Family Doctor

A Journal of the New York State Academy of Family Physicians

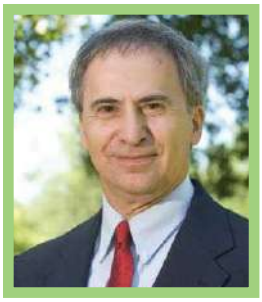
New York State Academy of Family Physicians

Fall 2024
Volume thirteen, Number two

Focus:

Doctor-to-Doctor Advice

FEATURE ARTICLES:



From the Executive Vice President

By Vito Grasso, MPA, CAE

We lost a great Academy leader, colleague and friend on July 6th when Jim Mumford passed away after a long and valiant struggle with pancreatic cancer.

Jim was a longstanding member of the Academy. His service since 2006 in a variety of leadership roles with NYSAFP and the AAFP was a testament to his personal commitment to his profession and to the many friends and colleagues he became connected with throughout his career.

I had the privilege of knowing and working with Jim for close to 20 years.

In his remarks to our Congress upon completion of his presidency, Jim displayed two of the many remarkable elements of his character. He entertained us with his customary good humor. And he also addressed with candor and sensitivity the personal health crisis he experienced.

He acknowledged and thanked his wife, Sarah, for her love and support during his long battle with cancer. My daughter was diagnosed with neurofibromatosis-2 in 2010. I know something of the burden it is to witness a loved one deal with serious illness. Sarah's love and support helped sustain his own courage and determination in fighting back against his disease. Together, they made his final years fulfilling.

Jim's diagnosis occurred at the beginning of his term as president. It also coincided with COVID. We all have challenges to face and burdens to bear in our personal lives and COVID certainly made those challenges larger and those burdens heavier. Jim carried on with exemplary grace, dignity and good humor even as the personal tribulation of serious illness cast a shadow over his year as president. But that shadow did not deter him, nor did it erode his essential character. It was a personal pleasure to work closely with him, to travel with him when the awful cloud of COVID began to recede and to celebrate with him the great moments he has made for the Academy, for his family, for his legacy and for everyone he has inspired.

Jim was a wonderful person, friend, and colleague. He mentored many students, residents and young physicians and his contributions to family medicine will endure for many years in the conduct and commitment of those physicians whose lives he touched and whose careers have been influenced by his example.

As for me, I will always recall Jim with the greatest affection, admiration and gratitude for the partnership we had and the work we accomplished together.

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President's Post

By Rachelle Brilliant, DO, FAAFP

This issue of *Family Doctor* focuses on a unique topic, advice from one doctor to another on a range of subjects many of us face at some point in our careers. Topics include burnout, sleep hygiene, imposter syndrome, mentorship, fertility and parenting as a physician. Even if you don't personally face one of these issues, we all know a colleague that is dealing with them.

Medicine can be isolating. Very often there are only two people in the exam room, you and your patient. More family physicians work as employed physicians than ever before. Even in these large groups, however, we are often in separate small offices with just a couple of other physicians. Having a group of colleagues that you can run ideas by or "curb-side consult" is an important component of my NYSAFP experience. This issue on doctor-to-doctor advice provides a small glimpse at the community our Academy can provide for its members.

The diversity of our membership has always been our strength. We hear from all categories of our membership including medical students, residents, and new physicians, to mid and late career physicians. Our Vice President, Wayne Strouse, discusses his direct primary care practice and our Past Present, Phil Kaplan, dispenses pearls of wisdom from his many years of practice.

NYSAFP is a community of people that provides friendship and mentorship, to remind us that we are never alone. Please reach out and get involved with your fellow family physicians. Join us for Lobby Day in Albany on February 24th. Consider applying next spring for a NYSAFP commission or to be delegate to NCCL in April in Kansas City. If you are not sure how you would like to get involved email me (rachellebrilliant@yahoo.com) or any other board member about how to get started.

NYSAFP is a community of people that provides friendship and mentorship, to remind us that we are never alone.

From the Editors:

This issue of the Journal is devoted to giving voice to the personal side of our practice of medicine. The emotional side that is so important for our wellbeing; the issues and challenges that can invigorate us and the ones that can burn us out.

We family physicians choose extremely diverse modes in which to practice. The NYSAFP recognizes this and through its advocacy with government and agencies, its educational programs, and this journal we seek to affirm and support our members' goals and aspirations and emotional health.

In this issue is an article on direct primary care (DPC). Dr. Wayne Strouse details how his shift from conventional practice to DPC enabled him to find increased joy in practice and energy to practice longer. Other articles will speak about coping strategies, our successes, and (yes) our shortcomings in the practice of medicine. They speak to the pearls we have gathered post residency as we practiced our craft, and how those pearls have stood us in good stead.

Truly the practice of medicine necessarily enrolls us in the "school of hard knocks." This issue of *Family Doctor* is a partial primer.

Bill Klepack

Reflections of a Grateful Family Doc

By Richard Mittereder, MD

Looking backwards, since I retired somewhat reluctantly from active practice at age 70, I have gleaned a few pearls from my archive of experiences as a family doctor who specialized in geriatrics in the latter half of my career. My retirement was suddenly decided for me by the tragic diagnosis of glioblastoma in my oldest son. Eric was 37 when he suffered a generalized seizure and subsequent brain scanning in the ER revealed the above horrific diagnosis. Eric had called me the day after he suffered the seizure and wanted me at his side. On the plane ride out to Chicago, I realized then and there that my medical practice was now going to be for a patient of one.

Long story short, Eric died after a 15-month valiant battle, ending with his poor head resting on mine as he gave up the fight in hospice at his home overlooking the Oakland hills of Northern California. I was at his side through it all as caregiver, medical advisor and Dad.

With that sobering thought in mind, here are some pieces of advice that I offer to young family docs just starting out:

1. **Remember, no matter what they have come in for, always touch the patient**

   In my 40+ years of doctoring, I have found this invaluable in almost every case. Folks need to feel that you care about them—the human touch is just as important as the stethoscope!

   More than once, my role in the exam room was to be a doc who listened and genuinely touched my patient, albeit professionally, but with sincerity. We too often underestimate the power of touching another. Also, this 'physical exam' aspect of the clinical encounter verifies for the patient, in their mind, that you have been thorough in making your assessment of their condition.

2. **Approach and address every person with respect**

   Early on in my first job in an urgent care clinic, an African-American physician gently pulled me aside when he noted that I had called the client by his first name. Although I stated that I had been trying to be friendly and reassuring, my colleague corrected me to adopt a more formal tone of respect. I never forgot this advice and it has provided many a patient with the sense of dignity which we all appreciate. And, some of my most challenging cases involved people who just needed to feel that the doctor was taking them seriously with respect.

3. **If possible, given the clinical situation, try to sit down across from the patient at some point in the encounter, not just facing the computer for documenting**

   I have found many times this puts people quickly at ease, more cooperative with your questions and more likely to be compliant with your instructions for care of whatever it is that brought them in to see a health care professional. Some of the many after-visit surveys of my care completed by patients have remarked on the importance of this...i.e. "he didn't just spend our time stuck on the computer".

4. **The simpler the care plan for the patient to go home with, the better...and most probable to be completed per your directions**

   Granted, we all have learned of the need to document well for getting our visit covered by insurance, but being succinct and clear in our discharge-to-home instructions is the real reason for our being there as physicians caring for people.

5. **A corollary of this that is taught to all geriatricians is to take away a med, if possible, when you're going to prescribe another. Use the fewest possible number of medications and the simplest possible dosing regimen**[1]

   Many studies have revealed that compliance drops as the number of meds and complexity of prescription increases.

   Some axioms that I did not learn/practice well enough in my decades-long career include:

6. **Seek balance in your life, allowing time for R & R with family and friends**

   This includes taking vacations or at least some time away from work. Otherwise, burn-out will likely happen and be manifested in ways that you may not have foreseen. No matter how passionate one is about their medical vocation, we have all experienced fatigue from too much patient demand. I was trained in the 'old days' (1970's-80's) when interns and residents were indoctrinated that we needed to demonstrate greater stamina than most of our non-health care peers. Fortunately, the hours have now been adjusted by law.

   Furthermore, practicing family medicine competently and responsibly includes a holistic approach that allows for the doctor to also be aware of costs, but not driven to distraction by the payers such that the patient's optimal care is compromised. Despite my best efforts, "efficiencies" of care got in between me and the patient at times. In looking back, I regret that.

7. **My last piece of advice is to try to take time at least once a week to look back and be grateful for the chance to have done this noble work for others**

   I loved my health care work and feel blessed to have been given the chance to fulfill my passion to help others using the unique medical skills, taught and learned in 40+ years of family doctoring. By allowing oneself to step back and reflect on some of the thoughts expressed above, my sincere hope is that a future generation of family medicine docs will find the path as fulfilling in providing primary care medical service for others as I have.

Endnote

1. Polypharmacy Stat pearls by Dona Varghese; Cecilia Ishida; Preeti Patel; Hayas Haseer Koya. https://www.ncbi.nlm.nih.gov/books/NBK532953/

Richard Mittereder, MD, FAAFP *recently retired from active practice. After completing medical school at the University of Pittsburgh, and a family medicine internship/residency at UCLA, his career began with Kaiser Permanente in Southern California during the 1980s-90s as a staff family physician. Dr. Mittereder further certified in geriatrics in 1990 and moved with his family to Rochester, NY for private practice for the Rochester Regional Multi-specialty Medical Group where he became the Chief of Family Medicine and Geriatrics. He retired from this position in 2017, and moved to Chicago where he worked part-time in emergency/urgent care and telehealth settings until his son's illness in late 2022. Dr. Mittereder remains licensed and board certified in New York.*

To the Editor:

I have long been aware of the power and effectiveness of NYSAFP to improve the practice environment for our members and their patients, but until now I had not experienced tangible immediate personal benefit, and in fact I would feel vaguely guilty if I reaped such benefit as a reward for prior service as chair of the advocacy commission, or as president of NYSAFP. To avoid the appearance of conflict of interest I have been fastidious in turning over any apparent compensation for service to the NYSAFP Foundation.

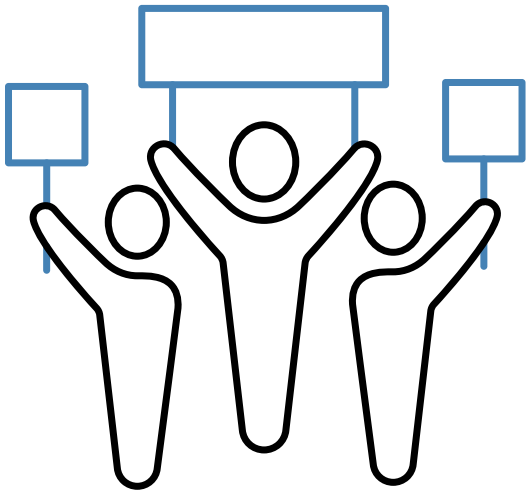
Then along came three crises that threatened the existence of my practice:

1. Change Health Care was hacked on February 18th and cash flows ceased.
2. Our largest local insurer was paying me $25 less for Bexsero than my cost for the vaccine.
3. I couldn't purchase Beyfortus for our newborns, making family medicine a poor choice for infant care in our local community. And a local pediatrician whose kids I had immunized when I had covid vaccine early in the pandemic would not return the favor.

In each of these predicaments I reached out to the NYSAFP. I did this without guilt because the help I received is available to any member of our Academy, and I share these stories to be sure our members are aware of the tangible immediate personal help available.

1. I reasoned that the insurers had collected the premiums and were not paying my fees. They were profiting while I was starving. Upon my request NYSAFP approached the DFS (state insurance department) which in turn made a "request" to my large local insurer, which in turn was enthusiastic about providing a no interest loan against future payments. And when the due date arrived and I was not yet able to repay, I was given an extension. This was not because I or my small private practice had influence, but because NYSAFP has standing.
2. I eventually was told by a colleague that my price problem with Beyfortus was because I was ordering it from Sanofi rather than GSK. I had expected that the convenience of ordering all vaccines from a single vendor/monthly invoice would cost a few bucks, but the price difference was about $1100. Not only did I get an affordable price from GSK, but NYSAFP, through Atlantic Health Partners (a purchasing consortium which is a benefit of membership) arranged that I received a sizable rebate for my prior purchase of this vaccine.
3. I did not preorder Beyfortus for this season as I expected that Abrysvo given to pregnant women would make this product obsolete. Then my first newborn of the late summer arrived and mom had not received Abrysvo. The OB office said "we don't stock it, we send them to the pharmacy." Mom is the opposite of an antivaxxer and I feel an obligation to reward her perspective. While a family medicine colleague has offered to share his supply, a better solution is pending. Atlantic Health Partners via NYSAFP has committed to freeing up a small supply for me.

In each of these instances the collective power for advocacy residing in NYSAFP is demonstrated. This power is available to any member. We are not helpless victims. To obtain solutions for your problems, to reap the rewards of membership, send a note to fp@nysafp.



Philip Kaplan, MD, FAAFP
Past President
Perpetual member

An Advisor Conversation

By Dan Young, MD and Aaron Bridgemohan, MD

It's late July when Aaron, 2nd year resident, sits down to meet with his advisor Dr. Y.

Dr. Y: Hi, Aaron, thanks for meeting with me. How's it going being a senior resident?

Aaron: Well it's only been a month but I experienced a lot over the first year and for the first time I am noticing how far I've come. I'm looking forward to new learning opportunities during the second year.

Dr. Y: What were your challenges during first year?

Aaron: Inpatient rotations were difficult. I definitely enjoyed the pace of outpatient more. One of the challenges of my first-year schedule was having a big portion of inpatient all at the end. While it was tiresome, I noticed the autonomy I've gained compared to when I first started.

Dr. Y: I understand, inpatient is not my favorite either but it's good to know that you can find positions that are outpatient only when you finish. But how do you feel you'll handle being a senior on inpatient service this year?

Aaron: I developed a system that worked for me so I'm going to show them my system and see how it works.

Dr. Y: Not everyone will want to use your system.

Aaron: I guess I'll have to be flexible and guide them to finding a system that works for them. This is a new situation for me. I've led some groups in undergrad and I have 2 younger brothers but I've never really been a supervisor before.

Dr. Y: The program director does a session on being an inpatient senior. Did you get ideas from that?

Aaron: I think I missed that session because I was on night float. I'll contact her to set up a meeting.

Dr. Y: Did you find some strength areas that you could lean on?

Aaron: I tend to break down my day into goals. When on inpatient I try to see what barriers might be holding a patient back from discharge and try to prioritize items. My seniors were great at helping me develop those skills. So, in terms of strengths, I guess it's keeping organized but also listening to patient needs and building rapport.

Dr. Y: It's always a good idea to build on your strengths but also improve your weaknesses. That reminds me, I got a copy of your individual learning plan from the program director. Do you want to talk about some of the goals you developed with her?

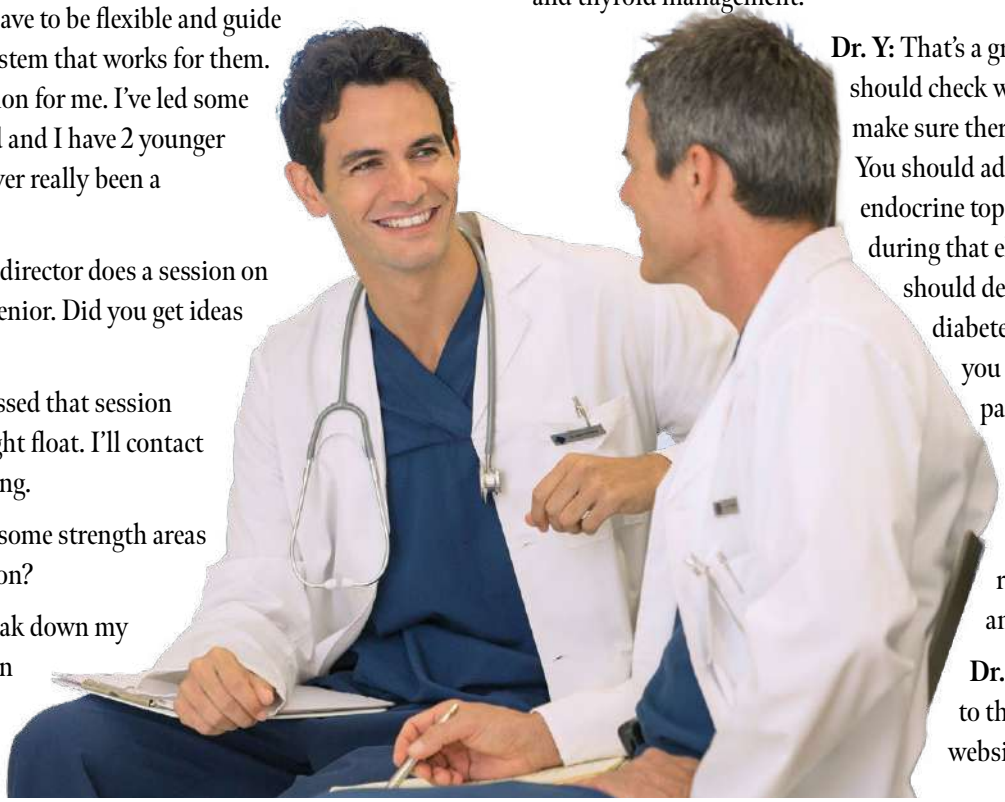
Aaron: I thought about myself in a future practice and what I would struggle with if I were there now. I'd like to do MSK related injections in my practice, so I set one of my goals toward becoming more proficient in that area. I'd like to revisit this topic at our next meeting to see how I'm progressing towards my goals.

Dr. Y: We can keep revisiting these goals throughout the year. Do you have any concerns about upcoming rotations?

Aaron: Really, it's just the inpatient block that I'm worried about but that's not until October.

Dr. Y: I think you should talk with your classmates about how they are handling inpatient senior duties and then we should meet again before that block. What are your plans for your elective blocks?

Aaron: I want to do endocrine. I'm hoping to learn better diabetes and thyroid management.



Dr. Y: That's a great choice. You should check with their office to make sure there is availability. You should add a few more endocrine topics to learn about during that elective and you should definitely sit in on a diabetes education class, so you know what your patients are learning.

Aaron: What resources or learning goals do you recommend I use for an endocrine elective?

Dr. Y: I think going to the AAFP journal website and looking under

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endocrine for all their topics. You can also ask Dr. W at the endocrine office what he recommends. What about your other elective block?

Aaron: I'm still giving it some thought but I heard that I can also split my month into two-week electives.

Dr. Y: Yes, you can split it. Send me an email with which 2-week electives you're thinking of and we can talk. I know that you were thinking about outpatient only practice. Is that still your plan?

Aaron: Yes, definitely outpatient medicine.

Dr. Y: For outpatient there is the typical primary care office but there's also walk-in and school-based care. Have you thought about nursing home jobs?

Aaron: I think I just want an office practice. But I hadn't thought about nursing homes. Is there someone I could talk to about that?

Dr. Y: Sure, I can put you in touch with a couple of local doctors that see nursing home patients. Since you want outpatient, how are you coming along with your office procedure skills?

Aaron: I'm looking forward to gyn rotation so I can get more women's health skills and sports medicine rotation so I can do more injections. Is there any way to get more outpatient surgery experience?

Dr. Y: You should look at doing more procedures during your office hours and some rotations have flexibility so contact Dr. A at the surgery office to set up some half days with him. We are almost out of time; we have talked a lot about work but what are you doing for your well-being goals?

Aaron: In my second year I want to focus more on my health. I've been trying to go on more hikes. I know you have quite the list of places nearby, maybe you could share some of the local hiking spots with us.

Dr. Y: I'll send you a list or we could set up a date to go on a group hike with other residents.

In conclusion, the advisor serves as a mentor, guide and coach. The advisor is in a position to help the resident reach their fullest potential as a physician. If you serve as a student or resident advisor, I recommend reading the "Coaching in Medical Education : A Faculty Handbook" by the American Medical Association.

***Dan Young, MD** is Associate Program Director at UHS Wilson Hospital Family Residency Program. He also serves on the American Medical Associations Council on Medical Education.*

***Aaron Bridgemohan, MD** is a second- year resident at UHS Wilson Hospital Family Residency Program.*

Upcoming Events

2024

Nov. 3
Fall Cluster
Virtual Board Meeting
Commission meetings virtual prior

2025

Jan. 23-26, 2025
Winter Weekend
Lake Placid

Feb. 23, 2025
Winter Cluster

Feb. 24, 2025
Advocacy Day

May 10, 2025
Congress of Delegates Opening Day

May 17-18, 2025
Congress of Delegates Reconvenes

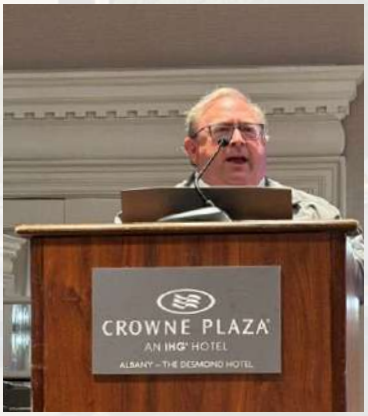
For updates or registration information for these events go to www.nysafp.org

Albany Report

By Reid, McNally & Savage

The New York State Legislature adjourned the 2024 session on June 8th with over 800 individual bills passed by both houses out of approximately 17,000 bills introduced since session started in January. At this point, many bills still await action by Governor Hochul before the end of the year. However, with no agreement reached after the Governor's last minute-decision to halt the MTA's congestion pricing program for Manhattan, and the MTA's capital program facing significant funding issues, the Governor may call the Legislature back for a "special session" to approve a replacement plan. Focus is on both congressional and state races though, with general elections less than 50 days away on November 5th, and state republicans hoping to chip away at the democrats' supermajorities in the State Senate and Assembly. Absent a call for a special session, legislators won't return to Albany again until January, 2025, when the next session begins.

Below we have provided a summary of ongoing advocacy efforts and priorities that we will continue to work with NYSAFP to address in the coming session, followed by the status of health-related bills that passed both houses and await action by Governor Hochul, as well as a New York State election update.



