

The trial was approaching in the summer of 2005 and I was a nervous wreck. My skills, competence, and most importantly, my integrity, were being impugned. I was outraged at Dr. Z's written report. My entire future was at stake against an opponent who was not interested in fairness, justice, or the truth. Suzan and I arranged for child care and we traveled to Harrisburg in July for the two-day trial.

At the trial, I finally met Dr. Z in person. He extended his hand to me and without thought, I shook it by default. I immediately regretted it. That single act of civility has haunted me since then. How could I possibly have accepted the hand of someone who was intentionally trying to destroy me without regard for the truth? I sacrificed my self-respect in that instant in the name of good manners. I have not been able to come to terms with that, even after all these years. It was truly a life-changing action for me. I was already 48 years old at the time, but I learned a lot about myself and grew up quite a bit that day. Courtesy and consideration are important but should not be rendered to those who engage in unethical behavior.

The trial then commenced. The hearing examiner allowed Dr. Z's testimony, despite his lack of qualifications. During the trial, Dr. Z continued to make ridiculous assertions that demonstrated his lack of knowledge of the current practice of medicine and more specifically the practice of rheumatology. This was not surprising as he had no rheumatology training, but it was distressing nonetheless. His oral testimony continued to demonstrate that he had not read my chart thoroughly. He repeatedly drew conclusions criticizing my care, which were not substantiated by the facts of the case. He was on the witness stand for a day and a half. It was excruciating to listen to him with the thought that the hearing examiner might find his testimony credible.

My expert witness was board certified in pain management. After he refuted the nonsense spewed by Dr. Z, it was my turn to take the stand. I did so with great apprehension and was visibly shaking as I sat there. The prosecuting attorney grilled me, but I had an answer for every question she posed. My chart was well documented on every challenge that she raised. My testimony must have been very damaging to their case against me, as I was only on the stand for 20 minutes, compared to the day and a half that Dr. Z had testified.

Then it was over. I was numb. I waited nervously for a result and tried to resume normalcy.

Rheum for Improvement

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The Evolution of a Health-Care Advocate

Mark Lopatin, MD



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*Rheum for Improvement:
The Evolution of a Health-Care Advocate*

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Introduction

On page 4 of his novel, *11/22/1963*, Stephen King writes “Life turns on a dime.” Based on my experiences, he was 100% correct. There are so many times in my career where a simple phone call, chance encounter, or something else took the course of my life on a dramatic detour. Even when life is going well, a car accident, a new cancer diagnosis, or a malpractice lawsuit can acutely change someone’s life in a negative direction. Spoiler alert: It was not either of the first two that changed me from a mind-your-own-business type of physician into an outspoken advocate for health-care reform. Most of my “turn on a dime” events have been positive ones, but some like the latter have thrown me into a tailspin. I therefore have tried to consciously appreciate all that I have, as it may not be there tomorrow. This is something I taught my daughters at a young age as I explained that all of the blessings we have in our lives—loved ones, friends, family, health, material possessions, and so on—are not worth much if we take them for granted and are unable to appreciate them.

One of the recurring themes in this book is how much I didn’t know, and how much I had to learn. My naiveté and lack of understanding of so many important things are well reflected in this book. That is why I consider myself an unlikely health-care advocate. Fortunately, anger is a powerful instigator. I was capable of learning and was motivated to act on what I learned in an attempt to effect change. I am still learning now even after retirement.

The most important messages in this book, however, are the critical importance of humanity in medicine and the sacred nature of the patient-physician relationship. The patient is listed first because they are the most important consideration in health care. We need to recognize that patients are people, not simply their diseases. Likewise, we must recognize that physicians are human as well, with all the attributes and flaws that non-physicians have.

Although I had known that I wanted to be a doctor from a young age to “help people,” I really was clueless as to what that cliché actually entailed. Samuel Shem, in his novel, *The House of God*, talks about “being with patients,” (that is, the ability to empathize with and relate to patient experiences) as the essence of medicine. Being a doctor is not simply about ordering tests, making diagnoses, writing prescriptions, and moving on to the next patient. The relationship between patient and physician is the crux of health care, or at least it should be, but it is being destroyed in so many ways by those who seek to control the health-care dollar. We are losing the humanity in medicine to corporate powers, and even to the government. Regulations such as prior authorization as well as a slew of acronyms, such as MACRA, MIPS, MOC, and PBMs inhabit the health-care landscape to the detriment of patients.

