HONORING EXCELLENCE

Congratulations to this year’s Edward J. Ill Excellence in Medicine Awards® Recipients
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At MDAdvantage®, our mission is to be a haven of safety, stability and strength for New Jersey healthcare. We advocate for physicians and actively support the practice of medicine in New Jersey. We have earned a reputation for integrity, responsiveness and decisive management, and stand prepared to assist healthcare providers in facing the challenges associated with today’s changing healthcare environment.
Welcome to the Spring issue of MDAvisor. We are pleased to provide our second CME article, which focuses on employment liability issues that physicians face as they manage their practices. We also review the current legislative environment and the hardships facing New Jersey healthcare.

We still have significant numbers of people in New Jersey without the security of health insurance coverage, and Garden State hospitals continue to provide more than $1 billion in charity care services annually to those individuals. Despite this fact, hospital charity care funding faces significant budget cuts in Governor Christie’s fiscal year 2016 budget. Meanwhile, the state seeks to address an anticipated physician shortage, due in part to a recent study that found New Jersey was particularly thin in family and general practice doctors, ranking 45th in the nation for the total number of these specialists per capita. And the percentage of New Jersey physicians accepting new Medicaid patients is the lowest in the nation. Clearly, we still have some work to do.

But despite all of the challenges that face New Jersey healthcare, we are home to some extraordinary healthcare professionals who are putting us on the map with their groundbreaking contributions and advances. I am proud to recognize the 2015 Edward J. Ill Excellence in Medicine award recipients on the cover of this issue, and to include columns from each honoree who eloquently describe the future of their respective fields. Through this awards program, we are able to highlight New Jersey’s reputation for excellence in medicine, research and education and distinguish New Jersey from other states through the recognition of our world-class healthcare leaders and their many accomplishments. I hope you will join me in congratulating the 2015 award recipients and, as you think ahead to next year, consider submitting a nomination for 2016. For more information, see the back cover of this issue or visit www.MDAdvantageonline.com.

Sincerely,

[Signature]

Chairman & CEO
MDAdvantage Insurance Company
ANNOUNCING THE NEWEST MEMBERS OF OUR EMERGING MEDICAL LEADERS ADVISORY COMMITTEE:

The Editorial Board is pleased to welcome the newest members of our Emerging Medical Leaders Advisory Committee:

**John Alexander**
Rutgers University School of Health Related Professions (2016)

**Steven Bialick**
Rowan University School of Osteopathic Medicine (Class of 2016)

**Erin Conway**
Rutgers New Jersey Medical School (2015)

**Kalvin Foo**
Cooper Medical School of Rowan University (2017)

**Ashley Silakoski**
Rutgers Robert Wood Johnson Medical School (2015)

**Emily Weinick**
Seton Hall University School of Health and Medical Sciences (2016)

The Advisory Committee advises the Publishing Staff and Editorial Board on topics, themes and invited papers for future issues of MDAdvisor that address the future of medicine and issues affecting young physicians and healthcare leaders. Committee members also author columns that provide insights into their experiences throughout their education and medical training.

See Emily Weinick’s column “There’s No Such Thing as Leaving Your Work at the Door” on page 35 and Steve Bialick’s column “The Power of a White Coat” on page 36. Look for the contributions of our other Emerging Medical Leaders Advisory Committee members in upcoming issues.

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A Journal for the Healthcare Community

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Lawrenceville, NJ 08648-2104

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LETTER FROM MDADVANTAGE® CHAIRMAN & CEO PATRICIA A. COSTANTE

AGUAS V. NEW JERSEY AND ITS IMPACT ON AN EMPLOYER’S VICARIOUS LIABILITY FOR HARASSMENT
By DanaLynn T. Colao, Esq., and John M. Losinger, Esq.

PERSPECTIVES ON HEALTHCARE FROM THE 2015 EDWARD J. ILL EXCELLENCE IN MEDICINE HONOREES
Edited by Janet S. Puro, MPH, MBA

E-CIGARETTES: A PUBLIC HEALTH CHALLENGE
By Commissioner Mary E. O’Dowd, MPH, & Deputy Commissioner Arturo Brito, MD, MPH

CHIKUNGUNYA VIRUS IN NEW JERSEY: WILL WE SEE A NEW ARBOVIRUS EPIDEMIC IN THE U.S.?
By Ronald G. Nahass, MD, Kathleen H. Seneca, MSN, APN, and Robert E. Segal, MD

WHATEVER HAPPENED TO COMMUNITY-ORIENTED PRIMARY CARE?
By Ellen S. More, PhD

NEW JERSEY LEGISLATIVE UPDATE: 2016 BUDGET & LEGISLATIVE BILLS TARGETING HEALTHCARE
By Michael C. Schweder

THERE’S NO SUCH THING AS LEAVING YOUR WORK AT THE DOOR
By Emily D. Weinick, Emerging Medical Leaders Advisory Committee Member

THE POWER OF A WHITE COAT
By Steve Bialick, Emerging Medical Leaders Advisory Committee Member
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1) Review the CME information along with the learning objectives at the beginning of the CME article. Determine if these objectives match your individual learning needs. If so, read the article carefully.

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3) Complete the evaluation portion of the Registration and Evaluation Form. Forms and quizzes cannot be processed if the evaluation section is incomplete.

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5) Retain a copy of your test answers. Your answer sheet will be graded, and if a passing score of 70% or more is achieved, a CME certificate awarding AMA PRA Category 1 credit™ and the test answer key will be mailed to you within 4 weeks. Individuals who fail to attain a passing score will be notified and offered the opportunity to reread the article and take the test again.

6) Mail the Registration and Evaluation Form on or before the deadline, which is May 1, 2016. Forms received after that date will not be processed.

Authors: DanaLynn T. Colao, Esq., and John M. Losinger, Esq., of Saiber LLC

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The bottom line is this: New Jersey law says that an employer can be liable for sexual harassment even if the harasser is not a decision maker for the company. This is something that all medical practices have to keep in mind as they develop and enforce anti-harassment policies.

Both federal and state law assert that an employer may be held liable in situations where an employee is alleged to have harassed another employee if the employer was independently negligent or reckless in allowing the harassment to occur. An employer may also
be vicariously liable, even without being negligent, if the harassment was perpetrated by a supervisor.

However, federal law and New Jersey state law have differing definitions of the term supervisor. Under the federal definition set forth by the U.S. Supreme Court, supervisors who control tangible employment decisions, such as hiring, termination, promotion and reassignment, can expose an employer to vicarious liability for sexual harassment. But federal law and New Jersey state law have differing definitions of the term supervisor. Under the federal definition set forth by the U.S. Supreme Court, supervisors who control tangible employment decisions, such as hiring, termination, promotion and reassignment, can expose an employer to vicarious liability for sexual harassment. The Supreme Court of New Jersey recently adopted a broader definition of supervisor that may expose an employer to vicarious liability for harassment perpetrated by any employee who merely “controls the daily activities of other employees.”

Unlike the federal definition, New Jersey’s definition of supervisor exposes employers to vicarious liability for the actions of a vast number of employees who have no traditional supervisory authority to hire, fire, promote or reassign employees.

Consider, for example, a small medical practice with six principal doctors, two nurses, a bookkeeper, an administrative assistant and three receptionists. The doctors make all decisions regarding hiring, termination, employee compensation and performance evaluation. The administrative assistant sets the daily schedule for the three receptionists. Due to her years of experience with the practice, she is perceived by others to oversee the office. In reality, she has no supervisory responsibilities and no ability to make any independent decisions that affect the practice or its employees. Nonetheless, based on the Supreme Court of New Jersey’s recent decision in Aguas v. State of New Jersey, if the administrative assistant was accused of harassing another employee, the medical practice could be vicariously liable for her actions simply because she controls the “daily activities” of the other employees and could therefore be considered a “supervisor.”

In the modern workplace, where administrative tasks, such as scheduling, are often delegated to low-level employees, New Jersey’s broad definition of the term supervisor poses an increased risk of liability for all employers. Fortunately, employers can avoid liability and protect employees from harassment by implementing an effective anti-harassment policy, educating employees about the policy, enforcing the policy and promptly investigating all concerns or complaints that may give rise to a claim for harassment. These types of affirmative measures will promote a workplace where employees understand that harassment is not tolerated and will allow the employer the opportunity to avail itself of an affirmative defense to avoid vicarious liability for the potentially harassing actions of “supervisory” employees.

**THE ELLERTH/FARAGHER AFFIRMATIVE DEFENSE**

A claim for hostile work environment sexual harassment is actionable if the harassment would not have occurred but for the employee’s gender, and it was severe or pervasive enough to make a reasonable person believe that the conditions of employment have been altered and the working environment is hostile or abusive.

An employer may be vicariously liable for such a sexual harassment claim, based upon a fact-specific analysis of 1) whether the employer delegated authority to the supervisor to control the situation of which the plaintiff complains, 2) whether the supervisor exercised that authority, 3) whether the exercise of authority resulted in harassment or discrimination, and 4) whether the authority delegated by the employer to the supervisor aided the supervisor in injuring the plaintiff.

An affirmative defense to sexual harassment claims against employers was first established in Burlington Industries v. Ellerth and Faragher v. City of Boca Raton and is referred to as the Ellerth/Faragher affirmative defense. The defense allows an employer to avoid liability in situations in which the employer has exercised reasonable care to prevent and promptly correct harassing behavior and the plaintiff employee unreasonably failed to take advantage of any preventive or corrective opportunities provided by the employer.

