MD Life

March 2026

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Laura Mattia, PH.D., MBA, CFP®
Steve Craffen, MBA, MS, CFA, CFP®
Alison Hall, CFP®
Greg Giardino, CFP®, CPWA®

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From Singapore to Canada: A Blueprint For Primary Care Transformation

Ivy Oandasan, MD

Recently, Dr. Tara Kiran made headlines when her robust national OurCare survey revealed 5.9 million Canadians still lack a primary care provider, the point-of-entry health professional, like a family doctor or nurse practitioner, who provides routine care.

Those who do have a primary care provider often wait weeks for an appointment, then get rushed through in minutes. Emergency departments overflow with patients who have nowhere else to go.

The federal government has responded to the crisis by creating 5,000 Express Entry spaces to fast-track permanent residency for international doctors already working in Canada.

But the problem isn't just more doctors. We have a care delivery problem. We need a care delivery transformation.

While providing interprofessional leadership training in Singapore over the past three years, I've seen and learned about their remarkable primary care transformation. Recently, a delegation from SingHealth generously shared their approach with over 75 primary care leaders across Canada.

Here is what we learned.

Singapore's approach: choice and incentives

First, Singapore gives patients real choice, with universal coverage and smart incentives for doctors.

Patients enroll with either a private family doctor or a government-funded polyclinic team with a family medicine specialist. Don't like your choice? Switch.

Health care is universal with a copay, funded through mandatory health savings accounts and workplace insurance, with government subsidies if funds run out.

Here is what makes it work: Private family doctors who participate in the national Healthier SG program are invited to join a Primary Care Network. In return, they get access to government-funded nurses, care coordinators, and services solo practices could never afford.

They are not threatened with a hard mandate but a smart one: substantial support in exchange for network membership.

Annual health plans and team-based care

Second, every clinic has a family physician who creates annual health plans with patients.

Government-funded polyclinics are one-stop shops staffed by certified family physician specialists working alongside nurses, pharmacists, and other health care professionals with lab and X-ray testing on

site. Most patients with chronic conditions choose polyclinics because of the accessibility of comprehensive services.

The family physician and patient's agreed-upon annual health plan is shared with the team for implementation. Throughout the year, nurses, dietitians, and pharmacists see the patient, bringing in the family physician when needed.

Accountability for outcomes

Third, Singapore measures what matters and holds regions accountable, with support.

Each Regional Health System is responsible for population health outcomes: fewer emergency visits, better chronic disease control, reduced hospitalizations. Accountability comes with resources.

The result? Early signs of significant reductions in emergency visits and hospital admissions. Taxpayer money saved, and better health for patients.

What would a Singapore-style approach look like in Canada?

Let's take for example a 35-year-old patient, slightly overweight, blood pressure creeping up. The family physician creates an annual health plan which may include goals like losing weight through diet and exercise. Throughout the year, the nurse, dietitian, and community supports help the patient succeed.

Same clinic. Different doors.

Mid-year, the patient mentions new shortness of breath. The nurse recognizes this is no longer routine. She knocks on the family physician's door.

This is where family medicine shines: the ability to reason through ambiguous symptoms, to know what to watch for and when to act. The physician steps in to address complexity team members cannot manage alone, leveraging their longitudinal relationship and seeing the patient as a whole.

Same team, different doors, connected through shared records and relationships. Each health care professional contributing their best.

Can we really compare Singapore to Canada, though?

Yes, Singapore is smaller. Yes, their governance differs. But the lesson is universal: When a nation commits to a clear vision, coordinates its efforts, provides real support, and holds everyone accountable for population health, transformation happens.

It is about more than just adding more doctors to the system.

Almost six million Canadians without primary care doesn't have to be permanent. New investments should focus on a coordinated national approach to team-based care, with resources tied to keeping populations healthy.

The question isn't whether Canada can transform primary care. It's whether we have the will to achieve a shared vision.

Ivy Oandasan is a family physician in Canada.

The Number That Unlocks Your Entire Life (And It’s Not Your SSN)

kimkomando.com

Your phone number is tied to your bank, your email, your health portal and every two-factor code you receive. Criminals can steal it with one phone call. Here’s how to lock it down.

Your phone number is the most dangerous number you own. Not your Social. Not your bank account. Those 10 digits are tied to your email recovery, your bank login, your two-factor codes, your health portal and your Amazon account.

And a criminal can steal it in minutes.

📲 It’s called a SIM swap

A scammer calls your carrier, pretending to be you. They use details scraped from data breaches or social media to pass security questions, tell the rep they got a new phone and need the number transferred. Done.

Your phone goes dead. No signal. No texts.

Meanwhile, the criminal is getting every two-factor code meant for you. They reset your passwords, drain your accounts and lock you out of your own digital life. The whole thing can take less than three minutes.

🔒 Lock your number right now

These settings are not turned on by default. That’s the problem. I walked through every one of these steps myself. Depending on your device or app version, things might look slightly different. Poke around. You’ll find them.

- **AT&T:** Open the **myAT&T** app or sign in online. Go to **Account** > **Services** (second tab at the bottom) > **Mobile Security** > toggle on **Wireless Account Lock**. This blocks all SIM swaps, device changes and port-outs until you turn it off.
- **Verizon:** Open the **My Verizon** app. Tap **Me** > **Edit profile and settings**. Toggle on BOTH **SIM Protection** (blocks SIM swaps) and **Number Lock** (blocks porting to another carrier). You need both.
- **T-Mobile:** Open the **T-Life** app. Go to **Manage** > gear icon > **Security** > enable **SIM Protection**. To lock your port-out, you may need to call **611** to set a port-out PIN if the app toggle is grayed out.
- **Consumer Cellular:** Call customer service at **1-888-345-5509** and tell them, "I want to add a manual port-out PIN to my account." Consumer Cellular requires this PIN before any number transfer.

And then, do these things

Set a SIM PIN on your phone (this is different from your screen passcode). It blocks access if someone physically removes your SIM card.

- On **iPhone: Settings** > **Cellular** > **SIM PIN**.
- On **Android: Settings** > **Security and privacy** > **More security settings** > **SIM card security**.

Switch your important accounts (bank, email, crypto) from text message 2FA to an app like Google Authenticator. SMS codes are the exact thing criminals steal in a SIM swap. Authenticator apps live on your device and can't be intercepted. [Learn more on my site here](#).

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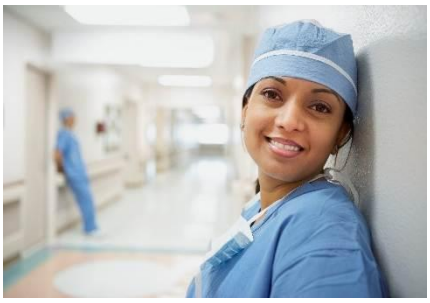
How 401(a), 403(b), and Governmental 457(b) Plans Work for Mid & Late-Career Medical Doctors

Retirement plans for medical doctors can be very confusing. There are unique features and nuances that pertain to many hospital and university hospital retirement plans. Mid- and late-career medical doctors need to maximize their contributions appropriately when investing between these vehicles for accelerated savings. Understanding which retirement plans to fund, and which ones afford additional catch-up planning, is critical to ensure retirement and legacy goals are met. The following will help uncover how popular 401(a), 403(b), and Governmental 457(b) plans work in the New Jersey retirement system.



