

WORCESTER medicine

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Editorial

Jane Lochrie, MD



Jane Lochrie, MD

Last summer, I attended a faculty development session at the University of Massachusetts Medical School where Dr. Stacy Potts, associate professor, Department of Family Medicine and Community Health, University of Massachusetts Medical School, presented how generational diversity effects graduate medical education and this issue of Worcester Medicine was conceived.

In her article, Dr. Potts, MD, Med, FAAP, described the differences in the four generations represented in our current physician workforce. Each generation has different standards of work ethics, professionalism and career goals. These generational differences have their own strong points and disadvantages that, at times, can cause conflict in the workplace. Potts also described the millennial generation as the “future of health care.”

Our Traditionalist, Dr. Richard Bishop, the former chief medical officer and chief of cardiology at St. Vincent Hospital describes the landmark article in JAMA that showed patients who had their hypertension treated did better than their counterparts who were not treated. At that time, hypertension was thought to be a compensatory mechanism that should not be moderated. In the past, patients went to their physicians when they were ill; today they go when they are well, looking for an illness that can be treated. Though the U.S. outspends every other country on health care, our outcomes lag behind most other countries. He opines, “It is important that we do not extrapolate the benefits of treating high-risk populations to benefit those at lower risk, especially in asymptomatic populations.”

Baby Boomer, Dr. Joel Popkin, the former director of the Internal Medicine Residency Program at St. Vincent Hospital, relates that one of his medical school role models actively discouraged students from marriage, as it would interfere with their commitment to medicine. Dr. Popkin believes that “choosing medicine as a career, rather than a job, means more of a sacrifice and challenge than posed by a 9-5 shift.” Finding the right balance is difficult to achieve, but the generations can all learn from each other.

Gen Xer, Dr. Mark Viner, the program director for pediatrics at UMass Memorial believes that the most important difference in the way that he was trained and the current system is the development of duty hour restrictions. He convinces the readers that resident education and high-quality patient care is alive and well, but this is in spite of, and not because of, duty hour reform. Residents are leaving the hospital to comply with the letter of the law, but with the advent of the electronic medical records, they are simply working from home. In addition, patient safety has markedly benefitted from the on-site supervision and consistent care of the hospitalists.

The challenges facing the Millennials are discussed by the chief medical resident at St. Vincent Hospital. This generation of physicians is defined by duty hours that, he accurately points out, are their inheritance, not their initiative. Shift work requires accurate handoffs and documentation, skill sets that are not necessarily easy to acquire.

Please don't leave this issue of *Worcester Medicine* without reading this year's MMS winning creative writing article by Dr. Claire Cronin. She movingly describes a patient's out-of-body experience and believes that he was a “temporary angel.”

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President's Message

Michael Hirsh, MD



Michael Hirsh, MD

The Generational Differences in Medical Training and Doctor-Patient Relationships is the theme of this edition of the *Worcester Medicine*, which will be the last edition appearing prior to my stepping down after three years as president of the Worcester District Medical Society. My 60th birthday is approaching in May, so I am of a generation in medicine that grew up at a very different time for our profession.

There were no work hour discussions, no electronic medical records and no real day-to-day considerations regarding costs of medical care ~ or even much thought about work-life balance. Much of the medical training in my day was a rite of passage, somewhat akin to military basic training in its hierarchical nature, and if there was kindness along the way, it was usually couched in a tough-love approach. As a surgeon, the hours were brutal and there were many sacrifices that my family endured so that patients and systems got the medical care I could provide.

As this issue will amply detail, the landscape has certainly shifted. The trainee is no longer looked at as a grunt. Training programs go to great lengths to maximize the learning experiences while minimizing the “scut” type of busywork with which my generation was burdened. Cafeterias serve healthier foods, and training programs provide on-site gyms, stress reduction/yoga classes and other amenities that today’s generation of trainees have come to expect. Medical care is run as a democracy in teams, with much less autocratic “my-way or the highway” pronouncements.

Going into my WDMS presidency, it became clear that another generational shift was beginning to show an adverse affect on organized medicine. With social media and increased emphasis on protection of home life, younger physicians were less inclined to join local medical societies or see the value in organized medicine. If this trend continues, WDMS and societies

like it will go the way of the dodo. But working with our WDMS leadership (special recognition here to Jane Lochrie, George Abraham, Jay Broadhurst, Denis Dimitri, Becky Spanagel and, of course, our Executive Director Joyce Cariglia, to name a few) and the UMass Medical School leadership (including Deans Flotte and Pugnaire and CEO Eric Dickson), we have made great efforts and strides locally to keep the appeal of membership in organized medicine at a peak, just as our newest medical professionals, the students of the UMMS, are at their most impressionable and humanistic phase of immersion into the medical profession. For the UMMS Class of 2017, 104 students out of 125 signed on as WDMS members. We have tried to keep the topics of our meetings and the nature of our outreach programs fresh, cutting-edge and, most importantly, relevant to our most junior members.

These types of efforts have resulted in wonderful participation by these students in the WDMS, especially on the Executive, Legislative, Public Health and Editorial Board committees and as members of our delegation to the Massachusetts Medical Society House of Delegates. We have been blessed over my three years of presidency with the best and the brightest that the UMMS had to offer, contributing thoughts, agenda items and programs and volunteering for our many activities. More than belying the notion that this new generation of physicians is not a generation of joiners, it has demonstrated to me that despite the fact that they can run circles around their elders with their “techie” abilities and social media savvy, they are more than willing to communicate and interact one-to-one with their medical elders and peers. In fact, I would even venture that they long for the mentoring and camaraderie that WDMS and societies like it offer and are grateful for the opportunity to voice their vision of where they think our profession should go. So as my presidency draws to an end, I remain enormously grateful to the WDMS for giving me the opportunity to lead us through a challenging time of transition. But I am comforted to see that we are witnessing the next generation of physicians take up the baton and carry our cherished profession forward in the pursuit of better health and wellness for our patients.

