ADAR KAPLAN | PORTFOLIO

OPINION PIECES

SOCIAL MEDIA

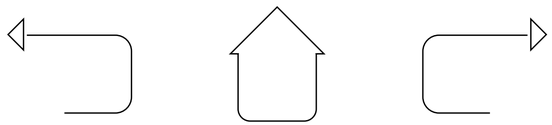
MY VOICE

MY EXPERIENCE

Ghostwriting is about listening.

It takes a trained ear to hear the thoughts
to highlight, humanize, and meld with
organizational messaging and editorial appeal.
It takes experience to hear expertise and
produce a balance of wisdom and edge.

And it’s humbling to be trusted with an expert voice.



Forbes

By William A. Haseltine

William A. Haseltine, Ph.D., covers genomics and regenerative medicine.

ORIGINAL ARTICLE

January 23, 2019

What The U.S. Can Learn From India's Emergency Response System

Minutes and sometimes seconds can often mean the difference between life and death. Knowing that, India took on the herculean task of transforming their fragmented and unreliable emergency response system into a groundbreaking one that is now the largest and the most effective in the world. In doing so, they provided a manual that every country should be emulating, including the United States — especially since a recent study published in the Journal of the American Medical Association found that Americans suffering from out-of-hospital cardiac arrest in low-income communities waited 10% longer for ambulances than those in high-income areas.

Today's 911 model may have inspired the overhaul of India's system, but the JAMA paper reveals just one of many problems with the delivery of urgent, prehospital care in the United States. The groundbreaking system developed in India offers a glimpse into how the United States may find more effective ways to deliver these vital services.

It took only 17 years for the world's second-most populous nation – with its many, many millions of people living in extreme poverty — to build a world-class emergency medical response system. The country faced about 300,000 emergencies per day, 80 percent of which involved its poorest citizens. Often, patients received no care during transport, arrived at hospitals via tractors and bullock carts, and received medical treatment too late — that is, if private hospitals didn't turn them away.

India's citizens had to choose from among three emergency phone numbers to call. A 35- to 45-minute response time for traffic accidents was routine. Just 12 percent of institutions in the trauma care sector had access to ambulances, and about half of the ambulance services were able to keep victims alive during transport. Formal emergency medical education was not available. A 2004 National Human Rights Commission report cited that 400,000 people in India — that's 10% of all those who died in the country annually — did so because of injuries treated too late or not at all.

The first step was an evaluation of their current system. A team of individuals assessed the emergency healthcare needs of individual citizens, examined available infrastructure and resources, and in doing so developed a unique understanding of what constitutes an emergency in India and the skills and resources needed to respond. Ultimately, the task force assigned to assess the situation found deficiencies in four major areas, each boiling down to access: to a single, universal toll-free number; to life-saving ambulances; to compassionate care; and to affordable services.

In 2001, an Indian foundation called Byrraju took the first steps towards repairing the system by launching an ambulance service that could harness India's technology and data analytics with workforce education and efficient management thereby creating a public-private emergency medical response system tailored to India's needs and conditions.

Using its knowledge of human resources, process management, administration and finance, the Byrraju team helped villages create development committees and community health centers that promote health, education and literacy, sanitation, and clean water. Once they developed a successful model, they replicated it throughout India. Communities began to lead and fund their own health centers. In their first four years, village health centers saw 3.5 million patient visits, including those associated with a program to screen more than 100 thousand children for nutritional and physical wellbeing. These centers have become a training and employment ground for young people who otherwise would have moved to urban areas.

After just 12 years, the Emergency Management and Research Institute (EMRI), has deployed more than 10,000 ambulances and 45,000 skilled personnel to respond to 56.1 million emergencies, save 2.3 million lives, serve 18.9 million pregnant women, and assist in 480 thousand births.

They have done this through a centralized, call-in system that receives 150,000 calls and responds to nearly 25,000 emergencies each day. Users can call into a free, emergency 108 telephone number, which provides integrated medical, police, and fire emergency services. A single call center can provide service for up to fifty million people at a cost of $0.25 USD per person per year. The service is free to the user and costs the provider less than $15 USD per emergency. This is less than one percent of what an emergency call costs in the United States as the U.S. system is based on a fragmented structure that allows different entities to manage and own the emergency phone number, ambulances, medical education, and other aspects of emergency management.

This restructuring of their emergency medical responses systems has led India to embrace telemedicine, now accounting for about a third of the country's primary care. India has built specialized and advanced ambulances — in some areas, boats — for specific medical emergencies. EMRI's Hyderabad campus hosts the Emergency Medicine Learning Center, the venue for the two-year post-graduate program, with Stanford University. Each citizen currently pays the equivalent of about 24 cents per year to support it.

In July 2016, EMRI expanded beyond India's borders, launching the '1990' Emergency Response Service launched in Sri Lanka under a public private partnership with the Government of Sri Lanka and with initial funding from the Government of India.

EMRI engages in research and collaboration with India's health ministry and academic experts from home and abroad. It also provides operational experience and the appropriate technological platforms. In turn, the government aids large-scale community awareness and political support. The police and fire department now accompany patients to the private medical centers that had previously turned away poor patients.

From the time an emergency is first reported until a patient is discharged from the hospital, there are "10 moments of truth," explains EMRI's CEO Venkat Changavalli. "These 10 moments of truth need to be handled with the greatest care to ensure a smooth experience for the patient and his family."

The overall secret to India's success lies in their utilization of ambulatory services, cutting-edge technology and outstanding corporate management. It is a lesson in how technology is flattening the pyramid and of how health care does not have to cost a fortune.

For the United States, the JAMA study uncovers a moment of truth — an opportunity to draw inspiration from India's integration, coordination, and best practices in its emergency response system to rebuild our own.

Newsday

By Dr. Jamie S. Ullman

Dr. Jamie S. Ullman is director of neurotrauma at Northwell Health's Institute for Neurology and Neurosurgery at North Shore University Hospital.

ORIGINAL ARTICLE

May 9, 2021

Our daughters, our neurosurgeons

When I was a kid in the 1970s, my mother didn't just encourage me to dream big. She encouraged me to dream bigger.

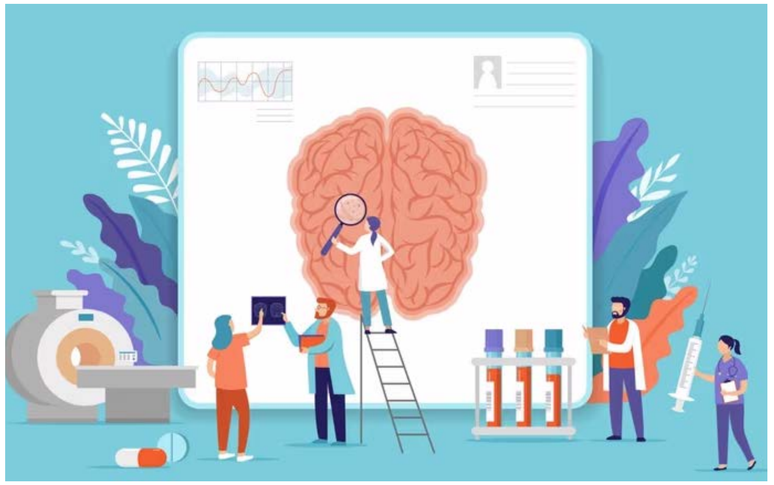
When I was about 10 years old, I told my mom that I wanted to work in medicine. Although she was a full-time homemaker — with no professional medical background — she urged me to expand my vision as much as possible. I like to think I took her advice to heart. I became a neurosurgeon. I wish more women had mothers like mine, because my field needs more women in this rewarding, complex and male-dominated field.

We need gender diversity because that diversity, in any field, strengthens it. Thankfully, we've achieved it in medical schools, where women make up just over 50% of medical students. But we're not there yet in neurosurgery, where women make up a little more than 8% of the workforce. (And it isn't just neurosurgery that faces this lack of representation. Other highly specialized fields face this, too. In interventional cardiology, women make up only about 4% of the workforce.)

Barriers to the field take several forms.

Let's talk about where the unconscious bias is. It's present when people talk about my job's "physical demands" — providing cover to those who mistakenly think women don't have the stamina to be surgeons. And maybe we should own up to what the "work-life balance" conversation really means. I don't know many people, let alone women, whose personal and professional lives are beautifully balanced — though we're trying to achieve it, every day, anyway. Experience has shown me that it's a conversation that often ends with professional women facing two options: taking on more responsibilities or thinking they can't "have it all."

Training to become a neurosurgeon is arduous: undergraduate work, medical school and a seven-year neurosurgery residency program usually followed by a fellowship. Of course, there is also continuing medical education, professional meetings and research. It's not for everyone.



The problem demands grassroots changes: Children are learning more about STEM (science, technology, engineering, mathematics) subjects and are participating in experiential programs that expose them to our world. This approach is making an impact. I hear from girls as young as 13 who want to shadow me to learn more about becoming a neurosurgeon. And the daughters of two of my women colleagues have penned a children's book called, "I Want to be a Neurosurgeon."

Exposing children to these subjects and professional options does more than inspire girls. It helps normalize what girls can do in the eyes of the boys next to them. When these future men consult with these future women neurosurgeons either as patients or as colleagues, it should be a common, typical experience.

I remember my medical school graduation, when my mother was delighted at my accomplishment. It's been gratifying and essential to have her support — and that of my whole family — as I've moved through the different stages of my career.

This support is on my mind as I observe and foster my own daughter's interests and passions. My daughter knows that I'm fully behind her as she finds her way, supporting her as she sees potential roadblocks in her own path — and knocks them down. Thanks for showing me the way, Mom.

Happy Mother's Day!

SCI AM

By David Rosenthal

David Rosenthal, D.O., Ph.D., is the founding medical director of the Center for Transgender Care; the medical director for the Center for Young Adult, Adolescent and Pediatric HIV; and an attending physician in the Division of Allergy/ Immunology at Northwell Health.

ORIGINAL ARTICLE

July 1, 2021

Transgender Patients Deserve Better Medical Care

We must train providers to understand their unique needs in order to deliver affirming, compassionate treatment

"This isn't something I do."

Patients do not want to hear this from doctors. Yet, sadly, many of my transgender patients have heard this from at least one medical provider.

Confused and exasperated, my patients come to me saying their requests for medical care, primary care or HIV-prevention medication are met with shrugs. It leaves them with a sense that it is the patient's job to educate their physician, and that their health and well-being aren't a priority.

Physicians' offices, hospitals and community health clinics aren't allowed to deny medical care to transgender patients, but patients may not know that — and doctors may not realize that their lack of knowledge is tantamount to a denial. Either way, it's a cycle that can lead patients to delay or stop seeking care.

