Mount Sinai

Call #:	INT 0175
Title:	Interview Remembering James P. Jones James P. Jones, MD by Lawrence Attia, MD, Hassan Khouli, MD, Ira Meisels, MD, and Norma Braun, MD
Date:	July 22, 2017; July 25, 2017
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"Remembering James P. Jones," with Lawrence Attia, MD, Hassan Khouli, MD, and Norma Braun, MD with a Statement from Ira Meisels, MD read by Norma Braun, MD
July 22, 2017, July 25, 2017

NORMA BRAUN: I'm Dr. Norma Braun, Chair of the Archives Committee at Mount Sinai–St. Luke's and Mount Sinai West–Roosevelt, of the Medical Board. We are here today to interview several physicians, one of whom is Dr. Larry Attia, regarding one of our distinguished young physicians who died prematurely, Dr. James P. Jones, MD. So I want to start with asking Dr. Larry how he knew James, and what their connections were, and what he remembers about him that made him such an outstanding physician. Larry, how did you first meet James?

LAWRENCE ATTIA: So, James did all his training here at St. Luke's and at West. He was an intern, and a resident. And I was lucky enough, I think it was in 2000, seventeen years ago, to be assigned as a medical attending for a two-week run. Dr. Jones was the senior resident on the team, maybe the junior resident, but he was in charge. And when you worked with James, he had great leadership skills; he worked with his house staff. We had a nutrition or a pharmacist student on the team, and we met every morning to discuss cases.

Well, at that time we had a very old computer system here with a light pen. It was a McKesson System. We called it CCS. In fact, I was very involved in that project, because we were one of the first, or the first, New York City hospital to have 100 percent physician order entry, CPOE at the time. It was very simplistic. It printed out a sheet of paper on the floor, and then the unit receptionist would read that paper and write it into the medication book. But it saved all of our problems with handwriting, and it saved all of our problems with decimal points and things like that, because you'd pick your patient, and you'd pick your medication, or your diet, and it was easy to read.

Well, James had interest in this, and said, "Hey, let's get order sets. Let's make our job easier," and was very involved and interested in the project. And I was always looking for volunteers for some of our committee meetings, and some of our quality meetings, so I very quickly drafted him to do that. It really turned into a passion of his where he got involved in a number of the IT projects. We both sat together as PRISM was selected and started in 2005 and '06. And he was really on the forefront as we move now to EPIC, in working with our IT. In fact, right before he passed he won an award from the IT division for the man of the year for 2016. So he was involved in that.

One of my pet peeves as a young, at the time, a young attending was that we had blue plastic plates associated with every patient. It said the name of the patient, and it said the birthday, and the medical record number. It also said the name of the attending doctor. And often, because the two-week period changed, or the emergency room made some changes, sometimes that name of the doctor was incorrect. If it was incorrect, it led to so many problems down the road. You got pathology that didn't belong to you, or you got reports of cultures that grew out two weeks later, and you're called by the laboratory, "Oh, we've got a positive culture and you didn't recognize the patient."

So, one of the things that I insisted was that for everyone on my team, I wanted my name on the blue plate, and for the other patients on the floor, I didn't want to see my name on those plates. And he did an unbelievable job collecting and writing orders to get new blue plates, and running down to the admitting office on the ground floor to get the blue plates and replace them, so I wouldn't be questioning about it afterwards. I saw that level of attention to detail, and that level of involvement and participation as a great example of the kind of leader that he was soon to become.

He became a chief resident in medicine. He became a fellow in a number of different areas, in nephrology and critical care. And he was omnipresent here in the hospital, working many different roles, juggling lots of responsibilities. I teased him that he was my personal help desk, because when I had problems and I couldn't get something done, I'd call him directly and he would—

NB: Me too. [Laugh]

LA: —solve the problems. So, his loss is really huge around here.

NB: Huge.

LA: We feel it every day. And the one thing that I'll always treasure is that James made working with him and working at the Hospital fun. He had a great sense of humor. He always had a smile. He teased gently when teasing was appropriate. Everyone loved him, and everyone listened, too. So, if he called a colleague or called me and said, "I need this done, or that done," or, "If we can get this work done," we'd be on it. We'd want to get it done as quickly as possible, and we always wanted to be on his team, and his committee on his meetings because of the enthusiasm.

