

MEDSTAFF NEWSLETTER

UPSTATE UNIVERSITY HOSPITAL

FEBRUARY 2015

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MESSAGE FROM THE MEDICAL STAFF PRESIDENT MITCHELL BRODEY, MD

I was driving back from the Duke game with my oldest daughter, my son-in-law, and several of their friends. As we passed the medical center complex, one of them from the back seat asked me where I would go if I were sick. I thought. And I thought, and I am still thinking. I have asked numerous members of the medical staff the same question and the usual response after a long pause is “it depends on what I have”. We have been one medical staff on two campuses for almost 4 years now. It has not been without its difficulties. One is the organizational issues when an academic center merges with a community hospital. I discussed that in the last issue. The other are systems issues. How do we create a medical community that best meets the needs of our patients with limited resources? What demand should we as

a medical staff place upon ourselves to fulfill the mission of this institution?

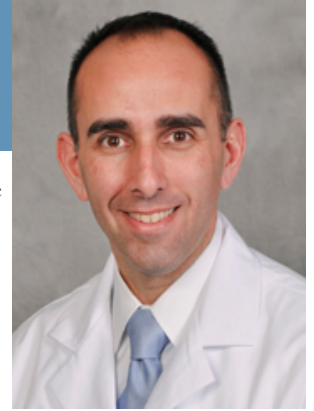
We have been discussing the issues of call, coverage, and consultations at the bylaws subcommittee. As you might remember, this committee was the birthplace of the mandatory flu vaccine policy. The results of this discussion will then be taken to the medical executive committee. The questions before us now are when, where, and by whom consultations are performed. Are we capable of dealing with any situation at any time, or just during daylight hours on weekdays (non holiday)? Will we go to the patient’s bedside, or will we bring the patient’s bed to us? Does a consultation performed by a Physician Assistant meet our standards as a medical staff? What does “On Call” mean? Do you always come in if called? Are you grateful that a colleague has asked your opinion or

annoyed that the caller is bothering you? We would be interested in hearing your opinion, as eventually any changes will need to be voted on by the entire medical staff. In the meantime, in order to foster dialogue and improve communication with the medical staff, we will be having our first clinical chiefs of service meeting next month. Forty doctors together in one room. Town and gown harmoniously (ok, perhaps I am pushing it a bit) trying to find common ground so that we will have a quick answer when friends and family ask us where to go for medical care.



MORTALITY

ANTHONY P. WEISS, MD, MBA



I've been thinking a lot about death lately. Perhaps it's appropriate for a month in which the temperature has not once climbed above the freezing point. But the real reason for my reflection on this topic has been a reinvigorated process of reviewing each and every mortality that occurs within the walls of our hospital. We are now sitting down weekly to discuss each case in an attempt to learn from their passing. This is not easy work – logistically challenging and emotionally taxing. I am grateful to the nurses, physicians, and pharmacists who are assisting me in conducting these reviews. I believe our efforts are already bearing fruit as we identify recurring themes that may lead to process change.

We've identified one large group of patients who are transferred from outside hospitals *in extremis*. Patients in hypovolemic shock, patients s/p cardiopulmonary arrest, patients with large head bleeds. As a hospital that accepts twice the number of transfers as the average teaching hospital nationwide, it is not surprising that some percentage of these patients cannot be saved. I know that some larger percentage *are* rescued, making the attempt worthwhile in most cases. I remain proud of being part of a hospital that serves as a place of hope for such a large region of Central New York, and I am proud of the doctors that are involved in this life saving work on a daily basis.

We've identified a second large group of patients who have un-savable conditions, patients admitted with respiratory compromise or severe pain from widespread metastatic cancer, for example. They are dying, and the first doctors to break the news to them or their families are the unfamiliar physicians who happen to be on service at that time. Although most are seen by our palliative care service and many are referred to hospice, the conversation occurs too late, and they pass away in an acute hospital bed.

There is opportunity for improvement in this second group. An opportunity to have a realistic conversation about treatment options, including the appropriate timing of palliative care and hospice, well before the 911 call that brings them here. This is a national issue – I encourage all of you to read Dr. Atul Gawande's latest book, "Being Mortal" (which was also the focus of a moving Frontline episode a few weeks ago), as he discusses just how difficult these conversations are. But it is particularly a Central New York issue – we have some of the lowest rates of hospice utilization (and highest rates of in-hospital mortality) in the entire country. This is an issue that needs physician leadership – and as the medical staff of the largest hospital in the region, I am hoping we can at least begin a conversation of what can be done differently, including how we can better educate physicians on having these difficult conversations.