The discouragement may be unintentional but can come in the form of patients being "deadnamed" in medical offices — referred to by the names they were given at birth instead of their chosen names. Or patients may be unable to indicate their gender identity on medical intake forms because their gender identity isn't an option. Many medical providers simply didn't learn in medical school how to gather stigma-free medical histories for transgender patients that would reveal helpful information about their physical, sexual and emotional health.

These are more than administrative details. It can cause patients to feel undermined even before we get to see and treat them.

The Centers for Disease Control and Prevention (CDC) has taken note.

"Transgender patients' concerns often arise at the front desk and in waiting areas because those are the first points of contact for most patients," the CDC states. "For instance, front desk staff may not know how to handle a situation in which patients' legal names and genders differ from their preferred names and gender identities and/or expressions. This puts patients in the uncomfortable position of having to explain their transgender status to the front desk within hearing distance of other patients."

The Center for American Progress goes on to cite that 1 in 3 transgender people reported feeling the need to teach their doctors about transgender care. It puts an already at-risk population at greater risk.

The Trevor Project has found that 19 percent of lesbian, gay, bisexual, transgender and queer (LGBTQ) youth ages 13 to 18, and 8.3 percent of LGBTQ youth ages 19 to 24, reported attempting suicide in the last year. So transgender patients' feelings of invisibility are real.

The Trevor Project also offers a hopeful view: LGBTQ youth with access to spaces that affirm their sexual orientation and gender identity report lower rates of attempting suicide than those who did not. My office is one of those affirming spaces, and my colleagues and I are trying to make medical practitioners better at creating them, from the bottom up.

We've created a medical school curriculum that has grown to include content on social determinants of health, what it's like to live with HIV and how to take full, telling medical histories. These future doctors are becoming more comfortable with transgender patients and are learning the power of asking the right questions, listening carefully to the answers and using them as a starting point for honest discussion about all aspects of a patient's well-being.

My colleagues at Northwell also are writing the textbooks on understanding the effect of hormones on musculoskeletal tissue and how to approach medical care for transgender patients. We're bringing multiple medical specialties under one roof to provide patients with accessible and comprehensive care, including mental health care; employing a "health navigator" to direct patients to the right specialists and insurance; and expanding our LGBTQ services to more locations.

It can take transgender patients a long time to find medical providers willing to offer the medical care and expertise they need and, along the way, many of them are forced to educate their providers. That dynamic results in many transgender patients fighting for appropriate medical care and feeling they need to earn the right to be heard and treated. We need to ensure that there are more safe spaces for the LGBTQ community to obtain health care that meets their needs.

We have an opportunity to positively rewrite medical care for transgender patients, starting in medical school. We can, and should, create standards for properly trained providers who understand the unique needs of transgender patients who can deliver affirming, compassionate care.

Newsday

By Simcha Silverman and Sonia Trew-Wisdom

This guest essay reflects the views of the Rev. Dr. Sonia Trew-Wisdom, director of chaplaincy care and spiritual services at South Shore University Hospital, and Rabbi Simcha Silverman, director of spiritual services at Lenox Hill Hospital.

ORIGINAL ARTICLE

June 30, 2021

COVID changed their spiritual DNA

Right down to our spiritual DNA, the COVID-19 pandemic has changed us. All of us. As hospital chaplains, we can only describe the spiritual toll of these experiences as massive. Our work always has been to comfort patients and their families. But COVID made supporting and standing by our medical colleagues a responsibility, a necessity and a privilege.

We stood with health care staff as they experienced the loss and exhaustion that presented them with the most challenging workplace challenges they'd ever faced — notifying faraway families of deaths, zipping up body bags and sometimes attending memorial services for their own colleagues. We offered renewal where we could.

"I didn't used to pray," one nurse said. "I'm not known to pray. But during the pandemic, I needed prayer." We tried to make space for reflection and peace.

At one Long Island hospital, we created a meditation room. At a Manhattan hospital, where square footage was scarce, we hadn't yet opened our chapel. We carved out space where it didn't exist: tables to hand out tokens of encouragement, like stones with inspiring words on them. These things may appear insignificant, but helped some feel grounded.

"I'm struggling," another nurse said. "I've got 30 seconds and I need a blessing."

We had chats in elevators and hallways. We were asked to set up prayer circles — inside or out. We listened and hung around, signaling our presence to staff, reminding them of God's presence, even in the midst of suffering. Letting us know how they were doing opened the door to deeper conversations, to recognizing each other's spiritual and emotional needs.

Differences in our religious beliefs disappeared, as Muslims, Jews and Christians gathered to let in God wherever and whenever they could. Even those who weren't enthusiastic about God or religion understood why others were.

Said one doctor: "I'm an atheist. But I realized that my colleagues needed me at that prayer service."

As chaplains, Psalm 23 echoed in our hearts. We came to understand its words more clearly: "Yea, though I walk through the valley of the shadow of death, I will fear no evil: for thou art with me; thy rod and thy staff they comfort me."

We walked alongside grieving health care workers. We became attuned to their struggles, shared them, and gave them what strength and comfort we could. We saw patients' suffering and loneliness through the eyes of medical staff.

The pandemic changed us — we let it — so we could see and feel a connection with God in our lives, not just as a detached creator, but as a force intimately connected with each of us, and that connects each of us. We see God's role in the wisdom of those able to help people in all facets of health care. We can't explain the "why" of the world's suffering. But maybe allowing holy connections between us and God and between each other, to simply exist, can help us reflect on life, our own fragility and the value of our relationships.

DAILY NEWS

By James Schneider

Schneider is the chief of pediatric critical care at Cohen Children's Medical Center and an associate professor at the Donald and Barbara Zucker School of Medicine at Hofstra/Northwell.

ORIGINAL ARTICLE

November 9, 2021

My 10-year-old can't wait to get vaccinated — and yours should be eager, too

Kids don't typically line up enthusiastically for injections.

But for my 10-year-old daughter, Maya, the COVID-19 vaccine she'll receive won't be a typical shot — even when she becomes one of 28 million children in the United States eligible to receive it.

My "Dad Radar" indicates she can barely contain her excitement at getting her first dose of the mRNA-based Pfizer vaccine.

That's because the COVID-19 vaccine represents beloved ski trips. It means playing violin in the school orchestra again and being a social butterfly who attends birthday parties and plans with friends. Even better, Maya says: Two shots, three weeks apart, and she can spend time with her grandfather in person, safely — it's a simple act she can take to make her world a little safer.

For me, the milestone is bittersweet.

From a scientific and medical standpoint, our decision to have Maya (and my 14-year-old son before her) vaccinated was easy. I know that's not the case for every parent.

But for me and my wife — a doctor and a nurse — the data and our professional experiences led us to one affirmative conclusion about having our kids vaccinated.

Nationally, we see a mortality rate for COVID-19 in children that is "substantially lower than that in adults" — yet the virus still was among the top 10 leading causes of deathfor children 5 to 14 years old at the beginning of this year. To date, COVID-19 has killed more than 700 kids in the United States.

The numbers may seem small. But they leave us with two realities — that vaccines now make COVID-19 somewhat preventable, and, more important, that each of the more than 700 lives cut short was someone's child.

As the head of a hospital system's pediatric intensive care unit, I associate those numbers with memories of caring for kids who suffered from acute COVID-19.

Mostly, I recall more typical pneumonias and respiratory failures associated with the virus. But some pandemic memories are more humbling, like the moment I used a heart-lung bypass machine to save a teenage girl who otherwise would have died because there were simply no other options. That wasn't a moment of clear-cut professional pride.

I saw dozens of kids experience the life-threatening disease we helped identify, MISC. It's a rare shock-like inflammatory condition that some children suffered shortly after a COVID-19 infection. These accomplishments are fraught because COVID-19 is a challenge we never asked to face.

And it's been near-impossible to keep those feelings from Maya and her brother. Getting vaccinated isn't just about returning to life as it was; our kids have had to give us up somewhat, as we cared for others in an environment of risks and unknowns. But, with her kid's perspective, Maya views it optimistically.

She knows we're encouraged by her vaccine's 90.7% efficacy rate, and the 3.85 billion people globally who have rolled up their own sleeves to slow the spread of the virus. She knows we wouldn't make this decision without unparalleled safety measures and reporting systems that track potentially adverse effects from the vaccines. (Thankfully, those have been incredibly rare.)

A sore arm and fever do not deter my daughter.

Maya and her brother know what it has taken to get our society to this point of the pandemic, and what we did to return home to them each day. Her enthusiasm demonstrates care, regard and responsibility for others, and I couldn't be prouder.

Newsweek

By Juan Serrano

Juan Serrano is the assistant vice president of military liaison services at Northwell Health. He served in the United States Marine Corps from 2000 to 2009.

ORIGINAL ARTICLE

May 30, 2021

This Memorial Day, Commit to Hiring Veterans Like Me

The memory of my 2009 drive from Marine Corps Base 29 Palms, California, to the airport, and the seven-hour flight back home to New York is still fresh. Though I had a medical discharge in hand for a fractured neck, I started the 10-hour trip away from my Marine Corps brothers feeling excited. But soon the optimistic "What's next?" began to turn into a hesitant, "Now what?"

I wondered how my combat readiness training would translate in the civilian world. My injury was sustained in a Humvee rollover during my first of four deployments, two in Iraq. But my apprehension wasn't just about my neck; I was permanently deploying back home, to a place I knew and people I loved, but they knew very little about my journey. I faced an emotional reckoning from my service experiences. I felt alone, lacking visibility and a sense of purpose.

Twelve years later, despite my injuries and emotional journey, I realize I was one of the lucky ones. I discovered my purpose when I found my way to a career in health care. But many of my fellow veterans haven't been as fortunate in finding meaningful careers.

Only a fraction of our returning veterans manage to secure employment within six months of being discharged. The U.S. Bureau of Labor Statistics tells us that the unemployment rate for active-duty veterans who served in the U.S. Armed Forces since September 2001 rose to 7.3 percent, and the jobless rate for all veterans increased to 6.5 percent, according to the most-recent data in 2020.

Before the pandemic, national veteran unemployment rate stood at 3.5 percent. Not surprisingly, COVID-19 didn't help.

It's unacceptable that our veterans struggle to find work after serving our country. But it's not just about the job. Unemployment can be a fast track to service members feeling disconnected. And that disconnection has taken a heartbreaking toll.

Consider this alarming statistic: In 2016, veterans were one and a half times more likely to take their own lives than people who hadn't served in the military, according to the House Committee on Oversight and Reform. The risk nearly doubles during the first year after veterans leave active duty, when many struggle to find employment.

We have a responsibility to our veterans. They need guidance throughout the entire job-hunting and hiring process.

First, they need careers, not just jobs. It's good for business when employers step up and hire these brave, skilled, highly disciplined individuals. If veterans can demonstrate bravery, leadership and commitment in the military, it's easy to imagine the incredible contributions they can offer civilian employers, who benefit from veterans' global perspectives, discipline, technical and interpersonal skills, willingness to take risks and unmatched commitment to teamwork.