As an example, let’s look at how documentation has exceeded actual patient care in level of importance. Documenting what you have done as a physician is essential, but it has gotten entirely out of hand. I have jokingly commented that my degree should be changed from an MD to a DEO, as I have become a glorified data entry operator. Getting the right answer no longer matters. Instead the focus is on whether a physician has shown their work and appropriately justified the reasoning for a particular diagnostic test or treatment to a third party. Documentation that is unsatisfactory to a third party may mean denial of a particular test or treatment or result in inadequate reimbursement. The electronic health record (EHR) has become nothing more than a billing tool. The price we pay is that the more time physicians spend documenting, the less time we spend engaging patients.

A typical office visit consists of six parts:

1. Exchanging pleasantries with the patient.
2. Gathering information via history, physical exam, and review of data.
3. Processing that information to formulate a plan of action.
4. Implementing the plan by ordering the necessary tests or treatment.
5. Communicating that plan to the patient.
6. Documenting the plan in the patient’s chart.

Physicians typically have 15 minutes to accomplish all of this for a follow-up patient.

Documentation should be focused on explaining a physician’s thought processes, but instead the emphasis has been placed on quantifying data.

For example, as a rheumatologist, one of the key things I must assess is pain. Pain is subjective and cannot be quantified using a 1–10 numerical scale. Physicians, however, are forced to use such a scale to satisfy one of the insurer’s criteria for reimbursement. The problem is that one person’s “8” is another person’s “2”. Furthermore, pain levels are different at different times, in different places, and for different conditions. Physicians are expected to provide one number at each visit to quantify a patient’s pain experience.

What happens, then, with a patient whose underlying chronic conditions are stable, but whose pain level fluctuates in relation to other acute issues? This actually happened to a patient of mine with stable rheumatoid arthritis (RA) and fibromyalgia, who was denied long-term insurance because the underwriter stated that her fibromyalgia was worsening based on her pain scores. As I explained to the underwriter in my letter:

In August 2016, her pain level was eight. But this eight referred to pain in her thumb from osteoarthritis. That progress note also documented that her fibromyalgia was improving, yet her pain score went up because of the thumb. In June 2016, her pain score was ten, but this was referable to an injury to her hamstring and had nothing to do with her fibromyalgia or rheumatoid arthritis.

The underwriter was absolutely clueless as to the use of pain scores. The fact that her chronic conditions were stable and that the pain in each case was due to something other than her chronic conditions did not matter. I spent several hours writing the above letter and communicating at various times with her financial advisor to try to resolve the problem, but to no avail. Despite my efforts, the insurer continued to deny her application by relying solely on pain scores, and she ultimately needed to consult an attorney. All of this because of the mandated need to quantify pain by recording one number in the chart, combined with the inability or unwillingness of an insurer to understand that one number is an essentially worthless assessment of a patient’s condition. Yes, bureaucracy harms patients.

One of the key elements in this case was whether the patient’s pain was getting worse. Physicians are also routinely required by insurers to not only provide a number to define a patient’s pain level but also to document if a patient’s pain is better or worse. The question is, since when? Since the initial diagnosis? Since their last office visit? Since last week? Since yesterday? How do I record the pain level for a given condition, if it is better than it was last week, worse than it was

yesterday, and about the same as it was at her last office visit a month ago? How should I document improvement when the pain in one joint is better, but pain in another joint is worse? What if the pain from her rheumatoid arthritis is worse, but her pain from fibromyalgia is better? Am I expected to document the pain at each visit, in each location, in each time frame, and for each condition? The amount of time it would take for me to document all of that would preclude me from actually providing medical care. Time spent documenting measures such as this is time not spent truly caring for patients.

Even documenting the diagnosis has become difficult. Physicians must use an alpha-numeric code for each diagnosis, and the number of codes expanded from 13,000 to 68,000 in 2015. These diagnostic codes often must be specified based on factors such as onset of the problem, an underlying cause to the problem, chronic versus acute, with or without complication, left versus right, initial versus subsequent visit, and so on.