NYS Health Commissioner Dr. James McDonald addressed NYSAFP Members/Delegates at the Congress of Delegates in Albany on May 18, 2024- featured with Immediate-Past President Dr. Heather Paladine

Wrongful Death Bill: Despite strong opposition from NYSAFP, partners in medicine as well as hospitals, insurers and others, an amended version of the "wrongful death" bill, vetoed twice now by Governor Hochul, was reintroduced and passed by the Legislature in the final days of the session. We have already sent the Governor a NYSAFP letter asking her to again veto the bill and are working in coalition with MSSNY, other specialty societies, and others to register strong opposition. We expect to launch a grassroots campaign this fall to encourage Academy members to reach out to the Governor urging her rejection of this legislation. Our efforts will continue to ramp up as the end of 2024 approaches as Governor Hochul likely won't request this contentious bill to come before her until then.

Reproductive Health Funding: $1 million was included in the final state budget this year and it has been broadly allocated towards abortion access specific to services in New York State. RMS has been working

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with NYSAFP leadership and members to meet with key legislators, agency staff, and the Governor's staff to seek funding to go toward interested family medicine training programs and support for medication abortion care provided pursuant to New York's 2023 shield law. We recently met with Senator Krueger and Assemblymember Epstein for a planning/strategy meeting with various stakeholders for their bill, S.3060-B/A.3279-C, which would establish a reproductive health services training program fund. We also had a productive meeting with Senator Hinchey in which she pledged her support for prioritizing these areas for state funding. We will continue advocating to set up a strong foundation for this funding as the Governor prepares her Executive Budget this fall, and ahead of the Academy's annual Advocacy Day on February 24, 2025.

Medical Aid in Dying: NYSAFP has been supporting legislation to authorize medical aid in dying in NYS for several years and was active again this session discussing the bill with legislators as well as participating in public relations activities in support. The bill got closer than ever to passing in its 9-year history and with support indicated in the Assembly by Speaker Carl Heastie. We have met with the New York Alliance for Medical Aid in Dying to share and coordinate advocacy efforts and will work with them in 2025 to move the bill forward.

Vaccine Advocacy: NYSAFP and RMS continue to lead a vaccine coalition in New York to help support education and advocacy around immunizations for children and adults. We are continuing to grow both the partners and funding for this important effort as we move into year 4 of this campaign in 2025. Further, during the legislative session this year, the American Cancer Society Cancer Action Network held a lobby day and included advocacy in support of legislation to require adult vaccine reporting to the State Immunization Registry which is strongly supported by NYSAFP. The Academy also continues to advocate for the public purchase of all vaccines with NYS to ensure access and treat vaccines as the public good they are.

Preceptor Tax Credit: The Academy has supported legislation to establish a personal income tax credit for clinicians who provide preceptor instruction to students, S.2067/A.2230, for many years. The bill was passed by the Senate this session and it will again serve as an Academy priority for 2025 to support family practice in New York. Dr. Brilliant recently sent letters developed by RMS to every medical school dean in New York asking for their help in building support for this legislation and we have scheduled meetings with some of the deans this fall to further discuss these efforts.

Insurance & Payment Reforms: We are continuing to pursue greater investments in primary care by supporting legislation to require a minimum investment of the health care spend in the State for primary care. We also continue to advocate for insurance simplification and reforms to remove insurance barriers to access to care and time consuming processes imposed on physician practices. We have also worked to support increased funding for primary care recruitment and retention efforts, as well as improvements in how the Doctors Across NY program operates to support private practices and a better and more timely approval/award process for eligible physicians. These efforts will continue in 2025.

Bills Passed by Both Houses in 2024, of Interest to NYSAFP

Following find specific legislation that we have acted on as well as bills that have been acted on by the Governor.

Hospital Flu Vaccines for Admitted Persons Age 50+ (A9886, Peoples-Stokes/ S9550, Skoufis)

This bill amends the public health law to lower the age requirement for hospitals to offer inpatients the influenza vaccine from age 65 to age 50. NYSAFP joined with a number of organizations and sent a joint sign-on letter to the Governor urging her to sign this legislation into law before the end of the year. We also noted the importance of having all adult vaccines reported to the State/NYC vaccine registries to avoid duplication.

Health Care Proxy (A7872-A, Paulin/ S8632-A, Hoylman-Sigal)

This bill would require a patient's attending health care practitioner to counsel a patient receiving palliative care about the benefits of completing a health care proxy and appointing a health care agent. We are working to gain confirmation from the State that medical residents would be included within the health care practitioner definition. We have sent a letter to the Governor, NYSDOH, and NYSED seeking clarification and explaining the negative effects this requirement would have on patient flow and medical residents' relationships with their patients if residents are not included.

HIV Testing (A8475, Paulin/ S7809, Hoylman-Sigal)

This bill would expand the means allowed for providing the required notice that an HIV-related test will be performed to include verbally, in writing, or by electronic means or other appropriate form of communication. The notice must also include the information that HIV testing is voluntary and a notice that pre-and post-exposure prophylaxis medications (PrEP and PEP) are available to persons at risk of infection. ***This bill was signed into law 6/28/24, chapter 125 of the laws of 2024 and took effect immediately.***

Physician Assistants as PCPs under Medicaid Managed Care (S2124, Rivera/ A7725, Paulin)

This bill would authorize physician assistants (PAs) to serve as primary care providers (PCPs) under Medicaid Managed Care. We have already sent the Governor a letter explaining our concerns with this legislation including the confusion it may cause related to roles

and practice standards. The bill does not change the scope of PAs or practice standards, and the lower standard of care this change could lead to. We again asked the Governor to veto the bill.

Physician Assistant Expanded Practice (S9038-A, May/ A8378-A, Paulin)

This bill would:

- Expand the ratio of PAs that a physician can supervise to 6:1 in private practice and 8:1 in Department of Corrections and Community Supervision (DOCCS) facilities;
- Authorize PAs to prescribe or issue a non-patient specific standing order to registered professional nurses for immunizations, emergency anaphylaxis, PPD or other TB tests, HIV testing, hepatitis C testing, naloxone or similar for opioid overdose, syphilis, gonorrhea and chlamydia screening, EKG tests, point of care glucose testing, administering tests/IV lines to persons with sepsis/septic shock, pregnancy tests and COVID-19 and flu tests;
- State that a PA employed/privileged by a hospital may write medical orders for DME under supervision of a physician; and
- The provision allowing PAs to issue standing orders to nurses for COVID-19/flu testing would expire 7/1/26.

While we were actively opposing this bill during session this year as it would have allowed PAs to practice independently, the bill was amended last-minute and now would maintain current PA supervision requirements. We are currently working on a media advocacy effort, including letters to the editor and an op-ed from the perspective of family physicians to be published by different media outlets across the state, to continue stressing the importance of physician-led care ahead of session in 2025.

Wrongful Death Expansion (A9232-B, Weinstein/ S8485-B, Hoylman-Sigal)

This bill would expand the possible damages in a wrongful death action to include compensation for grief or anguish, the loss of services, support, assistance, and loss or diminishment of inheritance, and the loss of nurture, guidance, counsel, advice, training, companionship and education resulting from the decedent's death. Limits those eligible to file for wrongful death to a decedent's spouse, domestic partner, distributees, or any person standing in loco parentis to the decedent. As mentioned previously, we have already sent the Governor a letter urging her to veto this legislation and are working in tandem with MSSNY and other groups to show strong opposition.

Permit Mobile Ambulance Services to Initiate Blood Transfusions (A5789-A, Woerner/ S6226-A, Hinchey)

This bill would amend the public health law to permit ambulance services and advanced life support first response services that provide transportation by motor vehicle to store/distribute blood and initiate/administer blood transfusions, as is currently authorized for ambulance services that provide transportation by aircraft. ***This bill was signed into law 9/17/24, chapter 316 of the laws of 2024 and took effect immediately.***

Written Notice of Adverse Determination to Step Therapy Override Request (A8501, McDonald/ S8038, Breslin)

This bill would require written notice of an adverse determination made by a utilization review agent in relation to a step therapy protocol override determination which includes the clinical review criteria relied upon to make such determination to enhance this process for all entities involved and accountable. ***This bill was signed into law 2/7/24, chapter 28 of the laws of 2024 and took effect immediately.***

Prohibits Discrimination for PrEP Use (A8834-B, Weprin/ S8144, Breslin)

This bill would prohibit discrimination against individuals who were prescribed PrEP medication for HIV prevention with respect to life, accident, and health insurance coverage. ***This bill was signed into law 6/28/24, chapter 126 of the laws of 2024 and took effect immediately.***

HIV Treatment Access (S1001-A, Hoylman-Sigal/ A1619-A, Rosenthal)

This bill would prohibit state regulated commercial health insurance policies that provide coverage for antiretroviral prescription drugs prescribed for the treatment or prevention of the human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) from subjecting such drugs to prior authorization. ***This bill was signed into law 6/28/24, chapter 152 of the laws of 2024 and takes effect after 180 days on 12/25/24.***

Medicaid Ambulance Services (S 8486-C, Hinchey/ A9102-C, Kelles)

This bill would authorize Medicaid reimbursement to emergency medical service agencies for:

- providing emergency medical care to Medicaid enrollees without requiring the transportation of these patients from the location where the medical care was administered; and
- providing emergency medical care to Medicaid enrollees and transporting them to alternative destinations (locations other than a hospital), such as an urgent care clinic or mental health or rehabilitation facility.

This bill was signed into law 9/17/24, chapter 317 of the laws of 2024 and will take effect on 10/1/24.

Coverage for Tattooing Performed During Breast Reconstruction Surgery (A5729-A, Paulin/ S6146-A, Cleare)

This bill would amend the insurance law to require commercial insurance coverage for tattooing of the nipple-areolar complex as part of breast reconstruction surgery, if such tattooing is performed by a licensed physician or other licensed or certified health care

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practitioner. ***This bill was signed into law 8/26/24, chapter 228 of the laws of 2024 and takes effect on January 1, 2025.***

PrEP Copayments (S9842 Hoylman-Sigal/ A10461 Simone)

This bill would prohibit insurers from requiring copayments for PrEP if it has in effect a rating of 'A' or 'B' in the current recommendations of the U.S. Preventive Services Task Force. ***This bill was signed into law on 6/28/24, chapter 180 of the laws of 2024 and takes effect immediately.***

2024 New York State Election Update

All 213 state legislators are up for election this November and several lawmakers have announced departures or retirement from office. Republicans are hoping to continue the trend from 2022 of flipping seats. Considering Democrats only have 101 members in the Assembly, the smallest majority the party has had in years, losing just three seats would cost the Democrats their supermajority. Below we have listed open seats and some NYS races to watch as November 5th closes in; to find more details, please click here. We will provide a comprehensive election update after the general election noting where there will be new state legislators in both houses when the session begins again in 2025.

Competitive Races for November 5 General Election

(*asterisk indicates open seat)

NYS Senate

District 7
Long Island, north shore from Great Neck to Laurel Hollow
Candidates: Incumbent Jack Martins (R, CON), Kim Keiserman (D)

District 17
Brooklyn, including parts of Bay Ridge, Dyker Heights and Bensonhurst
Candidates: Incumbent Iwen Chu (D, WFP), Stephen Chan (R, CON)

District 38
Hudson Valley, including most of Rockland County
Candidates: Incumbent Bill Weber (R), Elijah Reichlin-Melnick (D), Barbara Francis (WFP)

District 39
Hudson Valley, including much of Orange County, Poughkeepsie and Cold Spring
Candidates: Incumbent Rob Rolison (R, CON), Yvette Valdés Smith (D, WFP)

District 42
Hudson Valley, including most of Orange County
Candidates: Incumbent James Skoufis (D, WFP), Dorey Houle (R), Tim Mitts (CON)

District 46*
Capital District, including Albany, Amsterdam and Rotterdam
Candidates: Pat Fahy (D, WFP), Ted Danz (R,CON)
Senator Neil Breslin announced his retirement earlier this year, after multiple decades in the Senate. Seated Assemblymember Pat Fahy, a democrat, is leaving her Assembly seat to run to replace him.

District 50*
Central New York, including the suburbs of Syracuse
Candidates: Chris Ryan (D, WFP), Nick Paro (R,CON)
Senator John Mannion is vacating his Senate seat to run for Congress. Chris Ryan defeated Tom Drumm on the democratic line to run for the seat in November.

District 52
Southern Tier, including Ithaca, Binghamton and Cortland
Candidates: Incumbent Lea Webb (D, WFP), Mike Sigler (R)

District 63*
Western New York, including most of Buffalo
Candidates: April Baskin (D, WFP), Jack Moretti (R, CON)
Senator Timothy Kennedy left his Senate seat earlier this year to successfully run in a special election for an open Congressional seat to replace House representative Brian Higgins. He will run again in November against Republican Anthony Marecki to retain the Congressional seat in 2025.

NYS Assembly

District 4
Long Island, north shore Suffolk County including Port Jefferson and Coram
Candidates: Incumbent Ed Flood (R,CON), Rebecca Kassay (D)

District 11*
Long Island, including Amityville and Lindenhurst
Candidates: Kwani O'Pharrow (D), Joseph Cardinale (R, CON)
Assemblymember Kimberly Jean-Pierre announced earlier this year that she would not seek reelection, leaving her seat open for both parties.

District 21
Long Island, including Malverne, Baldwin and Rockville Center
Candidates: Incumbent Brian Curran (R, CON), Judy Griffin (D)

District 23
Queens, including Ozone Park, Lindenwood and parts of the Rockaways
Candidates: Incumbent Stacey Pheffer Amato (D, We the People Party), Tom Sullivan (R, CON, Common Sense Party)

District 40
Queens, including Flushing
Candidates: Incumbent Ron Kim (D, WFP), Philip Wang (R, CON)

District 46
Brooklyn, including Bay Ridge and Coney Island
Candidates: Incumbent Alec Brook-Krasny (R, CON), Chris McCreight (D)

District 96*
Parts of Rockland County, including New City and Haverstraw
Candidates: Patrick Carroll (D, WFP), Ronald Diz (R, CON)
After serving nine terms in the Legislature, Assemblymember Kenneth Zebrowski announced he wouldn't run for reelection this year. He has since stepped down before the end of his term to take a new job with a lobbying firm.

District 99
Part of Rockland and Orange Counties, including Harriman and Cornwall-on-Hudson
Candidates: Incumbent Chris Eachus (D, WFP), Tom Lapolla (R, CON)

District 133
Western New York, including the area south of Rochester
Candidates: Colleen Walsh-Williams (D, WFP), Andrea Bailey (R, CON)

Open Seats

NYS Senate

District 6
Long Island, south shore including Hempstead and Garden City
Senator Kevin Thomas announced his intent to run for Congress but has since decided not to. He is still vacating his Senate seat, leading to a primary challenge between current Assemblymember Taylor Darling (D-Hempstead) and Siela Bynoe to replace Thomas. Bynoe defeated Darling by a 6-point margin.

NYS Assembly

The following other Assemblymembers announced earlier this year that they would be vacating their Assembly seats so these will be open in November:

- Assemblymember Fred Thiele (D- 1st District)
- Assemblymember Taylor Darling (D-18th District) - running for Thomas Senate seat
- Assemblymember Jeffrion Aubry (D-35th District)
- Assemblymember Helene Weinstein (D-41st District)
- Assemblymember Daniel O'Donnell (D-69th District)
- Assemblymember Inez Dickens (D- 70th District)
- Assemblymember Aileen Gunther (D-100th District)
- Assemblymember Pat Fahy (D- 109th District) - running for Breslin seat
- Assemblymember Marjorie Byrnes (R-133rd District)
- Assemblymember Goodell (R- 150th District)

We would like to thank the NYSAFP Board, Advocacy Commission, Home Office and the full membership for your strong advocacy this year. We look forward to continuing to work with you to pursue priorities of import to family physicians and your patients.

TWO VIEWS: Fertility and Women Physicians

VIEW ONE

FERTILITY THROUGH ATTENDING YEARS: THERE IS NO RIGHT TIME

By Mary K. Ellis, MD, FAAFP

I was not the traditional pre-med student so the start of my medical career was never on track. I started medical school when I was 25 years old with a background in psychology and found myself in family medicine residency at 30 years old. I was a late bloomer in both my life and career. I did not meet my husband until intern year and we got engaged during my third year. We waited for the "right time" to get married which I decided back then would be after residency. There were no thoughts in my mind at that time that my biological clock was ticking past its prime; although I remember during residency, my OB-GYN attending calling a 30-year-old patient " advanced maternal age"... What was I then? I thought to myself. But I had no regrets and was just excited to begin my life as a new attending, get married and start a family. I had thought making an informed choice to wait until I was an attending was the right choice.

Reality quickly set in as I simultaneously settled into my first attending job and planned a wedding. Attending stress was different, and I started to think maybe my peers who were already married and had children knew something that I did not. Studies show that female physicians tend to delay pregnancies until after residency— which comes at a cost. A survey published in Women's Health (2016) showed that nearly 1 in 4 female physicians who try to conceive are diagnosed with infertility.[1] In addition, a 2021 retrospective cohort study found that the mean age at first birth is 32 years among physicians versus 27 years among non- physicians.[3]

I was already past this mean age as I got married at 34 years old. We tried naturally to conceive and nothing was happening. I blamed it on the stress of my new job and adjusting to a new city. However, this continued for another year and, soon enough, we hit the definition of infertility: failure to achieve pregnancy after twelve months of trying without birth control[2], and for women 35 years and older, an evaluation of infertility is recommended after just 6 months of trying.[2]

Again, the stress of being a new doctor was not helping and my first job out of residency was not at all what I thought it was going to be, ultimately leading to my leaving that job. My husband and I moved back to my home state of NY and I started a new job as faculty for a family medicine residency in the heart of Brooklyn. I regained my love for primary care through academic medicine and my career again became a focus. I did not realize then, what studies show now is that sleep deprivation, poor diet, and lack of exercise associated with the demands of medical training can also take a toll on female doctors' health and, in turn, their fertility.[2]

When I discovered my love for teaching and fully immersed myself in the role – even getting a promotion— I did not realize the real toll it was taking on my body. I thought I was happy, so getting pregnant should not be a problem. However, the stress lingered as I took on the daunting task

VIEW TWO

NAVIGATING INFERTILITY AS A PHYSICIAN

By Allison McKeown, DO and Courtney Taylor, DO

I was not prepared for infertility. It was the curve ball that I did not see coming. After getting married during my second year of residency, my husband and I were excited to start growing our family. We knew it would be hard during residency training. However, I had seen other residents overcome the challenges of pregnancy and taking care of small children. I also found myself reflecting on advice from my mentor during my gap years, a female physician, who had told me that there is no ideal time to have children. I felt ready for that step.

However, month after month passed without a positive test. After about 8 months, I scheduled an appointment with my PCP and my OBGYN, which is not easily done on a resident's schedule. I am forever grateful for my PCP, who recommended my husband also be tested. My husband saw the urologist and was diagnosed with low sperm count/motility and varicoceles. The good news is that it was thought this could be corrected with a minor procedure, which he underwent. Fortunately, the procedure did significantly improve his results. Around the time my husband was undergoing his varicocele repair, testing ordered by my OBGYN showed that I had a low AMH (anti-mullerian hormone) level, which is a marker of ovarian reserve. I can recall being surprised by this as I was only 29 years old. We were then referred to a local fertility clinic.

Infertility is defined as the inability to become pregnant after 12 months of unprotected intercourse.[1] In the United States, approximately 1 in 10 females suffer from some degree of fertility issues.[2] When specifically focusing on the married female population, 8.5% are diagnosed with infertility, a number which has slowly increased over the last several decades.[2] However, this number is significantly higher when looking at female physicians. It is estimated that nearly 25% of female physicians carry a diagnosis of infertility, rates greater than double that of the general population.[3] It is no surprise then that 25% of female physicians have sought out assisted reproductive technologies.[4] There are many different factors that can contribute to infertility, including male partner infertility, ovulatory dysfunction, physical abnormalities of the reproductive tract, and increasing age.[1] While the studies to determine a causal factor for the increased rates of female physician infertility are lacking, some of the following theories may play a role. When looking at the general US population, there has been a trend towards delayed childbearing, or purposely delaying the act of becoming pregnant until an older age.[4] This has been thought to occur due to increased access to contraception, increased participation in the

of trying to be a good teacher to the residents and a good doctor to my patients while facing the fact that I still could not get pregnant. I was surrounded by younger physicians who had children. It was a whirlwind of emotions as I tried to understand why it was not happening for me.

It was also a time of revelation as I realized how medicine does not support women like me. At the age of 36, I finally decided to see a fertility specialist and I remember juggling early morning appointments for blood draws and ultrasound checks and running to work right after. I remember once trying to sneak over to an afternoon appointment during an administrative session and my nurse manager getting upset that I had made that appointment because it meant I could not stay to cover for a male colleague who had called in sick that day. I was reprimanded the next day by my medical director for having had – what he called – a "meltdown" when I spoke back to the nurse manager.

Those are the moments that I think about now, still childless, that likely affected my ability to conceive. The stresses of the world as I tried to create life. We failed to conceive after five IUIs; the workup came back normal for both of us and the fertility doctor diagnosed "unexplained infertility." The only available next step was IVF. I was devastated and could not make up my mind whether I should proceed. Meanwhile, life continued to unfold and more career changes manifested. The lack of support and empathy persisted as I moved to another faculty position in a super high-volume family medicine program. The malignancy of that place forced me to put a halt on my IVF journey, and I found myself again putting my job over my life. Then COVID hit and conceiving a child was not even a thought.

Finally, last year, I tried my first IVF cycle after going to three different REI specialists. My REI doctor could not believe that I was 43 years old and still trying to get pregnant. I finally found a job that allowed me the time and space to try once again. However, time was not on my side and we were not successful. This was no surprise since at age 40, around 1 in 10 women will get pregnant per menstrual cycle.[4] That IVF cycle was difficult both emotionally and physically but gave me peace. After years of trying, I finally decided it was not in my cards and that was just the plan God had for me. I gave it a try and I did not regret that I gave myself that chance. I also realized that there is no "right time," just what works for you.

Infertility among female physicians can be lonely as I have experienced. It was difficult to even talk about it among my female physician colleagues. I eventually found out though, that throughout this process I was actually not alone. I have met a few female doctors along the way -- both colleagues and residents-- who have shared their infertility struggles when given the opportunity. My hope is that we lift the stigma to better support our female doctors in their fertility journeys, and that we allow them the space to grieve or celebrate. I hope that our specialty can take a look at how we can better support women going through this journey, wherever they are in their lives.

