

Maryland Medicine

VOLUME 21 ISSUE 3



**Racial Disparities
in Health Care:
We Need to Do More**

**Physician Well-Being:
Tips for Managing Stress**

**COVID-19 Realities:
What Can We Learn
from Each Other**

Virtual Meeting Held for American Medical Association

For the first time in its history, the American Medical Association (AMA) suspended its annual meeting in Chicago and held a virtual special meeting instead. Like many other associations across the globe, the AMA confronted the COVID-19 pandemic by moving forward with its meeting. But unlike most other associations, the AMA is filled with members who have a unique perspective on the effects of the disease. The stress and uncertainty of the meeting deliberations did not dim the good humor of Susan R. Bailey, MD, who was officially installed as AMA President, nor the resolve and optimism of Patrice Harris, MD, who ended her own tenure as President with a tribute to her colleagues for their strength and resilience. The AMA HOD conducted its vital business for the organization and will look ahead to gathering together again in the future. Maryland was represented (albeit remotely) by a full delegation, and we'd like to acknowledge the delegates' commitment and participation:

Harbhajan Ajrawat, MD, Delegate
Loralie Ma, MD, Delegate
Shannon Pryor, MD, Delegate
Stephen Rockower, MD, Delegate
Bruce Smoller, MD, Delegate
Renee Bovellet, MD, Alternate Delegate
Brooke Buckley, MD, Alternate Delegate
Padmini Ranasinghe, MD, Alternate Delegate
Gary Pushkin, MD, Alternate Delegate
Omar Harfouch, MD, Alternate Delegate, Resident
Elisabeth Fassas, Alternate Delegate, Medical Student

If you'd like to learn more about MedChi's participation in the AMA, please contact Catherine Johannesen, MedChi Chief of Staff, at cjohannesen@medchi.org.

Physician Identity: Defining a New Rockwellian Portrait

Cathy Peters

Norman Rockwell, a prolific American artist, evoked compassion, trust, respect and energy in his paintings. His unique abilities garnered the once prized cover page of *The Saturday Evening Post* 321 times over 47 years of his career. Medical portraits by Rockwell, gracing the walls of physician offices for decades draw the viewer in, providing a sense of the community physician. This was the portrait of the physician who cared for all patient needs, from birth

to death. These nostalgic memories of the past are, in part, the impetus for Michele Manahan, MD, President of the Maryland State Medical Society, to present, "Physician Identity: Defining a New Rockwellian Portrait." This CME accredited program will be presented via GoToWebinar, on the following dates:

- Tue., Aug. 18, 7 p.m. for western counties
- Tue., Sept. 15, 7 p.m. for mid-shore counties
- Tue., Sept. 22, 7 p.m. for eastern and southern counties

Please join MedChi for this enlightening opportunity to engage in the challenge of defining your new identity as a physician in the twenty-first century. To register, contact Cathy Peters at: cpeters@medchi.org, or 410.539.0872, ext.3369.



Five Things You Need to Know About COVID-19 Testing

1. Practitioners may now access COVID-19 test results in the CRISP Unified Landing Page (ULP) via the "COVID-19 Results Viewer."
2. Practitioners and patients may also get COVID-19 test results by calling 866.984.4405.
3. Most COVID-19 testing sites are now available to patients without a physician's order and many without an appointment. Testing sites are available on the Maryland Department of Health's website: <http://coronavirus.maryland.gov/pages/symptoms-testing>.
4. Encourage patients to provide their race when asked by COVID-19 testing sites so racial disparities can be appropriately tracked.
5. Tell patients with COVID-19 about the importance of contact tracing and alert them to answer the phone when the caller ID says: "MD COVID."

From the President...

Michele Manahan, MD, President, MedChi

It seems we are facing challenges everywhere we look these days. I hope that we can all at least take comfort in the hope that moving forward, things must get better. It's going to be pretty tough going for a while though.



While we ride the teeter-totter of ups and downs in COVID-19 cases, MedChi has started a new project, the IDEA Task force. "IDEA" stands for, "Inclusion," "Diversity," "Empowerment," and "Advocacy." The symbol for this initiative is the lightbulb, as we are "lighting the way to a brighter tomorrow."

The goal is to invite all physicians in Maryland to participate. Our actions will be determined by the group's will. If you are interested or know someone who is, please reach out to MedChi by contacting Catherine Johannesen, MedChi Chief of Staff, at cjohannesen@medchi.org or 800.792.1056, ext. 3308. This is a great opportunity for all of us to build alliances as we forge new paths over uncharted ground.

I hope everyone is hanging in there. We know that even simple tasks get harder when buried under PPE. On the other hand, we are grateful when we have PPE, and MedChi plans to continue to work to ensure supply chain dependability. MedChi will continue to advocate for physicians in Maryland, protecting us as we protect our patients' health. I hope the improvements we are seeing in some areas, such as access to testing, are reassuring.

Thank you to everyone who participated in the AMA COVID-19 survey. MedChi gained valuable information on the status of physician minds, hearts, and finances. MedChi will release the survey results in the near future. MedChi will continue to stand up and fight for the issues that we face.

Best of luck and health until we "meet" again.

Critical Conversations: COVID-19 & Health Disparities

A Perspective on Health Disparities: The Time to Take Action is Now

Noel Brathwaite, MA, MSPH, PhD

The nation's attention to the state of minorities' health has increased to a heightened level of awareness and consciousness due to the coronavirus. However, observations about the state of Black health began in 1895 with Booker T. Washington. He was a former slave who founded Tuskegee Institute in Alabama and built it into a major center of industrial training. In a pivotal speech given in Atlanta, Washington focused on the health and conditions of post-slavery Blacks. In a presentation titled "Addressing Health Care Disparities: Promising Practices in Maryland" (2004), Shirley Nathan-Pulliam and Dr. Carlessia A. Hussein note that this speech initiated a string of debates and inquiries into racial health differences. From 1895 to 2002, much research was conducted and published on the status of Black health and health disparities in the U.S., and in Maryland in particular. These publications include the 1968 Kerner Commission Report, which claimed that racial health inequalities are severe and troubling. In 1985 the Report of the HHS Secretary's Task Force on Black and Minority Health (Heckler-Malone) garnered a good deal of interest as it pointed out the continued prevalence of racial and ethnic health disparities. This work was then followed by the 2002 IOM Report: *Confronting Racial and Ethnic Disparities in Health Care*, which found race and ethnicity to be significant and accurate predictors of quality of health care.

According to Pulliam and Hussein, Maryland authorities were so dismayed by the extent of minority health disparities highlighted in the Heckler report that they took action to address these inequalities. The first was in 1987, with the establishment of "Now is the Time: Action Agenda for Improving Black and Minority Health" (Maryland Governor's Commission). Later, in 1994, it started the Office of Minority Health within the Office of Community Relations (not in statute). And in 2002, the *Healthy Maryland Chartbook* was



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published. This publication featured statewide health data with trends showing racial disparities in cancer, asthma, diabetes, HIV, heart disease, and stroke, as well as higher rates of infant and maternal mortality. Even now these disparities, these disproportionalities, continue to exist.

Entering into this environment of persistent health disparities comes the coronavirus. Interestingly enough, this global pandemic has brought about two unexpected outcomes: one, is that it has forced us to pay attention to the minority health disparities problem. And two, it presents an opportunity that forces us to address the problem head on and focus on its underlying causes.

In terms of racial disparities between minorities and their White counterparts, data continue to be the best way of understanding who is suffering and how. Prior to this pandemic, data on chronic diseases and infant mortality indicate that minorities (meaning Blacks and Hispanics, in this instance) have a higher incidence of disease and are more likely to be hospitalized and more likely to end up in the emergency department. Minorities were also more likely to die prematurely from these conditions — most of which are preventable. The COVID-19 epidemic has thrown a bright spotlight on the existing disparities in health conditions, and health care outcomes. Current Maryland COVID-19 data show that the trend continues. When the data for race and ethnicity are known, Black and Hispanics show disproportionately higher infection rates, hospitalizations, and deaths as compared to Whites. The disproportionate racial impact of COVID-19 is of no surprise to public health officials, who have been following these trends for decades. This trend could continue into the foreseeable future unless data-driven policy and systemic actions are urgently taken to reverse the trend.

