MD Life

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In the Corridor of Conscience: A Doctor's Story

By Dr. Stephen O'Neil

The first day of my obstetrics rotation as a third-year med student in 1989 started like any other first day. I arrived at the hospital and got lost. After the requisite amount of time searching I ultimately met the other students at the operating rooms for orientation. We all changed into scrubs and then gathered in the core area where there was a big whiteboard with the scheduled surgeries for the day. In a couple of rooms there were several scheduled C-sections; across the hall in another room there were several "D and E's." "D and E", I learned that day, stands for "dilation and extraction", a second trimester or later abortion where the baby is dismembered in the uterus and removed in pieces.

Those lucky enough to be on one side of the hall went home in car seats. Those across the hall left in red biohazard bags.

I was horrified and all of a sudden fully aware of what abortion is. In the '70's my parents would take us to an abortion clinic in the adjacent town to protest peacefully. We would walk back and forth and pray in front of the drab, one-story building with no windows in front and a long driveway down the side. Intermittently a car would turn in and speed to the back; a young woman would always get out, accompanied by a young man or another woman. No one seemed happy. Back then I knew why we were there but didn't grasp the reality of what was happening inside.

All that changed abruptly years later in the hospital that morning. What had been happening behind the walls of that clinic was now the reality in front of me. I was frozen with dread and the sense of powerlessness that still haunts me today. I couldn't do anything. The deliberate ending of life was a scheduled "procedure." I felt indirectly complicit just for being there and was ashamed of my chosen profession.

Weren't we supposed to help save lives?

Back then there was no overt pressure on students or healthcare providers to participate in abortions and physician-assisted suicide had yet to take hold. Pharmacies didn't prescribe drugs for abortion and nuns weren't sued by the government.

That has all changed.

For example, a nurse at the University of Vermont Medical Center was forced to participate in an abortion despite her objection and her clear communication that she believes abortion to be murder. The Biden administration recently dropped a lawsuit against the hospital regarding this case.

To see just how far conscience protections can be diminished in health care you don't have to look much further than to Canada. From abortion to "medical aid in dying", practitioners are being forced or coerced on myriad fronts. Laws mandating various levels of participation in abortion, physician-assisted suicide and

euthanasia are being passed across that country. Funding and certification is being withheld from those individuals or institutions that refuse to perform actions contrary to their consciences. Pro-life individuals are even being blackballed from entering healthcare in some cases or being removed for publicly professing their views.

Unlike Canada, we have the First Amendment and its religious protections so we are not as far down the path as they; but its enforcement is on shaky ground and variable depending upon the administration in office, as noted above, and we are trending in that direction.

Conscience protections have been eroded or challenged in the United States for years as the culture wars have escalated. Well known are the familiar cases that have been decided in the courts regarding bakers and florists. Some rulings have upheld conscience rights, others have not.

This potentially affects everyone regardless of their place in life as we all may be in a position to need to act as our conscience dictates in situations that are contrary to popular opinion.

But what happens when conscience rights in healthcare are diminished? This has a more potentially life-threatening or life-altering effect on the broader society, even if indirectly.

Both institutions and individuals can be the affected.

Catholic hospitals that provide a significant percentage of health care and indigent care will close their doors if forced to perform abortions or participate in physician-assisted suicide or euthanasia. Many patients will have nowhere to turn and the strain on the system will be overwhelming.

Hospices built on the premise of caring for the dying rather than hastening their deaths will close or rapidly change their culture and lose the essence of their care of those at the end of life—forced to kill rather than comfort.

Pharmacies that refuse to provide abortifacients can and have gone out of business for not doing so, despite no shortage of pharmacies willing and able to provide such compounds.

Nuns caring for the elderly poor can be sued by the federal government and threatened with closure for following their religious beliefs and not providing contraception and abortifacients to their employees that could easily be purchased for minimal cost.

Individuals currently practicing or seeking positions in healthcare may find themselves leaving or never even entering the arena if they know they will not be allowed to follow their consciences. Many good people trying to preserve and protect lives will no longer dedicate their own lives to doing so.

Without conscience protections of caregivers it is the most vulnerable within society who inevitably are harmed the most.

As those who provide a much-needed check on the progression of radical individualism and its selfish ideology are put out of business or forced to leave their profession, the erosion of a culture of life accelerates. Who is there to stop it?

The unborn, newly born, disabled, weak, elderly and infirm, those who cannot advocate for or protect themselves, will be the unwitting victims of a culture built on convenience and utilitarianism rather than conscience.

They will be the ones who suffer as abortion on demand and fetal tissue harvesting and sales become routine and failed abortion victims born alive are “just made comfortable.”

They will be the ones discarded as physician-assisted suicide, which was initially promoted as “compassion for the terminally ill”, morphs into euthanasia of those on the margins of health, age, utility or mental health.

They will be the ones who cannot find the care that they need because the only ones who would care for them have been run out of business because of what they believe.

Over 30 years ago I was horrified to face the reality of abortion.
Now I am afraid that by losing our conscience we may lose our nation’s soul.

Dr. Stephen O’Neil is a board-certified general surgeon in Indianapolis, Indiana. He completed his general surgery residency at Loyola University in Maywood, IL and Hepatopancreaticobiliary fellowship in Toronto, Ontario. He has completed several surgical mission trips to Central America and the Caribbean and speaks on culture of life issues in Central Indiana.

TURKEY STUFFED ZUCCHINI BOATS

thefoodiephysician.com

These *Turkey Stuffed Zucchini Boats* are perfect to make on the weekend when you have a little time. They require some prep work so I like to make a large tray of them on my day off. Then we can enjoy them throughout the week. They're perfect for busy weeknights when you want a nutritious dinner that both kids and adults will enjoy. They're also easy to pack up for lunch.

To make the *Turkey Stuffed Zucchini Boats,* I first cut the zucchini in half lengthwise and then scoop out the middle. Be sure to save the zucchini flesh to add to the filling. Zucchini is low in calories and is packed with water and fiber. It's a good source of several beneficial vitamins, minerals and antioxidants, especially vitamin C.

I like to pre-bake the zucchini while I make the filling so that they soften up a little. The turkey filling comes together quickly on the stove thanks to the help of jarred tomato sauce. You can definitely make your own sauce if you prefer but when I'm pressed for time, jarred sauce is a huge timesaver!

The final step is to fill the zucchini boats with the turkey filling and then top them with a mixture of mozzarella cheese and breadcrumbs before popping them back in the oven. The combination of ooey, gooey cheese and a little crunch from the breadcrumbs is the perfect finishing touch!

Turkey Stuffed Zucchini Boats

Prep Time
20 mins
Cook Time
12 mins

My Turkey Stuffed Zucchini Boats are light and nutritious- they're the perfect dish to kick off the New Year in a positive way!

Course: Entree, Main Course
Cuisine: American, Italian
Servings: 4
Calories: 241 kcal

Ingredients

- 4 large zucchini
- Olive oil spray
- 1 small yellow onion, chopped
- 1 pound ground turkey
- 1/2 teaspoon kosher salt
- 1/4 teaspoon black pepper
- 1 1/2 cups jarred tomato sauce (I use Rao's marinara sauce)
- 1/3 cup shredded mozzarella cheese
- 2 tablespoons Italian seasoned breadcrumbs

Instructions

1. Preheat oven to 375°F.
2. Slice the zucchini in half lengthwise. Using a spoon or melon baller, scoop out the flesh from the center, leaving a ¼-inch shell around the edges. Save the zucchini flesh in a bowl for later. Arrange the zucchini halves in a large baking dish and spray them with olive oil. Bake in the oven for 20 minutes until slightly softened. Remove from oven.
3. While the zucchini is baking, spray a large sauté pan with olive oil. Add the onion and ground turkey. Squeeze as much water as you can from the reserved zucchini flesh and chop it up. Add the chopped zucchini to the pan. Season the mixture with the salt and pepper. Cook, breaking up the turkey with a spoon, until turkey is browned and vegetables are softened. Stir in the tomato sauce and simmer a few minutes longer.
4. Spoon the turkey filling into the zucchini halves. Mix the mozzarella cheese and breadcrumbs together in a bowl and sprinkle the mixture on top of the zucchini boats.
5. Cover the baking dish with foil and bake in the oven for 20 minutes until the zucchini is cooked through and the cheese is melted. Enjoy!

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-Dr. Wilson E. Tabe MD,Goldsboro, NC

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A Breakdown of Google Health in 2021: 15 Things Leading Up To Division's Dismantling

Jackie Drees and Hannah Mitchell, beckershospitalreview.com

Google has begun dissolving its health division as it looks to split its healthcare projects and teams across several areas of the company, *Insider* reported Aug. 20.

The move comes as Google Health's chief, David Feinberg, MD, announced he would be joining Kansas City, Mo.-based EHR company Cerner in October as its new president and CEO.

Here are 15 things to know about Google Health's business strategy and partnerships in 2021 so far, based on reports from *Becker's Hospital Review*.

Leadership and strategy

1. Google said Aug. 19 that it's dissolving hundreds of employees in its health division into existing divisions.

2. Dr. Feinberg, the vice president of Google Health, left the company after three years as its lead for the CEO position at Cerner, the company said Aug. 19.

3. Google Health had 700 employees but began moving more than 130 employees into other areas of the company, including Search and the newly acquired Fitbit group, Insider reported June 17.

4. Dr. Feinberg said at The Wall Street Journal's June 9 health tech conference that Google Health isn't concerned if its health venture can turn a profit. He said the division is focused on global impact and that even though the ventures are expensive, revenue is an afterthought.

5. In June, Google had an active job listing for the director's chief of staff at Google Health. The executive would work with Google's chief health officer to ensure operational success and strategy.

6. Google Health hired Charles DeShazer, MD, in March to be its director of clinical products. Dr. DeShazer previously served as the CMO at health insurer Highmark. At Google, his role will focus on the development of Care Studio, Google's EHR search tool pilot program.

Google partnerships with healthcare players

7. Researchers from Google Health, Naval Medical Center San Diego and The Henry M. Jackson Foundation for the Advancement of Military Medicine in July developed an artificial intelligence model to predict breast cancer status and understand tumors better for treatment.

8. HCA Healthcare inked a multiyear collaboration with Google Cloud in May focused on building a health data analytics platform to support the Nashville, Tenn.-based system's clinical and operational workflows.

9. In April, Boston-based Beth Israel Deaconess Medical Center joined the pilot of Google's Care Studio EHR search tool.

10. Google announced plans to open its first office in Minnesota as part of its ongoing health partnership with Rochester-based Mayo Clinic, which the tech giant teamed up with in September 2019. The 10-year partnership focuses on cloud computing, machine learning and artificial intelligence work to advance the health system's healthcare innovation and virtual care initiatives.

