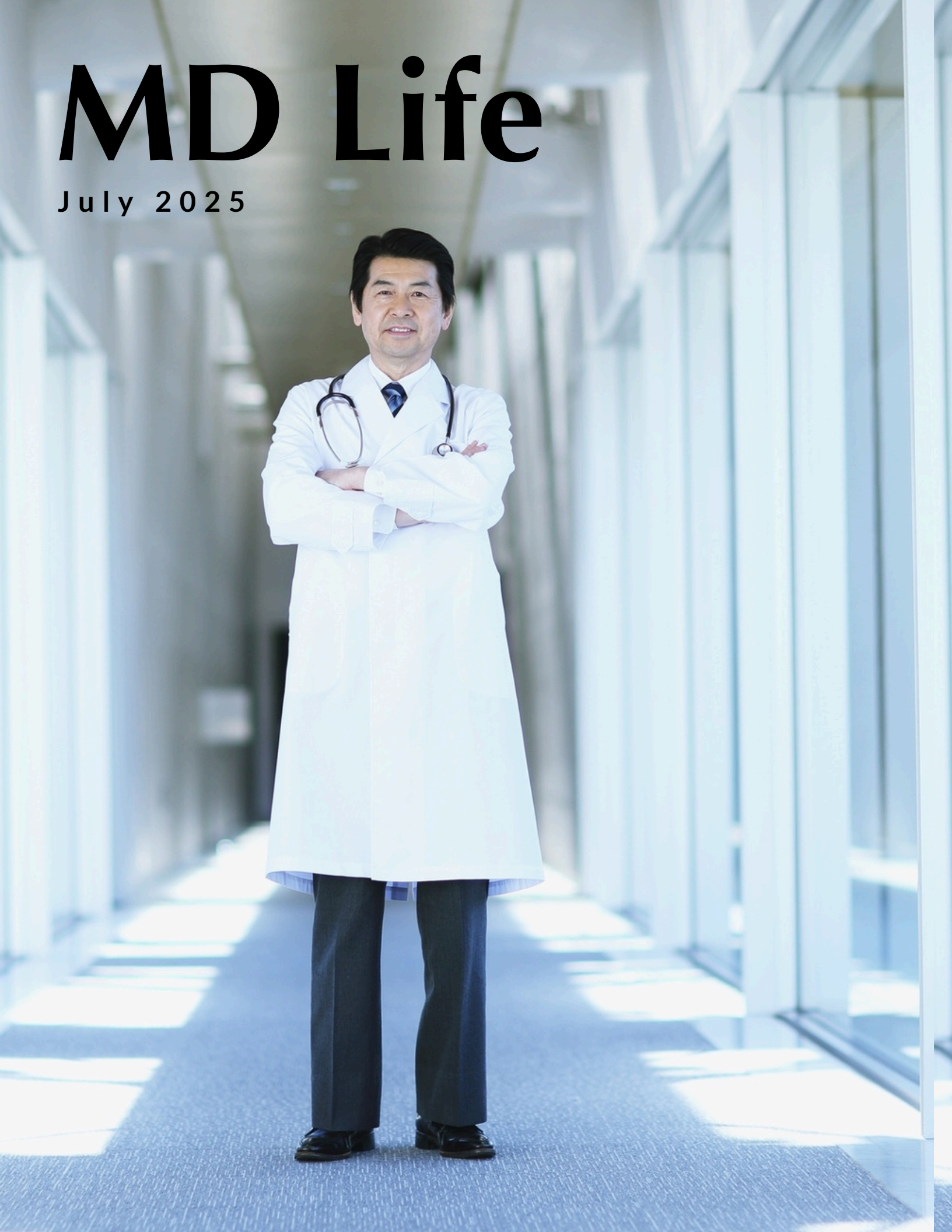
MD Life

July 2025



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Why “Do No Harm” Might Be Harming Modern Medicine

Sabooh S. Mubbashar, MD

Recently, while reading The History of Medicine by William Bynum, I was struck by a line that quietly reframed a great deal of what we claim to believe about our profession. Reflecting on how medicine has evolved, Bynum writes: “When in doubt, remember the Hippocratic injunction that health is most likely to be found in the middle way.”

That notion, nuanced, modest, and deeply clinical, feels worlds apart from the phrase now most loudly associated with the physician’s oath: “Do no harm.”

It might surprise many to learn that “Do no harm” is not part of the original Hippocratic Oath. The phrase “Primum non nocere,” Latin for “First, do no harm,” doesn’t appear in any version of the oath attributed to Hippocrates. In fact, it likely originated centuries later, possibly in the 19th century, and is often misattributed to Hippocrates himself. The earliest known printed use of “primum non nocere” in a medical context appears in the 1860s, credited to the English physician Thomas Sydenham or the American Worthington Hooker, depending on which historian you ask.

And yet, this late addition has become the most quoted and most misinterpreted principle in medicine. It adorns white coat ceremonies, hospital lobbies, and bioethics slideshows. It’s quoted by physicians and politicians alike. It has been flattened into a slogan, a badge of virtue, a kind of moral North Star.

But here’s the paradox: If taken literally, “Do no harm” makes medicine impossible.

Every time a scalpel touches skin, harm is being done.

Every time an SSRI is swallowed and causes even mild nausea, harm is being done.

Every time we sedate, inject, biopsy, intubate, irradiate, we are technically inflicting harm.

So what are we really saying when we invoke this phrase?

If “Do no harm” were a rule, we’d never treat a patient. We’d simply watch disease take its course, unchallenged. Because the truth is: Medicine isn’t about avoiding harm. It’s about understanding it, calculating it, and choosing it when it is the lesser evil.

Why is it important to discuss “Do no harm” at all? Because the problem lies in the disconnect between the phrase we’ve inherited as medicine’s moral rallying cry and the actual, lived experience of clinical practice. It is instilled from the very outset of a clinician’s training, echoed in white coat ceremonies, printed in ethics curricula, and spoken with near-scriptural reverence. But it bears little resemblance to the realities of practice, which are less about the clean execution of ideal principles and more about navigating the messy terrain of uncertainty, trade-offs, and clinical improvisation.

As is often the case when a rallying cry stands in contrast to the work it claims to represent, an unconscious dissonance begins to take root. The phrase promises clarity; the work demands ambiguity. And over time, the lived craft of medicine, its judgment, its instinct, its human nuance, becomes estranged from the slogans that once inspired it. As it must. Because that estrangement is not betrayal. It is evolution. It reflects the realities of what medicine actually is: uncertain, contextual, and irreducible to moral soundbites.

But dissonance, left unresolved, has a psychological cost. We stop thinking. We stop reflecting. We recite the phrase but no longer examine it. And so "Do no harm" continues, not as an ethical compass but as an unchallenged ritual, repeated more for comfort than clarity. It gives us moral cover. It creates the illusion that our intentions are enough, that our ethics are settled simply by invocation. But in doing so, it may discourage us from the harder, more essential task: weighing risk and benefit each time we intervene. The phrase soothes us into believing we are already being cautious, already being virtuous, when in fact, we may be defaulting to habits of intervention without pause.

American medicine is often criticized for being too aggressive, too quick to treat, to intubate, to operate. But as is so often the case, a profession's greatest strength can also be its greatest weakness. Our bias toward action, toward doing something — anything, is fortified by a slogan that implies we are always anchored in safety. Under the verbal anesthesia of "Do no harm," we may avoid the more uncomfortable reflection: Should we be doing this at all?

- Should we be offering hip surgery to a 90-year-old with severe congestive heart failure, someone already poorly mobile, dependent for most basic needs, and likely to emerge from anesthesia more disoriented, more delirious, and permanently worse cognitively than before?
- Should we be re-intubating a patient with end-stage COPD, already on maximal oxygen support, for the third time this month, when each intervention brings not recovery but prolonged suffering and prolonged dying?
- Is an antidepressant trial, or a new round of polypharmacy involving statins, supplements, and sleep aids, really what's needed for someone struggling with end-stage dementia, whose distress may be existential, not chemical?

Some would argue that it is precisely in these moments that harm is being done, not by withholding care but by pressing forward with interventions that offer diminishing returns and growing burdens. Here, "doing something" becomes the source of injury. It is not inaction that wounds, but action cloaked in the language of help.

And yet, the way our culture of medicine has evolved, substituting aggressive treatment with palliative or comfort-based management is still too often seen as withholding care, as if the absence of intervention is an abandonment of duty rather than its most humane expression.

These are the kinds of ethical questions "Do no harm" should provoke, but too often, it silences them instead.

In fact, in modern practice, our functional definition of "Do no harm" has become increasingly regulatory. It's less about nuanced clinical judgment and more about compliance with institutional guardrails, most visibly, the FDA's black box warnings, Joint Commission (JCAHO) mandates, CMS performance metrics, and an expanding web of hospital quality policies, sometimes real, sometimes imagined. These frameworks have become the

practical stand-ins for medical ethics, shaping what is flagged, what is tracked, and what is implicitly understood as “harm.”

But ask any frontline clinician in psychiatry, oncology, cardiology, or surgery, and they’ll tell you: These metrics rarely capture where harm actually happens. They miss the subtle calculations and gray-zone decisions that define the real art of medicine: a frail patient’s fall risk, a family’s quiet ambivalence, a child’s cognitive dulling after a medication change. These are the harms that don’t show up on compliance dashboards but live in the clinical margins every day.

If “Do no harm” is truly our ethic, then it must live in the gray areas, not just in the boxed warnings or the policy manuals but in the space where evidence ends and judgment begins.

