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SFMS Representatives Spend “Lobby Day” in Sacramento

On April 14, a healthy contingent of SFMS representatives visited the State Capital as part of the annual CMA-sponsored Legislative Leadership Conference. Co-led by SFMS President Charles Wibbelsman, MD, and SFMS Political Action Committee Chair Shannon Udovic-Constant, MD, the group heard presentations from CMA leaders and elected officials and then visited San Francisco representatives Senators Leland Yee and Mark Leno and Assemblypersons Fiona Ma and Tom Ammiano’s chief of staff.

Various medical and public health-related issues and proposed legislation were discussed, including those pertaining to universal coverage, reimbursement for vaccines, preserving peer-review integrity and the “corporate bar” on the practice of medicine by hospitals and others, increased taxes on alcohol to cover health costs, and much more.

Regarding the ongoing budgetary battles, Senate President Darrell Steinberg admitted that he was “striving for optimism” as the legislature struggled to “triage our way out of this budget crisis.” But CMA CEO Joe Dunn, a former state senator himself, had probably the most pithy observation on the topic when he quipped, “What it might take is that we get all the way to September and our public schools are not opening—that might get everybody’s full attention.”

The face-to-face meetings with our elected officials are an important part of ongoing SFMS efforts to keep good relations with policymakers, since a great deal of legislation, good or bad, that impacts medicine is constantly being proposed and debated (the agenda for the Assembly Health Committee on the day we were there was more than ninety pages long!). It was particularly rewarding to have a good contingent of UCSF medical students join in for this important day.

SFMS representatives for this day included Drs. Chuck Wibbelsman, Lucy Crain, Keith Loring, Amy Beck, Gary Chan, Rob Margolin, Peter Sullivan, Natalie Guerrier, Carey Levin, Shannon Udovic-Constant, Andrew Calman, Peter Curran, Nora Hirschler, Mickey Roekech, Sarah Libecap, Lisa Meneses, Shannon Shea, and Julie Stein; and SFMS staff members Therese Porter, Mary Lou Licwinko, and Steve Heilig.

Events

June 6, 2009
2009 Summer Workshop in Clinical Ethics: Ethical Issues Surrounding Nonbeneficial or Futile Treatment
University of San Francisco
8:30 a.m. to 4:00 p.m.
This annual one-day workshop provides an intensive, interactive introduction to the analysis of ethical problems in clinical care. The workshop is directed at physicians, nurses, social workers, chaplains, attorneys, teachers, and other professionals involved in the care of patients or the education of providers. CME provided. For more information, please e-mail ethics@sutterhealth.org.

September 26–27, 2009
The California Medical Association Foundation and the Network of Ethnic Physician Organizations Presents the 2009 Ethnic Physician Leadership Summit
Hilton Santa Clara Hotel, Santa Clara, California
Free for physicians, medical students, and members of community-based organizations; other attendees $150/person
For more information, please visit www.ethnicphysicians.org. If you have any questions, please contact Anna Gutiérrez, NEPO Project Assistant at agutierrez@thecmafoundation.org or (916) 779-6627.
Hepatitis B Awareness

Executive Director’s note:
Because May is Hepatitis B Awareness Month, I have asked Assembly Majority Whip Fiona Ma, who has been instrumental in leading education and treatment efforts regarding hepatitis B, to write about why this issue is of personal significance to her. The San Francisco Asian community is disproportionately affected by hepatitis B. The San Francisco Medical Society encourages everyone to educate themselves regarding the prevention and treatment of this life-threatening disease.

Approximately 1.4 million Americans are infected with hepatitis B. More than half of those 1.4 million Americans are Asian/Pacific Islander Americans—I am one of them.

I contracted the disease from my mother via perinatal exposure, which is a common way hepatitis B is transmitted. I am perfectly healthy and fine today, but hepatitis B is something that should be monitored closely, because the disease rarely shows symptoms until it is too late for treatment. This is why I feel it is extremely important for people to get screened and vaccinated.

Chronic hepatitis B affects nearly 280,000 Californians and is the leading cause of liver cancer and liver transplants in California. Individuals chronically infected with hepatitis B are at a higher risk of developing cirrhosis of the liver or liver cancer. Hepatitis B-related liver cancer is the leading cause of cancer deaths among Asian/Pacific Islander men living in California.

Talking about issues like hepatitis B isn’t particularly “sexy,” but hepatitis B is becoming more and more of a problem within the Asian-American community, and we need to do more about it. We need to bring the discussion to the forefront and make sure everything that can be done to promote awareness and prevention of hepatitis B is done.

A lack of awareness coupled with cultural differences and language barriers prevent many Asian Americans from getting screened and seeking medical attention. Many people who contract hepatitis B will never develop symptoms, but they can still transmit the disease to others.

For the last two years, I’ve worked in San Francisco to make people aware of the impact of hepatitis B in California’s diverse communities. Through the Hep B Free campaign (http://www.shelpfree.org), we’ve tested thousands of San Franciscans, provided vaccination and treatment information, and formed a network of groups committed to ending hepatitis B.

In 2008, I introduced Assembly Bill 158, which required the Department of Health Care Services (DHCS) to apply for a federal waiver to expand Medi-Cal eligibility for individuals with chronic hepatitis B. Unfortunately, AB158 did not make it through the legislative process due to costs associated with the bill, but I plan to continue working on legislation that promotes awareness and prevention of hepatitis B.

This year I introduced a resolution declaring May 2009 as Hepatitis B Awareness Month in California. The resolution supports collaborating with all interested parties to raise awareness and educate the public on hepatitis B. It also supports developing a comprehensive, statewide hepatitis B prevention and treatment plan. Next year I plan to introduce legislation that encourages hepatitis B education for physicians.

As we continue working on hepatitis B prevention and awareness in California, there have been parallel national and worldwide movements. In May 2006, U.S. Congressmen Charles Dent (R-PA) and Mike Honda (D-CA) formally recognized National Hepatitis B Awareness Week in Congress, and May 19 is designated as World Hepatitis Day.

I hope you will join me and other organizations in supporting hepatitis B awareness and prevention during the month of May. It is important that we all do our part to bring hepatitis B to the forefront.
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Talking to Teens

In this issue of San Francisco Medicine we delve into the topic of communication. As physicians, we communicate with patients, their families, our colleagues, and many others in our professional lives every day, without a second thought. It is usually when a sensitive subject arises that we pause and consider how we communicate. In my practice as an “ephebia-trician,” or a physician in adolescent medicine, one particularly sensitive subject that arises regularly is that of sex.

As parents, we may have all experienced the same angst of wondering how we can discuss issues of sexuality with our quickly maturing children, who often seem to achieve adolescence overnight. Although our educational system does perhaps provide students with some basic reproductive anatomy and physiology, parents usually need to address issues of sexual responsibility, personal safety, and good sexual health. And, again as the caretakers of growing teens, many of us hope that our adolescents are taking responsibility and making good choices as they embark on the expression of their sexuality and become sexually active. And no matter what our level of communication and sophistication in speaking with our teens may be, the majority of parents may place their trust in the physician who is caring for the teen to discuss these issues.

For every physician who cares for adolescents in daily practice, discussing issues of sexuality and sexual activity, and being comfortable with this discussion, is an integral component of the practice of medicine. For some clinicians, personal moral beliefs and religious convictions may affect one’s comfort level when walking into an exam room and speaking with an adolescent about sexual activity, responsibility, and sexual orientation.

Perhaps most important is to speak the language of the adolescent and relate to the teen in a nonthreatening, reassuring manner, with a manner that is comforting yet experienced. In my own practice, I once asked an adolescent if she was sexually active. She responded no, yet then went on to request an oral contraceptive. When I repeated my query about being sexually active, the very concrete-thinking adolescent replied that her partner was sexually active and she was passive.

In order to obtain a good sexual history from an adolescent, a clinician must ensure that confidentiality of communication is intact. This is sometimes a formidable challenge, if a parent declines to leave the exam room to allow such confidential questions to be answered. Many times the provider may find a useful communication tool with the parent by simply stating that now that their son or daughter has entered adolescence, this is an opportunity for the teen to spend some time alone with the clinician, to start taking responsibility for his or her own health care, and to ask or discuss some personal issues. In some situations, when the time comes for the male genital exam, many mothers are quite anxious to return to the waiting room.

Identifying an adolescent at risk for a sexually transmitted infection or unintended pregnancy involves a candid discussion of what types of sexual activity the adolescent may have engaged in. Many young adolescents may engage in oral sex yet still consider themselves virgins who are not sexually active. When discussing sexual orientation with an adolescent, one should be careful not to make any assumptions, such as asking a male adolescent if he “has a girlfriend.” I have found that a simple way of inquiring about sexual orientation is to simply ask the teen, on a scale of 1 to 10, one being least attracted to and 10 being most attracted to, what their attraction to the opposite sex would be; and, on the same scale, their attraction to someone of the same sex. Many a teen responds with a 10 and a 2. Yet some adolescents will respond with a 5 or 6. This method of questioning prevents the teen from being labeled and opens the door to discuss sexual orientation as a continuum, which is the case for some adolescents.

Talking to teens about sex is not always easy and does have many challenges. Yet once a physician becomes comfortable with this interview and can ask the tough questions, the ability to identify a teen who may be at risk for an unwanted pregnancy with limited options, or at risk for HIV infection, could well save that teen’s life.

When we, as physicians, pause to reflect on how we communicate about sensitive issues such as this one, it can improve our communication on the whole.
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The Mutual Protection Trust (MPT) is an unincorporated interindemnity arrangement among physicians authorized by Section 1280.7 of the California Insurance Code. Members do not pay insurance premiums. Instead, they pay tax-deductible assessments, based on risk classifications, for the amount necessary to pay claims and administrative costs. No assurance can be given as to the amount or frequency of assessments. Members also make a tax-deductible Initial Trust Deposit, which is refundable according to the terms of the MPT Agreement.
When I use a word, it will mean just what I choose it to mean—neither more nor less.”

Those words were spoken by Humpty Dumpty, an intriguing character in Lewis Carroll’s fantastical stories about Alice in Wonderland. Alice meets Humpty Dumpty after she leaves her ordinary life, passing into and through her looking glass to enter a topsy-turvy wonderland of reverse images and fuzzy logic—a paradoxical world of merging opposites and strange loops in which words can mean what one chooses them to mean.

In Western culture, reports of confusion about the meaning of words begin with the story of the Tower of Babel in the Book of Genesis, which tells of a time when human beings tried to build a tower to heaven and a jealous God halted the construction by deciding to “confound their language, that they may not understand one another’s speech.” Since that time, human beings have published thousands of dictionaries trying to define, circumscribe, and enforce the exact specific meaning of words.

In his book The Spell of the Sensuous, philosopher, ecologist, and magician David Abram discusses this contraction of the spoken and written word. He notices that among the ancient peoples worldwide—Semites, Egyptians, Greeks, Australian aborigines, Chinese, Aztecs, Mayans, and North American Plains Indians—spoken words were attached to the earth and sky and written words were accompanied by images from nature and the spirit world that could stimulate ideas and feelings far beyond a specific limited meaning. In pictographic systems such as Egyptian hieroglyphics and Chinese wen, for example, the figures of plants, birds, serpents, sun, and moon are referred to as ideograms, symbols that express the visible entities themselves so as to evoke qualities, phenomena, and meaning that are metaphorically associated with these living images. Abram points out that with the invention of the alphabet, this metaphoric and poetic quality of meaning, transmitted in images of nature and the cosmos, is lost in the less picturesque discipline of the exact arrangement of letters. He laments that it is “when a culture shifts its participation to these printed letters that the stones fall silent. Only as our senses transfer their animating magic to the written word do the trees become mute, the other animals dumb.”

On the other hand, science demands specificity in the meaning of words. A methodology of reason and logic that is based upon specific delineation and isolation of an element to be studied, objectivity upon which all can agree, and mathematical certainty that is repeatable and predictable requires carefully defined words through which consensus can be achieved. This process becomes even more essential in biomedical science in which life and death can be determined by the specificity of language. In healing practices, words must be impeccably precise so that quality of care and patient safety are paramount. There is a warning about the careful use of words in the medical story about the report of a biopsy frozen section in which the pathologist announced over the operating room intercom that “the specimen had no carcinoma,” and the surgeon heard “adenocarcinoma” and proceeded to perform radical cancer surgery.