Death is complicated, and the mere mention of the topic often raises the affective temperature in the room. I mention it not to create more heat (as tempting as that sounds on another below zero day), but because I know we can do better for these patients, and I will need your help.

E-PRESCRIBING CONTROLLED SUBSTANCES (EPCS)

As of March 27, 2015 all prescriptions, including controlled substances, will need to be e-Prescribed. Efforts have been underway here at Upstate to prepare for this new NYS mandate. EPIC has the required capabilities for electronic prescribing of controlled substances. In addition, Upstate's IMT team is working with Imprivata as our vendor for the new dual factor authentication element. Once in place, when entering a medication order for a controlled substance, the provider will be prompted for their password as they are today. Once the password is entered, there will be two options:

Option 1: They will be prompted for an additional password that will be sent to their smart phone (once received they will enter the additional password to sign the order).

Option 2: The provider can use a fingerprint scanner, if one is available to them, to sign the order. Fingerprint scanners will be provided in some areas.

The role out of this solution will be starting soon in a pilot area, and then expanding to all affected areas. Providers will be asked to meet a representative for required identity proofing, and issuance of dual factor authentication capabilities. Additional information will be forthcoming, including dates and times representatives will be available.

WHAT DO YOU THINK? GREGORY L. EASTWOOD, MD



Does Good Behavior Make a Good Physician?

“Moral virtue comes about as a result of habit... It is by doing just acts that the just person is produced.”

Aristotle, *The Nicomachean Ethics, Book II*

What comes first, good thoughts or good behavior? This may be a chicken-egg conundrum, but Aristotle would give the edge to behavior. Also, apparently, so would patients and society.

That our thinking drives our behaviors seems intuitive. Yet, Aristotle reminds us that our behavior may change our thinking. He says that by doing just behaviors, such as acting virtuously or courageously, we may become more virtuous or courageous (1). It seems that behavior and thinking influence each other by some sort of feedback loop. This evokes the question that circulates among medical educators, Can we teach empathy or other attitudes and traits of character? Perhaps we *can* teach empathy, as well as a host of other characteristics that we identify with professionalism and the ethical physician, by beginning with ideal behaviors.

Patients typically say they want their doctor to be compassionate, honest, knowledgeable, committed to their welfare, and the like. Since patients usually do not have access to their physician's thoughts and motivations, these characteristics are inferred by the physician's speech, body language, and other actions, in short, by the physician's behaviors.

Kahn suggests that, “Patients ideally deserve to have a compassionate doctor, but might they be satisfied with one who is simply well-behaved?” (2). He then offers six simple behaviors, beginning with “Ask permission to enter room; wait for an answer.” Of course, we hope that our physician has *both* the proper motivations *and* the related behaviors, but if patients had to choose between a compassionate thinking physician who did not behave compassionately, perhaps because of lack of training, ability, or insight, and one who simply behaved compassionately, I believe that most patients would choose the latter.

This emphasis on behaviors seems relevant to broader issues of professionalism and ethics. Patients want physicians to behave professionally and ethically and do the right thing. They generally do not ask *why* physicians behave professionally and ethically – whether it is out of compassion, or because that's what the codes of ethics and professionalism say, or the doctor has good ethical reasoning ability. And it appears that behavior is what society and the medical profession, including state professional conduct boards, ultimately care about. Thus, I choose to conceptualize professionalism by a set of behaviors.

We might arrive at a set of behaviors by listening to responses to the question, What do patients expect of their physician? When I ask that of lay people as well as medical students and physicians, I get a list something like this, all of which are behaviors or are expressed through physician behaviors.

I expect my physician to...

- tell the truth and be trustworthy
- show compassion, empathy, and respect
- listen and communicate effectively
- demonstrate the requisite knowledge and skills
- exercise good judgment
- maintain confidentiality
- ask for consultation and help appropriately

Focusing on the behaviors that characterize a good physician has implications for how we teach professionalism to students and residents as well as live it ourselves. Should the goal be to create more thoughtful medical students and physicians who are better able to reason about professional and ethical matters? Or should it be to improve the behavior of physicians along important scales of ideal behaviors? Clearly, this is a false dichotomy. We should not have to choose, but the dichotomy may help us understand better how behavior and thinking may be linked. Perhaps if we emphasize and require certain behaviors, as Aristotle suggests, the mind will follow.

