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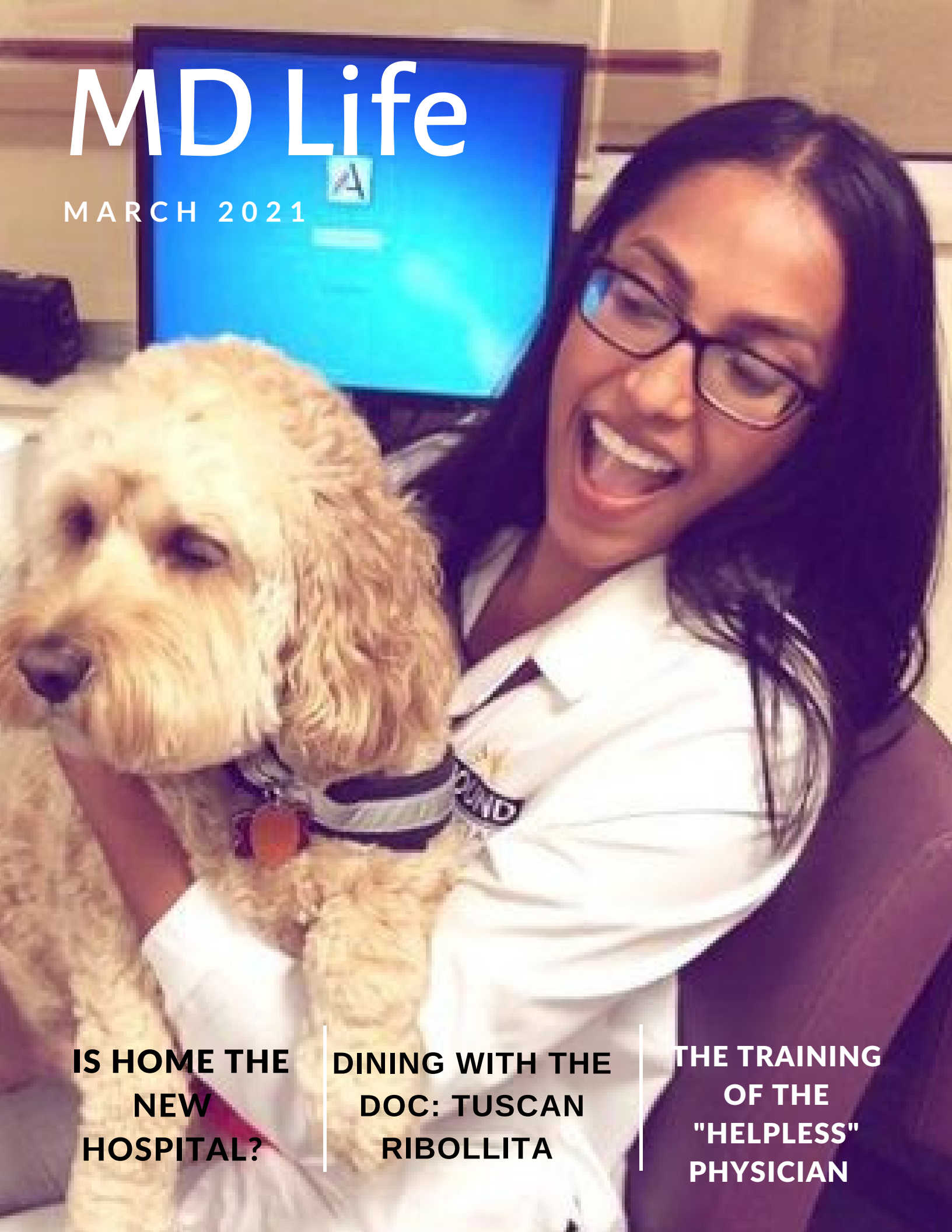

IS HOME THE NEW HOSPITAL?

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Is Home the New Hospital?

By Frank Astor, MD, MBA, FACS
Chief Medical Officer, WITHmyDOC

Changes in healthcare delivery have come about in the past year that likely would not have happened as quickly if it weren't for COVID-19. During the pandemic, physicians and patients turned to telehealth and virtual care in lieu of routine, in-person doctor's office visits and for chronic disease follow-up visits. Healthcare systems provided care at home for some COVID-19 patients in lieu of admitting them as inpatients in order to free up hospital beds for more critical cases.

This was made possible by remote patient monitoring (RPM). More attention centered on RPM programs because of their ability to successfully monitor patients outside of the hospital and the doctor's office. RPM allowed the care to be provided at home.

Home care is on the rise. In fact, care management, including RPM, was recently named as one of the top home care trends for 2021. One of the reasons is home care's role in new delivery systems designed to treat higher-acuity patients such as those with an increased risk for hospitalization and those with chronic disease – either newly diagnosed or recently discharged – and both have a higher probability for rehospitalization.

Another reason for increased popularity is reimbursement. Late last year, CMS announced its new Acute Hospital Care at Home program giving health systems the opportunity to reduce inpatient volume by treating certain acute care patients at home through a telemedicine platform that allows for daily check-ins and monitoring, it was a major step forward for value-based care.

Medicare also recognizes that RPM can help home health agencies improve the care planning process. In October 2018, CMS released a final rule allowing home health agencies to bill for remote patient monitoring. To incentivize the adoption of RPM, the costs of necessary equipment, set-up, and related services can now be included as allowable administrative costs on the home health agency's cost report. However, home health agencies are only responsible for the collection of data, not the 20 minutes of data interpretation and intervention the same way a physician would be.

Home health care providers aim to provide a continuous care experience by using programs like RPM. While home health's in-person provider visit may only be for a limited amount of time, RPM is with the patient 24/7. RPM is not a substitute for home health visits. Rather, RPM upgrades home health services, improving the quality of care for patients leading to better patient outcomes.

Clinicians and clinical staff can communicate modifications in medication and other self-care to the patient in real-time without any delays in the communication process. If symptoms and the disease progress to the point that hospital services are needed, providers will be able to arrange for care and transport that will ensure safety of the patient and health personnel.

Using RPM allows home health agencies to collect more data to better understand the patient's condition on a daily basis. It also helps to quickly identify fluctuations in vital signs and get the physician to intervene right away and adjust the treatment plan. RPM not only has proved to reduce hospital admissions and lower healthcare costs, but also to yield better healthcare outcomes.

In many ways, home has already become an extension of the hospital, albeit with the addition of the convenience and comfort we have grown accustomed to in our daily lives.

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Peer Support During the Era of COVID-19

SUSAN WILSON, MD

Burnout has been an issue for those in health care long before the COVID-19 pandemic, but the increased stress and anxiety we face now have caused a host of new problems. The current environment health care professionals (HCPs) find themselves in has brought issues of physical and emotional exhaustion, compassion fatigue, and moral injury, not to mention more instances of second victim syndrome (the effect of an unanticipated, adverse medical event on a clinician). If left untreated, these issues will contribute to burnout, which is already of epic proportion.

What is peer support for HCPs, and why is it needed now more than ever? Perhaps we should start with the definition and explore how peer support can effectively combat stress. In the strictest sense, "peer support" refers to a process through which people who share common experiences or face similar challenges come together as equals to give and receive help based on the knowledge that comes through shared experience. In the medical world, peer support of HCPs comes from those with direct experience and understanding of medicine's challenges. Traditionally, peer support has been seen as a tool to help those facing the challenges of second victim syndrome. Still, today's medical environment has brought on many more scenarios where this support is needed.