401(a) Retirement Plans

401(a) retirement plans are usually offered to medical doctors who are employed by university hospitals. Like 401(k), where the "k" designates a retirement plan offered for employees who work in the private sector, the "a" in 401(a) signifies a retirement plan offered to employees in public academia, or university hospitals.

401(a) is a higher education employer-sponsored retirement plan that is generally structured as a tax-sheltered annuity. This means that participants of the plan are required to contribute a specific percentage of their base salary (which it is why it is considered a "defined" contribution retirement plan) to the 401(a) whether they are part time or full-time.

An example of the 401(a) plan can be seen for medical doctors and physicians employed by Rutgers Robert Wood Johnson Medical School (New Brunswick, NJ) and Rutgers New Jersey Medical School (Newark, NJ). Medical doctors who are employed by RWJMS and the NJMS are typically part of the New Jersey Alternate Benefit Program ("NJ ABP") which is comprised of a 401(a), 403(b), and governmental 457(b) plan.

The 401(a) NJ ABP retirement plan for Rutgers Robert Wood Johnson Medical School and Rutgers New Jersey Medical School currently offers:

- ***5% Mandatory Base Salary Contribution***
- ***8% Rutgers Match Contribution***

Medical doctors who have high income should realize they may not receive a match on their full salary. For example, for Rutgers' 8% match contributions to Robert Wood Johnson Medical School and New Jersey Medical school doctors, the 8% is typically matched up to $175,000 in annual compensation inside the NJ ABP Plan.

For salaries higher than $175,000, the ABP Trust (typically offered by TIAA) allows the excess 8% match to continue up to the federal IRC (Internal Revenue Code) annual compensation limit which is $360,000 in 2026. Furthermore, for medical doctors who earn over $360,000 and were hired before December 31st, 2017[1], the BAP ("Benefits Assistance Program") could extend the compensation threshold for which the match could be received on.

Depending upon your 401(a) plan, there may be various insurance and investment providers who can invest your contributions. The New Jersey Alternate Benefit Plan 401(a) currently offers TIAA, Empower (formerly MassMutual & Prudential), Equitable (formerly AXA), MetLife (Brighthouse), VOYA, and Corebridge (formerly AIG). Each insurance company has its own fee. **Make sure you analyze both the expense ratios for each investment option and any mortality and expense (M&E) fees for each provider.** The M&E fee helps cover insurance provider costs and guaranteed death benefits and is assessed on top of your expense ratios of the funds you select. Keep in mind that an M&E fee is usually not assessed on a provider's general or fixed account investment option.

What is unique about the NJ ABP is you can change carriers without incurring any cost or penalties. You generally cannot withdraw 401(a) retirement contributions until you are retired or separated from service or you risk losing your match. Furthermore, the 401(a) is limited in that you cannot contribute more than the defined percentage or your salary into the 401(a) plan.

403(b) Retirement Plans

Like the 401(a) plan, the 403(b) plan is a tax-sheltered annuity retirement plan. If you do not have a 401(a), you may have a 403(b) with a matching contribution as your core retirement plan.

For those who have a 401(a), the 403(b) will serve as your voluntary plan, where you voluntarily contribute additional amounts above and beyond the 401(a) mandatory contribution. For 2026, the 403(b)-contribution limit is $24,500 for those under 50.

IRS CONTRIBUTION LIMITS FOR EMPLOYEES AGED 50 AND ABOVE

Plan	Age 50–59	Age 60–63	Age 64+
403(b)	$32,500 (IRS Limit plus $8,000 age-based catch-up)	$35,750 (IRS Limit plus $11,250 age-based catch-up)	$32,500 (IRS Limit plus $8,000 age-based catch-up)

* Age as of 12/31/2026

If you look at the above IRS 403(b) contribution limits, you will see that those age 60-63 can now contribute a "super catch-up" contribution of $11,250 (instead of the $8,000 catch-up). Ensure that your

[1] Rutgers University Human Resources, uhr.rutgers.edu/benefits/benefits-assistance-program-bap

employer offers this as it is optional. The 403(b) for Rutgers RWJMS and Rutgers NJMS offers this super-catch-up limit which physicians can take advantage of.

The 403(b) option may offer the same, or more attractive investment options than the 401(a) plan. For example, for participants working with TIAA inside the New Jersey Alternate Benefit Plan, TIAA Traditional (a guaranteed fixed annuity investment option) can have an 84 month lock up period to gain access to all their TIAA Traditional money in their 401(a) account. Inside the 403(b) plan, this same option may be 100% liquid with a slightly lower interest rate. For medical doctors approaching retirement, this flexibility may be extremely attractive and worth strategically weighting more of this option inside their 403(b) versus their 401(a).

Most 403(b) plans offer a loan provision. You can generally borrow $50,000 or 50% of your account, whichever is less, depending upon your years of service in the plan. Borrowing from a 403(b) or 401(a) plan should be used as a last resort. While some 403(b) plans will allow you to earn a credit rate of interest and not fully lose out on the investment opportunity cost of having the borrowed money completely out of the stock and bond markets, it is not without other drawbacks. Since you pay back your loan with after-tax dollars (money that has already been taxed) and you will eventually take out your money at retirement (taxed again), you will effectively be double taxed on your loan amount.

Inside the NJ ABP there is an in-service withdrawal provision for the 403(b) plan. This is available to late career medical doctors who reach age 59 ½.

The In-Service Withdrawal Provision allows a medical doctor to reposition 403(b) assets outside of your NJ ABP retirement system, which can be attractive for those looking to work alongside a fee-only financial planner who specializes in Rutgers RWJMS and Rutgers NJMS retirement planning.

We usually recommend not closing out the 403(b) plan and keeping a minimal amount of money in the plan to continue to maximize tax deferral savings (presumably in a doctor's highest peak earning years when you are in the highest tax brackets (37% Federal for example).

457(b) Governmental Plan

The state of New Jersey offers the New Jersey State Employees Deferred Compensation Plan ("NJSEDCP"). This governmental 457(b) Deferred Compensation Plan is a supplemental retirement plan exclusively offered to New Jersey state and university hospital employees. It is offered solely through Empower (which was formerly offered through Prudential).

The 457 plan is like the 403(b)retirement plan regarding contribution limits, but it has some important differences and can be an invaluable tool to supplement one's retirement income. The 457(b) plan has a separate contribution limit (which includes employee and employer contributions) that is not combined with deferrals made to your 401(a) or 403(b) plans.

The 457(b) contribution limits for 2026 are $24,500 for those under 50. The following chart will illustrate what contributions are for those over 50 in 2026:

	IRS Contribution Limits for Employees Aged 50 and Above		
Plan	**Age 50-59**	**Age 60-63**	**Age 64+**
457	$32,500 (IRS Limit plus $8,000 age-based catch-up)	$35,750 (IRS Limit plus $11,250 age-based catch-up)	$32,500 (IRS Limit plus $8,000 age-based catch-up)

Most Rutgers medical doctors and faculty don't realize that they can "max" out both their employee contributions to their 403(b) plan AND their 457(b) plan!

This is a huge opportunity many miss to further reduce their taxable income and deferring taxes for years, while simultaneously saving for retirement. For 2026, Rutgers medical doctors over 50 (but not yet 60) can max out by contributing $32,500 to both their 403(b) and 457(b) NJSEDCP plan.

In addition, there is a special provision only within the 457(b) plan that allows a saver to defer up to a total of $49,000 (double the $24,500 limit) in 2026 known as the "double limit catch up" or "last 3 -year catch up" provision, allowing medical doctors nearing retirement to compensate for years in which they did not contribute to the plan, but were eligible to do so. This can be implemented during the last three years of employment prior to the plan's normal retirement age.

