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Family Doctor

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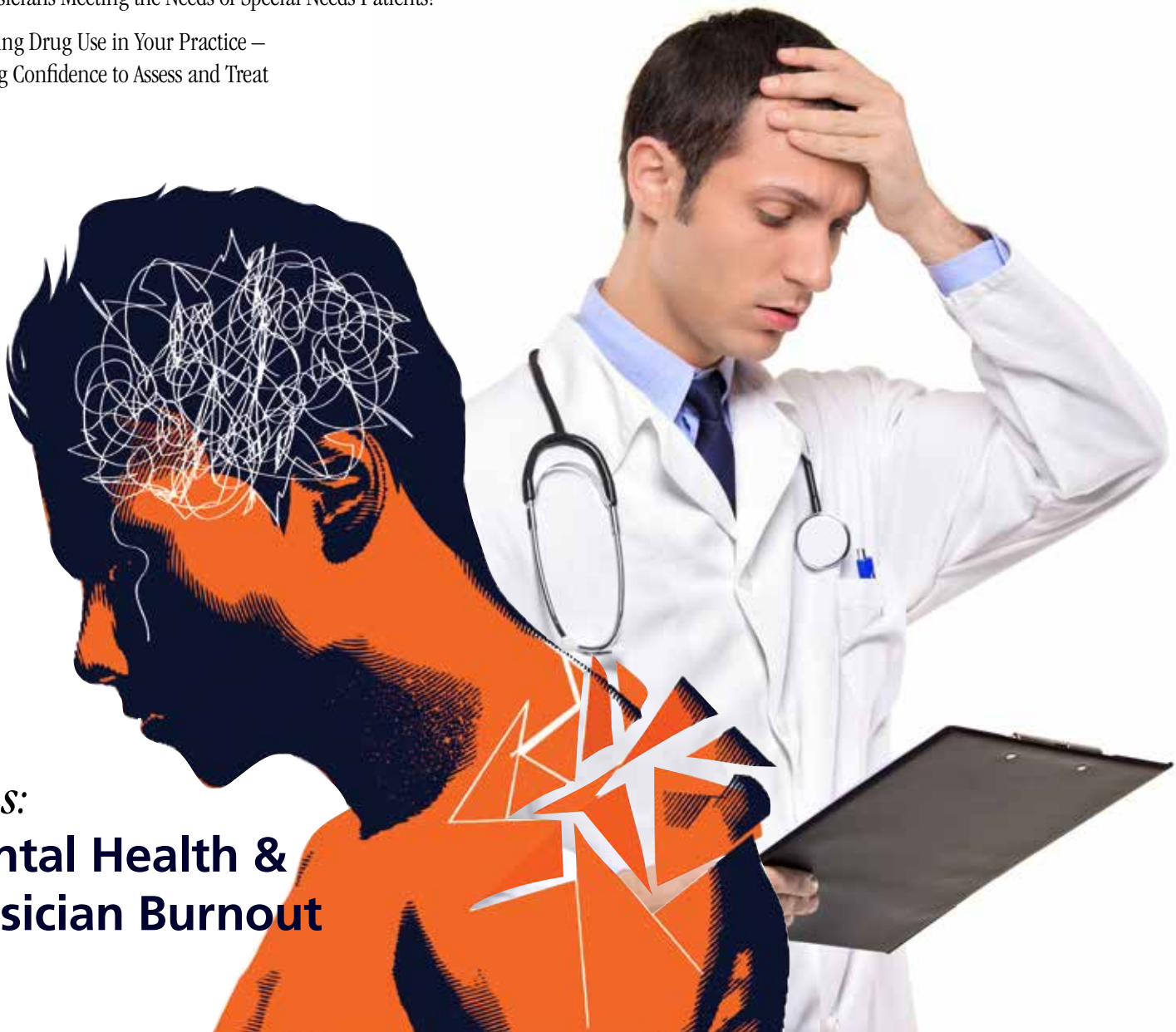
New York State Academy of Family Physicians

FEATURE ARTICLES:



Focus:

Mental Health & Physician Burnout

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	(Low-Fat) COW'S MILK[1]	SOY[2]	ALMOND[2]	COCONUT[2]	RICE[3]
CALORIES AND NUTRIENTS					
Calories	110	110	60	80	120
Protein	8g	8g	1g	<1g	1g
Fat	2.5g	4.5g	2.5g	5g	2.5g
Carbohydrates	12g	9g	8g	7g	23g
VITAMINS AND MINERALS** *(% Daily Value*)*					
Calcium	30%	45%	45%	45%	30%
Phosphorus	25%	25%	N/A***	N/A	15%
Potassium	10%	10%	1%	1%	15%
Riboflavin	25%	30%	30%	N/A	N/A
Vitamin B-12	20%	50%	50%	50%	25%
Vitamin A	10%	10%	10%	10%	10%
Vitamin D	25%	30%	25%	25%	25%
PRICE[4]					
Per ½ Gallon	$2.05	$3.37	$3.28	$4.99	$3.46
Per 8oz. Serving	$0.26	$0.42	$0.41	$0.62	$0.43

Naturally Occurring *Good Source = 10%–19% DV* *Excellent Source = 20%+ DV*

1. Cow's Milk levels are per the USDA National Nutrition Database (NDB No.01083 SR-27): available at: http://ndb.nal.usda.gov/
2. Silk Original Soy Milk, Original Almond Milk, and Original Coconut Milk. Nutritional information per Silk® website www.silk.com
3. Rice Dream Enriched Refrigerated Original. Nutritional information per Rice Dream® website www.tastethedream.com
4. Based on gallon volume equivalents per IRI DMI Custom Database Data for 2014 (Jan-Dec) – National Average (Cow's milk based on conventional white milk)
** The percent Daily Value (DV) provides nutrient information based on a caloric intake of 2,000 calories for adults and children four or more years of age.*
***Nutrient information not listed here can be found on the product website*
****Nutrient not listed on product website*

NATIONAL DAIRY COUNCIL®

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GREATER HUDSON VALLEY HEALTH SYSTEM

From the Executive Vice President

By Vito Grasso, MPA, CAE

Given the state of health care it is no wonder the incidence of overall mental illness, depression and physician burnout have increased. Engaging the health care system is guaranteed to invite anxiety, confusion, anger and frustration. For patients the threatening prospect of bad news about their health status generates enormous stress which exacerbates the negative aspects of dealing with health care and health insurance. For physicians and other health care professionals, the frustration of dealing with administrative obligations and paperwork undermines clinical effectiveness and disrupts relationships with patients which are essential in establishing confidence and trust.

Health care is certainly a high stress environment and there are innumerable opportunities for the most routine situations to escalate into confrontations and violence, or for the prolonged effect of continuous stress to cause or extend illness among patients and burnout among health care professionals.

Workplace violence is one manifestation of the encroachment of mental illness into the health care delivery environment. There have been numerous incidents of violence in the workplace directed at health care professionals, often by patients and occasionally by health care workers and professionals who are overwhelmed by the pressures associated with working in health care. One of the most recent and most grievous incidents was the murder of Dr. Tracy Tam on June 30, 2017.

Following the tragic shooting of Dr. Tam at Bronx Lebanon Hospital, NYSAFP resolved to have legislation introduced to extend existing protection for other health care professionals to physicians, and to assure that these safeguards are applied to any situation and setting in which health care professionals are treating patients.

New York law protects nurses, EMTs, emergency department medical personnel, firefighters, police officers, school crossing guards, sanitation workers and many others in certain settings including hospitals, nursing homes and surgical centers. Physicians, however, are not included and we sought to correct this injustice. We succeeded in persuading Senator Rich Funke (R of Fairport) and Assemblywoman Latoya Joyner (D of the Bronx) to introduce legislation (S.8055/A.1022) to amend the Penal Law to make an assault against a physician providing patient care a second degree assault and a Class D felony, regardless of the setting.

According to the Bureau of Labor Statistics, 74% of all non-fatal assaults that happen within the work place involve health care workers. A New England Journal of Medicine (NEJM) article on workplace violence against health care workers published in April 2016 points to international studies in Canada and Australia which found high rates of abuse toward family physicians, primarily by patients displaying narcotic-seeking behavior or those with mental illness.

The NEJM article also cited studies which found that 78% of emergency physicians reported being targets of workplace violence in the prior year with 21% being physical assaults. And one third of pediatric residents reported being assaulted by patients or patient families during their training.

Our legislation, if passed, will not undo the damage that has already occurred. But until such time as we may expect the stress and anxiety associated with working in and navigating the health care delivery system to abate, it will assure that violence against physicians will be adjudicated and perpetrators of such violence will be held accountable.

"Health care is certainly a high stress environment and there are innumerable opportunities for the most routine situations to escalate into confrontations and violence..."

President's Post

By Marc Price, DO

I represent the family physicians of New York at many meetings throughout the year. Many of these are within the American Academy of Family Physicians (AAFP). I've done so for over a decade. Many times, I present the perspective of a full time practicing physician who owns an independent, small suburban-rural practice.

At these meetings I see many of the same friends and colleagues who I've worked with through the years. It's interesting to see what positions they've taken on within their workplaces and what offices they've attained. CEOs, CMOs, medical directorships, department heads, directors of quality improvement, directors of residencies, directors of medical informatics - they're on the board of Family Medicine for America's Health or the board of an ACO or even our own AAFP. The list goes on and on. Their accomplishments for the advancement of family medicine are unparalleled and impressive and asking them what's new in their life starts a long conversation where I can soak in amazing insights and achievements.

When the conversation turns and they then ask me what's new with me, there's a different answer. My answer is to discuss how my children have grown, what soccer or lacrosse game or dance recital I've recently attended and what academic achievements my children have accomplished. That's because within my practice, the answer is: nothing… and everything.

Every day the office is open, I come in, see my patients and share in their lives and try to make them just a little bit better than when they arrived. I do all I can to make sure that my staff, who care so well for my patients and treat me so well, is also doing well. This is my routine every day. I've had this same practice for over 12 years. As the owner there are no new titles or positions to acquire. No ladder to climb or committee to sit on or chair. Nothing has changed.

But as I mentioned before, everything has changed. The way we get paid, the administrative burdens of practicing medicine, the use of new technology, contending with increasing requirements for prior authorizations, threats of diminishing payments unless we jump through hoops (in which case we get a minimal pay increase – though not nearly enough keep up with costs of doing business), hospital acquisitions of practices, care managers, integrating pharmacists and mental health providers, social determinants of health, physician burnout. Everything is changing. Some changes are great for our patients and communities and therefore our practice of medicine, others are detrimental. I think much of the change stems from good intentions, despite its actual manifestation.

I like to think of it, not as change, but rather evolution. I don't practice medicine the same way as I did when I started my practice and, when I speak with a retired physician whom happens to be a patient as well, he is amazed at how we practice now compared to when he practiced medicine in days past. Everything evolves. We can't stop it. We shouldn't try. Trying would be paramount to stopping a glacier from moving. Trying to preserve what is and what was will only serve to the detriment of what will be. However, I do feel that family physicians should be on the front line, leading the evolution, determining what will be. Not just by my impressive colleagues sitting on those committees and serving in those lofty leadership roles, but also by those practicing in independent and small, and even solo practices.

My role, as I mentioned in the beginning, is to sound the horn to advocate for my patients and my profession from my perspective within my chosen practice setting. As is my role with my patients to educate, advise and influence those who will influence and shape that change. This includes our elected legislators, our community leaders, our patients, our families and anyone else who will listen. It includes our chosen leadership within our professional societies locally as well as on state and national levels.

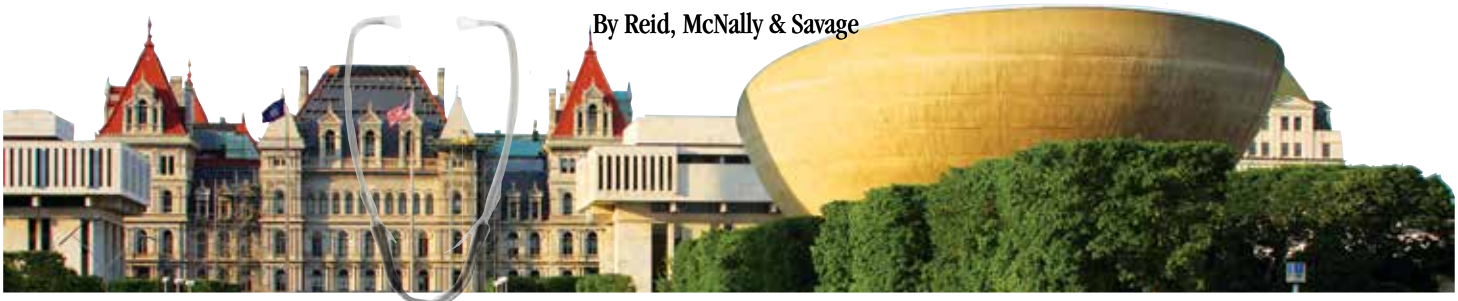
I too often hear that the NYSAFP and the AAFP are not representing the interests of its members. Often, those criticisms are from those who choose to be less active. Equally often, those criticisms are unjustly placed as the academies are addressing those issues of concern, but members may not be aware. Whether or not the academies are having success may be a different story. But that's exactly the reason we need more members involved in our efforts. Whether it's responding to an AAFP "Speak Out," answering surveys to get the pulse of the members on different topics, advocating on Lobby Day (both with the NYSAFP and the AAFP), representing your patients and colleagues on a commission or the NYSAFP Congress of Delegates, or donating to the AAFP and NYSAFP political action committee (PAC), I urge everyone to get involved. For our part, if members are not receiving the information they feel they need or want, and are not aware of academy efforts, then we need to do a better job of getting that information to them.

Although in a state as diverse as New York, it may be difficult, if not impossible to represent every side of every issue, there is much that we agree upon as family physicians. For those issues we disagree on, we must find common ground to stand on or agree to disagree. For those issues upon which we can agree, we should stand united to improve the care of our patients and the profession of family medicine. In this rapidly changing health care landscape, we need to work together to shape healthcare in the direction in which it needs to evolve.

Marc Price, DO *is the newly elected President of the NYSAFP Board. Contact Dr. Price at drprice@familymedicineofmalta.com.*

Albany Report

By Reid, McNally & Savage



As the New York State Academy of Family Physicians prepares its summer edition of the journal for print, Reid, McNally & Savage (RMS) has prepared an Albany Update focused on activities of the NYS Legislature and efforts undertaken on behalf of the Academy during the course of this year's legislative session. While currently engaged in tracking over 500 bills of interest to NYSAFP during this legislative session, Reid, McNally & Savage also helped to facilitate a successful 2018 Lobby Day in which 30 family physicians from around the state participated in legislative meetings on a number of topics including: universal healthcare coverage, prior authorization reform, and access to reproductive healthcare.

In particular, recent efforts have been focused on introducing and advancing important legislation which will ensure that physicians are protected from workplace violence. The Physician Protection Act of 2018 (S.8055, Funke/A.10225, Joyner) would extend protections against physician assault by classifying assault against physicians as a Class D felony. Many other professions are already included in this classification and this legislation will ensure that the same standards and protections are applied to physicians as other professions and that these protections apply to all health care settings, including private practices and clinics where direct patient care is provided.

Early in the legislative session, RMS drafted this bill and secured introduction. The bill sponsors are Assemblywoman Latoya Joyner, who represents the Bronx Lebanon Hospital where Dr. Tracy Tam was tragically killed on June 30, 2017 and where other physicians were seriously injured. Senator Richard Funke of Rochester, who has previously championed similar legislation, sponsors the bill in the Senate. Immediately upon introduction, support surged for the bill with co-sponsorships including Senator Avella and Assembly members Fernandez, Dickens, Ortiz, Seawright, Rivera, Mosley, Niou, D'urso, Arroyo, Skoufis, Simon, Pellegrino, Lavine, Englebright and Crespo.

Working with NYSAFP, we assembled a coalition of support for the legislation including the American College of Obstetricians and Gynecologists, District II, Medical Societies of Albany And Ulster Counties, Medical Society of the State of New York, NYS American Academy of Pediatrics, Chapters 1, 2 & 3, New York Chapter, American College of Physicians, Inc., New York Chapter American College of Surgeons, New York State Ophthalmological Society, New York State Society of Anesthesiologists, Inc., NYS Society of Orthopaedic Surgeons, New York State Society of Otolaryngology-Head and Neck Surgery.

"It must be made clear in the law that licensed physicians are given the same level of protection as well as any health professional providing direct care to patients, regardless of practice setting. This legislation provides this needed clarity"

- Sarah Nosal, MD, NYSAFP President

"Having been the victim of a violent assault in my office I can say it changes you and how you practice as a physician. This legislation is needed to ensure that physicians are given the same level of protection in law as other providers and first responders,"

– Christopher Gabriels, MD, Albany NY

Nearing the one-year anniversary of the death of Dr. Tracy Tam at Bronx Lebanon Hospital, NYSAFP held a press conference in the New York State Capitol to support this legislation and help prevent violence against medical employees. Joined by bill sponsors Assemblywoman Latoya Joyner and Senator Richard Funke, the Medical Society of the State of New York and the Medical Societies of Albany and Ulster Counties, NYSAFP President, Dr. Sarah Nosal provided remarks to remember Dr. Tam and call for stronger protections for physicians across New York State. Another physician also spoke, who had been the victim of assault of his office, urging support of this legislation.

Following the press conference, Dr. Nosal, EVP Vito Grasso, and Reid, McNally & Savage attended a series of high level meetings with Senate and Assembly staff to garner additional support for the bill. The outlook for the bill to pass both houses is positive, however, we need your continued support to ensure that this bill becomes law.

To find your Assembly member: **http://nyassembly.gov/mem/search/** and call 518-455-4100

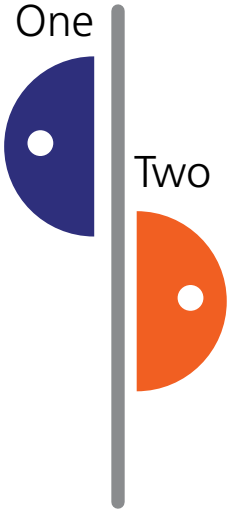
To find your Senator: https: **www.nysenate.gov/find-my-senator** and call 518-455-2800

All of us at Reid, McNally & Savage thank the Academy's leadership and full membership for your support and advocacy in furtherance of the Academy's goals and on behalf of the patients you serve throughout the 2018 session. We look forward to continuing this work as the next session begins.