**AGUAS V. STATE OF NEW JERSEY**

On February 11, 2015, the Supreme Court of New Jersey held that the Ellerth/Faragher affirmative defense, which the federal courts have recognized for several years in cases under Title VII of the Federal Civil Rights Act, is available to employers under New Jersey’s Law Against Discrimination (LAD).

Aguas involved an employee, Ilda Aguas, who alleged that her supervisors subjected her to sexual harassment in the workplace. Ms. Aguas was employed by the New Jersey Department of Corrections (DOC) as a Senior Corrections
Officer assigned to the third shift (10:00 p.m. to 6:00 a.m.). She alleged that Area Lieutenant Darryl McClish, who was the highest-ranking officer during the third shift, sexually harassed her by making inappropriate, sexually charged comments and by making unwanted physical contact with her.\(^7\)

Ms. Aguas alleged that in October 2009, Lt. McClish made a comment to her about accompanying him to a motel and made a comment about her having a romantic relationship with another officer. She also alleged that Lt. McClish “sat in her lap face-to-face while blowing his whistle and gave her a ‘lap dance’ by grinding his pelvis into her and shaking his face close to her face.” Ms. Aguas alleged that, on another occasion, Lt. McClish “approached her from behind, put her in a hold with her hands behind her back and pulled up to her shoulder blades. According to Aguas, McClish then bent Aguas over the table with his genital area touching her buttocks and repeatedly said, ‘What are you going to do?’”\(^8\)

At all relevant times, the DOC had a written policy prohibiting discrimination and harassment in the workplace:

- The policy states a commitment ‘to providing every State employee and prospective employee with a work environment free from discrimination or harassment.’ It proscribes ‘sexual (or gender based) harassment of any kind.’ Among other prohibited behaviors, the policy bars ‘unwanted physical contact such as intentional touching, grabbing, pinching, brushing against another’s body or impeding or blocking movement,’ as well as ‘verbal, written, or electronic sexually suggestive or obscene comments, jokes or propositions.’\(^9\)

- The policy also “encourages employees subjected to harassment to ‘promptly report the incidents to either a supervisor, or directly to the DOC’s Equal Employment Division/Affirmative Action Officer,’ without specifying that the employee must report the incident in writing.”\(^10\)

Ms. Aguas verbally reported the alleged sexual harassment to Captain and Acting Chief Robert Ryan, who advised her to meet with Assistant Administrator Helen Adams. Ms. Aguas alleged that she rejected Ms. Adams’ advice to report the harassment in writing because she feared retaliation.\(^11\) Based upon Ms. Aguas’ verbal complaint of sexual harassment, the DOC’s Equal Employment Division conducted an investigation of the allegations and concluded that they were unsubstantiated.\(^12\)

Ms. Aguas filed suit against the DOC alleging that it was negligent or reckless in allowing the sexual harassment to take place, and that the DOC was vicariously liable for the sexually harassing actions of her supervisors.\(^13\)

The trial court considering the DOC’s Motion for Summary Judgment found that Ms. Aguas presented sufficient evidence to suggest that she had been subjected to severe and pervasive sexual harassment. However, the trial court concluded that the DOC had established an affirmative defense by showing that the department had a written policy against discrimination, harassment and retaliation that included a procedure for reporting, and that Ms. Aguas failed to utilize the reporting procedure set forth in the policy.

After the intermediate appellate court affirmed the trial court’s decision, the Supreme Court of New Jersey granted certiorari and reversed the trial court’s dismissal of Ms. Aguas’ claims. The Court remanded the case to the trial court to be decided in accordance with its holdings relating to the application of the Ellerth/Faragher affirmative defense.

First Finding: The Ellerth/Faragher affirmative defense is applicable to claims of vicarious liability for a supervisor’s sexually harassing actions. Despite a strong dissent from Justice Albin and Chief Justice Rabner, the majority held that the Ellerth/Faragher affirmative defense is applicable in cases brought under the New Jersey LAD that involve vicarious liability for a supervisor’s sexually harassing actions.

The Court reasoned that “the existence and enforcement of a policy charging supervisors with ensuring a harassment-free workplace is central” to the analysis of whether an employer was vicariously liable and that the Ellerth/Faragher affirmative defense serves to motivate employers to create and enforce a policy against harassment.\(^14\) Based upon these and other considerations, the Court determined that the affirmative defense is applicable to supervisor sexual harassment cases brought under the New Jersey LAD as long as the supervisor’s harassment has not culminated in a tangible employment action, such as discharge, demotion or undesirable reassignment.\(^15\)

In consideration of the dissent’s argument that
employers will hide behind “paper anti-discrimination policies,” the majority specified that “the defense provides no protection to an employer whose sexual harassment policy fails to provide meaningful and effective policies and procedures for employees to use in response to harassment.” The Court clarified that the affirmative defense provides no benefit to “employers who fail to implement effective anti-harassment policies” or to “employers whose policies exist in name only.” In order to be effective, an employer’s policy must be understood by employees and supervisors, and the employer must adequately address and investigate all complaints of harassment.

Second Finding: Employers may be liable for harassing actions of any employee who has control over the daily activities of other employees. The second significant holding in Aguas involved a determination of which employees will be considered supervisors for purposes of imposing vicarious liability upon employers. The U.S. Supreme Court recently defined supervisor as follows:

An employer may be vicariously liable for an employee’s unlawful harassment only when the employer has empowered that employee to take tangible employment actions, i.e., to effect a significant change in employment status, such as hiring, firing, failing to promote, reassignment with significantly different responsibilities, or a decision causing a significant change in benefits.

In Aguas, the Supreme Court of New Jersey rejected that definition of supervisor and adopted a much broader one that includes “not only employees granted the authority to make tangible employment decisions, but also those placed in charge of the complainant’s daily work activities.” The Court reasoned that this broad definition, and expanded scope of liability, will prompt employers to focus attention not only on an elite group of decision-makers at the pinnacle of the organization, but on all employees granted the authority to direct the day-to-day responsibilities of subordinates, and to ensure that those employees are carefully selected and thoroughly trained.

The expanded definition of supervisor means that employers are now potentially liable for the harassing actions of a wide range of employees, beyond those who are charged with making tangible employment decisions.

“In order to satisfy the requirements of the Ellerth/Faragher defense, a ‘meaningful and effective’ policy must be comprehensive and must communicate the employer’s commitment to maintaining a work environment that is free from all forms of discrimination, harassment and retaliation.”

AN EMPLOYER MUST IMPLEMENT AND ENFORCE EFFECTIVE ANTI-HARASSMENT POLICIES

In the hypothetical case set forth above, the administrative assistant who controls the scheduling for the receptionists may be classified as a supervisor under Aguas. If the administrative assistant was found to have engaged in harassing conduct toward a coworker, the medical practice could be held vicariously liable for her conduct—even though such acts would clearly be outside the scope of her assigned responsibilities. The only way the medical practice could potentially avoid such liability would be to assert the Ellerth/Faragher affirmative defense by demonstrating that it had a “meaningful and effective” policy against harassment in the workplace and the plaintiff employee failed to take advantage of the policy.

In order to satisfy the requirements of the Ellerth/Faragher defense, a “meaningful and effective” policy must be comprehensive and must communicate the employer’s commitment to maintaining a work environment that is free from all forms of discrimination, harassment and retaliation. The policy must clearly define discrimination, harassment and retaliation and provide examples of the types of conduct that are strictly prohibited, including, but not limited to, demands for sexual favors; sexually oriented verbal kidding, teasing or joking; repeated offensive sexual flirtations, advances or propositions; continued or repeated sexual abuse of a sexual nature; graphic or degrading
comments about an individual or his or her appearance; the display of sexually suggestive objects or pictures; subtle pressure for sexual activity; and/or physical contact or blocking movement.

An effective and meaningful policy must also include a complaint procedure that encourages employees to come forward with any and all concerns about conduct that potentially violates the policy. The policy should expressly state that all complaints of discrimination, harassment and/or retaliation will be promptly and thoroughly investigated and that, if the allegations are substantiated, appropriate remedial and disciplinary action will be taken.

The complaint procedure should designate at least two individuals to whom employees can report potentially inappropriate behavior. It is important for an employer to designate individuals who have been properly trained to respond to complaints and to whom employees will feel comfortable speaking about the inappropriate behavior of other employees. The designated individuals must be educated about the importance of maintaining the confidentiality of the complaint. The complaint procedure should specify that complaining employees will be required to disclose all details of the alleged inappropriate conduct, to identify witnesses and to provide any e-mails or other documents that directly or indirectly relate to the complaint.

In order to protect employees from harassment and to protect itself from liability, it is imperative that the employer take affirmative steps to ensure that employees feel comfortable about coming forward with concerns of harassment or discrimination. Many employees who have been harassed or discriminated against are afraid to speak up because they do not want to lose their jobs or because they fear some other form of retaliation. Similarly, many employees who witness improper conduct are hesitant to participate in an investigation or to corroborate a coworker's allegations because they fear for their jobs. To address these concerns, an employer's policy must specifically state that retaliation against an employee who brings a complaint or who participates in an investigation is strictly prohibited and will not be tolerated. The policy should also specify that employees who believe they have been retaliated against are to report such conduct in accordance with the complaint procedures and that their allegations will be promptly investigated.