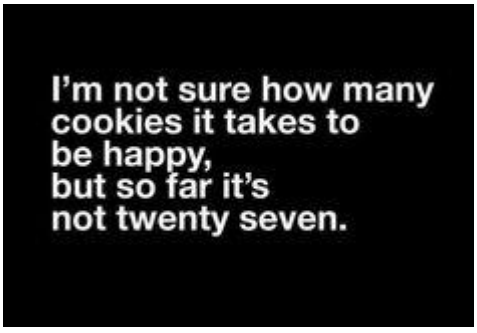
Physical and emotional exhaustion. Clinicians are working long hours, with the additional burden of a highly contagious virus that is overwhelming the health care system. Additional requirements of adequate PPE, appropriate donning and doffing, and awareness of new protocols instituted by their facilities all contribute to this exhaustion. In fact, emotional exhaustion is one of the primary symptoms of burnout.

Compassion fatigue. When clinicians are constantly bombarded with traumatic events (i.e., critically ill patients), the ability to empathize diminishes over time; HCPs have given all of themselves and cannot give anymore. Compassion fatigue, a.k.a. secondary traumatization or vicarious traumatization, is caused by the stress of caregiving work, and may lead to the following: blaming others, bottling up emotions, isolating from others, substance abuse, feelings of apathy, and recurring nightmares or flashbacks. It is easy to see how this phenomenon can readily cause one to decompensate into a state of PTSD or severe depression.

Moral injury. When clinicians are prevented from doing the right thing because of restrictions on their autonomy, lack of resources, or financial restrictions, they suffer a violation of integrity. As caregivers, HCPs put patients first, and when they can't do that, they suffer distress, often in the form of moral injury. While the concept of moral injury isn't new, the pandemic's anguish has heightened its impact on those practicing medicine.

Considering all the challenges of health care today, it becomes obvious that there is a great need for the emotional support of our HCPs. Some very significant systems issues need to be addressed, but this will require a major shift in the way we currently practice medicine. In the meantime, our clinicians must receive assistance to transition through this period. Peer support (along with coaching and other mental health services) needs to be available to our HCPs. The stigma of seeking emotional support needs to disappear, and the culture of medicine must change. Although wellness initiatives have been woefully inadequate for our HCPs, now is the time to invest in this valuable resource. If not now, when?

Susan Wilson is an emergency physician and physician coach.



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DINING WITH THE DOC: TUSCAN RIBOLLITA

Thefoodiesphysician.com

Ribollita is a traditional centuries-old Tuscan soup that is made with vegetables and beans and thickened with bread. It is said that the dish originated in the Middle Ages when servants were given leftover scraps of bread. To make a substantial meal from it, they would boil it in water with whatever inexpensive ingredients they had, such as vegetables and dried beans. And so ribollita was born.

The word "ribollita" actually means "reboiled" and it comes from the fact that traditionally, the soup is made from reboiling leftover vegetable soup the next day with the addition of bread. The process of reboiling the soup thickens it and makes it heartier. It also concentrates the flavors, so it is commonly said that ribollita is even better the next day.

Although every Italian cook probably has their own version of ribollita, almost all of them contain a mixture of inexpensive vegetables, cannellini beans and bread. While many versions contain cabbage and potatoes, the hallmark of the dish is cavolo negro or "black cabbage" also known as Tuscan kale. Tuscan kale, with its deeply wrinkled dark green leaves, has a mild flavor and sturdy texture which stands up well in this soup.

Because most of us don't have two days to make dinner, I've taken a couple of liberties with this recipe so that you'll be able to get it on the table in under an hour. I use canned beans instead of dried- if you have time, you can boil dried beans and then use some of the cooking water in the soup. Also, I add cubes of firm bread right at the end of the cooking process- this thickens the soup and the bites of bread are delicious as they soak up the flavors of the soup like a sponge.

This vegetarian soup is a hearty, stick-to-your-ribs dish that's filling and perfect for a cold winter's night. It's low in calories and fat and it gets a nice boost of protein and fiber from the beans and vegetables. Just one word of advice- you may want to double the recipe to make enough for leftovers because it tastes even better the next day!

Tuscan Ribollita

A hearty Italian soup with humble origins, Ribollita is made with vegetables and beans and thickened with leftover bread.

Course: Soup
Cuisine: Italian
Servings: 4

Ingredients

- 2 tablespoons olive oil plus extra for drizzling on top
- 1 large onion, chopped (1 ½ cups)
- 2 carrots, peeled and chopped (3/4 cup)
- 2 celery stalks, chopped (3/4 cup)
- 3 cloves garlic, thinly sliced
- 1/8 - 1/4 teaspoon red chili flakes (depending on how spicy you like it)
- Salt and pepper
- 1 tablespoon tomato paste
- 1 bunch (about 10 oz) Tuscan kale, chopped (stems and ribs removed)
- 1 can (14.5 oz) diced tomatoes
- 4 cups low sodium vegetable or chicken stock or water
- 4-5 sprigs fresh thyme
- 1 bay leaf
- 1 parmesan rind*
- 1 can (15.5 oz) cannellini beans, drained and rinsed
- 2 cups cubed, firm bread such as ciabatta, whole wheat or multigrain loaf
- 2 tablespoons grated parmesan cheese

Instructions

1. Heat the olive oil in a wide based pot or Dutch oven over medium heat. Add the onion, carrot, celery, garlic and chili flakes and cook 7-8 minutes, stirring occasionally, until partially softened. Season the vegetables with salt and pepper. Add the tomato paste and cook another 1-2 minutes until fragrant. Stir in the kale and cook until it starts to wilt, 3-4 minutes. Add the diced tomatoes, stock (or water), thyme, bay leaf and parmesan rind and raise the heat to bring to a simmer.
2. Meanwhile, pour about ¼ of the cannellini beans into a small bowl with a couple of tablespoons of the cooking liquid and mash them together with a fork to form a paste. Pour the paste along with the remaining whole beans into the soup and stir to combine. The mashed beans will help to thicken the soup as it cooks. Simmer the soup with the lid slightly ajar, about 25 minutes until the vegetables are softened but still al dente. Add the bread and simmer another 5-7 minutes, partially covered. The bread will start to dissolve into the soup and thicken it further.
3. Before serving, remove the thyme sprigs, bay leaf and parmesan rind. Adjust seasoning with salt and pepper. Spoon the ribollita into bowls and top with parmesan cheese and a drizzle of olive oil, if desired.

Recipe Notes

The soup thickens as it sits and should not be very liquidy. If you prefer more liquid, feel free to add more water at the end.

*Adding the rind of a block of parmesan cheese is a traditional Italian method of adding flavor to soups. The next time you buy fresh parmesan cheese, you can reserve the rind which is normally discarded. Wrap it in plastic wrap and store in the freezer to use in dishes like this. If you don't have one, just add some extra grated parmesan cheese as a topping at the end.

These 2 Canadian Provinces are Getting it Right in the COVID-19 Pandemic

SARAH FRASER, MD

I recently returned from Northwest Territories, where I'd been working as a physician for six months. Now, back in Nova Scotia, I'm reflecting on what it's been like to have worked in areas of Canada with relatively few cases of COVID-19.

A large part of my work is hospital medicine. As the name implies, a hospitalist is a doctor who cares for patients admitted to the hospital. Often, we work seven days in a row, with a few of those nights being on call. Hospitalists care for patients with a variety of conditions. Examples might be pneumonia, heart conditions, or a broken hip.

In addition to my work as a hospitalist during the pandemic, I was also able to witness the approaches of two separate Canadian public health departments. Just like they do in different U.S. states, laws in Canada vary across provinces. In two particular Canadian provinces, Nova Scotia and Northwest Territories, there happened to be more similarities than differences. Here are some approaches that have worked quite well in both regions.

First, both locations have a mandatory two-week isolation period, and it is taken seriously. This is similar to the 7-day isolation period that the CDC instructs U.S. citizens to return from international travel. Before traveling to Yellowknife, I had to submit a self-isolation plan, and my documents were checked upon arrival. Only essential workers were permitted in the territory. From the airport, I had to go directly to my hotel. My food was delivered to my door. Rule-breakers received fines in the thousands of dollars.

