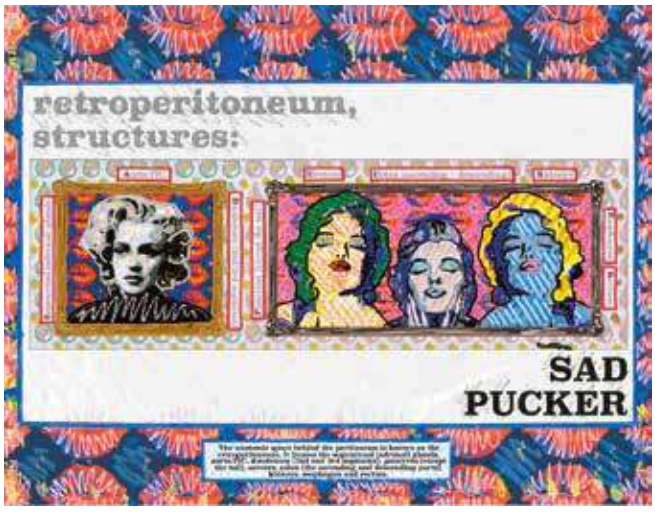
Letters to the Editor



Editor's Note: *We received several comments, e-mails, and messages regarding the medical mnemonics article in the Winter 2018 issue of* The Pharos*. Following are excerpted pieces from a few of those messages.*

MAP UR GOAL(S)

"The importance of medical mnemonics in medicine" by James Lewis (AΩA, University of Tennessee College of Medicine, 2007) and Rebekah Mulligan (*The Pharos* Winter 2018, pp 36–42) reminded me of my early days in training when, as a new intern, Drs. Robert Freeark and Robert Baker at the Cook County Hospital in Chicago taught us to write post-operative orders. The article challenged me to test my now Swiss cheese-like memory, and sure enough, more than 50 years later, their mnemonic came back to me.

Freeark and Baker asked the question, "What do you do when you have places to go or a set of orders to write?" Answer: You MAP UR GOAL.

- **M** - Medications: new that are needed or ones that need to be renewed.
- **A** - Alimentation: diet, from nasogastric tube to full as tolerated.
- **P** Pain: for relief and avoidance if there is a problem.
- **U** - Urologic: catheter, special medication, or none.
- **R** - Respiratory: special observations or treatments.
- **G** - Gastrointestinal: in addition to diet, like observations, colostomy care.
- **O** - Observation: routine blood pressure, pulse, I&O, etc., plus special.
- **A** - Ambulation: from bed rest to walking at will.
- **L** - Laboratory: any special need like hemoglobin, blood gases, etc.

S can be added if help is specifically needed for a reminder so as not to be called in the middle of the night.

This little challenge suggests the lasting value of

mnemonics (or maybe the value of a sponge-like 25-year-old's memory).

Robert E. Bunata, MD
AΩA, Northwestern, 1964
Fort Worth, TX

VINDICATES vs GIT MVN

I was extremely interested in the very current, yet historical medical mnemonics article. At the University of Arizona-Tucson College of Medicine, my colleagues who direct the bedside preclinical program have promoted the mnemonic VINDICATES as the approach to differential diagnosis. This complements a mnemonic that I contrived in medical school (Class of 1966), GIT MVN.

VINDICATES

- **V** - Vascular
- **I** Inflammatory/Infectious
- **N** - Neoplastic
- **D** - Degenerative
- **I** - Intoxication/Drugs
- **C** - Congenital
- **A** - Allergic/Autoimmune
- **T** - Traumatic/Iatrogenic
- **E** - Endocrine/Metabolic
- **S** - Sychosocial

GIT MVN

- **G** - Genetic/Con**G**enital
- **I** - Infectious/Immunologic*
- **T** - Traumatic/IaTrogenic
- **M** - Metabolic#
- **V** - Vascular
- **N** - Neoplastic

*includes Allergic/Autoimmune
#includes Endocrine/Degenerative/Intoxications/Drugs

Ronald E. Pust, MD
AΩA, University of Arizona, 2010, Faculty
Tucson, AZ

HALT

Mnemonics are very helpful tools, even beyond patient care. When considering an important decision, including caring for patients, as leader, or in everyday life, I have found the following to be helpful:

Never make a decision when you are:

- **H** - Hungry
- **A** - Angry
- **L** - Late
- **T** - Tired

HALT is a great strategy to mitigate bias, using the slow thinking mode as described by Kahneman. (Kahneman D. Thinking Fast and Slow. New York: Farrar, Straus, and Giroux; 2011.) It is common sense but worth revisiting as a principle.