One of my patients had been diagnosed with rheumatoid arthritis in 1972. This new coding system, however, would not allow me to use rheumatoid arthritis as the diagnosis. Instead, I was obligated to specifically designate whether a particular blood test was positive or negative. This test is useful in making the initial diagnosis, but it is not a test that is usually done thereafter. To code her visit properly, I had to look through 44 years of progress notes and labs trying to find this one lab result that no longer had any relevance to her care. The time that I spent buried in the computer looking for meaningless data could have been better spent focusing on the patient. Since I could not find the result, I had to order a new blood test with no benefit to the patient, just to satisfy the government's coding specifications.

One study in the *Annals of Internal Medicine* looked at reports from 57 U.S. physicians in family medicine, internal medicine, cardiology, and orthopedics who were observed for 430 hours.¹ Twenty-one of these physicians also completed after-hours diaries. The study showed that during a typical day, physicians spent almost twice as much time on electronic health records and desk work as they did on direct clinical face time with patients. Even while with the patient in the exam room, physicians spent more than one third of their time on documentation and only 52.9% on direct clinical face time. If we assume an office visit is 15 minutes, that means that five and a half of them are spent on the electronic health record, and only eight minutes are spent on direct patient care. Furthermore, physicians reported spending on average an extra one to two hours each day engaging in after-hours computer and clerical tasks. Another retrospective study of 142 physicians done at the University of Wisconsin² revealed that for a

typical 11.4 hour workday, 5.9 hours, or more than half of a physician's time, was spent on documentation.

This excessive need for documentation detracts from physicians' ability to care for patients properly. The key word here is "excessive." Documentation is important, but not to this degree. As noted by one physician, "Dr. Mom," on the medical blog "Sermo,"

Am I the only doctor who is sick and tired of being told how much my time is worth? I have to justify my time and substance of visits for each payment. I am spending more time documenting my visits than I am seeing my patients. If I see a patient for 30 minutes, I have to document for 30 minutes why I spent that time. I get the distinct honor of coding the assessments and then I get to code quality measures. AND LORD FORBID I DON'T—then I don't meet the standard of care. Just whose standard is that?

Furthermore, much of the documentation is required for billing purposes, rather than patient care. Doctors Christopher Notte and Neil Skolnick have noted, "The patient's chart, once considered a sacred text containing the key inflection points in a patient's story, has become merely a filing cabinet in which to stuff every piece of data about the patient no matter how mundane or trivial." The demand for documentation results in long computer-generated notes that contain little practical information. It is not uncommon for a 16-page progress note to contain only one paragraph of useful information.

We have seen tremendous advances in science and technology, but the take-home message needs to be that being a physician and caring for patients is inherently a human experience. This is where we need to be placing our focus, not on documentation for documentation's sake. How a physician relates to their patient may well be the most critical aspect of easing the patient's suffering and is not something that can be quantified. The corporate takeover of medicine is extracting the humanity out of health care at an alarming rate, resulting in unprecedented levels of physician burnout. I assert that the best doctors are the ones who genuinely care about their patients as opposed to the ones who know the most. Medicine needs to be filled with "H's": Helping, Humor, and Humility as corollaries to Healing, but Humanity remains the most important "H." Hopefully this message will come through in this book. The need for documentation is just one example of how humanity, and therefore health care, is being compromised.

PART I

EVOLUTION

Chapter 1

Beginnings

In the beginning, I was completely clueless. The year was 1975. The top movies that year were *Jaws* and *One Flew Over the Cuckoo's Nest*. “Love Will Keep Us Together” by Captain & Tennille was the top song, and gas was 57 cents per gallon. I was 18 years old but a very young 18 years old. I had just graduated high school in the top 1% of my class. I was book-smart but lacked life experience. Nerd, geek, dweeb—take your pick for the proper word that was applicable. The only job I had ever had was as a karate instructor, and I simply did not have the relationship skills necessary to be successful at teaching others. I had started karate lessons five years earlier at the insistence of my father after I had had the crap knocked out of me in a fight. It was the only fight I ever had.

I was a late bloomer. I only weighed 140 pounds when I graduated high school. My first girlfriend did not appear until after high school graduation, and she only lasted that summer, before we went to separate colleges. I was about to enter the University of Pennsylvania for pre-med.