Another perspective to consider: I believe that many physicians act ethically, not because they have reasoned a situation using ethical precepts, but because they feel a sense of duty and adhere to certain codes and thus have acquired a set of habits and behaviors. This view is explained by commentator David Brooks when he argues that feeling empathy may not be sufficient. He says, “People who actually perform pro-social action don’t only feel [have empathy] for those who are suffering, they feel compelled to act by a sense of duty. Their lives are structured by sacred codes. [Empathy] is overshadowed by their sense of obligation to some religious, military, social or philosophic code. They would feel a sense of shame or guilt if they didn’t live up to the code... The code isn’t just a set of rules. It’s a source of identity. It’s pursued with joy. It arouses the strongest emotions and attachments. Empathy is a sideshow.” (3). Practicing appropriate behaviors strengthens and validates the ethical framework of duties and codes in the process of making good behaviors habitual.

The acquisition of good behaviors is a tricky business. Students and young physicians learn about how doctors think and behave in nearly everything they experience, where the so-called hidden curriculum lurks (4). Some of what is learned in the hidden curriculum contradicts what is taught in the formal curriculum. It is through the hidden curriculum that compassion and idealism erode and we learn to refer to patients disrespectfully, to stereotype our colleagues in other disciplines, and to take shortcuts that may adversely affect patient welfare. Opportunities for students to meet periodically and discuss their experiences, such as what occurs already in our College of Medicine curriculum, may have a mitigating influence on this (5).

It is the job of all of us to reinforce the teaching of professionalism with appropriate modeling and experiences. The focus on professional and ethical behavior should pervade the entire institution to become an “ecology of professionalism” in which everyone is held accountable for professional behavior (6).

References

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The Schwartz Center Rounds®

A multidisciplinary forum where caregivers discuss social and emotional issues that arise in caring for patients

Mixed Feelings: Self-Destructing Patient with Personality

Tuesday, March 3,
2015

3:45 pm – 4:45 pm

East Tower 10405 A
& B

All Staff Invited
Refreshments

Panelists:

Matthew Glidden, MD,
Rev Terry R.

Culbertson, MDiv, BCC
LeAnn Askew, RN ,MSN

Facilitated by:

Holly McCurdy, MS Adult
Education

Physician Champion:

Colleen O'Leary, MD



WELCOME
NEW MEDICAL STAFF
&
APC MEMBERS

Catherine Goodwin, NP	Medicine
Joseph Coffey, PA	Orthopedics
Maggie Krywalski, NP	PM&R
Deborah Longley, MD	Radiology
Laura Hotchkiss, MD	Radiology

- We will focus on our feelings, reactions, and our feelings about those reactions to the frequent flyer who repeatedly “shoots himself (herself) in the foot”. The panel will open the discussion with a patient who was on: 6A,B, K, H, I on 5A,B; 4B, 8G with numerous visits to the ED. But he was in no way unique. Come to share your stories and feelings in this “staff only” safe place.
- *The Schwartz Rounds multi-disciplinary case presentations and discussions provide the safe, confidential forum for sharing lessons, expressing frustrations, or grieving.*
- *The Schwartz Rounds are open to all staff of University Hospital: Physicians, residents, faculty, nurses, students, therapists, social workers, spiritual care, housekeeping and other support staff.*
- For more information, please contact Rev. Virginia Lawson, PhD, Coordinator, Schwartz Rounds at Upstate lawsonv@upstate.edu, 464-5596.

Continuing Medical Education (CME) credits available

The Schwartz Center Rounds program is supported by the Dr. Daniel Burdick Compassionate Care Fund, established in 2013 by a generous founding gift from the children of Daniel and Billie Burdick.

The gift honors Dr. Burdick’s compassion for both patients and caregivers throughout his medical career as a surgical oncologist and general surgeon, and his foresight in recognizing the emotional toll of serious illness on care providers.

Rounds are continuing thanks to administrative support, with additional funding from *The Friend In Deed Fund, The Advocates of Upstate Medical University and The Upstate Medical Staff Fund*

WORKING WITH MEDICAL STUDENTS



The College of Medicine (COM) is responsible for preparing everyone who works with and teaches medical students for their responsibilities. To assist with this, the Educational Program Objectives have been aligned with the ACGME objectives for residents, in order to better prepare medical students for their future role in residency. In addition, to be sure that the learning environment for medical students is conducive to the ongoing development of appropriate professional behaviors, faculty and staff treat all individuals with respect.

There are three policies you can review for additional information:

1. **COM Graduation Competencies and Educational Program Objectives (EPOs):**
<http://www.upstate.edu/com/document/objectives.pdf> Learning
2. **Environment and Mistreatment:**
http://www.upstate.edu/surgery/pdf/education/clerkship/mistreatment_policy.pdf
3. **Professionalism:**
http://www.upstate.edu/com/document/professionalism_policy.pdf

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