

SAN FRANCISCO MEDICINE

JOURNAL OF THE SAN FRANCISCO MEDICAL SOCIETY

FROM THE OTHER SIDE OF THE BEDSIDE

Physicians' Own Stories
of Illness, Injury, Treatment,
Healing, and Lessons
Learned

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VOL.87 NO.5 June 2014

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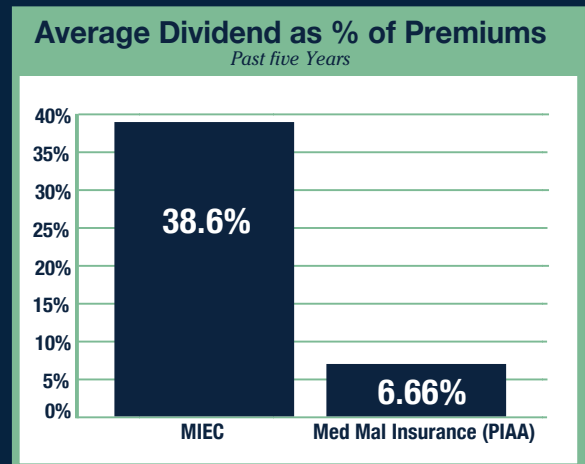
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From the Other Side of the Bedside

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Welcome New Members

The SFMS welcomes the following members:

ACTIVE REGULAR MEMBERS

James David Marks, MD | *Anesthesiology*

Carlos Quintana, MD | *Neurology*

Kendra Lyn Sawaya, MD | *Obstetrics and Gynecology*

Shoshana Rebecca Ungerleider, MD | *Internal Medicine*

Special Insert

Intimate Partner Violence

A Practical Guide for Physicians

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MEMBERSHIP MATTERS

Activities and Actions of Interest to SFMS Members

Measure to Raise Medical Malpractice Cap Qualifies for November Ballot

The trial lawyer-sponsored measure that would alter California law to increase the limits on medical malpractice compensation and mandate random drug testing for doctors has qualified for the November ballot. The measure is being called the “Troy and Alana Pack Patient Safety Act” and will be assigned a proposition number in early July.

The new initiative calls for quadrupling MICRA’s essential cap on noneconomic damages to \$1.1 million. If enacted, it has been estimated that lifting MICRA’s cap would increase health care costs by almost \$10 billion per year in California, or approximately \$1,000 per family of four.

In addition, the measure would require hospitals to conduct random drug and alcohol testing on physicians. Doctors also would be tested if they make preventable medical errors. Under the measure, physicians and pharmacists also would be required to consult a flawed state-run Controlled Substance Utilization Review and Evaluation System (CURES) online database before prescribing medications to patients.

SFMS and CMA have joined a broad coalition of more than 1,000 groups—including physicians, community clinics, hospitals, nurses, organized labor, the Chamber of Commerce, Planned Parenthood, ACLU, and many others—to fight this misguided, deceptive initiative that will increase health costs, reduce health access, and place sensitive patient medical information at risk. The campaign is well positioned to defeat the initiative, but victory is by no means certain. Physicians will play a very important role in this campaign.

Please join the fight to preserve MICRA by signing a pledge card online at <http://www.cmanet.org/issues-and-advocacy/cmas-top-issues/micra/join-the-fight/>. To learn much more about the myriad hidden costs, consequences, and flaws in the trial lawyer-supported MICRA lawsuit initiative, visit the “Stop Higher Health Care Costs/Protect Access to Care” website at www.StopHigherHealthCareCosts.com.

New ICD-10 Implementation Date Set for October 2015

CMS has announced October 1, 2015, as the new implementation date for the ICD-10 family of diagnostic and procedural codes. The previous compliance deadline was October 1, 2014, but Congress delayed that in passing another temporary “doc fix” measure. HHS is expected to release an interim final rule in the near future that will include a new compliance date that would require the use of ICD-10. The rule will also require HIPAA-covered entities to continue to use ICD-9-CM through September 30, 2015.

SFMS/CMA Defeats Bill That Would Have Eliminated In-Office Exception to Self-Referral Law

SFMS/CMA successfully defeated a bill that would have eliminated the in-office exception to the self-referral law for advanced imaging, anatomic pathology, radiation therapy, and physical therapy. SB-1215 (Hernandez) died in the Senate Business, Professions, and Economic Development Committee after receiving just one vote. This bill would have been a major blow to the integrated care model, resulting in increased costs as these services would have been driven toward the more expensive hospital setting and inhibiting the development of practices that integrate and coordinate care.

SFMS and CMA members advocated heavily against SB-1215 during Lobby Day in April. With the help of physician members and CMA partners, we have successfully managed to defeat this harmful bill.

Covered CA Update: New Survey Results Show Physician Confusion; SFMS Resource Page for Providers

The CMA recently surveyed more than 2,300 physicians about their contracting experience with Covered California plans. Eighty percent of respondents reported that they were confused about their participation status in a Covered California plan and that this has negatively impacted patient care. Visit <http://bit.ly/1i2uSdd> for the full survey findings.

To help local physicians understand the complexities of the health benefit exchange plans, SFMS has launched a new Covered California resource page for physicians and their staff. Visit <http://www.sfms.org/ForPhysicians/CoveredCalifornia.aspx> for FAQs and guides about plan contracting, patient enrollment and eligibility, grace periods, SHOP, and more.

Covered California Plan-Specific Information for San Francisco

As of April 2014, 289,021 individuals have enrolled in health plans through Covered California, California’s health benefit exchange. Of those, a majority were eligible for federal subsidy.

A wide array of new exchange-based insurance products have been offered by five participating health insurance companies in San Francisco. Additionally, federal law requires that every plan offered through Covered California also be offered outside of the exchange (called “mirror” products), with the same benefits, premiums, and provider networks.

The San Francisco Medical Society has compiled a one-page chart about the health plans participating in Covered California available, on page 6 (Ask the SFMS) and online at <http://bit.ly/1oJi8Jy>.



SFMS Meets with Assemblymember Richard Pan, MD



On May 1, SFMS physicians and medical students met with State Assemblymember Richard Pan, MD, to discuss the importance of physician representation in Sacramento. The event was organized by Drs. Lawrence Cheung, Roger Eng, George Fouras, Gordon Fung, Steven Fugaro, and Robert Margolin through the SFMS PAC in support of Dr. Pan's candidacy for California state senate candidate. With the implementation of the ACA, the attack on MICRA, and ongoing scope of practice issues, it is vital to support members in the legislature who are dedicated supporters of the house of medicine. Dr. Pan is a Sacramento pediatrician and representative for the California State Assembly's 9th District.



Top Photo—Left to right: Robert Margolin, MD, Yasuko Fukuda, MD, Richard Pan, MD, Lucy Crain, MD, and Robin Harris. **Middle Photo**—Assemblymember Richard Pan, MD addresses local physicians on the state of medicine in California. **Bottom Photo**—UCSF medical students Brian Shaw and Rowen Jin with Assemblymember Richard Pan, MD.

Get Ready for Sunshine: Phase 1 Registration Begins June 1

The Physician Payments Sunshine Act (Sunshine Act) requires manufacturers of drugs, medical devices, and biologicals that participate in U.S. federal health care programs to report certain payments and items of value given to physicians and teaching hospitals. Manufacturers are required to collect and track payment, transfer, and ownership information beginning August 1, 2013. Manufacturers will submit the reports to the Centers for Medicare & Medicaid Services (CMS) on an annual basis. CMS will soon allow physicians and teaching hospitals to review Sunshine (Open Payments) disclosures from industry about payments and other transfers of value made to them during the reporting period. Those wishing to review and potentially dispute disclosures must complete a two-phase registration process to access their data.

Phase 1 (begins June 1) includes user registration in CMS' Enterprise Portal. **Phase 2 (begins in July)** includes physician and teaching hospital registration in the Open Payments system, with 45 days to review and dispute data before its public release.

June 2014

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Health Plan	Anthem Blue Cross	Blue Shield of California
Exchange product(s)	Pathway X—EPO (tiered): Anthem Platinum DirectAccess—CEAC, Anthem Gold DirectAccess, Anthem Silver DirectAccess, Anthem Silver DirectAccess, Anthem Bronze DirectAccess—CACG, Anthem Bronze Direct Access w/HAS—caci, Anthem Catastrophic DirectAccess	Ultimate PPO, Preferred PPO, Enhanced PPO, Basic PPO, Get Covered PPO, Native American PPO
“Mirror” product(s)	Pathway	Same names as Exchange Products
Provider network/benefits	Anthem is the only plan that has a tiered hospital network. In the EPO network, enrollees have a lower out-of-pocket cost if they use Tier 1 hospitals (“Preferred Network”). Tier 2 hospitals are in network, but members have higher cost-sharing when using these facilities. Anthem reports EPO physicians were selected for the network based in part on a history of referring primarily or exclusively to Tier 1 hospitals.	Blue Shield reports 35,000 physicians from 28 counties in its individual exchange/mirror PPO and EPO networks. Blue Shield PPO enrollees can go to any Blue Shield Exchange PPO physician in any region as “in network.”
Provider directory	https://www.anthem.com/health-insurance/provider-directory/searchcriteria	https://www.blueshieldca.com/bsca/find-a-provider/home.sp?contentid=DoctorPPY
Contact information	Network Relations - (855) 238-0095, networkrelations@Wellpoint.com	Hugo Florez, Senior Director, PPO and Specialty Networks Network Management - (818) 228-2607, Hugo.Florez@blueshieldca.com

SFMS Guide to Health Plans Participating in Covered California

As of April 2014, 289,021 Bay Area individuals have enrolled in health plans through Covered California, California's health benefit exchange. Of those, a majority were eligible for federal subsidy.

A wide array of new exchange-based insurance products have been offered by five participating health insurance companies in San Francisco. Additionally, federal law requires that every plan offered through Covered California also be offered outside of the exchange (they are called "mirror" products), with the same benefits, premiums, and provider networks.

The San Francisco Medical Society has pulled together some key facts and detailed information about the health plans participating in Covered California.

KEY FACTS

- Covered California does not contract directly with physicians, hospitals, or other providers. All plans contract directly with providers, and the terms of those contracts—financial and nonfinancial—are proprietary to each plan.
- The ID cards of all patients who purchased a plan sold through Covered California are co-branded, displaying the logo of the health plan and the logo of Covered California.
- Beyond the required coverage of essential health benefits, the products offered to group purchasers are not required to have identical networks or benefits as those offered to individuals.

PLAN-SPECIFIC INFORMATION FOR SAN FRANCISCO

Chinese Community Health Plan	Health Net	Kaiser Permanente
Platinum90 HMO, Gold80 HMO, Silver70 HMO, Silver73 HMO, Silver87 HMO, Silver94 HMO, Bronze60 HMO, Minimum Coverage HMO	Health Net PPO Platinum, Health Net PPO Gold, Health Net PPO Silver, Health Net PPO Bronze, Health Net PPO Catastrophic	Kaiser Permanente Platinum 90 HMO, Kaiser Permanente Gold 80 HMO, Kaiser Permanente Silver 70 HMO, Kaiser Permanente Bronze 60 HMO, Kaiser Permanente Bronze 60 Health Savings Account HMO, Kaiser Permanente Minimum Coverage HMO
		KP Platinum 0/20, KP CA Gold 0/30, KP CA Gold 500/30, KP CA Silver 2000/45, KP CA Silver HAS 1500/20%, KP CA Silver 1250/40, KP CA Bronze 5000/60, KP CA Bronze HAS 4500/40%, KP CA Bronze HAS 3500/30%, KP Catastrophic 6350/0
	Health Net reports its PPO network includes 44,000 physicians. This network is used for all of Health Net's PPO plans, regardless of where they are purchased. Participation terms for physicians are the same for both exchange and mirror products.	Kaiser Permanente reports a network of more than 14,000 physicians, covering all specialties, and 36 licensed acute care hospitals. The entire network is available to all individuals, regardless of plan type.
http://www.cchphmo.com/sites/default/files/pdfs/Provider_Commercial.pdf	www.healthnet.com	https://healthy.kaiserpermanente.org
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PRESIDENT'S MESSAGE

Lawrence Cheung, MD, FAAD, FASDS

Bad Bugs Bite Back: Antibiotic Resistance from the Farm

When I was taking genetics courses for my molecular biology degree in college, I learned about an interesting pseudo-life-form known as a plasmid. I learned that a plasmid is a small DNA molecule that is physically separate from, and can replicate independently of, its host cell DNA.

Plasmids are frequently found in bacteria and are often symbiotic to the bacterial host cells by, conferring antibiotic resistance to the host cells in exchange for a cozy home within the bacterium. The interesting thing about plasmids is that they can replicate and can transfer to another bacterium easily through a process known as horizontal gene transfer during bacterial conjugation (as my professor would call it, "bacterial sex"). I learned to harness the power of the plasmids for my biology research at my lab bench, but I never really thought much about the plasmids' significance in nature.

Fast-forward four years to the mid 1990s and I was in medical school, and we were (and still are) in the midst of the multidrug-resistant (MDR) tuberculosis crisis in New York City. I learned from my infectious disease professor that *Mycobacterium tuberculosis* was rapidly developing drug resistance and this was hypothesized to be due to, among other causes, rapid antibiotic resistance genes (ARGs) transfer via vectors such as plasmids. Poor patient compliance and overuse of antibiotics by physicians were to blame for the emergence of MDR TB. But I was shocked to learn (I was young and naïve back then) that many other virulent bacteria were also developing resistance to our standard antibiotics. Again, poor patient compliance and overprescription of antibiotics by physicians were to be blamed.

What I did not realize was that only a small percentage of antibiotics are actually used in humans. In fact, statistics show that 70 to 80 percent of all antibiotics in the United States go to farm animals. These antibiotics are given to animals to promote growth and they are readily available over the counter. But this practice can have very serious public health consequences. An article from the *Proceedings of the National Academy of Science* in 2013 highlights the public health dangers seen in intensive antibiotic use in swine farms in China: Common ARGs were seen in manures of swine farms up to 192 times more than in soil control samples. Most concerning is the diverse set of resistance genes detected in the contaminated soil that includes resistance to macrolides, beta-lactams, cephalosporins, aminoglycosides, and tetracyclines. The ARGs are easily transferred through horizontal gene transfer, and the article warns of the implication of a spread of these ARGs to pathogens of human health significance.

One has to wonder why inclusion of antibiotics in feed is a standard part of animal husbandry practice. To understand the role of antibiotics, we have to go back to the 1950s, when low levels of antibiotics were first used. At that time, pigs given low levels of antibiotics grew 12 to 15 percent faster and needed less feed. However, recent advances in animal husbandry tell a different story. Essentially, the hypothesis for antibiotic use resulting in increased animal growth was due to prevention of disease in the

herd and prevention of low-grade infections. In the 1990s, the concept of multisite production gradually emerged. Prior to the concept of multisite production, animals were born and raised in a single barn or in several barns close together. As a result of this close physical proximity, diseases were easily transmitted from one generation to the next. In multisite production, groups of animals are raised in a single location until they are weaned. The entire group moves from one site to another, and groups are kept strictly apart. There is also strict infection control (such as boot changes) for people who move from room to room, which decreases the spread of disease from one group to another. When this new animal husbandry practice was studied scientifically, it was found that animals raised in multisite production farms with antibiotics achieved no growth advantages compared to those that did not receive antibiotics.

In light of these findings, the FDA is now taking action to rein in pervasive use of antibiotics in animal husbandry. Specifically, the FDA is asking drug companies to voluntarily revise the FDA-approved labeled use conditions to (a) remove the use of antimicrobial drugs for production purposes (in order to enhance growth and to improve feed efficiency); (b) add, where appropriate, scientifically-supported disease treatment, control, or prevention uses; and (c) change the marketing status from over the counter to Veterinary Feed Directive for drugs administered through feed or to prescription status for drugs administered through water, in order to provide veterinary oversight or consultation. I applaud the FDA for taking this issue seriously and I hope that the industry will follow these voluntary guidelines, since they make sense from a public health perspective.

Our medical society's role in this issue runs deep. More than a decade back, the SFMS convened a national meeting of leaders in medicine, public health, veterinary medicine, pharmacology, and more to address the overuse of antibiotics in agriculture. One result was a widely cited editorial by conference cochairs Drs. Philip R. Lee and Lester Breslow, two renowned figures in health policy nationwide and beyond, and our own Steve Heilig. Another was a policy resolution developed and adopted by the SFMS and then the CMA—and then the AMA, which garnered national news and has served as a model for many other associations and even legislation. The political battles continue, but hopefully science and health will prevail.