Such systemic actions can start today. This pandemic has provided us with an opportunity to do more to address health disparities and their root causes, and to create a fairer and more just health system. This transformation can begin by dealing more intently with underlying or preexisting conditions, including diabetes, hypertension, and obesity. These diseases weaken the immune system, which can make the outcome of COVID-19 particularly fatal. The conditions that drive these health states are known as social determinants of health. They operate at three levels, excluding genetic influence. The three levels are: the environment, or where people live and work; health care, where people receive health services; and individual behaviors such as substance use and a sedentary lifestyle. These disparities are showing up not only in Maryland and the United

States but worldwide. They are showing up wherever there are minority, marginalized, and vulnerable groups of people.

Maryland's response to this pandemic has been instructive and should become a model. We used a government approach; publicized the data by race and ethnicity (when it could be known); acknowledged the extent of the disparity; and have taken concrete steps to address this disparity at the state and local level. To slow down and even prevent the spread of the virus, Maryland relied on scientific and public health strategies, which included testing, contact tracing, and quarantining of cases. We have ensured a high treatment bed capacity and have been providing protective gear to health providers. In addition, encouraging and promoting the importance of staying at home, social distancing, wearing masks in public, frequent hand washing, and other practices to protect and save its citizens have been used. In addition, Maryland has been tackling the underlying social determinants of compromised health through a coordinated delivery of social and economic packages that target COVID-19 hot spots. As a result of these measures, the state has met the criteria of the WHO and the CDC for lifting COVID-19 restrictions and reopening some local businesses and restaurants (the criteria is less than 5 percent of new positive cases of COVID-19). This is a good start; yet there is more that still needs to be done.

Until a vaccine is available and widely distributed, Maryland's achievements in addressing COVID-19 and its accompanying health disparities can be regarded as a "jumping off point," a public wake-up call for dealing frankly, openly, and aggressively with the health disparity issue.

Noel Brathwaite, MA, MSPH, PhD, is Director, Office of Minority Health and Health Disparities, Maryland Department of Health. He can be reached at noel.brathwaite@maryland.gov.

Stopping the Spread of COVID-19: Cultural Memory and Trust Play a Role

Stephen B. Thomas, PhD

The novel coronavirus (COVID-19) pandemic is a defining moment for our state and our nation. With Maryland's racial and ethnic diversity, and innovative policies such as the Total Cost of Care Model and global budgets, I believe Maryland should be the model for the nation. Today, the devastating toll of COVID-19 on Maryland's African American residents reflects the burdens of race and history so clearly apparent through well-documented health disparities. Now more than ever, there is a compelling need to move forward to achieve health equity for all Marylanders. Of significant concern are also Maryland's Latinx residents, many of whom may be particularly vulnerable because of language barriers, immigration status, and lack of insurance. COVID-19 has exposed the deferred maintenance on our public health infrastructure and put a spotlight on the long-standing cracks in our medical care delivery system through which the health of minority populations has fallen.

There is an adage in medicine, "...you will never get the treatment right until you have the correct diagnosis..." As of July 7, 2020, there were 2.9M cases and 130,133 deaths from COVID-19.¹ Black and Latinx populations have death rates three times higher than their White peers (see below: "Coronavirus Cases per 10,000 People," *New York Times*, July 5, 2020). There are several explanations for these racial and ethnic differences including, but not limited to, a greater burden of underlying chronic diseases (e.g., hypertension, diabetes, asthma) among communities of color. Additionally, social and economic conditions restrict far too many minorities in "essential" jobs where they

cannot social distance by working from home or avoiding crowds. From health care workers in nursing homes to the janitors and cafeteria workers at academic health science centers and neighborhood hospitals, people of color are simply more exposed to community spread of COVID-19 and often have limited ability to make

personal health decisions in the workplace. As health care professionals, we must avoid victim blaming, be more self-reflective, and look within to explore how unconscious bias and institutional racism impacts our own work.

The history of racism in medicine and public health would be easy to ignore were it not so well documented. We need to understand why these disparities exist to understand where and how to focus our efforts to eliminate premature illness and death from preventable diseases. Today, as we battle the COVID-19 pandemic, the well-documented history of unequal treatment and abuse in the name of medical care and biomedical research is a legacy that cannot be ignored. There are well-documented examples of this legacy in the history of medicine, including the U.S. Public Health Service Syphilis Study conducted in Tuskegee (1932–72). In this study, approximately 400 Black men from rural Macon County, Alabama, were deceptively recruited into a natural history study on syphilis without medical treatment or concern for their well-being or that of their families. Government doctors went to great lengths to ensure that even when penicillin became available in the 1950s, the men in the Tuskegee Study did not receive treatment.² This legacy of distrust remains today, as part of the cultural memory among communities of color, especially African Americans. This distrust looms over our ability to adequately meet the challenges of COVID-19. Equally significant, the recent tragic murder of George Floyd sparked protests to stop police violence and re-established #BlackLivesMatter, propelling it to international

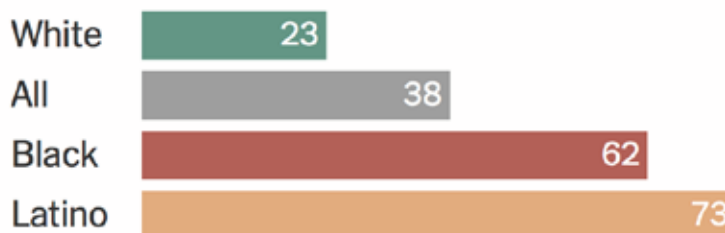
visibility and demanding the dismantling of institutional racism in all forms.

Trust is essential if we wish for the public's embrace of preventative COVID-19 behavior, such as frequent hand washing, wearing a face mask in public, and avoiding crowds. We know what works to stop the spread of COVID-19.

As the national demographic make-up gradually shifts from that of majority White to that of majority minority, we must not



Coronavirus cases per 10,000 people



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dismiss the mounting scientific evidence that structural racism can get under the skin (so to speak) and make you ill. Therefore the health of these minority populations may one day constitute and represent the health of the entire nation.

So where do we go from here? Chaos or community? This is the question Dr. Martin Luther King, Jr., asked at the height of the Civil Rights Movement. The convergence of the COVID-19 pandemic and the anti-Black racism movement have brought us to a major inflection point in this history of our nation. Every intersection offers possibilities and you must choose the right road even when choices must be made quickly. As individuals, we have major turning points in our personal and professional lives. Most of the time you cannot see these moments until they are in the rearview mirror; however, I am here to tell you that this is one of those defining moments.

We must feel a sense of urgency for how to ensure that the color of one's skin, the zip code where one lives, or how much money one earns does not define life expectancy. The political climate following the 2016 U.S. election was full of anxiety about how President Trump's administration was trying to dismantle all things associated with President Obama, including the Affordable Care Act. We must be vigilant about our code of ethics and how race and ethnicity can determine the outcome of one's health. We must focus on educating and inspiring the public to demand ethical treatment and bring an end to injustices in our health care system. If we are to succeed in the quest to achieve total health equity and eliminate racial disparities, we must bring to the foreground a history that — because of the magnitude of its shame — has too often been omitted from the discourse about the pervasive influence of racism in the fields of medicine and public health.

References

1. CDC COVID-19 Tracker (accessed July 7, 2020 at <https://www.cdc.gov/covid-data-tracker/index.html#cases>).
2. Jones, James H. *Bad Blood: The Tuskegee Syphilis Experiment* (Simon & Schuster, 1993).

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AMA Produces Health Equity Video Series

Victoria Hecht

The COVID-19 pandemic has exposed deep-rooted health inequities in the U.S., as the pandemic's impact has been felt unevenly among minority populations, with African American, Latinx and Native Americans having a disproportionately higher number of cases and deaths. If there's a silver lining to be found here, it is that this unfortunate outcome has reignited a national conversation about health and wealth inequality in America.

