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President's Column

Time for a Self-Checkup?

Joseph Simpson, M.D.

Physician burnout is currently a very hot topic, no pun intended. In a perhaps unhelpful trend, the concept has attained "buzzword" status. For example, I recently received an unsolicited email with the subject line "Physician burnout." The initial paragraph included the sentence, "Lately, every other doctor I have met is suffering from burnout." The email was a marketing message from an electronic medical record company, inviting me to click over to their website and enter my personal information, in exchange for which I would be able to watch a demo of their product. Also on the Internet, I came across an eight-page article entitled "How to Reduce Your Facility's Risk for Physician Burnout." Its author is the president of one of the large locum tenens placement agencies. Perhaps not surprisingly, step three of the article's recommended five steps for addressing physician burnout is "Use locum tenens and encourage vacation time."

So as with many phenomena in modern society, there may be a danger of trivializing a serious problem by overuse of the label. When something is being discussed ubiquitously, people may react by tuning out of the discussion. If you hear that literally 50% of doctors supposedly have burnout, you might say to yourself, "It's definitely not the case that half the doctors I know are on the verge of quitting their job or leaving medicine. So whatever they're calling burnout must be just the ordinary stress of a professional career. I don't know what everyone is getting so excited about."

But as experts in mental health, we should know better. There is a real phenomenon called burnout. It may not affect half of those in the medical profession, but it does impact large numbers of people, from medical students to residents to those in the middle or later years of their careers. And it can have extremely dire consequences, including substance abuse, premature departure from the field, depression and suicide.

One of the main agenda items for current APA President Dr. Anita Everett's term has been addressing physician burnout generally and psychiatrist burnout specifically. Shortly after taking office she established the APA Work Group on Psychiatrist Well-being and Burnout. APA launched a new feature on their website, "Well-being and Burnout," which includes a self-assessment checklist and a variety of tools and links to other websites for addressing burnout. If you look at *Psychiatric News* at all, then you've probably seen some of the numerous articles on the topic which that periodical has published in the last six months, many of them

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In This Issue...

under the header “Overcoming Burnout.” Dr. Everett’s “From the President” column has also focused on well-being and burnout frequently. If you’ve missed these but want to read any of *PN*’s burnout-related articles you’re in luck, because they can easily be found for free at the APA’s website.

Some people reading this may be experiencing some degree of burnout. Others are wondering if they could be. Consider checking out the APA’s Well-Being and Burnout online resource. You can take the online self-assessment, which includes a questionnaire called the Oldenburg Burnout Inventory. Obviously the APA tools are just one option, and you may have other ideas and strategies. If anyone knows of resources or would like to write about his or her experiences with burnout, please send them to us so they can be shared with our membership in a future edition of this Newsletter.

SCPS presents a 1/2 day meeting

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The Opioid Epidemic:
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SCPS residents held their first movie night on February 25th at the home of Michael Gales, M.D., and Heather Silverman, M.D. They watched *Captain Fantastic*. Patrick Wiita, M.D. was the moderator.

Improved Physician Health Leads to Improved Patient Health and Safety

By: Matthew Goldenberg D.O.

SCPS Newsletter Editor

As noted above in Dr. Simpson's article, physician burnout is a major concern for the field of medicine, as around 50% of physicians report signs and symptoms of burnout. However, there are many reasons to be optimistic. There are increased number of workshops and conferences that center around burnout prevention. Medical School and Residency training programs are increasingly teaching courses of resilience, emotional intelligence and work-life integration.

Much of my clinical and academic work, as I have written in this newsletter previously, centers around the evaluation and treatment of healthcare providers with mental health conditions and/or substance use disorders. Healing the healers is as rewarding as it is challenging. There is a stereotype that physicians make the worst patients. This is true when it comes to physicians with addiction because the same skills that make them excellent doctors, often assist them in hiding the signs of addictions and the consequences from family, friends and colleagues. Subsequently, physicians often present later in the stages of addiction, versus members of the general public, and often, their workplace is the last to be affected.