I have now completed my two weeks of self-isolation back in Nova Scotia, where the rules are very similar. At Halifax Stanfield International Airport, I had to give my email address. On a daily basis, I had to check-in online to report any symptoms. Northwest Territories had a comparable online check-in system.

In both places, testing is very accessible. Nova Scotia Infectious Disease leaders made headlines in recent months after opening pop-up test sites. A Halifax nightclub was converted to a test site one night for people who were out downtown.

In both Nova Scotia and Northwest Territories, public health leadership is strong. Dr. Kami Kandola and Dr. Robert Strang are examples of excellence as Chief Medical Officers of Health. They are role models. Their efforts strengthen trust and organization down to the levels of hospitals and communities. Early on in the pandemic, while working as a hospitalist in Antigonish, I witnessed the physicians, nurses, and staff working tirelessly and collectively to prepare for the unknown. In Yellowknife, my colleagues took the pandemic very seriously even though there were usually no cases. They went above and beyond to advocate for their patients.

In Yellowknife, an Indigenous elder taught me about the importance of traditional knowledge and the link between health and the land in his culture. Some Indigenous communities in the territory responded to the pandemic by building on traditional knowledge such as hunting and fishing. This would help ensure safe food supplies if the pandemic resulted in the halting of goods coming in. This intelligent approach is on the backdrop of a tragic history.

In 1928, a decade after the 1918 flu pandemic, the Hudson Bay Company's ship, the SS Distributor, brought supplies up the MacKenzie River. The company also brought a particularly deadly form of the flu, killing up to 15 percent of the territory's Indigenous population. The 1918 flu is estimated to have killed at least 3,200 Indigenous people in the United States. Indigenous communities across Canada and the United States have suffered greatly during previous pandemics. This is not forgotten in Canada's north, and it should not be forgotten elsewhere.

Days before departing from the Northwest Territories, I learned that Air Canada, Canada's largest airline, had stopped their passenger service to Yellowknife, so my flight was switched to another carrier. This meant my trip back to Nova Scotia took place over the course of three days. As I boarded my flight to Edmonton, Alberta, my sense of alertness was heightened. In Toronto, I didn't leave my hotel room. Once on the plane to Halifax, I didn't take my mask off the entire time, not even to take a sip of water. (I recognize that was likely overly strict. Given what we know so far, the risk of catching COVID-19 on an airplane is probably low). But I felt a strange sense of ease and

safety when I looked out my airplane window to see my home province.

The excellent pandemic management in these two regions of Canada does not mean we remain unaffected. In both Nova Scotia and Northwest Territories, the hospitals have visitor restrictions. It is heart-wrenching when patients cannot see their loved ones in person, especially during their final hours. Non-urgent appointments and surgeries were postponed, and sometimes patients' medical conditions worsened as a result. Many clinics have shifted to provide more virtual care. While this has some benefits, there are also many challenges.

According to the territorial government website, Northwest Territories had an increase in alcohol-related medical visits from May to July in 2020, compared with 2019. Despite low numbers of COVID-19 cases, anxiety and depression rates for Nova Scotians during the pandemic have been among the worst in the nation. Worsening mental health and substance use outcomes during the pandemic are something we're seeing widely, including in the U.S.

Public health officials do not have an easy job. They are often the victims of bullying and even threats. A man from Alberta is being charged with threatening Dr. Kandola, for example. Dr. Strang has received personal threats as well.

Last march, Canada closed its entire border to the U.S. (excluding the movement of essential goods and some essential workers) for the first time in history. Prime Minister Trudeau has claimed that the Canada-U.S. border will not be reopened until the pandemic subsides globally.

With the United States leadership changing hands, I hope that the U.S. government and community members alike support public health officials and listen to the science. As we grapple with our losses and the general changes that our society and our world has faced this past year, I have been privileged to work in two regions of Canada where the public health leadership is strong, and so are the people.

Sarah Fraser is a family physician who can be reached at her self-titled site, Sarah Fraser MD. She is the author of Humanities Emergency.

10 Reasons Why Beneficiary Designations Are Important

Beneficiary designations can provide a relatively easy way to transfer an account or insurance policy upon your death. However, if you're not careful, missing or outdated beneficiary designations can easily cause your estate plan to go awry.

We often complete these designations without giving it much thought, but they're actually important and deserve careful attention. Here's why: Beneficiary designations take priority over what's in other estate planning documents, such as a will or trust.

For example, you may indicate in your will you want everything to go to your spouse after your death. However, if the beneficiary designation on your life insurance policy still names your ex-spouse, he or she may end up getting the proceeds.

Where you can find them

Here's a sampling of where you'll find beneficiary designations:

- Employer-sponsored retirement plans [401(k), 403(b), etc.]
- IRAs
- Life insurance policies
- Annuities
- Transfer-on-death (TOD) investment accounts
- Pay-on-death (POD) bank accounts
- Stock options and restricted stock
- Executive deferred compensation plans

Because you're asked to designate beneficiaries on so many different accounts and insurance products, it can be difficult to keep up. However, it's worth the effort; failing to maintain the beneficiary designation on that 401(k) from three employers ago could mean money will go to the wrong place.

When you first set up your estate plan, go over all the designations you previously made and align them with your plan. After that, you should review and update them regularly – a least once a year.

10 tips about beneficiary designations

Because beneficiary designations are so important, keep these things in mind in your estate planning:

1. **Remember to name beneficiaries.** If you don't name a beneficiary, one of the following could occur:
    - The account or policy may have to go through probate court. This process often results in unnecessary delays, additional costs, and unfavorable income tax treatment.
    - The agreement that controls the account or policy may provide for "default" beneficiaries. This could be helpful, but it's possible the default beneficiaries may not be whom you intended.

2. **Name both primary and contingent beneficiaries.** It's a good practice to name a "back up" or contingent beneficiary in case the primary beneficiary dies before you. Depending on your situation, you may have only a primary beneficiary. In that case, consider whether a charity (or charities) may make sense to name as the contingent beneficiary.

3. **Update for life events.** Review your beneficiary designations regularly and update them as needed based on major life events, such as births, deaths, marriages, and divorces.

4. **Read the instructions.** Beneficiary designation forms are not all alike. Don't just fill in names – be sure to read the form carefully.

5. **Coordinate with your will and trust.** Whenever you change your will or trust, be sure to talk with your attorney about your beneficiary designations. Because these designations operate independently of your other estate planning documents, it's important to understand how the different parts of your plan work as a whole.

6. **Think twice before naming individual beneficiaries for particular assets.** For example, you establish three accounts of equal value and

name a different child as beneficiary of each. Over the years, the accounts may grow unevenly, so the children end up getting different amounts – which is not what you originally intended.

7. **Avoid naming your estate as beneficiary**. If you designate a beneficiary on your 401(k), for example, it won't have to go through probate court to be distributed to the beneficiary. If you name your estate as beneficiary, the account will have to go through probate. For IRAs and qualified retirement plans, there may also be unfavorable income tax consequences.

8. **Use caution when naming a trust as beneficiary.** Consult your attorney or CPA before naming a trust as beneficiary for IRAs, qualified retirement plans, or annuities. There are situations where it makes sense to name a trust – for example if:
   - Your beneficiaries are minor children
   - You're in a second marriage
   - You want to control access to funds

   Even in cases like these, understand the tax consequences before you name a trust as beneficiary.

9. **Be aware of tax consequences.** Many assets that transfer by beneficiary designation come with special tax consequences. It's helpful to work with an experienced tax advisor, who can help provide planning ideas for your particular situation.