11. Google and St. Louis-based Ascension in February continued the collaboration they began in 2018 by rolling out a tool, dubbed Care Studio, to help clinicians better organize and search for patient information.

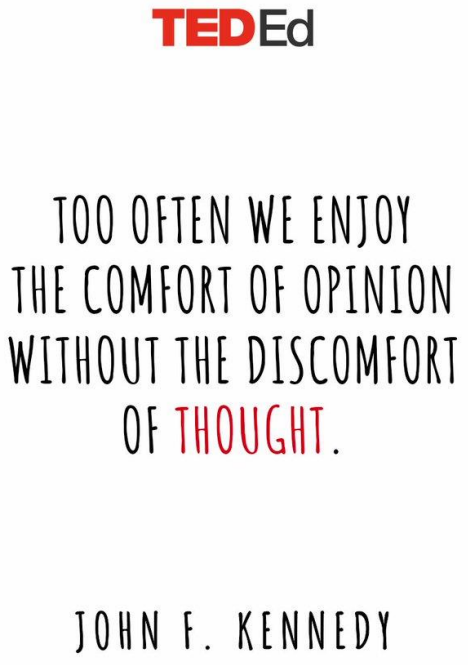
Google healthcare projects

12. Verily, the healthcare and life sciences sister company of Google, said Aug. 5 it plans to launch a new AI research and development center in Israel. The center will focus on using AI to address issues and inefficiencies facing the medical field, with Verily picking up some of Google Health's projects, including the company's initiative exploring the use of AI in colorectal cancer screenings.

13. YouTube launched an initiative to combat health misinformation, which had three main focuses: removing misinformation, reducing its spread and promoting credible sources of health information, it told Becker's in July. YouTube partnered with several leading healthcare providers to help populate its platform with credible health information, including Cleveland Clinic, Mass General Brigham, Rochester, Minn.-based Mayo Clinic, Stanford (Calif.) Medicine, and Kaiser Family Foundation. YouTube said it was moving away from a paternalistic approach to health information and toward a focus on patient engagement.

14. Google in April entered the early stages of a new project aiming to explore and develop a consumer-facing health records tool for Android users. Google did not directly partner with any healthcare organizations on the project, which could support the development of a medical records tool similar to Apple's Health Records app, according to STAT.

15. Google paid $2.1 billion to acquire Fitbit, solidifying its advances to improve wearables. The deal was first announced Nov. 19 and concluded Jan. 14.



Yes, Your Smart TV is Spying on You – Here's How to Stop It

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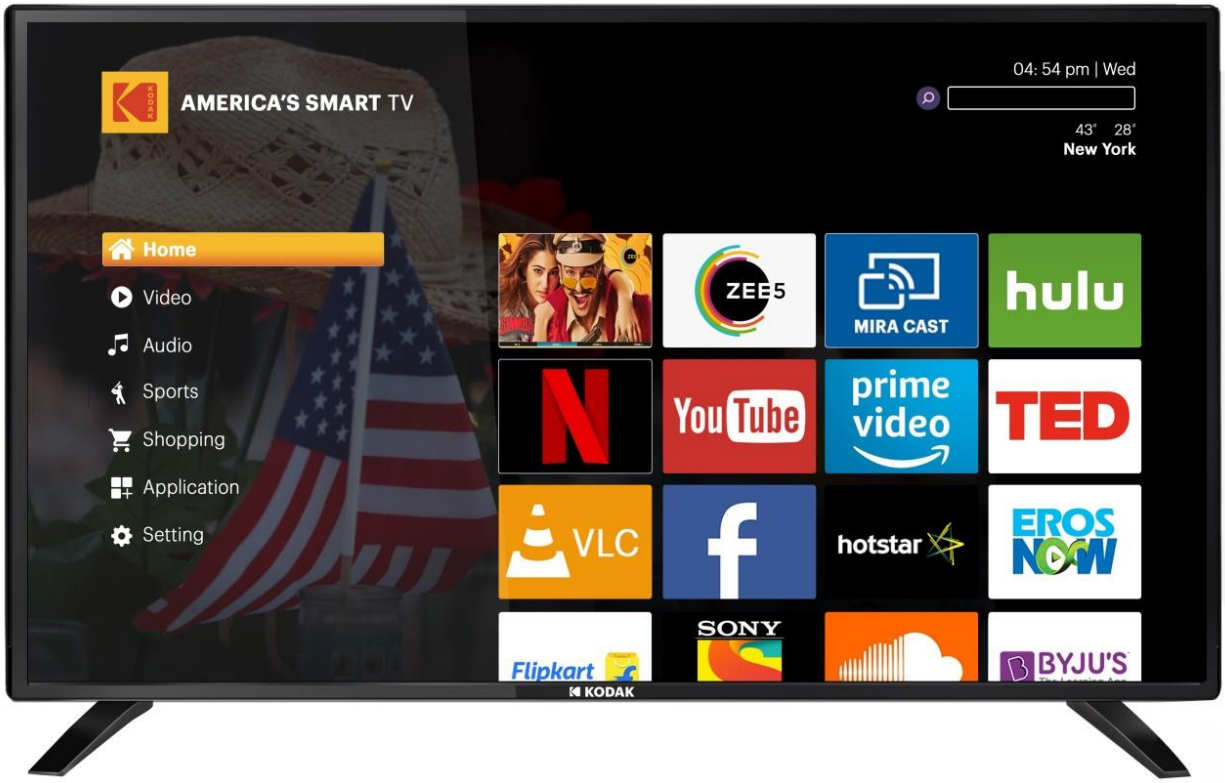

Smart TVs are big money savers compared to other tech on the market. Not only do they tend to be cheaper than traditional TVs, but they also include built-in apps that can save you from having to buy streaming devices like a Roku or Fire TV Stick.

But as with any smart technology, there's a price to be paid for the convenience. In return for an always-connected experience, smart TVs collect data on users — a lot of it.

You won't believe how your smart TV is not just gobbling up your viewing data. In some cases, it's also gathering information about your home. In this guide, we'll walk you through how to opt out of this data collection so you can get back to binging your favorite shows in peace.

Turn off your smart TV's tracking features

Can you minimize your smart TV's snooping activities? Yes. Our advice: Turn off its tracking features — especially Automatic Content Recognition.

What is ACR, and how do you turn it off? It's a visual recognition feature that can identify every ad, TV show or movie you're playing on your TV. This includes streaming boxes, cable/over-the-air TV and even DVD and Blu-Ray disk players.

This data is collected and can be used for marketing and targeted advertising purposes. If this all sounds too creepy to you, there are thankfully ways to turn it off. The exact methods will depend on your TV's brand.

Vizio

If you own a Vizio smart TV, you can turn off your set's ACR features. Here's how:

On older Vizio TV sets that use Vizio Internet Apps (VIA), go to the TV's **System**, and then: **Reset & Admin > Smart Interactivity > Off.**

On Vizio smart TVs that use the newer SmartCast system, go to **System** > **Reset & Admin** > **Viewing Data** > toggle it to **Off.**

Samsung

Some Samsung smart TVs include voice control. If you're concerned about your privacy, you can turn off voice control, ACR and ad tracking completely.

On newer Samsung sets, go to **Settings** > **Support** > scroll down to **Terms & Policies**. Here you can turn off **Viewing Information Services** (Samsung's ACR technology), **Internet-based Advertising** (for personalized ad tracking) and **Voice Recognition Services**.

On older Samsung smart TVs, go to the TV's **Smart Hub** menu **> Settings > Support >** look for **Terms & Policy >** then disable **SyncPlus and Marketing**. You can disable **Voice Recognition Services** in this section, too**.**

Keep in mind that turning off your Samsung TV's Voice Recognition Services will disable its voice commands.

LG

LG's ACR technology is baked into its newer WebOS-powered smart TVs, known as **LivePlus**. To turn this off, go to **Settings > All Settings >** scroll down to **General >** scroll down to a setting called **LivePlus >** toggle it to **Off.**

To limit other forms of data collection on your LG smart TV, go back to **Settings > All Settings >** scroll down to **General** > **About This TV** > **User Agreements >** toggle **Personalized Advertising** to **Off**.

Amazon Fire TV

Amazon's Fire TV platform is baked into some smart TVs. Although Amazon said that it does not use ACR to identify content on Fire TV Edition TVs, it can still collect data about the over-the-air channels you watch and the streaming apps you use.

To turn this off, go to your TV's **Settings** > **Preferences** > then scroll to the "**Right to Privacy Settings."** Turn off the setting labeled "**Collect App and Over-the-Air Usage Data**." You can also turn off **Interest-based ads** in this section.

Roku TV

On Roku-powered smart TVs, you can turn off ACR by going to **Settings** > scroll down and select **Privacy > Smart TV Experience.**

Next, uncheck "**Use Information for TV Inputs"** to disable ACR. Although this will stop your Roku TV from identifying your content on the pixel level, Roku can still collect data about the Roku TV streaming channels you've installed and use.

To prevent personalized ads on your Roku profile, go to **Settings** > **Privacy** > **Advertising,** then check "**Limit ad tracking**." **Note**: This setting is also available on Roku streaming gadgets.

Samba TV

Another way advertisers track you is through a service called Samba TV.

How widespread is Samba TV? According to the "New York Times," the company has struck deals with about a dozen popular TV makers to place its software on several models.

Brands with Samba TV include **Sony, Sharp, TCL, Element, Sanyo, Toshiba, Westinghouse, Seiki** and **Philips**.

Samba TV describes itself as "a cutting-edge technology layer on your TV that understands what your TV is playing, regardless of the source." It also "communicates with your devices, enabling personalized recommendations and unique second-screen experiences for compatible TVs and apps."

But wait, there's more! Samba TV's system can also reach out to other devices in your home connected to the same network as the TV. This means that aside from the ability to recognize and track content regardless of source, Samba TV can also create a "device map" of your home.

Samba TV itself doesn't sell its tracking data directly. Instead, advertisers and marketing firms pay them to send targeted ads to other connected gadgets in a home.

For example, they can direct ads and recommendations to your smartphone after a client's TV commercial plays. Advertisers can also add Samba TV tags to their websites to let them know how many people visit after watching one of their ads.

Did you opt-in to Samba TV?

Have you opted into Samba TV's service without even realizing it?

See, when a Samba TV-enabled device is set up for the first time, consumers are encouraged to opt-in to the service and agree to its terms of service and privacy policy.