Dr. Sarah Nosal, 2017-2018 NYSAFP President provides remarks in support of the Patient Protection Act of 2018.

VIEW ONE
A RETIRED PHYSICIAN'S PERSPECTIVE

By William Klepack, MD



In the spring of 2017 I made the decision to retire from my private practice.

Looking back over the years I believe I can identify several factors that helped me prevent burnout. Probably the biggest factor was being as much in control of my own destiny as one could hope for and the next was the satisfaction of meeting challenges.

Of primary importance was that (much of the time) I had a balance of work, family, and recreation that worked for me. What works for each of us is somewhat different, I am sure.

To achieve that balance meant being in a small group practice to ensure I had time off and was completely free (which included sharing with my office colleagues the responsibility of labor and delivery). It also meant that taking weeks for vacation was a given. A small group practice ensured that beauracracy was avoided and decisions were as quick as a discussion with my partner.

Being in a private practice meant freedom to do medicine in the manner I chose and to the extent that we could practically do so.

I wanted to do all of family medicine. For me the challenge was to use all of my family medicine skills and that led me to continually learn and continually acquire new skills. I looked for new opportunities. Over the years of practice I acquired colposcopy, sigmoidoscopy, allergy testing, and pulmonary function skills through specialized courses. Each new skill had an interest of its own which kept my interest in practice fresh as other aspects of practice became routine.

I took great pride in being an individual's personal physician and sought to be a family's physician as well. I valued being there when they needed crisis care and until the last 9 years of practice we followed our patients in hospital. Numerous experiences in which I was able to give a person far more personalized care than a hospitalist gave me pride, and my intimate knowledge of their hospital course improved the follow up care after hospitalization.

After the practice of medicine had become largely routine what remained so vital was the unique manner in which I was part of

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VIEW TWO
PREVENTING BURNOUT – A NEW PHYSICIAN'S PERSPECTIVE

By Lalita Abhyankar, MD, MHS

Burnout terrifies me.

I have seen what it can do to motivated, intelligent, skilled physicians. Many physicians start their careers with admiration for the complex, beautiful intersection between medical science and humanity, but in maintaining a fast-paced, sustainable medical system, they often have no time to enjoy this extraordinary junction. Therefore, what should be an incredibly rewarding career, ends up being emotionally and physically draining because of the disconnect between individual expectations and reality.

I fear that lack of joy more than anything. There are days when I fear it more than others. For example, when I'm with a patient, I want to be fully present as they narrate their stories. But on days that I'm busy and everyone shows up (often at the same time), I feel bullied by the clock. I'll walk into an examining room trying to find the fastest way to escape and move on to the next patient. While I value data and I adore population health, I also struggle on days where, instead of my medical skill and knowledge, the number of quality indicators I've achieved serve as a measure of my competency as a physician. I also feel utterly helpless when I face barriers to providing good care. Insurance denials, for example, for medications or studies that I've thoughtfully chosen, feel arbitrary and at times vindictive. On these days, I'm barely outrunning the specter of burnout. I worry that each subsequent moment of disillusionment will chip away at my idealism until all that is left of me is a mechanical sea monster, dispassionately gnashing its way through a patient schedule packed like sardines.

So, for my own sake, I've become obsessed with the idea of preventing burnout. I've started reading articles, attending webinars, and talking to colleagues about their experiences. I've found a lot of material that recommends building "resilience," a word taken from trauma psychology, defined as the process of adapting well in the face of adversity, trauma, tragedy, threats or significant sources of stress.[1] Recommendations to "build resilience" include boundary-setting, separation of work and home, meditation, mindfulness, spirituality when outcomes are out of our control, exercise, healthy nutrition, adequate sleep, vacations, connecting with loved ones, and asking for help when needed. All of these interventions are

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people's lives. Visits were little chapters in their individual novellas. Indeed, the hardest part of retiring was prematurely closing those books especially those that had just begun to be written or were at particularly interesting or poignant points. Retirement has heightened the perception of this privilege we enjoy as physicians

Winning in the battle against disease has always been a priority and until I had done all I could, I was not easy. It was never a 9 to 5 proposition for me. Going home after doing all I was able to do gave me solace and comfort. Having to say I am sorry for things left undone was not an option.

Leading my office successfully through the jungle of the changing medical care environment was a priority. I did not particularly relish the vagaries of the business side of medicine; nonetheless, I knew that if we were not at the table then our practice would likely be on the table. So I joined the board of our PHO and was a voice of primary care. Being informed gave me knowledge that was power and helped me steer our practice. It also gave me satisfaction.

All this did lead to a great deal of time away from family. There were evening meetings, nights and weekends of call, and being called away from parties on occasion. It worked because of who my wife is, who I am and how protected the time was that we, together, identified as personal time.

As time has gone on and EHRs came about and the "information highway" led tons of information (uncontrolled by us) to funnel into our office, I saw information management as a priority for burnout prevention. I had staff help in filing information according to my algorithm and emphasized "just in time information" to be present at the "point of care." Yet, this solution was imperfect. I believe this to be the major challenge facing us physicians. A solution is required to prevent burnout.

Soon to be 70, I felt my risk of losing function was increasing. In very good health, I nonetheless had musculoskeletal complaints that temporarily had cut me off from valued activities.

Watching my patients over the years and my own abilities, I had come to appreciate that our function does not decline in a steady progressive manner but, rather, in a step wise fashion. Some pivotal physical ability becomes compromised one day and (just as suddenly) the ability to jog, or hike, or board sail is lost. Musculoskeletal issues can occur without our deviating from our usual activities. Due to the increased fragility of our ligaments and the decreased ability of our body to heal minor damage, normal repetitive activity can become excessive.

The fact that we lose function when a tipping point is reached is one that we often use to help our patients regain function. We seek an opportunity to make a relatively minor tweak in their medication, or their physical therapy that might reverse that tipping point. A relatively minor tweak can often give back a relatively major function to a patient and substantially improve their quality of physical and mental life. It is very depressing to lose an element of function.

For myself I saw my clock ticking and the need to reapportion my time in favor of doing the activities which I enjoy and which my medical practice would not allow me time to do. And as that perception increased over the last couple of years, practice became more stressful.

Being in a financially good place these last ten years has been a boon. I knew I was practicing medicine because I wished to and not because I had to. One naturally asks how to eliminate some aspects of practice that are less rewarding. The answer is some but not all.

I could not stop my aging. And I could not do away with my responsibilities of medical directing. Staff issues still needed to be considered and constructive solutions found which sometimes meant unpleasant experiences such as disciplinary ones. Joy was found in working with staff in a collaborative manner and with staff who shared the desire for constructive solutions.

Now I am retired almost a year. I retired with a plan to continue my part time medical director work at the county health department because that work has satisfaction and a schedule compatible with my priorities of time and freedom and I can make a contribution.

I find the freedom from keeping up with appointments and "on time" to be wonderful. Coffee in the morning then breakfast then what ever the day calls for is at a comparatively luxurious pace. Tomorrow or next week I can do an errand or pay a visit without worrying about inconveniencing patients. I can march for the Poor People's Campaign on short notice. I can fill in at the office if needed and convenient. I no longer am the limiting factor in what my wife and I can do together. I am biking, hiking while I am able. When next a "wheel falls off" this body I will be able to say I did more than I would have been able to had I not retired and I gave more to my family. I look back and realize what an exciting, challenging, thrilling "ride" my medical practice has been.

William Klepack, MD *retired from a busy family practice in Dryden, NY. He remains very active in the NYSAFP and is a member of the Family Doctor editorial board.*

crucial for burnout prevention. After all, we recommend them to our patients for their own well-being. However, I've also received a loud message from colleagues who believe that focusing on resilience alone shifts the burden of wellness onto the physician, without addressing the systemic problems (or trauma and stress) that contribute to and promote burnout in health care professionals.

Over the last 10 years, fewer physicians are throwing up a shingle after residency to start their own practice. Physicians are choosing not to manage the administrative costs of owning an independent practice, and instead prefer to work for health care organizations with benefits, consolidated electronic health records, and access to specialists. Employment means not having to keep up with regulations, more flexibility of location, income security, and more predictable work hours.

However, that means that we've lost control of crafting our own practice, hand-selecting the teams that we work with, and shaping the culture we desire at work. In terms of administrative paperwork, we may still be doing about the same amount as before. According to The 2014 Physicians Foundation survey, employed and independent physicians spent 10.6 hours and 9.8 hours, respectively, on nonclinical paperwork.[2] Physician compensation can also be based on the revenue generated, potentially shifting the focus away from quality patient care to the number of patients seen or other reimbursement markers. In an emotionally demanding job, lack of emotional support and resources can make a physician feel unappreciated, isolated, disconnected from the values of the organization, and at times treated unfairly. The Maslach Burnout Inventory (MBI), a validated tool to measure symptoms of burnout, measures perception of control, workload, reward, community, fairness, and values to assess the three components of burnout: emotional exhaustion, depersonalization, and reduced personal accomplishment. When all of these indicators are compromised, it is no wonder that more physicians and health care providers are disengaged.

Disengagement and burnout among physicians do nothing to serve the health of patients. In fact, they don't help employers either. Burnout has been linked to decreased productivity, lower patient satisfaction scores, higher medical error rates and malpractice, higher physician turnover, addiction, substance abuse, depression and suicide.[3] Happier, engaged physicians are less likely to change jobs, often see more patients, and tend to go above and beyond the minimal requirements. It is profitable for companies to make sure that their physicians are positively engaged. With this increasing trend towards physician employment, wellness becomes, in part, the responsibility of the employer.

Large health care organizations are beginning to understand the responsibility of physician wellness. A handful or organizations have even hired "Chief Wellness Officers" to spearhead interventions to improve engagement. Keeping people well and engaged isn't an easy task. It is not easily solved by offering cupcakes or an "employee of the month" certificate. Unless interventions are thoughtful and intentionally designed to address symptoms of burnout, they will seem insincere and a waste of time. Which is why I challenge employers to ask physicians, "What do you need to do your best?" And then, to deliver those resources.

I recently attended a webinar presented by Jessica Sweeney-Platt, the executive director of physician performance research at Athenahealth. She argued that burnout was directly correlated to employee capability, defined as "an employee's self-assessment of his or her ability to perform the job at hand, focusing on resources and support rather than technical skill or ability. This is not a new thought in organizational design. The concept was developed in the late 1990s by Len Schlesinger, who recently applied this concept to physician burnout.[4] The study found that the higher the self-perceived capability physicians had, the more loyal they were, which led to improved engagement, correlating to increased productivity and more revenue.

In my own workplace, everyone knows that I'm obsessed with preventing burnout. I've informally asked many medical assistants, administrators, and physicians what they would need to truly enjoy working. While my sample size is small, patterns are already emerging.

So far, everyone wants meaningful opportunities to bond with coworkers. There is a desire for professional development and leadership training for everyone, so that teamwork is optimized, the burden of work is shared, and everyone knows how to communicate both expectations and constructive two-way feedback. There is a need for reward and appreciation that is meaningful. There is interest in skills based training to standardize care, instead of learning things (sometimes incorrectly) on the fly. There is physician interest in protected time to learn and discuss, with other colleagues, new evidence-based practices. And of course, physicians yearn for longer visits that do justice to our patients, as well as sufficient administrative time to complete all daily tasks in an efficient manner.

Everyone wants to serve patients the best they can, but we also understand the importance of guaranteeing our own capability to provide that care in a joyful, positive, and constructive manner. Implementing these interventions might not seem lucrative, but if employee engagement and loyalty leads to more revenue, better

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patient outcomes, and more patient satisfaction, it might be worth a try. As we know from in-flight etiquette, it is imperative that we put the oxygen mask on ourselves before helping others, and this just might be the way to do it.

I've chosen to be an employee because I like working with other physicians, and I like being a part of a system with a service oriented mission that can make a large community impact. I like limited work hours, and I don't want to manage the day to day of running a practice. However, I know that not everyone chooses this path. To those who own your own practice I say bravo! I do understand that having more say in running a practice doesn't mean you are immune to symptoms of burnout. There are many things that are out of our control that continue to create stress for our profession. I hope to keep advocating for change in those systemic issues as well. In the meantime, as more physicians enter employment contracts with monolithic health care organizations, we have an opportunity to intentionally design great places for health care professionals to work.

I know that serving patients isn't easy. I do not fear the emotional and mental challenge of working with patients. I fear doing so without compassion, and I dread disengagement. I hope that by taking ownership of my own wellness and also by sharing its responsibility with my employers, burnout won't feel as inevitable.

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Using Scribes to Reduce BURNOUT

By Peter Meacher, MD and George Scaravelli

Electronic medical records (EMR) have improved our ability to extract data, but have not delivered on the promise of easier documentation for healthcare providers including the family physician. It is widely accepted that EMRs have, in fact, increased the amount of time family physicians spend charting after each visit,[1] which has added to physician stress and burn-out.

Callen-Lorde is a Federally Qualified Health Center (FQHC) in New York City, which serves 18,000 patients with more than 107,000 annual visits. In recent years, family physician and nurse practitioner requests for administrative support have reached an all-time high. Medical providers spend a bulk of their non-clinical time on EMR note completion, and miss opportunities to capture structured information into the EMR within the duration of a short patient visit. Ultimately, these factors negatively impact the quality of the patient-medical provider interaction.

In response, Callen-Lorde integrated a wide variety of initiatives designed to support medical providers. These include, among others, electronic consulting with RubiconMD, additional provider training and mentorship, and offsite mid-level coverage when providers are out of the office.

Callen-Lorde identified the need for additional administrative support with hopes of relieving the burden of documentation while also improving the quality of patient care. In seeking ways to better support physicians and mid-level providers in the EMR environment, Callen-Lorde contracted with Scribe America to provide scribes to interested medical providers. For a cost-neutral and self-sustaining model, our providers with a scribe see at least one extra patient per half-day session.

At the start of the project, Callen-Lorde established objectives for program evaluation. Metrics were monitored in order to measure the impact of the program. These included the following:

- **Staff – qualitative satisfaction measures**
- **Patients – patient satisfaction survey**
- **Changes in diagnostic coding**
- **Revenue measures**
- **Patients per session**
- **Cycle time**
- **Number of unlocked appointments/month**
- **Documentation metrics**
  - **Substance use documentation**
  - **Smoking assessment and cessation advice**
  - **Sexual practices**
  - **Past medical/surgical and family history**
  - **Reconciled medications**
  - **PHQ-2, PHQ-9 and referrals**
  - **Colonoscopies**
  - **External PCP documentation**
  - **% appointments coded**

The medical providers who piloted the program were champions for the project, providing constructive feedback to help with the growth of the program. In subsequent groups, scribes were offered to medical providers who were disproportionately challenged by the EMR, as evidenced by incomplete notes, coding, and billing.

Medical providers were surveyed before and during each quarter following the program's implementation in order to monitor changes in attitudes regarding certain aspects of their jobs. Figure 1 shows the results of the medical provider satisfaction survey.

A majority of the scribes employed by Scribe America are pre-medical students who are interested gaining medical-clinical experience. They tend to hold these positions for 1-1.5 years. At Callen-Lorde, scribes are paired with a medical provider in order to foster an ongoing relationship and to maintain consistency across patient visits. Scribes are provided with a laptop so they can remain mobile, and do not require an additional static administrative space. This mobility also results in minimal interruption of the medical visit.

The majority of Callen-Lorde patients are LGBTQI identified, with more than 4,500 patients who identify as transgender or gender non-conforming and nearly 4,000 patients who are living with HIV. This unique clinical environment makes it especially necessary for staff to be held to a high standard of cultural sensitivity. Callen-Lorde invests in additional training time for the scribes and requires scribes to attend the standard staff orientation and organizational events scheduled within the clinic.

Since many LGBTQI patients have past trauma associated with the medical system,[2] Callen-Lorde was concerned that patients would experience discomfort with an additional person in the room. Ongoing requests for feedback from patients has reduced this concern, as patients have responded favorably to increased time with their medical provider.

Patients were surveyed to assess their attitudes regarding the presence of scribes during their visits. Patients who saw their medical provider both before and after scribe implementation compared their experiences through question responses. Figure 2 shows the results of the patient survey.

Coding within the chart was also analyzed in order to monitor changes in provider billing. The determinant of success was the application of medium or high coding within the chart. Figure 3 shows the results of the analysis.

Working with a scribe is a cost-neutral option for family physicians that are overburdened with the documentation that is necessary for data capture in EMRs. After eight months, the intervention has been successful in improving family physician satisfaction and in our experience, has great potential for improved data capture, billing, coding, and revenue.