Please keep in mind you cannot use both the age-50 catch up and the 3-year catch up (you can use only one of the larger of the two). A Rutgers physician 50 and over could defer $32,500 into their 403b, and $49,000 into their 457(b) governmental plan, which can greatly enhance saving capacity.

Finally, like the 401(a), you cannot reposition this account elsewhere until you are retired or separated from service. For those who are planning on retiring earlier than 59 ½, you may want to consider not rolling over your 457(b) to an IRA or you will be subject to a 10% federal penalty on early withdrawals. The NJ 457 plan is unique in that there is penalty free access to funds once you break from service which may be attractive for those retiring before 59 ½.

Conclusion

If coordinated correctly, leveraging New Jersey 401(a), 403(b), and 457(b) governmental plans can accelerate savings and significantly grow retirement wealth for NJ medical doctors and physicians. A careful analysis should compare all in fees for reach provider in each plan and be optimized for maximum diversification and liquidity when you reach retirement. It is also critically important that you have a plan for how to take money out from each account when the time comes to prolong your retirement nest egg.

If you would like to take a deeper dive and learn more, do not miss our upcoming online seminar on **Medical Doctor Advanced Financial Planning: How 401(a), 403(b), and 457(b) Governmental Plans work in NJ on March 24th (Tuesday) at 12 Noon.** Scan the QR Code below to register now!

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. Greg's accolades include being named InvestmentNews' Rising Stars | Best Wealth Managers and Advisors under 40 in the USA for 2025 and on NJBIZ's 2025 40 under 40 list.

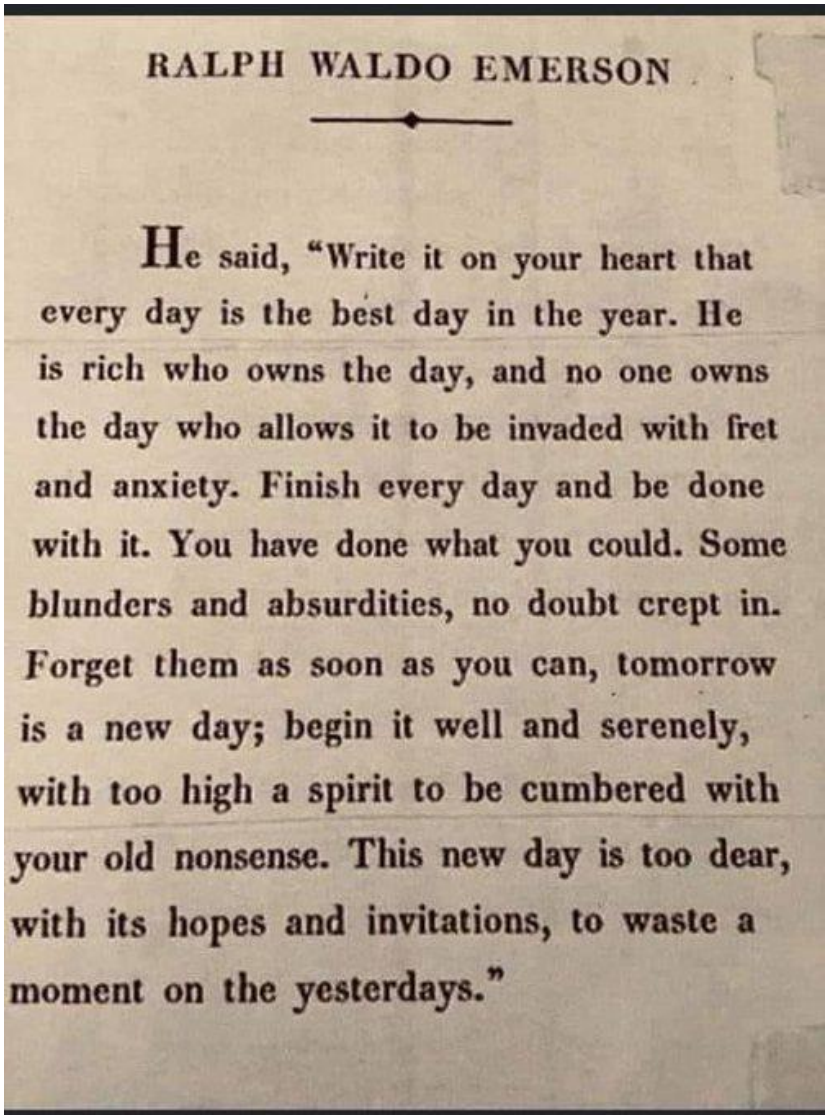
You can reach him at ggiardino@wealthenhancement.com.

Greg Giardino was named among Investment News Rising Stars "Best Wealth Managers and Advisors Under 40 in the USA', announced October 2025 for the time period October 2025-October 2026. Greg Giardino was named among NJBIZ's 2025 "Forty Under 40" honorees, announced September 16, 2025, for the period October 2024 – September 2025.

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.

Stephen Craffen was named among ThinkAdvisor's 'Though Lead of the Year for 2025" announced December 12, 2024, for the period January 2024 through December 2024.



RALPH WALDO EMERSON

He said, "Write it on your heart that every day is the best day in the year. He is rich who owns the day, and no one owns the day who allows it to be invaded with fret and anxiety. Finish every day and be done with it. You have done what you could. Some blunders and absurdities, no doubt crept in. Forget them as soon as you can, tomorrow is a new day; begin it well and serenely, with too high a spirit to be cumbered with your old nonsense. This new day is too dear, with its hopes and invitations, to waste a moment on the yesterdays."

Leadership In Action: How a Broken Pager Fixed a Hospital

Ronald L. Lindsay, MD

Sometimes, the smallest failures expose the largest truths. At a remote Air Force base hospital, a silent pager revealed not my incompetence, but my supervisor's lack of leadership, and set in motion a chain of events that reshaped the hospital's command structure and ultimately influenced the future of Air Force pediatrics.

What began as a malfunction during an award ceremony became the catalyst for decisive leadership, a reorganization of medical services, and the first domino in the development of what later evolved into the Air Force's medical home model.

Ironically, my supervisor accused me of being impaired during the ceremony, despite the fact that I was on call and had lined up nothing but diet sodas all evening. He himself was not present, having declined to attend, perhaps out of discomfort with social settings.

A ceremony overshadowed

The occasion was meant to honor a junior enlisted medical technician with a service medal. The room was filled with senior leaders, including the hospital commander and the base commander, a general officer. My supervisor chose not to attend, leaving me to represent pediatrics while officially on call.

Knowing my pager was unreliable, I placed it in front of the hospital commander and asked him to witness its performance, or lack thereof. True to form, it never activated throughout the evening.

The following morning, my supervisor erupted. He accused me of ignoring pages, of laziness, and of being intoxicated during the dinner. The accusation was especially dangerous; such a charge while on call could have ended my career. The reality was simple and verifiable: I had been on call, consuming only soft drinks, while he had avoided the event entirely.

A pattern of abuse

This was not an isolated incident. For more than two years, his unpredictable outbursts had created a climate of fear and poor morale within the clinic. Junior staff members, both enlisted and civilian, were frequent targets. Only one civilian colleague outside his chain of command was able to push back without consequence.