The Next Generation of Physicians: Embracing Change in our Workforce

Stacy Potts, MD, MEd, FAAFP



Stacy Potts, MD, MEd, FAAFP

For the first time in the history of medicine, there are four generations in our physician workforce. Generational differences often underlie conflict between colleagues in health care settings, as well as in our medical learning environments. A generation is defined as “a group of individuals, most of whom are the same approximate age, having similar

ideas, problems, attitudes, etc.” Each of the generations sees the world through a different lens based on the events that occur at the time the group is coming of age. The diversity of viewpoints can be a substantial strength in defining our new health care system.

GENERATIONAL DIFFERENCES

“Every generation imagines itself to be more intelligent than the one that went before it, and wiser than the one that comes after it.”

~ George Orwell

One thing all generations seem to agree on is that their generation has it “right.” The challenge is sorting out what variation can strengthen our workplace and what standards define professionalism. With each new generation come new definitions for work style, collaboration, teams, feedback and perhaps even what we expect for professional behavior

within the fast-paced environment of the medical workplace.

Traditionalists (Born 1925-1945)

The “silent generation” came to age just after World War II. Being raised in this era, they value duty and honor, are patriotic, and they understand the value of a dollar. They have been loyal to their careers and often have spent their entire lifetime at a single institution. They expect respect from others for the years of service they have put in. Traditionalist physicians see medicine as a calling and a full commitment. Medicine is not a job but a lifestyle.

Baby Boomers (Born 1946-1964)

The largest generation in our health care workforce today, Baby Boomers came of age at the time of the Vietnam War, the civil rights movement and the space walk. Baby Boomers are hardworking and competitive. They invented “feedback,” with annual reviews that were summative. Promotion up the ladder depended on putting in long hours and being recognized for it. Hence, they value authority and a hierarchy. They feel leadership opportunity comes from long hours and years of experience. They have been working hard and looking forward to retirement as the time to enjoy life and have often struggled with work/life balance throughout their careers.

Gen X'ers (Born 1965-1980)

The smallest generation in our workplace, Gen X'ers struggle with authority and are often seen as cynical towards organizational leadership. They are self-directed and seek to constantly expand their knowledge and skills. This gener-

ation has been focused on developing better balance with family life and has worked to set some boundaries between work and home. They do not feel that their profession alone defines them.

The Millennials (Born 1981-1999)

According to the U.S. Bureau of Labor statistics, by 2015, the Millennials will make up the largest cohort in the general workforce. Also termed the “Echo Boom,” these young adults were raised in the smallest families in U.S. history. Their Baby Boomer parents engaged Millennials in decision-making early, valued their opinions and challenged them to consider “out of the box” thinking. “Trophy kids” were rewarded for participation, so winning was less important than the fun of collaboration and teamwork. Millennials value near constant feedback that celebrates their strengths. Their generation was defined by Sept. 11 and the world’s response to terrorism. Hence, they live in the present moment and value meaningful work and time with family and friends.

THE MILLENNIAL GENERATION IN THE FUTURE OF HEALTH CARE

The synergy between the Millennials becoming the largest cohort in our physician workforce with the patient-centered medical home emerging as the beacon model is serendipitous. The Millennials will bring skills that uniquely suit this future in health care. Millennials function well within an egalitarian team approach that embraces diversity and collaboration. This generation is native to technology and will greatly enhance our accessibility, communication and medical records. As we look forward to systems of patient registries and practice quality measures, the millennial generation will embrace this feedback for constant improvement through collaboration without defensiveness or competition. Millennials are committed to leaving the world a better place than they found it. This socially-minded passion for medicine will change our health care landscape and our world. Do not expect the Millennial generation to wait their turn to lead; they will be leading early and often on many different fronts.

THE GENERATIONAL DIVERSITY OF THE PHYSICIAN WORKFORCE

The physician workforce should celebrate the strengths of its generational diversity. The Traditionalists bring a dedication to our calling as physicians and our institutions. Their experience and patience provides a wealth of problem-solving wisdom. The Baby Boomers are hard workers who are preparing to leave a positive legacy. They believe in the development of the health care system to serve patients and

communities through quality care and are eager to provide new physicians with the skills necessary to continue this work. The Gen X’ers are self-directed and natural innovators. They embrace new systems and quality improvement. They have high standards and don’t back down from challenges. The Millennials bring confidence from growing up in child-centered families, which provides them with a willingness to lead, innovate and challenge the status quo.

Despite the differences in approach and viewpoint, the core professional attributes of physicians remain the same. Physicians are caring and altruistic team players, value honesty and integrity, strive for excellence and accept the duty to serve. With respect for the strengths of each generation, we will succeed at the collective vision to reform the health care system and provide the U.S. population with a physician workforce that embraces these core professional attributes and the privilege that comes with the physician role.

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Musings of a Traditionalist

Richard Bishop, MD

In 1967, shortly after I finished my internship, one of the most important papers ever published appeared in JAMA. This VA trial randomized to treatment or placebo 143 men, mostly asymptomatic, with diastolic blood pressures between 115 and 129. Not surprising to us today, treated patients did substantially better. At that time, the result was somewhat of a surprise. Professor John Hay said prior to this trial, “The greatest danger to a man with high blood pressure lies in its discovery, because then some fool is certain to try and reduce it,” and Paul Dudley White said, “Hypertension may be an important compensatory mechanism which should not be tampered with. ...” Why is this small quirky trial considered a landmark? Prior to this publication, people sought medical attention only when they were ill. For the first time, there was a reason to visit a doctor and be treated even when you felt well.

Forty-seven years later, finding problems in well people has become an industry. Panels of physicians, often with conflicts of interest, formulate guidelines defining conditions in asymptomatic individuals that require further evaluation and treatment. Hospitals and physicians are judged by compliance with these guidelines. Medical companies sponsor multimillion-dollar randomized trials of carefully selected patients treated under ideal circumstances, hoping to find even a small outcome difference that achieves statistical significance, though the results may have little clinical significance, in order to launch the next billion-dollar blockbuster therapy. New definitions of a “disease” strikingly increase the prevalence of that disease. Millions of people go to bed healthy, new guidelines are issued, and they wake to find they have a disease that requires further evaluation and therapy. Is there a healthy person alive today? The NIH estimates that 90 percent of the population will at some time in their lifetime develop hypertension ~ never

mind pre-hypertension, pre-diabetes and osteopenia. We probe, screen and image. Today, instead of going to doctor when ill and looking for a cure, we go when we are well and find, in fact, that we are not.