Beyond the regulatory landscape, decision-making in American medicine is shaped by another deeply rooted ideal: patient autonomy. In many ways, it is the ethical bedrock of the U.S. health care system, a principle that insists the patient (or their legally appointed surrogate) is the final authority on medical decisions. This focus on individual choice is often cited as one of the greatest strengths of American medicine.

But like all great strengths, it can also be a great weakness.

In most parts of the world, especially in Europe and parts of Asia, decision-making in critical care leans more heavily on physician judgment or consensus-based models. But in the United States, clinical authority is often ceded, by law and by custom, to next of kin, health care proxies, or legal surrogates. It’s a uniquely American phenomenon in its extremity: empowering people with little or no medical training to make decisions about life-sustaining interventions, often under immense emotional duress.

And here’s where the paradox deepens: We expect family members to make decisions that even seasoned physicians struggle with. Whether to proceed with a high-risk surgery, to intubate one more time, to transition to comfort care — these are among the most complex, ethically fraught choices in medicine. Physicians wrestle with them. Teams debate them. Yet we routinely place this burden on a spouse, or a daughter, or a sibling, in the middle of the night, with no context, no training, and the weight of love pressing down on them.

Of course, the gut reaction of a loved one, when asked, “Do you want us to do everything?” is almost always, “Yes.” What else could they say?

And so, under the banner of autonomy and in the name of “Do no harm,” we sometimes end up doing exactly that: everything.

Even when everything is the most harmful choice on the table.

Add to this the ever-present specter of liability, the unspoken pressure to protect oneself professionally, and the result is a clinical culture that often favors doing more, not because it’s better medicine but because it’s safer documentation. In this environment, aggressive care becomes the path of least resistance: ethically complicated, clinically dubious, but legally and professionally defensible.

So maybe it’s time to rethink the very first introduction we give to future doctors. Not with slogans, but with substance. Not with borrowed mantras, but with context. A version of the oath that is both historically accurate and emotionally honest, one that prepares new physicians not just to inherit a phrase, but for what

actually lies ahead: A daily discipline of uncertainty, discernment, and the courage to choose wisely, even when all options carry risk.

After all, the original Hippocratic Oath never said “Do no harm.” What it did say was this:

“I will follow that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous.”
— Hippocratic Oath, translated by Ludwig Edelstein (1943)

That’s not a soundbite. It’s accurate, practical, and, most importantly, honest about what this profession really demands. It reflects the complexity, the imperfection, and the deep humanity of this beautiful art we call the science of medicine.

But first, we need to accept that harm is not the exception. It is the rule. The act of intervention always carries it. The real question is whether, in each individual clinical situation, the harm we are about to do — and it is harm, quite literally — is warranted by the benefit we hope to achieve.

Because real ethics don’t live in mottos.

They live in the middle.

Sabooh S. Mubbashar is a psychiatrist.

Robot Cars, Human-Size Problems

By Kim Komando

ChatGPT

Robotaxis are silently (and sometimes awkwardly) roaming around Phoenix, San Francisco, Austin and wherever else humans dare let cars do improv in traffic. Waymo, Tesla and soon Amazon want you to ghost your Uber driver and jump headfirst into a future with no one behind the wheel.

Tempting? Sure. But should you? Well…

🧠 **Waymo: sensor show-off**

Waymo is Google's souped-up baby Jaguar. And it's not just cute. It's packing serious hardware: GPS, radar, lidar and 29 cameras. You'd think it could see into next Tuesday.

In Phoenix, you can summon one with no driver. The doors unlock, you hop in, and off you go. Well, mostly.

Regulators have flagged 22 "incidents" ranging from boo-boos with barriers to cases of being directionally defeated by construction cones. One time, two women were straight-up trapped inside a car when the doors wouldn't open. (Waymo Escape Room: now accepting reservations.)

Let's not forget the recall: More than 1,200 vehicles were pulled after collisions with stationary objects.

Still, here's the twist: Waymo's crash rate is up to 80% lower than human drivers when it comes to injury-causing accidents. It's safer, just not graceful. Think: clumsy nurse with steady hands.

⚡ Tesla: risk-taker

Tesla's "Full Self-Driving" robotaxis skip the radar, skip the lidar and go camera-only. It's kind of like teaching your car to drive by binge-watching dashcam videos.

In Austin, they're testing 10 driverless Teslas with remote watchers instead of safety drivers. They need to. There's a video of one in Austin having a **brain-fart moment** when seeing cops on the side of the road.

FSD recently failed to stop for a child-size dummy next to a school bus … eight times. One drove onto train tracks. And yes, there's at least one fatal pedestrian crash under federal investigation. I love innovation, but I'm not about to trust my life to a car that still needs a hall monitor.

📦 Zoox: Amazon's baby

Zoox isn't so much a car as a couch with wheels. No steering wheel, no pedals, just four seats facing each other like a wine mixer on rails.

It's still in testing, but this is Amazon. If they can deliver a karaoke machine, a cat fountain and 38 granola bars in the same package in two hours, robot rides are inevitable.

💵 What does it cost?

Waymo rides are usually cheaper than UberX. No tips. No surge pricing. No pretending to care about your driver's screenplay.

During the Tesla tests happening now in Austin, it's a $4.20 flat fee, which feels suspiciously like *someone* just wanted to say "guinea pig."

🤖 Smart things you can say

🛸 Waymo's cars trained on more than 20 million real-world miles and 20 billion miles in simulation. That's like driving to Pluto. Twice.

👾 Tesla's FSD gets smarter every time you drive (which is both amazing and a little creepy).

⚡ Amazon's Zoox? It can drive forward and backward and soon sideways at full speed. Because of course it can.

Me? I haven't taken a Waymo yet.

I don't use rideshares much at home. But let's be real, tech fails at the worst time. Like the Waymo I got stuck behind that refused to move for a traffic cone in the middle of the street. Cops had to come sort it out, and I nearly missed my flight.

Leaving Medicine is Not a Failure: It Might Be the Change You Always Needed

Christopher Nmai

Four rigorous years, filled with countless long days and nights of education, is often just the beginning for most medical trainees. The Match and subsequent residency await on the horizon. It is the norm in health care, and very few stray from that path. But medicine is a long and arduous path, one that can take its toll on trainees and physicians alike.

As I entered my final year of medical school, something felt off. As much as I was invested in this path forward, I felt drained and unsure. As someone with chronic illnesses, I was particularly burnt out from being constantly surrounded by illness and suffering. I found myself struggling to show up to the hospital at my best, despite wanting to give my all in caring for patients. Surely residency and a life in clinical practice were not the only option after medical school. I decided to probe this question further and see what else was possible aside from a white coat career. As a result, I have made the decision to forgo residency applications and pursue a career outside of clinical medicine. It is probably the best decision that I could have made, for my career and for my health.

My story is not unique; an increasing number of physicians and trainees are stepping away from medicine each year. A November 2023 article from the American Medical Association reported that 40 percent of doctors were contemplating or set on exits from their current organization within the next two years, highlighting a significant exodus from the field. The reasons for this departure are multifactorial, including rising burnout rates, dissatisfaction with working conditions, bureaucratic red tape, and newfound work-life balance expectations, especially among younger trainees. Even among medical students, rising debt and stress levels have an impact and take their toll.

Burnout—one of the main drivers—has been examined heavily within medicine. In the early 2000s, rates of burnout among physicians were 25 percent. However, pre-pandemic rates jumped to as high as 40 percent, one physician writes. During the COVID-19 pandemic, when burnout rates were as high as 60 percent within medicine, the broader societal re-evaluation of work-life balance expectations found its way into the field. Burnout is a serious problem in health care; a recent Washington Post report found that doctors struggle with burnout and depression at higher rates than the public. They are additionally twice as likely to die by suicide, a

grim statistic that is further exacerbated by fears of mental health disclosure affecting one's medical licensure. Significant stigma and an expectation that doctors are to be "perfect" are creating an atmosphere where treatment-seeking is discouraged and potentially punished, at the expense of the well-being of the physician.

Within the American health care system, administrative responsibilities, navigating insurance, and other job-related stressors have become a regular part of a practicing physician's day, eating into the actual time spent caring for patients. A study published in the Annals of Internal Medicine found that for every hour spent seeing a patient, a provider spent nearly two additional hours on documentation and other desk work each day. What was once a noble pursuit to impact the health of others has become complicated by a myriad of extraneous factors that are affecting the very ability to deliver meaningful care, driving some out the door.

Going through medical training and becoming a physician is not the end all. The skills acquired during training, namely critical thinking, complex problem solving, and working within a fast-paced environment, are essential in a lot of roles, making trainees and physicians top candidates when exploring careers outside of clinical medicine. With an MD there are a variety of career options that exist that allow you to leverage your medical experience in a non-clinical way. Health tech, consulting, and other finance roles actively recruit MDs for their expertise, often offering a career with better hours, flexibility, and at times higher pay. Other roles, such as medical writing and medical science liaison work, offer similar benefits outside of clinical medicine, providing better work-life balance for those contemplating a switch in careers.

This current exodus comes at a cost, however: With the Association of American Medical Colleges predicting there to be a shortage of 124,000 physicians by 2034, something must be done about the conditions that are compelling doctors to leave the field. First and foremost, the workplace must improve. The causes of burnout—long working hours, piling administrative responsibilities, inadequate mental health coverage—need to be addressed. The pathway to becoming a physician is grueling and often without measures to support an individual through the process. There needs to be a decrease in the stigma around mental health treatment to improve the management of stress during while training or practicing, especially at a time when physician anxiety, depression, and suicide are on the rise. The administrative and bureaucratic burdens that have crept into practice need to lessen, either through the help of AI technologies or new policies aimed at reducing this load. Overall, there needs to be an adoption of flexibility within medicine; it is not a one-size-fits-all career, and allowing physicians to better tailor their careers to their overall life may help with retaining those who are contemplating leaving.