Figure 1: Medical Provider Satisfaction Survey

	Medical Providers with Scribes Mean		
	Pre	4 Mo	8 Mo
I am able to complete my office visit charting in a reasonable amount of time. *1= Not at all | 2 = To some degree | 3 = Mostly | 4 = Absolutely*	1.5	3.75	3.5
Overall, the interactions I have with my patients during an office visit are sufficient to provide good care. *1= Not at all | 2 = To some degree | 3 = Mostly | 4 = Absolutely*	2.5	3.25	3
When I see a patient for a return visit, the note from the prior visit captures all the key information I need to follow up. *1= Not at all | 2 = To some degree | 3 = Mostly | 4 = Absolutely*	3.25	3.25	3.5
Compared to what I know of how other providers work at other facilities, the proportion of my work time at Callen-Lorde spent doing what I was trained to do as a clinician is: *1 = Much less | 2 = Somewhat less | 3 = Slightly more | 4 = Much more*	2	3.25	3.25
Often I am concerned that I may have forgotten to do and/or missed something important in my clinical care. *1= Not at all | 2 = To some degree | 3 = Mostly | 4 = Absolutely*	3.25	2.5	2.25

Figure 2: Patient Survey, Percent Composition (n=50)

	Much Worse	Worse	Same	Better	Much Better
Compared to visits before the scribe, how would you rate your medical provider's ability to listen to you and understand your concerns?	0%	0%	50%	48%	2%
Compared to visits before the scribe, how would you rate your general satisfaction level with your medical visit?	0%	2%	64%	32%	2%

Figure 3: CPT Coding, Pre and Post Implementation

	6 months pre-scribe	6 months post-scribe
99212, low	9%	7%
99213, medium	84%	74%
99214, high	7%	19%

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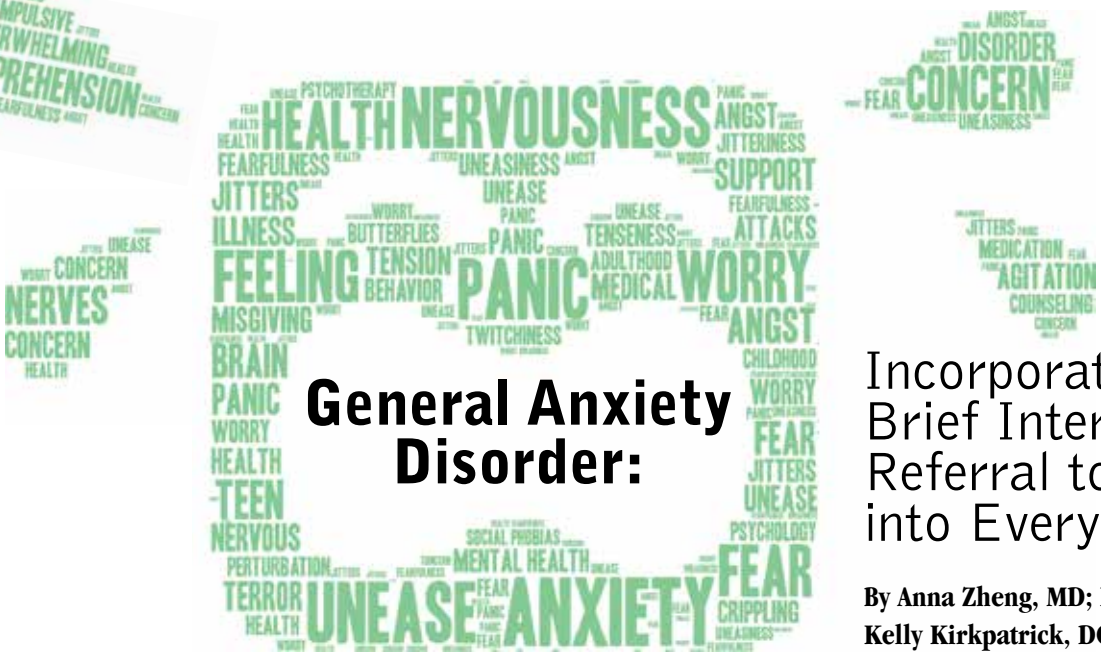

General Anxiety Disorder:

Incorporating Screening, Brief Intervention, and Referral to Treatment into Everyday Practice

By Anna Zheng, MD; Elaine Kang, MD; Stella King, MD, MHA; Kelly Kirkpatrick, DO and Scott Hartman, MD

Overview

Family physicians manage anxiety in patients on a daily basis. Patients with anxiety disorders are three to five times more likely to go to the doctor and six (6) times more likely to visit the emergency room.[4] Frequent office and emergency room visits along with extensive medical workups and sometimes multiple referrals to specialists not only add financial burden to our healthcare system but have the potential to lead to patient frustration and physician burnout. In this article, we describe a simple and effective strategy for recognizing generalized anxiety disorder (GAD) appropriate for use in any clinic visit called "SBIRT for GAD." We recommend that primary care physicians incorporate this easy to use tool for screening, brief intervention and referral to treatment (SBIRT) into their daily practice.

Introduction

Approximately 40 million adults in the U.S. between the ages of 18 to 54 are affected by anxiety disorders according to data published by the National Institute of Mental Health, making them the most common of all mental health disorders.[1] Anxiety is currently the top mental health issue in America. Generalized Anxiety Disorder (GAD) affected 3% or 6.8 million adult Americans each year from 2001-2003 data,[2] and it affects women more than men (3.4% vs 1.9%).[1] Frequent office and emergency room visits add financial burden to our healthcare system. The costs associated with anxiety disorders have previously been estimated to be $46.6 billion, 31.5% of total expenditures for mental illness.[3] Current costs are likely even higher given inflation, updated medical technology and increased prevalence. It has been reported by the Anxiety and Depression Association of America that anxiety disorders are highly treatable and yet only 36.9% of diagnosed patients are receiving treatment.[4]

Clinicians may find effective and prompt diagnosis of anxiety challenging in the office setting. Anxiety often presents as insomnia, nervousness, chest pain, subjective shortness of breath, abdominal pain, and nausea or in any combination of somatic symptoms. In working up a patient with anxiety symptoms, family physicians often feel compelled to order multiple laboratory tests, electrocardiograms and imaging tests. "Rule out" work-ups can be cumbersome and, many times, clinically unnecessary paths. Family physicians should find a quick, effective tool in screening for anxiety particularly helpful.

SBIRT for GAD Screening - Why it really Works!

Quickly and objectively fishing out anxiety is the first step in addressing and preventing an unnecessary medical workup. Like the PHQ-2 in screening for depression, the 2-question survey can quickly screen for anxiety. Persisting worrying thoughts present as a hallmark symptom of anxiety.[5] These thoughts usually propagate from negative past events, become projected onto the future and then lead to an anxious baseline emotional state. When these thoughts and emotions go unchecked and unaddressed, they breed overpowering feelings and the awful loss of internal locus of control over the emotional state. The 2-question tool is effective at screening because it asks about worrying thoughts, or the anxious state. It screens for the root symptoms of anxiety. If the patient answers "yes" to either question, then they move onto part two with more directed questions. In total, the survey takes 5-8 minutes to complete. It is quick and feasible in the office setting (see Figure 1-OVP).

By employing the SBIRT tool for GAD during triage, as with the PHQ2, patients can be screened with minimal cost and time. The two questions are:

1. "Over the past 2 weeks, have you been feeling, nervous, anxious, or on edge?"
2. "Over the past 2 weeks, have you not been able to stop or control worrying?"

A positive answer leads to a more detailed questionnaire called GAD-7 to help determine the severity of symptoms (see Figure 2). By training staff on how to administer the questionnaire with precise wording and empathy, a brief intervention to start treatment, a referral for therapy, and a plan for further treatment can all be completed during the visit.

Diagnosis: DSM-5 Criteria and Using Clinical Judgment

When a patient screens positive with the SBIRT tool and severity of symptoms have been discussed with the GAD-7, the physician should diagnose fully by DSM 5 criteria and assess for emergency and co-morbid conditions. While SBIRT described above should prove very helpful in distinguishing GAD from organic pathology, clinicians should still be sure to evaluate for organic pathology in the presence of potentially organic symptoms, such as chest pain, palpitations or severe gastrointestinal distress.[6,14,15] All findings should be discussed with the patient, specifically that they have been diagnosed with GAD. Then, a treatment plan should be discussed and implemented with shared decision making (see Figure 3).[16,17]

Treatment Modalities for GAD

GAD is treatable. The management plan should be individualized for each patient. It may involve pharmacotherapy, psychotherapy, alternative strategies (e.g. hypnotism) or a combination of modalities. Patients often are undiagnosed and many refuse treatment. Talking to the patient about GAD can be difficult, as the patient may be in denial or really feel that the symptoms have an organic cause and may also be worried about the stigma of such a diagnosis. There are talking points from Attachment C of OVP (Content for Discussion with Patients about General Anxiety Disorder) to help initiate or guide conversation after positive screens.

Referral to or partnering with subspecialists may be necessary for patients who have significant barriers to care or who are unable to engage in therapy with their primary care team. Co-location of primary care and behavioral health has been studied as an effective method of offering team-based care more efficiently, not just for anxiety but for many mental health conditions that often co-present with chronic medical conditions.[6,10] Cognitive behavioral therapy (CBT) is a technique which may help reduce symptoms of anxiety. It involves patient self-monitoring of worry, cognitive restructuring and self-calming techniques such as deep breathing and relaxation. The process may require multiple sessions to be effective.[8,10,12,13] In general, counseling or psychotherapy methods offer modest benefit in the resolution of anxiety symptoms but are considered foundational to the treatment of anxiety disorders. Moderate-quality evidence demonstrates CBT-based management to be some of the most effective for anxiety disorder treatment.[8,10,12,13]

Figure 1. Office Visit Protocol (OVP) for GAD Screening

Screening, Brief Intervention, and Referral to Treatment (SBIRT) for GENERALIZED ANXIETY DISORDER Office Visit Protocol

Patient Name: _____ Age: _____ Doctor: _____

ENCOUNTERS	DATE	TASKS
PART I **SCREEN** For Generalized Anxiety Disorder (suggest 5-8 min)		People with Generalized Anxiety Disorder (GAD) have recurring fears or worries and they often have a persistent sense that something bad is just about to happen. The reason for the intense feelings of anxiety may be difficult to identify. But the fears and worries are very real and often keep individuals from concentrating on daily tasks. The screening questions in this part are valid, but if you wish to use a longer screening device, see **"Attachment A. Screening Devices and Techniques for Anxiety" pp 4-9.** Otherwise, proceed: Over the past two weeks, how often have you been bothered by the following problems: ☐ Feeling nervous, anxious or on edge Not being able to stop or control worrying? ☐ If the patient says, "YES" to both of these two questions, or scores high enough on a longer screening device you use to be considered having GAD, then a thorough physical examination to rule out other causes of the symptoms should be the next step. Certain medications as well as some medical conditions (e.g., endocrine disorders, medication adverse effects, withdrawal) can cause the same symptoms as anxiety, and you should rule out these possibilities through examination and interview. ☐ If treatment for GAD is warranted, then proceed to ***"PART II Treatment for GAD"***

http://www.nysafp.org/NYSAFP/media/PDFs/Public%20Health%20Minutes/AFP-SBIRT-OV-Protocol-GAD-10-19-16.pdf

continued on page 20

Pharmacology for the treatment of GAD has been shown to be as effective as high intensity psychological intervention treatment, with no improved benefit documented for GAD with combination psychological and pharmacologic therapy.[6,9] First-line pharmacologic options include SSRIs and NSRI, but insufficient evidence exists to determine whether one category is superior in effectiveness over the other. These medications require up to 4 weeks to demonstrate maximum effectiveness, and, if the desired response is not achieved, may be titrated appropriately. Second-line medications for add-on treatment on an as needed basis include antihistamines such as hydroxyzine and benzodiazepines. Benzodiazepines should be used with great caution, given their rapid onset (minutes to hours) and significant risk for abuse, tolerance and dependence. Recently, family physicians have grown wary in prescribing them for anxiety. (see Table 1).

Antihistamines like hydroxyzine can be used for management of acute anxiety, specifically helpful in patients who are starting treatment and before achieving the effective SSRI dose. Buspirone can be used as an alternative single standing reagent. Buspirone may not be superior to benzodiazepines but does not have the same abuse potential. Similar to SSRIs, it takes approximately 4 weeks for clinical improvement to appear.

Collaborative care involves a multidisciplinary approach to patient care.[15-17] It may involve interactions between various professionals including the primary care team, psychiatry, psychology, nursing, and social work (see Table 2). Partnering with specialists can result in more efficient and timely use of resources and lead to better patient outcomes.[6,10]

Figure 2. GAD PHQ7: Mild anxiety = 0-5; Moderate anxiety = 6-10; Moderately Severe anxiety = 11-15; Severe anxiety = 15-21

Severity Measure for Generalized Anxiety Disorder 7 - Adult

Please read each statement and decide how often you have been bothered by the problem(s) during the past 2 weeks (circle the number).

Over the past 2 weeks, how often have been bothered by the following problems?	Not at all	Several days	More than one-half the days	Nearly every day	Item Score
1. Feeling nervous, anxious, or on edge	0	1	2	3	
2. Being unable to stop or control worrying	0	1	2	3	
3. Worrying too much about different things	0	1	2	3	
4. Having trouble relaxing	0	1	2	3	
5. Being so restless that it is hard to sit still	0	1	2	3	
6. Becoming easily annoyed or irritable	0	1	2	3	
7. Feeling afraid as if something awful might happen	0	1	2	3	
				Add score for each column Total Score:	

http://www.nysafp.org/NYSAFP/media/PDFs/Public%20Health%20Minutes/AFP-SBIRT-OV-Protocol-GAD-10-19-16.pdf

Figure 3. OCP for GAD Treatment

PART II **TREATMENT** For Generalized Anxiety Disorder (suggest 5-8 min)		☐ Explain to the patient who has just been diagnosed with GAD that it is common and can be successfully treated with close collaboration between doctor and patient. ☐ GAD can be treated with medication, psychotherapy ("talk therapy"), or a combination of the two. ☐ Medications (see **"Attachment B, pp 10-11"**) such as benzodiazepines and SSRIs may be prescribed. Medications will not cure anxiety disorders, but can give significant relief from symptoms. ☐ Talking Points. This section provides you or your staff suggested content for discussion with your patient. See **"Attachment C, Content for Discussion", pp 12-13**. ☐ Refer to Psychotherapy (see **"Attachment D, Referral" p 14**). Cognitive-behavioral therapy (CBT) actively involves the Pt in learning skills to help change thinking and behavior patterns. It teaches the Pt how to control worry, decrease the impact of anxiety on one's life, and learn new responses to stressful events, often within 12 to 16 weeks. ☐ Schedule follow-up visit

http://www.nysafp.org/NYSAFP/media/PDFs/Public%20Health%20Minutes/AFP-SBIRT-OV-Protocol-GAD-10- 19-16.pdf

Table 1. Currently FDA-approved medications for GAD

Category	Examples	Adverse Effects
SSRIs	Paroxetine, escitalopram, duloxetine, venlafaxine	Nausea, diarrhea, insomnia/agitation, somnolence, impaired sexual function, and hyponatremia
Benzodiazepine	Alprazolam, chlordiazepoxide, clonazepam, clorazepate, diazepam, lorazepam, oxazepam	Excessive daytime sedation, amnesia, rebound anxiety with cessation
Other	Buspirone	Insomnia, agitation and nausea
	Pregabalin, gabapentin (not FDA approved for GAD)	

Table 2. Interventions for GAD: Resources and when to refer

Reasons to Refer	Referral Options	Other Options
Lack of motivation	Psychologist – Cognitive Behavioral Therapy	Collaborative Care
Medication adverse effects	Psychiatrist - psychopharmacology	
Social issues	Counselor	
Environmental issues		

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National Association of Cognitive Behavioral Therapists (http://www.nacbt.org/)
National Institute of Mental Health (http://www.nimh.nih.gov/health/topics/anxiety-disorders/index.shtml)

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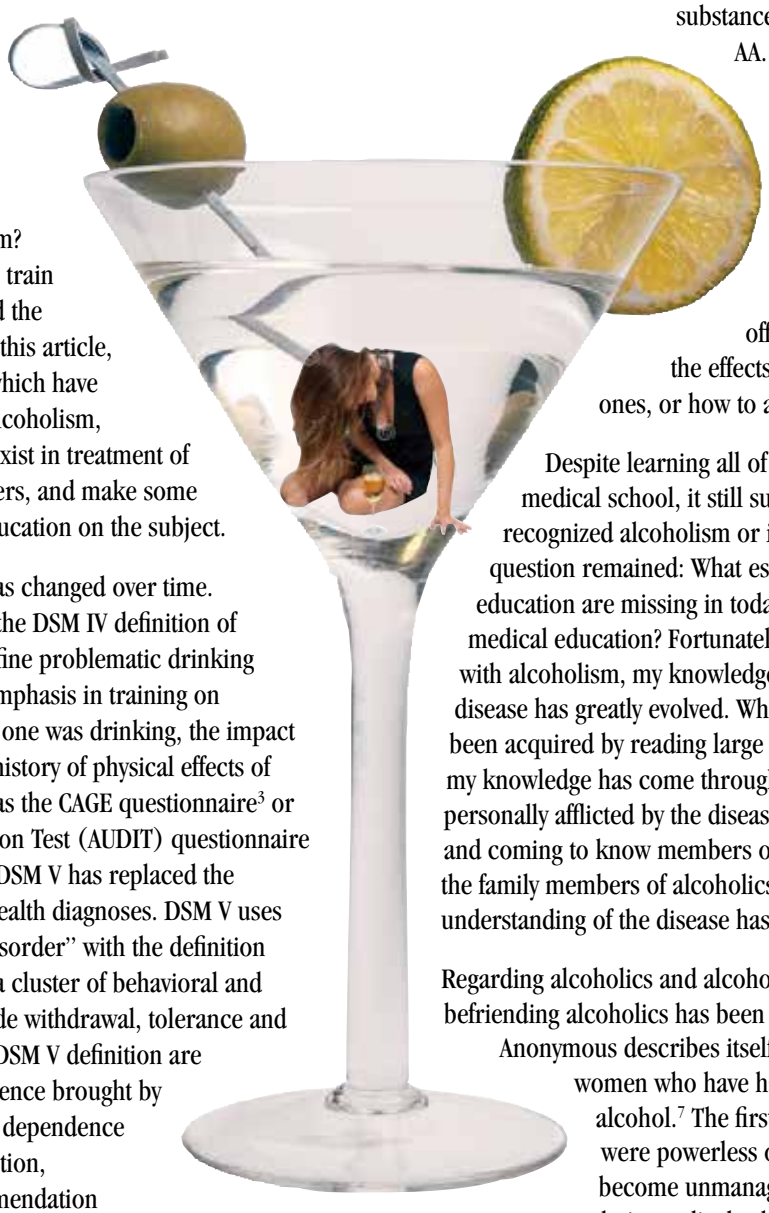
Lessons from the Sting of Alcoholism

By Marianna Worczak, MD

"We believe alcoholism is a family disease and that changed attitudes can aid recovery," reads a suggested pre-amble for Al-anon meetings.[1] A few years ago, I discovered rather abruptly that the man I had been planning to marry was an alcoholic. While this revelation was traumatic at a personal level, it also left me questioning my training on alcoholism and my clinical approach to this disease. Having been a mere two years out of residency at the time, I questioned the validity of my education on the topic. I began to ask: Do we as medical professionals really believe that alcoholism is a disease? Do we ask enough questions? Do we ask the right questions? Do we recognize that alcoholism is a family illness? How do we support and treat those affected by alcoholism? I also began to ask, "How should we train our residents to treat alcoholism and the family and friends affected by it?" In this article, I hope to explain some revelations which have emerged from my experience with alcoholism, discuss some deficiencies that may exist in treatment of both alcoholics and of family members, and make some suggestions to improve residency education on the subject.