Still, even while recognizing this need for clarity and specificity in the use of words, we might legitimately ask whether there is something lost in this rigorous scientific language of medical care. Does David Abram’s notion of the alphabet causing stones to fall silent, trees to become mute, and animals to be viewed as dumb have a counterpart in modern medicine? Is the technology in our offices, clinics, and hospitals sometimes silent, mute, and dumb? Is it possible that some of the widespread emotional and spiritual discontent of both patients and medical professionals might be viewed from this perspective of an uncaring and unfeeling alphabet that forms uncaring and unfeeling words? How can we proceed with a desire to bring deeper meaning to our healing words?

We might begin by reflecting upon the words of Sigmund Freud in his book Psychopathology of Everyday Life and in his public lectures at the University of Vienna. Through careful analysis of slips of the tongue, inadvertent substitution of words, and forgetting names, Freud convincingly demonstrates that such errors in language reveal repressed unconscious associations, desires, aversions, prejudices, and hidden motivations. Thus, upon analysis, words can, indeed, metaphorically mean far more than their literal translation.

Our modern American successor to Freud, James Hillman, in his seminal book Re-Visioning Psychology, speaks of the soul of words. He reminds us that psychotherapy is referred to as “the Continued on the following page...
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Editorial continued ...

talking cure,” in which words, used with a depth of understanding, help us to uncover hidden meaning. Hillman metaphorically says, “We need to recall the angel aspect of the word, recognizing words as independent carriers of soul between people. Words, like angels, are powers which have invisible power over us.” And another psychologist, Russell A. Lockhart, wrote a book called *Words as Eggs*. In it, he says, “Do you not know that words are eggs, that words carry life, that words give birth?” Lockhart goes on to point out that words are symbols whose etymology and poetry offer vast awareness. He says, “Words take on life, induce images, excite the imagination, begin to weave textures with one another, and tell whole stories, if we but scratch the surface of the word.”

Lockhart also points out that Humpty Dumpty, after his statement about words meaning what he says they mean, goes on to use words metaphorically, saying, “They’ve a temper, some of them—particularly verbs: they’re the proudest—adjectives you can do anything with, but not verbs.” In other words, words have a life of their own.

How might all of this language and vocabulary apply to healing practices in which the cold, precise, and scientific meaning of words can diminish in-depth warmth and soulful human contact? Robin Wilson, professor of pure mathematics at Oxford University, recently published a book, *Lewis Carroll in Numberland*, in which he points out that this author of the Alice in Wonderland books was himself a mathematician who popularized conundrums and symbolic logic in word games, which he called “sillygisms.” In his world of paradox, encoded messages, and riddles, he explored the paradoxes at the crossroads of logic, language, and literature. When questioned by Alice about whether an individual can really make words mean many different things, Humpty Dumpty says, “The question is which is to be master—that’s all.”

And so it is that even within the healing arts we can pass into and through the looking glass of our ordinary discourse and enter Alice’s wonderland of paradox, merging opposites, and strange loops of language—there to become masters of our words. Even as by necessity we must use specific words for precision of meaning, we might also embrace metaphor and the poetic so as to convey understanding, empathy, and human concern. When we make everyday medical statements—“I’m going to listen to your heart” or “Take a deep breath” or “Your tests have come back” or “The results of the biopsy show” or “We did everything possible to resuscitate but”—we can experience within and thereby express to our patients and their loved ones the deeply personal, heartfelt, and poetic quality of each word.

In other words, in our desire to be caring, kind, and holistically healing, words will mean what we say they mean.
Compassionate Communication
Breaking Bad News in a Better Way

Shieva Khayam-Bashi, MD

I could tell how nervous she was by the feel of her sweaty palm. She held onto my hand anxiously as she told me stories of her children and her husband and said that she had so much left that she wanted to do for them. Holding back tears, she told me how she was hoping and praying that it would not turn out to be cancer.

I was somewhere in the middle of my third year of medical school, doing my clerkship on the medicine wards. I liked her—she was a gentle and thoughtful person who loved her life and her family. It comforted her to share stories about them. It also helped me to hear her stories, to reiterate to me that she was a real person, not just another patient with unexplained abdominal pain and weight loss. She was someone’s mother, wife, daughter, best friend, and more.

After our team finished rounding on all the patients that day, I returned to her room to check on her, since I knew how anxious she was about getting the biopsy result. Holding my hand and telling me a story about her son, she suddenly stopped mid-sentence and squeezed my hand tightly. Her eyes shifted to the shadow in the doorway, and we both looked over and saw the resident standing at the threshold. We became silent, knowing that he was the one who would have news to give her. Surprisingly, the resident did not come into her room—rather, he stayed in the doorway and said, in what seemed like one very long sentence without pause, “Hello Mrs. W I have your biopsy result it turns out to be metastatic ovarian cancer I have called the oncology resident to come to talk with you more about it sometime later today my team will come by to check your wounds later also.”

The bomb was dropped. And he left. Mrs. W and I were alone, in the dust and smoke—with more terror than comfort, more questions than answers, more isolation than support. I looked at her, dumbfounded. She looked at me in the same way, with tears in her eyes. What just happened? We both were utterly shocked—not only at the actual news, but also at the hurried and insensitive manner in which it was given. How could anyone be so cold and impersonal about something so important? Did he realize what irrevocable harm he had just inflicted with his words and manner?

I held her hand and she asked me questions, none of which could I answer. I told her that I would go to find out more, and ask my resident and team to come by and help her understand what this meant, what could be done. I had had no experience with this prior; but one thing I did know: This experience was one that Mrs. W would never be able to forget—the moment that she was given the news that would change her life forever. Though I did not know exactly how, I knew that this could have been done in a better way.

After I spoke to my attending and resident, we met with Mrs. W a few hours later to pick up the pieces. To say that it was very difficult for her and for us is a serious understatement. My attending later spoke with the bomb-dropping resident to give feedback, so that he could learn from his mistake. The resident’s explanation was that he was tired, post-call, and didn’t realize the enormous impact that his words would have. He was uncomfortable with the task and had not really had any training in this kind of communication.

The resident had reasons that are common to many doctors who feel unprepared for the task of breaking bad news—inadequate training, time, understanding, and role modeling. Many doctors also report a fear of destroying patients’ hope and discomfort with dealing with emotional responses. As a result, physicians often perform the task of delivering bad news in a manner that is disengaged, dissatisfying, and even damaging—to the patient, of course, but also to the physician.

I have read many articles about delivering bad news, to educate my own practice and for the purpose of teaching residents and students. One of the best approaches for communication of bad news to a patient is found in an article by Walter F. Baile and others called “SPIKES—A Six-Step Protocol for Delivering Bad News: Application to the Patient with Cancer.” I will summarize the sequential six-step SPIKES protocol here, with parts taken directly from the article, and also with several modifications and additions from my own experiences.

S-P-I-K-E-S:
STEP 1: Setting Up—Setting up the interview
STEP 2: Perception—Assessing the patient’s perception
STEP 3: Invitation—Obtaining the patient’s invitation
STEP 4: Knowledge—Giving knowledge and information to the patient
STEP 5: Emotions/Empathy—Addressing the patient’s emotions with an empathetic response
STEP 6: Strategy and Summary

STEP 1: Setting Up the Interview
Review the patient’s clinical
Would you like me to give you all the information, or sketch out the results and spend more time discussing the treatment plan?"

If patients do not want to know details, offer to answer any questions they may have in the future, or to talk to a relative or friend.

**STEP 4: Giving Knowledge and Information to the Patient**

Foreshadow the bad news: “I have bad news . . . I am so sorry to have to tell you that . . . “

Speak gently, compassionately, and honestly.

Do not use medical jargon. Use language appropriate to patient’s understanding. Use simple, nontechnical words such as “spread” instead of “metastasized” and “sample” instead of “biopsy.”

Do not speak too fast or too much; allow for silence.

Give information in small portions, and check periodically as to the patient’s understanding.

Proceed with giving more information at the patient’s pace—allow space and time for tears and other emotional responses.

Avoid the impulse to talk to fill the silence, to overcome your own discomfort.

Use eye contact and touch where appropriate.

Encourage questions.

Write/summarize on paper, to give to the patient to take home—including such things as the diagnosis, diagrams, and essential information (this is because most patients will not remember much of what was said after the bad news is given).

**STEP 5: Addressing the Patient’s Emotions with Empathetic Responses**

Validate the patient’s emotions—including disbelief, anger, grief, crying.

Allow for the patient to express emotions; resist the urge to block or redirect feelings.

Offer empathic responses: “I can see how upsetting this is to you” or “I can tell you weren’t expecting to hear this” or “I was also hoping for a better result.”

Ask exploratory questions: “Could you tell me what you’re worried about?” or “You said this frightens you. Can you tell me more?”

Use validating statements such as, “Most people would have that same reaction” or “It is very natural to feel that way.”

Ask about the patient’s emotional needs and what kind of support she or he has at home.

**STEP 6: Strategy and Summary**

Ask the patient if she or he is ready for a discussion about treatment strategy.

Ask the patient about her/his hopes and goals.

Summarize, discuss treatment plans and follow-up plans with specialists, etc.

Keep plans clear and simple; write them down on paper. Offer a printed handout if appropriate.

Convey to the patient that you will not abandon her/him and that you will be available for questions or problems as they may arise.

Communicate compassion, realistic hope, and a supportive relationship.

Offer a clear way for patient to contact you with questions—phone, e-mail, etc.

Make close follow-up appointments.

In 1847, the American Medical Association’s first code of medical ethics stated, “The life of a sick person can be shortened not only by the acts, but also by the words or the manner of a physician.” The insensitive manner of the doctor’s communication left an indelibly painful mark on Mrs. W, and, sadly, I have heard many similar stories from other patients about their news-receiving moments.

Most medical schools do not offer much more than a few lectures on how to break bad news. Perhaps a practically structured and sequential approach such as SPIKES can be used as a tool to teach students and residents this very important skill, which would reduce the damaging effects that unskilled communication can have on patients.
Five Communication Concepts

Five Ways to Improve Communication in the Medical Setting

Terry S. Stein, MD

My career teaching other physicians about communicating with patients is nearly as old as my son, who turns twenty this summer. Over those two decades, technology has inserted itself into every aspect of our daily lives. While my son and his friends text relentlessly and lobby for second iPods to contain their eclectic music collections, we physicians reckon with the joys and the pains of keeping up with desktop medicine, honing our typing skills, and assimilating the constant flow of new biomedical studies.

My job has been to make communication skills for clinicians relevant in the context of all the changes, pressures, and distractions afforded by data and technology. A focus on the physician-patient relationship has helped some doctors rekindle the meaning of practicing our craft, difficult when so many of us experience high stress, struggle with time pressures, and develop defenses against compassion in order to avoid burnout.

Over the years I have found five communication concepts useful to the physicians I’ve worked with. These skills can be particularly helpful given the fast pace of practice, the diversity of our patients, and the nearly ubiquitous desire for all of us as patients to feel cared for by our doctors. The five concepts may seem simplistic and self-evident. But my experience is that these five areas represent aspects of our interactions with patients in which we are well intentioned but too often miss the mark, given the competing priorities for our attention.

How You Enter the Room Matters

I am always looking for ways to enhance the sense of trust and rapport between doctor and patient without taking extra time. It has been fascinating to see the wide variety of approaches that clinicians use to signal their entry into an exam room and to begin an interaction. Cultural background, temperament, and one’s self-definition (healer, technician, expert, consultant) all shape the way physicians announce their presence. Some of the most effective doctors I have seen manage to “show up” fully with their patients; others put on the white coat and seem to leave their liveliness and humor outside the door.

We all have a set of nonverbal tools that are particularly potent as we meet someone new. It takes no additional time to greet the patient with a warm voice and smile (versus a quick hello and a beeline for the computer). Being deliberate about one’s facial expression, body position, and level of animation is highly worthwhile; as Malcolm Gladwell teaches in his book Blink, we make rapid cognitive assessments that shape our sense of ease with one another.

Though some clinicians and patients are hesitant about the hygiene of a handshake, I believe that the benefits of the gesture outweigh the risks. A moment of eye contact during the greeting and handshake can greatly reduce a patient’s anxiety and build trust. These nonverbal actions can help calm everyone’s neurophysiology.