While I am by no means encouraging doctors to leave medicine, I am advocating for the field to have a moment of reflection. We can only be the best practitioners for our patients when we are at our best personally. The field of medicine is one that demands this standard, for the sake of our patients. But if burnout or some other factor is taking that passion away and interfering with life, it is predictable that some will re-evaluate their career choices. Sometimes sticking with the norm can cause more harm than good when more sustainable options exist.

Christopher Nmai is a medical student.

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The Atlas Team of Wealth Enhancement are Fee-Only Certified Financial Planners who specialize in the financial challenges that medical doctors encounter. What makes the Atlas Team unique is their investment approach is based on an academically supported, market-tested framework that aims to create efficient portfolios with less risk, for any given level of return. Additionally, each advisor on the Atlas Team is a Certified Financial Planner professional and they maintain advanced financial degrees and certifications. The MDLife team has decided to ask the Atlas Team some candid questions about what medical doctors should know before hiring a financial advisor.

Q1: What is the difference between working with a financial advisor who is "Fee-Based" vs. "Fee-Only?"

Atlas Team: Generally speaking, there are many financial advisors who are "Fee-Based." Fee-based (it should really be labelled "commission-based") means a financial advisor can be compensated by both a fee *and/or* a commission. According to Cerulli Associates[1], there are more than 72% of financial advisors in the US who are compensated by the Fee-Based Model. Financial advisors who are associated with a Broker-Dealer – a firm that takes orders from clients to buy or sell securities (or the firm can trade from their own inventory), are known to be fee-based. Many independent advisors who represent insurance companies, banks, or wire houses can usually charge a commission or a fee. If you look at a financial advisor's business card or website disclosure, you may see the words, "Securities offered through XYZ

[1] Cerulli.com/press-releases/more-than-72-of-financial-advisors-are-compensated-by-fee-based-models, 3/18/2025.

company" or "Insurance products offered through XYZ company." If so, this will convey that the financial advisor is fee-based. Advisors who accept commission must have a Series 6 or Series 7 securities license and must be associated with a Broker-Dealer.

Advisors who receive commission are more likely to have conflicts that affect you -the customer. They may recommend one product over another because they receive more compensation, and they rarely ever disclose to you how much they are paid. Fee-Only advisors derive their compensation directly from you, so you know exactly how much they are paid.

What most medical doctors do not know is that advisors who operate under the fee-based model do not have to act as a fiduciary (a person who has a legal obligation to manage and make recommendations for solely their client's benefit) **100% of the time**. This is because when recommending a financial product, fee-based advisors are held to a "best interest" standard which is less stringent and not as broad as the fiduciary standard. Financial advisors who operate under the "Fee-Only" (only the client can compensate the advisor) compensation model is legally required to act as a fiduciary all of the time. While no compensation model is conflict free, this distinction is important for those medical doctors who would prefer to work with someone who has less conflicts of interest.

Q2: What is one service that is typically offered by your firm that is not found with other medical doctor focused advisory firms?

One area that has become increasingly important to review is tax planning. We are often surprised to hear that many medical doctors' advisors had never reviewed their tax return before! The tax return is an integral piece to someone's financial life – it reveals income sources, deductions, credits, carry forward losses, taxes incurred, and more. This information is critical when doing more advanced financial planning and for generating scenarios to maximize client outcomes. We believe that you cannot make a proper recommendation without a thorough understanding of someone's tax return, which is why it is ingrained in our process to review tax returns annually.

While we are not tax advisors and prefer to work in conjunction with your trusted tax professional, we engage in proactive tax planning and will simulate various tax implications when implementing certain strategies, such as Roth conversions or charitable giving strategies. From a tax perspective, when implemented at the right time, these advanced tax planning strategies can potentially lower your lifetime tax bill by hundreds of thousands of dollars or more. It is exceedingly rare for us not to uncover additional ways to provide value on the tax side when we meet with doctors and physicians.

Q3: What would you say is a common misconception that most MDs get wrong on investment planning?

While there is a ton of research on low-cost index investing, the typical capitalization weighted index like the S&P 500 may not be entirely the way to achieve the best expected return while taking on the least amount of risk (especially as a medical doctor approaches retirement). We believe owning a simple S&P 500 index fund is particularly risky. That index is highly concentrated to just a few companies. As of the

end of May, the top seven companies held in the S&P 500 index accounted for over 34% of the index![2] While those seven companies have been great, there are times historically when these stocks have been down 50-80, instead holding an index fund that weights its holdings based on their free cash flow or owning the S&P 500 equally amongst its individual companies could provide better risk adjusted returns.

In addition, we find that most MDs desire to become more defensive in nature as they retire to prudently protect their wealth. Losses hurt, and math works against us when we lose money. If you lose 20%, you need 25% to get back to even. If you lose 40%, you need approximately 67% to get back to your original starting point. Finally, if you lose 50%, you need 100% to get back to even!

Our investment approach is designed to minimize these losses to enable you to recover more quickly. It is rooted in an advanced mathematical version of Harry Markowitz's Nobel Prize Winning Modern Portfolio Theory.

Q4: What sets your team of advisors apart from other advisors?

In addition to being compensated by the Fee-Only model, we also have among the highest levels of advanced credentialing in education among advisory firms. Our principals maintain multiple advanced degrees: an MS in Financial Planning, PhD in Financial Planning, MBAs in Finance, and multiple industry designations including CFP (Certified Financial Planner), CPWA (Certified Private Wealth Advisor), CFA (Chartered Financial Analyst), CLU (Chartered Life Underwriter), and ChFC (Chartered Financial Consultant). We do not just advise our clients - we believe strongly in educating them using our advanced knowledge.

Our financial planning and investment process are among the most sophisticated in the profession. In fact, Steve Craffen was awarded thought leader of the year by ThinkAdvisor for 2024 because of our approach to creating portfolio models. Finally, we have decades of experience counseling clients through many volatile markets and generally work with our clients' children as a trusted family advisor.

➔ If you would like to see more of our valuable insights and educational videos, please scan the first QR code below to visit our YouTube channel, "It's Your Smarter Money." Scan the second QR code if you would like to be added to our monthly newsletter.

About the authors:

Greg Giardino, CFP®, CPWA®, is a Fee-Only Fiduciary Certified Financial Planner, and Certified Private Wealth Advisor Consultant. Greg specializes in counseling high-net-worth MDs and academics. You can reach him at ggiardino@wealthenhancement.com.

[2] The Motley Fool, "The Magnificent Seven's Market Cap Vs. the S&P 500, https://www.fool.com/research/magnificent-seven-sp-500/#:~:text=How%20much%20of%20the%20S&P,8%20out%20of%209%20years.

Stephen C. Craffen, BE, MBA, MS, CFA, CFP®, ChFC, CLU, BFA, is a Fee-Only Fiduciary Certified Financial Planner, and former Chair of the National Board (2018-2019) of the National Association of Fee-Only Advisors (NAPFA). He was named Thought Leader of the Year for 2024 by ThinkAdvisor. Steve specializes in working with high-net worth professionals. You can reach him at scraffen@wealthenhancement.com.

Laura Mattia Ph.D., MBA, CFP® is a Fee-Only Fiduciary Certified Financial Planner, an Educator, and an Author. She is a contributing author, to An Emergency Physician's Path: What to Expect After an Emergency Medicine Residency https://www.amazon.com/Emergency-Physicians-Path-Medicine-Residency/dp/303147872X and provides Financial Planning and Investment Management for Physicians. You can contact her at lmattia@wealthenhancement.com.

[1]Awarded 12/24/24 for the ranking year 2024.

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Traditional IRA account owners have considerations to make before performing a Roth IRA conversion. These primarily include income tax consequences on the converted amount in the year of conversion, withdrawal limitations from a Roth IRA, and income limitations for future contributions to a Roth IRA. In addition, if you are required to take a required minimum distribution (RMD) in the year you convert, you must do so before converting to a Roth IRA. Investing involves risk, including possible loss of principal.

2025-8263

The Top Real Estate Predictions for Summer 2025

Courtesy of victorytitle.com

The heat is on! But does that hold true for the summer housing market? With economic uncertainty and high home prices/interest rates still in the mix, this summer's market may not get as hot as we want. Here's some insight into the top real estate predictions for summer 2025.

The Market is "Calming"

Calm. Is that a word to describe the housing market? Normally, no. However, over the last year there hasn't been dramatic changes to the housing industry. Rates have stayed between 6-7%, home prices have risen or fallen (depending on the region) by minimal amounts, and the demand for homes has remained relatively consistent. With that being said, right now the market could be considered "calm." But we don't really like calm. We want "on fire," "hot," "growing like crazy," "flourishing", "perfect conditions," etc.

One can dream…but with those wishes in mind we've got to look ahead and be ready for the next half of 2025. Experts are predicting much of the same pattern in the market, particularly over the summer months.

Local Markets Matter

One area we are seeing a shift in the housing industry is within local markets. It's almost as if each local market is a country in itself. There are different impacts on demand, availability and costs of homes in local markets versus national. For example, a smaller local housing market may be booming while merely two hours away the larger market is at a standstill. This is why it's so important to understand your local market and advise clients appropriately so they can make a move when the time is right.