Eve Higginbotham, SM, MD
AΩA, Morehouse, 2008, Faculty
Philadelphia, PA

UNLOAD ME

Student and intern rounds: Treatment of acute pulmonary edema. Think UNLOAD ME

- **U** - Upright
- **N** - Nitrates
- **L** - Lasix
- **O** - Oxygen/Bipap
- **A** - Afterload
- **D** - Dobutarine
- **M** - Morphine/Milrinone
- **E** - Electricity

Richard Byyny, MD
AΩA, University of Southern California, 2000
Denver, CO

Protecting academic thought and patient humanism in private practice

I am an academic practitioner of medicine. I teach, publish, and lecture. Of all the things I am privileged to do, caring for patients is the most important, and most enjoyable. I believe in humanism in medicine, death with dignity, and practicing medicine with the best evidence available and high-quality clinical experience.

However, these fundamental principles are being snuffed out by practice administrators whose only agenda is profit. These non-physician administrators count the physician's minutes in the patient's examination room;

criticize if the billing code for reimbursement is not high enough for the practice-expected revenue; demand more patients per hour, per day; and threaten penalties or dismissal if the doctor doesn't perform to an administrator's expectations. Administrators have become the doctors, and the doctors have become a commodity.[1]

Administrators are consuming the cost of medicine. In a recent analysis of the contributing factors to health care costs, administrators now consume 31 percent of total health care costs.[2]

The practice group where I am employed is wonderful with a great group of physicians. However, the revenue (production), number of patients seen per day to keep the practice "above the hole," and the required demands of electronic health records are all regularly scrutinized by regulators. Computer invasion is transcending health care.[3,4]

If I, as the only internal medicine specialist in a complex unispecialty practice, spend more time with a patient who has multi-system, complex diseases, the practice administrators admonish me. If I need more time to explain to the patient their disease or clinical pharmacology of the medications I am prescribing, I am told I am taking too long with one patient. I ponder, "What medical school did these people go to?"

The humanistic practice of medicine—as most of us were trained—is vanishing. The practice of medicine is being engulfed by regulators, administrators, corporations, and unaccountable insurance companies. The result is that the patients suffer.

What can we do? It is unclear if a universal health care implementation would lead to lower administrative costs. There will always be the need for some form of a safety net so we, as a civilized society, can protect the health of all of our citizens. However, the abdication of our physician intellectual and moral commitments to ethical health care is not what is best for our patients, or for us as physicians.

References

1. Miller PD. It's hard to be a real doctor, now. The Pharos of Alpha Omega Alpha Honor Medical Society. 2015; 78(4): 66-7.

2. Woolhandler S, Campbell T, Himmelstein DU. Costs of health care administration in the United States and Canada. N Engl J Med. 2003; 349(8): 768-75.

3. Salem DN, Pauker SG. The adverse effects of HIPAA on patient care. N Engl J Med. 2003; 349(3): 309.

4. Berwick DM, Gaines ME. How HIPAA harms care. JAMA. 2018; 319 (7): 691-7.

Paul D. Miller, MD
AΩA, George Washington University, 1969
Golden, CO

Social determinants of health

Your excellent and stimulating editorial on social determinants of health (*The Pharos*, Autumn 2017, pp 2–7) was slightly marred by the comments on John Snow and the Broad Street pump. The account mistakenly mixed up the pump, which drew water from a well unconnected with any water mains, with the larger investigation Snow was simultaneously conducting in South London, comparing death rates of two water companies, one of which drew sewage-contaminated water while the other drew clean water upstream.

For the details of these investigations, please see "John Snow Revisited: Getting a Handle on the Broad Street Pump," which appeared in *The Pharos* Winter 1999, pp 2–8.

Howard Brody, MD, PhD
AΩA, Michigan State University, 1988, Alumni
Knoxville, TN

Correction

In the Spring 2018 issue, the article "Leonardo at 500," the second paragraph should have read, "Within a year, he would suffer a disabling stroke, and within three years he died. He was 67 years old."

We apologize for any confusion or inconvenience this may have caused.