The exact definition of alcoholism has changed over time. During my medical school training, the DSM IV definition of Alcohol Dependence was used to define problematic drinking (see Table 1).[2] There was a strong emphasis in training on assessing the amount and frequency one was drinking, the impact on personal and family life and any history of physical effects of alcohol. Often screening tools such as the CAGE questionnaire[3] or the Alcohol Use Disorder Identification Test (AUDIT) questionnaire were taught.[4] Since my training, the DSM V has replaced the DSM IV as the standard for mental health diagnoses. DSM V uses the diagnostic term, "Alcohol Use Disorder" with the definition "Alcohol use disorder is defined by a cluster of behavioral and physical symptoms, which can include withdrawal, tolerance and craving."[5] The exact criteria for the DSM V definition are outlined in Table 2. The major difference brought by DSM V, was that while tolerance and dependence are still considered part of the definition, there is no longer the strong recommendation to differentiate between these terms. The disease is seen along a spectrum of symptoms of disuse. Trainees are taught to ask questions about the amount of alcohol consumed, frequency of consumption and social impacts.

Once the diagnosis of Alcohol Dependence or Alcohol Use Disorder was established, I was taught many different tactics to "treat" such patients. In inpatient settings, there was always an appropriate discussion about the need for withdrawal screening and/or treatment. In outpatient settings, some attending physicians favored brief interventions such as telling a patient that they were drinking too much, recommending that they cut back and offering support and or referral for treatment. There is a fair body of research to suggest that physician-led brief interventions such as these do in fact lead to increased rates of change.[6] Learners and physicians are also taught to make referrals for substance abuse counseling and possibly AA. A few, who were well versed in substance abuse would bring up naltrexone or other medical treatments. There was little to no emphasis in my training on addressing the deception and denial that accompanies alcoholism. There was nothing offered in my training that addressed the effects of alcohol on family or loved ones, or how to approach these individuals.

Despite learning all of the above in residency and medical school, it still surprised me that I had initially not recognized alcoholism or its severity in a loved one. The question remained: What essential elements of alcoholism education are missing in today's undergraduate and graduate medical education? Fortunately, through my personal experience with alcoholism, my knowledge and understanding of the disease has greatly evolved. While some of this knowledge has been acquired by reading large amounts of literature, most of my knowledge has come through what I learned from those personally afflicted by the disease. Through attending the meetings and coming to know members of the fellowship of AA, and later the family members of alcoholics in the fellowship of Al-Anon, my understanding of the disease has grown greatly.

Regarding alcoholics and alcoholism, attending AA meetings and befriending alcoholics has been very enlightening. Alcoholics Anonymous describes itself as a fellowship of men and women who have had a problem with drinking alcohol.[7] The first step of AA states "We admitted we were powerless over alcohol-- that our lives had become unmanageable." [7,8] While physicians are taught in medical school that alcoholism is a disease, what is often not taught is the critical concept that the alcoholic needs to completely accept this before they can hope for recovery from it. They must firmly come to believe that their minds are fundamentally different than those not afflicted and they must come to terms with the idea that they cannot drink again. They must accept that many of their social, family, and physical problems all are related to this disease. It

Table 1: DSM-IV Criteria for Alcohol Dependence:[2]

DSM-IV Criteria for Alcohol Dependence: A Maladaptive pattern of alcohol use, leading to clinically significant impairment or distress as manifested by three (or more) of the following, occurring at any time in the last 12 months:
1. Tolerance
2. Withdrawal
3. Alcohol is often used in larger amounts over a longer period than was intended
4. There is a persistent desire or unsuccessful efforts to cut down or control alcohol use
5. A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects
6. Important social, occupational, or recreational activities are given up or reduced because of alcohol abuse
7. Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol

quickly becomes apparent that alcoholics also typically suffer from grave emotional turmoil including feelings of inadequacy, guilt, shame and failure. The alcoholic is propelled to drink often as a mechanism to "deal" with these emotions. The disease also includes a set of behaviors or "isms" as they are called in AA that perpetually persist even after the alcoholic has become sober. These "isms" are persistent behaviors or ways of thinking, unique and varied between alcoholics, and sometimes are part of the root cause of the alcoholic's drinking. Some examples of "isms" may include obsessive thoughts and fears, including fear of failure, social angst, and poor self- esteem. More frequently they are the results of survival mechanisms gone awry. Avoidance of conflict, lying, cheating, bottling emotions and feelings, failure to utilize finances appropriately, apathy, poor financial skills, self-doubt, and the denial of the severity or the presence of alcoholism itself are common. The social, economic and often legal issues notable in most alcoholics over time are symptoms of this disease.

Several keys to sobriety were also readily shared. The nature of AA is that it is a spiritual program and members stated again and again that accepting this ideal, following the steps, remaining vigilant about recovery, and staying connected to the fellowship were all critical to sobriety. It also was quickly apparent that "dual-diagnosis" is very common among alcoholics. This is the presence of alcoholism plus another psychiatric disease, and includes depression, bipolar disorder, anxiety, ADHD, schizophrenia and PTSD to name a few.[6] Many alcoholics had stories of recurrent trips to rehab for substance abuse followed by temporary periods of sobriety and relapse. For many, recognition of a co-morbid psychiatric condition, and subsequent treatment of both the alcoholism and other mental health disorder at the same time seemed to be key to their sobriety. Finally, the AA members discussed the need to hit a bottom. Members frequently related that they needed to experience a certain threshold or pain in their lives in order to develop the insight that they were alcoholics and needed to dramatically change their lives.

It is now clear to me that a physician cannot treat alcoholism without understanding alcoholics and the elements that most alcoholics in recovery believe have been essential to their recovery. Despite this understanding, the remaining void I identified in my educational experience was a personal one. Nowhere in my medical training had I been specifically taught about the effects of alcoholism on family members and friends or how to address them. Fortunately, I was enlightened by a fellow physician who, after learning of my predicament, kindly suggested that I attend Al-Anon, the partner program to AA. Al-Anon is a 12 step program designed to help the family and friends of alcoholics recover from the effects of alcoholism.[9] I took this physician's advice and learned about the powerful effect of alcoholism on others and why those affected often come to realize that they have a need of recovery themselves.

Al-Anon also follows twelve spiritual steps, adapted from AA.[1] Historically, the program was started by the wives of the early AA founders who identified behaviors in themselves that persisted long after alcoholics achieved sobriety.[9] It became clear that the loved ones of alcoholics displayed many predictable behaviors such as enabling, becoming emotionally distant, sarcasm, criticism, self-reliance, co-dependence and maladaptive patterns of thinking. These behaviors sometimes lead to psychiatric issues like depression or anxiety. For others, these mal-adaptive behaviors had initially been "survival skills," but had transformed into behaviors that negatively affected other relationships. Many came to Al-Anon hoping that they would find a support group where they could "vent" or debrief about the troubles of life with alcoholism. Within a few meetings it became clear that the focus of Al-Anon had very little to do directly with the alcoholic. The program focused on the family members working on themselves and improving their own lives, while living in the aftermath of alcoholism, with active alcoholism or with alcoholism in sobriety.

I found much relief in realizing that many of the faces in the Al-Anon rooms were men and women who had similar academic and social backgrounds to my own. Some had grown up with alcoholism but others had never seen it and completely missed it in a loved one. I was taught quickly that alcoholism is insidious at onset and thrives on deception. The same concept of the first step of AA was frequently cited by Al-Anon members: the alcoholic will not recover until she or he had reached a bottom, and until she or he had admitted that they were powerless over alcohol. The program teaches 3 C's emphasizing that the member did not cause the alcoholic's drinking,

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Table 2: DSM-V Criteria for Alcohol Use disorder[5]

DSM-V Criteria for Alcohol Use Disorder: A problematic pattern of alcohol use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:
1. Alcohol is often taken in larger amounts over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control alcohol use.
3. A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects.
4. Craving, or a strong desire or urge to use alcohol
5. Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school or home.
6. Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol.
7. Important social, occupational, or recreational activities are given up or reduced because of alcohol use.
8. Recurrent Alcohol use in situations in which it is physically hazardous.
9. Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol.
10. Tolerance, as defined by either of the following: → A need for markedly increased amounts of alcohol to achieve intoxication or desired effect. → A markedly diminished effect with continued use of the same amount of alcohol.
11. Withdrawal, as manifested by either of the following: → The characteristic withdrawal syndrome for alcohol → Alcohol (or a closely related substance, such as a benzodiazepine) is taken to avoid withdrawal symptoms.

members cannot control the alcoholic's drinking, and that the members can not cure the alcoholic's drinking.[9] From a professional perspective, this drastically clashes with approaches taught in medical school that suggest that with enough prodding, enough displaying of the facts, with the right medical assisted therapies, and possibly with the correct screening tools, physicians can treat, cure, or control alcoholism. It is clear to me now that until the alcoholic truly believes she or he cannot drink again, there is nothing a family member or a physician can do to induce sobriety. This knowledge is of great help to a physician in how they approach their patients. Simply suggesting that family members be "supportive," "loving," or "understanding," of the alcoholic is not terribly helpful. Similarly, building home environments that are devoid of alcohol, not purchasing alcohol, avoiding discussions of alcohol in the home and throwing away alcohol are of no lasting benefit to sobriety. They could even be harmful.

The current system of undergraduate and graduate medical education could vastly improve how it teaches learners to approach, treat, and think about alcoholism. Seasoned physicians could also greatly improve their understanding of this disease and its impact on others. Fortunately, most schools now teach that alcoholism is a disease, and some enhance learners exposure by piloting programs where learners go to AA meetings, work in recovery groups, or hear from a panel of substance abuse patients.[10] This is an evolving trend in which there is much research regarding the most effective way to provide learners with meaningful exposure. Very few programs offer training on how to treat or interact with family members during active drinking or after sobriety has been achieved. This is an area I believe is very important to developing a comprehensive curriculum.

As family physicians, we have the unique opportunity to treat patients as more than just diseases. We treat entire families. Alcoholism is a disease of both the individual and the family, with an impact that extends to relationships as well as the physical and mental health of those affected. It is my hope that the lessons I have shared will help others to help their patients. Since I work in a new family medicine residency program, it is my goal that the next wave of trainees will learn more about the disease of alcoholism than has been taught in previous years, and that this instruction includes practical experience where learners have the opportunity to meet alcoholics outside of an office setting. It is also my hope that training programs will teach learners about AA and Al-Anon, and by understanding their functions, feel comfortable referring patients who need help. Trainees can and should learn how to treat the entire alcoholic family.

Endnotes

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RETIREMENT – BE PATIENT AND WAIT...

By Richard Mittereder, MD

OK take a deep breath slowly – – – repeat after me: time, as you know it, has finished. You've entered the enviable moment in life when you don't have to be 'the Doctor'. Instead try this on: husband, dad, lover of_____ (fill in your favorite non-work activity). So-o, now that you took that breath and collected yourself, what now? How to bring forth the new non-physician persona? In the last six months since I retired from being a physician, I've seen life from both sides now (sing to the tune of the Sinatra song) and here are some helpful tips.

(1) Maintain and embellish relationships

We are, first and foremost, social creatures. Gerontological literature suggests that loss of social connectedness and loneliness in senior populations is an underestimated risk factor against successful aging. Physicians, and many other similar highly engaged professionals, can experience this humbling truth quite profoundly upon their birth into retirement. Furthermore, be they family or friends, these poor people have been waiting around for you all these years to finally have flexible time to spend together – – relish it!

(2) Maintain your routine, especially eating and sleeping schedule

What! You say: "but I've been on the physician treadmill for 30+ years! I can't do that." Oh, yes, you can, for here is the startling truth - by employing the same discipline that was used being a doctor, it is possible to prioritize what and when you eat and, and just as important, to retrain yourself to have proper sleep habits.

(3) Exercise regularly and frequently

OK, so now you have the time to practice what you preached all those years. Doing exercise with proper frequency and intensity builds over time on the rather interesting story that you can teach an old dog new tricks – – again, prioritize it!

(4) Meditate, read (non-medical) stuff

Spiritual character needs grooming and pays dividends in one's psyche, if practiced.

(5) Take up a project or hobby (non-medical preferably)

But be careful not to over-commit if it involves other people. Your skill set as a care taker person that's been honed by your doctor career can easily be transferred into a situation in which you're going off the rails in the project, thus consuming you in the "need", albeit well- meaning desire to take care of others.

(6) Savor every little joy

But also embrace and grow with every suffering. Sounds paradoxical, but being on opposite sides of the coin of life, joy and suffering go hand-in-hand. They are life's yin and yang and to achieve balance, we need to be aware of and accept both wholeheartedly.

And, now for the really good stuff!

(7) Plan vacations

And give in to the feeling of playing. It may go without saying that this implies recognizing and exercising flexibility in time and space. It's not important that you see every piece of art at the Chicago Art Institute or go to all the islands of Japan on vacation. Again, savor your freedom! Stop the frenetic habit! It's a broken record.

(8) Learn to be patient and wait

That's right, WAIT! You're not the big cheese anymore so stop acting like it! You might need to mind your own business sometimes, allowing others to drive the car or boat or what have you. Take in the scenery...ENJOY!

(9) 'It's not about me all the time'

Let it go. (Say this to yourself every morning while leisurely sipping your coffee)...and, remember to laugh out loud hard every day! You'll feel better as a result. Even a grumpy old primary care physician who's heard or seen it all can find some humor to laugh about every day!

And finally,

(10) Be True to yourself and the rest will follow

The growing continues even as one retires both inwardly and outwardly – – You can do this!

Richard Mittereder, MD *received his medical degree from the University of Pittsburgh School of Medicine and completed his internship and family practice residency at UCLA. While in California, he worked for Kaiser Permanente and was also an adjunct Clinical Professor for UCLA's Family Practice Residency Program. Following certification in geriatrics, he moved with his family to Rochester where he became Chairman of Unity Health System Family Medicine Department in addition to a full time practice that included outpatient, hospital and nursing home work. Dr. Mitt culminated his career in family medicine and geriatrics as the Medical Director of the Rochester Regional Health System, retiring in the fall of 2017.*

Addressing Drug Use in Your Practice – Building Confidence to Assess and Treat

By Christopher Ferraris, LMSW; Terri L. Wilder, MSW; Martha A. Sparks, PhD; Kelly S. Ramsey, MD

Introduction: In New York State (NYS), there is an estimated 1.9 million people who have a substance use problem.[1] This urgent concern, especially in the context of a growing opioid epidemic, has prompted NYS to take concrete steps to provide education and awareness targeting both the public and medical providers in the hope of increasing implementation and uptake of comprehensive services in NYS. There is a growing need for family physicians to routinely screen for substance use and treat appropriately. Although practices can vary greatly in their level of expertise or the amount of resources within the community, there are a few approaches and concrete steps that family physicians can take when working with patients who are using drugs. Christopher Ferraris, LMSW, Program Manager at the Mount Sinai Institute for Advanced Medicine spoke with Dr. Kelly S. Ramsey of HRHCare and Dr. Martha A. Sparks of the Mount Sinai Institute for Advanced Medicine about incorporating frank conversations about substance use in their practices.

Christopher Ferraris: *Hi Drs. Sparks and Ramsey, thanks for taking the time to speak with us about discussing drug and alcohol use with patients. In your opinions, what's the value of asking questions about substance use in your practice?*

Martha Sparks: Substance use is part of health, and so in order to best understand exactly where our patients are and how we can help them effectively, we need to know what they're doing. So, just like we ask them about whether they wear seatbelts, and just like we screen their blood pressure every time they come in, drinking and drugs are an important part of their general health and wellbeing. That's my general answer. My specific answer is that we can't treat people effectively, or even differentially diagnose them, without knowing everything that's going on in their lives. So, you know, if somebody's coming to me and complaining of sleep difficulties, cognitive behavioral therapy for insomnia or Ambien is no match for cocaine or crystal meth.

Kelly Ramsey: I think in my practice its part and parcel of what we do, because I treat HIV and hepatitis C. So a way that I look at it is, one, it's just part of the rest of the dialogue; and two is that, my expectation when I talk to my patients, particularly for what they come to see me for, is that the answer to, "Tell me about your substance use history," is that there is going to be a substance use history. So, I think that we have an overburdened primary care system and, unfortunately, when you try to cram not only all the value-based things that you have to do, and care for five or six different issues into a 15-minute visit, primary care providers don't want to talk about sex and drugs, because they're afraid that a Pandora's box is going to open, and they're not going to have the time, or the skill set, to address it.

CF: *In your first visit with a patient- what do you think realistically could happen for that provider, in a primary care setting, within that crammed window?*

KR: I think there are a lot of different ways to look at that. I think, one, it would be interesting to know whether it was elicited by the provider, or it was offered by the patient -- because those are two totally different scenarios. Say the provider elicits that information. I think that would be an ideal situation in which they ascertain the frequency with which the person is using whatever substance they're using, again, how they're using it, and behaviors associated around it. So if they could elicit if there were unsafe practices occurring that would put them at risk for a variety of infectious diseases and sexually transmitted infections that would be ideal. Because then they could do harm reduction and address the behaviors specifically. But it's also important to determine if this -- again, is this just episodic, experimental use? Is this riskier use (in other words, escalation of use)? Is the person starting to have any kind of consequences due to their use? How does the patient view their use? Are they concerned about it? And so, sort of trying to tease out where they are in the stages of change. And if you do think that it's a harmful use pattern then, again, just doing a brief intervention by saying, "You know, I'm concerned about some of

the things you're sharing with me. Here are some things you could do to do it more safely. Would you feel OK coming back and talking to me in a couple months, so I can check in with you and see how you're doing?" If the person clearly is exhibiting very concerning use -- in other words, they're having consequences, it seems like it's escalating out of control -- then what often happens is that that person is then handed off to social work, or behavioral health, to do an SBIRT (Screening, Brief Intervention, and Referral to Treatment) or to do a DAST-10 (Drug Abuse Screening Test), or whatever screening tool you're using. And then probably, in the primary care setting, say that person was interested in treatment. Obviously, we don't have any -- for crystal meth, in particular -- we don't have any medications for treating that. So they might be referred to a treatment program, etc. But all of that is going to be based on what's going on specifically. Is this just use? Is it risky use? Or is it a use disorder? And it's also going to be based on the stages of change.

MS: Having had an open conversation such as people disclosing that they use substances and especially drugs I think indicates a level or trust and alliance that I think is a success. We're setting the scene for continuous care, good continuity. And so maybe you have the conversation today, and you can talk about immediate risks, reducing potential lethality, referring to treatment if people are ready for that. And it's OK to say, "Can we talk about this next time?" And so that, all by itself, with an agreement to keep discussing in the future is successful.

