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Doctor, What's the Story?

Tips for talking to the media



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Patient Handoff
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Reframing the
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Tackling a Taboo—
Talking About Burnout



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DECEMBER

2011

CONTENTS

Winner of 6 MMPA Excellence Awards



p. 22

COVER STORY

Doctor, What's the Story?

| By Kate Ledger

Saving lives and treating disease may be all in a day's work for physicians. But for many, talking to the media can be unnerving.



PULSE

6 Rare Encounter | By Suzy Frisch
Women who met online have challenged researchers to study their condition.

9 Reframing a Conversation
| By Carmen Peota
Nephrologists rethink how to talk to older, sicker patients about dialysis.

12 Too Much Information | By Kim Kiser
With new studies and guidelines coming out by the minute, how can docs keep up with the latest in their field?

14 What Breaks the Bond? | By Kim Kiser
A look at two trends that are chipping away at the physician-patient relationship.

15 Family Medicine's Fan Club | By Carmen Peota
Medical students are the specialty's biggest boosters.



BOOK REVIEW

29 Deciding Factors | By Charles R. Meyer, M.D.
Physician authors explore the complexities behind patients' medical decisions.

PERSPECTIVE

30 The End of the Medical Deity | By Therese Zink, M.D., M.P.H.
Deciding what's right for a patient is no longer about bringing them around to the doctor's way of thinking.

32 Parallel Worlds | By Fran Lebajo Wu
A medical student discovers threads of her own story in that of an immigrant patient.

COMMENTARY

34 Tackling a Taboo | By Patricia J. Lindholm, M.D.
The first step toward alleviating burnout is talking about it.

36 The New Language of Medicine | By Pamela Hartzband, M.D., and Jerome Groopman, M.D.

Terms from commerce have found their way into medicine. How will this affect the next generation of doctors?



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- 16 MMA in Action
- 17 Meet a Member: David Johnston, M.D.
- 18 MN Supreme Court Rules on Newborn Screening Samples
- 19 Minnesota Resolutions Move Forward at AMA Meeting
- 20 Alexandria Surgeon Gets MMA Quality Award
- 21 Viewpoint: Improvement also Applies to Quality Improvement

CLINICAL & HEALTH AFFAIRS

38 Inaccuracy in Patient Handoffs: Discrepancies between Resident-Generated Reports and the Medical Record

| By Michael J. Aylward, M.D., Tyson Rogers, M.S., and Peter G. Duane, M.D..

43 Meeting the Needs of Somali Patients at the End of Life

| By Keith M. Swetz, M.D., Abdi A. Jama, M.D., Onelis Quirindongo-Cedeno, M.D., and Lena Hatchett, Ph.D.

47 Whose Best Interest? | By Ryan M. Antiel, M.A., Jon C. Tilburt, M.D., M.P.H., Fredric W. Hafferty, Ph.D., Michael D. Brennan, M.D., And Paul S. Mueller, M.D., M.P.H.

50 Talking to Sexually Abused Children: Tips for Physicians

| By Kathleen McDowell, M.A.

END NOTES

64 How Do I Help You Understand? | A poem by Michelle Huysler

ALSO INSIDE

- 4 Editor's Note
- 53 2011 Index
- 58 Index of Advertisers
- 58 Employment Opportunities

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Photo by Scott Walker

Working with Words

For the practicing physician, a day can become a flurry of words sent by more media than Morse or Marconi could have imagined.

“**W**ould you get that?” I ask my wife as our home phone rings. It’s 6 p.m., and I’m home and not on call. There are some days when one more phone call, even if it involves telling a solicitor “No thanks,” is one too many. I realize I’ve been communicating for the past 10 hours—talking to patients in the hospital, in the office, and on the phone; talking to my office staff and partners; responding to faxes and emails—and communication fatigue has set in. I feel like Hal Holbrook finishing his one-man Mark Twain show.

Yet I feel guilty. All that conversation is important, part of the job, what I signed up for. And the topics I’ve covered are important. I’ve explained the rationale for statin therapy to a man with high cholesterol. I’ve discussed a move to assisted living with a patient and her family, trying to “spin” the idea by explaining that her family and I know the decision is the right one. After gathering information about biopsies and scans for a patient with colon cancer, I’ve tried to provide him with some perspective about the recommendations he’s heard from the surgeon and the oncologist. And I’ve discussed with a patient why there isn’t really a good reason to do CT scans of her entire body to look for cancer. During a 10-hour day, I have gone from playing educator to mediator to translator to debater—a tiring assignment for any actor.

And for doctors, communication isn’t just talking anymore. We can email patients with advice and reports. We can text our colleagues about patient handoffs and requests. We can tap social media to reach out to patients and other professionals. For the practicing physician, a day can become a flurry of words sent by more media

than Morse or Marconi could have imagined. Given how important communication is for physicians, it is surprising how little time is devoted to teaching it during medical training. Traditionally, medical schools have chosen students by the cut-and-dried calculus of their MCAT score, GPA, and aptitude for science. Speaking or writing skills are rarely considered. As a result, medical students and medical school graduates sometimes have difficulty writing declarative sentences much less a paragraph with logic that flows. Writing clearly doesn’t necessarily predict the ability to explain clearly, but it helps. Although some may demean such skills as mere fluff for doctors, they are indispensable tools of medical practice. Communication, not anatomy, physiology, pathology, or pharmacology, is the basic science of medicine.

Unfortunately, it is a science that is hard to teach, although our medical institutions are trying. Using videotaped student-patient encounters and instruction on mindfulness, many medical schools are attempting to train future doctors to not just absorb facts but to listen to people, whether they’re patients, partners, or colleagues. They realize that what a doctor misses could mean the difference between life and death. Communication is two-way for physicians no matter what role they are playing.

It all does seem so basic, listening. Open up the ears and the brain and try to understand what the other person is saying or writing or even what they’re not saying, which is sometimes more important. All so basic, and all so tiring.

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Charles R. Meyer, M.D., editor in chief, can be reached at cmeyer1@fairview.org



Stephen Voss for The Wall Street Journal

■ Social Networking

Rare Encounter

Women who met online have challenged researchers to study their condition. | BY SUZY FRISCH

In 2003, just two months after the birth of her second son, Katherine Leon experienced crushing chest pain and found herself fighting to breathe. Leon, who was 38 at the time, thought she was having a heart attack.

Doctors weren't so sure, however. After a few days of continuing cardiac symptoms, an angiogram revealed that Leon had spontaneous coronary artery dissection (SCAD), a condition in which a coronary artery develops a tear, causing blood to flow between the artery's layers, forcing them apart and leading to a blockage that can induce a heart attack. She immediately underwent double bypass surgery. "It's like being hit by a truck—you've been told that

you're healthy, and you have this condition in spite of doing everything right," says Leon, who is from Alexandria, Virginia. "You think, 'Why me?'"

Getting diagnosed with SCAD, which primarily affects women (70 percent of cases), especially those who are pregnant or postpartum, and can result in a heart attack, arrhythmias, or sudden cardiac death, raised numerous questions for Leon. She was especially concerned about whether she could pass the condition on to her two children. After two surgeries to address complications involving her sternum, she turned to the Internet to perhaps find answers and locate other SCAD survivors.

By 2009, about 85 other sur-

vivors from the United States, Australia, New Zealand, the United Kingdom, and Sweden had congregated on the WomenHeart website. None of them had ever met another person with SCAD. They discovered that their treatments varied widely—some had had bypass surgery, others had stents placed or were taking medication—mainly because no clinical studies on how best to treat the condition had been conducted.

The group puzzled over questions about what causes SCAD, why it primarily affects women, how it can be prevented, and whether it can recur. They also wanted doctors to develop a treatment protocol. As a member of WomenHeart, Leon applied

to participate in the annual WomenHeart Science and Leadership Symposium, one of the leaders of which was Mayo Clinic cardiologist Sharonne Hayes, M.D. Leon decided to approach Hayes about researching SCAD.

"I said, 'I don't think SCAD is as rare as doctors say, and I think someone needs to research it,'" Leon recalls telling Hayes at their initial meeting. She also told Hayes that she had met a number of other women with SCAD online. "She got this look on her face like 'Aha!'" Leon recalls.

Intrigued and impressed with the fact that Leon had access to a group of women who wanted to know more about their disorder, Hayes began looking into the condition herself. A literature search turned up only case reports and case series, with the largest one reporting just 40 subjects. Leon had connections with nearly twice as many women, which prompted Hayes to think about doing her own research.

A Source for Subjects

Hayes and a team of Mayo researchers decided to start by assessing the idea of employing social networking to find patients for a study. They used the WomenHeart site to recruit women who had experienced at least one episode of SCAD and then collected and reviewed their medical records. They also had subjects complete a questionnaire. Within one week, they had the number of volunteers who met their criteria. Hayes and her team published their findings

in the September 2011 *Mayo Clinic Proceedings*, calling the social media methodology a novel way for researchers to find subjects in order to investigate rare conditions. For Hayes, the pilot confirmed that it was feasible to study people who aren't patients at one institution.

Using social media to help identify potential research subjects is a huge step forward, Hayes notes, as two frequent roadblocks to conducting investigator-initiated research are the cost and the challenge of finding willing participants. If patients come together virtually through social media and volunteer to be subjects, it will make studying rare conditions more feasible, she says. After an article about the SCAD project's success appeared in the

Wall Street Journal this summer, Hayes received more than 200 inquiries from SCAD survivors who want to participate in future studies. Additionally, representatives from two other organizations for people with unusual conditions contacted Hayes to learn how to find researchers willing to study those diseases.