At one point, the base psychiatrist even recommended an inpatient psychiatric evaluation of my supervisor. That recommendation was quietly suppressed, though the hospital commander was aware of it. To cope, several of us sought guidance from the base social worker and psychologist. Still, the accusation of impairment crossed a line that could not be ignored.

The reckoning

Rather than respond emotionally, I calmly invited my supervisor to take his complaints directly to the hospital commander. He stormed into the commander's office, shouting accusations and insults.

The commander listened quietly. Then he stated a single fact: The pager had not gone off during the dinner. He had personally observed it.

The commander ordered my supervisor to issue both a verbal and written apology, with copies placed under command review. Failure to comply, he warned, would result in formal documentation affecting future evaluations. To ensure the problem was resolved, the commander summoned the communications sergeant responsible for pagers, confirmed the malfunction, and demanded a replacement, tested repeatedly before issuance. I personally tested it several additional times to confirm reliability.

Leadership in action

Recognizing that this was a systemic problem, not a one-time conflict, the hospital commander moved decisively. After consulting with senior leadership, he reassigned my supervisor to a newly created administrative role, one with prestige in title but minimal operational authority.

At the same time, the commander appointed new service chiefs for pediatrics and internal medicine, clinicians known for stability, collaboration, and mission focus. This was leadership in action: decisive, strategic, and centered on protecting the mission and the people doing the work.

The commander understood a difficult truth: that clinical competence does not always translate into leadership ability. Rather than humiliating or destroying careers, he used a strategic lateral reassignment to remove dysfunction from critical roles while preserving institutional dignity.

The domino effect

The leadership restructuring did more than stabilize morale. It created space for innovation.

Within weeks, with command support, I implemented a coordinated, patient-centered care model within pediatrics, emphasizing continuity, accountability, and team-based systems. That model later informed broader Air Force initiatives and became an early foundation for what evolved into the Air Force medical home concept.

What began with a broken pager and a commander willing to act rippled outward into lasting institutional reform.

Closing cadence

Leadership is not about titles, volume, or fury. It is about shielding teams from dysfunction, insisting on accountability, and ensuring systems work as intended.

A silent pager taught me that lesson. A commander's decisive intervention ensured it became part of my own leadership philosophy and, ultimately, a model of care that improved the lives of thousands of military families.

Ronald L. Lindsay is a developmental-behavioral pediatrician.

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"My name is **Lindsay Tapp** and I'm the Director of Marketing with Helios Home Health. I have been in the industry for 16 years and absolutely love what I do! Helios in Greek means the God of Sun. My hope is that we can bring light and be a ray of sunshine to those who are in need of compassionate care. This isn't just my job but my calling to make a difference and positive impact in the lives of others".

My direct cellphone number is **561-255-6705** or email me at **lindsay@helioshomehealth.com**

Lindsay Tapp, Director of Marketing
Helios Home Health
www.helioshomehealth.com

Brain Food for March 2026

By Shane Parrish

Tiny Thoughts

Arguing with a fool doesn't change them; it changes you.

**

Talent and potential mean nothing if you can't consistently do the boring things when you don't feel like doing them.

***

Simple and shallow sound the same until you ask the second question. The person who earned their simplicity can go ten levels deep when challenged. The person who skipped the work falls apart at level two.

*

All battles are internal ones.

**

When you are at peace, you don't pick fights, create drama, or worry about what others think of you.

***

Stubbornness and flexibility aren't opposites; they're responses to different inputs.

Be impenetrable to social pressure and quick to adapt to evidence.

Insights

Singer Kurt Cobain on being weird:

“They laugh at me because I'm different; I laugh at them because they're all the same"

**

Comedian Jerry Seinfeld on seeing the best:

“Every artist is only showing you his best. When you watch a movie, every scene—they only show you the one take that worked. Seventeen times, they missed it. You’re only seeing the peak of it.”

***

Freestyle skier and physicist Eileen Gu on the mindset that wins medals:

“I'm a very introspective. I spend a lot of time in my head, and it's not a bad place to be. I journal a lot. I break down all of my thought processes. I think I apply a very analytical lens to my own thinking, and I

kind of modify it because it's so interesting. You can control what you think. You can control how you think, and therefore, you can control who you are."

*

Philosopher Lao Tzu on real wisdom:

"Knowing others is intelligence; knowing yourself is true wisdom."

**

Ella Fitzgerald on persistence:

"Just don't give up trying to do what you really want to do. Where there is love and inspiration, I don't think you can go wrong."

***

Rick Rubin on trying to win by pleasing others:

"Do you know the biggest mistake most musicians make?" He said. "Their first album comes from love, heartbreak, passion, or depression. They have no expectation of how the world will respond. They write it from the heart, and if it catches on, they're validated by the world. But then they start writing their second album, and they don't necessarily write it based on love, heartbreak, or passion. They write the album they think the world will want."

The Knowledge Project

Phil Knight is the founder of Nike, the brand that reshaped sports and became one of the most powerful companies in the world.

Before reading Shoe Dog, I had no idea that Nike teetered on the verge of bankruptcy for over a decade. Phil Knight's bank cut him off, his supplier turned against him, and the government came after him—all at the same time. What surprised me most was that Knight was a misfit.

A few of the Tiny Lessons I took away:

1. "Belief is irresistible."
2. "My life was outta balance, sure, but I didn't care."
3. When you see only problems, you're not seeing clearly.
4. Let people surprise you. Tell people what to do, not how. When you tell them how, you cap the upside at your own imagination.
5. If you bet on people the world has overlooked, they'll spend their lives proving you right.

Physician Burnout and Gaming: Why Doctors Turn to Video Games

Gerald Kuo

“The problem is not that physicians play games. The problem is that we are embarrassed to admit we need ways to feel alive again.”

At 3:17 a.m., we called the code. Thirty minutes of compressions. Three rounds of epinephrine. A room filled with controlled urgency. When it ended, the monitors fell silent before the hallway did. I finished my documentation. I washed my hands. I walked to my car. And I did not open a medical journal. I logged in. Not to escape medicine. But to remain human inside it.

The coping strategy we rarely name

Physician burnout has become institutional vocabulary. Emotional exhaustion. Moral injury. Productivity pressure. We prescribe resilience workshops and mindfulness modules. We talk about yoga and reflective journaling.

But many male clinicians decompress differently. We play. And we do not say it out loud. Because it sounds adolescent. Because it does not match the image of professional stoicism. Because “serious doctors” are not supposed to unwind with controllers. Yet what if gaming is not regression, but regulation?

Why games work when medicine does not

In medicine, effort does not guarantee outcome. You can make every correct decision and still lose the patient. In games, feedback is immediate. Improve, you see it. Coordinate, you win. Fail, you respawn.

This February, “Resident Evil: Requiem” became one of the most discussed releases in global gaming. At its core, it is not about zombies. It is about triage. Limited ammunition. Scarce resources. Risk assessment under pressure. Deciding when to retreat. Sound familiar?

The same cognitive circuits we use in emergency medicine, prioritization, rapid threat analysis, and resource allocation, are mirrored in survival gameplay. The crucial difference? In the game, failure is reversible.

That reversibility matters more than we admit. It allows the nervous system to discharge accumulated stress within boundaries. It lets us rehearse intensity without irreversible consequence. For clinicians who live daily with permanence, reversibility is restorative.

Competition, coordination, and cognitive reset

Consider global esports. Teams like T1 competing in the LCK under Riot Games demonstrate something many outside gaming culture misunderstand: Elite gameplay is structured teamwork. Macro strategy. Micro execution. Clear role identity. Communication under pressure.

