strategies to help design your ideal life through effective negotiations.

1. Always ask. Of course, you will make some asks. The boss just might say "yes." If you don't ask, the answer is "no." Some considerations may be non-negotiable, but you won't know until you ask. So ask.

2. Direct your ask to the person who makes the decisions. Many centers send the letter of offer from the secretary with a curt, "Please sign and return." This is a basic negotiating technique to feel uncomfortable making asks, but you are not a basic applicant. Determine who the person who makes the decisions is, and direct your asks to her. Ideally, direct your questions in a face-to-face format, such as video conferencing, so you can gauge the room and most effectively deliver your ask.

3. Know your value. You have decades of life experience. You are a decorated, highly-trained physician in a pandemic. Write a list of your amazing accomplishments to remind yourself of your value. Know what sets you apart from other candidates.

4. Ask until you hear a "no." When you hear the "no," don't make it mean anything bad. Your job is to advocate for yourself. No one else will do this essential job as well as you. If I don't hear a "no" during a negotiation, I didn't advocate hard enough for myself. When I hear the "no," I feel great because I pushed until I found a boundary. I got every dollar on the table. I sometimes make an impossible ask just so I can get that "no" and help pressure the boss to say "yes" to an even more valuable negotiating item.

5. Make it easy for them to say "yes." Instead of asking, "Can you raise the salary?" couch the ask with a reminder of why they want you: "Based on my 10-year subspecialty experience, I would like to discuss a salary that reflects my additional skills, network, and training."

6. Ask and then bite your tongue. A common negotiating mistake is for an applicant to make an ask and then look away, withdraw the ask, or not give the other party time to respond. It is too easy to say "no" to an applicant who doesn't appear to think she deserves the ask. The silence is uncomfortable only if you make the silence mean something uncomfortable. Ask with confidence, strong eye contact, and then create space, so the

boss has time to respond. If you need to distract your brain, count in your head, remind yourself that you are worth it, and think of all the opportunities ahead if you can be strong in this brief negotiation session.

7. If you can, let them pick the first salary number. Their number might be higher than your ideal number, so you want them to provide the first number. In general, the person who offers the first number has a weaker negotiating position. If you have to share your number first, pick a higher number than your ideal number so that you have built-in space to negotiate down and still land at or above your ideal number.

8. Don't get distracted by shiny objects. Some centers offer a one-time signing bonus to incentivize you to accept a lower base salary. Since future raises often tie back to the base salary, pushing for the highest base salary (and not becoming distracted by a shiny signing bonus) may make the most financial benefit over the long-term.

9. Some centers have fixed salaries. If your future boss cannot negotiate on the salary, don't forget that there are loads of additional negotiating items to consider still: book fund, research funds, administrative support, office space, annual bonus, signing bonus, academic time, upgraded equipment, clinical load requirements, moving expenses, leadership titles, accelerated promotion tracks, and additional training, among others.

10. Of all the potential negotiating items, prioritize your top three. Negotiations are a delicate balance between advocating for yourself while maintaining a positive relationship with your future boss.

11. If you have trouble advocating for yourself, pretend you are negotiating on behalf of your daughter. You sort of are negotiating for her because if you set yourself up for success, your family will undoubtedly benefit.

12. When you feel unsure of yourself, have an out of body experience. Pretend you are the future version of yourself who is 15 years older, full professor, and full of confidence and wisdom. Invite her to run the negotiations. Pretend to be her. Get out of your head and focus on what you need to succeed. If your goals are aligned with your institutions, it is in everyone's interest for you to succeed.

13. Yes, it is uncomfortable. And you can do hard things. These 90 seconds will be worth millions of dollars over your career. You can feel uncomfortable for 90 seconds for millions of dollars.

14. Plan a gap. Once you start a new job, you often have to wait a few months before taking time off. Secure time to mentally and physically transition by pushing out your start date to allow for a gap. Make sure to carefully look at your finances and insurance to determine how much of a gap you can afford.

Christina Arnold is a pathologist and career coach. She can be reached at Your Path In Focus.