Summer Interest Rates

All signs are pointing to interest rates remaining between 6-7% for the summer season. We may see a slight dip, but nothing significant. It's important to help clients understand the days of 2% interest rates are long behind us, and this is the new norm. By working with lenders and real estate agents, prospective buyers can create a plan to manage the costs associates with the new rates and in most cases still get the home of their dreams.

New Home Sales are Stalling

Builders usually see their biggest growth sales in the springtime, and in 2025 this just wasn't the case. Because of current economic uncertainties, demand for new homes has decreased slightly. This has led to builders offering large incentives to move their inventory. To learn more about this, click here.

Home Price Predictions

The cost of homes has a huge impact on the housing market. When the cost goes up, alongside higher interest rates, you can see a stall in home sales. It's all about the supply and demand balance. What is on the horizon for the summer months when it comes to home prices? It looks as if prices will remain consistent and only see a rise or drop by small amounts, either way. This has to do with the amount of inventory in an area, current interest rates and any changes in real estate taxes or laws.

Overall, there are not any massive changes predicted for the summer months in the real estate industry. However, we know things can shift without notice so it's important to stay up to date on the latest real estate news and information.

THE BEST GRILLED SHRIMP

By Alyssa Rivers, therecipecritic.com

The BEST Grilled Shrimp is the perfect weeknight meal because it is super quick, full of flavor, and so easy to make. Everyone will absolutely love and devour it!!

Grilled Shrimp Recipe

Grilling shrimp is a great way to cook this very popular seafood. The grill gives them a fantastic smoky flavor and adds to the perfect tangy spices of the marinade. Due to the size of the shrimp, you will need to put them on skewers so they won't fall through the grate. I prefer jumbo shrimp for size but this will also work well with smaller size of shrimp. The marinade is that best part of the shrimp and takes them to the next level!

This shrimp recipe is perfect for a quick meal during the week or a side dish along with steak or lobster. Marinating them is simple and so worth the juicy, flavorful result. This is the best grilled shrimp I have had in a long time. It will be a go-to meal for a long time to come too!

Shrimp Ingredients:

For the best results, marinade the shrimp ahead of time. This marinade is so simple to make and many of the ingredients are things you will already have as staple ingredients. The savory and tangy juices combined with the grilled shrimp is amazing!

- **Jumbo Shrimp:** You will need about a pound peeled and de-veined. Either frozen or fresh will work, but I prefer using fresh so I can skip the thawing process and get the best flavor possible.
- **Salt and Pepper:** Add salt and pepper to taste before soaking the shrimp in marinade.
- **Red Wine Vinegar:** Adds a tangy taste and tenderizes the
- **Garlic Cloves:** Rich depth of flavor
- **Italian Seasoning:** Use a store bought mix, or make your own by adding a pinch of basil, oregano, rosemary, and thyme.
- **Lemon Juice:** The acidity will help break down the shrimp and tenderize it.
- **Soy sauce:** Either regular or low sodium will work great, it is just up to your preference.
- **Dijon mustard:** Bold flavor and a bit of acid to tenderize.
- **Worcestershire sauce:** Adds savory, sweet and tangy flavors to the marinade.

Grill Up Some Shrimp!

If you are in need of a quick meal for a weeknight, this grilled shrimp is a fantastic option. It cooks up so quickly. Whisk up this tangy marinade and impress your family with all the flavors. Then, just grab your shrimp and toss it on the grill, and its done in less than 5 minutes!

1. **Season and Marinate shrimp:** Salt and pepper the shrimp. In a medium sized bowl combine olive oil, red wine vinegar, garlic, Italian seasoning, lemon juice, soy sauce, Dijon Mustard and Worcestershire sauce. Add the shrimp and let marinate for at least one hour or overnight.
2. **Grill Shrimp:** Preheat grill to medium high heat. Thread the shrimp on the skewers. Place on the grill. Grill on each side for about two minutes or until no longer pink.

What to Serve with Shrimp:

I love to pair this grilled shrimp with some thin angel hair pasta and my amazing Homemade Alfredo Sauce. A quick salad and some steamed veggies on the side are also a great pairing. My family loves the combination and fills us all up, even the teenage boys.

The good thing about this grilled shrimp is that it goes with anything really, but if you need a few ideas to get you started, here are my suggestions...

- **Rice or quinoa**
- **Pasta**
- **Scalloped potatoes**
- **Baked potatoes**
- **Salads**
- **Steamed vegetables or vegetable skewers**

Tips to Make the BEST Grilled Shrimp:

- **Do not overcook:** Shrimp are fully cooked when they turn a pink color and look opaque and white on the inside. Pull them off the grill as soon as they are done.

- **Rinse:** Clean your shrimp before cooking them. Rinse in cold water to remove any debris, pieces of shell, etc.
- **Cook from frozen:** Save yourself time and cook your shrimp directly from frozen. No need to thaw first.
- **Pre-cooked shrimp:** You can grill pre-cooked shrimp. Essentially you will just be heating them on the grill so it will take less than cook time. You just want to leave them long enough to warm them.

How to Store Shrimp:

Properly storing your shrimp before, during, and after grilling is very important. Bacteria grows very quickly at temperatures between 40-140 degrees. You will always want to think about keeping your food either colder than 40 degrees or warmer than 140 degrees. Food should only be left at room temperatures for a maximum of 2 hours.

Grilled shrimp storage should follow these guidelines:

- **Tightly pack:** Store shrimp in a shallow airtight container or heavy-duty aluminum foil or plastic wrap.
- **Refrigerator:** 3-4 days cooked, 1-2 days raw
- **Freezer:** 3 months cooked, 3-6 months raw
- **To re-heat cooked shrimp from frozen:** Thaw in the refrigerator and then keep 3-4 days max before cooking. Do not re-freeze. If you thaw in the microwave or in cold water, it needs to be eaten right away, then discarded.

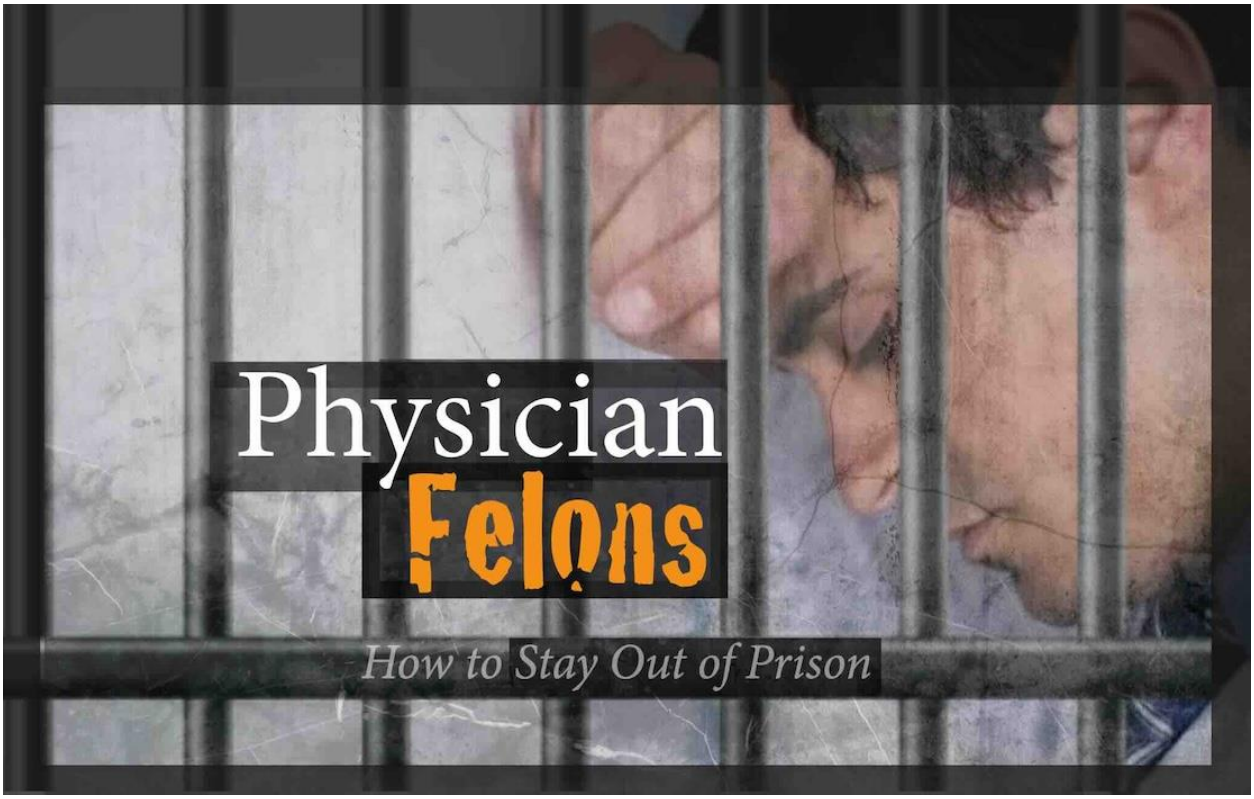
Ingredients

- 1 pound jumbo shrimp peeled and deveined
- salt and pepper
- 1/2 cup olive oil
- 1/4 cup red wine vinegar
- 3 garlic cloves minced
- 1 Tablespoon Italian seasoning
- 1 Tablespoon lemon juice
- 2 Tablespoons soy sauce
- 1 teaspoon dijon mustard
- 1 Tablespoon Worcestershire sauce

Instructions

Salt and pepper the shrimp. In a medium sized bowl combine olive oil, red wine vinegar, garlic, Italian seasoning, lemon juice, soy sauce, Dijon Mustard and Worcestershire sauce. Add the shrimp and let marinate for at least one hour or overnight.

