MD Life

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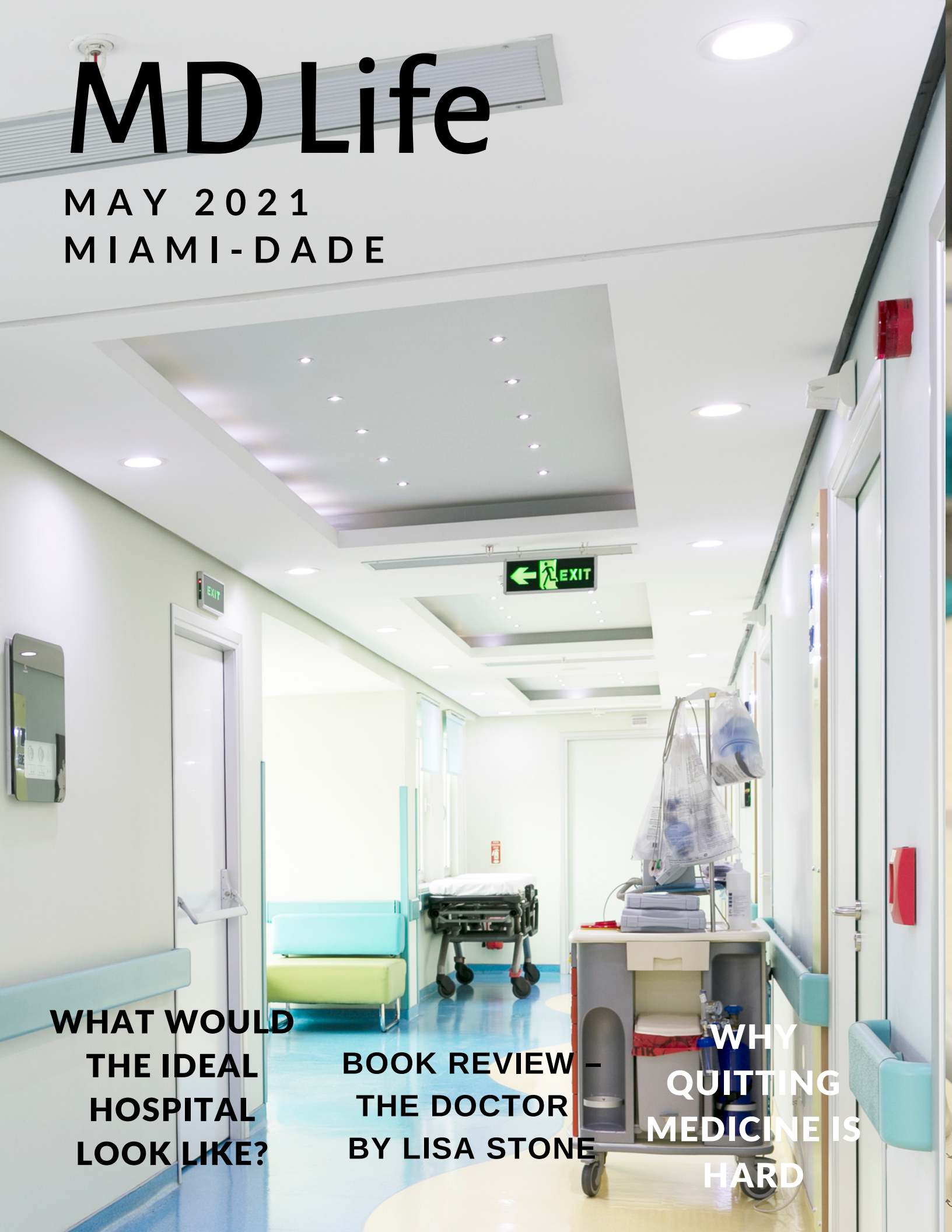

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BOOK REVIEW – THE DOCTOR BY LISA STONE

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Contents in This Issue

Moral Injury and Burnout in Medicine: A Year of Lessons Learned

By Wendy Dean and Simon G. Talbot, statnews.com

When we began exploring the concept of moral injury to explain the deep distress that U.S. health care professionals feel today, it was something of a thought experiment aimed at erasing the preconceived notions of what was driving the disillusionment of so many of our colleagues in a field they had worked so hard to join.

As physicians, we suspected that the "burnout" of individual clinicians, though real and epidemic, was actually a symptom of some deeper structural dysfunction in the health care system. The concept of "moral injury" seemed to encapsulate the organizing principle behind myriad drivers of distress: the growing number of reasons we couldn't keep the oath we had made to always put our patients first.

Moral injury describes the mental, emotional, and spiritual distress people feel after "perpetrating, failing to prevent, or bearing witness to acts that transgress deeply held moral beliefs and expectations." It was originally described by VA clinicians to account for the way that the suffering of some military veterans did not respond to standard treatment for post-traumatic stress disorder. This way of conceptualizing soldiers' suffering felt deeply familiar to us, and we thought it might provide a compelling account of the cause of the burnout we have witnessed in our colleagues and ourselves.

Posing a new question in the conversation around physician burnout, we published a First Opinion on moral injury on this date last year. We were stunned by the response. That article started an international conversation among health care professionals and others about the moral foundations of medicine and has begun to change the language around clinician distress.

Why moral injury resonates

Since our article appeared in STAT, we have discussed, debated, and reconsidered our thoughts about moral injury with audiences across the breadth of health care — in person, on podcasts, by phone and email, on social media, and from podia across the country. In the process, we have learned that the concept of moral injury resonates powerfully, not just with doctors, but with every kind of health care professional we've met, from nurses and social workers to hospital administrators, personal-care assistants, first responders, and others.

The concept of moral injury allows clinicians to express what the burnout label failed to describe: the agony of being constantly locked in double binds when every choice one makes yields a compromised outcome and when each decision contravenes the reason for years of sacrifice. All of us who work in health care share, at least in the abstract, a single mission: to promote health and take care of the ill and injured. That's what we're trained to do.

But the *business* of health care — the gigantic system of administrative machinery in which health care is delivered, documented, and reimbursed — keeps us from pursuing that mission without anguish or conflict. We do our best to put patients first but constantly watch the imperatives of business trump the imperative of healing.

Day after day, health care professionals find themselves with no viable choice but to act in ways that transgress their deeply held beliefs in the primacy of care. As a result, many experience the well-understood symptoms of burnout — and they keep burning out, in defiance of the many and well-meaning interventions designed to combat it. The burnout epidemic continues unabated because the moral injury at the root of the problem remains unaddressed. Burnout may be the symptom, but in many cases moral injury is the cause.

From our conversations over the past year, we have learned that moral injury resonates because it suggests a broadly shared cause for the seemingly solitary experience of burnout. In other words, moral injury lets us understand that we are burned out as *individuals* because each of us is trying, in vain, to compensate for the dysfunctional way health care is structured for *everyone*.

Collective action for structural challenges

Those who suffer from moral injury in health care are desperate for healing. How do we do that? Each of us has been trying to fix the system on our own, in our own individual ways. Now it is time to work together to that end. Clinicians get burned out because health care is rife with double binds and no-win situations for clinicians and the patients we care for. Changing that system to make it less harmful will demand collective action from everyone called by conscience to do better.

When an individual falls ill, her or his clinician looks for the cause of the problem and its corresponding medical solution. We need to approach moral injury in the same way, knowing full well that the solutions aren't medical but are social, economic, and political.

The conversation around moral injury, then, summons clinicians to look outside their own expertise to heal the system that is harming themselves, their colleagues, and their patients. The solutions to heal moral injury don't look much like the medical interventions we are used to. They are more likely to come from the tool kits of epidemiology and public health, public policy and law, and grassroots organizing.