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FROZEN: THE HOOPS MARY HAD TO JUMP THROUGH WHEN JOHN DIED

By Stacey Riley Walters, Esq

John unexpectedly died of heart failure after contracting a respiratory virus. He left behind his wife of 36 years, Mary, his son and his two grandchildren. The day after the funeral, Mary received a call from the funeral director. He informed her that the check she wrote to them was returned for insufficient funds. When Mary called the bank, she found out that the joint checking account she shared with John was frozen because of his death. Mary was very upset because this was her account too, not to mention the fact that John's will left everything to Mary! When Mary spoke to the bank concerning this matter, they told her that joint accounts are equally owned 50/50. In the event of one account owner's passing, the account does not automatically pass to the surviving owner, and unfortunately, John did not set-up the account with a right of survivorship. The banker went on to explain that until Mary started the Court Probate process, and jumped through the necessary hoops, there was nothing the bank could do about the frozen account. The saddest part…that was NOT the only asset FROZEN when John died.

This is an all too familiar scene for a lot of families in North Carolina. Most people do not realize that whether you die with a Last Will and Testament or without a will, the only way your non-beneficiary assets can be divided and transferred to others is through a legal process called Probate. The Estate division of the County Court in North Carolina where the deceased resided is the governing body. Probate is usually necessary for assets you own individually, jointly owned assets with no right of survivorship, and assets that do not have named living beneficiaries.

Probate starts with gathering a large amount of information that is needed to complete a myriad of court forms which must be completed in the Probate process. This process can have 8-12 steps, and can take up to a year or longer to complete.

So where does Mary start?

MARY'S WALK THROUGH THE MANY STEPS OF PROBATING JOHN'S ESTATE:

- Mary hired an attorney since the clerk of court cannot advise people on how to complete the legal forms or on how to proceed with handling probate.
- After that, Mary went to the bank where she asked for a certified bank check to pay the court filing fee of $120.
- Next, Mary had to meet with the clerk of court, in person, in order to file the application to open the estate and to be legally qualified to serve as Executor of John's Estate.
- Once Mary qualified to serve as the Executor of the estate, she then had to navigate through all of the following steps at the direction of her lawyer:
    - Obtain a tax ID. for John's estate for tax reporting purposes.
    - Open a bank account in the name of John's Estate.
    - Draft and mail letters to all of John's known creditors, to notify them of his death.
    - Draft the court mandated notice to creditors, and then pay for the notice to run in the local newspaper for 4 weeks so other potential creditors can make a claim against the estate for any outstanding debt owed by John. This step is required by law.
    - Inventory the estate assets and determined the value of each at John's date of death.
    - Travel back to the courthouse 90 days after opening the estate to file the proper court form that lists all of John's assets and their values on his date of death.
    - Pay Inventory costs to the Court based on the total value of the assets.
    - Pay all the estate debts owed to John's creditors, including commissions the court awards to an Executor which can be up to 5% of the total estate assets plus debts.
    - Keep a detailed accounting of all transactions, receipts and money paid

into the estate and debts paid out, as the court will not close an estate unless it balances out to the penny.
    - Prepare the annual accounting as required and travel back to the courthouse *again* so the Probate clerk of court can review and approve the accounting as balanced, as well as pay any additional costs the court calculates as being owed at that time.
    - Pay the lawyer who guided and assisted her to successfully complete her fiduciary duty as executor once the Court approves the petition for legal fees. (NOTE: a lot of lawyers will forgo this technical step and require a large retainer up front, which they bill against throughout the probate process for their services.

- PLUS, Mary had even more to do to meet the probate requirements before everything could be finally distributed to her (or named the heirs) and before the Court would allow the estate to be closed as completed.

TRUTH: 67% of Americans* do not even have a Will, but never fear- *the State has a plan for you!*

When a person dies without a will determining who is entitled to inherit the assets comes down to each state's "intestacy" laws. Sometimes, it is the state where the decedent lived, which determines the heirs. Sometimes, it is the state where the physical property of the deceased is located at the time of his death. In more complex cases, sometimes both states will be required to make that determination. The order in which heirs inherit from a decedent's estate when there is no valid will is called "intestate succession." State laws prescribe a list of next of kin who have the "first right" to inherit the assets of the estate. A surviving family member who is further down the kin list, typically, will not inherit anything if the "first right" heirs are still alive.

Here is an example of how an intestate probate — one without a will — is typically distributed under the North Carolina intestacy laws:

MARRIED PERSON DIES WITHOUT A WILL- The surviving spouse may only receive approximately half of their deceased spouse's assets, after collecting the year's allowance and the first $100,000 in assets of the estate. He or She usually receives the entire estate if the decedent leaves no living children, grandchildren, or parents (the surviving spouse's in-laws), but only after all the debts of the deceased spouse are paid off. Yep, not at all like most married couples would expect!