CF: *Dr. Ramsey, you discussed making a hand-off to a social worker, psychiatrist, etc., - How do you make that connection in a way that doesn't stigmatize the process of engaging with mental healthcare.*

KR: When we initially see our patients, we take an extensive trauma history, an abuse history, and a mental health history. And we talk to patients about that from the get-go. If you have unresolved issues from a trauma history -- the vast majority of my patients have a trauma history and/or an abuse history, and the vast majority have mental health diagnoses in addition to their substance use disorder diagnoses. So some people already come engaged in mental health, or even dual diagnosis, programs. And that's great. We just encourage that ongoing involvement. But, you know, we try to be a low threshold setting for medication assisted treatment (MAT). In other words, patients that are never going to walk into a methadone maintenance program; they're never going to walk into an OASAS (NYS Office of Alcoholism and Substance Abuse Services) program voluntarily -- we try to meet them where they're at, and we try to do an individualized treatment plan that's based on their needs. So, from the get-go, other than doing a one-time meeting with our social worker, which -- they do a comprehensive biopsychosocial with them, like an hour-long appointment, which is very detailed. And then they make clinical recommendations that they see, based on that visit, for the patient. But we know from the get-go that just getting them stabilized on MAT is the first goal. And so they may not be ready. They may be in denial about those other issues, or they just may not be ready to engage around those issues. So, we give them time to stabilize. And then often once people are medicated -- for example, with buprenorphine -- then often whatever they were masking, certainly from a psychiatric perspective, is going to come bubbling up to the surface. And so we point that out to them. Once we treat you and you're not masking your mental state anymore, you may be a lot more depressed than you think you are. You may be a lot more anxious than you think you are. And we're going to have to address that when it comes up. And so often, again, we've planted that seed. When their major depression actually does persist after they've stopped using, then often they're ready to address it. So either we can address it with them -- for example, with an antidepressant -- or we, the team (because we operate as a multidisciplinary team) will say, "You know, you're doing really well with respect to your opioid use disorder. But it doesn't seem like you're very happy. And you're very anxious. And we really recommend that you do some counseling."

CF: *And you Dr. Sparks as the mental health practitioner how do you ideally envision this handoff or referral?*

MS: There is still a lot of stigma around mental health treatment -- psychiatry, psychology. "Are you sending me there because I'm crazy, Doc?" A lot of people say that. A lot of people think it and don't say it. So, the beauty of a setting like ours, where we offer a lot of interdisciplinary care under one roof, including psychiatry, psychology, psychiatric nursing and social work, is that we can say to our patients, "Hey, there's a member of my team, Dr. Sparks. I think she would be really helpful for you to talk to. She's really knowledgeable about X and Y that we talked about today. Would you be willing to have a meeting with her?" I think that sometimes there's a hesitation, on the part of PCPs, to name mental health, or name substance use treatment. They'll be like, "Oh, I want you to go talk to Martha. She's nice," and don't really explain why they're making the referral, or what my specialty is. And I think that comes from a place that's compassionate and sensitive. But I think, in fact, that kind of delicacy contributes to stigma in a way, because, "This is so scary that my doctor can't even name it." Like, we're not going to be embarrassed about referring somebody to the endocrinologist? Right? What is that language that we use, then? What is that? We call it behavioral health services. Is it calling it behavioral health? I think

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one thing I want this interview to do is to help clinicians develop vocabulary and to build a language for this. So, when we're talking about behavioral or mental health and we talk about the stigma of it. A less stigmatizing way to say the same thing is "The things that we've talked about this session, there was a lot. We have behavioral services here on-site, and you're a perfect candidate to talk with them a little bit." I would echo back what the patient said, and use the same neutral language that you're using when you're asking the questions. Like, "We talked today about your drinking. You were telling me that you drink six drinks a night on Friday and on Saturday, and couple drinks every other day. We talked about how that might be affecting your relationships, be affecting your health. I want you to have the opportunity to continue discussing this with one of my colleagues, who really specializes in helping people address their drinking." I don't know that you even need to name the discipline. I think it's important to discuss the reason for the referral. And using language like that I hope does not sort of imply that this is too scary and that I, your PCP, can't handle it.

CF: *What's the next easy step clinicians can take from here if they want to be more inclusive of those who might be using?*

MS: I think we want to recognize common contributors to health problems. And alcohol and drugs are both those. So I mean, I would incorporate it into the flow of standard care, whatever that looks like in your practice. So, whether it is training medical assistants or nurses to do these screening questions as they're taking vitals; that can be a nice way. It can be using prompts within the EMR, using a template for an annual visit that includes these questions. As much as they can be routine and part of ordinary care, I think we're going to be identifying more people and recognizing more potential problems.

KR: I think it's kind of a way of being in the situation: being nonjudgmental; being curious; being empathic; and also recognizing that substance use disorder can happen to anyone. I think with the opioid crisis we certainly have probably seen empathy from quarters we haven't seen it previously, because it's touched so many more people, so widely, across all socioeconomic strata, and race, ethnicity, ages, etc. For instance, when we roll out our MAT program at additional clinic sites there's always fear among staff. It's something that, they're just afraid of the program coming, that there's going to be chaos in the clinic, and all of these drug users are going to be there. And so I have to break it down for them. I take every stigma, stigmatizing statement and fear, that I've been given at every clinic site and I throw them back at them, and I explain why that's not really reality based. And I say, "I doubt that any single person in this room could tell me they have not been touched, either themselves, by a family member or friend, someone that they know in their life, with a substance use disorder," whether it's alcohol, or nicotine, or whatever it is. And so this touches all of us. And we have to remember that people don't choose to have a substance use disorder. But do it because you're really interested in the patient population, and you're interested in helping people get to a place where they want to be and not going in with preconceived notions that everybody needs to be abstinent in recovery, and the patient defines what that means.

For additional resources to address harm reduction, and drug/alcohol use by patients, information can be found at the websites of the New York State Drug User Health (link below), the National Institute on Alcohol Abuse and Alcoholism, the Substance Abuse and Mental Health Administration (SAMHSA), and the Motivational Interviewing website.

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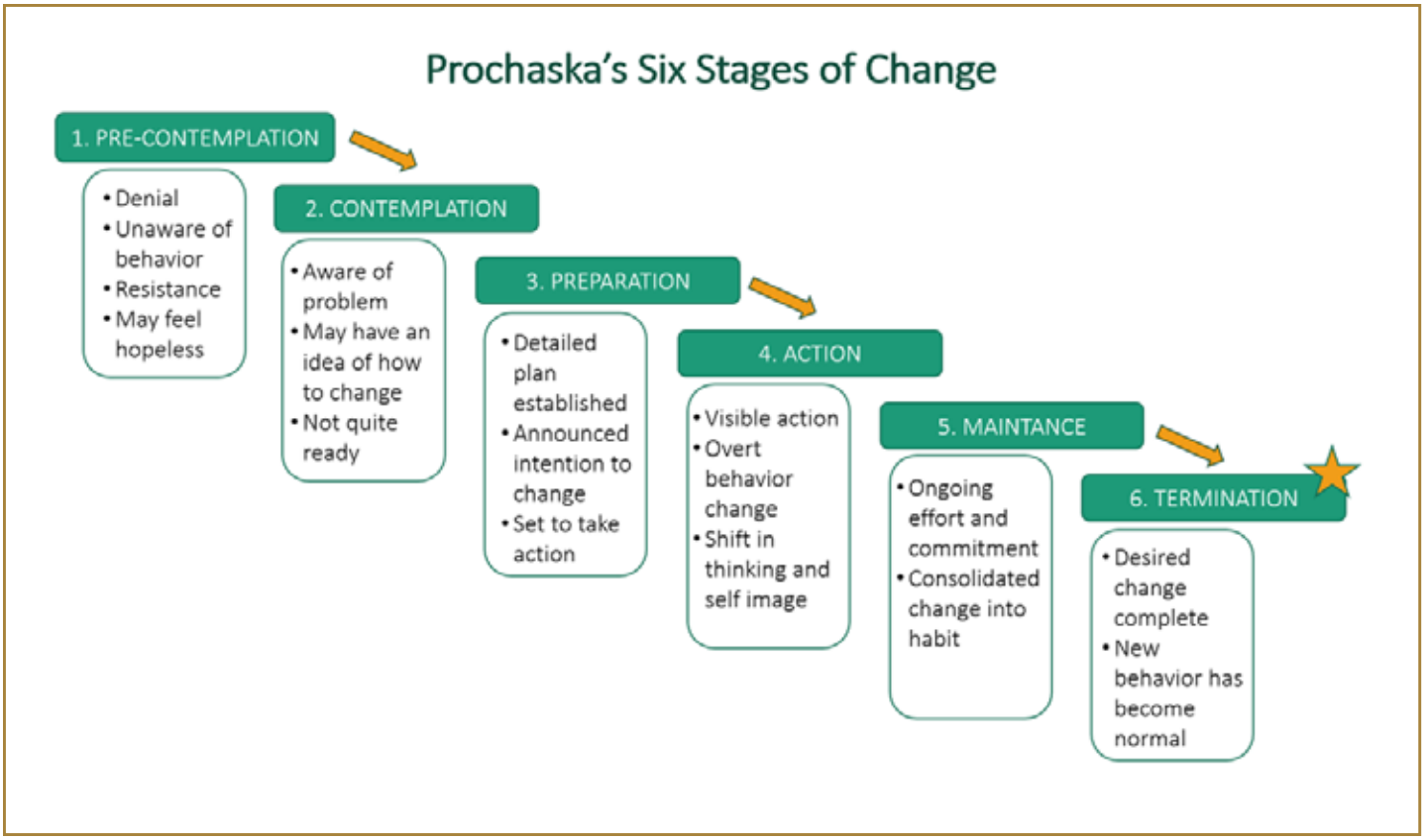

Endnotes

1 New York State Department of Health: https://www.health.ny.gov/diseases/aids/general/about/substance_user_health.htm

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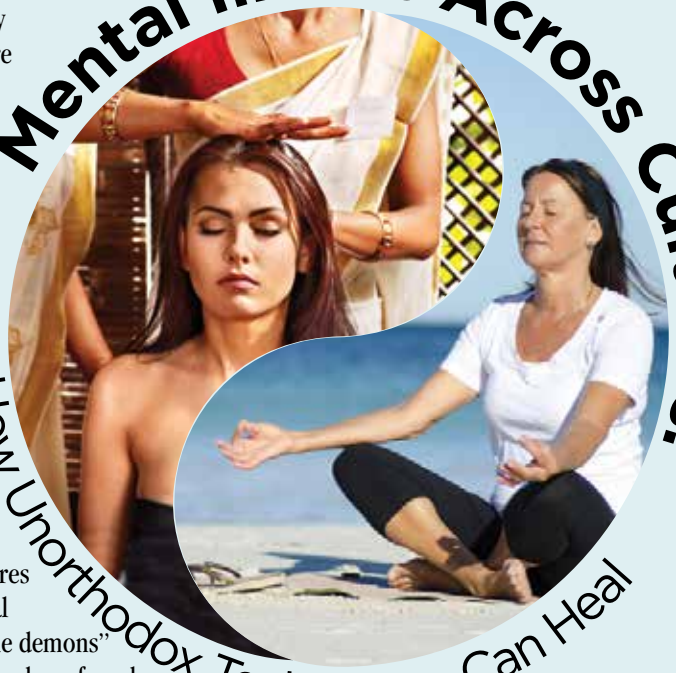
Mental Illness Across Cultures: How Unorthodox Techniques Can Heal



By Syeda T. Qasim, MD

The spiritual aspect of disease and health has captivated generations.[1] This makes us question, what is illness and what is health? As well as what is the state of emotional and physical wellbeing? The answers to these questions are numerous, and give rise to a number of other perplexities. For millennia, humans have tried to link spiritual health and disease even in the face of modern medicine. It can also happen that the unknown, especially in the context of health, is not only a source of fascination, but fanaticism as well. When individuals are uncertain of the cause of disease, the result can be the transfer of blame for the disease; some stand steadfast by the unwavering doctrines of medicine, whereas others do not hesitate to seek mysterious and unforeseen justifications for their ailments. Recent research has linked the physical aspect of disease and recovery to its spiritual and cultural counterparts.[2] Many people have recovered from life threatening illnesses through faith healing,[3] however there are many sides to the same story; what is one person's success story may be another's failure. Family physicians are presented with diverse cases of mental illness, which can be better understood and treated with knowledge of cultural background, to better treat the patient and successfully establish a healthy patient physician relationship.

In some cultures, hanging a talisman from the neck is believed to bring about luck and cure disease, whereas in others, the "evil eye" is perceived to be the reason behind all mayhem.[4] In fact, humans have always found a mystic aspect for that which they cannot explain or treat. This can be traced back to ancient times when many civilizations believed that natural calamities were the cause of divine anger. They would also attribute spiritual powers to innate objects, such as trees or mountains, which they believed could protect them. This reliance on superstition has some therapeutic effect on believers, however it has also resulted in skewed perceptions in many cultures.[5]

In the Southeast Asian culture, for instance, illness has been affiliated with religion for centuries. This perception is not solely restricted to physical health, and mental health is also influenced by this superstition.[6] There are many spiritual techniques that are practiced by individuals from this culture, including Ayurveda and other purification techniques. Many people have reported an alleviation of symptoms of distress and anxiety, though little evidence suggests improvement in severe symptoms.[7] In some instances, the media overwhelmingly shares advertisements of "spiritual healers" who will "drive the demons" out of the mentally ill.[8] Many have found themselves seeking out these healers due to psychosocial pressures and the outcomes have been either astoundingly positive, or negative.

I have encountered patients being referred from various healthcare centers after many unsuccessful sessions of treatment. One patient, who is etched in my memory, had been diagnosed with chronic refractory depression. The patient was in distress after many years of therapy. Upon further inquiry, I discovered that the patient had been noncompliant with medications due to cultural beliefs and had been relying solely on cultural therapy of Ayurveda from a local source. I realized that the patient's distress was not only due to the prolonged disease course, but also the lack of understanding between the previous physicians and the patient with respect to the nature of treatment. After researching various aspects of Ayurveda, I discussed with the patient how I understood that their belief in the effectiveness of Ayurveda was important to them, but medicine was also needed as an adjunct to this treatment. This resulted in the path of recovery for the patient and it also allowed me to gain deeper understanding of the fundaments of cultural therapy.

Different African cultures have also been influenced by the association between illness and spirituality. It is not uncommon for various tribes to shun the ill by banishing them from society or, even in radical cases, go to the extent of physically harming them.[9] Many women claim to be equipped with the powers to eradicate disease by removing the "devil" through various measures. Family physicians and therapists regularly come across patients who come to their clinics after trying various forms of cultural therapy, and with firm conviction in the efficacy of their conventional treatments. A better understanding of these concepts as well as acknowledgement of cultural variations has had various levels of efficacies in treatment in the United States.[10] An estimated 70% of South Africans will visit a spiritual healer before seeking conventional medical help.[11] This makes us question, what techniques can be implemented not only to improve patient healthcare, but also effectively aid family physicians in decreasing strain and burnout from late presenting patients.

It is a common practice in traditional Chinese medicine to associate disease with an imbalance of energy (yin and yang) and consequently, many East Asian cultures practice homeopathy and acupuncture as a means of treatment.[12] It is useful for the family physician to have an understanding and knowledge of the homeopathic

medications used by patients and be open to understanding the pharmacokinetics and pharmacodynamics of these medications with various conventional medicines. There have been many focused therapy groups in North America which incorporate traditional healing with conventional medicine, and many have advocated a better understanding of using culture as therapy to help heal various ailments.[13]

I have had the opportunity to witness this firm conviction in the healing effect of unconventional treatment though work in our department, which overflowed with patients of all age groups and social backgrounds who held the unshakeable belief that they would be cured by an unseen force, so refused to take any medications. What is essential in this clinical setting is to try and understand the patient's beliefs and to work effectively with the patient and their families, taking in consideration their cultural practices. I have also witnessed some cases of miraculous healing where medicine failed to provide answers to many questions and patients were treated based on their beliefs and religious doctrines. It is imperative for the physician to realize the effect of motivation and determination in the natural course of disease, and how important it is to find a middle ground with the patient when seeking solutions.

The mental healthcare system in Netherlands provides one of the quintessential examples of incorporating alternative methods of healing in the treatment of mental illness. Their unconventional approach involves the community in the treatment of disease and has led to increased compliance with treatment as well as a decreased incidence of mental illness. The Dutch use the community to deliver effective healthcare services in partnership with clinicians, to not only decrease the clinical workload, but also provide patient centered services.[14]

A method to approach this technique can be implemented among family physicians by incorporating the Culture Formulation Interview (CFI) in patient encounters. This is an assessment instrument formulated by the American Psychiatric Association (APA) which is composed of questions that focus on the patient's cultural experiences, perceptions and social context of the mental illness.[15] This can help to identify cultural issues that arise in patients using a person-centered approach and can lead to building of a better rapport and collaboration between the physician and the patient. The CFI has been used in the Netherlands after some modifications to provide patients with culturally appropriate care and has resulted in the betterment of the patient physician relationship as well as optimal and effective healthcare services.[16]

A model of culturally inclusive therapy is demonstrated by some clinics, where there are case managers assigned to patients based on their cultures and languages.[17] This helps in better understanding the patient's needs as well as helping develop a stronger patient physician relationship, as the culturally competent case worker aids in forming an effective liaison between the patient and the physician.[18] The case workers have a thorough understanding of the history and treatment plan for the patient, and are able to communicate effectively with the physician to highlight and discuss the patient's problems to help decrease the workload of the physician.

In the modern day of technological advancement, we have answers to many medical, scientific and theological questions that were once perplexing. With the increasing influx of immigrants with different cultures and belief systems, the modern family physician should be culturally aware of their patients' needs and maintain a holistic approach towards treatment. Human beings are made up of both mind and body, and a malfunction in either of these can result in upsetting the delicate balance of disease and health. Ultimately, for some people, faith in both the physical and spiritual aspect of disease is essential in the effective treatment of disease, and as such, provides the path to recovery.