My employer, Northwell Health, has been reimagining how veterans can serve in a health care environment and become critically important assets in the workplace.

In addition to hiring hundreds of veterans annually, we offer career counseling to veterans in the community, including assistance with resume-writing, interview preparation and connecting with college networks. We've found success pairing veterans who are already part of our workforce with new hires to help them transition to the civilian workforce. And we're using preexisting resources — all over New York City and Long Island — that fold job training into their programs.

Meaningful employment can help end the isolation veterans commonly feel after leaving military life, but the biggest winners are the businesses that hire them. There's a significant return on investment in bringing on employees who have the proven skills that bring success: entrepreneurialism, trustworthiness, advanced technical training and resilience.

Considering the sacrifices our service men and women — and their families — make in preserving our freedom and keeping us safe, it's incumbent on all employers to prioritize veterans in their hiring decisions.

TIME

By Sandra Lindsay

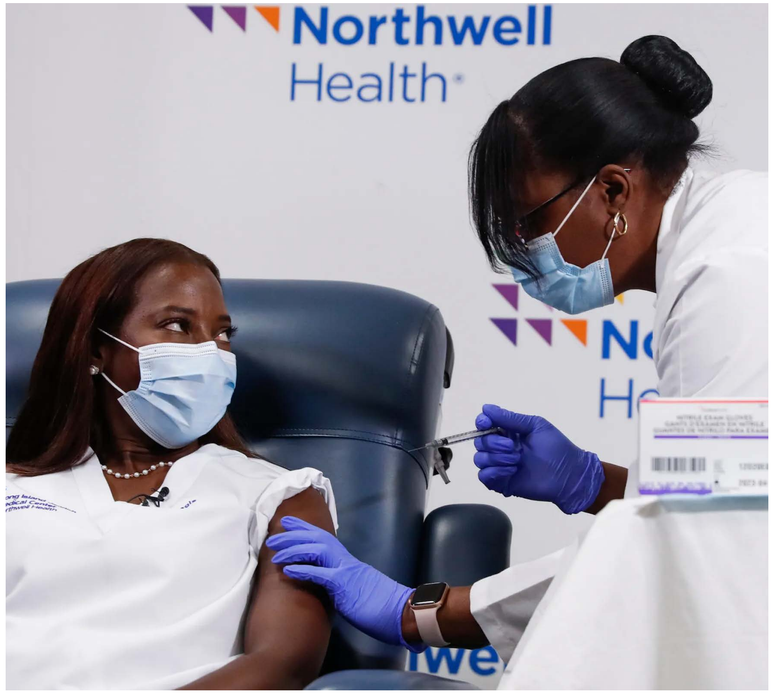
Sandra Lindsay, DHSc, MS, MBA, RN, CCRN-K, NE-BC is the director of Patient Critical Care Services at Long Island Jewish Medical Center and the first person in the United States to receive a COVID-19 vaccine outside of a clinical trial.

ORIGINAL ARTICLE

July 7, 2022

I Was the First Person in America to Get a COVID-19 Vaccine. It Taught Me a Powerful Lesson

I was always ready to say yes to the COVID-19 vaccine. I'd been following its development from the very beginning of the pandemic and said, again and again, that I'd happily get vaccinated. Working in critical care during the first deadly wave of the virus, my team and I had yearned for any relief from the frustration and sorrow we felt. We lived in the constant presence of death and loss, treating patients without treatment options while living in fear of contracting the virus ourselves.



We needed the hope a COVID vaccine might deliver. When my employer, Northwell Health, asked for volunteers to get the shot on day one, I stepped forward to say, "Yes."

It ended up being a milestone in the history of the pandemic. In the first year they were available, vaccines saved at least 19 million lives around the world. Mine may have been among the first.

Later, some people would say I'd been used, coerced, even paid. But getting the first COVID-19 vaccine outside of a clinical trial was not a mistake. The only mistake was thinking that, after the injection, I'd be going immediately back to work.

The day had other plans. There was a press conference, and a whirlwind of interviews, then speaking engagements. When I said, "Yes," to the vaccine, I unknowingly opened my eyes to a world of possibilities and advocacy.

Risk, for example, looks different to me now.

More than 6.3 million people worldwide have died from COVID-19 so far. As of this writing, almost 549 million people have been diagnosed with it. That'swhere risk and true danger exist–in people eschewing data and the evidence-based advice of medical professionals in favor of anger and falsehoods and fear, often fomented online.

Saying yes also gave me a renewed sense of responsibility. I've heard so often that COVID-19 has pulled back the curtain on health inequities that I sometimes worry we'll accept those inequalities as an entrenched fact that we cannot undo. I take seriously the opportunity I have to support public health in underserved communities and communities of color. This is my space; I'm a Black immigrant from Jamaica who came to this country to become a nurse.

For some, it's uncomfortable to discuss the fact that too many communities of color in the United States lack access to acceptable health and medical care. Let's discuss it anyway. Transforming health care deserts into healthy, robust communities with affordable, high-quality resources is a massive challenge. We may not find a perfect solution but it's our responsibility to say yes to conversations about how we can remove barriers and inequities in our health care system.

I felt empowered when I said yes to the COVID-19 vaccine — it was more than a dose of antibodies. It represented a hopeful, new beginning. That moment has been a gift, an opportunity to grow and expand my professional purpose. I certainly didn't predict receiving a Presidential Medal of Freedom. But in some ways, it was less of a choice than it was a seamless transition. Maybe my having said, "Yes," will inspire others to do the same.

USA TODAY

By Eddie Reyes and Scott Strauss

Eddie Reyes is program manager for Northwell Health Emergency Management, and Scott Strauss is vice president of Northwell Health Corporate Security. Both are former New York City police officers.

ORIGINAL ARTICLE

Retired NYPD officers: We dug through the World Trade Center rubble, looking for our brothers

The area that would come to have different names: Epicenter, Ground Zero, The Pile and, eventually, hallowed ground. For us it was Dante's Inferno.

The tears still come, especially when we recall our wives and children waiting for us that day – from home, from work, from school – not knowing if we'd walk through the door again.

We were New York City police officers at the time. We each took different paths to the World Trade Center that day. Those paths converged as we tackled opposite ends of a dangerously intense rescue of two New York and New Jersey Port Authority police that changed our lives.

Only 20 people survived the collapse of the twin towers and were pulled from the rubble. We were able to help save two of them.

We'd both ended shifts just before the planes crashed into the towers, although the notion of working a shift quickly became meaningless. We drove through civilian-directed traffic into Manhattan because police officers and firefighters already were running toward danger at the World Trade Center site.

We couldn't see the men we rescued

Officers set up perimeters and saved as many dust-covered people as they could around the area that would come to have different names: Epicenter, Ground Zero, The Pile and, eventually, hallowed ground. For us it was Dante's Inferno. We choked on thick, black smoke that kept us from being able to see the men we were rescuing, even as we were chest-to-chest with them.

We'd both ended shifts just before the planes crashed into the towers, although the notion of working a shift quickly became meaningless. We drove through civilian-directed traffic into Manhattan because police officers and firefighters already were running toward danger at the World Trade Center site.

Two officers, Port Authority Police Sgt. John McLoughlin and rookie Port Authority Police Officer Will Jimeno, were trapped under 30 feet of rubble. Will's wife was seven months pregnant. They were injured, stuck and in pain.

Our team crawled over and through hot steel beams. We stripped ourselves of "extra" equipment – even our service weapons, which is unheard of – to fit through a dark, narrow opening in the ground about the size of a manhole. There wasn't room or time for sophisticated equipment.

We scraped at the rubble with hand tools and knives to free our brothers while dozens formed bucket brigades to carry away and sort through rubble and remains. Choking and dry heaving from the heat and smoke, we dug with our bare hands. When the medical kit a medic brought to the rescue wasn't compatible with the one given by an emergency room physician, we improvised, doing things like using a ball point pen to puncture vials of medication while officers McLoughlin and Jimeno were trapped beneath cinderblocks.

Firefighters yelled at us to get out of the hole as two more buildings collapsed in the area, while McLoughlin and Jimeno worried we were going to leave. We stayed, but worried they may not survive the rescue. Ultimately, we wedged a perfectly angled piece of rebar between Jimeno and the cinder blocks that were crushing him, and were able to get him out. About eight hours and hundreds of rescuers later, we were finally able to pull out McLoughlin the next morning.

We didn't know until later that we'd endured burns and cuts through our uniforms and our boots, right through to our feet. We worked until supervisors forced us to get medical attention. We were just two of hundreds of people who helped save those two men, but we'll always remember our colleagues who didn't return to their families. Those two men were all of us, and we used every bit of training, strength, and even gallows humor to free them.

Still suffering the fallout

We worked on the pile for nine months. Today, we're haunted regularly by the images of the people and things we saw and uncovered – body parts, shoes, souvenirs ¬– to offer what solace we could to as many families as possible.

Now our families worry as we cough and use inhalers to treat our labored breathing. We get checked regularly for conditions that we acquired from toxic conditions and materials at the piles, and encourage everyone who worked downtown after 9/11 to get medical consultations free of charge through the World Trade Center Health Program, which was established under the Zadroga Act.

Now our families worry as we cough and use inhalers to treat our labored breathing. We get checked regularly for conditions from toxic conditions and materials at the piles, and encourage everyone who worked downtown after 9/11 to get medical consultations free of charge through the World Trade Center Health Program, which was established under the Zadroga Act.

Most important to us now, is to remember those we lost on 9/11, and those we continue to lose too soon from the effects of Ground Zero. That gallows humor still keeps us intact as we discuss our ailments the way elderly people might. Many of us are managing the most serious medical conditions, like cancer, as a result of our work, so we need it.

We don't regret one moment of work on the rescue and in those piles. It has brought us to today and we consider it a privilege to carry the memories of those who were lost, and those memories we've been able to create with our families ever since.

THE HILL

By Louis Miller And Andrew Yacht

Louis Miller, MD, is assistant dean for career advisement and assistant professor at the Donald and Barbara Zucker School of Medicine at Hofstra/Northwell.

Andrew Yacht, MD, MSc, FACP, is senior vice president of academic affairs and chief academic officer for Northwell Health and professor of medicine and associate dean of graduate medical education at the Donald and Barbara Zucker School of Medicine at Hofstra/Northwell.

ORIGINAL ARTICLE

June 16, 2024

Draconian abortion laws are driving OB-GYNs from red states

Though evidence may not sway some lawmakers' decisions on abortion, the realities of reproductive health care are driving the decisions for medical school students in the field of obstetrics and gynecology.

For the second straight year, fewer students in MD-granting U.S. medical schools are applying for OB-GYN residencies in abortion-restricted states. Just as numerous states have sent a signal since the overturn of Roe v. Wade by enacting abortion bans and restrictions, future doctors are sending one in return: They do not want to work or live where these restrictions exist.

