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About the Cover
The Stethoscope is a compilation of artwork and articles submitted by physician members, friends of the society, and community partners. The cover of the magazine always showcases a person, place or event. Over the years, we’ve had award-winning photographers, designers, and painters share their work with you. This cover is a sampling of the work that graced the covers of 2016 & 2017 editions. Thank you to all our contributors over the years – past, present and future!

Cover photographs and stories for the Stethoscope are gladly accepted from members of the Volusia County Medical Society. If you are interested in submitting a cover photograph or article, please contact Sami Bay, Executive Director, 386-255-3321.

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Winter / Spring 2017 3
President’s Message - Delicia M. Haynes, MD

The Who, What, Where, When & Why of How We Choose Medicine

When was the last time you thought about why you chose medicine as your livelihood and your life? Was it when you were fed up entering information into a computer instead of having a meaningful, eye-to-eye conversation with a patient? Or maybe it was when you delivered a life-changing diagnosis to a patient – for the better! So why did you go into medicine? Do you remember what your first experience at a doctor’s office was like?

Mine was memorable. When I was in the 7th grade I felt a lump in my breast while taking a shower. At first I thought that maybe I would finally get some volume in the breast department and if there was a lump on the other side I’d be evened out.

But that thought was fleeting and immediately turned to fear. But I didn’t tell anyone right away. Why? Because being a 12-year old girl, I knew I would literally have to bear my chest to get anything done about it. So, I waited and I hoped it would go away. It didn’t. More than two months passed before I confessed to my mother. Off we went to a doctor.

We waited for nearly two hours in a small waiting room before being escorted back to a room with peeling blue paint, where we spent another hour of waiting time. I remember the environment as cold but thankfully, my thoughts didn’t dwell on the immediate situation but rather on the future. Crazy as it sounds, I was excited because, up to that very moment in time, I was convinced my future vocation would be as a doctor, or a teacher, or a lawyer and I realized if I became a doctor I could do all three. I was about to meet my mentor! As a doctor, I could teach my patients (the educator in me); I could advocate for my patients (the lawyer in me); and I could heal people (obviously, the doctor in me).

Another hour passed as we sat in the blue room and finally, in walked the doctor. With all the enthusiasm of a 7th grader who had just figured out what she wanted to be when she grew up, I squealed, “I want to be a doctor too.”

The doctor looked at me over his glasses and said “take off your top.”

For a moment, I sat in stunned silence; and then looked over at my mom. She nodded that it was okay and I took of my blouse. He walked over and started pressing on my chest with ice cold hands. Then he stepped back, started writing in his chart and said “it’s probably just a benign fibroadenoma but we won’t know for sure until we have it surgically removed. Due to the location, the scar will be minimal so if you want to be a stripper when you grow up that will be fine.” And he walked out the door.

My mom was a Baptist deaconess so needless to say, that did not go over well with her. I was devastated. I didn’t know what benign meant or what a fibroadenoma was, but I knew what surgery was and I looked at my mom with tears streaming down my face and said “mom they’re going to cut me.”

My mom simply said, “Delicia put your shirt on”, and she went out the door to find the doctor. He was already in another exam room and wouldn’t talk with us.

In retrospect, our interaction that day moved me to action. As I slipped my blouse over my head, I made the decision that I WOULD be a doctor and I WOULD be the type of doctor that I wish I would have had that day. I would be the type of doctor who doesn’t make you wait hours for a seven-minute visit; the type of doctor who explains things in words you can understand; the type of doctor that helps you make good decisions and who you know how to care of your health.

So, I set out with my idealistic self to do just that. I went to under grad at the University of Louisville; medical school at the University of Kentucky; completed my Family Medicine Residency at Halifax Hospital; and in 2009 started a solo family medical clinic straight out of residency with zero business background or sense.

I couldn’t afford an office manager at first so I studied what other offices did and made friends with office managers so I could get help when needed. I reached out to my colleagues for mentorship, and for their guidance and support I am still very grateful. It was a struggle but after several long and laborious semesters at the school-of-hard-knocks, I built a reputable and financially profitable solo family medical practice. We gave meaning to meaningful use. We learned to navigate the unnecessary complexities of medical billing. We had finally arrived…or so I thought.

In the fall of 2014 I received an insurance contract in the mail with what equated to a 40% reimbursement reduction to some services. When I finally learned the game, the rules had changed. I realized when a third party could make a decision that almost put me out of business, I wasn’t working for myself. I wasn’t working for my patients. I was working for the insurance company.

The harsh reality of it all was that I had come to the proverbial fork in the road and had some hard and fast choices to make: sign the contract, which would have required me to double my patient load while cutting staff to make it work financially (and become the type of doctor I never wanted to be in the first place); sell to a larger organization with unquestionably better negotiating power but perhaps practice medicine with values that may not be aligned with my own; shift to only doing the aesthetic side of my practice; leave medicine and go back to being a decorating consultant; or take a calculated leap of faith and change my entire business model.

I chose the latter and in 2015 became Volusia County’s first Direct Primary Care clinic. The main idea behind direct primary care is this: 80% of what most people go to the doctor for is primary care. Direct primary care provides comprehensive primary care for an affordable flat monthly fee.

Unlike traditional concierge medical practices which bill insurance and charge a fee for services above and beyond what insurance covers, direct primary care is a direct payment relationship between the doctor and patient. No copays, deductibles or insurance hassles. It works like a gym
membership: for a predictable monthly investment, patients get a defined set of primary care services such as same or next day appointments, longer 1:1 time with the doctor, convenient virtual visits for healthcare while traveling, and our membership even includes basic labs. Prices are completely transparent and the patient-doctor relationship is always at the forefront. When patients need to see a specialist, they can either use their insurance or we negotiate to secure prompt-pay discounts for our patients who pay the specialist up front at the time of service. We actively partner with doctors seeking a simpler direct patient-doctor relationship.

Coupled with high deductible insurance plans or a health care cost sharing ministry, our patients have reduced their total health care costs while experiencing an improved level of service plus they don’t have to worry about ACA penalties.

Think of it this way. You wouldn’t use your car insurance for an oil change or claim a broken window on your homeowner’s insurance. We keep insurance to cover things that would be financially devastating to our families. Then why are we using health insurance for primary care? Does it really make sense to file an insurance claim for every sinus infection, chronic disease visit, or preventive visit? Why don’t we use our health insurance like every other insurance product and keep a maintenance plan in place for more routine things?

As a small business owner, I realize that my employees are one of my company’s best assets. That’s why I offer primary care memberships to other small business owners who are interested in reducing their total healthcare costs, attracting and retaining talented team members, reducing absenteeism, and creating a healthy work force.

Business models will come and go. The alphabet soup of regulatory challenges and opportunities will too. At the end of the day the patient-doctor relationship is, has been, and must always remain at the heart of healthcare. Let’s never lose sight of that. Stand up for yourself, your profession, and your patients.

In 2016, Family First Health Center was awarded the Small Business of the Year award by the Daytona Beach Chamber of Commerce.

I love what I do now and I love how I do it. Better yet, I get to help others to do the same. Medicine is an apprenticeship profession. The business of medicine is too.

Today, when I look in the mirror and see the woman that the scared 7th grader grew up to be, I know that I AM the doctor I always wanted to be.

I wish each of you the same as you move forward this year and always.

Sincerely,

Delicia M. Haynes, MD
President, VCMS
Doctor Cromartie served as a physician in the US Army at the 93rd Evacuation Hospital in Long Binh, the 18th Surgery Hospital in Quang Tri, and the 91st Evacuation Hospital in Chu Lai in 1971.