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An Update on Screening and Managing Postpartum Depressive Symptoms

By Anna K. Zheng, MD and Scott G. Hartman, MD

INTRODUCTION

Postpartum depression affects approximately one in nine American women, according to the 2017 CDC report.[1] The data revealed that the self-reported incidence of depression declined significantly from 14.8% in 2004 to 9.8% in 2012 ($p < 0.04$) for 13 of the 27 surveyed U.S. states with an overall incidence of 11.5% for 2012. Previous estimates have shown point prevalence of 19.6% within the first 3 months postpartum.[4] Postpartum depressive symptoms (PDS) are common, associated with adverse maternal and infant outcomes, such as lower rates of breastfeeding initiation, shorter breastfeeding duration and poor maternal and infant bonding.[3-6,8-9,13] Yet, effective treatment strategies exist for reducing PDS. Decreasing the proportion of women with PDS is an important goal of the Healthy People 2020 campaign.[2] Interconception care (ICC) when employed effectively can reduce PDS.[13-17] In the following we describe a novel ICC strategy developed by family medicine faculty at residency clinic sites.

POSTPARTUM BLUES VS MAJOR DEPRESSION

Postpartum depression, whether typed minor or major, needs to be clinically distinguished from postpartum blues, which is benign and ubiquitous with a self-limiting course that usually resolves within a few days or up to 2 weeks postpartum without medication or intervention (see Table 1).[3,6-7] Women with postpartum blues report feeling depressed, anxious or upset, sometimes with anger towards the newborn, the father of the baby or, if applicable, to the other children. Signs include crying for no apparent reason, having trouble sleeping, eating, and making decisions, and questioning whether they can handle caring for a baby. Postpartum major depression, on the other hand, has to meet DSM-5 criteria. These criteria are defined as the loss of interest in doing things or depressed mood lasting for at least 2 weeks and 5 of the following: loss of interest in hobbies, psychomotor agitation or retardation, significant unintended weight loss or gain, disturbance in sleep (either insomnia or hypersomnia), fatigue or loss of energy nearly every day, feelings of worthlessness or feeling like a failure, thoughts of hurting oneself or doing away with oneself and recurrent thoughts of death (not just fear of dying).[25]

RISK FACTORS WITH NO CLEAR ETIOLOGY

Postpartum depression is underdiagnosed and its etiology is unknown.[3-4,6] Prior history of depressive symptoms either in the pre-pregnancy or peripartum period is the strongest predictor of PDS.[3,6,9] Data shows that women with the following characteristics had increased relative risk of displaying PDS: maternal age ≤19 years or 20–24 years, fear of childbirth, ≤12 years of education, unmarried status, active postpartum cigarette smoking, 3 stressful life events in the year before birth, delivery of term, low-birthweight infants, delivery of infants requiring neonatal intensive care unit admission at birth, unintended pregnancies, maternal anxiety or gestational diabetes.[3] In an age where active management of the second stage of labor includes universal administration of Pitocin with the delivery of the anterior shoulder or the placenta, there is emerging evidence from retrospective studies showing that synthetic oxytocin increases the risk of postpartum depressive and anxiety symptoms.[10,24] Contrary to the hypothesis that oxytocin would decrease PDS since it is thought to be the hormone of maternal-infant bonding, the evidence demonstrates that synthetic oxytocin may increase risk of PDS. However, well designed, randomized control trials are needed to correlate direct causality. Lastly, some women who develop PDS have no detectable risk factors.[3]

SCREENING AND DIAGNOSING POSTPARTUM DEPRESSION

Since 2016, the American Academy of Family Physicians (AAFP), the American College of Obstetricians and Gynecologists (ACOG), the American Academy of Pediatrics (AAP) and the U.S. Preventive Services Task Force (USPSTF) all recommend screening for depression in pregnant and postpartum women, including adolescents starting at age 12.[1,5,15-16] The 2017 CDC MMWR on PDS did not, however, mention AAFP's 2016 recommendation for PDS screening, nor recognize the interconception care delivered by family physicians.[1] Both deserve recognition.

Table 1. Postpartum Blues vs. Postpartum Major Depression

Characteristics	Postpartum Blues	Postpartum Major Depression
Duration	10 - 14 days	> 2 weeks
Course	Self-limiting (resolves with no meds)	Requires intervention
Incidence	Up to 80%*	11.5% (2012 CDC data)
Suicidality	none	May be present and with a plan
Severity	mild	Moderate to severe

Buttner MM, O'Hara MW, Watson D. The structure of women's mood in the early postpartum. *Assessment*. 2012;19: 247–56.

Although the Edinburgh postpartum depression scale (EPDS) is the most validated screening tool in published studies, the Patient Health Questionnaire (PHQ) offers increased ease of use and familiarity for primary care physicians due to its validity in screening all adults in general.[3,6,11-12] There is validity in using 1-step or 2-step PHQ screen for postpartum depression.[11,12] Each of these screening tools are readily available online by using search keywords "postpartum depression toolkit" or by clicking on the following links: http://www.fresno.ucsf.edu/pediatrics/downloads/edinburghscale.pdf for the EPDS and http://www.integration.samhsa.gov/images/res/PHQ%20-%20Questions.pdf for the PHQ.

Ultimately, each of these screening instruments are tools in working up a patient for postpartum depression.[3,6] Physicians need to use sound clinical judgment and the criteria as set forth in the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) in accurately diagnosing postpartum depression and capturing psychiatric emergencies such as suicidal or homicidal ideation and plans. Accurate diagnosis should be made using DSM-5 criteria for major depressive disorder (MDD), dysthymia, bipolar depression and adjustment disorder with mood features. Postpartum MDD is defined as MDD with the onset of symptoms within 4 weeks of delivery and, according to experts, up to 12 months after delivery.[3,6]

COMORBID CONDITIONS

If hallucinations or delusions are present, then the next step in evaluation is to use DSM-5 criteria to distinguish between bipolar mania, schizophrenia, schizoaffective or acute psychotic episode. Anxiety is often comorbid with depression, so screening for postpartum anxiety may be necessary in some cases.[3,6] Alcohol, opioid or other substance use and abuse may be present with PDS, which a good social history can capture. Consultation with a psychiatrist and/or a specialist in complex cases is advisable and prudent.[3,6,19] Recurrent suicidal ideation without a specific plan in the setting of any previous suicide attempt or a specific plan for committing suicide are red flags for emergent intervention.[3,19] One-to-one observation is necessary until transport arrives to bring the patient to the nearest psychiatric emergency department if a patient endorses an active plan.[19]

IMPORTANCE OF ICC AND PDS

Effective preconception and interconception care are prime strategies for reducing maternal and fetal adverse health outcomes.[1,4,7-10] Interconception care (ICC) is defined as the care delivered to women of childbearing age in between the birth of one pregnancy to the conception of next pregnancy. Family medicine faculty from 11 residency programs created the Interventions to Minimize Preterm and Low Birth Weight Infants through Continuous Improvement Techniques (IMPLICIT) Network as a screening and intervention strategy during well-child visits from birth to 24 months of age for maternal health assessment in 4 domains: depression, smoking, family planning/contraception counseling and multivitamin/folic acid supplementation.[17,21-23] The health assessments of mothers are conducted by employing the 5 A's: "Ask" mom questions about her behavior in the 4 domains, "Advise" and educate about healthy behaviors, "Assess" for any positive risk in the 4 domains, "Assist" in arranging interventions and "Analyze" and collect data for quality improvement research. See Figure 1.

The model strategy was implemented in 20 family medicine residency clinics. Data collected from 17,630 well-child visits between February 2015 and April 2017 detected depression in 8.1% of the visits (representative of national statistics) and interventions for women at risk of depression were provided in 92.8% of the visits.[17] The results further support that ICC can be utilized as an effective screening strategy with high patient satisfaction and ease of implementation for primary care practices. It is important to recognize the tremendous work that family physicians achieve in bridging the gap in caring for both mom and newborn by seeing both of them in the same clinic visit. Family physicians find themselves in an ideal position to offer comprehensive patient-oriented care to women and families, and to offer excellent models for screening and follow-up of women with PDS.

TREATMENT AND MONITORING OF PDS

Mild to moderate PDS may only require psychotherapy or nonpharmacological interventions alone while more severe cases require medical intervention and/or nonpharmacological modalities.[3,6,19] Selective serotonin reuptake inhibitors (SSRIs) remain the first-line treatment for any depression.[3,6] Relapse rate is high (up to 68%) with peripartum discontinuation of medications,[18,19] and treatment in pregnant and

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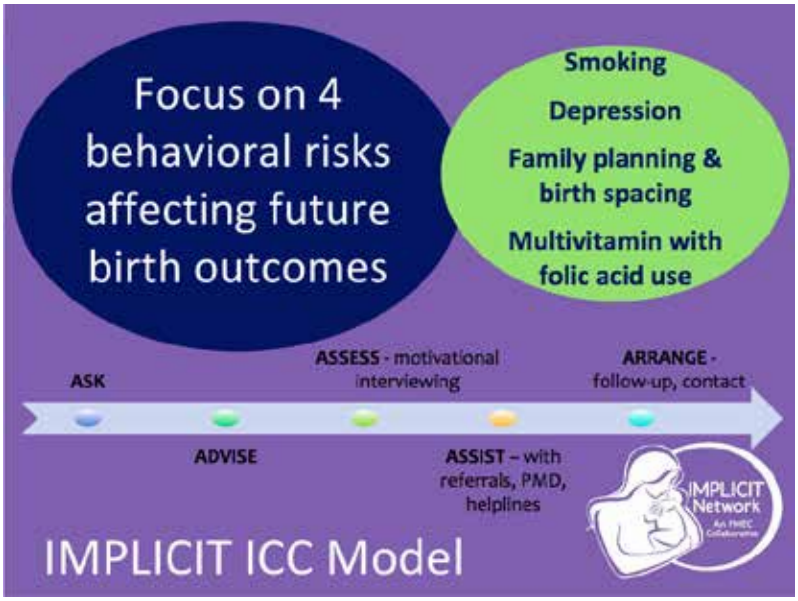
Figure 1. IMPLICIT Network Model for Effective ICC and the 5 A's.



breastfeeding women should be individualized.[3,6,18-19] The treatment period should be at least 6 months even if remission is achieved before 6 months.[3,19] Treatment should be monitored for improvement, resistance, side effects in mom and her newborn.[2] The Armstrong et al. 2008 article printed a useful table summarizing breastfeeding considerations of antidepressants in treating PDS.[20] ACOG guidelines list fluvoxamine, nortriptyline (Pamelor), and sertraline in the safer category, while the FDA and the AAP places them in a higher risk category because of serum medication levels.[20] Women at risk for PDS should be screened for suicidal or homicidal ideation throughout the pregnancy, at delivery and postpartum and, if positive, the case requires emergent interventions.[2]

CONTRACEPTION, ICC AND PDS

ICC also assesses for family planning or contraception needs for women in between pregnancies. Unintended pregnancy increases risk of peripartum and postpartum depression.[3,6,8,13-17] Progestin only birth control methods do not interfere with breast milk production or breastfeeding.

CONCLUSION

Reducing PDS in women of childbearing age is a national priority. Interconception care as a bundle strategy during well-child or pediatric visits during the first 24 months of the newborns' life as implemented by the IMPLICIT network is a very effective way in screening, intervening and managing postpartum depression and co-morbid conditions.

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Lessons From Our Patients – Are Physicians Meeting the Needs of Special Needs Patients?

By Danielle Stansky BA, BS, MS; John W Huppertz, PhD; Katherine Wagner, MD and Elizabeth Irish, MLS

INTRODUCTION

Primary care physicians occupy a unique role of being the first line of defense for treating the special needs population. Family doctors, assuming the role of primary care provider for these patients who cannot advocate for themselves, need to be equipped to facilitate interactions between the patients, their caregivers, and other providers. While special needs are becoming increasingly common in the US population, little to no research has studied caregiver satisfaction with the medical care their patients receive.[1] In April 2018, the CDC released their latest figures on the prevalence of autism among US children to be as high as 1 in 59.2 Over $400 million dollars is spent each year on autism research in the US, but hardly any of these funds focus on creation of care guidelines to support best possible outcomes and optimize patient and caregiver satisfaction for this patient group.[3]

In order to best assess the existing relationship, two surveys were designed to elicit the perspectives of both caregiver and physician. While the results demonstrated a recognition of the importance of each role, it points out some specific areas where improvements can be made to improve the care physicians are providing. Results emphasize the need for training at all levels of medical education to better address the needs of this unique patient group.

METHODS

The two surveys were designed with the intent to better understand perspectives on care from both providers and caregivers. One set of surveys was administered to parents and caregivers of individuals with special needs including ASD, ADHD, CP, Down syndrome, OCD and genetic disorders. Another survey was administered to health care professionals. The majority of the caregiver sample came from parents of children who attend Developmental Disabilities Institute (DDI) on Long Island. This organization provides its special needs individuals with medical care from a team of doctors that are specifically trained to work with this population, therefore the results may not be representative of all caregiver experiences with their primary care physicians. The medical professional survey was sent out to New York physicians, predominantly in the Capital District and Long Island regions. Overall there were 82 responses for the parent and caregiver survey and 32 responses for the medical professional survey.

RESULTS AND DISCUSSION

How are Primary Care Providers Perceived?

First, caregivers were asked about their overall PCP satisfaction. Based on the sample, 69.3% of respondents were satisfied or extremely satisfied with their PCP. Many caregivers recognized the advantage of working with providers associated with DDI which impacted their level of satisfaction. Despite the level of satisfaction, many respondents followed up with comments saying, "We lucked out." Others mentioned that they thoroughly screened and hand-picked all the doctors their special needs individual sees. Some indicated it took as long as 13 years to find a PCP with which they were satisfied. Many were unsuccessful in identifying a PCP on their own and required recommendations from other parents in the special needs community to help find compassionate physicians skilled in the care of individuals with special needs. This suggests the respondents' opinion that most people are not this lucky and that it is not usually so easy to find PCPs that meet their needs. Caregiver's indicated that they want physicians who display patience, compassion, respect, understanding, time, and adaptability.

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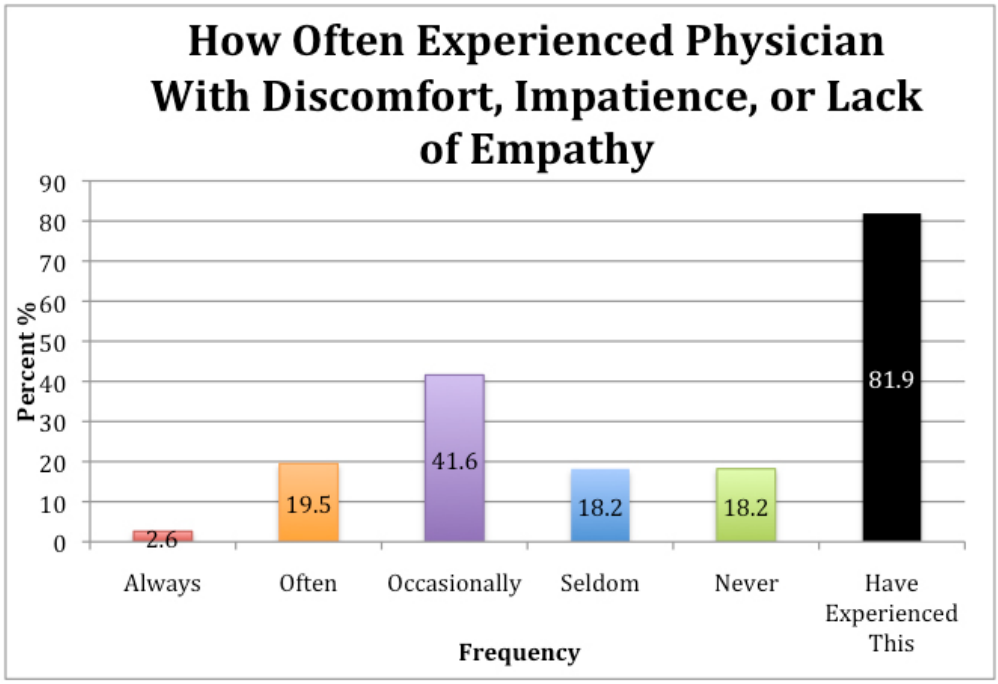
NEGATIVE EXPERIENCES

While many of the caregivers were satisfied with their PCPs, 81.9% indicated that they had experienced a physician who exhibited discomfort, impatience, or lack of empathy (Figure 1). Over 87% of respondents agreed that physicians experienced more difficulty treating special needs patients. 52% of caregivers had a physician refuse to examine the patient (Figure 2). Of this percentage, 55.4% were individuals with behavioral challenges that experienced a physician who refused to examine a patient, while 30% were patients without behavioral issues that indicated having had this experience. Respondents stated that some physicians resorted to the use of restraints due to lack of knowledge of other techniques to deal with behaviors. Respondents confirmed that this inability to more effectively deal with patients that have behavioral concerns impacts care delivery, sometimes precluding receipt of care entirely.

LESS HAPHAZARD, MORE DEDICATED TRAINING

When caregivers were asked if physicians would benefit from added training the response was almost unanimous, with 98.6% in agreement of this statement. 86.2% of physicians agreed when asked the same question (Figure 3). When reflecting back on their training, the vast majority of physicians, 71.9%, indicated their medical education included no training in the practical care of patients with special needs (Figure 4). The remaining 28.1% said that this training included lectures not based on communication skills, but rather diagnosis and treatment. Anecdotally, some providers considered their training to be haphazard, in that they happened to be assigned a special needs patient. One respondent wrote, "Although I cared for some kids with autism and disabilities during residency, I did not receive any formal training in their care." Another resident stated "In my pediatrics residency, we had numerous noon-conferences and grand rounds lectures about dealing with/treating these patients. However, these were predominantly ACADEMIC lectures. They failed to meet the more day-to-day practical issues in dealing with these families." Their responses indicated that there was no significant programmed education within the medical school curriculum and potentially even residency. Trainees had to learn on-the-go when expertise was already expected. These responses from physicians could explain why one caregiver dismissed residents and preferred to have their family member seen by an attending physician. While these findings may suggest a lack of trust in newer physicians, savvy caregivers who advocate for the best care of their child often express discomfort with less experienced physicians to provide care for them. This could demonstrate a lack of training beginning in medical school and that more knowledge from hands on experience is preferred.