These are not distractions from medicine. They are parallel systems of disciplined cognition. And in 2026, cooperative titles like “Reanimal”, built entirely around shared survival, reflect a broader cultural hunger for collaborative challenge. Whether coordinating a team fight in “League of Legends,” surviving a co-op horror environment, or strategizing in a “Pokemon” tournament, shared goals restore something burnout erodes:

- Agency
- Connection
- Competence

Depersonalization fades when you are part of a functioning team again, even a digital one.

The other side of the screen

But nuance matters. In the same digital ecosystem where we log in to decompress, we are also aggressively targeted. Sports betting apps like bet365. Instant scratch-off simulations. Crypto day-trading platforms promising rapid returns. Algorithmic reward systems engineered to exploit uncertainty.

The difference is not the screen. It is the structure. Gaming at its healthiest is mastery-based. Gambling is outcome-based. Gaming builds skill. Gambling exploits hope. Gaming strengthens social bonds. Compulsive betting isolates.

When clinicians feel depleted and powerless, the craving for control intensifies. If that search for agency shifts toward chasing wins instead of building mastery, the relief becomes hollow. The dopamine hit is immediate. The emptiness afterward is deeper. Healthy play restores. Compulsive chasing consumes. We must distinguish between the two.

Burnout and the need for restoration

Surveys continue to show alarming burnout rates among physicians and nurses. Emotional exhaustion. Depersonalization. A diminished sense of accomplishment. Healthy gaming, at its best, directly counters each:

- Emotional exhaustion becomes controlled adrenaline discharge
- Depersonalization becomes voluntary teamwork
- Reduced accomplishment becomes measurable improvement

In medicine, teamwork is sacred but strained. In games, teamwork is voluntary and often joyful. That contrast recalibrates identity.

The ICU and the respawn screen

In the ICU, death is permanent. In a game, failure is temporary. That psychological contrast reminds us of something we forget during long call nights:

- Mistakes do not define identity.
- Effort can be retried.

- Improvement is visible.

When the shift ends, many of us are not escaping reality. We are restoring agency.

A cultural blind spot

Medicine still prizes stoicism. But stoicism without outlets becomes suppression. Not every nervous system resets through silence. Some reset through engagement. Through strategy. Through mastery.

If a surgeon coordinates a raid at midnight, if an ER physician decompresses through structured competition, or if a resident survives digital horror after surviving clinical reality, that is not immaturity. That is adaptive regulation.

Health care organizations invest heavily in wellness programming, often centered on introspection. Perhaps we also need to acknowledge action-based recovery. Not every coping mechanism must look serene to be healthy.

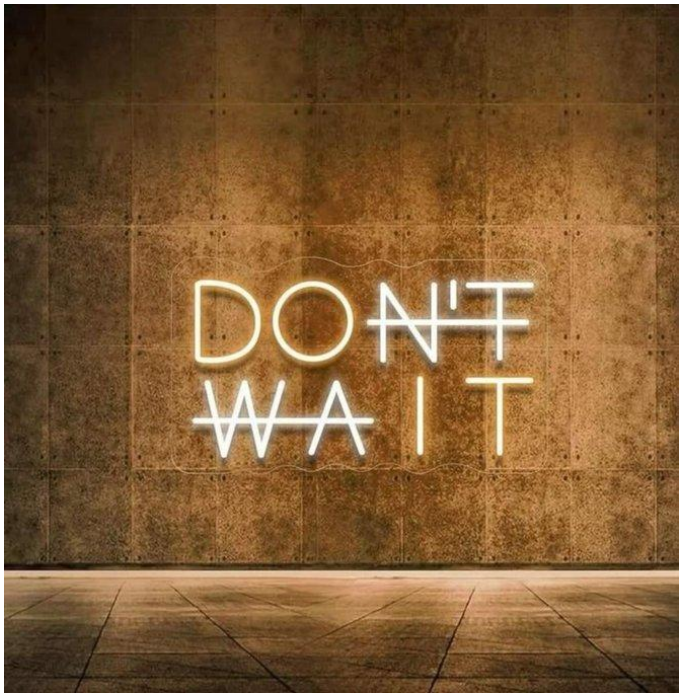
When the shift ends

Some clinicians run. Some meditate. Some write. Some of us log in. Not to abandon medicine. But to return to it steadier.

The problem is not that physicians play games. The problem is that we live in a culture where we are embarrassed to admit we need ways to feel alive again.

When the shift ends, we log in. And sometimes, that is exactly what allows us to log back in tomorrow, to medicine itself. We do not log in to escape medicine, we log in so medicine does not erase us.

Gerald Kuo, a doctoral student in the Graduate Institute of Business Administration at Fu Jen Catholic University in Taiwan, specializes in health care management, long-term care systems, AI governance in clinical and social care settings, and elder care policy. He is affiliated with the Home Health Care Charity Association and maintains a professional presence on Facebook, where he shares updates on research and community work. Kuo helps operate a day-care center for older adults, working closely with families, nurses, and community physicians. His research and practical efforts focus on reducing administrative strain on clinicians, strengthening continuity and quality of elder care, and developing sustainable service models through data, technology, and cross-disciplinary collaboration. He is particularly interested in how emerging AI tools can support aging clinical workforces, enhance care delivery, and build greater trust between health systems and the public.



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Pumpkin Chili

Dr. Sonali Ruder, The Foodie Physician

Your new favorite chili! This cozy dish combines ground beef, beans, and pumpkin purée for a rich, hearty meal packed with flavor and nutrients.

Prep Time10 minutes mins

Cook Time 45 minutes mins

Total Time 55 minutes mins

Course: Entree, Main Course

Cuisine: Southwest

Servings: 8 cups (6-8 servings)

Calories: 225kcal

Ingredients

- 2 teaspoons olive oil
- 1 pound 93% lean ground beef
- 1 large yellow onion, diced
- 1 red bell pepper, diced
- 3 cloves garlic, minced
- 1 teaspoon Kosher salt
- 1 teaspoon black pepper
- 1 tbsp chili powder
- 2 teaspoons ground cumin
- 1 teaspoon chipotle chili powder (can substitute canned chipotles in adobo)
- 1 teaspoon oregano
- 2 cans (15.5 oz each) low-sodium kidney, pinto or black beans, drained and rinsed
- 1 can (15 oz) pure pumpkin
- 1 can diced, fire-roasted tomatoes
- 1 cup low sodium beef broth (can substitute chicken broth or water)

Optional garnishes:

- shredded cheese, sour cream or Greek yogurt, sliced scallions, cilantro sprigs, diced avocado

Instructions

1. Heat the oil in a large Dutch oven or other heavy-bottomed pot over medium heat. Add the ground beef and season it with a pinch of salt and pepper. Cook until browned, breaking it up as it cooks.

2. Add the onion, pepper and garlic. Cook, stirring occasionally, until softened, 4-5 minutes. Stir in the chili powder, cumin, oregano, chipotle chili powder, salt, and pepper.

3. Add the beans, pumpkin, diced tomatoes, and beef broth and stir to combine well.

4. Bring to a simmer and cover the pot. Cook 30-35 minutes, stirring occasionally. Add more broth or water as needed to thin the chili out to desired consistency. Taste and adjust seasoning to taste.

5. To serve, spoon chili into bowls and top with desired garnishes like shredded cheese, sour cream or yogurt, scallions, cilantro, and/or avocado.