10. **Use disclaimers when necessary — but be careful.** Sometimes a beneficiary may actually want to decline (disclaim) assets on which they're designated as beneficiary. Keep in mind disclaimers involve complex legal and tax issues and require careful consultation with your attorney and CPA.

Next steps

- When creating, updating, or simply reviewing your estate plan, pay attention to your beneficiary designations.
- Remember, beneficiary designations take precedence over what you may have specified in a will or trust.
- Put a reminder on your calendar to check your beneficiary designations annually so you can keep them up-to-date.

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Six of the Coolest New Medical Gadgets on the Market

Meet the latest generation of medical tech toys

By **Dr Robert Turner**

Tech is becoming pervasive in almost every aspect of our lives and in some areas it's not so welcome. Medicine, however, benefits hugely and inevitably, the biggest winners are the patients. Here is a quick look the latest gadgets, either fresh off the shelf, in production, or in development.

6. Can Your Smart Watch do this?

Researchers at the UCLA Samueli School of Engineering and the Stanford School of Medicine have developed a smartwatch that uses electrochemical analysis to track levels of a drug in the body by analyzing a patient's sweat.

The watch works by stimulating sweat glands in the underlying skin through an electric current. The device can then analyze the sweat and can identify the electrochemical signature of specific drugs using a voltammetric sensing interface. The result is real-time continuous measurement of drug levels. -

"This technology is a game-changer and a significant step forward for realizing personalized medicine," said Ronald W. Davis, a researcher involved in the study.

"Emerging pharmacogenomic solutions, which allow us to select drugs based on the genetic makeup of individuals, have already shown to be useful in improving the efficacy of treatments. So, in combination with our wearable solution, which helps us to optimize the drug dosages for each individual, we can now truly personalize our approaches to pharmacotherapy."

You can read more about the research behind the project here. Noninvasive wearable electroactive pharmaceutical monitoring for personalized therapeutics

5. Meet Thinklabs One, a Covid friendly Stethoscope

We're not too sure about this one. Nothing says, "Trust me, I'm a Doctor" quite like a stethoscope dangling around your neck. It is however pandemic season and given that, this redesign of the classic stethoscope may just take off. It also kicks some serious butt when it comes to amplification and the Thinklabs One is a lot more than just a stethoscope.

One of the devices patients immediately associate with check-ups is the stethoscope – a tool not only for assessment, but for bringing a sense of connection between doctors and patients. Thinklabs Medical has created leading electronic stethoscope technology, which the company believes has helped mitigate the spread of COVID-19.

Clive Smith, the CEO and Founder of the company, was the inventor behind designing the electronic stethoscope: Thinklabs One, the company claims, is the smallest and most powerful stethoscope in the healthcare industry with over 100X amplification, compared to a typical acoustic stethoscope. Since it has a standard headphone jack, small off-the shelf Bluetooth transmitters can be used to connect to it and beam auscultation sounds from the patient to the doctor's headphones.

During the ongoing pandemic, the two can stay at a distance from each other while the physician guides the patient where to position the puck-like stethoscope on the body, all while wearing headphones and listening to the results. The product is obviously perfect for telemedcine and pandemic scenarios and even hooks into your smartphone via an app. Brilliant.

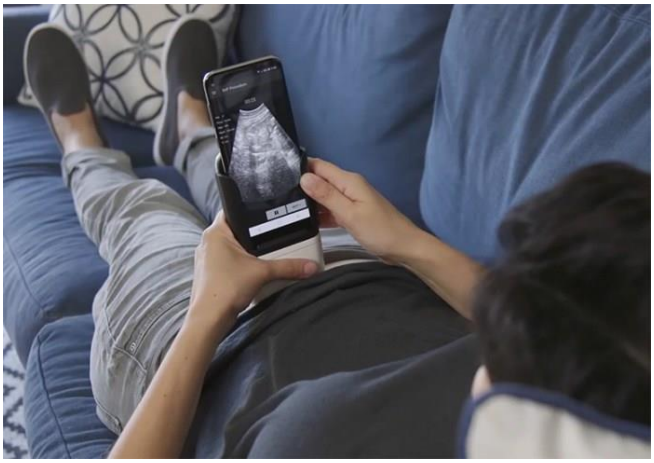
In terms of specifications, this high end piece of simplified tech really delivers.

- Amplification: More than 100x
- Audio Filters: 5 bandpass filters
- Display: Volume, filter, battery LED scale
- Output signal level: Low impedance headphone driver, 3V p-p
- Power input: 5V DC (USB charger compatible)
- Power source: Internal lithium ion cell
- Battery Capacity: > 120 patient exams per charge (2 minutes per patient)
- Transducer: Thinklabs' patented electromagnetic diaphragm
- Connector: 4-conductor 3.5 mm jack
- Dimensions: 46mm x 28mm
- Weight: 50 g

This post is too short to do the Thinklabs One justice and we highly recommend stopping off at the Thinklabs site to learn more or to order the stethoscope. It is one of the few items in this list that is already commercially available.

4. With Baby? An at home Ultrasound Device for moms

If you're an Obgyn this one's for you! PulseNmore At-Home Tele-Ultrasound for Pregnant Women has just launched and we love it. How are you not going to spend the entire day on the couch at home taking ultrasound selfies? Obviously, there are a huge range of mediclal benefits to the product as well.



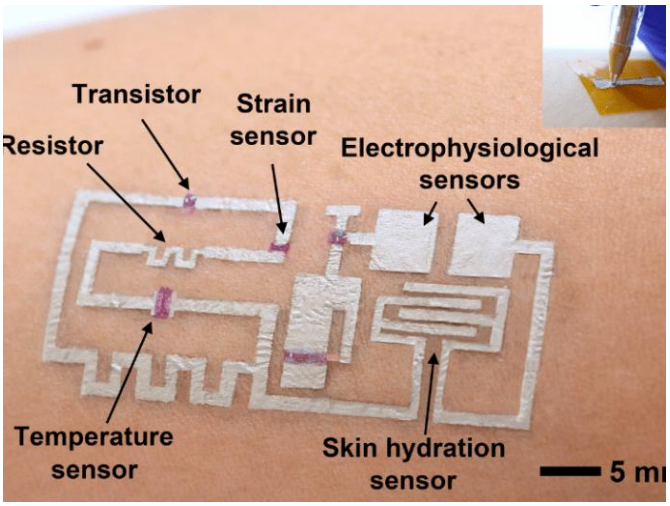
A new device has just been unveiled by PulseNmore, an Israeli firm, that allows patients to perform ultrasound exams themselves and share the results immediately with their sonographers or physicians.

The device is a dock for a smartphone, the bottom being the ultrasound transducer. An app on the smartphone provides training and guidance to the patient so that a scan is performed to achieve high-quality results. Captured images are then shared with the patient's clinical team and those can be used to guide further decisions.

The people behind PulseNmore hope that the new tele-ultrasound will help clinicians to provide optimal care for their patients while reducing the chance of viral transmission. Israel's largest HMO, Clalit Health Services, which has over 4 million members, has signed a contract to provide tens of thousands of PulseNmore devices to pregnant women under its management.

3. Tron 2.0. Never mind wearing tech, now we can embed it on the skin.

Okay, so you cant buy this to use at home, not yet anyway, but if you don't think this is awesome, then you probably shouldn't be reading this article. Drawing Biomedical Electronics directly onto skin is rapidly becoming a reality and will be lifesaving for some patients.



A team of researchers at the University of Houston has developed a way to simply write electronic circuits, including different kinds of body sensors, directly onto the skin. Using this approach, the scientists have created fully functional sensing systems that can measure, with great accuracy and few artifacts, things

such as skin hydration, electrophysiological signals, and body temperature.

Other sensors still need to be developed using this technique, but once they're designed there should simply be a template that the user can follow to generate new ones.