Endnotes

1. Female Physicians Face Higher Rates of Infertility and Pregnancy Complications. November 2021 Bonus ASH Annual Meeting Preview Edition
2. Evaluating Infertility. www.ACOG.org
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workforce and higher education, changes in family values, and other financial considerations.[5] According to a national survey, both males and females who completed higher education were less likely to have a biological child, were older if they did have a child, and had a decreased overall number of children.[5]

Within the female physician population, it is hypothesized that increased infertility rates may be secondary to increased stress, increased workload, delayed childbearing, physician burnout, decreased support and resources, and maybe most interesting, the overall culture and lifestyle of medicine.[6] For female physicians, it has been reported they have their first child approximately 7 years later than the general population at an average age of 30.4 years.[3] Historically, medicine has been a culture that emphasizes putting medical training and career goals first before considering starting a family. These ideals inherently result in less support and an overall negative environment for those in the stages of family planning.[6] Residency training consists of an extensive number of hours worked coupled with a strenuous workload and variable shift work. The increased difficulty becoming pregnant is not where the challenge ends for physicians. Subsequently, with delayed childbearing there is increased risks for both mother and child throughout the pregnancy and even beyond delivery.[5] Not only are infertility rates increased, but it has also been demonstrated that female medical residents have increased reports of gestational hypertension, placental abruption, preterm labor and intrauterine growth restriction[3] once they do become pregnant.

Although it was comforting to know that I was not alone, it was challenging to navigate my residency workload while initiating fertility treatments. Shortly after establishing care at the fertility center, my husband and I were shocked to learn that we did become pregnant without intervention. However, that pregnancy was quickly diagnosed as an ectopic pregnancy and required treatment with methotrexate. This was the first time that I discussed my struggles with my chiefs and a few of my co-residents.

During the first 6 months of my chief year, we proceeded with two IUI (intrauterine insemination) cycles, both of which failed. We then felt cautiously optimistic about starting IVF. I was fortunate that the health system I was employed by had excellent insurance coverage, which made IVF feasible for us. We had our egg retrieval and

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proceeded with genetic testing of the embryos. We were ecstatic to learn that 5 of our 6 embryos were euploid. We went through 3 embryo transfer cycles in the next 6 months. What I wasn't emotionally prepared for was that the embryo transfers would fail. The label for our condition was "unexplained infertility." All the specific testing I had undergone did not give us any insight into the root cause of our infertility. As a physician, I think the "unexplained" nature made it even more frustrating. We were devastated and quickly losing hope that we would be able to have children of our own. During those transfer cycles, I had spoken to a few of my mentors at my residency program. I found that people were supportive, however I believe it is hard to understand the grief and emotional toll that infertility and its treatments takes on a person unless you have experienced it firsthand. It felt incredibly lonely. I was witnessing multiple residents and attendings around me announce their pregnancies and grow their families. It affected my relationship with my peers, my friends, and my husband. For the first time in my life, I faced a challenge where studying more or working harder/longer was not going to be the solution. My husband and I took advantage of free mental health counseling through the fertility center, which I am still so grateful for. I completed my chief year, no closer to growing my family.

After a second opinion and a change in protocol, our fourth embryo implanted. I gave birth to our daughter this past March. I am so unbelievably grateful for her. I also acknowledge how lucky we are. Fertility treatments and IVF, despite their many appointments and costs, do not always result in a healthy baby at the end. During my journey, I was able to connect with a few other physicians and acquaintances who had experienced similar journeys. These interactions gave me comfort in the fact I was not alone. Infertility is so hard. Navigating the treatment schedule and following the medication regimen as a physician is so hard. The emotional impact is so hard.

I feel very fortunate to live and work in New York State. During my training, I had excellent fertility coverage through my employer. Compared to other states, New York has more robust fertility coverage. As of January 2020, New York State legislation mandated that large group insurance plans cover in vitro fertilization, and that all insurers must cover medically necessary fertility preservation (egg or sperm freezing). This is a huge step in the right direction.

In the last year, fertility treatments, specifically IVF, have been under the spotlight in the news due the political climate in this country. Access to IVF has been threatened in certain states. Additionally, appropriate and timely treatment for ectopic pregnancy and miscarriages has been limited. Personally, I am grateful to live in NY, but this issue impacts so many physicians and patients across the country.

As we look to the future, I hope that there is more education about fertility and family planning in medical school and residency. I don't think this would have changed my trajectory, but the awareness would have made me feel more prepared to face the challenges of acknowledging and treating my infertility. To date, most of the discussion and literature focuses on infertility in heterosexual female physicians. There needs to be more awareness and support surrounding male infertility and for LGBTQIA+ individuals looking to grow their families. I hope by sharing my story, I can help raise awareness for this important issue that impacts so many physicians and medical trainees. At the very least, I hope I can help others to feel less alone during this journey.

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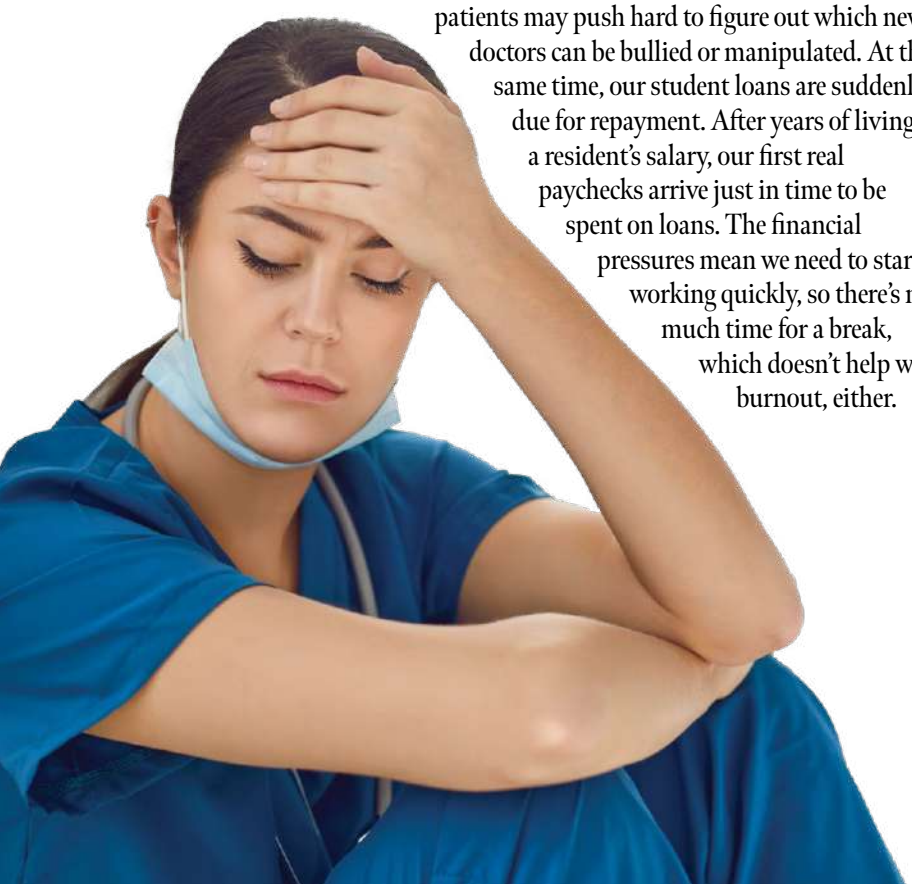
Combating Burnout by Remembering Who We Are

By Michael Gumuka, MD

Physician burnout has been an important topic of conversation for years. It's not surprising, really, given the amount of time, money, and stress it takes to become a doctor. From our initial education to our on-the-job training, burnout is built into our career path. Once we become attendings, financial and legal pressures dictate way too much of our practices. Social issues and pharmaceutical advertising can create nightmares for doctors – especially those of us in primary care. Add some administrative responsibilities and the demands of a family, and suddenly burnout seems like a foregone conclusion.

Our medical education structure is ideal for causing burnout. As physicians, we watch our friends and family graduate from high school or college and start making careers for themselves – while we go back to school. After two years of forcing unhealthy amounts of information into our brains, we start clinical rotations. In addition to helping us explore the various medical specialties, these rotations often make us feel inadequate every six weeks or so, as each rotation has a completely new set of rules, goals, and procedures. When we start residency, that feeling intensifies. With each post-graduate year under our belts, we take on more and more responsibilities, so rotations that should feel familiar are still frustratingly new.

As new attendings, we start paying off our loans, trying to find homes, and learn our personal styles of medicine as we finally get a chance to breathe. Unfortunately, this is also the time that most of us need to learn the business aspect of medicine, and we may or may not be lucky enough to have a mentor. In clinical practice, some patients may push hard to figure out which new doctors can be bullied or manipulated. At the same time, our student loans are suddenly due for repayment. After years of living on a resident's salary, our first real paychecks arrive just in time to be spent on loans. The financial pressures mean we need to start working quickly, so there's not much time for a break, which doesn't help with burnout, either.



Over the past decade or so, the financial and legal stresses placed on doctors have increased significantly. Obamacare, as well-intentioned as it was, had the unforeseen effect of forcing doctors into larger and larger groups to keep up with rising overhead and administrative costs. Many self-employed physicians found themselves having to cope with corporate structures again. State and federal governments have been cracking down on controlled substances and dictating what procedures we're allowed to perform. The years during the COVID pandemic produced immense pressure on doctors, especially smaller practices, as we had to learn to use telemedicine services and come up with new procedures on the fly. The media often influenced the information on COVID and the treatments that were available, leading to more time spent educating patients about the same issues multiple times per day. While so many people were being paid to stay home and start new hobbies, we were working harder than ever. Insurance companies kept changing their formularies, so patients that were finally doing well had to start all over with new medicines. No one has enough time to see all their patients, let alone get to know them. We could spend years debating how to change the system to make things better, but I believe there's a much simpler answer that makes a big difference – we just need to remember who we are.

As doctors, especially family practice doctors, we're the front lines of the medical world. Whether we find ourselves working in primary care settings, urgent care clinics, or even through telemedicine, we are usually the first providers that patients turn to with their problems. The key word here is *providers*. We are healthcare *providers*. We don't sell it. We don't offer it. We *provide* it. Sometimes we don't even get paid for our work, yet we still show up, day after day. We give everything we can to make sure the people that come to us for help are taken care of. We work late, we work on our off days, we even skip meals on occasion. Then we wonder why we get burned out. However, if we look back to our early days as physicians, I suspect most of us were doing these

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things without burnout, so the real question is what changed? I propose the answer is simple. Nothing.

Over time, repetitive tasks take a toll on everyone. As family practice physicians, we see this play out in our patient populations all the time. Repetitive motions can cause shoulder issues. Runners can develop hip and knee issues whether they sustain an injury or not. People who are treated poorly can find it harder to trust others over time, leading to higher risks of depression or anxiety. Eating the same foods on a constant basis can cause nutritional deficits in certain cases. The potential dangers of repetitive tasks apply to the physical, emotional, and social aspects of health. As doctors, our 'repetitive tasks' often include taking extra work, missing meals, losing sleep, and answering pagers. While none of these things really change, they do take a toll over time, just like other tasks take a toll on our patients. However, instead of developing joint problems, depression, or nutritional issues (although we could certainly develop these issues in our lives), our repetitive tasks tend to affect our relationships with our families, our friends, and even our coworkers.

Having an idea of where our burnout might be coming from allows us to use the same methods we give our patients to help ourselves. Those with muscle injuries can use stretching and exercise to improve their function. Patients with nutritional deficits can work on their eating habits. People with anxiety or depression can consider exercise or therapy. So, what about us? What can we do as physicians to improve our function? The obvious answers are things like exercise, eat lunch, and limit how often we accept extra work. We can try to get more sleep, stay better hydrated, and learn to meditate. Unfortunately, the obvious answers don't always work. For many of us, it's a struggle to add these activities to our weekly routines. The answer needs to be something simpler. Something easier and more natural. We just need to remember who we are. Allow me to provide the following example.

We've all had those days. The first patient is late, the second one is complicated, and the third patient is a parent with two kids who need treatment, too. After that, the delays start to snowball as labs come in, the phones are nonstop, lunch is minimal (or nonexistent), and you go home late. Only half your notes are done. By the time you're caught up, bedtime has come and gone. Sometimes that's the end of the story – you get up the next morning, more tired than you should be, and life goes on. Every so often, though, the story has a different ending. As you look back on the day, you remember one single patient (who took up way too much of your schedule) that really needed help. Maybe they were having a heart attack, and you finally helped them move past their fear of hospitals and convinced them to go to the ER. Maybe it was the adult who came in for a physical and started crying unexpectedly because their aging parent is dying. Maybe it was the young adult who found out their new spouse was cheating on them. Whoever it was, whatever the circumstance, they just needed someone to listen. So, you listened. You closed the laptop, put down the pen, and just connected to someone, and when they left the office that day, they were much calmer than when they arrived. In those moments, we change lives. Something as simple as a conversation can help someone choose the right path when they're at a crossroads in life. Those opportunities are rare for most people, but they're so much more common for doctors.

We have the chance to interact with vulnerable people all the time. I doubt there's a way to quantify those opportunities, but I'm willing to bet they come up at least once or twice per month, if we look for them. At this point in my career, I work exclusively in telemedicine – and I still find these opportunities every month. The times when I grind my day to a screeching halt and spend way too long with a particular patient are the best, most frustrating days I have. I wouldn't trade them for the world. I still get the same feeling of making a difference now as I did when I was an intern, and it's the best fix for burnout I have ever found.

To be fair, I fully acknowledge that self-care, mindfulness, exercise, and hobbies are necessary and help reduce stress and burnout. I also acknowledge that finding time for all these things can be difficult, but it doesn't cost much time at all to simply remember why we came to medicine. We help people. We provide care to people. The stress of keeping to a schedule, arguing with insurance companies, and trying to balance family time and work is real. It's not going anywhere, either, but as long as we remember that our job during every single patient encounter is to simply provide the best care we can, the schedules and money will sort themselves out. Don't be sad or angry about the days you lose time while making a difference for someone else. Cherish them, because they're truly special days.

In closing, I believe the most effective way to combat burnout over time is to remember who we are. By taking pride and satisfaction in knowing how many ways we help people every day, especially the ones who are at their most vulnerable, we can rekindle the same passion for medicine we had when we first started out as attendings. Obviously, taking time for mindfulness, exercise, families and vacations is important, but the mindset of being a *provider* first is something everyone can manage. I firmly believe that schedules and finances will fall into place as long as we do our best work. Sometimes, that means we're going to have long days, but if we can remember to have those days, despite all of the pressures and barriers we face, everyone will be better off – especially us.

Michael Gumuka, MD *lives in Upstate New York. He started in primary care, then transitioned to working in urgent care full time. As a result of COVID-related changes, he now works in telemedicine. He has self-published "Life Lessons for Healthcare Workers: The Ones You Might Not Learn in School" as a handout for his students, when he has them.*

DPC – Could It Be A Cure For Burnout?

By Wayne Strouse, MD

One of the more difficult things that I have witnessed in the past couple of decades, has been the growing levels of frustration, irritation, and downright anger about the office practice of medicine. There is increasing pressure to do more with less, see more patients, respond to insurance companies putting up more and more road-blocks to needed and appropriate patient care, and to document ever more metrics in the EMR (in the name of "quality"). Failure in any of these areas can threaten one's income.

But you know all of that. What you may not know is that there is a growing group of physicians who have jettisoned all of these obstacles, and are once again enjoying the practice of medicine. Five years ago, I became one of them. It was the best move I ever made.

So, let's talk about DPC (Direct Primary Care).

First, you rid yourself of all insurance companies. Instead, you are paid directly by your patients. You can toss your billing system, and the endless coding, because those are required by insurance companies and you don't take insurance. All of those coding updates, coding courses, and coding programs – you can forget about them – they are no longer necessary.

You can also stop creating EMR notes packed with useless information. Your notes are free to be solely the information needed to take care of your patients. The other useless garbage is required by insurance companies to justify the code you use to get paid. But you don't take insurance, and you no longer need to code, so you can start creating ½ page notes that really summarize the visit, instead of the 6-page notes, in which you will later dig for the information you need. Oh, and you can skip the quality metrics as well. You and your patient decide upon the quality of your work, instead of some insurance company executive. You do, however, still have to include the verbiage which will protect you against liability...DPC isn't a panacea.

You could even consider getting rid of your EMR (in favor of a paper chart), since EMRs were designed to get doctors paid by insurance companies, and you don't take insurance.

So how, exactly, do DPC practices get paid? There are a couple of different options, but let's start with the "pure" DPC practice. Basically, your patients pay you a monthly amount – call it a stipend, or a membership fee. This amount is billed to their credit/debit card once a month (rarely, we have patients who prefer to pay by check – which we allow as long as they are reliable). Then, the patient sees you as often as is needed. The fee covers most everything – I will charge extra for vaccines, but not for procedures, nor for long visits.

At this point you may be thinking, "This is concierge medicine, and you will need a number of wealthy patients." DPC physicians balk at this characterization. Typical concierge practices charge upwards of $2000/month, and do require wealthy clientele. They may have perhaps 40 patients total in their practices (do the math: $2000/month x 12 months x 40 patients is pretty close to $1,000,000).

DPC is more of a "blue collar concierge." We typically charge $75-$100/month, and have 400-600 patients in our practices. My patients pay $90/month. Many of them are farmers; they are not exactly wealthy.

So, what do my patients get for their money? First and foremost, EXCELLENT CARE! Typical DPC practices see 6-12 patients a day, so you have time to see your patients, get to know them better, really analyze what is going on, do some teaching, and still have time for a note that covers all the salient information without the useless stuff. It's a WIN-WIN. Patients love the extra time they spend with their doctor, and doctors love the time they get to spend with their patients. Billing occurs once a month using credit/debit cards. Your front office is small – and they have the time to get to know the patients, since they aren't signing in 25 patients per doctor per day. And there is no back office. You don't deal with insurance, and you just charge your patients credit/debit cards once a month, so no money changes hands day to day.

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On surveys asking what frustrates physicians most about their practices, there are three things that are always at the top of the list: 1. Not enough time with patients, 2. Too much time documenting, and 3. Prior authorizations. DPC fixes the first two, and because there are fewer patients, there are fewer PAs – plus you have more time to process them when they do occur.

The net result is that the doctors are happier now that the practice is manageable, and it becomes a joy to practice again. The patients are happier – they get to see the doctor when they need to, and the doctor spends much more time with them. And even the staff are happier, as the office is much less hectic and work is more fun (which makes for a pleasant work environment and improves the esprit de corps, which improves the office environs for both doctor and patients).

The second DPC option is a "Hybrid DPC" practice. Your patients can still sign up as they do with "pure DPC", but the alternative is to "pay as you go." In that option, you will be charged for the visit based on its length and complexity, not unlike what your current office probably does for patients without insurance. This alternative does require you to collect money daily, and depending on the reliability of your patients, the need to do some billing for those who don't pay right away. Depending on how you want to run your practice, you could keep a credit/debit card "on file", and charge it whenever the patient makes an office visit. Since your overhead is less, your charges may be less than what your patients would be charged elsewhere.

My practice is hybrid DPC. We have about 40-50 DPC patients, and see about 10-14 patients a day. An average visit costs $100, but can go as high as $250 for long visits, procedures, circumcisions, etc. I have a large number of Mennonite patients who don't have insurance and are used to "pay as you go." They prefer coming to my office, as they receive more time and personalized attention without paying more. At my practice, we have about 2000 patients, although many are not active (Mennonite families often have 13 or even 15 members, however, I usually only see a few of them). My staff (I have 1 nurse and 1 receptionist) are also quite happy with the change in our practice.

In recent years, I've met with a number of physicians who tell me they are experiencing burnout. I understand, as I, too was heading down that road. Even though I was in solo private practice, I wasn't working for myself – I was bound by my agreements with insurance companies. I was frustrated by the lack of payment for the good work I did, and the seemingly endless hassles and obstacles I had to go through to get my patients the care they needed and deserved.

I can honestly say that all that changed when I changed my practice into direct primary care. I now work for my patients, who appreciate the time I spend with them and the first class care they receive. It's deepened my relationship with them and I have a loyal (and growing) patient base. I enjoy practicing medicine again! This is the reason I went to medical school!

Feel free to contact me if you want to learn more. DPC is a real game changer! Wayne S Strouse, MD, FAAFP, 315-536-2273

Postscript:

This article is an overview of DPC, but we've added on some frequent questions/ concerns that others have had about specific groups and services" under a DPC system

Q: Dr Strouse – what about serving the poor? Does DPC address it?

A: It can. If you choose the "pure DPC" model you have the option of waiving, reducing, or charging the full monthly stipend. Since you would not be enrolled in any insurance program (including Medicaid) you can make any arrangement you choose with your patients.

If you choose a "hybrid model" you are, again, not participating in any insurances, and you can choose to offer discounts, or just charge less for your office visits. I have one patient who pays a discounted "co-pay" – an amount we negotiated for each visit. I have another who is a DPC patient who pays a discounted DPC fee. Of note, any Medicaid and Medicare patients need to understand that their insurance won't reimburse them (though some commercial insurance will reimburse, and they can use HSA and FSA accounts to pay for the office visits, but not for DPC fees, though there is movement to change that.)

For families I charge the usual fee for the adults plus $35 for each child but cap the stipend for the family at $225 (lower if I deem it warranted).

There are no restrictions because there are no insurance companies involved to restrict you. This really is the best part of DPC. You and your patients are in charge. There are no other rules other than the ones you create.

Q: What about vaccines?

A: I have found for children with adequate insurance that they are not able to be vaccinated at pharmacies or public health clinics. If I vaccinate them I must charge the full cost of the vaccine, and they probably won't be reimbursed by their insurance. Since costs of vaccines are quite high, it doesn't make sense economically. For uninsured or Medicaid insured, childhood vaccinations are available through public health. Theoretically, you can get around this if you can find a local clinic that is willing to vaccinate your patients without the requirement of becoming patients of that clinic, although I haven't found this option in my area.

Q: What about insurance companies that require the patient to declare an in-network practitioner?

A: I advise them to pick a name from the insurance company roster for the record, and then see me for their care. If the patient finds they must see the practitioner of record periodically they can usually satisfy this with a preventive care checkup or some other level of visit.