A recent national survey shows that nearly all medical students applying to OB-GYN residencies ranked programs in states with greater abortion access higher than programs in states with restrictions. Approximately three-fourths of this year's survey respondents cited the Dobbs v. Jackson Supreme Court decision as having influenced their residency application plans.

That follows a 2023 survey in which 82 percent of early- to mid-career doctors and medical students who responded expressed the preference to work or train in states without abortion restrictions. The Association of American Medical Colleges also has reported that the number of applicants to residency programs in states with near-total abortion bans declined by 4.2 percent, compared with a 0.6 percent drop in states where abortion remains legal.

Abortion-restricted states should interpret this as more than education-related data. It's cause for alarm regarding medical staffing in their states and, in turn, their constituents' health.

These surveys mirror frank conversations medical school advisers are having with advisees pursuing careers in obstetrics and gynecology. Political considerations have become more prominent in training and career decisions, as students hesitate to apply to residencies in states where they believe they cannot be fully trained or where they do not want to settle permanently.

Many OB-GYN residency applicants see the field as a calling. But there's a strong thread of advocacy and reality within that sentiment. Even as they train to help as many patients as possible experience pregnancy, labor and delivery safely, they know that they need to learn how to perform abortions. It is a reality of reproductive health care. There will always be high-risk patients for whom pregnancy may be life-threatening, or patients who experience ectopic pregnancy or incomplete miscarriage.

Residents in abortion-restricted or banned states simply won't be trained to provide comprehensive care for those patients — potentially putting patients in harm's way and forcing colleagues in other states to manage the fallout.

One applicant from the school of medicine where we work was interested in an OB-GYN residency in a state with significant abortion restrictions but only applied after being reassured that the program arranges for out-of-state abortion training for residents. That's something larger residency programs at academic medical centers may have the resources to manage, but other programs may not have that capacity, desire or political will.

Potential OB-GYN residents also are keeping an eye on a shortfall in the field.

About 4.7 million patients already are living in "OB-GYN deserts," areas with limited access to basic gynecological and obstetric care. Now there's an anticipated OB-GYN workforce shortage. About 3,000 fewer OB-GYNs will be practicing throughout the country by 2030, the Department of Health and Human Services projects. If current aging, burnout and political trends continue, it's feasible there won't be enough fully trained OB-GYNs to care for patients or train future generations of OB-GYNs.

This scenario endangers every facet of reproductive health, and medical educators aren't well positioned to remove that danger alone. This decision sits where the political meets the professional and personal: After all, these doctors-in-training (and/or their significant others) may not have full bodily autonomy, depending on where they settle. It's a challenging, fragile responsibility to help future doctors weigh these options.

We're charged both with training future doctors and advising them on their professional paths. How can we encourage them to move to states where they're prohibited from using the evidence-based skills and reasonable medical judgment they've begun to build in medical school?

Of the graduating medical students we advise annually who pursue OB-GYN, the overwhelming majority are advocates for reproductive rights. That is not a "blue state"-only philosophy. They want to guide patients through safe pregnancy, labor and delivery experiences, to fully meet their patients' needs. That can include abortion. Does it make sense to encourage graduating students to complete their training in states where legislation has taken medical decision making out of the hands of OBGYN practitioners?

Successful residents have access to complete training in their chosen field. Those who have the most opportunities to hone their skills and learn from more experienced colleagues go far. Though we want our graduates to go where they're needed, abortion restrictions and bans are creating an environment in which they can't fully offer OBGYN care.

Medical schools' role in guiding them through these decisions may increasingly mean helping them accept that their chosen profession is being undermined. And it may mean encouraging them to train — and ultimately practice and live — where they can offer, and perhaps receive, the full spectrum of reproductive care.

MEDPAGETODAY®

by Stacey E. Rosen, MD

Stacey E. Rosen, MD, is the senior vice president of the Katz Institute for Women's Health and professor of cardiology at the Donald and Barbara Zucker School of Medicine at Hofstra/ Northwell.

ORIGINAL ARTICLE

November 26, 2023

No Laughing Matter: Women's Health Is Not a 'Women's Issue'

It's about time the U.S. focused on women's health research

Stand-up comics aren't usually my go-to source for making a professional point. But a searing insight from Amy Schumer has me reconsidering. In her most recent comedy special, Schumer discusses her complicated 2019-2020 pregnancy.

"I had this awful condition while I was pregnant called hyperemesis gravidarum. Severe nausea and vomiting the whole pregnancy," she explains. "I was so relieved when I was diagnosed ... 6 months in I was like, 'Okay, we know what it is. What do we do?' And they explained to me, 'Well, we haven't been able to study it because it only happens to women.'"

In one mic-drop moment, Schumer nailed both the laugh and the scientific problem. Her bit also made me wonder: Did men hear the punchline or is this an echo chamber?

Thankfully, it seems President Joe Biden heard it. With First Lady Jill Biden next to him, the president established the "first ever" White House Initiative on Women's Health Research. It will bring together experts from the entire administration, the private sector, research institutions, and philanthropic organizations "to drive innovation in women's health and close research gaps."

Those gaps are present at the most fundamental level: women have been historically under-represented in clinical trials, and research focused on women's health has been vastly underfunded. I'm not talking about reproductive organs: what we call "women's health" goes well beyond that.

Women have been left out of, or underrepresented in, a huge range of studies. Consider the health conditions that are more common in women, such as Alzheimer's disease, rheumatoid arthritis, and even adenocarcinoma. Clinical presentation in many conditions is different for women as well, especially with heart disease. For too long and for too many women, these differences — and lack of targeted studies — have led to misdiagnoses, mistreatment, and poor health outcomes.

I want this White House initiative to transform how women's health research is funded and conducted. That can only happen by starting with the basics — understanding that men and women are different at the cellular level. About a third of the genes that people carry are expressed differently in men and women. As a result, clinical presentation, treatment options, and health outcomes often differ.

It is why Erica Ollmann Saphire, PhD, MBA, president and CEO of the La Jolla Institute for Immunology, said, "Studying sex-based differences in a systematic manner will help uncover the causes and allow for treatments that are in tune with biology."

My expertise comes from cardiology, where not taking this approach meant we didn't learn until the mid-1980s that women were dying from heart disease at higher rates than men. I'd been taught it was a "man's disease." In fact, over 60 million women in the U.S. (44%) are living with some form of heart disease, the leading cause of death for women and men. The president's task force will have to contend with another tough fact: women represent only about one in five participants in cardiovascular disease clinical trials.

I want this team to succeed because women's health and well-being is not a "women's issue." It is a human and equality issue. And it has an impact on public health and the economy. Sociologist Chloe Bird, PhD, MA, drives home this point in the RAND Corporation's Women Health Access Matters (WHAM) report.

Women make up more than half the population and workforce, Bird says, yet are more likely than men to be caregivers and make 80% of all healthcare decisions, all while medical sciences underfund studies focused on women. Like Schumer, she has a mic drop:

"By underfunding the study of women's health issues, we've left a tremendous amount of money on the table....Even a slight increase in capital invested in basic research into women's health would unleash staggering returns that would capture the attention of anyone on Wall Street or in Silicon Valley."

A 2016 McKinsey Global Institute report makes the economic benefit of bolstering women's health even clearer: "If women were to participate in the economy identically to men, they could add as much as $28 trillion, or 26%, to annual global GDP in 2025."

As President Biden's group spends the remainder of the year defining the roadmap to address the longstanding inequities that keep us from achieving these gains, I hope there are men in the room, too. Their presence here matters because women's health is not solely an issue for women. We need more men to become outspoken, expert advocates for equity and representation for this to stick.

Hopefully this initiative will deliver solutions and help get out that message. The comedy world, it seems, already has started to hear it.

STAT

By Elizabeth Schmidt

Elizabeth Schmidt, M.D., is the chief of family planning in the Department of Obstetrics and Gynecology for Northwell Health, and assistant professor of obstetrics and gynecology in the Donald and Barbara Zucker School of Medicine at Hofstra/Northwell.

ORIGINAL ARTICLE

June 13, 2024

The fight over medical abortion has worsened pregnancy care

The Supreme Court unanimously shut down one of many troubling tugs of war over access to abortion. By tossing out FDA v. Alliance for Hippocratic Medicine, it quashed the utterly mistaken notion that the Food and Drug Administration improperly approved mifepristone, a drug used for medical abortion, nearly a quarter century ago.

This Texas-based case, which sought to roll back access to one of two abortion medications, was not really about anti-abortion doctors supposedly being harmed by the government's actions. It was about a political drive to unfairly question and restrict a longstanding, safe, and sometimes necessary medical treatment to end pregnancies.

Mifepristone's safety record is firm: it has been used in more than 630 clinical trials, 420 of which were randomized and controlled, since the FDA initially approved it for pregnancy termination with a second drug (misoprostol) for up to 49 days of pregnancy. Given the millions of people in the U.S. who have used it successfully, the FDA approved its use for up to 70 days in 2016. The death rate from mifepristone is 0.0005% — the U.S. death rate from giving birth is 0.019% — and decades of research show a 0.4% risk of major complications from it, lower than with Tylenol or Viagra.

Despite that record, the FDA placed this medication under a Risk Evaluation and Mitigation Strategy (REMS) drug safety program, the FDA's extra way of ensuring that a drug's benefits outweigh its risks. Part of the this strategy meant that mifepristone had to be picked up in person at the doctor's office.

The American College of Obstetricians and Gynecologists (ACOG) has advocated that the REMS restrictions aren't necessary. Citing decades of evidence, the success of lifting the in-person dispensing requirement during the Covid-19 public health emergency, and a broad consensus of the medical community to underscore that mifepristone is safe, ACOG argues that the FDA requirements do not benefit patients. Furthermore, the mitigation strategy disproportionately burdens communities already facing structural barriers to care, including people of color and those living in health care and reproductive deserts.

Medical professionals also know that the risk of dying from a full-term pregnancy and childbirth in the United States is 14 times higher than that of dying from a legal abortion. Medication abortions without mifepristone may be less effective and result in nausea, diarrhea, chills, vomiting, or cramping.

Doctors rely on mifepristone for other uses, such as inducing labor and managing miscarriages, and when a fetus dies in utero. This medication helps keep patients as safe as possible during these processes. Mifepristone also may be helpful in treating fibroids.

The Texas case had caused enough concern over the availability of mifepristone that New York, like other states, began building a supply of misoprostol, the second in the two-drug regimen, in case mifepristone becomes unavailable. Some individuals have been obtaining personal doses of these medications from Europe.

Fortunately, the New York-based health system where I regularly prescribe mifepristone has not experienced a shortage of the medication since the Texas ruling. A stockpiling mentality, however well-intentioned, can be harmful because it squirrels away medications for future patients, which could make them less available for today's. It's not a sustainable solution because obstetricians need to be able to prescribe doses to patients before they expire and become unusable.