It will be argued that this has led to important improvements in health status and longevity over the past 47 years. We do live longer and are more robust in our older years than individuals were in 1967, but we need to be humble and skeptical before concluding that this is the result of medical treatment in a well population. A recent *New England Journal of Medicine* “Perspective” suggests “that medical care accounts for only 10% of overall health, with social, environmental, and behavioral factors accounting for the rest.” Some would consider the 10 percent an exaggeration, and if we accept the 10 percent, a great deal of our improved health comes from the treatment of sick individuals, for example, benefiting from the use of antibiotics, trauma centers and neonatology units. Is it not possible that the opposite is true? Is it not possible we are actually are, at best, wasting money and, at worst, causing harm?

It has been noted, perhaps too frequently, that we spend twice as much on health care as any other country and yet produce dismal results. According to the CIA Fact Book in 2013, our country rank is 51st in life expectancy, more than 10 years behind the first. Isn't it possible that high spending/low quality are related? Malcolm Gladwell in his book, *David and Goliath*, describes a U-shaped curve. He argues that when a good thing is applied, it produces benefit, but when too vigorously applied, it causes harm, demonstrated by the ascending backside of the U. After all, the harmful effects of a treatment are fairly fixed across populations ~ a straight line.

When we begin to apply therapies to lower risk populations, the potential benefit shrinks ~ a downward sloping line. At some point, the downward sloping line of potential benefit crosses the straight line of harmful effects, and we are on the backside of Gladwell's U curve. There is little question that treating blood pressure as defined by the 1967 VA study is immensely important. As guidelines define hypertension by ever smaller numbers, the benefit of therapy, if it exists, is infinitesimally small and the potential for harm increases. The recent report from the National Institute of Health (JNC 7) suggesting a higher threshold for blood pressure treatment, is at least a tacit suggestion that we have been overmedicating for years. It is important that we do not extrapolate the benefits of treating high-risk populations to benefit in those at lower risk, especially in asymptomatic populations.

There is unfortunately a self-enforcing cycle, and the medical community has done little to discourage it. Every patient who has a screening-detected cancer, every patient who has an abnormality detected on an exercise test and undergoes an angioplasty, every patient who starts a statin believes his or her life has been saved or prolonged. This often makes medical providers heroes. If there were more time to spend with patients and a better statistical knowledge of risks and benefits of interventions, more appropriate discussions might follow. I suspect, aware of the expense and inconvenience and better informed of realistic numbers needed to treat and needed to harm, many persons would alter their perception of the value of screening and treating of many conditions.

Prior to the VA study of 1967, most people sought medical care when they were sick. In the early 21st century, the opposite seems true. As Dr. Gilbert Welch notes in his book, *Overdiagnosed*, we are "making people sick in pursuit of health." We are an over-tested, over-diagnosed and over-medicated society. It is said that at some point in the early 20th century, a visit to the doctor changed from producing net harm to one of producing net benefit. In the 21st century, we do not want to reverse that trend by moving to the wrong side of Gladwell's U-shaped curve. More is not always better.

Richard Bishop, MD, was formerly chief medical officer and chief of the Division of Cardiology at Saint Vincent Hospital. He was also vice president and chief of Cardiology at the former Fallon Clinic. He is currently professor emeritus of medicine at the University of Massachusetts Medical School and an honorary member of the medical staff of Saint Vincent Hospital.



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Baby Boomer Practitioners of Medicine: An Unabashedly Non-Evidence Based, Ponderous View of Balance

Joel Popkin, MD



Joel Popkin, MD

When I look back at the traditionalists who were my teachers, I believe they provided the best service to their patients that medicine in that era could provide. By and large, they knew everything about their patients, which is generally more than I know now, which, in turn, is more than my young Gen X and Y colleagues usually know. Traditionalists handed off nothing and never worked shifts. They lived by continuity of care. But

they knew no balance in life, and while my own Baby Boomer sense of balance is probably better (my family may not agree), the next generations look askance at my own practice modes and shake their heads. And so, in terms of caring for our patients, we may still not have settled on what is the best balance. One thing is clear: We can learn a lot from each other.

Some background is in order. Residency training for Baby Boomers in the early '70s was a free-for-all ~ an exercise in stoicism, anxiety and duty hours that often crushed the remains of our cerebral compassion receptors. "It was tougher in our day," the Traditionalists would tell us, but I'm not sure there were enough hours left in our work weeks that could have made it so. An in utero ACGME allowed for the abuse of trainees, but at the same time, maximized exposure to patients and to the teachers of medicine. Autonomy reigned supreme. Ready or not, residents owned their patients and learned to take full responsibility. Procedures? "See one, do one, teach one" was

the dictum, sometimes absent the "do one." Documentation yielded to patient care and learning. And bedside rounding actually took place, as opposed to today's conference room-based "teaching rounds" that purportedly have everything to do with our patients ~ minus their presence.

In that context, I well remember a comment one of my father figures in medicine made 40 years ago, during my internship. I was enthusing about my upcoming two-week March vacation, which would include my first full weekend off since starting the prior July. He smiled and said that he was glad to hear that I "admitted" looking forward to vacation. His colleagues, after all, characteristically returned to work after three days of vacation, stating very publicly that they couldn't stand being away from their practices any longer than that. (OK, I do admit it. While away, I had experienced no such three-day yearnings.)

In medical school, our role models were even tougher. Our chief of medicine, Dr. Ludwig Eichna, actively discouraged marriage, an institution which would only interfere with an absolute commitment to medicine. (I suppose if his beliefs had become the standard, the propagation of doctors would have probably met the same fate that finished off the Shakers.) Dr. Eichna was tall, imposing and intimidating, but he was a superb and kindly teacher, and even a bit of a pussycat in disguise. It seemed to me, even as a naive student, that he actually lived in the hospital, as virtually every time I ate dinner in the cafeteria, there he was in his white coat, reading a journal while chomping down notably unenviable institutional food. Amidst my admiration for this giant in medicine, I felt sad for him. A couple of years later, despite his extraordinary intelligence and contributions, he faced age-directed mandatory retirement from the state of

New York. I can only speculate that the reason he decided to re-enter and graduate from medical school after retirement was not only to write unique perspectives of medical education but also to continue living the only life he would ever know.