For its part, the American Medical Association (AMA) is now hosting a Thursday night video series called "Prioritizing Equity." Hosted by AMA Chief Health Equity Officer Aletha Maybank, MD, MPH, the Prioritizing Equity series illuminates how COVID-19 and other determinants of health uniquely impact marginalized communities, public health and health equity, with an eye toward the root causes and the long-term implications. Recently covered topics include The Experience of Physicians of Color and COVID-19; The Root Cause & Considerations for Health Care Professionals; Police Brutality & COVID-19; LGBTQ Voices; and COVID-19 & Latinx Voices in the Field. In case you missed them, all the videos have been posted on YouTube and can be found at <https://bit.ly/33QPTGo>.

On a local level, the Maryland Department of Health (MDH) Office of Minority Health and Health Disparities (MHHD) has prepared a *white paper* on COVID-19 and its impact on minority communities, which includes data about COVID-19 among diverse populations and strategies that have been implemented to tackle this pandemic. In an effort to make resources accessible and clear for non-English speakers, the office has translated COVID-19 FAQs, orders, and guidance into more than a dozen different languages. This important information can be found at <https://goc.maryland.gov/covid19-translations/>.

An IDEA Whose Time Has Come Inclusion, Diversity, Empowerment, Advocacy: MedChi's IDEA Task Force Takes on the Pressing Issues of our Day

Catherine Johannesen

In January 2020, MedChi President Michele Manahan, MD, launched the IDEA Task Force to address issues of inclusion, diversity, empowerment, and advocacy in organized medicine. Like so many of MedChi's projects and initiatives, the progress of the fledgling task force was waylaid by the COVID-19

pandemic. With the current Black Lives Matter protests of this spring and summer a fresh, passion-fueled interest in issues of racial inequality has been reinvigorated. Coupled with the startling health disparities that were laid bare by the pandemic, the IDEA task force now has a renewed sense of urgency.

It was within this context that the IDEA Task Force held its inaugural meeting on July 2. The task force began the process of exploring the role of organized medicine and the individual physician's role in addressing and overcoming implicit bias, achieving health equity for patients, and ending the public health crisis of racial disparity.

The work has only just begun. If you would like to join the IDEA Task Force, please contact Catherine Johannesen at cjohannesen@medchi.org.

BCMS Foundation Focuses on the Mental Health of Seniors

Lisa Williams

In her remarks during the May 2018 Baltimore City Medical Society (BCMS) President's Gala, Padmini Ranasinghe, MD, quoted a well-known ancient Buddhist as saying: "Arogya Parama Labha." Translated, this means that "the ultimate profit or gain that anyone can make is in one's own health and wellness." As President-Elect, Dr. Ranasinghe has led a series of wellness initiatives that include establishing a Wellness Advisory Committee to provide guidance on programming and several continuing medical education activities. "The goal of our efforts is to reach out to physicians at every stage of their career, and our collective vision [is] that physicians who invest in their own wellness will become the true healers for everyone in their community," Dr. Ranasinghe stated.

BCMS Foundation, established in 1972 by BCMS physicians, shares this vision, and is using its Speakers Bureau to expand its reach to city residents on topics of well-being. The Speakers Bureau — a signature program of BCMS Foundation (BCMSF), has long provided BCMS members and other professionals a means of presenting to community, business, college, and faith-based audiences on a variety of medical and health care topics. Before COVID-19, BCMSF's volunteer physicians gave a series of presentations at senior centers and dining venues on the theme of "Mind, Body, Spirit," or mindfulness.

A series of presentations were also held at the Zeta Phi Beta Center for Healthy and Active Aging, located in northwest Baltimore, led by La Keita D. Carter, Doctor of Psychology. Dr. Carter, a certified clinical trauma professional, and her team engaged center participants in discussions on stress, anxiety, depression, and grief. Reflecting on her presentations, she noted that with COVID-19, "it is likely that many of these concerns have persisted or gotten worse." And with the Center now closed, "the social support they were receiving [from one other] has been halted." In addition, the decrease in face-to-face interaction with family and acquaintances (i.e., friends, church members, and neighbors) can further foster feelings of isolation and loss.

Dr. Carter shared ways that seniors can reduce stress and anxiety, recognize and cope with depression triggers, and work through their grief. Equally important was the discussion of when to seek treatment for mental health, in the same way that one seeks treatment for physical health. Dr. Carter stressed the importance of physicians referring patients for mental health consultations, as doctors are often the first point of contact when it comes to their patients' mental well-being. "Mental health providers are now offering in-person and telehealth treatment to patients in large numbers during this pandemic," she observed.

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Critical Conversations: COVID-19 & Physician Well-Being

Covid-19 Realities: A Personal Reflection

Basil Morgan, MD

The reality of COVID-19 became clearly apparent to me while attending Wilmer Eye Institute's Current Concepts in Ophthalmology course in Vail, Colorado, this past March. The meeting was held at the Grand Hyatt Hotel in a picturesque setting with fresh snow falling almost every day. A number



of people who were slated to speak could not attend, because of “no fly” restrictions imposed on them from their respective universities. Those of us who were in attendance followed the daily news about COVID-19, not realizing that a number of hotel workers and a few faculty members at the meeting would later test positive for the virus.

At the end of the meeting, I flew back to Baltimore on a packed and oversold flight, and the next day the state of Colorado was

placed on lockdown. Eagle County, where Vail is located, was found to be an epicenter of the COVID-19 outbreak.

I now faced a dilemma. I was asymptomatic but obviously exposed, and since I showed no symptoms I could not obtain a COVID-19 test. I was now a potential carrier so the sensible thing to do was to close my office so as not to risk exposure to my patients or staff. This decision was not taken lightly, as it would cause hardship to my patients, staff, and me. I told myself that it would only be a fourteen-day hiatus from the office. In due time COVID-19 became a global pandemic, and my self-imposed quarantine unintentionally turned into a two-and-a-half month hiatus from my office — the longest time away since I began practicing in 1981.

With this much time off, how did I stay focused? My 3.5 mile morning walks became even more important to me. My walk was followed by daily gardening, mulching, and pruning, which provided a respite from the continuous 24-hour pandemic news coverage. I also attended webinars on the pandemic and on various ophthalmology-related topics. I kept in constant contact with my staff, and patients were managed through a hybrid form of telemedicine.

Financially, the office balance sheet did take a hit, but we survived because I have always kept a ninety-day survival fund that kept us afloat. No staff members were laid off or furloughed, and their health insurance was kept in place. With the prospect of eventually reopening, I have looked for guidance from MSEPS, CDC, AAO, and Johns Hopkins Hospital.

Moving forward, my office protocol will now include mandatory masks for all patients and staff, PPE for myself, and hand sanitizer (Purell) for every patient prior to being seen. To ensure proper social distancing, carefully spaced appointment scheduling and reduced patient capacity will be the order of the day. Telemedicine will continue to be used judiciously to reduce in-office visits, until full scheduling can resume.

Reflecting on this period of forced absence from in-office practice, I now have a greater appreciation for the privilege of in-person, “hands on” patient care. I have truly missed seeing my patients and now have renewed energy when going to work on a daily basis. I am also reaping the benefits of my beautiful outdoor garden.

Basil Morgan, MD, is an Eye Physician and Surgeon in Baltimore and Assistant Professor of Ophthalmology at the Johns Hopkins Wilmer Eye Institute.

Physician Stress: Fight or Flight?