I hope that between the Supreme Court's ruling and the country's two largest drugstore chains preparing to dispense mifepristone at stores and via mail order, stockpiles won't be necessary. The notion that both abortion medication and access are dwindling following the 2022 overturn of Roe v. Wade, has left OB-GYNs and their patients in chaos.

In the tense run-up to the Supreme Court decision, OB-GYNs have seen their patients being denied insurance coverage for their desired method of managing miscarriages. Insurance companies have been denying coverage for uterine evacuation for miscarriage and also denying coverage for medical management of miscarriage. People have been forced into surgery or medication they don't want.

The argument that the anti-abortion doctors who brought this case to court are the ones harmed by mifepristone was always unacceptable. In fact, their case has caused more harm because this unnecessary debate undermined patients' abortion and pregnancy management options. Further limiting or losing mifepristone, a medical tool used in more than half of all U.S. abortions, would have been incredibly dangerous for patients.

Contrary to the opinion of a Texas court, based on now-retracted studies, the FDA did not take shortcuts to approve mifepristone in 2000, nor had it harmed the doctors who brought this case — even if those who seek to politicize and outlaw abortion say otherwise.

I for one am grateful that the Supreme Court was attentive to the scientific data, In the tense run-up to the Supreme Court decision, OB-GYNs have seen their patients being denied insurance coverage for their desired method of managing miscarriages. Insurance companies have been denying coverage for uterine evacuation for miscarriage and also denying coverage for medical management of miscarriage. People have been forced into surgery or medication they don't want.

The argument that the anti-abortion doctors who brought this case to court are the ones harmed by mifepristone was always unacceptable. In fact, their case has caused more harm because this unnecessary debate undermined patients' abortion and pregnancy management options. Further limiting or losing mifepristone, a medical tool used in more than half of all U.S. abortions, would have been incredibly dangerous for patients.

Contrary to the opinion of a Texas court, based on now-retracted studies, the FDA did not take shortcuts to approve mifepristone in 2000, nor had it harmed the doctors who brought this case — even if those who seek to politicize and outlaw abortion say otherwise.

I for one am grateful that the Supreme Court was attentive to the scientific data, realities, and outcomes, just as the FDA was when it approved mifepristone more than 20 years ago. At least for now, one aspect of pregnancy care has been settled.

THE HILL

By Heather Hugelmeyer

Heather Hugelmeyer, LCSW, is senior director of behavioral health at Northwell Health, overseeing addiction services at Zucker Hillside Hospital and South Oaks Hospital.

ORIGINAL ARTICLE

September 8, 2024

The normalization of gambling is fueling addiction

Let's not call gambling the "hidden addiction" anymore.

The medical, personal and financial wreckage of this condition is right in front of us as we watch the betting line scroll across the screen of sports broadcasts. Those of us who treat patients with problem gambling, as the condition is known, can feel it happening as our phones turn into portable casinos. We can hear it coming as we're told stories about teens amassing gambling debt.

It's a race against the clock to offer treatment for problem gambling as a primary addiction in the U.S., because it has become prevalent, accessible and normalized. My colleagues and I are bracing for a public health challenge akin to the opioid epidemic.

We're seeing individuals face foreclosure and tremendous debt because they're using mortgage, rent and grocery money to place bets. They feel fearful and without hope as their relationships splinter — not only from financial wreckage, but from the accompanying conditions from which problem gamblers also often suffer: anxiety, depression, and substance use disorders. Nearly 40 percent of people with a gambling disorder will consider suicide.

The demographics of the condition are startling, too. Young adults, particularly young men between the ages of 18 and 24, are more likely to engage in "risky" gambling behavior; teens don't necessarily view gambling as an activity that can lead to problems. Age, cultural background and socioeconomic status also may contribute to an increased likelihood of developing a gambling problem.

Problem gambling is exploding nationally, to the tune of about 7 million U.S. adults. Some of the same states that have legalized sports gambling have been overwhelmed by increases in calls to their gambling addiction hotlines.

That legalization has helped normalize gambling culture. It's legal in casinos or at racetracks in 38 states and Washington, D.C., and six states have measures pending to authorize it. Televised sports shows have done their part, too, because we barely notice the "betting line" on our screens. Some sports shows are dedicated entirely to gambling. About $23 billion was spent legally gambling on the last Super Bowl alone.

Of course, gambling goes beyond sports. We visit casinos, buy scratch-off or lottery tickets, bet on horse races, play bingo, and participate in office raffles. Online gambling opportunities are endless.

Many people can treat gambling as a form of entertainment without developing an addiction. But for others, it's not so simple. People with problem gambling are chasing that dopamine rush — the high associated with every other type of addiction. And, like other addictions, gambling is a societal problem, not just an individual one.

The national annual social cost of this addiction is around $14 billion. That includes gambling-related criminal justice, healthcare spending, job loss and bankruptcy. I'd like to see states weigh that against the relatively modest revenue increases they've seen from legalization.

In the meantime, there is nothing modest about how my colleagues and I are preparing for the fallout.

We're screening more patients for problem gambling, creating starter support groups and applying for state certification to treat gambling as a primary addiction. The federal government, states and individual families have roles to play, too. Lawmakers can take a close look at the Gambling Addiction Recovery, Investment and Treatment Act. If passed, this legislation would dedicate federal funds for programs to prevent, treat and study gambling addiction; support state health agencies and nonprofits that address gambling problems; and invest in best practices, comprehensive research into the condition, and early education about the risks of gambling.

The healthcare workforce needs to know this problem is right on the horizon. Let's prepare to understand the impact of problem gambling and expand screening across a variety of healthcare settings, so we can identify the condition and intervene early.

When educators and parents discuss the responsible use of phones and social media with young people, they can add problem gambling, and how to obtain help for it, to the conversation. There are numerous apps and other gambling opportunities to track, and we need to keep underage kids from sidestepping age restrictions and parental permission to gamble. The hard truths about social media platforms collecting personal data also apply to gambling apps, as is the reality that gambling apps, like casinos, are specifically designed to keep us betting.

We can all send the message that enjoying sports doesn't have to include placing bets. Maybe one form of entertainment at a time is enough. Do we need our smartphones beside us as we spectate? Perhaps we can watch games without the betting line.

Gambling now is in plain sight. Labeling it as entertainment doesn't allow us to help our overwhelmed — and overmatched — patients. There are too many facets of this problem to heal, from accompanying conditions and addictions to financial counseling and relationships. We can't do that until we're honest about how normalizing and expanding gambling has contributed to this burgeoning addiction.

By Michael Dowling

President & CEO, Northwell Health

ORIGINAL ARTICLE

May 1, 2023

Can the Workplace be a Starting Point for Addressing Mental Health?

Yes. It can help employees thrive when healthcare leaders thoughtfully offer usable, accessible resources.

One of the most effective first steps we can take in managing our mental health is to pause and take stock of how we're feeling. While patients may receive this advice from healthcare providers, I hope our country's healthcare workforce of about 22 million are doing this ourselves.

It's clear our industry's workforce faces challenges on that front.

U.S. Surgeon General Vivek Murthy has described the level of burnout – a state of emotional exhaustion, depersonalization and low sense of personal accomplishment at work – being experienced among health workers as "alarming." He highlighted last year the association between burnout and anxiety and depression. Even before the intensity of the COVID-19 pandemic, the National Academies of Medicine (NAM) reported in 2019 that burnout had reached "crisis" levels. Following the height of the pandemic, more than 50% of public health workers have reported symptoms of at least one mental health condition, such as anxiety, depression and post-traumatic stress disorder.

We owe it to ourselves, our loved ones and our patients to address these personal challenges. Let's take that necessary pause as we begin Mental Health Awareness Month. It's an opportunity to join nationally in addressing "stigma, provide support, educate the public and advocate for policies that support the millions of people in the U.S. affected by mental illness," including healthcare workers.

Health systems and healthcare leaders have a significant role to play in creating cultures that address mental health challenges. It's imperative to consistently tune into how employees feel. We can get ahead of certain challenges by listening and asking for input about what type of support is needed, rather than waiting for them to arise or worsen.

At Northwell, our Employee Wellness team and internal partners have helped to do this by assessing, building and offering a wide range of mental, emotional and financial resources and programs that support employees and their loved ones/dependents. The focus on mental and emotional well-being support is grounded with our Employee and Family Assistance Program (EAP), as a no-cost benefit to our workforce.

Though Northwell is a large employer, we've built the EAP to be agile and responsive to day-to-day requests and/or crises using a "No Wrong Door" approach. Through a collaboration with Chaplaincy Services, Team Lavender (professionals dedicated to supporting colleagues during times of stress or hardship) and the Center for Traumatic Stress and Resilience and Recovery, the EAP ensures that employees and/or their loved ones obtain the services they need.

- So far, employee use of the program — which provides counseling, coaching, referrals and follow-ups for a range of mental health needs — has led us to double the size of its clinical team to serve the needs of our growing workforce.
- In 2022, the EAP's clinical team fielded more than 6,000 calls, referring half to other resources in the health system and serving nearly 3,000 Northwell employees.
- The EAP also offers assistance and training to our managers and leadership on how to handle difficult situations that may arise in the workplace, and mental health educational workshops and resource fairs.

We also use a survey to find out which resources employees are using and communicate regularly and closely with team members to build awareness about the services we offer. It's one of the many lessons that the pandemic amplified – that we must make it a primary goal to take care of ourselves and each other.

Taking the time to pay attention allows us to recognize when to lend a hand or make a referral. Mental Health Awareness Month is the perfect time to remember the importance of listening and assess how we feel, so we can work toward building resilience, optimism and health for the future.

By Michael Dowling

President & CEO, Northwell Health

ORIGINAL ARTICLE

March 16, 2023

Curiosity: One of our most powerful tools

It helps us open our minds to new information, questions, perspectives and connections.

Continuous learning and the resulting curiosity were a big part of my childhood. My family did not have much in the way of material benefits – struggling with poverty was a constant. My mother, however, made sure that books were always available and that we understood that education and learning were essential to future happiness and success.

I loved books and was curious about everything. I dreamed of what was "over the horizon" – what lay beyond. These dreams inspired me to leave, expand my experiences and eventually lead to a life in education, government and health care.

Curiosity fueled me – inspired me to get first-hand experience and take risks. Curiosity educates and it provides perspective. Each Monday I meet with all new employees of Northwell Health – almost 300 per week. At those meetings I encourage and speak about the benefits of continuous curiosity – it leads to creativity, innovation, flexibility and adaptability. It is, I explain, a core part of our culture.

I'm not alone in valuing this characteristic in the workplace, and I encourage other leaders to value it, too.

A 2021 study reports that nearly 72% of surveyed managers believe curiosity is "a very valuable trait in employees, with more than half strongly agreeing that curiosity drives real business impact." It adds that employees who are more curious are higher performers.

The COVID-19 pandemic has played a large role in making clear the power of curiosity. At the pandemic's height, curiosity brought us 3D printed swabs, new critical care spaces and new ways to treat patients in the face of a previously unknown virus.