By taking affirmative steps to ensure that its policies are sufficiently comprehensive to give rise to the Ellerth/Faragher affirmative defense, employers will not only be protecting themselves from potential liability, they will be creating and promoting a workplace in which employees understand that harassment, discrimination and retaliation will not be tolerated and that their complaints will be taken seriously.

DanaLynn T. Colao, Esq., is a member of the law firm Saiber LLC. John M. Losinger, Esq., is an associate with Saiber LLC.

4 Aguas, supra at p. 25 (quoting Lehmann v. Toys ’R’ Us, Inc., 132 N.J. 587, 620 (1993)).
6 Ellerth, supra. 524 U.S. at 765; Faragher, supra. 524 U.S. at 807–08.
7 Aguas, supra. at pp. 7–10.
8 Id.
9 Id. at p. 5.
10 Id. at p. 6.
11 Id. at p.11.
12 Id. at pp. 11–12.
13 Id. at p. 12.
14 Id. at p. 26.
15 Id. at pp. 25–38.
16 Id. at pp. 38–40.
17 Id. at pp. 39–40.
18 Vance, supra. 133 S. Ct. at 2434.
19 Aguas, supra. at p. 46–47.
20 Id. at p. 47.
1) In New Jersey, an employer may be found vicariously liable, even without being negligent, if the harassment was perpetrated by a supervisor.
   a) True
   b) False

2) Under which jurisdictions can supervisors who have traditional supervisory authority to hire, fire, promote or reassign employees expose their employer to vicarious liability for sexual harassment?
   a) Federal
   b) New Jersey
   c) Both federal and New Jersey
   d) None of the above

3) New Jersey’s definition of supervisor is ______________________ the federal law.
   a) Broader than
   b) More narrow than
   c) The same as

4) In New Jersey, an employer may be vicariously liable for an employee’s unlawful harassment only when the employer has empowered that employee to take tangible employment actions.
   a) True
   b) False

5) An effective and meaningful anti-harassment policy should state that employees who make allegations that are ultimately found to be unsubstantiated should be prepared to face retaliation by the employer and/or the defendant employee.
   a) True
   b) False

6) Under New Jersey state law, sexually oriented verbal kidding, teasing or joking will never constitute harassment.
   a) True
   b) False

7) The Ellerth/Faragher affirmative defense is not applicable in supervisor sexual harassment cases brought under New Jersey’s Law Against Discrimination.
   a) True
   b) False

8) To benefit from the Ellerth/Faragher affirmative defense, a physician employer must:
   a) Have a meaningful and effective policy against harassment
   b) Address and investigate all complaints of harassment
   c) Demonstrate that the plaintiff employee failed to take advantage of the harassment policy
   d) A and B
   e) All of the above
AGUAS v. NEW JERSEY and its impact on an EMPLOYER’S VICARIOUS LIABILITY FOR HARASSMENT

REGISTRATION & EVALUATION FORM
(Must be completed in order for your CME Quiz to be scored – Deadline May 1, 2016)

REGISTRATION FORM
First Name ___________________________ Middle Initial ___________________________ Last Name ___________________________ Degree ___________________________
Practice Name ___________________________ Address ___________________________
City ___________________________ State ___________________________ ZIP ___________________________
Phone ___________________________ E-mail Address ___________________________ Specialty ___________________________

ANSWER SHEET  Circle the correct answer.

Number of hours spent on this activity _______ (reading article and completing quiz)
I attest that I have read the article “AGUAS v. NEW JERSEY and Its Impact on an Employer’s Vicarious Liability for Harassment” and am claiming 1 AMA PRA Category 1 Credit.™

Signature ___________________________ Date ___________________________

EVALUATION  Completed by ___________________________  ☐ Physician  ☐ Non-Physician
1. The content of the article was: Excellent___ Good___ Fair___ Poor___
2. The authors’ writing style was: Excellent___ Good___ Fair___ Poor___
3. The graphics included in the article were: Excellent___ Good___ Fair___ Poor___
4. The stated objectives of this program were: Exceeded___ Met___ Not met___

Was this article free of commercial bias? Yes _________ No _________
If not, why not ____________________________________________________________

Please share your name and contact information so that we may investigate further.
Participant Name ___________________________ Telephone/E-mail: ___________________________

5. Will the knowledge learned today affect your practice? Very Much____ Moderately____ Minimally____ None____
6. Based on your participation in the CME activity, describe ways in which you will change the way you practice medicine.
   ___Yes Describe                                                                                     ___________________________
   ___No Why Not                                                                                       ___________________________
   ___N/A Were you the wrong audience for this activity? ___________________________

7. Did this CME activity change what you know about:
   • Differentiate between the federal and New Jersey definitions of the term supervisor.  Yes ☐ No ☐
   • Discuss how physician employers can avoid liability and protect employees from sexual harassment. Yes ☐ No ☐
   • Explain how to establish an Ellerth/Faragher affirmative defense against supervisor sexual harassment cases. Yes ☐ No ☐
   • Describe how to implement and enforce effective anti-harassment policies. Yes ☐ No ☐

8. Based on your participation today, what barriers to the implementation of the strategies or skills taught today have you identified?
   ___________________________

Suggested topics for future programs: ___________________________
The 2015 Edward J. Ill Excellence in Medicine honorees all have one thing in common: They constantly challenge themselves and those in their fields to improve the way the medical community provides quality care to patients. We asked these distinguished healthcare professionals to consider the future of their respective fields and to discuss the greatest challenges they face. The replies give us a peek at the work, as well as the concerns and the hopes, of these remarkable and diverse leaders in healthcare.
Outstanding Medical Educator Award
Richard P. Mackessy, MD
Orthopaedic surgeon, Union County Orthopaedic Group and Chief of the Orthopedics Department at Trinitas Regional Medical Center

The preparation of future physicians in these times is a threefold process. First, there is the calling of the profession itself, then the remarkable physical and mental demands made on the physician and, last, key obstacles that must be overcome in order to put the first two into play.

The calling comes to each new physician in its own unique way, but for all of us, it is built on a passion to help others. This passion, however, is not always enough. We have to understand the physical and emotional stamina that is needed to do our job. We have to understand the role of our families in maintaining this stamina. We must also commit to lifelong learning and patient-centered care built on empathy if we expect to keep the passion alive.

Last, we must overcome the obstacles that occur in the day-to-day business of healthcare and tear us away from the passion that fueled our initial calling. The need to be united to solve our problems is key, and thus, we must use our medical organizations to form an effective lobby for us. We need business advice and business models so we can run our practices; we have to take back autonomy so we can make appropriate medical decisions without inappropriate government interference. We need to negotiate fair rates with insurance companies, control malpractice costs and determine how to best deal with the institution of electronic medical records. We must know how to deal with our own specialty boards and with costly recertification. We must figure out what obstacles can be overcome so that taking an emergency room call is not so burdensome. We must learn how to combat the “customer service” model of medicine and bogus Internet evaluations. We must also be taught not to be apologetic about being paid well, especially since that is often not now the case. We must work as a group to overcome these obstacles.

When these obstacles have been addressed, then our future physicians can use their intellectual and physical talents to connect with and heal another human being—to establish the Human Moment. That is the main reward that drives our profession.

Outstanding Healthcare Executive Award
Amy B. Mansue
President and Chief Executive Officer, Children’s Specialized Hospital, Mountainside, New Jersey

In any time of unprecedented change, there are both challenges and opportunities. The healthcare industry is currently going through such a turbulent period; it will never be the same again. I say this because the intersection of unprecedented change in technology, patients’ increased out-of-pocket cost expense and different expectations for the customer experience will be nothing short of transformational.

For patients, this is a wonderful opportunity to take more ownership and partnership with their healthcare professionals regarding their health. For the professionals, it will be a sea change. Patients are going to want more answers and expect those answers to be fast with high levels of engagement from their care providers. Speed has not been what is common or, in some cases, even desirable in healthcare. This will cause huge stress on the marketplace but tremendous opportunity for health systems like ours.

If, as members of the healthcare community, we do not capitalize on opportunities for improvement or advancement in process or in the way in which healthcare is delivered, we will soon be irrelevant and obsolete. At Children’s Specialized Hospital, which is considered a “specialty healthcare provider,” we have to seize every opportunity to meet the ever-increasing demands of our patients. Anticipating their unspoken needs and staying
ahead of the curve are key to any care provider’s success. In just the past few years, Children’s Specialized Hospital has opened several new locations and launched an interactive patient portal. We are now sending robots home with our most fragile patients so physicians can use HIPAA-compliant telepresence to examine patients and answer questions immediately. We created and implemented a brand-new model of care specifically for children with specialty pediatric healthcare needs, and we designed a digital resource that educates families about choosing the best health insurance plans for their children with special needs.

All of this could not be possible without including our patient families in every decision we make. We survey parents of current or former patients to guide our decisions and determine the direction in the improvements we make, and these parents help us keep our eye on the objective—keeping the entire family the focus of all we do.

Do not shy away from change. Turning obstacles into opportunities is how you will survive.