I was oblivious to the world, having grown up in the amniotic fluid of a sheltered middle-class existence in the suburbs of Philadelphia. I remember being sent home early from first grade, but nothing else, on the day JFK was assassinated. The tumultuous events of 1968; the assassinations of Martin Luther King, Jr. and Robert Kennedy, the war in Vietnam, and racism as exemplified by George Wallace, barely registered on my radar as an 11-year-old. The Kent State shootings occurred in 1970, when I was 13 and did not move the needle for me. Even Watergate, a few years later, did not attract my interest or arouse my curiosity. In 1975, the war in Vietnam finally ended, but to me that did not matter because I knew very little about it anyway. I knew nothing of racism and politics. Although I am Jewish, I had never experienced anti-Semitism. I did not know the difference between a Democrat and a Republican, nor did I care. I would be able

to vote for the first time in the 1976 election, but even having that privilege did not spark my interest. It would not be until the early 2000s that politics would register on my radar. I had no idea of what was going on in the world around me.

Growing up, my passions were sports, especially the four major Philadelphia sports teams. I played street hockey and football with the other kids in the neighborhood. I was an avid hockey fan. I cried when the Flyers missed the playoffs by four seconds at the end of the 1971–72 season. I played tennis and golf regularly with my dad. I knew the layout of Valley Forge golf course by heart. As a senior in high school, my classes were often done for the day by 11:30 a.m., and I would sneak on to Merion with a friend of mine to get in a few holes here or there. The Flyers had just won the Stanley Cup for the second time, and I kept a record of every game that season, listing the final score, goaltender, and losing team. Not surprisingly, my high school calculus teacher labeled me a “Flyers nut” when he signed my yearbook. I followed the rules and deferred to authority. Skipping school was unheard of for me, but somehow I found a way to assuage my guilt enough to attend the Flyers’ parades in 1974 and 1975. I was such a fan that my first year in college, I took it upon myself to visit Joe Watson, a Flyers defenseman, in a local hospital after he was injured. I can only imagine what he must have thought of this 18-year-old who showed up at his hospital room to meet him in person. It would not be the last time I presented myself to a complete stranger to achieve a goal.

Growing up, we had season tickets to the Eagles, first at Franklin Field and then Veterans Stadium, and I loved them despite their lack of success in the 1970s. In 1975, the Phillies were about to be good again. The 76ers told me that they owed me one. Sports was my focus.

I had no way of knowing in 1975 what the future would hold and the unexpected paths my life would take. There was no way to predict that I would become political, or that I would someday be leading a protest outside a local hospital carrying a sign advising patients that if they were sick, to call their lawyer, rather than their doctor. An AP photographer recorded the event and it was featured in *Time* and *USA Today*.

Nor did I know that I would be interviewed for a *New York Times* article³ criticizing how pharmacies operate, or that I would write numerous articles and/or op-eds for newspapers across Pennsylvania and in national physician blogs regarding our broken health-care system. I could not imagine that I would be asked to do national podcasts, addressing issues that compromise the care that patients receive. I could not foresee that I would serve first as president and then chairman of the board of my county medical society and also serve on the

board of trustees for both the Pennsylvania Medical Society and their political action committee. I had no way to envision that I would be afforded the opportunity to speak at the Library of Congress or serve on the National Physicians Council for Healthcare Policy. I did not know that I would meet and communicate with many other physician advocates from across the country as well as many legislators. Social media was unimaginable at that time, and so was my ultimate future as an advocate for health-care reform. In 1975 that concept was beyond my realm of comprehension, with good reason.

At age 18, I viewed medicine as a noble profession. Doctors were highly respected in the community. Marcus Welby was an icon, appearing on television every Tuesday night to ease yet another patient's suffering. There was no mention of the corruption that exists in health care. I had not yet learned that some physicians will say anything, even in a court of law, where the truth is required, or that lawyers could bring a case against you simply because you were a treating physician. It was a foreign idea to me that when the state board of medicine has an agenda, the facts of the case don't really matter. It was truly a rude awakening for me when I experienced these realities.

I did not yet realize that many would find it acceptable for those without a medical license, medical degree, or medical training to be able to practice medicine, and that some corporate entities would even promote that. Abbreviations such as MOC, MACRA, MIPS, or PBMs were not yet part of my lingo. Scope of practice was a foreign concept. I could not conceive that I would one day testify in Washington, D.C., regarding the sham that maintenance of certification has become. I had no way to know that middlemen and bureaucrats would hijack health care for their own financial gains. There was an awful lot about practicing medicine that I had yet to learn or could even imagine. My ideals were about to be shattered!