The data obtained using the new sensors seem to be almost completely unaffected by movement, potentially allowing, for the first time, the gathering of highly accurate biomedical data when individuals are performing strenuous physical activities.

One more potential use of this technology is on and around wounds. Running electricity through the inks helps to speed up healing, something the University of Houston researchers have already demonstrated in experiments. Color us impressed. Follow the progress of this amazing team via the University of Houston website

2. Nothing says you've arrived quite like own portable CT Scanner

Wheel this bad boy into a patients room to really make an impression. Siemens' Somatom On.site portable CT head Scanner has just been FDA cleared. The device can be easily brought directly into patient rooms thanks to its powered wheels and an on-board battery. It evens features inbuilt cameras for parking and hallway navigation!

Normally, patients have to be moved to the CT scanner, wherever it may be in the hospital. With the SOMATOM On.site, patients that need head scans do not have to be unnecessarily disturbed, reducing the potential for injury and further aggravation of a condition during transport. Moreover, since only one person is required to move the new CT scanner from room to room, fewer clinical staff are tied up than when moving a bedridden patient.

On the front of the scanner there's a built-in camera that lets the person moving it see what's ahead, helping to avoid people and objects on the way.

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"The SOMATOM On.site transforms the delivery of care for critically ill patients who require a CT head scan," said Douglas Ryan, VP of Computed Tomography at Siemens Healthineers North America, in the announcement. "The system delivers reliable and consistent image quality demanded by healthcare professionals in the ICU, neurology, and radiology departments. Additionally, bedside imaging helps to reduce patient transports, thereby reducing the risk of infection while improving workforce efficiency."
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Why Creative Endeavors are Important for the Future Surgeon

THOMAS L. AMBURN

As an aspiring surgeon, I at times contemplate whether being creative has any effect on my future career. On one hand, if you see surgery as an "art," then possibly a creative personality is beneficial.

On the other hand, surgery often seems objective and clear-cut, qualities often deemed uncreative. Perhaps even my goals of surgery and my interests in artistic creation are independent, noncommunicating personality features that are unrelated and unimportant to each other. Although it may seem that being artistic is unusual for a surgeon at first, the reality is that creativity and surgery are undeniably connected. The result is one affecting the other and vice versa, like the frames of a ladder linked by its steps. Together, they allow a surgeon to continually grow in their craft and attain even greater heights.

Unsurprisingly, a surgeon is extremely attentive to precision and detail. Whether during a lipoma resection or a heart transplant, surgery has risks that range from injury to surrounding structures to anesthetic complications and more. Every aspect of the operation must be fine-tuned and closely monitored. In a similar fashion, yet without life-altering risks at stake, art often draws upon and forces such intent from the artist. Writing a poem requires a keen attention to word usage and understanding that each sound, syllable, and meaning compiles into the composite creation. A painting is a result of individual markings conglomerating into a complete image. Regardless of the art, you will find an artist who has spent the grueling hours of attentive exactness to bring it into life. The dedication of perfection is what produces a result that is clear and effective.

Such focus and precision also introduces another quality that is key to the surgeon and artist alike, which is perseverance. Once a surgery starts, there is no turning back without seeing it through. Just because a surgeon may become frustrated or tired does not allow them to simply be done. Instead, choices must be made, and the operation must be completed. Much like the surgeon, an artist also pulls upon this patient perseverance even through the worst of performances. Regardless of exhaustion or even mistakes, the artist must continue. A scratchy or pitchy note is no excuse for a violinist to pack up and leave. Or a missed queue in theater does not mean the curtain must be drawn. The show must go on despite personal discomforts and preferences.

Core to this steadfast dedication of both the artist and the surgeon is practice. No amount of innate skill compensates for a lack of rehearsal of a technique. Even the most brilliant minds disservice themselves if the time and effort is not made to practice their chosen craft. For the artist, practicing comes in the form of long hours of not only repeating certain skills but also reflecting on areas of improvement. However for the surgeon, the practice of surgical skills is similar but requires extensive supervision given the risk that errors can have. Established surgeons guide and teach their trainees as they gradually grow and reinforce their repertoire of surgical knowledge. A skillful surgeon is the product of practice defined by years of attentive effort while identifying mistakes to prevent in the future.

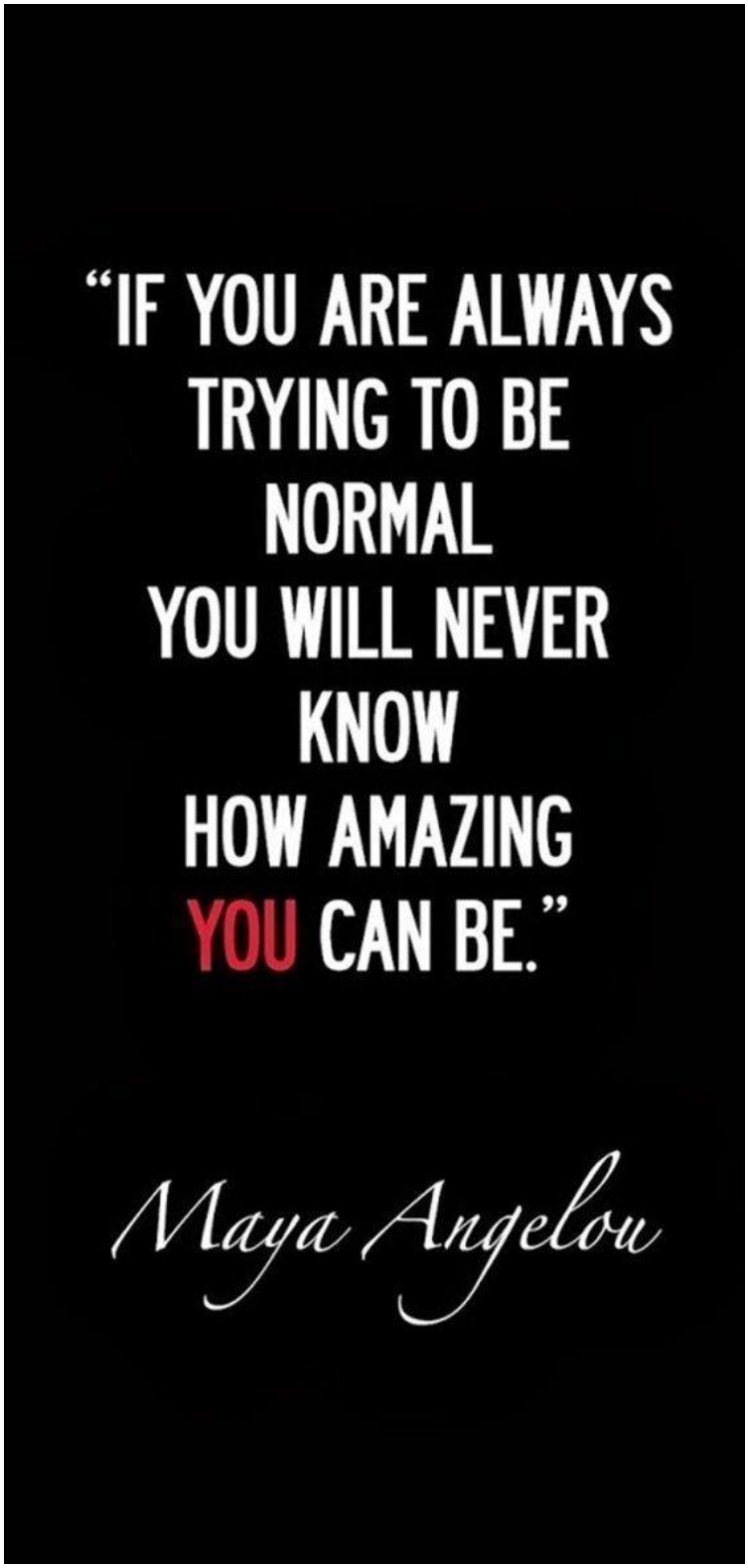
Perhaps being artistic might help the future surgeon in being patient, perseverant, and dedicated to precision. However, the creativity involved in arts has an even greater impact on their fluid thinking and problem-solving skills. Central to creativity is the ability to take what is known and synthesize something original. Consider an art such as abstract painting. The subject may be just a living room, but through the artist's work, they create something extraordinary and unseen before. However, in medicine, creativity takes on a different appearance. Research is a great example of creativity as it continually devises new ways to build upon the known to elucidate the unknown. Even the surgeon requires creativity in the operating room. Regardless of extensive training, there is always something unexpected, whether that be anatomical variants or unforeseen complications. In those unpredicted moments, a surgeon must utilize their adaptive knowledge and find a solution quickly. Such a skill departs from the conventional knowledge of a textbook and enters the realms of creativity.