We continue to work hard to encourage that mindset throughout our health system. We give employees an opportunity to receive funding for the research and development of employee-driven projects through an internal competition called the Innovation Challenge.

Our 2021 competition produced ideas that have the potential to transform the future of medicine: a new treatment for bleeding disorders, a device to detect ulcers and an AI algorithm that predicts patients' stability so clinical staff know when to let them continue to sleep. I look forward to seeing what our 2023 competition brings. It gives me a chance to see how people think — which problems they approach and how they brainstorm and develop solutions.

A curious mind leads to lifelong learning, both in and out of work. It allows us to ask questions and question ourselves, to take a fresh look at old problems and anticipate future challenges. The day we stop educating ourselves and start to think we know everything is the day we fall behind.

Social psychologist Adam Grant put it beautifully:

"In a changing world, expertise quickly becomes obsolete without humility and curiosity. Expertise is what you know. Humility is knowing what you don't know. Curiosity is how much you want to learn. Expertise yields insight today. Humility and curiosity fuel growth tomorrow."

I'd add that curiosity creates pathways, allowing us to meet and connect with people. It allows us opportunities to find out about others and, ultimately, ourselves. Curiosity can help us better assess and evaluate challenges. It can help us shed assumptions, ask questions and "read the room" instead of jumping to conclusions.

It's also an invitation to join a conversation. Curiosity allows more people to offer their varied ideas and viewpoints, including those that differ from our own. That can lead to wider perspectives, more options and, hopefully, a clearer path.

Curiosity lays a strong foundation for an innovative workplace and a thoughtful, open mind. Hopefully, it helps us work toward the type of professional and emotional growth we all seek.

By Michael Dowling

President & CEO, Northwell Health

ORIGINAL ARTICLE

April 25, 2022

Want progress at work? Allow employees to push back

The ability to ask tough questions is not a “soft” skill. It’s essential. Any organization looking to grow and progress needs employees who are willing to evaluate what’s happening around them and challenge what they do.

When we encourage people to ask questions, it gives us a chance to pause and rethink.

That’s the moment when growth happens.

Our health system, for example, grows when our experts have enough room to push back on norms. In some cases, it leads directly to better patient options and outcomes.

David Hirsch, MD, DDS, FACS asked how he might be able to decrease the number of surgeries needed to reconstruct a jaw and teeth after tumor removal. He found a way to turn multiple surgeries over months or years into a one-day process. His innovative thinking improved patients’ outcomes, minimized their trauma and reduced costs to both the patient and hospital.

Concerned about teens’ chances of becoming addicted to opioids as adults, Vishal Sarwahi, MD asked whether teens undergoing complex scoliosis surgery might be able to manage their post-surgical pain with fewer opioids. Challenging the status quo and considering another dimension of their future drove Dr. Sarwahi to work with anesthesiologists, nursing staff, patients and their families to manage post-surgical pain effectively — he was able to reduce opioid use associated with the procedure by 80 percent.

But to challenge our approaches, we need a work environment that makes it possible. An organizational culture has to be both strong enough and flexible enough to support employees asking those tough questions. Here are three steps to creating a work culture that encourages tough questions:

- Foster trust: Solutions like those that Drs. Hirsch and Sarwahi created come about when a workplace fosters trust. We need to trust those with specific knowledge, expertise and experience because they know what’s needed. Medical teams work closest to their patients and their loved ones; they’re most likely to know what their patients need. They understand exactly where procedure and processes need to change — or, sometimes, stay the same — and which questions they need to ask.
- Engage in meaningful listening: Listening also helps create a culture that boldly questions norms. We need doctors listening to their colleagues to learn about different approaches to the problems that need solving. They also need to listen to patients so they know where to place boundaries around the new processes and procedures they create, or where to push further. Listening can tell us where we need to improve.
- Transparency: To build a workplace where people are comfortable enough to challenge and ask questions, we also need transparency. It creates a safety net for the reasonable failures that come with experimentation. We need to feel secure enough to admit when we’ve made an error and can do better. Failure is a memorable and meaningful teacher that, coupled with transparency, can position us to ask more questions that will, ideally and ultimately, propel us to improve.

When effective leaders create a workplace culture that builds trust, engages in meaningful listening and encourages transparency, the whole organization can better serve both the clients (in our case, patients) and the workplace itself. It allows employees at all levels to feel secure enough to question and assess what they do and how they do it.

By Michael Dowling

President & CEO, Northwell Health

ORIGINAL ARTICLE

March 21, 2022

Making mistakes can make stronger leaders

Workplaces benefit when leaders and employees have space to make mistakes. It gives us a chance to reflect how we can improve professionally — and personally.

Effective leaders know that it's important to make room for mistakes.

Some of our best and toughest lessons come from our mistakes. When we can find ways to shake off the unattainable expectations that come with so-called perfection, there's more freedom to learn and move forward differently in the future.

Mistakes give us a chance to reflect.

When employees inevitably make mistakes — and when we leaders do — it can be a good time to evaluate where we are and how we got to the mistake. What went wrong here? Was this mistake the result of something that an individual did? Or is there a systemic problem that led to this?

Reflecting on our mistakes helps us take a closer look at what our impact is on a given situation or process. It's important to pause so we can break down our thoughts, behavior and actions to see how we might proceed differently when we face similar circumstances in the future.

Mistakes give us a chance to show vulnerability.

Some people may mistake vulnerability for weakness. But when we accept and share our vulnerabilities, we're strengthening work culture. Sharing our vulnerabilities is a worthwhile risk.

It demonstrates to people who we really are, not just as leaders, but as people — and hopefully inspires them to share more of themselves. When we learn how to flip vulnerabilities into strengths, it can also relieve pressure and allow us to share what makes us human. We can help build a more open and creative work environment when we free people to be themselves and, ultimately, make their best contributions.

Mistakes give us an opportunity to learn.

Within reason, failures push us to learn — in fact, they help us learn more than our successes do. After all, teachers know that students are more likely to analyze wrong answers after a test than the ones they got right.

Mistakes give us a chance to ask more questions and request potentially valuable feedback. They keep us in a learning, growing mindset that hopefully spreads throughout an organization.

Mistakes give us a respite from imperfection.

The idea of perfection itself, or a mistake-free organization, is a myth that can weigh heavily on some. "Perfection" adds a heaviness that can make it difficult to move forward and puts unnecessary pressure on people. It can cause some people to struggle to set goals and begin projects, and can cause others to stall at the first sign of trouble, instead of reaching out to leaders and colleagues for support.

When we shake off unrealistic expectations of perfection, it allows us to become more creative and ultimately take reasonable risks that can drive an organization forward. It makes us more likely to manage mistakes and dive into why they occurred.

It's difficult to embrace our mistakes because they can expose vulnerabilities. But mistakes should not be mistaken for weakness: They can be a jumping off point for reflection, discussion, growth and new ideas.

Could Sex Relieve My Migraine?

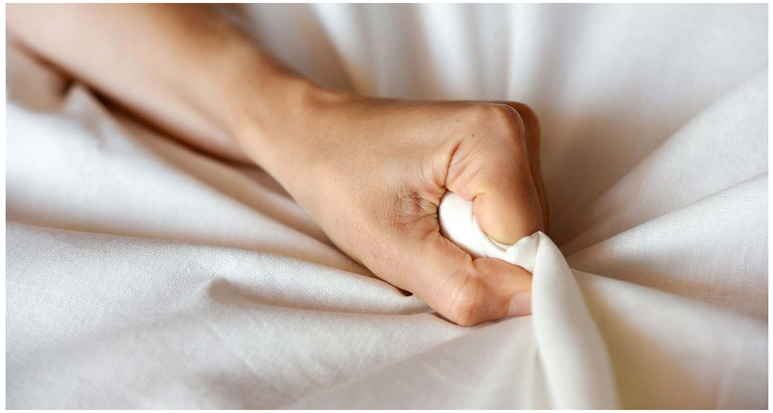
The headache-orgasm connection isn't a perfect science yet. But it could be worth a try!

By Adar Kaplan

ORIGINAL ARTICLE

As much fun as it is to chat about sex, it wasn't exactly my go-to conversation one day last fall, when I found myself suffering through yet another massive migraine.

I was into the second day, felled by symptoms that had become, for me, the upsetting usual: severe eye and head pain, light sensitivity, and nausea.



I'd also lost my sense of humor, which became all the more evident when a friend happened to "casually" mention (with a smirk) that they'd heard orgasms can relieve headache pain.

"Thanks," I quipped. "That's exactly what I'm in the mood for."

But as I spent more time in my cool, dark room, I couldn't help but give in to my (intellectual) curiosity. And so, I did what I'm pretty sure any health care communications professional shouldn't do: I Googled "orgasms and headaches."

And it was certainly a ... fruitful search.

But, to my surprise, amid the "Honey, I have a headache," and not-so-subtle references to "banging" and "pounding" headaches, I found one article after another citing a 2013 observational study conducted in Germany that looked at the pain-relieving properties of sex and orgasms as they relate to headaches.

It noted that although the majority of patients with migraine and cluster headaches don't engage in sexual activity during "headache attacks," the data did suggest it can lead to "partial or complete relief of headache in some migraine and a few cluster headache patients."

Suddenly, this didn't sound like such a far-fetched option anymore — not to mention I was out of over-the-counter remedies. But I couldn't help but wonder if it was also the too-good-to-be-true option? (After all, I had also found a fair share of results that indicated there are people who suffer from orgasm-induced headaches.)

Not wanting to prolong the migraine, I turned to Noah Rosen, MD, a neurologist and headache specialist with Northwell Health, to learn more.

(A colleague of Rosen's once gave him a pin that says, "Sex cures headaches." And a slogan printed on a pin must be true, right?)

"Headaches are filled with mythology," Rosen says. "And some of it crosses over into stigma. Some people think migraine sufferers, for example, just complain a lot or are seeking medication." So adding sex and orgasms to the discussion of headaches likely doesn't do much to reduce that stigma, he adds. Perhaps that's why Rosen recalls only a handful of patients who have linked headaches and sex in his 20 years of practice.

But while he says this study is a good first step in breaking down stigmas around conversations about orgasm-headache pain relief, he also explains that it is not without its flaws. (Darn.)

For starters, the 1,000-patient study is somewhat small, Rosen says. Not to mention there also may be a built-in bias: Those who responded to the survey may already have felt more strongly about sexual activity and headaches.

That said, there are a few reasons some of the study's headache sufferers may have experienced relief with sex, starting with the idea that hormonal surges can minimize pain. "Some people talk about an endorphin rush during sex," Rosen says, referring to the "happy" chemicals our nervous systems naturally produce. "But what people may not realize is that they can also help with pain suppression." (And he's not kidding: The Association of Migraine Disorders lists endorphins as providing pain relief that's even faster than IV morphine.)