At that time, I simply anticipated the wonderful feelings that come from helping people. I had no idea of forthcoming legal cases or that I would experience a form of post-traumatic stress disorder (PTSD) as a result of fraudulent testimony against me that threatened my career. I never considered the feelings of helplessness when a patient suffers and you can't fix them; the introspection that comes when a patient is angry or upset with you; or the despair that sets in when you feel you may have actually done something that might have hurt someone else.

I was about to get schooling in more than just medicine. I was about to get an education in life and in myself that would take more than 40 years. It is still ongoing.

In 1975, I headed off to college armed with a letter from my older brother with life advice regarding the future. I continued to bask in the glow of my naiveté. While in college, I joined a fraternity. I got drunk for the first time in my life. I tried marijuana but never anything stronger. During my entire four years in college, I only had one girlfriend, and that was only for a total of two to three months. I watched a stacked Phillies team fail to win the pennant for three straight years from 1976 to 1978. I celebrated Hey Day and Skimmer Weekend at Penn each year. I “drank a highball” and “raised a toast to dear old Penn” at college football games. I watched Penn go to the NCAA final four in 1979. Mostly, however, I spent college taking science classes and studying in preparation for medical school.

During my sophomore year, I got a job working as a lab technician at Lankenau Hospital. This was my first occupational foray into the world of health care. One of my colleagues there later became my roommate in med school and a groomsman at my wedding. *Saturday Night Live* was all the rage, and with some friends, I made a movie detailing what would happen to Mr. Bill if he came to our lab to get his blood drawn. This was 1979. AIDS was unknown at the time, and we used real blood to illustrate Mr. Bill’s travails. The world was innocent, or to be more accurate, I was.

I applied to medical school and was accepted to one in Philly and one in Pittsburgh. Naturally, I chose to stay close to home and attended the Medical College of Pennsylvania (MCP). MCP initially was founded in 1850 as the Female Medical College of Pennsylvania and became known as the Women’s Medical College in 1867.⁴ It was the first medical school in the world authorized to award women the MD degree. It ultimately became co-ed in 1970 and was renamed the Medical College of Pennsylvania. It was not well known as an academic institute. Instead, its strength was in its diversity, attracting students who were more well-rounded rather than simply accepting those with the highest grades and highest scores on their Medical College Admission Test.

Medical school was a whole new world for me, but most of my memories of that time are superficial ones. The first two years were merely an extension of college, albeit with much more material to learn. Of course, I never dissected a cadaver in anatomy lab as an undergraduate. We had many lectures every day, and each day a different student was required to take notes on the material. These notes would then be submitted to the instructor for accuracy and then distributed to the rest of the class for their study purposes. During my second year I had the opportunity to be the note taker for the session on history and physical

exam. I have always liked a good pun and even more so, a bad one. I therefore proceeded to describe in my notes that when you ask a patient multiple questions about the abdomen and they answer no to all of them, they are referred to as “an abdominal no-man.” The instructor at that time was the chief of medicine and he was not amused by my feeble attempt at humor. He was quite an intimidating figure to a second-year medical student. His response was to scrawl “NO” across my notes in large red letters. It was my first inkling that perhaps what I was doing should not be taken so lightheartedly. This man was a stickler for details, and he emphasized the commitment we needed to be making to medicine. As one example, he demanded that we do rectal exams on all patients admitted to the hospital, with the only two reasons for not doing so being no finger or no rectum. I did not appreciate him at that time. I thought him a curmudgeon with no sense of humor. Little did I realize the lesson he was teaching us in terms of being dedicated to our career path.

We played football or softball on the weekends. I was never much of a partier, although we sometimes would hit the local saloon after games, where I would slowly sip my one beer. I rarely finished it. When I was not studying, my outside life continued to revolve around sports. The year 1980 was a banner year for me, as all four Philadelphia sports teams went to the finals, with the Phillies winning the World Series. I had my first serious girlfriend, whom I had met at my brother’s wedding. I was beginning to mature, but only a little.

We did not really start to see patients until my third year, and this was in the hospital setting. I did not have patients that I considered my own, and therefore did not really form any type of long-term relationships with them. I remember the name of my first patient that I saw in the hospital, but nothing more about her.

We learned how to conduct a history and physical as well as the diagnosis and management of different diseases. I remember being taught the importance of obtaining a complete history, including a sexual history, and practicing this skill on my patients. When I asked one patient if she was sexually active, she responded with, “No, I just lie there.” Another patient must have thought he was Vanna White from *Wheel of Fortune*, as he reported trouble “moving his vowels.” Yes, patients do say some unexpected things.