In the meantime, I will be vigilant in eliminating food products raised with antibiotics and in decreasing the use of antibiotics in my own clinical practice.



FOR ALL THINGS SAN FRANCISCO MEDICINE VISIT SFMS.ORG



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EDITORIAL

Gordon Fung, MD, PhD, and Steve Heilig, MPH

From Physician to Patient . . . and Hopefully Back Again

“A physician who treats himself has a fool for a patient.” —Sir William Osler

In his famous 1980 essay titled “Arrogance,” *New England Journal of Medicine* editor Franz Ingelfinger was most likely at least half-joking when he proposed that only those who had experienced severe illness while young should be admitted to medical school. But there’s a good concept behind his proposal—we truly never know what it’s like to be seriously ill, and in need of care, until we are there.

And of course eventually we will all be there, short of a sudden, unexpected demise. Another famous teacher, the Buddha, stressed that life is temporary, and more modern interpreters of his teachings have noted that even the most robust of us are only “temporarily healthy.”

But why was Ingelfinger’s piece titled “Arrogance”? Because, after his own experience as a cancer patient, he (perhaps reluctantly) concluded that some degree of “authoritarianism, paternalism, and dominance” was inherent in the good physician’s role. Ironically, his “knowing too much” about his diagnosis, prognosis, and treatment options confused and compromised his care, as he was “barraged by well-intentioned but contradictory advice” and eventually felt he needed to trust in his doctors’ competence and advice—to give himself over to their expertise, even as a very well-informed patient.

That implied vulnerability—ironically, in some ways an opposite of arrogance. Physicians as a group seem no better equipped to deal with their own vulnerability than anybody else—in some cases, the reverse can be true. Admitting vulnerability requires an erosion of denial, an acknowledgment that we too can be ill and that we ourselves do not always possess the knowledge and tools to reverse that. Clinicians who see illness and even mortality each working day unavoidably develop denial. It is adaptive, at least in some ways. Thus we might hear of doctors not seeking diagnosis until far too late, about an oncologist unable to even talk with his wife about her cancer, and other such scenarios. And even once in treatment, physicians may receive compromised care due to too much respect on both sides of the bedside, with both physician and patient/physician trying to please and impress the other. As people nowadays sometimes say about their “relationship status,” “It’s complicated.”

On the other hand, there is more recent research indicating that physicians are much less likely to seek “aggressive” treatment toward the end of their own lives—a preference that likely comes from having witnessed what that too often means in practice. Such choices can reflect the growing consensus of specialty groups and efforts such as the Choosing Wisely campaign—an interesting twist on practicing what we

are coming to preach.

There is significant work from the Institute of Medicine on empowering patients with the necessary information to make the right decisions for themselves. We are seeking to modify our approach to patients in an effort to make our health care system more cost efficient and patient centered. This movement will definitely affect the actual practice of medicine from the very foundation of the doctor-patient relationship. No better place to begin than to look carefully at how we care for health care professionals, who are assumed to be among the best-informed patients.

For this edition of our journal, we put out word that we were looking for physicians willing to share their stories of illness, treatment, and thoughts about what colleagues might benefit from hearing about. We heard from many. Some thought about it and decided it was still too personal. Others, as you can read here, took a leap, and we are grateful. They present stories featuring a diversity of illnesses, age, gender, specialty, and—so far—outcome. From medical student to senior teacher, they tell of confronting their conditions, fears, choices, and more when they or those close to them face serious disease. Sometimes there are recommendations for improving care and our systems; sometimes the lessons are more personal and emotional. We want here to honor all our authors, including and perhaps especially Drs. Loring, Liner, Iverson, Li, Horowitz, Grotke, Mangurian, LaVoy, the late Drs. Atchley and Levin, and medical student Shenoy for taking a leap and telling their own stories. And Drs. Pating, Skeff and Sorem, while not speaking as patients themselves, distill much expertise about taking care of physicians as patients—and about “prevention” where possible.

Much of what our authors provide in this issue could be said to fit into the category of “hard-won wisdom.” Again, we are thankful to them for sharing it, and we hope you will be too.



REMISSION

A Yearlong Journey into Cancer

Robert Liner, MD

A year ago, on my sixty-ninth birthday, I checked into Kaiser Hospital for work-up of a chronic cough, back pain, severe anemia, and a low-grade fever.

Believing that patients often overreact to symptoms and seek medical attention prematurely, I had let things go a bit far.

I'd been easily fatigued and a bit short of breath, but when a couple of days prior to my hospital admission my wife saw me leaving food on my plate at a favorite restaurant, she insisted on taking me to the ER. I told her this would be an abuse of ER resources but, once there, learning that my hematocrit was 24 and watching two units of blood being transfused into me, I brilliantly arrived at the conclusion my wife had reached some time before: I was seriously ill.

Once in the hospital, I resolved to conform to the role of being a patient and to follow doctor's orders.

Generally, when getting medical care, I avoid mentioning that I'm a physician. Even experienced providers sometimes have steadier hands when not aware they're administering to a physician.

Or, for that matter, to a malpractice attorney. Also, keeping one's doctor-identity under wraps can provide insight into some of our profession's foibles.

For example, I hadn't been in my room long before an endocrinologist came to see me. He was shadowed by a medical student who kept silent while her mentor waxed didactic about me: "He has a thready pulse," said the specialist, whereupon I was tempted to provide a lecture of my own: "'He' is sitting here and shouldn't be referred to in the third person. 'He,' like most patients—even unconscious ones—will be hypersensitive to remarks that seem to apply to him. So speak reassuringly, speak to the patient directly, or save your observations until later." I thought these things but, perhaps as an instance of the power imbalance that tends to keep patients passive, I bit my tongue. (Don't cross the one who holds the knife. Anyway, why antagonize someone who is, after all, trying to help?)

On hospital day one, a CT scan revealed an 8 cm mass riding atop each of my adrenal glands. Annoying back pain from those masses disappeared soon enough—within twenty-four hours of my first dose of prednisone. Still, I want to talk about pain; that day, it was the prospect of going downstairs to interventional radiology for a needle biopsy of my abdominal masses that put me on full alert.

Fortunately for me, Kaiser's radiology staff are from a different school of thought than the one I saw too much of during my medical training. My introduction to the art of circumcision, for example, seemed to borrow from some fisherman's manual that must claim, "Fish don't feel pain." The foreskin of a newborn, I was told, has not developed pain receptors. The first and only time I applied a he-

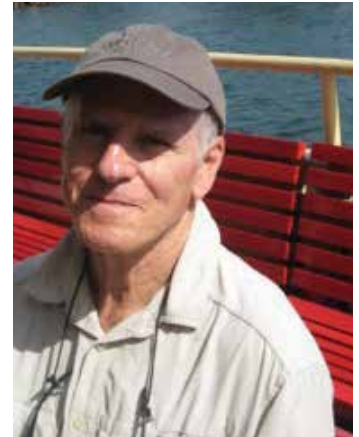
mostat to a nonanaesthetized foreskin . . . well, out of the mouths of babes! Since those days, when the procedure is not avoided altogether, use of a local anesthetic has become routine.

As my gurney was rolled into the treatment room for my needle biopsy, not knowing what school of thought regarding pain I was about to enter, I was apprehensive. While large and therefore hard to miss, those masses of mine were down deep. As a specialist in prenatal diagnostics, I'd done literally thousands of amniocenteses, so I had to admit that being on the receiving end of a long needle was poetic justice. Over the years I did my best to make amniocentesis as anxiety and pain-free as possible, employing a bit of clinical hypnosis when anxiety seemed high, but now that it was time for my own experience at the receiving end of the needle, I wasn't sure what to expect.

I needn't have worried. No sooner had my gurney come to a stop than a young woman loped, grinning, to my side. Holding in one hand a fistful of syringes, she announced, "I have drugs. I'm going to make you soooo comfortable!" She did just that. I remained conscious, turned on my side, partly covered with a warm blanket. While the biopsy was being done, my friendly drug provider held me on my side, enfolding me in fetal position. The procedure surprised me with its absence of anticipated pain. Kudos to the drugs and the technical skill of the radiologist with the needle, and one can never discount the value of human touch. I recall the whole enterprise as having been pleasant. It was also successful, obtaining tissue that provided me with a diagnosis. Happily, that diagnosis—diffuse large B-cell lymphoma—was one that gave me a reasonably good chance of being cured.

In my case, complete remission with low percentage chance of recurrence involved more than six months of further diagnostic tests, chemotherapy, radiation therapy, and a lot of drugs. Aside from anti-nausea drugs, which worked beautifully—I experienced no nausea at all—I took drugs to deal with pain. My cancer didn't directly cause me significant pain, but a flare-up of spinal arthritis did, and that pain was ferocious—frightening. It was also ill-timed in that it caused me to initially flunk out of radiation therapy; I couldn't lie on the table in the required posture for more than a few seconds. Carrying out the therapy would have required general anesthesia.

I wasn't worried about getting addicted to narcotics. I'd taken Percocet for a herniated disc and for knee replacement surgery. No



problem. This time, needing to get on with my radiation therapy, I took lots of it, along with 45 mg a day of prescribed oral morphine. With that on board, I still needed two steroidal epidural treatments. None of the medication produced anything like euphoria, and that was fine. Blunting of pain was what it was about and what eventually enabled me to hold still for my radiation therapy. But maybe it was partly the absence of euphoria that led to my foolishly cavalier approach to stopping the narcotics. It's also possible that cautionary instructions about taking and discontinuing opioids were omitted because of assumptions that, as a doctor, I would be well versed. I more or less was, but that didn't seem to matter. Once I'd completed my radiation treatments and having benefited from the epidural steroids, I no longer felt in need of the narcotics. Stupidly, I failed to ask for advice. I just stopped taking the drugs—all of them. I figured I could handle the let-down.

The result was interesting. Soon, narcotic withdrawal manifested not only as insomnia and maddening restlessness but also as profound depression. Ordinarily, I don't get depressed but, lying in bed one night, I confessed to my wife that, while not suicidal, I finally understood how people can want to throw in the towel. I was just sick and tired of feeling sick and tired. At the same time, I knew this was mainly the drug withdrawal talking. I had recently had a spectacularly reassuring repeat PET scan. I wasn't terminally ill. I'd made it through all my scheduled treatments. It was a ridiculous time to be feeling so depressed, but an interesting introduction to a deeper level of empathy for patients who suffer depression. I should add that, had I been in Oregon (or, now, Washington, Montana, or Vermont), I would not have qualified for "aid in dying" as defined and permitted there. I wasn't terminal and would have simply been referred for help with my reactive depression.

Months earlier, while I was still in the hospital, my wife and I had about thirty-six hours during which it seemed likely that my disease would, in fact, be terminal. She has told me that, for various reasons, she cried a fair amount during my illness, but that was one of the few times I did. I wept with profound sadness over the notion of leaving the life I loved. There was nothing irrational about that sadness. Patients who are genuinely terminally ill and who seek physician aid in controlling the time and circumstances of their deaths should not be thought of as irrational or pathologically depressed. If, unexpectedly, my lymphoma recurs, the prognosis would be "dismal." If that happens, I believe it should be within the scope of ethical, legal medical practice for my doctor to provide me with a lethal prescription—a key to the exit. Physician aid in dying is something distinct from suicide. The disease would be killing me. No compelling state interest here. No slippery slope. Only a decision to be made by me as a patient, along with my family and my doctor. As a physician and as a patient, I see this as a fundamental liberty interest and as sound, compassionate practice of the art of medicine. Of course, where my death is concerned, I'd rather skip the whole thing. Couldn't I be an exception?

Robert Liner, MD, spent twenty years as an obstetrician/gynecologist with clinical and teaching positions, principally at Mt. Zion Hospital in San Francisco, followed by twenty years in private practice of prenatal diagnosis and gynecologic ultrasound. Most recently he did clinical work and taught in the prenatal diagnostics division of UCSF medical center. Now retired, he is taking piano lessons and trying to publish an illustrated lullaby. He volunteers on the Leadership Council of Compassion and Choices in Northern California.

Discover Health Medical Partners, Inc.—N1 Health—Seeks Associate in Clinical Practice

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Deceptive Drug Education Program Back in Schools

SFMS Played Key Role in Earlier Removal. A decade ago, a *San Francisco Chronicle* investigation revealed that Narconon, a drug education and treatment offshoot of the Church of Scientology, was common in public and private schools. The San Francisco Superintendent of Schools asked the SFMS to provide a "peer review" of the program, which was done using the expertise of local addiction medicine and drug education leaders. Founded to have many questionable assertions, the program was then removed from the schools, and the SFMS took a policy resolution to the CMA and AMA, resulting in further examination and removal of such programs.

In May, the *Chronicle* again published a front-page story revealing that Narconon (which is not Narcanon, or Narcotics Anonymous) had re-entered schools statewide; their cover story featured the SFMS's Steve Heilig, who coordinated the earlier review, provided much detail and is again prompting further school action.

The story may be read at: <http://www.sfgate.com/education/article/Narconon-Misleading-antidrug-program-back-in-5504351.php>

LEARNING TO BE A PHYSICIAN

Experience Gained from Being a Patient

Keith Loring, MD

During the final year of medical school, when hopes and anxiety are expected to run high, when sights are entirely focused on finding the best residency, and when confidence in one's clinical abilities is on a steep upward curve, I seroconverted HIV-positive. I know the exact moment when I was infected: The condom broke. I know the exact day when the seroconversion syndrome occurred: I had just arrived in Southern California for a residency interview. And I will never forget the day when I first heard someone utter the words, "You are HIV-positive." A counselor at an anonymous HIV testing center confirmed my worst fears on January 16, 1991, the day George H. Bush launched Desert Storm.

I had only recently come out of the closet and stood on shaky ground. I was at odds with my family. And I was still very much at odds with myself. My classmates at Johns Hopkins had been amazingly supportive when I came out, but with this new reality, I froze. I simply kept it to myself, went into complete denial, and headed into residency deeply wounded. It was a lonely, tumultuous, and difficult three years. At one point I was placed on probation for cutting corners with patient care. That woke me up enough for me to pull it together and make it through without any further problems. But it was not enough for me to begin dealing with being HIV-positive. I just did not feel safe enough to pull that trigger.

Immediately after residency, I gathered the courage to begin dealing with things. I returned to Johns Hopkins for a fellowship in emergency medicine. It was the place of my coming out and, fittingly, it became the place where I would begin to find healing.

It was the place where I learned what it really meant to be a physician—by becoming a patient. Clearly, once I chose to seek help, being a physician was hugely advantageous in finding the best resources and negotiating the system. However, what really mattered were the connections that I made: the personal touch of my caregivers who opened up a direct, personal, and unfettered connection with me as a patient. And that is the heart of my story as an HIV-positive physician—the network of caregivers, each of whom contributed to my health by listening to me, answering my questions, counseling, guiding, and firmly directing me when necessary.

My first step was to reach out to Joel Gallant, a friend, who was in charge of the Moore (HIV) Clinic at Johns Hopkins. As soon as I opened up, a flood of questions poured out. Could I safely practice in the ER or did I put my patients at risk? Where

could I get lab work done without using my insurance? Who was the best HIV specialist? Would I have to take medications? How would I handle insurance? How would I keep things confidential? He immediately began plugging me into the network of caregivers at Johns Hopkins who quietly cared for a sizable number of HIV-positive health care workers in the Baltimore area.

Joel referred me to three people, each of whom had a profound impact on my well-being. First and foremost, I needed to know if I could safely practice clinical emergency medicine. Being HIV-positive, was I placing patients at risk? At Joel's recommendation, I called on John Bartlett, the chairman of infectious disease, who had just finished serving on a presidential advisory committee tasked with setting policy on this very question. After patiently listening to my story, John described the advisory committee's deliberations in detail. He went out of his way to assure me that I was not placing patients at risk and that I was under no obligation to disclose my status to patients or colleagues. However, he did caution me, "You are placing yourself at risk by practicing in the ER. You need to decide if that is a risk you are willing to accept." I was so relieved. He was so unequivocal that I would not be placing patients at risk. My own risk was of little concern.

The next step was to get a handle on the state of my immune system. I did not want to use my insurance, and I didn't want to go through the hospital lab. So Joel referred me to an HIV research lab on campus. I met with the head of the lab, an MD/PhD and a nonclinician. He agreed to run my lymphocyte panel, but only after sitting down and hearing me out. With one foot still firmly planted in the land of denial, I was anticipating that my CD4 count would be relatively intact and that I would have plenty of time before needing to start on medication. Sitting on a high stool, leaning on one of his cluttered basic science lab benches, he looked me in the eye and gave me two of the most important pieces of medical advice I have ever received: "I can run your labs for you, but you need to figure out what this all means to you in your life; you need to get your head straight. And, when you start on medications, you make sure you start on at least two medications at once." This was long before combination therapy had come to the fore.