Balance was never a part of Dr. Eichna's vocabulary, but it had snuck into mine, even including marriage, of all things. Nevertheless, during training in the intensive care units, my senior resident peers and I still chose to take call every other night ~ despite the misgivings of our chief of medicine and the consequence of no days off during those months ~ simply because we feared the loss of continuity of care.

Admittedly, "balance" is not a word I have understood very well, even though it seems to have lately evolved into a sign of student accomplishment. In applications to residency programs, its appearance has blossomed. (I still counsel our residents not to list "balance" as an achievement on their applications for post-graduate positions, since there are still old Boomer curmudgeons like myself, who do read these things.)

As I see it, for pure dedication and continuity of care, Traditionalists practiced the best brand of medicine. They protected their independence so fiercely, however, that the lack of collaboration was a detriment to overall quality of care. At the other end, despite the advantages and dependence on the free flow of information, Millennials are collaborative and shift-oriented to the point of blurring their patients' big pictures and the responsibility of ownership.

My bias places Boomers somewhere in the middle. The glass half empty points to us post-Traditionalists providing lessened care, despite little improvement in parenting and socialization, while the half-full glass shows improvement in family life over Traditionalists and delivery of a more complete package of care than Gen Xs or Ys. I hasten to add that these views are not likely shared by our recent graduates, but I do hear this sentiment repeatedly from our patients.

Over the years, subtle counseling from my family has suggested that I've been crazy to have done what I've done, and quite frankly, had it not been for the infinite patience of my wife and kids during all these years, my particular form of balance would have tossed me into failure. So Dr. Eichna and my kids would have both thought I had gone off the deep end.

In the meantime, I still struggle to this day with the goal of balance in medicine. I do firmly believe that to choose medicine for a career, rather than a job, means more of a sacrifice and challenge than posed by a 9-5 shift. In many ways, I would want my own physician to lean toward the Traditionalists (he does), as long as it hasn't made him crazy (it hasn't). But personal risk may be especially high for any Gen Xs or Ys trying to emulate Traditionalists and having to face their colleagues' wary glances.

I wonder even about the very term "balance." I think Gen Xs and Ys look at balance as making personal choices about how much time to allocate to all the units that make up their lives, which include patient care, while Traditionalists more likely divide the day into patient care and "other."

An old cartoon says a lot. Two friends are walking down the street, and one says to the other, "Between massage, Pilates, the gym, tai chi and therapy, I don't have any time left for myself." We probably don't want our own personal physicians struggling with that kind of quandary. We do want them to be humanistic, knowledgeable and fully vested in our health. There are members of each of the generations who do it all. To tag them, we need to get a sense of ~ and feel comfortable with ~ their individual definitions of "balance."

Joel Popkin, MD, is a clinical professor of Medicine at the University of Massachusetts Medical School, the director of Special Services at the St. Vincent Hospital Internal Medicine Residency Program and a staff physician at the Reliant Medical Group.

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Generation X: Working Toward a Better Balance in the Era Before Big Brother Was Watching

Mark Vining, MD



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As a medical student, I vividly recall the more senior attending faculty recount the glorious days of their training, when they drew their own blood counts and walked the specimens down to laboratory and reviewed the smears or spun the hematocrits themselves. How foreign that world seemed to me. So, when asked to reminisce about the differences between my residency training (a mere 15 years ago) and that of residents today,

I panicked that I had nothing as dramatic as my predecessors to describe. While this may be true, there are changes in the structure of graduate medical education that deserve commentary and critique, the most significant, of course, being the advent of ACGME-mandated duty hour restrictions in 2003 and 2011. Using comparisons with my residency days, I will attempt to convince the reader that resident education and high quality patient care are alive and well ~ perhaps even better than ever ~ but this is in spite of, not because of, duty hour rules.

Duty hour restrictions were intended to be one piece of major systems changes to improve patient safety. Critics worried that limiting residents' time in the hospital would negatively impact their education, implying the mere number of consecutive hours present in the hospital would equate with better understanding of disease progression and management. Defenders of restrictions claimed tired residents who have been up for 30-plus hours are not learning much anyway and pose threats to themselves and their patients. Both sides have a point, of course. So let's compare a day-in-the-life of my residency compared to residents today.

To comply with duty hours, residents now work in shifts. Shift work requires more frequent handoffs. When I was a resident and I knew I was on call that night, I was keenly aware of the sickest patients on the wards, knowing I would be taking care of them overnight. Even for patients on other teams, it was not difficult to have a peripheral knowledge of events of the day, and my colleagues communicated with me informally throughout the day about changing plans, worsening status, etc. In other words, the "signout" was often a day-long work in progress, and the official evening handoff was filling in last-minute details.

Today, all residents during the day spend enormous amounts of time preparing for the evening handoffs to the "night team." What the creators of duty hour restrictions failed to realize, I think, is that crafting and delivering an effective handoff takes significant time. Residents are spending more afternoon time than ever in front of computers creating handoff documents, and this naturally equates to less time at the bedside with patients. This is an unfortunate side effect of the duty hour regulations.

Many worry about a "shift work mentality" in medical education leading to a lack of ownership of one's patients and feel we are developing residents who are lacking what many feel is a critical aspect of professionalism we should be teaching. In my experience, this is not true at all. In the days of a night call, how often did I (regrettably) utter the phrase "I'm sorry, I'm just cross-covering" when I didn't know a historical detail relevant to a particular patient. While that problem will never completely go away, the current system can, if designed correctly, promote ownership. It is typically the same providers each day and the same providers each night for a stretch of days, allowing providers to know patients better. No one is really "cross-covering" any more.