In order to make real change, we will need to engage "activists" from all aspects of the health care system — clinicians, health care administrators, policymakers, and, above all, patients and their families — to pitch in to address the structural causes of moral injury in health care.

Here are a few ways that have emerged to nudge the U.S. toward moral health care:

Value health care professionals. When clinic or hospital policies and insurance constraints force health care professionals to deliver suboptimal care to their patients, providers feel powerless. Administrators must recognize their clinicians' expertise, earned by years of grueling training, and seek their input before implementing policies that could affect patient care. Forming focus groups of health care professionals to advise on the consequences of policy changes is an important first step toward ensuring that their voices are heard. Holding administrators responsible for the work environment in health care is a strong second step.

Privilege the patient-clinician relationship. Clinicians are stationed on the front lines of health care and are solely responsible for tailoring treatment plans to meet the needs of each patient. Insurers and health systems must allow clinicians the latitude to treat patients according to their specific needs without constraining the tests they can order, the drugs they can prescribe, or the referrals they can make without incurring undue burdens. Health care professionals

abide by an oath to do no harm while doing everything in their power to heal the sick and injured — they must be trusted to uphold this oath as they are trained to do.

Reestablish a sense of community. The hypercompetitive, perfectionistic, resource-scarce health care environment has eroded a sense of community among health care professionals. Each of us instinctively guards our own territory, fearing the encroachment of others as a threat to our already scarce resources and to our professional survival. Nurses are pitted against physicians, advanced practice providers are pitted against both, and we are all pitted against patients (satisfaction surveys, anyone?). No one wins in that scenario, and patients lose the most.

Advocating effectively for the sweeping changes desperately needed in health care requires health care professionals to look in other places for inspiration and to work together toward a common goal. Industry constraints affect every health care professional in some way, and we must be united — with each other and with patients — to drive the changes we believe are necessary.

When we boil the ocean of health care down to its single organizing principle, all health care professionals — nurses, doctors, first responders, physical therapists, respiratory therapists, phlebotomists, technologists, and more — are in this together with a single goal: to provide the best care for patients. When we get back to this, we all win.

Wendy Dean, M.D., is a psychiatrist and senior vice president of program operations at the Henry M. Jackson Foundation for the Advancement of Military Medicine. Simon G. Talbot, M.D., is a reconstructive plastic surgeon at Brigham and Women's Hospital and associate professor of surgery at Harvard Medical School. They co-founded the nonprofit MoralInjury.Healthcare. The authors acknowledge Neil Chudgar, Ph.D., for critical assistance in developing and shaping this work.

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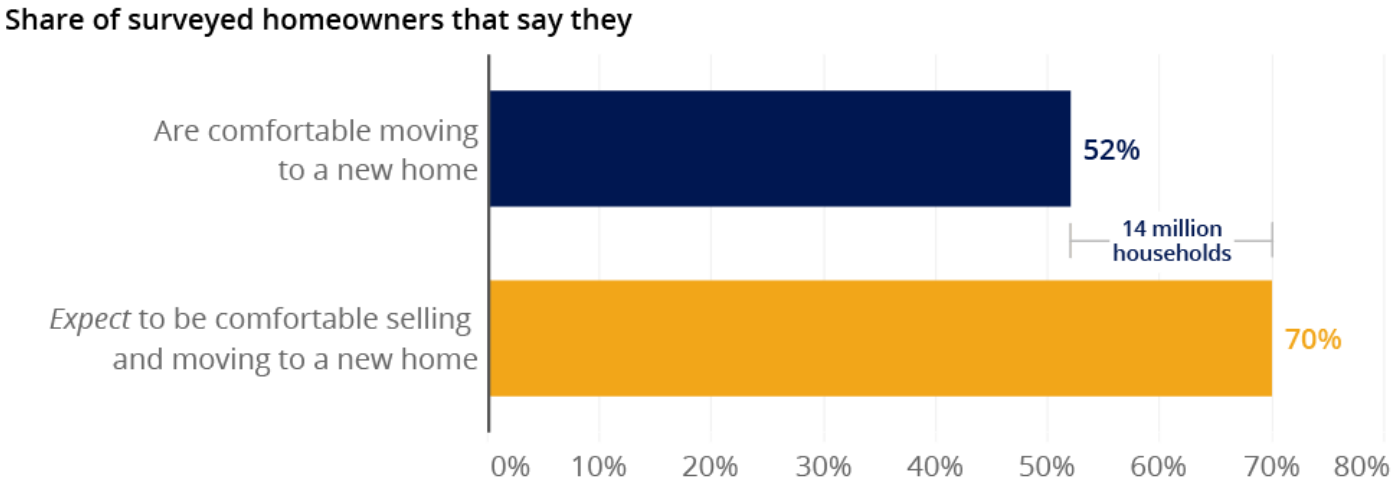
Get Ready for a Weird Spring 2021 Housing Market

by Brad Cartier, tessa.com

During normal times, the spring selling season is one typically marked by competition and increased volume. As we look at the ongoing supply crunch in housing, the fear is that competition will be that much more fierce. **Diana Olick** of **CNBC** reported this week that there were only half as many homes for sale by the end of February compared to the same time in 2020. According to Olick:

A pullback by sellers resulted in roughly 207,000 fewer homes newly listed for sale in the first two months of 2021 compared with the average for the same period over the last four years. To catch up, new listings would have to grow by 25% annually in March and April, which is unlikely.
Add a successful vaccine rollout, and this calculus changes quite a bit. According to **Zillow**, 78% of homeowners said the vaccine would positively impact their decision to sell, and also say they expect a vaccine to make them more likely to move. This could improve supply, but also demand.

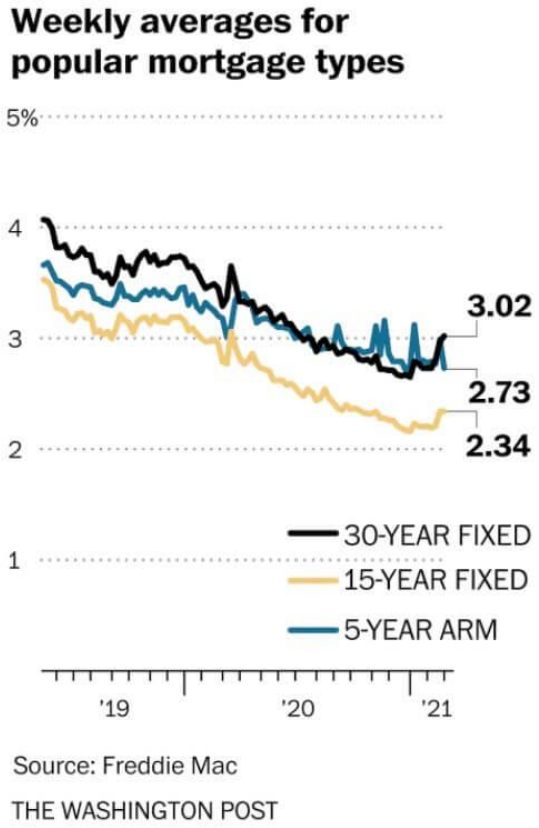


Source: Zillow
According to Zillow, “We expect that the vaccine rollout will likely boost inventory, as sellers become increasingly willing to move despite Covid-19 — resulting in greater numbers of new listings beginning this spring. That injection of inventory could give buyers more options and breathing room in a competitive market. The vaccine, however, will also likely add to already-strong demand, given that most sellers will become buyers as they trade in for a home that better suits their new needs.”