Again, if you run into problems, feel free to give me a call. I don't have all the answers, but I've had a significant amount of experience and can help you work things out.

DPC Reference/Resources

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www.dpcfrontier.com – general information about DPC (including location of DPC offices)

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Reviving Interest and Satisfaction in Being a Family Physician

By Norman Wetterau, MD

In 1967 I graduated from Duke Medical School, a school committed to specialty and subspeciality care. In the same year the Millis Commission for post-graduate medical education released a report that recommended the formation of a new specialty in primary care. My family lived near Cleveland where several commission members worked, so during Christmas vacation I met with one of the members of this commission. After this meeting, I decided I was going to become a residency trained family physician, even if the specialty and residencies did not exist. I then interned in Kentucky, where Dr. Pisacano, the founder of the American Board of Family Medicine, chaired community medicine. After a year there I joined the new family medicine program at University of Rochester and then practiced in a rural group in Dansville and Nunda in New York for 48 years. I retired at age 80, 3 years ago and still miss that practice

Fifty years after I started practice, some family physicians have become disillusioned with family medicine. Some retire earlier or go into other areas. Why is this happening? Can we return to the Ideals that formed our specialty? Do we need new ideals and approaches, or do we need an updated version of the Millis Commission with new authors and new recommendations?

The report released by the Millis Commission was incredibly influential in forming the specialty in primary care. The report was named *Graduate Education of Physicians* and was commissioned by the American Medical Association in 1966.[1] The 112-page document recommended a new specialty in primary care or family practice and called on the need for residency programs. It was also recommended that physicians work together in groups. Graduates of most family medicine residencies are aware of the report, since it describes what their training and what the specialty of family practice looks like.

When I first meet Dr. Pisacano in 1967, he saw residency training of family physicians as more than just medical training. He observed that doctors would leave an internship, practice alone, and become over-worked, out of date and possibly bored. Specialists would develop close friendships in residency and often stay connected to their residency program. He wanted future family physicians to have the same experience. Residency was to include community medicine, psychiatry, practice research, and public health. All of this was part of the Rochester program I participated in. As a new resident, I also joined the department chair, Dr. Eugene Farley, to staff evening migrant clinics. This was something I continued with others in Cohocton, New York as part of my practice there. Together, we learned that health was a community affair. Looking back, my commitment to my partners and the community kept my mental health in better order. What I really valued was not the money I made, the number of patients I saw, or even awards I received, but my relationships with our group, our patients and with our community. I made a difference in patients' lives, but I also made a difference through the migrant clinic. I helped start a county mental health clinic and led a large community effort that successfully reduced teen drinking and encouraged involvement in other activities. The changes made in our community will last, not because of what I did, but because we worked together.

I was one of the four doctors that helped get Tri County Family Medicine started in Danville and in clinics in surrounding villages. We developed a good call system and insisted our medical staff members take vacations and attend medical conferences. Many of our staff also attended NYSAFP functions. I was involved in the medical society where I not only made friends but brought about change. The county medical society had access to many of the county leaders. Our medical group had monthly meetings where we spent an hour discussing business and additional time discussing cases. We had a monthly journal club over breakfast Saturday mornings and did quarterly audits. These audits were different than modern audits as they were more qualitative than purely quantitative. We asked what differentiated patients who did well and those who did not. These audits were presented at an evening meeting where a specialist from Rochester was invited. When my partners presented an audit, I often changed how I approached a patient and what I ordered. I did practice audits on drug use, teen

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drinking, and chronic pain. Some of my partners changed how they approached patients with these problems.

Our group members had some special interests. For four years, I was chair of the county community service board where we developed mental health and addiction services. The group allowed me to take off for the two-hour monthly and special meetings. Several of us were on the hospital board. One partner was connected to a county nursing home. Another group member was involved in developing hospice care. Dr. Paul Frame wrote articles and spoke nationally on screening and encouraged our group in this. We had a sheet on the front of each chart to keep track of screening. When we got our electronic records, these sheets disappeared and unfortunately the electronic records we used then made it difficult to track this. Screening went down and suddenly it was a terrible chore requiring multiple clicks.

Numerous articles have recently been written on physician burnout, in many specialties, including family medicine. Yet the early members of our group and many members of the NYSAFP worked into their 60s and 70s. The AMA has not commissioned a new Millis Commission report, but they have various reports and online resources on burnout[2], as does the American Academy of Family Physicians.[3] The AAFP has continuing medical education around this issue. Below are my own feelings and observations, and I encourage physician groups to have some honest and lengthy discussions of this subject.

Many physicians complain about the use of current electronic medical records. Many of these records are oriented to billing and not helping doctors or patients. Patient communications also changed. Before the EMR, people could get through via the phone lines and a nurse would screen calls. At times I would be interrupted and take a call. People could also get in for short appointments that day. Because we had no EMR we could book a quick visit and then have the patient return. Now every message is sent electronically and must be answered. Some doctors spend hours each evening finishing charts and documenting calls.

We used to make hospital rounds and would talk informally at the hospital. When many doctors stopped doing this, they did not establish other ways to connect with each other and with the hospital staff. Eventually, we arrived at the office and went right to the messages on the EMR. Lunch time disappeared. Our group stopped having evening meetings. People dropped out of medical organizations. Our county medical society closed.

Since several of the physicians did not do hospital care, most stopped going to hospital meetings. CMEs were done online which can be very useful, but meetings where you can discuss cases and talk with other physicians became less frequent. Fortunately, our members did continue to be involved in community organizations. We also continued to teach medical students and NP students which helped us connect to the medical school and to each other. Our group still has good retention of medical staff members. Our practice is not owned by a hospital or large organization. It is a good place to work, however that may not be the case for other primary care physicians in New York.

Numerous articles and studies outline some of the current problems of primary care. Problems are part of life, but isolation is not the answer. It is imperative that we stay connected to one another. Get together with medical staff outside of administrative meetings. Stay involved with the NYSAFP. Although there are many audits using the EMR to see what you did not order, consider an audit on a subject and let each medical staff member share what they did do for the patient. I strongly encourage administration to simplify how things are done. Our staff had some big problems with our EMR and everyone kept it to themselves. Once we came to administration and pointed out that this was a common problem, we saw some changes happen. We only saw this change because we were willing to speak up. Some things cannot change but you need time to do what needs to be done. Change what has to be done or provide sufficient time.

The Millis Commission report mentioned that various primary care doctors in a group might develop special interests. This happened in my group (myself in addiction, one in hospice care, one in OB). Maybe your group needs its own physician led commission to look for new ways to go forward. Practice based research can be helpful, even if it is not published. Granted some of these things take time but they can give you more energy and satisfaction. Finally, many practicing family doctors are doing fine. Through our Academy we can share some of these experiences.

Medicine has changed. Many practices are owned by hospitals or insurance companies. The COVID-19 pandemic also severely impacted healthcare, and many physicians became overworked while society became more isolated. Now more than ever, we must try to build community. Community helps overcome burnout and provides satisfaction both in our careers and in life. Invite your medical friends over for pizza this week.

Endnotes

1. Council on Medical Education, American Medical Association, The Graduate Education of Physicians: The Report of the Citizens Commission on Graduate Medical Education: Commissioned by the American Medical Association.
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3. AAFP, "Family Physician Burnout: Preserving Your Well-Being." 14 Jan 2022

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Letter to Parenting Docs – You are Not Alone!

By Sandy Wang, MD, MPH and Sarah Minney, MD

I'm running behind (again) and keep silencing the pumping alarm going off on my phone. *I'll just finish up seeing this one patient and then I'll go pump.* I'm uncomfortable and already behind on my ounces goal for the day, but I know this patient has a long drive to see me and I don't want to make them wait. She asks me about my son and I show her pictures while I wait for the computer to load, feeling happy that all my patients care so much about my family, but also feeling sad being reminded that I won't see him until much later tonight. We finish up the visit with her new prescriptions taken care of, and I can finally head back to my office to pump. I log into my laptop and see there's over 30 unread emails just from this morning, my phone keeps beeping as I have 12 unread texts, and my in-basket, though empty yesterday, has over 60 items. I begin setting up my pumps while tears start to well-up in my eyes – *how am I ever going to balance all of this?* I reflect on the endless amount of worries that now seem so difficult. Sitting with my pumps on in my office with the door shut, I feel incredibly alone and confused.

I had a positive impression of working clinician parents who seemed to be performing at the level I witnessed them performing at prior to having children. So why was I having such a hard time? And when I did go back to these clinician parents and voiced my struggles, the #metoo moment of motherhood seemed only now available after one has joined the club. I felt betrayed. Where were mentors who could have been more honest before? I felt pulled into a vicious cycle to perpetuate perfection to our next generation. I know I am not alone, as female academic physicians lament that we do not have enough mentors to truly model the difficult act of being a successful physician and mother.[1]

I then looked at myself at the previous pediatrician's office visit when the pediatrician kindly asked if I was doing ok, and I had immediately pasted on a big grin, when in truth I wanted to hug her and cry, saying this whole parenting endeavor was absolutely exhausting. It wasn't just me. I flash back to the hundreds of moms at their well-child check-ups who had mastered a stoicism that I just did not quite understand at that time. I voice this observation to raise awareness that honest conversations must be encouraged to balance the overwhelming social media posts that seem to portray a false positivity of golden, laughing family time and picture-perfect birthday candid moments. Could toxic positivity explain part of why postpartum depression prevalence has increased by 10% in the past decade?[2] It actually took me years to realize that I likely had clinical postpartum depression (PPD) and yet, our healthcare system has so few resources and bandwidth for it. Despite trying to break down mental health stigma for my own patients, I was ashamed to admit that I needed help and feared judgment. 1 in 7 mothers will experience documented PPD, with another half who do not disclose it to their physicians for privacy reasons[2] and likely also fear of losing social support. To those mothers in silent suffering, you are not invisible and I understand.

Many of us who are in medicine are perfectionists as well as highly organized individuals. Conflictingly, parenthood is quite unpredictable. Unlike any board exam where one can make an educated guess from sheer hours of preparation, there is no manual and no courteous Google calendar to mark unprecedented illnesses, tardiness due to toddlers demanding independence, or last-minute childcare holes. Especially the childcare holes. It is hard to explain to those who don't have young children in their household how the lack of affordable, accessible, high-quality childcare affects many US families, keeping approximately a million people out of the workforce.[3] Even for physician households with relatively higher incomes, it is hard to find reliable and economic childcare for our long and sometimes irregular shifts. It is imperative to have

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high-quality childcare so that our children's safety and wellbeing does not distract us from focusing on our patients. Yet, with high-quality care comes proportional costs that many young physicians cannot immediately and easily afford, as they are also paying off new home loans, asking for forgiveness for a large shadow of educational debt, and working with limited previous savings from residency.

Young physician mothers are at high risk for burnout as they usually defer parenthood to the end of their residency which coincides with the stress of navigating new attending positions. This shift in financial, social, and professional responsibility is perhaps one of the steepest experiences one can go through as they evolve into "working physician mom." However, it seems that our nation's structural system makes it impossible for the "working mom" to succeed, let alone the "physician mom." Perhaps that is because there is actually not one ideal definition of a "physician mom." What if we need to change and challenge this notion of the "working mom"? Just like families can all look different in shapes, sizes, and composition, perhaps every family needs a different working physician mom to make that family work. Afterall, every parent is going to be different and therefore, everyone's so called "work– life balance" will look different and should not be compared to an impossible and unattainable model. Perhaps a perfect work-life balance is really just a series of choices you make each and every day, and no matter the outcome, you are doing more than enough.

Many people talk about the changes in one's free time, friendships, romantic relationships, and home life that come with becoming a parent, but the changes in one's professional life and relationship to your job are often totally unexpected. Gone are the days when a physician could spend extra time at the end of the night having long phone calls with patients, reading articles, working on various projects, flipping back and forth between night shifts and day shifts with ease. Now those days are centered around the timing of a child's naps and being stressed over seemingly mundane parenting decisions such as screen time amounts or choice of snacks. It feels that I had sacrificed my twenties for education and training, only to now feel I am unable to thoroughly pursue my career. I felt left behind when coming back from maternity leave, realizing my clinics, patients, and co-residents had all continued with life. Despite the dramatic surge of female physicians, medical centers have moved relatively slowly to provide support for women to simultaneously pursue medical careers while managing their families, which limit women's specialty choices, decisions whether to have children, and necessary time needed to obtain promotions and leadership positions.[4]

I write this to other moms: don't worry, you aren't the only one who feels at times that it is not fair that we devoted our lives to our careers only to still face glass ceilings that no one can find a good way to break through.

I write this letter not to express regret or reimagine a future of childless physicians. On the contrary, it is to let others know that your lonely moments are part of a larger group of other physician parents also experiencing the same feelings and thoughts. I write this to start the conversation that physician parents are also human and deserve space and time to talk about struggling.

Yet, we also reflect and remind each other that becoming a parent can bring so much happiness and joy as well as a whole new perspective and skill-set in taking care of families. Our own empathy and patience can grow tremendously, both for our colleagues and patients. I feel guilty for the times I judged the overnight practice calls from anxious parents over seemingly minor health concerns; the parents that didn't want to be separated from their kids and therefore did not go to the hospital for treatment; the new moms who seemed overwhelmed with making it to appointments, and the list goes on. I just didn't understand the magnitude of their worry or their emotions or anything then. Though now perhaps I understand only a sliver of it, I know that we all have loved ones we care for and becoming a parent can expose you to a life experience that you will share with many of your patients. I no longer feel guilty about being a working mom-physician, as I recognize the benefits I bring to my child as well as to my patients by being both. I've learned how to lean-in to my "mommy brain" as it is not flawed, it is just more right-brain than left-brained these days.

I once heard someone's kids say to them: I know you're not perfect, but you were the perfect mom to me. I heard that and thought, I won't ever be on time to anything nor will I host splendid well- planned birthday parties, but in the end if my patients thought I did the best I could, and my child thought I was perfect for them, then perhaps that is my definition of a successful "working physician mom." And honestly, that is good enough.

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Women in Medicine: Beyond the Womb

By Sarah D. Baden, MD, MAHA, FAAFP

Upon learning I was accepted to medical school at age 37, a friend's mom exclaimed with concern, *"What about marriage?"* A few weeks later, on the Greyhound bus to search for an apartment in my soon-to-be city, the stranger sitting next to me immediately inquired *"Did you freeze your eggs?"* after I shared the reason for moving. My accomplishment quickly diminished to marital and reproductive status.

My first year of medical school, after a Women in Medicine Interest Group meeting that centered on being a wife, mom and doctor, a classmate and I clandestinely bonded as soon as we realized we both did not plan to have kids. I knew myself and the decision to enter the rigorous path of medical training so late in life closed the door on procreating – a sacrifice I was willing to make.

During residency, a senior OB resident on labor and delivery took me aside unsolicited to let me know he could hook me up with IVF at a discounted price. I was OK with not having kids but it seemed those around me were not. "But you would be such a great mom" and "you have plenty of time" were refrains heard over and over.

Now, as an attending, I am asked to cover holidays so others can be with their families which I am happy to do when I can, but other childfree coworkers and I are also expected to fill in during extended parental leaves; it is hard to not feel that our time is not worthy of respect too, which, unfortunately, leads to resentment instead of solidarity, unintentionally pitting those with children against those without.

At a recent conference, during a "women in medicine" plenary, one of the speakers reflected on choosing medical school over getting married but added at the end, "Don't worry, I plan to get married soon and have lots of babies!" At another conference later in the year, my colleagues and I led a roundtable with the same title as this article; the table was buzzing with participants' yearnings to discuss subjects affecting women in medicine which are neglected because the sole focus of motherhood and marriage typically dominate.

Of course, in such a rigorous field as ours, talking about balancing parenting and the challenges of becoming pregnant is imperative; however, constantly being reduced to topics of reproduction and parental leave trap us within the confines of what patriarchy has historically dictated.[1,2] It not only excludes those of us without children (by personal choice or not) but it occludes broader essential issues that affect women in medicine that must be addressed to ensure all women in medicine thrive; for example: gender bias, lack of adequate support, insufficient investment in growth and promotion, gaps in pay equity, and the exodus out of medicine and elevated suicide rates among female physicians. Of the dozens of women colleagues I have witnessed leave their jobs recently, the reason was not due to balancing family duties, but instead due to the myriad conditions that make life as a primary care physician difficult. Indeed, conversations about women in medicine need to move beyond marriage and motherhood for our patients and ourselves.

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A 2017 JAMA study revealed patients treated by female doctors have better outcomes compared to male doctors which is attributed to more time spent with patients and more preventative care, patient-centered communication, and psychosocial counseling.[3] But this comes at a cost. To achieve such outcomes in systems focused on productivity, women are likely to work many uncompensated hours;[4,5] this is compounded by patients' making more requests of women PCPs and support staff deferring non-clinical work (for example, form completion and photocopying) to female physicians that would not necessarily be deferred to male physicians;[6] this is further exacerbated within academia as women are more frequently asked to perform tasks to nurture the departments in which they are part; for example, to serve on committees and plan events.[6,7] All of this free labor translates to women not only earning less[8] but these demands also do not allow for the time or energy required to pursue academic or leadership interests and growth. An article in Harvard Business Review found that sixty percent of women physicians either go to part-time or leave medicine entirely within the first eight years after residency[9,10] due to exhaustion, lack of professional fulfillment and high rates of depression. This results in unquantifiable loss for patients, community health and academic departments. Furthermore, a recently published article in BMJ revealed suicide rates for female physicians are 76% higher than the general population.[11] Our patients deserve better, women deserve better.

To avoid such dire outcomes, workplaces and residency programs must move beyond being simply proud of their maternity leave policies (which should be the bare minimum), and self-evaluate to ensure all women including women without children are supported and not exploited and that their voices are heard. Family physicians who identify as women know what is needed for ourselves and for our patients but, unfortunately, when we speak up, we are often dismissed as pushy, angry or aggressive; when a female PCP expresses that more support or time is needed for a complex case or to sift through an avalanche of inbasket messages, she is instead told that she should go faster and learn to be more efficient.[6] Listening to women would not only prevent more women from leaving medicine by meeting their needs but would allow them to continue to excel. Moreover, it would improve conditions and build humanity and health for patients, society and physicians of all genders with longer visits, reasonable workloads, more administrative time, mutual respect, sufficient staffing and proper compensation.

In regards to women without children, although it is exciting when others make the decision to grow a family, it is not fair to assume those without children will carry the administrative and clinical burdens of the void left by a parental leave. People without kids also have lives and responsibilities outside of work (or maybe they just want to rest!). Employers need to supply the proper support and temporary staffing so none of us burn out. The personal and professional growth of women without children matters, too! In addition, it is important to not assume all women plan, can, or want to have babies. There are so many reasons why women do not have kids: financial, environmental, political, social, medical, personal... For me, it was a confluence of experiences and circumstances. Like many little girls, I had once fantasized that I would grow up to have children, but life unfolds and I realized I could be a full and whole woman beyond the productivity of my womb (or left ring finger). Once the decision became apparent, I felt free.

If you are following a path without children and/or without marriage, you are not alone. Pursuing medicine and being a family doctor is a recipe for not ever feeling enough as it is impossible to know it all or catch up with the endless demands; and everyone's obsession with our having babies and being a wife can easily feed into this idea that we are less than, exacerbated by myriad intersecting cultural factors which disparage and stigmatize single women and women without kids. In actuality, you are enough: a complete woman and an amazing accomplished physician!

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Life Lessons Learned:
On the Road to Old Age and Wisdom

By Wayne Strouse, MD

If you are reading this article, I can say without hesitation that you have been well trained. Think of it! You've had 12 years of primary education (plus, a year or two of Kindergarten and preschool), 4 years of college, 4 years of medical school, and a minimum of 3 years of residency. Add it all up and we are talking 24 years! Add a couple more years for any fellowships. That's close to 1/3 of a lifetime! We postpone much during our training—perhaps we deserve a degree in delayed gratification.

Finally, we are "turned loose", making some real money, but also with some impressive debt. Despite all the years of training, little if any has been spent on how to "live life." Here are some tidbits, and some hard lessons, I've learned along the way. Maybe you can avoid at least some of the pitfalls.

1. Even though you can't wait to improve your present, you still need to think about your future

   You may want to go out and buy (or build) that big dream home that you can suddenly afford, and/or trade in the beat-up old car that's been held together with baling wire for something big and beautiful with all the modern bells and whistles.

   Certainly, it is reasonable to get a place of your own, and not have to share housing with a handful of others. It is also reasonable to update your ride so that you won't have to have your mechanic on speed-dial. Just keep in mind that you have a pile of debt already and you will need to be paying it off with some of that new- found money. Be careful not to make yourself "house and/or car poor" by taking on even more debt, especially if it is more debt than you need to assume. You want to be working for more than just paying off the banks.

2. Retire as much debt as you can as quickly as you can

   Getting that burden off of your shoulders will give you a real sense of freedom. Yes, your lifestyle won't be as extravagant as you may wish right now, but you can always adjust for that later on, when the debt is paid off. Ratcheting up your lifestyle comes easily. Realizing you've overdone it and you need to ratchet down your lifestyle and "tighten your belt" is decidedly more difficult. Sadly, it often involves taking on extra work (moonlighting), or working way more hours than you planned to.

3. Live below your means

   This is really a corollary of the previous 2 life lessons. It's really the foundation upon which everything else is built. It's also very difficult to pull off. After all that delayed gratification, it seems like you will have to put off gratification even longer. To some extent, that is true. The difference is in the degree. Instead of a multi-million-dollar home, and a car that costs $100,000, try getting a comfortable, but less ostentatious home and car. You can still eat out, have fun, and enjoy your vacation time, but spend in moderation. You'll find you can still enjoy life, but not have significant credit card debt. It's fine to splurge every now and then, but try saving up and putting the money aside first, rather than trying to figure out how you are going to pay for it after the fact.