Let us help you in your time of need or to help you put the perfect plan in place! Our caring and compassionate Lawyers will customize your wishes to make things simple and easy for your family, ensuring they do not have to suffer through a time consuming probate process, saving them both time, money and the stress of it all, while ensuring your wishes at met.

To learn more, look us up on the web at www.twestateplanning.law or call (888) 787-1913 for a free virtual consultation or request a free legal guide.

*Forbes "*American's O strich Approach to Estate Planning*" April 4, 2014

** The above summary is general information. Do not rely upon the above for definitive legal advice. In accordance with N.C. State Bar Rules, note this contains dramatizations. Not all scenarios represent actual people or real events

THOMAS-WALTERS PLLC
PROBATE, TRUSTS AND WILLS

North Carolina licensed Attorney Stacey Riley Walters is a North Carolina native, who graduated Magna Cum Laude from Elon University. She attended Thomas M. Cooley Law School and has been in practice for more than 20 years. The cornerstone of Stacey's practice is planning for the unexpected after she was unexpectedly blessed her disabled daughter. She focuses solely on Estate Planning, Wills, Probate Avoidance, Trusts, Special Needs, Probate and Trust Administration. Stacey has served on UNC Children's Hospital Family Advisory Board, Make-A-Wish Foundation and has participated with the Triangle Down Syndrome Network. Stacey is member of the National Association of Elder Law Attorneys, the Society of Financial Service Professionals, and Elder Counsel.

A Physician's Story of Sexual Harassment

Anonymous Physician

Like many surgical specialties, the one I was aspiring to is a male-dominated field. As such, all my colleagues were male, and I often felt as though I was trying to be a part of a boy's club. I shed my intrinsic femininity and instead equipped myself with diplomacy, banter, a light-hearted attitude, and contagious enthusiasm.

I knew nothing about the footy, and I hated beer, but I was witty, I had a good sense of humor, and I consistently went above and beyond to help my colleagues. The work was not easy, and the hours were long – but I looked forward to it every day. All the warnings I had been given cautioning me against a surgical career seemed far-fetched.

However, despite my efforts to mute it, my second X chromosome functioned as a glowing red target on my back, and I became exposed to the sexism present in medicine that I was often warned about.

1. "Janine (a resident) kept trying to take my theatre time when I was her registrar, well, you know I made sure she never did that again! I made sure her career was over."

2. "When are you two going to hook up? You know Max (a co-resident) wants to f*** you, right?"

3. "Why do you think he keeps asking you to adjust his catheter?"

4. During my evaluation: "You are very good … one of our best … but you will never make it as a surgeon. You are too opinionated and loud. The bosses think you are whiney. You are a woman, and you need to learn to put your head down and get the work done. I'm only telling you because I care about you."

5. "You know Shaun (my immediate senior colleague) would have slept with you if you had let him?"

After the first statement, I politely half-smiled.

After the second, I stood silently with a stern expression conveying disapproval and disbelief, whilst my five male colleagues laughed hysterically.

After the third, I walked away in silence.

After the fourth and fifth statements, I excused myself, found a nearby bathroom, and cried until my eyes were raw.

I cried at the unfairness of it all.

I cried because all my efforts, my passion, my personality, and my worth had ultimately been reduced to my sexuality.

I cried because I had, with great difficulty, fought myself out of an oppressive cultural upbringing as a child, only to find myself in a similarly oppressive environment in the illusory Western world.

I cried because I was plunged into the same emotions that I was forced to navigate after I was sexually assaulted as a fourteen-year old – I felt weak, helpless, dirty, and angry.

I cried for all the women before me who had experienced the same.

And I cried because I was crying – how could I be so weak? If I was crumbling now, how dare I think I could ever become a surgeon. I was warned this would happen. I was told to brace myself and be resilient. When did I become so weak?

Working in an environment where you are continually objectified can eat at even the grittiest trainees. I made myself small. I wanted to blend in. I wanted to disappear. I was told repeatedly: "They don't want trouble-makers in surgery."

Where I was initially the breed of resident who asserted themselves when subjected to rude or unprofessional behavior – I now felt that I was not entitled to be

treated respectfully, and accepted a newer, lower standard of interactions as my 'new normal', which only lowered my self-worth. I second-guessed my decisions and lost my confidence entirely. I felt disempowered and hopeless.