It was a lot to swallow, but he was spot-on. My CD4 count was 132. I needed a physician, I needed to start medications, and I definitely needed to get my head straight. Joel's third referral was to Janet Horn, a community internist with a large yet unassuming HIV practice. She became my first doctor. She took me in, led me by the hand, showed me how to be a patient, and helped me negotiate the treacherous waters of managing HIV while staying under the insurance and medical records radar. I established my insurance and official records under my middle name, and we found a clinical trial in which I could start on at

least two of three medications and through which I would get all my clinical labs. It was a perfect fit—as long as my CD4 count remained above 100. My enrollment CD4 count came back at 86. That was a dark day; I'd hit rock bottom. But when I called Janet, she didn't skip a beat. "CD4 values fluctuate a lot," she said. "Today is Friday. You go, relax, and have a nice weekend. Stop worrying about this. Come in on Monday and have it redrawn. It will be just fine." Sure enough, the count came in at 112.

After all the build-up, I was completely unprepared for the emotions that came flooding in when I began taking meds. That's when my HIV infection finally became very real. And reality hit hard. I shed a lot of tears and relied heavily on the counselor I had found through the Episcopal Cathedral congregation in Baltimore. For a good ten days, it was all I could do to stay awake long enough to get through an eight-hour shift. Yet it was in those dark days of starting medication that my spiritual journey finally took off. Suddenly and unexpectedly, I woke up one morning feeling like a kid, fully energized. I was also filled with a profound awareness of just how much my body—and my spirit—had been hijacked by the virus. In that moment of awakening, it was clear to me that I had a great deal to be thankful for, not the least of which was quality of care I was receiving.

Renewed energy also awakened my inquisitiveness about HIV in general, which in turn heightened my level of anxiety about every little itch and scratch. I began reading obsessively and started pestering Janet with every little worry. She cured my hypochondriasis in one fell swoop by asking me what I was reading. "Harrison's chapter on HIV." "And who wrote it?" "Anthony Fauci." "Do you know how many patients Anthony Fauci has seen in the last ten years?" "No." "The answer is none! Keith, I need you to stop reading for now and let me be your doctor." It was a liberating moment, a release and a relief. I could place my energies elsewhere, trust in my physician, and move forward with my life.

With my fellowship year quickly coming to a close, my heart was set on returning to the Bay Area, which prompted one final referral from Joel: his former residency colleague, Lisa Capaldini, who became my physician here in San Francisco. And like every good doctor before her, she set some very clear expectations: "I have two rules. Number one: If you experience any symptom for more than three days, then I want you to call me. Number two: Every Christmas, you have to send me a card with a picture of your dog. If you don't have a dog, a cat will do." Like Janet before her, when it comes to managing my HIV, I defer to Lisa. And it is all working out just fine.

In that moment when I knew I was exposed to HIV, I knew exactly what I needed to do. My intuition was to go out and get some AZT and start taking it. At that time there was no data to back such a move; however, I just knew it would work. In retrospect, my intuition was spot on. But I didn't follow it. I was frozen by shame. I allowed myself to believe in a lesser me who was getting just what he deserved. When I finally was able to gather my courage and reach out for help—as a patient—I was met with nothing but courageous compassion. Was it because I was a physician? Did that make a difference? Perhaps. But looking back at those delicate, angst-filled moments two decades ago, I find it hard to believe how anyone I confided in could see



much more than a frightened little boy in need of some direction and a lot of reassurance. Because my caregivers believed in me when I didn't, they showed me how to care for myself, and thereby others, in a very profound way. As a patient, I was taught ever so elegantly by Joel, John, Janet, and Lisa how to be a physician, how to listen with my ears and my heart as the best way to help patients muster the strength and courage they need to find healing in their lives.

And now, two decades later, thanks to a lot of good fortune and a willingness to follow my intuition, I'm currently participating in a Phase I HIV immunotherapy protocol. Whether it is in the direction of a cure or not, I cannot begin to describe the amount of gratitude I feel to be in a position to participate.

Keith Loring, MD, currently practices emergency medicine at the Davies Campus of California Pacific Medical Center. He graduated from the Stanford University/Kaiser Permanente Emergency Medicine Residency Program in 1994 and served as assistant chief of service in the Department of Emergency Medicine at Johns Hopkins Hospital from 1994 to 1995. He then joined the part-time clinical faculty in the Division of Emergency Services at San Francisco General Hospital (1995–2010) and established a full-time clinical practice at St. Mary's Medical Center (1998–2012), where he served as medical director and chief from 2002 to 2006 and vice chief of staff from 2007 to 2010. He is a longtime member of the SFMS and has served as SFMS treasurer, alternate delegate to CMA House. He has also served on the SFMS Board of Directors, the Finance Committee, and the Executive Committee.

NAVIGATING THE PAIN PATH

Notes from a Reluctant Patient

Nancy Iverson, MD

I try to squeeze all the pain inhabiting my six-foot body into the three-inch outline on the page in front of me.

I cram arrows (for radiating pain), circles (aching), diamonds (stabbing), stars (pins and needles), lines (cramping), checks (wait—what do they represent again?) up and down the legs, back, shoulders, neck, and feet in the Pain Map diagram. (There is no suggested symbol for the sense of hot barbed wire twisted tightly around my tibia, nor for that of a dentist's drill boring straight into the center of my femur.) Now I must Rate the Pain—so I jam in numbers: a 4 in my left anterior leg, a 3 alongside my right scapula, a 6 (or would 6.5 be more accurate?) down my left medial thigh—knowing any one of these will escalate up to 7 fairly quickly if I'm sitting just a bit longer in this chair that doesn't quite fit, or increase to an 8 by the time I've walked all the way down the hall to the exam room and maneuvered onto the too-short table, or shoot up to a 9 because I'm standing for more than one minute in the pharmacy line—or skyrocket up to a 9.5 for no reason that I can identify.

Medical education carries a consistent message: We must be right. Patients' lives are at stake, and one slip, one fact not learned correctly, one diagnostic clue overlooked has huge ramifications. Now, as a patient, I'm struggling to bring that precision to my own history. I know that pain doesn't fit neatly into these symbols and boxes and categories. But I also know that charts and numbers are mandated, with an implied message that they are more manageable than the complexities of a narrative and the patient who comes with it, and I know this document, along with summaries of previous MRIs and computerized problem lists, may be more carefully examined by the medical team than I will be.

Diagnosed in my thirties with multiple levels of spinal stenosis and advanced degenerative disc disease, I never dreamed that, twenty-plus years later, being a patient would run my life and shape my identity at least as much, if not more so, than being a doctor has. Having scaled the heights of medical education to become a physician, I was catapulted into a new learning curve as a patient—different, but also incredibly steep. And one for which I've been a very reluctant student.

I've learned that it's very hard for me to be a "good" pain patient. "Living well with pain" isn't an inherently easy goal to accept or achieve. But I try. I embrace acupuncture, biofeedback, nerve blocks, surgery, medication, meditation, nutritional supplements, and modalities I can't even remember right now. I try to "listen to my body" and slow down when pain screams at me—and then feel criticized for not being active enough. And the pain



doesn't stop anyway. I "push through the pain" until I collapse in misery and then fear that I've made things worse. I want to believe that consistent and total pain relief is possible, and I'm terrified that it isn't; and even as I'm coached on how to learn to live with pain, I can't deviate far from my personal goal of getting the pain to stop so I can get back to a fully active life as a practicing pediatrician, not as a patient. I want to be out of pain far more than I want to be coping with pain, and I want my "restored level of functioning" to be 100 percent.

I haven't learned to eradicate my sense of shame about missed workdays, my embarrassment when surges of pain leave me powerless to hold back tears in awkward places like the exam room or the reception area, or my humiliation when I can't stifle a whimper or a moan as I stand in line to register or take one excruciating step after another down a long hospital or clinic corridor.

I feel outrage when I remember colleagues labeling a patient's pain as "supratentorial." I cringe at the thought that any doctor categorizes symptoms that way—and recoil at the possibility that one of my physicians may do so. When I'm experiencing depths of exhaustion and despair beyond anything I'd ever imagined, I launch into an internal monologue, contending that there must be a doctor somewhere who knows everything and can do anything—obliterate my pain and leave me fully restored. At the same time, I'm mortified by my unreasonable insistence, knowing, as a physician, the vast range of limitations inherent in diagnosis and treatment.

I repeat a pain management principle over and over: "I am a patient with pain. I am not my pain." But, for me, that mantra is incomplete. Because I am also a doctor, and that irrevocably informs the nature of my journey. I'm longing to be alongside my colleagues who are at the bedside, solid in the role of doctor, not the one in the bed. I know the satisfaction and joy inherent in diagnosing a condition, finding a solution, and championing a patient's return to health, and I want to celebrate that. I also know the intensity of frustration and raw disappointment we doctors

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PARTNERING WITH PATIENTS

Caring Relationships Make All the Difference

Allison LaVoy, MD

I was an AIDS doctor. I trained in San Francisco at the beginning of the epidemic and went into private practice, where my first ten patients were colleagues with what was then a mysterious disease. I worked fourteen- to sixteen-hour days for twenty-two years, then moved on to a job with fewer hours and a needier population in the San Francisco jail system. I also volunteered in an HIV clinic in Marin. Although I knew I hadn't seen everything, I had certainly seen a lot.

In July 2009 I got a routine Tdap. I was sixty years old and was following the recommendation I had made many times to my patients. Fourteen days later, while at work in the clinic where I volunteered, I felt throbbing in my forehead. When I checked in a mirror, I was horrified to see first right- then left-sided facial paralyses. I began acyclovir and steroids that day, but the following morning, in addition to a paralyzed face, I began to experience tingling in my feet. Of course I knew this was not "atypical Bell's palsy."

I hobbled in to see a respected neurologist/colleague whose first action was to put a hand on my shoulder and quietly say, "I am so sorry this is happening to you." Although I had always been the kind of doctor who touched her patients, I had never thought until that moment that I would ever be the kind of patient who needed that kind of doctor. His empathy then and during each of many visits made a tremendous difference to me.

I had a battery of blood, imaging, and nerve-conduction tests. I was struck by the kindness of a cardiologist who gave up his lunchtime to perform an echocardiogram and an MRI tech who likewise squeezed me in because "we take care of our own." I understood this might not be the treatment other patients always receive, but I was grateful nonetheless.

I experienced rapidly progressive paralysis up to the diaphragm, and my FVC dipped to slightly below normal. My treating physician was very concerned about progression but respected my desire to avoid hospitalization if possible. (I am sure my having a pulmonologist husband helped sway him.) I began IVIG for Guillain-Barré first in an infusion center, then at home. The response was rapid and dramatic, but subsequently I rode a roller coaster of recurrent symptoms. Multiple relapses changed the diagnosis to the more sinister CIDP—chronic inflammatory demyelinating polyneuropathy (incidence 0.8-8.9/100,000). This is a poorly understood and understudied illness that tends to be slowly progressive in most people, but some have a "relapsing-remitting course." Which would I have? Since IVIG alone often does not fully control CIDP, I also received oral and much larger doses of IV steroids and long-term azathioprine, all of which gave me side effects—severe headaches, abdominal pain, back pain, chronic nausea and fatigue, and anemia, to name a few.

My older husband, for whom I have always assumed I would

provide medical support in his later years, carried me up and down stairs. Some of my dearest friends, some physicians, some not, were unable to face me or cope with my situation. Yet as many an ill patient had told me, the people one least expects to do so come out of the woodwork in times of need, with food, to run errands, to offer respite to one's family members.

I regained much strength and mobility but continued to have painful neuropathy of hands and feet as well as significant balance problems. I learned not to complain of the pain since gabapentin, Lyrica, Cymbalta, and NSAIDs did nothing for me, and I had no intention of using narcotics. Every step I took hurt, but having experienced paralysis, even painful walking was a much-appreciated improvement.

I was a practicing internist, not a consultant or an academician. It seemed irresponsible to return to practice when I couldn't feel anything with my hands, since physical examination is a major contributor to correct diagnosis and therefore treatment. It is one thing to retire with a plan in place to address all of the things you have been putting off for years, and quite another to be thrust into it without any preparation. This may be especially true if you are no longer able to do many of the things you did not make time for in the past. With the uncertain prognosis for CIDP and many other diseases, there is one certainty: Live your days to the fullest.

The deal we make with our patients is that we will partner with them to try to keep them healthy, and if that fails, to do our best to diagnose and treat them. In return, we have the honor of being invited into their lives, knowing things about them their friends and families often do not.

During my years of practice, these relationships were among the most meaningful in my life. I knew it at the time, and they remain so in retrospect. EMRs, HMOs, PPOs, Medicare, and Medicaid each do their part to disrupt those special two-way relationships that doctors have with their patients, yet somehow, although they may be fragile, they manage to survive. I now know how powerful they can be from both sides.

Allison LaVoy went to Mount Holyoke, Smith, the Sorbonne, and New York Medical College, then did internship and residency in San Francisco at what was to become California Pacific Medical Center, Pacific Campus. She was in private practice in internal medicine/HIV there until 2002 and then worked in the San Francisco jail system at the Forensic AIDS Project and at the Steel Clinic in Marin.

CHANGES IN HOSPITAL CARE

My Multiyear Experience as a Patient

Jordan Horowitz, MD

My first experience as a patient occurred in 1980, shortly after I completed my ob/gyn residency at UCSF and joined the Children's Hospital Medical Staff. I ruptured an L5-S1 disc and could barely walk. At that time, diagnostic testing such as CT or MRI did not exist. After six weeks of conservative treatment for severe sciatica, I underwent a successful lumbar laminectomy at Ralph K. Davies Medical Center. I recall feeling embarrassed at being a patient rather than a provider. I had never previously experienced immobility and the vulnerability of relying on others for even basic help.

The technical care at Davies was excellent, but what I remember most was the hands-on, un-rushed nursing care. In addition to typical post-operative monitoring of vital signs and administration of medications, etc., the nursing staff also offered massage and excelled at comfort care.

I have a strong family history of coronary artery disease and, despite regular exercise, appropriate diet, and having never smoked, I experienced a heart attack in 1999 at age forty-nine.

I was working that day in labor and delivery when I developed severe angina. I was taken to the CPMC Pacific Campus ED and was relieved when I saw my cardiologist and CV surgeon colleagues awaiting my arrival. I knew that they would fix my problem. I was taken to the cath lab and underwent placement of three bare-metal stents in my right coronary artery (RCA). Fortunately, my other vessels were fine. What was not well known at that time is that some patients, including me, can develop an inflammatory scar reaction to those first-generation stents, called in-stent stenosis. Over time this causes vessel narrowing and anginal symptoms.

As a result of this condition, during the past fifteen years I have had more than twelve cardiac catheterization procedures involving my RCA and the placement of many additional, newer-generation drug-eluting stents as well as in-vessel radiation, called brachy-therapy. Most procedures have been performed at CPMC under the direction of my cardiologist, Dr. Bruce Brent, but others have been performed at Stanford, Cottage Hospital in Santa Barbara, and at Scripps Hospital in San Diego.

Based on my admissions to those institutions and their units, including the ED, cath lab, CCU, and telemetry ward, I have had firsthand observation of differences in health care delivery at each institution, as well as over time. Some changes have been



positive, while others have been less so. These institutions share many common themes:

As more care is delivered in the ambulatory setting, the patients who do get admitted are typically sicker, with higher-acuity needs.

There has been significant focus on patient safety through time-outs before procedures and bar coding for safe medication disbursement (this is good).

The transition from paper charting and order entry to an exclusive electronic health record requires a significant learning curve for older physicians and nurses and takes time away from the patient's bedside.

Concerns about declining health care reimbursement has led to tighter nurse staffing ratios and focus on documentation of charge-master capture of billable items, leaving less time for patient comfort care.

Each institution prides itself on having the newest technology. That technology sometimes benefits patients, but sometimes it adds expense with questionable patient benefit and seems to be a marketing tool.

Care provided by hospitalists, teams of housestaff, and consulting specialists leads to care that is not optimally coordinated and is confusing for nurses and patients.

Every hospital has invested extensively in consultants regarding patient satisfaction, the patient experience, and staff training in customer service. Nevertheless, the system is not patient centric but rather based on hospital work flow. In my experience, the lab staff would draw blood at 0400 even if I were asleep, so that the results could be available for physician rounds at 0900. EKG would arrive at 0600, followed by end-of-shift rounds for vital sign documentation at 0700. This eliminated any possibility of sleep. The CCU is deafeningly loud and not an environment focused on patient rest or room for family to help with comfort care. It is common for monitor alarms to be ringing for long periods of time, and the staff is either desensitized to them or too busy to respond. There is typically minimal privacy, and I could often hear confidential information about other patients through open doors and curtains. Those observations have not changed over time and were similar at each hospital.