Preheat grill to medium high heat. Thread the shrimp on the skewers. Place on the grill. Grill on each side for about two minutes or until no longer pink.



By Pamela Wible MD

Doctors behind bars — learn how to avoid common legal traps in this guide for physicians.

How to protect your medical license, your freedom, and your patients

A physician called me just hours before her sentencing for opioid diversion. She was grateful for my advice. I only wish she'd reached out sooner.

I'm writing this to help other good docs **avoid prison time**.

Here are 11 unforgettable cases involving my friends & family—with hard lessons learned.

Real Cases: How Good Doctors End Up in Prison

1. Lorraine – Nuclear Medicine Physician, Texas

My dear friend, Lorraine DeBlanche, M.D., was taking time off to grieve her beloved **physician husband's suicide** when a colleague recommended a part-time telemedicine job. Her role seemed simple: confirm veterans' requests for non-opioid pain cream and sign scripts. At $30 per patient, she earned $33,000 over one year before moving on.

Unbeknownst to her, the company was billing the U.S. military healthcare program $6,000 per tube. Years later, at midnight, FBI agents pounded on her front door. Barefoot, trembling in her nightgown, she was interrogated, her laptop seized, and ultimately she was indicted for fraud. Lorraine never even had a parking ticket; now she's a felon.

Though she harmed no one (and some patients were complicit), Lorraine was found guilty of **telemedicine fraud** ordered to repay $33,000, fined $180,000, and spent over half a million in legal

fees just to narrowly escape prison. Her career ended overnight. She's now disabled from a stress-induced autoimmune disease and still startles when anyone knocks on her door.

2. Aaron – Anesthesiologist, West Coast

My friend had a spotless 20-year record running pain clinics for underserved complex patients. He used a blend of oral, topical, and innovative non-drug therapies—with great results.

Then came the shock: a business associate had involved him in a fraudulent pain cream **kickback scheme**. His license revoked, his high-risk patients left without care, Aaron was sentenced to more than a year in federal prison for insurance fraud. Now released, he hopes to get his license back and resume caring for patients.

3. Judith – Psychiatrist, Texas

In the 1980s, two men approached my mom, Judith Wible, M.D., at her Dallas office with a business proposal. She declined. They still used her Medicare number to fraudulently bill millions. Thankfully, the FBI chose not to prosecute her.

4. Matt – Internist, Ohio

When their main doctor left, Matt stepped up to help a friend working at a local detox center by performing exams and continuing Suboxone for opioid-dependent patients—assuming a physician with a DEA waiver had initiated treatment.

DEA waiver requirements for prescribing Suboxone ended in 2022. Since Matt had no waiver at the time, the U.S. government convicted him for **distributing controlled substances**. He narrowly avoided a 20-year prison sentence.

He worked as a cashier at Target while his case dragged on for years. Though he now has a probationary medical license, he's barred from billing Medicare and Medicaid (the detox center defrauded Medicaid of nearly $50 million). Despite the reputation hit, he's back in his hometown running a small private clinic.

5. Dan – Family Physician, Midwest

Near retirement, Dan took a pandemic telemedicine job reviewing charts for patients needing braces, splints, or lab tests. He never spoke to patients—just signed orders presented to him.

Paid $20 per chart, he later discovered his employer created fake physical exams and fraudulent paperwork to bill Medicare more than $4 million—all using his signature!

Dan had a clean record (no malpractice claim in 40 years) and had no intent to defraud, though may face 20 years in prison for **Medicare fraud**. He now volunteers at a free clinic and is spending his retirement paying off more than $250,000 in legal bills.

6. Mark – Hospitalist, Florida

Mark took a pandemic telemedicine side gig. His Medicare number was used to bill nearly $3 million in fraudulent genetic tests. When he suspected wrongdoing, he quit and refused all payment.

Despite taking no money, he was arrested, lost his license, and served six months in federal prison. Today, Mark is a restaurant manager. He earns $45,000 a year and borrows money from relatives to support his family and wife, who now has a stress-induced life-threatening cardiac illness.

7. Brenda – Nurse Practitioner, New York

For over a decade, I've helped health professionals leave assembly-line medicine to open their own businesses. While mentoring Brenda, I was alarmed by an aggressive compounding pharmacy pressuring her to partner with them for weight loss meds. I warned her to steer clear. Less than 24 hours later, the pharmacy was raided and shut down by federal agents.

8. Sheila – Family Physician, California

A graduate of our business seminar, Sheila contacted me in crisis. Her Medicare number was used to bill fraudulent home health and hospice services. Though she hadn't authorized these services, physicians are held accountable for how their credentials are misused by others. She needed urgent legal help and found an excellent attorney.

9. Randy – Internist, Louisiana

When I helped **Randy Lamartiniere, M.D.**, launch his private clinic, we had no idea DEA agents were already posing as his patients. Doctors opening new practices are often inundated with patients abandoned by other physicians afraid to prescribe opioids. Randy tried to help these folks—but a pharmacist likely tipped off the **DEA investigation**. Wired undercover agents visited his clinic. At age 65, Randy was sentenced to 15 years in federal prison.

10. Richard – General Practitioner, Philadelphia

At age 79, my friend's father, Richard Minicozzi, M.D., was sentenced to 7 years in prison for running a "pill mill."

He wasn't a criminal—just an old-school, kind-hearted doc trying to help people in an inner city plagued by poverty and addiction. As his health declined, his secretary began selling Vicodin and Xanax for cash out of his office. Richard was held responsible.

Disgraced, he died alone in prison at 81.

11. Ted – Pathologist/Addiction Medicine, Philadelphia

My father, Ted Krouse, M.D., self-prescribed, gave meds to family, and dispensed tranquilizers like Valium to anxious patients. Growing up in the 1970s (back when many doctors worked out of their homes), my basement was full of pharmaceutical stock bottles, many with controlled substances.

Always willing to help the less fortunate, my dad would likely be under DEA surveillance today—or behind bars like Randy and Richard.

What these cases reveal

Naive doctors. Physicians take an Oath to ease suffering and put patients first. The legal system operates differently—and our training makes us easy prey for exploitation by bad actors. Remember: *First, do no harm to the government.*

No willful criminal intent. These real stories show how easily **physicians are prosecuted**—often without knowing they broke the law. This can be a defense to criminal charges, even if the government disagrees. Some doctors unfortunately may have pled guilty to crimes they did not actually commit. This may avoid prison time, but any criminal conviction can strip doctors of their careers and have harsh collateral consequences.

Abandoned patients. When good doctors are prosecuted, patients suffer. Some die from medical neglect. Others die by suicide—like my friend **Michelle Fernandez, M.D.,** an emergency physician who couldn't get her meds refilled after her doctor retired. I recommended she see Randy—then he was imprisoned, so she shot herself.

Impact on medicine today

Doctors now fear:

* Treating family and friends

* Self-prescribing

* Medicating patients with legitimate pain

* Prescribing controlled substances

Some even surrender their DEA licenses or opt out of Medicare just to avoid the risk of DEA surveillance or federal fraud charges.

Six steps to stay safe and protect your medical license:

1) Don't accept jobs outside your usual scope of practice.

2) Avoid **"chart review red flags"**—gigs without direct patient contact.

3) Never accept a flat fee per chart or per patient—it's a red flag.

4) Be cautious when assigning billing rights. You are still legally responsible for what happens with your (publicly-available) billing numbers.

5) Review your Medicare billing history. Make sure it reflects your actual work.

6) Avoid aggressive compounding pharmacies or telemed startups pressuring you to work with them.

Watch **this Medicare fraud video** for more red flags.

Check your Medicare billing data

Your Medicare billing data is public. Verify that your Medicare number is not being misused.

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Brain Food for July 2025

By Shane Parrish

Tiny Thoughts

Success has a way of attracting people who disappear in storms.

The gift with the highest return: believing in someone before they believe in themselves.

Everyone wants the summary. But the summary is what's left after someone else decided what matters. Their priorities aren't yours. Their filters aren't yours. When you operate on summaries, you're thinking with someone else's brain.

Insights

Legendary Coach Bill Belichick on competing:

“Helping the team win doesn't look warm and fuzzy. It looks like work—usually hard work—if you want to outcompete your opponent.”

**

Tolstoy on shortening the distance between where you are and where you want to go:

“A man on a thousand-mile walk has to forget his ultimate goal and say to himself every morning, ‘Today I’m going to cover twenty-five miles and then rest up and sleep.’”

***

Singer Jewel shares her formula for happiness: *“Do things that lend themselves to the happiness you desire. Exercise. Eat well. Do something that makes you feel joy, even when you don’t feel like it. Surround yourself with people you admire and who add substance to your life.”*

The Knowledge Project

I loved this conversation with Pepsi's former Chairman and CEO, Indra Nooyi. You'll learn exactly how to rise to the top. You'll also learn why you might not want to. Here's a story that I've been thinking about ever since:

One night after a big promotion, she rushed home full of excitement to share the big news. But her mother barely looked up before saying, "the news can wait, I need you to go out and get milk." When Indra returned with the milk, she was furious, saying loudly, "I've just become president of PepsiCo, and you couldn't just stop and listen to my news?"

"Listen to me," her mother replied. "You may be the president or whatever, but when you come home, you are a wife and a mother and a daughter. Nobody can take your place. So you leave that crown in the garage."

As she put it, *“You don’t get to be CEO by being the perfect Mom, the perfect wife. You don’t. You do the best you can. It’s hard to make those sacrifices.”*

Why Health Care Leaders Fail At Execution—And How To Fix It

Dave Cummings, RN

Health care leaders don't have a vision problem. We have an execution problem.