We all would benefit from having a primary care physician. This physician would not only treat our diseases but also, more importantly, would help keep us healthy. For children, the ideal primary care provider is a pediatrician who looks for the child’s and the parents’ strengths and uses them to keep the child healthy. I do not think that the public or the insurance industry appreciates the value of primary care and the medical home. In fact, the opening of minute clinics, urgent care centers and online medical advice challenge the concept of a medical home and continuity of care. These services can easily fragment care and negatively impact a person’s health.

The second challenge is payment of primary care doctors, especially pediatricians. Notice that I use the word payment, not reimbursement. We must be paid for what we do; reimbursement is appropriate for something like travel expenses, but payment is what is required when a person visits a physician. Inadequate payment limits access.

Finally, all physicians must be lifelong learners. The explosion of knowledge means that we find ourselves falling behind daily. It seems the more we know, the more we realize there is much more to know. This is a wonderful aspect of science—there is always more to discover!
mTOR, which stands for mechanistic target of rapamycin. mTOR's discovery can be traced back to the isolation of the bacterial antibiotic, rapamycin, from soil samples originating from Rapa nui (Easter Island). This drug was shown early on to have immunosuppressive action and to block growth of T cells. mTOR controls nutrient uptake and metabolism and is critical for the regulation of growth or cell size. Since the discovery of mTOR in the 1990s, rapamycin is not only used as an immunosuppressant but also is currently undergoing clinical trials as an anti-cancer drug. Intriguingly, it is also touted to prolong lifespan in animals, including mice. However, clinical applications, along with the importance of mTOR in physiological and pathological processes, have yet to be explored.

Research in my lab aims to understand how mTOR orchestrates nutrient uptake, metabolism and cell growth. We know that mutations in mTOR and members of the mTOR signaling pathway often occur in a number of cancers. When this pathway becomes overactivated, cells take up and metabolize nutrients ravenously and multiply uncontrollably. Our lab is particularly interested in how mTOR signals become deregulated in breast cancers and in T cell lymphoma. It is exciting to realize that a better understanding of the role of mTOR in the growth and metabolic signaling network will allow us to identify predictive biomarkers in tumors that can be highly susceptible to mTOR inhibitors as cancer therapy.

The challenge going forward is to understand, given the role of mTOR in immune regulation, how manipulating the mTOR and metabolic pathways can be exploited for immunotherapy.

OUTSTANDING MEDICAL RESEARCH SCIENTIST AWARD FOR CLINICAL RESEARCH
M. Maral Mournadian, MD

William Dow Lovett Professor of Neurology and Director of the Center for Neurodegenerative and Neuroimmunologic Diseases in the Department of Neurology at Rutgers Biomedical and Health Sciences, Robert Wood Johnson Medical School

A physician often has to deliver bad news to a patient. This is certainly true in our field that deals with devastating, progressive neurodegenerative disorders for which no cure is available. Explaining to patients the natural course of such an illness, telling them that they will likely have difficulties with their basic activities of daily living, walking and even thinking cannot be the highlight of a career. But, as a physician-scientist equipped with the knowledge and personal experience of the latest discoveries about the patient’s disease, conveying that glimmer of hope makes a huge difference, not only for the patient but also for the physician.

This dialogue becomes the foundation of an ongoing partnership between the two in which the physician provides patients with the intellectual tools to hope for the promise of new discoveries that might help them in their lifetime or, in some cases, help their descendants. That has been my experience treating patients with Parkinson’s disease and conducting basic, translational and clinical research at the same time.

Looking back at the pace of research in neurodegenerative diseases over the past several decades, it is clear that we are now living during the boom time of biomedical sciences. Technological advances in genomics, the transcriptome, protein structure, molecular modeling and high throughput screening have opened up wide-ranging opportunities for creating new hypotheses, designing new drugs and testing them in animal models and eventually in patients. Believing that we are poised to make paradigm-shifting discoveries in many of these diseases is exhilarating. There is certainly no shortage of brilliant ideas about how best to find cures for debilitating disorders, even though the road to such a goal is never a straight line or without setbacks. However, for physician-scientists, giving up when hitting a roadblock in an experiment is not an option, not for the sake of the patient for whom we have to keep the flame of hope burning and not for fulfilling a career committed to making a large impact beyond one patient at a time.
Standing on the sidelines and complaining does not help anyone—neither the individual physician nor the profession as a whole.

Doctors need to be involved: Join your local, state and national medical societies and organizations. Engage with your government representatives.

For doctors, patient care is paramount to service. We as physicians pledge to care for our patients to the best of our abilities. It is incumbent on all of us to do the right thing for our patients, including care for the military—active duty, reservists and retirees—as well as their dependents. Every physician should accept TRICARE insurance as a show of support by the medical community to those individuals who wrote a blank check to this nation, pledging to keep us safe, regardless of risk to their own lives.

In addition to service to our neighbors and our country, we, as physicians, owe a service to our profession as we face the many obstacles that challenge the medical profession. Standing on the sidelines and complaining does not help anyone—neither the individual physician nor the profession as a whole. Doctors need to be involved: Join your local, state and national medical societies and organizations. Engage with your government representatives. Express your concerns and issues, on behalf of your patients and your profession. If we, as physicians, do not tend to and care for our profession, no one else will. We must be the captain of our ship. In doing so, we are the champions and protectors of our profession and ultimately patient care.

It is said in the Bible (Isaiah 6:8) that God asked, “Whom shall I send?” The response came: “Here am I. Send me!” Here we are, doctors, ready to provide care and service to the community, the nation and the profession of medicine.

Janet S. Puro, MPH, MBA, is Vice President of Business Development and Corporate Communications at MDAvantage Insurance Company.

Peter W. Rodino, Jr.,
Citizen's Award®
Captain Joseph P. Costabile, MD
General and vascular surgeon, Virtua Surgical Group

Service to our communities, nation and profession is a responsibility physicians, as leaders, must accept and, more importantly, provide. It is good for all, and it is what makes our nation the greatest nation on earth.

For doctors, patient care is paramount to service. We as physicians pledge to care for our patients to the best of our abilities. It is incumbent on all of us to do the right thing for our patients, including care for the military—active duty, reservists and retirees—as well as their dependents. Every physician should accept TRICARE insurance as a show of support by the medical community to those individuals who wrote a blank check to this nation, pledging to keep us safe, regardless of risk to their own lives.
Health advocates have seen tremendous progress in reducing smoking in our state and nation. However, electronic cigarettes (e-cigarettes) pose a new public health challenge. E-cigarettes have been promoted as a substitute for traditional cigarettes for smokers looking to quit. Although many believe that e-cigarettes are a safer alternative to conventional smoking, this has not been scientifically proven. What is known is that nicotine (which is present in e-cigarettes as well as traditional cigarettes) is a highly addictive drug and that smoking harms nearly every organ of the body, causing many diseases and 90 percent of all lung cancer deaths.

TARGETING OUR YOUTH

Of particular concern is that nationally the use of e-cigarettes is increasing among our youth. The same generation who would have most benefited from the success in reducing traditional smoking in our society are the targets for this new nicotine product.

More than a quarter of a million youth who had never smoked a cigarette used e-cigarettes in 2013, according to a Centers for Disease Control and Prevention (CDC) study published in the journal Nicotine and Tobacco Research. This number reflects a three-fold increase from approximately 79,000 in 2011 to more than 263,000 in 2013. E-cigarettes are also more often marketed towards and appealing to children and adolescents. The same CDC study, which surveyed middle and high school students, showed that youth who had never smoked conventional cigarettes but who used e-cigarettes were almost twice as likely to have intentions to smoke conventional cigarettes as those who had never used e-cigarettes. Among non-smoking youth who had ever used e-cigarettes, 43.9 percent said they have intentions to smoke conventional cigarettes within the next year, compared with 21.5 percent of those who had never used e-cigarettes. Flavored of e-cigarettes may increase the appeal to youth; there is some evidence suggesting that most have tried and prefer sweet- followed by menthol-flavored e-cigarettes. Enticing flavors of electronic cigarettes include cherry, chocolate, gummy bear and bubble gum. Nationally, 10 percent of high school students reported being current users of e-cigarettes in
2012; in New Jersey, the number is much smaller at 6.1 percent. Still, as we see more young adults using e-cigarettes, the impact of this unregulated product on the health of our youth is concerning.

The U.S. Food and Drug Administration (FDA) conducted a laboratory analysis of electronic cigarette samples and found that at least half of the brands contain carcinogens and toxic chemicals such as diethylene glycol, an ingredient used in antifreeze. In addition to chemicals, e-cigarettes deliver nicotine, a highly addictive chemical, increasing the likelihood of lifelong use of tobacco products. Like heroin or cocaine, nicotine changes the way the brain works and causes the user to crave more and more nicotine. Most smokers become addicted to nicotine, a drug that is found naturally in tobacco. More people in the United States are addicted to nicotine than to any other drug.

The rise in e-cigarette use can hurt more than just the user. In 2014, the CDC released a study noting a steady and rapid increase in the number of calls to poison control centers nationwide about e-cigarettes and ingestions of liquid nicotine. The analysis compared total monthly poison center calls involving e-cigarettes and conventional cigarettes and found the proportion of e-cigarette calls jumped from 0.3 percent in September 2010 to 41.7 percent in February 2014. More than half the calls were about children less than five years of age, the most vulnerable to the toxic effects of nicotine. Although the most common adverse effects include nausea, vomiting and eye irritation, death is a real risk. In an e-mail communication with a representative of the New Jersey Poison Information and Education System (NJPIES) on January 30, 2015, the authors learned that calls to NJPIES have also risen from nine calls in 2011 to 45 calls in 2014 related to e-cigarettes or liquid nicotine.