Professionalism is a worthwhile topic to discuss further, however. In my experience, duty hour restrictions can indeed be at odds with modeling professionalism, but for different reasons. When I was a resident, we worked until job was done, even after signout, and we weren't bound by the clock on the wall. This is not to say we didn't try to wrap things up in a reasonable time, as anyone would, but our natural commitment to the quality of our work was evident by the time we spent "tucking in" our patients for the night. Today, our residents are no less professional and show no less commitment to their patients. What we tell them, however, is that they need to leave at 6 p.m. or they are in violation and are in trouble. Research clearly shows that residents simply leave and go home and finish up their work remotely. They follow up on tests from home; they finish their notes from home; and they are in contact with the night team. My experience supports this finding, as well. So, in essence, we are teaching residents to lie. How is that for modeling professionalism?

Ten years after duty hour restrictions took effect, many hoped to see significant changes in patient safety outcomes. Results, unfortunately, have been mixed, at best. Surveys of program directors and residents themselves demonstrate no improvement in the perception of education quality or patient safety. Pretty much the only outcome measure that has improved is resident quality of life (not insignificant, of course). This is not surprising to most who understand the origins of the duty hour evolution. The Libby Zion case in New York ~ which sparked the initial lawsuit, report and subsequent duty hour regulations ~ was not, in fact, a case of an overworked or overtired resident, but one of inadequate supervision. And supervision of residents is something that has definitely changed over the last several decades, including in the time since my residency days.

I was a resident before the era of hospitalists and the era of evidence-based medicine. I was taught and supervised by a dizzying number of community providers and faculty. I developed wonderful relationships with these dedicated individuals, but there was not the same eye on consistency of care and evidence-based decision-making as we see today. The advent of hospitalist medicine has led to improvement in patient safety and quality of care. In my field, this has served as a distinct advantage to trainees as compared to my experience. Hospitalized patients are sicker, have more complicated diseases and require a degree of supervision that has evolved over time. For other specialties, however, I realize there is such a thing as "too much" supervision, leading to residency graduates who are ill-prepared for practice (surgical training programs being the most oft-cited



example), so there needs to be a continued eye on balancing supervision vs. autonomy.

I worked long hours as a resident, and today's residents still do. Professionalism and commitment among residents is alive and well. While restricting excessive shifts makes intuitive sense, the one-size-fits-all list of restrictions that exist now has done little to improve what we want to improve. Luckily, other measures have (electronic ordering, hospitalist services). I predict there will be a loosening of duty hours as we know them today, allowing for innovation in implementation of common-sense schedules that maximize the quality of education (shift work that is staggered, allowing for more continuity; individual determinations for shift length that can vary day-to-day but still fit within ultimate weekly limits, to name a few). In my opinion, such innovations will enable the practices that "worked" when I was a resident to return while sustaining the very real improvements recent iterations of program requirements have fostered.

Mark Vining, MD, is clinical associate professor of Pediatrics and the program director for the Pediatric Residency Program at the University of Massachusetts Medical School and the New-born Nursery director and general pediatrician at UMass Memorial Health.

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On Being a Millennial

Praveen Sudhindra, MD



Praveen Sudhindra, MD

Every generation believes it has surpassed the old guard and become the gold standard for the next generation. These attitudes profoundly affect, for better or worse, professions where a “master and apprentice” paradigm exists. As pervasive and commonplace as these ideas might be, there has been a lot of thought and print devoted to the challenges of training the Millennial generation (the birth cohort of 1981-1999).

My initial reluctance to write this article was based on my own background as an international medical graduate student and the notion that I was ideologically different when compared to my American peers. My time as chief resident, however, has altered this perception to an extent. Every country has its unique generational traits, but increasing global connectivity has blurred these lines. Several articles have already been written on the unique traits that identify the Millennial, as well as effective modes of interaction with them (some of which read like a handbook Captain Kirk and Mr. Spock might have carried on the Enterprise), and I will not dwell on them. Instead, I will share some thoughts regarding my own observations on the matter.

If I was to choose an alternate term for this cohort, it would be “the duty hour doctors.” There were undoubtedly compelling reasons to enact the sweeping changes that occurred in 2003. However, it is also true that work hours have come to define the Millennial more than any other attribute. One would assume that the changes have generally been met with enthusiasm by the residents, but this is not always the case. Strictly enforced duty hours certainly help maintain a good work-life balance and ensure that fatigue does not usually play as much of a role in medical errors. Anyone who has worked at a hospital recently knows that fatigue is just part of the problem. Shift work and handoffs as a cause for medical errors have been at the forefront of patient safety. In addition to this, attitudes regarding patient ownership have also come into question.

The 80-hour work week was an inheritance from, not a product of, the actions of the previous generation of medical trainees. Still, deal with the repercussions of this we must. Having recently completed my residency, I can certainly allay some of the more exaggerated fears surrounding the values and attitudes of my peers. Yes, we enjoy our lives outside of the workplace and do not necessarily define ourselves by our passion for medicine. At the same time, we do take great pride in delivering quality care and owning our patients. Shift work does necessitate a different mentality, where multiple physicians own the patient. For those of us raised in a more traditional system, it did take some getting used to. I make no secret of the fact that I enjoyed my ICU rotations as an intern in the pre-16-hour workday era because I felt I knew everything about my patients when I was on a 30-hour call. But I have also learned that working 12 hours a day for six days a week is challenging in an entirely different way. People depend on accurate handoffs and documentation, which is not an easily acquired skill. Tablet computers and smartphones are employed routinely in patient care and have certainly helped reduce physician error.

The other side of the coin is perhaps the Traditionalist’s nightmare. The texting, first name-calling, clocking in and out resident isn’t necessarily anyone’s idea of a doctor. I have certainly been guilty of, and irked by, this behavior.

Feedback is a word thrown around about as often as duty hours, and we seemingly can’t get enough of it ~ unless it’s not good feedback. By that, I mean glowing tributes to efficiency, knowledge and all-round perfection. Anything short of that might invite panic or denial. Timely and constructive feedback is the backbone of residency training today, but sometimes, one feels that perhaps going back to the “no news is good news” policy might not be such a bad thing.

I suppose it all comes down to your reaction when you read *The House of God*. Whether it is wistful thoughts of the good old days or a mixture of horror and envy that you experience, it does, in most cases, reaffirm your decision to train as a physician.

Dr. Sudhindra is the chief medical resident at St. Vincent Hospital.