Hayes is now leading two more studies on SCAD. One is evaluating the cases of 200 survivors to uncover commonalities. The other involves building a bio-bank of blood samples from 400 patients and family members in hope of finding a potential genetic cause and encouraging research by other physicians.

"If we're not all talking to each other and comparing notes, we're not going to ad-

Friending GI Patients

Several years before Mayo Clinic became a social media juggernaut, a gastroenterologist at Mayo's Jacksonville, Florida, facility started a Facebook page for Mayo patients with Barrett's dysplasia or esophageal cancer. Most had undergone or would soon have endoscopic therapy or esophagectomy, removal of all or part of the esophagus and top of the stomach. The surgery can lead to problems including reflux, difficulty swallowing, nausea, diarrhea, and fatigue after eating, to name a few.

Patients, who could access the page by invitation only, quickly began connecting with one another, sharing tips, providing each other with support, and answering questions that their physicians often could not about what it was like to go through the procedures, according to Herbert Wolfsen, M.D., who created the page in 2008 with the help of his daughter.

He said that in addition to finding answers and support, patients have enlightened physicians about the issues they face and the coping strategies they have adopted. Wolfsen spoke about the Facebook initiative in October at the American College of Gastroenterology's annual meeting in Washington, D.C.

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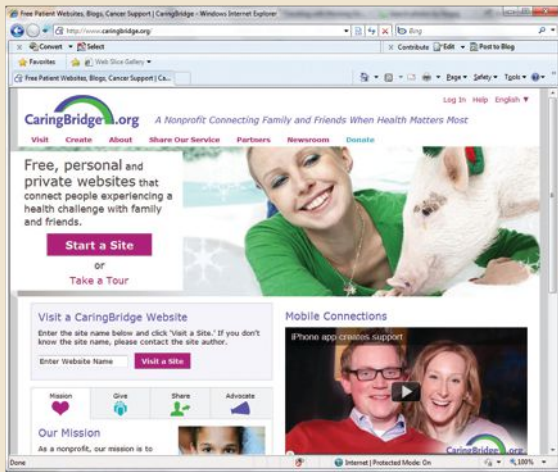
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A Minnesota Original: CaringBridge

Long before the term social media was coined, Sona Mehring created an online community out of necessity. A dear friend had given birth to a premature baby in 1997, and she wanted to help the couple tell family and friends how mom and infant were doing. Mehring, who was working as a website developer at the time, created a site where she could post updates and allow the couple's friends and family to send them messages.

The site Mehring created became a source for news about the couple, who were isolated at the hospital during their daughter Brighid's nine days of life. Just a few weeks after Brighid died, Mehring decided to offer a similar service to others going through health crises, and she launched the CaringBridge website, www.caringbridge.org. She turned CaringBridge into a stand-alone nonprofit in 2002 and today serves as the Eagan-based organization's CEO.

Since 1997, CaringBridge has had nearly 2 billion unique visitors, and about 295,000 people have told their story or the story of a loved one on the site. Each day, half a million people connect on the site. Users have come from every state and 225 countries.

"The idea of bringing people together when they are going through a significant health journey or important life event has always been at the core of what we do," Mehring says. "When someone gets diagnosed with a serious condition, their number of contacts drops by 50 percent. People don't want to bother them or they don't know what to say. CaringBridge compels people to be engaged; it eliminates the idea that I'm bothering them and it empowers them to understand the journey that their loved one is going through." — S.F.

vance the science. I hope through these studies that we better understand the causes and treatments for SCAD," Hayes says.

Social Media Gurus

Using social media to advance medicine is nothing new for Mayo Clinic. In 2010, it opened its Center for Social Media to forge deeper relationships with patients and educate other health care providers and organizations about the most effective ways to use social media.

Most recently, Mayo created online health communities similar to the one Leon joined for more than 50 conditions. People can join for free and share information, read articles, ask questions, and get advice. Being a Mayo patient isn't a requirement. Mayo's goal was to attract 1,000 members to the various communities by the end of 2011. As of October, they had more than 7,500 members, according to Lee Aase, who directs the Center for Social Media.

Aase says the SCAD research project is a great example of how social media can be used in medicine. "Social media is going to affect the way people make medical decisions. It already has," he says. "When people get sick, they go online and look for advice from others and look for in-depth resources. It's making patients empowered."

And in the case of Katherine Leon, it has turned some traditional relationships upside down, enabling patients to partner in research and better participate in their care. Before she approached Hayes about researching SCAD, the disorder wasn't really on anyone's radar.

"We're one of the first groups of patients with a rare disease to come together through social media and go to an institution and say 'We need research done' and have the institution comply," she says. "I couldn't believe it when Dr. Hayes announced Mayo had approved two studies on SCAD." ■



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For some older, sicker patients with renal failure, medical management without dialysis may be the best option.

■ Dialysis

Reframing a Conversation

Nephrologists rethink how to talk to older, sicker patients about dialysis.

| BY CARMEN PEOTA

The patient was 88 years old, had had several strokes, and suffered from dementia when her renal failure reached the end stage. Her nephrologist, Jeffrey Connaire, M.D., recalls telling the woman's adult daughter, who was in charge of her care, that he doubted whether she would do well on dialysis and recommending medication to manage her symptoms as best as possible. The daughter agreed that medical management without dialysis was the better option. That might have been the end of the discussion, but extended family members questioned whether the woman was being offered less-than-optimal care because she was Native American. Connaire found himself involved in ongoing discussions as the family worked through their options.

Connaire, a nephrologist at Hennepin County Medical Center, shares the story as an example of how the decision about whether an elderly person with renal failure should go on dialysis is rarely straightforward. "It always strikes me in these situations that it's easy for someone on a podium to say we shouldn't offer dialysis for 88-year-olds or whatever," he says. "But in reality, you have to treat everybody as an individual and respect their feelings, culture, and social background because

in the end, everybody involved has to be comfortable with that decision."

Connaire says he often finds himself having multiple meetings with patients and family members to explain that dialysis may or may not prolong the patient's life and may or may not help them feel better. "I'm happy to do that," he says, "but it's a lot of effort."

Having a discussion with older patients about whether they should go on dialysis is something he and other nephrologists are doing a lot more these days. And, Connaire says, the conversation is often a difficult one.

The Disconnect

That's largely because there is a mismatch between what patients expect and what nephrologists know about the effectiveness of dialysis. Patients see dialysis as a treatment that will extend life. They know it's covered by Medicare, and they expect it. The 1972 Congressional decision to publicly fund dialysis through Medicare has contributed to the perception that pursuing dialysis is nearly always in the patient's best interest.

Doctors know differently, however. They know the data show that good outcomes for dialysis decline with age. The

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one-year survival rate for 45-year-olds is 90 percent. For 85-year-olds, it's about 57 percent. They also know that good outcomes are less common if elderly patients have comorbidities. Recent research has shown that dialysis may not confer much of a survival advantage in patients who are older than 75 years and have health problems such as diabetes, congestive heart failure, or chronic obstructive pulmonary disease.

Also mounting is evidence that dialysis diminishes the quality of life for certain elderly patients. A study published in the *New England Journal of Medicine* in 2009 found nursing home residents on dialysis experienced “sharp and sustained” declines in their ability to perform activities of daily living. Such information led the authors of a 2010 article in *Hospital Practice* to make the case that even though survival among the elderly who do opt for dialysis may be better than among those who opt for medical management, their lives may not be. “Health-related quality of life may be better,” they wrote, “especially if the chronic kidney-disease-associated complications are appropriately addressed through effective palliative care.”

Today, there's an increasing awareness among nephrologists that they need to approach the conversation about dialysis with elderly, sicker patients somewhat differently than they do with younger, healthier patients. As writer Gina Kolata stated in a *New York Times* article last March, “Kidney specialists are pushing doctors to be more forthright with elderly people who have other serious medical conditions, to tell the patients that even though they are entitled to dialysis, they may want to decline such treatment and enter a hospice instead.”

Last year, kidney specialists codified that sentiment in a clinical practice guideline. The guideline, issued by the Renal Physicians Association, calls for shared decision-making around initiating dialysis and urges physicians to fully inform patients with end-stage renal disease about their prognosis and treatment options. Physicians, it says, need to inform those chronic kidney disease patients who are elderly, have comorbidities, have marked functional impairment, or have severe chronic malnutrition that dialysis may not help them survive, may not improve their functional status over medical management without dialysis, and may detract from their quality of life.

Conversation Starters

In order to best inform patients, kidney experts recommend that physicians change the terminology they use when discussing options. For example, instead of telling patients they can “forego” dialysis, physicians can instead say they may choose “medical management without dialysis.” The article “Dialysis and the Elderly Patient: Decision, Not Default,” published in *Nephrology Times* in July 2010 quoted Mark Swidler, M.D., of Mount Sinai Medical Center, as saying doctors need to avoid terms such as “withdraw,” “withhold,” and “forego,” and instead of referring to “conservative therapy” simply refer to “nondialysis therapy.” Swidlers' argument is that such subtle shifts send the message that patients have a choice between two equally valid therapies, rather

than between dialysis and doing nothing.

Nephrologist Bobbi Daniels, M.D., CEO of University of Minnesota Physicians, says her approach is to make sure that patients and their families are aware of their options and have realistic expectations about outcomes. “I like to start off by making sure that patients understand the risks and the benefits and that [they know] they can make the decision to start treatment and that sometime in the future they can make a decision to stop treatment and pursue medical therapy instead of dialysis therapy,” she says. She stresses that there are things that can be done to help patients who choose medication therapy manage their fluids and cope with symptoms such as itching.