At each institution, the nursing staff is generally quite experienced and devoted to their work. Fortunately, I was often their least-ill patient and so was triaged in that manner. The nurses are well attuned to pain management, hand hygiene, and medication safety. Bar coding with focus on safe medication admin-

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WOUND CARE

A Story of Autoimmunity and Healing by Intention

Cynthia Li, MD

I sit in an exam room on the top floor of a prominent teaching hospital.

For the last year, I have received care here from top researchers and clinicians on thyroid disorders. On the wall hangs a framed quote, “Happiness lies in good health and a bad memory.” Doctors and nurses murmur in the hallway. I am five years out from my internal medicine residency, and I feel at home here.

Despite the cliché that doctors make the worst patients, I have been a very good patient. The cumulative years of my doctors’ experience gave me immense comfort during my first notable health challenge.



My Chinese heritage instilled in me a deferential respect for elders. My introspective personality makes it second nature to observe and listen.

Four months after my first child was born, I developed postpartum thyroiditis. I had severe hyperthyroidism, followed by prolonged hypothyroidism. When my daughter turned one and a half, my numbers normalized. I completely tapered off of my thyroid supplements. The majority of postpartum thyroiditis resolves similarly.

I am back now at the clinic for two reasons: First, to learn what may lessen my chances of developing thyroiditis again. And second, to follow up on persistent symptoms—palpitations, fatigue, and insomnia.

My doctor enters. He is a grandfatherly figure who is both gentle and authoritative.

To my first concern, he states there is nothing I can do. “It is genetic,” he says. I know of twin studies citing genetic factors that contribute 40 to 75 percent of the risk in developing autoimmune thyroid disease; the remainder is attributable to environmental factors. I also know that the thyroid gland is highly sensitive to environmental toxicants. I share this information with him and ask for his counsel. “It is genetic,” he repeats.

To my second concern, he assures me that my labs are normal. They are within “the reference range,” as if that phrase means something to someone feeling unwell. I explain that my symptoms have progressed and I’ve had to take leave from work. He looks at me with concealed but palpable frustration, uttering no words. I know precisely what he is thinking, as I’d said it so many times before to patients I’d seen. *It’s not your thyroid. Your results are normal.*

Within those few seconds of awkward silence, I morph from being the compliant patient to the dreaded difficult patient. I no longer fit neatly into any symptom complex. The etiology of my condition is ill defined. From the exam table on which I sit, my mind is illumined to the misnomer of the “difficult patient.” By its design, our medical system relies on diseases falling under certain set criteria, but patients are dynamic beings and often fall outside of the criteria. When this happens, doctors often feel impotent and patients stigmatized.

That was my last visit to the thyroid clinic. How many people have felt this before me? How many people have I inadvertently dismissed? How do they navigate this maze, if I haven’t the slightest clue?

As I comb the medical literature for an answer, several months pass. My symptomatology becomes increasingly more chronic and complex. From a simple diagnosis of thyroiditis, I develop conditions that elude catchy, concrete terms. Despite ICD9 codes that exist for them—dysautonomia, chronic fatigue syndrome, fibromyalgia, gluten sensitivity, Ménière’s disease, just to name a few—doctors hold differing opinions about the realness of many of these. I myself am not so sure either.

I begin my journey through the jungle. It is a rich and vast terrain. I experience magic and renewal in relationships with mentors and fellow sojourners; with my piano, a reunion after twenty years; with an iridescent green hummingbird that oft returns to bathe in the spray of my garden hose.

But the jungle is also unpredictable, terrifying, and lonely. It embodies the paradoxes of the human condition. In many places it is dark as night. Some go in and don’t return.

One day in April, a year or so after my last visit to the thyroid clinic, I am in Beijing with my husband and daughter. We are visiting my family. We dine at the famous Dumpling Palace after a jaunt to the Great Wall. I suddenly feel like I am going to pass out, but I don’t. I lie down, but the sensation intensifies. I am unable to breathe. As I await the ambulance, my life flashes before me.

Images of dumplings, chopsticks, and smoky air swirl in my mind as I emerge in a primitive-looking emergency room. The doctor tending me is a resident. He tells me in Mandarin that my blood pressure is alarmingly low, and if I don’t respond to IV fluids, they will give me stronger drugs. I experience perpetual vertigo. No one, including myself, understands the situation. This is one version of hell. Seeing as I am the doctor-patient, I access my mind just enough to order a precautionary pregnancy test. To my bewilderment, it is positive. At a time when I have a near-death experience, I learn I am to give life. There is another passenger

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Wound Care

Continued from previous page...

aboard this wild roller coaster ride of neuro-endo-immune dysfunction.

At times I think I cannot go on. But do I really have a choice? I breathe deeply and rub my hands deeper into the mud, going ever downward into the thicket of root causes of my conditions. Then I reach a point beyond which I can descend no more.

I begin the ascent.

Postpartum thyroiditis has the same pathophysiology as Hashimoto's thyroiditis. It is the most common cause of hypothyroidism in iodine-rich regions. It is an autoimmune condition, so I find it curious that it is traditionally approached as an endocrine disorder rather than an immune one.

The immune system is a complex network of cells and tissues that guards the body from pathogens and foreign substances, destroys infected and malignant cells, and removes cellular waste. When the immune system goes awry and attacks self-tissue, the same well-trained cavalry of inflammatory cells that attacks foreign invaders gets called up to destroy native tissues. My body is wounding itself. But who is the enemy when self attacks self?

In Greek mythology, Chiron, a great healer and teacher, was wounded by a poison arrow. His wound did not heal quickly, nor was it fatal. He endured the wound and learned to live with and beyond it. Thus, the *wounded healer* archetype arose. Psychoanalyst Carl Jung elucidated this archetype. Jung said that a good half of every treatment that probes at all deeply consists in the doctor's examination of himself. It is his own hurt that gives a measure of his power to heal.

So healing occurs as self examines self.

And poet Jalaluddin Rumi said that the wound is where the light enters.

Intuitively and intellectually, I begin to see that all of my conditions have a common denominator—autoimmunity. With time and patience, I discover the wisdom of ancestral health, using an evolutionary lens to better understand our modern ills. I study the fundamental connection between nourishment and health. I learn to cook delicious, nutrient-dense foods and avoid inflammatory ones. I explore our inextricable connectedness to the outer environment as well as the mysterious inner world of the microbiome. I delve deeper into epigenetics—the science of how the environment regulates gene expression.

After piecing together these different studies, I fortuitously stumble across functional medicine. This paradigm of medicine consolidates all of these elements and integrates the best of my internal medicine training. It uses models of systems biology, recognizing that each person's unique genetic make-up, coupled with cumulative life exposures, creates wellness or disease. In his book examining breast cancer through a similar lens, Dr. Ted Schettler pores through scientific research and epidemiology to illustrate how a similar disease endpoint may have multiple and different causes that may warrant different treatment strategies. This model provides a map for conditions like mine.

After a prolonged medical leave, I am able to practice medicine again. I am not fully well, but I weave together what the poet Rainer Maria Rilke aptly called the "ill-matched threads" of my life. I live each day with a heightened awareness of the intricate

balance between mind, body, and spirit. There is a difference between wellness and wholeness.

I have gained a freedom from fearing or dreading the complex patient. Is it possible that wounded healers are necessary to address the wounds of our medical system? And that the wounds of the system are themselves openings to a more deeply satisfying approach to patient care, for both doctor and patient? Surveys show that physicians would, more often than not, choose therapies different for themselves than what they recommend for their patients. Doctors being the worst patients—is there something more to this than merely a grumpy attitude?

I have patients who begin to heal even though they have yet to begin any of my recommendations. Perhaps, just perhaps, some light is trickling in through my wounds after all.

Cynthia Li, MD, is board-certified in internal medicine. She completed her medical training at the University of Texas Southwestern Medical Center in Dallas in 2000. For ten years, her practice centered around public health and environmental health, with a focus on underserved communities: primary and urgent care at San Francisco General Hospital, HIV/AIDS in private practice, and HIV/AIDS with Doctors Without Borders in China. She currently has a private functional medicine practice and is on staff at U.C. Berkeley Health Clinic.

Changes in Hospital Care

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istration has been a very positive change in patient safety. Basic things like changing sheets, towels, and hygiene care seem to have declined in priority due to the competitive time demands mentioned above. Food services have improved.

So what will hospital care of the future look like? In addition to improvements in preventive care and chronic care management that will hopefully keep some patients out of the hospital, there will likely be a greater focus on palliative and hospice care that may reduce end-of-life admissions. For those patients who do get admitted, there needs to be greater return to patient-centric care with a focus on culturally sensitive and family-involved care. A pleasant physical environment promotes healing, so a focus on natural light, sound reduction, private rooms, and modern technology will be helpful. As CPMC plans for its new hospitals at Cathedral Hill and St. Luke's, these considerations are already part of the planning. Nevertheless, I still prefer to be the provider rather than the patient.

Jordan Horowitz, MD, is a gynecologist who has been on staff at California Pacific Medical Center since 1980. He is a former chief of staff and serves as Medical Director of Credentials and Chairs Bylaws at CPMC. He is also the Medical Director of Quality for Sutter Pacific Medical Foundation and Physician Foundation Medical Associates. He is active in teaching and is a clinical professor of Obstetrics and Gynecology at UCSF and also at the Geisel Dartmouth Medical School. His professional interests are minimally invasive gynecologic surgery and management of menopausal issues.

A LITTLE BIT LUCKIER

What Really Separates Physicians from Their Patients?

Anuhka Shenoy, MS1

For two harrowing weeks, I experienced the health care system from the other side. My grandmother, visiting from India, had a fall that turned into an emergency room visit that turned into an electrolyte imbalance that turned into an idiopathic neurological problem that turned into a coma that turned into her unexpected death. Less than two weeks after what seemed like a routine fall, she died.

The ten days my grandmother spent in the hospital confused all of us. One night she got two CT scans and an MRI (she was underinsured and no one gave us a straight answer about billing). She saw a doctor roughly every twelve hours, and we relied mostly on her nurses for information about her health and schedule. We got excited about an occupational therapist who never showed up. A young, probably exhausted resident ordered an extensive procedure without explaining it, her attending canceled it, the specialist ordered it again, and, ultimately, it was not performed. We had to remind her health care teams to change her, move her, give her medications, and even take the necessary labs. My father and I ensured that one of us was always in the room, but we were both moved almost to tears on several occasions by the difficulty of receiving not only care but also basic information about her status.

A year ago, I would have cursed the hospital for this treatment. Now, I understand how tired the resident must have been, and I know the feeling of waiting for your attending, worried about asking a stupid question. I know that a hospitalist can see two dozen patients a day. I see how hard nurses work. I vaguely understand the process of making a differential diagnosis, and I know that when a pattern is not easily recognizable, the process can be arduous, didactic, and, yes, expensive.

What if my grandmother were a young woman with children to care for? What if her son were not able to take two weeks off of work to be with her almost full-time? What if she did not have

physicians in her family who could use back channels to advocate for her care? Even with family friends with privileges at the hospital, her son by her side, and a granddaughter in medical school, my grandmother languished in the hospital for a week before leaving without a diagnosis. It's not just the "others," the "health care illiterate," who are scared and confused in hospitals. My father is an educated, highly successful man, and he was flummoxed by the doctors' schedules and recommendations. I am a medical student, and I felt helpless every moment I was there.

The hospital, where we gossip, laugh, share stories about our weekend trysts, is not a terrifying place "for other people." It is a terrifying place for anyone who is there because they are sick, or someone they love is sick. The difference between our patients and ourselves is nothing more than circumstance.

I hope that our system evolves so that an unexpected hospital visit does not have the possibility to bankrupt a family. I hope that we are able to incentivize bright, hardworking people like the nurses I met to need the growing needs of our health care system. I hope that medical research continues to expand the edges of our knowledge, laid so painfully bare by this case. Most important, I hope that my peers and I remember that we are on our side of the hospital bed not because we are special, not because we are intrinsically better or even different than those we care for, but because we are a little bit luckier. I hope we remember to care for our patients and their families as though they are our own, because, not so infrequently, they are.

This article originally appeared in the Oregon Health and Science University blog.

Navigating the Pain Path Continued from page 16...

face—both on a professional level and on behalf of our patients—when we encounter constraints in diagnosis and treatment, and I don't want to inflict that on my medical team. I strive to reconcile my identity as a patient struggling with a difficult condition with that of a physician facilitating healing.

I reflect on patients I've witnessed as they've sojourned through severe illness with grace and dignity. I am grateful for my time with them and for the reminder that patients are an integral part of the healing circle, just as kind and caring medical staff are. For now, at least, I am indeed repositioned from the physician role I've chosen, but I do not have to be dismissed from the medical team. I do my best to adapt to whatever each day brings, dedi-

cating myself to discovering opportunities to rekindle inspiration and cultivate resilience—for myself and for those around me.

And, although the saying may mean something different to me than it used to, I never stop hoping that each morning I'll "wake up on the right side of the bed"!

Nancy Iverson, MD, has practiced pediatrics for more than twenty years in the San Francisco area and has been on staff at CPMC, Kaiser, and UCSF. She worked early on with the development of the pediatric palliative care programs, especially educational, at UCSF and served as a pediatric consultant for Comfort for Kids, an in-home pediatric palliative hospice and palliative care service. Through Support for Families of Children with Disabilities, she runs a support group for parents living with loss. She is the founder and director of PATHSTAR, a nonprofit dedicated to revitalizing health and well-being within Native American communities.

REMOVING THE STIGMA

Doctors, Too, Suffer from Depression

Hal Grotke, MD

Author's Note: A few years ago, and about four weeks before the California Academy of Family Physicians' Annual Scientific Assembly (ASA), I got an email from Dr. Thomas Bent, former CAFP president. He was planning a session on barriers to care in patients with depression and he asked if I had an illustrative case I could discuss. I responded simply, "Sure, I can be your patient with the illustrative history of barriers to treatment of depression." On the day of the presentation several physicians shared cases from their practices. After each case, Dr. Bent presented clinical pearls that supported the patient encounter. This platform was okay with me, although in discussing my own experience I did not give a case presentation in the same fashion as those who went before me. Rather I shared a narrative of my decades of remitting and relapsing symptoms that at times had been severely disabling. The story I told, my story, is as follows.



I vividly remember having symptoms of severe depression by about age fourteen. I vaguely remember having such symptoms years earlier. I did not, however, gain any real insight until many years later.

By the time I was sixteen, I was doing very poorly in school. My parents, a high school English teacher and a lawyer, hired a private tutoring service. After some testing, the tutor told my parents that I didn't need academic help, but instead I needed a psychiatrist. On the initial visit, the psychiatrist decided I should be "in hospital." This was a few years before there were laws limiting "commitment." I was fortunate, I think, that I was not committed. My father and I declined hospital admission, and that was the extent of my mental health care for several years to come.

After graduating from high school with a 1.9 GPA, I started at community college. I didn't last long there and dropped out to go to work. After a few years of unpleasant jobs and debilitating depression, I found myself living in my car. It took only a few months for me to decide that I wanted to live indoors again . . . and the only way I could think to do that was to join the military. After I completed my Navy training as a surgical technician, I found myself stationed on the battleship *USS Iowa*. A few weeks later we were off the coast of Vieques, Puerto Rico, when 200 pounds of propellant (military speak for gunpowder) detonated in the open breach of the left sixteen-inch gun of Turret 2. Forty-seven of my shipmates died. That was easily the worst day of my life as yet.

A couple of years later, I was stationed on the aircraft carrier *Abraham Lincoln*. We were in the Persian Gulf during the first war with Iraq, and I was having a hard time. I went to the physician's assistant, who was on duty on a particularly bad

day. He told me, "You're a sailor and we're at war. Suck it up." I will interject right here that "suck it up" is not an efficacious treatment plan.

Years went by. I got married, got out of the Navy and went to college—for real this time—and then to medical school. All the while I had some low times, but I got through. During residency, however, I went into a deep depression. One day when I was feeling very bad, a patient came in for follow-up. He thanked me for having started him on fluoxetine and told me, "It gave me my life back." I was thirty-six years old at the time. Later that same day my officemate, with whom I had superficially discussed my symptoms, asked me how I was doing. Rather than

answer her, I called in a prescription for myself. After some dose adjustments, I had complete remission for several years.

Then right around the time that I got that email from Dr. Bent, I noticed that once again I was pondering how I might kill myself. Just a few days before the ASA, I saw my family doctor and we added a second medication. I have been doing much better but have not achieved full remission again.