The opt-in sounds enticing enough – "Interact with your favorite shows. Get recommendations based on the content you love. Connect your devices for exclusive content and special offers," it states.

The problem? The nitty-gritty details of its terms of service are only available online via browser or if you click through to another screen on your TV.

Although these documents do disclose their tracking practices, they are also long and difficult to understand. The company's **terms of service** exceed 6,500 words, and the **privacy policy** is over 4,000 words! (Who actually reads these cryptic terms of service anyway?)

It's no wonder that more than 90% of people choose to opt-in, not realizing the amount of information they're giving up to the company.

How to opt-out of Samba TV

If you're totally creeped out by Samba TV's data collection and you do want to opt out, here's how.

Smart TVs

According to Samba TV's website, you can opt-out of its smart TV services anytime by finding the option in a TV's "Settings" page or within the "Interactive TV Service" user interface.

If applicable, another way to limit spying is by enabling "Limit Ad Tracking" from the "Privacy" menu within the "Interactive TV Settings" on your smart TV.

Samba TV wrote that its advertising platform would opt your Samba TV ad ID out of targeted advertising based on content viewing if you do this. You can also opt-out of Samba TV web and app-based interest advertising with these steps:

Web browsers

You can opt-out of having Samba use your web browsing information for interest-based advertisements by visiting the Network Advertising Initiative's (NAI) **opt-out page** or accessing the "Opt out of Samba TV Ads" option within the company's **privacy policy page**.

Mobile devices

According to Samba TV, the most effective and up-to-date method is to limit ad tracking on your mobile device.

Here's how you do this:

For Apple:

iPhone, iPad, or iPod Touch – Go to **Settings** > **Privacy** > **Apple Advertising** > Toggle "**Personalized Ads**" to **Off**.

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The Business School Mindset Doesn't Mind Physician Burnout

PATTY FAHY, MD

Even those of us with a meditation cushion and a gong app are likely to recoil when mindfulness practices are suggested as solutions for physician burnout. Sure, these practices are important. No, they do not address the causes of physician burnout.

Certainly, a more genuine effort by organizational leaders would be to respond to the data. There's lots of it. The burnout — now "wellness" — data is collected endlessly and sliced and diced to populate hundreds of published articles. None of the survey results I've seen clamor for resilience retreats or new wellness infrastructures.

On the other hand, where is the swift investment and action on those career-wrecking problems that do emerge in one physician survey after another? Where is the big dollar investment required to fix the "death by a thousand clicks" EMR? And where have organizational leaders mustered the political will to mitigate the toxic sinkhole of prior authorizations or arrange staffing that facilitates (rather than impedes) excellent patient care? Now those are issues that show up as flashing neon headlines year after year when burnout (I mean "wellness") surveys are tallied.

The fixes are not forthcoming. Instead, a new chief wellness officer is appointed in a high-profile display of leadership largesse. A resilience retreat follows soon thereafter.

The fixes are not forthcoming because there is a clash of ideologies: Medicine vs. the Business School Mindset. And the "BSM" is winning.

Another term for the BSM is managerialism. This is the ideology promulgated inside the gleaming towers of business schools. I use the term "Business School Mindset" rather than specify the MBA degree because the ideological mindset can exist with or without an MBA. And of course, there are people with graduate business degrees who have not adopted a BSM.

The BSM is characterized by the belief that management is a learned profession with a body of knowledge and special "scientific" tools. I suppose a fly in the "learned profession" ointment is those pesky pop-up ads for "fully accredited/fully online MBA degrees — no GMAT/GRE required." Nevertheless, graduates are assured that an MBA degree has prepared them to manage in any industry: a tattoo parlor, a government entity, or a hospital system.

Other BSM elements:
Managers are an elite caste, separate from those who are managed, monitored, and controlled.
Efficiencies gained by controlling the behavior of professionals and other workers garner financial rewards and power for the elite caste.

The principle of rational egoism that declares an action is rational only if it maximizes self-interest (witness super-sized CEO salaries in not-for-profit health care systems, lay-offs while executives collect bonuses, and private equity decimation of medical practices, community hospitals, and nursing homes).

While physicians, the health care industry, and other swaths of society have been left swirling by subjugation to the managerial caste system, we haven't named it. But brethren inside business schools have sounded the alarm for decades.

Martin Parker wrote a 2018 article for the Guardian titled, "Why we should bulldoze the business school" with the subtitle "There are 13,000 business schools on Earth. That's 13,000 too many. And I should know—I've taught in them for 20 years." Parker states that "business schools have a huge influence, yet they are also widely regarded to be intellectually fraudulent places, fostering a culture of short-termism and greed." Henry Mintzberg, the author of 150 articles and 15 books, says management is not a profession and not a science. He said that you can't teach management in a classroom outside the context and culture of an actual business — and telling graduates that they are "managers" creates hubris.

Warren Bennis and James O'Toole wrote a 2005 Harvard Business Review article "How Business Schools Lost Their Way," describing comprehensive failings of business schools to be effective or ethical. That article foreshadowed the 2007 subprime mortgage crisis—attributed in part to the opportunism fostered in graduate business education.

So back to burnout.

- The BSM in our health care institutions is what causes burnout.
- The BSM and the profession of medicine are incompatible.
- The steps to address physician burnout are anathema to managers who prioritize profits over patients.

Monitoring, controlling, and cost-cutting are reflexive necessities when leadership doesn't fully understand the industry. The current EMR is a revenue collection system with a remarkable feature from the BSM perspective: The data entry clerks work all hours, and they double as doctors! And since the work always gets done, why increase support to physician practices or attempt to mitigate the crazy-making prior authorization demands?

We can't expect those with a BSM to solve physician burnout. What is needed is leadership throughout health care organizations by those with expertise in the core business, deep commitment to health care workers and patients, extensive tacit knowledge, and credibility. Physician CEOs have better outcomes in all critical metrics, including engagement among staff. And physician leaders have an ethical and fiduciary responsibility to serve patients. Those with a business school mindset do not.

Patty Fahy is an internal medicine physician and founder, Fahy Consulting. She can be reached on Twitter @pattyfahyMD.

A Physician Faces Criminal Charges for Going Above and Beyond #WeAreDrGokal

NISHA MEHTA, MD

Imagine that you're a physician in the middle of the global pandemic. The life-saving vaccine has just come out, and your job includes administration of the vaccine. At the end of your day, you have 10 extra vaccine doses in an opened vial that will need to be discarded if not used. You know there are not enough vaccines available yet to vaccinate everyone who needs this vaccine as soon as possible, and COVID-19 cases are surging. You go out of your way to spend hours after work seeking patients who meet vaccination criteria and driving around town administering the remaining doses before the doses expire.

In most circles, you would be praised for going above and beyond the call of duty to do something life-saving for someone else. As a physician myself, my gut response is that this action embodies the physician spirit. Ethically, it feels like it was the right thing to do. In December 2020, when cases were surging and when so many of us were desperate for vaccines, it was an atrocity that there were unused doses that needed to be discarded.

However, in this story, the story of Dr. Hasan Gokal, the dialogue was quite different. A few days later, this physician was fired from his public health job, and was subsequently faced with criminal charges for stealing a vial of the vaccine. His case was also brought to the Texas Medical Board.

Health care is complicated. We exist in a sea of regulations and protocols, which we hope are well-intentioned and in the best interest of patient care and safety. That said, most physicians will tell you that the practice of medicine is both a science and an art. In our day to day practice, there is a lot of grey and white, because ultimately, we're dealing with people's lives, and every case is different. Our training emphasizes always prioritizing patient care, even when it comes at our own personal sacrifice.

Medicine is a calling. Over the past year, we have heard so many stories of health care heroes putting themselves at risk to care for patients and providing care in suboptimal situations. Policies and protocols take time, understandably, but in the interim, the immediate needs of patients have needed to be addressed. Until March of last year, it would have been grossly against protocol to ever reuse a mask or perform a procedure without adequate personal protective equipment, and yet, we were encouraged to do so by both our institutions and our government because patient care necessitated it. Unfortunately, this has resulted in the loss of the lives of many health care workers. Despite this, we've continued to show up to work every day with a commitment to serve our patients.

On the day that Dr. Gokal administered the shots, there were no written protocols for what to do with the unused vaccine doses, nor was there a waiting list for vaccine doses. He called a public health official in charge of operations to inform them of his plans to find 10 people to receive the remaining doses, and was given an OK.

After reviewing the unique aspects of the case, the Texas Medical Board dismissed the investigation, and a Harris County judge dismissed the original criminal charge, pointing out in his statement that he rejected the imposition of criminal law to a doctor's administration of a vaccine during a public health emergency.

However, the Harris County District Attorney's office continues to explore criminal charges. They anticipate presenting this case to a grand jury, who would determine whether a criminal charge is appropriate. As Dr. Gokal faces pending criminal charges, his job options are limited.

This story has shook the physician community, who has rallied behind Dr. Gokal and expressed widespread support for the spirit of his actions. It is hard not to perceive the decision to pursue prosecution as a lack of recognition for the good faith efforts the health care community has made to do its best throughout a year of extraordinary circumstances and uncharted territories. When one of our own governing bodies, the Texas Medical Board, an institution that is familiar with the intricacies of health care delivery over the past year, has chosen to drop the investigation, continuing to pursue a criminal case for an attempt to serve patients sends a very clear message to physicians. Unfortunately, the message is that we are not safe from threats to our careers and personal lives when making well-intentioned efforts to serve our patients in these extraordinary circumstances.

On one hand, there has been a rush to laud health care workers for their sacrifices during the pandemic, and the coining of the term "health care hero," and yet on the other end, we have failed to protect health care workers. Over the past year, health care workers have faced retaliation for asking for adequate personal protective equipment and for informing the public about what they were seeing in hospitals, despite doing so in order to educate the public about the seriousness of the disease. Many health care workers have lost their lives. Burnout and mental health concerns have been exacerbated in a population where burnout was already a very real threat to the workforce, and many are considering leaving the field. Physicians have been furloughed, fired, or asked to work for less pay. Requests to bolster and support the physician workforce through expansion of residency programs and granting of visas have not made significant progress. We have not provided support to the families of essential workers who have lost their lives in this fight. When the medical community asked for liability protections to cover deviations from normal protocols and requests to perform duties outside of their normal scope of practice, they were not offered liability protections on a national level.

It is no wonder that each member of the physician community can see a little of their own story in Dr. Gokal's story.

To be clear, nobody was hurt. In fact, 10 patients received life-saving vaccines that would have otherwise been discarded. This happened in the midst of a global pandemic where these vaccines were widely sought and not readily available.