Residency provided new opportunities. For my first rotation, I was sentenced to go to West Park Hospital. West Park was a local community hospital that did not have a great reputation for teaching. The house staff held little respect for the attending physicians there. They were community doctors rather than academic doctors, and in our minds as hotshot residents, they knew very

little. I feel quite differently now that I have been a community rheumatologist for 28 years, but I did not know any better at the time. I complained to the director of our residency program about having to start my training there. I wanted to go to a more powerful affiliate hospital for my first rotation where I could learn more. She taught me a very valuable lesson by explaining that my education and my future depended much more on me than on where I did my rotations. This was something I took to heart, so off I went to West Park. I learned medicine but also the importance of showing respect to those attending physicians whom I held in such low regard. That point was driven home when a nurse informed me that a patient I was seeing had an elevated blood pressure that I needed to address. My blunt response was, "No wonder his blood pressure is up. Look who his surgeon is."

That surgeon happened to be standing directly behind me at the time. He never said a word to me and I am guessing that he did not hear what I had said, but I was mortified. It was an example of how words can matter a great deal. I escaped without harm in this case and learned something valuable in the process.

Other hospitals taught me other lessons. Computers were just beginning to come into vogue at that time, and Frankford Hospital was using them so that staff could easily obtain patient information, usually lab results. Prior to this, if a doctor wanted to get a lab result, they needed to call the lab and wait on hold while someone found the result. With the computers, one could simply log in to the computer to get said results. The only problem with this was that administration did not see fit to give computer access to house staff, only to attending physicians and nurses. Now when we wanted to get lab results, instead of calling the lab, we would interrupt one of the nurses, and they would stop what they were doing to log in to the computer to provide us with the results. We did not always want to be bothering the nurses for this mundane task, so eventually one of my colleagues and I simply asked some of the nurses for their passwords so we could get results more expeditiously. We did not know, however, that the computer recorded every time we logged in, and suspicion was soon aroused when it was discovered that these nurses were accessing the computer at all hours of the day and night, even when they were not working. We were called on the carpet for this and almost got thrown out of our residency. However, the other residents rallied against this injustice, questioning why access to lab results was not given to the house staff in the first place, as we were the ones who needed it most. The issue was ultimately dropped, although not without quite a bit of anxiety.

It registered with me that advocacy can make a difference. I did not realize at the time the importance of that lesson, but I unconsciously stored it away for later use.

Then there was the VA, the Veterans Administration Hospital. We sarcastically called it the VA spa. It was anything but. I have stated many times, somewhat tongue in cheek, that the only reason we were asked to rotate through the VA was so that we would have unusual stories to tell later in life. Given that it was a government-run facility, the bureaucracy should not have been surprising. The day-to-day operations there astounded me.

Let's start with the "anti-nurse," as she was known to the house staff. She was a middle-aged nurse with tenure who clearly did not like the house staff and did everything she could to annoy and antagonize us. The nickname "anti-nurse" was analogous to the Anti-Christ. She was the exact opposite of what a nurse should be.

There were numerous examples. It is amazing how many times a patient's IV would just happen to stop working within an hour or two of a resident trying to get a few hours of sleep. We eventually adopted the strategy of checking every single IV before we went to bed at two or three o'clock in the morning, but it did not matter. One of the IVs that was working fine at 1:30 a.m. invariably seemed to stop running at 3:00 a.m., which meant we had to wake up, get out of bed, put our shoes on, and go the floor to replace the IV. Frequently, when we got to the patient's room, the IV was running without a problem, so we simply trudged back to the on-call room to try to get back to sleep. There never seemed to be a problem with IVs during the day, only at night.

Once, I received a call in the middle of the night to advise me that my patient's temperature was normal. When I asked the anti-nurse why she had woken me up to inform me of this, her response was, "I just thought you would want to know." At 3:00 a.m.? One of my colleagues once got a phone call in the middle of the night informing him that a constipated patient for whom he had ordered a laxative, had just had a large bowel movement. I routinely got calls for the next day's medication orders. Oftentimes, the dosage would depend on the results of the morning labs, so there was no way I could answer the question in the middle of the night. I would get phone calls waking me up asking for orders for a patient's lunch the next day. There was no reason this question needed to be asked in the middle of the night as opposed to the next morning.