When the patient is accompanied by family members or friends, it is well worth the extra seconds to extend the smile, handshake, and introduction to everyone. Besides easing nerves, it can be helpful to know the relationships between the entourage and the patient.

Be Patient-Centered and Take Control

We often feel dynamic tension between our need to stay on time and our desire to be receptive to the patient’s agenda. Toward the beginning of visits, explicitly summarizing the patient’s concerns and planning the visit accomplishes two important goals: letting the patient know that he or she has been heard (thereby reducing repetition) and providing a sense of organization to the interaction.

A simple example: “So you’ve had a sore throat for three days without fever or cough, and you are concerned that you might have strep. Is that right? What I’d like to do is ask you a few more questions, take a careful look at your throat, and then talk about possible tests and treatments. How does that sound?” This kind of recap and suggested plan gives both the clinician and the patient a sense of order and predictability. Especially when the patient has a list of issues and/or is expressing strong emotions, summarizing and planning can be highly reassuring. Clinicians who insert this step into their routines have reported that they become more efficient and that the patients appreciate knowing what to expect.

Find Out About Hidden Worries

I call this step “pushing the fast-forward button,” because asking patients about their hidden worries can surface worst-case scenarios that are best discussed rather than avoided. Patients may provide explanations of their symptoms that are accurate and not obvious. Many newer clinicians hesitate to ask patients what they think might be causing their symptoms for fear of seeming less than...
competent. In training programs, we recommend saying something like, “I have some thoughts about what could be going on. Since you have been living with these symptoms, it would be helpful to me to know what you think might be going on, or if you are worried about something in particular.”

One of the benefits of asking this question is that the patient’s answer may challenge our assumptions. For example, based on the patient’s reason for the visit, I may be thinking that the patient is going to request narcotics for pain (and start mentally preparing my reasons for refusing). As I explore more of the patient’s perspective, I may learn that the worry centers more on uncertainty about future physical limitations than on current pain control. The answer has fast-forwarded our conversation to the patient’s hidden concerns and increased the likelihood that our time will be well spent.

Getting the patient’s perspective often gets dropped in the fast pace of the clinic or hospital. While efficiency might be gained in the short run, omission of this inquiry can result in lower adherence to treatment and repeat visits or calls.

**Emptiy Is Golden**

Of all the skills we teach, empathy is the cornerstone. I like to see how someone’s natural expression of empathy comes across and then encourage more deliberate use of it. For example, one clinician who grew up in a culture that avoids statements of emotion was highly adept at conveying empathy through eye contact, appropriate pauses, and body posture. Once he identified these nonverbal tools as personal strengths, he was able to apply them more consciously and frequently.

We also teach explicit ways to express empathy using comments such as, “Sounds like you’ve been very worried,” or “You’ve done a great job handling a really tough situation.” It is often a challenge to encourage the genuine use of empathy because adding these kinds of statements can initially feel awkward and artificial. I recommend that physicians experiment with finding ways that empathy can work using their own styles.

Empathy can also facilitate conversations in which the doctor and patient disagree. For example: “I can see how you are really frustrated that the medication hasn’t worked and you think that you need an MRI. I wish that an MRI would give us the answer.” Empathy helps the patient feel understood, a useful prelude to the ensuing discussion about options.

We can be so focused on tasks, differential diagnoses, and treatment plans (and typing on the computer) that we fail to express our compassion. We may worry that naming an emotion will result in the patient crying about aspects of their lives over which we have no control. On the other hand, the power that we hold by virtue of our profession means that our words and gestures can have tremendous therapeutic value.

**Keep It Simple**

In the last few years, I have become fascinated by the problem of low literacy—and thus low health literacy. The statistics on the extent of Americans’ struggles with reading and writing are jaw-dropping. Understanding the impact of this literacy deficiency on patient care is a sad revelation for many physicians.

What low health literacy means for communication skills is that in general we need to use much simpler language and limit the amount of information we convey during any single interaction. These two changes confront us with our sense of our professional roles as expert (with fancy words for things) and educator (as keepers of critical data and experience). If we use simplified language and restrict how much we teach our patients, are we doing our job?

Self-awareness about the words we choose and the lengthy explanations we give is just the kind of mindful practice that makes me love the job of bringing communication-skills training to physicians. We all spend countless hours staying up to date on biomedical advances. Why not a similar investment in the finesse of how we listen and talk with our patients, so that we are equally effective in technical and interpersonal skills?

In summary, the best part of teaching doctors ways to enhance their communication with patients is that small changes can make big differences. Walking into the exam room with more gusto can create a welcoming atmosphere that makes everyone feel better. Using summary statements and planning the visit provide a roadmap that lets busy physicians and anxious patients feel a greater sense of control. Eliciting the patient’s perspective and making sure that each patient comprehends our diagnosis and treatment plan fosters partnership. Demonstrating empathy connects two individuals who share a moment of understanding.

I recently chose a new primary care physician for myself. I had never realized how sweat-producing those blue plastic exam room gowns are. And then she proceeded to do everything right—listen intently, discuss options, convey her commitment to be my doctor. Being on the receiving end of her kindness and competence renewed my passion for my career. 

Terry S. Stein, MD, is the director of Clinician-Patient Communication for the Permanente Medical Group in Oakland, California.
The Old Man at the Door

Gestures, Stories, and Healing

Robert Romanysyn, PhD

If you are fond of words, if you love words, you can hear within them the ancient songs and rhythms of the soul. Words are like stars of the soul. The poet has something to do with calling us to experience joy and endure the deep, stirring waters of suffering. Words are here for giving voice to the world, here for the sake of being its witness and, perhaps, its spokesperson. When we speak we are speaking up for the things of the world, giving voice to their desires, and, in a way of speaking, breathing with them in a conspiracy of dreams.

Yet there is a field of gestures within this field of dreams. For the ghosts who haunt the symptomatic body; the words that are spoken, the stories that are made, may not be enough. Within the silent gesture we practice a way of speaking and of healing that holds onto meanings and stories by letting go of them. These attributes of gestures entered my own body, felt in the deep marrow of my bones, when many years ago I briefly encountered an old man.

He was about seventy, maybe about seventy-five, an old man with thinning white hair; shoulders bent by age, and a slight limp in his walk. He was accompanied by a woman whom I assumed to be his wife; she was about as old as he, also with white hair, but straighter in posture and more subtle in her walk. They approached the door of the coffee shop as I was about to leave. Opening the door for them, I stepped aside; but the old man took the door in his right hand and, with a sweeping gesture of his left arm accompanied by a slight bow and a broad smile, he ushered me across the threshold and into my day. We exchanged only one word, the “thanks” I spoke as I passed them. Beyond that one word something like a small miracle happened, and I have remembered that moment, that brief moment, these long years.

At the threshold the old man outlined with his gesture a whole universe of manners, a landscape of civility, an old world of grace and charm, whose space and time echoed an earlier, slower, more quiet rhythm. Present to that gesture, I was offered a kind of citizenship in the world that it carved out, gifted with a sense of belonging to a common space, a community, a tradition of which somehow I was already a part but had forgotten. Beyond that man, his wife, and myself, the gesture brought with it an assembly of all those others who belonged to that old world of practiced etiquette, polite manners, genuine respect, and measured patience.

Afterward I found myself thinking of my father and remembering those long Saturdays, once a month, when we would sit in the kitchen of his aunt and uncle, old European immigrants, and I, as a young boy, would listen to their stories. The smell of strong coffee served in a glass, the taste of hot, freshly baked bread, the slow ticking of an ancient clock in the next room, the fading afternoon light filtered through yellow shades: All of that was enlivened again by this simple gesture, all of it made to live again as an assembly of ghosts brought to presence with a courteous bow and a sweep of an arm. That was the gift of this gesture, an appeal to enter into that world, an appeal addressed by the old man at the door to me, a stranger, and yet one who was made to feel that he now belonged.

The gesture is the outline of a world, the chiseling of what is otherwise a neutral space into a significant place. It is the seed from which a cosmos is born, a field of radiating lines and vectors, which draw the participants into a mutual presence. As such, every gesture is an appeal, an invitation not only to enter into a world, but also to partake of its experience. The appeal of the gesture of the old man at the door was for me to inhabit again those Saturday afternoons of my boyhood, when in the ambiance of their fading light I felt something of the presence of my ancestral heritage.

The gestures that each of us make carry the signature of those significant others who have gone before us, those others who have mattered to us, who live again through us. You make a gesture, always without thinking of it, and your companion says to you how much you look and seem like your grandfather. Our gestures are the habitat of history, its embodied testimony to the power to heal one another. 

Robert Romanysyn, PhD, is a teacher, writer, and psychotherapist. In his many books, he applies his knowledge to an analysis of contemporary cultural and historical issues. He is a core faculty member at Pacifica Graduate Institute.
The Word Doctor

Literature on the Wards

Danielle Onfri, MD, PhD

Like many in the medical humanities, I backed into this field accidentally. My background is straight medical science training. But an unplanned hiatus from medicine—a budgetary hiring freeze just when I was ready for my first job as an attending physician—offered me the opportunity to start writing about my experiences in medical school and residency. When I was eventually hired, I wanted to find a way to combine my interest in literature and writing with my practical work in medicine. My first foray into the alchemy of medicine and literature was with the third-year students who rotated in my medical clinic. Each student was required to hand in several H&Ps (“history and physicals”) over the course of the month. After reading scores of these, my brain became bleary with the carefully honed argot of passive voice and specialized jargon that seemed designed to keep the doctor and the patient at a healthy linguistic distance. Why should we say such odd things, I wondered, as, “The patient admitted to shortness of breath, but denied chest pain.” Why couldn’t we simply say, “The patient had shortness of breath but no chest pain,” rather than sounding like stock characters from a legal thriller?

But beyond the dullness and tedium, the most frustrating realization was that H&Ps failed to capture the essence of the patient—the patient’s voice. The standard H&P sounded like the interrogation of a corpse. Every case of pneumonia, for example, sounded nearly identical: “The patient reports pleuritic chest pain accompanied by purulent sputum. Admits to subjective fever. Denies associated nausea.”

With that as a backdrop, I asked the medical students to write one of their required H&Ps in a different form that I called a “narrative write-up.” Jettisoning all the jargon they had worked so hard to acquire—remembering to refer to the belly button as the umbilicus, the forearm as the distal upper extremity—they had to simply tell the patient’s story as a story.

At first, the students were perplexed. We had trained them so well to follow formulas, algorithms, and mnemonics that they were disconcerted by this unstructured task. But they rose to the occasion, writing engaging and illustrative accounts of the patients they cared for. Beyond enjoying themselves—as most eventually, if somewhat grudgingly, did—they also found that they uncovered many critical clinical facts that directly affected patients’ care—information that would not have come to light in the standard medical H&P. A young woman’s asthma, one medical student learned, was continually exacerbated by the dog in her apartment, but she wouldn’t dream of getting rid of it because she thought her boyfriend would be crushed. The student, in trying to incorporate all points of view into the story, spoke to the boyfriend and learned that the boyfriend was pained to see his girlfriend suffer from asthma but wouldn’t consider getting rid of the dog because he thought she would be crushed. The student brought these “Gift of the Magi”-like observations back to the couple. They were genuinely surprised at their own misconceptions and agreed to give the dog to a friend. The woman’s asthma rapidly improved.

My other foray into combining literature and medicine took place on the inpatient medical wards. In the frenetic world of inpatient medicine, it is difficult to find space for anything outside the absolutely mandatory tasks of the day, and house staff are far more locked into the rigid medical world than the students are. I started by leaving copies of a poem in the doctors’ station each morning, next to a pile of bananas or apples. I affixed a sign that said, “Poem of the Day, Fruit of the Day. Please Take One of Each.” Feeding the mind and the body, as I’ve learned, are complementary activities, and taking advantage of an intern’s desire for free food is a perfectly legitimate way of teaching medical humanities.

My next approach was to keep a stack of poems or short essays in the pocket of my white lab coat. Whenever my team was waiting for an elevator—a frequent and often protracted experience—I would distribute my sheets. Elevator reading became a common activity, because the choice was either reading the poem or staring endlessly at that same sign admonishing us not to discuss information about patients in public.