Of the three million American soldiers who served in Vietnam, many were exposed to Agent Orange, an herbicide used extensively to defoliate forests and to destroy crops between 1961 and 1971 in Vietnam, Laos, and to a small extent in Cambodia. Agent Orange contained the toxic chemical 2,3,7,8-tetrachlorodibenzo-p-dioxin (TCDD).

The US Air Force delivered over ninety-five percent of the herbicides as aerial spray in Operation Ranch Hand with the remainder being applied by Americans in other branches of the military or by RVN soldiers using spray trucks, hand sprayers, boats, and helicopters. Spraying was also performed in the demilitarized zone between North and South Korea and around some US Air Force bases in Thailand.

Since the war, veterans have developed a number of diseases and malignancies which may be related to this exposure and which may entitle the veteran for compensation if he meets conditions shown in Table I.

Table I.
• Served in Vietnam between 9 January 1962 and 7 May 1975.
• Served on a boat or a ship that operated in the inland waterways or docked in Vietnam with the soldier going ashore.
• Served in certain areas of Korea between 1 April 1968 and 31 August 1971.
• Served at certain air bases and in certain occupations in Thailand.

The following table lists conditions that the VA presumes are caused by Agent Orange exposure and for which compensation is likely.

Table II. Diseases Recognized by the VA as Presumptive for Agent Orange Exposure.
• AL Amyloidosis
• Chronic B-cell Leukemias
• Chloracne
• Diabetes Mellitus Type 2
• Hodgkin’s Disease
• Ischemic Heart Disease
• Multiple Myeloma
• Non-Hodgkin’s Lymphoma
• Parkinson’s Disease
• Peripheral Neuropathy, Early-Onset
• Porphyria Cutanea Tarda
• Prostate Cancer
• Respiratory Cancers (Cancers of the Lung, Larynx, Trachea, and Bronchus)
• Soft Tissue Sarcomas (excluding osteosarcoma, chondrosarcoma, Kaposi’s Sarcoma, & Mesothelioma)

Veterans with other diseases or neoplasms may still apply for disability and make the case that Agent Orange was the cause.

Spina Bifida is a birth defect recognized as caused by Agent Orange in a child conceived after a male or female soldier entered Vietnam or the Korean demilitarized zone. That is the only birth defect recognized by the VA for male veterans. Multiple birth defects are recognized for children of female veterans. Veterans, male and female, may still apply for compensation for other birth defects not listed.

Exposure to TCDD can cause elevations of serum TCDD, which diminish slowly over many years. With men, the median half-life is about seven years, whereas women exhibit a half-life of about nine years.

The VA maintains a registry of veterans who may have been exposed to Agent Orange. Registering for this involves questions about military service, exposure history, medical history, and tests for various diseases associated with Agent Orange including blood chemistries, chest X-ray, urinalysis and a physical exam. The closest facility for this process is the Orlando VA Medical Center (telephone # 407 646 5544).

Enrolling in the AO Registry does not serve as a claim for compensation. Veterans who wish to make a claim may find it helpful to consult with the director of Volusia County Veterans Services in Deland (telephone # 386 740 5102).
An native of Montgomery County Pennsylvania, CDR Bernard graduated Villanova University with a degree in General Science and was commissioned an Ensign in May 1985 through the Naval Reserve Officer Training Corps.

CDR Bernard began her Navy career in Naval Aviation as a Naval Flight Officer receiving her wings in 1986. She was one of only four women chosen that year to fly jets and after completing Electronic Warfare School in 1987 she was assigned to Electronic Warfare Squadron Thirty Three in Key West, Florida where she flew EA-4's and subsequently EA-7's. At the completion of this operational tour, she was selected to attend the Naval Postgraduate School in Monterey, California leading to a Master's Degree in Technical Intelligence in 1991.

Follow on tours as the Assistant Administrative Officer at the Enlisted Aircrew School Naval Schools Command Pensacola, Florida and as the NROTC Scholarship recruiter for Naval Recruiting District Jacksonville, Florida allowed her to complete her medical school requirements and in 1995 she was selected to attend the Uniformed Services University of the Health Sciences in Bethesda, Maryland.

Dr. Bernard excelled in her new specialty and was inducted into the National Medical Honor Society, Alpha Omega Alpha, in 1998 and was awarded the Naval Surgeon General Award at her graduation in 1999.

Dr. Bernard completed an Internship in Family Practice at the Naval Hospital Jacksonville, Florida followed by an operational tour as a Flight Surgeon with Patron Squadron Thirty also in Jacksonville. She completed residency in Radiology at the Naval Medical Center Portsmouth, Virginia in 2008 and returned to the Naval Hospital Jacksonville, FL as a staff radiologist.

She was selected for fellowship training in Breast Imaging in 2011 and was subsequently assigned to the Walter Reed National Military Medical Center as the Division Officer of the Breast Imaging Center. Under her leadership Walter Reed became the first DOD center to implement tomosynthesis (3-D mammography) technology and the Breast Imaging Center became the first DOD treatment facility to receive the American College of Radiology designation as a "Breast Imaging Center of Excellence".

Dr. Bernard returned to the Naval Hospital Jacksonville in 2015. Under her leadership the Breast MRI imaging and biopsy program was successfully implemented, the first such Navy program outside a tertiary care facility.

Commander Bernard has been awarded Joint Service Commendation Medal, three Navy Commendation medals and two Navy and Marine Corps Achievement Medals.
“Have you ever had thoughts of wanting to commit suicide?”
Thirty seconds went by without an answer but the clock in my head ticked off what felt like thirty minutes of unbearable silence.
I considered how much easier the questions were at the beginning of my scheduled doctor’s appointment…
“How often have you needed to use your inhaler?” the interning medical student asks as she flips through my chart and jots down some notes.
“I’ve probably been using it daily. My mom thinks my asthma has been worse over the last couple of months but I do not really think it is that big of a deal,” I tell her.
I am sixteen years old and I have only ever been plagued by asthma and the inability to read my teacher’s whiteboard from the back of the classroom.
“Any nighttime symptoms?” the student continues. My mother jumps in for me and informs her of my shortness of breath with a frantick desparation. It truly has not been that much of a bother but in my mother’s account I might as well be a middle-aged coal miner dying from the black lung.
The student continues with her questions and I do not bother racing my mom to an appointment…
I inhale, and I exhale. The room is silent as the student listens and my mother focuses in so intently I can tell she is hoping to hear whatever the student hears from her chair. Systematically the student moves to my heart. I feel it pound heavier. The student smiles at me again.
“Sounds good Elizabeth, do you mind if I check your pulses?” she asks. I hesitate but then rest my hands face up on my lap. She places her fingers over my wrist. I can tell she notices the bright red tracks across my forearm. The student does not react but I wonder if she is counting the marks, tallying every sad thought I have had over the last ten years.
“Okay, we are all done,” she says. She turns to address my mother, “If you do not mind Mrs. Green I would like to ask your daughter a few more questions in private and then I will call you back in.” My mother looks as if the Queen of England turned to address my mother, “If you do not mind Mrs. Green I would like to ask your daughter a few more questions in private and then I will call you back in.” My mother looks as if the Queen of England has just been asked to dine at Burger King, but she is too polite to make a scene and respectfully leaves the room.
I know what she is about to ask and I can feel my heartbeat quicken and the skin on my face get warm. “Can you tell me about the marks on your arm Elizabeth?” she asks.
I try to formulate the sanest sounding explanation but the best I could come up with is, “Just some old scars from a year ago.” I look down because I am afraid she will think I am lying. Everyone always thinks I am lying because I am a teenager and apparently, that is what we do. The student does not challenge my answer but continues to ask me about my home life and what kind of friends I have at school.
I tell her. The student does not seem less concerned. I explain to her that I know I am loved by my overbearing mother, father, and two-year-old little brother, and they are reasons I try to be happy.
“Do you feel happy today?” she asks.
I realize I am not sure how to respond. The doctor in Pennsylvania once told my mother I was depressed because I stopped hanging out with my friends. I slept all day on the weekends and I lost some
My husband and I found out he had colon cancer. It was a long week. Last Friday I found out he had colon cancer, and tomorrow, we will be putting our cat, Patches, to sleep because he too has cancer. "Honey, I'm scared," I said to him as we waited for the doctor to come in. "You're a strong woman and we'll get through all of this," he replied softly.