Over the last two decades, I've seen countless strategic plans crafted with care, insight, and bold ambition. Mission statements get refreshed. Core values are realigned. Retreats are held. Vision decks are created and shared from the C-suite to the frontlines. And yet — within weeks — most of those plans fade into the background.

The problem isn't poor leadership intent. The problem is that we stop at intent. And in the high-pressure, rapidly evolving world of health care, intention alone won't carry the weight.

The chasm between what leaders envision and what teams actually experience is wide. And in health care, that gap isn't just frustrating — it's dangerous.

Why execution fails in health care

The stakes in health care are too high for misalignment, ambiguity, or passive leadership. But we see execution fail time and again due to:

Top-down announcements without ground-level buy-in. Most strategic rollouts are top-down broadcasts, not two-way conversations. Clinicians, schedulers, techs, and therapists aren't just passive receivers of vision — they're the executors of it. If the strategy doesn't make sense to them, it doesn't go anywhere.

Lack of clear ownership. Who owns the follow-through? Many times, vision dies in the handoff between leadership and operations. No one is clearly accountable, or worse, multiple people assume someone else is.

Misaligned incentives and metrics. If your team is still measured and rewarded based on outdated KPIs, they'll focus on those — not your new priorities.

Failure to cascade communication. A new strategic goal might be discussed in a boardroom, summarized in a staff newsletter, and forgotten by the time a physical therapist opens their next patient note. Without consistent, cascading communication through multiple levels and formats, vision dissipates.

Frontline fatigue. The very people tasked with executing the new strategy are often overwhelmed by staffing shortages, tech issues, or policy changes. If we don't lighten their load, even the best ideas stall.

Closing the execution gap

Vision becomes reality when it's:

- Translated into action
- Owned at every level

- Sustained through systems

Here are three core strategies I coach health care leaders to adopt:

1. Start with clarity, not complexity. Boil down your vision to its simplest form. Instead of launching a 24-page initiative, ask: “Can every leader and employee articulate what we’re trying to achieve in one sentence?” If not, refine it.

Then clearly map the “what this means for you” layer by layer. A new scheduling model doesn’t just mean faster access for patients; it means specific behavior shifts for intake, clinicians, and support staff.

2. Assign champions, not just checklists. Execution lives or dies with ownership. Assign a real person at each level who is responsible for making the vision real — not just tracking metrics but solving friction.

Champions ask, “What’s getting in the way for our team?” and then remove it. They give voice to the frontline and close the loop between executive assumptions and real-world application.

3. Build rhythms of reinforcement. One-and-done town halls won’t embed change. You need weekly rhythms of reinforcement: huddles, dashboards, feedback loops, and storytelling. This is where AI and tech can help — surfacing progress, flagging gaps, and allowing leaders to re-engage quickly.

It’s not about micromanaging. It’s about maintaining a pulse.

The cost of non-execution

When visions fail, morale suffers. Teams grow cynical. Patients notice. Resources get wasted. And worst of all, innovation gets shelved.

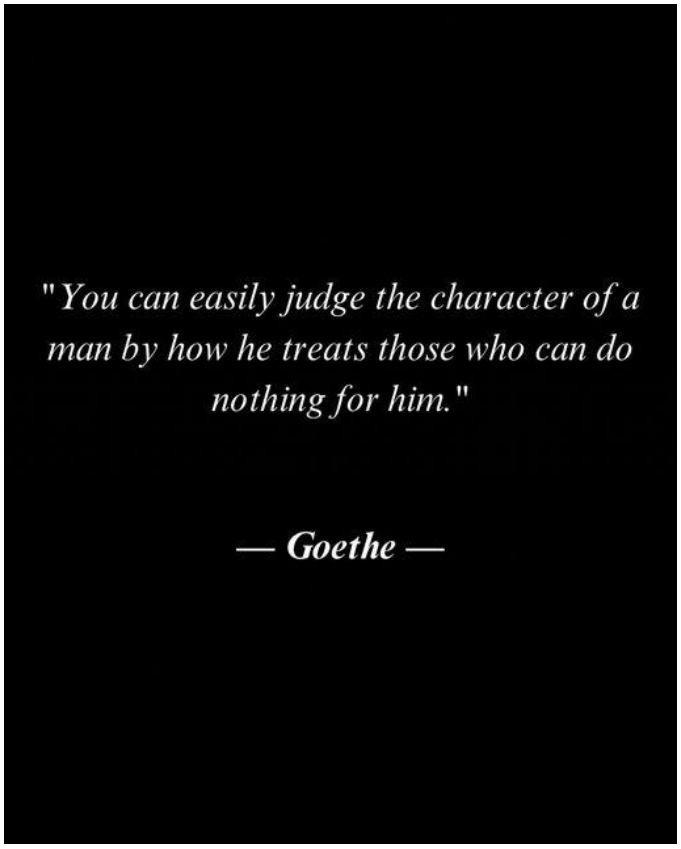
Health care doesn’t lack vision. We lack execution habits.

If we’re serious about transforming patient care, improving clinician engagement, and building resilient systems, we must move beyond strategy slides. We must embed vision into the daily heartbeat of our organizations.

Execution isn’t glamorous. But it’s where leadership is proven.

Let’s close the gap.

Dave Cummings is a health care executive.



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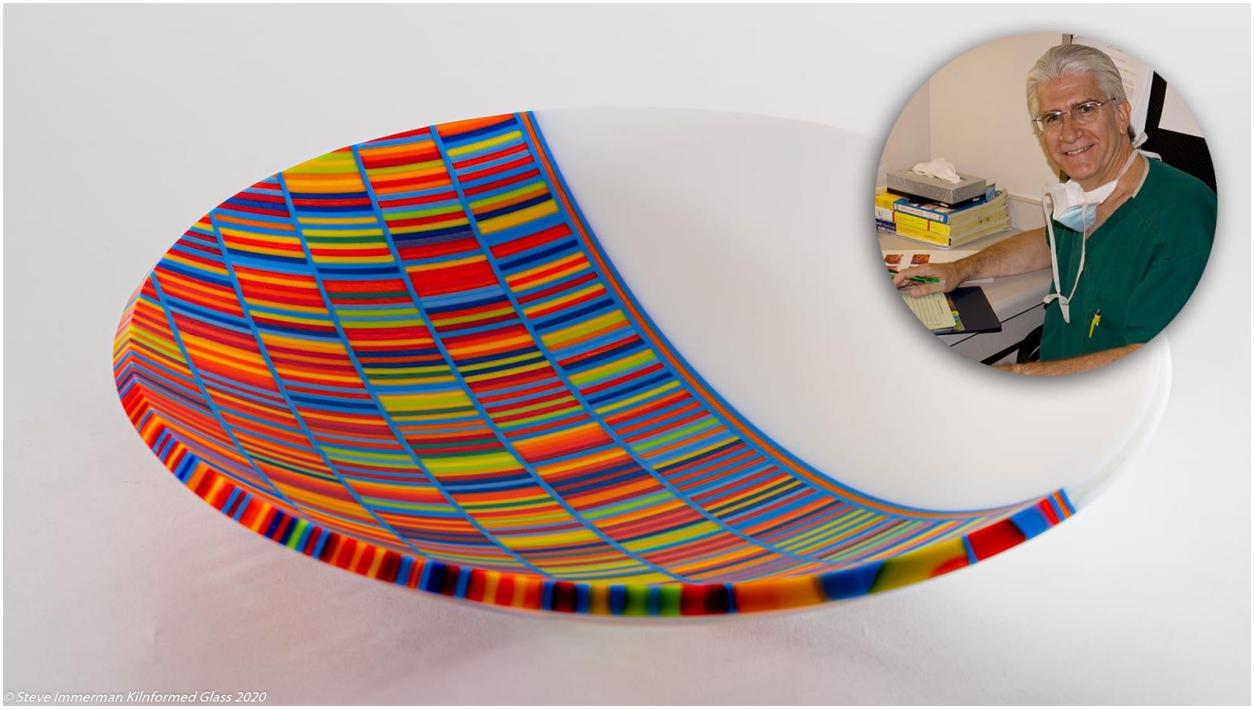
Are Your Hobbies Connected to Your Specialty?

— Physicians' work may influence how they spend their free time

by Arthur Lazarus, MD, MBA



Dr. Steven Immerman and a piece of his kiln-formed glass art.

Throughout my career I have met doctors with some of the most interesting hobbies -- car collectors, wine makers, coffee roasters, and many others. I've often wondered whether physicians who have utilized their specialized skills in the practice of medicine have parlayed those skills into hobbies. In other words, is there a connection between physicians' hobbies and their medical specialty? My take is that doctors' hobbies and their specialty choices are often inextricably linked.

To be sure, the COVID-19 pandemic has drawn considerable attention to the importance of having a hobby. Physicians under prolonged stress need outside activities to decompress from hard-fought battles lost and won on the COVID front lines.

According to the September U.S. Department of Labor report, 524,000 healthcare workers have left the field since February 2020 -- doctors are among them. Of course, it's impossible to say whether having a hobby would have mitigated the exodus, but the importance of having a hobby has been shown to be crucial in achieving relaxation and work-life balance, as well as coping with anxiety, depression, and traumatic medical experiences.

My son-in-law Austin, for example, is a second-year medical student and an avid gardener. Gardening has allowed him to unwind from the pressure of medical school, while simultaneously parenting a newborn child. Conversely, he feels that gardening has made him a better clinician by teaching him to be patient, learning from failure, and accepting death. Most importantly, gardening has taught Austin concepts related to preventive medicine. "Any gardener knows the importance of their soil's composition.