Annette Pham, MD, FACS

Fear. Frustration. Fury. Fatigue. Fight. Or flight. So many “F- words” conjured up during these times of stress. But I am a physician and a surgeon; a mother and a wife; not necessarily in any given order of priority. Stress is not new. In some situations, I thrived on it. I worked better under pressure and produced results. In other situations, I was pushed down, but fought to get back up. As students of medicine, we learned about the innate, physiologic response to stress — the physical, mental, or emotional factors that could be external or internal causing bodily or mental tension. We understood the protective “fight-or-flight” acute stress response. We learned about the general



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adaptation syndrome with the different stages of stress. But somehow for me, these last few months have turned all this basic knowledge into a sum of those “F” words above. Some of us have been able to repair and recover during the resistance stage of the general adaptation syndrome of stress, but others have been continually under chronic stressors that can catapult them into the exhaustion stage of that syndrome. So what is the path, then, to how we will become resilient (or resist and repair) in times of stress versus the path to how we will succumb to the exhaustion?

In my world, I call out those stressors — identify them through self-awareness, communication, and sharing. That was pretty straightforward in the beginning. Stress of the virus itself and its unknowns and even the stress of doing something as simple as trying to secure appropriate PPE. As the disease process made itself known, there was then the stress of secondary effects: economic turmoil, financial uncertainty, practice instability, social isolation during physical distancing to name a few. Each one piling on and on. As these other stressors came to light, a

big stressor that was lurking all along in our health care system sprung forward in the headlines. Those key phrases: social injustices, health inequities, social determinants of health. What can we do as physician leaders, as healers in our society? A very big question that stressed me out even more. I felt like a nail, being hammered down. Tap, tap, Tap, tap, tap-tap, and TAP. Now realizing that I am not actually stuck in a bad position, I am placed exactly where I should be. I am calling out these stressors, so we can address them head on. I am calling on my colleagues to join in and help, so we can better advocate for our patients and for ourselves and get to the healing of the ailments of our society. So fight? Or flight? Physicians are stressed. I know. I get it. Everyone is stressed. Let us keep moving forward as we move to action.

Annette Pham, MD, is a practicing otolaryngologist and facial plastic surgeon practicing in Rockville, MD. She is President of Montgomery County Medical Society. She can be reached at drannette09@gmail.com.

My Personal and Professional Challenges Experienced During COVID-19

Robert Atlas, MD

As a maternal fetal medicine specialist and chair of the OBGYN department at Mercy Medical Center, my day usually consists of a combination of briskly walking (sometimes a light jog or run) to catch a newborn, teaching residents and medical students, performing surgery, and administrative tasks. Deliveries have not been put on hold and rescheduled like elective surgeries, and the rapid titration of telemedicine's role in health care has not quite found its place on labor and delivery these past few months. So far, my day-to-day role as a clinician has not changed very much.



The pandemic has infused a sense of angst and uncertainty into not only my professional work but also my home life. My patients' well-being weighs heavily on my mind. The community I serve is predominantly African American, and we are aware that women of color at baseline are at higher risk for maternal and infant morbidity and mortality. This baseline risk is augmented as COVID-19 disproportionately affects people of color. We are not equipped similarly to other

centers for testing all patients who present to triage and Labor and Delivery (L&D). With asymptomatic carriers, my staff and other clinician providers put themselves and their family members at risk for viral transmission. Routine deliveries feel a little less routine with everyone wearing additional personal protective equipment.

Having a risk factor for COVID-19 while walking around the hospital makes my heart pause, a little longer than it usually does at my age. Managing Type-2 diabetes in a hospital setting can be a challenge when you have a sweet tooth. Why does it feel like the donuts and pastries are always 100 percent stocked when I make an appearance in the physician lounge? I do my best to follow all the policies and procedures and rapidly changing PPE requirements. The additional stress is sometimes difficult to manage, but it helps to be surrounded by talented, supportive colleagues as a reminder of why we went into this line of work in the first place.

I have the pleasure of working with a varied group of colleagues. The GYN oncology surgeons are busy as usual with a similar volume of cases, as many of their cases are urgent or emergent. The pulse of the office has slowed, but

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Personal & Professional Challenges, continued from pg. 11

with the addition of headsets to support the surge in telemedicine services. My benign minimally invasive gynecologists were not so “lucky.” All of their surgeries were canceled, and many have been reassigned to the ICU and Labor and Delivery. I don’t think they ever thought they would step foot back on Labor and Delivery doing deliveries, but their versatility and collaborative spirit is inspiring. The hospital has done a great job dealing with this pandemic. It quickly developed plans for the surge, implemented PPE, and all staff were retained, albeit some found themselves in a slightly different role.

I struggled with wellness before the pandemic. I enjoy my work, yet sometimes the lines are blurred between home and work. Often it is challenging for me to unplug from the “matrix” — aka health care. Healthy routines and well-developed coping strategies for work stress were not fully developed for me before COVID-19. I know that I should exercise more, eat a balanced diet, and introduce mindfulness into my daily routine.

The decrease in in-person meetings has now allowed me to go home earlier some days to spend more time with family or tackle home improvement projects. As I reflect on how things have changed these past few months, including the profound loss of life and economic hardship, I wonder what this “new normal” will look like for me, moving forward. Although my work volume has not changed, the pandemic has allowed me to reflect on how I define wellness and how I might start to add more balance to my life.

I have a job, my family is healthy, and we will get through this. I experience fatigue even though my kids liken my energy to the Energizer Bunny. To quote from the movie “Cast Away,” “We just have to keep breathing in and out for the tide may change at any time.” I sure hope it changes quickly.

Robert Atlas, MD, is Chair of The Department of Obstetrics and Gynecology at Mercy Medical Center in Baltimore.

Physician Wellness: What We Can Learn from Children

Richard Cook, MD



Eighty percent of the vagus nerve is afferent, meaning its signals travel from the gut to the brain. The reason most physicians are constantly stressed and overwhelmed is because their brains have changed. As has been observed, stress doesn’t simply act as a releasing agent for symptoms; rather, constant and cyclical stress acts like a foreign body that must be regarded as an agent that is still at work long after input. From heart problems to an increased risk of cancer,

insomnia, and a poorly functioning immune system, chronic mental stress is rarely if ever healthy. Like a bee sting or a peanut allergy, it is the body’s response to the foreign object that becomes the problem, not the stressor itself.

Modern neuroscience solidly supports the notion that many of our conscious thoughts or complex rationalizations, or the flood of instincts, reflexes, motives, and memories, emanate from the unconscious. The insula is the part of the brain that interprets and integrates information from the internal organs — including muscles, joints, and proprioceptive systems — to generate a sense of being embodied. The insula then transmits signals to the amygdala that triggers the “fight or flight” response. This does not require any cognitive input or conscious recognition that something has gone wrong. You feel on edge, “stressed,” unable to focus; or worse, you have a sense of imminent doom. These powerful feelings are

generated deep inside the brain and cannot be eliminated by reason or understanding. Only by getting in touch with your body and viscerally connecting with yourself can you regain a sense of who you are, your priorities, and values. So how do we do this?

Children typically laugh 300 to 400 times a day. They play. They make art. They explore. They socialize. They do all this more than they get stressed, thereby keeping their fight or flight mechanisms at bay by dialing down the body’s stress response, which decreases the afferent vagus nerve input. Physicians’ rigorous training and work ethic have produced, in many, a high level of constant fight or flight response that we never learn how to properly manage, and therefore our brains and bodies become very efficient at stressing, to the point at which we automatically get “fired up,” with or without an actual stressor. The answer, then, is to run, play, sing, and dance. Get some rest. Paint a picture. Build something with your hands. Meditate, pray, eat right, travel, and exercise. Join a group and socialize more. Disconnect from the internet and your cell phone. Become a kid again to rewire your brain back to its normal, healthy physiological state. As with most things in life, change won’t happen overnight. But practice makes perfect. And remember, Rome wasn’t built in a day.

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Cultivating Deliberate Resilience During Difficult Times

Emerson Wickwire, PhD

What are some tools to help alleviate stress after long and difficult work hours?

When you ask about stress, you are really asking about distress, or the negative aspects of stress such as unpleasant tension, frustration, exhaustion, and so on. Reducing these negative states is vital, and it's easiest to start with the body. Try exercise, stretching, deep breathing, and the like — even after long and difficult work hours, twenty deep breaths can help dissipate physiologic stress in a way that you will feel.