But, as it stands now, inventory is at historical lows according to **Realtor.com** data. Homes for sale across the U.S. in February were down a total of 48% year-over-year, with new listings down 24.5% year-over-year. Further, “the typical home spent 70 days on the market in February, 11 days less than last year.”
Couple this with **Derek Thompson** of **The Atlantic’s** excellent discussion on the topic titled, *‘This Is Unprecedented’: Why America’s Housing Market Has Never Been Weirder*.

Why interest rates are rising

For the first time since July, interest rates hit slightly above 3%. **Kathy Orton** of **The Washington Post** reports that "The 30-year fixed average, which hasn't been above 3 percent since late July, has jumped more than 35 basis points since January." That said, we are still sitting at record-low rates.



Source: The Washington Post

Kevin Stankiewicz of **CNBC** quotes LGI Homes Chairman and CEO Eric Lipar as stating that:
"I think in historical perspective, rates are still very low…The rates we're offering customers, the mortgage rates, are approximately 50 basis points still lower than they were at this time last year, the pre-pandemic where the market was still really strong…Even though rates have increased a little bit, that … also gives the buyers the urgency to go ahead and write a contract on a house because we're seeing prices continue to go up and rates go up."

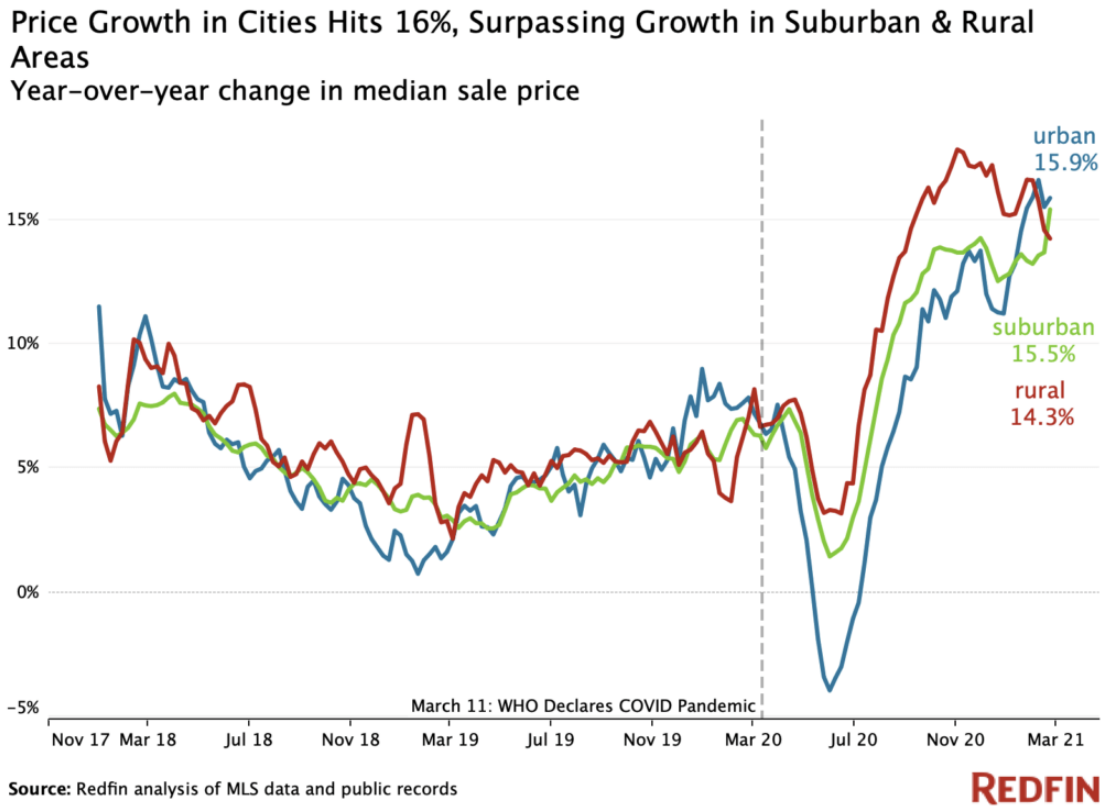
So why are we seeing interest rates increase? Bonds. **Jacob Passy** from **MarketWatch** helps explain that this new rise in interest rates is caused by movements in the bond market. With the positive economic outlook as well as potentially successful vaccine rollout, investors have been leaving the bond market, driving up interest rates on those assets.
The **Associated Press** does a great job of breaking down the relationship between bonds and other investment classes: "For years, yields have been ultralow for Treasurys, meaning investors earned very little in interest for owning them. That in turn made stocks and other investments more attractive, driving up their prices. But when Treasury yields rise, so does the downward pressure on prices for other investments."

David Payne of **Kiplinger** goes into more detail on where interest rates are heading in the short-term. "The rise in the 10-year rate will also push up mortgage rates, from 3.0% currently to 3.5% by the end of the year. The upward drift may cause some panic home-buying, as buyers rush to lock in a low mortgage rate, giving an extra boost to rising home prices." That certainly won't help the supply crunch we currently find ourselves.
Suburb vs city

We've spoken a lot about the city versus everyone else debate. The reality is that as vaccines roll out en mass cities may start to see more positive inward migration (or a slowing of outward migration) as people become more comfortable

with living in close proximity to one another. As with anything, there is significant nuance to this debate and it is highly localized in nature.

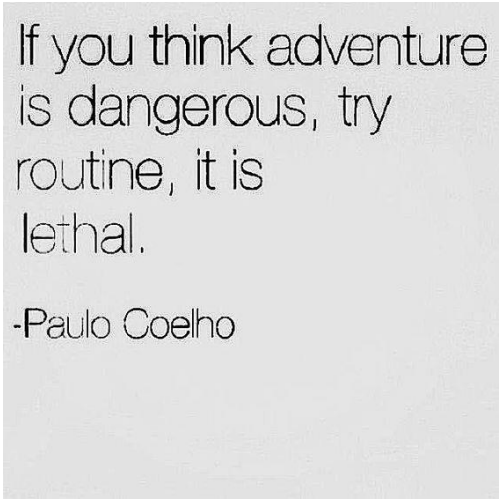
According to the **National Association of Home Builders (NAHB)**, "the suburban shift in home building to meet growing buyer preferences for lower density, lower-cost markets stemming from the COVID-19 pandemic…has continued throughout the rest of 2020." That said, there was still growth. In large core metropolitan areas, single-family home building increased 9% in 2020, the lower gain among all segments, but growth nevertheless.
Further, **Redfin** reported this week that the price per square foot for homes inside city limits increased 16% year over year, compared to a 14% increase for single-family homes in greater metro areas.



Source: Redfin

Redfin Chief Economist Daryl Fairweather is quoted as noting that "For all the talk of an urban exodus, the housing market in cities is as hot as we've ever seen it, especially for single-family homes…There are plenty of buyers out there with deep pockets who are coming out ahead financially during the pandemic. They want a house with lots of space while they are still working from home, but they also want to live in a walkable area near urban amenities as shops and restaurants reopen."

Finally, the same Redfin data shows that pending home sales increased the most in rural areas (32%), followed by 25% for urban areas, and 20% in suburban areas for the month of February.