Figure 1. Measuring Experience of Physician Discomfort, Impatience, or Lack of Empathy



N= 82, Missing= 5

USING THE CAREGIVER AS A GUIDE

While physician survey outcomes supported many of the caregivers' views, some results highlighted differences between providers and caregivers. While 100% of physicians agreed that caregivers are an essential component to successful care, many caregivers wished physicians would include and utilize them more. An overwhelming number of caregivers repeatedly indicated that it was important for physicians to listen to what they had to say regarding the patient. There was concern that when this did not occur, there was often a negative outcome for the patient. Most physicians, 53.6%, indicated that they never received training on how to utilize and consider the caregiver in the treatment of these patients. However a total of 93.8% agreed or strongly agreed that parents and caregivers were an extremely important component in the care of these individuals.

IN-OFFICE TOOLS

As all of our physician respondents indicated, visits for patients with special needs can best be facilitated with the assistance of the caregiver. Techniques that facilitate communication offer methods for decreasing both anxiety and behaviors during office visits and allow for better outcomes for the patient and provider. A lack of education and knowledge is one of the most identifiable causes for the dissatisfaction of physician providers by caregivers, "Some specialists don't understand how to communicate, assess and treat the non-verbal and non-compliant patient. This may be caused by inadequate medical training, lack of experience or personal lack of compassion." Communication skills are a quality that caregivers recognize as lacking. Physicians should assess a patient's ability to communicate whether it be verbal or through other means. If the patient is non-verbal or has difficulty communicating there are established techniques that the patient may already be using at school or at home. If not, the following techniques can be established between a provider and patient:

COMMUNICATION TECHNIQUES

Colleagues experienced in treating special needs patients have some ideas. One such physician notes the need for flexibility, "I do spend more time with these patients, trying to be as noninvasive as possible and adjust to their circumstances. For example I have examined a patient on the floor because that is the only place he would feel comfortable. I also ask parents what works best for their child. Parents input is always very helpful." Caregivers are often times the best resource for understanding communication tools with the patient and can offer invaluable insight via some of the following questions:

BEFORE THE VISIT	DURING VISIT	AFTER VISIT
☐ At time of scheduling ask if the patient has any special health care needs if there is no flag or label already present in record ☐ Call the caregiver ○ How does the patient communicate? ○ Triggers? ○ Toys or distractions that are helpful ○ Sensitivities? Light, noise, colors? ☐ Waiting ability? - Do they need first or last apt of the day? ☐ Are there behaviors we should be aware of?	☐ Apply information caregiver provided before visit ☐ Use communication strategies identified prior to or at start of visit: ABA (reinforcement, pairing), PECS, desensitization ☐ Prepare environment- remove triggers(needles, white coat) ☐ Provide toys or distractions or utilize those brought	☐ Use of EHR- Prepare the next provider! ☐ Coordinate care- verbal communication is best. Specialists should always contact PCP. PCP should always prep specialist at time of referral ☐ Follow up phone call to ensure plan is being implemented and if not assess and adjust as appropriate

- How does your family member best communicate?
- Do they have a specific communication system such as a picture exchange communication system (PECS) book?
- What are the patient's triggers, such as certain words or touch that they may not appreciate?
- Are there any toys that may help distract or ease the patient while at the visit?
- Does use of reinforcement or applied behavioral analysis (ABA) techniques at home or school result in cooperation that can be incorporated into the visit?

Knowing these answers before the visit can be extremely helpful with the use of a pre-visit phone call from office staff, but these questions can be asked at the beginning of a visit upon entering a room as well. In addition, there are questions that can be asked during and after the visit (Checklist 1).

SPECIAL TECHNIQUES

Several special techniques exist that may offer added options for better physician-patient interaction:

- Applied Behavioral Analysis (ABA): ABA includes a variety of behavior modification. One of the most useful methods includes reinforcement, when a desired behavior is rewarded by something valuable to the patient. For example, if a patient finds watching videos on the iPad rewarding, this can be used to encourage compliance. In the doctor's office, if the desired behavior is for the patient to let the physician listen to their heart sounds, the PCP could allow the patient access to the iPad for 3 minutes after complying with the behavior. Pairing is the process of associating positive things with the person in charge who is going to place demands on the individual.[4] Ensuring that you are aware of pairing with the patient will help build a positive relationship between provider and patient over time. For example, when you give a pediatric patient a sticker every time they leave the office, you are engaging in pairing.

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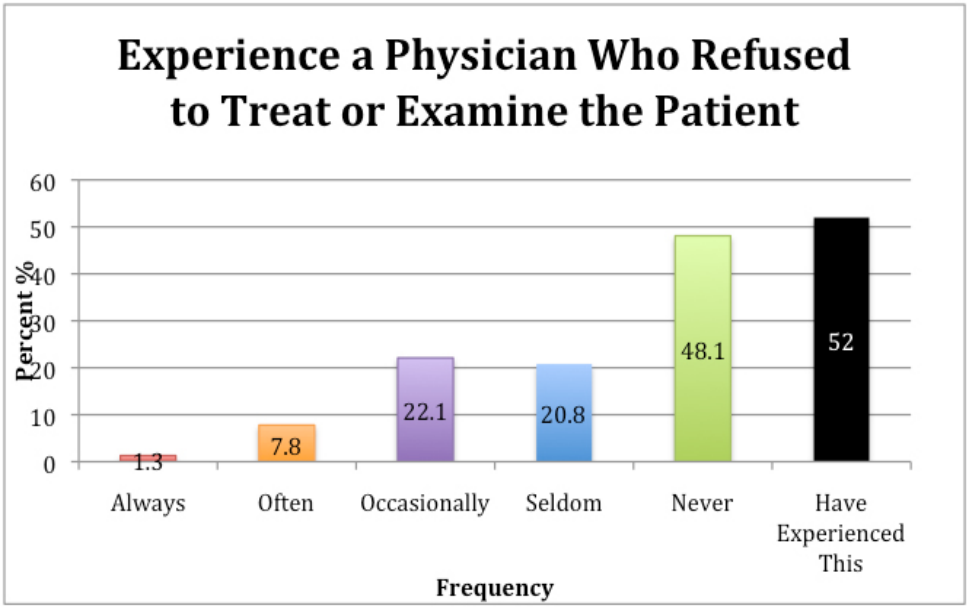
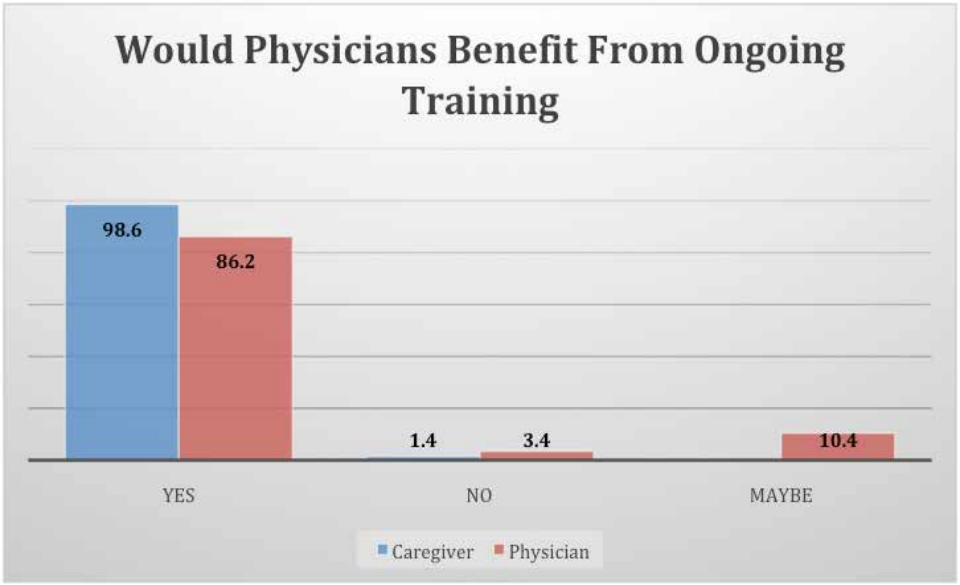
Figure 2. Measuring Physician Refusal to Examine or Treat Patient



N=82, Missing= 5

Figure 3. Would Physicians Benefit From Training on Working with Special Needs Patients



N (caregivers) = 82, Missing= 11
N (physicians) = 32, Missing= 3

- Picture Exchange Communication Systems (PECS): Physicians should always ask the caregiver or patient if they have a communication system, either via paper or electronic methods. These are resources the patients may be using at home to communicate their needs such as pictures of the toilet to indicate the need for toileting. It is possible to coordinate with the caregiver in incorporating these tools.

- Desensitization Programs: Desensitization programs are also useful for those individuals fearful of physician's visits. Some caregivers mentioned they used desensitization techniques like going to the doctor first just to say hello, then the next visit just sitting in the exam room, then letting the individual touch the stethoscope and other tools, followed by the physician doing a small exam such as listening to the heart, until finally the physician can complete the entire exam. Slowly adding more steps to each visit is often a successful method to get the patient more comfortable with visits. Physicians and office staff can easily be taught such methods and use them to more easily treat special needs patients.

COORDINATION OF CARE

A dimension somewhat unique to this population is that multiple specialists are also involved in their care since special needs patients often have multiple syndromes that require treatment over many medical specialties.[5] An overwhelming majority, 87.5% of physician respondents, indicated that they do coordinate the care of these patients. However, only about 50% of caregivers were satisfied with their physicians' communication. A medical specialist noted, "Although we try our best, the PCP

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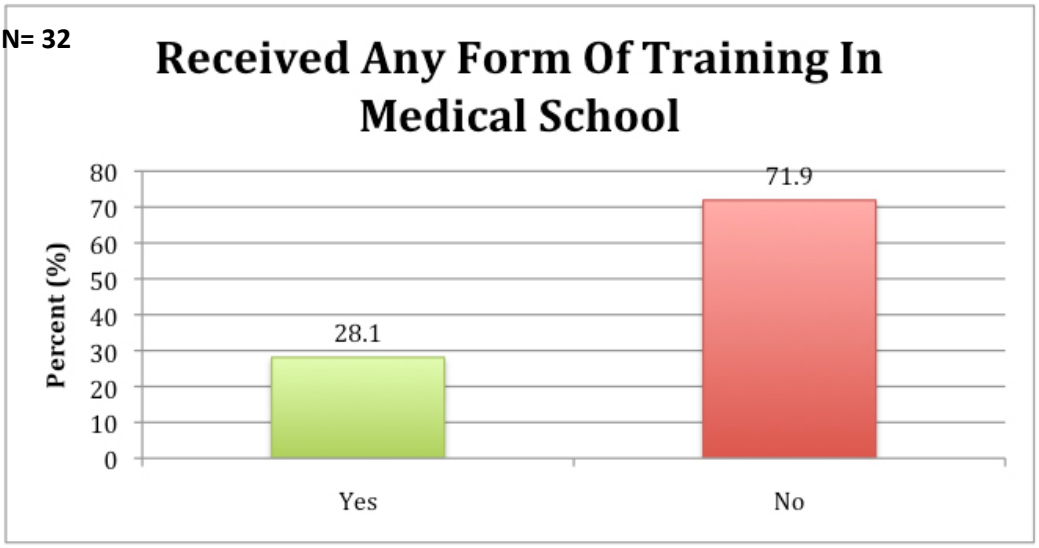
Figure 4. Did Physicians Receive Training in Medical School on Treating Special Needs Patients



is often left out of the circle. This clearly is a place where significant improvement is needed." The need is more acute for special needs individuals who often have a complex set of medical issues that may require a detailed explanation from a consulting physician, especially since caregivers rarely have the medical knowledge to relay all important aspects of the condition.[6] Ensuring that your patients' specialists have this line of communication will be vital to well-coordinated care.

CONCLUSION

The surveys shed light on the relationship that currently exists between physicians, caregivers, and special needs patients. Despite an initially high caregiver satisfaction level noted on the surveys, it is evident that it can take a significant amount of time, assistance, and effort to establish that level of care. Both caregivers and physicians surveyed recognize the need for training starting in medical school and continuing throughout a physician's career. Caregiver concerns helped to identify areas where additional training would be most beneficial. To embrace the findings of this study, medical school and residency curriculums should improve communication for this unique group of patients, so rising physicians are better equipped to tackle this challenging patient group. By incorporating techniques that are utilized in other areas of the patient's life into the physician visit, the physician can help foster a comfortable environment that will allow the physician to better interact, examine, and meet the needs of these patients.

This study was approved by the Human Subject Review Committee at Union College.

Endnotes

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Danielle Stansky, BA, BS, MS *is a medical student at Albany Medical College. She graduated from Union College in 2015 with a Bachelors in biology and sociology. Danielle received her Masters of Science in Health Care Management from Union Graduate College in 2015. Her research focuses on autism training for future physicians.*

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Elizabeth Irish, MLS, AHIP *is an assistant professor at Schaffer Library of Health Sciences, Albany Medical College who has the Medical Library Association's Consumer Health Information Specialization's Level 2 Designation. She has contributed articles and serves on the editorial board of Autism Asperger's Digest.*

Katherine Wagner, MD *received her medical degree from Albany Medical College and completed residency training at Albany Medical Center Family Medicine Residency. She is currently Vice Chair for the Department of Family and Community Medicine at Albany Medical College, where she also serves as the department's Director of Community Outreach.*

Every Family Physician Has Something Worth Sharing

In my work as an academic family physician I have had the opportunity to collaborate with a number of family medicine physicians, residents, educators and students and have learned much from these interactions. Those who know me know that I am fond of saying, "You need to write that up and present it to others!" I usually get a look of incredulity with their thoughts conveying that it would take too much time and take them away from valuable clinical and administrative work. My challenge is that the work we do as family physicians is so valuable that we can't afford to not share our knowledge!

Over the past years I have been fortunate to collaborate with others on various topics that have helped to inform and sometimes shape the education of those in family medicine across the country as well as globally.

One collaboration resulted in the revision of the curriculum guidelines of medical informatics for family medicine residency programs.

Another was used to discuss the various geriatric ophthalmologic conditions that we see in our ambulatory practices.

Yet another touched on how to deal with the agitated patient in various settings including the office, hospital, patient's home or long term care facility.

My colleagues have worked with me to discuss global infectious disease issues like Zika, Ebola and malaria as well as the questions pertaining to travel medicine as a career option or how to develop a global health program.

The administrative lessons learned from being in the trenches have informed presentations and articles on quality, leadership and advocacy as a family physician. As well as informing the career options for the new, the mid- career and the semi-retiring family physician.

Each collaboration taught me much and allowed me to share my experiences and knowledge. No matter the audience, there was always someone for whom the story or lesson resonated.

So the next time the call for authors goes out and you see a topic you are passionate about, instead of ignoring it, jot down the one or two lessons or pearls you would want to share with colleagues from around our state or country. Then every morning or evening add one sentence – they don't necessarily have to be in any particular order. By the end of one month you have 30 sentences! Organize them into a cohesive piece and give it to someone else to proof for you. Now find someone to help you find literature or articles related to your subject. Could be as few as 1-3 if it's an opinion or as high as 10-20 for more comprehensive submissions. Read through them and highlight the take home points you want to add to your piece. Make sure to number the references so you can track them. And once again, reach out to your colleague to edit. Add extra sentences or paragraphs as you see fit and submit!

You will get feedback from the publication source and you should use that to help inform how you do your next set of edits - whether you continue with the current source or another.

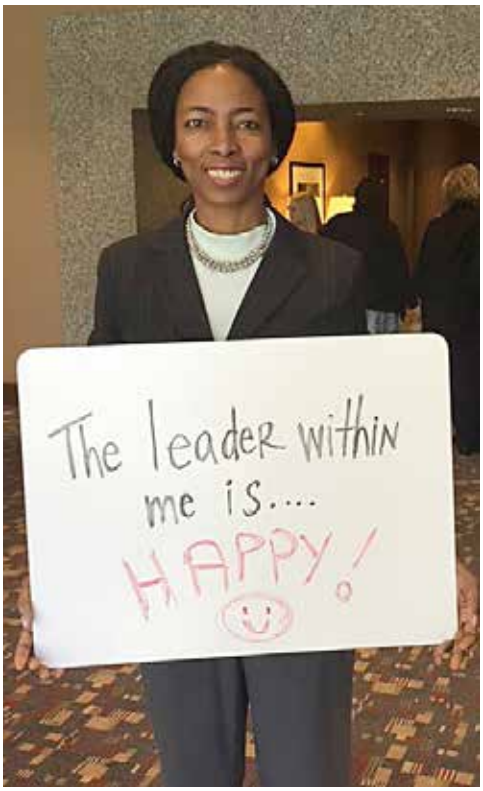
As family physicians- it is important that we shout from the rooftops and tell everyone and anyone our story! Of how we are able to do what we do on a daily basis in research, academics, administration or clinical settings (or a combination of these). We do it because we are passionate about our specialty and our patients and our communities. We do it because we know what needs to be done to truly reach the quadruple aim. We do it because we can.

Tell your story. Tell our story.

We've got this.

Tochi Iroku-Malize, MD, MPH, MBA

Tochi Iroku-Malize, MD, MPH, MBA, *is the inaugural chair of family medicine at Northwell Health and professor and chair of family medicine for the Donald and Barbara Zucker School of Medicine at Hofstra/ Northwell. She has been involved in numerous leadership capacities with NYSAFP and the AAFP since her residency years, serving as a past president of NYSAFP, and currently as the alternate delegate from New York to the national Congress. Dr. Iroku-Malize has worked for over the past three decades on clinical, research and academic initiatives to enhance health and equity for providers and patients across various communities locally, nationally and internationally, and has been active in advocacy work on behalf of the Academy in both Albany and DC for over a decade.*



Congratulations to 2018-2019 NYSAFP Board Officers and Members

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Letter to the *Editor*

To the Editor:

I am writing this letter in response to the Winter 2016 NYSAFP Family Doctor journal article "The Magic of Medicine: How Magical thinking influences Medical decision-Making." I was taken aback at reading Dr. Hanspal's article which in the first sentence equated CAM practices to quackery. As CAM practices have grown in popularity and acceptance over the past decades, there has been more research and funding available. Integrative medicine is now the preferred term for a medical approach that values and combines different perspectives. Fellowship training in this area is available and highly sought. In 2014, The American Board of Physician Specialties recognized integrative medicine as a legitimate board certification (ABOIM). Integrative medicine is now a recognized specialty just like cardiology, pulmonology and infectious disease. Academic medical centers are recognizing the need to study, embrace and teach complementary and alternative medicine. The Academic Consortium of Integrative Medicine and Health now includes more than 60 top medical schools in the country.