Even with the new guideline for shared decision-making, the advice about how to phrase things, and the new data on outcomes, nephrologists say that leading the discussion about whether an older person with other health problems should go on dialysis is challenging. “It's one of the things that relates to the art of medicine,” Daniels says. “It takes a lot of time to frame the discussion so that patients can make appropriate choices. It takes more time to do that than to just start dialysis.” ■



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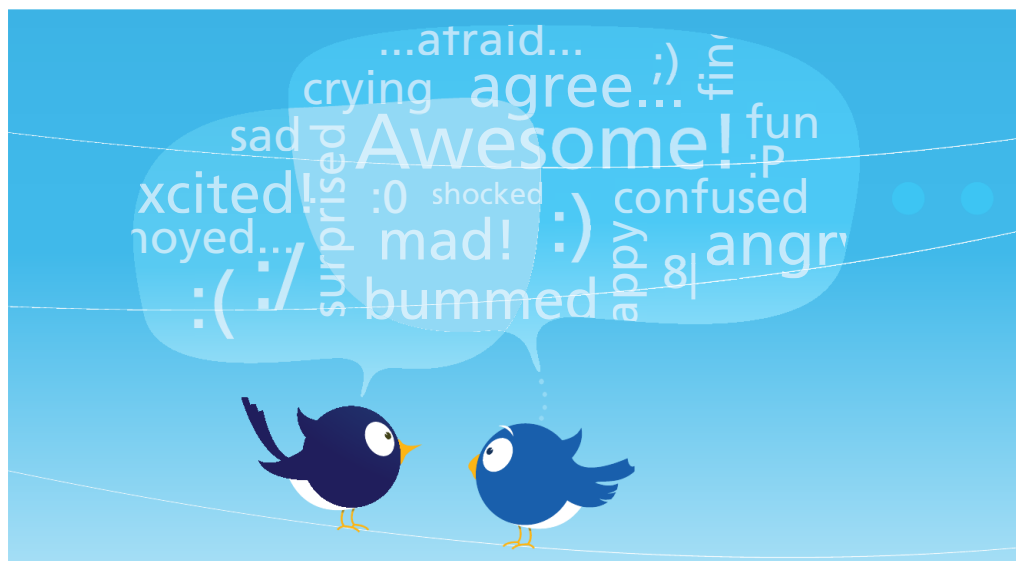
■ Twitter

Tweeting Your Mood

Cornell University sociologists recently turned to Twitter to study how people's emotions fluctuate throughout the day.

The researchers studied messages posted by more than 2 million people in 84 countries between February 2008 and January 2010. They analyzed the tweets using a standard computer program that associated words such as "awesome," "fine," and "agree" with a positive mood and words like "annoy," "mad," and "afraid" with a negative mood. The program also analyzed emoticons.

During the work week, the



Watch for negative tweets between 3 and 4 p.m.

most positive posts occurred between 6 and 9 a.m. and the most negative ones between 3 and 4 p.m.; the number of positive posts rose sharply in the early evening. On weekends, the morning peak was closer

to 9 a.m. and the evening peak closer to 9 p.m.

The researchers also found no evidence that people tweeted more negative remarks during the winter. They did, however, find positive mes-

sages increasing around the time of the spring equinox and falling around the autumnal equinox.

The study was published in the September 30, 2011, issue of *Science*.

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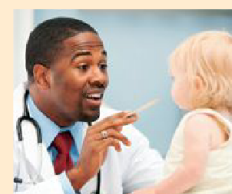
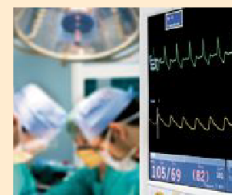
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■ New Research

Too Much Information

With new studies and guidelines coming out by the minute, how can docs keep up with the latest in their field? | INTERVIEW BY KIM KISER

In an article published in the *British Medical Journal* last December about the impossibility of keeping up with published medical reports, a cardiology professor and statistician from Cardiff University in Wales cited daunting statistics: there are now 25,400 science, technology, and medical journals, and their number is increasing by 3.5 percent a year; 1.5 million articles were published in those journals in 2009 alone; and the National Library of Medicine's PubMed database now cites more than 20 million articles. They noted that a trainee in cardiac imaging reading 40 papers a day, five days a week, would need 11 years to get up to speed, during which time another 82,000 relevant articles would have been published. With new information coming out at breakneck speed, how can docs keep from falling behind?

We asked Don Deye, M.D., an internal medicine physician in Cambridge, Minnesota, who has long been involved in sharing relevant information with fellow physicians about what it takes to cope with medicine's information tsunami and whether technology is helping us manage the deluge or contributing to it. Deye serves as medical director for Oakstone Medical Publishing, which produces continuing education materials for health care professionals. In that role, he has been recording audio versions of the American College of Physicians' (ACP) Medical Knowledge Self-Assessment Program (MKSAP) for 15 years. He also compiles a "medical news of the weird" segment about unusual things hospitalists should know for *Practical Reviews in Hospital Medicine*, an electronic journal club. And he runs Allina Medical Group's journal club.

Q. What's behind the information explosion?

The number of journals and the quantity of data has exploded because, as a global culture, we have developed research, and most of these articles come out of research. Now, medical companies are developing drugs and devices, which leads to more studies. There is also NIH and government-sponsored research. Plus medical knowledge has become specialized and subspecialized. Each specialty has a universe of knowledge and researchers. All those things together have created a huge explosion of information. It has gone up exponentially and shows no signs of stopping.

Q. You've been using the ACP's MKSAP since you finished residency in 1979, long before you got involved in recording audio versions for Oakstone. Why do you feel this is a good way to keep up? And what else do you do to stay on top of your game?

I do general internal medicine, which, alarmingly, covers all specialties of primary care medicine aside from pediatrics and obstetrics. The self-assessment program comes out every three years. The ACP forms committees—one for each specialty within internal medicine. They spend a year figuring out what's new that's clinically relevant and important to know and then write chapters on each topic. Because three years is a long time, the ACP comes out with updates every six months. These are a good way to keep up with what's generally accepted as current practice.

Many of us also use UpToDate. Every four months, they come out with a revision and each revision has a chapter on



Photo by Steve Wewerka

Don Deye, M.D., advises doctors to have a strategy for keeping up with the medical literature and to make use of technology when possible.

what's new for each specialty—cardiology, gastroenterology, etc.. Another is ACP Medicine, an electronic medical reference that helps physicians keep up with new guidelines and treatment recommendations. I also go to meetings, including the ACP Minnesota Chapter's meeting, and internal medicine review courses at the University of Minnesota and Mayo Clinic.

The other thing I use that has been around forever is the journal club. These started in medical schools and residency programs. They would meet monthly and each person was assigned specific journals to review for landmark or unusually interesting or clinically relevant articles. But if you're out in the middle of nowhere, there may not be a journal club.

Q. *Practical Reviews* started out as a journal club at the University of Alabama Birmingham. How has it changed the concept of what a journal club is?

These days, it's all computerized and you can do searches. Oakstone has a database from journal clubs in nearly all specialties. All these journal clubs have a team of docs around the country reviewing the current literature. It's like local journal clubs used to do. But there are now 450 docs doing

this every month. So if you imagine 450 docs individually looking with a critical eye at the current literature as a group, they cover virtually all the relevant journals. It's like you took Medline and the incredible amount of data there and put it through an intelligent filter. But the intelligent filter isn't some algorithm, it's the brains of all these docs. So now you can go online and search all of these journal clubs at once. Instead of coming up with a couple thousand hits like you would on Google or Medline, you come up with maybe eight or 15, but they're ones you're looking for. Journal Watch is similar, but they don't have as many specialties.

Q ■ What do you do to prepare for your 15-minute segment for *Practical Reviews in Hospital Medicine*?

I go through the content of all the Oakstone journal clubs—the ones that have anything to do with primary care medicine or hospital medicine. I pull out articles that grab my attention as being really interesting or really important. Then I rate them on a scale of 1 to 5. The ones that have the highest ratings, I use as content for my segment.

Q ■ How do you prepare to lead Allina Medical Group's journal club?

In the process of doing research for the segment, I create this document with 70 to 100 of the best articles with the reviewers' abstracts and critiques of each article. I share those with the docs in the club.

Q ■ What else might be done to help us with information overload?

Electronic medical records create very searchable data. At the clinic level, we're being tracked for patients who have an A1c less than 7, blood pressure that's under control, lipids that are under control, and we get score cards. It does change behavior, but it's primitive. Third-party

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payers are working on logic rules for analyzing medical claims data. These include rules that grade or measure a physician's quality. I'm working on a project called ASAP, Automated Self-Assessment Program, that would use this data to point out what physicians don't know they don't know. The idea is to close the loop—to take the data these rules generate and create a profile for each individual and feed print, audio, or video information to that individual to address their learning needs. The idea is to create a curriculum for you as an individual. I think this is the next big wave for CME. But right now, it's a pipe dream.

Q. What else is on the horizon?

One idea we're working on is doing something similar to what happens when you shop online. If you order a CD, a message will pop up saying 'Buyers who bought this also bought that.' The idea is to do the same thing as it relates to the interests of physicians. If you search for a term, you can pull up what you get in the search engine but also pull up related items. Another way to do this is for the person to choose from a list of terms that he or she would like to have monitored and have print articles, MP3 audio downloads, video downloads, or any combination sent to their iPad, smartphone, or even emailed to them.