Even going back seventeen years, as a young, fresh face here, he had some of that same enthusiasm as a medical team. So he made those two weeks—which I enjoyed, but sometimes it was hard, I had to run a practice, I had other responsibilities. And it was really two or three hours a day, and you would celebrate when it was completed because you'd feel like you did this task. And yes, teaching is an important part of our mission, and teaching is an important part of what we do here, but there are some days as a young physician that you are pushed in lots of places. He made those two hours a day a fun time for everyone.

NB: He was remarkable in that degree and I think his ebullience and energy actually seemed to stimulate others.

LA: I agree. We used to meet Tuesday night, as we'd design our PRISM program. We had that CCS, and we would start it at 4 o'clock in the afternoon on Tuesdays, and we'd work through till 7:00 or 8:00, or 8:30, and order in dinner. We'd keep going because he kept going, and so, that was part of the fun.

NB: Do you think his interest in that component was for problem solving as a mechanism to do that, or was it a primary, nerdy IT interest?

LA: Well, I think he had some nerdy IT interest. That's one of the things I liked about him. He didn't want to know things on the surface; he really wanted to delve right in. Later on, in recent years, he had a project where he had to look at coding, and look at where we stood with coding. He went through reams of data to try to understand what is a profitable diagnosis, what is a missed diagnosis. He had constantly heard—and he's an internist, a nephrologist, and a critical care doctor. I'm a gastroenterologist, but the world of obstetrics and gynecology is a little separate from the things that we do.

But he had heard in a lot of meetings that we attended that we're a very busy obstetrician practice down at the west side, at Mount Sinai West, and we deliver a lot of babies. But there was always some talk that it wasn't profitable, or it wasn't something we wanted to expand, and he delved into that problem and said, "Wait a second. Why are we delivering as many babies as any hospital in New York City, yet our reimbursement per baby was less than average, was in the bottom 25 percent?" He delved even further and tried to find ways in which—and I think this story is well known, but meconium, which is often in a delivery's mouth and needs to be suctioned out, and it happens in about 25 percent of vaginal deliveries. And if it's coded properly, the reimbursement for the stay is substantially higher.

NB: Well, I thought that represented fetal distress, and that was the reason it was a higher level of attention required for the child.

LA: It's a higher level of care. So, we often found that in fact this material was suctioned properly and it was documented, but at the end of the—

NB: Stay, yeah.

LA: —whole stay it wasn't documented as one of the ongoing problems. And that itself bumped up the reimbursement. Well, then he learned that you can go back eighteen months, and go through the charts for eighteen months of deliveries and see which ones had this misdocumentation, and resubmit to the insurance companies, and be properly reimbursed. He created a project which generated thousand and thousands of dollars to the institution by being curious, by going through the data, and understanding what's going on.

NB: Asking the big question: Why?

LA: Exactly.

NB: Yeah, that's important. A lot of people don't take the time to do that.

LA: So, one thing he did very well was not only understanding the problem, but trying to really understand it from all angles. I always joke, because I'm the—I have a title for associate medical director for IT, and I'm the end user guy. I understand the clicks. How many clicks does it take to go from NPO to a regular diet? What does it require? And he also understood the computer side of it, what it requires in terms of timing, and programming, and other things like that, which I never was able to grasp too well. But he, maybe coming from a generation ten years younger, but maybe—

NB: Yeah, that's part of it.

LA: —just understanding that component. So, when someone asks me, can our current PRISM system do something? I would always say, "Well, let me inquire." And often I would inquire to James, because he would know if it could do it or not, or if there was a barrier technically. So, yeah, he was a special guy. It was a loss that not only all of us on

the West side feel, but the entire health system, because he was so involved in so many different aspects of things.

NB: Yeah. Well, with this busy guy spending so many hours here, when did he squeeze in his family life?

LA: He had a lovely wife and a young son, and he coached soccer. When he had to run out—he missed our medical board meetings in the fall of this year on Wednesdays, because that was soccer day. But, it was always a balance. We know that at a young age he suffered a heart attack, and he lived in suburban New Jersey. His wife found him gasping in the middle of the night, and tried to revive him, and called 911, and it took a number of minutes. And, one of my crazy thoughts was that he spent fifteen, sixteen, seventeen hours a day sometimes in the hospital, and if only this crazy clot, or whatever happened, happened here, we would have had a better chance. We would have had a better chance.