Finally, I attempted to incorporate literature directly into our work day. Each morning, I tried to carve out five minutes at the end of rounds for something literary. I’d read the poem or essay aloud—because no one would ever deign to volunteer—and then allow some time for discussion. Sometimes an intern would venture a thought, but often there was silence. I’d offer a comment or two and then I’d stop there, hoping I’d implanted some insight of the creative, however slight, into their brains before they plunged back into the chaotic world of the practical. The hardest part for me was to press on despite the silence, despite the lack of uproarious cries of approval. Certainly there has been feedback: Some students enjoy the change of pace, others think it is a waste of precious time that could otherwise be used for practical tasks such as

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Poetry in Medicine

Recovering the Poet and Healer in All of Us

Rachel Naomi Remen, MD

As a girl I hated poetry. So, much more the irony that I have spent hours, even whole days, writing and reading poetry with people with cancer, with their doctors and their nurses, and with their family members. But this poetry is different than the poetry of my youth. Much of the older poetry was pretentious and erudite, full of references to mythology or the ancient Greeks, whose words I could not easily understand. The poetry of my youth made me feel diminished.

But this poetry is simply speaking truth. Each of us has a truth as unique as our own fingerprints. Without knowing that truth, without speaking it aloud, we cannot know who we are and that we are already whole. In the most profound way, speaking our truth allows us to know that our life matters, that our viewpoint has never existed before. That our suffering, our joy, our fears, and our hopes are important and meaningful. One of the best-kept secrets in this technically oriented culture is that simply speaking truth heals.

Often the first poem is the hardest, the one caught by a lifetime of being smaller than you are, trapped by your ideas about what art is, what an artist is, immobilized by the judgments of teachers whose names you may never again remember. How did we come to forget that anything true is beautiful? How young were you then?

Writing poetry is contagious. Once past the first, we may discover that we have written poetry for years without knowing. Because no one was listening, not even ourselves. Those of us on the Commonweal Cancer Help Retreat staff began by listening to the poems of people with cancer, then joining them in writing sessions, and finally writing for ourselves just because we are alive, too.

Our poetry allows us to remember that our integrity is not in our body; that despite our physical limitations, our suffering and our fears, there is something in us that is not touched, something shining. Our poetry is its voice. To hear that voice is to know the power to heal. To believe. The first poem I ever wrote took me by surprise. Between one breath and the next, there was the truth of my own decades of chronic illness.

Oh body—
For 41 years
1,537 experts
with 14,355
combined years of training
to
cure
your
wounds.

Deep inside,

I
am
whole.

A lot of healing lies in the recovery of a personal sense of meaning, that capacity that enables us to endure difficulties, to find and draw on unsuspected strength. In times of crisis, meaning is strength. But the deepest meaning is carried in the unconscious mind, whose language is the language of dreams, of symbols, of archetypes. Poetry speaks this language and helps us hear meaning in illness, in the events of our lives, often for the first time. Finding such meaning feels like revelation. Like grace.

Writing poetry together heals loneliness. What is true for someone on the deepest level is often true for us all. Reading a poem aloud and listening to the poems of others can heal the alienation that is so much a part of our world. These days, much of life is masked. Poetry wears no mask. In taking off the masks we have worn to be safe, to protect ourselves, to win approval, we become less vulnerable. Less alone. Our pain becomes just pain. It is no longer suffering.

We may have lost faith in our ability to write poems, just as we have lost faith in our ability to heal. Recovering the poet strengthens the healer and sets free the unique song that is at the heart of every life.

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Beyond the Campfire

Bringing Poetry into the World of Medicine

John Fox

“By making us stop for a moment, poetry gives us an opportunity to think about ourselves as human beings on this planet, and what we mean to each other.”
—Rita Dove, former U.S. Poet Laureate

Jack Coulehan, physician, poet, and founder of the Center for Medical Humanities, Compassionate Care, and Bioethics, who has done so much to raise awareness of literature related to the medical humanities, wrote a poem that takes a risk.

My Machine

If I had a machine to use
in a case like yours, I’d use it
on the nucleus that makes
my feelings, to deepen them.

I’d take a long time, like a monk
at morning prayer, before I spoke
and turned each word into a sign
of passion. When I told you,

Yes, the damage is more
than anyone knew, I’d hold you
in my arms, desperately close
like death. I’d throw off the sham

of working in a reasoned way
to find the answers to your pain.
Instead, I’d use an archaic
neural poem and feel the pull

of healing, skin to skin, instead of
acting neither man nor woman
and doing the decent thing. The ache
would be a price worth paying.

—Jack Coulehan, MD

The poem projects cool sensibility.
It’s ironic, absurd. The poet wants to dispel
the chasm between physician and patient.
Constrained by medical formulations and
technical words, he struggles to find a more
visceral language for love and connection.

Under the surface, the tension feels
volcanic. He goes way over the line. He
wants to be human. How can a doctor
communicate compassion and genuine
concern in a depersonalized medical
world? Especially when death is at our
right shoulder?

Jack risks the question: Who is it that
cares and who is being cared for? He writes in
Academic Medicine:

“The usual formulation of the physi-
cian-patient relationship contains a
paradox. Medical education encourages an
attitude called “detached concern” toward
patients. But this term contains a nascent
contradiction: If you are truly detached,
then how can you be concerned? Caring or
concern implies a connection. If physicians
care for their patients, they experience
them as subjects rather than as objects; in
other words, they form an empathic
connection with them.”

If we intend to set in motion lasting
change and move from sickness care to
health care, it is essential that we look
not only at what we do and how we do it
regarding medicine but that we also ask
the question who is served and who offers
treatment.

In addition to lowering cost, increasing
access, and lessening bureaucracy and
paperwork, we must do what we can
together to create healing environments
that empower and cherish a whole person.

A poem, one made of healing words,
makes it possible for patients and those
dedicated to their care to creatively voice
the unique facets of truth that each of them
brings along in the journey of healing.

It’s people who cherish and empower;
not buildings or technology. When a family
member is depressed or a patient is facing
a major change in body image because of
a medical intervention, it is you and I who
care, or not.

John Wright, before he retired as
director of medical education at Swedish
Medical Center in Seattle, began to write
poetry. In the following poem he wants
his psychiatrist to know that it was not just
pharmacology and biology that helped him
out of depression:

Therapy
to Phillip

You attribute my recovery
to nor trip tyline—
its effects on neurotransmitters,
on the a my dala.

You barely nod towards your worth—
insisting on blood levels,
on a therapeutic dose.

While I credit half our success
to pear trees blossoming white
beyond your left shoulder,
to the wisteria—
its pink flowers hanging
lush and fragrant
over the portico,
to the warmth of your hand.

—John Wright, MD

Continued on the following page ...
Beyond the Campfire continued...

John knows the problem of disconnection a physician can feel. He wants Phillip to acknowledge and remember his part in the healing process, to see the place natural beauty and tenderness have in the art of healing.

Stephen and Ondrea Levine, who do so much to bring our troublesome minds into the caring heart, write: “It is said we could look the whole world over and never find anyone more deserving of love than ourselves. Medicine poetry is a poultrie capable of drawing poisons out of our forgetfulness. It reminds us.”

It’s been my good fortune for more than twenty-four years to show people in hospitals, medical schools, wellness/cancer support centers, and hospice care throughout the United States how they can connect with the evocative and expressive power of words. It’s nothing short of revelation what can happen to a person and a group. I am often moved in ways where silence, one that honors this sacred sharing, is the only appropriate response.

An essay I wrote, “Healing the Within,” appeared in The Healing Environment, published by the Royal College of Physicians in 2003. In 2004 my work was documented in Healing Words: Poetry & Medicine, a deeply moving film that also features the inspiring Arts in Medicine program at Shands Hospital at the University of Florida, Gainesville (see review on page 33). “Poetry Therapy: Reclamation of Deep Language” was published in the three-volume Whole Person Healthcare.

Can words heal? Can they reveal who we are and help us learn what we mean to each other? To consider this, after Coulehan’s and Wright’s poems, I would like you to visit another world, one very different from the world of medicine. Kim Nelson works with incarcerated kids in gangs. She writes to them in “There Is No Place Dedicated to Solitude”:

It is with words we begin

to know where we are,

the details of existence

reveal our code of connection.

And there’s a light in their eyes

when the silence is burned.

They can see all around themselves

the past, the present, and future.

We all begin to know

Africa, Pajaro, the liquor store,
a basketball court, Grandmother’s house, the park

Watsonsville, Antarctica, the rodeo, home

Where we live, and the lives of our minds,

our relationships to trees, animals, and buildings,
to clouds, rivers, and shootings,
to neighbors, and strangers, and war

To loneliness and oranges, to ancestors and the morning.

We learn from our stories

erasing the blind spots

that make myths of our lives

For we depend on each other, like words

saw horse, rocking horse, sea horse

I take meaning from you

near you, around me, at my side—

There’s no place dedicated to solitude.

Kim insists her kids write about details of their lives, to learn where they are and learn who they are. She says bluntly, “The alternative for them is to murder people.”

Nearly everything she reflects upon is something that could help create a more healing environment in hospitals: For caregiver and patient, what silence needs to be burned? Why not use our words to see all around? Use words to see the details of our existence, to say where we are, tell our stories, erase blind spots, depend on one another?

We don’t need a new expensive machine for this, only paper and a pen. (For someone who can’t write, I scribe poems while they speak.)

Again, Stephen and Ondrea Levine: “Poetry is a shortcut to the subconscious. It can, in a few words, turn the mind away from its forgetfulness. Erupt in the heart with the shamanic-like power of the ‘hidden word’ an unimaginable acceptance of healing.”

People who have never written poetry in their life (or not since fourth grade!) write things that emerge raw and authentic. Sometimes even a few words can say a lot. They release pain on the page. They uncover “hidden words.” They touch one another.

“You led me to a place where my own six lines of poetry would take me to, on the profound journey to my lost friend. For that I will forever be grateful.”

—Tom Roberts, Clearwater, FL

“During the workshop, I felt something stir within that has been silent for many years, and I am anxious and committed to begin writing poetry again. Yes, we were few in number; but nevertheless, words touched each other.”

—Shirley Gerecke, Cleveland, Ohio

When illness shakes up our lives, writing can give us the courage to listen deeply to what we don’t know.

How Poetry Comes to Me

It comes blundering over the

Boulders at night, it stays

Frightened outside the

Range of my campfire

I go to meet it at the

Edge of the light.

—Gary Snyder

I met Sydney Long while offering a writing program at the Wellness Community in Columbus, Ohio. Sydney, writing in what turned out to be the latter stages of breast cancer, went out, as Snyder recommends, to the “edge of the light.” She turned away from the campfire, to be with herself and her world, with the unknown that was blundering over the boulders.

Here is a fragment from a longer poem that reflects on chemotherapy:

After a long day I felt pulverized

Like plaster dust—fine and desiccated.

Scattering on the wind preferred.

Dispersing care and burden.

Poems became a way to put one’s attention on what the poet William Carlos Williams called “the thing itself.” They enable a person to “give birth to their images,” which Rainer Maria Rilke said are “the future waiting to be born.”
Those images are where Sydney takes refuge:

The dark is palpable and soft.
It hugs me.
Sanctuary
The Darkness-that-knows holds me
Like a mother comforting her babe,
Like a cave wintering a bear:
Outside my body is wracked with
Procedures:
Surgery, transfusions, needle pricks,
Ice blankets, respirators, code-blue
Until all crises pass and
I’m ejected from haven to
Join matter once more,
To mold spirit with body in the
Long, slow journey of recovery.
Dark indigo only a memory
And a deep longing for home.

Sydney makes a place in her poem—and within herself—for wild and deep rest. She makes a place for the cave wintering a bear and in that breathing wildness, a deep longing for home awakened. Is that an awakening beyond the body? As a woman living through breast cancer, she imagines the tender mercy of a mother holding a baby. These are words that heal. They help her remember her true nature.

When I was eighteen, studying creative writing at Boston University, I was faced with a heavy decision I carried during the course of my freshman year. It had crept up on me since I was four: After years of surgeries, the gradual disintegration of my lower right leg, because of a bone and nerve disorder, made the amputation of the leg inevitable.