We could hear the medical student presenting my information to the doctor on the other side of the door. "This is a healthy 59-year old female referred to us because she was found to have a 5.5 centimeter incidental left hilar mass on CT scan. Today, she complains of left upper back pain that is focal, non-radiating and dull. She has no coughing, wheezing, or shortness of breath. No fevers, chills, night sweats, hemoptysis, or recent unintentional weight loss. She has been smoking one pack per day for more than 30 years and is currently trying to quit. She has had a decorative painting business for over ten years, and she does a lot of plastering and is exposed to several chemicals…"

Could it be true? Could my life's passion of painting have put me here in this doctor's office today? Awaiting a diagnosis of cancer? "Find a job you love and you'll never work a day in your life," they said. But they never told me I would have to pay for my pleasure by coming face to face with cancer itself. My husband and I moved to Florida 25 years ago from upstate New York. Why? The weather. After so many years of kneeling down fixing crooked baseboards installed by commercial businesses, and climbing up ladders to ensure precisely painted edges at the confluence of wall and ceiling, these knees of mine couldn't handle that cold weather, especially not now. I have always loved to paint, and I finally mustered up the courage to start my own painting business.

"Past medical history is significant for hypertension controlled with medications, and cervical cancer in 1993 treated with radiation, chemotherapy, and total hysterectomy…"

Man, was that hell. Going through chemotherapy. A simple office visit to my OB/GYN for a routine pap smear, and the next thing you know, you wake up with no hair. Your body so weak you can barely move. The mouth sores preventing you from having an appetite, the uninvited diarrhea making social outings a fear. Yes, I beat cancer once, but the toll those toxins took on my body is nothing like anyone could imagine. And just because I've been cancer free for almost twenty years doesn't mean it won't come knocking back at my door. I've lived with anxiety for years, and prayed that day would never come. My husband, so supportive and loving through it all, now fighting the battle himself. Our marriage has had its ups and downs. It's difficult to communicate sometimes when you're swimming in a pool of medical bills. But we've pulled through. Painting has been one of my only reprievs.

There was a knock at the door. "Good afternoon. Sorry for the wait, but thank you for being patient." The doctor and medical student entered the room and after a few minutes of reviewing the scans and results, I felt an intense blow to my stomach as if I had been sucker punched in the gut. "We still need to confirm, but I am ninety nine percent positive this is cancer," explained the doctor. "I'm going to order a PET scan and we'll then proceed with a CT-guided biopsy."

So here we are. Sitting in this cold room with unpleasantly painted walls. My life rudely invaded by the dreadful return of what once almost took my life. Cancer now knocking on my door, yet again, and I wish I had never answered. Biopsies, scans, surgery, chemotherapy, radiation. These words of my future reality back to haunt me again. Should I fight this battle once more? Or throw in the towel? I'm only 59 years young. My husband says I'm strong. I know he needs me. And that dining room wall! I have to go back to Mr. Williams' house and finish painting that wall! It's funny the things that run through your mind when you're confronted with death…

My attention was brought back to the...
exam room by the doctor’s voice. “We’ll get those tests done as soon as possible. Please come back and see me later this week so we can discuss the results. You are a healthy woman and we need to be aggressive because you have many more years ahead of you, and I think we can cure this.”

“Thank you so much for your help, doctor.” I never imagined being diagnosed with cancer. Not to mention twice. Have you ever heard the saying, “When it rains, it pours”? Or, “Bad things happen in threes”? I never believed it myself. But here we go. Round two. Along with my husband and Patches. Despite the apprehension I felt, I also had a sense of confidence because of the faith my doctor had in me and his positive attitude for my treatment and recovery. I shook his hand, and as I began to walk out of the room, I quickly turned back to the doctor to make mention of something very important. “By the way doc, here’s my business card. If you ever need these walls painted in here, just let me know!”

-Angelina Malamo

The chief complaint is the first step in history taking that every physician follows. It is the concise statement highlighting the reason for the medical encounter. Today’s first chief complaint is “my feet hurt.” As a third year medical student, my mind begins racing with thoughts of plantar fasciitis, stress fractures, tarsal tunnel syndrome, and other medical problems to list in my differential diagnosis. The chief complaint is useless without context; therefore, I begin gathering more history from the patient to know her story.

I have the pleasure to meet Mrs. H. She is an 83-year-old black female who was born in Jamaica. When asking for her age, she explains the secret to her longevity. She never used a cigarette in her life and found the taste of alcohol unappealing. Mrs. H. is a quiet person, but enjoys conversations with the clinical staff. In addition to being followed by this primary care office, she is having regular visits to an oncology office. Regular visits is an understatement. She has to undergo blood work every two weeks due to her multiple myeloma. Her arthritis, type two diabetes mellitus, hypertension, and stage II chronic kidney disease do not help her situation either. When I pry further into her past medical history, I learn she was diagnosed with multiple myeloma in 2014 and has been carefully followed by her oncologist ever since. Multiple myeloma is a cancer formed by malignant plasma cells, an important component of the immune system, within a person’s bone marrow. Within the first few minutes of the encounter and with further history taking, it is clear that Mrs. H. is an educated, well-spoken woman who is meticulous when answering my questions.

Mrs. H. earned her Associates and Bachelors degrees in Jamaica and her Masters of Education in the United States. Before retiring, she was a deacon of the Episcopal Church and a university professor within a Department of Fine Arts. Her eagerness to mentor others led her to these supportive roles within her community. She clearly has accomplished many achievements in her life; in addition, she lived during the time of the Second World War and in the era when Jamaica finally gained independence. Throughout her entire life, her faith and active participation within her local church has been a constant component of who she is. She participates in her church services at least once per week. This has become increasingly more difficult to accomplish due to her financial and transportation limitations.

Within the past few years, Mrs. H. has relied on her family members for transportation, especially to church and doctors’ appointments. She refrains from driving due to her lower and upper extremity arthritis and limited mobility. Her family members have been very supportive and have helped tremendously with her transportation needs. In addition to her transportation limitations, her finances have been greatly impacted with her increasing medical problems. Like many people in her age group, Mrs. H. collects Social Security. Her monthly income has been financially limiting when accounting for her personal finances and medical bills. She spoke of her current predicament regarding her foot pain. She was previously diagnosed with peripheral neuropathy, which could be caused by her diabetes, multiple myeloma, or a combination between the two. She unenthusiastically states her previous peripheral neuropathy medications cause her “to be in the fog” while she points with her index finger toward her temple. Additionally, her last prescribed medication was too expensive for her to purchase each month. This medication was the last of an exhaustive list of medications that her physicians have recommended as a possible treatment for her neuropathy. With the lack of possible treatments, Mrs. H. is concerned that she may have to live with the pain.

In Mrs. H’s perspective, the peripheral neuropathy and the financial cost of the medication are the most concerning and stressful components of her cancer. She understands her oncologist is continually assessing her kidney function and checking her “blood components.” She feels her current knowledge about her multiple myeloma is adequate for her and she trusts her oncologist’s choices regarding her treatment and workup. The constant surveillance of her cancer has become an integral component within her life.