The good news is that physicians have far superior outcomes to the general public when they receive the standards of care set forth by the Federation of State Physician Health Programs (FSPHP). For those with moderate to severe substance use disorders, this often includes 90 days of treatment, in a residential setting, with other healthcare provider peers. Then following acute treatment, aftercare recommendations include 5-years of monitoring, including random drug testing, monitoring groups, AA/self-help meetings often for 5 years.

Multiple published studies have shown that as many as 70 to 90% of physicians who complete treatment and enter monitoring by their States Physician Health Program (as described above) return to work. This is a remarkably high number as compared to outcomes seen in the general population.

The key is the early intervention and detection, consultation, referrals and monitoring provided by Physician Health Programs (PHPs). Sadly, California does not have a PHP. Per the CA Medical Board Website: On July 1, 2008, the laws for the Diversion Program became inoperative and are repealed on January 1, 2009. Therefore, the Medical Board no longer has a Diversion Program.

California is only one of three states across the country that does not have a PHP. Regardless of the perceived reasons that the diversion program was shuttered, the fact remains that patients are now less safe. When healthcare providers have access to a PHP they have access to a confidential lifeline. This allows a doctor who is suffering from addiction to self-refer or a colleague of an impaired healthcare provider to assist them in getting help, without fearing their colleague will face punitive actions from their licensing Board. When confidentiality and a therapeutic PHP is taken away, healthcare providers stop reaching out for help. We know this because every diversion program in California has seen their number of participants decrease since the new Uniform Standards erased any semblance of confidentiality in the referral process.

The good news is that the California Legislature authorized the Medical Board to initiate a PHP program for substance abuse in 2017. At least initially, this program will not assist physicians who suffer from mental illness. The California Medical Board is currently in the process of writing the necessary regulations to establish a new PHP program for substance abuse. The hope is that they will put out a request for proposals (RFP) to potential contractors to run the PHP in the coming months and then the program will become operational soon thereafter.

You may wonder if doctors are given special treatment? The answer is no. Pilots have a similar program called

the HIMS program, which assists pilots with addiction. Having been in existence for several decades there has been no record of any participant in the HIMS program having a substance related safety issue. Similarly, there are no documented cases in medical literature of cases of a physician who is a PHP participant who has harmed a patient. In fact, with the random drug testing, workplace monitoring and regular check ins with the PHP and their treatment providers, physicians who are monitored by a PHP are likely the safest and highly scrutinized health-care providers in any setting.

Based on the lessons we can learn from the data published related to airline pilots in the HIMS program and published data related to outcomes of physicians who have participated in PHPs, we know that the public is safer when confidential, therapeutic and non-punitive rehabilitation is available.

As the newly appointed chair of CPPPH, I am eager and motivated to work tirelessly to help get a PHP back in California. A PHP will improve the lives of our colleagues (and their families) who suffer from addiction and also improve patient safety.

If you have a story about overcoming addiction or your experience with the previous diversion program in CA or an experience with another States PHP please write to me and share your story. I am open to keeping your story anonymous or sharing with this or other audiences if you are willing.

Email: docgoldenberg@gmail.com

Advertisement

Creating Future Success for the CPA

By Randall Hagar, CPA Director of Government Relations

It is an exciting time for the CPA in the legislature. We have assumed a strong state leadership role in developing mental health policy. The success of CPA's Annual Advocacy Day is an exciting element in our success. Last year we had 19 RFMs participate. We also had three CPA bills signed by the Governor. A new record for the number of bills CPA carried, and we managed to do it with zero votes cast against our bills! Something we should all be proud of.

However as great as Advocacy Day success has been, once it's over CPA members and RFMs who participated go back to their practice settings or programs and advocacy is more or less over for the year. My hope had always been that the advocacy skills learned would continue to be honed, and the knowledge base about mental health policies would expand throughout the year. And, in individual cases it has. But, CPA didn't have the resources to actively support broad continued education and growth in advocacy.