Sex also can act as a "diffuse noxious inhibitory complex," he adds. This is a phenomenon that occurs when someone has a headache, and another physical feeling — in this case, sexual activity — acts as a distraction from it. "It's like rubbing the area around a paper cut to disrupt a pain signal."

To that end, Rosen points to FDA-approved armbands used by some headache sufferers that electrically stimulate the arm to block the brain's pain signals, pulling focus from the headache.

On the flip side, some people report getting headaches from sexual activity. It's a small, though perhaps underreported, condition that tends to manifest in three ways: It can mimic a tension headache, begin suddenly during orgasm like a "thunderclap," or be a result of leaking spinal fluid that causes the brain to sag when the sufferer stands.

Rosen also suggests that the sex- and orgasm-linked headaches could be similar to exercise-induced (or exertional) headaches, with similar features to a migraine — adding that these headaches can have a vascular component, and may require a doctor's assessment.

Still, regular aerobic exercise has been shown to reduce migraines, Rosen says, so more research may be warranted to determine whether sexual activity and orgasms can actually help prevent headaches for some patients, too, rather than just providing pain relief during an attack.

But whether you're experiencing a headache right now, or looking to prevent future episodes, he explains that whether sexual activity or an orgasm will provide relief may come down to the type of headache you're suffering from. Rosen discusses three kinds:

- Migraines are throbbing, one-sided, moderate-to-severe headaches that worsen with movement and are associated with nausea and vomiting.
- Tension headaches tend to form a longer, dull band of pain that is less impairing and without many associated features.
- Cluster headaches are extremely severe but brief, with profound agitation and autonomic effects.

In the case of cluster headaches, some experts say the key to finding relief may be finding that moment of climax. This is because researchers have postulated that orgasms may have the same effect as deep brain stimulation on the area of the brain affected by cluster headaches. When it comes to migraines, Rosen says the likelihood is that any pain-relieving properties have more to do with those endorphins we talked about earlier.

And although there is anecdotal evidence of sexual activity and orgasm providing relief for other types of headaches — like tension headaches — Rosen says the jury is still out.

With so much left to discover about the headache-orgasm connection, what is clear is that physicians need more robust data in order to offer guidance to their patients. It's almost enough to make me look forward to my next headache.

Northwell Health®

By Adar Kaplan

ORIGINAL ARTICLE

June 23, 2022

New ways to lower cholesterol

Battling high cholesterol? There are new treatments that can help manage your levels and protect your heart

A staggering 28 million adults in the United States have high cholesterol — they have too many lipids (fats) in their blood.

That number, from the Centers for Disease Control and Prevention (CDC), doesn't even tell us the entire story. Though high cholesterol is a leading cause of heart attacks and strokes, the condition has no symptoms. Many people have no clue their cholesterol is too high.

A simple blood test can measure cholesterol levels, and the CDC recommends that "most healthy adults" have cholesterol levels checked every four to six years. The test measures LDL ("bad") cholesterol, HDL ("good") cholesterol, and triglycerides. (Those who have heart disease, diabetes or have a family history of high cholesterol should have their cholesterol checked more often.)

You've probably heard that lifestyle changes are your first line of defense against high cholesterol. And for good reason: Adopting a healthy lifestyle can drop high cholesterol by as much as 10%.

The American Heart Association (AHA) recommends following a diet featuring whole grains and plenty of produce while reducing your intake of meat and sugar. Nutritional meals plus regular exercise, avoiding tobacco and maintaining a healthy weight, will go a long way to protecting your heart and arteries.

However, some patients will need additional help to manage their cholesterol levels, and their doctor may recommend additional medical intervention.

Cholesterol-lowering treatments

Methods for lowering high cholesterol have come a long way, says cardiologist Eugenia Gianos, MD, director of Women's Heart Health at Lenox Hill Hospital and director of Cardiovascular Prevention for Northwell Health.

"Even as early as five years ago, there was only so much we could do for certain patients, and they'd still end up in the emergency room," Dr. Gianos says. "They'd need repeated stents and bypass surgery or suffered from multiple heart attacks or strokes."

High levels of LDL cholesterol can lead to fatty deposits in the walls of arteries. That's how heart disease can begin; as those deposits grow, they can impede blood flow and lead to blockages in arteries, resulting in heart attacks or strokes. Most cholesterol-lowering therapies are aimed at reducing LDL.

"To prevent heart disease, we must get patients' LDL as low as possible," Dr. Gianos says, and adds, "Thankfully, now we're in an era of prevention when we can offer far more advanced therapies."

Daily cholesterol medications

These medications are the first medical option for patients trying to lower their cholesterol. The drugs are most effective when patients combine them with a healthy lifestyle.

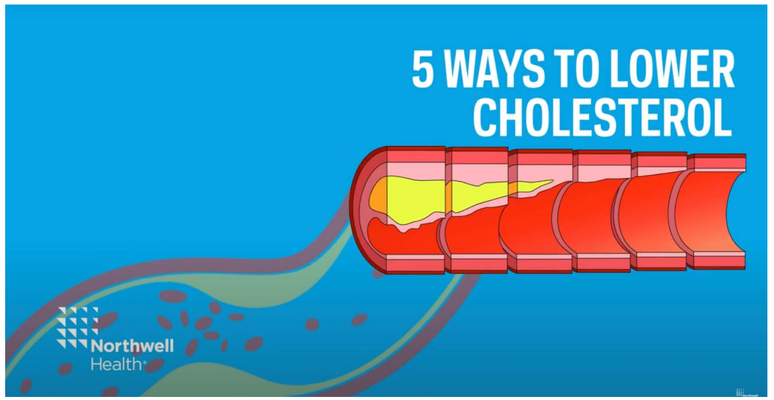
Statins: By slowing the liver's production of cholesterol while also increasing the ability of the liver to clear cholesterol, statins can reduce LDL levels by as much as 55 percent in some patients. Statins may play a role in reducing inflammation, as well, which can also help prevent strokes and heart attacks.

Ezetimibe: Another common cholesterol medication, ezetimibe interferes with the body's ability to absorb cholesterol in the gut, and it can lower levels between 15-20 percent. Patients can take this drug alone or with a statin to gain additional cholesterol-lowering benefits. Using the two types of therapies together after a heart attack may reduce the likelihood of another cardiovascular event.

Cholesterol-lowering injections

A more recent development, injections can be for patients who didn't get adequate results from daily medications or they may provide an option that's easier for patients to adhere to since the shots only need to be given once every few weeks or months.

PCSK9 inhibitors: Patients get this injection every two to four weeks. The inhibitors can reduce the risk of heart attacks, strokes and death. This option can be more expensive and is limited to patients for whom statins and ezetimibe have been less effective.



Inclisiran: Another new injectable sold under the name Leqvio, inclisiran may work better for certain patients. It can lower cholesterol and may work well for patients who have trouble adhering to a medication schedule; the maintenance injections are given every six months.

Blood filtering

LDL apheresis: Some patients have dangerously high cholesterol levels and medication or injectables aren't enough to address the issue. A genetic condition known as familial hypercholesteremia can trigger very high levels; other patients may need stronger measures due to a combination of high cholesterol and heart disease.

For these patients, a procedure called LDL apheresis can help: The plasma portion of the patient's blood is diverted through an apparatus that filters out LDL cholesterol and returns the plasma back to the body.

Patients must get the three- to four-hour treatment every two weeks for the rest of their life, but LDL apheresis can be lifesaving. The reduction in cholesterol also lowers inflammation and reduces the risk of artery damage and other cardiac issues.

More protection is on the way

One other very important risk marker is lipoprotein(a), a unique type of cholesterol that is linked to early heart disease and aortic valve stenosis — a condition in which a valve in the heart can't open fully. Identifying this risk factor is key in patients with early disease or when multiple family members suffer from heart disease, especially as new therapies are in development targeting this specific cholesterol and may significantly lower their heart disease risk.

Finding the right therapy will require a discussion with a cardiologist, Dr. Gianos says. Sometimes cost, side effects and the ease of taking a medication may have an impact on a patient's treatment.

"For some patients, we may be able to connect them with something new in a clinical trial," she says. "For others, we may need to take a larger perspective and conduct genetic tests and find out what role their family history may play in their treatment. It's key for patients to understand how these factors, along with cholesterol levels, affect their cardiovascular health."

Weill Cornell Medicine

By Adar Kaplan

ORIGINAL ARTICLE

September 2, 2020

What You Need To Know About Low Dose Naltrexone

The “typical” patient Neel Mehta, MD sees at his practice has been experiencing chronic pain for at least 90 days. Some have been su ering for a lifetime.

Now Dr. Mehta and the Weill Cornell Medicine pain management team have begun using a safe, old drug in new ways — and in low doses — to treat certain patients.

Their work with the drug, Naltrexone, is an outgrowth of an international partnership with the UK-based LDN Research Trust Charity. According to The Trust, Naltrexone is safe, non-toxic, and inexpensive, and has been used in the United States since the FDA rst approved it in 1984.

Though physicians previously prescribed Naltrexone to treat opioid addictions, they now are employing the drug in o-label uses to aid patients with conditions ranging from pain and a dysfunctional immune system, to in ammation, cancer, and mental health issues.

Here’s what else is new: the WCM team is not prescribing the old, high dose that had originally been considered standard, 50 mg to 100 mg per day. Their patients are using “low” or “ultra-low” doses of Naltrexone.

“We’ve discovered that, if you give patients doses far less than 50 mg, we may be able to achieve pain relief,” says Dr. Mehta says. “In fact, some of the doses we give in tablet or liquid form range from as low as 0.01 mg to six to eight milligrams. We usually start patients with a 1.5 mg dose on an empty stomach at night, and then look for a response after a few weeks.”

Keeping a close watch on patient’s symptoms and use, a WCM physician may increase the Naltrexone dose to 3 mg, and then perhaps 6 mg.

Naltrexone works by temporarily binding and blocking a mechanism called the MU receptor, which is linked to pain. Blocking the receptor tells our bodies that we aren’t producing enough endorphins (our natural pain relievers), and then releases them.

“Generally, my patients report pain relief greater than 50 percent, that they’re sleeping better, or can return to work,” Dr. Mehta reports. “And some patients end up responding well to doses as low as 0.1 for reasons we don’t yet completely understand. Patients are experiencing good results with low harm in these early studies.”

If a patient is a good candidate for low-dose Naltrexone, they can ll their prescriptions from compounding pharmacies that grind up the higher dose tablet into the ultra-low doses.

“Patients should know that there are additional opportunities and innovations in pain relief,” Dr. Mehta adds. “I advise patients to ask their physicians about it and learn more about the LDN Research Trust online.”

Weill Cornell Medicine

By Adar Kaplan

ORIGINAL ARTICLE

August 5, 2020

Commonly Asked Questions About Breastfeeding

It's World Breastfeeding Week — and time to take the stress out of breastfeeding. We spoke with Carolyn Migliore, RN, a clinical nurse specialist with Patient Education at Weill Cornell Medicine Pediatrics, about some of the breastfeeding basics. Here she addresses many of those, and some of the questions she's most commonly asked about nursing.