**PUBLIC AWARENESS AND CONSUMER PROTECTION**

New Jersey is working to limit the impact e-cigarettes have on our youth. The Department of Health has been working to raise awareness of the serious health risk, particularly to young children, of liquid nicotine commonly used in e-cigarettes. The Department, through newspaper articles, letters to caregivers and alerts, is highlighting the potentially deadly toxic properties of nicotine, an active ingredient used at varying levels in e-cigarette liquids, which are unregulated products sold over the counter in convenience stores.

The Department is reaching out to partners across the state to join in alerting the public to the dangers of e-cigarettes and liquid nicotine. For example, the Department is asking local health departments to distribute a warning advisory online and during the course of their routine inspections of restaurants, bars and other retail food establishments. The goal of the Department’s liquid nicotine poison prevention efforts is to protect the lives of children and prevent tragic and avoidable harm through public awareness and consumer protection. This initiative builds on New Jersey’s leadership in addressing the health risks posed by e-cigarettes.

New Jersey has led the nation as the first state to include e-cigarettes as a tobacco product in the Smoke Free Air Act, which was amended in 2010 to ban the use of e-cigarettes in...
public places and workplaces and ban e-cigarette sales to people under the age of 19.\(^\text{11}\)

New Jersey also has a specific initiative to help reduce the incidence of women smoking during pregnancy. Mom’s Quit Connection (MQC) links pregnant women and new mothers in New Jersey who want to quit smoking with Certified Tobacco Treatment Specialists to help them decrease the number of cigarettes they smoke with the goal of becoming smoke free. Funded by the Department of Health, this free, individualized counseling can make a critical difference in the health of mother and baby. New Jersey also has a Quitline that can help all residents stop smoking. Quitline is a toll-free hotline (1-866-NJSTOPs) that offers three free counseling sessions and a two-week supply of nicotine replacement therapy.

The FDA has announced plans to regulate e-cigarettes, but that will take time, and our children cannot wait. The Department urges the state’s healthcare providers to talk to patients about e-cigarettes. Parents and guardians need to be aware that these products are being marketed to their children. Working together, we can prevent New Jersey’s youth from entering into life-long nicotine addiction.

Mary E. O’Dowd, MPH, is the Commissioner of the New Jersey Department of Health. Arturo Brito, MD, MPH, is the Deputy Commissioner of the New Jersey Department of Health.\(^\text{m}\)

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Dominic A. DeLaurentis, Jr.

David P. Brigham  
Robert D. Brown  
Marcia Stander Freedman  
John A. Talvacchia  
Scott C. Bushelli  
Sharon K. Galpern

Bryan Gaster  
Scott N. Wilson  
Laura A. Tull  
Douglas C. Maute  
Erica L. Busch  
Edward I. Wicks
It is only a matter of time before endemic transmission of the chikungunya virus (CHIKV) occurs in the United States. The factors discussed in this article regarding the increase in CHIKV case numbers, the geographic proximity of the Caribbean to the United States and the presence of competent vectors in large areas of the country point out why it is vital for physicians to remain aware of CHIKV as a potential diagnosis. Certainly, early identification of CHIKV can prevent widespread, localized transmission.

BACKGROUND

Chikungunya virus is an arbovirus of the alphavirus genus of the Togavirus family that causes chikungunya fever (CHIKF). Arboviruses are arthropod-borne viruses from the Flavi, Alpha and Bunya virus genera. CHIKV infections are endemic in Africa, Asia and Europe, with most concern recently focusing on India and Pakistan.1,2 Although epidemics are supported by human-to-human spread, various animal reservoirs have been identified, including birds, monkeys, rodents and other vertebrates. Sporadic cases of CHIKF occur in parts of Europe, and actual transmission of the virus has been reported.1,2 In December 2013, the first autochthonous cases were identified in the Caribbean islands. Since then, transmission has been documented in 17 countries, including Dominica and Haiti.1 Aedes aegypti and Aedes albopictus are found in the United States, and both have been shown to transmit CHIKV in regions where the infection is endemic. Ae. albopictus, the Asian tiger mosquito, is more ubiquitous and gives the greatest concern for establishment of endemic transmission in the United States.3 We report two cases of CHIKF in travelers to the Caribbean who returned to New Jersey in May 2014 with active infection.

REPORT OF CASES

CASE 1

A healthy 48-year-old female traveled to Haiti in mid-May 2014 for 10 days. Two days before her return to New Jersey, she began to feel warm, with diffuse joint aches and itchy skin. Her symptoms continued with low-grade fever of 100°F, fatigue and severe joint pain involving the knees, ankles and wrists. The pruritus persisted, and she developed rash on her extremities. In the emergency room, her temperature was 97.7°F, heart rate was 66, and blood pressure was 151/76. The physical examination was normal except for a faint erythematous and a patchy and slightly raised rash on both arms and legs. There was no involvement of the palms or soles. Laboratory results are shown in Table 1. Possible dengue virus (DENV) infection was diagnosed, and the patient was discharged on Naprosyn.

At follow-up two days later, there was little change in the rash. No swollen joints were found, despite the severity of joint pain. Serologic testing for CHIKV IgM was 1:2,560 and the IgG was 1:1,280. DENV serology was not obtained. Ten days later, the patient reported no further symptoms and returned to work.
DISCUSSION

There were 171 cases of CHIKV infection reported in New Jersey in 2014. A previous review of CHIKV in the United States reported on 109 cases from 1999 to 2009, all from Asia or Africa. Although the epidemic in Africa is in part supported by infection in the sylvatic population, the autochthonous infections occurring in Asia and parts of Europe do not appear to have involved an animal host. Instead, a mutation of the genome (the A226V mutation in the E1 glycoprotein) in the African strain allows the virus in the Asian epidemic to replicate readily in Aedes albopictus, sustaining a human-mosquito-human epidemic there.

The autochthonous outbreak in the Caribbean appears to be caused by a strain with the same genetic mutation as the Asian genotype. As of February 2015, more than one million suspected cases in the Americas have been reported.

The parallels with the West Nile virus (WNV) establishment in the United States are notable. WNV, too, is an arbovirus. Originally identified in Africa, it was transmitted by the Culex univittatus and Culex pipiens molestus mosquito. WNV was originally introduced to the United States in 1999 with a strain that was circulating in Tunisia and Israel. In the United States, it is transmitted by the Culex genus but has also been found in Aedes and Anopholes mosquitos. WNV first appeared in dramatic fashion on the East Coast from a presumed importation during the summer months. The virus successfully overwintered in the United States and is now found annually throughout much of the country. Given the large numbers of cases of CHIKV within the past six months in

CASE 2

A 50-year-old male with a past medical history significant for impaired fasting glucose and eczema traveled to Dominica in early May. Abrupt onset of fever to 103.5°F developed 48 hours after his return. Debilitating joint stiffness, particularly of the hands, hips and knees, accompanied the fever. Headache with retro-orbital pain and light sensitivity was present. He denied other complaints. His temperature was 98.8°F, heart rate 90, and blood pressure 100/66. The physical examination was normal. No rash and no swollen joints were noted. Laboratory results revealed mild leukopenia and thrombocytopenia. (See Table 1.)

One week later, he reported resolution of fevers, weakness and joint stiffness. An intercurrent flat, red macular rash, located primarily on the trunk, came and went quickly. An enlarged, non-tender posterior cervical lymph node was found. Serologic testing revealed the DENV IgM was 1.7; the IgG was 5.04; the CHIKV IgM was 1:1,280; and the CHIKV IgG was 1:2,560. The symptoms abated 12 days later.

These two cases of CHIKF in New Jersey during May 2014 in travelers returning from the Caribbean emphasize the concern about the establishment of CHIKV in the United States.

TABLE 1: LABORATORY VALUES

<table>
<thead>
<tr>
<th>LAB VALUE</th>
<th>CASE 1</th>
<th>CASE 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>WBC x 10^9/L</td>
<td>3.4</td>
<td>2.5</td>
</tr>
<tr>
<td>LYMPH (%)</td>
<td>32</td>
<td>35</td>
</tr>
<tr>
<td>MONO (%)</td>
<td>25</td>
<td>12</td>
</tr>
<tr>
<td>NEUTROPHILS (%)</td>
<td>39</td>
<td>51</td>
</tr>
<tr>
<td>HGB (g/L) x 10</td>
<td>11.6</td>
<td>14.7</td>
</tr>
<tr>
<td>PLTS x 10^3</td>
<td>322</td>
<td>147</td>
</tr>
<tr>
<td>ALT (IU/L)</td>
<td>24</td>
<td>24</td>
</tr>
<tr>
<td>AST (IU/L)</td>
<td>27</td>
<td>28</td>
</tr>
<tr>
<td>ALKP (IU/L)</td>
<td>59</td>
<td>45</td>
</tr>
<tr>
<td>CALCIUM (mmol/l)</td>
<td>2.4</td>
<td>2.4</td>
</tr>
</tbody>
</table>
the Caribbean, its proximity to the continental United States and the presence of competent vectors in large areas of the United States, it is likely only a matter of time before transmission occurs.  