Until now.

The CPA has been awarded an APA Innovation grant. With the funds CPA will form an advocacy community specifically for RFMs. We want to invite all RFMs to join in shaping and advancing CPA leadership in policy making. Using digital/online/social media as well as some face-time with CPA leaders we want to take the advocacy skills we teach, and the information about specific policy issues we impart from Advocacy Day on the road. Freeing RFM advocacy engagement from the one-event-a-year format to an ongoing process throughout the year.

Darinka Aragon, MD and Jorien Campbell, MD CPA Council RFM Representative and Deputy Representative respectively will help oversee the statewide effort and assure the CPA gets this right.

CPA has also hired a communications consultant to oversee communications, develop content and generate the social media/internet/digital aspects of our project.

Our consultant has been renewing the CPA website with these goals in mind, with a new secure section for RFMs who desire to participate. She has also set up for the first time a Facebook page for broader educational content. My twitter account is also receiving a makeover. Drs Aragon and Campbell are helping to establish a list of topics to develop into short, succinct basic "explainers" of fundamentally important policy topics.

Stay tuned!

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Permanent Supportive Housing: Los Angeles County Pretrial Diversion Program

by: Torri Montgomery, M.D.

The population of mentally ill individuals has rapidly increased in the criminal justice system, and many of these offenders need treatment instead of incarceration. Approximately three times more individuals with mental illness are incarcerated than in hospitals (9). The Bureau of Justice Statistics reports that in local jails 75% of women and 63% of men are diagnosed with mental illness (8).

Los Angeles County estimates that one in three inmates serving time in jail are afflicted with a serious mental illness (defined as; persons aged 18 or older who currently or at any time in the past year have had a DSM-V diagnosis, excluding developmental and substance use disorders) this estimate is more grim than the one in four national average. In 2015, Los Angeles County jails booked 112,500, making it the largest inmate population in the United States. Of the total booked, twenty-two percent of inmates were considered mentally ill (3).

Cook County Jail in Illinois, Los Angeles County Jail, and Rikers Island Jail in New York have, by default, become the largest mental health service providers in the United States (9). The Bureau of Justice reports that only one in six inmates with mental health problems receives treatment during their admission to the jail (8). The cost of caring for and supervising mentally ill inmates makes them two to three times more expensive to house and despite this higher cost, it doesn't guarantee adequate levels of care or safe cell assignments. In Brown vs. Plata (2011), the Supreme Court found that California's prison overcrowding resulted in inadequate care, and cruel and unusual treatment of mentally ill people incarcerated in California.

Los Angeles now has a new hope for the treatment of mentally ill defendants. LA County Department of Health Services, Office of Diversion and Reentry (ODR), started the Pretrial Felony Diversion into Permanent Supportive Housing (PSH) program in August 2016. This program was created specifically for defendants with mental and/or substance use disorders who are homeless and awaiting trial within Los Angeles County jails. The Superior Court approved this pilot project designed to divert criminal defendants from the county jail and into permanent housing with community mental health treatment.

The Los Angeles County PSH program follows a post booking, pre-trial, court-based diversion model. In this type of post-booking diversion, mental health clinicians work directly with the courthouse. They conduct assessments and negotiate with the prosecutor, defense, and judge to develop a treatment plan to secure a conditional release of the defendant (6). Once the diversion plan is approved by the court, the ODR team including, a psychiatrist, caseworker, and social worker, secure outpatient treatment and housing for the client.

This permanent supportive housing diversion has a flexible referral program. Inmates can be referred for screening by a multitude of encounters as long as they are in custody. Referral sources include: law enforcement, prosecutors, judges, defense bar, jail mental health, and jail medical. After the referral is made the defendants are screened by a psychiatrist for eligibility while they are still in custody. At any given time there are about 50-100 referrals awaiting screening, this amount has consistently increased since initiation of the program . If an inmate is deemed eligible a suitability hearing is scheduled. During this hearing attorneys and the judge confer about pretrial release or plea and disposition options. Cases are resolved with a grant of formal probation with terms and conditions to cooperate with the ODR treatment and housing team.

