Brave new data world

BY PETER A. ZEDLER, MD

As physicians today we are constantly bombarded by what's become known as "Big Data." Every keystroke we take seems to be gobbled up by some machine or organization that is collecting data on our patients, our practice, or on us. We are told that collecting this data will provide incredible insight into how we act, how our patients respond and in the end will provide better health care. Cool!

In late May, I attended a conference convened by the Virginia Chamber of Commerce and the Center for Health Information that focused on Big Data. Experts from across the healthcare spectrum—state, federal, insurance plans, information services, innovators and entrepreneurs of all kinds—enthusiastically embraced this burgeoning world of digital health technology. Now, I must confess that as a practicing physician I felt like an outsider and even a bit intimidated. Clearly, the rapid rise in government spending on health care has attracted plenty of players and investors who are ready to enjoy that financial feast. The event seemed to provide a strange brew of government and capitalism, all centered on health care.

Don't get me wrong, I'm not averse to change, especially when it leads to better outcomes for my patients. Like many of you, I've had to learn plenty of new skills that I could never have imagined when I first began practicing in 1980. So despite any personal doubts and skepticism, I kept an open mind.

And I was glad I did. Todd Park, Chief Information Technology Officer of the United States, made a compelling case and helped me understand the explosion that we were seeing in the convergence of Big Data and health care.

The first big change is the transformation of the way we are paid for delivering health care. The switch from being paid for the number of patients seen or procedures performed to "pay for performance"—that is, moving from quantity to quality of care—will require data collection and measurement. We need to know the standards with which we will be measured and paid. Whether organized as an ACO, medical home, or recently enrolled in the health plan, we are being measured and paid.

"Brave," continued on page 2

My kind of data

BY ISAAC L. WORNOM III, MD, FACS

School's been out, the daylight has lasted longer, and some of us had more time away from work to enjoy it. If that does not describe your summer, then maybe you need to rethink things. Because Virginia's public school year is roughly based on the 19th century agrarian calendar, coupled with providing cheap summer workers (i.e. high school kids) to Kings Dominion and Busch Gardens, for better or worse, most of us see summer as a time to slow down and not do as much work.

Certainly there are generally not as many night meetings during the summer, even if patient care does not necessarily suffer. (Including patients whose voices often seem to get lost in the media buzz when the government does things such as "dumping" Medicare payment data on the Internet.)

In The Atlantic piece, a Cornell professor tells Peck that he's seen a "huge surge in demand for workforce-analytics roles." From Google to General Motors to Little Debbie (snack cakes), the data race is on. In the end, the main question about playing "data ball" is this: Who will hit home runs with the data, and who will strike out?

Chip Jones is RAM's communications and marketing director.

"Data," continued on page 3

Swinging at the data ball

BY CHIP JONES

If doctors are feeling overwhelmed by the use and misuse of their medical data, it may be small solace to say: Welcome to the club.

Across the U.S., new technologies have transformed the workplaces of most professionals, whether they are doctors, engineers, teachers or cupcake makers. Perhaps you read "Moneyball," Michael Lewis' best-seller that followed the cerebral moves of Oakland A's General Manager Billy Beane. Beane "entrusted player-acquisition decisions to mathematical models developed by a young, Harvard-trained statistical wizard on his staff," writes Don Peck in The Atlantic. The team's low-budget winning became legendary—and it represents the silver lining of an American workplace that's increasingly driven by data.

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In The Atlantic piece, a Cornell professor tells Peck that he's seen a "huge surge in demand for workforce-analytics roles." From Google to General Motors to Little Debbie (snack cakes), the data race is on. In the end, the main question about playing "data ball" is this: Who will hit home runs with the data, and who will strike out?

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exchange, we will need data to know how we are helping or hurting our population of patients.

The second piece to this puzzle, Park explained, is the rapid adoption of electronic medical records. By now, more than 50 percent of doctors and 80 percent of hospitals are using electronic records. With the progression of standards of reporting driven by the carrot of meaningful-use dollars, the EMR becomes a tool to collect the data to measure our collective ability to provide health care.

The next step in the data evolution is sharing with the public this great mountain of information. HHS has already begun to open a huge treasure trove of collected healthcare data to the public. Remember Medicare’s dump of provider payment data earlier this year? There are more than 1,100 “data sets” ready to be opened to the public.

This availability of data to innovators and entrepreneurs will provide the raw materials for data wonks to get in there—and “slice and dice” the data to show us better ways to help our patients. Because taxpayers—including you and me—provided the funds to collect the data, they (we) should have access to it, or so the mantra goes.

Finally, the data collected about patients belongs to patients. To improve transparency and improve care coordination, patients must be able to see their own records. This is the carrot of meaningful-use dollars, presented. Democrats and some Republicans also applauded a modification to the EMR to allow direct access to patient information held by the government as well as others. I had heard some of this before, but the atmosphere at the chamber’s event was electric and stimulating.