Yet equally important, being creative in surgery could likely make a more humanistic surgeon. Although procedures are often rather objective and direct, a surgeon must also become a master communicator

while connecting with vulnerable, anxious patients. It is frightening for any patient to enter the operating room, but having a personable surgeon builds trust in the patient-provider relationship. Using art to help a surgeon become more humanistic is not surprising though. Art exists because a person considered what is a human experience and how to best portray that. Then the result was a connection with other people experiencing that artist's perspective. Having a surgeon that already exercised these empathic and sociable skills is an undeniable strength.

Finally, creativity has an importance to the future surgeon that lies outside just the intertwining of art and surgery. The arts give people an "out" from the daily grind and distract from the stressors in life. Surgical residencies and careers have the infamous reputation of being time-consuming and extremely rigorous. Both the personal creation and the enjoyment of creative endeavors have a role in reducing burnout and frustration. Although arts and creativity are no substitutes for mitigating harsh work environments, for many, they could help ease personal stress while practicing surgery. Even the surgeon, as dedicated and hard-working as they are, deserves to enjoy life.
To the future surgeon, consider how creativity could improve yourself and your career. Find ways to be creative in medical school and reflect on how creativity enhances your future contributions to surgery. Both art and surgery benefit each other because ultimately, the aim is simple and the same – creating a human connection through the perfection of a craft.

Thomas L. Amburn is a medical student.



The Training of the "Helpless" Physician

by Charles Bond, Esq

Each year medical schools turn out well-trained doctors, highly skilled and competent in every phase of practice -- except surviving economically. Medical training programs do not provide young physicians basic information about doctors' options in the workforce -- for example, the pros and cons of private practice vs employment -- nor is there any effort to explain to them the larger economic forces at work in healthcare in the United States, so physicians do not understand the competitive forces that are shaping today's radically changing economic climate. One attempt to institute a seminar-style course in "real-world" healthcare economics at a major State University School of Medicine was met with a refusal to fund even the modest travel stipends for the national experts lined up to teach the course. Also, disillusionment with the realities of the profession is not limited to our broken healthcare system. For the first time in its history, McGill University School of Medicine, Montreal, Quebec, Canada, is experiencing fourth-year students dropping out after being exposed to real-world medicine in their preceptorships.

Few American physicians -- young or old -- understand that in the last 15 years healthcare economics have been radically changed. Physicians have largely abandoned the pure fee-for-service model that has been the economic cornerstone of Western medicine since Roman times. In its place doctors now contract with health plans for rates negotiated in bulk under so-called "managed care" plans. Economically, there can be no greater change in a personal services industry than changing how people get paid; yet medical students, residents, and fellows are provided virtually no education on the nature or implications of this profound change. The need for such practical education has never been greater.

In the meantime, while taking advantage of physician's failure to comprehend and respond to these economic changes, health plans across the country have systematically merged into huge monolithic companies and have converted from nonprofit to for-profit status. According to Fortune Magazine, there are 7 healthcare insurance and managed care companies in its 2006 "Top 500" list, generating revenues of over $212 billion. As a result of the for-profit consolidation of the health plan industry, the well-being of health plan profit margins for shareholders must now compete with the well-being of patients' health.

Just as health plans have merged over the last decade, hospitals, too, have aligned. Most local markets now have just 1 or 2 hospital systems that have complete control over these markets. Many of these systems are generating significant net revenues and behaving like for-profit companies despite their tax status as charities. Meanwhile, in the face of these ever-consolidating markets, doctors remain locked in a cottage industry model. The latest available statistics have shown that 82% of physicians practice in groups of 9 or fewer.[1] Doctors, having received no training in adapting to the current market conditions that are occurring rapidly around them, are ill-equipped to function in this radically changed economic -- and ethical -- landscape. These changes unavoidably are undermining the very core of the physician-patient relationship.

In place of old-fashioned fee-for-service medicine in virtually every medical market in America, the economic lifeblood of today's medical practice depends almost entirely on contracts. Almost all of a physician's private patient flow depends on his or her contractual relationships: Private patients are provided either under an employment contract with an employer or they come into the practice through a contract between the physician and a health maintenance organization (HMO) or preferred provider organization (PPO). However, few young physicians are trained in how to analyze contracts, or when, where, and how to get the appropriate help with their contracting relationships. Instead, unfortunately, they are blithely following the model of older physicians who literally signed away fee-for-service medicine and continue, for the most part, to accept what health plans offer without significant legal or economic scrutiny.

As for nonprivate patients, 36% of the average physician's patient base is paid for by the federal and state government, yet no medical training program offers a practical course in coping with Medicare and

Medicaid regulations and claims procedures. Nor is there any medical school training about the practical implications and economic ramifications of treating the 45 million Americans without any health insurance.

Beyond the basics of medical economics, young physicians are generally not introduced to the regulatory and political environment in which they will have to practice. Although most trainees quickly comprehend the concept of malpractice, few appreciate the impact of interlocking laws that require reporting and disclosure of any malpractice claim or disciplinary investigation. The tight web of mandatory reporting requirements runs from every hospital and state licensing board to the National Practitioners' Data Bank and is reinforced by self-disclosure requirements on virtually every professional application. ("Have you ever been named in a lawsuit or been the subject of disciplinary investigation" is a typical question on such applications.) The combined effect of reporting and disclosure means that any black mark on a doctor's record -- even the disclosure of a mere unproven allegation -- can deprive the doctor of economically valuable advantages, such as hospital privileges, employment, or participation in a managed care plan. Understanding the power of this reporting network, including the possibility of its abuse, should be an essential part of every doctor's preparation for the real world.[2]

The foregoing are but a few examples of the practical areas not addressed by medical training. More insidiously, however, medical training is inculcating a culture among physicians that may be deepening their woes and contributing to the decline of the profession.

Training "Helplessness" Instead of Resilience

Modern psychological theory has focused on how individuals can be trained to be "helpless" and how that feeling of "helplessness" contributes to a sense of depression and isolation.[3] Helplessness can be trained into individuals when, regardless of repeated best efforts that should be rewarded, no reward is forthcoming; as a result, the individual eventually learns to give up and sinks into a lonely feeling of futility and malaise. It would appear that collectively the medical 33profession has mastered this art and is suffering the symptoms en masse.

Unfortunately, medical training is helping to create the foundation for the profession's helplessness. Regardless of the new limitations on work hours, conditions in many training programs remain reminiscent of medieval, monastic, ascetic orders. Self-deprivation -- especially sleep deprivation -- continues to be viewed as a necessary virtue, especially during subspecialty training. Learning is still most often imposed on the basis of the model of strict authoritarian discipline, with a high degree of emphasis on shame and fear of failing. Good patient care is so expected of trainees that it is rarely rewarded. Residents' pay is usually set at bare subsistence levels or below, so there is no financial reward for the hard work of medical training, and indeed most medical graduates emerge with huge school loan debts.