Mrs. H. has “learned to live with the multiple myeloma” to the best of her ability. She is still eager to do everything that makes her happy, such as going to church and spending time with her husband and son. This encounter was my initial interaction with Mrs. H. and I have had the privilege to see her multiple
times during my Chronic Care Clerkship. I personally learned from Mrs. H. the value of trying to make the most out of a bad situation. She is a reminder to continue to value the aspects and people in our lives that bring us happiness, while not continuously dwelling on the negative circumstance surrounding a medical condition.

- Anthony Miller

Breathe in. Breathe out. Breathing is something that we often take for granted until we consciously have to work on it. For most, it is as automatic as blinking, or the unconscious beating of one’s heart. My name is JR and for me, breathing is something akin to drowning on dry land. I have metastatic bladder cancer and congestive heart failure, attributed to my vice as a young man when I came home from the Vietnam War — smoking. Some of the people I’ve met since I’ve become so sick have labeled me by my plight - “that’s the guy with an exacerbation of CHF and bladder cancer mets in room 416,” someone once said. For me, however, I am much more than my disease. I am a husband of forty-six years. I am a father of two healthy, adult children. I am a veteran of the Vietnam War. I am an American citizen. Yes, I am a former smoker now dealing with the repercussions of smoking thirty plus years later. My name is JR and for me, breathing is something akin to drowning on dry land. I have metastatic bladder cancer and congestive heart failure, attributed to my vice as a young man when I came home from the Vietnam War — smoking. Some of the people I’ve met since I’ve become so sick have labeled me by my plight - “that’s the guy with an exacerbation of CHF and bladder cancer mets in room 416,” someone once said. For me, however, I am much more than my disease. I am a husband of forty-six years. I am a father of two healthy, adult children. I am a veteran of the Vietnam War. I am an American citizen. Yes, I am a former smoker now dealing with the repercussions of smoking thirty plus years later, but I am so much more than that.

I finally got discharged home from the hospital five days ago after being there, this time, for almost two weeks. My wife and children are understandably upset – I went in for a round of chemotherapy to try to halt the progression of my cancer, but developed shortness of breath and built up more fluid in my legs and in my lungs. This is what landed me in the hospital for my latest stay. While there, I was told my kidney function had gotten worse (I have stage IV chronic kidney disease) and my kidneys are no longer responding to Lasix. I developed clots in both of my legs from the fluid that built up, which made it difficult to get up and walk around on my own. I went home on oxygen, new medication, and was weaker when I left than when I first got to the hospital two weeks prior. I can no longer sleep in the same bed as my wife. I can no longer help her around the house. I can no longer do many things that I used to do, but this latest experience has shown me what I want to do — spend the rest of my time I have left with my family, making it as easy on them as possible.

This is why I am here at my doctor’s office today. I need to fill out some forms — a DNR form and an Advanced Directives form. My family and I previously wanted all lifesaving procedures to be utilized; anything that could be medically done to prolong my life. Over the last two weeks, I have had the unlucky fortune to not only suffer the constant hustle and bustle of the ICU in the hospital, but to also see how it affected my family emotionally and financially. I do not want to spend the rest of my life in and out of hospitals, constantly making myself only slightly better (with no chance of a real cure). After much discussion with my family, we all have agreed on what’s truly important — time. It is not the quantity of time, but the quality of time I have left to spend it with those I love the most, which is key. In the case of my Advanced Directives, I do not want any life sustaining measures to be taken in the event I can no longer eat, drink, breathe, or have a heartbeat of my own. These are my new wishes.

During our many lengthy discussions about the DNR and Advanced Directives forms I wanted to fill out, my family and I made a list of the activities we wanted to do together with the time I have left. Over the course of many years, we’ve always put off traveling to see Yellowstone and Yosemite National Parks, to dip our toes in the Pacific Ocean, and to do so by traveling across the United States in an RV from one destination to the next. My sons each took a leave of absence from work and my wife and I are retired. With the most recent decline in my health, we all know my days are limited. So, with what little precious time I have left, I will be spending it with the family I love crossing off as much of the remaining items on my bucket list as I can. There is nothing that has put what my last wishes are on this earth into perspective for me like the thought of dying. As someone once said, death is the great equalizer. You can’t take anything with you when you go, but the memories you’ve made. So, I have decided to breathe in and breathe out my own personal life’s breath — my time with family. Although it is the physiological function of my body that keeps me here for the time being, I have learned it is the love of my family that makes me who I am at my very core. So, until I take my last breathe, I will continue my goal of taking each moment one breath at a time.

- Kristen Noud

Coming of Age

The television chatters softly in the corner of the waiting room and I listen absent-mindedly as the local news anchors discuss the weather and morning traffic patterns. The office is still quiet, aside from an elderly couple seated at the opposite side of the room, bickering about where to eat breakfast. It’s time for my Welcome to Medicare visit, and I arrived promptly to fill out my mountain of paperwork. Yet another reminder of my advancing age and the unfortunate consequences that tend to come with it. I can no longer read without glasses. My tennis game has suffered. I ache in places I didn’t even know were possible. But, I woke up again this morning. I’m alive. My mind is sound. Those are some things to be grateful for.

I’m ushered back into an exam room and left in solitude for several minutes until
diminished, and her left arm was essentially useless. It was a halting, one-handed walk. Her voice was hoarse and strained, and her eyes drooped. I could see the exhaustion on her face. She was clearly in pain, and her body was shaking with the effort of moving. I was moved to tears, and I knew I had to do something. I made a decision then and there that I would do everything I could to help her. I would be there for her, no matter what. I promised myself that I would be strong for her. Tears and pity will not be an option. I have no choice but to put on a happy face and be strong for her. Tears and pity will do no good for her now.

“How is your mood? In the last two weeks, have you felt down or depressed?”

“No. I have stresses in life like anyone else, but nothing I can’t handle.”

I don’t divulge the overwhelming guilt I feel for moving my mother into a nursing home. She lived with us for almost a year after her Alzheimer’s diagnosis. I was able to juggle doctors’ appointments and radiation and chemotherapy visits for several months, but I knew I could no longer offer her the care that she needed. I made the final decision when we found her wandering a half mile from our house one night. She had awoken while we were sleeping, dressed up in her Sunday best, and walked right out the front door. Now, she shares a 250-square foot room with a woman who thinks she’s Amelia Earhart. I visit when I can, almost weekly. The guilt, however, remains.

The young woman leaves and returns with my doctor. We’ve known each other for many years. He’s a member of our church and took care of our two daughters until they left home for college. Unfortunately, he knows me well enough to read through the jokes and dismissive answers. He can tell that I’m barely holding on by a thread. He asks about my mother and how she’s adjusting to her new home. He doesn’t push me when my voice cracks as I talk about my wife’s disappointing prognosis. Eventually, my regrets, anxieties, and fears flow out of my mouth as if I haven’t spoken to another human being in weeks. He listens intently and compassionately, only interjecting when he knows I have said all I needed to say. We talk in detail about end of life planning and the benefits of hospice. He reassures me about my decision to move my mother into a long-term care facility. I’m provided with resources for support groups and bereavement counselors, and he refills my cholesterol medication, orders follow-up bloodwork and urges me to take the time to take care of myself. I know the lobby is no longer empty and there are now several patients waiting to be seen, but I never once feel as if my problems are a trouble or inconvenience. They matter to him as well, and that offers me great comfort. I leave his office today feeling a little lighter and reassured. My heart is still heavy, but I know I’m now a little better prepared for the difficult decisions that will be made in the coming weeks.