You need to have the right amounts of organic matter, nutrients, minerals, fungi, and bacteria to give your plants the best foundation to grow ... The garden has reminded me that in order to help our patients grow and maintain their health for longer periods of time, we must grant them solid ground beneath their feet and a clinician who can help them when needed," he wrote in an op-ed.

One of my most influential and admired medical school professors is infectious disease expert Bennett Lorber, MD, a professional painter. Lorber was raised in a family that valued art and music -- his cousin is the accomplished jazz keyboardist and Grammy award winner Jeff Lorber -- and Lorber has painted since early childhood. He also emphasized the importance of having a hobby as a doctor. "Doing something that is important to you, makes you happy, and keeps you sane is just as important as what you do as a doctor ... To best take care of patients, you have to first take care of yourself ... I am a doctor and a painter. Painting for me is not a hobby, but rather a calling equal to my calling to medicine," he said.

Some incredibly talented physicians have found their calling outside of medicine and have left the profession altogether. But the overwhelming majority are satisfied to straddle the fence, like psychiatrist and world-renowned jazz pianist Denny Zeitlin, MD, who maintains a private psychotherapy practice when not recording or touring.

Zeitlin has noted striking similarities between his two vocations: "The psychotherapeutic journey has commonalities with improvising music, which, as a jazz pianist and composer, has been another major passion. Empathy and communication are paramount in both, and I believe my most creative level of psychotherapy and musical expression occurs when I am able to trust that I will be able to bring to bear everything I have studied and learned while simultaneously allowing myself to be so immersed in the activity that I become 'one' with it -- to merge with the music, the musicians, or the patient and his psychological life. I've been fascinated with the nature and challenges of this merger state ... The cross-pollination of music and psychiatry has greatly aided me in both fields."

Success notwithstanding, Zeitlin is quick to add that his musical activities have always remained subordinate to his primary responsibilities to patients and trainees (he teaches at the University of California San Francisco).

The same holds true for general surgeon and kiln-formed glass artist Steven Immerman, MD, who specializes in treatment for pilonidal disease. "Though I was extremely busy, I knew I needed a creative outlet," he said. "I found I really missed having a hobby in which I could use my hands. I was a surgeon at work, but even at play, I needed to work with my hands."

Once when Immerman attended a workshop and proposed a project -- a block of colored glass with a window through which viewers could observe the contents inside -- the instructor remarked, "Well, of course. You're a surgeon. You make little openings in people and you look inside."

Immerman has since observed similar parallels between people's choice of work and their extracurricular activities. Perhaps the most profound parallel can be seen in his own practice, because both surgical and artistic outcomes entail a period of waiting and uncertainty. "They both have a period of time when the process is seemingly out of my control," he said. "For surgery, it is the patient's healing process; for kiln-formed glass, it is the time it is in the kiln. Then, hopefully, there is the joy of seeing the finished product in both endeavors." Immerman also cited the example of a pathologist friend who enjoys astronomy in his spare time. "Both activities consist of looking through a lens and making order out of chaos," he observed.

I have searched for correlations in my own career, as an established psychiatrist and an amateur musician who collects rock and roll live music recordings. As best I can determine, with psychotherapy

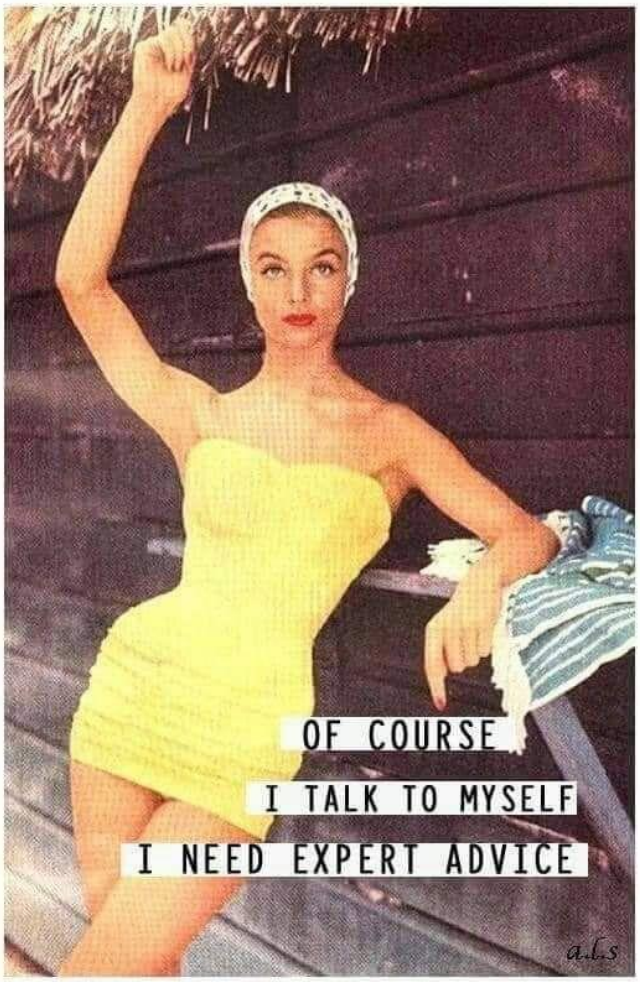
as my currency, the flow of the therapeutic conversation (the melody), combined with the spoken word of the patient (the lyrics), unites my practice with my hobby.

The relationship between work and hobbies need not be esoteric. For example, Christos Ballas, MD, a very busy ob/gyn, trains and competes in triathlons. He noted, "My hobby is like my career, a big grind, but a lot healthier than going to work. I train and do endurance events, so when not working I'm swimming, running, or biking and thankful that at 61 I can still do it and practice full scope ob/gyn."

I invited physicians blogging on Doximity to share their views about the similarities between their hobbies and medical specialties. A plastic surgeon stated that he makes large-scale production model cars. "Maybe my hobby makes me a different kind of 'plastic' surgeon," he surmised. Emergency medicine physician and author Jeffrey Wade, MD, commented, "Stories are a way I receive the world as a big reader and how I report it back. Writing stories from my life has almost been like psychotherapy and gives me individual stories or books to hand out to people who seem like they could benefit from it."

A retired ER trauma physician stated that he builds and shoots black powder Buffalo rifles from the 1800s and percussion muskets and flintlocks from the 1700s. What a curious hobby, I thought, for a physician who has probably treated hundreds, if not thousands, of gunshot victims during his career. One physician asked, "Since I race cars as my hobby and I am a neonatologist, I wonder what that says?"

My favorite comment, however, came from a psychiatrist who snapped, "I wonder how many people [blogging] here would choose to do medicine as a hobby?"



It's like asking physicians who hold both medical and business degrees how many of them went to medical school because they couldn't get into business school? Physicians who are accomplished in their specialties and hobbies usually thrive on the interplay between them. It makes sense that our hobbies reveal a great deal about our passions and the activities that sustain us. Although our hobbies may not always align with our work, it's possible that the more it does, the higher our level of job satisfaction.

In fact, when graduating medical students were asked to rank the most important factors that influenced their specialty choice, "fit with personality, interests, and skills" consistently ranked the highest, behind specialty content, work-life balance, length of residency, and income expectations. The factors motivating physicians to pursue certain career pathways may be the very same factors leading them to choose lifelong hobbies.

Arthur Lazarus, MD, MBA, is a member of the Physician Leadership Journal editorial board, a 2021-2022 Doximity Luminary Fellow, and an adjunct professor of psychiatry at the Lewis Katz School of Medicine at Temple University in Philadelphia.

From Burnout To Balance: A Neurosurgeon’s Bold Career Redesign

Jessie Mahoney, MD

When a neurosurgeon tells you she thinks she might want to leave surgery for interior design, you listen closely.

Not because it’s outrageous, but because it’s honest. Many physicians carry similar longings. They wonder whether it’s OK to want a different life.

In medicine, conformity is expected and often a means of survival. Especially for women in male-dominated fields. The unspoken expectation is to blend in, push through, and never question the mold.

This neurosurgeon didn’t end up leaving. Through reflection, support, coaching, and a willingness to question long-held assumptions, she redesigned her relationship with her career and created a career that fit her authentic self.

She now practices in a nontraditional model: Commuting for one week of clinical work, then returning home for a full week of rest, connection, and personal life. What at first seemed like an imperfect compromise has become the foundation of a deeply fulfilling life.

She is more present with her family. She has cultivated meaningful friendships. She reconnected with hobbies she once believed didn’t belong in the life of a neurosurgeon. On top of it all, she enjoys her clinical work again.

Career shifts aren't simply logistical. They require us to change our internal settings as well.

Almost everyone who leaves a role in medicine experiences the all-too-familiar narrative that if you step off the traditional path, you must not have been able to "hack it." The feeling of shame is universal in medicine.

Shame, blame, and guilt keep many physicians working in situations that are not aligned, not healthy, and often even toxic. The shame we feel is not a signal of failure. It's simply cultural conditioning.

Just because medicine, and especially surgery, wasn't built for women, it doesn't mean we have to walk away. We can redesign our role in it.

When we do this, we all benefit. Our patients receive more presence. Our families receive more connection. Our teams receive more grounded leadership. More importantly women physicians get to love their work in medicine and surgery again.

If you feel stuck, misaligned, or quietly ashamed that the traditional model isn't working for you, you're not broken. The system wasn't built with you in mind. It wasn't built for the kind of medicine we practice in 2025.