In addition to permanent housing, this program implements an intensive case management provider to each participant. This provider works with the individual as they transition from custody to community. The client receives ongoing case management services at every stage of the housing stabilization process. They are also considered the core point of contact for the client's medical, mental health, and any other supportive treatment services that may be needed.

“Chronic homelessness is a powerful mediator of crime and disproportionately affects the mentally disabled” (7). A recent article in the Los Angeles times reported that LA city and county’s homeless population has increased by 75% in the last six years (4). The 2017 The Los Angeles County Homeless Report estimated that 30% of the homeless population are considered severely mentally ill and 18% have a substance use disorder (5). These statistics highlight the need in Los Angeles for diversion that includes housing. The ODR permanent supportive housing program uses a Housing First (HF) model as a key part of diversion. Housing First (HF) is defined as rapid rehousing in permanent accommodations; it does not have strict requirements around sobriety or treatment adherence.

Thus far, national studies of the Housing First model have shown improvement in housing stability and health service involvement amongst mentally disordered, formerly homeless individuals. A more recent randomized control trial demonstrated that “HF programs promote significant reductions in offending and reconviction among people who were previously homeless and have a current mental disorder” as compared to the usual treatment (7). The trial also highlighted that two-thirds of the study population met criteria for substance use disorder, in addition to their mental disorder; this did not predict the amount of convictions. The presence of co-occurring substance abuse, severity of mental illness, or number of diagnosed mental disorders were not associated with increased offending. This would indicate that supportive housing and treatment can decrease reoffending regardless of diagnostic status and comorbid substance use (7).

It may be inferred that the greater the amount of supportive services, within one diversion program, the better chance that mentally ill individuals have for treatment instead of incarceration. Psychiatrists throughout Southern California must consider the growing number of incarcerated and homeless mentally ill individuals living in LA County. It is probable that even when working outside of the correctional setting, we are treating these individuals during various stages of illness in the community.

The Los Angeles County Permanent Supportive Housing Program is unique in that it addresses homelessness, mental illness, substance abuse, and overall transition back into the community. As of 2017, Los Angeles County Pretrial Supportive Housing Program has released approximately 1,000 inmates to housing and currently has about 100 defendants waiting for a suitability hearing. This program gives defendants a motivating opportunity to have an active role in their treatment. It also provides incentive to stay out of custody in order to maintain their permanent housing arrangement. Since the implementation of this pilot program, outcomes are being monitored for further study. This unique program encompasses multiple areas for future diversion research.

In conclusion, psychiatric wellness and outcomes are greatly entwined with the socioeconomic difficulties of each individual. In order to provide a foundation for successful treatment these social barriers must also be addressed. The collaboration between The DHS Office of Diversion and Reentry and the criminal justice system in Los Angeles is providing mentally ill offenders desperately needed treatment and support. Although it is a relatively young program, preliminary outcomes thus far have been positive. Breaking the cycle of mental illness and incarceration is cultivating hope in these individuals and the Southern California community.

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Matthew Goldenberg, M.D., Appreciation Award
Michael Blumenfield, M.D., APA Bruno Lima Award

The Medical Incapacity Hold: Safeguarding the Medically Ill and Avoiding Misuse of LPS law

by: Erick H. Cheung, M.D.

Cindy is post-operative day 7, following a decompression surgery for a brain mass. She wakes, frightened and confused. "I have to go, they need me downtown, I'm late for my meeting," she mumbles as she moves towards the exit. Completely unable to acknowledge the nurse's calm re-assurance and explanation of her recent surgery, Cindy presses forward, "No, get out of my way, my car is waiting for me downstairs." She has no history of psychiatric illness. She is married with 2 kids, high functioning as a lawyer until 4 weeks ago.