Psychologically, young physicians often expect residency and fellowship to be the crowning experience of their long educational path. Since they were 5 years old, these young people were told that they were the brightest and the best, a message that was socially reinforced as they successfully progressed through school, college, and medical school. Everything about their experience reinforced their belief in the Puritan work ethic: If you work hard and do well, you will be rewarded -- until they reach residency, a point at which rewards are so few and far between that they begin to believe that if they work hard and do well they will be resented.

Young physicians become so well trained in deferring gratification that many give up on ever getting any meaningful rewards for their sacrifices. With their resilience worn away, many just give up the fight. A dispirited acceptance of one's individual fate seems to be the dominant mood of physicians nowadays rather than a motivated mobilization toward a better lot for the individual practitioner and the profession as a whole. Most doctors focus so hard on trying to provide good patient care -- ie, taking care of others -- that they forget, or have no energy, to take care of themselves. Thus, when some doctors propose positive collective action, they are usually quickly quieted by a few naysayers whose negativity taps into the helplessness learned so well during medical training. The progress of the profession is being effectively paralyzed by its own failure to teach leadership and the skills of self-survival.

Consequently, physicians have lost the social contract or bargain that medicine used to have with America. As

Paul Starr observed in The Social Transformation of American Medicine, the previous generation of physicians traded years of their earning power to become highly trained, in exchange for significantly higher income and enhanced social status. With physician earnings plummeting over the last decade, it is clear that the medical profession no longer enjoys the benefit of such a bargain.

These changing socioeconomic conditions are undeniable, yet medical education has not adapted one iota. Virtually none of the training programs in the country offer 20 seconds of business administration or modern medical economics. The rigors of medical training prevent young physicians from acquiring economic survival skills on their own. Instead, medical training effectively places young doctors in a "cocoon," shielding them from the lessons of the real world. While residents and fellows are going through their training, their young nonmedical contemporaries are out in the world making little mistakes with little amounts of money. Meanwhile, residents and fellows are working all the time, living on subpar wages, and amassing mammoth debt from student loans.

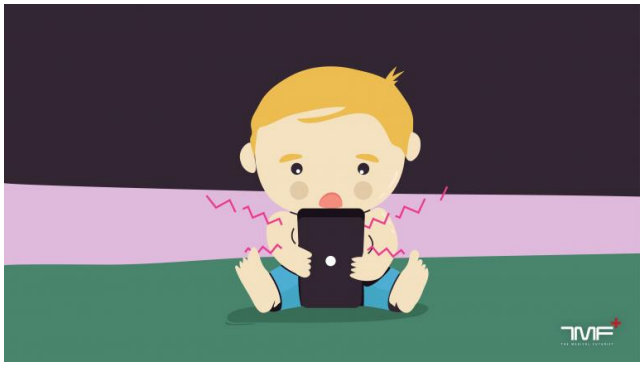
So training programs are sending forth untutored and unprepared graduates. Instead of teaching physicians the more businesslike approach of relying on deliberate due diligence and seeking the advice of experienced and qualified advisors, physicians are more inclined to make independent life-or-death decisions that are based on the rapid assessment of a situation and to go it alone and shoot from the hip on the basis of their best instincts. After all, that is how they have been trained to diagnose and treat.

Is this the model for training bold and competent leadership in our most important profession, or are we damning these young people to a future that will thrust them unprepared into a battle for the very survival of the medical profession -- a battle in which the stakes are whether our healthcare will be dominated by profit or by patient need -- a battle that will surely profoundly affect our lives and the lives of the ones we love?

References 1. Bond C. Editorial in response to "what is sham peer review?" MedGenMed. 2005;7:48. Available at: http://www.medscape.com/viewarticle/515869 Accessed August 22, 2007. 2. Casalino LP, Devers KJ, Lake TK, Reed M, Stoddard JJ. Benefits of and barriers to large medical group practice in the United States. Arch Intern Med. 2003;163:1958-1964. Available at: http://archinte.ama-assn.org/cgi/content/abstract/163/16/1958 Accessed August 22, 2007. 3. Peterson C, Maier S, Seligman S. Learned Helplessness: A Theory for the Age of Personal Control. New York: Oxford University Press; 1993. Authors and Disclosures Charles Bond, Esq, Health Law and Appellate Attorney; Strategic Planner; Policy Advisor, Physicians' Advocates, Berkeley, California

Generation Q(uarantine): Children of The Pandemic

Courtesy of medicalfuturist.com



A child, who is now 10 years old has spent one-tenth of his/her life in quarantine, away from grandparents, friends, school, sports and other activities. This has a devastating effect on their social, physical and mental development. More than a quarter of children (aged 5–16 years) reported disrupted sleep. 18% of kids in the UK with probable mental health problems felt fearful of leaving the house because of COVID-19. COVID-19 became the monster under the bed – and it's likely to stay. No wonder these kids are already being dubbed as **Generation Q – as in quarantine**.

COVID-19 has put a spotlight on existing problems that some call the biggest pandemic issue we face today: mental health.

The fears implanted by the virus are going to be embedded into this young generation. We can't even begin to think about how it will turn out when they grow up. Will they be more fearful? Less independent, less brave, or right the opposite, will they become more resilient? Studies are in the making, but what is certain is that this generation has way too much on their shoulder.

A worldwide scale of anxiety, loneliness and fear that had been there before added up, and investigation found rise in school safeguarding reports, eating disorders and sleeping pill prescriptions. Parents struggle to get help, and, as a social worker in the UK put it "*everybody feels anxious at the moment. You don't want that to develop into anything more sinister for a young person*." And without help, these kids have the chance to deteriorate.

Help is hard to come by

Despite the fact that governments know of the impending issue of children being unable to cope with the aftermaths of the pandemic, with vaccinations and economic struggles on their minds, these issues are most likely not on the top of their agenda. Small-scale solutions are, however, popping up. Even though they don't reach too many children (like this teacher who wrote a children's book about COVID-19 while in quarantine), they are steps into the right direction.

"*By April last year, the pandemic had disrupted education for around 90 per cent of the world's school-age children. An unprecedented 1.4 billion students were shut out of schools in 192 countries*" – wrote advocacy NGO Human Rights Watch in a report. And those who had access to technology were considered lucky, as, according to the same report, "*more than a third have no access to remote education because they have not been provided with the tools or support to continue learning from home*."

The ups and downs of technology

Technology was at hand to help kids participate in online classes, do exercise and stay social. But that didn't always turn out right.

As UNICEF pointed out, "*while technology and digital solutions provide significant opportunities to keep children learning, entertained and connected, these same tools may also increase their exposure to a myriad of risks. Even before the pandemic, online sexual exploitation, harmful content, misinformation and cyberbullying all threatened children's rights, safety and mental wellbeing."*

Key recommendations to mitigate the effects of COVID-19 on children and their families

UNICEF recommendations

In their February 2021 statement, the agency put forward several milestones on how various stakeholders can step forward and protect children. Some of the key suggestions were

1) **For Governments:** train health, education and social service workers about the impact of COVID-19 on child well-being, including increased online risks;

2) **For the Tech Industry:** guarantee that online platforms have enhanced safety and safeguarding

measures for children as well as to increase investments in safe technologies and content that promote quality learning and skills building;

3) **For Parents:** help the children understand the risks presented by the Internet and digital technologies as well as be alert to signs of distress that may arise with online activity;

4) **For Schools:** grant children access to school-based counselling services.
If you want to know more about how children are exposed to these sometimes problematic technological developments, The Global Campus of Human Rights created an online course, where experts (from Edward Snowden to Dr Bertalan Meskó) are promoting a more ethical, human-centric, and accessible tech-infused future for our kids.