Our practice was an early adopter of the EMR. I believe it is better for my patients. There were lots of smart people at the event with some very sophisticated ideas about how we could do a better job taking care of our patients. For example, what about that app that would automatically review a patient’s weight and blood sugar and spit out the insulin dose? Patients don’t need doctors; they need smartphones! While it was fun to fantasize about the digital future of medicine, I knew that the history of our profession and our ability to care for individual patients or populations has never been a straight line. Think how long it took us to adopt Joseph Lister’s ideas about sterilizing surgical instruments. In 1995, Gartner, an information technology research and advisory company, used “the Hype Cycle” to describe the acceptance of new technologies. After a “peak of inflated expectations,” emerging technologies pass through the “trough of disillusionment,” but eventually go up a “slope of enlightenment” and eventually reach the “plateau of productivity.” What is the promise of Big Data? Will it reach the “plateau of productivity” and dramatically improve our ability to care for our patients and our community? Will all this data bring true information? I hope so. In the meantime, I’ll remain secure in the knowledge that doctors remain the heart of this very brainy system. I understand that the real key to helping my patients be successful is to educate them and help them make modifications in behavior that will keep them healthy and happy. While I might have a computer in the room linked to a literal world of data while I talk to the patient, it will still be the touch, the look in the eye, and a nod of understanding that will make the real difference.

Why White Coats On Call matters more than ever

Nearly 200 Virginia physicians visited our legislators on a series of White Coat Days during the 2014 legislative session to advise them on issues of importance to both our patients and our profession.

Medicaid expansion for the uninsured was one of the items of concern for many. Democrats and some Republicans also applauded a modification of this expansion and all we met showed great interest in our opinions. Nevertheless, partisan politics eventually ruled the day in the rancorous fight over the 2014 budget, and the legislature placed new strictures on any expansion of Medicaid—ending our initial hopes for a compromise that would certainly improve the lives and overall health of an estimated 400,000 uninsured Virginians.

But does this mean our advocacy efforts are a failure? I believe that the answer to this understandable question is a resounding NO! This recent disappointment regarding our effectiveness on the Medicaid expansion issue does raise a legitimate question regarding our appropriate role in the overall political process.

After years of involvement in the advocacy for the American Cancer Society, the Massey Cancer Center in Richmond and the Medical Society of Virginia, I am convinced that we—like experts in other fields—are unique and knowledgeable professionals with a responsibility for providing our legislators and their aides with valuable and much-desired advice on all aspects of health care. A few of our colleagues (like past RAM President Dr. John M. O’Brian III) have made truly monumental contributions by becoming totally involved as effective and respected legislators.

In the past, some of us lobbied legislators as individual physicians but the first-ever formal White Coats on Call efforts initiated by the Medical Society of Virginia 10 years ago really expanded this medical advocacy program. Back then, our professions was a medical malpractice crisis. As a result, the first event brought out a regimental-sized force of doctors in white coats—some 2,500 physicians participating! That was a real eye-opener for all of us as "White Coats," continued on page 3
to evaluate our own performance, so this is nothing new to us. But when outside entities start to look at how we do things, using metrics that we don’t necessarily understand or control, skepticism can reign. Hopefully, this trend will lead to an opportunity for improvement for us all. That is certainly the rationale.

There are those who think data evaluation may hold the key to improving the general health of our whole country and even the world. At this point in time, this strikes me as overly simplistic, pie-in-the-sky thinking. Having said that, however, we are all collecting data now via EHRs, and we’re collecting it in huge batches. Mining that data over the next few years is going to lead to changes in how we do things. There’s no doubt about that.

Physicians work hard. Our jobs can have significant stress. The combination of caring for the sick, documenting the care given and, for some of us, running a business fills our days and our minds with many tasks. Those in academic medicine can add teaching and research to this mix as well. The trend to use Big Data to evaluate us could make our already stressful lives even more stressful.

I would hope as these methods of evaluation evolve that they will come closer to measuring more of what we actually do and how well we do it. Currently, I cringe to see the gargantuan amount of data out there in the blogosphere that does not reflect the reality of physician performance. It also is ripe for misinterpretation by the general public, politicians, and trial lawyers alike. Some might even see it as cyber-ammo that could blow up in our faces!

The classic example of this would be the multitude of doctor rating sites which immediately pop up when someone Googles a physician’s name. Many of these are just uncontrolled complaint departments that clearly do not reflect reality. There are also ways to manipulate them and I, for one, get solicitations almost daily in my email from commercial ventures that will improve how I look on these online searches for a fee. This makes the whole system flawed, but the public does not know that.

With all this before us, it’s good to take time out to enjoy summer when we can. I read a lot, especially on vacation, and I recently returned from a week at the beach. One book I especially enjoyed was “Wonder” by R. J. Palacio. I would like to finish this column by sharing with you a little about the book and why you should take the time to read it. “Wonder” was written for middle schoolers so it is a quick read. It has become a best-seller for that age group and has been the recipient of many awards.

It’s the story of Auggie, a rising fifth grader who was born with a severe facial anomaly. It tells the story of his fifth grade year at Beecher Prep where he goes after being home schooled. It is told from his perspective as well as the perspective of his family and classmates.

Auggie’s experiences going to school and interacting with the world are not easy, and the book deals really well with the subjects of acceptance, bullying, and tolerance of differences. “Wonder” has been the inspiration of a movement known as “Choose Kind.” You should check it out. The book and “Choose Kind” will remind you of the human-to-human things we do that matter the most. Have a great summer. Take a break. Don’t let “Big Data” bring you down.

Dr. Wornom practices at Richmond Plastic Surgeons and is a past president of RAM. He can be reached at Wornom@richmondplasticsurgeons.com.
No data left behind

BY LISA CRUTCHFIELD

Remember how No Child Left Behind was going to revolutionize and ultimately change education in the U.S. for the better? The premise was that by collecting and measuring data, good performance would be rewarded and poor results not tolerated.

In April, Medicare released a huge database with details of how much it pays physicians.

Fast-forward a dozen years: NCLB’s attempt to use Big Data is now much-maligned. Nevertheless, medicine is trying something similar: crunching the numbers to determine rewards and remediation.