Notes

- Be sure to use canned pumpkin purée, not pumpkin pie filling, which is sweetened.
- I like to use both regular chili powder (which is a combination of spices) and chipotle chili powder (which is made from dried, smoked jalapeños). Chipotle powder adds a deep, smoky heat that complements the earthy sweetness of the pumpkin beautifully. You could substitute canned chipotles in adobo.
- For spice lovers, you can add some cayenne pepper or diced jalapeño.
- Kidney, pinto, or black beans all work well - use what you have on hand.
- Store leftovers in the fridge for 3-4 days or in the freezer for up to 3 months.
- **To make this chili in a slow cooker:**
    - Brown the ground beef and sauté the vegetables on the stove first, then transfer everything (including the pumpkin purée, beans, and broth) to your slow cooker. Cook on Low for 6-8 hours or High for 3-4 hours until the flavors meld together.

Nutrition

Serving: 1 cup | Calories: 225kcal | Carbohydrates: 27g | Protein: 20g | Fat: 5g | Saturated Fat: 2g | Polyunsaturated Fat: 1g | Monounsaturated Fat: 2g | Trans Fat: 0.2g | Cholesterol: 35mg | Sodium: 769mg | Potassium: 747mg | Fiber: 9g | Sugar: 6g | Vitamin A: 9327IU | Vitamin C: 24mg | Calcium: 87mg | Iron: 5mg

AI In Health Care Data Management: Curing the EHR Overload

Hamad Husainy, DO

Once upon a time, clinicians didn't have enough data about their patients.

To put it mildly, things have changed. Today we're drowning in data. As a practicing emergency physician, it is a reality I see every day.

In an emergency department (ED) environment characterized by constant time pressure, staffing constraints, and high patient acuity, clinicians sometimes must wade through reams of electronic health records (EHR) data to find critical patient information that has become buried among endless details.

Insights gained in the ED are highly relevant to primary care, where analogous data challenges evolve over longer periods and across multiple touchpoints. Primary care physicians today are experiencing their own challenges with data overload.

For example, PCPs spend roughly between one-third and one-half of every patient encounter on EHR work, rather than directly interacting with patients, a 2025 Journal of General Internal Medicine study found. This imbalance reduces the time available for meaningful clinical conversations and contributes to clinician burnout.

Adding to the challenges, the percentage of Medicare beneficiaries who visited five or more providers per year increased from 17.5 percent in 2000 to 30.1 percent in 2019, according to a study in the Annals of Internal Medicine. With every additional provider a patient sees, the likelihood of fragmented data, duplicative tests and procedures, and delayed follow-up increases.

However, emerging AI tools offer physicians some hope of relief from data overload. By helping doctors organize and interpret the large volumes of information surrounding each patient encounter, these tools support clinical judgment. The result is greater focus on the most relevant details within the workflows that practices already rely on.

Deeper insights in less time

The practice of medicine demands efficiency, and no area more so than emergency medicine. ED clinicians must quickly synthesize and interpret information, identify risks, and take decisive action. In my more than 15 years of practicing emergency medicine, I've witnessed how better data presentation improves clinicians' efficiency.

For example, AI can summarize and structure patient data in ways that support clinical reasoning, reducing complexity for doctors. By advancing small gains in clarity and speed, AI tools create opportunities for improvement.

In my ED experience, AI-supported summaries have accelerated the speed at which care teams can assess patients admitted from skilled nursing facilities. In moments, we can assess changes in vital

signs, treatment updates, and care plans, enabling us to reduce duplicative testing, speed up evaluation, and drive quicker, more-informed decisions about whether patients can return to their prior settings.

Additionally, AI-generated predictive insights support better clinical decision-making. With risk-scoring models, physicians can identify patients most likely to deteriorate following acute events. As a result, these models drive earlier interventions and stronger coordination between acute, post-acute, and primary care providers, helping clinicians reduce preventable readmissions.

However, it is essential that AI does not function as a black box. Clinicians should understand how results are produced, be able to validate source documentation, and maintain full control over care decisions. Transparency and validation foster confidence and support safe deployment across varied patient populations.

Better visibility, better decisions

EDs often function as a crossroads for acute, post-acute, and community-based care. Limited visibility across these settings drives avoidable readmissions and repeat emergency visits.

Similarly, PCPs need visibility as patients move across different care settings, including data on discharge timing, medication changes, recent interventions, and urgent concerns. With timely data, PCPs can identify potential issues and intervene before conditions grow worse.

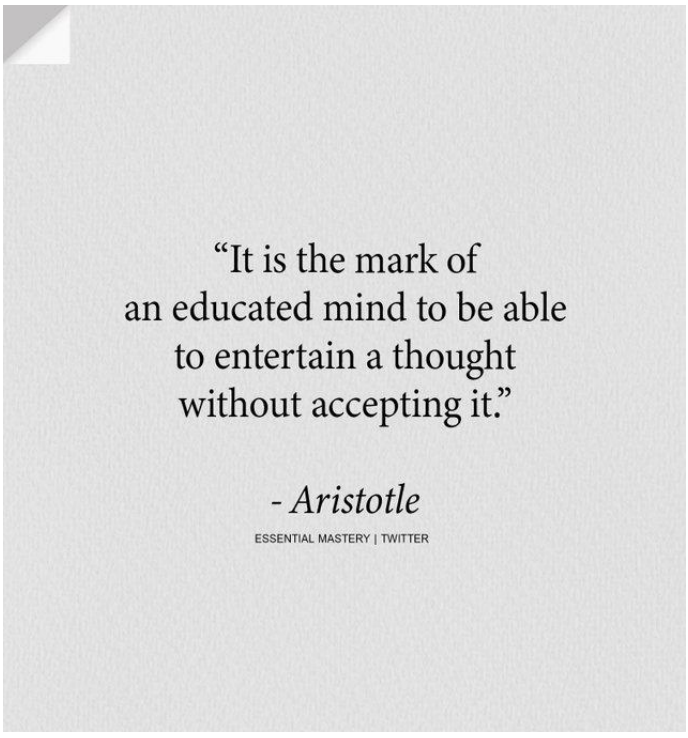
AI-based tools support these needs by integrating and standardizing data from hospitals, post-acute facilities, and home-based providers, helping PCPs gain a full 360-degree view of patient health.

When practices consider adopting these technologies to support future care delivery, they should seek solutions that ease administrative demands, fit within existing workflows, and facilitate cross-setting information exchange. Responsible AI principles, transparency, and clear physician oversight of all clinical decisions should remain central requirements.

Conclusion

As data volumes continue to grow across health care, AI offers a practical way to help physicians surface what matters most without adding complexity to already demanding workflows. When thoughtfully designed, these tools can reduce administrative burden, improve clinical clarity, and strengthen coordination across care settings. Ultimately, AI's value lies in supporting clinical judgment, enabling physicians to deliver more informed, efficient, and patient-centered care.

Hamad Husainy is an emergency physician and physician executive.



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Luxury Travel Destinations and Their Appeal to Upscale Travelers

by James Miller, GetTransfer.com

The travel preferences of affluent individuals are evolving, with recent reports shedding light on their favorite destinations and spending habits. The findings highlight the destinations that are capturing the attention of the wealthy and how these choices can influence the broader landscape of travel and transport services, including transfers and taxis.

Understanding Affluent Travelers

The latest Visa Global Travel Insight report indicates that households earning over $200,000 a year are the driving force behind a significant portion of global travel spending. This elite group, representing less than 5% of households worldwide, accounted for nearly one-quarter of travel expenditures in 2024. Such insights reveal not only where these travelers are heading but also their distinct spending patterns, positioned to reshape the tourism landscape.