Child rights in healthcare

Children's rights were also compromised in healthcare systems. That is why a new organization called the European Children's Hospitals Organization (ECHO), representing leading pediatric hospitals across Europe, calls on children's hospitals and public health systems to ensure that the rights of children are central in the new normal of COVID-19.

As they mentioned in their study in The Lancet, "*as anchors of pediatric care in our communities, children's hospitals have a moral responsibility to ensure that the rights of children are protected and promoted in pandemic response planning. This applies not only to the COVID-19 response but also to planning for future pandemics.*"

Netherlands-based international children's aid and advocacy organization KidsRights created their KidsRights Index 2020, and began with the statement "*around the globe, children's rights are seriously affected by the coronavirus outbreak.*" The organization also pointed out how under-funded child's issues are globally: "*The index shows that countries worldwide allocate insufficient budget for children's rights, specifically on domains such as protection, health and education."*

Swiss-based Terre Des Hommes created a worldwide survey to measure children's wellbeing during COVID. Their project, #CovidUnder19: Life Under Coronavirus is an initiative to meaningfully involve children in responses to the COVID-19 pandemic. 26,258 children from 137 countries responded to the survey – and the results are not surprising.

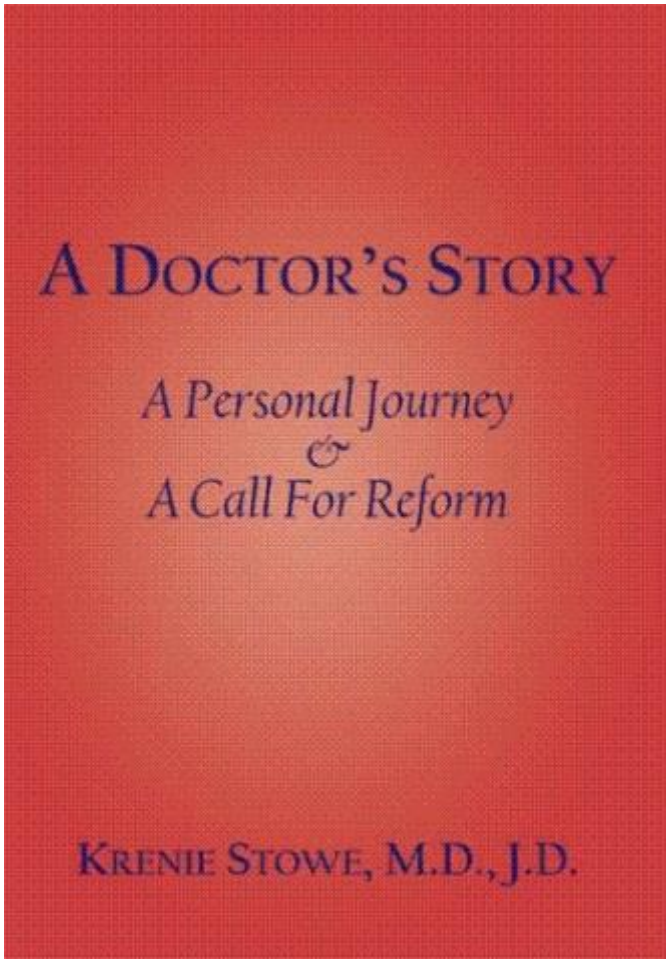
"I'm waiting when school will reopen so that I don't need to work,"
said a 13-year-old girl from India.

The pandemic had a major impact on children's experiences and rights. Beside feeling pressured from school tasks, respondents also spoke about missing physical closeness and hugging their family and friends, missing out on key milestones such as birthdays and graduation.

As the survey also served as a channel for children around the world to portray their thoughts and feelings about the pandemic to the world, they took the chance and put forward a couple of suggestions to governments. For example to provide reliable & accessible information and prioritize & invest in health.

Maybe it's time for us adults to start listening to them.

Focus on a Physician Biography



About the Book

A Doctor's Story uses the highly personalized narrative of one woman's educational and professional path to highlight shocking flaws in our profit driven medical delivery system. Employing moving anecdotes to illustrate glaring deficiencies in health care policy and delivery, and in medical training, the book takes a refreshing and distinct approach to a topic on the mind of virtually every American. Can we reshape our expensive, inefficient and inhumane health care system to meet the needs of all? The book is structured as an autobiography, so the discussion of policy is laced with humor, compassion, sarcasm and anger. It is, as the title states, a story, not a scientific study or research project. The book's premise is that real experiences of real people can speak volumes, and that one person can effect change.

About the Author

Dr. Stowe describes herself as "a mother and activist first, a physician and attorney second." Grounded in a lifelong commitment to social justice, she is a tireless advocate of sweeping health care reform. After graduating cum laude from Phillips Academy in 1977, she attended Yale, receiving her BA in 1981. She received her MD from Albert Einstein College of Medicine in 1985. Following a pediatric internship at New York University Medical Center, she attended Harvard Law School, graduating magna cum laude in 1990. She then returned to New York to complete pediatric residency training at Montefiore Medical Center's Residency Program in Social Medicine. Committed to providing medical care to underserved communities, she moved to North Dakota in 1992 to practice on a remote Native American Territory.

Newly aware of the crisis in rural health care, she sought an underserved, demographically complex region in which to implement a unique plan. Texas , ranking near last in the health status of children, fit the profile. She relocated there in 1994 and co-founded the Frontis Project, a non-profit health care facility that provided medical care and social, support and advocacy services to 11,500 children.

In 2004, she resigned that position to pursue her dual passions of health care and educational reform by writing and consulting. In 2005, she founded Health Education, Advocacy & Literacy, and is now working on growing The Real School. She also practices with a small group. She has been honored by the Houston Young Lawyers Association and the Center for the Healing of Racism. Her work has been featured in the Houston Chronicle and numerous local newspapers. She has done dozens of radio and television spots. Although she has lived in Texas for over 12 years, she remains a member of the New York Bar.

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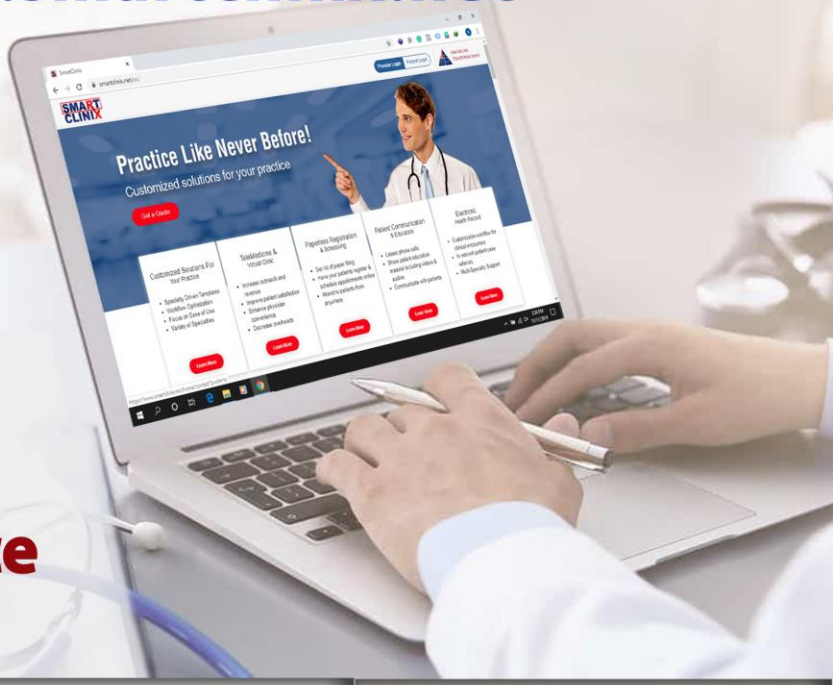

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