Will it work? Used correctly, it really could affect change for the better. But there’s also the potential that the data won’t be interpreted correctly, or even that some providers could figure out how to game the system. And certainly nobody wants to be “teaching to the test” when it comes to patient safety.

There’s a lot of information out there, and it’s getting easier to get, said Carolyn “Cindy” Watts, Ph.D., the Richard M. Bracken Chair and Chairman of the Department of Health Administration at Virginia Commonwealth University.

“People can get access to information without going through an agent. Think about other fields where that’s happened—real estate, travel, stockbrokers—all the people who had preferential access to information and doled it out for a fee.”

With payers, including the government, opening their records, physicians can track, measure and compare what used to be privileged information.

In April, Medicare released a huge database with details of how much it pays physicians. Modern technology has made it much simpler to monitor physicians’ work and outcomes, as patient records are compiled electronically instead of on paper. Health systems use dashboards that allow physicians to see exactly where they fit in the mix.

“I do believe in data,” said Dr. Khiet Trinh, chief medical officer of Bon Secours St. Mary’s Hospital. “If used correctly, it drives quality improvement. There’s the old saying that you can’t improve what you can’t measure. And that’s so true.”
“It opens up possibilities and starts to give us insight into how we can reduce the variations of care,” said Dr. Gigi deBlois, chief medical officer at Virginia Quality Care Partners. “There’s little doubt that managed properly, more data transparency can lead to better quality care and lower costs. And physicians can lead the charge.”

Medical societies can be important drivers of innovation and change. One of the best-known data repositories is the Society of Thoracic Surgeons database, which has tracked millions of surgical outcomes since 1989 and allows members to share important findings. It’s often cited as an effective example of using data to improve care.

“I think there’s this idea that it’s all about making money for the hospital, trying to nickel and dime,” said Trinh. “But it’s all about patient care, and if there’s a financial benefit, so be it. I think doctors look at it suspiciously, this is about making money. For me, though, it revolves around patient safety.”

“We have to practice medical resource stewardship,” acknowledged deBlois. “Data can help us figure out where we can best use resources to have the greatest patient benefit.”

“The availability of all kinds of information to people has a huge impact on what physicians are called upon to do,” noted Watts. “That information is available not just to patients but to entities involved in this complicated dance we call healthcare delivery—payers, employers, the government, taxpayers—and so now everyone is able to see this is how much they’re paying and what they’re getting.”

Aggregated data also allows payers to flag potential problems, such as patients not going for follow-up care (for example, a specialist in a different system) or not filling prescriptions. Though payers are not practicing medicine, they are in a position to alert docs about gaps in care that if closed, can lead to better patient outcomes.

Garbage in, garbage out

The information is out there. But do people really know what the data means? Dr. John F. Butterworth IV, professor and chair of the Department of Anesthesiology at VCU, stresses the importance of accurate interpretation. As with No Child Left Behind, where one student in one school could skew data for a whole district, it’s important to understand what the results really mean.

“For example, years ago—at another hospital—there was a problem with an excessive number of patients listed with postoperative respiratory failure. It turned out that many of these patients were, in fact, patients who had had a major operation and the team had elected to send them to ICU to be ventilated overnight, a perfectly normal procedure. But if there were a nationwide audit of excessive respiratory failure, I’m sure that hospital would have looked really bad. That is my concern: misinterpretation and the accuracy of the data.”

“The downside is that the possibility that data will be dumped without being interpreted properly. There’s always the problem of garbage in, garbage out.”

For that reason, said Trinh, it can sometimes be difficult to get physicians to trust the data. “If you do well, you think it’s the greatest thing. If you don’t do well, you hear physicians say that their patients are sicker, this is data mining and it doesn’t really capture what I do.”

Try explaining these nuances to a pugnacious medical reporter who’s splashing stats all over the front page. After all, many people expect to hear that they’re paying more and getting less than everyone else.

Butterworth explained, “If you don’t put down all the risk factors for your patients, you might be doing a good job, but the assumption is that the patient is healthy. You may be at the bottom of the list even though you’re taking care of the sickest patients.”

And that’s why the data doesn’t necessarily identify “good” or “bad” doctors, said deBlois. “You have to look closely and see if you can find out the specific details that might explain why you are two standard deviations off from the care of apparently comparable patients.”

Trinh tells colleagues at St. Mary’s that the three most important things they can do are “document, document and document.”

Physicians realize, though, that every keystroke takes time away from touching a patient. Even with meticulous documentation, Trinh said, there’s still another issue. “These dashboards tend to lag. You’ve got to wait for people to abstract data, analyze it, collate it. It’s not uncommon to be running six months or more behind.”

Big Data, Big Brother

As more physicians work for hospital systems (a 34 percent spike between 2000 and 2010), they’re under more pressure to hit quality goals while cutting costs.

Many systems strike deals with insurers that back away from the traditional fee-for-service reimbursement model. Federal health law is pushing these models. Under the law, hospital payments and penalties from the federal Medicare program will be linked to a hospital’s performance on quality gauges, especially costly readmittances. The law also created a new Medicare initiative that rewards providers for efficiency and quality performance.

But wait, you say, we tried something like this before and it failed. In the 1990s, hospitals began acquiring doctor groups and insurers tried paying for care based on per-patient fees instead of charges for each service. Both patients and doctors resisted managed care and many of these initiatives failed.

Big Data, big business

Many believe that today’s technology will make a difference and make the system work.

Big Data already is a big business; more than 2,000 people attended the most recent Health Datapalooza in Washington in June, learning more.