Q. What advice do you have for busy physicians who are trying to stay current?

Use electronic medical references, and be aware of new products coming out that will be helpful in meeting your information needs without taking time away from your work or home. For a physician, time is your only saleable commodity, and it's your most limited resource. Things that save time are critical. ■



Photo courtesy of Hennepin County Medical Center

Morris Davidman, M.D., kicked off the recent Best of Hennepin conference by discussing how good communication is critical to patient-centered care.

■ Patient-Centered Care

What Breaks the Bond?

A look at two trends that are chipping away at the physician-patient relationship. | BY KIM KISER

On a recent trip to Chicago, Morris Davidman, M.D., a nephrologist who practiced at Hennepin County Medical Center for 35 years, ended up in the hospital. Soon after being admitted, a hospitalist came into his room and introduced himself, noting that he would be caring for Davidman for the next eight or nine hours and that afterward, a new physician would take over. "He then said, 'Don't worry about a thing because we have your electronic medical record, so we know all about you.'"

Davidman's experience isn't unusual, as scenes like this play out in hospitals in Minnesota and across the United States

daily. They reflect two changes in the way health care is delivered: the introduction of electronic medical records (EMRs) and the use of hospitalists. "Many good things have come out of these changes; but there are some unintended consequences that break the bond between the doctor and patient," he said during his opening remarks at the recent Best of Hennepin conference in Minneapolis.

Davidman noted that he considers the EMR "one of the greatest innovations of the last decade" because it allows patients' medical information to follow them wherever they go. However, the EMR has affected the way doctors and patients interact and communicate. "The new bond sometimes is with the keyboard as opposed to the person sitting in the office," he said. "That depersonalizes medicine a little."

The introduction of hospitalists has further eroded the relationship between physician and patient. "In the old days, you saw a patient in the office. If they were hospitalized under your name, you took care of them. That system is disappearing very quickly," he said. Davidman noted that there are a number of good things about the move to hospitalists. He recalls days when he would get a call about a hospitalized patient and have to figure out a way to handle the situation while dealing with an office full of waiting patients. "It wasn't an efficient system," he says. "Now, you know there is someone standing by to care for you. But the doctor is a stranger to the patient. The issue is to make them not strangers."

Davidman told the audience that there's a revived concern in medicine about the doctor-patient relationship. He noted that earlier this year, the Matthew and Carolyn Bucksbaum Family Foundation gave \$42 million to the University of Chicago to create a program to identify best practices in doctor-patient interaction and teach them to the next generation of physicians.

He said that although medical schools have long offered courses on professionalism and ethics, the Bucksbaum Institute for Clinical Excellence is believed to be the first institution devoted exclusively to improving the doctor-patient relationship. "It gets at what some of us are concerned about—this bond between the doctor and the patient that we've always taken for granted," he said. ■

■ Public Image

Family Medicine's Fan Club

Medical students are the specialty's biggest boosters.

| BY CARMEN PEOTA

Two years ago, a handful of students at the University of Minnesota Medical School approached the family medicine department asking for help reinvigorating the family medicine interest group. Concerned that medical students were gravitating toward specialties that either might pay more or that seemed to have more cachet, the students wanted to raise the specialty's profile on campus.

With a commitment of administrative, financial, and faculty support from the department, the students launched a year-long effort to ramp up the group's activities. They organized lunch-time lectures, skills workshops, and a dinner series in which faculty from different residency programs invited students to their homes for a meal and discussion.

The following year, interest in the interest group itself had grown, and eight students stepped up to lead the group. The new leaders added a book club and community service projects to the interest group's growing list of activities and,

among other things, organized a food, clothing, and toiletries drive; collected journals for overseas medical schools; and developed a health curriculum for homeless children living in a shelter. In June, the group was recognized for its efforts with an excellence award from the American Academy of Family Physicians.

“They were dedicated to spreading the word about our wonderful field.”

— Krista Skorupa, M.D.

Krista Skorupa, M.D., who served as faculty advisory for the group for three years and now works as medical director of HealthEast's Rosville Clinic, says she can't say enough about the students who set out to remake the image of family medicine at the university. “They were dedicated to spreading the word about our wonderful field and engaging the student body in activities that displayed how diverse a field we are,” she says. “More importantly, the student leaders wanted to make sure that their colleagues pursuing other specialties had a broad understanding and respect for the field.”

Fourth-year student Dylan Bindman, who was among the



Top: Tricia Hadley, a third-year student, practices suturing on a pig's foot at the Family Medicine Interest Group's suturing workshop.

Bottom: Jeremy Springer, M.D., who directs the University of Minnesota's Methodist Hospital family medicine residency program, assists second-year student Andrew Pisansky with his suturing skills.

student leaders to step up the interest group's activities two years ago, says he got involved because he believed students needed to hear about what they could do in family medicine and how much the physicians who are in the specialty love it. “I really feel strongly about family medicine,” he says.

Bindman says he's concerned about the shortages predicted for all the primary care specialties including family medicine. “We're not producing enough primary care doctors. For that reason alone, we need to make sure people know about primary care and get them excited about it.” ■



MMA in Action



Dave Renner

■ In preparation for the 2012 legislative session, Dave Renner, director of state and federal legislation for the MMA, and Eric Dick, manager of legislative affairs, met with lawmakers last month to discuss the MMA's legislative priorities, including the need to update Medical Assistance reimbursements and prohibiting the use of tanning beds by minors. On a trip to Rochester, they met with Rep. Mike Benson (R-Rochester), Rep. Duane Quam (R-Byron), and Sen. Carla Nelson (R-Rochester). In St. Paul, they met with Rep. Steve Gottwalt (R-St. Cloud), chair of the Health and Human Services Reform Committee, and Rep. Jim Abeler (R-Anoka), chair of the Health and Human Services Finance Committee.



Eric Dick



Janet Silversmith

■ Janet Silversmith, MMA health policy director, and Dave Renner, director of state and federal legislation, met with the Minnesota Department of Health's

Assistant Commissioner for Health Policy and Reform, Lauren Gilchrist, to discuss health care reform. Silversmith also attended the first meeting of the state's Health Care Reform Task Force.

■ Approximately 50 physicians, clinic administrators, and other health care leaders attended the MMA-sponsored conference "Battling Physician Burnout" on October 27. Gregory Poland, M.D., director of the Vaccine Research Group at Mayo Clinic, and his daughter, Caroline Poland, gave the keynote presentation, in which they stressed the importance of balancing one's work and personal life. Following their talk, a panel of speakers shared ideas for promoting physician well being. The panel consisted of Karen Lawson, M.D., director of health coaching, University of Minnesota Center for Spirituality and Healing; MMA Past-President Patricia Lindholm, M.D.; William Spinelli, M.D., a fellow at the Allina Center for Health Care Innovation; Carl Patow, M.D., executive director and vice president for HealthPartners Institute for Medical Education; and Daniel Whitlock, M.D., vice president of medical affairs at CentraCare Health System in St. Cloud.

From left: Karen Lawson, M.D., Patricia Lindholm, M.D., Carl Patow, M.D., William Spinelli, M.D., and Daniel Whitlock, M.D.

■ Britta Orr, manager of public health policy for the MMA, worked with the team that is reviewing State Health Improvement Grant applications and attended the first meeting of the state's Health Insurance Exchange Advisory Task Force. Roger Kathol, M.D., represents the MMA on the task force.

■ In November, MMA Manager of Quality Improvement Rebecca Schierman gave a presentation to the Twin Cities Medical Society about quality reporting in Minnesota.

■ Karolyn Stirewalt, J.D., the MMA's policy counsel, represented the MMA at meetings of the Minnesota Health Professional Services Program Advisory Committee and the Minnesota Board of Medical Practice.



Karolyn Stirewalt



Photo by Scott D. Smith

Meet a Member

David Johnston, M.D.

As the MMA's representative on the University of Minnesota Medical School's admissions committee, David Johnston has had a hand in choosing tomorrow's physicians. | BY SCOTT SMITH

When David Johnston, M.D., was considering potential students for admission to the University of Minnesota Medical School, he looked for three things: intelligence, curiosity, and that they “sincerely give a rip about their fellow man.”

Johnston spent six years as the MMA's representative to the medical school's admissions committee, screening hundreds of applications from young people hoping to be part of the next generation of physicians. An emergency medicine physician at North Memorial Medical Center, Johnston stepped down earlier this year; the MMA's new representative is Beth Baker, M.D.

Johnston says he applied to serve on the committee because he “wanted to see good people come into the profession.”

To winnow the 3,500-plus applicants a year to a class of 165, the 25 committee members take into consideration an applicant's residency (with a strong preference given to those from Minnesota), academic achievements, written essay, medical and nonmedical work or volunteer experiences, and interview. They then debate the merits of various candidates. Johnston says he favored those with humility and a commitment to service. “It helps if you don't have an ego because this is a service profession, and I always look for a willingness to think you might be wrong about something,” he says.

Committee members then give a numeric score to each candidate, and candidates are offered admission based on those



Photo by Richard Anderson

David Johnston, M.D., gave preference to medical school applicants who expressed a commitment to service.

scores. Johnston's emphasis on service goes along with a philosophical change on the part of medical schools, which now place greater emphasis on candidates' nonacademic abilities than in the past. Johnston says when he applied to medical school in the late 1970s, it was all about academics. Today, the ability to communicate well and show empathy matter, and candidates with stellar MCAT scores can get passed over because of poor interview performances, arrogance, or a lack of service work.

“One surprising and uplifting thing about doing this was just the quality and idealism of the people who want to go into medicine,” he says.