This experience was the blundering frightened creature outside the range of my campfire. I held out as long as I could and finally I edged out to meet it. It was during this time I found I wanted to look beyond the literary enterprise of writing. What I had to wrestle with during this time in my life set me on the path of poetry and healing. Perhaps that’s why, after so many medical interventions to save my leg, I understand and remain startled by those lines by Jack Coulehan, “Yes, the damage is more/ than anyone knew…”

I’ve not shared this many times:
In the early morning hours before the amputation, a nurse, or perhaps it was a nurse’s aide, appeared at my bedside. It was dark. Her blue-sweatered arms, white nurse’s uniform, long brown hair, her compassionate face. There was no campfire. She had stepped beyond its range to find me. I was frightened. She let down the railing, laid down in the hospital bed, and held me. John Fox is a poet and certified poetry therapist. He is adjunct associate professor at the California Institute of Integral Studies in San Francisco and he teaches at John F. Kennedy University in Berkeley, The Institute for Transpersonal Psychology in Palo Alto, and Holy Names University in Oakland. John is author of Poetic Medicine: The Healing Art of Poem-Making and Finding What You Didn’t Lose: Expressing Your Truth and Creativity through Poem-Making. He presents in medical schools and hospitals throughout the United States and is president of the Institute for Poetic Medicine. Find out more about his work at www.poeticmedicine.org. The poems in this piece were printed with permission of the authors.

The Word Doctor
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ferrying stool samples to the lab, still others speculate about my basic mental faculties as I harp on about issues of literary craft rather than randomized-controlled, double-blind clinical trials.

The first reason is that medical training can streamline the thought process into a very cramped, indurate style. This becomes obvious when I observe interns engaging in cookbook medicine, diagnosing and treating patients with all the scholarly sophistication of a clerk at the bagel store. To me, this is the most critical reason to introduce literature and creative writing. These processes are inherently “illogical”—from a pragmatist’s perspective, at least—and therefore most needed for flexible thinking. They require the stitching together of disparate parts of the brain, neurological loop-de-loops involving keen observation, description, action, emotion, language, and aesthetics. For many students, this requires unkinking long-dormant intellectual muscles that they haven’t called upon since early college days.

Another critical reason to incorporate literature—especially poetry—into medical education is metaphor. Poetry is all about metaphor, and the great poets force us to think deeply when interpreting their metaphors. Challenging patients do the same. When a patient approaches us with multiple somatic complaints or a complicated, Byzantine story, we may brush them off as complainers or malingerers, but they are often really speaking in metaphor. To successfully help those who come to us in need, we must interpret their metaphors, or they will hunt for other physicians with more nuanced understanding.

Lastly, there is something to be said for the sheer pleasure of great literature. Medical journals are written with a sterility of language that would not allow a single staphylococcal organism to flourish. In the dank and dreary expanse of medical training and medical literature, this can be an eye-opener: words for pleasure, language for beauty. What a bracing concept—almost subversive, and possibly life-sustaining. For the trainee who is drowning in the drudgery of medical school or residency, a sprinkling of literary pleasures and creative writing can be a rare ray of sunlight.

At the end of each of my months on the inpatient medical wards, I read the poem “Gaudeamus Igitur” by John Stone. It is a four-page poem and often requires a four-layer chocolate mousse cake to ensure full participation. The poem was written as a commencement for a graduating medical school class and is filled with many sage bits of advice, but I always take care to draw attention to this one: “For you will learn to see most acutely out of the corner of your eye, to hear best with your inner ear.” These are the ways that poets and artists view the world. While it isn’t always easy—or even always appreciated—we can help our students become far better physicians if we learn a bit from the poets.

Danielle Ofri, MD, PhD, is associate professor of medicine, New York University School of Medicine, and editor-in-chief and cofounder of Bellevue Literary Review. This article was first published in The Lancet, vol. 371, January 12, 2008.
A Great Lesson

Healing Words in the Teaching Environment

Robert E. Markison, MD

The Oxford English dictionary confirms that the word doctor means teacher. This article is about teaching surgery residents, but it applies equally to teaching medicine to anyone.

Most of us read Charles Bosk’s Forgive and Remember: Managing Medical Failure, and this remains a helpful book for doctors, residents, medical students, patients, and attorneys. But there is more to it than cautionary verse for those of us teaching doctors “on the way up.”

I was a full-time staff surgeon and a teacher of young surgeons in San Francisco General Hospital/UCSF during 1981 to 1989, equally interested in life- and limb-sparing surgery, frequently conducting fresh cadaver dissections, and teaching clinical surgery in and out of the operating room. I was fortunate to work alongside my mentors in hand surgery, doctors Kilgore and Newmeyer; and I was fortunate to work alongside my mentors in surgery, doctors Blaisdell, Trunkey, Steele, Lim, Lewis, Thomas, Sheldon, Schecter, Crass, Horn, Way, Galante, Clark, Wylie, Allen, Schrock, Hunt, Stoney, Ehrenfeld, Ebert, Buncke, Roan, Russell, Volpe, Pinto, Levin, Esterkyn, Spotts, Leeds, de Lorimer, Harrison, Hohn, Richards, Olcott, Heer, Bossart, Macho, and many other esteemed and innovative teachers.

During the 1980s, I quickly realized that I would need to bring up my teaching skills. I studied illustration at U.C. Berkeley, and I studied Disney-style hand-drawn animation at San Francisco State University in order to bring more life to my teaching.

Since 1989, I have also been fortunate to teach the orthopedic residents at the San Francisco Orthopedic Residency Program. As I approach thirty years of surgical teaching experience, I am humbly aware that doctors on the way up are a remarkable resource, each one most worthy of time and tending.

Teaching Tips

Loving history: Mark Ravitch’s Century of Surgery 1880–1980, volumes 1 and 2, is still my favorite recommendation to excite the historical imagination of trainees. Future hand surgeons are advised to read Joseph Boyes’s On the Shoulders of Giants: Notable Names in Hand Surgery.

The obvious goal is to learn the history of each operation performed, the pioneers who advanced the art and science, and the history of each surgical instrument used to get the job done. When physicians humbly share their historical referential system with patients and with each other; virtuous cycles are set in motion.

Rendering a diagnosis: I’m glad to be my own illustrator, and I strongly encourage all trainees to study representational rendering techniques so they can visually explain (i.e., render) the diagnosis and treatment options. This is particularly useful in multilingual environments in which patients may have a modest command of words but respond readily and favorably to visual explanations. Representational rendering is also a trust-builder, because patients truly appreciate the time and effort taken by a physician to render anything from any perspective, and they are always pleased to walk out of the office with the original drawings. Betty Edwards’s Drawing on the Right Side of the Brain is favorite starting reference for anyone who wants to build confidence in drawing. Those who make a serious study of drawing are always encouraged to read Harold Speed’s classic The Practice and Science of Drawing.

A sensitively rendered graphite drawing speaks its own healing words.

I learned the power of real-time illustration during the 1980s, when I frequently acted as the San Francisco District Attorney’s witness for the prosecution to assist victims of violent crimes. I asked for four colors of chalk and a large blackboard in full view of judge and jury. This cut the testimony time by at least 50 percent.

Better listening: Although I don’t insist that trainees learn to play one or more instruments, I certainly advise them to listen to patients through “musical ears.” By that I mean that musicians listen equally for content, tone, and dynamics; and the best musicians memorize what they’re hearing. Memory ranges from eidetic to pathetic. It is not simple flattery to remember that the patient has fairly well-controlled diabetes, supplemented hypothyroidism, fairly well-controlled hypertension, and is a Jehovah’s Witness before major surgery is undertaken. I always assume that the medical file will be unavailable at critical decision-making junctures. This forces me to listen well and memorize more rather than less. When I was a fledgling jazz musician, I was advised by master pianist and music theorist Mark Levine to learn 900 tunes in twelve keys. He actually listed 965 essential jazz standards in his extraordinary book Jazz Theory.

Clear short- and long-term memory is a remarkable time saver, and patients appreciate being remembered.

Since I often act in the role of Agreed Medical Examiner within complex workers’ compensation claims, and since some patients come back three, five, or even ten years later, it is best to remember as much as possible about the history and physical examination; again with the assumption that the complete medical file will not be available.
Improvise: I’m always surprised how many straight-A students with sky-high test scores fail to improvise when improvisation is absolutely necessary. We have all known talented but ill-tempered surgeons who get fussy when the perfect surgical instrument is not available. Surgical trainees are encouraged to know everything possible about their instrument armamentarium, but they are also advised to seek out new and better ways to do any procedure. I will admit that I have gone overboard by studying metal machining, smithing, and casting, but I decided long ago that I should be able to make the tools of my trade.

I am often delighted by the improvised solutions of trainees. But there is another reason to encourage clever physician work-arounds: The lessons learned can be readily shared with patients. Now that we are in a rather serious economic downturn, many patients are facing pink slips, foreclosures, and deepening misery beyond the medical problems at hand. I encourage them to remember their best and most durably successful improvised solutions from any time in life. This is not game playing. Once they understand that many variables remain manipulable, they shift from pessimism toward optimism and come up with some very practical ways to get back into the workforce. The readers are often referred to Martin Seligman’s remarkable book *Learned Optimism*.

Shun arrogance: I have been fortunate to look after a fair number of musical child prodigies at the San Francisco Conservatory of Music over the past few decades. It is humbling to realize that there are eight-year-olds who have mastered most of the classical piano repertoire. Some of them can breeze through Liszt and Chopin with their eyes closed. I must smile when doctors are arrogant at peer levels or within patient care settings, because they often have far less mastery than the eight-year-old giants at the conservatory. I certainly encourage debate between orthopedic residents regarding the management of complex hand problems, but I am ever watchful for those who would treat themselves before treating patients.

A wink and a smile: Humor is a sensitive matter in a cross-cultural clinical environment, but it is always fair to ask the young doctor or patient what makes him or her smile. Build on it.

Harry Connick, Jr., composed this lyric:

*We go together like a wink and a smile
Now my heart is music
such a simple song
singing again, the notes never end
this is where I belong
just the sound of your voice
the light in your eyes
You’re so far away from yesterday
Together, with a wink and a smile
We go together, like a wink and a smile.*

Bill Schechter, MD, did a remarkable job organizing and moderating the trauma case symposium at the Naffziger Surgical Society Postgraduate Surgery Course on March 21, 2009, reminding me that the act of thoughtful teaching in the “heat of battle” is indeed the ultimate use of healing words. 

Robert E. Markison, MD, is a hand surgeon and an associate clinical professor of surgery at UCSF.

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Technology and Communication

Delivering Twenty-first Century Medicine

Robert Pearl, MD

For much of his retirement, my father traveled back and forth between New York and Florida, joining many other so-called “snowbirds” who spend their winters playing golf in the Sunshine State.

But five years ago, my father became ill. My father’s New York physician assumed he received the recommended pneumococcal vaccine in Florida. His Florida physician assumed he received the vaccine in New York. Sadly, because neither physician had access to my father’s complete medical history, neither had any way of knowing their assumptions were wrong, and my father died from a preventable pneumonia.

When I returned home from my father’s funeral, I put his medical information into Kaiser Permanente’s computerized health-record system, which factors gender, age, and myriad medical variables and generates a regimen of recommended care. There, at number seven on the list, was the pneumococcal vaccine.

The American health care system is archaic, fragmented, and paper-based. As a result, it’s highly ineffective. The Institute of Medicine has pointed out that close to 100,000 Americans die every year from medical errors, and a Rand study found that patients receive only 55 percent of the recommended treatment for preventive care, acute disease, and chronic conditions. This is unacceptable.

Providing the best health care in the twenty-first century requires a relentless pursuit of prevention, a comprehensive electronic medical record, powerful online applications, and a commitment to patient safety. When all four of these elements are present, health outcomes improve measurably.

Today, we have the ability to prevent illnesses that were once unavoidable. If all physicians ensured that every patient received all recommended preventive services, we would dramatically lower the incidence of heart disease and strokes, prevent nearly all deaths from cervical and colon cancer, and diagnose breast cancer earlier.

Unfortunately the fragmented nature of American health care and its archaic fee-for-service system does not support this pursuit of prevention—and in fact pays significantly more to treat a heart attack than to prevent one. Modern medical technology has made outcomes after interventional procedures relatively consistent, but the variation in prevention is astounding. For example, more than one-third of American women with health insurance do not obtain a mammogram in a timely fashion, while patients in integrated, prepaid organizations such as Kaiser Permanente do so more than 80 percent of the time.