If we as a nation don't stand behind Dr. Gokal, and in fact present him with criminal charges, which physician will go above and beyond the next time they have the opportunity to help?

Nisha Mehta is a radiologist and founder, Physician Side Gigs and the Physician Side Gigs Facebook group. She can be reached at her self-titled site, Nisha Mehta, MD, and on Twitter @nishamehtamd.

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It’s Football Season! Best TVs for Sports 2021

By Simon Lucas , Henry St Leger

Which TVs are the best for sport? If you enjoy watching sport at home, this is an important question, especially because the next few months will involve a lot of must-see action, like Euro 2020 and all of the top tennis tournaments.

Despite what you might think, not all of the best TVs on the market right now are suited to watching big sporting events. They might be cinematic and great for movies, but sport is a different ball game.
If you’re buying a TV and you know you'll be watching a lot of sport, there are a few key things to consider. For starters, there are many different aspects of picture performance to bear in mind, including detail retrieval, color fidelity, and edge definition. Of course, these are all the hallmarks of a good TV, but a great TV for sport needs some extras.

For example, televised sport is overwhelmingly concerned with on-screen motion. That’s the case whether you enjoy watching football, cricket or WWF – with all of these sports the on-screen images are constantly on-the-go.

We’d expect slow camera pans to follow faster movement, abrupt changes of direction, movement in the opposite direction the way the camera is moving, and great big swathes of uniform color with smaller elements of different color in constant motion. You get the idea, the way a TV handles motion is extremely important.

This means there are 50 images broadcast per second, which is what makes still pictures look like they’re moving. Therefore, how well a TV can handle this rate of transmission will determine how smooth and convincing the on-screen motion is going to look.

Bear in mind that there isn’t a TV out there with a refresh rate of less than 50Hz. So in theory, one TV should be very much like another when it comes to taking those 50 images per second from the broadcaster and delivering them at a rate of 50 per second on the screen.

Or at least that should be the case. In practice, some TVs are much more accomplished at handling refresh rates than others. Here’s our guide to the TVs that are great at handling motion, and have all the other top picture-making talents built-in to go along with it.

1. **LG CX OLED -** Lack of Freeview Play aside, this is a sterling choice for sports viewing

SPECIFICATIONS
Screen size: 48-inch, 55-inch, 65-inch, 77-inch
Resolution: 4K
Panel type: OLED
Smart TV: webOS
HDR: HDR10, HLG, Dolby Vision

$1,129.99
REASONS TO BUY
+Stellar picture quality**+**Great gaming features too

REASONS TO AVOID

-No HDR10+ support-Missing UK catch-up apps

You'll need to overlook the inexplicable and quite significant lack of UK TV catch-up services if you're going to find a place in your home for LG's superb OLED55CX – but if you're a sports fan then you should try your hardest. The LG is a great TV for sports-viewing – once you have a delve into the LG's extensive set-up menus.

Weirdly enough, it's not the OLED55CX's 'Sports' picture preset which makes sport look its best. Instead, get down into the depths of the set-up menus and select 'TruMotion', and then have a fiddle with the 'de-judder' and 'de-blur' adjusters. It's fairly straightforward to get a balance that makes the LG's motion-handling as smooth as freshly polished silk, while retaining all the detail and lovely color balance that the screen is capable of.

2. Panasonic HX800 LCD TV (UK) - An excellent mid-range television for sports

SPECIFICATIONS
Screen size: 40-inch, 50-inch, 55-inch, 65-inch
Resolution: 4K
Panel type: LED-LCD
Smart TV: My Home Screen 5.0
HDR: HDR10, HLG, Dolby Vision, HDR10+

REASONS TO BUY
+Universal HDR support+Brilliant price

REASONS TO AVOID
-Could be brighter-Not much is new

In general terms, the Panasonic HX800 is something of a steal – the 'picture-quality-per-pound' ratio is perhaps stronger here than with any other TV in this list. And while it's generous enough to offer complete HDR support (by no means a given, sadly), one of the headline reasons it's such a bargain, relatively speaking, is the absolutely sterling work it does with televised sports.

For once, this Panasonic is a TV that looks its best with sports when set to its 'Sports' picture mode. From there, it takes only a moment's finessing of the 'Intelligent Frame Creation' setting to get a result that combines utterly convincing motion-handling with the fine edge-definition and detail retention that makes the Panasonic such an enjoyable and absorbing watch.

3. Philips OLED 805 - Gorgeous Ambilight colors with an OLED panel? Count us in

SPECIFICATIONS
Screen size: 55-inch, 65-inch
Resolution: 4K
Panel type: OLED
Smart TV: Android TV
HDR: HDR10, HLG, Dolby Vision, HDR10+

REASONS TO BUY
+Lovely design+Immersive Ambilight

REASONS TO AVOID
-No Freeview Play-Android TV issues

The Philips OLED 805 is a winning combination of excellent picture quality, powerful processing, and lovely build quality.

The 805 isn't quite as competitively priced as its step-down sibling, the OLED 754, but it packs in all the same features with even more impressive specs.

And Philips, of course, is the TV brand that trusts its customers more than any other. That's why the 65OLED805 comes complete with an absolute stack of picture-adjustment options for its owner to spend hour after hour fiddling with.
It's possible to make minute changes to the way the P5 fettles images – and as long as you have the patience, the 805 is capable of turning out some of the best-controlled and most lifelike sports pictures around. Just turn off all the 'noise reduction' options in 'Standard' mode and you're most of the way to some brilliantly controlled sports action.

If you don't want to have to fiddle with your settings too much, though, this might not be the best choice for you.

4. Samsung Q60R QLED TV - Samsung's budget QLED won't let you down (with the right settings)

SPECIFICATIONS
Screen size: 43-inch, 49-inch, 55-inch, 65-inch, 75-inch, 82-inch
Resolution: 4K
Panel type: QLED
Smart TV: Tizen
HDR: HDR10, HLG, HDR10+

$597.99

REASONS TO BUY
+One of the cheapest QLED TVs**+**Decent processing for the price

REASONS TO AVOID
-Edge lighting-Older model

Sasmung's QLED technology has a lot going for it, and the company has extrapolated it into a bewildering number of TV ranges. But the price/performance sweet-spot is almost certainly here, in the Q60 range.

The Q60R is an across-the-board success in every aspect of picture-making. The sound it makes doesn't match up in the slightest, but that needn't concern us here. What sports fans need to know is that the Samsung is pretty capable of gripping motion hard, even with its default, out-of-the-box settings – so spend a few minutes in the 'Picture Clarity' section of the set-up menus and a really gratifying picture can be yours. Just remember to leave 'noise reduction' well alone in favour of trimming 'judder reduction' and you're in business.

It's worth noting that there's a newer Q60T model now– with a Q65T variant with the Samsung OneConnect box – though due to some shuffling around of new Samsung TV models, these new versions actually have a lower-spec processor than the older Q60R. Keep an eye out for our full Q60T review in the coming weeks.

5. Sony A8H/A8 OLED - Wide viewing angles make this a good choice for multiple spectators

SPECIFICATIONS

Screen size: 55-inch, 65-inch
Resolution: 4K
Panel type: OLED
Smart TV: Android TV
HDR: HDR10, HLG, Dolby Vision

$1,698
REASONS TO BUY
+Good sound quality**+**Ultra-wide viewing angles

REASONS TO AVOID
-Android TV can frustrate**-**Potential for screen burn

As the most expensive TV in this list, it seems only right and proper that the Sony A8H should also be the most capable TV here. Whether or not it's worth the premium over, say, the LG CX OLED is debatable – but there's no denying it's a better watch. Sony's remarkable Acoustic Surface Audio system, which utilises the entire screen as a speaker, is superior too.

As far as watching sport goes, there's no arguing with the Sony A8H's quality. The initial settings aren't much help, it's true, but things improve once you get into the set-up menus and pay proper attention to 'Motionflow' and, within that setting, 'Smoothness'. Then, examine the 'Clearness' adjuster until you've got what you deserve: buttery-smooth motion with no loss of detail or color volume.

Should You Join an Existing Medical Group?

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

When you enter the medical field, there are a number of decisions to make: should you join an existing group, take a salaried position with a healthcare system or start a new practice by yourself or with a partner or two. Obviously, there's no right or wrong decision that applies to everyone. But be sure you understand your options and make an informed choice.

Joining an existing medical group is probably the most popular option for newly minted doctors and dentists. You can begin to practice your profession without being overly concerned about the business aspects. There will be support staff in the group who handles patient scheduling, billing and collections, marketing and technology – key aspects of running a successful practice that were not covered in medical school.

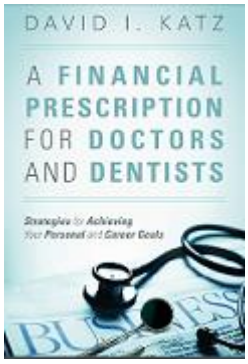
But before making a decision, you should plan to spend time with the firm's partners and office managers to learn as much as you can about the practice and the people with whom you'll be working. The more you know about the culture of the group, the better you'll know if it's a good fit for you or not. For example, some practices emphasize seeing a high volume of patients. If you're a new doctor who prefers long patient encounters, you may need to adjust to that different philosophy. You may also enjoy the opportunity to work with one or more experienced physicians in your particular specialty.

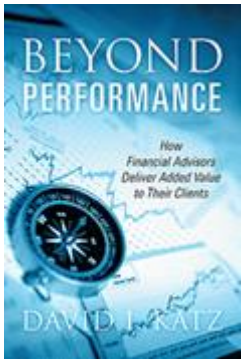
When joining a new group, be sure you know the right questions to ask:
• How will you be compensated?
• What about vacation time and rotating coverage responsibilities?
• Will you be compensated for time away from the office for continuing medical education (CME) activities? • What are the insurance benefits?
• What are the retirement benefits?
You should also think about an exit strategy if joining the group proves to be a poor decision. Many practices require new professionals to sign employment agreements and restrictive covenants that might make it

difficult to open a competitive practice. Be sure to discuss your options with your attorney before signing any agreement.

Also remember that while you will be the "new kid on the block," the negotiation process doesn't have to be one-sided. Take a look at what the practice is offering, talk with your legal advisor or a mentor in your profession and listen to what they have to say.