Johnston did his own medical training in California and Colorado. He came to Minnesota in 1986 to take a job with Children's Hospitals and Clinics of Minnesota. But he missed practicing adult emergency medicine. So he moved to North Memorial that same year and has been there ever since.

A supporter of organized medicine, Johnston has been an MMA member since the late 1980s. He admits that he has been disappointed by its lack of support for a single-payer health care system but says other benefits outweigh that negative. He says being a member of the MMA gave him entree to a meaningful volunteer experience

David Johnston at a Glance

- **Medical School:** University of California San Diego School of Medicine, 1978
- **Residency:** Pediatrics, University of California San Diego, 1978-1981 and chief residency 1982-83; emergency medicine, Denver General and Affiliated Hospitals, 1984-1986
- **Practice:** Emergency medicine physician at North Memorial Medical Center, Robbinsdale
- **MMA Involvement:** MMA representative on the University of Minnesota Medical School Admissions Committee, 2005-2011
- **Hobbies:** Biking, walking his dog, reading, playing the trumpet

with the university's admissions committee. “My world is pretty limited to my colleagues at the hospital; but through this, I gained a connection to the university and met some wonderful people,” he says. And he had a chance to have a say in deciding what type of person will be the physician of tomorrow.

MN Supreme Court Rules on Newborn Screening Samples

The state of Minnesota may continue to screen newborns for various childhood diseases, but it cannot store, use, or disseminate blood samples for other research without parental consent, the Minnesota Supreme Court ruled last month.

The decision reverses two lower-court decisions and was unfavorable to researchers. “This is a disappointing result,” says Karolyn Stirewalt, J.D., MMA policy counsel. “The holding of this case will impact the resources that researchers have to further study inheritable disorders of newborns and to improve upon the tests that measure them. It could also lead to many new cases being brought against the state.”

The MMA has been a long-time advocate of newborn screening, which identifies approximately 100 babies a year who can be saved from death or disability through early treatment.

Piero Rinaldo, M.D., co-director of Mayo Clinic’s Biochemical Genetics Laboratory, said in a story in the *Rochester Post-Bulletin* that the samples are useful for developing new tests for potentially fatal disorders.

Health Commissioner Ed Ehlinger, M.D., said in a statement that the Department of Health was reviewing the implications of the ruling on the operations of the program, which, he said, protects Minnesota babies from serious diseases. It is not clear whether the Department of Health will be compelled to destroy its more than



The Minnesota Supreme Court ruled last month that the state cannot store, use, or disseminate blood samples gathered through the newborn screening program without parental consent.

800,000 samples, which are a few blood drops on a specimen card.

Court Battle

At issue in the case was the interplay between the newborn screening law (Minn. Stat. sections 144.125-.128) and the Genetic Privacy Act (Minn. Stat. section 13.386).

The Minnesota Department of Health collects blood samples from newborns to check for more than 50 diseases and disorders. A small portion is retained indefinitely for other uses unless there is a specific request to have it destroyed. Those uses include developing new tests and assuring the quality of the existing tests.

Four years ago, nine families sued the State of Minnesota, the Department of Health, and the commissioner for collecting, using, storing, and disseminating the samples and test results without obtaining written informed consent. The families alleged that this was in violation of the Genetic Privacy Act, claiming they had justification for both a tort action (for

improper governmental taking) and a constitutional claim (for invasion of privacy).

The district court ruled that the Genetic Privacy Act did not apply to newborn screening because the screening “was conducted on biological samples, not genetic information.” It also stated that newborn screening under the statute is exempted from the Genetic Privacy Act, which regulates the use of genetic information “unless otherwise expressly provided by law.”

The Minnesota Court of Appeals upheld the district court decision, ruling that “the informed consent provisions of [the Genetic Privacy Act], are not triggered when newborn blood is collected and tested for heritable and congenital disorders as part of the state-wide screening program mandated by [the newborn screening statute].” The court denied the plaintiffs’ claims and requests for a legal remedy.

The Minnesota Supreme Court reversed the prior courts’ opinions, ruling that blood samples collected by the Department of Health fit within the defini-



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tion of “biological information collected from an individual” under Minnesota law, so the Genetic Privacy Act applies. “Unless otherwise expressly provided by law, the Department must have written informed consent to collect, use, store, or disseminate those samples,” the court said.

The court also ruled that “the newborn screening statutes [allow the Department to] administer newborn screening by testing the samples for heritable and congenital disorders, record and report those results, maintain a registry of positive cases for the purpose of follow-up services, and store those test results as required by federal law. The newborn screening statutes do not expressly authorize the Department to conduct any other use, storage, or dissemination of the blood samples.”

The Supreme Court sent the issue of an appropriate remedy for the plaintiffs back to the district court. It will determine whether any of the parties had established the facts necessary to show that their children’s blood samples had been used, stored, or disseminated in violation of the Genetic Privacy Act.

The MMA will continue to follow the case and provide updates.

Minnesota Resolutions Move Forward at AMA Meeting

Minnesota’s AMA delegation successfully moved forward two resolutions at the AMA 2011 interim meeting in New Orleans last month.

The AMA House of Delegates referred a Minnesota resolution about secure examinations for maintenance of certification to the AMA Board of Trustees for further consideration. The resolution (Res. 911) calls for the AMA to work with the American Board of Medical Specialties to remove the requirement for a secure examination as part of the Maintenance of Certification program.

Physicians with time-limited board certifications have to take an exam every seven to 10 years. But now that maintaining certification also requires them to complete learning modules, computer-based simulations, and quality assessments, physicians are questioning whether an exam that measures factual recall, rather than diagnostic reasoning, is necessary.

“We pushed hard to get the resolution adopted, and there was a lot of sympathy to the fact that there is no evidence that these tests verify competence. But in the end, the majority view was that it made sense to have the AMA Board consider the issue and come up with the best remedy,” says Dave Renner, MMA director of state and federal legislation.

The House also passed a resolution that the Minnesota delegation co-sponsored with the American Society of Anesthesiologists. The resolution (Res. 602) calls for the AMA to ensure that the Current Procedural Terminology (CPT) Editorial Panel uses the term “physician” in a way that is consistent with AMA policy, which defines a physician as a doctor of medicine or doctor of osteopathic medicine.

The resolution is in response to the CPT Editorial Panel’s plans to review and potentially revise the CPT code set. The CPT advisors participating in the project decided, for the purpose of the systematic review, that “physician” refer to any professional who is currently allowed to report E/M services in the Medicare fee schedule. This would include registered nurse practitioners, physician assistants, certified nurse midwives, and others.

2011 Minnesota Delegation to the AMA

- John Van Etta, M.D.
- Ray Christensen, M.D.
- Sally Trippel, M.D.
- Ken Crabb, M.D.
- Paul Matson, M.D.

Alternate Delegates

- John Abenstein, M.D.
- David Estrin, M.D.
- Ben Whitten, M.D.
- Will Nicholson, M.D.

Alexandria Surgeon Gets MMA Quality Award

The MMA presented its Physician Leadership in Quality Award to Paul Dale, M.D., for his work in establishing the Joint Replacement Center at Douglas County Hospital in Alexandria.

Dale is an orthopedic surgeon with Heartland Orthopedic Specialists in Alexandria, which worked with Douglas County Hospital to open the Joint Replacement Center in 2008. Dale, now the center's orthopedic medical director, promoted an innovative treatment approach.

Before the center was established, patients underwent their procedures and rehabilitation individually. Now, the patients go through a presurgical orientation in groups. After their surgery, they eat meals together and rehabilitate together at the

center, which has a lodge-like atmosphere. The approach has paid off in lower complication rates, improved patient satisfaction scores, and better treatment outcomes. The Joint Replacement Center was one of only six programs in the state to receive the highest quality rating by the independent hospital quality evaluator, CARECHEX.

The MMA Quality Committee noted that Dale's innovative efforts to engage patients before and after surgery is a model that could be replicated in other practices and in other specialties.

The MMA Quality Committee has been recognizing physicians who advance the quality of health care in Minnesota since 2006. This fall, the MMA Foundation presented the MMA's quality award as



MMA Foundation Director Dennis Kelly (right) presents the Physician Leadership in Quality Award to Paul Dale, M.D.

well as the association's awards for service to minority communities and excellence in journalism, and its medical student award.



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Improvement also Applies to Quality Improvement

At the MMA, we are hearing concerns about the usefulness and validity of some of the measures and methodology used by MN Community Measurement. To be clear, the MMA and I support the use of measurement to improve quality. You cannot improve what you do not measure. That being said, the process of measurement needs to be continuously improved just like other processes in medical practice.

Specifically, we are hearing about measures related to asthma and depression treatment. My own experience with these measures illustrates how flawed methodology can result in scores that do not reflect the actual quality of care being given.

The asthma measure, which assesses how providers care for patients with asthma, requires that a written action plan be given to the patient and placed in his or her chart. However, the data supplied by our colleagues with expertise in allergy care increasingly show that an action plan is only useful for high-risk asthma patients, not the majority. This may be a requirement that Community Measurement needs to alter to reflect the best standard of care.

Community Measurement also bases its measure on the five-question Asthma Control Test (ACT). The problem for me is that I have a high percentage of athletes in my practice, and a fair number of them have exercise-induced bronchospasm (EIB). Here's why that's a problem: Patients with EIB who exercise vigorously and often (five to seven days a week) may

feel short of breath as often as once a day and use albuterol before exercising five to seven times a week. As a result, patients with EIB often have ACT scores that indicate their asthma is not controlled. They also receive an action plan, which may be of no value to them. Most of us would agree that people who exercise daily and use albuterol before exercising and then exercise to the point of being short of breath are not poorly controlled. Rather, they are athletes who are receiving the care they need in order to pursue their sport. But my scores are low because of that.