As I did when I told that story at the ASA, I have left out some details, mostly not to bore you but also to protect the innocent and, in some cases, the not-so-innocent. Suffice it to say that I have strong hereditary as well as social predispositions to this disease.

That brings me to my first intention in writing this. Our patients' stories are always deeper, with much we will never know.

We will never know when they were told to go into hospital when they really didn't need to, or when they were told to "suck it up." But we are competing with all of those experiences when we prescribe some course of treatment. People want to respect and trust their physicians. When physicians we will never meet erode that trust in a general sense, we must first regain it before the patient will accept even the ideal treatment from us. This, of course, is not limited to mental health care, but it is certainly magnified in mental health care for a number of reasons, but particularly because of stigma surrounding all mental illness.

That, in turn, brings me to my second and much more important purpose. *We need to break down that stigma!*

This was not my intention when first sharing my story, but what happened after the session increased my resolve. Immediately after giving that presentation, after telling my story, I realized how much I had underestimated the pervasiveness of stigma. Over the course of that day, a dozen or more academy

Epidemiology of Depression in Physicians	
Higher rates among medical students (15%–30%), interns (30%), and residents than in the general population	Both higher than the general population
Lifetime rates of depression among women physicians were 39% compared to 30% in age-matched women with PhDs	
Lifetime rates of depression among male physicians (13%) may be similar to rates of depression among men in the general population, or they may be slightly elevated	Data from Denmark show that male physicians have elevated rates of care
Welner et al, <i>Arch Gen Psych</i> , 1979; Clayton et al, <i>J Ad Dis</i> , 1980; Frank and Dingle, <i>Am J Psych</i> , 1999; Wieclaw et al, <i>Occup Environ Med</i> , 2006; Center et al, <i>JAMA</i> , 2003; Valko and Clayton, <i>Am J Psych</i> , 1975; Kirsling and Kochar, <i>PsycholRep</i> , 1989	

members came to me and very quietly thanked me for sharing my experiences and told me that they could relate. I was very pleased that I had touched at least some in the audience, but I was equally disturbed that doctors, even after seeing one of their own speak openly, could not openly acknowledge the personal, internal familiarity of the topic. OK, please do not think that I am being critical of those individuals for staying so quiet. That is a symptom of the problem. They are perpetuating the stigma because they are victims of the stigma.

If doctors cannot lead the fight to end the stigma of mental illness, I hold very little hope for our patients to escape its bonds.

Dr. Hal Grotke studied at the University of California, San Diego, and is now located in Eureka, California. He is the president, CEO, and a practicing physician at the rural health clinic Redwood Family Practice.

For more information about depression, suicide prevention, or other mental health issues in the medical profession:

- *Physician Burnout, Depression, and Suicide Prevention: A Report from the University of California, San Diego Committee for Prevention of Physician Suicide.* 2011. <http://health.ucsd.edu/specialties/wellbeing/Documents/Physician%20Burnout%20Depression%20and%20Suicide%20Prevention.pdf>
- American Foundation for Suicide Prevention. <http://www.afsp.org/preventing-suicide/our-education-and-prevention-programs/programs-for-professionals/physician-and-medical-student-depression-and-suicide>
- www.kevinmd.com/blog: <http://www.kevinmd.com/blog/2011/08/absence-joy-doctors-journey-depression.html>
- When doctors get depressed. <http://www.nytimes.com/2010/10/07/health/views/07chen.html>
- New study finds more burnout, depression among physicians who work long hours. <http://www.news-medical.net/news/20130917/New-study-finds-more-burnout-depression-among-physicians-who-work-long-hours.aspx>
- The painful truth: Physicians are not invincible. http://www.medscape.com/viewarticle/410643_2

Reprinted in edited form from the California Academy of Family Physicians' e-newsletter CME-Spotlight series.

Join CMA at the California Democratic Party (CDP) Executive Board to Showcase Health Care Efforts

CMA and the MICRA Campaign Team are looking for physicians and medical students to attend and speak at selected events during the three-day CDP Executive Board in July. Volunteers are not required to attend the entire three days; CMA is scheduling for each time block separately.

The CDP Executive Board is composed of approximately 330 Democratic Party delegates who will be convening to discuss CDP business, including taking a formal position on the MICRA ballot initiative. The Board will take a formal vote on the initiative, whether to support, stay neutral, or oppose. This vote by the Board becomes the official position of the California Democratic Party and is of critical importance to the success of the campaign. Your efforts to educate CDP delegates will make the difference.

California Democratic Party (CDP) Executive Board

**July 11 at 5 p.m. to July 13 at 12 p.m.
Marriott Hotel | 1001 Broadway, Oakland, CA**

Please contact Jay Hansen at jhansen@cmanet.org or (916) 444-5532 for more information or to sign up. CMA will conduct a special briefing for all volunteers via webinar and onsite during the three-day CDP Executive Board.

THE MISSING VITAL SIGN

A Physician's Journey as a Patient's Mother

Christina Mangurian, MD

The pediatric bone marrow transplant team entered my ten-month-old son's isolation room for a second time one morning. It was supposed to be Anderson's "day of rest" between chemotherapy and his transplant. As a physician, I knew something was wrong—busy doctors do not do rounds twice. They had returned to tell me that the umbilical cord blood needed to cure my son of his rare condition, Wiskott-Aldrich syndrome, had been thawed a day early. The doctor who had just finished his fellowship said that the early thawing would not affect Anderson. He then went on to blame the lab, saying that the "mistake probably happened because we don't really do many cord blood transplants here." The nurse practitioner told me that she thought it was likely a communication problem and promised that "this will never happen again."

At four months, Anderson had been diagnosed with the most severe form of Wiskott-Aldrich syndrome, a genetically inherited immunodeficiency disease affecting 1 in 250,000 men. Children with severe Wiskott-Aldrich syndrome die early of infection or hemorrhage if not treated with a bone marrow transplant (BMT). Children receiving a BMT from an unrelated donor or via cord blood donation can be hospitalized for up to three months—all in an isolation room because of the risk of infection. My family had already endured a three-week hospitalization when my son was only one month old, and I knew that I had to develop a plan to take care of not only Anderson but also my four-year-old daughter, my husband, and myself, physically and emotionally, during this marathon.

In stereotypical doctor fashion, I do not normally ask people to help me, nor do I prioritize taking care of myself. But facing an extremely long hospital stay with a critically ill infant and having an energetic (and thankfully healthy) four-year-old, I overcame my default tendencies.

I knew the evidence that children do well, physically and emotionally, if their parents are doing well. So my husband and I developed a plan for self-care and family care based on discussions with the BMT team, families who had experienced BMTs, child psychologists, colleagues, and friends.

We prioritized seeing both of our children every day, getting a good night's sleep at home at least every other night, having breaks from the hospital to spend time together, and scheduling time to exercise. We created a detailed weekly schedule and asked family, friends, and colleagues to help us with child care, laundry, and other household chores. Thanks to the Lotsa Help-

ing Hands website, many of our friends and relatives signed up to have dinner delivered to our home every night and gifts given to our floor nurses every week.

Despite all of our planning, the love showered on us by family and friends, and support from the BMT providers, nothing could prepare us for the reality of the hospitalization. Until I began "living" on the BMT unit, I hadn't really understood what it was like to be on the other side of the patient-provider relationship. It opened my eyes to the universe of fear and vulnerability—where health care providers are in complete control, and patients (even those who are doctors) are at their mercy across a wide logistic and emotional divide.

The disclosure of the premature thawing of Anderson's cord blood was just one example of a missed opportunity to bridge the emotional gap. Most patients want honest discussions and the opportunity to express their feelings about bad news. Unfortunately, the initial "bad news" discussion failed on both counts. When they told me the blood was thawed early, I was petrified that Anderson had lost his chance to live. It took all of my strength not to slap both clinicians and just scream. After the team left, the physician in me needed to mobilize: I contacted the lab supervisor at a major academic medical center specializing in cord blood transplantation to understand the gravity of this situation. Although this expert gave me information that reassured me, the phone call that day from our primary doctor, the chief of BMT who was on vacation at the time, really eased my worry. He apologized (using the words "I'm sorry"), took the time to explain why it was OK to do the transplant a day early, and said, "Anderson will be just fine." In addition, the mother in me received the most important gift of all . . . a nurse gave me the space and permission to cry.

In another example, despite the scores of publications outlining the importance of sleep, there is an unfortunate disregard for sleep in all hospitals. Getting a ten-month-old to sleep can be challenging at the best of times. Add chemotherapy, pain, nausea, fevers, and vital sign checks every four hours, and the sleep routine becomes extraordinarily complex. With additional interruptions—such as second-year residents eyeballing the child at 9 p.m., noisy intravenous line changes at 10 p.m., or a dermatology fellow conducting a late-night exam and biopsy—the situation becomes a nightmare. I understand there are excellent clinical reasons for these interruptions—especially for critically ill children—but hospitals must start paying more attention to protecting the sleep of their patients and their carers, which could improve clinical outcomes and reduce emotional stress.

Feeling absolutely no control over this life-and-death situation, my husband and I struggled constantly with emotions such as vulnerability, fear, and anger. As a psychiatrist, I knew these feelings were normal, but there was no mental health profes-

sional on the BMT team assigned to help us. Social workers were available, but they seemed to deal with the “problem cases,” not the “easier” ones such as ours. Child-life specialists made my son’s daytime life “normal,” but they did not attend to my emotions. Thankfully, I had my own psychiatrist, my husband, my parents, and friends to turn to for the emotional support I needed. Many families are not so fortunate.

It struck me again and again that, because of the increasing complexity of medical care, doctors do not seem to have the time to take the “emotional temperature” of patients or their carers during prolonged hospitalizations, nor are providers thinking critically about essential, patient-centered concerns to facilitate wellness. In my opinion, we were treated at the best pediatric BMT unit in the country, but the empathic failures made me wonder about the emotional experience for families at other hospitals.

I believe that doctors who are treating children for prolonged periods should ask the parents how they are feeling about being in the hospital every day. If this is unreasonable given time constraints, then add a team member to fill this role. Again, there is plenty of evidence that children do better if their parents are emotionally grounded. By not being asked, parents may have the impression that the doctors don’t care, and clinicians may miss important warning signs of parental depression or anxiety that could negatively affect outcomes for critically ill children.

About a week after the transplant, the chief of pediatric BMT visited us on the day he returned from vacation. By that point, it was clear that the cord blood cells had been in optimal condition, so the mistake did not seem to have had ramifications. That said, it was obviously still on our minds. Without ceremony, his first words to me were, “Hi, Mom, how are you doing? Do you need a hug?” As a psychiatrist, I was taught not to hug my patients, but at that moment I did need a hug, and I needed it from him. I needed it from my son’s doctor, the person we were counting on to save his life, the person who was supposed to help us through this terrible ordeal. Although his bedside manner is not generally “touchy-feely,” our doctor knew that I needed him to cross the doctor-patient-parent boundary. His small gesture took no extra “resources” and little extra time. Yet it instantly made me feel better and is ultimately what makes him not just good but a great doctor.

Useful Resources for Health Professionals, Patients, and Carers

• **Be the Match: National Marrow Donor Program** (www.marrow.org)—“For people with life-threatening blood cancers like leukemia and lymphoma or other diseases, a cure exists. Be the Match connects patients with their donor match for a life-saving marrow or umbilical cord blood transplant.”

• **Carers UK** (www.carersuk.org)—A charity set up to help people who care for family or friends. It provides information and advice about caring, plus practical and emotional support for carers.

• **Caring Bridge** (www.caringbridge.org)—Has personal, protected sites that make it easy to stay connected during any type of health event. Family and friends can visit the site to stay

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A Clinical Perspective

By Morton J. Cowan, MD

As a physician who has cared for children receiving bone marrow transplants (BMTs) at a major academic medical center for more than thirty years, I know full well that a BMT hospitalization is among the most challenging experiences a family will ever go through. On top of that, for most patients (and parents), the disease for which the transplant is being done is life threatening and usually incurable without a transplant. Also, it is among the most challenging medical procedures in the hospital, requiring a large medical team to pay meticulous attention over a relatively long period of time to numerous details that affect patient outcomes. The social issues that our teams must consider are also complex, including parents who are frightened and depressed, living far from home and support systems, being separated from each other and their other children, and dealing with financial stresses over costs for food and travel not covered by third-party payers, potential job loss, etc.

Anderson’s mother highlights the critical need for psychological and social support for all patients and their families who are hospitalized, especially those undergoing complex, life-threatening, and lengthy care. Can we do better in terms of psychosocial support? The answer is clearly yes, but we also need to design improved ways of using the resources that we already have to optimize this aspect of care. The problem is, how do we do this?

Although intuitively, providing this psychological support makes perfect sense, there are limited studies to guide us as to who on the team should be providing this support for carers. At most centers, it is up to the team as a whole to work together for the mental health of the carer and patient. Not every health care professional has the ability or expertise (or experience) to provide the support that’s needed. While some centers rely on psychologists to provide this support, most rely on social workers to identify psychosocial issues and work with the team to resolve them. Nurses, who often spend hours with a patient as part of the team, can also provide important support. In addition, there is no question that some patients and families require more support than others. Since the individual needs vary, there may not be one person who can satisfy the psychological needs of every patient or parent.

Since everyone is involved in the care, I believe that the psychosocial status should be on the patient’s “problem list” and addressed every day. In addition, someone should be checking in with the family at least once or twice a week, or daily if necessary. Weekly psychosocial rounds to address particular problems can also be held to help focus on the needs of carers. Parent support groups may also help. The most important goal with respect to psychosocial care is to attempt to identify and deal with problems before they become crises. What is desperately needed in this area are well-defined studies and controlled interventions to identify the most optimal and cost-effective approaches for all of our patients.

The Missing Vital Sign
Continued from the previous page. . .

informed and leave supportive messages. They also have a SupportPlanner calendar that helps family and friends coordinate care and organize helpful tasks such as providing meals, offering rides, and taking care of pets.

- **Care Pages** (<https://www.carepages.com>)—Websites are free patient blogs that connect friends and family during a health challenge.

- **Family Fund** (www.familyfund.org.uk)—"The UK's largest provider of grants to low-income families raising disabled and seriously ill children and young people. . . We can help with essential items such as washing machines, fridges, and clothing but can also consider grants for sensory toys, computers, and much-needed family breaks together."

- **Immune Deficiency Foundation** (www.primaryimmune.org)—Provides information and support for patients with a primary immunodeficiency disease. It also provides information for health care professionals.

- **Lotsa Helping Hands** (www.lotsahelpinghands.com)—"Connects people through the power of community—whether you need help or you want to provide help. You may be caring for an ill loved one, an aging parent, a child with special needs, or a veteran. You may want to volunteer to help a friend or others in your neighborhood."

- **Rainbow Trust Children's Charity** (www.rainbowtrust.org.uk)—Provides emotional and practical support to families who have a child with a life-threatening or terminal illness.

- **WAS Community** (www.wiskott.org)—Community resource portal created by the Wiskott-Aldrich Foundation for patients and their families. It includes practical information about the disorder and links to support groups and other resources.

Christina Mangurian, MD, is assistant professor of clinical psychiatry. Morton J. Cowan is a professor of pediatrics and chief of the Division of Allergy, Immunology, and Blood and Marrow Transplantation at UCSF. This article originally appeared in BMJ (formerly the British Medical Journal), an international peer-reviewed medical journal. BMJ 2013; 346:f4163.

Physicians and Their Own End-of-Life Treatment Prescriptions: Different From for Their Patients

MDs and End-of-Life treatment: SFMS Representative on Increasing POLST Utilization. The SFMS has been funded via the California Health Care Foundation for the past few years to improve POLST utilization in our area. NBC TV recently did a story on a new Stanford survey of physician desires for their own care and this effort, filmed at the SFMS offices and featuring SFMS member and former board member Jeff Newman MD, MPH, now of UCSF's Institute on Health and Aging.