The medical ethics principles of non-maleficence and beneficence require that physicians take all reasonable precautions to prevent harm from coming to their patients. When patients can demonstrate decisional capacity, the principle of respect for autonomy supersedes physicians' paternalism, effectively allowing the patient to make a "bad" decision such as leaving a hospital "against medical advice." Cindy falls into a category of patients who lack capacity to understand her condition and the risks of terminating her hospital care, but nonetheless insist on leaving (commonly these patients have suffered delirium from a medical condition such as traumatic brain injury, stroke, seizure, brain cancer or surgery, encephalopathy or encephalitis, or metabolic abnormalities). Providers facing a scenario like this recognize the moral and ethical duty to keep such a patient in the hospital. But how?

As psychiatrists, we have often been called upon to evaluate for and placed an involuntary psychiatric hold. Yet, civil commitment (WIC 5150 et seq) statutes were not intended for, and generally do not address, the needs of the medically ill patient without psychiatric illness. As we know, civil commitment is permitted for patients who pose a danger to themselves or others, or who are gravely disabled, specifically as the result of a mental illness, and allows the transport of such individuals to facilities for psychiatric evaluation. It does not permit detention for medical illnesses nor the involuntary administration of medical treatments. The absence of decisional capacity is not a criterion for involuntary psychiatric detention hospitalization under current state and federal laws (at least not yet), and the use of mental health civil commitment statutes in such cases is therefore a questionable practice at best, if not entirely improper or illegitimate at worst.

We have been looking for the "white unicorn" to solve the problem that has vexed hospitalists across the country. This is how bioethicist and medical hospitalist Dr. Paul Schneider (West Los Angeles VA) described the elusive and mystical "medical hold" https://www.youtube.com/watch?v=1mtPtkdEEhA.

This ball of medical-ethical-legal-risk wax has gummed up the system for decades (Byatt). So, roughly 18 months ago UCLA explored this topic in depth, and developed hospital policies and procedures which we have coined the "Medical Incapacity Hold". This policy articulates the appropriate means of detaining medically hospitalized patients who lack capacity to understand the risks of leaving the hospital. The policy establishes the clinical grounds for a Medical Incapacity Hold, addressing several key factors, including: delineating the process for determining if a patient is best served by psychiatric evaluation and civil commitment, by being allowed to leave AMA, or by being placed on a MIH; establishing clear criteria for the placement of a MIH; and embedding procedures that uphold and protect patients' rights.

Since implementation over 1 year ago, we have seen the number of inappropriate psychiatric holds drop significantly, saving time and resources for providers and the mental health court system, and sparing patients from the mis-labeling of psychiatric illness. An initial study of patients who were placed on a MIH has shown that the duration of such a hold averages 4 days. Further study of reduction in adverse events, elopements, and treatment for agitation is pending.

For full article on this topic please see: DOI: https://doi.org/10.1016/j.psym.2017.09.005
Cheung, E.H., Heldt, J., Strouse T., Schneider P., "The Medical Incapacity Hold: A Policy on the Involuntary Medical Hospitalization of Patients who Lack Decisional Capacity." Psychosomatics, In Press, September 20, 2017
http://www.psychosomaticsjournal.com/article/S0033-3182(17)30195-0/pdf

Sexual Harassment: A Historical & Legal Context

by: Kavita Khajuria, M.D.

The hashtag # MeToo initiated a national movement last year.

Sexism, sexual misconduct, sexual harassment, and sexual assault became frequently used words. Individual stories exposed personalities in the entertainment buisness, media, political & medical fields. Those who spoke out emerged from all walks of life, and included individuals from various occupations, races, genders, and IQ levels.

Sexual harassment and assault are not new.