1.8 million people

The number of medical identity theft victims, including 313,000 victims in 2013 — a 19% jump from 2012.

Source: Politico, July 1, 2014
about investment opportunities emerging from all the information.

“Insurers have long had a lot of data about physicians,” said deBlois. “If physicians think that the claims data they generate is private, privileged, proprietary information that the physician owns, they are mistaken. The data is for sale.”

Venture capitalists are pouring money into digital health startups—more than $2 billion so far in 2014, according to the venture capital firm Rock Health. Those investors are betting that entrepreneurs can help doctors, hospitals and insurers become leaner.

Just as education became more accountable because of demands from lawmakers and data-hungry consumers, healthcare providers are feeling the pressure.

With health care at 18 percent of the U.S. GDP, change is inevitable. “In a sense, we’re already teaching to the test,” said Watts. “Now, we’re going to have to be clever and think about what’s the right test. We have to have standards and we have to have sensible standards that measure what we really care about.”

“Whatever happens with the Affordable Care Act,” notes Watts, “we are moving toward a world where people are going to be paying more out of pocket for health care. Individuals are going to be more aware and demanding of what they’re getting and what they’re paying. They’re going to be questioning more and making life more uncomfortable for physicians.”

Some insurers already have cost estimators on their websites for patients, allowing them a reasonable guess at what a procedure will cost—something that physicians, health systems or insurers couldn’t always do in the past.

Because insurers have had the data and crunched the numbers for decades, said John Syer, regional vice president of provider engagement and contracting at Anthem’s Richmond office, they’re in a unique position to help physicians and practices sift through the data and find meaningful ways to improve. “You should leverage the resources of the payer.”

It’s likely there will be pains associated with the rise of Big Data. Physicians will be asked to defend their care plans and as more players enter the game, documentation becomes even more important to ensure safe patient handoffs through the care system.

Big Data may well help lower costs and increase quality of care. But information isn’t action, noted Watts. “You can have a lot of information. For 50 years, we’ve known smoking is harmful, yet nearly 20 percent of the population still smokes.”

And so the physician’s role may evolve. The question now is how we use all this data and turn it into information that is actionable.

“There are a lot of frustrated people in health care and this is an opportunity for physicians to step up and take a leadership role.”

Lisa Crutchfield is a Richmond-based freelance writer.
hen a suicide bomber blew up the marketplace near Dr. David Bettinger’s Army outpost assignment in northern Afghanistan in 2010—killing or wounding dozens of innocent civilians—it was a gruesome sight. Yet as he assessed patients from the soccer field on the edge of the village Maymana, as bad as it was, Bettinger knew he was prepared to deal with it.

Serving in the province of Faryab in the mountainous northwest part of the country, his team helped the local health system which worked under sometimes Spartan conditions—such as coal heat and a two-bed operating room—with only one bed that was fully functional. The anesthesia machine often didn’t work.

Looking ahead to the day most American forces would leave, Bettinger said one of the Army’s goals was to improve the level of medical training among local physicians. “We had one day to bring in local doctors and teach them what we could.”

But the additional training in Miami helped reduce the stress of seeing kids and adults alike torn to pieces by a bomb’s shrapnel. “You just get through it,” he said. “Through it,” continued on page 8

BY CHIP JONES

2,184 American troops killed in Afghanistan since 2001.

19,600 Americans wounded

Source: CBS News, May 27, 2014
Bettinger said. Sniper fire could be heard while he operated, but again, he downplayed the danger he felt, saying “I don’t think the snipers hit closer than 20 to 30 feet to us.”

His base was surrounded by a 7-foot-tall fence with barbed wire on top, then a second fence that was under constant patrol by the Ugandan Army. There were other interesting defenses, such as big white observation balloons equipped with surveillance cameras. “Unfortunately, they put them right next to the hospital,” making them easy targets for snipers trying to shoot them down.

“We ran mainly a burn center for Iraqi kids and support for Special Forces and 3rd Infantry patrols,” he said. Asked about the facility and equipment, he said, “You just go do your job, and everyone else was there doing the same—the nurses, the techs and the lab people.”

Outside his trauma unit, the American forces were bolstered by guards from Iraq, Poland, Romania and Uganda. The base also had a helicopter crew that could be used to transport any of the more seriously wounded. For example, if it was a local car accident or another kind of injury, it probably fell outside the treatment criteria. Or “if it was an insurgent who attacked a local,” it also fell outside the standards of allowed care and would require approval from the higher-ups to provide treatment.”

On the other hand, “If somebody was injured by our troops or was injured in an activity with our troops,” then that person would be treated. Over time, the MEDRO became narrower.

Bettinger joined the Army Reserve in 2008 because “they were short on surgeons.” He’s always worked out to stay in shape for the deployments, which often sent him to hot climates and/or high terrain that required plenty of endurance and stamina.

In 2009, he was part of the Army’s Task Force 28 based in Fort Bragg, N.C. From there he was deployed to be part of the forward surgical team attached to the Army’s 3rd Infantry in Al Qut, Iraq, which was located southeast of Baghdad, near the border of Iran. At the time, the U.S. conducted a “surge” of forces to rout out Iranian-backed insurgents.

“There were a lot of Iranian rockets that locals would shoot at the base. Only one rocket hit the side of one of our barracks, but it was a dud and didn’t go off,” Bettinger said.

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wounded soldiers to larger facilities.

During this three-month tour of duty, he was paid by the Army while his fellow physicians at SAR covered for him and supported the hospitals on Richmond’s South Side.