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





David is an Accredited Investment Fiduciary® (AIF) and an Accredited Asset Management Specialist (AAMS®) who advises professionals, retirees, families and other clients on personal financial strategies along with his partner Eitan Esan. They focus on financial planning and asset management. David has more than 27 years of investment and wealth management experience, and is the author of two books "A Financial Prescription for Doctors and Dentists: Strategies for Achieving Your Personal and Career Goals" (2015) and "Beyond Performance: How Financial Advisors Deliver Added Value to Their Clients" (2018) Eitan received a Bachelor of Arts in economics from Yeshiva University, a Master of Public Administration from CUNY John Jay and a Master of Business Administration from Arizona State University, where he graduated cum laude.

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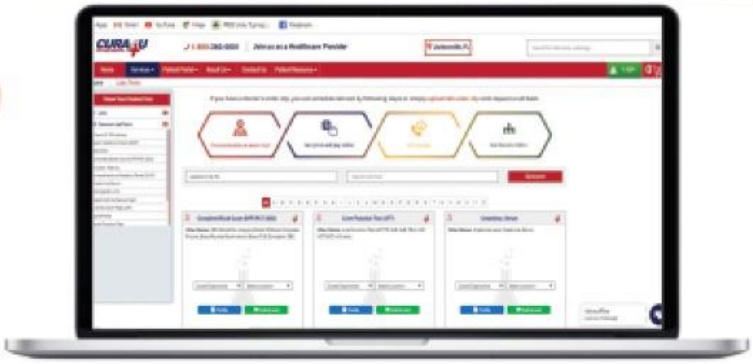

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Healthcare in Crisis: Diagnosing Cybersecurity Shortcomings in Unprecedented Times

By Lindsey O'Donnell, threadpost.com

In the early fog of the COVID-19 pandemic, cybersecurity took a back seat to keeping patients alive. Lost in the chaos was IT security.

When the COVID-19 pandemic first hit the U.S. hard in March, the Elmhurst Hospital was forced into a logistical nightmare.

It was a grim sign of the times, as the Queens, N.Y. hospital was flooded with hundreds of sick patients, with one medical resident describing conditions as “apocalyptic”, according to a New York Times interview. At the same time, hospitals also began a similar rush to increase capacity to keep up with growing infection rates, and scrambled to find personal protective equipment (PPE), ventilators and trained staff.

Lost in the chaos was IT security. In the early fog of the pandemic, cybersecurity took a back seat to keeping patients alive. But it did not take long before important hospital systems such as telehealth patient portals, backend billing and coding systems, connected medical devices and video-conferencing platforms were stressed.

Cybercriminals took notice. Cyberattacks targeting healthcare firms have increased 150 percent since the COVID-19 virus hit the U.S. shores. The pandemic’s unprecedented impact on healthcare lay bare the gaping holes in the healthcare industry’s cybersecurity defenses. It is a sobering wakeup call that security experts say will have a lasting impact on the healthcare industry well into 2021.

Cyberattacks Target Vulnerable Systems

The goals for cybercriminals are varied. At one end of the spectrum, they’re targeting personally identifiable information to be later used in credential stuffing attacks or for resale on criminal black markets. At the other

end, attackers have also launched costly ransomware attacks against insecure healthcare systems- potentially endangering patient lives.

"Frontline health professionals have been heroes during this pandemic, saving lives," said Beau Woods, a Cyber Safety Innovation Fellow with the Atlantic Council.

Woods, who has worked for the past 10 years with small hospitals, healthcare focused nonprofits and government entities, added, "If technology goes offline, doctors and nurse practitioners can no longer give the quality of care that they were able to, or to as many people. Right now, with COVID-19, there's a dramatic rise in the attack surface and the number and types of systems that are being used," he said.

Healthcare Insecurity: A Chronic Condition

Of course, healthcare cyber-challenges aren't new. Security researchers have long pointed out myriad threats facing this critical industry segment. For instance, the hospital equipment mix includes millions of insecure, single-purpose, connected medical devices, including insulin pumps and defibrillators, that are often open to hacks because they haven't been updated. Medical environments are also rife with critical infrastructure that runs on legacy platforms (such as Windows XP).

As an example of the magnitude of the outdated equipment problem, the Food and Drug Administration issued an emergency alert last year warning that Medtronic MiniMed insulin pumps are vulnerable to potentially life-threatening cyberattacks. The flaw, which has since been patched, could have enabled cybercriminals to connect wirelessly to a MiniMed insulin pump and change its settings, allowing them to either deliver too much insulin, or not enough – with potentially fatal results for patients. Another existing issue is the ongoing digitization of patient data and a growing reliance on connected medical devices. In general, this has created a massively expanded threat landscape for the healthcare industry.

Then there's the fact that there are millions of decentralized endpoints associated with telehealth – including patient facing portals, new COVIDrelated and existing mobile apps and wearables – all providing new ways to gather and process health-related data. As such, they crack open wide the attack vector for adversaries.

Financial Illness

With COVID-19, all of the existing issues that make healthcare cybersecurity difficult have become magnified, say experts.

For instance, telehealth adoption by primary caregivers jumped by 50 percent between January and June of 2020. That required new investment in technology, when facilities are already paying a premium for testing, additional staff, PPE and ventilators.

"The biggest challenge with COVID-19 and healthcare security in my view is the significant strain on available resources," Jeff Tully, a pediatrician and anesthesiologist at the University of California at Davis, said. "With a precipitous decrease in elective surgical procedures and routine outpatient visits, hospitals and other

healthcare facilities already facing razor-thin margins pre-pandemic are now forced to make increasingly difficult decisions about how to prioritize limited funds."

He points out that elective surgeries are a significant money-maker for hospitals, in normal times. Reuters news agency reported in March that the New York-Presbyterian Hospital postponed all elective surgeries, impacting 10 New York area hospitals.

These realities make it hard to advocate for something like a newly segmented network or increased IT security staffing, when healthcare workers may be furloughed or patient-care programs underfunded, he said.

Cyber-Infections Surge

While hospitals, doctors' offices and other healthcare stakeholders wrestle with a morass of cybersecurity challenges, threat actors have been paying attention – as evidenced by a cresting cybercriminal offensive on the healthcare industry.

A recent study by SecurityScorecard and DarkOwl found that attacks have increased 16 percent on web applications since the coronavirus pandemic hit states hard in March, while attacks on endpoints are up 56 percent and attacks targeting IP addresses have climbed 117 percent (PDF).

For hackers, COVID-19-related attack vectors remain low-hanging fruit. Patient data represents a lucrative store of goods to sell on the criminal underground. And ransomware attacks are all too easy, thanks to a lack of patching and user awareness/distraction – according to SonicWall, ransomware attack volumes have grown 109 percent annually in the U.S., in part due to the pandemic. Espionage meanwhile continues as attackers strive to get their hands on valuable coronavirus treatment and vaccine research.

Real-world examples abound of cybercriminals taking advantage of the weaknesses. As an example, in 2019 a breach of AMCA impacted the data of 25 million patients – including their names, addresses, dates of birth and payment data.

Ransomware examples are readily available too. For instance, Hammersmith Medicines Research, a London-based healthcare provider that was working with the British government to test COVID-19 vaccines, was recently hit by a ransomware attack. A ransomware attack in October also hit eResearchTechnology, a medical software company that supplies pharma companies with tools for conducting clinical trials – including trials for COVID-19 vaccines.

And on the espionage front, APT29, a Russia-based advanced persistent threat (APT) group also known as Cozy Bear, reportedly targeted academic and pharmaceutical research institutions in various countries around the world in July – just one of several such incidents.

Human Impact

With medical cybersecurity in a state of perpetual disruption – and ongoing attacks – there's a darker side to consider. Researchers and healthcare professionals alike worry that the heightened security threats are

evolving from impacting technology availability and patient data privacy to actually threatening patients' physical safety.

The Atlantic Council's Woods cited academic research that examined the impact of re-routing ambulances around marathon race routes versus ambulances that did not face any obstructions. That study determined that delays of just five minutes in care can impact patient outcomes.

A cyberattack's effect is no different, said Woods: A system-crippling incident can freeze access to care for hours, and sometimes days, he pointed out.

There's precedent for the concern. The WannaCry cyberattacks of 2017, which spread to more than 300,000 computers in 150 countries, not only brought down computer systems, but paralyzed hospitals' ability to keep customers' appointments, preventing patients' access to care.

"During WannaCry, in some areas many hospitals shut down, with at least 30 to 40 percent shutting down for a day to a week," said Woods. "If you think about someone with a stroke, with a 90-minute timeline of being treated, no one got the care needed during that time, which leads me to believe people have died because of these things before."

More recently, a ransomware attack on the Duesseldorf University Hospital in Germany led to the hospital turning away emergency patients. During this attack, a woman who had to be sent to a different healthcare facility, around 20 miles away, died. German prosecutors suspect it's because of delayed treatment after the cyberattack.

While the Duesseldorf University Hospital incident "might be the first smoking gun," Woods said, the incident is not the first death that's been caused – or at least partly influenced – by ransomware.

UC-Davis' Tully knows the potential human consequences of poor IT security in healthcare facilities first-hand. At a Black Hat USA session in 2018, Tully demonstrated a proof-of-concept attack against a computerized Health Level 7 lab-results system. He was able to tamper with lab results coming from blood gas machines and urinalysis machines, which could lead to a lethal dosage of the wrong medication to treat an already sick patient.

"Certainly, sentinel events like WannaCry and, more recently, attacks explicitly directed at hospitals caring for COVID patients raise the specter that the quality of care, particularly for time-critical conditions like heart attacks, strokes or sepsis, may be affected enough to result in increased morbidity and mortality," Tully said.

The Future of Healthcare Security

Against this bleak backdrop, the prognosis isn't all bad. There are several steps that healthcare organizations can take in order to secure patient data and critical infrastructure.

For one, in order to secure systems across the board, healthcare providers need to incorporate a patching cadence as an integral part of their vendor due diligence. In a report published in August, analyst firm McKinsey identifies patching as the first in a list of required controls (PDF) that healthcare organizations need to put into place.

Beyond that, hospital networks can bolster security by adopting proactive monitoring programs to weed out risks of breaches, conduct risk analyses to keep tabs on their connected devices and follow cybersecurity

frameworks – like the National Institute of Technology (NIST) cybersecurity framework – to further understand new threats.

And, as is the case in many industries, prioritizing staff training and awareness across the organization is crucial — awareness can prevent spear-phishing and close other attack vectors. Building relationships between the IT teams and the hospital staff should also be at the top of the to-do list, Dan Costantino, CISO at Penn Medicine, said, stressing that hospital CISOs shouldn't "run programs in a vacuum."