The Impact of Economic Fluctuations

Even during economic downturns, affluent travelers continue to thrive in the tourism sector. Their higher budgets allow them to indulge in luxurious accommodations, unique experiences, and exquisite dining options. The preference for off-the-beaten-path destinations demonstrates their search for tranquility and exclusivity.

Top Destinations for the Wealthy

The report outlines key destinations attracting affluent travelers, blending culture, luxury, and natural beauty. While cities like London remain perennial favorites, newer contenders are making waves.

London, England

Regarded as the pinnacle of luxury travel, London blends historic allure with modern elegance. The city is renowned for its world-class museums, high-end shopping districts, and opulent hotels, making it a staple for high-net-worth visitors seeking tailored experiences.

Hokkaido, Japan

Japan’s northernmost island, Hokkaido, is gaining recognition for its majestic winter scenery and high-quality skiing resorts. Wealthy travelers are drawn to its serene environment and upscale lodges, tucked away in lush valleys, often favoring privacy over bustling urban settings.

Mersa Matruh, Egypt

Nestled along the tranquil shores of the Mediterranean, Mersa Matruh offers affluent visitors pristine beaches and luxury accommodations, far removed from the hustle of more crowded locales like Cairo. This hidden gem has become a favored retreat for those seeking exclusive relaxation.

Mendoza, Argentina

The picturesque region of Mendoza captivates with its stunning landscapes and renowned wineries. Offering private vineyard tours and personalized tasting experiences, it appeals to travelers wishing to combine leisure with adventure in a serene countryside setting.

Emerging Trends in Affluent Travel

The experience of luxury travel is evolving, especially in the Asia Pacific region, which is becoming increasingly significant in global tourism. The projected rise in wealthy households from emerging markets, particularly in China and India, signals a dynamic shift in travel norms.

Spending Patterns

Affluent travelers exhibit unique spending behavior, with a significant portion allocated to indulging in gourmet dining, premium drinks, and luxury shopping. In Australia, for instance, luxury guests typically spend approximately one-third of their budget in high-end restaurants and boutiques.

The Role of Loyalty Programs

Loyalty programs successfully attract affluent travelers. Reports indicate that a substantial percentage of wealthy American tourists consider airline or hotel loyalty points a decisive factor when booking journeys, fostering brand loyalty within high-income segments.

Comparison: Affluent vs. Average Tourists

In the coming year, wealthy travelers are expected to increase their international travel spending by 38%, significantly surpassing the average tourist. Luxury accommodations and exclusive experiences are not optional but essential for this elite group, indicating continuing demand for high-quality travel services.

Implications for the Tourism Sector

As highlighted in the Visa report, affluent travelers are a vital component of the global tourism engine. Their travel preferences lead businesses to tailor their services to meet high expectations. Cities and regions investing in luxury offerings are poised to attract this lucrative audience.

Conclusion

The rise of affluent travelers is not just a trend but a fundamental shift in tourism. Cities embracing luxury services, exclusive experiences, and personalized travel options stand to benefit. GetTransfer.com aligns with this shift by providing a platform where travelers can book personalized transfers tailored to their needs. With a focus on transparency, vehicle choice, and user-friendly service, travelers can ensure their journeys are as smooth and luxurious as their destinations. Even amidst changing trends, seasoned travelers know the worth of firsthand experience. By choosing GetTransfer.com, you empower yourself to navigate the evolving travel landscape efficiently, with a range of options to suit your preferences

Why I Stopped Accepting Pharmaceutical-Sponsored Lunches

Timothy Lesaca, MD

A pharmaceutical representative recently brought lunch to my office to present a new drug. The drug may help some patients. The food was abundant. The room was full, with excess all around, including leftovers that were eventually thrown away. None of that is unusual in American medicine.

What has become unusual, at least for me, is how hard it now is to separate the plate in front of me from the patient in front of me, the one who asks whether there is a cheaper alternative, whether the coupon will still work next month, or whether they can wait until payday to fill the prescription.

The dissonance of care

This dissonance exists in a country where the cost of medication routinely distorts care. KFF recently reported that about one in five adults have not filled a prescription because of cost, and one-third report skipping, substituting, or rationing doses. Against that backdrop, researching the scale of the "lunch economy" is striking. A 2024 analysis of CMS Open Payments data identified more than 1.1 million industry-sponsored events for clinicians in a single year. Of those, more than 920,000 were lunches. Together, they represented $137 million in food-and-beverage spending for physicians and nurses in one year. Lunch alone accounted for nearly $73 million.

Although the usual rhetorical move is to make those numbers sound trivial compared to corporate revenues, that is not really how moral life is experienced. Patients live in a stressful reality of copays, deductibles, and refill delays. If one translates $137 million into human terms, the result is difficult to dismiss. At $10,000 per patient per year, that sum could cover 13,700 people for a year of treatment.

No serious person believes that if the lunches disappeared tomorrow, the money would flow neatly into patient subsidies; corporate budgeting does not work that way. The more sobering truth is that it would move elsewhere in the marketing apparatus. A JAMA analysis found that medical marketing rose to nearly $30 billion by 2016, with $20 billion directed at health professionals. The lunch is not the problem because it is large, but because it is revealing, one visible and very sharp edge of a much larger machine that has found a way to eat away at my conscience.

The illusion of immunity

There is a comforting rationalization that we tell ourselves: The food is incidental, the prescribing is evidence-based, and the sandwich changes nothing. But the literature does not let us rest there. A 2016 study in JAMA Internal Medicine linked Open Payments data with Medicare Part D records for nearly 280,000 physicians and found that even a single industry-sponsored meal, with a mean value under $20, was associated with higher rates of prescribing the promoted brand-name drug.

Additional systematic reviews have reached similar conclusions: Financial interactions with pharmaceutical companies are associated with increased prescribing, higher costs, or lower prescribing quality. This matters because medicine claims fiduciary seriousness. The question is whether a profession can look squarely at evidence that small gifts are not neutral and still insist they are harmless.

Professional organizations clearly acknowledge this conflict. The AMA's Code of Medical Ethics states that physicians may not place financial interests above patient welfare and addresses gifts and conflicts of interest explicitly. The American Academy of Family Physicians went further in 2021, arguing that physicians should refuse industry gifts because high drug prices are a public health problem and physician-directed marketing sustains an unjust system.

Unfortunately, the conflicts here are layered:

- **The conflict of allocation:** Patients ration medication while industry feeds the prescribers.
- **The conflict of influence:** Physicians believe themselves immune while the data suggest otherwise.
- **The conflict of appearance:** Even when judgment remains intact, the scene tells a story a patient could reasonably distrust.
- **The conflict of entitlement:** The quiet kind that emerges when hospitality becomes so ordinary that its absence would feel strange.

The power of refusal

Then there is the conflict that is hardest for me to write about: Futility. Suppose I decline the lunch. Will the drug suddenly become affordable? No. Will the company lower the list price? Almost certainly not.

But not every meaningful refusal has to be directly effective. Some refusals matter because they clarify what one is willing to participate in. They mark a boundary and reject the moral logic of a system even when the system cannot be corrected. If a drug is genuinely valuable, perhaps it should be able to survive a hungry audience. Refusing a lunch is not a solution to the drug pricing crisis, nor is it a grand gesture that will topple a multibillion-dollar marketing machine. It can, however, be something much smaller and more personal; an opportunity to at least pause and mindfully reflect and reassess the space between the prescriber and the patient. While every clinician must navigate these waters for themselves, for me, the choice has become clear: Lunch is no longer just a meal; it is a weight I have found too heavy to carry.