A few months later, I return for my follow-up appointment. The young medical student and I have now met on multiple occasions, as I’ve accompanied my wife and mother to their regular check-ups as well. She asks how the family is doing, and I proudly inform her that Charlotte, my daughter, is expecting a baby in the spring. She and her family are moving back here from Virginia, and I’m looking forward to all of the opportunities to spoil our new grandchild. I tell her about my wife’s passing almost two months ago. She was at home in her own bed, surrounded by the people who loved her. I ensure her that I’m coping well, and it helps to know that my wife is no longer suffering. I’ve reluctantly joined a support group, and was surprised at how much I’m truly enjoying our weekly meetings. I’ve actually made quite a few friends there. My mother is adapting well to her new home, and seems to get along well with the residents and staff. I visit her every Monday to have lunch and watch old western movies. The student asks if I’ve been taking the time to do things I enjoy. I laugh and tell her that I now feel like an old man with too much time on his hands. It’s been a long time since I didn’t have the responsibility of caring for another, and I’m slowly beginning to discover new things that bring joy into my life. It’s been strange getting used to making my health a priority again. I might be able to predict the weekend forecast from an achy hip, and a cheeseburger does much more damage than it used to. But, I woke up again this morning. I’m alive. My mind is sound. Those are some things to be grateful for.

Emily Ost

“So Ms. B, tell me what you do for fun. What’s a day in your life like?”

“Umm nothing. I don’t do much. I stay at home. I am happy.”

Surely she must have been exaggerating. I mean, who could live like that?

“No, it’s true. I leave the house when I have to for groceries or doctor visits and stuff... but I spend my days alone at home. That’s how it has always been.”

To say this was how it had always been was not entirely true. She lived what most would consider to be a normal life until her early 20’s. Born and raised locally, she lived at home with her parents. After school, she and her friends would take their bikes
and ride around the neighborhood until someone’s parent would come outside yelling, “about homework or something.” In the summer her father would treat her to ice cream once a week and then they would go to beach. Sometimes they would go to people watch. Most of the time they would just walk and chase birds around. On occasion her father would impart lessons of life that he had “learned the hard way”. To her amazement, no two days at the beach were ever the same, “Each time it felt new to me.”

The day Ms. B. ran away from home to a nearby motel was the day her life changed. Her parents reported her missing and after a frantic week she was eventually caught on a golf course lighting portable bathrooms on fire. “That was my first episode. That was when everything became different.” That was when Ms. B. and her family learned she had bipolar disorder. Unfortunately for Ms. B., there was a poor understanding on the severity of her condition and she lacked adequate follow-up care. The end result was a stepwise deterioration of her mental being. Over the next decade, she would go on to lose all of her meaningful relationships in her life. Unable to work for a living, a significant portion of her adulthood was spent in and out of homeless shelters. In fact, her impairment became so intolerable to others that the most significant relationship she could name today was her landlord who would come to check up on her and the property every few weeks.

“I realize that my life is the way it is because of my bipolar. I don’t get other people as much or my disease, but I get myself and what makes me happy.” Ms. B. had a daily routine but she did not adhere to any schedule. She went to bed when she pleased and got up when she desired. Sometimes she would sleep in bed for upwards of 15 hours. She loved her TV set and the days she spent outside of her bedroom were enjoyed in the living room. She was not able to name a favorite show or a specific genre that she enjoyed more than others. To her, as long as there was sound and moving pictures she could stare at it all day. Aside from a small sofa, there really was not much else in terms of furnishings in her place. Well, there was, but the majority of her belongings were still in boxes that she had not touched for over a year. She would not dare to unpack; something about unfinished business provided her with a peace of mind. Ms. B. was not much of a cook either, or even an eater for that matter. Eating was too much work she explained. She had a microwave, “…but you have to plug it in and push buttons.” When she does get hungry she makes herself a PB&J; sometimes tuna depending on her appetite. If she felt the need to be around people she could always take a walk outside and observe others from afar; rarely did she have to resort to this.

“I pick my own clothes. I decide what I get to do. No one bothers me and I can just be myself.”

As Ms. B. went on to explain her satisfaction I realized her solitude had become her most valuable possession. Yes, she lived in isolation, but she had accepted this state with open arms and taken full advantage of the opportunity. Obviously, I understood that Ms. B’s thought process was a byproduct of her disorder. It was unfortunate to hear how much her life had changed because of her condition, but if there was one silver lining, it was that Ms. B. did not fill her days with regret. Whether due to ignorance or not, she was happy, she was content. More than anything my conversation with her made me cognizant of the fact that my definition of happiness is not always going to be the same as my patient’s. How could it be when I have not gone through the same experiences as them?

“How are you not burning up? I’m so thirsty.”

This was about the fourth-time Ms. B. had commented about her dry mouth. I did not think anything of it at first but she was really starting to look uncomfortable. As she finished the bottle of water I had just grabbed for her, I perused through her paper chart. I noticed she had failed to get any of her requested labs done for the past 6 months.

“Well, did you learn anything from a crazy person today?”

At that moment I could only think about the fact that Ms. B. may be experiencing adverse effects from her lithium treatment. In retrospect, I am not sure how much of my conversation with Ms. B. was true to her definition of happiness. Nonetheless, each time I ask a patient how they choose to enjoy life I think about her.

-Mueez Qureshi
my new wife and beginning a family was an upheaval of my previous routine. The stress and angst lapped at my neck, often rising higher, overtaking my ability to breathe. It finally passed after a year. Now, I fear this time it won't.

As I grab my keys, thankful for a task, I see the reminder on the refrigerator. I have a doctor's appointment tomorrow morning. I've been dreading it for three months since my last visit. I was told to have labs done. I haven't. I'm worried what they could show. My cholesterol is usually high. I wish I could cancel, but I desperately need a refill on my anxiety medication. I ran out three days ago. The panic attacks are becoming more insufferable.

That night, like most nights, the battle ensues. The fear of not being able to fall asleep begins early in the evening. By the time my wife is in bed, I know I should start the ritual of trying to make myself go to sleep. The mere act of undressing begins the cascade. My mind races with frantic thoughts of what my appointment will bring tomorrow. What should I say about the absent lab work? I'm sure my blood pressure will be high. I just have to get in and get out with my prescriptions. In and out. The red analog clock on my nightstand reads 10:30...midnight...1 AM.

I wake at 5:30 AM. I may have gotten four hours of sleep at the most. I shower and dress. I make coffee and try to read the newspaper. My stress is building. I get into the car and the angst begins rolling into an excruciatingly loud crescendo in my mind. The traffic and red lights are sending me over the edge. I can tell my blood pressure is high. My heart rate quickens. I feel my chest rising and falling faster than it should. I pull into the parking lot and try to cool down.

I walk to the front desk and sign in. I sit, fidgeting in the cold waiting area. My stomach lurches when the nurse calls my name. She politely greets me and seats me in the exam room. I try desperately to take slow measured breaths, willing my pulse to slow as the blood pressure cuff tightens around my left arm. She tells me it's a bit high. Of course it is. She asks if anything has changed since my last visit. “No,” I tell her. And that's the problem. “Did you get your lab work done?” she asks. I lie and tell her I didn't know I had any to complete. She leaves the room. My doctor is going to rebuke me for the absence of labs. I hear a knock at the door. I try desperately to still my nerves.

It's not my doctor. A young woman with brown hair and matching horn-rimmed glasses greets me with a smile. She tells me she is a medical student and would like to interview me before my doctor. I agree. She asks how I am doing. “I'm alright.” I assume she'll brush past the unenthusiastic response and start asking about the blood pressure readings I'm supposed to check at home, but she doesn't.

She returns my response with a thoughtful look, and a query to tell her more. I hesitate, debating on how much to divulge. I relent. I explain the attacks that come daily now. How they rise and escalate and soon I'm in over my head. I relay to her the fight it was this morning, just driving to the appointment. She listens carefully. Not taking notes, not looking into the computer screen, but giving me full attention. I tell her I'm out of my anxiety medicine and she asks if it has been helping; if I'm improving. I concede that it seems I'm getting worse.