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Why Quitting Medicine is Hard

Elijah Sadaphal, MD

This is a message to any medical doctor who is unhappy with their career. The individual reasons for this dissatisfaction will vary. Whatever the issue, it is important to ask, “Is the problem correctable?” If yes, then you must act and secure your happiness. If no, you must consider other options. One uncomplicated choice is to stay in medicine and practice somewhere else. However, you may also be unhappy in your career because you don’t like medicine. Maybe you are burnt out or no longer feel challenged. Then again, maybe you just don’t want to do it anymore or explain (for the 7,000th time) why a patient doesn’t need antibiotics. This means your options are now down to pursuing a nonclinical medical career or leaving medicine altogether. Regardless, if you don’t like clinical medicine, then why are you still doing it? Perhaps reality is teaching you a lesson: that once you’re in medicine, it’s hard to leave it. This begs the question: why is medicine so hard to quit?

Because you’ve already put in so much work and you’ve come so far—how could you ever throw it all away or sell out? Because you don’t want to give up your prestige or your paycheck. Because you don’t want to disappoint your family or fail to provide for them. Because your identity is married to your clinical career, and you don’t believe in divorce. Because your fear and inertia are greater than your discontent. Medicine is hard to quit because it is easy to stay.

The first consideration is that making a career transition is perfectly reasonable, especially if you are moving into something that you have a greater passion for. Understood this way, you are not throwing anything away but are instead bringing the education, experience, and skills you already have to another field. Your achievements and accomplishments go with you. And you will always be a doctor. This is a distinction that no one can take away from you after you have earned your degree. Quitting medicine does not mean that you are weak or selfish; it can mean you are wise enough to currently engage in self-preservation to secure a happier future for you and your family.

The second consideration is that people are more than things, so it would be foolish to presume that things—like money, clothing, or accolades—could ever satisfy you. They may temper your appetite for a time, but then they invariably lose their ability to sustain. Frame your situation differently: Do not ask, “How much will I lose if I go?” Instead, ask, “What more will I lose if I stay?” Seriously consider the worth of your time, your health, peace of mind, and your quality of life. When I began seeking advice about transitioning into a nonclinical medical career (from urgent care), I asked a mentor, “How can I afford to leave?” He smirked and said, “Don’t you realize how underpaid physicians in your field are? You can’t afford to stay. Think about all the money you will continue to give away if you don’t make a change.”

The third consideration is that if you do quit medicine, you never quit on creating value and being productive. Quitting does not mean giving up. What it does mean is redirecting your time and effort to more fulfilling ventures. Therefore, always move ahead to, never away from. Perpetual escape indicates you will always be on the run with nowhere to go. Anyone who works in the medical field knows that many patients are simply unwilling to put in the effort to get better. So then why should a physician be unwilling to put in the work to build a better career?

No physician ought to underestimate themselves when they consider their abilities applied outside clinical practice. If you have what it takes to become a medical doctor, then you already possess the intellect, perseverance, and skills needed to excel in any other field in life. With a clear focus, hard work, and persistence, you can do almost anything you set your mind to. Robert Tew once said, “Sometimes what you’re the most afraid of doing is the very thing that will set you free.”

Just because a physician is unhappy in their current career does not mean the best solution is early retirement or an indefinite vacation. It would be a mistake to think that all labor is drudgery and that you should do whatever you can to withdraw. Labor

is a good thing; it gives you purpose and enables you to serve those around you with your good works. The point is that joy in your career is possible, and I think any person can and must rejoice in their work. So if you are unhappy in your clinical medical career, begin with a thorough analysis of the person who is the most invested in transitioning—that's you. Ask yourself,

- Why am I seeking a non-clinical career?
- What type of career would make me genuinely happy?
- What is stopping me from transitioning into the career that would make me happy?

If you do decide to quit medicine, you will obviously take more steps. You will explore what you want to do, prepare for it, and then transition. In the end, whatever choice you make, that is what you have decided to do. I wish you well, and always remember that medicine is hard to quit only if you don't know where you are going.

Elijah Sadaphal is an emergency physician.

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Thefoodiephysician.com

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Course: Appetizer
Servings: 12
Calories: 168 kcal
Author: The Foodie Physician

Ingredients

- 1 tablespoon olive oil
- 1 ½ cups grape or cherry tomatoes halved
- Kosher salt and black pepper
- 1 package (10.5 oz) Gorton's Garlic Butter Shrimp Scampi
- 4 tablespoons Neufchatel or cream cheese
- 12 slices baguette toasted
- 4 tablespoons pesto store bought or homemade
- 2 tablespoons pine nuts toasted
- Optional garnish: chopped fresh basil

Instructions

1. Heat a large skillet over medium heat and add the oil. Add the tomatoes and season them with a pinch of salt and pepper. Cook, stirring occasionally, until the tomatoes soften and start to burst, 6-8 minutes. Transfer the tomatoes to a plate and wipe the skillet clean.
2. Cook the Gorton's Garlic Butter Shrimp Scampi in the skillet according to package directions. Remove from heat.
3. To assemble the bruschetta, spread about a teaspoon of Neufchatel cheese on each slice of toasted bread and spoon a teaspoon pesto on top. Top with a few tomatoes and 1 or 2 shrimp. Garnish with toasted pine nuts and fresh basil. Serve immediately.

Dr. Sonali Ruder DO is a board-certified Emergency Medicine physician, trained chef, mom, and cookbook author

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Health Care as an Uncommon Good

TOM ROBERTSON, MBA

American medicine is facing an identity crisis. The COVID-19 pandemic brought renewed attention to socioeconomic health disparities and turned up the heat on the question of whether health care is a right or a privilege. The financial strain on hospitals resulting from the temporary postponement of scheduled surgeries exposed a vulnerability caused by an inherently flawed payment system.

The answer to the right versus privilege question has much more significant implications than the resolution of a philosophical debate. It determines which economic model — that of a public good, a private good, or a common good — makes the most sense for the delivery of medical services. For health care to be what we want it to be, broadly accessible, with no socioeconomic disparities, and long-term affordability, it must eventually be recognized as a common good, with all of the economic implications that come with such a recognition.

Public goods, such as national defense, are those whose availability to others is not diminished by their consumption by some, with no social tolerance for access barriers to those unable to pay. The nature of public goods, in particular the lack of any incentive for consumers to voluntarily pay for a benefit determined to be essential by society, typically results in that good being produced directly by the government. In some countries, health care has been treated as a public good provided by the government. In the United States, sentiment is strongly against a publicly provided health care system.

That leaves us with the choice between common good and a private good. Until we resolve that question deliberately, we will continue to bounce between the two economic models, experiencing the worst of each.

Americans struggle with the idea of health care as a private good — uncomfortable with the philosophical debate between a right and a privilege. The five-decade failure of the market to establish either sustainable prices or a meaningful understanding of quality by consumers should be enough to convince us that the good private model is ill-suited to health care. Health care as a private good has been an economic failure, both in terms of price and the ability of consumers to understand the quality of services provided. Some providers are paid hundreds of dollars, while other providers are paid thousands of dollars for the same test in the same market. Differences in prices for low acuity hospitalizations can vary by tens of thousands of dollars for the same diagnosis in the same city. It is not uncommon to see one provider paid 5 to 10 times what another provider is paid for the same service in the same market.

The market's failure to reward quality is apparent in the prevalence of low-volume/high-risk surgeries. It is well established in the medical literature that clinical outcomes improve with increased volume for high-risk surgical procedures. A study published in the June 2019 issue of the Journal of Clinical Oncology compared clinical outcomes to the degree of centralization in high-risk surgical procedures. The removal of part or all of a patient's esophagus, usually related to cancer, is called an esophagectomy — a high-risk surgical procedure. For esophagectomies, mortality was over two times higher in the least centralized health systems compared to the most centralized. Complication rates were 20 percent higher. The study found the procedure performed in 1,536 U.S. hospitals, with an average annual volume of 25 cases and a median of 14. One in four hospitals, however, performed the procedure only once per year.