He also urged IT teams to bring other business leaders to the table and give them "skin in the game." Doing so, he said, would help build strong security advocates within the business. This is particularly important during the ongoing pandemic, where security teams need the extra support of the healthcare leadership.

"The COVID-19 pandemic has been challenging for everyone, both personally and professionally," said Costantino. "Cybersecurity teams have found themselves in a position where business operations are changing at warp speed. COVID-19 presents the need to turn that known state of operations sideways as the business scrambles to adjust, and implement a model capable of responding to our communities' needs while maintaining employee safety."

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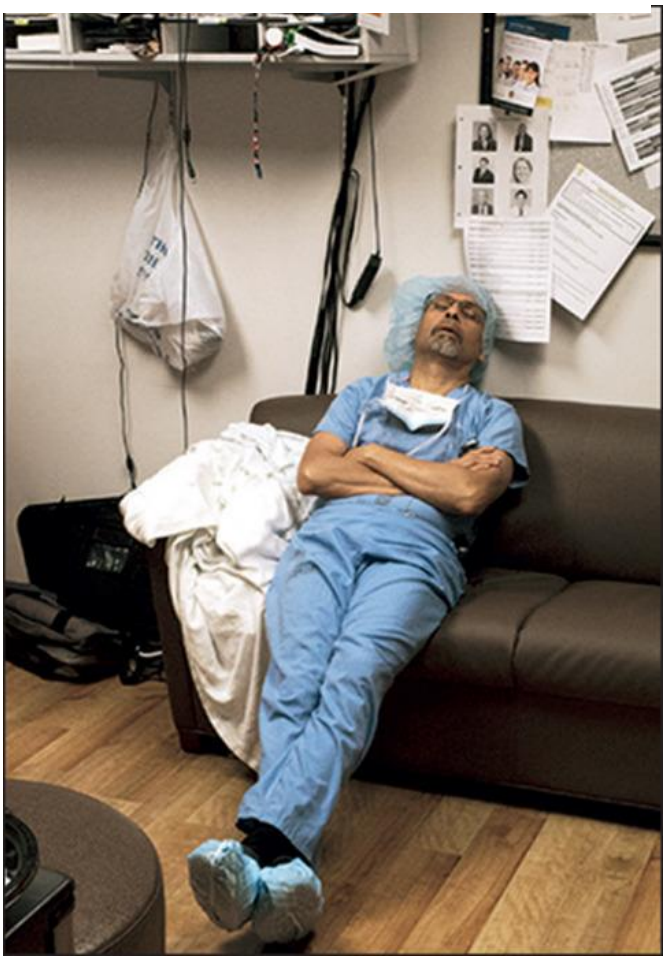
Can Clinical Empathy Survive? Distress, Burnout, and Malignant Duty in the Age of Covid-19

Adrian Anzaldua, Jodi Halpern



In an article for the *New York Times Magazine,* Helen Ouyang, an emergency room doctor in New York City, illustrated her experience caring for an elderly man dying from Covid-19 when the city's case count was skyrocketing:

I want to spend time with him, but more patients, much younger patients, keep arriving, struggling to breathe. I have to tend to them instead. The disease has won against him; the new patients have a chance. I don't want to think that way, but it is the dismal truth of our new situation. I hope the morphine is enough to blur the reality that he's all alone. I move on, forcing myself not to think about him again. Too concerned about the new patients, I never take the time to check on him again. Too exhausted at the end of my shift, I don't say goodbye to him either. He dies later that night.[1]

Distancing herself from the harsh realities of treating Covid-19 patients, and emotionally and physically exhausted, Ouyang appears to be in a state of sympathetic distress and showing signs of burnout, a serious psychological syndrome brought on by bad workplace conditions.

Ouyang's account appeared on April 14, 2020, just as health care workers in New York and surrounding areas were shouldering their way through the peak of the deadliest coronavirus surge the country had faced. Mental health data collected on New York City health care workers during that surge proves that Ouyang's experience was far from isolated. One study of 657 of the workers showed that 57 percent manifested symptoms of acute stress (which could lead to post-traumatic stress disorder), 48 percent experienced depression, and 33 percent showed signs of generalized anxiety.[2]

While these data represent mental health impacts during one of the most devastating regional outbreaks on record, such outbreaks are recurring now, during January 2021. The national Covid landscape has turned into a mosaic of multiple hotspots around the country, and things are getting worse as winter wears on. Now, a year since the first U.S. cases were identified, conservative estimates from Johns Hopkins University show at least 450,000 people killed and nearly twenty-seven million confirmed cases.[3] The trends in stress, depression, and anxiety among American health care workers brought on by the pandemic surely anticipate a similar rise in burnout.

Burnout is a psychiatric syndrome that stems from prolonged exposure to a deleterious work environment. It manifests with symptoms of emotional and physical exhaustion, feelings of professional inefficacy, and depersonalization, a sense of lost identity marked by feeling disconnected from one's own thoughts and feelings.[4] These symptoms have profound impacts on both the individual sufferer and the health care system. Data published in 2010 from an international study of 53,846 nurses across six countries showed a negative

correlation between burnout and nurse-rated quality of care.[5] Data from a smaller retrospective study assessing the relationship between physician burnout and independent quality of care indices (such as medical errors and patient satisfaction) showed similar correlations.[6] The picture is clear: as burnout increases, quality of care decreases.

Increases in burnout are also linked to the loss of clinical empathy.[7] This is not surprising given that two of the three core features of burnout—emotional exhaustion and depersonalization—undermine, respectively, the emotional reserve and sense of self required for the practice of clinical empathy. Clinical empathy is a health care worker's capacity to listen in a way that integrates cognitive and emotional empathy.[8] It improves clinicians' collection of patients' medical history,[9] patient adherence to treatment,[10] patients' capacity to cope with bad news,[11] and clinicians' ability to resolve difficult conflicts with patients.[12] Research indicates that, as clinical empathy goes up, physician-reported error rates go down, and vice versa.[13]

The poor American handling of the pandemic has created novel, intolerable pressures on the health care system and on health care workers' mental health and personal safety. Optimists may believe that the pandemic's additional injury to health care workers' mental health and capacity for clinical empathy will quickly correct itself once the pandemic ends, without longer-term impacts. And perhaps this would be realistic if not for the high baseline rate of mental health issues among health care workers before Covid-19. Pre-pandemic burnout rates approached 50 percent for physicians;[14] for nurses, the prevalence was approximately 35 percent.[15] Given the compounding of preexisting mental health concerns with current, novel burdens, we are concerned not only that an entire cohort of health care workers are too burned out to provide empathic care but also that those injuries may result in permanent psychological injury.

Why have health care workers tolerated such injurious workplace conditions for so long? And why, after more than thirty-three hundred health care workers' deaths to date from Covid,[16] do they continue to tolerate deterioration of their work environment? The answer is undoubtedly multifaceted. With burdensome debt so common among medical trainees,[17] many health care workers have little choice but to keep working. Others might be the sole earners for their families. It's also possible that fear of retaliation is keeping some health care workers from making their concerns known.

Personal considerations undoubtedly reinforce tolerating psychologically injurious workplace environments that undermine the conditions for clinical empathy, but problematic structural and cultural forces also bear responsibility. In this essay, we'll consider how health care workers motivate themselves under alienating conditions, which is through a sense of obligation or duty[18] to provide care no matter the circumstance. Acting from duty is seldom necessary when workplace conditions permit the practice of clinical empathy, which provides professional motivation, meaning, and psychological protection. When clinical conditions do not permit the practice of clinical empathy, health care workers turn to their sense of obligation or duty to not abandon patients. Submitting to professional duty can protect some from psychological injury, for at least a while, but the chronic suppression of authentic reactions of outrage, fear, and grief that accompany submission to duty can further contribute to distress and burnout.

The American experience of Covid has been a traumatic shock to an already burdened health care system. The remainder of this essay explores the interplay between burnout, clinical empathy, and medical ethics revealed by the heightened stresses of the current moment. While the relationships between these phenomena are complex, we might summarize the thesis as follows: burnout begets burnout. The clinical behaviors commonly available to prevent burnout often cannot be deployed due to poor clinical conditions (in the case of clinical empathy); other behaviors, like submission to professional duty, lessen burnout in the short term while worsening it in the long term.

To support this thesis, we'll first develop an understanding of the phenomenon of clinical empathy, showing that, at its core, clinical empathy is based on genuine emotional engagement, which requires the mental freedom to process difficult emotions. The injurious clinical conditions leading to burnout (such as the battlefield-type conditions seen in hospitals throughout the pandemic) undermine the mental freedom clinicians need to think, feel, and connect. This inevitably undermines clinical empathy and further contributes to burnout.

Loss of the conditions required for clinical empathy forces health care workers to fall back on internalized duties to motivate themselves, especially in the setting of heightened physical and mental health risks. Different clinical situations elicit different professional duties; for example, Covid-19 has called upon and tested the duty of nonabandonment.[19] While the substitution of duties for clinical empathy may be beneficial in the short term, we'll show how relying on duty without clinical empathy for extended periods undermines mental freedom, further fomenting burnout and distress.

Finally, we'll argue that health care workers are particularly susceptible to remaining bound to injurious workplace conditions because they tend to identify personally with their professional roles. They are, in this regard, virtuous—they practice health care according to their values: they live their values in their work. However, acting on values from a sense of obligation or duty alone is unsustainable when at odds with one's emotions and sources of meaning. Thus, during prolonged exposure to overwhelmed clinical environments such as those seen during Covid-19, health care workers risk deep moral and psychological injury. The conditions health care workers are contending with during Covid-19 might be fatally damaging the virtuous ethical center of medical professionalism. If this is true, medicine will be forced to reexamine not only its professional ethics but also how those ethics interact with other interests present in today's complex medical industry.