Comparing Iraq and Afghanistan’s medical systems, Bettinger said, “Iraq was a fairly modern country, with health care very up to date in their private hospitals.” Near his base was a local hospital that had a CAT scanner and an oncology service where Bettinger provided educational talks monthly.

“A lot of it was built with their private money,” he said of the Iraqis. “Afghanistan was very different—very rudimentary.”

Bettinger returned to eastern Afghanistan for a third tour in November 2012 and stayed until March 2013. He usually deployed during holidays, which allowed his fellow Army surgeons to come home over the Christmas-New Year holiday season.

This last deployment with the 691st Forward Surgical Team proved to be the “slowest of times,” he said, as he was at an Army base with 3,000 American and Turkish troops. Once again, he was close to Special Forces who were conducting the bulk of the combat operations.

The base was 7,000 feet above sea level, across from the town of Ghazni, but Bettinger always maintained his physical readiness, jogging for several miles at a time.

Looking back on his tours of duty, he said, “Through it,” continued on page 10
If cancer becomes part of your patient’s life, you’ll want the best team to help them fight it. You’ll find that team at Virginia Cancer Institute. Our group includes three of Richmond Magazine’s 2014 “Top Docs” for Oncology. Four of our doctors were just recognized by OurHealth’s Bedside Manner Awards. And every physician here is committed to bringing the world’s latest advancements to people with cancer, while helping them live as full a life as possible. Great doctors and a treatment plan that’s centered around the patient. That’s fighting smart.

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Visit vacancer.com to learn more about the independent practitioners at Virginia Cancer Institute.
Earlier this year, I traveled with two friends to deliver some donated medical supplies to refugees of the Syrian civil war. It’s one thing to plan a trip like this—and another to organize the medical supplies that came from VCU Medical Center and International Rescue Committee. VCU students Ali Salman and Karima Abutaleb and I traveled to Kilis, Turkey, in March. Kilis is on Turkey’s southern tip bordering Syria and about a 30-minute drive from a Syrian refugee camp. We traveled there over our spring break to work on a humanitarian relief project, and to make connections with trustable field workers to ensure the delivery of our donated medical supplies to the devastated hospitals inside of Syria.

Everybody we met was wounded in some way by the war and was open to sharing their stories. My most vivid memory was of a highly-educated man whom Ali and I met. He said he’d earned a Ph.D. in Arabic language and used to be a professor. He shared many of his poems with us.

My personal favorite was “A Man at the Window.” It was a poem he wrote to the woman he eventually married. It was a romantic poem and I liked it because it conveyed how love is what holds us together through thick and thin and reminded me of the Latin phrase “Vir Quisque Vir,” or “every man a man.”

He had a genuine smile and I was impressed that he shared his poems and feelings after all he’d been through. Similarly, my friend Karima was impressed by a female Syrian doctor who promised to keep serving her fellow countrymen even under the harshest circumstances. This doctor always kept pictures and a list of names of loved ones who had died from the fighting.

Serving people around-the-clock, this doctor did not have time to grieve over the loss of her loved ones or to otherwise interrupt her medical work.

One of the highlights of our trip was meeting with a non-governmental organization called Physicians Across Continents. Its members were very sincere, honest people and easy to work with. The Richmond-based World Pediatric Project.

Before we left, we could only imagine how these generous donations might help save lives on the other side of the world. It was quite another to actually see, shake hands and talk with the refugees from the terrible strife that has created one of the worst modern-day human tragedies, with some 600,000 Syrians fleeing the conflict, according to the
plained how they are helping in Syria as well as their shortcomings regarding that effort. They also explained the many complications Syria is facing. We felt confident enough in them to exchange contact information in hopes of partnering to get our donated medical supplies delivered to the right places.

Even though our journey only lasted a week, those seven days marked a turning point in learning how to become progressive global health leaders. To make your efforts of helping others more valuable, we encourage you to visit places, investigate the problem, conduct research for answers and talk and listen to people.

Most importantly, do not limit yourself. Our organization, United2Heal, is about discovering our world and giving ourselves to it with all our hearts. Those seven days in Turkey made that statement come to life.

Albara Elshaer is a junior at VCU. He can be reached at elshaeran@vcu.edu or by calling (571) 723-3004.

“Window,” continued from page 11

Of 2.5 million Syrian refugees, HALF are children

“This is the biggest humanitarian tragedy since the Rwandan genocide.”
Antonio Guterres, UN High Commissioner for Refugees, on the crisis in Syria.

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Closing or leaving a practice?
Make appropriate arrangements for medical records

BY SUSAN SHEPARD, MSN, RN

When a practice closes, the physician or group is responsible for making appropriate arrangements for the disposition of all medical records—regardless of whether the records are in paper or electronic format. The possibility of a lawsuit always exists.

- When choosing to destroy clinical records after a set period of time, use a record destruction service that guarantees records are properly destroyed without releasing any confidential information.
- If you make custodial arrangements for retaining records, make sure these arrangements are in writing and guarantee future access to the records for both physicians and patients.

Medical record retention laws and regulations differ from state to state. After a physician has left or a practice has closed, to help defend against any future claims, proper retention of records is vital.

To help reduce risks when making arrangements for medical records:
- Know the guidelines or laws in your state concerning the time period for retaining records.
- If you turn your practice over to another physician, have agreements in place that address recommended retention time and access capability.