A population-based study in England, published in the April 2016 issue of the Annals of Surgery, demonstrated a proficiency relationship between surgeon volume and mortality for esophagectomies. Each additional case reduced the surgeon's odds of mortality by 3.4 percent. The study concluded that mortality after resections for esophageal, gastric, and pancreatic cancer falls as surgeon volume rises to 30 cases. The prevalence of low-volume surgical programs, in the extreme performing only one high-risk procedure per year, indicates that the market assumption of perfect information is not being realized.

Health care as a common good is aspirational. According to the Kaiser Family Foundation, the number of uninsured Americans increased for three consecutive years beginning in 2017, leaving almost 29 million without insurance in 2019. A recent study published in the American Journal of Public Health reports approximately 530,000 family bankruptcies per year arising from medical issues and bills; two-thirds of all family bankruptcies cite medical costs as a contributing factor. Inability to pay remains a significant barrier to access to care.

Common goods — having a limited supply and a social ambition to avoid access barriers over inability to pay — are often regulated to ensure availability and affordability. It may be time for the industry to embrace all-payer rate regulation, where private insurers pay lower prices, the government pays higher prices, and all payers pay the same prices — thereby eliminating the need for providers to negotiate private sector rates to subsidize government shortfalls.

Purposeful rate setting, by marginally increasing reimbursement for medical admissions combined with offsetting decreases in surgical prices, could reduce financial pressure on hospitals to maintain low-volume/high-margin surgical programs when proficiency thresholds associated with better outcomes cannot be achieved. It could facilitate a systemic adoption of minimum volume requirements. The market has failed because health care aspires to be a common, not a private good.

Coming out of the pandemic, the health care system has the opportunity to avoid going back to business as usual. We need to answer the question, “What is health care?” Our answer will have consequences.

Tom Robertson is a health care economist.

Physicians Can Benefit from Professional Financial Advice

Like most new physicians, Richard Greenwald, MD, had no training in business or finance during medical school, residency or fellowship. As a result, he had to learn "by trial and error" when he teamed up with two other physicians to form a new specialty practice in Boca Raton, Florida.

"What I would suggest is getting appropriate advice early on in your training," said Greenwald, who graduated in 1971 from Mount Sinai School of Medicine. He completed a residency in internal medicine at Mount Sinai and a fellowship in gastroenterology at the University of Miami/Jackson Memorial Medical Center.

"Just because you're smart and a good doctor doesn't mean you're automatically going to be an expert in business," Greenwald said. "Medical school doesn't teach you about negotiating contracts, preparing a budget or asking for a loan. So, find well-qualified people who can help you get up to speed quickly on these kinds of issues."

While the nation's healthcare delivery system continues to change, medical professionals continue to face personal and career-defining decisions as they prepare to enter practice. A professional financial advisor can help in developing sound personal financial habits, constructing a solid investment plan and providing guidance on implementing that plan.

To find a financial advisor, you can ask your colleagues for referrals. Ideally, a financial advisor will have worked with other medical professionals and understands their general issues. Then, you should interview several advisors in person, and ask questions about the following topics:

• Professional firm. Is your advisor affiliated with a national or a local firm? What are the firm's capabilities and services?

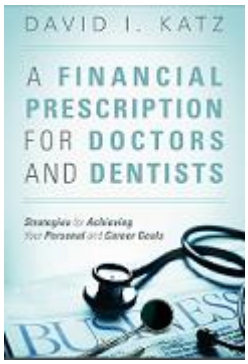
• Education and experience. Look at the advisor's education, training, certifications and other credentials, as well as years of experience.

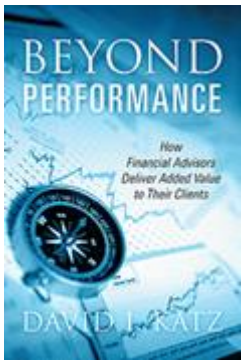
• Clientele. Has the advisor worked with other doctors or dentists, helping them navigate business and personal financial issues? That's an important consideration because medical professionals tend to face similar financial challenges and issues. You should also ask an advisor about the typical net worth of his or her clients.

• References. Ask a prospective advisor for references from other medical professionals, and talk to those people. You should also ask if the advisor has ever been disciplined by a regulatory agency or sued by an unhappy client.

As Greenwald said, "A young physician doesn't have to be an expert, but you should get expert help. Ask plenty of questions and learn about the practical side of medicine."

Adapted from David Katz' book, "A Financial Prescription for Doctors and Dentists: Strategies for Achieving Your Personal and Career Goals"





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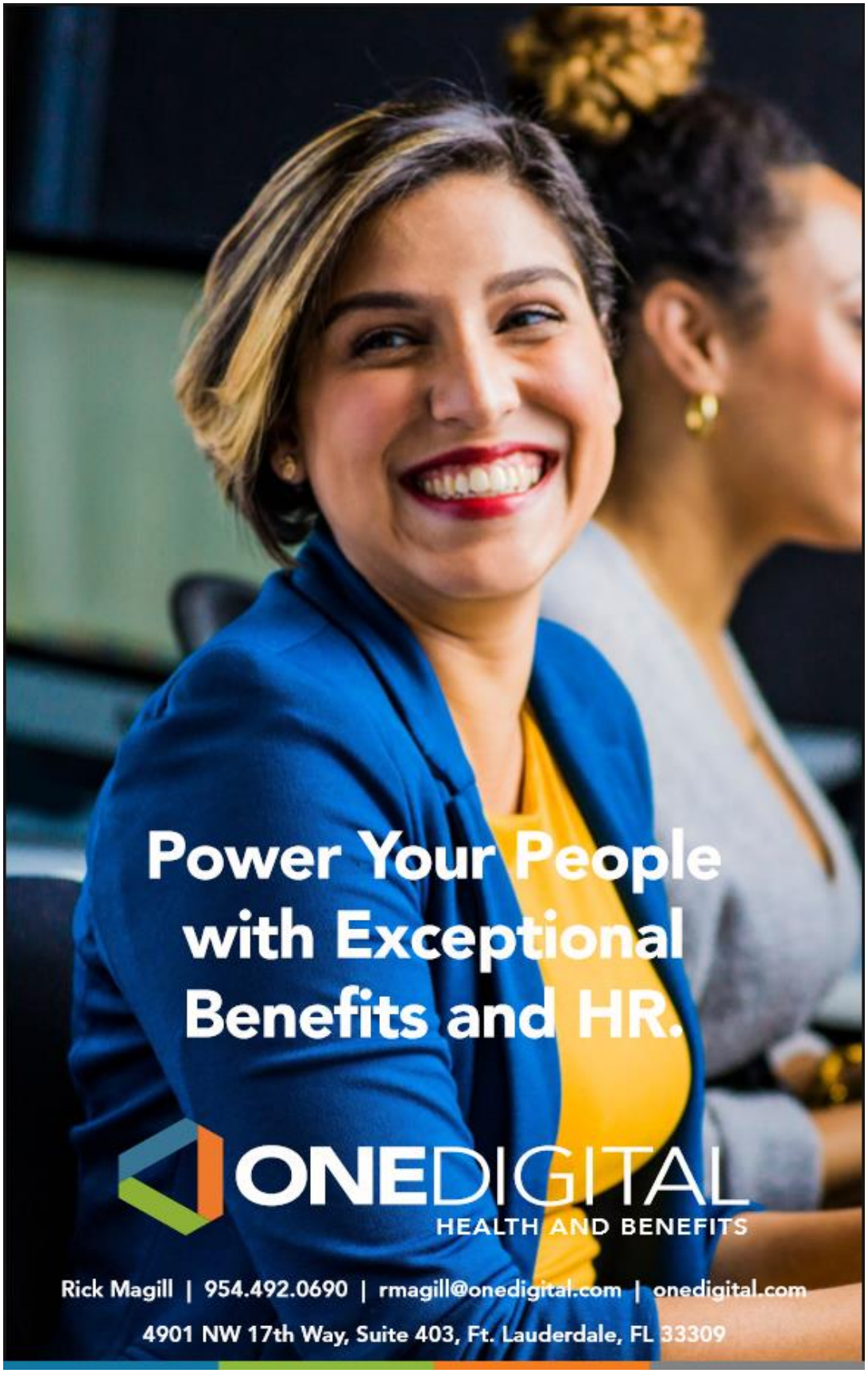
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What Would the Ideal Hospital Look Like?