The Dynamics of Clinical Empathy

Clinical empathy, a specific form of empathy that has therapeutic impact in the medical setting and is professionally sustainable, was first conceptualized by one of us, Jodi Halpern, as emotionally engaged curiosity.[20] Her work challenged the expectation that physicians should limit themselves to detached cognitive empathy, showing how affective resonance, when redirected into curiosity about the patient, is essential for therapeutic impact. Halpern's interactive model of affective and cognitive empathy has been supported by empirical research, including findings regarding improved diagnosis, treatment adherence, and coping as well as studies of specific diseases (for example, about improved diabetes outcomes[21]), though more research is needed to precisely identify the specific ways that affective resonance and cognitive curiosity contribute to meeting specific clinical needs.[22] This model is also supported by neuroscientific findings showing how affective attunement improves cognitive empathy.[23]

Models of compassion in medical care add valuable practices of mindfulness but do not emphasize an individualized appreciation of each patient's predicament. We thus work with Halpern's model, which emphasizes using emotional resonance to inform imagining the world from each patient's perspective. Halpern defines the cognitive aim of imagining each patient's perspective as “curiosity” because the practice of clinical empathy as engaged curiosity is founded on the recognition that each patient brings their own distinct world, with a unique set of values and needs that the physician cannot presume to know. This is a subtle but vital point. As often as clinicians feel compelled to say to a patient, “I know how you feel,” these words cover up a profound fact: one can never truly know the lived experience of another. Rather, it is when health care workers realize that they cannot fully know, yet still need to know, what matters to the patient that they become curious to learn more about the patient's particular lived experience. This is clinical empathy as engaged curiosity, and a departure from responding to patients with detached scientific curiosity or a generic “detached concern”—viewpoints that obfuscate the patient's individuality and so create the conditions for ethical and clinical failures.[24]

This emphasis on curiosity may make clinical empathy sound like a mostly cognitive process, whereas our everyday idea of clinical empathy is one of emotional resonance, of fellow feeling. However, this affective component is crucial for the model of emotionally engaged curiosity, insofar as it is emotional resonance that helps guide what the listening clinician imagines and it is also nonverbal resonance that conveys to the patient that the clinician is attuned. When emotional resonance develops between health care worker and patient, the benefits of clinical empathy are richest for both.[25]

As essential as clinical empathy is to effective care (and to preserving physician wellness), clinical empathy as engaged curiosity does not happen automatically in all contexts. Engaged curiosity is an energy-intensive process requiring specific conditions for safe deployment. In addition to having sufficient physical and emotional energy to engage curiously with another's lived experience, a medical provider requires a degree of mental freedom to have the capacity for engaged curiosity. Experiencing emotional resonance with suffering patients when lacking the freedom to therapeutically channel it into engaged curiosity can lead to sympathetic distress.[26] Even before the pandemic, medicine's trajectory favored the conditions of worsening burnout and sympathetic distress due to overwhelming administrative tasks, heavy caseloads, and insufficient time with individual patients, undoubtedly contributing to increasing rates of physician dissatisfaction.[27]

National failures during the pandemic have left the health care workforce sick and struggling. Those who have been able to avoid contracting Covid-19 amidst shortages of personal protective equipment and overflowing emergency rooms now work extra hours to cover for those less fortunate and for those who chose to retire early rather than continue on in health care. Many who did contract Covid-19 continue to work despite ongoing fatigue and respiratory issues. Increased workload pressures have risen in concert with rescue pressures, the moral injury of losing patients due to insufficient resources, and the need for additional vigilance to ensure health care workers maintain their families' physical safety.[28] This collapses the space for mental freedom, undermining both the health care worker's sense of their professional self and clinical empathy as engaged curiosity. The depersonalization that comes with collapsed mental freedom, coupled with the loss of psychological protection afforded by clinical empathy as engaged curiosity, starts the health care worker well on their way to burning out.

Duty to Provide Care as a Substitute for Clinical Empathy

Of course, it is perfectly reasonable that the conditions for clinical empathy would be greatly curtailed, if not altogether absent, during a crisis. It is in such situations that health care workers rely instead on their personal and professional sense of duty. For this sense of duty to safely and effectively motivate them to continue taking personal risks during difficult times (and for long periods), it is critical that this duty emanates from a person's character. When duties are internalized, they can be relied upon to motivate and sustain health care workers in the face of personal hardship and oppressive conditions. The expression of an authentic, internalized sense of duty toward patients and fellow practitioners is not dissimilar from the sense of duty we see among soldiers, which helps us understand the outpouring of respect and even love we have seen among health care workers. Duties, when they authentically spring from within, are powerful drivers of group cohesion and social good.

Duty-motivated behavior can be protective for some, for some amount of time, but it is incredibly energy intensive. Moreover, acting strictly from duty further collapses the space for mental freedom, worsening the individual's ability to engage with authentic reactions of outrage, fear, and grief. This encourages a process of depersonalization. A depersonalized sense of duty can be tolerated only for a short period without the risk of further loss of clinical empathy and burnout. Prolonged reliance on a strict sense of duty encourages a prolonged experience of exhaustion and depersonalization, raising the prospect for chronic burnout and other mental health issues. If the mental health burdens wrought by the American experience of Covid-19 undermine clinical empathy and ask too much, for too long, of workers' sense of duty, then health care workers may begin associating professional duty with mental health issues like burnout. If leaders of the

American health care system allow this association to take hold, they risk undermining the duty itself. If duties lose their inspirational power, what will be left to provide professional meaning and motivation in the strained everyday practice of health care in America, let alone to motivate meaningful work during the next public health crisis?

The Rise of Malignant Virtue

What animates the health care workers' sense of duty? The basis for medical professional duties, we argue, is not merely that health care workers make an external promise, like taking an oath; rather, internalized, virtue-based ethical practices are what ground and animate medical professional duties.[29]

Virtue ethics views the person acting in the role of health care worker as largely indistinguishable from who that person is in private.[30] Whether medicine selects for individuals with virtue-based ethical practices or the profession develops these practices in its trainees, medical duties are deeply personal commitments. This is why countless Covid-era op-eds and purpose statements have tried to rally health care worker morale with phrases like "This is who we are"[31] and "we run toward a fire."[32] The virtuous center of medical professionalism is what animates and informs the everyday sacrifices we've come to expect from health care workers, as well as the exceptional sacrifices we've seen from them throughout the Covid-19 pandemic.

A virtue-based medical professional ethics can be beneficial save for one notable weakness: internalized virtue cannot be silenced or shed at the end of the day. This means that clinical conditions that violate medical ethical principles directly threaten the health care worker's sense of self. When this happens, virtue morphs into a malignant force.

In the modern American medical system, the clinical conditions favoring this malignant transformation are not only commonplace; they result from fundamental structures on which modern medicine relies. For example, miserly and arbitrary insurance formularies can turn a provider's beneficent prescription into an onerous economic hardship, transforming the physician's moral good into a moral liability. Similarly, health care workers who are forced by circumstance to discharge homeless patients in delicate medical conditions back to the streets must either detach themselves from their ethical values or experience moral injury.[33] The capacity or incapacity to address patients' social needs has been shown to affect primary care physician burnout.[34]

Workers in other fields might protest the corruption of their profession's ethical standards by outside forces, but the virtue animating medical ethics precludes many forms of resistance. In this way, the virtuous nature of medical professionalism becomes a force that traps health care workers in clinical environments that undermine their ethical goals, exposes them to psychological injury, and precludes them from deploying methods like strikes or protests to fight for change.

Any chance of returning to clinical conditions that don't predispose health care workers to these types of malignant ethical transformations seems far-fetched in this current moment. In fact, it is worse than that: Covid might be the tipping point that existentially threatens the sense of virtue-informed duty for which clinicians are known. Like any precious but fragile element of professionalism, medicine's ethical center must be protected. It requires adequate hospitals and affordable medications, housing on discharge, decent caseloads so patients can get empathic attention, and more, and these measures in turn depend on the right combination of social structures, including responsive local, state, and ultimately federal governance.

Covid-19 has done more than exacerbate the weaknesses in the social structures that undergird the virtue-driven ethical center of medicine; it has also summoned new phenomena that chip away at its foundation. American health care workers have witnessed a dangerous conception of personal liberty drive a backlash against commonsense preventive health measures. A certain percentage of Americans have fallen prey to the delusion that the pandemic is a hoax perpetrated to justify restricting individual rights. Federal leadership has not only been absent but has, in many cases, worked against medical health care workers, as evidenced by the former president imploring the public to not "be afraid of Covid" despite his recent hospitalization.[35]

Health care workers have long understood, perhaps implicitly, that the virtue informing their professional ethics puts them at outsized risk for burnout, sympathetic distress, physical exhaustion, and mental health issues. The pandemic has supercharged these risks in a new way, a development that health care workers are starting to notice and acknowledge. Take Erik Andrews, a nurse at Riverside Community Hospital in one of Southern California's hardest hit counties, who openly lamented to the *Los Angeles Times* in June about what he perceived to be a pattern of deliberate understaffing in the middle of a Covid surge: "Our professionalism is being exploited."[36] Whether medical ethics and professionalism as we know it survive the pandemic remains to be seen.

Changing the System

Covid-19 has exacerbated a number of systemic and cultural issues long present in medicine. But the difficulties are also opportunities. The crisis may catalyze a necessary restructuring of our medical system, a restructuring centered on securing and maintaining the clinical conditions required to provide genuinely empathic care. Accomplishing this goal will undoubtedly proceed from the inside out, beginning with individual health care workers who, driven by the devastation of the pandemic, will demand more benevolent clinical environments for themselves and their patients. Already there have been work stoppages around the world aimed at securing better personal protective equipment.[37] Unfortunately, these actions, though disruptive, will be necessary to force industry and government to provide the physical and emotional safety that clinicians need to provide empathic and effective medical care.

Finally, the health care professions must develop new models of professionalism in which individual and collective action undertaken to protect health care workers' well-being and clinical empathy will be seen not only as defensible but as an expression of foundational professional duties. This new professionalism will undoubtedly benefit students in health professional schools who experience burnout at alarming rates.[38] Inculcation of a new professionalism could mean that future medical professionals would be better positioned to demand concessions from insurance companies, pharmaceutical companies, and state and federal governments to better serve patients.

Such aspirations might have seemed far-fetched even a year ago, but Covid-19 has softened the grout holding together our patchwork health care system. A new medical professionalism built upon the twin pillars of clinical empathy and provider well-being could reorient the complex American health care system to finally meet the needs of clinicians and patients alike. Health care workers have the opportunity to create lasting, systematic change now. The only question is whether they can overcome their collective trauma, burnout, and exhaustion enough to do so.

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Top East Coast Vacations for a Fall Getaway 2021

Visit Maine

East Coast America is a great place to explore, and there's nothing like waking up to elevated views of lush woodlands and tranquil waters in secluded Maine, one of the best places to vacation. East Coast vacations are sure to inspire even the most discerning traveler. Top it off with a tree house rental with a cedar hot tub, and relax the morning and night away. One of the top East Coast fall vacations destinations and at less than an hour's drive, the city of Portland, one of the best places to visit on the East Coast, awaits glampers for the quintessential, New England fall experience. For lovers of the outdoors, there are endless hiking trails and fall foliage coloring nature at every angle. A popular spot to *ooh and ah* over the leaves is Bradbury Mountain State Park, one of the best vacation spots on the East Coast.