Any arrangement for retaining records—either with a physician designated by the patient or with a custodian—should include the following points:
- The medical records will be retained for the amount of time required by the state.
- No one can access the information contained in the medical records without a signed release from the patient or an authorized representative or a properly executed subpoena or court order.
- The original physician or physician’s personal representative will be notified of any change in the custodian’s or designated physician’s address or phone number.
- The terms apply to all persons in the custodian’s or designated physician’s employment and facility.
- Copies of medical records will be released to a person designated by the patient only with the patient’s written request.
- The custodian or designated physician will comply with state and federal laws governing medical record confidentiality, access, disclosure, and charges for copies of the records.
- There is an agreed-upon fee for maintaining the records (in the case of a custodian).
- The agreement includes language that addresses any personal practice decisions made by the custodian or designated physician (such as retirement, selling, or moving) to ensure the safety of and continued access to the records by the original physician or physician’s personal representative.

Medical record retention laws and regulations differ from state to state. Once a record is destroyed, it is difficult, if not impossible, to defend a malpractice case. Physicians should contact their attorney for guidance on record retention laws in their state.

Contributed by The Doctors Company. For more patient safety articles and practice tips, visit www.thedoctors.com/patientsafety.

Susan Shepard, MSN, RN, is the director of patient safety education at The Doctors Company. She earned a master’s degree in nursing administration from Medical College of Virginia-Virginia Commonwealth University, a master of arts degree in management from Webster University, and a bachelor of science degree in nursing from St. Louis University.
Dr. Marcella F. Fierro’s life story would fill a thick memoir or, if she were so inclined, a stack of film scripts.

Over her 34-year career in forensic medicine, Virginia’s former chief medical examiner was no stranger to the spotlight—from bearing the self-effacing Fierro shakes her head and says, “I’ve seen so much horrible stuff in my life, please! I don’t want to go back.” Instead, Fierro focuses on the continuing improvement of her profession—including serving on a National Academy of Sciences heavy responsibility for the autopsies of the 33 students and faculty who died in the 2007 Virginia Tech shootings to providing a character prototype in Patricia Cornwell’s crime novels. Fierro served as the inspiration for Cornwell’s first major character, Kay Scarpetta, the Richmond-based chief medical examiner known for her perfectionist ways and love of Italian cooking.

Yet when the idea of writing her own memoir arises, the low-key and committee that recommended the establishment of a National Institute of Forensic Science. The underlying concept, she explains, is to ensure the evolution of a branch of science and medical research that for more than a century often has been treated as a kind of Rodney Dangerfield of the medical profession—that is, not getting the respect it deserves. “Many of them don’t know what a medical examiner is,” she says of her fellow physicians, “and clearly don’t understand the distinction between a medical examiner and a coroner. A medical examiner is a physician and a forensic pathologist, with at least five years of training after medical school and is board certified.” A coroner, by contrast, in some parts of the country, may be an elected official with little or no formal medical training, with “a regular hodgepodge of systems responsible for death investigations.”

Before becoming Virginia’s chief medical examiner in 1994, Fierro was board certified in three subspecialties—anatomical, clinical and forensic pathology—and completed six years of training after medical school. “That’s right, I’m a physician,” she says with a directness that comes across as honest, but not brash. Fierro also has a sly sense of humor, such as when she says, “I take care of patients. The only difference is I don’t listen to their chests.” And when she speaks, others listen. Fierro has appeared on various TV programs and been a consultant to the FBI. Starting in 1973, she served on the faculty and became chairman of the Department of Legal Medicine and Pathology at VCU/MCV. She retired in 2008.

Recently, she appeared on a PBS special based on “The Poisoner’s Handbook: Murder and the Birth of
Forensic Medicine in Jazz Age New York,” by Deborah Blum (2010, The Penguin Press). The book tracks the appointment in 1918 of Charles Norris, New York’s first trained medical examiner who was “a charismatic pathologist.” Then Norris hired “an exceptionally driven and talented chemist named Alexander Gettler and persuaded him to found and direct the city’s first toxicology laboratory.” Together, Blum writes, “Norris and Gettler elevated forensic toxicology in this country to a formidable science. Trailblazing scientific detectives, they earned a respected place in the courtroom, crusaded against compounds dangerous to public health, and stopped a great many Jazz Age poisoners in their tracks.”

Their groundbreaking work “became a legacy for future generations,” including Fierro’s. When she’s asked how forensic science helped to advance medical knowledge, Fierro reframes the question. “How did forensic medicine—not science—contribute to the public health?” She explains: “The medical examiner is a public health officer. He’s not just a medical detective for criminal or civil cases.” That aspect of the book wasn’t emphasized in the PBS program, Fierro says.

The New York City medical examiner’s office set the gold standard for best practices around the country and helped create what she called “a model system” in Virginia. “The East Coast is lucky that it has multiple contiguous state medical systems,” including West Virginia and North Carolina. When it comes to forensic medicine, interstate cooperation is key.

“Say someone is injured in Virginia but dies in a North Carolina hospital, or someone in western Virginia dies in West Virginia,” she says, then it makes all the difference if both states are working in tandem.

Taking things one step further, Fierro says, “If I could design the perfect system, the forensic science labs and the medical examiner would be basically located on an academic campus where you can consult between the basic scientists and the translational medicine guys.”

That’s how it works in Japan, she notes, where during the American occupation of Japan after World War II, Gen. Douglas MacArthur “used the New York medical examiner system as his model.” Ultimately, Japan’s universities assumed that role, and they started doing more forensic research than was done back in the U.S.