Medical futurist.com

If your imagination could run wild, how would you envision the future of hospitals? Hi-tech big machines, physicians analyzing data obtained from patients' devices, LED screens greeting visitors by their names using facial recognition, virtual patient visits, and robots leading operations… Well, experts have pretty much the same idea. Recently we wrote a lot about the future of hospitals. We emphasized the importance of good design both inside and outside the point of care. We imagined that these institutions will become "*health centres for patients for preventing diseases, for acute care patients and for patients who need surgical procedures or large radiology machines*."

The following points about the ideal hospital might sound utopistic or even naive; however, each one has already been implemented in a hospital somewhere in the world, proving it's indeed not some dreamy speculation.

The need for speed

On The Medical Futurist Patreon channel, Kimberly Powell, VP of NVIDIA talked about how NVIDIA could build hospitals in a matter of days. She went on about how NVIDIA envisions these institutions. "H*ospitals will use A.I. cameras to automatically screen for elevated body temperature, use genomics sequencing to predict how lethal a virus or suspected condition could be for each patient, use A.I. in medical imaging for detection and predicting clinical outcomes, incorporate A.I. into everyday cameras and microphones to monitor and interact with patients.*"

In going a full 360 on hospitals, we decided to give you a full insight on how a hospital in 2030 should (and even could) look like. As you'll see, it won't take a leap into science fiction; instead, these are logical and unambiguous steps, leading to better patient experience, lowering healthcare costs and safe data handling. We have already seen some elements of the following in practice, but not all in one institution. Let's have a look.

The ideal hospital is…

1. **…paperless**
Yes, it starts here. Patient data stored on paper is as old as medicine itself. Now is the time to get rid of paper entirely. There is no place for paper and handwriting in a well-functioning hospital. (Yes, this is also the end of illegible doctors' notes.) Eliminating paper-based records is a huge undertaking – but achievable. For example, Bedfordshire Hospital NHS Trust has been successfully working with Xerox on reaching this goal. The hospital uses an electronic document management system for handling patient records, digitizing paper records, thereby also adding to patient data security.

"*There was an area within the pediatric service with benching on the side,*" Josh Chandler, associate director of IT for the Trust explained in this article. "*It was always completely taken up with patient notes that had been tracked in for that day's clinics. That's now all completely empty because it's all accessible through a computer*." The next steps will be data intake and safe remote data management. That is still to come, for this particular hospital, but they set a good example for others. To see how to ensure a smooth transition, check out these five steps to a paperless hospital.

2. **…connected to the homes of patients**
An ideal hospital aims for patients to spend as little time as possible within its walls. The place of treatment should be the patient's home; just as well as the place of diagnostics and the place of rehabilitation. What is needed to achieve this is first and foremost good connection. Staff and data should be connected with the hospital and the patients' homes. If a hospital has 5G with wi-fi in the wards, the data will run faster than people. This will allow faster decision-making and future-readiness.

One of the world's first 5G-enabled hospitals was the Veterans Affairs Department's health care facility in Palo Alto, California, which opened in February 2020. At the launch of the concept, the hospital stated "*VA providers are presently tapping into virtual reality to treat patients with post-traumatic stress disorder and piloting exoskeleton devices to help vets with spinal cord injuries regain their mobility—both of which could possibly be enhanced through the budding technology.'* The team primarily used the capacities and the connectivity in medical education.
Moreover, with the pandemic, the team also "*recognized that the system also offered an opportunity to bring people who are meant to be social distancing together in a virtual environment and enable them to collectively interact*."

3. …designed, not built for a purpose
Through its Patient Room 2020 project, non-profit design organization NXT Health aimed to design the future of hospital rooms. It's a high-achieving, inspiring project built with designers along with healthcare professionals with the aim to "*both improve patient experience and optimize caregiver performance*." It features a streamlined, patient-centered design, deployable bedside work area with embedded technology as well as various safety features. Unfortunately, the project has not (yet) been deployed anywhere, proving that even the best ideas can get stuck at viability.

But indeed, the design of a hospital building should not facilitate the meeting of patients and doctors; it should be planned so that patients and doctors can meet there *in the best conditions.* We recently wrote about the specific hospital design both in- and outside the point of care in our articles. There we explained with our experts how interior spaces and patient rooms should be built; and pointed out four key elements for future (re)designs of medical institutions.

4. …would use patient design
We wrote about it over and over again: the ideal hospital is designed by patients. This is exactly what Professor Stefaan Bergé did. He redesigned his whole department based on the book, The Guide to the Future

of Medicine, covering patients' suggestions. It turned out that patients wanted the simplest things like more privacy and more information. But as hospital design directly affects how patients receive care and, ultimately, how they heal, the design of these institutions should also change. The spaces should help the best possible patient experience, should be compassionate, and should even decrease the stress of incoming patients. Who else would know better how to create a human-centered hospital room than the patients themselves?

5. **…would have special places for telemedicine**

COVID-19 has changed how we look at healing altogether. It helped us realize how many tasks could be conducted from afar, often with much greater efficiency. Telemedicine came and conquered, and will stay with us even with the pandemic gone. The fact that patients don't actually need to get to the hospital/clinic, and doctors don't necessarily need to meet them in person decreases stress, time wasted – but the effectiveness of the consultation remains, at least in most cases. Remote patient monitoring works well for example at UCLA Health in their post-surgical remote monitoring program. Their Cardiac Telehealth Program is for patients who undergo heart surgery. Therein patients receive a cardiac telehealth kit upon leaving the hospital. This telehealth technology can send important health data over the internet to UCLA nursing staff; but patients can also contact their doctors using the tablet provided in the kit.

Hospital design needs to follow this transformation; and even provide doctors with dedicated teleconsultation spaces with appropriate design, devices, connection, lamps, and an acceptable hospital background for the video. Pretty much like a miniature studio within the hospital. It's important to have proper patient rooms in the hospital; it should be just as important to have the right venue for remote care because that is the new norm.

6. …has places for healthcare personnel to relax

The well-being of healthcare personnel also got exposed during the pandemic – and hospitals, in general, were falling short. Well-maintained and equipped common rooms, resting spaces should be provided for frontline personnel even outside a pandemic. The pressure for these people both physically and mentally is so high that hospitals need to create the opportunity for them to recharge. The ideal hospital should be a wellness center for patients AND health personnel alike. A good example here is the Mount Sinai Hospital in New York. Here David Putrino, Ph.D., Co-Director of the Abilities Research Center and Director of Rehabilitation Innovation at the Mount Sinai Health System, has "converted his lab into recharge rooms for front-line healthcare workers." Along with his team, he created "*multi-sensory experiences that can reduce stress in just 15 minutes*" – he explained in this podcast.