She asks if I'd be willing to try a daily medicine that could, over time, help bring the sea of anxiety from the level of my neck down to my waist and maybe further—like equipping me with a life jacket instead of rescuing me at the point of nearly drowning. I wonder about this. It's something different. I fear potential side effects. She tells me this medication would modulate the chemicals in my brain, to help prevent my nervousness from building, to help prevent the attacks instead of treating them after they've already begun. This actually makes perfect sense to me. She continues to tell me the most effective means of treatment is a combination of therapy and medicine. I'm not a guy to go to counseling; I politely decline the offer.

Oddly, having just disclosed my embarrassing struggle to a complete stranger, I feel immensely better. Soon, my regular physician and the student return. He agrees with the thought to try a different means of confronting my problem. He still criticizes me for not having completed the lab work, but tackling the underlying issue brings me a new sense of peace. Somehow, now, I feel a new leaf is about to be turned. I schedule another appointment on my way out for one month from now. I feel encouraged that next time, I'll be better and prepared, with lab work completed. Maybe then, I'll finally be beginning to enjoy the swim.

-Stacy Ranson

Nearly 25 years ago, Danny traded in his harsh Midwestern winters for the year-round sun in Daytona Beach. He had just been laid off and heard he could find work at a hotel that would also provide living arrangements. With a suitcase and a bus ticket, he hugged his mother goodbye and waved to his father, who replied with a tip of his whiskey glass. When Danny arrived in Florida, he could taste the salt in the air. He headed to the beach, feeling entirely warm and free once his toes hit the water, and knew he would not need much more than this.

Misfortune has a way of finding people in threes, the saying goes. Danny's job prospects never did come through, so he moved in with a couple of guys who were in a similar point in their careers, that is to say, in between. Shortly after, Danny's parents passed away; they were killed in a car accident on their way home from a dinner at the local Moose Lodge. The police suspected alcohol was involved. Judy, his only sister, said she would
never forgive Danny for not coming to the funeral. He was too ashamed to tell her that he was broke and missed his bus because he was drunk. Danny was drunk for most of his days after that. He decided he didn't mind living paycheck to paycheck, especially if he could bike down to the beach and enjoy a beer with the sunset. Years of living in the elements can change a person. Danny enjoyed his alternative lifestyle; no one demanded anything from him–no rent, no showing up on time, no responsibilities. The trade-off was sometimes going hungry or having to hide from the police, but overall, it was a simple life drenched in sunshine and salty humidity. Most days Danny spent the few handfuls of cash solicited from tourists on snacks and beer and made rounds to the local soup kitchens for main meals. He kept to himself and after years of silently roaming, most people thought he was sullen and too drunk to notice much of anything. The truth is, he didn't get drunk much these days. He drank out of habit, and perhaps because of a deep genetic calling. He kept to himself because he realized it was usually safer–the streets had a way of swallowing people up and he had seen it with his own eyes. Alone, Danny lived day to day tied to existence by a thin thread of comforts.

A few times Danny had gotten a cold, or had been scratched by some sharp object, but overall he felt healthy and had not sought medical attention in many years. That changed on a spring day near the intersection of Granada and Beach Streets. Just after dawn, Danny was riding his bicycle to the store for breakfast when he was hit by a car. Danny was motionless but the car was in a hurry to get away. He laid there and could feel his chest throbbing, his head spinning, and his stomach grumbling. He doesn't know how much time passed before he was surrounded by people who were lifting him into an ambulance. He didn't hear any words; just loud voices coming at him with various tones. Finally, he heard someone say he was at a hospital and so he thought he must be getting help and he fell asleep.

Several times he was awoken with a gentle shake and an unfamiliar face demanding answers from him. He was cold and hurting, and could only breathe with short shallow breaths. Danny was worried that he was getting worse, but he was so tired he couldn't say anything. Some time passed before he was being jostled around and moved to another bed. He thought something was being done to help; maybe he needed surgery or an x-ray. Danny decided to let the professionals do their job and he fell asleep.

The day was drawing to a close, but Danny did not know. He was trying to sleep away the pain as he had done various times next to his pile of belongings on the ground. He didn't hear the statements of disgust, fear, and pity directed at him, but even if he had, it would not have been anything he had not heard before on the streets. He didn't know he was at a different hospital now. He didn't feel the tube go in his chest, the stitches on his head, the monitors and catheters all over his body. He didn't feel the tubes go in his throat or the wires in his skull. But it was too late and now he was giving up. He couldn't answer any questions if he tried. He thought about his sister, such a distant memory and yet he could hear her laughing when they had a snowball fight. He could feel his mother's arms squeezing him after he brought her a bowl of black berries, picked from just down the road. In the end, Danny thought about his first days in Florida and with his toes in the water he felt warm and free one last time.

-Rachel L. Rider

**A Tale of Meetings**

The first time we met, I did not know it. There is no question as to why you were so anxious; it is obvious you have never seen a patient like me. Yet, you would get to know me very well. God did not intend for man to witness such things, yet everyone was given a choice and everyone chose to stay. I laid there while you acted like things were “par for the course”, but I was an “albatross”. That was the beginning of a formidable journey; I was never going to be the same.

I met you again; this time I was aware. You seemed so out of place next to the mature healer who has seen it all. Even he would learn something from me in the time to come. Moving from bed to floor and from floor to window, my goal was to get back to a normal life. You came to understand my world when you met my wife, my sister, my nephew and my daughter. Her occupation became something of a game. We all played and it kept spirits up. I was nearly there, as if the seasons changing in the window was a foreshadowing for my imminent discharge. Then, seemingly in an instant, I found myself moving from the window to the bed. I already knew by looking at his face; I could see what was coming next. Your face was neutral because you did not know.

We met again without me knowing. It did not seem much different from the first time. I am sure you were probably thinking, “It couldn’t get any worse.” I already explained this – “you have never seen a patient like me.” His experienced hands worked magic again although things were not perfect. This time, there was a different room with a different window. What had been “goals”, changed to “hopes” and “prayers”. I was no longer focused on the window; I just hoped that I did not have to leave the room again. You came to say “goodbye” every night and I prayed I would live to see the morning. The most advanced contraption on the planet and I will be damned if a little fluid is going to take it down – “over my dead body!”

The events to come would put this to the test. You were not there this time. What happened to me does not seem possible; what a story this will be! I just have to get out of this bed first.

You made your first of your multiple visits
for the day. It had been many weeks since we first met and you were different. You did not flinch when you saw what they had done. Though you would say later, “something like that should not exist outside of the operating room. I cannot believe it”. He would tell you “bottom line, this doesn’t happen every day”. We hoped something would change, but it did not.

I remember thinking “Please tell me this is the last time we will meet like this.” If there was any reason to hope, it was lost on me. At least this one was quick. Gas exchange is important to keep things in balance, especially in such an advance piece of machinery like this. It seems odd that this little piece of plastic is all I needed. There was improvement, but something was still missing. In my core, it felt as if there was a gaping void that would never close. There were other machines to fix that.

The sun feels so good. I have not seen it since before we first met. It is hard to explain my appreciation for this bright heat. Though, I gather that after such an ordeal, my appreciation for many things will be difficult to explain. You have changed and so have I; so has my entire world. I am on the other side of the window now but I will have to return to my room. I am sure I will see you one last time. You have undoubtedly learned something from me; that is my gift to you. God, if I did not learn how lucky I am to be alive.

-Thomas Shakar

Maybe the Voices Aren’t So Bad

“Can you trust him? He’s watching you. Be careful what you tell him.” When it comes to the voices, I can’t turn them off. Some days are certainly worse than others, and today is an average one. But they’re always there in the background. Overall, I don’t think I can complain much. I’m doing better now than I was before, that’s for sure. I wish I could tell you the exact condition I have, but I don’t even think the doctors are sure. Between all the medications and diagnoses that have changed over the years, I guess you could say I’ve had a little bit of everything. But for the most part now it’s the voices that I notice the most. They’re saying nice things about you now in case you’re wondering.