NB: Yeah.

LA: But it just happened overnight, at home.

NB: But it was Christmas.

LA: It was the day after Christmas.

NB: That's probably the reason he was home, Christmas.

LA: He was home Christmas, and it still was a busy time. He spoke of—right before that there was a fire at one of the residential buildings, at 555, a few days before. And we created a command center, a post, for issues with residents over Christmas. He was to do that morning after Christmas an 8:00 am shift, and he didn't make it. But he was dedicated. We commented, "We're doctors. We're not in the emergency management business, or in the fire business." This is a whole new world for the team that was involved. But it was part of running a hospital and understanding all the different aspects of things, emergency management, and crisis control, and he was at his best in those situations.

We're going to go live next March with EPIC, and I'm going to miss him more than ever, because he would run our command center, and be available in making sure that every

patient—and we had upgraded and we changed our computer systems. But if you can imagine with hospital computer systems, when you do make a change, every single patient needs to be reconciled. So they come into the hospital with one system, and then sometime, on a Saturday night during their stay, we convert to another system.

NB: Switch it over.

LA: So, we'd either have to rewrite orders or turn things down, wait the hours, upgrade the system and then turn on the new system. And so every patient needs to reconcile before we can go live and before we can—we need every single patient.

So, the goals in the days leading up to a change like this is to make sure that anyone who needs to go home should go home, and that's keeping the censuses as safe as possible, but then understanding that we've got to make sure that every patient, big or small, old or young, have a complete reconciliation where everything is exactly the same, and that takes time. And that takes a command center, and that takes a lot of help, with all disciplines working together to make sure that everything is right.

NB: Right, because a preventable error sits right in that.

LA: Right, exactly. So you could imagine, during the down time an antibiotic is started, and if it's not continued when the new system goes up, we could lose track, or lose a patient's day, or a problem.

NB: Right.

LA: Obviously, we want—safety is our first priority. These computer systems are supposed to help us with safety, but also, they're flawed.

NB: Hopefully.

LA: Hopefully. They're flawed, and he was clear to point out to us when we have benefits for sure, and efficiencies, which is what we're all after, but when we're flawed. One of the things that he argued often was alert fatigue in these things. We've got to pick alerts when we're working with computer systems very carefully, for the real important ones, because if we throw every little interaction at providers, then you start to blow by them.

NB: Ignore them, yeah.

LA: You start to ignore them. So there are always different dials, and different levels of alerts, and he always argued that we want definitely to have the severe ones to pop up, but the simple ones, the ones that we encounter every day, but have a one percent chance of interaction, he didn't want that same level of alert to go on, because otherwise it makes the riskier ones more dangerous.

NB: Is that how he got into quality improvement?

LA: Right. He got into quality improvement over a number of things. One was the issue of coding, right? He wanted to make sure that we not only cared for patients accurately, but we documented what was going on. So it was a big advantage when we moved from handwritten notes to an electronic documentation note, not only—same sort of thing. You can read the notes; you can read the handwriting. Some of our colleagues have very questionable handwriting.

NB: You mean squiggle?

LA: The squiggles. Yeah, the wiggles and squiggles. But also an opportunity to make sure that problems that exist get carried over. That's part of quality billing, but it's also compliance, also, because we're ranked with other hospitals on a nationwide scale based on certain criteria. It's unfortunate when we're doing a great job, but then we come in in the second tier, or we're not where we belong, not because we're not taking care of patients, not because we're not having great outcomes, but because of documentation. He would meet with residents, because we know in a teaching hospital we're driven by residents, and by our Pas, and by our providers who write those daily progress notes.

Another great story that James shared was we had a surgeon who was at Mount Sinai, at Mount Sinai East, as we call it here, and was a fantastic surgeon. Then she came over here, and it seemed that her numbers and her complexity of her cases were even greater. They were even more complex cases, and her surgery case mix index was even higher. But she does the same thing; she has the same patients. She had Pas here at St. Luke's who would document every small, little thing, and make sure that they're very accurate, and that raised up this case mix index. On the national scale, she appeared to be even more successful and have even more complex cases, and even a lesser

complication rate, and it was all about the staff documenting properly. So, he used that as an example as well.