The factors that can affect my score on the depression measure are even more complicated. Community Measurement bases its depression measure on the PHQ-9 test and views depression as an isolated, acute illness rather than a chronic or episodic disease. A patient with a score greater than 9 during an index period is considered depressed. These patients are followed over time and monitored for remission (a PHQ-9 score less than 5 after six months). I recently reviewed my charts and found that during the past 18 months, I had a total of 214 patients coded for visits for depression. Of those, 126 (59 percent) were in remission. However, according to Community Measurement, I had far fewer depressed patients and a much lower remission rate.

The primary reason for the discrepancy is that Community Measurement doesn't count all the patients I've helped to achieve and maintain remission over time, nor does it count those patients I've

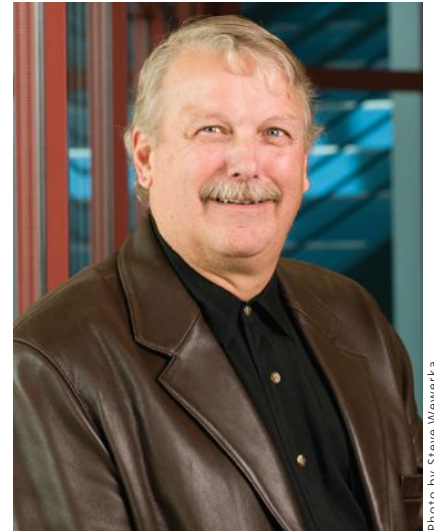


Photo by Steve Wewerka

David Thorson, M.D.
Chair, MMA Board of Trustees

The process of measurement needs to be continuously improved just like other processes in medical practice.

helped before they met the strict definition of depression. Because I have been seeing many of my patients for many years and can take only a limited number of new ones, I don't have many new patients with depression. Also, our clinic treats depression as a chronic, rather than acute, condition, and we aggressively screen for it (using the PHQ-2) and treat it early. The result is that even though I effectively manage my depressed patients, I am left with a concentrated population of chronically depressed patients who are receiving optimal care but who do not achieve remission. And I am also left with an unrepresentatively low Community Measurement score for depression care.

Although the MMA supports MN Community Measurement, we feel it needs to dialogue with physicians regarding these and other issues so that measures better reflect the care that physicians are providing to their patients.

Doctor, What's the Story?

By Kate Ledger

Saving lives and treating disease may be all in a day's work for physicians. But for many, talking to the media can be unnerving.

When the 35W bridge collapsed at the height of rush hour in Minneapolis on August 1, 2007, the first medical responders on the scene had one objective in mind: to rescue the drivers and passengers who were still trapped in cars and in the river amid the wreckage. The scope of the disaster was staggering, and emergency personnel worked quickly in the chaos of smashed vehicles and upended concrete to locate survivors and evacuate the injured. John Hick, M.D., medical director for emergency preparedness at Hennepin County Medical Center (HCMC), arrived at the devastation about 15 minutes after the collapse occurred and began working with rescue teams and assisting with triage.



Although Hick was focused on the rescue efforts, he was aware that members of the media had arrived on the scene bearing cameras and microphones. Hick didn't have time to talk with journalists. "Few of us spoke to the media that night," he recalls. But the following days were another story. Interview requests poured in from national news organizations and then from international ones such as the BBC and Al Jazeera. Hick and the HCMC media team planned their responses, assigning medical spokespeople to talk about the event, scheduling press conferences, and arranging for certain media outlets to have exclusive interviews with physicians from the medical center or emergency medical services.

Navigating the needs of the media is an important, though sometimes uncomfortable, role for medical personnel, notes Hick, who was one of several people providing updates on the victims and reassuring the public about the work of the response crews during the days and weeks following the crisis. "This was a tragedy, but we had adequate resources to deal with it," he says. Hick recalls that during the interviews he emphasized the fact that everyone got timely care, that all the emergency personnel worked together, and that they were pleased with the patient outcomes. "I think we were successful in getting those messages out."

As Hick and other physicians who get calls from the media note, the press is essential to communicating health information to the public, whether it's updating them about a disaster, interpreting screening recommendations, or conveying the realities of a disease outbreak. Even so, some physicians are wary of being interviewed. Some have felt their quotes were taken out of context or that the subtleties of their research were misrepresented. Others have squirmed when they found their statements hyped into promises of

cures for diseases.

Keeping the message focused is just one way Hick handles an interview. "There's basic stuff about working with the media that a lot of physicians are not well-informed about," he says. As doctors who frequently talk with reporters are quick to point out, certain communication strategies are worth learning because speaking effectively with the media can be another tool in practicing good medicine.

Build a Partnership

Imparting timely health information is part and parcel of the job for infectious disease physician Ruth Lynfield, M.D. As state epidemiologist with the Minnesota Department of Health, she's often interviewed about the latest disease outbreak, so she works at maintaining long-term relationships with reporters. "It's really important to partner with the media in order to get accurate, useful information out to the public," she says. "Often, we need to explain the latest about what's happening, and we need to get information to people about what they can do to protect themselves."

The need for such a partnership became overwhelmingly clear during the

H1N1 outbreak two years ago, when it was critical that the public understand that the virus was significant enough to merit taking precautions, while not being cause for panic. "You want to get information out to people before they hear about it from another venue," she says. "We had the ability to provide accurate information, as much as we knew, and if we didn't provide it, we were aware journalists could get information from places less-informed," she says. The press was able to help her put the disease in perspective, communicate which groups, such as pregnant women, were at higher risk, and provide information about how to avoid it such as covering a cough or staying home if you had symptoms.

One important tactic she has learned is determining early on in an interview what medical understanding the journalist has and what his or her reporting interests are. She has found most of them earnestly want to help the public get accurate health information. Occasionally, though, "you'll run into someone whose objectives are a little different from yours, and they're not as interested in getting information out, and may be more interested in the excitement of the story." When the first wave of

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There's basic stuff about working with the media that a lot of physicians are not well-informed about.

—JOHN HICK, M.D.



the H1N1 pandemic was over and a fall recurrence was on the horizon, many journalists wanted to write about the worst possible scenario, as if the virus would undoubtedly follow the deadly pattern of the 1918 Spanish influenza pandemic. Lynfield pointed out that pandemics have different levels of severity and that the second wave of this one might not be very severe. When she senses a reporter is likely to focus on the sensational, she invests extra time in the interview. “Spending enough time with the journalist and making sure that they understand the situation and that their questions are answered goes a long way toward being sure that there’s not a confused message,” she says.

Earlier this year, when a longtime health journalist whose knowledge base and reporting skills she trusted was seeking information on the measles outbreak in the state, she readily answered questions. She was pleased to see that the piece that ran in the Minneapolis *Star Tribune* focused on the case of a child who’d spent two weeks on a ventilator in the ICU because of measles-related pneumonia. This was important as it illustrated the consequences of not immunizing children. “This was a story that let people know that this is an illness that can be very severe and is worth preventing,” Lynfield says.

Taking the time to talk with reporters is also a priority for forensic pathologist Lindsey Thomas, M.D., of the Minnesota Regional Medical Examiner’s Office. “When you’re in forensic pathology, there are cases and issues that are inherently interesting to the press,” she says. When reporters want the scoop about an unusual death, her main objective is to stick to facts that she can legally share. Although not bound by national HIPAA requirements, which protect patient privacy, medical examiners are limited by Minnesota’s laws and must refrain from divulging certain information such as blood alcohol levels or the number of bullet wounds. “We take that seriously,” she says. Even when reporters push with more questions,

“you have to stick to what you can say and not speculate.”

What’s often helpful, she finds, is providing context. “The details of a homicide you can’t give, but you can say, here’s how the office investigates a death, here’s what we’re looking for,” she explains. “You’re providing useful information without giving a lot about the specific case.”

When the relationship with the press is working well, she adds, a knowledgeable, keyed-in reporter can do wonders to illuminate an important health issue. A few years ago, amid a rising number of infant deaths caused by accidental suffocation in bedding, then-WCCO reporter Caroline Lowe became interested in the topic and interviewed Thomas and other forensic pathologists. “We described how we interact with families and how we investigate infant deaths,” Thomas says, recalling being concerned that the report would hit a nerve with parents devoted to having their babies in bed with them. “We were just saying, ‘Here’s what we see and how awful it is when we have to tell families why their child died.’ She did a very sensitive but educational piece promoting safe sleep.”

Stick to Your Message

The fact is, says David Hilden, M.D., an internist at HCMC, interacting with the media effectively isn’t usually part of a physician’s training and involves a learning curve. “Most doctors are taught a little bit in medical school and residency about how to communicate with their patients, but we get almost no experience in dealing with the press.”

Hilden, who offers his services to the hospital’s public affairs department, was surprised when reporters called on him to discuss an array of medical topics or to comment on the latest health issue in the news. “I think the role of a physician in that case is to provide context and perspective on the story, for example, a new study that people need to exercise more. You provide context to help people understand why they should care, and you choose your words carefully so that you don’t come across as alarmist.” Moreover, he has realized how important it is to keep the latest medical evidence in mind when speaking, so he makes it a habit, if there’s time before an interview, to brush up on the most current information. When a reporter called recently for an interview about vaccines and autism, Hilden only had a few hours’ notice, but he took 10 or



Spending enough time with the journalist and making sure that they understand the situation...goes a long way toward making sure there is not a confused message.