4. Early on, start planning for retirement

   I'd recommend setting up a plan with a financial adviser. Doctors

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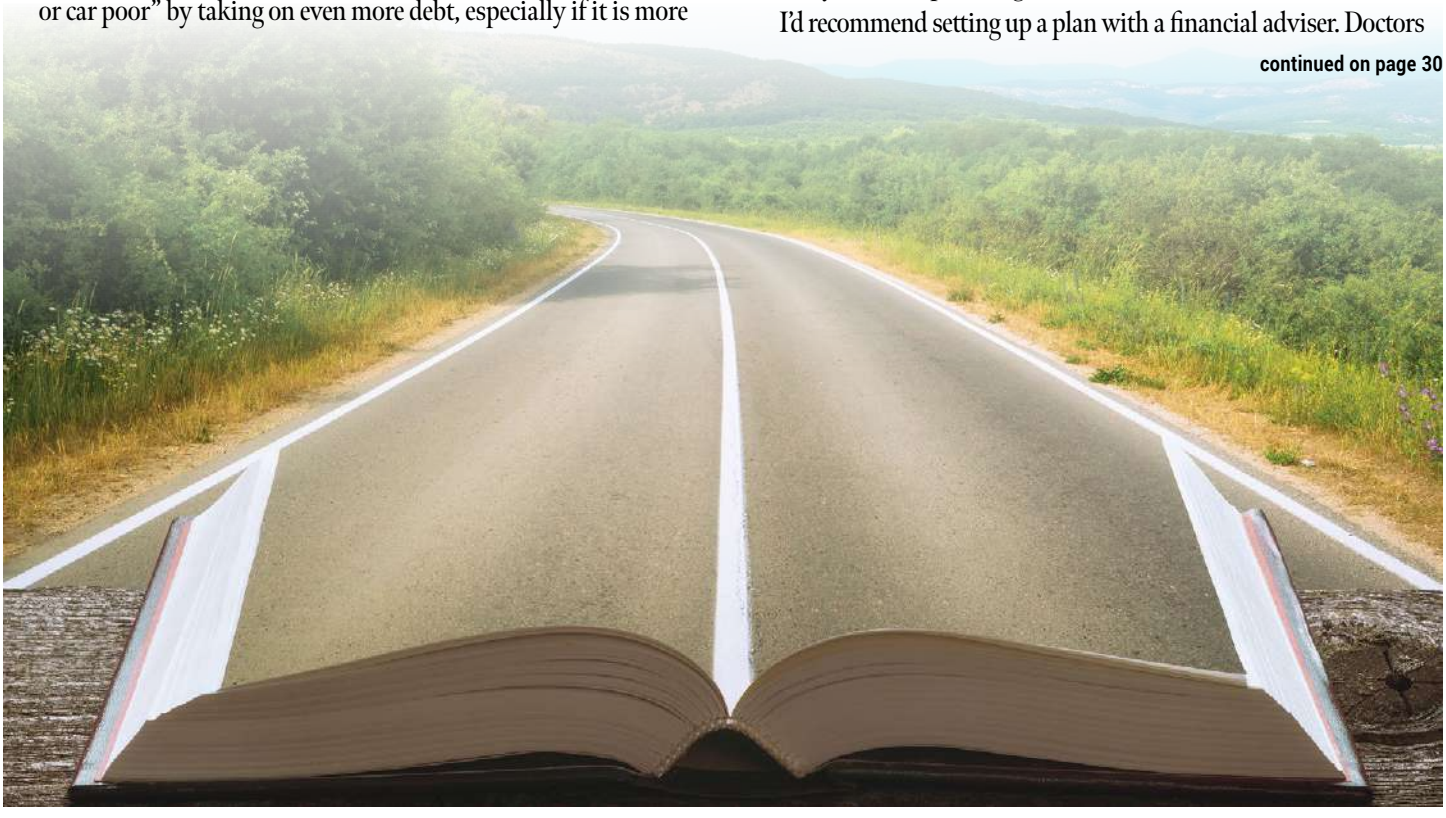

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who are "sure" they know the tricks of investing, often find they are left out in the cold when it is time to retire. It's important to put a little bit away with every paycheck. The earlier you start, the smaller the amount you will have to put away. You want this money to be invested in a way that it will accumulate over time, in a way that beats inflation--so, not in a bank account--but this is also not money to be invested in a "get rich quick" scheme. It is, after all, the money you will depend upon when you cannot (or don't want to) continue working. The investment adviser will help you figure out your retirement lifestyle in order to decide how much to set aside. When looking for a financial adviser, it is important to enlist one that is a fiduciary. That is, they are required to put your financial interests first. Other so called "advisers" may be salespeople for insurance companies, or get paid commissions.

I know it sounds like a long way off, but that is the advantage of starting to work out the details now. If you wait too long, something will have to give. Either you will need to work longer or more intensely than you wanted to, or you will have to have a less lavish retirement lifestyle.

Enjoying the Journey

5. Travel lightly

   At one point in my career, I felt I had started on the road to burnout. I actually closed my practice and moved to New Zealand for a year with my family. By the way, I use burnout because it best describes how I felt. Others prefer "moral injury." That's fine—I think we are both talking about the same feelings.

   During that trip, we were allowed to take 2 suitcases worth of personal items. So more than 98% of our "stuff" was left behind...and we didn't miss those items whatsoever. We learned that what was important was our relationships with each other (our family), our friends, coworkers and schoolmates in the case of my daughter.

   We spend a lot of time and money here in the US accumulating "stuff." If we would reduce the urge to acquire things, we would have more time and money to spend on experiences that are far more meaningful, all the while avoiding unnecessary debt.

6. Figure out what is really valuable to you, and act on it

   For example, if time with your patients is valuable to you, you can adjust your schedule (albeit for less salary). When I returned from New Zealand, I saw fewer patients and enjoyed my practice far more.

   We tend to use money as a measure of "value." It is a convenient short cut, but money and value are not quite equivalent. We derive value in our lives from a number of differing kinds of experiences and it is hard to monetize those experiences accurately. And sometimes, striving for more money leaves us "poorer"--emotionally, relationally, and recreationally, as we are left deprived—of time, of energy, of sleep, and of engagement with friends and family.

   There are many more things that are valuable other than money. Seek out what you truly value, and work to attain it. It's the path to a more rewarding life and will immunize you against burnout.

7. Do work you enjoy

   Some doctors seem to feel "stuck" in their current situation. They may feel they don't have the energy to make a change, so they just "put up" with their current situation. Whatever the reason, this tends to just get worse over time.

   Yes, you may feel guilty about leaving your patients, but consider—if you are burning out, how good a doctor can you be for your patients? Acknowledge that this is not healthy for you, and start investigating other options. There are lots of possibilities out there.

   And perhaps, when you make the change, you can keep in mind the lifestyle errors you may have made in the past, so that this time you will choose a more modest lifestyle and won't have to work so hard.

8. Consider trying out multiple options

   Locum tenens, in particular, can offer multiple options. You can work locally, or in an area of the country you always wanted to check out, or a foreign country to experience a different part of the world and a totally different cultural experience. You can work for as little as a month at a time. However, if you are traveling a long distance (like New Zealand, for instance), you typically need to stay at least 6 months to a year. Other possibilities include working at the VA, at a prison system, Indian Health Service, etc. A new and growing area is DPC. (More about that elsewhere in this issue...)

9. Red Flags

   Lastly, you should recognize "red flags." Heavy substance use (legal or otherwise), is an effort to "self- medicate," and is dangerous and a sure sign you need to get some help, right away. In NY State there is the Committee for Physician Health (CPH), that allows you to get help without putting your license at risk. They can be reached at: **1 (800) 338-1833**

   If you start to "hate your patients", you need to get help.

   And, of course, any suicidal thoughts should be addressed immediately by calling **988** or going to your local emergency room.

   Another program in NY State is available via the Medical Society of the State of NY (MSSNY). It is known as Peer to Peer (P2P) and information is available at: www.mssny.org/get-help/p2p-program. They can be reached at: **1-844-P2P-PEER**, or by email at: **p2p@mssny.org**. It is available 24/7, and is confidential.

   There is also a help line, staffed by psychiatrists, to reach out to anonymously at: **1-888-409-0141**. It can be accessed for whatever is troubling you, work issues, relationship issues, depression, anxiety- not just suicidality. Seek help earlier, before you reach a crisis. You will usually have more options that way.

And you can feel free to reach out to me if I can be of service at:

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Mentorship and Chocolate Chip Pancakes

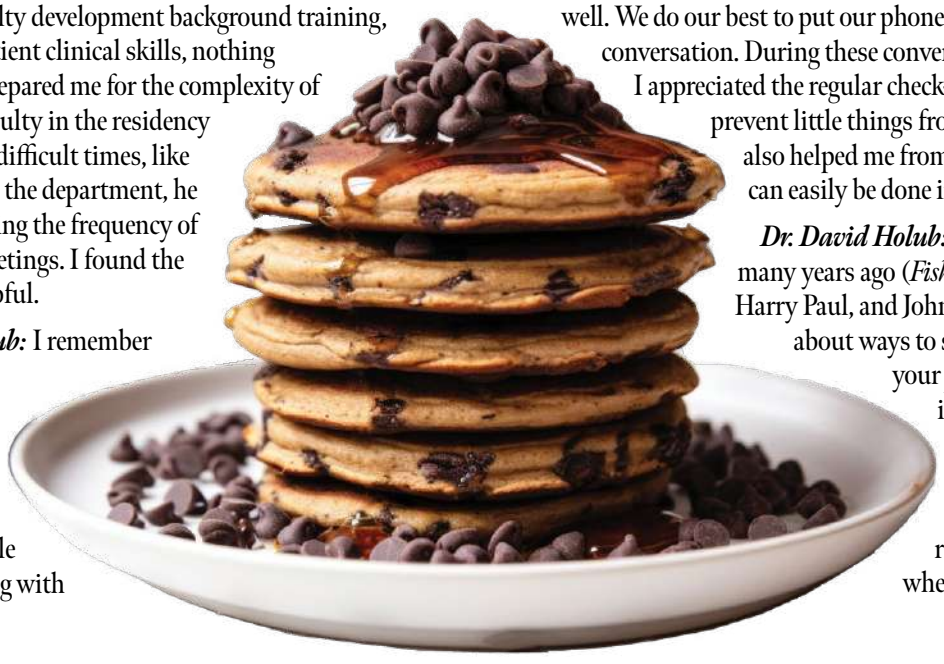
By Arthi Chawla, MD and David Holub, MD

A quick internet search will help you find why mentoring is important,[1,2,3] how to find a mentor,[4,5] and what the perceived best practices are for making a mentorship work.[1,5,6] But what you don't find is first- hand experience from a mentorship that, while far from perfect, works.

Dr. Arthi Chawla: I have known my mentor since 2018. I joined a new job, and he was my assigned advisor. At first, I admittedly thought meeting with him was just one more thing I needed to do on my never-ending to-do list. But as time went on, I found myself looking forward to these meetings. A dedicated safe time and place, where I could be myself, a place to discuss ideas, voice concerns, and complain about the never-ending amount of paperwork.

Dr. David Holub: When I was first assigned as Dr. Chawla's advisor, I also worried that it might feel like "just one more thing to do" on my own never-ending list. We are all constantly busy and the number of things to do never seems to fit into the time at work. I've had my fair share of mentees and have found each relationship to be unique. Some barely want to meet at all while others have been heavily invested and want to meet even more often than is customary. The latter turned out to be the approach that happened here. Working in a large university-based academic department of family medicine is complicated in many ways. Typically, mentors and mentees in our department have monthly meetings. In the beginning, we actually met about every 2 weeks for quite a while before eventually settling into the monthly meeting pattern. When challenging issues arose, we again would increase the frequency of our meetings.

Dr. Arthi Chawla: What I have found to work, is, primarily, that we make time to meet. Usually, over chocolate chip pancakes. When I first came to this new job, the transition was significant. I went from doing locum tenens at an FQHC in California, to working in a large university-based academic department in New York. Even though I had faculty development background training, and strong outpatient clinical skills, nothing previously had prepared me for the complexity of functioning as faculty in the residency program. During difficult times, like my adjustment to the department, he suggested increasing the frequency of our scheduled meetings. I found the extra support helpful.



Dr. David Holub: I remember a conversation once with a junior faculty colleague who was new in her first leadership role and was struggling with one of our residents who was reaching out to her constantly for advice and feedback. We were discussing it and I ended up saying words to the effect of, "When you become a leader or a mentor, your time doesn't always belong only to you any longer." So, I do think that making the time to meet is a hallmark of a good mentor, even when you have so much else on your plate. Scheduled meetings matter – they speak to the importance of the time together. On-the-fly meetings are certainly necessary too. And hey, why shouldn't they be at the diner across the street over chocolate chip pancakes if possible?

Dr. Arthi Chawla: Often I would come to our meetings with an agenda. Typically, with some dilemma I was facing that I wanted to talk through. I knew he had a checklist that the department wanted him to fill out, but he often let it go by the wayside when I needed more specific guidance. I appreciated him listening to me and responding to my needs rather than what the checklist dictated. Other times, I did not have an agenda, and would show up without anything planned.

Dr. David Holub: The checklist is actually something very important and helpful that our department leadership developed years ago. It helps ensure that all new faculty are building a foundation in the many different domains necessary when working at a university. But there were definitely times when the checklist never even came out of the file and we just talked about whatever had been happening recently. It's kind of like agenda setting in the exam room. I usually have my own agenda of issues to address with patients during their visits, but a lot of the time what they need to talk about is going to take priority and my checklist will just have to wait until the next time.

Dr. Arthi Chawla: We all lead busy lives, with many demands for our attention and time. We both make a point to not just physically show up to our meetings, but show up emotionally as well. We do our best to put our phones down and have an actual conversation. During these conversations, I felt heard and seen. I appreciated the regular check-in, because it helped to prevent little things from turning into big things. It also helped me from feeling lost, something that can easily be done in a large academic setting.

Dr. David Holub: I read a terrific little book many years ago (*Fish!* by Stephen C. Lundin, Harry Paul, and John Christensen)[7] that talked about ways to stay engaged and fulfilled in your job. It left a permanent impression on me. One of the tenets in the book was "Be there" – be emotionally present. We evaluate our residents on that very skill when we directly observe them in

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the exam room with patients. It isn't any different with mentorship. Active listening, without distractions. "Seek first to understand, then to be understood" as Stephen Covey wrote in *The Seven Habits of Highly Effective People*, another book that has figured prominently in my approach over the years.[8] We did eventually cover most of the items in the checklist. As a mentor I had to balance my responsibilities to my mentee as an individual with my commitment to the department to help her meet her obligations. We found enough time to do both.

Dr. Arthi Chawla: He has many traits that make him a good mentor. Besides showing up, listening, and meeting me where I am, he pushes me to think deeper and more critically. He has given me feedback that I may not necessarily want to hear, but need to hear. When issues came up, he would take the time to have a conversation with me to hear my perspective. I know he has my back because I have seen him advocate for me when I couldn't. He earned my trust, and respect. I took many of the lessons I learned from Dr. Holub as a mentor and applied them to my mentees. I tried to listen, meet my mentees where they were, and partner with them to help develop plans to help address whatever issues were bothering them, whether professional or personal.

Dr. David Holub: And she has traits that made her a good mentee. The one that always pops into my mind first was being solution-oriented rather than complaint-oriented. There will always be issues and struggles at work (and in life). Almost always she would come to me to discuss an issue and had already thought about one or two possible interventions that might help. We were able to tease those apart, and also come up with other potential solutions. It made the process so much more effective. Another important trait was her organization. She had an agenda and consistently brought a list to our meetings of items she knew she wanted to discuss. Most importantly, she was open to feedback and not defensive. I can be conflict-avoidant like many, but it became very easy to be candid with someone who you know really wanted to hear and work on the hard stuff. I'm not grading anyone - you don't need to impress me. I'm just giving advice to help you. Mentees who can do this will get so much more out of their mentoring relationships.

Dr. Arthi Chawla: Life is a team sport, and I believe we help each other. We celebrate each other's victories, and lend a compassionate hand during tough times. We all make mistakes, but he is humble enough to be open to my feedback, acknowledge and own his mistakes, and make efforts to correct them. When there are bumps in the road, as there always are, I feel comfortable communicating my concerns that both honor my authentic self, and also work with how he thinks.

Dr. David Holub: Well, I haven't actually made any mistakes. No, seriously, it is true that the feedback has to be bidirectional. Mentors often get as much out of the relationship as the mentees. Sometimes I have even found that when I am considering a particular situation for a mentee, it turns out that I am actually facing a similar problem and it has helped me realize a different way of approaching that for myself. I've done some things well, but I am also grateful for the feedback about things I haven't done as well that now I am able to do better for all of my mentees.

Dr. Arthi Chawla: I have had a lot of mentors, and mentees, that have come and gone. And while all of them at one point have been near and dear to me, this relationship seems to have stuck. And for that, I am forever grateful.

Dr. David Holub: We still talk regularly and are sharing this story with others even though we don't work together any longer. I think that fact speaks to the value that a great mentoring relationship can have.

To summarize, this is what we have found to be mentoring best practices:

Schedule time to meet. Show up. Be present. Listen. Meet each other where you are. Communicate issues as they arise. Be trustworthy. Be open to feedback. And most importantly, incorporate chocolate chip pancakes whenever possible.

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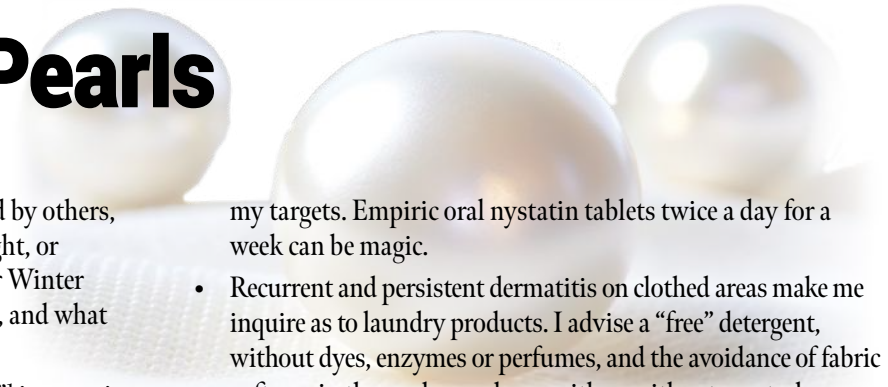
Fifty Years of Pearls

By Philip Kaplan, MD, FAAFP



This is a string of pearls, bits of wisdom not shared by others, either because I have had a unique experience or insight, or because I am wrong. I assembled such a collection for Winter Weekend presentations at several points in my career, and what follows are my favorites.

Three books guide my care: (1) "How Doctors Think"[1] is a treatise written by a Harvard department chair in which our decision-making process is analyzed, which advocates making the patient an ally in problem solving, and makes us aware of unconscious biases that can interfere with successful problem solving. I recommend it to patients who feel hesitant to express their fears and gathered intelligence. (2) "Happiest Baby on the Block"[2] changed my parenting advice. The author posits that the first three months of life are the fourth trimester, and that which sooths in utero should be emulated in infant care. I keep a supply on hand and give it to new parents, like the owner's manual in a new car glove box. (3) "Aids to Examination of the Peripheral Nervous System", Elsevier,[3] is a short atlas that makes us all neurologists. Photographs and line drawings remind us of medical school trivia when it becomes important: the course and vulnerability of the dorsal scapular nerve when injured, the proper way to test the L5 nerve root with dorsiflexion of the IP joint of the 1st toe, not the MP joint of the toe and not the foot.

- VIS, vaccine information statements, must be given before each immunization, but most parents don't attend to them at a visit when siblings are climbing the furniture. We give a booklet of the first two years of VISs to new parents, with a description of NYSIIS and a schedule of vaccines so they may review these explanations at home at leisure. The 2019 CDC vaccine schedule had a description of the illnesses prevented on the reverse side, so we make this part of the packet.
- The early burp: "Newborn spits up all the time." I believe that infants swallow air when they cry for the next meal, that feeding them to the level of the gastric entry of the esophagus traps gas in the fundus, distends the fundus and leads to hiccups, and the cure is burp them after the first half dozen swallows. Then finish feeding.
- The tired adult consumes a large portion of our intellectual bandwidth. Vitamin B12 absorption problems should not be overlooked, especially with the general overuse of OTC PPI medications.
- Post dysentery prolonged diarrhea sparked a series of articles in the NEJM in the 1970s. Temporary gluten sensitivity, temporary lactose intolerance, and diarrhea induced folate deficiency were each posited as the cause. So, when I counsel such a patient I advise a short course of fat free, lactose free, gluten free diet with generous folate supplementation. The patients thus relieved are forever grateful.
- Equally grateful are the patients relieved of pruritis ani. Food sensitivities (beware the cinnamon bun) and rectal yeast are my targets. Empiric oral nystatin tablets twice a day for a week can be magic.
- Recurrent and persistent dermatitis on clothed areas make me inquire as to laundry products. I advise a "free" detergent, without dyes, enzymes or perfumes, and the avoidance of fabric softener in the washer or dryer, with or without scents, because my wife had this insight for my dermatitis decades ago.
- Recurrent yeast or staph infections on clothed areas of the body suggest the clothing may be a fomite. When I was a kid the hot water tank was set at 160°F, as is the commercial laundry that does our exam gowns. Most home hot water tanks are now set at 120°. We can emulate the good old days by ironing affected clothing.
- Beware red dye #40. Young lady had hives when singing in the chorus. She was not anxious – she was headed for a career in vocal music. She had wetted her whistle with a red fruit rollup before each performance, and upon breaking out she took a Benadryl capsule bearing the pink circumferential stripe, colored by red dye #40.
- Ever notice a correlation between trismus, jaw or ear pain, and bilateral lateral epicondylitis? Tender mandibular condyles, tender lateral epicondyles, masseter hypertrophy resulting in Dick Tracy square jaw fascies (who is Dick Tracy) mark this phenotype. When I see one I ask about the other. Awareness begins a cure.
- How do you treat hyperventilation? Breathing in a paper bag induces more anxiety in the anxious. Walk up the stairs to generate CO2. The relief with exercise also induces confidence that the symptom is not coronary or pulmonary disease.
- In the coldest weeks of winter patients present with toes that have painful red to purple swellings and that itch when warmed. I have seen colleagues treat these with antibiotics or attempts at surgical drainage. The diagnosis is pernio or chilblains. These are the result of torso chilling, peripheral vasoconstriction and some historic or genetic vulnerability. The treatment is wear layered warmth on the torso, keep the feet warm, and if you have a hairdo like mine, sleep with a knit hat.
- Some of our patients do not get anesthesia from lidocaine or procaine. They have "sodium tunnel defect", apparently an inherited difference in nerve membranes that does not match the anesthetic molecule. They do get anesthesia from mepivacaine or the dental anesthetic Articaine. Keep some on hand.
- Needles are needlessly large. A pharmacist gave me a covid booster with a harpoon. We draw blood with 23-gauge needles without hemolysis; we give vaccines with 27 gauge and anesthetic with 30 gauge.