I guess before all of this started, I had a relatively normal childhood. I was the youngest of four brothers growing up in Virginia. I eventually moved to Florida after my dad got stationed here for the military. Things were smooth-sailing through the time I was in community college. Sure, I smoked and drank my fair share. I don’t think I ever really thought twice about it when it was offered. Between that and my surfing, I would occasionally go to class when I could remember. Life was good for a while. And then, everything changed. A lot of it is a haze in my mind, so all I can tell you is what I was told after the fact. For some reason, I started believing out of nowhere that I was Jesus. You heard that right, and I couldn’t tell you why. Not long after, I stopped going to classes completely. In addition, I pretty much broke off all contact with my family and friends that were closest to me. After some searching, my parents said they found me in the beach dunes acting like a maniac. I was immediately hospitalized in the psych ward. All it took was one shot of medication and I miraculously came back to reality for the first time in a long time.

A lot of my time has been spent thinking about the things that I said and did back then. Some regimens were rougher than others, but overall they’ve helped me turn a huge corner in terms of my overall well-being.

All in all, I feel like I have made peace with my current situation. I have seen how far gone some of the other patients are in this mental health clinic. Many of them won’t admit that they have anything wrong with them. Some are even paranoid that the staff is out to get them. Thanks to the medical care and counseling that I’ve received through this program, I’ve been fortunate enough to get my life back together in some sense. I know that I will probably never completely get rid of mental illness, but I embrace the hand that I have been dealt in life. Now if you don’t mind, I’m going to catch a wave.

-Theo Strom
SINATRA’S L’ALDILA

Cautiously making our way down the misty darkened back roads of downtown Cassadaga we suddenly found ourselves staring at the famous landmark of the town itself. Brightly lit, the Hotel Cassadaga stands proud and prominent among the surrounding antiquated edifices incorporating the 100 or so known spiritualists the town is famous for. Since 1894 Cassadaga has been known as the Psychic Center of the South. The Hotel itself was rebuilt in a Spanish revival motif after it burnt down. Since 1928 it has hosted many who have come to talk to their dead relatives in séances, palm readings, tarot readings, and attend spiritualist classes.

Upon entering the front door we noticed a sign that read, “Séance in progress, do not disturb”. The restaurant was off to the other side of the building. As we entered, we could here the talented music of a pianist playing and singing songs of the ‘60s and ‘70s.

Several people were singing along with him. Our waiter Merle led us to our table surrounded by windows and wall decorations that exuded a funky charm. Merle then told us about Chef Mathew C Odett who hails from New England where he was master chef at a catering hall. He has since moved to Florida in April 2016 where he revamped the menu at Sinatra’s.

Joining Lisa and me tonight included friends from Deland and Orlando. Sinatra’s was therefore a great place to meet up. Sinatra’s is primarily an Italian restaurant. They do have a full bar available including wine, beer, and (no pun intended) spirits. After some of our guests had cocktails, we ordered several appetizers to share. The calamari was done quite nicely with a marinara and Cajun seasoning with pepper rings.

The delectable bruschetta was done with a watermelon base and finished with a balsamic reduction served on toasted French bread. My favorite appetizer was the Shrimp I-Thai-Gano that is a fabulous and definitely mouthwatering, lightly fried and breaded large white shrimp tossed in a not too spicy but creamy Thai chili sauce and served over a bed of homemade sesame pasta salad. To go with our appetizers and meal I ordered a nice drinkable red 2013 Argentinian Malbec called Tamari. It proved to pair well with our meals.
Our meals came with a standard Caesar salad with homemade dressing. These proved to be a decent intermezzo for our main courses.

The main dishes were quite diverse and you could even create your own pasta bowl. You simply pick your choice of any homemade pasta: spaghetti, fettuccini, tortellini, cavatappi, or farfalle; add a style of sauces such as marinara, vodka, aioli, Mediterranean, Alfredo, diavolo, carbonaro or creamy pesto. Last of all choose your protein: chicken, meatballs, vegetarian, Italian sausage, calamari, shrimp, salmon or mahi. One of us chose simple spaghetti and meatballs with marinara. This was quite tasty. I opted for the Vitello Amatriciana, containing a wonderful conglomeration of cream, cheese, garlic and amaretto all sautéed to perfection. This was served over a nice al dente risotto.

Lisa ordered veal with fig and mushroom served with a sweet brown marsala containing sweet mission figs, cremini mushrooms and locally grown red onion.

Our friend who loves hot foods ordered a very spicy Italian Jambalaya. This contained scallops, shrimp, chicken, roasted red peppers, onions and risotto in a spicy chicken broth. He loved it. The braised short ribs Italiano were roasted perfectly and served with a Parmesan risotto. They were quite good but were served too cold for our guest and needed rewarming before eating.

Deserts are not homemade but are still quite good. We split a very savory five layer chocolate cake and a mouthwatering Tuxedo Bomb chocolate mousse which contained several layers including white and milk chocolate.

By evening’s end we became caught up in the entertainment and enjoyed singing along with the pianist. They do have live entertainment Wednesday through Saturday and even have dueling pianos twice a month.

Our total bill for the evening was very reasonable. My entrée was the most expensive: $19.00. Not bad at all. We enjoyed ourselves immensely and do plan on returning for dueling pianos.

I give this fine establishment 4 stethoscopes for its funky ambience, 5 stethoscopes for value, 4 stethoscopes for quality, and 4.5 stethoscopes for service.
The Centers for Disease Control and Prevention (CDC) lists heart disease as the top cause of death in the U.S. since the early 1900’s. More than 600,000 deaths were due to heart disease in 2014, a rate of 192.7 per 100,000 population. In Volusia County, heart disease accounted for 23.3% of all deaths in 2015 with a rate of 176.4 per 100,000 population. This rate was 9.2% lower than the nation but 15.4% higher than Florida at 152.9.

Risk factors associated with heart disease such as obesity, high cholesterol and hypertension are common chronic illnesses in our community. The 2013 Florida Behavioral Risk Factor Surveillance Survey reported that over half of adults in Volusia County (58.1%) were obese or overweight, 39.3% were told they had high cholesterol and 40% were told they had hypertension.

Emergency department (ED) visits rates for heart disease increased from 590.5 to 668.6 (13.2%) from 2011 to 2015. Heart disease hospitalizations decreased 4.0% from 1010.3 to 969.9 during that period. Volusia County heart disease death rates for 2011-2015, on average, were 20 points higher than Florida rates. While the Florida heart disease death rates remained nearly unchanged (less than 1%) from 2011 to 2015, the rates in Volusia County grew from 163.4 to 176.4 (7.9%).

Key to understanding the impact of heart disease is an assessment of its distribution across racial groups and geographic boundaries in Volusia County.

**Racial Distribution**

According to the CDC, heart disease is the leading cause of death for most racial/ethnic groups in the U.S. Similar patterns occurred in Volusia County as non-Hispanic black residents had a higher heart disease death rate than other racial/ethnic groups (223.5) in 2015 in Volusia County. Hispanic residents consistently had lower rates of heart disease deaths among all racial/ethnic groups but like their fellow residents their heart disease death rates trended upward and represented the largest percent increase (39.7%) from 2011 to 2015.

**Geographic Distribution**

Volusia County is partitioned into four geographic quadrants (northwest, northeast, southwest, and southeast), constructed from zip codes, to assess population health at the sub-county level. The northwest quadrant had highest average heart disease death rate (175.3) from 2011-2015; yet it logged the only downward trend among the quadrants. Heart disease death rates among the quadrants have increased over the years. The lowest heart disease death rate in 2011 was 149.5. The lowest rate in 2015 was 168.9, a difference of 19.4 points. While other chronic diseases show a high rate of disparities across quadrants, heart disease has become more evenly distributed from 2011-2015.