We must take full advantage of the life-changing impact that advanced information technology can have on medicine. We need complete electronic medical records to be available whether the patient is in a physician’s office, an emergency department, a hospital, or a skilled nursing facility. When patients’ current medical histories—including test results—are available around the clock, emergency department physicians can make a more rapid and more accurate diagnosis of a patient who shows up at 3:00 a.m. with chest pain. That means treatment can begin sooner, and success is more likely.

The benefits of advanced IT in medicine go beyond medical records. Patients who receive handwritten prescriptions or are in hospitals without bar coding for medications have a greater chance of experiencing an unnecessary complication, regardless of how well trained their physicians may be.

Today, patients want the same convenience in their health care as they do in the rest of their lives. They go online to purchase airline tickets, and they update financial records and obtain cash without ever stepping into a bank.

Why does American medicine believe that people will tolerate anything less from physicians, laboratories, and pharmacies? Integrated health care systems such as Kaiser Permanente’s allow members to make appointments online, order prescription refills that are delivered to their home, view their laboratory results through secure servers, and e-mail their physicians at no cost. These tools increase convenience, and other powerful clinical applications allow physicians to provide medical care that is current and continuous, not episodic.

At Kaiser Permanente, we have invested in a complete electronic medical record (KP HealthConnect) that offers online convenience and focuses on prevention and patient safety. As a result, we have reduced the incidence of stroke by 20 percent, and our patients have a 30 percent lower chance of dying from heart disease than the general public. For our patients, cardiovascular disease is no longer the number-one cause of death.

As the Obama administration starts to tackle the task of providing health care...
Translation and Technology

Interpreter Services at San Francisco General Hospital

Gloria Garcia Orme, RN, MS, and Bruce Occena, MPH, MBA

Beginning around 2006, San Francisco General Hospital Trauma Center (SFGHTC) began a multi-stage project to restructure its Interpreter Services Department with the introduction of videoconferencing and cordless telephone technologies. The change allowed providers caring for LEP (Limited English-Proﬁcient) patients to access the hospital’s staff interpreters remotely. The result has been a dramatic improvement in ease and access to trained medical interpreters. For example, the average wait time for an interpreter has been reduced from roughly thirty minutes to three minutes. Equally important, the practice of skipping LEP patients in queue due to interpreter unavailability has been virtually eliminated.

The availability of real-time videoconferencing equipment has made the shift toward remote interpreter services more palatable at San Francisco General Hospital because the technology allows for the interpreter to be “virtually” present in the room. And from the interpreters’ point of view, video allows them to access visual body language cues that, in turn, enhance their ability to facilitate the most effective and sensitive communication between patient and provider. This is particularly true in interpretation sessions that are longer and entail more complicated and complex interactions.

As a safety-net provider, San Francisco General Hospital and the Department of Public Health serve a disproportionate share of the city’s recent immigrant communities. On any given day, more than 30 percent of the patients seen require some level of language assistance. Consequently, a strong commitment to cultural diversity, in particular recognition of the importance of access to trained medical interpreters, has been an integral part of the mission and practice of San Francisco General Trauma Center for decades. On a typical day in 2009, the Interpreter Services Department handles well over 300 interpreter requests, primarily for Chinese, Spanish, Vietnamese, and Russian.

The cornerstone of this long-standing commitment of both effort and resources to the provision of interpreter services is the recognition of how central communication is to quality health care. LEP patients especially are seriously handicapped without the assistance of trained medical interpreters—on the most basic level, they would be without the capacity to relate, in a nuanced fashion, their medical histories, current ailments or injuries, concerns or questions. On the provider side, the communication chasm is equally limited and frustrating—they would be without the ability to query the patient in any depth, to provide even the most basic explanations and/or instructions with sufﬁcient conﬁdence that they have been understood, to fully convey concern, to counsel on alternatives, or even to express empathy.

Every day we are fortunate, at San Francisco General, to witness how a well-trained medical interpreter can transform the encounter between a LEP patient and a provider who are separated by language and cultural barriers. Sessions that might otherwise be characterized by uncertainty, hesitation, truncated, and compressed communication, flower into lively and meaningful interactions, focused on the issues at hand but often including the tangential discussions that can subtly facilitate mutual comfort and trust.

In a fundamental way, quality health care services require that a relationship be forged between patient and provider. The quality of communication is crucial to the building of relationships. However, for LEP patients—often separated on so many levels from their providers—taking the most basic steps in building a mutual working relationship requires the assistance of a trained medical interpreter. 

Gloria Garcia Orme, RN, MS, is the nursing and operations director of Primary Care, Medical Specialties and Language Services at San Francisco General Hospital. Bruce Occena, MPH, MBA, is coordinator of the VMI (Videoconference Medical Interpretation) Project.

Technology and Communication

Continued from opposite page...

Average to all, it’s important that we use the opportunity to advance American medicine into the twenty-ﬁrst century. It’s time to apply to health care the knowledge and tools that have revolutionized and improved other aspects of modern life. We owe it to all Americans.

Robert Pearl, MD, is the executive director and CEO of The Permanente Medical Group (TPMG), whose 7,000 physicians provide care for 3.3 million Kaiser Permanente members in California, and president and CEO of the Mid-Atlantic Permanente Medical Group, whose 900 physicians provide care for 500,000 members in Washington, D.C., Virginia, and Maryland.

This article originally appeared in the San Francisco Chronicle.
Furthering Translation Efforts
A One-Stop Shop for Language for All

Diana Lau, RN, PhDc, CNS; Gordon L. Fung, MD, MPH, PhD; Steve Fugaro, MD

It is difficult to imagine how medical care can be delivered effectively when the most basic premise of communication between health care providers and patients cannot be fulfilled. Avedis Donabedian, dubbed the “Father of Quality Assurance,” described the art of medicine as that special human relationship and trust between health care providers and patients capable of improving health care outcomes through enhancing mutual trust and improving patient compliance.

In a city such as San Francisco, a favorite first stop where many immigrants congregate, more than half of the residents speak a language other than English at home (used as a measure of English fluency). Communication issues can complicate the already burdensome health care system by the need to use interpreters. So it should not be surprising that medical leadership as well as patient advocacy groups strive to find a solution to battle this long-standing issue of patient-provider language barriers.

A project was initiated by the California Association of Family Physicians (CAFP, funded by the California Endowment) to host two stakeholders’ meetings to discuss how to solve the language problems most effectively and efficaciously. This language project could not have happened at a better time, as the passage of SB 853 mandated HMOs to provide medical interpreters to patients with limited English proficiency (LEP) by January 1, 2009, with oversight and enforcement provided by the California Department of Managed Health Care. With deadlines in sight at that time, it was not difficult to get cooperation to attend the meetings.

Recognizing and supporting the need to improve culturally competent and language-competent care, the San Francisco Medical Society took leadership of the project in San Francisco. Dr. Steve Fugaro participated in the stakeholder group meetings as president and representative of the SFMS; and Steve Heilig, project director, and Mary Lou Licwinko, executive director, both of SFMS, provided leadership, support, and consultation for the meetings. Eighteen other stakeholders were invited: physicians; clinic managers; and representatives from insurance and interpretation companies, an IPA group, the California Healthcare Interpreters Association, the Language Office of the City and County of San Francisco, the video medical interpreting (VMI) project of San Francisco General Hospital, the interpreter training program at City College, and patient advocacy nonprofit groups representing patients. Significant to notice was the absence of labor unions representing employer groups, such as the restaurant and hotel industries with large numbers of immigrant employees. They were invited but chose not to participate. Leadership from the Asian Healthcare Institute, supported by Scientific Analysis (both of them San Francisco nonprofits), helped facilitate the meetings.

Two group meetings were held in April 2008, strategically placed one week apart, which not only enabled group members to have time to contemplate and assimilate the information discussed from the first meeting but also made it possible to keep the momentum flowing from the first to the second meetings. The first meeting emphasized brainstorming, while the second developed consensus for the proposed solutions. Given the complexity of the subject matter and the diverse backgrounds of the stakeholders, the importance of the preparation work in bringing the meetings together and achieving their goals in an efficacious manner cannot be overemphasized.

Amazingly, the group was able to come to a consensus and agree on a centralized operation model that can be deployed on a regional basis in California. The flow chart for this model is posted at www.sfms.org. This finding was presented to the Medical Leadership Council of the California Medical Association at a meeting hosted by the California Endowment last November. It drew immediate interest and enthusiasms from many attendees. The group was at once energized by the offer from representatives of two large health insurance companies to take the idea back to their companies for approval, if a draft of a budgetary plan could be developed for San Francisco to become a pilot site to deploy the centralized plan.

Obviously needing more time to work out the details, the HMOs each set up their individual structures to offer language services in order to meet the January 1 deadline. But should the centralized plan materialize in the future, much could be gained from its benefits, including decreased administration cost, uniformity in standards for interpreters, quality monitoring and improvement programs, minimization of liabilities, and centralization of data for tracking usage and efficiency. Most important, the centralized system provides convenience to patients as well as health care providers as a “one-stop shop.”

Diana Lau is a consultant for the SFMS Language Solutions project, the administrative director of the UCSF Asian Heart and Vascular Center, and an assistant clinical professor at the UCSF School of Nursing. Gordon Fung is past president of the SFMS, director of the UCSF Asian Heart and Vascular Center; and a clinical professor at the Division of Cardiology at UCSF. Steve Fugaro is the immediate-past president of the SFMS.
Sergeant Friday Was a Physician

Communication from the Nurse’s Point of View

Vicki White, RN, MS

There and back again.” You might think I am referring to The Hobbit, but in fact I am describing the context within which nurses and doctors communicate. Have you ever been in another country where you do not speak the language very well, or at all? Think about your experiences in trying to navigate your way to the sites you want to see, on foot or using public transportation, without a guidebook or translator. During a visit to Mexico many years ago, I repeatedly explained to a very pleasant cab driver that I wanted to go to a church in town, and instead I found myself at the local school.

Sometimes you have to walk a mile to understand how you could have approached the situation differently and reached the intended outcome in a few steps. The circumstances are similar when working to develop the foundational relationships that are required for communication with physicians. Lest you think I know more than what I am sharing, nothing could be further from the truth. Trust me, I have been told so many times. In fact recently, during a conversation with a physician I have known for many years and one whom I consider a trusted partner, he expressed how it would be better if I listened more to what the physicians thought was important.

After over three-and-a-half decades of working with physicians from multiple specialties and in many organizations, and having enjoyed the support of a number of physician mentors and translators, I have discovered that the challenge truly seems to be learning the “language” of physicians. In my mind, this is a colloquium for appreciating the needs of the individual physician. While that sounds fairly simple, and in fact individualized care is what so many of us learned to provide in nursing school, most of us never learned to apply it to our working relationships with physicians. Well, it is time. Similar to our patients, physicians want to be understood by those to whom they entrust their patients for care, and they do not want to have to take the time to make sure we get it. They want us to get it and get it right.

Do the phrases “Just the facts ma’am,” or “Just tell me what you want,” or “ADD” (“additional detail declined”) resonate? Dragnet’s Sergeant Joe Friday had an approach that lives in all physicians, whether as an inherited or learned trait. Time is the commodity by which physicians broker their success. Time is money, time is being able to see or operate on more patients, and time has to be filled with meaningful activity. Physicians are not only providers of care but also business owners. They must attend to multiple demands on their time. If we can understand that fact, we are inclined to approach this relationship and our communication differently. This is why techniques such as SBAR, an interesting but old concept meaning “Situation-Background-Assessment-Recommendation,” are so useful. Call it by any letters or acronym you wish, but anticipating what you need from physicians, communicating it briefly and clearly, and stating what you need or want for the patient does make a difference. Some of you may have seen some of the strategies from the Institute for Healthcare Improvement in support of provider communication, such as, “Got chart?” I cringe when I see these tips and tools, and yet they make the point, as long as we understand why we need to use them.