**DISEASE MANIFESTATIONS**

The disease associated with CHIKV is abrupt in onset—four to seven days after the bite of an infected mosquito—and occurs in two stages: acute illness and the late stage.  

Acute illness is characterized by high fever and profound symmetrical, small-joint pain in up to 98 percent of patients.  

In the Makonde African dialect, chikungunya describes a bent-over posture, probably related to the severity of the pain.  

These two symptoms were the overriding features in our cases. About 40 to 50 percent of infected persons (including our two cases) develop a pruritic maculopapular rash. The rash is usually on the face, trunk and extremities. Nausea, vomiting, diarrhea and abdominal pain can occur in up to 47 percent of patients.  

Additional manifestations of CHIKV include headache, fatigue, conjunctival infection and extremity edema. Guillain Barré syndrome, myeloradiculopathy and encephalitis have been reported.  

In the Reunion Island epidemic of 2005, the autochthonous CHIK cases affected 266,000 and caused 65 deaths. Although death from this virus infection has been reported, death is uncommon and usually limited to older individuals as noted in the Reunion outbreak.  

Typical laboratory values of acute CHIK include lymphopenia, thrombocytopenia and, in some cases, leukopenia, transaminitis, hypocalcemia, elevated creatinine and creatinine kinase.  

The late stage of CHIKV infection can be characterized by arthritic complaints for years after infection. Risk factors for late-stage arthropathy have been investigated, but no clear associations have yet been recognized. There are no antiviral-specific medications for CHIKV; thus, treatment is supportive.  

The distribution of CHIKV is similar to DENV, and the two viruses can be confused because of similar symptoms, as in our cases. Co-infection with DENV and CHIKV has been reviewed. Shorter durations of fever, conjunctivitis, acute arthritis, myalgia/arthralgias and rash were more characteristic of CHIKF.  

Our first case may have had a simultaneous DENV and CHIKV infection; however, the low IgM serology and absence of significant thrombocytopenia suggest a prior infection with a false-positive IgM serology.  

**THE NEED FOR DIAGNOSIS**

The rapid establishment of epidemic CHIKF in the Caribbean is resulting in more frequent reports of CHIKV in the United States, heightening concerns for autochthonous transmission and the need for early diagnosis. This is especially true as we approach the summer months. The timing of our cases in New Jersey would provide an opportunity for the establishment of epidemic CHIKF in the United States via transmission by Ae. albopictus mosquitoes, which are active in the summer and present in 20 of 21 counties in New Jersey. A mosquito that bites an infected person with high viremia could then transmit the virus to subsequent persons.  

Clinicians should be aware of and consider CHIKF in patients presenting with fevers, severe arthralgias/myalgias, conjunctivitis and rash in the summer regardless of travel history. Early recognition of this disease could help limit the transmission by advising the patient to limit outdoor activity, use protective measures such as insect repellent when going outdoors, and it would limit incorrect diagnosis due to overlapping symptoms of other seasonal vector-borne diseases such as Lyme disease or anaplasmosis.  

Because many of the pieces for the establishment of endemic CHIKV exist in the United States, clinicians should consider this emerging disease for patients with a compatible clinical illness.


Whatever Happened to Community-Oriented Primary Care?*

“It survives into the 21st century insofar as family practice-dominated community health centers can muster the budget, technical capacity and personnel to carry out the population health dimension of COPC. Under the Patient Protection and Affordable Care Act (ACA), however, will it play a more robust role in primary care?”

*An earlier version of this article was presented at the 2012 annual meeting of the American Association for the History of Medicine, Baltimore, Maryland.

**The term “family practice” is used to denote a clinical approach; the term “family medicine” denotes the corresponding academic specialty designation.
By Ellen S. More, PhD

This article examines the fate of Community-Oriented Primary Care (COPC), a hybrid offspring of primary care and community medicine that originated in the 1950s and 1960s. In the words of a leading American proponent of the model, COPC is “a modification of the traditional model of primary care in which a primary care practice or program systematically identifies and addresses the health problems of a defined population.”1 Ideally, it also engages and empowers the residents of its target community. COPC would seem to be an apt response to the U.S. healthcare dilemma of high costs and comparatively poor outcomes. Yet, COPC, an idea that is now more than half a century old, was, until recently, little known and less practiced. For decades, COPC was a casualty of scarce resources, a decline in visibility of its initial sponsor (the field of community medicine) and the challenges of incorporating “population medicine” into a patient-centered specialty like family medicine. COPC survives into the 21st century insofar as family practice-dominated community health centers can muster the budget, technical capacity and personnel to carry out the population health dimension of COPC. Under the Patient Protection and Affordable Care Act (ACA), however, will it play a more robust role in primary care?

THE EMERGENCE OF COPC

Although Community-Oriented Primary Care is now associated most closely with community health centers and, therefore, with family practice** (the dominant specialty in such sites), it originated as an outgrowth of community medicine. The founders of the specialty of family practice, which originated in 1969, defined the individual patient and family as its locus of care and research. Although family practitioners were committed to practices anchored in specific communities, the concept of community signified something different from the term as employed in public health or community medicine.2 Community medicine, on the other hand, attempted a union of population health with primary care. As a distinct specialty originating in 1948, its research and practice were directed toward entire communities. By the late 1960s, community medicine curricula usually comprised preventive medicine, public health (including epidemiology and biostatistics), medical administration and healthcare planning. Some within community medicine also hoped to amalgamate clinical medicine with population health in ways that could be applied to underserved communities.3

That was the challenge a handful of U.S. physicians began to address in the 1950s. (The American College of Preventive Medicine was chartered in 1954.) One of their only models, an English country general practitioner (GP) with the unlikely name of Will Pickles, published a book in 1939 about his innovative practice. As the only doctor in charge of seven rural villages, he combined “traditional public health epidemiology [with] primary care medical practice.”4 The work of Drs. Sidney and Emily Kark and colleagues from 1940 to 1960 with the Pholela Health Center on a Zulu tribal reserve in Natal, South Africa, however, emerged as the polestar for American physicians interested in community health.4 Sidney Kark is credited with coining the term “community-oriented primary care” in 1952. COPC required more than excellent primary care of individuals and families. As envisioned by the Karks and those they inspired, COPC comprised: 1) health surveillance of the community, 2) addressing community-wide health needs, 3) participation by community members and 4) continuing assessment of the measures taken to address them.5 Kark defined communities in terms of their cultural cohesiveness; for example, a village, a neighborhood, even

“Kark defined communities in terms of their cultural cohesiveness; for example, a village, a neighborhood, even a collection of city blocks might represent a ‘community’ for the purposes of the COPC model.”6
a collection of city blocks might represent a “community” for the purposes of the COPC model. Community-oriented primary care, the Karks believed, could serve the health needs of defined populations and of the individuals and families who made up those defined communities through a combination of primary care, epidemiology, community participation and public health interventions often based in a community health center. Indeed, community health center pioneer Jack Geiger, MD, who worked with the Karks in South Africa, credits Sidney Kark as the inspiration for the first two U.S. community health centers in Boston and Mississippi.

In the United States, the COPC model was first put to the test at a clinic led by Dr. Walsh McDermott of Cornell-New York Hospital. A renowned infectious disease specialist, in 1952 he piloted a successful tuberculosis surveillance and treatment program for the Navajo in Arizona. That experience led to a clinic at the Many Farms-Rough Rock tribal political district where a COPC model was applied to a wide spectrum of Navajo healthcare needs. McDermott chose Dr. Kurt Deuschle to head up the clinic. Deuschle’s concept of COPC emphasized community participation, i.e., “bridging …language and cultural differences” and “development of a cadre of local health workers to assist the professional staff in outreach activities.”

In 1958, one of the first physicians Deuschle hired was a young internist named Hugh Fulmer, whom he had met when they were both at Syracuse University medical school. Two years later, Deuschle was hired to create the first community medicine department in the United States at the new University of Kentucky College of Medicine, as well as a residency in preventive medicine. Deuschle recruited Fulmer after first arranging for him to get an MPH at Harvard. They later tried to establish a family medicine residency within Deuschle’s department, intending ultimately to create a COPC-style program, but were blocked by opposition from another department. Deuschle left for Mt. Sinai in New York City to establish a community medicine department that successfully sponsored COPC-style initiatives.

Fulmer left the University of Kentucky for the University of Massachusetts Medical School (UMMS) in 1969. There, he hoped to carry out his plans for a fully realized COPC program when the school opened a year later. At UMMS, Fulmer encountered opposition of a different sort. Although he was hired to create a community medicine department as the superstructure for both family and community medicine residencies, he never gained the confidence of the family physicians he hired to create the clinical side of his envisaged COPC initiative. By 1974, they refused to work for Fulmer, insisting on a separate, independent family medicine department. Within a decade, family medicine emerged as the dominant partner in a reunited department, a trend mirrored in many academic health centers over the next two decades (see Figure 1). Fulmer left UMMS in 1983 and led several COPC initiatives in Boston.

**OBSTACLES TO IMPLEMENTING COPC, C. 1980–2000**

Through the 1980s, COPC generally failed to catch on, particularly when contrasted with the rapid growth of family medicine and, by the mid-1980s, general internal medicine. At the same time, family medicine within the academic health science center, as Rosemary Stevens has discussed, gradually redirected itself towards fulfilling the requirements of academic medical specialty departments rather than aligning itself with community-responsive initiatives. Thus, residencies might be based within community health centers, but faculty physicians were encouraged to produce research and see patients along parallel lines to those in, for example, general internal medicine.