NB: That's a huge problem. We need to teach more at the house staff level, because that's part of the problem.

LA: Right, right. And sometimes we say, "Oh, the goal is to take care of the patient, right, and to be at the bedside and spend time with the patient." So you want more time with the patient and less time in front of a screen. But they go hand-in-hand, and so yes, you want quality time at the bedside, but then you want to use your computer time as quality time as well, where you're accurate and you're thorough, and if the patient has five problems, you don't document three or four, you document all five.

NB: What have you learned from this experience with James? Anything particular?

LA: I sent out an email to—I'm the champion for this EPIC project. EPIC is a computer system that will replace our current system, and connect us with the entire Mount Sinai health system, all the hospitals. I sent an email saying that I want everyone to take James' enthusiasm, and his desire to get things right, and bring it to this project, because even if it might be a little less fun, and even though there might be a little less teasing and laughing, we really have to take that energy and spirit that he provided to everything we do and all our of our patient interactions. So I miss James every day, and I miss his energy and enthusiasm, but I hope to take a small part of that with me in the way that I take care of patients.

NB: That is a wonderful tribute, because I call it the drop of water effect. It just makes bigger and bigger circles, and encompasses more and more of the, our family. I call it our family.

LA: One other comment. I know that both the West campus and St. Luke's are looking for ways to commemorate and memorialize James. He was one of our leaders, and he is gone way too soon. And he was so loyal to both campuses. He got an office down at Roosevelt, and the only piece of art that he displayed really was a picture of St. Luke's hospital that meant something to him, an old portrait.

NB: He asked me, was it something we could share with him? So I said, "Would you like that?" And he said, "Yes!" right away, so I took it down to him.

LA: Right. So, that was something special to him. And I don't think it's unfair to say, I really expected him to continue on this path and to lead us down the road. At some point in his career, he decided to go into administration.

NB: Right.

LA: Just in the last year or so, and to focus full-time, and pull away from some of his ICU—

NB: Clinical, yeah.

LA: —and clinical responsibilities. So he met with the hospital president, and they said, "Really, James, what are your goals? Where do you expect to be?" Common questions that you ask in an interview. And, James said, "I expect to be on the other side of the desk in five years. I want to lead this place. I want to be part of this hospital." I also know that once the merger happened, other people in the system, Mount Sinai system, took notice of James. He was offered opportunities in some of our team hospitals, and he turned them down, more than one down, because he really wanted to—

NB: Stay here.

LA: —stay here, stay with people he was comfortable with, and really see this through and get us to this next level.

[Pause in recording] I'm Dr. Lawrence Attia, a gastroenterologist and internist, and also Associate Medical Director for Information Technology, IT, both here at Mount Sinai West and Mount Sinai–St. Luke's.

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HASSAN KHOULI: James started with us as an intern, then as a resident, then as a Fellow in Nephrology, then in Critical Care, and then he really joined us as an Attending physician in critical care, as well. Throughout every phase of his career, he has been a star, as I think you'll hear from anybody there. A star, not just because he was a brilliant physician, just because as a person, he really symbolized what St. Luke's and Roosevelt are, a family type of atmosphere that James just really naturally fit in, this type of culture that we had here for a long period of time, I believe. I know since I joined here. So, I dearly remember him in every way as a close friend, as a superstar, someone that we counted on throughout these times that he was with us there. When Dr. Mike

Lesch, then the chair of the Department of Medicine, asked me to find an opportunity for James with us in Critical Care, joining as a faculty, this was really a no-brainer.

NB: That's right. [Laughs]

HK: Knowing who James is. Mike, Dr. Lesch really adored James, and as the [unclear] James felt so strongly, and as a mentor for him too. This probably one of the best decisions that we made, being able to retain James, have him really stay with us, as he continued to thrive and to make us a better division, a better department, a better institution as well. James was a fun guy, too, which made it even more interesting and more fun to be around him. Everybody wanted to have a piece of James, either at work or as a person.