Charlie

Claire Cronin, MD, MBA

NOTE FROM ROBERT SORRENTI, MD: *Once again Worcester Medicine is publishing an article that was submitted to the Creative Writing Exposition, sponsored by the MMS Arts, History, Humanism & Culture Member Interest Network (Arts MIN). Each year, the Arts MIN invites physicians to send in their written work ~ fiction or non-fiction, poetry or prose ~ whatever their creative spirits have led them to put on paper. We have selected this particular work of non-fiction as the blue-ribbon best from a number of submissions in various styles and formats. I think you will be as intrigued as we were by the personal account and the reference to an “out-of-body” experience.*

The Arts MIN Creative Writing Exposition allows physicians and their spouses to share with others their talent and interest in literary endeavors. We know that over the years, there have been many physicians who have gained fame for their written word. I want to thank all the contributors to the exposition this year. I urge others in our Medical Society community to participate in the next exposition and think about a submission this coming fall. Perhaps there is a William Carlos Williams or an Oliver Sacks among us.

The Arts MIN provides other opportunities, besides the written word, for members of MMS and of its Alliance to explore, develop and participate in non-medical activities that range from bird-watching to bonsai-planting, from art exhibitions to astronomical viewing. We invite MMS and MMS Alliance members to take part in the activities and events the Arts MIN sponsors and to join us on the Executive Council to promote new areas of interest.



Claire Cronin, MD, MBA

I found out a few days ago that Charlie Murphy had died again. Charlie had been dead twice before, but it was short-lived, so to speak. This time, he succeeded. I am not really sure what he died of, but I heard that it happened at home, and therefore, I suspect it was his heart.

My niece was the one who told me, which was one of those weird “it’s a small world after all” moments. Unbeknownst to me, she had become best friends with his granddaughter at some point in the five years since I had been up to my elbows in his blood. The girl’s mother, Charlie’s daughter, made the connection and told my niece that I might want to know that he had passed on.

I find myself at a loss as to what to write to Charlie’s wife on the

blank card in front of me. I want to write that I am sorry that I almost killed him and then saved him and then almost killed him and then saved him again. I want to tell them how special he was for thanking me for his life, rather than blaming me for almost losing it. Charlie was a glass-half-full kind of guy. The way he saw it, we were forever bound together after what we had been through ~ like in a fairytale.

My office called him my boyfriend, despite the fact that he was 30 years older than me and happily married. He would stop by the front desk anytime he was in the hospital to say hello or leave a message that he was still kicking. Nurses from different departments would stop me in the halls of the hospital to let me know that Charlie Murphy had been in for treatment and regaled them all with stories about me. To this day, I am conflicted by feelings of embarrassment for my medical error and pure joy for having him in my life whenever his name comes up. I met my “boyfriend” on a July Fourth weekend. He was in the ICU and bleeding heavily from his colon. The gastroenterologist could not stop it, and we didn’t have the capacity for

interventional radiology embolization of the offending blood vessel, so it was left up to me to do something surgical about his diverticular bleed.

When I walked into Charlie's ICU room, I was met by a view of his tremendous buttocks with a colonoscope snaked through the cheeks and blood pooling around it onto the bed. His loud and cheery voice, welcoming me to the party, came from the other side of this mound of flesh. He had received numerous transfusions, and I told him there was nothing to do but to take him to the operating room and remove his sigmoid colon. He said, "I trust you to do the right thing."

It took all hands to move Charlie onto the table, as it was not only his personality that was larger than life. I opened his abdomen and proceeded to attempt to remove his colon. The CliffsNotes version is that operation wasn't as straightforward as it usually is, and because of that, there was some serious bleeding that led to the aforementioned blood-up-to-the-elbows scenario. The fourth year surgical resident standing next to me was shaking so badly out of fear that the operating room bed was vibrating. We both were grasping blindly in the pool of blood for the source of the bleeding, unable to suck it out quickly enough to identify the source. To this day, whenever I am faced with a difficult task, I think about that moment and realize that nothing can ever be that scary again.

Eventually, I found the source of bleeding and tied it off. I never ended up removing Charlie's colon, which just proves the surgical dictum that "all bleeding eventually stops" (since there is no blood left to continue bleeding). Charlie never officially died in the operating room, but it got close.

After I closed him, we went to the ICU with him intentionally sedated and on a ventilator. I left to find his family and explain the sequence of events when the operator's voice announced a code red in the ICU. Even at midnight, the code announcement drew a large crowd of would-be saviors, but no actual life-saving measures could occur, due to the inability to get anywhere near Charlie. He was already lined up and intubated from the OR, so there was nothing for a surgeon to do. I retreated to the northeast corner of his room and put my head in my hands, not relishing a return trip to Charlie's belly to control more bleeding. A respiratory therapist new to our hospital was assigned the job of chest compressions while the ICU doctors yelled out orders for medication. The EKG showed he was having a heart attack.

I would venture out of my corner for a moment or two to feel for a pulse or check the lines and then retreat back to it and continue my praying. I had become religious again in the OR when I was fighting to control the bleeding and now was bar-

gaining with God for all sorts of acts of human kindness in return for Charlie's life.

We got Charlie back, and I went back to the ICU waiting room to update his family on the latest events, and then, Charlie died for the second time. The code team resumed their positions, and after some significant chest pounding, Charlie decided that it wasn't his time, and he stayed with us.

Two days later, he woke up and after the respiratory therapist removed his endotracheal tube and said, "Hey, thanks buddy for saving my life."

"It wasn't me who saved your life," the respiratory therapist answered.

Charlie said, "Sure you did, I saw you pounding on me."

There were 20 people in the room, and no one could have reliably pointed out the new respiratory therapist two days later, but Charlie, who was drugged and whose eyes were closed, recognized him. Word of this made its way around the surgical service and eventually to me.

On afternoon rounds, I asked Charlie if the story was true. He said, "Sure it is, Claire." After all we had gone through, Charlie had decided to drop the Dr. before my name, and I was in no position to stand on principle. "I saw everything."

"But Charlie, your eyes were closed. I was right there. You were asleep," I argued.