I blamed myself for being too easy-going and hence "inviting" the sexually charged comments. I grew a "work-skin" and limited my interactions to only those necessary for good patient care. No more banter and no more friendly checking in – I didn't want to encourage any unprofessional behavior.

Work became heavy and dry. Walking from the carpark to the hospital, I felt like I had weights tied to my ankles. I felt lost. I barely slept four hours a night for two months.

Ultimately, I spoke up and the organization was receptive to my feedback, though this was not without collateral damage and a warning that real change takes an agonizingly long time to be achieved. Frustrated and morally injured, I packed up and moved in search of a fresh start. I took stress leave and connected with my GP, a psychiatrist, and a psychologist.

Whist I am thankful for the support I received, I also acknowledge and ache for those in similar situations who:

- Did not feel as though they could speak up.
- Did not receive the support, compassion, and healing that they should have received.
- Were forced to abandon or modify their aspirations as a result of their experiences.

During our first session, my psychologist said: "You need to accept that the world you work in is inherently unjust." This sounds counter-intuitive, but her words helped me breathe easier.

I had been carrying the weight of the injustice shown towards females in the medical workforce for months. I felt obligated to speak up to ensure that no other person experienced what I had, and I felt responsible and representative for my female colleagues. When things did not immediately improve, and when I found myself in similar situations again – the weight increased.

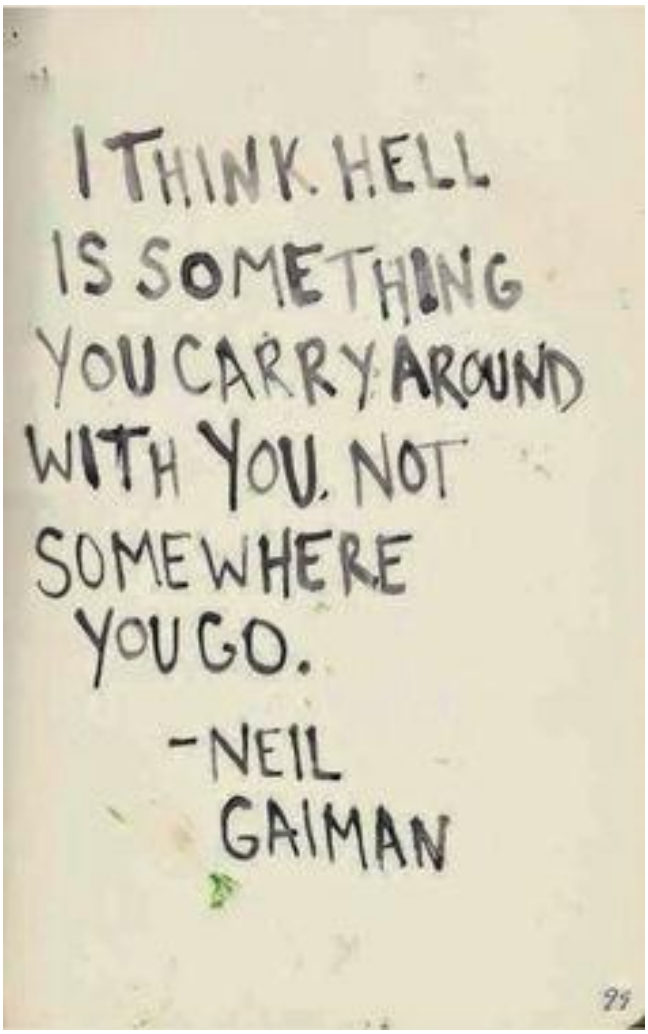
It takes more than me to fix the system. We are fighting a system that has been ingrained in our culture for decades. Minorities cannot shine in the system as it is currently because it is catered to an entirely different shape of trainee.

We can start by choosing to advance the right trainees, those who are deserving, those who are passionate, humane, empathetic, and those who genuinely care for their patients, and ostracizing those who speak up is counter-productive to this agenda.

We must support and empower our colleagues in speaking up. This ensures that, over time, unacceptable and unprofessional behavior is systematically eliminated.

"The crucial point, ethically, is to observe how much of one's success and happiness are due to luck – and then feel committed to canceling the worst disparities in luck on that basis."
– Dr. Sam Harris, neuroscientist and philosopher.

The author is an anonymous physician in Australia.



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