Doctors Prefer to Pass on Aggressive Treatment: Study A new study from the Stanford University School of Medicine reveals most doctors would decline the aggressive treatment they often deliver. Jean Elle reports: <http://www.nbcbayarea.com/video/#!/on-air/as-seen-on/Doctors-Prefer-to-Pass-on-Aggressive-Treatment-Study/261202071>

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FROM AN ORDINARY ROOM

Persistence through Pain

Lawrence Levin, MD

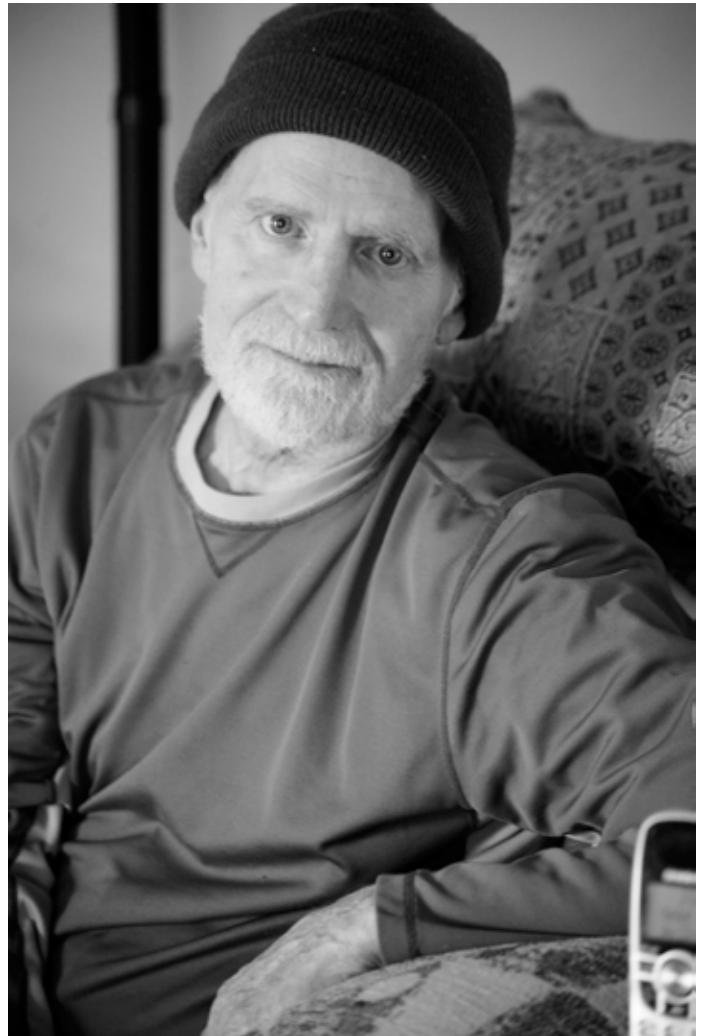
When, in 2009, I experienced the shock of extreme, persistent pain beginning two days after surgery on a pinched nerve in my back, I found myself caught up in an immense struggle to reach some semblance of a life worth living. It happened in March and, except for brief intervals of time, it has not significantly improved over the course of four-and-a-half years. During the most difficult times I find myself overwhelmed by feelings of hopelessness and helplessness. The emotions of rage, resentment, fear, and sorrow pose huge challenges. This adds to the burden of dealing with the daily pain, and the loss of my ability to engage in my outdoor hobbies and to work as a physician.

I'm reminded of distraught patients with serious illnesses who used to say to me, "I want my life back."

As a rheumatologist I saw hundreds of patients with very severe arthritis. I'll never forget how many of my most crippled patients were able to cope with their illness and, in some cases, thrive. How is it that some people have such difficulty coping with pain while others seem to manage so much better despite dealing with a more disabling condition?

Clearly, there is a lot more to pain than giving it a number or checking off a mark on a line. Before I developed my illness, I never really understood the many perplexing issues and difficult challenges regarding chronic pain. I always felt that I was an empathetic person. However, when asked to perform consultations for patients with chronic, severe spinal or joint pain that evaded a diagnosis, I often found myself confronted with an uncomfortable enigma. Usually these patients were referred to me to see if the treating physician had missed an unusual disease. Occasionally this was the case and I had a diagnosis and treatment plan to offer. These people would become my long-term patients. But there were others for whom I couldn't offer any help. Most physicians truly feel dispirited and frustrated when they must tell a patient they have nothing further to offer. There were two things I could always offer for such situations. I could offer kindness and empathy.

In March of 2009, I had my first spinal surgery for sciatic nerve pain after five weeks of worsening pain in my left lower back and leg. I also had numbness, a sensation of pins and needles, and weakness in the left foot. An MRI of my spine showed a ruptured disc and a bone spur putting pressure on the fifth lumbar nerve root on the left as it exited the space between the two vertebral bones. My neurosurgical colleague felt there was about an 80 to 90 percent chance that he could fix this with a minimally invasive forty-five-minute surgery. So I said, "Let's do it."



There was a 10 to 15 percent risk of developing a serious complication such as bleeding around the spinal cord or inflammation of the nerve. The first thirty-six hours after surgery, I felt like a man who had been given a reprieve. Then the pain of the inflammatory complication hit. I had been introduced to overwhelming pain. When asked, I called it a 10. By the end of the first two weeks of this catastrophe, I remember feeling that I had been mortally wounded.

With the complication of nerve inflammation followed by dense scar tissue around the nerve root, my pain and function gradually worsened despite two vertebral fusions over the course of two years. Both had the goal of increasing the opening of the neural foramen (the opening between the bones referred to above) and taking pressure off the nerve root. Both had initial

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improvements but failed after four to six months.

My fourth and final surgery was in December 2012. This was the placement of a spinal cord stimulator (an SCS). The device is inserted and secured just adjacent to the spinal cord and used to alleviate chronic nerve pain caused by a variety of underlying problems. Unfortunately, I developed pain and muscle spasms around the site of the implant in my spine. At this time there is no certainty that the pain around the implant will resolve if it's removed, and there is concern that another surgery might lead to another complication.

I have now joined the ranks of those enigmatic chronic pain patients I used to encounter in my practice.

In the last four years, I have tried a multitude of treatment modalities, including a variety of approaches to physical therapy and alternative medical care, none of which have provided any long-term relief. I've stopped all narcotic pain medicines. They don't help me and they cause side effects. Over the past year my condition has gradually declined so that I am essentially homebound. The most difficult part of this is watching the progressive deterioration in my functional abilities and the worsening of persistent pain. For the last year my wife, Olivia, and I have chosen to have private caregivers in our home several days of the week. Some have become close friends.

Whatever the changing outward circumstances of my life may be, here I am, no less human than at any other time in my life and still finding ways to have a purpose and enjoy myself.

I'm not saying that this isn't a huge challenge. It's just that life keeps moving forward, constantly changing. I find that I have to choose to accept my life on its own terms and go on living as best as I can manage, or give up, become a nonparticipant, sidelined and just watching life pass by.

I spend most of my waking hours sitting in a comfortable armchair reading or watching movies and videos of sailboat racing. I walk around the house for two to four minutes several times a day. I enjoy talking with family and friends and spending time with my wife. I'm a Wikipedia junkie. I've traveled around the world two or three times this last year just using the Wiki site. I've studied genetics, biochemistry, immunology, and neuroscience over the past year and a half.

I write prose and poetry. I write my way through all manner of hardships and questions that arise. There are more than thirty notebooks and a handful of really useful nuggets of learning and insights to show for it. And I meditate. There are the rare, transcendent moments when I am magically lifted above it all. There is a presence within me that knows all is well regardless of the outer circumstances.

I wish the latter would happen more often.

A couple of months ago, as I was writing this piece, I researched some of the current science regarding chronic pain. Two things stood out. First, a great number of Americans suffer from chronic pain, and most describe the pain as moderate to severe. Second, research experts in pain are saying that, as of June 2013, a cure for chronic pain is unlikely and that the real work for chronic pain patients is coming to terms with the fact that the problem is not going to resolve.

How will I live my life in the face of that knowledge? If you have the misfortune to develop chronic pain, how do you live your life? It is a complex and difficult process that changes over time as the conditions of your health improve, stabilize, or deteriorate over days, months, and years. For myself, I've had to become skilled in the art of compromise, acceptance, and adjustment. I've learned to have patience. It's taken a lot of practice, but the effort has been worth it.

One day I wrote my own version of the 0–10 point scale of pain. I readily admit that when I wrote it I was feeling alone, raw with misery and disappointment, and desperately helpless. I was determined to write my own personal experience of pain severity. I had the need to express it for myself. When I finished I looked at it, thinking, "Yeah. This is true for me."

I felt I was also giving a voice to all my past patients and finally hearing something in the moments of silence that had passed between us after the only words I had had to offer were, "I'm sorry."

When will I return to some semblance of an ordinary life? Probably never. I use the word ordinary because it was precisely from the encounter with such personal suffering that I realized all that made up my ordinary life was actually extraordinary. At first I felt so foolish not to have seen it. Now the troublesome things I used to find in my past life seem like nothing. I realize that, for the most part, I will not be burdened by those same simple troubles any longer. With time and dedicated practice, I have come to realize that beneath the veneer of my personality, my likes and dislikes, I have always had an appreciation for ordinary pleasures. I always knew that simple problems would reach resolution, that the usual challenges of living would pass as life kept moving forward.

I still have significant pain every day, yet everything has changed. My life is no longer ordinary. It is difficult and it is extraordinary. I've finally learned why many of my patients were annoyed with a numerical pain scale. I've learned why some patients can thrive and others collapse under the burdensome conditions of chronic pain. To do so, I had to come to terms with my own suffering.

I continue to learn. I am inspired by the lives of others and by the world around me. I am still here. Present, whether the circumstances of the day be easy or difficult.

*Knowing that
I may be overcome
at any moment,
I relinquish my fear,
accept my vulnerability
and step back into
the world.*

Lawrence Levin, MD, was a rheumatologist. From an Ordinary Room (El León Literary Arts Berkeley, California, 2014) is a collection of prose and poetry that represents his personal journey through anger, resentment, fear, and sadness to acceptance and noticing the richness of his life. He died in 2014.

CHOOSING BOTH LIFE AND DEATH

William Atchley, MD, on Living with a Terminal Disease

Steve Heilig, MPH



One of San Francisco's most respected and beloved physicians, William Atchley, MD, came to UCSF in 1952 following medical school at Harvard and internship at Columbia. He practiced as an internist for more than forty years, serving as the

first head of the cancer research ward at UCSF, professor and chief of the UCSF medical staff, and chair of the ethics committees at both UCSF and the SFMS, where he was elected an honorary member in recognition of his devoted and distinguished clinical, teaching, and advocacy contributions. This interview was done at his home, where he was living with prostate cancer, on home hospice care. Bill died in 2007. He is pictured here teaching at UCSF.

San Francisco Medicine: *Let's start with a bit of clinical data: Have you recently been startled by your personal lab results?*

Atchley: My PSA is 3025 ng/ml. Some of your readers might think that's a misprint, but it's true. The National Cancer Institute considers a count over 20 "significantly elevated." So my result makes me chuckle to think of how worried I was when it hit something like 50.

You recently went on hospice care, after years of treatment for cancer. That's often a difficult transition for people, both patients and physicians.

Yes, it's the transition from "cure" to "care," as the palliative mantra goes. I was consumed by pain. Prostate cancer often goes to the bones, and I could not sit, stand, walk, or think. I was a wreck, on large amounts of morphine already; but when the hospice people came in they changed the medication schedule and approach, and I have been pain free, completely, for a month. It's remarkable.

So you're a convert to choosing hospice.

Yes, but I was an easy and early convert, as I was closely associated with people who first got hospice going in Marin decades ago. This just makes it personal. The whole arena is so much more open now. Long ago, my father, also a physician, overheard me using the word "cancer" with a patient and was stunned that I would even mention it. It was all hidden. Now it's more like I have a chronic illness with side effects under bet-

ter control, so I can still have a comfortable life at home. And people do talk about it, and rightly so. I think of all the people I've known who died but could have been saved by more open discussion and aggressive screening, and I tell people not to take "maybe" as a diagnosis.

On the pain issue, one concern has long been that pain meds are too tightly regulated, so that physicians are afraid to use appropriate amounts.

Yes, we really need to continue to loosen up there. Those publicized cases of abuse get way too much attention and ruin the context for other doctors who often should be prescribing a lot more medication. I have enough methadone in my drawer to get rich selling it out on the street, but my caregivers know I won't abuse it. Dame Cicely Saunders, a founder of modern hospice approaches, was one of the first to demonstrate that if you assure patients they'll get all they need, they tend to use less, not more. Few people truly choose pain.

And how about the controversial issue of "physician-assisted dying"?

I think that option should always be there for the really sick person. It must be regulated and reviewed, but to take away that last vital choice, especially for patients with a horrible disease like ALS, is just cruel. So I favor controlled legalization, like in Oregon and Holland. It can be done safely.

Has facing death changed you?

A big thing is just being able to talk about it, and now we do. In fact, it's hard not to. My wife, Annalise, and I have become essentially one person, we're into it so deeply, on both practical and emotional levels. Just keeping track of the meds is a major job. It's very remarkable how close we've become; our love has just burgeoned. I'm a very lucky man. And so in choosing not to squeeze every last drop of blood out of the patient—me, in this case—and in no longer trying to "cure" me, and to not see death as a failure but rather as part of the cycle of life, you might say I've in fact chosen life.

Dr. Atchley exacted a promise that I'd add a plug for Hospice by the Bay: "Whatever I might do for them, I want to do, and hope others might too." <http://www.hospicebythebay.org> (415) 526-5550. This article first appeared in San Francisco Medicine in 2007.

CARING FOR OUR COLLEAGUES

The Physician-Physician Relationship

Kelley M. Skeff, MD, PhD

Having a physician as a patient or as a member of the patient's family brings unique challenges to the physician as care provider. At first thought, one might believe that caring for a fellow professional—being the doctor's doctor—should bring a gratification of the highest professional order. Yet the experience of some physicians as patients belies this hypothesis.

To illustrate the challenges and make recommendations, I will present brief physician-patient examples, quote a patient, and highlight a principle of physician care that I have seen assist physicians as care providers and as patients. My hope is that this recommendation may simplify and enhance both the process and the outcome of caring for colleagues.

Examples of Physicians as Knowledgeable Patients or Family Members

One physician recounted the story of having physical symptoms of impending problems that made him worried about a serious problem post-op. He thought that the vague symptoms were significant. Yet the symptoms were discounted by the care provider team until the situation became a true emergency, when physical findings indicated a serious surgical complication, internal bleeding.¹

Another nationally prominent physician had an elderly family member hospitalized in another city. When calling to check on his beloved relative, he spoke to a house staff team member taking care of his relative. The calling physician sensed a resistance by the provider on the phone, implying intrusiveness in the case. He was struck that he needed to provide his academic credentials in order to ask questions and express his concern and thoughts to the care provider. The physician felt marginalized as a family member.

Perspective of a Patient

Following a conference of oncology patients where I spoke about the importance of patient-physician communication, I received the following e-mail from one of the patients, who was a high school principal. "I believe . . . that most patients do not want to 'upset' their doctors because the doctor will be 'mad' at them. I also believe there is a preconceived notion by patients that if you question your doctor, the doctor might then not offer you the best care possible. The next visit could create a great deal of anxiety for the patient, whether it is warranted or not." Doctors and their families have described the same fear and difficulty of talking with the caring physician.

How can we prevent these unfortunate outcomes? In my mind, the answer is simple. *The physician-carer can overtly invite the physician-patient or physician as family member to become a*

meaningful team member whose unique perspective and knowledge expands the resources available to the caring physician and the health care team. Instead of thinking of the physician-patient or physician-family member as a potential "problem" or "difficulty," the physician-carer can reframe these potentially complex, troublesome interactions as "opportunities" for genuine collaborative management, which can improve care and outcomes. The physician-carer can take advantage of the fact that every physician-family member and physician-patient has been thinking overtime about their "case," including the meaning of their symptoms and laboratory abnormalities.

A two-step process can facilitate the communication by 1) overtly acknowledging the potential hesitation or fear of the patient that he or she may be perceived as imposing, disrespectful, or offensive; and 2) explicitly inviting participation with such questions as, "Have you thought about anything you think we are missing?" "Are you worried about anything in particular, knowing your perspective is important to the care?" The physician should know that his or her views are significant, respected, and often crucial to excellent care.

In the same manner that we should show respect for and incorporate any patient's understanding of symptoms, we can look to the physician as patient or family member to provide a unique perspective about their care. When openly provided the opportunity to become a welcomed participant, a physician-patient's conflicts and resistances can lessen. Paternalistic care can become more gratifying collaborative care. This invitation to team membership also can help patients who wish *not* to participate in care decisions. All patients, including physicians, should know that their care will continue even if they choose not to be active participants in the medical decision making surrounding their illness. However, they must know that their perspectives are welcomed and their comments should be unconstrained by hesitation or fear.

In my experience, physicians as family members welcome the same professional behaviors that can enable other patients to become effective team members.