“We don’t do much in the U.S. because the medical examiner positions are public service positions rather than academic,” with a few exceptions, such as New Mexico, where the state medical examiner’s office is housed at the University of New Mexico’s Department of Pathology. In addition to increasing the academic role in forensic medicine, Fierro says she favors a statewide system of control “because it provides uniformity of care,” no matter what a jurisdiction’s fiscal situation might be. This also allows for economies of scale and creates uniform procedures (such as the types of deaths that are investigated and standards for examinations; these are important factors for the courts, prosecutors and defense attorneys).

Over her career, the “three greatest advancements” in forensic science have been the automated fingerprint identification system (AFIS), nuclear DNA and mitochondrial DNA testing which allows you to test very degraded biological material. The latter is the same process used by archeologists.

Dr. Fierro was part of the Committee on Identifying the Needs of the Forensic Science Community that issued a key report in 2009 to improve forensic science.

Forensic Medicine in Jazz Age New York,” by Deborah Blum (2010, The Penguin Press). The book tracks the appointment in 1918 of Charles Norris, New York’s first trained medical examiner who was “a charismatic pathologist.” Then Norris hired “an exceptionally driven and talented chemist named Alexander Gettler and persuaded him to found and direct the city’s first toxicology laboratory.” Together, Blum writes, “Norris and Gettler elevated forensic toxicology in this country to a formidable science. Trailblazing scientific detectives, they earned a respected place in the courtroom, crusaded against compounds dangerous to public health, and stopped a great many Jazz Age poisoners in their tracks.”

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gists, anthropologists and the military when it is trying to identify casualties of war. Fierro is equally excited by some promising advances being made to raise the bar for forensic medicine and science. This follows a 2009 report by the National Academy of Sciences that criticized the scientific validity of many criminal investigation labs around the U.S. that “rely on unproven techniques such as analyzing bite marks or examining the markings on a bullet,” according to a 2012 ProPublica news article. What needs to be done is the basic research that establishes the validity of the methods and interpretation, according to Fierro.

Fierro served on the National Academy of Sciences Committee on Identifying the Needs of the Forensic Community, an elite group of doctors, professors and legal scholars whose work resulted in the 2009 book, “Strengthening Forensic Science in the United States: A Path Forward.”

For the past few years, that effort lagged, but Fierro has been heartened lately that the group’s work likely will be funded by Congress. She notes the work of other Richmond physicians and professors, such as Dr. Andrea Ferreira-Gonzalez, a molecular pathologist at VCU, who has done groundbreaking work on alterations of DNA in heart disease and SIDS.

“What she does at the highest academic level is very important to us at the service level. This is a great era of translational research,” Fierro says. The key is transferring that knowledge to “what medical examiners are doing every day.”

Tapping a copy of the 2009 book she helped write, Fierro says, “If you ask me what’s the most important achievement of my career, this had to be one of them.”

But she’s not interested in returning to the scenes of the crimes she’s helped solve. Asked how she coped with what she’s witnessed, she said it’s no different than the experiences of trauma surgeons or other doctors who help crime or accident victims.

“You realize what the patient needs is not your emotions or your outrage. What the patient needs is your care, and no one but you can provide it. The discipline is you know you can do something—you can speak for that patient.

It is a privilege to be entrusted with the care of the dead. Sometimes after a trial, the families of crime victims have thanked Fierro “even though it broke their hearts to hear what I had to say. They at least knew someone spoke to what happens to their loved one.”

Even in retirement, Fierro is thinking about ways to help people stay out of the medical examiner’s office. One simple change she’d like to see in Virginia is a box on the death certificate that could be checked to answer this question: “Was this death preventable? Then we could devise preventive strategies and save lives.”

Many drownings are preventable, for example. “We don’t have enough people who are swimmers,” she said, noting a need for more swimming lessons for inner-city children. “You have to be taught to float and how not to panic . . . so when you’re 15 years old and step off the rock in the James River and get water up your nose, you know you will be up to the surface in a few seconds and breathe through the mouth and not to panic. We could save hundreds of lives!”

She compared it to the use of seatbelts in the 1960s, and “look at the lives seatbelts have saved.”

“Retirement” is a relative term for Fierro, since “my old cases never go away” because there’s no statute of limitations on homicides. “As long as I am living and breathing and mentally competent they will come after me for those old cases.”

Top four ways to improve forensic sciences:

• Create a National Institute of Forensic Sciences (NIFS).
• Standardize terminology and reporting practices.
• Expand research on the accuracy, reliability, and validity of forensic sciences.
• Remove forensic science from the administrative control of law enforcement and prosecutors.

What you might read on your summer vacation

BY RICHARD P. WENZEL, MD, MSC

For many physicians, summer vacations offer a renewed promise of time to read—just for pure fun. On the beach, in the mountains or at 30,000 feet, there is a sense of excitement about holding a book—or an e-reader—and losing oneself in the make-believe world of fiction or the insightful perspectives of a nonfiction authority.

Ron Smith, a distinguished poet living here in Richmond, recommended that I reread “The Great Gatsby.” I did and loved it, and subsequently I read excellent reviews of “Z: A Novel of Zelda Fitzgerald,” a wonderful companion read to complement F. Scott’s masterpiece. These are great reads. In addition, as an ongoing fan of British author Ian McEwan, I had to pick up his latest work of fiction, “Sweet Tooth,” and highly recommend it as a page-turner full of surprises.

For the more serious reader, I have a firm recommendation: “The Unwinding: An Inner History of the New America” by George Packer, a nonfictional account of the social, political and economic forces shaping the United States in the last 30 years. This is one of those books about which I found myself saying, “Every five-10 years, an author comes by and distinguishes him or herself with such insight as to rise above others.”