But it's not enough to focus only on distress, or reducing the negative. You also need to increase the positive. Eustress is the positive side of stress, such as learning a new skill, or being challenged by a hobby. Especially in health care, where the focus is rightly on alleviating disease, there is a huge need to focus on positive aspects of living and especially positive emotions, such as optimism and gratitude. Beginning a gratitude journal can go a long way toward managing long work hours and improving self-care.

Why is it important to discuss resilience?

Resilience means the ability to bounce back from adversity and to stay positive, flexible, and focused on our goals and priorities. By this definition, resilience is more important now than ever. What health care worker, parent, spouse, or child has not been affected by the Coronavirus pandemic?

Can someone improve their own resilience?

There is no question that resilience can be increased. Of course, resilience is multifaceted, and some aspects of resilience are more modifiable than others. As an analog, consider cardiovascular disease (CVD), which will be familiar to many readers. Much of the risk for CVD is based on lifestyle and modifiable factors, such as stress management, diet, exercise, and sleep. At the same time, genetic factors can increase risk for CVD, and practically speaking, genetic factors are not modifiable. Resilience works just the same way. Just like we can learn to eat a healthier diet or improve our sleep habits, we can learn to become more resilient, even though we cannot change our genetic makeup. Sometimes having a coach or guide can expedite the process.

If I can't sleep for eight straight hours, can I catch up on sleep on my day off?

About twenty years ago, two highly controlled laboratory studies were conducted by two separate research groups, with strikingly identical findings. In these studies, volunteers

were randomized to a little sleep (three or four hours per night), some sleep (five or six hours per night), or enough sleep (eight or nine hours per night). Each day, volunteers underwent a battery of cognitive tests, as well as physiological monitoring for objective sleepiness.

Three of the most important findings were: (1) the cognitive, emotional, and physiological effects of sleep loss are acute and cumulative, such that differences between groups were evident right away and continued to increase over time; (2) humans are very poor estimators of the effects of sleep loss — each day, the objective performance of the volunteers got worse and worse, but the self-ratings did not change; and (3) even after three days of recovery sleep, mental performance was still significantly worse than at baseline. Researchers have not yet determined exactly how long it takes to recover from one to two weeks of sleep loss, but three nights is not enough.



What are three small changes someone can make to help them to obtain more quality sleep?

In terms of getting more sleep, there are three approaches: go to bed earlier, sleep in later, or nap. Going to bed earlier is largely a time-management function, in that careful planning and eliminating daytime activities (i.e., checking email, paying bills) during evening hours can make an earlier bedtime more realistic. To go to bed earlier, think “dusk.” Once the sun sets, it does not return until the next morning. Sleeping in later also involves careful planning, such as choosing an outfit ahead of time, for you and/or your children. And, turn the alarm clock around, so that sleep is protected in time and space until the end of the sleep period. Checking the clock during the night is a sure-fire way to undermine sleep. Last, for shift workers and healthy sleepers alike, naps can be a refreshing and enjoyable way to increase total sleep time and provide a temporary boost to cognitive performance. But for day workers who have trouble sleeping at night, we generally recommend against naps because they can diminish nighttime sleep.

Emerson M. Wickwire, PhD, is Associate Professor of Psychiatry and Medicine at the University of Maryland School of Medicine, and Director of the Insomnia Program at the University of Maryland Medical Center, Midtown Campus.

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Thoughts on COVID-19

Brooke M. Buckley, MD, FACS

Pandemic. A word with a simple definition: A disease prevalent over an entire country or the world. At first it seemed terrifyingly simple. A virus that spreads quickly and indiscriminately kills many. In terror, we locked our doors and started ordering online. As a profession, we went to war. We have always waged battles against pathology, but the magnitude of this acute reckoning was different. Life as we knew it literally disappeared.

The front line, although terrified, maybe had it best in medicine. A call to purpose...meaningful work... and even the regulators willing to throw the rules out the window. As long as they worked, they were (mostly) ok. Busy. Saving lives. In the moments after work, afraid to go home, terrified their own hands...those used to heal...might in fact spread the disease that would kill those most dear to them, spouse, parents, children and self. The front line was called to an unexpected war, the enemy is not dead and most are exhausted. There is also anger at the lack of respect for this killer. What will become of these battle weary doctors?

The redeployed...humbled by loss of purpose, loss of livelihood... a blank lostness glazed our stares. The family practice doc in the community closing his doors and letting his manager of twenty years go. The otolaryngologist closing to elective practice and struggling to find meaningful practice in telemedicine. The orthoped learning about ventilators and wondering how to get back to the OR. Those who had been trained with front line skills in retirement, administration, or elective practice... questioning, should I get credentialed and run into the fire. The unknown. What if I am afraid to be called to this fight. What will my colleagues think if I don't run in? Guilt, shame, and loss fill many minds.

Little did we know, as we dealt with the science of the virus... all aspects of our global pandemic would show themselves in disgusting detail. Social and economic inequity, centuries old, an under-reported simmer now boiled-over. Addiction and listless minds, finding shiny objects on social media and in bottles. A dying planet given a moment to breathe. Deeply divided political sensibilities playing out as families, unable to

leave their homes, divide their living-spaces by party lines. Loneliness, shared by so many, formalized and deepened in physical and social distance. A disease prevalent over the entire country or world. Pandemic.

The mystery in all this chaos is that to survive . . . we must heal. Conversations, really difficult and messy discussions... are starting to happen. Not one regulation or relationship is protected from this probing inquiry. 2020 has brought us to our global knees and demands that we finally do the work. We can no longer sit on the couch, fixin' to get in shape,

twinkie-in-hand, wondering why we gained five additional pounds. We are raw, broken, sick, and fully exposed in our flaws. We have no security, no normal, no safety.

All we have is each other...time... intellect... and the uniquely human ability to understand not just what is, but what might be. The pandemic is brutal. I wonder how it will all

be remembered. I can only imagine what survives will be characterized by how much grit and love we gave to healing.

Brooke M. Buckley, MD, is Board Certified in General Surgery, Chief Medical Officer of Henry Ford Wyandotte Hospital, and Past President of MedChi. She has been studying physician health and burnout for many years. COVID-19 has placed a huge emotional and physical strain on physicians that will require all of us to care not just for the sick but also each other in innovative and compassionate ways. If you are need of support please contact the Maryland Physicians Health Program, 1.800.492.6836.



“The mystery in all this chaos is that to survive . . . we must heal.”



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Physician Mental & Physical Coping Strategies During Crisis

The personal and professional challenges that have come from COVID-19 are unlike any experienced before. An upheaval of daily routines poses obstacles and new opportunities in caring for patients, families, and ourselves. To make the best of a tough situation, it's good to focus first on your own well-being. The following MedChi members provide their tips and strategies for coping during the pandemic.

Importance of Exercise – Aruna Nathan, MD (Internal Medicine & Lifestyle Medicine)

It is even more important to maintain a consistent exercise routine during and after COVID-19. Dramatic changes in day to day schedules and overlaps between work and home activities can be tricky to navigate. Some physicians are feeling overwhelmed and this may be demotivating to care for your body and your mind. As physicians, it is important to focus on our well-being to be able to better care and support others.

Those who are accustomed to regular physical activity and exercise should persist with their routines while others should use this opportunity to start. Here are a few pointers to help those who are starting this new habit or working on being more consistent.

Most exercise routines begun with short-term goals to look good or to lose weight do not last. Studies show that focusing more on the long-term benefits, about how you will feel when you are healthier, is a greater motivator to form the habit of regular physical activity.

- 150 is the Magic Number — All it takes is 150 minutes of exercise a week to deliver measurable health benefit. Doing more is fine, but only adds modest incremental value.
- Join the Party — Exercise is fun and motivating when done as a team or a group. Humans are social beings by nature, and exercise can be used to derive greater physiological benefits.
- Body and Mind — A cluttered and unfocused mind leads to tired bodies and unproductive days. Exercising requires focus on the body and this in turns tunes the mind.
- Failure to Start — One of the biggest impediment to success is failure to start. Start exercising, start low, and go slow to stay safe and healthy.