He shook his head and said, "I could see everything from above. Bob (he even knew his name) saved my life by pounding on my chest. The rest of the room was filled with people yelling. And you, Claire, were standing over in that corner shitting bricks!" Charlie pointed to my corner and started to laugh. "Shitting bricks!"

"I was," was all I could say. "Did it hurt Charlie?"

"No, not really. I could see everything happening, but I couldn't feel it. Anyway, thanks for saving my life in the operating room." "Yeah, about that Charlie; I never took your colon out because you started bleeding badly from something else. It was pretty touch and go there, as well, but we got you out of it," I explained. "Did you see us in the operating room like you did when your heart stopped in the ICU?"

Charlie shook his head and said "No, of course not. I was asleep in the operating room." He used a tone of voice that implied that I was being ridiculous, which was a little judgmental,

I thought, coming from someone who had just told me that he was floating on the ceiling of his ICU room watching himself be resuscitated.

During his recovery, I became close with Charlie and his family. He told me stories about his grandchildren, and I told him about my kids. Charlie was one of those guys who had long ago figured out that life is not about things but about connections. He loved people, and I was lucky enough to be a part of his life for a little bit.

Charlie is the only patient of mine that has described an out-of-body experience. I don't usually go in for other-worldly things, except when I find myself awake in the middle of the night, and then I unfortunately start to believe in all sorts of ghosties, but during the day, I stick to a no-nonsense Calvinistic attitude. Despite the literature that explains these occurrences away, I believe Charlie was temporarily an angel, watching us in the ICU that night. How else would he have known that I was "shitt-ing bricks in the corner"?

I don't share Charlie's story with many people. It's too special. I write it all down for Charlie's wife. I tell her that I believe he was an angel in life and that he continues to be one in death.

Claire Cronin, MD, MBA, is a board-certified general surgeon who practices full time at Newton-Wellesley Hospital. She said, "I went into medicine because I was 'good' in math and 'bad' in English. That was when English was mostly about handwriting. Mine was so bad that it practically guaranteed me a spot in medical school." Three years ago, Cronin was one of the five finalists in this contest. Since then, she has been recording her observations of what she encounters daily in medicine. This entry is about one of her favorite patients.

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Dr. Paul V. Nally
1931-2013

It was 40 years ago, during my internship, that I first met Dr. Paul Nally. At that time, he directed the Dermatology Clinic at St. Vincent Hospital, and as such, he was one of the first of some of the extraordinary mentors from whom I have been most fortunate to learn. To this day, I well remember his refreshing humor and honesty. “Dr. Nally, what is this blistery rash?” “Who knows? How about if we just call it a ‘vesicular dermatitis?’ That should cover about anything.”

Two years later, both of us moved to Shrewsbury, where we ended up as next door neighbors. Paul and I, our wives, Ann and Zenie, and, yes, our dogs, Nicky and Bugs, enjoyed friendships fostered by many walks together. Paul’s humor, kindness and perpetual optimism made for fond memories of those gentle moments. Perhaps the social worker side of him from his prior career was part of this.

A graduate of Holy Cross, Paul ultimately went on to his MD from Creighton University in 1965. His internship at St. Vincent Hospital preceded residency in Dermatology at Tufts New England Medical Center. He practiced for many years in Worcester, serving on the staffs of St. Vincent Hospital and UMass Medical Center. He was a member of the Massachusetts Dermatology Association, the New England Dermatology Society, the Worcester District Medical Society, the Massachusetts Medical Society and the American Medical Association. In addition to his earlier career as a social worker in Worcester, Paul served as a 1st Lieutenant in the National Guard for 10 years.

Having had the honor of providing Paul’s primary care over many years, it was truly inspiring to see his acceptance and rational approach to the unremitting incapacities unleashed by end-stage renal disease, among other things. His beloved wife of 44 years, Ann Marie, never once left his side throughout his relentlessly progressive debility.

Paul’s understated, gentle demeanor and optimism are traits to emulate. Those of us who knew and worked with him in better days have only the warmest of memories.

~ Joel Popkin, MD

Health Care Proxy Law Clarified

Peter Martin, Esquire



Peter Martin, Esq.

Since 1990, the Massachusetts health care proxy statute has been construed a number of times; for example, to permit a health care agent to consent to the incapacitated principal's admission to a mental health facility or to be administered antipsychotic medications, unless the principal expressly limits such authority in the proxy document itself. Massachusetts courts have also overruled a health care agent's authority when the agent proved himself incapable of making health care decisions based on the patient's best interest. Two recent Massachusetts Supreme Judicial Court decisions have further defined the statute's parameters.

The first case, *Johnson v. Kindred Healthcare, Inc.*, was a wrongful death action in which the administrators of the estate of a deceased nursing home resident accused the nursing home of negligence. The resident's wife, acting as his health care agent, had signed an arbitration agreement with the nursing home operator. The plaintiffs argued that this action was not a "health care decision" within the agent's authority and, therefore, the arbitration agreement could not be enforced.

The court read the language of the health care proxy statute to confine "health care decisions" to those that "directly involve the provision of responsible medical services, procedures, or

treatment of the principal's physical or mental condition." Such decisions include whether to admit a person to a mental health facility for treatment, but not whether to arbitrate rather than litigate a health care-related dispute. The court also contrasted the scope of the health care agent's authority with that of other substitute decision-makers, such as a holder of a durable power of attorney, a guardian or a conservator. The court noted that those other sources of authority are broader than that of a health care agent, to include decisions that require business, estate planning, financial or legal knowledge and experience. To expand a health care agent's authority to include non-health care decisions would upset the statutory scheme that allocates decision-making authority and create confusion and potential conflict between a health care agent and one or more of those other patient representatives.

The decision is consistent with the common practice of attorneys representing older clients recommending that the client execute both a health care proxy specifically for health care decisions (perhaps adding a statement of wishes to deal with end-of-life issues) and a durable power of attorney to handle business, financial and legal issues. It sets some parameters to "health care decisions" that add some clarity to the scope of a health care agent's decision-making authority. What is not entirely clear from the court's definition is whether the term could include decisions about the principal's health insurance. For example, might a court in the future declare that it is a "health care decision" to elect on behalf of an incapacitated principal a health insurance policy with deductibles as low as possible,

based on an assessment that the principal will be a frequent user of health care services?