Whatever time physicians spend with us, in hospitals especially, is time away from their practice; and yet we often complain that this physician and that physician will not do “what they are supposed to do.” Sometimes this may be true; however, I prefer to try to understand what the roadblock may be. Advocating for how we can get what we need (e.g., discharge rounds and orders earlier in the day, completion of medical records, use of preprinted order sets, legible documentation) could be more about using methods to better support the physicians to do what we need in a way that takes less time and wasted effort on their part. They have to understand the importance of using more time to do or provide what we need—and that we appreciate what it takes for them to comply. This is not intended to excuse a lack of accountability, and yet if our priorities are so different that we fail to understand each other, what real progress have we made? Personally, I describe this approach as “Bang head here.” Isn’t it far less painful to try to understand what might produce a different result? Sometimes it really means letting go of frustrations and having a conversation person to person, sincerely trying to understand. Think about your frustrations in working with physician colleagues. Now ask them what frustrates them most about working with you or practicing in your organization. They will share, and you might even be surprised.

Physicians are unique in that they are not only customers but also business and care partners. Without them, we would have no business. With little exception, I have found that they consistently want the best care and service for their patients. Continued on page 28...
Changes in Communication

One Physician’s Opinion

Toni Brayer, MD

There was a time, not too long ago, when doctors talked to each other face to face about patients they shared. The physicians’ lounge, the medical records room, the hospital cafeteria were all venues where physicians of all specialties would meet and dialogue about interesting cases, patients, referrals, and hospital politics. Any day you might hear a conversation like this:

“Oh, Dr. Joe, I’m glad I ran into you. I have a patient with arthritis and a painful red eye. Is it something you should see?”

“Sure, Toni. Sounds like it could be uveitis. Send her over. I’ll tell Katy to make room for her today. What’s her name?”

Or:

“Hi, Fred, I haven’t seen our patient since you removed her kidney. Anything I should know about before I visit her this morning?”

“The surgery went great. We had to give her two units of blood, but other than that she did well. The path report will be out this afternoon. I’ll give you a call when I see it.”

Ah, how civilized. How pertinent and timely.

I know the good ol’ days weren’t always so good and communication was not always this easy or effortless. But the proximity of colleagues to each other enhanced the ability to interact in ways that were beneficial to patients, and it was a way to share medical knowledge directly.

Doctors rarely have the time or luxury of sipping coffee and eating doughnuts in a doctors’ lounge these days. With the advent of hospitalists, fewer and fewer general internists are even coming to the hospital, and medical staff meetings have variable attendance at many institutions.

The ability to interact with medical colleagues directly just isn’t easy.

But rather than lament about a past that isn’t coming back, it is good to reflect on new ways of communication between caregivers that can enhance patient care. The technologic advances of the past fifteen years have revolutionized our practice of medicine. When you think about it, this has also had an impact on our ways of communicating . . . mostly in a good way.

No longer do we need to carry coins and know where every pay phone in the city is located so we can dash to one when our beepers go off. Cell phones have provided us with great mobility when we’re on call, and we can be sitting at our kids’ baseball games without worrying that we’ll miss a call. Pay phones themselves are a relic of the past, too.

The advent of electronic health records promises to connect doctors via the patient record, in real time and with concurrent information, so that everyone who sees a patient will see the same information. No more duplication of tests. No more wondering if the patient saw another doctor. Consult notes and test results will be available as soon as they are entered into the record for all to view.

E-mail is another great way for physicians to communicate with each other, and it can be quicker than a phone call. Young physicians are wired in to electronic communication through encrypted e-mail, text, and Twitter and other social networking sites. Although some of this technology doesn’t lend itself to a busy practice, electronic tools will be adopted more and more commonly as quick ways to get the job done.

Technology can both separate us and bring us together. I find it amusing that as we have more communication technology, patient-safety experts are recommending multidiscipline rounding (attending physician, nurse, RT, PT, discharge planner) as the best way to communicate about patients and save time and errors from occurring.

So we may have come full circle. Nothing takes the place of seeing a physician colleague and talking directly about a patient or interesting case.

Toni Brayer, MD, has practiced Internal Medicine in San Francisco for over twenty years. Dr. Brayer has served as President of the SFMS and currently serves on the Editorial Board for San Francisco Medicine. She is a known speaker and writer on a variety of medical topics and authors a blog entitled EverythingHealth. To read more of her work, visit her blog at http://healthwise-everythinghealth.blogspot.com/.

Sergeant Friday Was a Physician

Continued from page 27...

They want us to make the best use of their time. They want us to listen and be responsive to their concerns and needs, even if it does take a long time to get to the best outcome. They’ll even give us some of their time for free if we make the outcome worth the investment. And, in the end, they are people like us in many ways, who expect that we will get to know who they are and what they need and want. As caregivers and team members, isn’t that what we have always committed to doing?

Vicki White, RN, MS, is an Assistant Administrator at Novato Community Hospital.
Take a Word for a Walk

Reviving the Exquisite Corpse

Malaya V. Quinn

The world is quaking in change. Unfortunately, the grand palette of possibility so characteristic of the right brain has paled due to neglect. How do you stretch the boundaries of your thinking and infuse your intellect with color? The voices resound, “Where is my imagination?” Your creative genius wakens and triggers your right brain to play. Its mission is to spread an epidemic of joy that will improve your health, calm your voices of doubt, and maybe even contribute to world peace. The problem is that most of us have forgotten how to play.

Remember a time when you were so engaged in an activity you loved that you were completely transported? True play doesn’t have an agenda. Uncensored imagination is free to direct the voice of the unconscious without the fear or shame that accompanies the rational brain. There is no right or wrong, nothing to gain and nothing to lose. Play initiates states of discovery in which elation, vitality, and enthusiasm becomes an antidote to pain. The word enthusiasm comes from the Greek, en-theos, “inspired with God.” When imagination is aroused, we are offered a glimpse of the most profound aspect of Self, the spirit of our creativity. People speak of this mysterious presence, in and of itself, as healing.

In 1925, following the First World War, a group of avant-garde artists and intellectuals met in a small hotel in Paris to seek revolutionary ways to shift the depression of the day. They investigated methods that included the elements of play, the mystique of accident, spontaneity, chance, surprise, unexpected juxtapositions and non sequiturs that could potentially unshackle the mind from cultural and self-censorship. They hoped to unlock the truths of the “surreal” domain of the unconscious.

On this particular day, these Dadaists, or Surrealists, as they were called, led by their founder, André Breton, played an old parlor game called Consequences. Each player took turns writing one random word on a sheet of paper. They folded it to conceal part of the writing, leaving only the last word visible, and then passed it on to the next player who then wrote a new word. That first sentence composed, “The-exquisite-corpse-will-drink-new-wine,” christened the game Cadavre Exquis, the Exquisite Corpse.

What better way to activate imagination than to revive this art of the Exquisite Corpse?

We can experiment with words in a safe environment where we can encounter the most frustrating and agonizing parts of our lives, the gap between what we feel and what we can consciously articulate. Word play can transform the fear of uncertainty into “negative capability” (John Keats), the ability to comfortably live in the zone of the unknown. Especially in difficult times, don’t forget to play.

If you are feeling stuck, overwhelmed, or anxious, call a friend and jump-start the Exquisite Corpse. Invite the words to come alive. Give them autonomy. What do they want to do? Take turns being the scribe. Take a few minutes and, with soft focus, let your breath slowly bring your awareness to each of your senses. Allow the words to spontaneously float onto the paper. Forgo imposing any preconditioned intention onto your words.

Take it deeper and invoke Mnemosyne (memory), mother of the muses, and let her inspire and drift your words into connecting form. Watch how the words flow into sentences. Notice how one word completes and moves concurrently into what’s next. Feel how your intense focus supports your “disappearance” into the words. Lose yourself in the joy of collaboration and surprise. Let suspense, synchronicities, irreverence, anomalies, and mystery pop up to fertilize your mind field. One client reflected how her experience with words-turn-upside-down-bow-at-your-feet-open-your-view enlightened her and deepened her sense of Self.

Out of the potpourri of words, notice how the spirit of the unconscious rearranges and composes new images. Call up your metaphorical mind. Give the words free rein to synthesize into poetic form. You may suddenly notice a mysterious stillness or sensation quivering through you. Making contact with this dynamic part of your unconscious has a vivifying and inspiring effect. It is the shock of recognition that you have touched on something ancient within you, a telltale sign that all is well. Automatic word play has the potential to extend that numinous connection into a constant current that can ignite insight, inspire creativity, and satisfy our soul. Remember that the mind wants to heal itself. What-did-word-want-to-say-on-your-walk?

Malaya V. Quinn is an artist with an MA, Psych, and a certified expressive arts therapist who specializes in facilitating healing conversations between the metaphorical mind and the creative process, encouraging the community to blur the boundaries between art and life. Visit her website at www.malayavquinn.com.

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Healing Words

Poetry and Medicine

Amanda Denz

“Poems are emotional opinion, closer to your mad reactions to life, closer to the self, the wounded. A lot of poetry comes from wounds. It is your own emotional outcry. Poetry gives a voice to our innermost fears and joy. Art in all its forms, but especially language, carries us from illness and loss to hope and understanding.”

—Ruth Stone, Healing Words

Healing Words: Poetry and Medicine is a one-hour program dedicated to exploring the role of poetry in the healing environment. Using the University of Florida Shands teaching hospital as a backdrop, patients, physicians, and medical students are observed and interviewed while they participate in the hospital’s unique arts program.

Shands is one of the first hospitals in the country to fully integrate the arts into its treatment plans through the artist-in-residency program. Dancers, painters, poets, and other artists work with patients one on one and in small groups to explore feelings related to their lives, their illnesses, and their healing processes. Healing Words specifically focuses on the writing and poetry portion of the program.

At the beginning of the program the questions is posed: “How does the reflective art of writing help us—does poetry heal?”

Dr. John Graham-Pole, a pediatrician and the medical director of the arts program at Shands, replies to this question by noting that the effect of poetry is hard to quantify. “Science reduces and analyzes, and art expands and endures,” he says.

He later elaborates. “How does it work?” he asks, “We don’t know—we have a sense of it, that at a biochemical level there is something about endorphins. I’m sure that it is about connection, intimacy, about building community. It’s a very sacred thing. How does prayer work? I don’t know, but I don’t know many people who die without being prayed for.”

Neurologist Michael Okun, who runs the center for neurodegenerative disease at Shands, also shares his view of poetry’s healing abilities.

“As a neurologist I can tell you that [poetry does heal]. There are behavioral things that change in the brain based on the context of any situation. Any conversation that we have, or any poem that we read, is going to cause a cascade of events in the brain that we don’t yet understand but we know can influence brain function by changing chemicals. Changing overall mood can change and improve function. As a neurologist I know the secret, and the secret is that behavioral interactions influence the brain because the brain is smart, it’s plastic, it can change. If you read somebody a poem and they have a medical disease they can, and will, have some biological effect from what you do. Now, whether or not the cumulative effect in some diseases can be beneficial as treatment is still debatable and under study.”

Healing Words explores how poetry works to help patients both from a biomedical point of view and from an anecdotal point of view. After watching a group of patients, facilitated by poet John Fox, create poetry based on their experiences with illness, a woman named Krista comments on what the group experienced.

“You never know exactly how much you have inside you until you let it out,” Krista, a twenty-nine-year-old woman with a brain tumor, comments. “One gentleman in particular [was] moved so greatly that it got deep inside of him and freed feelings that had been bound there for so long. A lot of times our brain will make us sick. And it’s all the things that we hold up in there, we don’t realize what a small storage area we have but how much it can hold, and sometimes the negative stuff gets the best of us when it should be the opposite—letting the most beautiful, wonderful things engulf us and take us into the better places.”

In Healing Words both patients and physicians share moving stories about their experiences using poetry in the medical setting. Patients say that it helps them to release emotions related to illness and suffering and bring them to a better place. Physicians say that it helps them process some of the challenges they face in the medical setting, such as witnessing the suffering and death of other humans. All agree that bringing this form of expression into the hospital has greatly improved the quality of interaction, and that genuine interaction between patients and health care providers is the true source of healing.

“It’s very difficult to get into the head of the person who is suffering from a disease and understand what they are going through, and in fact there probably are not words to describe it,” says Okun. “[Poetry] is the purest form of communication. It is communication by emotion rather than by specific words. Words are imprecise. The only way I get the message is by the emotion. If I can feel the emotion that you’re feeling, then you and I understand each other. If I can’t, then we don’t connect. The poem is the vehicle to do that.”

To learn more about Healing Words, visit www.pbs.org/healingwords.
All of us encounter or treat patients who express difficulty paying for medical care. Many of us provide health care services to patients who are uninsured and have no ability to pay for the services they receive. As the director of health for the San Francisco Department of Public Health and a practicing physician, I’m often asked by uninsured persons, “How can I get care if I don’t have health insurance?” My response is, “Healthy San Francisco.”