This piece is based on a Kids Health Cast podcast episode with Carolyn Migliore.

What are the health benefits of breastfeeding for babies?

Carolyn Migliore: To start, breastmilk is fully natural, does not contain arti cial ingredients, and is a complete source of nutrition.

The American Academy of Pediatrics has made clear the bene ts of six months of breastmilk (exclusively) for newborns: It's easy to digest, strengthens a baby's immune system, and diminishes the risk of asthma, allergies, upper respiratory problems, and ear infections. Breastmilk even cuts the risk of sudden infant death syndrome, childhood obesity, juvenile onset diabetes, and childhood malignancies including leukemia, lymphoma, and Hodgkin's disease.

Are there health benefits for breastfeeding moms?

CM: Breastfeeding helps the uterus contract after delivery and burns calories because the body works hard to produce milk. It also lowers the risk of breast cancer, ovarian cancer, osteoporosis, and adult onset diabetes.

How can nursing moms take good care of themselves?

CM: Nutritionally, a breastfeeding mom needs to consume about 2500 calories a day — that's as straightforward as three healthful meals and four to ve nutritious snacks. Some women have found that foods like almonds and oatmeal can boost the breastmilk supply, and that herbs including parsley, sage, and mint can shrink it.

Staying hydrated is key: moms should drink a minimum of three liters of water per day. It can help to keep water where moms nurse to keep up with water intake.

Some physicians may recommend multivitamins for breastfeeding moms, and it's important to ask whether/which medications are safe since they can pass through breastmilk.

Partners can help take care of nursing moms by keeping the kitchen stocked, storing pumped milk, o ering relief bottles, and keeping home quiet if the nursing mom needs a break.

What about some of the possible breastfeeding challenges: How do we know the baby is getting enough breastmilk? What physical discomforts do some women face?

CM: Parents can determine whether a baby is getting an adequate amount breastmilk by checking the baby's diaper content and noting how frequently they change the baby's diaper.

Weight gain and growth are another good way to gauge whether a baby is getting enough nutrition. Nursing is usually going well if the baby seems content after a feeding and can last an hour or two until the next one.

Women can overcome some of the physical discomforts of breastfeeding, such as nipple soreness, by air drying nipples after feedings. It also can help to rub breastmilk on the nipples after feedings before air drying them.

Lactation consultants are a great source for new nursing moms — they can guide moms through reading the baby's hunger cues, positioning mom and baby for a comfortable latch, and solving issues such as clogged ducts. Lactation consultants are easy to nd — we run an outpatient breastfeeding support program at our newborn clinic — and many insurance companies cover the cost of those visits.

Is it okay to use a breast pump, and how should breastmilk be stored?

CM: Lactation consultants typically recommend waiting until two weeks after delivery to before using a breast pump to give the baby and mom time to establish a consistent milk supply. Pumps can help fully empty the breasts after nursing, stimulate the milk supply, and allow breastmilk to be given with a bottle.

Here's what moms need to know about storing pumped milk:

- milk that's going to be used right away can sit at room temperature for four hours
- refrigerated breastmilk is good for four days
- frozen breastmilk can be used for up to four months (and six months for a deep freezer — but breastmilk should not be refrozen once thawed).

Write the date that the milk was pumped on the breastmilk storage bags to keep track of which milk is the oldest, and which is the newest. Give breastmilk to the babies oldest to newest.

Kveller

By Adar Kaplan

ORIGINAL ARTICLE

October 4, 2015

My Laid-Back Approach to Allergies Almost Killed My Daughter

I can be pretty persuasive. Especially when it comes to my daughters' food allergies.

I convinced myself it was alright to give my younger daughter a drop of peanut butter because, I told my husband, laughing, "We have Benadryl in the house!"

I convinced myself that my older daughter wasn't, in fact, having her first allergy attack in a Thai restaurant.

"Your lips aren't swollen, sweetie," I said, annoyed. "They're just chapped."

I even persuaded myself that my children's food allergies would define them if I didn't take a laid-back approach. That I would telegraph my anxiety to them, and they would become social outcasts.

Besides, I didn't want to be "that mom."

The mom who talks about her kids' food allergies until people's eyes glaze over, who details every close call, every allergic symptom, and every graphic online story about anaphylaxis. The mom who is front-and-center checking ingredients at every school and synagogue activity. The mom who defines herself by her children's condition.

Until the cake.

After a summer of stress and worry, with a move and lots of unanticipated work on our new home, I decided Labor Day would be the perfect time to relax at my parents' home. Swimming, lounging, and a barbecue was everything I needed.

As I felt some of my stress melt away, a cake on the counter beckoned. I had one small slice, then another. My older daughter asked if she could have a piece. I asked if the cake contained nuts, and after a brief exchange with my parents and nothing that I, myself, detected, I cut my daughter a small piece.

Two bites later, she put down her fork on the table forcefully.

Her defiant 12-year-old voice said, "Mommy, I have the taste in my mouth like I just ate nuts, and I am NOT OK."

With no Benadryl or EpiPens with us — who would need those at Grandma and Grandpa's house? — we raced to the nearest pharmacy. I grabbed the Benadryl and, panicked, could barely read the correct dosage on the box. Before I even paid for the medicine, I gave the Benadryl to my daughter, a little less than she might need because I didn't want to overdo it. I paid for the medicine and we walked to the car.

"This is going to make you tired, sweetie," I said. "Are you ready to go home?"

"I'm not ready, Mommy, and I'm not alright. You need to take me to the doctor."

Sweating, yet forcing myself to be pretend to be calm — grinding my teeth to a pulp, yet trying to smile at my daughter — I drove like a freaking bat out of hell. When we arrived, I cut a long line of parents registering their children to be seen by the emergency pediatric staff. They took my daughter in immediately.

Then came the gagging, the vomiting. Bye, bye, Benadryl. I tried to convince my daughter — and mostly myself — that it would be OK as I cleaned the vomit from her hair and listened to the doctor say that my daughter needed epinephrine.

My daughter complied as the needle went into her arm. Then I learned that the EpiPen only buys about 15 minutes during an allergic reaction, so the medical staff also had to administer both Benadryl and a steroid to reduce the likelihood of a rebound reaction. After she had thrown up, taking the medicine orally wasn't an option. Did I prefer for her to have a shot of the medicines in each leg or administered intravenously?

"Explain it to my daughter," I said. "She's calm and understands what's happening. She can decide."

She opted for the IV and was monitored every half hour for a few hours. I turned off the cartoons and darkened the room so she could rest. When my guilty head wasn't in my hands, I listened to her groan and watched her wrestle with the cumbersome, painful IV.

I realized I chose the wrong time to relax and the wrong issue for relaxing. And my daughter paid the price.

While my daughters' condition doesn't define them or me, my actions surrounding them do. It's my job to protect and advocate for my children, and just as important, for them to see me doing it at every school and shul and family event. Every day.

Now every handbag I carry accommodates Benadryl and two epinephrine injectors for each daughter. I'm trying to persuade our synagogue board and catering committee to make our shul nut-free. I'm telling everyone about our experience so it never happens again. I may be "that mom," but I wouldn't have it any other way.

Adar Kaplan

Roslyn, New York 11576

917-453-4801 | Adar.N.Kaplan@gmail.com

EXECUTIVE SUMMARY

Communications professional with long-term diverse experience in storytelling, strategic communication planning, innovative content development, stakeholder engagement, media relations, and brand enhancement. A versatile communicator recognized for creativity, curiosity, adaptability, positive collaboration, and a proven ability to shape and humanize perceptions while building trust among colleagues and managers in media relations and marketing, executives, subject matter experts, and media, ultimately driving positive outcomes.

PROFESSIONAL EXPERIENCE

Northwell Health | New Hyde Park, NY

Public Relations Advisor, March 2021 – Present

- Utilize editorial judgment, writing expertise, and editing skills to collaborate on content planning, strategy, and campaigns that highlight and develop health system thought leadership and knowledge
- Build on marketing initiatives by creating and consulting on industry- and customer-facing content that enhances the health system's regional, national, and global reputation
- Develop strategic editorial content contributing to the annual collaborative team goal of researching, writing, editing, and pitching 50 opinion pieces published in local, regional, national, and medical publications
- Ensure that content emphasizes the health system's experience and reputation in identifying and treating medical challenges, enhancing the patient experience, providing specialized care, and boosting health equity, access to care, and health outcomes for more communities
- Collaborate with social media team, managers, and executives to ideate, schedule, create, edit, and share original LinkedIn essays and social media posts for the chief executive officer that focus on health system accomplishments, and workplace issues such as effective leadership, strategic listening, emotional intelligence, the development of a cohesive employee culture, and employee and patient advocacy and initiatives while highlighting the health system's prominence in the healthcare industry
- Partner with media, cross-functional teams, and event partners to create comprehensive executive briefings and speeches/talking points for speaking engagements and events that promote the health system's local, regional, and national expertise, relationships, and brand
- Support the media relations team and marketing initiatives by creating content for campaigns that build on the health system's purpose and principles
- Build relationships with marketing and health system department leaders to determine a systematic approach to creating unique content that meets the needs of departments, the health system, and patients

Triomphant Communications | New York, NY

Communications Consultant (Contract), March 2017 – October 2017

- Partnered with global communications and public relations company and private insurance client's legal, public affairs, and communications team to overhaul, redevelop, and refine the communications strategy and messaging for consistency; promote and publicize community and industry events that showcase thought leadership and core company messages; and create internal, industry-and client-facing content and deliverables, including brochures, informational one-pagers, ghostwritten content, press releases, media alerts, media reports, and media distribution lists

HR Train | Bellmore, NY

Communications Consultant (Contract), July 2018 – January 2020

- Consulted for human resources company HR Train to create and manage communications strategy, including the writing, editing, and distributing of a client-facing monthly email newsletter and blog with consistent brand- and policy-based messaging that included private companies and government employees. Managed and created content and assets to support scripts for human resources training videos for diverse clients nationwide

NYU Langone Faculty Group Practice, New York, NY

Communications Consultant (Contract), October 2010 – February 2016

- Consulted and collaborated with NYU Langone Faculty Group Practice executives, practice managers, and business managers to create a comprehensive, strategic in-house communications strategy, including collaborating with an external vendor to create a branded communication that highlighted and promoted health system policies, the acquisition of new practices, and innovation and expansion in the patient experience

ADDITIONAL EXPERIENCE

Columbia University College of Physicians & Surgeons

Communications Specialist, March 2002 – October 2003

American Technion Society, New York, NY

Public Relations Writer/Coordinator, November 2000 – March 2002

EDUCATION

Cornell University College of Arts and Science | Ithaca, NY

Bachelor of Arts