NB: Mm-hm. He was down-to-earth.

HK: Down-to-earth guy. Wanted to help all the time. He was a team player. He was a guy who felt that he can always really support and help the mission that everybody had.

NB: Yeah, problem solver. Problem solver. He was always, "Whatever it is, I'll take it on."

HK: I think we all—he solved so many problems, and helped so many people, patients, and colleagues, and institution at different levels, that he became so valued, and more and more loved, and obviously more and more missed for us at this point.

NB: Very much. Very much.

HK: With all the things that he has done.

NB: James had passion for St. Luke's–Roosevelt, real passion, which is rare, I think, among house staff. They go through a period of training, they go elsewhere, they don't have the same passion. And it showed in everything that he did.

HK: I agree. He was proud, also, of being really one of us here.

NB: Yeah.

HK: So, he did not hide it. He was proud of it. And he continued to really add value to this great institution and its great history over time, too.

NB: Right.

HK: Every step of the way he accomplished more and more, and by what he did, he made the people around him better. That's really a sign of a strong leader, a strong team player, too.

NB: Exactly. Right.

HK: Gracious, with his time, and with his ideas, and being a contributor at every level, too, at the same time a fun guy who, people wanted to be around him at these parties, the divisional parties, departmental parties that we had.

NB: Yeah. And he jumped in feet-first in everything, including fun.

HK: Including fun.

NB: [Laughs] Yes.

HK: He was so good at it, right? He was so good at being a physician. He was so good at being a leader. He was so special at being a friend, at being really a team player in everything he did, which is so remarkable and so unique. When you talk about once-in-a-lifetime brilliant friend and colleague, that's who James Jones has been. And these are the memories that we'll continue to have of him as we really miss him dearly.

NB: The sad thing, that future generations won't have that opportunity. That's the only sad part I can see. He was one of the few young physicians who actually came on the St. Luke's alumni executive committee. He was willing to give that time there, too. When I was president, I said we should definitely nominate James for the Young Doctors Achievement Award. At one of the meetings he attended, he said, "Oh no, not me." So when he missed a meeting, that's when we named him. And then I said, "Since you didn't come, you had no say." [Laughter] It was my sneaky way of—and there was a unanimous feeling that he should get the Young Physicians Achievement Award.

HK: I'm not surprised that James missed that meeting. James did not like meetings.

NB: No.

HK: He really liked to get things done. He was a doer.

NB: Right. Right.

HK: He was a fixer. He was a person who really wanted always to be out there, helping out at the frontline, engaged with people, and making things better.

NB: Right, exactly.

HK: And he just did a brilliant job at every step of the way, mainly really by committing, right? When you believe in something, when you're passionate about a cause, about an institution, about an entity that you feel that you belong in, you give 100, 200 percent.

NB: He did.

HK: That's what James did, and consistently did, which is so remarkable. You know, people give it some time; they have peaks. They contribute at some point, they stop, they slow down. He was a non-stop passionate advocate of what this institution really stood for.

NB: Yeah, he was. I was his first Pulmonary Attending when he was an intern. It was before my accident. And he remembered that. It was because I was so focused on detail, and patients. He said, "That was amazing, the things that I learned at that time, that focusing on details give you a much deeper insight into what the problem was." So, it was fun.

To me it was like losing a son. That's what it felt like. I guess I'm old enough to be the generation to feel that way. I think the loss is poignant for so many different reasons that we can't even enumerate here, because he was a force, a true force. I'm hoping that we can facilitate another James in the future, too. Bound to come sometime, and I'm hoping that our culture will continue to allow that to develop, and for us to recognize such people.

HK: He was a role model. I think a lot of people looked at him, looked up to him in that role, and wanted to be who he was, not just because of the successes that he was able to really accomplish professionally in a relatively short period of time, but as a person, of how he handled himself, how he carried himself really through, and how people looked at it and said, "Look at this gracious person, who is a brilliant physician at the same time! How can I really be a bit like him?"

NB: Right.

HK: I know many of our really young faculty, and not just really trainees, felt that this was really a person who I wish I could really become where he is, or at least learn what he has done, and maybe model my career—

NB: A little bit like that.