Healthy San Francisco (HSF) provides universal, comprehensive, affordable health care to uninsured San Francisco adult residents irrespective of income level, employment status, immigration status, or pre-existing medical conditions. It capitalizes on the full spectrum of public, nonprofit, and private providers, serving uninsured residents by restructuring the often fragmented health care safety net system into an organized delivery system for those seeking care.

The following is a quick guide to the program for clinicians. With this information, I hope that you will be able to explain the program to your uninsured patients and direct them to further information about eligibility and enrollment.

**A Health Access Program**

Healthy San Francisco (HSF) is not a health insurance program. Health care services provided outside of San Francisco are not covered by the program. HSF is a health access program that provides access to a broad array of health care services. Any resident enrolled in the HSF program is still uninsured.

**Eligibility**

Currently, HSF is available to any San Francisco resident who is uninsured, is ineligible for public health insurance (such as Medi-Cal), has income at or below 500 percent of the Federal Poverty Level (for one person, $54,150, for a family of four, $110,250), and is between the ages of eighteen and sixty-four years old.

**Services**

Uninsured, adult residents enrolled in HSF have access to a range of comprehensive services: primary care, prevention, specialty, diagnostic, ancillary, pharmacy, emergency, hospital, behavioral health (mental health services and substance abuse treatment), and durable medical equipment. Excluded services include, but are not limited to, cosmetic procedures, dental services, fertility treatments, organ transplantation, vision care, and long-term care.

One of the key features of HSF is providing all enrollees with a primary care medical home (i.e., a health clinic/center). When uninsured residents apply for the program, they select a primary care medical home of their choice. Providing enrollees with a medical home improves treatment outcomes and reduces the likelihood of costly emergency-room visits and duplication of care.

It ensures that uninsured residents have access to a primary care medical home, a range of services, and a coordinated health care delivery system.

**Provider Network**

HSF could only work as a partnership between the public, nonprofit, and private provider communities. HSF enrollees have a choice of more than thirty primary care medical homes to ensure that the uninsured have a usual source of care. One of the medical home choices is Chinese Community Health Care Association, an association of individual practicing physicians. Specialty care and inpatient services are provided at San Francisco General Hospital. In addition, four hospital systems (Catholic Healthcare West, California Pacific Medical Center, Chinese Hospital, and the University of California at San Francisco Medical Center) have either partnered with specific medical homes to provide inpatient and/or specialty services to enrollees or partnered with the program to provide other needed services.

**Participant Fees**

Some HSF participants pay fees to remain enrolled in the program (a participation fee) and also when they access services (a point-of-service fee).

Individuals with incomes at or below 100 percent FPL, those who are homeless, and those receiving General Assistance/General Relief pay no participation fee or point-of-service fees. Other participants pay point-of-service fees when they access services, and the fees vary depending upon the service received. Individuals with incomes between 101 and 500 per-

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Loyalty to the organization has traditionally been a hallmark of those associated with Chinese Hospital. During our recent Joint Commission Survey, this fact became remarkably clear: Everywhere the surveyors went, they encountered staff and physicians who have been here for ten, twenty, thirty, even forty years. I feel like such a youngster in my fourteenth year of practice.

In this same vein, I must recognize our Performance Improvement Medical Director Dr. James Yan. Dr. Yan has been tackling this role for the past decade since he took the reins from our past director, the renowned Dr. Gordon Fung. I owe a debt of gratitude to Dr. Yan. He is, of course, a busy gastroenterologist, married to a busy Kaiser internist, Dr. Pearl Wu, and they have three fairly young children, Alexander, Matthew, and Victoria. Somehow, between being a good doctor, soccer coach, and loving dad, he has found the time to contribute much to our organization, leading us through the past three surveys and managing all the tough PI problems that that every hospital has. Dr. Yan resigned this post on April first—no joke—but I am sure we will see him back soon in other leadership roles.

And I need to welcome our new PI Medical Director Dr. Mai-Sie Chan. Good luck and thanks to Dr. Chan for taking on this challenging role.

Also, I never mentioned that the medical staff defeated our hospital staff, board, and health plan staff at last year’s Christmas party. Our team was led by the consistent scoring of Drs. Edmund Tsai, David Tuan, James Yan, Ho Tan, Irwin Wong, Fred Lui, and myself. Finally the monkey is off my back, after defeats at basketball, softball, and a prior bowling tournament. This may be the highlight of my tenure as chief of staff.

Dr. Martin Brotman has been named president and CEO of the Sutter West Bay Region. Within the next few months, he’ll take over that role full-time, and a new president and CEO will be appointed to CPMC.

Dr. Steve Cummings and his team at the San Francisco Coordinating Center of the California Pacific Medical Center Research Institute had a study out in last week’s Journal of the National Cancer Institute. It surveyed dozens of other studies and the available medical literature on the most accurate methods of predicting a woman’s future risk for breast cancer. Right now, mammograms are the main method used to screen women. They are good for detecting issues now but not so good for measuring their future risk. This study found that by pooling together information about age, race, education level, family history, socioeconomic status, and a measurement of the woman’s breast density, you can much more accurately measure a woman’s risk of future cancer. It also offered some advice on chemopreventive methods for women at high risk.

The study got a lot of attention; it was the featured medical story on NBC Nightly News and the NBC Today Show, as well as showing locally on ABC-7 San Francisco and CBS-5 San Francisco (and on more than a dozen network stations around the U.S.). It was also reported on Bloomberg News and dozens of health-related websites around the country.

CPMC, in conjunction with the American Liver Foundation and the Wilson Disease Association, will present the Wilson Disease Symposium on Saturday, May 2, 2009, at California Pacific Medical Center, 2333 Buchanan Street (Enright Room), San Francisco. Please register by Monday, April 27, by contacting Sue Kventus at atkventus@sutterhealth.org or calling (415) 637-2670 (cell) or faxing (415) 600-2955 with your name and number of attendees.

Several of my Saint Francis colleagues have been actively sought after by the local media. Jim Garrick, MD, medical director of the Centers for Sports Medicine, appeared on KTVU in an interview on head injuries and skiing. He also appeared several times on the Joanie Greggains show on KGO radio to discuss topics of interest in sports injuries. Sports podiatrist Remy Ardizzone has also been a regular on the Joanie Greggains radio show, discussing various topics related to foot and ankle injuries. Sports orthopedic surgeon Susan Lewis was interviewed on KCBS radio on shoulder injuries and repair, as well as quoted in a New York Times Style section article on fitness and yoga. Saint Francis Hospitalist Anita Gandhi, MD, was recently interviewed for the article “Understand When The Time Is Right to Call in the Ethics Committee” in The Hospitalist magazine. Dr. Gandhi commented on the involvement of the Ethics Committee in the care of hospice and palliative care cases and the importance of understanding the cultural background of patients. Saint Francis neurologist and noted headache and Alzheimer’s disease researcher Jerome Goldstein, MD, has been on the lecture circuit, addressing medical staff audiences at Saint Francis and the CPMC Davies campus with his presentation “Neurobiology of Sexual Orientation: The Gay Brain.” Dr. Goldstein was also interviewed on KGO-ABC News on Alzheimer’s disease. Hand surgeon Edward Diao, MD, attended the American Academy of Orthopedic Surgeons (AAOS) Research Capitol Hill Days in Washington, D.C., with his patient and UCSF professor Joan Howley, MD. The Research Capitol Hill Days program works to raise awareness of the chronic, debilitating, and costly musculoskeletal disease and disorders afflicting our nation and to request continued support of musculoskeletal research. And finally, kudos to psychiatrist Mel Blaustein, MD, for being honored by the American Foundation for Suicide Prevention at its annual Shining Stars Benefit on April 2.

WWW.SFMS.ORG
Child Life Services at UCSF Children’s Hospital is promoting healing words between teens. Teen patients at UCSF Children’s Hospital wrote the theater piece *Tomorrow . . . A Better Day*, based on their experiences with chronic illness. Healthy teens from Northwest School in Seattle will perform it in May at three locations in San Francisco.

“This fascinating human collage captures the many facets of how teens experience health care,” says Michael Towne, Child Life manager.

UCSF Medical Center offers certified medical interpreting services in approximately 150 spoken languages, plus American Sign Language. Eighteen staff interpreters for Spanish, Mandarin, Cantonese, and Russian maintain daily schedules just like UCSF’s physicians and nurses, serving clinical appointments as well as hospital and emergency visits, according to Natalie Krassovsky, supervisor of the Interpreting Services Department. For languages outside those provided by UCSF staff, Krassovsky calls on trained agency interpreters. UCSF provides about 50,000 interpretation sessions yearly, with no charge to patients.

Addressing the link between miscommunication and poor health outcomes, two doctors have devised a simple, inexpensive tool to help patients take their medicines correctly. Dean Schillinger, MD, professor of medicine and director of the UCSF Center for Vulnerable Populations; and Edward Machtinger, MD, associate professor of medicine and director of the Women’s HIV Program of the UCSF National Center of Excellence in Women’s Health, developed the Visual Medication Schedule (VMS), with color images of medication dosages by week. Instructions are in both English and the patient’s native language.

“This tool helps patients understand how to take their medicines correctly and leads to significantly improved health outcomes,” says Machtinger.

Surprisingly little clinical research exists on the mental health impact on male and female veterans of taking a life in combat. San Francisco V.A. Medical Center Staff Psychologist Shira Maguen, PhD, is conducting important research that will fill this important gap and improve V.A. mental health services.

The first objective of her study is to understand how the taking of a life in the war zone affects a veteran’s mental health outcomes and use of health care services. The study will compare those who have taken a life in combat to those who have not. The hypothesis is that those who have taken a life in combat will have significantly higher symptoms of posttraumatic stress disorder and depression, and that they will report greater functional impairment, than those who have not.

The second objective is to develop a valid measure of the thought processes associated with having taken a life in the war zone. There is no existing measure to specify the thoughts associated with killing in combat and, as a result, the development of measurements will be a crucial step prior to designing any treatment intervention.

The third objective will focus on designing and testing treatment.

The outcomes of work such as this will help improve mental health care provided to veterans not only at the San Francisco V.A. Medical Center but throughout the entire V.A. system.

**Healthy San Francisco**

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percent of FPL pay participation fees based on their income and family size, and their point-of-service fees do not vary by income.

The HSF fee structure recognizes the importance of affordability and its impact on access. On average, HSF participants will pay no more than 5 percent of their income on fees (both participant and point-of-service).

The quarterly participant fee starts at $0 for those whose incomes are at 0-100 percent of the poverty level; then increasing to $60 for those with incomes at 101-200 percent; $150 for incomes 201-200 percent; $300 for incomes 301-400 percent; and, finally, $450 for those whose incomes are 400-500 percent of poverty level.

**Applying for HSF**

Uninsured residents can apply for HSF at any of the more than thirty primary care medical homes and at two enrollment centers. HSF has a common Web-based program eligibility and enrollment system (One-e-App) so that applicants are not required to undergo duplicative and time-consuming application processes. **If one of your patients inquires about Healthy San Francisco, please refer them to the City’s 3-1-1 Call Center, www.healthysanfrancisco.org, or (415) 615-4500.**

Healthy San Francisco is the City and County’s effort to improve the health care delivery system. Since its debut in July 2007, 39,000 of the estimated 60,000 uninsured adult residents have enrolled in the program. Collectively, the City and County have taken great strides to improve health access and outcomes for uninsured residents. As providers, we can each do our individual part in helping move this effort move forward. **Chef**

Mitchell H. Katz, MD, is the director of health for the San Francisco Department of Public Health, and Tangerine M. Brigham is the department’s deputy director of health.
In the current economic climate, spending more than you have to for workers’ compensation insurance doesn’t make sense. Workers’ compensation premiums are on the rise again, right at a time when reducing practice expenses must be a priority for every physician.

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We are heart failure cardiologist Ernest Haeusslein, M.D. and cardiothoracic surgeons James Avery, M.D. and Donald Hill, M.D.—and we would like to make an appointment to see you in your office. We’d like the opportunity to acquaint you with our facilities, staff and specialized therapies. We’d also like to review referral indicators to help identify your patients who may benefit from these advanced therapies.

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