Importance of Healthy Eating Habits – Marsha Seidelman, MD (Internal & Pulmonary Medicine)

This is a good time to evaluate the quality of the food we reach for. We can use these choices to feel better and have more energy now, and come out healthier on the other side.

Consider these ideas:

- Prepare a large bowl of green salad; beans or lentils; add hearty grains like farro, bulgur or barley; use pastas made of lentil or chickpeas, nuts and seed; and other proteins like tempeh, tofu, fish, eggs, chicken or others.
- Make soups or chili that can provide a few meals; freeze any that won't be eaten. Top with cilantro, nuts, seeds, non-dairy cheese.
- Shopping for quality foods is key. Buy lots of dried goods (lentils, beans, grains); frozen fruits and veggies; fresh fruits at different levels of ripeness.
- Snacks - healthy easy to grab things: yogurt – preferably non-dairy; Kite Hill Greek style almond yogurt is better than the rest; apple or banana with peanut butter. Sometimes grazing can be limited by having water instead, or brushing your teeth.
- Substitute ingredients: try new recipes but don't run to the store each time you need something. Google for potential substitutes; use 1/4 to 1/2 teaspoon dried herbs instead of 1 teaspoon fresh. Substitute lentils for chopped meat.

Overall, try to increase whole-food, plant-based foods, and increase fiber to improve cardiovascular and cancer risk.

Consider watching “The Game Changers” on Netflix. It is an amusing documentary about the benefits of whole food plant based diet in elite athletes. Other references include Nutrition Action newsletter (cspinet.org); Michael Greger (nutritionfacts.org); CookieandKate.com; Onceuponachef.com.

The Importance of Meditation and Sleep – Mindi Cohen, DO (Family Medicine)

Meditation is a practice using certain techniques to train attention and awareness in order to quiet the mind and support mental clarity. In doing so it helps reduce stress and anxiety, creating a better sense of well-being. There are many ways to meditate to achieve the same goal. Meditation is to the mind what physical exercise is to the body.

1. Transcendental Meditation, or TM, is a form of silent mantra meditation, developed by Maharishi Mahesh Yogi. The meditation practice involves the use of a mantra and is practiced for twenty minutes twice per day while sitting with one's eyes closed. When the mind wanders

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Physician Coping Strategies, continued from pg. 19

- you go back to repeating the mantra. Mantras are sounds that create vibrations (e.g., OM, Shalom, Hallelujah. TM has been shown to relax the sympathetic nervous system, creating a sense of calm (www.tm.org).
2. Mindfulness Meditation is the ability to be fully present in the moment. Thich Nhat Hanh, A Vietnamese Zen Buddhist Monk teaches to be mindful is to be truly alive. In his 1975 book *The Miracle of Mindfulness*, he taught the idea that mindfulness can be practiced when you are eating, walking, or even doing the dishes. Resources: *Peace is Every Step*, by Thich Nhat Hanh; calm app, headspace app; Mindfulness-Based Stress Reduction (MBSR) Jon Kabat-Zinn; www.palousemindfulness.com.
 3. Laughing Meditation is a practice using laughter to release stress. When you are laughing you are truly in the moment. Laughter meditation is best done in a group. Laughter reduces stress hormones, which could support our immune system (www.mindbodypal.com/laughing-meditation-why-how-to-do-laughter-yoga).
 4. Compassionate Listening is the process of truly listening to another person with full intention. You listen without judgment and without trying to fix the problem. In doing this you also learn to have self compassion (www.tarabrach.com).
 5. Sleep —Meditation improves our relaxation response which improves our ability to sleep. A simple meditation for sleep is just observing your breath, counting your inhalation and exhalation. If you are feeling tension in any area of your body, you can tighten and then release the muscle in your body beginning with your feet moving up to your face. Guided meditations can also help with sleep (www.chopra.com).

Strategies for Work Life Balance (or Harmony) During COVID-19 – Annette Pham, MD (Otolaryngology/Facial Plastic Surgery)

During this time of working at home more with children underfoot, finding the right balance is important to appreciate this time together. These are strategies to consider that have worked for me.

1. Communication is key: no one can read your mind (yet)
2. Create a team approach: address the unique needs of your family, taking into account that different ages and different personalities have different needs
3. Create a common schedule: work on it together and share it
4. Check-ins to plan for the next day: almost like a daily huddle you do with your staff before seeing patients

5. Build in ways to recharge, for yourself AND your family, (e.g., dedicated “alone” time and then also “family” time)

Remember, it’s a marathon, not a sprint. Invest time in yourself AND in each other because that’s what we have right now, time.

And lastly, how do you climb Mt. Everest? Keep putting one foot in front of the other and so on.

Tips for Managing the Stress of COVID-19 – R. Patrick Savage, Jr., PhD (Psychologist)

The COVID-19 crisis presents to each of us both danger and opportunity. Danger that the demands we face as healers, parents, spouses, and friends can become overwhelming or debilitating. On the other hand, if the stressors presented by this experience are well managed, this experience can offer us a chance to grow, heal others, and learn to care for our own selves: the later a task that many of us have not focused on and at times appear encouraged to overlook. During this time it is just as important, perhaps more so, to care for ourselves as we care for others. Consider putting together a “Stress Survival Kit” or build one that includes:

1. **Awareness, Planning, and Pacing.** Develop an awareness of the way in which stress is experienced (physical and emotional signs) and create a plan to manage stress when first sensed. Remember this is a marathon not a sprint so pace yourself by doing what you can and recognizing that there is more to do than any one of us can do. Pay attention to those tasks and challenges that you can affect and let go of those you can’t. For those who are inclined, the Serenity Prayer offers some guidance.
2. **Limit your exposure to stressors.** It is important to be informed, but being too informed can overwhelm you and make it difficult for you to focus on your plan and the things you need to do to keep your balance. Setting boundaries with yourself and others, learning to say no, and taking breaks to restore yourself are examples of how to limit your exposure to the myriad of stressors present today.
3. **Break down large overwhelming tasks/experiences in to smaller more manageable tasks/experiences and learn to focus on what you are required to do in the moment.** For instance, I just need to address the patient in front of me, or the staff member or family member that needs me in the moment, enjoy a tree in full bloom, or the softness of the fur on your dog, cat, etc. Become mindful!
4. **Restore yourself regularly.** Engage in any healthy activity that you enjoy or offers the opportunity to re-energize yourself. Examples include: slow and deepen your breath

(4-square); exercise; eat a good meal; engage in a hobby or leisure activity; connect with others (colleagues, friends, support groups, or talk to a therapist); hang out with your pet; get a massage; practice meditation, guided imagery, or prayer; take vacations (mini and regular).

5. **Forgive and learn to be optimistic.** Let go of negative emotions that become toxic over time and feed anxiety and depression. Forgiveness is about you not the other whom you perceived has offended or hurt you. See what you can learn and take away from even the most difficult experiences. Practice patience, be playful, use humor, and post aspirational messages for yourself, your colleagues, your family, and your friends.

A final word. Many of the suggestions above require lots and lots of practice and time to really learn. Set your expectations low so you can exceed them. It is better to succeed than become frustrated and convinced you can never learn a different way of thinking or skill. It is all doable one small step at a time. A useful tool that can help in your endeavor is an app called “The Virtual Hope Box.” It is free, downloadable to your phone, portable, and contains a place to keep many of the tools for a “Stress Survival Kit” all in one convenient place.

Red Flags of Crisis Stress – Bruce Smoller, MD (Psychiatry)

Under the stress of long term semi-isolation, alteration in usual patterns of socialization and especially the open ended loss of control over one’s environment, preexisting affective and anxiety based conditions worsen. It is important, as with most illnesses, to recognize “red flags” and to take steps to intervene before a “tipping point” is reached and a clinically florid depression, generalized anxiety disorder, or other psychiatric syndrome ensues. This can occur even in otherwise healthy people with no previous psychiatric history under these conditions.