7. …should resolve the issue of alarm fatigue

Even today's institutions are packed with technology, and the hospital of the future has even more. All these devices have their own alarm systems. Caregivers can therefore become desensitized to alarm signs from the myriad of devices emitting a cacophony of beeps all day in the clinical setting. There are as many as 187 alarms per bed per day. 72% to 99% of these are false alarms; it's understandable that alarm fatigue came to exist. Healthcare practitioners are easily at risk of disregarding important alerts, which might even be fatal. A.I. could be a solution to this issue: researchers have developed an A.I. solution to help caregivers cope with the auditory overload.

Describing The Ideal Hospital of the Future in 1932, authors argue that there is no need for radical change in hospital operations. Perhaps it wasn't needed then; but it certainly is today. With the increasing use of digitization, A.I., other technologies, as well as the flourishing development of patient empowerment, the demands towards our hospitals are changing rapidly and radically. It is up to us to stand up for these changes to actually happen

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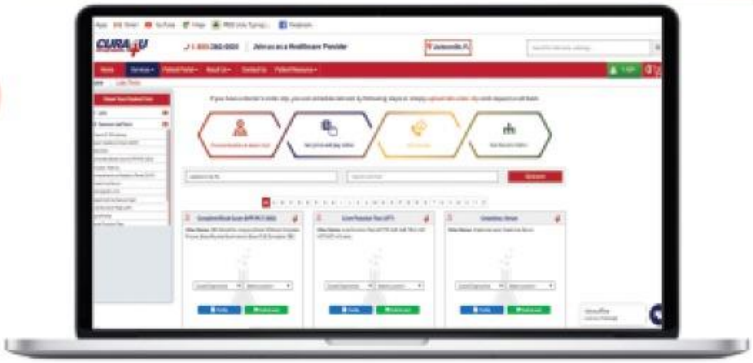

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Delete Your Search History from Social Media and Your Browser

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So how do you go about clearing your search history? Did you know you can do this for both your browser and your favorite social media sites? We'll tell you how, starting with Facebook.

Facebook

Facebook really likes to keep tabs on you, including your search history, to show you targeted ads. To keep some semblance of privacy on the site and app, follow the steps below to clear your Facebook search history:

1. In a web browser, log in to Facebook and go to your **profile page**.
2. Tap the **three-dot menu** and select the **View Activity Log** button.
3. Click on **Logged Actions and Other Activity** in the left sidebar.
4. Select **Search History**.
5. You'll now see a list of every search you've made on Facebook up until this point. To delete this history, choose **Clear Searches** in the top right part of the page.
    - If you'd like to delete single search history items instead of your entire history at once, click on the **circle with the three dots** in it to the right of each search in the history list and tap **Delete**. A menu will appear to confirm. Hit **Delete** again. That will remove just that one search.

Twitter

Twitter also keeps track of your search history. This can help you find profiles you look for often, or it can be annoying and reveal information you don't want others to know.

To delete your Twitter search history:

1. On a web browser, log in to your Twitter profile.
2. Click on the **Search Twitter** bar on the top right corner of the screen. A list of your recent searches will appear.
3. Tap the **X** next to individual searches to delete them one at a time.
4. To clear all of your searches at once, click **Clear all** at the top of the menu.

Unlike Facebook, clearing your Twitter search history on your browser won't carry over to your smartphone experience. To clear your mobile Twitter search history:

1. Log in to the Twitter app on your smartphone or tablet and tap the **Search** tab at the bottom of the screen. It's the tab with the magnifying glass icon.
2. Tap the **Search Twitter** bar at the top to bring up your recent searches.
3. Tap the **X** in the circle to the right of **Recent searches** and tap **Clear** to clear all of your recent searches.
4. To delete individual searches, swipe left on a search from the list and tap **Delete**.
    - You can delete term searches but won't be able to delete recent profiles you've searched without clearing your entire search history.

Instagram

Facebook owns Instagram, so it loves keeping track of your data, too. Once again, it can be convenient, but it's good to occasionally clear your search data to save space on your phone or browser and maintain a little bit of privacy.

Since Instagram is more often used as an app than on a browser, let's go over how to clear its search history from the mobile app:

1. Open and log in to the Instagram app.
2. Tap on your profile (the tab at the bottom of the screen that has a circular icon of your profile picture) and tap the icon of three lines on top of each other in the top right part of the screen.
3. Tap on **Settings**, then **Security**.
4. Under **Data and History**, select **Clear Search History** on an iPhone or **Search History** on an Android.
5. You'll be brought to a list of your recent searches. Tap the **X** next to individual searches to delete one by one. Tap **Clear All** in the top right corner to delete them all at once.

Your Instagram search history is like your Facebook search history. If you clear the searches in mobile, or in your browser, you'll clear it in the other.

Google Chrome

Google Chrome exists on computers and mobile devices, and clearing search history is basically the same on both. If your devices sync to one cloud, deleting your Chrome search history on one will delete the history on all of them:

1. Open Google Chrome on your computer and click the **More** menu, the three dots on top of each other in the top right of the browser.
2. Mouse over the **History** menu, then click the **History** option at the top.
3. To delete individual searches, click on the box to the left of different search listings and click **Delete** in the top right part of the window.
4. To delete your entire search history at once, click **Clear browsing data** from the left menu and select what data you want to delete — just your browsing history or also your cookies and cache. Click the **Clear Data** button once you've decided.
    - **Note**: You'll clear up more memory space and get more privacy by clearing out everything.

Google lets you delete your search history, too. **Tap or click here to clear your search history from the Google website**.

Firefox

To clear your search history in Firefox:

1. Open Firefox and click the three-line menu.
2. Click on **History**, then **Clear Recent History…** to delete all of your recent search data.

3. A box will pop up asking you the timeframe to clear (last hour, last two hours, current day, everything, etc.). Choose your timeframe and hit **Clear Now**.
4. To delete items one by one, click **History**, then **Show All History**.
    - You'll get a list of all your recent searches. Right-click what you don't want and select **Forget About This Site.**

Edge

To clear your search history in Edge:

1. Open Edge and click **Settings and more…** then **Settings** in the browser.
2. Click on **Privacy and services** and find **Clear browsing data**.
3. Select **Choose what to clear** and choose a time range of data to delete from the **Time range** drop-down menu. We suggest doing everything.
4. Next, select the kind of data you want to clear — just search history, cookies, cache, even passwords and form-fill data.
    - You'll likely want to keep passwords and form-fill data unless you prefer inputting everything by hand for safety reasons.
5. Click **Clear now** and that data will be erased.

Safari

To clear your search history in Safari:

1. Open Safari and click on the **History** menu tab at the top of your screen.
2. Click **Clear History** on the pop-up menu that appears.
3. Select how far back you want to delete. We recommend going back as far as possible.
4. Click Ok and your browsing history will be deleted.
    - To delete certain searches, in the History tab, select **Show All History** and delete items by clicking on them once, then tap the **delete** key on your keyboard.
5. For mobile, open **Settings**, **Safari**, **Advanced**, **Website Data**, then **Remove All Website Data**.
    - This will delete *all* data, so be sure to bookmark what you want to keep before wiping everything.

Keep your next gift a surprise on a shared computer by clearing the search history on your browsers and social media.

Your computer and mobile devices will have more memory space and you'll keep your data more private, too. So, clear your search history periodically and maintain some privacy while you browse online.

Book Review – The Doctor by Lisa Stone

This was one of my most **wicked** reads. Not because there was a witch or a demon, but a **doctor**, an **anaesthetist**, who was conducting **experiments**, **playing God** and wanting drastic results. Something which, according to him, was **life saving**… But noooo… the **doctor** in me says it was **murder**.