After the initial introduction in the 70's, the 1991 Supreme Court hearings of Clarence Thomas and other publicized cases further increased sexual harassment awareness, and unveiled a wave of claims and lawsuits. Between 1992 and 2012, sexually based charges of discrimination filed with the EEOC and Fair Employment Practices Agencies increased to almost 40% (1). Monetary awards increased from $30.7 million to $138.7 million (1). Discrimination claims now constitute approximately 40% of the federal court docket with SH claims contributing approximately10% of all discrimination charges (2,3).

The legal system has often used the words 'sex' and 'gender' synonymously. An individual's *sex* is a fact of biology, whereas *gender* is a social construct, defined by cultural beliefs, values and stereotypes (1). References to illegal 'sex-based' discrimination encompass behaviors based on both biological sex and gender constructs (1). Gender discrimination is a subtle but equally harmful version of sexism (4).

Legal attempts to address gender disparities in the workplace began with the Equal Pay Act of 1963. By 1964, Title VII of the 1964 Civil Rights Act prohibited discrimination on the basis of sex, race, color, religion, or national origin. In 1980, the EEOC expanded its guidelines on discrimination (2).

A universal definition of sexual harassment (hereafter referred to as SH) does not exist. Illegal SH in the workplace is a subset of gender-based workplace discrimination, defined by federal, state, and case law (1)

The EEOC defines SH as 'unwelcome sexual advances, requests for favors, and other verbal or physical conduct of a sexual behavior', and defines two types of SH: quid pro quo, and hostile environment (6).

Quid pro quo was first established as a form of illegal sexual discrimination in 1976 under Title VII. In the 1986 Meritor Savings Bank v Vinson case, Michelle Vinson filed suit under Title VII, claiming SH by her supervisor. She had worked her way up by merit from a teller to assistant branch manager at the Meritor bank (6). The court held a 'hostile environment 'to violate Title VII, and defined the test as to whether the advances were *'unwelcome'*.

In Harris v. Forklift (1993), Teresa Harris sued Forklift Systems, alleging conduct of the company's president to constitute an 'abusive work environment' harassment based on her gender. The conduct included insults and sexual innuendos. It also included behaviors such as asking her to pick up objects he had thrown on the floor, and to collect coins from his front pants pocket. The Supreme Court held that a plaintiff is not required to have suffered psychological harm or to prove psychological injury in order to win monetary charges (6) i.e one doesn't need to prove evidence of a nervous breakdown to prove SH.

Landmark cases eventually expanded to include same sex harassment.

In Oncale v. Sundowner Offshore Services (1998): Joseph Oncale worked at an oil rig in the Gulf of Mexico. He was forcibly subjected to humiliating sex-related actions by co-workers and sexually assaulted by a male co-worker. The Supreme Court held that *same-sex* harassment could constitute an illegal form of sex discrimination under Title VII; the harassing conduct need not be motivated by animus or hatred (6).

Same-sex harassment later became an issue when supervisors exhibited the same behavior to both male and

female employees (*Holman v Indiana, Romero v. Caribbean Restaurants, Inc*). The courts held the behavior not to be discriminatory between men and women, and thus not actionable under Title VII (2).

Sexual discrimination could also arise from actions based on gender stereotypes.

In 1989, a woman was not promoted due to perceived nonconformity to a female stereotype and the Supreme Court held gender stereotyping to constitute a form of sexual discrimination (*Price Waterhouse v. Hopkins*). Cases of same-sex SH of men have also been successfully litigated on the basis of lack of conforming to traditional male stereotypes. In 1997, the 7th circuit court held that an employee could claim same-sex SH if the employee was treated poorly for failing to live up to a sexual stereotype *(Doe v. City of Belleville)* (2).

An increase in SH litigation occurred throughout the '90s involving diverse scenarios, but 'scope of employment' and 'negligence standards' were unclear when determining employer liability. Supreme court hearings held that an employer may not be liable if he/she exercised reasonable care to prevent and promptly correct any sexually harassing behavior (the reasonable employee prong), and the plaintiff unreasonable failed to take advantage of any preventive or corrective opportunities provided by the employer (unreasonable employee prong) (2,7,8,).