The second case, *Licata v. GGNCS Malden Dexter LLC*, also was a wrongful death action where the defendant nursing home operator sought to compel the plaintiff to engage in arbitration, based on an arbitration agreement signed by the patient's health care agent upon the principal's admission to the nursing facility. Three weeks after admission, the patient's attending physician completed a one-page document titled "Documentation of Resident Incapacity Pursuant to Massachusetts Health Care Proxy Act 201D" that set forth the cause, nature, extent and probable duration of the patient's incapacity. The *Licata* court referred to the *Johnson* decision in disposing of the question of whether the health care agent could sign the arbitration agreement. It turned to another question raised in the case, which was what document triggers the authority of the health care agent under the statute.

In this case, the nursing home operator contended that a transfer report, from the hospital where the principal had been treated prior to admission to the nursing home, satisfied statutory requirements as a determination of the principal's incapacity. That transfer report included the physician's diagnosis of dementia and noted that the principal's insight and judgment were chronically impaired. It was not given to the principal or to her agent, nor were they otherwise advised of the physician's determination. In contrast, the statute requires that the patient's attending physician document his/her determination that the patient lacks the capacity to make or to communicate health care decisions; that the documentation contain the physician's opinion as to the cause, nature, extent and probable duration of the incapacity; and that the physician must give prompt oral and written notice of the determination to the patient, if he or she can comprehend the notice, and to the agent.

The court reasoned that because the purpose of notifying the principal of the incapacity determination is to give the principal an opportunity to object to the determination and its resultant activation of the health care agent's authority, use of a note in a medical record as both the incapacity determination and as notice of that determination could potentially deprive the principal of that opportunity, create uncertainty as to when the proxy was triggered and lead to liability for providers who treat the principal after failing to give that notice. Consequently, the court ruled in this case that the health care agent's authority did not commence until the determination document was executed by the physician, three weeks after the purported health care agent signed the arbitration agreement.

The lesson of the *Licata* case for both institutional and individual health care providers is to not rely on informal documentation of a patient's incapacity determination. They should take steps to ensure that they employ only a determination document that meets the statute's various requirements and a process that ensures the determination is made known to the patient, where applicable, and to the agent.

Peter J. Martin, Esquire, is a partner in the Worcester office of Bowditch & Dewey, LLP, whose practice concentrates on health care and nonprofit law.

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2014 Annual Business Meeting Wednesday, April 16, 2014

2014 Community Clinician of the Year Award



Annie Abraham, MD

Dr. Annie Abraham is a board-certified internist with Primary Physician Partners. She is an assistant professor in medicine at UMass Medical School and is actively involved in teaching students and residents at the Worcester Medical Center.

The Community Clinician of the Year Award was adopted at the Interim House of Delegates meeting in November 1998. It was established to recognize a practitioner from each district medical society who has made significant contributions to patients and the community.

Guest Speaker



Secretary John Polanowicz

Secretary, Executive Office of Health and Human Services,
Commonwealth of Massachusetts

With the implementation of the state's health reform law in 2006, Massachusetts has led the way in achieving near-universal coverage. The state has followed that success with comprehensive reforms to address the problem of rising health care costs. Nationally, the Affordable Care Act builds on both of these efforts, by expanding coverage to millions who do not have it, and by driving innovation in health care payment and delivery. Remarks will address the impact of the Affordable Care Act in Massachusetts and nationwide, including challenges and opportunities for the Commonwealth and for providers.

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Celebrate National Donate Life Month with New England Organ Bank this April

This April marks the 11th annual National Donate Life Month, a celebration commemorating those who have given the gift of life through organ and tissue donation. For those whose lives have been saved or healed by a transplant, National Donate Life Month provides a chance to share their story to encourage more people to register as donors.

Suellen Canfield was a happy wife, mother and grandmother when she died suddenly in 2001. Her family had no doubt that, if given the opportunity, she would continue to help others even after she had passed. At 61 years old, Suellen's gift of organ donation saved the lives of three people. Her husband, Bob, volunteers for New England Organ Bank, sharing his story of how in great loss he found comfort in his wife's ability to help others.

"There are many patients in New England who are in dire need for an organ transplant," said Dr. Heard, professor of Anesthesiology and Surgery, chairman of Anesthesiology and chairman of the UMass Memorial Organ and Tissue Donation Committee, UMass Memorial Health Care. "Only a fraction of individu-

als who die in the hospital are suitable to become donors. That is why it is important that we medical professionals reach out to our patients and discuss organ donation, encourage them to have conversations with their loved ones and to sign up to become a donor on their driver's licenses. Multiple lives can be saved with one donor."

In addition to organ donation, tissue donations help more than 1 million individuals each year. Heart valve, bone and skin donations give recipients a new chance at a healthy life; the recovery of tendons and ligaments can help heal a severe sports injury; and cornea donations give the gift of sight.

Thanks to a group effort made up of healthcare professionals, New England Organ Bank, motor vehicle department offices and Donate Life volunteers, the number of registered donors continues to climb. There are now 112 million registered donors in the United States, more than 5.5 million from New England. Still, the number of people in need of transplants rises, as well, and the number of people in need of transplants continues to outpace the supply of donated organs. More than

120,000 people are currently awaiting a transplant, and sadly, an average of 18 patients die every day because the organ they needed was not donated in time. The solution to this problem is to continue educating the public about the lifesaving effects of donation and transplantation and encourage them to sign up through their state donor registry.

To register to be a donor or for more information visit www.DonateLifeNewEngland.org



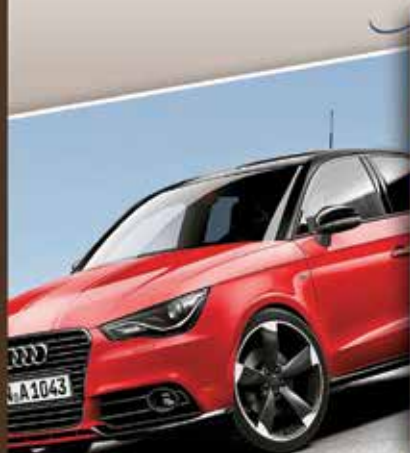
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