Timothy Lesaca is a psychiatrist in private practice at New Directions Mental Health in Pittsburgh, Pennsylvania, with more than forty years of experience treating children, adolescents, and adults across outpatient, inpatient, and community mental health settings. He has published in peer-reviewed and professional venues including the Patient Experience Journal, Psychiatric Times, the Allegheny County Medical Society Bulletin, and other clinical journals, with work addressing topics such as open-access scheduling, Landau-Kleffner syndrome, physician suicide, and the dynamics of contemporary medical practice. His recent writing examines issues of identity, ethical complexity, and patient–clinician relationships in modern health care. Additional information about his clinical practice and professional work is available on his website, timothylesacamd.com. His professional profile also appears on his ResearchGate profile, where further publications and details may be found.

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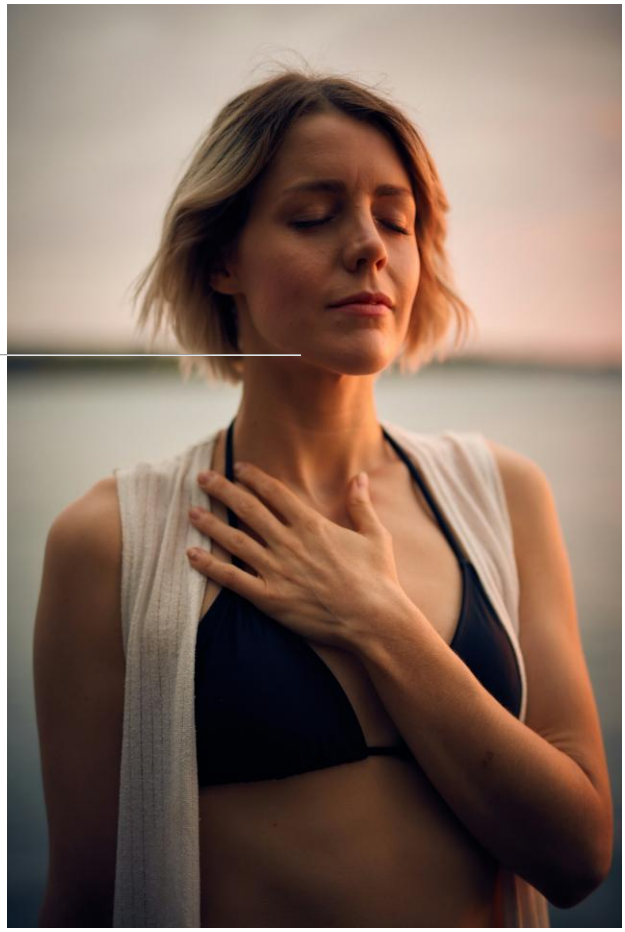
Top 10 Lifestyle Trends That Will Define 2026



As we move into 2026, the global lifestyle landscape is undergoing a radical shift. The frantic "hustle culture" of the early 2020s is being replaced by a more intentional, high-tech, and nature-centric way of living. From "brain wealth" to the "analog maximalism" movement, here are the top 10 lifestyle trends defining 2026.

---

1. Brain Wealth: The New Longevity

In 2026, the conversation has moved beyond simple "mental health" to **Brain Wealth**. This trend treats cognitive function as a long-term financial investment. Instead of waiting for signs of decline, younger generations are proactively using nootropics, neurofeedback wearables, and "brain-training" retreats to optimize their neural performance.

- **Must-Try:** Bio-aligned supplements and "digital-disconnect" cognitive resets.

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2. Digital Minimalism & Analog Maximalism

We are seeing a "Great Unplugging." In response to AI saturation, the most coveted status symbol of 2026 is **Digital Privilege**—the ability to go offline without consequence. This has sparked an **Analog Maximalism** boom: a return to physical media like cassettes and CDs, handwritten journaling, and tactile hobbies like crochet and film photography.

- **Must-Try:** Swapping your Spotify for a curated vinyl or CD collection.

---

3. Glowcations & Longevity Retreats

Standard vacations are out; **Glowcations** are in. These are travel experiences designed specifically for a "bio-reset." These retreats focus on hyper-personalized health data, including DNA-based nutrition and cellular-level skin treatments, ensuring you return from holiday as a physically "upgraded" version of yourself.

- **Must-Try:** Forest-immersion stays and mineral hot spring destinations in regions like Rishikesh.

---

4. The "Opera Aesthetic" (Dramatic Interiors)

Minimalism is officially in the rearview mirror. 2026 home design is dominated by **Theatrical Interiors**. Think velvet drapery, "stage-lit" rooms, and dramatic color palettes like "Transformative Teal" and "Cherry Lacquer." Our homes are becoming stages for personal storytelling rather than just functional spaces.

- **Must-Try:** "Color capping" (painting the upper part of walls and the ceiling in a deeper shade).

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5. Adult Playgrounds & Social Fitness

The era of suffering alone on a treadmill is over. 2026 is the year of **Organized Play**. "Adult playgrounds" featuring soft-play obstacles, climbing frames, and group-based movement classes are replacing traditional gyms. These phone-free sessions are scientifically designed to lower cortisol and boost creative problem-solving.

- **Must-Try:** Women-only lifting clubs and "candlelit yoga raves."

---

6. Bio-Harmony Nutrition

Forget "one-size-fits-all" diets. 2026 is about **Bio-Harmony**—eating patterns aligned with your specific circadian rhythm and metabolic markers. This includes "protein timing," anti-inflammatory "super-herbs" like Indian frankincense, and a total reckoning with ultra-processed foods.

- **Must-Try:** Blood-sugar-friendly meal stacking and personalized fiber blends.

---

7. Guardian Design: Protective Luxury

As economic and climate uncertainty continues, a new trend called **Guardian Design** has emerged. It focuses on luxury items with built-in protection, such as RFID-blocking jewelry, anti-theft high-fashion bags, and "rugged luxury" gear that is both runway-ready and survivalist-functional.

- **Must-Try:** Gold jewelry that doubles as a portable asset during travel.

---

8. "Sober-Sparkly" Members' Clubs

The "sober-curious" movement has evolved into a full-scale luxury industry. 2026 marks the rise of **Sober Members' Clubs**—countryside and urban havens that offer all the exclusivity of traditional clubs without the alcohol. Expect botanical "social tonics," high-end mocktail menus, and late-night forest saunas.

- **Must-Try:** Alcohol-free "glow-up" weekends at dedicated sobriety resorts.

---

9. Intergalactic Glamour (Otherworldly Opulence)

In beauty and fashion, the "Clean Girl" look has been replaced by **Otherworldly Opulence**. Inspired by space exploration and AI-generated aesthetics, this trend uses holographic finishes, "alien-inspired" makeup, and cosmic accessories. It’s a futuristic, shimmering look that embraces the surreal.

- **Must-Try:** Iridescent "glacier" makeup and star-shaped hair clips.

---

10. The Fifth Wall: Ceiling Design

Ceilings are no longer being ignored. In 2026, the "Fifth Wall" is the primary canvas for home expression. We are seeing hand-painted murals, dramatic wallpaper, and even 3D architectural textures on ceilings to create immersive, cocoon-like rooms.

- **Must-Try:** Deep blue or "sunset coral" ceilings to ground a minimalist room.

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