—RUTH LYNFLD, M.D.



The Changing Face of Independent Medicine



MINNESOTA
MEDICAL
ASSOCIATION

Physicians from around Minnesota are invited to discuss the state of independent medicine at a one-evening event sponsored by the Minnesota Medical Association (MMA).

The event, "The Changing Face of Independent Medicine" will give physicians the opportunity to share their issues, concerns, and ideas about the future of independent medicine in Minnesota. These ideas will be used by MMA to outline priorities and develop strategies to address independent practice needs.

Featured Speaker

Jeremy Lazarus, MD,
president-elect, American
Medical Association
"National Trends in Independent
Practice."

Small Group Discussions

Participants will break into small groups for facilitated discussions to share their ideas and concerns.

Networking

Physicians will have the opportunity to network with their independent practice colleagues.

The program is open to all physicians. Clinic administrators are invited to attend with their physicians.

The Changing Face of Independent Medicine

Tuesday, January 31, 2012
6 to 8:30 p.m.
Ramada Plaza Minneapolis

Doors open at 5:30 for networking.
Hors d'oeuvres and a cash bar will be available.
No charge for MMA members and \$25 for nonmembers and administrators.

To register, visit mnmed.org/jpevent. For more information, call 612-362-3764.





Even when reporters push with more questions, you have to stick to what you can say and not speculate.

—LINDSEY THOMAS, M.D.



One of the realities of being a physician in our society, is that people—rightly or wrongly—tend to listen to us.

—DAVID HILDEN, M.D.



15 minutes to look up the latest research. “It confirmed in my head that there is no link,” he says. “When I gave the interview, I could give some information based on fact, and it wasn’t just my opinion.”

He also learned early on that it’s important when speaking with reporters, particularly for television, to get to the point quickly. “You have to know going in what your message is,” he says. “What is it that you want your listener to take away? And you have to stick to that.” A long, contemplative introduction or a speculative interpretation (the kind a physician might offer at a medical conference) is likely to get edited out of a two-minute nightly news segment, and the critical information the public needs

can get lost. “You want your message right up front,” he says. “You don’t want to give a lot of qualifiers.” What’s more, physicians who don’t get to the point can be surprised when they see their much-chopped quotes. “You see it and think, I was much more eloquent than that!”

In addition to fielding requests from reporters, Hilden does a live radio show called “Healthy Matters” on Sunday mornings on WCCO AM, during which he talks about health issues and takes calls from listeners. Because listeners introduce topics during the calls, he isn’t able to prepare as he would for a reporter’s interview. “I think it’s important to say when you don’t know something,” he acknowledges. “If you’re humble and you can say, ‘Well,

you’ve really stumped me,’ that really goes a long way.” Appropriate humility from a doctor is helpful for the public, too, he adds. “One of the realities of being a physician in our society, is that people—rightly or wrongly—tend to listen to us.”

Learning the Hard Way

Interacting with the media tends to get easier with experience, note physicians who do interviews often. But crucial lessons sometimes come out of painful incidents. One that neurologist Mark Mahowald, M.D., still can’t forget happened 20 years ago when he was interviewed by a reporter from the *Village Voice*. An East Coast colleague passed his name along, and Mahowald agreed to comment for a piece the reporter said was about the importance of animals in biomedical research. Mahowald, who directed the Minnesota Regional Sleep Disorders Center and is now a visiting professor of psychiatry and behavioral medicine at Stanford University, says his lab had made inroads in the study of people with abnormal REM sleep, “and we couldn’t have done that if it hadn’t been predicted by animal models in the 1960s.” But the published article shocked Mahowald. It was staunchly against the use of animals in research, and quoted Mahowald as though he agreed. “It was the exact opposite of what I had said,” he says. There was no recourse for the misquote, he decided, nor was it worth getting involved in a lawsuit against the paper. But the incident did prompt him to be more cautious about accepting interview requests.

These days, he’s as careful as he can be to find out who’s doing the interview. He asks the public affairs department to vet publications he’s never heard of and turns down invitations to appear on certain television shows if he feels they’re sensationalistic. When he is interviewed for publications, he asks to see the text before it goes to print. “Most of the higher-end periodicals and newspapers will let you look at an article and check for accuracy,” he says. “You should always ask.”

10 Tips

FOR TALKING TO THE MEDIA

Although media training tends not to be part of medical education, many physicians are eager for guidance. A number of resources are available. For example, the Department of Homeland Security offers science-based tips in risk communication for physicians: www.epa.gov/nhsrc/news/news040207.html. The American Association for the Advancement of Science offers guidance on how to talk about research findings: <http://communicatingscience.aaas.org/Documents/AAAS%20Media%20Tips.pdf>. Eastern Washington University has a list of dos and don'ts for working with the media worth checking out: <http://access.ewu.edu/Marketing-and-Communications/Media-Inquiries/The-nitty-gritty-of-talking-to-the-media.xml>.

Here are other tips from local veterans.

- Determine your main objective.** Before the interview begins, ask yourself what you want readers or listeners to know. "Make sure your message is clear and simple and that it specifies what you want people to do," says Ruth Lynfield, M.D., Minnesota's state epidemiologist.
 - Know privacy rules.** Don't reveal patients' private information, and be wary of sharing details that might enable a reporter to use other means to identify a patient. "There was a pregnant patient in the 35W bridge collapse," notes John Hick, M.D., an emergency medicine physician at Hennepin County Medical Center (HCMC), who was one of the first on the scene. "But we were careful not to say that because reporters could potentially contact hospitals or find other sources to get her name."
 - Use language that's understandable and free of medical jargon.** "You want to be able to explain information in plain English," advises forensic pathologist and medical examiner Lindsay Thomas, M.D. "You can always write up a journal article that will have the appropriate scientific details and terminology."
 - Be proactive about contacting the media.** When a case of anthrax turned up recently in Minnesota, health department officials were quick to get the word out that it was a single incident involving an individual who had been in environments where anthrax exists in the soil, that the FBI had ruled out bioterrorism, and that the patient was doing well. "A case like this is likely to get into the press, and people might get very upset," Lynfield says. "It's important to say, 'This is what we know, it's being investigated, people are being treated appropriately, and it's not a concern for the general public.'"
 - Be empathetic as you answer questions and give information.** Health concerns often hit home—and sometimes involve deaths. You'll be a source the public wants to hear from and your message will have more impact if you use a supportive, sensitive tone, Lynfield says.
 - State what you know based on medical evidence or studies; avoid speculation and personal opinions.** "Physicians are often asked about topics that they're not necessarily experts on," says David Hilden, M.D., an internist at HCMC and host of WCCO radio's "Healthy Mat-
- ters." "I'm often asked about diets, when a nutritionist would be more of an expert. It's important to separate out your opinions from the medical facts. Doctors have to be careful about what they say because people believe it."
- Repeat the take home-message to reinforce your point.** Lynfield's approach: Don't presume the reporter will focus all the information the way you want. Help them by stating, "What I would like your readers to know is. ..."
 - Give the journalist your contact information in case questions arise when he or she is preparing the story, and be available for follow-up inquiries.** This will give you the best opportunity to get correct information across. "Be sure to return reporters' calls," advises Thomas.
 - Take the risk of talking to the press.** "The press is going to get a story, whether you cooperate or not. I'd rather be part of the story and have some influence on what the story says," explains Thomas. "The biggest fear anyone has is that they're going to look stupid, that things will be taken out of context, and their words will be misconstrued. But it's so important because physicians have knowledge that the general public doesn't have. We need to put ourselves out there and take the risk because it's in the public's best interest."
 - Never say "no comment."** Says Hick, "If you don't want to answer a question, redirect your answer to state the message you want to get across. But don't refuse to answer. It just looks like you're hiding something."—K.L.

There are lessons to be learned, others point out, even when the media exposure goes well. Hick, for example, discovered something following the collapse of the 35W bridge that he hadn't realized before, despite his extensive experience with the press: not to put staff in front of the cameras and microphones too soon. During the days after the incident, several medical spokespeople had trouble staying composed in front of the cameras. "In hindsight," he says, "we probably shouldn't have put some people in front of the camera. They were too raw, they were still choked up. Because they didn't have a lot of media training or background and, because of the intensity of what they'd experienced, there was a lot of emotion, and they just couldn't go on talking. If you're going to do an interview, you need to feel you're not going to be injured as a part of it."

Part of the Job

Gary Schwitzer believes that even if physicians may not seek to be in the public eye, they have a responsibility once they get there. A longtime health reporter who later worked for Mayo Clinic, Schwitzer was a professor of journalism and media ethics at the University of Minnesota until last year, when he left to devote himself to his passion: running the media watchdog website he started, HealthNewsReview.org. The site grades health-related articles on such factors as whether the reporting is balanced, the information is accurate, conflict of interest is disclosed, and whether it contributes to sensationalistic disease mongering. "It's not your responsibility as a physician to ensure, because you have no control over that, how the filed story comes across," Schwitzer says. "But we all have to think what our ultimate contribution is to patient or public understanding."

For physicians, one of the primary responsibilities is not to opine on a topic but to present evidence-based informa-



Most of the higher-end periodicals and newspapers will let you look at an article and check for accuracy. You should always ask.

—MARK MAHOWALD, M.D.



tion. Too often these days, he says he sees physicians, particularly those on television shows, standing in as journalists. But then they give opinions that become promoted as "news."