The *pièce de résistance* occurred one morning when one of my confused patients decided he wanted to be a urologist and proceeded to yank out his Foley catheter. A Foley catheter is inserted through the penis into the bladder, with a

small balloon that is blown up in the bladder to keep it in place. Before removing it, the balloon needs to be deflated as it will not fit through the urethra. My patient, however, did not understand that and simply gave it a strong jerk. When I reached him, blood was spewing from his penis, and I needed another set of hands immediately. I called for the anti-nurse, who refused to help. She informed me that she was “busy giving morning report.” I did the best I could under the circumstances, and finally got the situation under control. Her refusal to help me compromised the patient’s care. It would not be the last time that I saw behavior that negatively affected patient care, by people who had other agendas.

It was not just me. Her passive-aggressive behavior was directed at most, if not all of the residents, and we swapped stories, each one more absurd than the one before it. We complained to the administration and were told that there was nothing they could do. She had tenure. This was my first taste of bureaucracy at its finest. Once again, it would not be my last.

It was not just the anti-nurse. Before I would see patients on morning rounds, I would check their charts for vital signs. On more than one occasion, there would be a normal blood pressure and temperature written on the chart, yet the patient was dead when I went to see them. There were times when lab techs would write on the chart that the patient declined to have their blood drawn. On one occasion, the patient who reportedly refused was comatose. Obviously, there was no way he had refused.

This was life at the VA, where it seemed that everything fell to the house staff due to limited support staff, especially at night. There were no lab techs to draw blood, except in the morning, or orderlies to transport patients. If you wanted something done, you needed to do it yourself, in between taking histories and physical exams and writing orders.

One night, I got an admission who had a fever and a change in mental status. That is an extremely labor-intensive proposition for an intern, because it meant that in addition to doing a history and physical and writing orders, I needed to draw blood, including two sets of blood cultures half an hour apart, transport the blood to the lab each time, do a spinal tap and transport the fluid to the lab, do gram stains in our makeshift residents’ lab to look for bacteria, and transport the patient to radiology, their room or wherever else they needed to go. I drew all the fluids I needed to obtain, transported the patient to radiology, and then proceeded to work on the gram stain and attend to other patients who needed attention. I had not received a page from radiology that my patient was finished, so I finally called them to learn that he had been ready to be transported back to

his room for 30 minutes. When I arrived at the radiology department, the technician was sitting in the lounge with her feet up, watching TV. She proceeded to tell me, “The next time, do you think you can get here a little faster? I have other things to do.” The lack of respect for a physician, even a lowly intern, was striking to me. I would later write in 2019 about how physicians are being devalued,⁵ but this was my first experience with it.

It was crazy at the VA, but I learned how to take care of patients and how to deal with adversity. It was almost like a hazing, which resulted in increased bonding with the other residents. The VA taught us more than just how to take care of patients and how to be a better doctor. I also learned how to take care of myself.

It was at the VA that I got my first taste of rheumatology. While seeing patients in the hospital, there were daily attending rounds, where a member of the attending staff would review cases with the house staff. The purpose of these meetings was not for direct patient care; it was strictly for educational purposes. We would present our most difficult or troublesome cases for some form of guidance or further education about the disease at hand. While rounding in the medical intensive care unit at the VA, our attending was Ralph Schumacher, a world-renowned rheumatologist with special expertise in crystal arthritic conditions, such as gout. As we presented a patient with a complicated cardiac history to him, his focus was on joint pain and whether the patient might have gout. When we saw the patient at bedside, he did not listen to the heart. Instead he examined the big toe. It seemed irrelevant, and almost laughable to me, given the acute nature of the patient’s cardiac status, but it planted a seed in me that a career in medicine did not have to be about taking care of the sickest patients whose lives hung in the balance.

Over time, I slowly developed more competence and confidence in my abilities. That was made apparent my first night as a second-year resident at Frankford. Frankford was a small community hospital and did not have a large inpatient population, but the patients there tended to be extremely ill. They were a stoic lot who would not arrive in the emergency room unless they were in absolute crisis. They would not come when they had angina with mild chest tightness; they would wait until they were having an actual heart attack with crushing substernal pain, nausea, vomiting, and shortness of breath. I commented, on more than one occasion, that an extremely ill patient who was having a heart attack with severe congestive heart failure, and in need of an emergent intra-aortic balloon pump, often could not get admitted to the ICU because there were already ten patients there who were sicker than them.