**Financial Burden**

Over half (50.4%) of emergency department (ED) visits with heart disease in Volusia County were patients who were 65 and older. In contrast, only 23% of the county population was 65 and older. Northeast quadrant residents had the highest number of ED visits in 2015, but southwest quadrant had the highest amount in total charges. The total charges for heart disease in 2015 were $27,463,943, a 28.7% increase from 2014.

Health care costs have increased nationally and Volusia County was no exception. In 2015, there were 55 fewer ED visits for heart disease. Although ED visits for heart disease decreased, the average...
The average charge per visit rose 23% from 2014 ($4,709) to 2015 ($6,134). The chart below depicts the steady upward trend with the average charge per ED visit for heart disease increasing by 104% from 2011 to 2015.

<table>
<thead>
<tr>
<th>2015</th>
<th>Volusia County</th>
<th>Quadrants</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Northwest</td>
</tr>
<tr>
<td>Ed Visits</td>
<td>4477</td>
<td>675</td>
</tr>
<tr>
<td>Total Charges</td>
<td>$27,463,943</td>
<td>$4,752,099</td>
</tr>
<tr>
<td>Average Charge Per Visit</td>
<td>$6,134.45</td>
<td>$7,040.00</td>
</tr>
</tbody>
</table>

Conclusions

Heart disease impacts our community on many levels.

Eliminating barriers to care is critical to prevention and treatment. Barriers to efficient healthcare delivery exist at multiple levels including financial, community, patient, provider and organizational. The manner in which patients and providers interact during a visit must foster productive patient-provider relationships. A system of care is designed to assist providers in cardiovascular disease prevention may include one or more of the following:

- Reminders for overdue cardiovascular disease preventive services, including screening for CVD risk factors
- Assessments of patients’ risk for developing cardiovascular disease
- Recommendations for evidence-based treatments to prevent cardiovascular disease
- Recommendations for health behavior changes to discuss with patients
- Patient alerts when indicators for cardiovascular disease risk factors are concerning

And when combined with other effective strategies such as culturally competent healthcare, team-based care, or other infrastructural improvements to facilitate the delivery of evidence-based care, this has been proven to reduce patients’ risk for cardiovascular disease.

Sources:
Florida Agency for Health Care Administration (AHCA), Volusia County Hospitalizations & Emergency Department, 2011-2015
Centers for Disease Control and Prevention, Heart Disease, https://www.cdc.gov/heartdisease/
The Hidden Cost of Quality Reporting

By Steve Miles, M.D.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) passed in 2015 as a fix to the Sustainable Growth Rate (SGR) Physician Fee Schedule issue stopping proposed draconian cuts to the Physician Fee Schedule in favor of a 0.5% increase. Hidden from most of us, buried within this 1,000 page document, was Medicare’s movement from a payer to a purchaser of service. This process started in 2012 when Medicare commissioned a study on the quality of Medicare reimbursed health care in the United States. Out of this commission grew the idea that Medicare should start focusing on value and not volume.

What Medicare did was provide a carrot—a 1.5% increase in physician fee schedules beginning in 2015 for use of a compliant electronic medical record (EMR), reporting of quality measures, e-prescribing, etc.

Beginning in mid-2016, this carrot became a stick with an increasingly larger percentage of deductions from physician professional fees for not meeting these “goals”. A 0.5% increase in physician fee schedules now resides with an escalating decrease in fee schedules, up to a minus 9% if quality goals are not met.

Bottom line: Quality reporting costs both time and money and there is now voluminous data showing how much.

Researchers at Weill Cornell Medical College teamed up with the Medical Group Management Association (MGMA) to put a price tag on the time providers spend inputting quality data into an electronic health record (EHR). This group also studied the time required to input these newly introduced measures and protocols of tracking and reporting them.

Globally, this answer according to Weill Cornell is approximately $15.4 billion a year. This study was published in the March 7, 2016 Health Affairs. The 2016 MGMA survey reports revealed health care technology costs have now topped $32,500.00 for physicians. Dr. Fisher Wright, MGMA President and CEO, opined, “We remain concerned that far too much of a practice’s IT investment is tied directly to complying with the ever increasing number of federal requirements to provide better care.”

Health Affairs also reported that quality metrics is becoming an increasingly time consuming task for physicians and their practices. U.S. physician practices in four common specialties spent, on average, 12.5 hours of physician’s staff time per week entering information into the medical record for the sole purpose of reporting quality and measures for external entities. There is also a hidden cost of EHR use in hospitals. A 2010 study by the UC Davis Graduate School of Medical Management revealed a 25-35% decrease in productivity in the clinic outpatient section. In 2012, an HIT Consultant Survey indicated that more than 26% of physicians reported decreased productivity and 50% were not happy with the EMRs. Only 23% of the physicians responding said that EHR made them more efficient. In 2014, Medical Economics published an article stating that 65% of respondents reported EHR use resulted in financial losses to their practice.

There have been multiple and very visible failures of EHR implementations in hospital systems. The University of Texas M.D. Anderson Cancer Center reported a 56.6% decrease in adjusted income in a seven-month period related to an EMR implementation. Boston-based Partner’s Health Care reported an operating income loss of $74 million for a quarter partly due to its Epic implementation. Also, Brigham and Women’s Hospital in Boston reported its first budget shortfall in more than 15 years partly due to unexpected costs associated with its EHR transition.

Similar findings are noted in California. Jeff Sprague, CFO of Sutter Health Care in Sacramento, attributed a 31.5% decrease in operating income from a onetime only EHR implementation cost.

There was also an article published in the Annals of Internal Medicine, September 2016, with a conclusion that for every hour physicians provide direct clinical face time to patients, two additional hours are spent on EHR deskwork within the clinical day. Outside of office hours, physicians spend another 1-2 hours of personal time each night doing additional computer and clinical work.

The small amount of money that Medicare added to the beginning of this process pales in comparison to the cost of implementation of these measures.

What can be done to stop this bureaucratic mess? Organized medicine, including the American Medical Association, must form a strong coalition and present this evidence to the RVU (Relative Value Units) Advisory Board. We should demand the RVU Commission add a specific expense for EHR/Quality implementation.

The way a physician payment is calculated is a simple formula. The payment equals the RVU for work times a Geographic Pricing Cost Index (GPCI), plus RVU expense times a GPCI expense, plus RVU malpractice insurance cost times the GPCI for malpractice cost, times the conversion factor currently of 35.8043 cents. A simple way to mitigate some of the cost of implementation of EHR and quality metrics is for the RVU Commission to add an RVU/ EHR expense into the conversion factor.

Payment = [(RVU work x GPCI work) + (RVU expense x GPCI expense) + (RVU EHR/Quality X GPCI EHR Quality cost) + (RVU malpractice insurance cost x GPCI malpractice insurance cost)] x conversion factor of $35.8043 (Jan. 1-Dec. 31, 2016).

The 0.5% stabilization to our fee schedules on the professional side pales in comparison to the amount of money and time spent in implementation of these products.

Until organized medicine wakes up and shines the light on this hidden cost of “quality” mandates, including the promises made for Health Information Exchanges (HIE), patient care will continue to suffer. Physicians will become less efficient and information will remain siloed into fragmented electronic databases that do not communicate with each other.

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**Otorhinolaryngology**

**noun:** *oto*rhi*no*lary*ng*ol*ogy*

The study of diseases of the ear, nose, and throat.

**Densitometer**

**noun:** *den*si*tom*eter*

An optical device used by printers and photographers to measure and control the density of ink or color.