Equating CAM practices as quackery and as unscientific, is uninformed. To start, this statement shows that the author has not reviewed current research that is available, and is not aware of differences that arise when studying CAM modalities compared with traditional pharmacotherapy. In the current era of evidence based medicine, integrative medicine has not been left aside. In fact, one the focuses of integrative medicine is to use evidence based practices to broaden the depth of options and allow for shared decision making with patients.

Although there is a current flow of funding from NIH's NCCIH (National Center for Complementary and Integrative Health) to improve the research base available for integrative medicine, the pharmaceutical business is a billion dollar industry that has economic incentive for studying their products. It is unfair to compare studies done by pharmaceutical companies to those studies of other modalities for which no one is poised to earn billions of dollars for a successful treatment strategy.

Second, the author has missed basic understanding of study design. For example, if you try to study acupuncture in the same way as you do a medication, you encounter difficulty with creating placebos that are blinded. Sham acupuncture, often used as a placebo, can have some of its own effects on treatment, thus reducing the appearance of a difference in treatment outcome.

Finally, the author has clearly missed some extremely relevant and important research published by Kaptchuck and Miller who study the placebo effect.[1] Healing is complex and there is more and more information to suggest that social, environmental and other factors contribute to healing.[2] It is imperative that we understand the implications of placebo and nocebo effects on healing from both CAM modalities and medications as it affects the way we treat patients. The placebo is a complex effect that occurs from interplay of neurobiological and psychosocial factors and contributes to the healing property of the therapeutics.[1] The nocebo effect receives little attention but functions in the same way.[1] An example of the nocebo effect is when a patient may feel symptoms associated with a new medication after the prescriber has suggested that it may be a side effect.

By saying that anything beyond traditional allopathic approach only works because of "magical thinking," the author is discarding other philosophies and whole medical systems that have been in practice for thousands of years. I argue that minimizing the value of other approaches harms patients and promotes practices that we know are harmful such as overprescribing of opiates medications for pain. The current health care payment system is not set up for integrative medicine. While costly and poor evidence- based strategies such as back surgery and epidural steroid injections are covered by the majority of insurance companies, $80-$100 acupuncture sessions are not easily covered. The belief that integrative medicine is not real medicine preserves a huge disparity in access. Despite having reasonable evidence of effectiveness and safer/cheaper than traditional medical treatments, insurance companies consider these treatments inferior, and they are not covered. At the same time, those who have the income and are able to afford this care, do not have to go through the insurance and medical system to get the care they prefer. This creates two health care systems in this country: a health care system that is accessible only to those who can pay the fees for integrative approaches and those who have only access to what is offered by insurance companies.

I agree that regulation of supplements and CAM is a must. More research on homeopathy, acupuncture and other medical systems is also imperative, but it is important to start looking at new ways to study these therapies. Help from NIH's NCCIH is imperative but acceptance and open mindedness from within the medical community is crucial. Those who are missing out are the indigent community and they are the ones who often suffer from stress related and other chronic health issues that are better treated by integrative approaches.

Endnotes

1 Kaptchuck T and F Miller. Placebo Effects in Medicine. New England Journal of Medicine 2015; 373:8-9.
2 Jonas W. How Healing Works. 2018.

Elena Rosenbaum MD *is an Assistant Professor and Director of Integrative Medicine in the Department of Family and Community Medicine at Albany Medical College. She completed the HIP fellowship at Lawrence Family Medicine Residency in 2008 and is board certified in family medicine (ABFM) and integrative medicine (ABOIM).*

4th Annual Writing Contest Winning Entries

The Power of a Story

By Anthony Okolo, MD

"...He says his right arm and leg feel weak. Should we go to the hospital? Text me back soon"

Stories empower us. I learned this truth during the recent AAFP conference in Kansas City. As part of the national team for Primary Care Progress, we were tasked with coaching a cohort of Family Medicine Interest Groups on how they can strengthen their chapters through relational leadership and storytelling. I began by sharing the story of my parents.

When we first came to the United States in June 1996, the four of us moved into a one-bedroom apartment in Brooklyn, NY. My parents had won a lottery visa the year before, and made the decision to leave Nigeria to pursue the American dream. For my parents, my two-year-old sister and me, this was a time of uncertainty. I recall not seeing my father much during those initial years, as he worked three jobs during the week and that work often extended into the weekend. My mother also worked, and was usually available in the evenings to pick us up from a baby sitter and put us in our beds to sleep. In my memory, it was a time of sadness, as I often longed for times where the four of us could be together. It wasn't until many years later that I truly appreciated the sacrifice my parents made. I imagine how scared and alone they must have felt, navigating a strange environment far from the comfort of family and friends. I often attribute my drive to succeed to the realization that I must do right by my parents, and ensure their sacrifices for me were not in vain.

"Driving him to the hospital now, will keep you posted."

When my dad had the stroke in August 2016, I wasn't sure how to react. I had just finished taking a diagnostic test in preparation for my USMLE exam when the barrage of texts came to my phone. I could see that beyond the text messages, was the fear that had enveloped my family. I wanted to stop everything I was doing and travel home, and I would have if not for the strong resistance from my parents. Since I couldn't be there, I could only hope that the team of healthcare providers caring for him would treat him as their family. I prayed his providers would see him as more than years of poor eating habits and "a stroke waiting to happen." I desperately wanted them to see him as I saw him, a hero who spent years of his life working to make sure my sister and I never had cause to beg elsewhere. A hero who barely had time to take care of himself because he dedicated his time to ensuring his family would make it in this new environment. I wanted his providers to validate his struggles, and put his fears to rest with a plan forward. What I wanted more than anything, was for his providers to embody the very spirit of a family medicine physician.

For the family physician, stories are diagnostic and therapeutic. The man from Pakistan who drives his cab from sunset to sunrise to send money back home needs more than his cholesterol medication, as does the woman with chronic alcohol use who just lost a daughter to suicide a few years prior. To a family physician, a patient is more than their chief complaint; they are human beings with stories of trials and triumphs, faith and fears. They are loved ones who need others to see their stories without bias or judgement. To the specialist, the family physician is the storyteller and guardian. To the patient we are their friends, someone who has dedicated their career to be a listener and a healer, a companion through the journey of life.

When I finished telling the story of my parents to the FMIG cohort, I knew right then that I had made the right choice. I felt empowered, my story and my passion made clear. And when I looked at the rest of the audience, I was glad I wasn't the only one.

"The doctors say he will be discharged soon and we can go home. He's really determined to take better care of himself. Make sure you're also taking care of yourself and come home soon.

Love, Mom."

Anthony Okolo, MD *is a first year resident physician at Montefiore Medical Center. Prior to that, he was a student of the Sophie Davis School of Biomedical Education/ CUNY School of Medicine, where he started the Family Medicine Interest Group chapter. He has also been active in Primary Care Progress, and serves on the national team as a trainer and coach for interdisciplinary health teams. Anthony finished his clinical rotations at Albany Medical College, where he received his medical degree and was selected by his peers to join the Gold Humanism Honor Society. He looks forward to working with underserved communities in the Bronx, and will continue to do so after residency with the National Health Service Corp.*

The HeART of Medicine

By Umara Saleem, MD

I can't remember if Katherine was assigned to me; or if I assigned myself. I remember meeting her for the first time, with her son present, and feeling very flustered as I tried to wrap my head around all the issues she was presenting with. I was a first year and had that hour long visit with her, yet it didn't

Please enjoy three of our winning entries from our 2018 writing contest. First place: The Power of a Story, by Anthony Okolo, MD. Runners up: The HeART of Medicine, Mrs. COPD and Episodes – Now and Then (which will be featured in the fall issue of *Family Doctor*)

seem enough as I was trying to understand her and trying to solve her "problems" all at once. I remember the precepting attending pulling her chair away from the computer towards me, telling me to take a deep breath and saying, "Hey, let's address this part today and have her come back for the other things...these patients, you have to see more often and take it piece by piece."

I guess that fit, as Katherine was a new puzzle to me and I couldn't fully understand her. I laugh as I remember perhaps my first note on her. I think I had almost 10 bullet points in the chief complaint! I've gotten to know Katherine for three years, as a PGY3 now, with three years of different struggles. I still tell her, she's special to me as she was my very first patient.

I think how certain patients of mine, the ones with more serious health conditions, I know better than my own family. I don't know my own brother, who I grew up with for 33 years of my life now, as well as I know Katherine, or Jane who gets admitted every month. In fact at my residency program, I doubt anyone who trained here doesn't know Jane. And I think of and talk to these "patients" (should I call them "family" perhaps?) more often.

I think of medicine, how everyone that was premed in college said that they pursued this field because they wanted "to help people." That statement seemed all encompassing back then, but medicine turned out to be much more complex. A myriad of colors, in multiple dimensions – rainbow mixed media perhaps if you looked at it as an artist.

You see your patient, you get to learn everything about their history, not just medical history, but who they are and how they define themselves. You know them so well that you can see how your patient gets up every morning, what stresses she faces, how her blood pressure gets elevated, how she has her breakfast, walks over to her machine and measures it, then takes her medicine.

You see how the medicine works, how it enters her body though her mouth, gets processed in her stomach, enters her bloodstream through kidney or liver and vasodilates her blood vessels. Sometimes you can see and understand to the depth of the indefinite cell, the ever powerful nucleus and how the proteins get transcripted and carried out into the cytoplasm. You can almost hear the whoosh of the ion channels as the cell membranes contract and feel the flow of the current racing through. But you worry how the membranes in the kidney are reacting with that pressure gradient and how the bladder is accumulating proteins with their negative charges and you work up the safest plan in your mind for this patient's biology like a physics and mathematical equation...

Zoom back and see your patient breathe a sigh of relief as she looks at the numbers on the BP machine, sees a happy range for her, smiles, and continues through her day making a mental note that when she sees you next she's going to complain about her pills sending her to the bathroom so much.

That's medicine. Your patients become so profound, they present themselves to you like a canvas, where you are the painter that applies the healing art of medicine with your tools. Your hands are the paintbrushes that coat your patients. You can see their color come back as you treat them, but it's not just your patients who leave with an enriched life, bright and glowing. Look with your eyes and see your hands with splotches of paint that have streaked back onto you. You become the living breathing art that you practice, or are you the artist?

There is the art of medicine and there is the science of medicine. There are the patients that live and breathe with you, and there are the patients that took their first breath in your hands when they opened their eyes. There are those that breathed their last as you stood by their side, closed their eyes when you had to brokenheartedly pronounce them dead. Yours may be the first smile they see and yours may be the last tears thy feel.

There are the families that come back, in anticipation, of having more children, and there are the families you bond deeper with as you console them over a lost loved one that you had the privilege to know as they called you their "doctor." I went to the funeral of one of my recently established patients and I met her son in the office weeks later. I looked into his eyes and shared his sadness, then treated the heart he brought to me so it didn't develop the leaky valve that took his mother away from him. Our patients become the colors we see when we open our eyes in the morning and put our white coats on - our white canvas. They become the living breathing paintings on the wall, the heART that you call your life.

Umara Saleem, MD *is a third year resident in the Mid-Hudson Family Medicine Residency Program, which is part of The Institute for Family Health in NY. She is passionate about immigrant health, working with underserved populations, women's and pediatric health, and academic medicine. She enjoys time with her family, serving her community, patient advocacy, travel, and narrative medicine.*

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Mrs. COPD

By Ronald Dunphy, DO

Last year at the end of the summer on Rosh Hashanah I picked up the phone in my office and the voice at other end was a sobbing daughter of a ninety year woman I had known for the past year and a half, "My mother is lying in her bed. She can't breathe, smells of urine and the place is filthy. I don't know what to do. I can't take it anymore."

"Okay I will be right there." I answered. I put the phone down, packed my black bag and rode off in the late morning summer. There was very little traffic as I took my time under the overcast warm skies. When I pulled up into the driveway I saw the patient's daughter by the garage smoking a cigarette. She clutched the cigarette between her puffed up lips and exhaled a cloud of smoke as I turned off the car. A nice woman overwhelmed with life and her face dramatically altered by years of cosmetic surgeries. She had tears running down her face. The presence of alcohol was apparent. "I'll go inside." I mumbled while she stayed outside and continued smoking. The scene was exactly the way the daughter described it. Her frail thin body lying diagonally across the living room couch and her mouth was open gasping for air. She was nearly unconscious and didn't respond to my entrance. The nasal cannula was falling crookedly off her face. Her open mouth and tongue were parched. She was dying before me. I didn't know what to do.

I ran out and asked, "What happened to hospice?"

"They wouldn't take her. They said she needed to see a psychiatrist", she responded with her frozen stare.

When I spoke with hospice several weeks earlier, they took her name and said that they would access her records from her hospital stay and her subsequent placement in a short term nursing facility to help her recover from a hip repair caused by a fall at home. They never got back to me and I didn't follow up with the daughter to find out the results of my referral. When I visited her a month ago after she had been discharged from the facility she didn't look well. She was oxygen dependent, barely able to walk and almost completely deaf. She had end stage COPD and was also showing signs of cognitive decline. She had wanted to leave the skilled facility to go home and be with her dog, but she couldn't care for herself or the dog.

Her daughter had called me all summer for advice. After the patient had her hip repaired she was transferred to the skilled rehabilitation facility. It sounded as if they were trying to convince the patient and the daughter that she need permanent placement in a nursing home. She was not interested in doing so. I never spoke with social work or any other professional at the nursing facility. I was never really sure of the patient's condition or the facility's recommendations.

I called hospice and demanded an explanation. They knew I was angry. Eventually someone familiar with case got on the phone and said that they were sorry and really didn't have an explanation as to what occurred with the referral. I realized I was wasting time and rushed them off the phone. They were of no help and this poor woman was fading quickly. I then called the other hospice agency that I referred patients to and asked them to help me. I explained to a very sympathetic nurse that the patient was dying.

"Does she have a DNR?" she asked with a whisper.

"No", I answered realizing that of course she needed that ridiculous piece of paper stuck to her refrigerator with an old magnet to help ward off futile attempts at resuscitation. She explained it was necessary. I quickly spoke to the daughter and she agreed to a DNR. I thanked the nurse and tried to figure out how to get the official New York state DNR order. I didn't have time to run to my office and print one out and return with it. I looked over at the Catholic Church that was right there across this very narrow street. The street the patient lived on was almost an alley behind that church. Her house was in its shadow.

I picked up my black bag and brought it with me to convince the people inside the rectory that I really was a physician. I knocked on the door, which was only about 100 feet from my patient's house and was let in immediately.

"I am a doctor and I need your help. The lady across the street is dying and I need your computer to print out a DNR order. I don't want to call an ambulance."

The woman behind the desk looked up and rolled away from her computer.

"It's all yours."

I thanked her and told them what was happening as I easily downloaded the DNR order from her computer and printed it. I couldn't believe I was able to get the help I needed so quickly.

"I know that lady. We used to wave to each other when I was outside having a cigarette," said her co- worker with sadness.

I left with paper in hand and ran across the street with excitement. I was happy to have the document that would allow this poor lady to be left alone and die in peace. I had no medicines around to relieve her suffering but at least I could bring some comfort by letting her pass quietly in her own home. I spent more time during the visit organizing her care than actually providing it. I don't think I even touched her or examined her with my stethoscope. I looked at the old paneled walls behind the patient and saw these wonderful charcoal drawings of her that were done when she was probably well into her sixties or seventies. They revealed her frail beauty. She was a petite woman with large blue eyes.

I told her daughter to call the police when she passes away and that they would call me to confirm that I was her physician and discuss the case with them. She understood and thanked me. Her face showed little expression. I asked her if her mother would want a priest to visit. She looked at me and rolled her eyes, "No."

I drove away in the fading summer morning. I thought of our previous visits over the past year. I had been to the house only three or four times. Our first visit was with her daughter present. My patient was wearing oxygen and had to count out "One, two, three," as she walked across the cluttered living room from the bed to her chair. She would be gasping for air as she reached the table and would count over and over in a whisper until she was able to reach it. She regained her ability to speak only after a few minutes rest, and showed me her medicines by pouring the pills into her shaking hand. The next visit she seemed better, and was able to sing the song, "Laura" with the oxygen tubing dangling in her hands. Her dog's name was Laura. Her kitchen table was covered with boxes of prepared food from the local Meals on Wheels programs.

I didn't hear from her for another six or seven months. She had improved a little and was able to care for herself. I helped remove the oxygen equipment from the house as her daughter had left for a while to visit Turkey and buy a new dog. At the beginning of summer, her daughter called me to tell me her mother was in the hospital with a fractured hip and worsening COPD.

The police called me at the office about an hour later. The officer's soft spoken voice expressed remorse. I thanked him for the call and agreed to sign the death certificate.

Ronald Dunphy, DO *completed his residency in 1995 at Southside Hospital in Bay Shore, NY. He enjoys being a physician in private practice and takes great pride in providing the local community with house call services. He no longer cares for his patients in the hospital but he provides continuing care to all of his patients to the best of his ability.*

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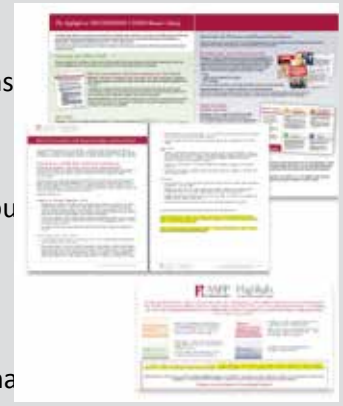
Highlight on VACCINATIONS 4 TEENS

Features a robust Resource Library of materials for family physician offices, including:



- **Back-of-office materials**
  - – Q&A to address questions from teen patients and parents/guardians
  - – Three educational videos from Dr. Margot Savoy, MD, MPH, FAAFP and AAFP liaison to ACIP, on:
    - The value of the immunization platforms and making the most ou of the 11-12 and 16-year-old visits
    - Tips for using the schedule
    - Standing orders and activating staff as champions
  - – Links to other educational videos on meningococcal and HPV vaccina
  - – A fact sheet on the importance of addressing under-vaccination

- **Front-of-office materials**
  - – Reminder communications for parents/guardians
    - Letters/emails
    - Postcards
    - Text messages
  - – Teen vaccination overview poster/handout
  - – Template digital and social media content directed to teens and parents/guard ians

Visit www.aafpfoundation.org/vaccinations4teens to download these resources.