Discussions at the International Conference on Primary Health Care at Alma-Ata sponsored by the World Health Organization with UNESCO in 1978 tried to reinforce belief in the efficacy of “involving communities in the identification and remediation of their own health care needs.” Rising concern about healthcare costs also gave renewed, if transient, vitality to the prospect of using primary care settings to coordinate healthcare costs and minimize high-cost tertiary care. In 1982, the Institute of Medicine convened a commission to examine the effectiveness and marginal costs of COPC. Community-Oriented Primary Care again seemed an enticing prospect. This proved elusive. COPC initiatives
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did make inroads in some community health centers, which, despite some exceptions, are dominated by family practitioners. The Health Resources and Services Administration (HRSA) sponsored the publication of a voluminous handbook on COPC in 1987, emphasizing the many ways that COPC objectives could be integrated into existing primary care practices. However, under President Reagan, federal funding lapsed for community health centers, the primary loci for such efforts.\textsuperscript{16}

Paradoxically, enthusiasm for COPC may also have been hindered by its early association with the field of community medicine. In fact, departments of community or preventive medicine, which were represented in nearly two-thirds of all accredited medical schools by 1970, declined steadily as free-standing departments as measured in both numbers of full-time equivalents (FTEs) and overall spending from the mid-1970s on, a trend noticed as early as 1975. In contrast, the number of departments of family medicine, encouraged by federal project grants and capitation payments, grew rapidly, as Figure 1 indicates. Community medicine as a discrete discipline was slowly repositioned within joint departments of family and community medicine or sidelined to the non-clinical, basic science side of the departmental divide.\textsuperscript{17}

Nor was academic family medicine at the time an ideal institutional sponsor for COPC. A 1994 study of family practitioners, the predominant medical providers in community health centers, found that of a large, random sampling of family practitioners, 45 percent had never heard of COPC. Only about 50 percent of a similar sample of family practice residency directors even knew “how to go about” using systematic health surveillance data to plan community interventions. Sixty-five percent acknowledged not having the time.\textsuperscript{18} The physician and historian Donald Madison has called activities like health surveillance, community involvement and community-responsive preventive medicine the “Cinderella” services of primary care. A lack of systematic funding for the services and personnel trained in its techniques, in part the result of a lack of an overriding government mandate for prevention, made the services easy to ignore.\textsuperscript{19} In the words of a study from 2001, “because of lack of predictable reimbursement for COPC services and difficulties encountered incorporating COPC in medical and residency curricula, widespread application of COPC has not occurred.”\textsuperscript{20} The lack of a strong disciplinary sponsor for COPC combined with a national culture more attuned to classic primary care than to community-focused prevention initiatives, contributed to a lack of acceptance in academic medicine and public policy making for this type of medicine.\textsuperscript{21}

**COPC IN THE 21ST CENTURY**

COPC has not been forgotten. In 1996, the Institute of Medicine issued a report redefining primary care to include “the community context of medical practice.”\textsuperscript{22} In 1999, the Association of Family Practice Residency Directors recommended requiring study of COPC methodologies in all family practice residencies.\textsuperscript{23} By 2002, when the Public Health Service’s Fitzhugh Mullan again looked at the status of COPC, he concluded that in “this world of pluralistic, evolving, and cost-constrained health systems, we think it unlikely that COPC will, or should, emerge in any country as a discrete,
stand-alone, governing principle for clinical practices.” However, “[t]he multiple health effects… poverty, illiteracy, and crime are within the reach of the health sector and should be considered by community-oriented practices.”

HRSA, too, sees health surveillance and amelioration of chronic disease as integral to its mandate for federally qualified community health centers. Indeed, community health centers are the sites where COPC continues to make inroads. Such sites, even when affiliated with a medical school, all too often lacked the resources to carry out full-scale epidemiological studies or even community health surveillance. However, the reinvigorated role of community health centers under the ACA, as well as the implementation of electronic health record keeping (despite the many difficulties posed by the latter), may now facilitate health surveillance of defined patient communities and bring COPC into wider use. Otherwise, the lack of a robust COPC approach may cost the United States a viable way to integrate population health and primary care.

Ellen S. More, PhD, is Professor, Department of Psychiatry at the University of Massachusetts Medical School.

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2. Cashman, S. B., Savageau, J. A., Ferguson, W., & Lasser, D. (2009). Community dimensions and HP5A location: 30 years of family medicine training. Residency Education, 41(4), 255–261. Note: This stance has gradually been modified since the late 1990s, partially in view of the Institute of Medicine’s redefinition of “primary care” to include “the community context of medical practice.”


10. Note: According to Deuschle’s Community-Oriented Primary Care: Lessons Learned: “The term ‘community-responsive medical practice’ denotes a practice that is oriented to serve the par-
ticular needs of a defined population.” This definition is derived from the National Academy of Science–Institute of Medicine report, “The Community-Responsive Practice—New Directions for Primary Care,” from 1981. The sense of community implied here can be geographic, social or occupational. It usually is used to suggest the under-served or medically isolated.


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February 24, 2015, marked the start of budget season as Governor Chris Christie presented his fiscal year 2016 (FY16) budget to the members of New Jersey State Legislature in Trenton. Governor Christie proposed a budget of $33.8 billion, with an expected revenue growth of approximately 3.8 percent.¹ These revenues include a 5 percent increase in gross income tax revenues totaling $13.652 billion, a 3.5 percent growth in sales tax revenues to $9.199 billion and a 2.2 percent growth in corporate business tax revenues to $2.646 billion.²

Other important elements of the budget include the largest single payment to the pension system at $1.3 billion, a record investment made in New Jersey education totaling more than $12.7 billion, providing $1.1 billion for property taxpayer relief programs, all while maintaining a surplus of $388 million.² However, not all sectors will see an increase in funding, and many New Jersey hospitals will have to operate with less.

The Governor's budget slashed charity care funding by $148 million, equaling a 22 percent cut that brings the total to $502 million this year, which is down from $650 million a year ago.³ The State Treasurer, Andrew Sidamon-Eristoff, explained that the administration has “noticed a dramatic reduction in documented charity-care claims,” citing the Affordable Care Act for drastically reducing the number of uninsured patients.⁴

There are many issues the Governor is attempting to address in his proposed budget; one is certainly the doctor shortage in New Jersey. The Governor’s budget responds to the projected shortage by proposing a $45 million annual increase in reimbursement rates for certain primary and specialty care services through NJ FamilyCare, the state’s main Medicaid program.² These rate increases are to become effective in January 2016.

The move to bolster the ranks of New Jersey physicians is partially due to a recent study that found New Jersey was particularly thin in family and general practice doctors, ranking 45th in the nation for the total number of these specialists per capita.⁵ It is also partly due to the projections of some medical experts of a possible shortage of 2,800 medical doctors by the end of the decade.⁶ Governor Christie’s budget proposes an “additional $27 million investment in Graduate Medical Education funding for New Jersey’s teaching hospitals. These amounts include state and federal funds.”² Also addressing the situation of a doctor shortage in the Garden State is the planning process for the yet-to-be-named medical school partnered by Seton Hall University and Hackensack University Health Network.⁷

**LEGISLATIVE BILLS TARGETING HEALTHCARE**

Outside all the attention on the budget, the members of the State Legislature have been busy introducing and debating health-related legislation in the State House.

**Senate Bill No. 1183/Assembly Bill 647:** This familiar piece of legislation has found its way back into the halls of Trenton. S-1183/A-647 “establishes minimum registered professional nurse staffing standards for hospitals and ambulatory surgery facilities and certain DHS facilities.”⁸ This legislation is being advocated by a coalition of labor unions that are attempting to have the state revise its “minimum nurse-staffing rules for the first time since 1987, and to add teeth to the mandates by including penalties for hospitals that don’t follow the rules.”⁹
“Governor Christie proposed a budget of $33.8 billion, with an expected revenue growth of approximately 3.8 percent. However, not all sectors will see an increase in funding, and many New Jersey hospitals will have to operate with less.”

The New Jersey Hospital Association (NJHA) has been opposed to S-1183 for many reasons, but the primary reason is the belief that the bill would cause a significant increase in hospital costs. The NJHA has estimated that S-1183 would “require the state’s acute care hospitals to hire 2,054 additional registered nurses at an annual cost of $159 million.”

Although this bill has been around the committee rooms in the State House, it has never reached the floor for a vote. The primary sponsor of S-1183, Senator Joseph Vitale (D19), thinks it will finally reach the Senate floor.

Senate Bill No. 2180/Assembly Bill 3450: This bill requires certain health benefits plans to provide coverage for behavioral healthcare services. Senator Robert Gordon (D38) is the primary sponsor of this bill that aims to require insurers to cover the treatments that providers determine are medically necessary. Senator Gordon has explained that this bill would apply to those who receive benefits through public-employee benefit plans and individual and small market groups, and would cover approximately 30 percent of residents; however, this bill would not apply to those covered by employers that self-insure or those in federal programs like Medicare and Medicaid. The Senator believes that insurers purposely use the review process to wear down patients and providers, and this is all “just a prescribed set of protocols I don’t think make sense in behavioral health.” Senator Gordon stated, “By advocating on behalf of those with behavioral healthcare conditions and removing barriers when dealing with insurance companies, we can ensure that individuals are able to receive the treatment and help they need to recover and heal.”