One of the best East Coast getaways, don't miss out on stocking up on Bean Boots in Freeport, a nearby town with the original LL Bean factory. All beer, wine, and food enthusiasts can find their niche at the variety of festivals throughout the fall months in Portland for one of the best weekend trips on the East Coast. As a seafood capital of the East Coast, fresh lobster, fried clams, and succulent oysters are awaiting your arrival. Let's just say no one will be feeling *crabby* while visiting Portland, one of the best East Coast weekend getaways and best fall vacations in the U.S.

I *Lo-Vermont*: Burlington, the perfect October vacation destinations, USA

Known for beautiful foliage, abundant nature, and Ben & Jerry's, Vermont is one of the best places to go for fall foliage trips, East Coast getaways, and one of our favorite October vacation destinations, USA. Staying at this tree house will be an unparalleled experience—the handcrafted design includes a wrap-around staircase, large pines holding the floors together, and a panoramic room facing the Green Mountains. Set in the quaint town of Waterbury, there are many local shops to browse and nearby peaks to climb, perfect for weekend getaways in November & vacations in nature and earlier. In many surrounding towns, you will be busy between the harvest festivals, apple picking, corn mazes, and fall foliage.

One of the best east coast getaway ideas, fall vacations, USA, or weekend vacations on the east coast, and just a short drive away, both Ben and Jerry's and Cabot Creamery offer tours to see the products in action. Guests must travel half an hour to Burlington, the most populated city in the state, for beautiful views of Lake Champlain, local restaurants and shops on Church Street Marketplace, and the hopping art and music scene.

It's hard to decide which will be sweeter—the pure Vermont maple syrup you'll taste or your time in the Green Mountain state, one of the best places to visit in the fall East Coast.

Head to Massachusetts, one of the best fall ideas for families

The perfect East Coast vacation ideas for a family fall getaway on the East Coast and great East Coast weekend getaways, this cottage is just steps to the ocean, set in the lovely coastal town of Rockport, Massachusetts. The indoors is simply elegant with a cozy feel and attractive decorations that will put you at ease. Enjoy a crisp morning sipping your coffee on the deck, taking in the East Coast fall foliage surrounding the rental, and later, head to the magnificent city of Boston for the day. On the way, be sure to stop at Salem, a Halloween destination where the norm is to be dressed in spooky costumes while exploring the haunted houses and fall-themed shops.

When it comes to good vacation spots on the east coast, known for its crisp weather, rich history, and adoring sports fans, Boston is a perfect place to visit in the fall, and one of the best places to visit on east coast. Catch a seat (or better yet, a home run ball) at Fenway Park and watch the Red Sox defeat the Yankees. Or, walk along the Freedom Trail while viewing fall foliage, eat at restaurants near Faneuil Hall, or shop on Newbury Street and find out why Boston is one of the best cities to visit; East Coast America really does spoil us for getaways.

Visit Lancaster, one of the best places to visit in October

One of the best places to visit on the in October, Lancaster, PA, is less than an hour from this stunning A-Frame rental in Robesonia, Pennsylvania. Surrounded by woodland and off the beaten track, as far as East Coast vacations go, this is one of our favorite places to visit in East Coast USA. Of all the charming East Coast towns to visit, Robesonia is one fo the best East Coast towns to visit for anyone looking for quiet **places to visit on East Coast** vacations over the fall, 2021.

See some of the best fall foliage in Pennsylvania

If you're looking for somewhere unique for your weekend getaways on the east coast, a stay in this charming A-Frame cabin will only add to your secluded getaway. One of the best weekend getaways East Coast America can boast, with woods on the doorstep, you can kickstart your day with a morning coffee while enjoying epic views over some of the best East Coast fall foliage, before heading out and exploring this stunning area for your fall getaways in 2021.

Do you have it *in ya* to go to Virginia? Blue Ridge Mountains for the best fall weekend getaways East Coast style

When it comes to cabins, Virginia knows where it's at. Every piece of this Virginia cabin rental speaks fall—from the warm color scheme to the forest-themed bedding and furniture and wooden accents in each room. The charming porch overlooks stunning woodland, perfect for uninterrupted views of the fall foliage, and it provides a relaxing space to sit back and enjoy the lush surrounding forest. Tucked away in Skyline Drive, VA,

along the Blue Ridge Mountains, this is the ideal location for fall activities, and the best **fall weekend getaways** America can boast.

With a number of places to see on East Coast vacations, your biggest problem is picking one place among so many great destinations to visit. Among some of the best east coast vacation destinations, and perfect for **October vacations in USA**, you can hike trails surrounded by colorful trees, taste your way through the vineyards and wineries of the area, or visit the annual food, sport, and beer festivals. With over 400 miles of breathtaking sights, driving on the Blue Ridge Parkway provides hours of fall foliage viewing. After seeing such beautiful leaves, you'll stick to the area and won't want to branch out to see another place.

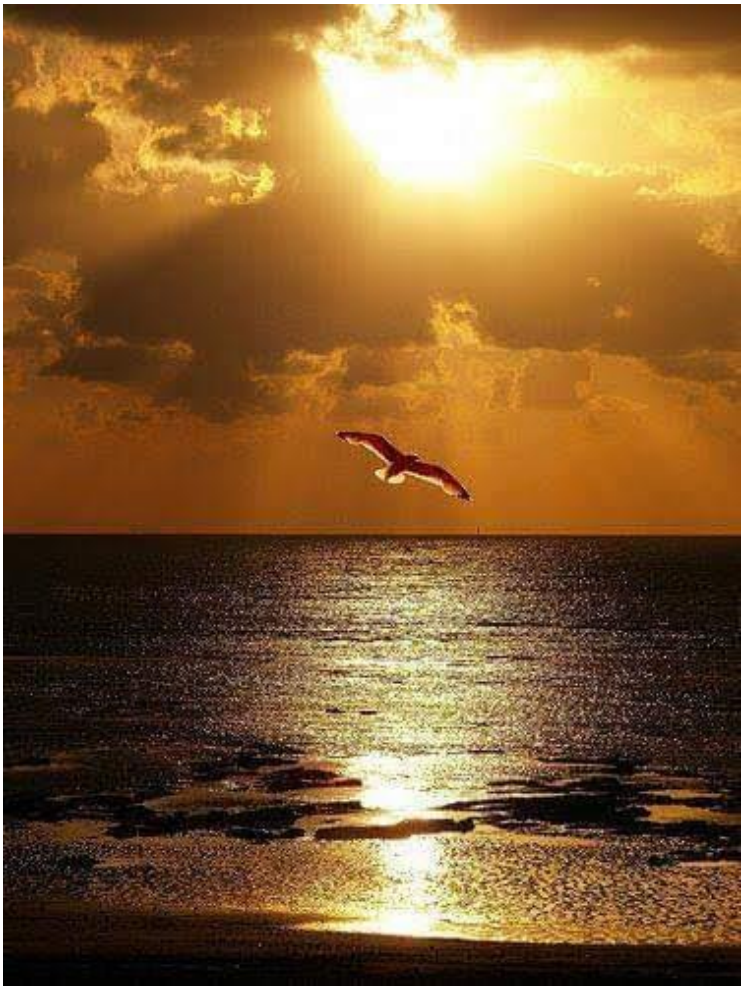
Cozy Cabin rental in Skyline Drive, VA

Visit Asheville, NC, for great places to vacation

Imagine wooden furnishing, tree-themed decor, and quaint accents in each room. This elevated cabin is completely immersed in the forest, making you do a double-take at the sight of the log beams. No, you're not in a tree—you're just one with nature in one of our favorite East Coast vacation spots. Just a bit south, you'll reach the fall destination of Asheville, undoubtedly one of the best east coast cities to visit on vacation, especially for vacations on east coast for couples. One of the great places to vacation on the East Coast, and known for its vibrant arts scene and historic architecture, autumn adds more of a reason for visitors to fall for the city. With its locally-sourced restaurants and over 15 farmers' markets, you will be tasting the fall harvest at every stop.

Situated near several national forests, Asheville, one of the most popular vacation spots on the east coast, is an easy drive to both the Great Smoky Mountains and the Blue Ridge Mountains, one of the best places in the East Coast. Whether you want to hike one mile or 10, there is a peak for you with lovely views of the foliage, making the area unequivocally one of the best October vacation destinations. The sounds of the wind sweeping past your ears won't be the only thing you'll hear. Prepare for the many music festivals lining the streets and, hey, next thing you know, you may be bopping down the sidewalk.

Dakota Studios Gallery



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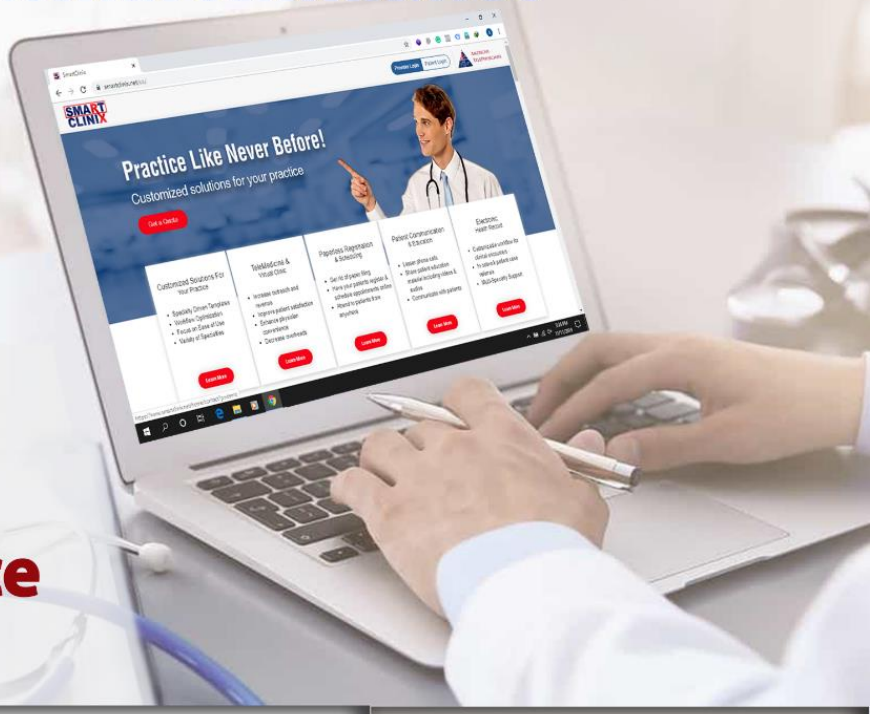

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