HK: —a little bit like that. And some of them, I believe that even though he's not with us, he's with us really as, you know, in real life, but he's with us in spirit. I know a lot of people are going to really remember what he did, and how he did it, and what he really stood for. They will carry on that, and be a little bit of what he was, and achieve some of the successes, more importantly, really be able to carry themselves in a dignified, respectful way that symbolizes what our institution is all about. [Pause in recording]

I'm Dr. Hassan Khouli. I'm the chief for Critical Care section in the Department of Medicine at Mount Sinai St. Luke's and Mount Sinai West. I'm also a professor of medicine at the Icahn School of Medicine at Mount Sinai, and a director for the Center for Advanced Medical Simulation at Mount Sinai St. Luke's and Mount Sinai West.

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NB: Not every physician who interacted with James Jones who wanted to speak was able to be present today. So I'm going to try to fill in some of what they said, and also a little bit more about his demographics. James was a New Jersey-born young man, who because of his spirit, did not always attend seriously to his entire curriculum. But anyway, he went to Stony Brook University and graduated there, and then wound up going to Universidad Autónoma de Guadalajara, Mexico, for his medical degree.

He then came to New York to do his residency, and internship, and fellowship at Mount Sinai St. Luke's. He was a fellow both in Nephrology and in Critical Care at St. Luke's, and I was the first Attending that he had when he was an intern when he started here in July. He used to complain because I was very detail-oriented. I wanted him to know everything about the patient, not just the medical issues, but the social issues, and other issues that impacted on healthcare as a comprehensive approach to patient care, was not just the diagnosis code, but the whole person. So he used to tease me about that, but he actually loved it.

But at any rate, then he went on to get interested in informatics, and he became Director of Medical Informatics here. But because of his incredible energy, enthusiasm

and interest, for his six out of the seven years he was here training, including as Chief Resident in Medicine, he received the Outstanding House Staff Award from his peers. So he was valued at a very early time. He wound up also getting the President's Award for Excellence, again because of his intense interest and depth into what he did. That was in 2008. In 2014, he actually received the St. Luke's-Roosevelt Alumni Association Young Distinguished Physician Award, again for his impact on the institution in his many, many areas of function. He received a leadership fellowship advancement, and he took a fellowship in healthcare transformation, which led him into more of the IT components.

So he was advancing very rapidly through the system, seeing where problems needed to be solved, could be solved, and he took a direct hand in trying to solve every problem, including whether you had a sore ankle and you needed to see Dr. Blank. So he took an interest in people in the work that he did. He was definitely feeling that St. Luke's–Roosevelt, becoming Mount Sinai St. Luke's, Mount Sinai West, was his base of operations, his family. He was very intensely involved.

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NB: **Dr. Ira Meisels** became the Chief of Nephrology Division here after Dr. Stanley Cortell retired. Ira was going to be here today but at the last moment, his plans had to change. So he sent me this missive, which I will read, because I think it's important to see that perspective from the nephrologists. But again, what did Dr. Meisels say?

He said, "James was truly exceptional person. I first got to know him when he was a Resident, and saw him in action as Chief Resident, Renal Fellow, Critical Care Fellow, attending in our division, and finally as Vice President. He had the rare combination of being smart, personable, and driven, and at the same time being a really nice guy. His energy was legendary. He did the job of three people at once, and always with a smile. We used to call him Mr. Fix-It because if you needed the problem solved he was the guy to go. The word no was not in his vocabulary. He rose to a challenge, and his intelligence and ability to see all sides of a problem would allow him to figure out the solution, even in areas that might have been totally new to him.

What really distinguished James, however, other than his boundless energy and enthusiasm, is his being what we would call a 'true mensch.' This word, mensch, in Yiddish, means a person of integrity and honor. That is what James was. No matter how driven he was to succeed, James always treated everyone he dealt with with

integrity, respect, and truth. This was true whether he was dealing with the president of the Hospital or the guy cleaning the floors. They were both the beneficiaries of James' integrity, warmth, smile, and smart. He was a rare individual. He will be so sorely missed, but he will live on for many years in the memories of all those who are fortunate enough to have known him."

So, that was Dr. Meisels' contribution, as the chief of the Division of Nephrology at Mount Sinai St. Luke's and Mount Sinai West.

[End of Recording]