1. **Red Flags of Crisis Stress:** Some “red flags” to be aware of are difficulty concentrating, difficulty learning or understanding new material, flattening of affect, heightened autonomic arousal, inappropriate affective discharge. Strained social relations, sleep and appetite changes, irritability, increased use of alcohol or drugs, withdrawal, tearfulness, shortened attention span, somatic analogs of emotional distress such as frequent upset stomachs, headaches, and sighing respirations.
2. **Levels of Stress:** People react to unusual or overwhelming stress based on their previous history and their genetic and learned resilience to stress. Under most circumstances, most of us fall into the “worried well” group and can deal with moderate amounts of stress. Some folks have more

difficulty based on prior history and need to pay a bit more attention to the “red flag” buildup.

3. **Stress Interventions:** These include regularity of sleep and eating. Irregular, shifting schedules can play havoc with affective stability. Impose structure on one’s schedule, but add novelty to your schedule...start painting, take up a musical instrument, take a Zoom course. Use humor...binge on all the old episodes of Cheers (they are funny), send and read all the jokes you can. Humor is a wonderful antidote. Confide in someone...a spouse, a friend, clergy, a therapist. Externalizing conflict and stress can help a great deal. Limit alcohol to reasonable amounts. Alcohol over and above moderate amounts is a depressant.
4. **Use of Medication:** For those people who are on or who need to start medication, absolute regularity is key. SSRI half-life is twenty-four hours, and it is gone by forty-eight hours. It may take two weeks or longer to stabilize after a lapse of even two days in antidepressants. For short-term use in anxiety states, benzodiazepines may be used, but anything longer than very short term, use antidepressants supplemented by prn (very prn) use of benzodiazepines. The antidepressant effect of SSRIs is mediated through synaptic receptors and these take a few weeks to spin up to speed, while the anti-anxiety effect is cell membrane mediated and takes a much shorter time. It may not be as “punchy” as benzodiazepines but works as well or better over time. Most people, however, who experience “red flags” will not at all need medication. I include this for those folks with a history of affective or anxiety based disorder, or who are in danger of developing their first episode under the stress of this pandemic.

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Fighting the War on COVID-19, Our Nation's Pearl Harbor

Rene Desmarais, MD



We are all wondering how the United States will heal after the pandemic. The renewal should be a future better than the past. The future should have better jobs, an improved health care system, fewer homeless and socially disadvantaged people, and better treatment of mental illness. Our country is calling on the house of medicine to rid us of the COVID-19 threat. Perhaps this same house of medicine can help heal our country. The pandemic has made it clear that the strength of a country's health system is proportional to the strength of its economy. The pandemic has been a nightmare.

The time has come for us to build some dreams. It is what we do best.

We are conducting two wars in our country: the war against COVID-19 and the cold civil war that we have been fighting for years. The cold war hampers the efforts of those actively engaged against COVID-19. Unity of purpose at the initial recognition of the pandemic gave some hope that we might, at least, suspend the cold civil war. The Surgeon General called the fight against COVID-19 "our Pearl Harbor" and there are many stories of great courage, dedication, and sacrifice. Enormous good continues to be done in the trenches. But, after a brief cease-fire, many have reverted quickly to partisan divides. Unilateral blame for this will not be assigned here. Although personal freedom and the well-being of individuals and businesses should be goals common to all, consensus on the means is absent. Vigorous disagreements over risk versus benefit have driven us into different camps. Reversion to, and even exacerbation of, a partisan divide was highly predictable given the defects in both our body politic and in our health care system that the pandemic has laid bare. And sometimes there seem to be more than just two sets of opinions. Clearly, there are many that have views that collectively do not fit into one tidy box. A review of recent partisan politics is beyond the scope of this writing. Suffice it to say, the wounds existed well before the pandemic. However, from a health care delivery viewpoint, why has reconciliation failed thus far, and is it irredeemable?

Too many of us have amnesia for the limitations and uncertainties of medical science. We are all too familiar with medical "truths" that have gone the way of the flat-earth theory. Successful treatments and vaccines are not guaranteed. Yet many seem to forget the large gray area of

medicine. We started with very little knowledge about many aspects of combating COVID-19. Typically, medical knowledge is cultivated and pruned over years, with the research and development of any new medication or device witnessed by few. Yet with this pandemic, all the academic wrangling has taken place out in the open. Somewhat unfairly, our political and health care leaders have been asked questions they cannot possibly answer. The gaps in our knowledge remain apparent: how and when to socially distance, use masks, reopen, and use medications. Misinformation breeds division, and worse — inaccuracies that make their way into the public arena. Confirmation bias along existing divides is frequently a hindrance to progress. While we search for answers, we are going through a grieving process for the loss of our pre-COVID-19 lives. As each of us is at a different stage in this grieving process, communication becomes more difficult. This multitude of constantly changing variables makes it difficult to reach a general consensus. So how do we get out of this? Will medical science come to the rescue with a highly effective vaccine and/or an anti-viral?

Correcting foundational health care delivery system problems could go a long way toward building consensus and ensuring the best outcome. A path we should all agree to follow would address these problems — such as inadequate health literacy, limitations in information technology and electronic health records, insufficient behavioral health treatment, and poor social determinants of health. National efforts to combat these ills would rekindle a shared purpose in all of us. Some of these efforts would have immediate effect, and some long term.

The pandemic has led most individuals to become more actively engaged in the pursuit of health and the widespread recognition that surviving the pandemic is intimately related to your existing health condition. However, this beneficial patient activation and engagement is limited by inadequate health literacy in our country. Health literacy is defined as the ability to make informed health care decisions by acquiring and understanding health information. Poor health literacy can be present in very smart people. Inadequate health literacy costs an estimated 500 billion dollars to the health care system annually, and is at the root of not understanding the gray areas of medicine and in the ignorance that prohibits consensus building. Health literacy and patient engagement are synergistic. Patient engagement occurs when a patient takes responsibility for their health and takes an active role in the care they receive. The patient feels in control, feels hopeful and anxiety is lessened. Perhaps the most stressful experience for any patient is uncertainty. Even those in dire circumstances are relieved when doubt is diminished. Improvement is easily available within the realm

of telemedicine and information technology tools. Benefits of improved messaging could include more reliable and vetted updates; opportunities for interactive conversations with experts; tools for decreasing the risk of missing health maintenance; and education in the statistics and probabilities of health care. Finally, any such efforts must allow for robust discussion of differing opinions while keeping the messaging consistent.

Although our electronic health record system (EHR) has come a long way, the potential of technology to help with pandemic management remains largely unfulfilled. EHR interoperability is substandard despite federal legislation, which greatly hinders the mining of data. Patients, doctors, and hospitals should be able to freely exchange data, yet too often this is not the case. Imagine if iPhones could not communicate with Androids! We continue to lack the means to find meaningful clinical associations between patient variables, and we lack a method to mine databanks of information contained within EHRs to perform virtual clinical trials. Perhaps if we could easily mine the enormous amount of health care data already collected, we would now have more answers about COVID-19's causation and treatment. Rather than rely on randomly controlled trials that take years to yield answers, an easily accessible immunization data bank would help maximize our preparedness for any future pandemics.

We have unmet and interrelated needs in behavioral health treatment, the management of homelessness, and the leveling of social determinants of health. We see these poorly addressed problems rear up in disaster situations, and this pandemic is no exception. Improved health literacy and information technology might help, but the underlying structural defects in access to IT along social gradients would remain. Quick fixes for these problems are not possible. With that in mind, please consider the following proposal, submitted modestly and with recognition that it would require a great national will for fulfillment: build dozens of regional behavioral health centers across the country in economically depressed neighborhoods and recruit and train the necessary workforce. Behavioral health needs would be addressed under one roof, including, but not limited to, depression, PTSD, addiction, ADHD, anorexia nervosa, and mood disorders. As the overlap of these afflictions is recognized and treatment methods evolve, having everything under one roof makes the most sense. Research and development of treatments would improve. Homelessness, often a result of a complex intermingling of behavioral health issues, would be addressed as a matter of course. Leveling the social determinants of health could be aided by focusing on the education and employment of local populations to build infrastructure

and meet staffing needs. Treating mental illness in a diffuse, almost exclusively outpatient manner has been a failed experiment that began decades ago to help control costs and rid us of some horror show state hospitals. We should be able to do better some fifty years later. Worried about the cost? Five hundred million dollars per hospital for fifty hospitals equals twenty-five billion dollars. The return on investment would be far greater.