Last year, the Pension and Health Benefits Commission recommended to the Legislature that it not enact this bill; however, S-2180 was recently voted out of the Senate Commerce Committee 4-2 and has since been referred to the Senate Budget and Appropriations Committee.

Senate Bill No. 2435: This bill provides Medicaid coverage for advance care planning. Senator Richard J. Codey has introduced this bill because “low-income individuals and families in New Jersey can’t participate in end-of-life planning because the state Medicaid program does not pay for this service.” Senator Codey wants to change this fact by making New Jersey only the third state to have Medicaid reimburse providers for advance care planning. These consultations can help a patient thoughtfully discuss and decide on critical issues like being placed on or off life support. To date, only Colorado and Oregon have adopted this healthcare measure into law. Death doesn’t discriminate, and S-2435 helps make the most difficult choices available for all New Jerseyans, no matter their economic status.

Senate Bill No. 1184: This bill “revises the licensure requirements for physician assistants under the ‘Physician Assistant Licensing Act’ and authorizes the creation of an expanded, physician-delegated scope of practice.” In addition to the physician assistants permitted practices already authorized by law, S-1184 would also allow a physician assistant to “make pronouncements of death, and to undertake any other duties and responsibilities that a supervising physician elects, in their discretion, to delegate thereto, pursuant to a written delegation agreement.”

The requirement for a physician assistant to be under the continuous supervision of a physician still exists, but this does not necessarily mean the physician has to be physically present, “so long as the supervising physician and the physician assistant maintain contact through electronic, or other means of, communication.”

S-1184 has some difficulties that have yet to be figured out, such as what effect this bill will have on physicians’ medical malpractice liability insurance. The bill calls for a “physician assistant to be covered by medical malpractice liability insurance or a letter of credit.” But will physician assistants need to have their own insurance, or will they fall under the supervising physicians? Only the insurance providers will be able to answer this question. Recently, S-1184 passed through
the Senate 38-0 with two abstentions and now heads to the General Assembly to be debated.

**Assembly Bill No. 3674:** This bill provides for Medicaid and NJ FamilyCare coverage and reimbursement for healthcare services provided through telemedicine. Telemedicine is quickly becoming a new trend practiced in healthcare fields. The primary sponsors of this bill, Assemblywoman Pam Lampitt (D6), Assemblyman Joseph Lagana (D38) and Assemblyman Dan Benson (D14), have introduced this bill to help reduce late-night emergency room visits for non-emergent illnesses and pains. Instead of costly and time-consuming trips to the hospital, New Jersey insurers are making doctors available to talk at any moment over the phone or through computer and mobile devices for video conferencing.

A-3674 is meant to provide for Medicaid reimbursement for telehealth consultations. The bill has been referred to the Assembly Health and Senior Services Committee. In the past, similar legislation relating to telemedicine has been introduced, but none of those bills have made it up to the floor for a vote.

**Michael C. Schweder is the Director of Government Affairs at Cammarano, Layton & Bombardieri Partners, LLC, in Trenton, New Jersey.**


On a New Jersey-bound train in the dead of winter, I was staring out the window at the heavy gray sky when I felt a presence beside me. Turning my head, I saw an elderly man motioning towards the seat adjacent to me. I nodded my head, moved my bag and turned my eyes back toward the window.

I was thinking. I had only started my rotations a few months before, and yet hundreds of patients were slipping in and out of my thoughts. Meeting patients is both clinical and intimate. I want to express what I know to them, though I still have infinite material to learn. I want to make sure they know that the team is doing everything to help. But I also need to ask questions; I need to probe into their daily functions, thoughts and expectations. As a student, I find myself teetering on the line between helpful and helpless.

I recalled a particular pediatric patient on my surgery rotation on whom I checked after a shunt revision for hydrocephalus. Entering the room, I saw the mother lying in bed next to the patient. The father stood up, and we shook hands as I introduced myself. The child appeared somnolent, letting me examine him without resistance. The father began asking questions. Why was the post-operative CT scan showing no change in the size of the child’s ventricles? What was the next step? Who was going to fix his child? I didn’t have any answers.

As snow began to fall outside, I felt grateful that I was far away from the hospital and the patients it housed. Then, I heard a voice remarking about the snowfall, and I remembered that there was someone sitting next to me. We began to talk. He worked for the government, supplying artillery to American allies. Tipping his blue hat at me, I saw the gold embossed letters of the agency. Next year, he told me, would bring retirement. He planned to buy a house in Florida and one abroad, splitting his time equally between the two. Beneath his wrinkled brow, I saw youth flickering from his eyes. The conversation soon turned to my life. We began talking about medicine, both its merits and its downsides. It was then that I learned that the man had epilepsy. His childhood had been a phenobarbital haze. At the time, the doctors had not found a way to control the violent tonic-clonic seizures that plagued him. His shoulder had dislocated so many times an orthopedist had been involved in his case. By the time he was 14, he had met with an oral surgeon who replaced two of his avulsed teeth. School was an issue because his medication was more successful as a sleeping agent than as an anti-epileptic. His seizures were not managed well until his second decade of life, when a thorough search for an answer led him to Washington, DC. Relief came in two forms: a neurologist, who listened better than anyone else had, and a pink pill called Depakote.

A few stops later, the man gathered his belongings as he got ready to leave the train. We exchanged well wishes and smiles, and then he was gone. I never caught his name, nor he mine, but through our brief interaction, I realized something about the nature of being in the medical field. Even though one can be grateful to be away from the heaviness of the hospital, clinic or office, there is no such thing as leaving your work at the door. Your patients’ lives extend beyond the facet in which you know them to exist. They are walking down the streets you walk down, they are eating at the restaurants you eat at and they are riding on the trains you ride on—sometimes sitting right next to you.

Emily D. Weinick is a physician assistant student at Seton Hall School of Health and Medical Sciences, Class of 2016, and a 2015 Edward J. Ill Excellence in Medicine Scholarship Recipient.
It starts with a photo. You’re too far away for the camera’s resolution, but the snapshot of the Dean draping a white coat over your shoulders still becomes the background image on your dad’s iPhone. He’s so proud and brags about his child, the future doctor. After the photo, parents, siblings, friends and colleagues take to social media to decorate your pages with congratulatory cheers. And then… it begins.

Those same family members and friends who watched you don the white coat start a cascade of phone calls, text messages and e-mails. “So, I have this rash…” or “I’ve been getting these headaches…” or “I’m having trouble sleeping…” From hangnails to high blood pressure, your white coat draws attention from everyone you know with a medical condition. As a first-year medical student with a medical knowledge base of (almost) zero, the best answer to these inquiries lies in the most omnipotent of resources: Google. It’s frustrating, at first, having such a limited grasp of medicine because the outside world assumes you can assess, diagnose and treat all problems, simply because you now carry a stethoscope. In reality, all you can do is rattle off the rate-limiting enzymes in the glycolysis pathway. This frustration is what keeps you eager to quench your thirst for information in your later years of medical school.

As your education progresses past the biochemical nuances into the broader, more applicable and clinical medicine, your confidence increases, and you start providing bits of real-life medical advice, even without the Internet. Frustration as a first-year transforms into satisfaction as a second year when your recommendation for an over-the-counter remedy is the one that finally improves your sister’s acid reflux. In reality, all you can do is rattle off the rate-limiting enzymes in the glycolysis pathway. This frustration is what keeps you eager to quench your thirst for information in your later years of medical school.

The gratification builds with each patient you successfully help. This cycle continues: reading and learning, then treating and teaching, then reading and learning and so on. Each day you realize something new that can benefit your grandpa’s lymphedema or your best friend’s anxiety further affirms that your decision to become a doctor was the right move. But what happens when a more ominous disease presents itself in the routine cascade of medical inquiries? This time, it’s not simply poison ivy or a pulled hamstring; instead, someone you love is diagnosed with cancer. The eagerness to learn more vanishes and the desire for knowledge dissolves because in these cases, you wish you knew less. But you don’t.

This highlights the dangerous power of your white coat, the one that forces you between two worlds. On one hand, you don’t want to learn more because you fear what you’ll discover. On the other hand, you need to learn more to find the hope that you can relay. It’s your job to straddle the line between optimism and realism, reminding a sick patient how you’re both on the same team and he or she is not alone. Even in the darkest moments, the white coat’s power of reassurance and commitment to recovery can give the slightest smile to even the unhealthiest patient.

That’s why I force myself to keep learning—so that I can provide comfort and make the patient smile. Because that smile—and the courage, bravery and heroism that live behind it—makes every frustration I felt as a medical student worth more than I can measure. Osteopathic philosophy dictates that we treat patients in a holistic fashion, focusing not on a specific symptom or diagnosis but on a person in his or her entirety. The patient is not defined by the disease and shouldn’t be referred to as the “cancer patient.” Instead, I call him the fighter. He is a father, and on the home screen of his iPhone is a med student draped in the powerful white coat that fuels the smile that we, the healthcare providers, strive so hard to expose.

Steve Bialick is a medical student at Rowan University School of Osteopathic Medicine, Class of 2016, and a 2015 Edward J. III Excellence in Medicine Scholarship Recipient.
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