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- I have previously reported on my beliefs for removing cerumen, subungual slivers, and poison ivy sap,[4] not to be repeated here.
- We gave up using an answering service a dozen years ago. The human interface introduced frustrations. We have an in-house system via ITStelephone.com which provides an outgoing message after hours, takes the patient complaint in the patient's voice, and sends it to the cell of the provider on call with in depth alternatives for failure of the first provider to pick up the call, and battery backup for power failures.
- Keeping vaccines safely stored requires constant vigilance. The VFC required temperature monitor tells us when we have failed, but the critique can be noted after a solution is no longer possible. Enter CorisMonitoring.com. They offer a refrigerator sensor which constantly communicates with a modem to their base station. If the temperature approaches a preset limit a message is sent to my cell to alert me to go evaluate the deviation before catastrophe. And we get a weekly online printout of vaccine temperatures. Like watching paint dry. (see report below)
- My career took an entirely new direction when I became active with NYSAFP. I have come to believe that advocacy is an antidote to burnout.[5] If we are effective agents of change we are no longer passive victims.

In this issue of our journal I have listed a few of my pearls and I am excited to read the pearls of others. Perhaps our Academy can develop a clearing house for pearls, an online discussion group for pearl sharing. We each make insightful observations about nature, illness, the human condition, and we are too busy to subject them to scientific rigor. By finding some observations that we share (if two people see it, it is not an hallucination) we can begin the process of benefiting from the pearls that survive the rigor of discussion. If you enjoy this issue, and if you have a pearl to share, send an email to fp@nysafp.org or to philzoffice@gmail.com (my email address) or if our leadership agrees, there could be a pearls@nysafp.org.

Endnotes

1. "How Doctors Think", Jerome Groopman, Mariner Books 2008
2. "Happiest Baby on the Block", Bantam Books 2003
3. "Aids to the Examination of the Peripheral Nervous System" Micheal Obrien editor, Guys Hospital London
4. "Two Guiding Principles" Philip Kaplan, Summer 2023 edition Family Doctor
5. "Immunize Against Burnout" Philip Kaplan, Family Practice Management, March 2017, p42

Phil Kaplan, MD, FAAFP *is a family medicine physician at Fairgrounds Family Medicine in Manlius, NY. He has served the NYSAFP for many years in many roles, including President.*

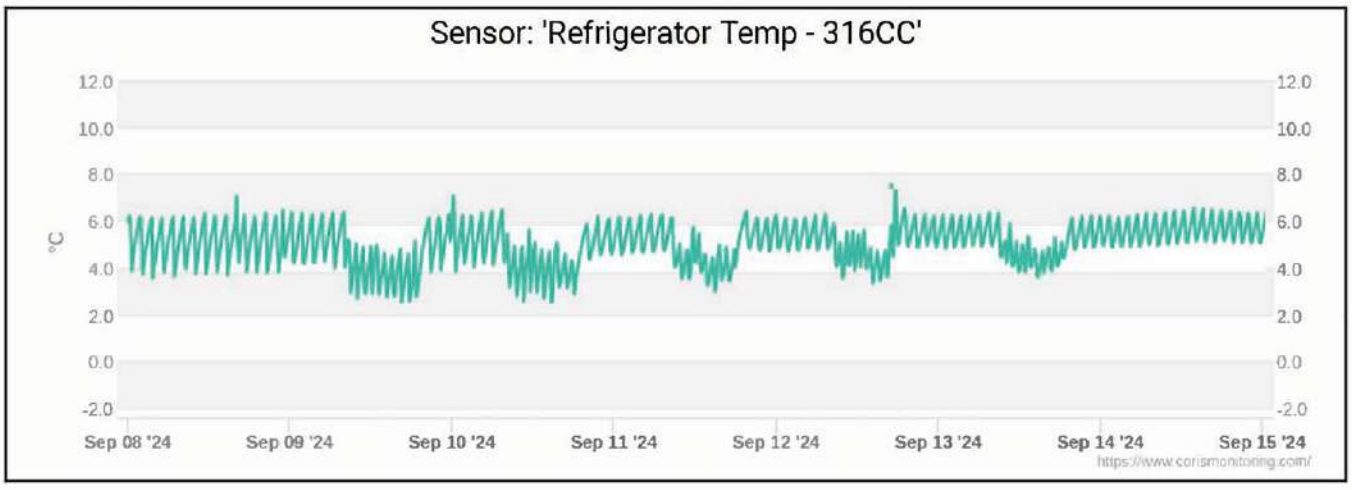
CORIS

Weekly vaccine temp report (weekly)

September 8, 2024 thru September 14, 2024

Sensor	Avg.	Min	Max	Range
Refrigerator Temp - 316CC	5.19 °C	2.6 °C (2024-09-10 14:14)	7.54 °C (2024-09-12 16:54)	4.94 °C

Sensor Statistics (Daily)	09/08	09/09	09/10	09/11	09/12	09/13	09/14
Refrigerator Temp - 316CC (Daily Avg)	5.28 °C	4.76 °C	4.81 °C	5.11 °C	5.3 °C	5.24 °C	5.8 °C
Refrigerator Temp - 316CC (Daily Min)	3.74 °C	2.64 °C	2.6 °C	3.18 °C	3.52 °C	3.76 °C	5.03 °C
Refrigerator Temp - 316CC (Daily Max)	7.2 °C	7.23 °C	6.68 °C	6.58 °C	7.54 °C	6.51 °C	6.7 °C



Upside to the Downside

By Anonymous

I was an average child. My mother made that abundantly clear. But then she would add, almost as an afterthought and with a smile, "Average people make the best doctors, they can talk to the common man." She confirmed I was unremarkable by having me tested for a learning disorder. At 5 years old, I was too young as a girl to have attention deficit disorder. Besides, all they did was confirm my mother's clinical judgment as a family doctor that I was in fact, just average.

Nevertheless, my mother fiercely believed in my ability to achieve success. In fact, growing up at a time when peak mediocrity was seen in the highest office of the land, through President Bush, my mother questioned why I couldn't similarly achieve greatness. My modest grades meant nothing to my mother and her belief in me created ambition far beyond what my teachers expected. So, I went outside my school and worked diligently with tutors, completed, and sometimes failed, community college night classes, and applied for writing scholarships. I never came close to winning those. Meanwhile my mother showered me with support as only Asian parents know how, with tutors and rides preparing me for greatness.

I looked at medicine early in adolescence and couldn't imagine any other career. I considered seven-year programs and discovered I lacked the academic excellence expected from applicants. It didn't matter. I decided I would make my own seven-year program. I consolidated my four-year undergraduate bachelor of science degree into a three-year degree by taking summer classes, including a few necessary repeats. My less-than-stellar 2.7 science GPA was bolstered by my passable MCAT score. Yes, my averageness followed me through college.

When I applied with all the audacity I could muster to medical school, I felt the burn of thirty medical schools sending out easy rejections as my failures overshadowed a patchwork of successes. Undeterred, I called each school that had granted me an interview and asked about how I could overcome my inadequacies. I applied again, diligently following the recommendations I received and was granted entry to not one, but two medical schools! My mother and I were elated! Finally, I could start the journey and move from ordinary to extraordinary.

However, the road was bumpy as my first semester I failed my classes despite one advisor stating, "You didn't do that badly." I was promptly placed in a post-baccalaureate program with the ominous threat that if I failed to maintain an eighty percent average, medical school was not for me. Terrified that I might slip below average, I studied and exercised religiously, enduring the stares and whispers of my former classmates and the brazen questions about "what went wrong?" I continued to work despite the shame of walking into the same building for which I had been told I wasn't good enough. My mother sighed over the phone, and said "Don't worry, I didn't pass my first year either."

I applied myself and was rewarded with a new spot in the first-year class while repeating my first year. I also found a group of friends that discovered breaking content into manageable chunks was how they learned best. This study group is likely the main reason I passed my remaining classes and entered my clinicals. I excitedly informed my family of my upcoming white coat ceremony, but only my mother and brother attended as the rest of my family believed I would not end up finishing medical school and it was not worth the trip.

Despite demonstrating resilience in the face of failing out once, I hit a roadblock with the first step board examinations. It was an exam unlike medical school's basic sciences testing, and I struggled to pass not once, but twice. Hearing this my mother

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promptly bundled me off to a board review program in the Midwest that I'd found in desperation. She casually advised me not to worry since she didn't pass her boards the first time either, and ended up having to leave the country while awaiting the results as a foreign medical graduate educated in India.

The board review class and another study buddy were a huge help and I promptly passed my boards, allowing me to continue with my class despite being off-sequence, a problem I hid with multiple successfully-completed shelf exams and competitively excelling on the remainder of my board exams until graduation day. Then, while my peers showed off their new degrees, I kept my folder firmly closed, knowing I had another two months before my degree would be mailed to me. Despite the competitive board scores on my steps 2 and 3, I was off-sequence and forced to find a residency that would be willing to accommodate me. I was relegated to a rural residency that struggled to find residents to fill its slots. A perfect match and my fourth choice! I spent my rotations there to become acclimated to the new hospital, my home for the next three years.

On my first day as an intern I struggled to put in orders for an infant needing light therapy, as I was still a medical student in the EMR's eyes. My attending at the time quipped, "Well, that is discouraging." I couldn't help but agree. It didn't help when I failed two pediatrics rotations during the course of my intern year. Refusing to tolerate any evidence that I was not meant to do medicine, I chose to do my away rotation at Vanderbilt in the pediatric emergency room. I wanted to go somewhere where the teaching was excellent and I could feel confident in my pediatric procedural and diagnostic skills.

Upon return I passed my family medicine board examination and started a new job in primary care at another rural hospital, still 2 months late thanks again to my failure of step 1. I wanted to get away from the clinging stench of failure that had followed me throughout my career. Ironically, I found myself teaching residents from a program that had refused to take me on as a resident. Suddenly, now I was good enough to teach as a clinical professor despite being unqualified to learn from their program as a resident.

At my first job I developed a side hustle of writing test questions for board prep companies. I wrote hundreds, enjoying the academic work and feeling less isolated in a rural health environment. While at a conference, I learned that the NBME was looking for support from clinicians. I sent my resume and found myself writing and editing test questions for the same exam I failed multiple times years ago. While at an NBME workshop I was offered a teaching position at a medical school that had rejected me outright as an undergraduate. I was told as a reason for the position that "Very few professors know how to write questions for the board examinations." I didn't disagree with him.

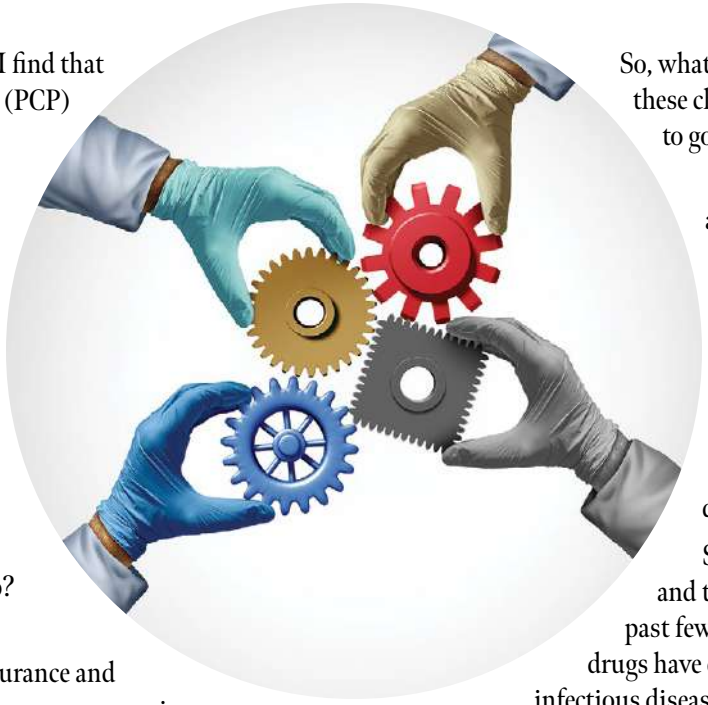
Even now, as I write this, it requires a suspension of disbelief to see my work published, given all my failed attempts at writing competitions in high school. Each failure brought out naysayers, whispering explanations for why I shouldn't be there, that I was not good enough and never would be. Catching a whiff of the failures along my career path, more than a few "friends" told me I didn't belong in medicine. Each setback taught me how to get back up and try a smarter approach. But the thing about getting knocked down is that when you always get back up, every failure just looks like a new opportunity. At some point my failures revealed determination as an intrinsic aspect of my character. This is a trait that is overlooked and undervalued during medical education, where academic talent reigns supreme.

My mother no longer speaks much as vascular dementia has claimed much of the person who was my greatest cheerleader. However, she has taught and lived as Ambrose Bierce wrote, "Perseverance - a lowly virtue whereby mediocrity achieves an inglorious success."

***The Author** graduated in 2012 from medical school and is currently board certified in family medicine. The author has practiced for a decade in rural medicine and has transitioned to telehealth.*

Reflections on Being a Primary Care Physician

By Asad Butt, MD



Now two years out of residency, I find that the life of a primary care physician (PCP) is not exactly what I imagined. Working with a patient who has hepatitis C for weeks to find him the right treatment, only to find out that he cannot afford the medication. He makes too much to be on Medicaid but not enough to be able to buy the antiviral medication. Needless to say, the drug manufacturers don't provide financial assistance or discounts on the medication he needs. So, what does the patient do? How do I best practice medicine?

The government, along with insurance and pharmaceutical companies, have immense power in dictating how I practice medicine. It's frustrating, and quite ironic, that the CEO of a pharmaceutical company who just received a million-dollar bonus has no trouble stating that $2,000 for a given medication is just too much for them to cover.[1] Or that a politician can be so proud to announce a multi-billion-dollar project for space exploration, yet apparently there isn't enough money to build affordable housing here on planet Earth.[2]

Therefore, I am often left prescribing older generic medications that are not ideal but at least affordable. This is after I have spent hours submitting prior authorizations trying to prove that the patient really does need the medication.[3] And yes, after more than a decade of studying and seeing thousands of patients in training and practice, I am sure they need it.

I do not blame the government or corporate America for all of the troubles in medicine. I wish it was that simple! Patients, and the decisions they make, also play a role in this situation. There are very real consequences when patients refuse to take medications, decline vaccinations, and do not make healthy lifestyle choices.

Every doctor faces the difficult task of motivating patients to do the "right" thing while respecting their autonomy to make "bad" decisions. I am not blaming patients for their sickness and do not wish to trivialize their socio-economic circumstances. But I am skeptical of people in the medical field who use corporations as a scapegoat.

So, what makes me optimistic despite all these challenges? What makes me happy to go to work every day?

First, there is the idea of accompaniment. I have come to learn that not all problems need to be solved. Sometimes patients just want to be seen and heard. They realize that you cannot cure all of their ailments. But you can support them on their journey as they live with certain diseases.

Second, advancements in science and technology continue apace. In the past few decades, as an example, new drugs have come about to treat and manage infectious diseases like HIV and hepatitis C. The rapid development of Covid-19 vaccinations is another example of the triumph of scientific inquiry and investigation. No medication or vaccine is perfect, but they have undeniably led to reduced morbidity and mortality rates. I am excited to read the latest journals to see what new trials and experiments are being carried out, and the promise they hold.

And lastly, when the outcome looks bleak, I try to find the humor in tragedy. As one doctor told me, in medicine, "You are either laughing or crying." I have stories that you would never believe took place because they are so awful; in the face of such tragedy, humor has served as one of the best coping mechanisms. And it will continue to be so.

Endnotes

1. Rosenbaum, Andrew Dunn, Leah. n.d. "Here Are the 15 Highest-Paid CEOs in Biopharma, Bringing in Paychecks of at Least $25 Million in 2021 – with 2 Making over $100 Million." Business Insider. Accessed June 7, 2024. https://www.businessinsider.com/list-top-paid-pharma-and-biotech-ceos-2022-5#immunitybio-ceo-richard-adcock-29016727-6.
2. CNN, Ashley Strickland. 2022. "Biden's $26 Billion Proposal for NASA Paves Path for 1st Human Exploration on Mars." CNN. March 28, 2022. https://www.cnn.com/2022/03/28/politics/nasa-2023-biden-budget-scn/index.html.
3. Stockton, Alexander. 2024. "Opinion | 'What's My Life Worth?' the Big Business of Denying Medical Care." *The New York Times*, March 14, 2024, sec. Opinion. https://www.nytimes.com/2024/03/14/opinion/health-insurance-prior-authorization.html?searchResultPosition=1.

***Asad Butt, MD** is a family medicine physician originally from Cleveland, Ohio. He practices medicine in New York City and is passionate about helping his patients lead healthy, fulfilling lives.*

Advice on How to Live Your Family Medicine Residency Experience to the Fullest

By Janice C. Lau, MD

Congratulations on being a current or future resident family physician! Everyone is going to have a different residency experience, but two things are guaranteed: the days are long, and the three or four years of training will fly by. No matter where you are, residency can be very challenging, but as I have experienced personally as a recent family medicine resident graduate, it can be an extremely rewarding journey. Whether you are just beginning your intern year or are in the final stretches of your training, the following pieces of advice have helped me to optimize my residency experience, and I hope they will also help you to maximize your learning and well-being.

1	**Don't be afraid to ask questions and know when to ask for help.** Residency is the time to ask all the questions! In fact, you are highly encouraged to ask questions. There are no expectations for you to know all the answers, so now is the opportune time to learn as much as possible. A sign of a good and caring physician is knowing when to ask for help and acknowledging when you are outside of your comfort zone. Take advantage of your attending physicians, fellow residents, nurses, and pharmacists, and pick their brains as often as you can. It is absolutely acceptable to reach out and verify medication dosing or brainstorm possible differential diagnoses. No one will fault you for doing the right thing for patient care and wanting to learn more.
2	**Be on time and be prepared.** No matter what rotation you are on, showing up on time and giving yourself ample time to prepare for the day will always serve you well. Not only will you have more time to review patients' charts and develop a plan, but the day will also feel less chaotic. Furthermore, numerous people are depending on you: your co-residents, nurses, attendings, and most importantly, your patients. If you do find yourself with extra time later in the day, catch up on your in-basket, squeeze in a quick stretching session, or take a walk to the café
3	**Learn something new every day.** Now is the time to soak up as much medical information and experience as you can! As residents, we have the privilege of unlimited learning. Depending on what you will do after residency training, you may not have this opportunity again. If a code is called and you have never run one before, be brave and volunteer to run it while you have the support and guidance of a whole team. If you have the opportunity to observe a fine needle aspiration of the thyroid, go for it! If you are presented with the opportunity to spend a day with the inpatient geriatric psychiatry service, take advantage of it. Doing all these things will only enhance your knowledge and understanding, even if you do not plan on incorporating these things into your future practice, and provide you with a better foundation as a family physician.
4	**Expect the unexpected.** A core part of residency training is learning to be flexible and being comfortable with the unknown. You never know what unforeseen curveballs may come your way. For example, your rotation schedule and experiences may change for a variety of reasons, including scheduling conflicts, attending availability, or even to observe a once-in-a-lifetime total eclipse. You may be looking forward to an elective that you have waited for years, but you may need to cover for a colleague on an essential service for a variety of reasons, such as illnesses, family emergencies, or jury duty, and sometimes on short notice too. You may also find a particular rotation or aspect of residency challenging that catches you off guard. Regardless of the circumstances, take every situation as an opportunity and make the best out of it.
5	**Be patient with the electronic medical record (EMR).** Regardless of what EMR your institution uses, it can take a very long time to become accustomed to it. Physicians who have been using the EMR for years are always learning new shortcuts from each other. At the beginning of each rotation, it can be helpful to spend some time with fellow residents and attendings to personalize your EMR and note templates to optimize efficiency. One of my attendings once told me that the EMR is a tool that can be used to help us, rather than a hindrance to our workflow. Rest assured that your efficiency and ease with charting and documentation will definitely improve with time. Soon, you'll be the one showing everyone all the EMR tools and tricks!

6	**Attend conferences and medical meetings.** Conferences and meetings are fun and exciting! It is a fantastic way to meet other family medicine residents and physicians to make new connections that could span your career. You will have countless opportunities to learn about the newest ideas in family medicine, and going to conferences will get you feeling energized and excited about the work that you do. You will feel motivated and will come away with many ideas for the future. Popular conferences for family medicine residents include the AAFP National Conference, AAFP FMX, FMEC, STFM, and the NYSAFP Winter Weekend.
7	**Participate in scholarly work.** Explore a topic of interest with other co-residents and faculty members to submit an abstract for a conference or journal, such as NYSAFP's journal, Family Doctor. The process will teach you about medical inquiry and the process of formulating good clinical questions. The field of family medicine is always evolving, and we can be at the forefront in helping to provide the best care possible for our patients.
8	**Be a physician advocate.** Meet with legislators and advocate for issues that you are passionate about. As a physician, your stories of meaningful patient encounters can have a profound impact on policy. This is also a good way to learn about the legislative process and how physicians can be a vital voice. In New York State, you can participate in the annual Physician Advocacy Day with the Medical Society of the State of New York, as well as the NYSAFP Advocacy Day.
9	**Explore different practice settings and practice models.** One of the strengths of family medicine is that the breadth of our training allows us to practice in diverse settings and environments. Whether you decide to practice outpatient medicine, inpatient medicine, rural medicine, or obstetrics in a private, academic, or community setting, spend some time at different environments than the ones you are at in residency. Take advantage of your residency's alumni network to explore different settings. Learning about different practice and payment models can be very informative when it is time to start the job search and figuring out what suits you as a family physician.
10	**Volunteer to teach medical students and co-residents.** Do you remember being a medical student and being grateful that a resident took the time to teach you and show you the ropes? Now you can be that resident and pay it forward! It may not feel like it, but you have so much knowledge and mentorship to offer as a resident. Whether you are teaching on inpatient medicine or in the clinic, or giving a lecture on a topic that you are passionate about, teaching can be a very rewarding experience and a confidence booster because you will realize how much you have learned.
11	**Relax during your time off!** Having time off from work is essential to letting our brains reset. Carve out some time each week, whenever you can, to do something fun that will leave you feeling refreshed, renewed, and fulfilled. Residency schedules can make it difficult to see friends and family, so be sure to find time to reconnect with those who are important to you.