Drawing from the work of Stephen Cole and his colleagues,² the physician behaviors of reflection, legitimation, and respect can facilitate all patients, including physicians, to become meaningful collaborators in their own care. With the human acknowledgment of the feelings, legitimacy, and unique capability of the physician receiving care, both physicians—the one receiving and the one providing care—can openly discuss their roles, including

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OCCUPATIONAL PTSD

Identifying and Caring for the Vicariously Traumatized Physician

Kimberlee A. Sorem, MD, MA

The culture of medicine places a low priority on physician mental health. Despite the known high levels of stress present in many fields of medicine, for example obstetrics, the significant personal and actual costs of psychological impairment are frequently minimized. Depression, for example, is associated with increases in a number of physical diseases and is a leading cause of disability. Furthermore, the costs to society in terms of reduced physician productivity and even medical errors by physicians working under physical, emotional, and financial stress may be quite high.¹

According to the Association of American Medical Colleges, in 2013 the cost of educating a physician, including premedical education and loan repayment (but not including lost income from other career paths that require fewer years of training) was approaching \$1,000,000 per physician. Physicians who cut short their careers (either by leaving medicine for another career or by giving up working altogether), become mentally or physically disabled, or, in extreme cases, commit suicide represent incalculable losses.

Occupational posttraumatic stress disorder (PTSD) has been reported in the nursing literature, but rarely in the medical literature, and has been alternatively referred to as secondary traumatic stress (STS) or vicarious trauma. STS has been reported as 30 to 35 percent among nurses in labor and delivery,² trauma units,³ oncology units, and pediatric intensive care. This form of occupational PTSD is characterized by a group of emotions and behaviors a person experiences as a result of being exposed to another person's traumatic experience.

Obstetricians and RNs have overlapping experiences of difficult and traumatic births on the delivery suite. The patients themselves are frequently young and mostly healthy, and there is increasing pressure for the "perfect birth experience" (and, naturally, the perfect baby). The practice of obstetrics involves both calculated and unknowable risks. It can be a difficult, complex process, one that will never be error free. Unfortunately, when a birth is traumatic, with or without medical errors, a number of victims emerge: Mother and baby are possible first victims, although family members may suffer STS. The labor and delivery nurse(s) and the obstetrician(s) involved in the traumatic birth may themselves become traumatized and later on are at risk for PTSD. Occupational PTSD involves symptoms that are grouped into three categories: flashbacks, avoidance symptoms (including feeling emotionally numb, depressed, or anxious; having trouble remembering the traumatic event), and hyperarousal symptoms (being easily startled, feeling on edge, having difficulty sleeping).

Virtually every obstetrician has had the sickening feeling that a medical error was either suspected or made in the event of a sick or dying mother or baby. Historically, one famous obstetrical case that changed the course of the English monarchy as well as the

course of modern obstetrics was the "triple tragedy" involving the death (in 1817) of the only heir to the throne, Princess Charlotte, following the delivery of her stillborn son, and the subsequent suicide of the obstetrician Sir Richard Croft. Although the princess died of postpartum hemorrhagic shock, it was the physician who had to deal with unrelenting and intense public scrutiny. His humiliation and severe self-reproach ultimately led him to commit suicide.

Another physician reflecting on his own mistake (a medical error) stated it thus:

"It is a crime. I'm not sure how it gets translated that way, but it is. Medicine has always had this very high ethical standard, and to fail that standard is to be guilty. There's some anonymous court someplace—I mean Osler or God somewhere at Massachusetts General Hospital—and you've been convicted and tried at the same time" ("The Heart of Darkness: The Impact of Perceived Mistakes on Physicians").⁴

Physicians are an often-overlooked at-risk group for development of STS. One account of the process that follows an adverse medical event described it in six stages: 1) chaos and accident response, 2) intrusive reflections, 3) restoring personal integrity, 4) enduring the inquisition, 5) obtaining emotional first aid, and 6) moving on.⁵ Those who require more than a bit of emotional first aid may benefit from a more in-depth response to their suffering.

Left untreated, physicians with STS may experience increased rates of substance abuse, depression, anxiety, insomnia, poor physical health, relationship discord, and even suicide.

The Joint Commission on Accreditation of Healthcare Organizations reported in 2007⁶ that among 2,909 physicians who reported involvement with a harmful medical error or near miss, 61 percent increased their anxiety about potential future errors, 44 percent reported less job confidence, and 42 percent reported increasing difficulty with sleep. Of this cohort, 90 percent reported inadequate support from hospitals and health care organizations. Although 81 percent reported that they were very interested in counseling, many felt that barriers to counseling were significant and included difficulty taking time off work, concerns about confidentiality if the physician were sued, and concern that counseling would affect malpractice costs. It is critical that when physicians experience depression, anxiety, or sleeplessness following an adverse event, these more troubling signs of STS are attended to. Failure to adequately respond to any level of physician distress not only decreases patient safety but also delays treatment of the physician, potentially more refractory or harmful.

As physicians themselves become patients struggling with

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PTSD, anxiety, insomnia, and depression, the imperative to identify, destigmatize, and treat becomes strong. Sadly, although there have been significant advances in the treatment of depression, the incidence of depression among physicians has actually increased. Physicians seek treatment at a lower rate than the general public, while struggling with increased comorbidities and suicidality at a higher, and unacceptable, rate. In fact, female physicians die by suicide at a rate four times higher than that of females in other professions.⁷ Given the high stress and long hours of work, with a baseline rate of depression at about 19 percent, recognition of STS and options for stabilization and healing are paramount.

According to Leilani Schweitzer, a mother who lost a child to medical error in a pediatric ICU, the death was a “full stop” for the patient, but a “terrible beginning—slow, painful, and toxic” for the survivors. She described a memory of her child’s ID band at the time of death, and she imagined “new ID bands being given to the health care team” that day, the day that they too became patients, struggling with a Medusa-like disorder called occupational PTSD or secondary traumatic stress.

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how the physician as patient or family member can be useful to the physician as care provider and to the entire health care team.

In 1926, Francis Peabody educated Harvard students and many of us afterward with his statement, “The secret of the care of the patient is caring for the patient.” I have taken the liberty of modifying that quote for physician-teachers: “The secret of the care of the patients is caring for the professionals who care for the patients.” And for the purpose of this article: “The secret of caring for professionals whose loved ones are patients is to care for the professional by incorporating his or her views into the care of their family member.”

It is truly an honor to care for our colleagues and their family members, to be the doctor’s doctor. However, it can be a challenge to do so in an effective, successful, and consistently gratifying way. By taking the initiative to overtly incorporate the physician as patient or family member as a contributing team member, I believe care providers can effectively reduce communication barriers, and thereby reduce, if not prevent, feelings of imposition, frustration, anger, and fear from the physician-physician interaction. We hope for this for all patients. Our colleagues deserve no less.

Dr. Skeff is the George DeForest Barnett Professor of Medicine at Stanford University. He received his MD degree from the University of Colorado, completed his residency and his fellowship in general internal medicine at Stanford University, and completed a PhD at the Stanford School of Education. He has served as vice chair for education and was the residency program director for two decades in the Stanford Department of Medicine. He and colleagues founded the Stanford Faculty Development Center for medical teachers, a train-the-trainer program developed to assist medical faculty nationally and internationally to improve their teaching effectiveness. He has received local and national awards, including the AAMC Robert Glaser and Abraham Flexner awards, as well as awards from the Society of General Internal Medicine and the Association of Program Directors in Internal Medicine. He is currently a regent and a master of the American College of Physicians.

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SUSTAINABLE MEDICINE

Preventing Physician Burnout

David Pating, MD

No doubt about it, health care reform is changing the practice of medicine. According to Harvard's health policy guru, Dr. Atul Gawande:

We are at a cusp point in medical generations. The doctors of former generations lament what medicine has become. If they could start over, the surveys tell us, they wouldn't choose the profession today. They recall a simpler past without insurance-company hassles, government regulations, malpractice litigation, not to mention nurses and doctors bearing tattoos and talking of wanting "balance" in their lives. These are not the cause of their unease, however. They are symptoms of a deeper condition—which is the reality that medicine's complexity has exceeded our individual capabilities as doctors.¹

Dr. Gawande suggests that physicians take a step back to look at new ways to do medicine, suggesting that medicine needs fewer "cowboys and more pit crews." Personally, I don't know about you, but being on a pit crew seems as frightening as being a rodeo rider—neither offers a vision for a "sustainable" practice of medicine.

It is no wonder, then, that many physician colleagues are grumbling about the stress of medicine—and in recent studies, up to 40 percent of physicians report feeling "burned out."² Burnout, stress, and depression among physicians are becoming more common. In some studies, up to 12 percent of men and 18 percent of women physicians are affected by depression. And we already know from a generation of studies about residents in training that 30 percent of residents are affected by depression and one out of every medical school class dies by suicide. While I am a big fan of health care reform, I hope that the enormous change it entails does not push our physician colleagues off a cliff.

For this reason, I have been very proud to work with the California Public Protection and Physician Health (CPPPH) program in its attempts to develop a comprehensive referral and assessment program for physicians needing help. CPPPH was established in 2009, following the closure of the Medical Board of California's diversion program in 2007. At that time, four organizations (CMA, CHA, CSAM, and CPA) came together to establish an alternative physician health program to meet the needs of physicians with health concerns. Under CPPPH, standards of care for the assessment and evaluation of physicians have been created. CPPPH has also provided trainings to many hospital and county medical societies on the responses to a physicians with health problems, including stress, burnout, depression, substance abuse, and other medical conditions, which may diminish our capacity to practice effectively.

Currently, CPPPH sponsors workshops three times a year in four regions of California, and in addition has established a network of medical school well-being committees, published guidelines for evaluation and management of physician health issues, and produced an e-newsletter about current topics related to physician health that is distributed to this growing network. CPPPH

is also working with other California health care organizations to secure legislation to establish a comprehensive statewide physician health program to assure that California has the healthiest and most sustainable physician workforce.

A career in medicine is a long-term investment, more like running a marathon than a 100-yard sprint. As we participate in the dash to cross the health care reform finish line, we must remember that this is just one leg in our broader efforts to provide excellent patient care. This message is particularly important for young physicians who may have another thirty years of practice ahead of them. If we are to keep our physicians healthy over the long term, we must invest as a society by supporting our physician workforce in ways that will help them achieve good working conditions, work-life balance, and, most important, offer some support and help when they complain of stress and burnout.

CPPPH believes that with coordinated efforts by physicians, medical societies, hospital and university well-being committees, and the Medical Board, policies can be established to keep the practice of medicine sustainable. For Californians, I hope we all hear this message—and understand that healthy physicians produce sustainably good-quality treatment results.

David Pating, MD, is chief of addiction medicine at Kaiser, San Francisco, and treasurer for CPPPH. For more information about CPPPH and physician health resources, see <http://cppph.org/>.

Identifying Burnout³

- Overwhelming physical and emotional exhaustion
- Feelings of cynicism and detachment from the job
- A sense of ineffectiveness and lack of accomplishment
- Overidentification
- Irritability and hypervigilance
- Sleep problems, including nightmares
- Social withdrawal
- Professional and personal boundary violations
- Poor judgment
- Perfectionism and rigidity
- Questioning the meaning of life

References

1. Gawande A. Cowboys and pit crews. *The New Yorker*. May 26, 2011.
2. Balch CM, Freischlag JA, Shanafelt TD. Stress and burnout among surgeons—understanding and managing the syndrome and avoiding the adverse consequences. *Arch Surg*. 2009; 144(4):371-376.
3. Adapted from Kearney MK. Self-care of physicians caring for patients at the end of life. *JAMA*. 2009; 301:1155-1164.

MEDICAL COMMUNITY NEWS



KAISER
Robert Mithun, MD

As providers at Kaiser Permanente, we strive not just to take excellent care of our patients but also of ourselves. In order to be the most effective physicians that we can be, we need to be aware of issues related to our own physical and emotional well-being.

Several Kaiser Permanente physicians participated in a workshop called "Doctors Treating Doctors," which gives physicians the opportunity to discuss sensitive communication issues that can arise when caring for a physician colleague. Raising awareness and developing communication strategies around this sensitive interaction, when doctors take care of other doctors, is one of the main purposes of the workshop.

Another focus of the workshop is to assist physicians in becoming more comfortable when seeking care from other providers. One of Kaiser Permanente's organizational goals is for all physicians to have a personal physician from whom they receive appropriate health care, and this includes preventive care. We want to ensure that physicians are not avoiding medical care because they have anxiety or feel awkward when seeking care from colleagues.

One aspect of the workshop includes a discussion entitled "The Elephant in the Room," which explores a variety of issues related to the questions, concerns, and anxieties of physician-patients and the physicians who provide care for their colleagues. The workshop provides a safe place where people can feel comfortable raising personal and sensitive issues. Because physicians feel they are in a safe environment, where confidentiality is respected, it is not uncommon to hear stories about the challenges and benefits of taking care of physician colleagues and also their family members.

Physicians can be quick to overlook their own health care needs when consumed with caring for their patients, but it's vitally important for them to address their own health so that they can continue to provide the excellent care they do at Kaiser Permanente.



SFVAMC
Diana Nicoll, MD,
PhD, MPA

There have been several recent important clinical appointments at San Francisco VA Medical Center.

Ken McQuaid, MD, chief of Gastroenterology, has been appointed chief of the Medical Service and vice chair of the UCSF Department of Medicine.

Hubert Kim, MD, PhD, chief of Orthopedic Surgery, has been appointed chief of the Surgical Service and vice chair of the UCSF Department of Orthopedic Surgery. He holds the James O. Johnston Endowed Chair in Orthopedic Surgery.

Shirley Pikula, RN, MSN, MS-HSA, is our new nurse executive. She transferred from the VA Medical Center in Bath, New York.

Wafa Samara, PharmD, has joined SFVAMC as associate medical center director. She recently served as associate chief of Pharmacy and acting associate director at the VA Northern California Health Care System in Sacramento, California.

Our medical center director, Bonnie Graham, MBA, joined us in September 2013. She was previously associate director at the VA Pittsburgh Health Care System and deputy director of the VA's Office of Patient-Centered Care and Cultural Transformation.

Gita Uppal, MPH, FACHE, is executive assistant to the Medical Center director. She was most recently the director, Policy Analysis, within the VHA Office of the Assistant Deputy Undersecretary for Health and Policy Planning in Washington, D.C., working on the Affordable Care Act.



UCSF
Michael Gropper,
MD

Life today is challenging for most of us due to the pressures of work demands, financial difficulties, emotional stress, family concerns, and health issues. As the only institution in the ten-campus University of California system devoted exclusively to graduate education in the health and biomedical sciences, we at UCSF see up close how these stressors can acutely affect physicians. We also are keenly aware that, left unchecked, these work/life issues can have a direct effect on the care we provide our patients. The growing prevalence and awareness of workplace violence, and the roles that stress and mental illness play in this phenomenon, also compel us to provide a safe, free, and confidential place for our physicians to seek help for the wide range of issues that can affect their personal and professional lives.

The Faculty and Staff Assistance Program (FSAP) at U.C. San Francisco is that place, providing counseling, coaching, and referral services to assist our physicians, and all UCSF employees, in managing the challenges of daily life. Being part of the campus community, the FSAP team, led by clinical psychologist Andrew Parker, PhD, fully understands the unique, often intense, environment here. Be it a resident and spouse faced with the tensions of long hours apart in a new city, an attending physician dealing with difficult work relationships, or the myriad issues involved when a physician demonstrates signs of impairment, FSAP's psychologists provide individual counseling that protects both our patients and our physicians.

In addition to individual counseling, FSAP provides professional organizational consultation services to managers and supervisors. These services are based on the principles of organizational psychology and behavior and are designed to restore or enhance the functioning of employees in their jobs and to strengthen the organization itself. The services FSAP provides have truly saved many careers and many lives. For more information on our program, visit <http://ucsfhr.ucsf.edu/fsap>.



CPMC
Edward Eisler, MD

Congratulations to Robert Kahn, MD, who has been reappointed as chair of the Department of Urology for a second five-year term.

CPMC has reached its first major construction milestone for its Van Ness and Geary campus with completion of the demolition of the Cathedral Hill Hotel (formerly Jack Tar). The demolition began last fall and generated 56,000 tons of debris in steel and concrete that has been hauled away to Bay Area material recycling centers. Both the Van Ness and Geary and the St. Luke's campuses are scheduled to open in 2019. The construction site will now undergo excavation to prepare the foundation for the new twelve-story hospital. Excavation will reach a level of thirty feet below grade at Van Ness and Geary and seventy feet below grade at Franklin and Geary. The schedule calls for excavation to be complete in November, with foundation work beginning immediately thereafter.