A second nonfiction book I would recommend is “Antifragile: Things That Gain From Disorder,” a remarkably provocative work focusing on how the many decisions an individual or a corporation makes need not only to be made durable (that is, non-fragile) but also to thrive in the time of uncertainty—to be antifragile.

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The story of Gatsby takes place in 1922 on Long Island and explores the decay of values resulting from newly-acquired wealth in the fictional town of West Egg. A new arrival to the area, a Midwesterner named Nick Carraway who narrates the novel, eventually receives an invitation to the lavish weekly parties thrown by the mysterious Jay Gatsby at his magnificent mansion. Nearby live Nick’s cousin Daisy and her husband Tom Buchanan, a classmate of Nick’s when both were at Yale.

The plot involves an affair between Tom and a woman named Myrtle Wilson; the unrelenting passion that Gatsby has for Daisy with whom he had an affair before her marriage; and Nick’s romantic relationship with Jordan Baker, a beautiful young woman full of cynicism. The affairs come to light with great twists related to a car accident, lies and deaths.

In 1998 the modern Library Editorial Board voted it the best American novel and the second best novel in the English language.

‘Z: A Novel of Zelda Fitzgerald’

This “novel,” written by Therese Anne Fowler, is a first-person narrative of the creative and creativity-repressed wife of F. Scott Fitzgerald. Fowler follows Zelda in 1918 from her home in Alabama where she met Army officer Fitzgerald. She then moves on to describe their love and marriage, frenetic life in New York City and Paris—attending parties, meeting celebrities in art, music, dance and literature, with never-ending drinking. What emerges is the strong character of Zelda, who is continually met by a domineering and narcissistic husband willing to heap frustrations on this beautiful woman, eventually damaging her physical and mental well-being. Along the way we meet W. Somerset Maugham, Ernest Hemingway, Ezra Pound and numerous other artistic luminaries. It is exceptionally well-written and chronicles the love story of a hugely popular literary couple in the 1920s.

‘Sweet Tooth’

English author Ian McEwan lives in London and has written the highly acclaimed “Atonement,” “Amsterdam,” “Saturday” and several others for which he has won numerous literary awards. “Sweet Tooth” is his...
latest, taking place in 1972 during the Cold War and focusing on a beautiful woman named Serena Frome, an avid book reader who is on a secret MI5 mission, code-named Sweet Tooth. The mission is to secretly supply cash to fund several promising authors who are likely to cast the West in a favorable light. In her formal duties she meets an exciting writer named Tom Haley and falls in love with his "Read," continued from page 17

writing and then with the man. A conflict arises—how and when can she reveal her true self? In the end, is she the one investigating or, in fact, is she the one being investigated?

'The Unwinding: An Inner History of the New America'

This nonfiction work is written by journalist, novelist and playwright George Packer, a writer for The New Yorker on topics related to U.S. foreign policy. Packer is the son of two academics at Stanford and is a Yale graduate himself who early on had spent time in the Peace Corps in Togo. In 2003, he joined The New Yorker as a staff writer. He currently lives in Brooklyn.

“The Unwinding,” published in 2013, recently received the National Book Award. The judges said the following: “...The tale exposes the tattering seams in the national tapestry. In an account of economic decline that traverses large cities and small towns, (Packer) casts a discerning eye on banks and Wall Street while tracing the painful dissolution of much of our economic infrastructure. His compelling profiles of struggling, ordinary workers, amid snapshots of wealthy, ambitious and ever notorious celebrities dramatize the widening gulf between rich Americans and everybody else.”

The theme in “The Unwinding”—the story of America over the last 30 years—is the loss of infrastructure, manners, the social contract, ideals and institutions that held life together; now we have more freedom yet also more illusions, more loneliness and risk. Packer covers the loss of the farms, factories, subdivisions, unions, churches and noble statesmen. The high-profile characters include the following and in general are given scathing reviews: Newt Gingrich, Robert Rubin, Sam Walton, Colin Powell, Oprah Winfrey; only Elizabeth Warren receives positive comments. It’s not a happy book. But it is powerfully written with compelling narratives, and it is convincing.

In the prologue, Packer acknowledges that “unwindings” are not new in American history, but previous

Should you have questions about any of our upcoming meetings, please call the Academy at 804-643-6631.

Academy members had a great time at the Children’s Museum of Richmond in May. Here are some snapshots from our family event!
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Dr. Richard P. Wenzel is Emeritus Professor and former Chair of VCU’s Department of Internal Medicine. In addition to his scholarly work in infectious disease, he is author of two popular books: “Stalking Microbes,” a series of nonfiction essays focusing on the interaction of people and microbes, and “Labyrinth of Terror,” a fictional work on bioterror laced with Greek mythology.

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Nassim Taleb, a former derivatives trader and quantitative analyst, is very much a take-no-prisoner philosopher who is a distinguished professor of engineering at New York University’s Polytechnic School of Engineering. His best-seller, “The Black Swan,” written in 2007, argues that large and improbable yet highly consequential events are not predictable—are beyond statistical modeling.

In “Antifragile,” he argues that such “black swan” events are increasing as the world becomes more complex and global. He then goes on to say that our personal lives and public policies, finances and social lives need to be made not just less vulnerable to such unusual events but thrive—to become, in that sense, “antifragile”—amid such chaos. He thinks that top leaders’ efforts to avoid all volatility actually contribute to the size and adverse events that follow “black swan” events. Taleb brings up his issues often randomly and in a self-promoting language. His is a philosophical selfie writing a book with contradictions but it is a highly provocative discussion of randomness, probability and current uncertainty.

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