While maintaining the values we hold dear, we must modernize and reform large parts of our health care system. We must not forget that we have more in common — especially now in the throes of this pandemic — than differences. While many struggle to survive, we must help each other get through the grieving process and enter into a new phase of hope. Medicine can help us to win one war and limit the damage of another one. We need more jobs, and we have many health-related needs. Let's put those needs together. Let's put us back together and begin the healing.

Rene Desmarais, MD, is a cardiologist practicing in Berlin, Maryland. He is also on MedChi's Board of Trustees. He can be reached at rdesmarais713@gmail.com.

Save The Date!

MedChi House of Delegates Meeting Saturday, November 7, 2020

On behalf of the Speaker of the House, Loralie Ma, MD, and the Vice Speaker of the House, James York, MD, MedChi would like to invite you to join us on Saturday, November 7, 2020, for our **first-ever virtual House of Delegates Meeting.**

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National Capital Physicians Foundation Offers Counseling to Physicians During COVID-19 Crisis

Susan D'Antoni

The studies are clear, physician stress before COVID-19 was at an all-time high. Enter the pandemic, physician stress has exponentially increased due to the changing practice and personal demands of COVID-19. How can physicians cope?

The National Capital Physicians Foundation (NCPF) which is a 501(c)3 educational and charitable tax-exempt foundation initiated by Montgomery County Medical Society offers a complimentary, confidential counseling program (the Physicians Resource Network or PRN) to help physicians through these challenging times. Counseling is available using telemedicine during COVID-19 and is provided by licensed MSWs and psychologists. No insurance is filed.

To access the services, physicians practicing in Montgomery County can request counseling services by completing a secure online form at www.dedicatetohealth.org. Physicians indicate


their availability and appointments are often available within 72 hours.

Since the inception of the program in late 2017, thirty-seven physicians have reached out to PRN and have received counseling funded by the National Capital Physicians Foundation. Evaluations of the program have been stellar with many physicians noting that it made a considerable difference in their ability to respond to the challenges of medical practice.

To learn more about the program, request services, or to make a tax-deductible donation, go to www.dedicatetohealth.org.

Susan D'Antoni, FAAMSE, serves as the CEO of Montgomery County Medical Society and the National Capital Physicians Foundation. She can be reached at sdantoni@montgomerymedicine.org.

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MedChi's Newest Physician Members

MedChi welcomes the following new members, who joined between May 1, 2020, and July 1, 2020.

Rohini Chakravarthy, MD
Ifeanyichukwu Chinedozi, MD — University of Maryland Medical Center
Sandra Ginsberg, MD — Sibley Memorial Hospital
Franciska Gudenkauf, MD, MPH
Brent Gudenkauf, MD — Johns Hopkins Hospital
Harry W Kaplan, MD — Wister & Kaplan, LLC
Elizabeth Kiernan, MD
Isa Mohammed, MD
Athmananda Nanjundappa, MD — MedStar Franklin Square Medical Center
Jasvinder Sidhu, MD
Sharleen St. Surin-Lord, MD — Visage Dermatology & Aesthetic Center
Katherine Danuta Stolarz, DO — MedStar Franklin Square Medical Center

MedChi Events

For a complete list of MedChi and component events, visit <http://www.medchi.org/Events>.

August 18

Western Counties Webinar, Topic: New Rockwellian Portrait CME, Speaker: Michele Manahan, MD. 7 p.m. GoToWebinar

September 10

The Maryland Society of Plastic Surgeons Virtual Annual Meeting. 7–9 p.m. GoToWebinar.

September 15

Mid-Shore Counties Webinar, Topic: New Rockwellian Portrait CME, Speaker: Michele Manahan, MD. 7 p.m. GoToWebinar.

September 16

Baltimore County Medical Association Board of Governors' Meeting. 6:15 p.m. GBMC, Rooms D & E, 6701 N Charles St. Baltimore, MD.

September 17

MedChi Board of Trustees Meeting. 6 p.m. Zoom Web Conference.

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CARR Healthcare is the nation's leading provider of commercial **real estate services for healthcare tenants and buyers**. Our team of experts assist with start-ups, lease renewals, expansions, relocations, additional offices, purchases and even during practice transitions.

As a healthcare provider you are an attractive tenant! See a brief video Shay did on how to posture for your next negotiation! <https://vimeo.com/405164448/d03395bbd9>

"Shay was amazing to work with and saved me a ton of time! She got my concessions I had never thought of and saved me thousands!" - Anil Bajnath, MD



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MedChi's History of Inclusion

From its earliest days, MedChi was forward-thinking in its broad admittance policies. Joshua I. Cohen, MD (pictured) was admitted to the Faculty in 1823, and was President from 1857 to 1858. Four generations of the prominent Jewish Friedenwald family were active in MedChi from the 1870s through the 1950s, including as President and Vice President. In 1882, Whitfield Winsey, MD, an African-American physician practicing in Baltimore, was elected to the membership at MedChi.

In 1885, the Faculty amended the By-Laws and Constitution to change the word "gentleman" to "person," which included both free blacks and women. Anna Louise Kuhn, MD, was the first woman to graduate in medicine in Baltimore, and became a member of the faculty in 1889, although Amanda Taylor Norris, MD, was the first woman physician, being admitted in 1886. Roland Smoot, MD, was the first African-American President of MedChi, serving in 1983.



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MedChi
The Maryland State Medical Society



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The Time is Now to Join MedChi

Many things outside your practice environment directly affect your work and livelihood as a physician. Make an impact to your profession today and how it will look tomorrow. Join with other MedChi physicians in a strong, unified voice.

MedChi is that voice.

MedChi is the only organization representing all Maryland physicians, and the only organization with the clout to successfully influence laws, rules and regulations that determine how health care is delivered in Maryland.

Today, MedChi membership can help you directly:

Telemedicine Support:

- Currently assisting hundreds of practices with rapid implementation of telehealth by providing targeted and informative resources and advocating for physician-friendly policies.
- Developed a comprehensive, up-to-date summary of coding guidelines to help answer billing questions on telehealth.
- Implemented grant programs with CareFirst and the Maryland Health Care Commission to ensure physician access to affordable HIPAA-compliant telehealth platforms.

Economic and Educational Resources:

- Economic Policy – MedChi has been working closely with the American Medical Association, the State of Maryland, and federal officials to advocate for additional economic support for physicians.
- Currently providing assistance to thousands of doctors with help applying for PPP, State grants, State loans, and EIDL, and helping practitioners who did not get CARES Act money.
- MedChi and our components developed comprehensive practice reopening toolkits.
- Secured access to and complimentary CME accreditation for informative webinars with the Maryland Department of Health, three times a week.
- President Michele Manahan, MD and CEO Gene Ransom, have participated and served as advocates for physicians in panels and workgroups, and in media outlets, ensuring that the public understands the needs, concerns, and sacrifices of physicians on the front lines.
- MedChi has produced several short videos to answer frequently asked questions on telehealth grants, immunity protections, and more.

Maryland State Medical Society is comprised of physicians from more than fifty specialties and continues to grow with more than 8,500 members, including private practitioners, academic physicians, retired physicians, residents, and medical students. Sixty percent of your dues are tax deductible and include membership in your local society.

Join MedChi or renew your membership - www.medchi.org/Get-Involved. Current members may contact members@medchi.org or 410.539.0872, ext. 3301 for questions about your membership.