Medicine is a journey filled with people who will help shape and guide you as a physician, and that includes residency. Residency can be a very challenging, but enriching, time, and this is when you make mistakes and grow from them. As my favorite clinic counselor says, "Discomfort and growth travel in the same vehicle." Be patient with yourself and know that you are never alone throughout this journey. Take the time to explore what family medicine has to offer and to envision the kind of family physician that you would like to be. I look forward to working with you as future colleagues!

Resources

American College of Physicians. "First Year Residency Tips." American College of Physicians: Residency Career Counseling. <https://www.acponline.org/about-acp/about-internal-medicine/career-paths/residency-career-counseling/first-year-residency-tips>.

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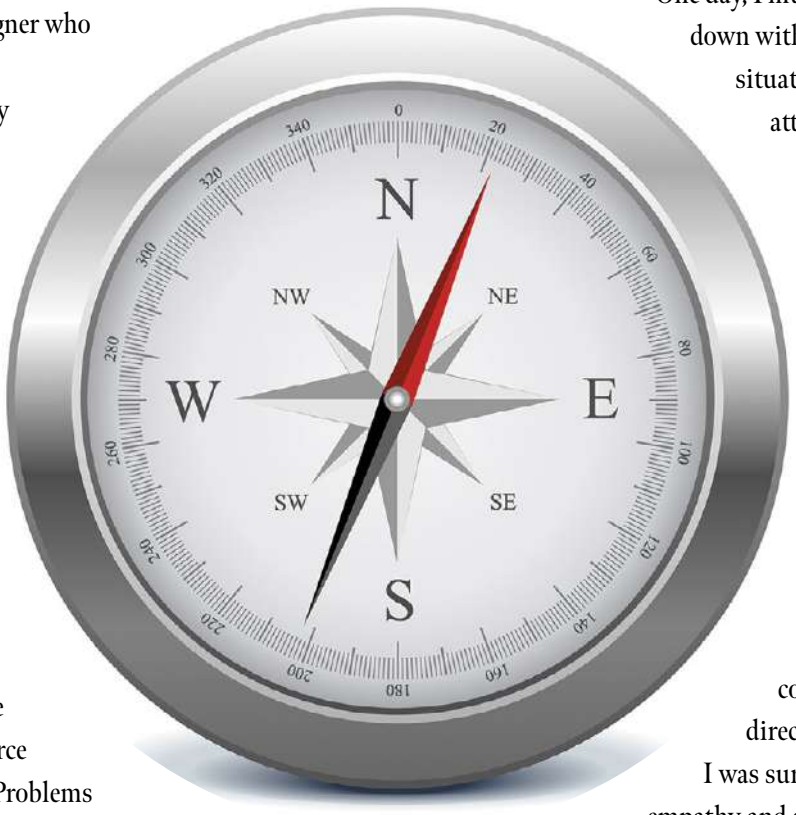
***Janice C. Lau, MD** is a graduate of the University of Rochester Family Medicine Residency Program's Class of 2024.*

Navigating Residency and Single Parenting as a Foreigner – Lessons Learned from a Personal Crisis

By Yuki Takeuchi, MD

Residency is universally challenging, and the additional stressors of personal upheavals can significantly impact both mental health and professional performance. In the middle of my second year, I went through a divorce and decided to become a single parent to my 3-year-old daughter. Moreover, as a foreigner who moved from Japan for this residency, I had no local family members for support. I felt like there was "no hope." I had to decide whether I could continue my residency as a single parent. I also wondered if it would be doable even if I chose to continue. How could I manage busy rotations or on-call duties? Would there be available childcare? Could I afford it? Additionally, I had to navigate the stressful processes of divorce and custody simultaneously. Problems kept arising one after another. The duties as a resident also weighed heavily on me, and there were moments when I felt overwhelmed. I struggled with loneliness, exhaustion, and the constant pressure to perform professionally while dealing with personal turmoil. Fortunately, I managed to continue my residency, overcoming numerous challenges. Here, I would like to share my experiences and the lessons I learned from these challenging moments, as well as how I navigated residency during a personal crisis.



Be Open About Your Weaknesses, Vulnerability, and Challenges

The most important thing I learned during this challenging time was the value of being open about my weaknesses, vulnerabilities, and challenges. Accepting my own weaknesses was never easy, and sharing them was even harder. However, I had no choice but to break out of my shell and ask for help. If I didn't, I felt like I would drown. I feared inconveniencing others, being perceived as weak, and not being understood due to my minority background. But in reality, this was not the case at all.

One day, I mustered the courage to sit down with my advisor and explain my situation. My advisor listened attentively, nodding in understanding as I described the challenges of balancing my demanding residency with the responsibilities of being a single parent. After a long pause, she looked at me and said, "You don't have to go through this alone. We're here to support you."

Following that conversation, my program director and I had a meeting where I was surprised by the level of empathy and support offered. They adjusted my rotation schedule to allow more flexibility for childcare, and we discussed strategies to manage on-call duties. My chief resident even stepped in to rearrange the call schedule, allowing me to manage childcare during challenging shifts.

In addition, several co-residents offered to help with childcare or cover shifts if an emergency arose. I remember one instance when I had to leave the hospital early because my daughter fell ill at daycare. I was overwhelmed with guilt, but my co-resident, who took over my patients, reassured me saying "We're a team, and your family comes first."

These moments of support were not isolated; we met repeatedly to explore feasible ways to continue my residency as a single parent while meeting ACGME requirements. Despite

being a foreigner without family nearby, I managed to continue my residency for about six months with this incredible network of support. Throughout this time, I received many encouraging words that helped me overcome the challenges.

If you find yourself standing still, unsure of what to do in the face of difficulty, please don't be afraid of being open about your vulnerabilities. You are surrounded by kind and warm-hearted people working in the field of family medicine, and by sharing your struggles, you allow them the opportunity to support you in ways you may not have imagined.

Reflect on your Values

Facing a situation where I could no longer manage everything as before, I found myself at a crossroads between my career and parenting. This forced me to reflect on my values and consider what I needed to prioritize and what I might have to sacrifice. As an international medical graduate who was born and raised in Japan, starting and continuing my family medicine residency at the University of Rochester required immense effort—something I couldn't easily give up. However, I realized my limitations and understood that I could no longer do everything perfectly. To balance my career and parenting, I had to seriously think about what was truly important and assess my priorities.

The journey to this point had been marked by years of hard work and dedication, and my career was deeply significant to me. Letting it go was not an easy option. At the same time, my responsibility as a parent was equally vital, and I couldn't afford to neglect it. In this struggle, I reflected deeply on what truly mattered to me. I couldn't simply choose between my career goals and raising my daughter; both were incredibly important. There was a moment when I considered giving up my career and returning to Japan for the sake of my daughter. But then I asked myself, how would I feel if I were in her shoes, watching a parent abandon their dreams? What kind of life would I want her to aspire to?

I want my daughter to chase her dreams and not give up easily, even when faced with difficult circumstances. To achieve that, I needed to set an example as a father who challenges himself, even when the path was tough. I wanted to build a relationship where, regardless of the outcome, we could look back and say, "We faced the challenges together." As a result, even though I knew it would be a difficult journey, I chose to continue my career while prioritizing time with my daughter and ensuring I could support her growth.

Be Mindful of Your Cognitive Limitations During Emotional Surges

During a crisis, my brain was overwhelmed with a mix of emotions: sadness, regret, shame, guilt, anger, hopelessness, and more. I tried to stay strong and perform as usual, but several attendings noticed a significant decline in my performance. This feedback pushed me further into a desperate situation. Looking back, it's clear why this happened. Even in my personal life, I made many mistakes that I usually wouldn't, such as forgetting to turn off the car engine and running out of gasoline or leaving the stove on after cooking. I learned that under significant stress, the brain's prefrontal cortex doesn't function properly due to the activation of the amygdala, leading to a decreased ability to focus and make good decisions.[1]

Fortunately, my advisor and program director were very understanding about how emotional stress affected my performance. After discussing it with them, I decided to take a short-term leave and temporarily reduce my clinical load. Gradually, I returned to my normal workload with frequent check-ins. For emotional care, I began seeing a therapist, and started journaling. Talking with family and friends also helped me process my emotions. To conserve my cognitive resources, I managed my to-do list and schedule on a smartphone. By addressing both my cognitive and emotional needs, I was able to navigate through the challenging period more effectively.

Building a Bigger Team

It was impossible to manage residency and parenting alone. To make it work, I needed to build a bigger team. Fortunately, I received a great deal of support not only from my residency program, which showed understanding and cooperation, but also from local friends and the Japanese community. They provided invaluable help, especially with childcare and meals, which also became a form of psychological support. To reduce the burden of household chores, I implemented some efficiency strategies such as utilizing grocery shopping delivery and using a cleaning robot. By optimizing tasks and seeking external help, I was able to create a bigger team that made this challenging endeavor possible. I am deeply grateful for all the goodwill and support I received.

Don't Put Off Self-Care Even in a Crisis

It's easy to say that self-care is important, but practicing it is difficult. Especially during a crisis, it becomes much harder as your plate is overflowing. In my case, finding time for self-care between

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work and single parenting was extremely challenging. However, I found some strategies to maintain my own wellness during these difficult moments. I recommend making a list of quick wellness activities. For me, these included shooting a basketball, short meditation, walking outside, or simply sitting outside. I would engage in these activities whenever I found spare time, often between finishing work and picking up my daughter from daycare. Even though the time was short, having moments without the responsibilities of being a resident or a parent was a relief.

Another important tip is to secure time for your wellness activities in advance. It's easy to become overwhelmed by the many issues that arise. On some weekends, I asked babysitters or friends to take care of my daughter so I could make time for self-care. I felt bad about leaving her with others on some weekends, but I realized that staying on top of my own wellness was crucial to surviving those challenging times. More importantly, maintaining my wellness allowed me to be truly present and attentive with my daughter when we were together. Creating a life calendar in advance that included time for self-care was a useful way to ensure I practiced this.[2]

Setting Limits and Having a Safety Net

After many discussions with my family in Japan, we decided that if balancing residency and parenting became too difficult, I would temporarily have my parents take care of my daughter. Knowing I had this safety net provided significant psychological support. About six months later, I found myself in a situation where managing on-call duties and childcare became nearly impossible. As I watched my daughter's peaceful sleeping face one night, I realized with a heavy heart that I could no longer ensure both safe childcare and the continuation of my residency. It became clear that the best thing I could do for her was to focus on securing a stable future for both of us, even if it meant sending her to stay with my parents in Japan temporarily.

Making this decision was incredibly tough, and it left me feeling deeply lonely and guilty. However, because we had anticipated this possibility, the transition went relatively smoothly. Although it was not easy emotionally, I found some comfort in knowing that my daughter was receiving excellent care from my family in Japan. Thanks to technological advancements, I'm able to stay in touch with her daily, even from overseas. We plan to live together again once my residency is completed. In hindsight, I believe this was the best possible decision for both my daughter and me, allowing me to focus on my residency while ensuring she is in safe hands.

Appreciation for Unwavering Support

As I reflect on this challenging chapter of my life, one thing stands out more than anything else: the unwavering support from those around me. The kindness, understanding, and genuine concern I received from my program, colleagues, friends, and the broader community were instrumental in helping me navigate through the darkest times. I am profoundly grateful to my advisor, program director, program coordinators, chief residents, co-residents, co-workers, and many others who not only adjusted schedules and provided resources but also extended empathy and encouragement when I needed it most.

My friends and the Japanese community in Rochester became my surrogate family, offering emotional support, childcare assistance, and even home-cooked meals during the most trying days. Their acts of kindness not only lightened my load but also restored my faith in the power of community and human connection. This experience has taught me that even in the face of seemingly insurmountable challenges, you are never truly alone. There are always people willing to help, and it's okay to lean on them when needed. I now carry with me a deep sense of gratitude for everyone who stood by me, and I am committed to paying forward the kindness and support I received. This journey has been a testament to the incredible resilience and compassion of the human spirit, and for that, I am eternally thankful.

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Doctor to Doctor: A History of Relations

By Thomas C. Rosenthal, MD

From his 1804 arrival in New Amsterdam (today's Buffalo, NY), apprentice trained thirty-five-year-old Dr. Cyrenius Chapin maintained a focus on doctoring and the value of a large patient panel to support his family. Riding horseback from Fort Erie, Canada to the Pennsylvania border, Chapin took barter when necessary, and trusted that at least a few families could pay in cash. Like his contemporaries, Chapin used about thirty remedies for a broad range of conditions. Soon his reputation attracted a steady stream of apprentices, including a few who had college degrees. (G. F. Pratt, 1869) They found Dr. Cyrenius Chapin to be a consummate preceptor, despite being cantankerous, difficult, indefatigable, and fond of hard liquor.[1]

Cashless farm families, spurred on by the self-sufficient individualism of post-Revolutionary America, consulted a hand-me-down home remedy book when they got sick. If that failed, they sought a neighborhood healer. Calling for a doctor meant desperation.[2] Most neighborhood healers were well-meaning people who offered a variety of folk remedies. Others followed a sectarian model as devotees of sometimes bizarre speculations; and they disparaged regular medicine. Samuel Thomson was one such huckster; an herb and botanical imposter who attracted a network of devotees basing their cures on the mildly psychedelic lobelia plant. Thomson's book declared regular doctors to be frauds. (S. Thomson, 1835) By 1830, the competing and systematized dilutions of homeopathy rose to overshadow even the popular Thomson.

Still, the most damning criticism of regular doctors came from other regular doctors themselves, particularly where the competition for patients was intense. Cyrenius Chapin's first competition came from a college-trained doctor named Daniel Chapin. Though unrelated, their disagreements caused many to assume they must be cousins.[1,3]

The City of New York first tried to regulate medical practice in 1760 by requiring anyone wishing to call themselves 'doctor' to pass an oral exam. The restriction was simply ignored. If regular medicine was to survive sectarian competition and internal brawling, regular doctors needed to unite, establish training standards, create avenues for continued education, and establish ethical norms.

In 1805, Dr. John J. Stearns of Saratoga took up the issue. Stearns, a graduate of Yale college and the University of Philadelphia, described untrained practitioners and sectarians as "ignorant, degraded and contemptible."[4] His target included sectarians, barber surgeons, bonesetters, and the lithotritists who made a living cutting stones from urinary bladders. But these 'irregular doctors' argued that licensing was just a ruse to corner the market on patient fees. There were even a few established physicians who feared that examinations might confuse patients into thinking that recent graduates were equal to, or better than, experienced physicians.[3,5]

Dr. Stearns believed that medicine would prosper only if regular doctors embraced a guild like structure. He teamed up with Dr. Asa Fitch of New York's Washington County and Dr. Alexander Sheldon, a New York State Assemblyman from Montgomery County. They presented the legislature with a proposal to formalize an infrastructure of county medical societies charged with examination and licensing of regular doctors. Each county society would send a representative to form a statewide board to govern the program.[6] Stearn's newly organized Medical Society of the State of New York elected Dr. Alexander Coventry of Utica as its first president.[4,7]

Stearns also published a table of fees physicians might charge if a member of the NY medical society. It listed a charge of $5 for an initial consultation with charges for subsequent visits set at $2 each. Bloodletting by lancet was valued at $5, and delivering a baby was set at fifteen to twenty-five dollars. Given the average weekly wage of a laborer in 1805 was about $5, these fees were high, but the table attracted society membership.[7] The New York Journal of Medicine reported that the legislation would achieve "the suppression of empiricism and the encouragement of regular practitioners."[8]

Upon its passage by the New York legislature in 1806, Stearn's program encountered immediate opposition from sectarians, quacks, and snake oil salesmen. Medical colleges complained the law would discourage students from paying for lectures if not guaranteed a license. The law's first amendment granted New York based medical colleges the power to license their students upon graduation. Before long, about the only advantage to being licensed was the privilege of suing patients for unpaid fees. Though practicing without a license could trigger a fine of $25 a month, it was rarely enforced.[9]

Both of Buffalo's Dr. Chapins were confident they possessed the knowledge, experience, and reputation to form the first Niagara County Medical Society. (Niagara County included Buffalo and Erie County until 1821.)[5] Acting first, Dr. Dan Chapin gathered a group of physicians who met several times between 1808 and 1810, but never finished the paperwork necessary for official recognition.

On November 17, 1811, frustrated by endless delay, Dr. Cyrenius Chapin began his own effort to form Niagara County's medical society. Cyrenius first consulted a group of former partners and apprentices, then had his current partner, Dr. Asa Coltrin, publish an invitation to all county physicians. Dr. Dan Chapin followed with a newspaper

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announcement on December 31, 1811, claiming his assemblage was the only legitimate organizing group. Cyrenius answered with an announcement in the January 22, 1812 issue of the *Buffalo Gazette*. This time, he accused Dr. Dan of improper procedures that "failed in accomplishing their object[ive]." Cyrenius referred to his own group as "The Regular Medical Society."[10]

For several weeks, the *Buffalo Gazette* dutifully published invectives from both men. Dr. Dan called Cyrenius, "A mutilated, ill-starred brat scotched with the characteristic marks of its empirical accoucheur" and little more than an untrained midwife. Their tirades were selling newspapers, but the *Buffalo Gazette* published its own commentary on February 19, 1812, titled, *"Who shall decide when doctors disagree?"* The editorial stated the obvious: Niagara County could recognize only one medical society under state law. If the two doctors were to continue their foolhardy battle in print, the *Gazette* resolved they would need to purchase print space. It concluded, "And while this furious warfare between brethren of the same profession exists, that confidence we have in physicians (which is half the cure) will be virtually destroyed, and a door will also be opened for impostors to introduce themselves into that society which may be most in want of recruits." The February 19th issue also contained the last published shot by Dr. Dan objecting to Cyrenius using the name, 'The Regular Medical Society.'[11]

The *Gazette* offered a generous view of regular doctors, writing, "We cannot conceive of a more worthy character, of a more estimable citizen, than the physician, whose practice extends alike to the indigent as well as the opulent, and whose conduct in his profession shows that he is as much interested in the welfare of his fellow creatures, as he is attached to the fascinating pounds, shillings and pence." (Editor, 1812) Dr. Josiah Trowbridge, secretary to the Cyrenius faction and former partner of Cyrenius, sent a completed application for a county society to the Medical Society of the State of New York. Upon its acceptance, the *Buffalo Gazette* congratulated the Cyrenius led group for receiving formal recognition, but in one last volley, Dr. Dan accused Cyrenius of stealing the letter of acceptance, claiming it was meant for his group.[9]

Once the Cyrenius group received its approval, another physician, Dr. Ebenezer Johnson, attempted to referee the shillyshally between the Drs. Chapin, but his efforts at reconciliation were overshadowed by the War of 1812. It would be 1816 before the Niagara County Medical Society regained a toehold adequate to send Dr. James H. Richardson to the New York State Medical Society as a delegate.[5,12,13]

When it came to patient care, the doctors Chapin overlooked their differences. A memoir written by William Hodge (1781-1848), another early Buffalo settler, recalled a gruesome episode involving an attack by an enormous bird on his infant daughter. The bird's effort to lift the infant failed, but its talons pierced the child's skull. (Hodge, 1885)

The first to be consulted, Dr. Cyrenius Chapin instantly recognized the serious threat to the child's survival and called on Drs. Daniel Chapin, Ebenezer Johnson and Josiah Trowbridge to examine the child. The child's only hope, according to the four doctors, was trephination to promote the free flow of the inevitable inflammatory products expected to develop. The child died four days after the injury, little having been achieved by the three-quarter-inch hole they drilled in the infant's skull.[14]

Medical society functions were suspended by the War of 1812. Then, in 1821, Niagara County was split and a medical society was needed for the new Erie County. Both Chapins lived in Buffalo, now in Erie County, but this time they collaborated. Cyrenius was elected president and Dr. Dan was elected vice-president in anticipation he would be president in 1822. However, in the winter of 1821, Dr. Dan died of exposure while walking home in a blizzard following a late-night delivery.[9]

The profession found collaboration could achieve improvements in medical education and practice through a balance of self-regulation and government licensing. In 1847, state medical societies joined to form the American Medical Association. Their intent was creating a profession out of interstate chaos. In the decades after the Civil War, physicians began to specialize, leading to the formation of the American Board of Medical Specialties in 1933. Today, each specialty brings unique skills, standards, and perspectives in service to the patient. The family physician's expertise overlaps these many medical domains, resulting in even better outcomes. It is the generalist's knowledge, defined by its own special board, that brings patient needs and aspirations into focus, and completes the circle of patient centered care.[15]

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Sleep Deprivation and the Clinician

By Ambika Sharma, DO, MS; Brian Hendrickson, DO and Elizabeth Loomis, MD

Sleep- deprivation for clinicians often begins in medical training[1] and lasts for the duration of our medical career with 40% of health care workers reporting one or more sleep disorders in a 2018 study.[2] The American Academy of Sleep Medicine recommends 7-9 hours of sleep daily for adults aged 18-64 with a strong recommendation against a sleep time of less than 6 hours.[3] Adults aged 65 and over may be able to have less sleep time with 7-8 hours being recommended.[3] In a meta-analysis of 30 studies, the mean sleep time for medical residents ranged from 4.2 to 8.6 hours with the median time being 6.2 hours.[4] Sleep is lost when clinicians work long weekday hours, have frequent on-call duties, frequent night work or short shift intervals.[5] Inadequate sleep for anyone results in negative health outcomes. In acute sleep deprivation a person's mood may change in ways that mimic depression and anxiety[6] while chronic sleep insufficiency has much more severe physical effects including increased cardiovascular risk and immunosuppression.[7,8]

In addition to personal health effects, there is a growing body of research showing how sleep deprivation negatively affects a clinician's ability to provide safe and optimal health care. Sleep loss while on call has been shown to lead to increased risk taking,[9] increased patient complaints[10] as well as a loss of overall cognitive functioning.[11] Sleep deprivation is also associated with interpersonal disengagement, work exhaustion and overall burnout.[12]

Sleep deprivation can present itself in many different ways, and it is good for people to understand their individual symptoms. One obvious sign is feeling like you need to sleep all the time, or feeling tired even after sleeping for 7-8 hours. Some other symptoms to look out for are brain fog, taking longer to complete tasks, yawning, having a short temper, feeling more depressed or anxious.