The legal standard as to whether behavior rises to an actionable level includes whether a 'reasonable person' would have found the behavior offensive or distressing (1). A 'reasonable' standard requires culture and diversity sensitivity in order to appreciate a multicultural population.

Multiple causes of action are common in gender discrimination and SH cases, and plaintiffs typically offer evidence of emotional harm (1). Tort claims include emotional distress, invasion of privacy, defamation, and wrongful termination & discharge, to name a few.

Filing a charge is a serious matter, however the timeliness of a complaint could be significant, given that an employer could avoid liability if the employee doesn't complain or report the SH in a timely fashion (2).

Most Large U.S companies now have policies on SH, and many have anti-sexual harassment training programs. State and local governments have also taken steps. New rules at the federal level require members of Congress and their staff to complete mandatory SH training (9). House lawmakers recently proposed reforms to the 1995 Congressional Accountability Act about how to create more transparency. Under this new legislation, lawmakers who settle harassment cases are required to pay their settlement amount back to the Treasury within 90 days or risk garnishment of their wages. It also prohibits lawmakers from using their budgets to pay for settlements, and eliminates mandatory counseling and mediation as prerequisites to filing a harassment complaint or federal lawsuit (9,10).

In sum, research confirms SH to be a widespread, persistent, and systemic phenomena. It affects everyone on some level. Confusion of definitions and terminology may fail to provide an accurate reflection of reality, but history and research underscore the need for SH recognition, sensitivity training, and interventions. Prevention is key.

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https://artofstorytelling.squarespace.com/

SCPS held its 29th Annual Psychopharmacology Update on Saturday, January 27th. Here are some photos from the meeting.

Joe Pierre, M.D.

Scott Fears, M.D.

Stephen Stahl, M.D.

Stephen Marder, M.D.

Book Review: Crossings

by Larry Lawrence,M.D.

My book for review this month is titled “Crossings” a doctor-soldiers story. The author is John Kerstetter. He defines crossing as changes in his life. These involve transitions from one world to another or one status to a new status. As the Iraq and Afghanistan wars move into their 17th year, his book offers a quiet, yet powerful contemplation on the cost of war.

Dr Kerstetter had been raised on the Oneida Reservation in Wisconsin. Through a combination of his own drive, solid mentoring, and an ever supportive family, he enters medical school as an older student. He explores the transition from “Indian “into” Non-Indian”world and the subtleties and complexity of this process

He selects Emergency Medicine , and initially enjoys his chosen medical profession. Over time, he begins to regret the pace and dislike the process of E.R. work.

Based on religious convictions and a commitment to service, he and his wife agree to his wish to serve in war torn countries. He puts his skill set and medical and administrative abilities to good and needed use in Rwanda and later in Bosnia and Kosovo. During this time he and his wife also are busy raising a family, often separated by his chosen work.

He later signs up in the Army and eventually does three tours of duty in Iraq. Here he starts his career as a doctor-soldier. He carefully articulates the ethics, challenges, sadness and dilemmas that face a care giver in a hostile and dangerous setting. His reflections on the severely injured and those who don’t survive reflect his compassion , and caring for colleagues, living and dead.

Following injuries sustained in Iraq, we follow the doctor-soldier home to the United States. Following reparative surgeries he suffers a stroke. This leads to memory impairment, word selecting difficulties and sequencing difficulties. This begins a long painful, and arduous recovery. His impatience with his recovery slowly gives way to trusting and admiring those who assist him to regain his skills.

Slowly and reluctantly, he unravels the effects of PTSD on himself and his loved ones. Through his process of recovery he begins writing . He choses a new career, as a middle aged man, embarking on a career as a writer. His short stories and non fiction book become the journey.

This is a story about many things, but the drive, persistence, resilience and willingness to accept help and profit from it, are a tale we can all appreciate

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