CPMC has been identified by the Scientific Registry of Transplant Recipients (SRTR), in its 2014 Annual Data Report, as the nation's only hospital with both kidney and liver transplant programs that have higher-than-expected one- and three-year adult patient survival rates. The term "higher-than-expected" refers to adjustments for various patient risk factors that help registry experts measure outcomes equally to create the ranking. CPMC conducts approximately seventy liver and 200 kidney transplants per year. At CPMC, 97.4 percent of liver patients survived one year after transplant, compared to the expected 89.3 percent. CPMC also saw 98.4 percent of kidney patients survive one year after transplant, compared to the expected 96.6 percent. SRTR is an organization that supports ongoing evaluation of organ transplantation in the United States and publishes data for transplant center programs around the nation. It allows online comparison of programs' risk-adjusted performance and survival rates on a regular basis.



ST. MARY'S
Robert Weber, MD

All of us at St. Mary's are excited about the continued growth of our Sister Diane Grassilli Center for Women's Health. On May 20th, we opened our doors to office managers and clinical staff so they could become more familiar with all of the services our Center offers.

In a recent column for this publication, I referenced the new GE somo•v Automated Breast Ultrasound (ABUS) system. St. Mary's was the first hospital in San Francisco to implement this state-of-the-art 3D imaging technology. In the past couple of months, the Center for Women's Health has expanded to include a Genetics Counseling Program as well as an Incontinence Center.

Since opening last year, we are proud of the growth in services we've seen in our Center. In the coming months, expect to see more and more events take place there as we look to educate physicians and medical staff on what our women's health program has to offer.

We continue to be so proud of the quality and safety achievements of St. Mary's over the past few months. In April, we were once again recognized by Leapfrog with an "A" grade for hospital safety, the highest score possible. This is the second consecutive quarter St. Mary's has received such an honor.

This accomplishment goes on top of everything else St. Mary's has achieved since January. To review, we received the Distinguished Hospital Award for Clinical Excellence from Healthgrades, ranking us among the top 5 percent of hospitals nationwide. And just prior to that, St. Mary's was honored as being of the country's top 100 hospitals for orthopedic services, stroke care, gastrointestinal care, and general surgery.

I believe these honors are reflective of the conscientious efforts of our doctors, nurses, and caregivers. We strive to provide the best possible patient care and patient experience, and I highly commend our staff for these recognitions.



SAINT FRANCIS
Robert Harvey, MD,
MBA

Saint Francis is excited to announce the appointment of Jim Houser as our hospital's new interim President and CEO, effective May 5, 2014. Jim has a wealth of leadership experience in the healthcare field, and he is currently the Principal of Houser and Company, LLC.

Jim has served as the president and CEO at St. Thomas Health Services in Nashville, Tennessee, and the executive vice president/chief operating officer at St. Vincent Health in Indianapolis. He has also held several leadership positions for the St. Joseph Health System in Southern California. So we are in very good hands with Jim at the helm.

I'd also like to thank Dr. Hugh Vincent for his fantastic work serving in the Presidential role over the past three months. His guidance and hard work help keep us moving in the right direction.

Here's some very good news from our system all of us at Saint Francis were happy to hear: As a result of a reduction in readmissions and hospital-acquired infections, Dignity Health hospitals positively impacted more than 10,000 patients and saved an estimated \$30 million from January 2012 through December 2013.

Our success level was so high, in fact, that the U.S. Department of Health and Human Services named Dignity Health as one of its Partnership for Patients' Hospital Engagement Networks for a third consecutive year to continue implementing changes that improve health care. We were one of only 26 health systems in the nation to receive status as a Hospital Engagement Network.

At Saint Francis, we are enthusiastic and passionate about providing the highest quality and safest patient care for everyone who comes through our doors. When we receive news such as this, it favorably demonstrates our staff's hard work. I commend everyone for these outstanding efforts.

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Sutter Pacific
Bill Black, MD, PhD

Telehealth, or technology-enabled health care services, has been an effective tool at Sutter Pacific Medical Foundation. Our Stroke Telemedicine program, based at California Pacific Medical Center, has made it possible for hundreds of stroke patients at small community hospitals to receive expert advice, diagnosis, and a treatment plan from our trained team of neurologists at SPMF.

Dr. David Tong, medical director of the CPMC Stroke Program, started the telemedicine program in 2006. Today, approximately twenty hospitals in communities from the Oregon border to Visalia, California, are part of the program. By using one-on-one video consultation, Tong and other SPMF stroke neurologists recommend care for any patient presenting in the local ER of a participating hospital with a stroke or stroke-like symptoms. The program helps leverage a short supply of neurologists in the profession.

"This is a way of getting highly trained doctors to manage patients in hospitals where there is limited neurological coverage," Dr. Tong says. "Our care is time-sensitive. Everything must be done quickly."

The program benefits patients and also makes health care delivery more efficient. About 20 percent of patients evaluated in the program end up coming to CPMC for complex interventions. But the majority can be treated effectively at the local hospital, a convenience for the patient and the participating hospital. Dr. Tong shows in a recent study of 500 patients, that the outcomes for patients are the same, whether treated at the local hospital through the telemedicine program or at CPMC, a certified primary stroke center.

Telehealth is another way to serve our communities, and it presents new opportunities that physicians need to consider. Sutter Health recently invested in MDLIVE, which gives consumers with nonemergency medical problems direct access to doctors via telephone, e-mail, and videoconference. Sutter-affiliated physicians will be working together and with MDLIVE to determine how to best integrate telehealth services into our medical practices and systems of care.

Communicable Disease Update from SFPDH

Invasive Meningococcal Disease: Vaccination Recommendations for Certain Men Who Have Sex with Men

In April the Los Angeles County Department of Public Health (LAC-DPH) reported an apparent cluster of invasive meningococcal disease (IMD) in men who have sex with men (MSM); during the first quarter of 2014, MSM represented four of eight total cases. In response, LAC-DPH recommends meningococcal vaccination for MSM in Los Angeles who are HIV-positive or whose activities (close or intimate contact with multiple partners, seeking partners via digital applications, sharing cigarettes or using illicit drugs) increase their risk of infection.

San Francisco has had no cases of IMD in MSM since 2011. For MSM living in San Francisco who expect close or intimate contact with MSM from Los Angeles County, San Francisco Department of Public Health (SFPDH) recommends that medical providers:

- Offer meningococcal vaccine to San Francisco MSM and M-to-F transgender persons, regardless of HIV status, who expect close or intimate contact with MSM currently residing in, or traveling from, Los Angeles County. To achieve protection, vaccination should be completed at least 7–10 days prior to potential exposure. HIV-positive individuals require a two-dose primary series with a meningococcal conjugate vaccine (Menactra or Menveo).
- Remind patients that vaccination is not 100 percent effective, and that MSM wishing to further reduce their risk of contracting IMD should consider avoiding contact with oronasal secretions from other persons, especially persons not well known to the individual.
- Report suspected or confirmed meningococcal disease immediately to SFPDH Communicable Disease Control Unit (CDCU) at (415) 554-2830. Do not wait until the diagnosis is culture-confirmed.

For more information, go to sfcdcp.org/healthalerts.html.

MERS-CoV: First U.S. Case Reported in Early May in Indiana

Middle East Respiratory Syndrome Coronavirus (MERS-CoV) is a novel coronavirus that causes severe respiratory illness with a high mortality rate. The illness is transmissible between humans, though sustained human-to-human transmission has not occurred. The first case of MERS-CoV infection in the United States, identified in an individual recently arrived from Saudi Arabia, was confirmed by the CDC on May 2, 2014. As of May 2, 2014, a total of 401 confirmed MERS-CoV cases have been reported worldwide. All reported cases have originated in the Arabian Peninsula, with imported cases occurring in Europe, North Africa, and now the United States. The CDC has posted case counts, clinical and laboratory guidance, questions and answers, and additional information at cdc.gov/coronavirus/mers/index.html.

Clinicians should consider the diagnosis of MERS-CoV in patients with severe respiratory illness and a compatible travel history. For more information, go to sfcdcp.org/healthalerts.html.



SAVINGS OF OVER \$95,000

The Medical Injury Compensation Reform Act (MICRA) is California's hard-fought law to provide for injured patients and stable medical liability rates. But this year California's trial lawyers have launched an attack to undermine MICRA and its protections, and we need your help. Membership has never been so valuable!

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San Francisco Physicians Are Saving an Average of \$95,088 This Year

Are you a SFMS-CMA member?

2012 SAN FRANCISCO MICRA SAVINGS CHART

	General Surgery	Internal Medicine (Non-invasive)	OB/GYN	Average
San Francisco	\$26,612	\$7,392	\$36,964	\$23,656
Miami & Dade Counties, FL	\$190,088	\$46,372	\$201,808	\$146,089
Nassau & Suffolk Counties, NY	\$127,233	\$34,032	\$204,684	\$121,983
Wayne County, MI	\$121,321	\$35,139	\$108,020	\$88,160
FL-NY-MI Average	\$146,214	\$38,514	\$171,504	\$118,744
MICRA SAVINGS	\$119,602	\$31,122	\$134,540	\$95,088



San Francisco Medical Society
1003 A O'Reilly Avenue, San Francisco, CA 94129
Phone: (415)561-0850 • Fax: (415)561-0833

* Medical Liability Monitor - Annual Rate Survey Issue, Vol. 37, No. 10, October 2012. Annual rates with limits of \$1 million/\$3 million.

TEN QUESTIONS

SFMS Member Profile: Judith Martin, MD

The San Francisco Medical Society is launching a new member spotlight column to feature profiles of leading stakeholders from the medical community and to get their personal views on medicine. We hope to showcase members from across the SFMS spectrum to reflect the rich tapestry of our membership and help highlight some of the great work of our community.

1. What's the biggest barrier to practicing medicine today?

For those of us working in the “safety net,” this year is a time of opportunity and expansion. Many persons who were previously uninsured now have benefits. A big challenge is the fractured funding streams that get in the way of integrated care. Mental health, substance use, and primary care each have their own certifications and eligibility, and even when the patient interface may be provided as seamlessly as possible under the same roof, there are administrative silos that get in the way.

2. If you could change or eliminate something about the health care system, what would it be?

Professional turf issues. Team care works best for patients with complicated chronic conditions. We are not very good at working as a team.

3. Why are you a SFMS member?

I am interested in the leadership that SFMS provides to CMA on policy issues.

4. What advice would you give to a medical student or resident just starting out today?

Part of your job as a medical student or resident is to figure out where you fit best in a complicated field. Of course, part of this is finding what you are good at, but also finding the kind of work that draws you, that you want to dive into, that feeds you in ways that may not have anything to do with the pay scale.

5. What's the best piece of advice you've gotten in your career so far?

Practice what you preach. Stay healthy.

6. What is the most rewarding aspect of being a doctor?

Hearing people's stories. I especially like to hear how patients have managed their health problems. For example, how they remember to take their pills, what they do to relax, how they know when they are getting worse. Everybody is different.

7. What is the most memorable research published since you became a physician?

I'm pretty old, so there have been many milestones. Prochaska, DiClemente, and Hall published a prospective study of how people intentionally change their behavior and how to intervene at each “stage of change.” Their work changed how we approach addiction treatment—and is now used in other forms of health behaviors. So, sometimes I say that in the 1990s it became outdated to scold patients; it was no longer evidence-based to do so.

8. What is your advice to other physicians on how to avoid burnout?

I don't like the metaphor of being a candle or some kind of combustion that burns out. I do get exhausted, but for me the problem is a kind of hunger that leads to impatience and irritability. So, based on my experience, I would say do things that feed you as a person, that you emerge from refreshed, happy, and with a kind of satisfaction.

9. Do you have a favorite hospital-based TV show?

I don't like hospital drama shows. I like plot-driven drama about other professions, but I walk out of the room if I hear “clear” or “stat” or “diagnosed.”

10. If you weren't a physician, what profession would you like to try?

I would be a librarian.

Judith Martin, MD, is an addiction medicine physician who has worked with opioid-addicted patients and their families for more than twenty years. She has provided training about methadone and buprenorphine treatment of addiction to physicians and clinic staff from many states.

Dr. Martin is medical director for Substance Abuse Services at the San Francisco Department of Public Health's Community Behavioral Health Services, where she works on integrated care issues in mental health, primary care, and addiction medicine.

Dr. Martin is a past president of the California Society of Addiction Medicine (CSAM) and currently serves on the board of the American Society of Addiction Medicine. She has also participated in the National Institute of Drug Abuse (NIDA)'s Clinical Trials Network (CTN) on multisite research studies of treatment of opioid dependence and cocaine dependence.

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REQUIRED

- Graduate of accredited school of medicine or osteopathy
- Unrestricted California medical license
- Internal medicine or family practice board certified (or board eligible and board certified within 6 months of hire)

PREFERRED

- Experience serving LGBTQ populations
- Experience in a college health setting
- Strong technology skills
- Public speaking skills to conduct primary care outreach/education

The Sister Mary Philippa Health Center at St. Mary's Seeks a Rheumatologist

Seeking rheumatologist interested in attending the Rheumatology Clinic twice a month. Sessions last 3 hours and patients are seen with Internal Medicine residents. Our medical home provides comprehensive care to an underserved, multiethnic population. Please contact Dr. Ingrid Block-Kurbisch at (415) 750-5890.

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(M/Tu/Th) at 2100 Webster Street, Suite 506, to share with Board Certified Plastic Surgeon. 1795 square feet, private MD office, 2 examination rooms, consultation room, recently renovated front office. Contact info@drkarenhorton.com for details.

6/20: Billing and Coding—Basic Training | 9:00 a.m. to 4:00 p.m. | ACCMA Office, Oakland

SFMS has teamed up with ACCMA and nationally recognized trainer Mary Jean Sage to offer a six-part series that provides solid training in billing and coding through a manageable sequence of seminars and webinars. Participants attend a "Basic Training" seminar at the ACCMA Office, followed by five in-depth online webinars scheduled throughout June, July, and August. The training is \$249 for SFMS members and at \$499 for nonmembers. For more information, contact Dennis Scott at dscott@accma.org or (510) 654-5383.

6/23–6/27: Forty-Second Annual Advances in Internal Medicine Course | UCSF Parnassus Campus

Now in its forty-second year, this course reviews the most recent developments and current controversies in the field of internal medicine. Designed for practicing internists, family practitioners, and other primary care health professionals, it is also appropriate for hospitalists. For more information, visit <http://www.ucsfcmc.com/2014/MDM14M20/info.html>.

7/4–7/6: Overeaters Anonymous Convention | Hyatt Regency San Francisco Airport

It is a weekend of recovery from compulsive eating and a great way for SFMS physicians and their patients to learn about the resources available through Overeaters Anonymous. There are a limited number of comp registrations for medical professionals, which can be obtained by emailing PIPOC@oasf.org.

9/8: SFMS General Meeting | 6:00 p.m. to 7:30 p.m. | Commodore Room inside the Golden Gate Yacht Club

Calling all SFMS members! Save the date for SFMS' General Meeting. The event is a good opportunity to network with colleagues, meet with SFMS leadership, and learn firsthand the issues SFMS and CMA are advocating for on behalf of physicians and their patients in San Francisco and California. Dinner will be provided. Detailed information is available at <https://www.sfms.org/Events.aspx>.

9/20: Zero Prostate Cancer Run/Walk | 9:30 a.m. | Crissy Field, San Francisco

Join SFMS physician members from Golden Gate Urology for the second annual Zero Prostate Cancer Run/Walk. This tight-knit community activity brings together athletes, doctors, cancer survivors, and those who care about them to end prostate cancer. Visit <http://bit.ly/1u0RQ9G> for more information on how to get involved.

Complimentary Webinars for SFMS Members

CMA offers a number of excellent webinars that are free to SFMS members. Members can register at www.cmanet.org/events.

July 16: Recipe for Financial Success: Key Steps to Increasing Your Net Income • 12:15 p.m. to 1:15 p.m.

July 30: What to Expect from a Medi-Cal Audit • 12:15 p.m. to 1:15 p.m.

July 31: HIPAA Breach Notification and California Requirements • 12:15 p.m. to 1:15 p.m.

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Robert W. Osorio, M.D., FACS,
Chairman, Department of Transplantation



Surpassing national expectations is how we help you surpass yours.

At Sutter Health, we believe healthcare is better when patients come first. And now we have proof. A third-party report just found that our adult liver and kidney transplant programs at California Pacific Medical Center in San Francisco were unmatched by any other in the country.* So we'd like to congratulate CPMC's transplant staff and thank our patients for putting their trust in us. Together, we're making healthcare better. That's how you plus us and we plus you.

Learn more at [CPMC.org](https://www.cpmc.org)

*Based on risk-adjusted survival rates published annually by the Scientific Registry of Transplant Recipients, CPMC was the only transplant program in the U.S. with better than expected survival following both liver and kidney transplants in adults.