One of the great difficulties in recognizing sleepiness is that people often think they are fatigued or have lack of energy, and will search for alternative explanations without realizing the impact sleep deprivation is having on them. This can happen with people who have busy work schedules or while taking care of family. Losing a little sleep for one or two nights may not seem that bad initially. Clinicians may compensate with caffeine, which makes it harder to tell there is a problem. They often write off their sleepiness as something they have dealt with for a long time and so it could not be a source of the worsening fatigue or brain fog. If a clinician has had daytime sleepiness their whole life, they should get checked for obstructive sleep apnea (OSA) as well. Questionnaires such as Epworth Sleepiness Scale is a good screen for OSA while further testing with a home sleep study or polysomnography can confirm OSA.

The most recent evidence within the world of sleep medicine is moving away from pharmacologic interventions for treating insomnia and more towards focusing on sleep hygiene and employing cognitive behavioral therapy (CBT). The non-pharmacologic therapies are more effective and have less side effects compared to pharmacologic interventions.[13] Sleep hygiene in particular is an easier intervention that all persons can work towards employing, and entails both one's behavior and environment. Research has demonstrated that forming these good habits is pivotal to our overall health and improved quality of sleep.[14]

To foster better sleep habits, start by establishing a consistent sleep schedule that continues even on days off. Create a calming bedtime routine that signals to your body that it is time to wind down; this could include activities like reading, taking a warm bath, or practicing relaxation techniques.[15] Your sleep environment also plays a crucial role—ensure your bedroom is dark, quiet, and cool, and invest in a comfortable mattress and pillows. Limiting exposure to screens and bright lights before bedtime can help regulate your circadian rhythm, as can avoiding heavy meals, caffeine, and alcohol at least three hours before bedtime.[16] By integrating these practices into your daily routine, you can improve both the quality and duration of your sleep, leading to better overall health and well-being

Clinicians can have very stressful lives with constant changes in schedule. When also considering call, night shifts, and long shifts of 12 hours or more, special adjustments need to be made. There are many strategies for adjusting between the day shift schedule to night shift schedule. Sleep banking is where one sleeps in excess, to 9 hours or more with their regular schedule. Early transition is where you try to push sleep times 2 hours or later in an attempt to shift sleep schedule. While both strategies may be helpful, sleep banking has shown a higher mean predicted performance effectiveness with the least amount of impairment.[17]

Sleep deprivation among doctors is a critical issue with significant implications for both patient safety and physician well-being. The demanding nature of medical training and the high-stakes environment of clinical practice often lead to chronic sleep deficits, adversely affecting cognitive function, decision-making, and overall health. Addressing this problem requires a multifaceted approach that

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includes restructuring work hours to allow for more consistent rest, implementing fatigue management training, and promoting a culture that prioritizes wellness.

Personal Advice from the Authors:

Ambika:

Becoming a mother in residency gave me a deeper, personal insight into how disrupted sleep can profoundly affect one's quality of life and overall performance. I experienced firsthand the challenges of sleep deprivation by going to work and caring for an infant. I quickly realized how my performance in managing patients and even taking care of myself was deteriorating due to lack of sleep. My mood, ability to care for my patients and family was suffering. This encouraged me to develop healthy sleep hygiene habits for my own wellness. My hope is that there will be changes in both residency and attending schedules to promote regular circadian rhythms.

Brian:

I had felt tired most of the time for my whole life. I would often take naps in the evening, yet still would not feel well rested. Residency only exacerbated that with long work hours and overnight calls. I finally got diagnosed with OSA, and have started using a CPAP with a huge improvement in sleep quality. I feel that I am able to think more clearly, have more energy throughout the day, and often do not need naps. For anyone who has dealt with a lifetime of sleepiness, I strongly suggest getting tested for OSA and getting treatment if necessary.

Elizabeth:

I still remember how much my personality changed during 24+ hour calls as an intern. A simple overnight page from a nurse for a Tylenol order would be met with anger and rudeness. This was not who I wanted to be. I found I actually needed to add more meaningful activities into my personal time to better balance out what was required from me at work. I advise all of our residents now to make sure they are giving space to the things in life that give them energy. This is especially important to do in the days and weeks leading up to challenging rotations or scheduled calls.

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The Future of Medicine

By Robert Bobrow, MD

As a senior faculty member in a residency training program, the residents often ask me what I think medicine will be like in the future. I am nearing 70 with over 40 years' practice experience, and it must seem reasonable for these fledgling practitioners to consult me, just as I listened to experienced physicians when I was young. The only problem is- most of the predictions I heard failed to come true, and other things happened that no one foresaw.

To begin with, I am a board-certified family practitioner. This is interesting only because in medical school during the late 1960s, anyone I asked told me the generalist was gone from medicine, permanently. There were still general practitioners (although I never met any at my school), but they were disappearing and, I was told, would soon be gone. Everyone will need to specialize. No more "Doc", the kindly old man from the then-popular TV show "Gunsmoke" who could take care, by 19th century standards, of whatever came his way. The American Board of Family Practice was quietly created in 1969 while I was still a medical student, and I was "Doc", with 20th century certification, not too long afterward.

In the early 1970s came the staff-model health maintenance organizations. A lovely 2-story medical building sprung up in my area. Physicians were hired as its direct employees, patients were recruited through contracts with large employers, and it was an odd island in a sea of private practice. This was a nationwide trend, and all predictions said it constituted the future of medicine. It wasn't, and most of these vanished; the lovely building now houses a tech company.

No one seemed to foresee managed care, which seeped in like the fog. First there were one or two managed care plans, curiosities. Some of us signed up, gave it a try, brought in a few more patients. Then we were enveloped. As much as we like to foresee the future and be prepared, sometimes we can only adjust.

Within specialties, there were many surprises. My medical school colleagues who went into gastroenterology or cardiology did so because these were intellectual challenges, involving meticulous history-taking, physical-finding analysis, and interpretation of data. Suddenly they became procedure-based,

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defined more by technical skills than hard thinking. Classmates who chose infectious disease careers out of an interest in tropical diseases found themselves treating HIV, and didn't have to travel to see a case. Friends of mine became psychiatrists because they were fascinated by Freudian analysis, only to find psychopharmacology was the order of the day.

But despite all the unimagined and unforeseen shifts, certain things have remained constant. The practice of medicine is stressful. Starting out in the 1970s, I couldn't help but notice the senior attendings in my teaching program, established practitioners, often looked like they were carrying the world on their shoulders. The stressors were different then. Imagine three-figure malpractice insurance premiums, few third-party payers overseeing decisions, no managed care or government regulations intruding into daily office routines. Today's doctors can only dream of such an era.

There were however, patient care responsibilities that might make the modern doctor wince. Emergency rooms had not yet matured into the all-purpose catchalls they are today, and specialists did not permeate hospital practice. Family doctors in the 1960s sutured their patient's lacerations in the middle of the night, and ministered to their patients having acute myocardial infarctions as well. Today, many of us don't have to provide any hospital care if we don't wish to, but the stress level remains stable (at "high") over many decades and practice changes.

Medicine, then as now, was rewarding, at least on a good day. The worry on patients' faces that you could soften with the right words or the satisfaction of seeing a clinical improvement made you feel that your career briefly made sense, even if you barely had time to reflect about it. This hasn't changed. And those who choose a career in cardiology will still take care of diseases of the heart, whether they employ a stethoscope or a robot. Gastroenterologists, in the future, will still be responsible for mouth-to-anus ailments and will allay such suffering with whatever wisdom or technology is available. And so on. That much is predictable.

Beyond that, when soon-to-graduate residents ask me what the future of medicine may hold, I can tell them it will be most stressful, and at times, most rewarding. It will consume a lot of time and energy. It will be essential to keep learning new things and to adapt to changes. The future is unpredictable, in medicine, in finance, in life.

Forty years later, I'm not exactly "Doc" from the Wild West of yore, but I have removed pellets and BB's shot into my patients. I have been able to maintain continuity with many people over decades. On good days it seems like I got what I wanted out of medicine. (Residents take note.) It may seldom feel that way, but I'm living my dream.

The previous text was written 10 years ago. There have been notable unforeseen changes since:

Electronic medical records. In our computer age, there was no question that medical records would become electronic. What was not foreseen was that they would be designed to maximize billing rather than patient care, and be inaccessible outside of each institution. As we know, they are padded with gibberish and riddled with inaccuracies, and add substantial time to each patient encounter. There are still many advantages, and an awareness of the shortcomings, so perhaps they can evolve into a more efficient tool.

Covid. We were overwhelmed suddenly and unexpectedly. In addition to the enormous toll on the entire population, the medical profession suffered considerably, particularly emergency medicine physicians and hospitalists. Many left our profession for good. "Burnout" became a topic of regular discussion, along with possible remedies. One unintended benefit ensued: telemedicine and Zoom meetings.

Who could have imagined rolling out of bed and right into a staff meeting or lecture? Or delivering patient care via "telemedicine"? While I miss human contact, I can't bemoan the convenience. When I was vacationing and my return flight was cancelled due to bad weather, the lecture I was due to give the following morning went on as scheduled, remotely.

And then there's the corporatization of medical care. The majority of doctors are now employees, in sharp contrast to the world I entered 50 years ago. Entire practices, as well as hospitals, are bought and sold as commodities. I have colleagues who don't even know who they're working for. Private equity firms, and now special purpose acquisition companies[1] have turned medical care into a business that emphasizes profits, not patient care. The term "moral injury" has entered the lexicon. I don't know where this is going, but I hope that the credo that medicine is meant to improve health, not fatten pockets, will somehow, eventually prevail.

Fifty years into this I still can't predict the future, but I have no regrets about the past.

Endnotes

1. N Engl J Med 2024;390:1842-1845 DOI: 10.1056/NEJMp2400608

Robert Bobrow, MD *is a graduate of the Albert Einstein College of Medicine, and has been board certified in family medicine since 1975. He has worked in clinic medicine and private practice, and is a Clinical Associate Professor of Family Medicine in the Family, Population and Prevention Department of Stony Brook University. At age 80, he still works 12 hours/week, precepting residents and doing direct patient care.*

Transforming Passion into Purpose: Rediscovering Meaning and Avoiding Burnout in Primary Care

By Mary Rose Puthiyamadam, MD; Zoe Quint, DO, MPH and Minah Ebrahim, MD

Dr. Mary Rose Puthiyamadam

Many of us in medicine find ourselves on a linear path. We do well in school to get into college, to get into medical school and then residency. That is 12 years of post-graduate education. I love clinical medicine—the intellectual challenge and the relationships with patients and the team. I was able to work in many countries serving the poor and often forgotten people. Though these experiences fulfilled me, they were not a solid foundation for marriage. I was fortunate to be able to continue the mission at a federally qualified health center. Soon after, I had marriage, medicine, and motherhood. Electronic medical records became a reality in medicine. Patient records accessible at all hours, which facilitated charting at home. I was happy to get home earlier but knew that while my child slept, I was now working. Also, the EMR eroded meaning as much time was spent clicking boxes and not caring for patients. Upon reflection I realized the moments I enjoyed most were teaching the medical students and the patients. Thus, I joined faculty at a family medicine residency program. Educating and eliciting excellence in future physicians was the dream. However, I discovered that reality is in both parenting and medical education: everyone is on their own journey. Our role in both is simply to be a guide. My purpose became to quietly mentor others to a career which would hold deep meaning.

Dr. Minah Ebrahim

I had been at a crossroads. I had entered medicine with a determination to make a difference, but throughout the course of medical school and residency, the daily grind had taken its toll. The long hours, the emotional weight of patient care, the sense that I was losing myself—it all culminated in a deep burnout. However, as I spent more time in the family practice clinic, it was a conglomeration of conversations I had with Dr. Puthiyamadam which ignited a process of reflection. Sitting in the staff workspaces in between patient care, Dr. Puthiyamadam became more than just a mentor for me; she became a lifeline. Dr. Puthiyamadam encouraged me to take a step back, to reconnect with the reasons I had chosen medicine in the first place. I had always been drawn to the idea of healing the whole person—body, mind, and spirit. In medical school, I had been fascinated by the idea that the body's systems were interconnected, that true healing required more than just addressing symptoms. I began exploring integrative medicine. Immersed in learning about nutrition, meditation, yoga, acupressure, and the mind-body connection, I felt a shift. The burnout began to ease, replaced by a growing passion for this holistic approach. I started integrating these practices into patient care, focusing on prevention, wellness, and the healing power of the body's natural processes. I found that patients responded in ways I had never anticipated. They were not just healthier; they were happier, more engaged in their own care. They started asking me about more than just medications; they wanted to know about lifestyle changes, stress management, and how to find balance in their own lives. My work became a calling. I was helping people transform their lives.

Dr. Zoe Quint

Family medicine, with its focus on continuity of care and whole-person health, has always been my chosen path. It allows me to build lasting relationships with patients and their families, addressing both acute and chronic issues within the context of their lives. I encounter patients at their most vulnerable. Their stories are

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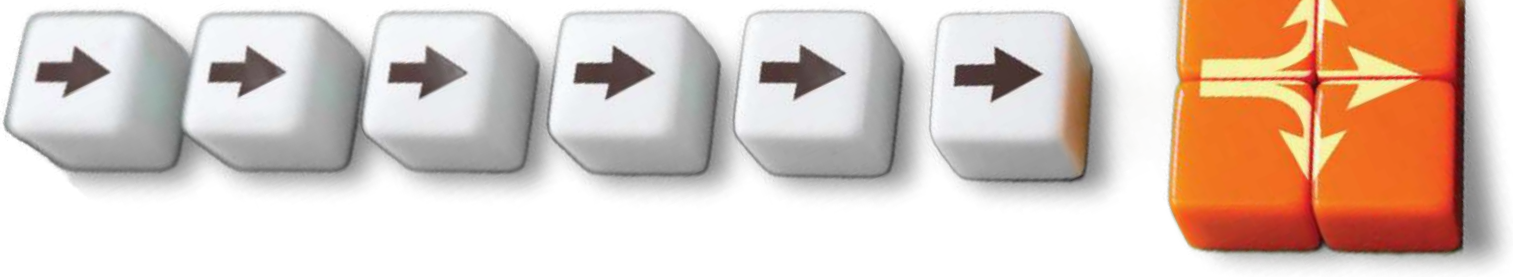

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etched with the starkness of mortality, and the gravity of their presentations often forces me to confront the fragility of life. I see that fragility mirrored in my own life, in the quiet moments spent pumping while wondering if I am giving enough of myself to both my newborn and patients. The emotional tug-of-war is palpable, a constant negotiation between my professional duties and the tender, constant demands of motherhood.

During these challenging times, I often reflect on the osteopathic principle that the body has an inherent ability to heal itself. It is a philosophy that extends beyond the clinical and into the personal, offering a sense of hope and continuity even in the face of adversity. As I help patients navigate the complexities of their conditions, I draw on this holistic view to offer comfort and empathy, recognizing that the process of coming to terms with morbidity and death is as much about emotional and spiritual healing as it is about physical care.

Balancing the demanding role of a family medicine resident with the responsibilities of being a first-time mother to a six-month-old is a complex and deeply personal journey. The anxiety of leaving my child in someone else's care while trying to remain focused at work is palpable. I've felt an added pressure to excel and prove myself. Keeping up with patient care, following up on lab results, and managing my notes while maintaining a high standard of work performance will forever be a hill to climb. The fear of falling behind or missing crucial details in patient care is ever-present. I began to reach out to physician mothers around me. During a clinic session Dr. Puthiyamadam empathized and asked why I was not doing osteopathic manipulation. At the time it felt daunting, but the role of therapeutic touch and hands-on treatment have opened an opportunity for me to connect with patients in a different way. It requires a certain partnership between patient and provider, to allow this connection to help restore homeostasis to the body.

Osteopathic touch is not one guided by force, but rather by responding to match the reciprocal energy and force put forth by the body. It is a yielding path, through which a patient can regain and reset compensatory patterns in the body that develop because of trauma, environmental or structural factors. It is deeply satisfying to help patients regain a sense of calm and an overall greater sense of being in their own body, grounding themselves and tuning in to their body's signals. At the beginning and end of my sessions, I guide patients through deep, diaphragmatic breathing. I do it with them, resetting and grounding myself in the moment as well.

When I'm home with my son, I am so filled with joy and simultaneously with the terror of knowing that time is passing. I don't want to miss a single second of our time together. I never want to forget how he holds my finger when he nurses and moves it around like a lever, the angle of his jaw working to get the milk. How we worked together to figure out the most comfortable positions for nursing. My heart overflows when I hold him, and he nurses and I have such deep gratitude to experience it at all.

The duality of my life—as both a new mother and a physician—often feels like a balancing act on a tightrope, with each shift demanding a different part of my heart and soul. As I continue to navigate the journey of residency, I am reassured by the knowledge that my dedication to a holistic approach to medicine and to nurturing my family are complementary forces. I have a renewed sense of purpose for how to handle the challenges of residency and intricacies of motherhood. Ultimately, the intersection of a demanding residency and new motherhood is challenging but also transformative. It requires navigating significant physical, emotional, and professional hurdles while also offering opportunities for personal growth and deeper connections with patients and colleagues. Osteopathic medicine has been instrumental in helping me balance these roles, emphasizing the importance of holistic care and resilience in both my personal and professional life.

Passion aligned with our strengths allows us to feel purposeful and engaged. Connection with each other allows for a safe place for reflection. The wonderful thing about family medicine is that the possibilities are endless. Sometimes, the path you are meant to take is the one you never expected to find. We find our way in medicine, supporting each other as life and priorities shift. We embody the essence of what it means to be a healer—whole, connected, and ever-evolving.

Mary Rose Puthiyamadam, MD *is a dedicated physician and faculty member at Open Door Family Medical Center where she provides compassionate care to underserved populations. She also mentors family medicine residents at the Phelps Family Medicine program. Her interests include quality improvement , global health and mentorship*

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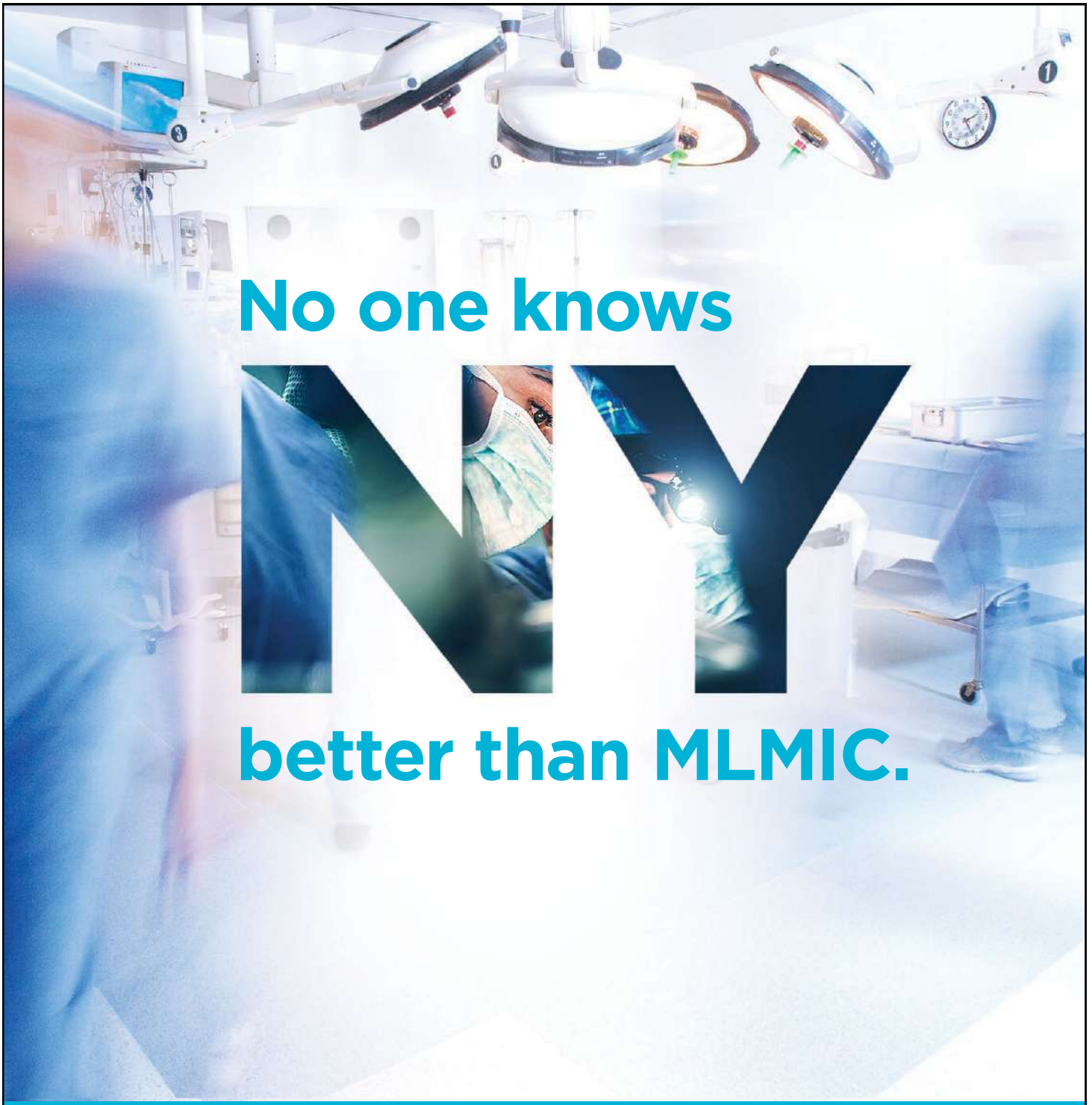
Zoe Quint, DO, MPH *is a third-year family medicine resident at the Northwell Phelps Family Medicine program in New York. With a dual degree in osteopathic medicine and public health, Dr. Quint is passionate about integrating osteopathic principles into patient care, and advancing the practice of family medicine through a holistic and patient-centered approach.*



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