This doesn't mean there isn't a path that can work for you. It simply means that finding an authentic path will take creativity, courage, and support.

Jessie Mahoney is a board-certified pediatrician, certified coach, mindfulness and yoga teacher, and the founder of Pause & Presence Coaching & Retreats. After nearly two decades as a physician leader at the Permanente Medical Group/Kaiser, she stepped outside the traditional medical model to reimagine what sustainable well-being in health care could look like. She can also be reached on Facebook and Instagram.

Dr. Mahoney's work challenges the culture of overwork and self-sacrifice in medicine. She helps physicians and leaders cultivate clarity, intention, and balance—leveraging mindfulness, coaching, yoga, and lifestyle medicine to create deep and lasting change. Her CME retreats offer a transformative space for healing, self-discovery, and renewal.

As co-host of the podcast, Healing Medicine, she brings self-compassion and presence into the conversation around modern medical practice. A sought-after speaker and consultant, she partners with organizations to build more human-centered, sustainable, and inspired medical cultures.

Dr. Mahoney is a graduate of Dartmouth College and the University of California, San Francisco, School of Medicine.

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Exploring Appalachia: Mountain Drives, Breathtaking Hikes, and Asheville Strolls

A destination itself that you can spend days exploring, Asheville is also an ideal home base for immersing yourself in the beauty of the surrounding natural environment and picturesque small-town communities of the Blue Ridge Mountains. Part of what draws visitors and residents alike is the seemingly infinite number of places to visit within about an hour's drive or less.

On this five-day itinerary, you'll get a taste of Asheville's downtown before setting sights beyond the city limits. The journey takes you up the scenic Blue Ridge Parkway toward the charming town of Black Mountain. Throughout the trip, you'll enjoy Asheville's most fantastic southern hospitality, incredible cuisine, the option to take a tour, and of course, one (or more) of the area's many local craft brews.

DAY 1
Hello, Asheville

Today, you arrive either by plane or car. Driving into downtown Asheville, your stay begins at Hotel Indigo Asheville Downtown. This 13-story hotel, located within walking distance of all the vibrancy downtown has to offer, features rooms and suites with hardwood floors, and some with mountain views and/or balconies. What's more, starting rates here are among the most reasonable in town. If you prefer a more immersive stay, try one of Asheville's many historic Bed & Breakfasts.

For a taste of Appalachia (and maybe a little something to bring home), grab a pulled pork and collard greens sandwich or other lunch option at award-winning chef John Fleer's The Rhu, a café, bakery, and grocery. History buffs can spend the afternoon

learning about Asheville through architecture and stories on one of History@Hand's walking tours. Or for those who love comedy, consider LaZoom Comedy Tours.

You're eating downtown tonight, at the rooftop restaurant Hemingway's Cuba. Arrive before sunset to savor the view and one of their famous Cuban daiquiris as you make the most difficult decision of the day—what to eat. In case Hemingway's gets you in the mood for more alfresco libations, this is just one of many rooftop bars in downtown Asheville such as the especially charming Antidote at Chemist Spirits, which features old-style cocktails. For multiple libations and three different views of the city, book an experience with Asheville Rooftop Bar Tours.

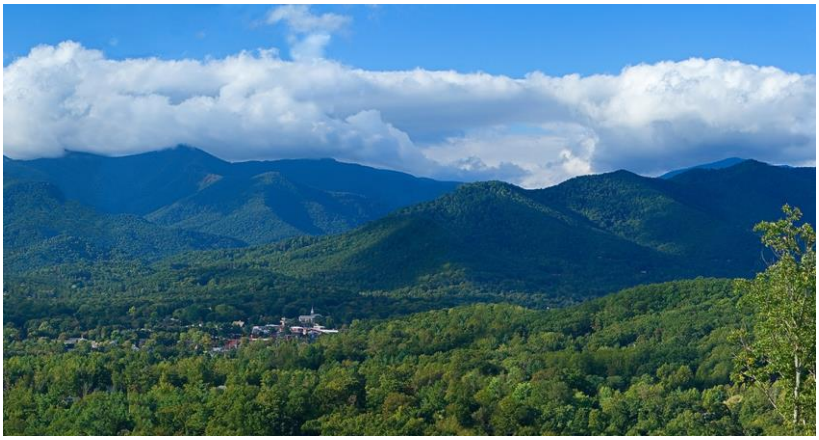
DAY 2
Choose your own outdoor adventure

It's time to immerse yourself in the Appalachian landscape. For a fun experience in nature that's more active and engaging, try zip-lining from Navitat Canopy Adventures or the Adventure Center of Asheville. Or get into the Asheville ethos on a guided mushroom-foraging expedition with No Taste Like Home. To check out the French Broad River instead, consider a relaxing float with Zen Tubing or kayaking on the river with a naturalist from Hike Bike Kayak Asheville.

For something a little more easygoing, take the scenic route through Pisgah National Forest toward the famous natural waterslide Sliding Rock with its adjacent Looking Glass Falls. There is no hike required to access the slide or see the falls, and this can be a pretty popular site, especially on weekends so we recommend visiting on a weekday.

After some time outside, you'll probably want to grab a beer. Head to one of Asheville's great microbreweries, like Forestry Camp, set in a building that once housed young forestry workers in the New Deal-era Civilian Conservation Corps. Alternatively, visit the Highland Brewing Company, regarded as the founding brewer of the local beer scene.

DAY 3
Goodbye, city life

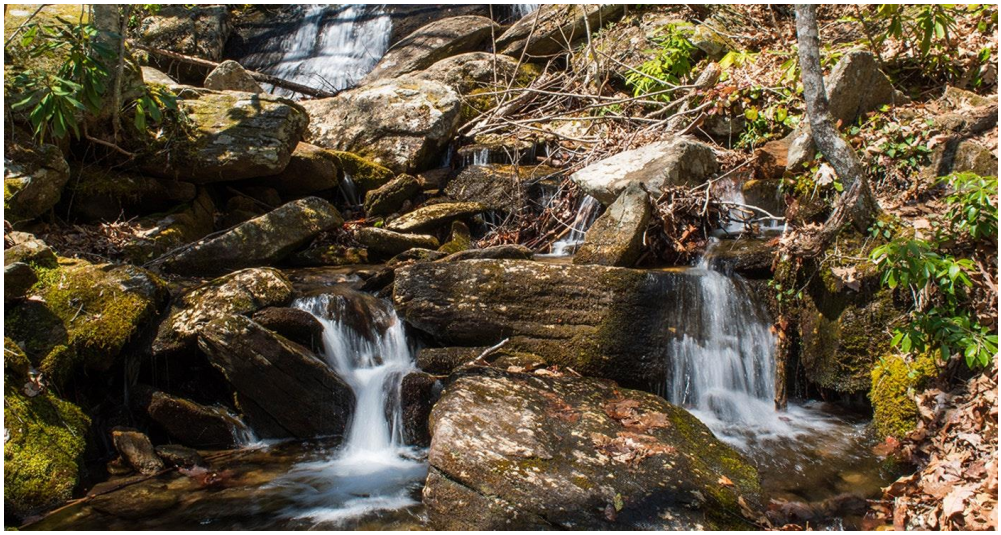


After checking out of Hotel Indigo, hop in the car and head toward the Blue Ridge Parkway, bound for Black Mountain, just 20 minutes away and often referred to as "the front porch of Western North Carolina." Check into a vacation rental from Greybeard Rentals, one of the seven log cabins at High Rock Rentals, or Arbor House before heading downtown. There, you'll get a full dose of small-town life. The mountain town's quaint streets are lined with cute shops and restaurants, so you'll want to take your time weaving in and out of each one. Highlights include Chifferobe, Dancing Dragonfly, CW Moose, and Europa.

After all that shopping, refresh yourself with a glass of hard cider from Black Mountain Ciderworks + Meadery. Last but not least, stop in for some southern-style "casual fine dining" at the old Red Rocker Inn with homey dishes like

buttermilk fried chicken breast and grilled Carolina mountain trout. The Victorian-style house has been a part of the Black Mountain landscape since 1896.

DAY 4
Happy trails, y'all



Head toward Montreat for the Graybeard Trail, one of the more challenging and exciting hikes in the region. This trail is 9.5 miles roundtrip, so be sure you've packed plenty of snacks and water. As you make your way, you'll be rewarded with several sights, including small waterfalls and spectacular vistas. The trail is particularly stunning in the fall, when the mountainsides are sparkling with color. For a deeper connection to nature, consider hiring a guide like the folks at Blue Ridge Hiking Company to hike with a certified naturalist.

For something more low-key (and delicious), head out on the W.N.C. Cheese Trail. The trail includes a total of 17 Appalachian cheesemakers and farms, and you can visit up to six. Consider starting at Round Mountain Creamery in Black Mountain, and making your way back with stops at Blue Ridge Mountain Creamery, Looking Glass Creamery, and Hickory Nut Gap Farm.

If you prefer a beautiful drive instead, take the Blue Ridge Parkway toward Mount Mitchell the highest peak east of the Mississippi River. Here, you'll enjoy some of the most stunning views in the Blue Ridge Mountains, making for prime selfie backdrops.

For dinner, savor local seafood and ingredients at Que Sera including dishes like white cornmeal fried oysters and steak frites.

DAY 5
Just one more hike

Before heading out of town, get in one last taste of the Blue Ridge Mountains. Drive up the Blue Ridge Parkway and make your way to the Rattlesnake Lodge Trail, an easy 1.4-mile jaunt to the ruins of a lodge that burned in 1926. Once back at the trailhead, it's an easy drive back to the interstate to drive to the next destination or to the airport.

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