Amit was the **doctor** and **Alisha** his silent **never-leaving-home wife**. She kept to the house with easygoing **friendly** couple who wanted to befriend the doc and his wife but were **stalled**. Emily's **curiosity** soon led to the **disappearance** of the **cat** followed by her own.

When Emily goes missing a few weeks later, Ben is plunged into a panic. His wife has left him a note, but can she really have abandoned him for another man? Or has Emily's curiosity about the couple next door led her straight into danger?

Lisa Stone has created an **aura** of the **mad doctor** quite well in this book. I could read the doctor's thoughts and his notes about his experiments with **horrified** eyes. Lisa's portrayal of the other characters was **distinct** and contrary. Alisha was the **scared one** who couldn't leave home even if she wanted to. Her hidden **secrets** had more **depths** than the doctor's. I enjoyed knowing her. Emily was the **ever-curious** one who couldn't let go despite her partner's advice. And things came to a **hair-raising climax** when Amit decided to take matters in his hands….

Few things were **unbelievable**, but it went with the **creative license** of writing a fiction. **I quite enjoyed this book.**

12 Sonoma Wines to Reach for This Spring

by HANA-LEE SEDGWICK

Beautiful Sonoma County is a wine lover's paradise, home to 18 distinct appellations featuring stunning vineyards planted to over 60 grape varieties. With so many different types of grapes and wine styles produced, there truly is a Sonoma wine for every type of wine drinker, whether you like lean, mineral-driven whites, bold red wines, or everything in between.

Despite all the options that Sonoma wineries offer, when the spring season rolls around, it's hard to deny the appeal of a crisp white wine or a refreshing rosé in your glass. To help inspire you this season, we've compiled a list of fun Sonoma County wines to reach for this spring, from the usual suspects, like sauvignon blanc, to the slightly unexpected, such as pet-net.

Sauvignon Blanc
Fun fact: Sauvignon blanc is a white wine grape that's so old, it's a parent to cabernet sauvignon! While by no means a red wine, this popular varietal is known for its crisp, refreshing character and strong herbaceous flavors — naturally, it's an ideal wine for tasting in spring and for pairing with springtime fare. Sonoma styles can vary from light and crisp to more structured and ripe (especially those which are aged in oak and/or blended with other grapes like semillon), but across the board, sauv blanc from Sonoma delivers enticing notes of lemongrass, tropical fruit, and dried herbs, with bright acidity and delightful mineral impressions on the palate.

Wines to try

Aperture Sonoma County Sauvignon Blanc, Sonoma County, $40

Medlock Ames Sauvignon Blanc, Alexander Valley, xander Valley, $35

Rosé
While rosé deserves to be a year-round beverage, spring is inarguably the official start of "rosé season," when Sonoma County wineries release the newest vintages of their much-loved pink wines and warmer weather beckons for #roséallday. Given the dramatically different microclimates throughout Sonoma County, it's not surprising that rosé grapes and styles here run the gamut. You can find rosé being made from such grapes as pinot noir, sangiovese, grenache, zinfandel, and syrah, in styles that range from light and tart to delicate and sweet to more robust and spicy.

Wines to try

Red Car Rosé of Pinot Noir, Sonoma Coast, $28

Benziger de Coelo Rosé, Sonoma Coast, $45

Capture Rosé of Sangiovese, Alexander Valley, $25

Chardonnay

Chardonnay is a white grape widely planted throughout Sonoma County, where it thrives in cool-climate regions like Carneros, the Russian River Valley, and the Sonoma Coast. While it naturally displays a medium-to-full bodied character and rich fruit flavors, due to Sonoma County's proximity to the cooling influences of the Pacific Ocean, chardonnay from Sonoma tends to showcase bright acid and refreshing minerality, making it easy to reach for as the weather warms up. Mouthwatering flavors of green apple, pear, and citrus are the norm, but you can also expect notes of roasted nuts, caramel, and spice (from barrel aging) and/or creamy characters like buttered brioche and shortbread (from malolactic fermentation).

Wines to try

MacRostie Russian River Valley Chardonnay, Russian River Valley, $36

Sonoma-Cutrer Les Pierres Vineyard Chardonnay, Sonoma Coast, $45

Three Sticks Durell Vineyard Chardonnay, Sonoma Coast, $55

Other Top Picks for Spring

Just because varietals like sauvignon blanc and chardonnay are more recognizable doesn't mean you need to always play it safe. Spring is a great time to whet the palate with new flavors and textures, especially since Sonoma County is home to some stellar lesser known grapes and styles. Whether it's a mouthwatering vermentino or a lively Pétillant Naturel (aka Pét-Nat), Sonoma County wineries are producing plenty of fun, refreshing wines that one can't help but fall in love with this spring.

Wines to try

J Vineyards Pinot Gris, Russian River Valley, $36

Ryme 'Hers' Vermentino, Carneros, $25

Scribe Rosé Pét-Nat, Sonoma Valley, $38

ABOUT THE AUTHOR

Hana-Lee Sedgwick is a writer and editor based in her hometown of Santa Barbara, California. A Certified Specialist of Wine and Sommelier, Hana-Lee specializes in all things wine, food, and travel, and her work regularly appears in publications such as The Tasting Panel, Edible, and Food & Home. Whether for work or play, she never tires of exploring California wine country. Follow her on Instagram at @wanderandwine or visit her blog, wanderandwine.com.

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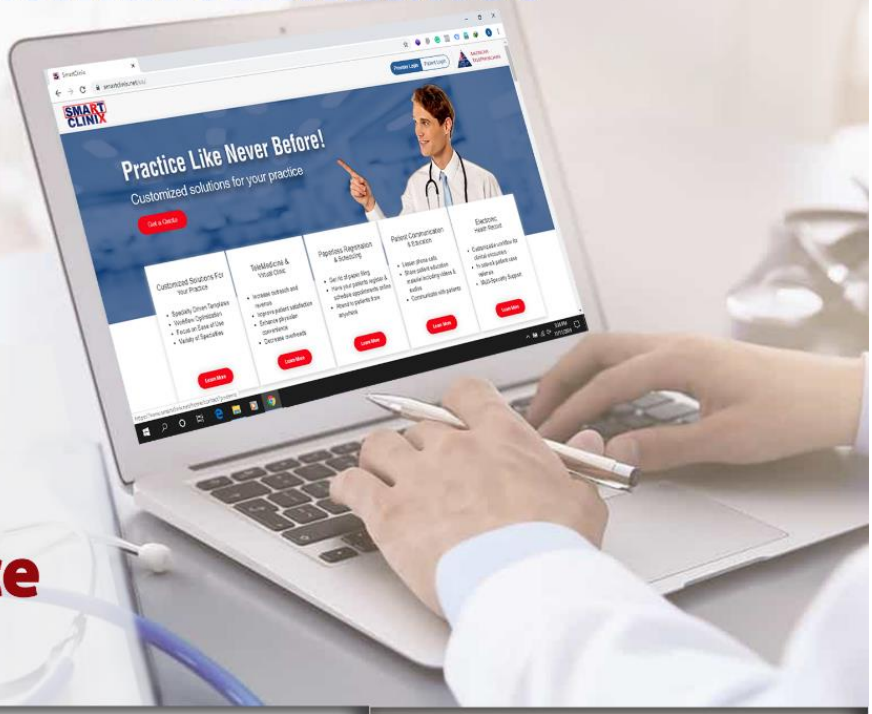

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