Another critical responsibility, he says, is to help the public understand subtler concepts such as the tradeoffs between the potential benefits and side effects of treatments. Training in how to convey risk would be helpful for most doctors, Schwitzer believes, and would benefit society as a whole. In the recent reporting on findings that prostate cancer screening puts men at risk for unnecessary procedures, physicians had an obligation to explain the issues to a public that surveys have shown "believes that in health care more is always better, newer is always better, screening always makes sense for everybody," he says. "We have to ask ourselves, 'Are we guilty of simplifying and promoting false certainty, when we ought to be admitting, and grappling, and helping the public understand the rampant uncertainty that exists?'"

Don't Go it Alone

Many medical institutions have media personnel who will help a physician run through possible questions before an interview or even teach strategies to elucidate the key message that will be helpful for the public. Mayo Clinic's Mary Jurisson, M.D., a physical medicine and rehabilitation specialist, found media

training helpful as she began doing interviews about topics ranging from arthritis to rehabilitation for patients having hand transplants. She notes that physicians tend to think like scientists and often see all the nuances rather than the single message that consumers need as a takeaway.

Jurisson admits that when she first began doing media interviews she struggled to determine the most effective points and questioned whether they could be expressed accurately while being concise. A session with the public affairs department helped her learn to encapsulate the information that was most relevant, and that, she says, has alleviated some of the stress that goes with doing an interview. "I'd never anticipated giving interviews," she says. "It wasn't that media training gave me sudden confidence—but I didn't have to go it alone. It was a huge relief to know I could get help."

MM

Kate Ledger is a St. Paul writer and a frequent contributor to *Minnesota Medicine*.

Deciding Factors

Physician authors explore the complexities behind patients' medical decisions.

| BY CHARLES R. MEYER, M.D.

Making decisions is so easy these days. To pick a restaurant, look at the best restaurant issue of *Mpls-St. Paul Magazine*. To choose a movie, see whether Roger Ebert gave it a thumbs-up or thumbs-down. To choose the best route, go to Google Maps. For patients needing to make a medical decision, things aren't so simple. Choices rarely boil down to thumbs-up or thumbs-down and options seldom can be neatly ranked. We physicians are charged with helping patients chart their journey, but finding the right way can be perplexing for both doctor and patient. Although Boston oncologist Jerome Groopman and endocrinologist Pamela Hartzband's book *Your Medical Mind: How to Decide What Is Right for You* is written for patients, it holds sage advice for physicians as trip planners.

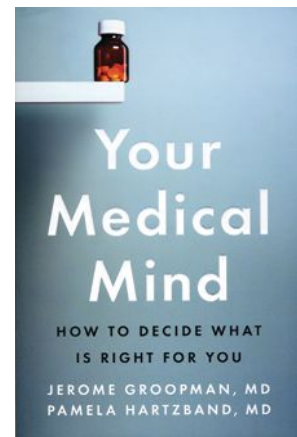
To understand how patients make important medical decisions, Groopman and Hartzband conducted extensive interviews with patients wrestling with medical problems. Most were well-educated, thoughtful people who tackled problem-solving aggressively. I would place the medical dilemmas they faced—including prostate cancer, breast cancer, hypercholesterolemia, and end of life—on my Top 10 in terms of the most difficult to counsel patients about. In all of these situations, right answers are elusive and decision-making about care is arduous.

Groopman and Hartzband tap psychological theories and mathematical models to explain why patients choose one path over another. The patient, they note, is a complex human package with pre-existing biases and fears. Some are "minimalists" who walk into the doctor's office wanting to do as little as possible and hesitate to try something new ("the

devil you know is better than the one you don't"). Some search for the "natural" way, shunning chemicals and the high-tech answers of modern medicine. Some come in prepared to believe what the doctor has to say—"blank slates" on which physicians can write the answer; others are born doubters, ready to reject whatever is offered. Each mindset will drive the search for a solution and shape the eventual decision.

Also influencing a person's choice are stories, leading to what Groopman and Hartzband identify as "availability bias." They write: "Certain tales and testimonials, especially those that are dramatic or unusual, become firmly imprinted in our minds; we remember them easily, and they are readily 'available' to us when we ponder difficult choices in anxious moments." The authors tell the story of a patient with prostate cancer who calculated, analyzed, listed, and explored all alternatives only to be swayed by the story of a fellow prostate cancer patient. They contend that "availability bias is perhaps the most powerful and prevalent force shaping how patients initially assess their options." Drug companies capitalize on the power of the anecdote in direct-to-consumer ads, as "they frame information about benefit in the most favorable fashion and exploit the power of availability bias using carefully crafted images and anecdotes." Good PR people know how to tell a convincing story.

Even when patients look at statistics, it is stories that are important. The authors quote mathematician/writer Howard Gardner, who explains: "All of us respond most profoundly to stories; they echo in our minds and become imprinted in our memories. Ultimately, we want numbers and graphs to tell us a story—a



Your Medical Mind: How to Decide What Is Right for You, Jerome Groopman, M.D., and Pamela Hartzband, M.D., Penguin, 2011

story where we can imagine ourselves as the central character."

Curiously, for two physicians at an academic medical center, Groopman and Hartzband distrust the current trend of universally applying statistics when choosing treatments for patients. They are concerned that statistically driven guidelines rigidly dictate treatment, resulting in "a creeping paternalism on the part of health care policy makers and insurance companies to standardize care based on guidelines." Groopman and Hartzband's approach is the antithesis of paternalism.

The authors quote a physician who notes that "caring for people is all about negotiation," negotiation that takes time and a sensitivity to whom you are talking. As Groopman and Hartzband write, "There are no shortcuts around serious, time-consuming, and emotionally charged conversations between the patient, loved ones, and doctors. ... Such conversations do not follow one script and sometimes take sharp detours. But repeated communication can bring clarity to the complex choices that all of us may one day face."

In the end, the physician doesn't drive patients to their destination or tell them the best route; instead, he or she shows them the map, tells them about the rough roads, and stays with them as they decide how to make the journey. **MM**

Charles Meyer is a practicing internist and editor in chief of *Minnesota Medicine*.

The End of the Medical Deity

Deciding what's right for a patient is no longer about bringing them around to the doctor's way of thinking. | By Therese Zink, M.D., M.P.H.

There is no longer a medical deity. During my medical training in the 1980s, the concept of a god-like, all-knowing physician was disintegrating. In 1999, the Institute of Medicine's watershed report "To Err is Human" dealt the fatal blow. It pointed out that preventable mistakes by medical personnel in hospitals killed more than 44,000 patients a year, more than the number who die each year from suicide (34,600) or homicide (18,400).

Clinics and hospitals retooled and struggled to build a "safety culture." Medicine was turned on its ear. It became O.K. for staff to check and recheck each other's work. It was not only O.K., it was a co-worker's responsibility to ask questions if a physician's order did not seem right.

This culture shift should have been a huge relief to physicians. However, it required us to recalibrate our thinking about apologies. And we had to learn another skill: how to explain to patients and families the collateral harm that can and sometimes does accompany our remedies.

During my residency, our team studied Mr. Brown's chest X-ray. What looked like a snowstorm obscured the bottom half of his left lung. The image of Mr. Brown lying on his left side showed that the white opacity had shifted and confirmed fluid in his lung cavity. We needed to insert a needle into his chest, draw out the fluid, and send a sample to the lab to diagnose the cause—infection, cancer, or heart failure.

By that time, I had done a half-dozen taps. I explained the procedure and risks to Mr. Brown and his son—that causing a leak in his chest could necessitate inserting a chest tube. I helped them sign a consent form that said we had discussed the procedure, including the risks and benefits. As Mr. Brown sat upright, I painted his back near the lower part of his ribs with betadine soap, injected lidocaine to numb his skin, inserted a needle and drained two ounces of straw-colored fluid. Mr. Brown breathed easier. "All went well," I told him and his son.



Test results from his lung fluid suggested infection, and I wrote the order for antibiotics.

Later that day, Mr. Brown was gasping for breath. Almost as pale as his sheet, he sat upright in his bed and sucked air through his open mouth. He had suffered one of the complications—his lung had collapsed. We explained the new procedure, obtained another signed consent, and inserted a 1-cm diameter tube in his chest. It would remain there for several days.

Mr. Brown's condition worsened. He spiraled downhill for reasons we could not figure out, and three days later, he died. Throughout Mr. Brown's decline, our team discussed the case with his son. We apologized for his father's death. Had the lung tap precipitated his decline and caused his death? Probably not. Still, I felt guilty.

Current research shows that it is best to apologize when something goes wrong. In the past, physicians made statements to downplay errors in order to avoid malpractice claims. This was driven to some degree by the medical deity mindset. Physicians decided what was best for the patient and presented the risks and benefits in a manner that recruited the patient and his/her family to the physician's way of thinking.

Now, physicians are encouraged to be transparent from the beginning: Be honest with patients when there is uncertainty about a diagnosis or treatment, when there is no clear answer about how to proceed. Provide as much education as possible about the risks and unexpected outcomes of the different options. Be frank when the course does not proceed as hoped. We are to say, "I am sorry. The treatment has not helped. ... This is what happened. This is what we are doing about it. We will keep you informed. Is there anything else you need?"

In this way, we become partners with patients and families, taking into account their values and goals. We weigh the pros and cons of the many treatment options as best we can and decide how to move forward. Together, we negotiate the subtleties that separate illness from health. In an imperfect world, this is a good place to start.

Yet, how realistic is it? In the heat of a crisis, when a patient treads water in an ocean of fear or pain, the list of risks is long, and the probabilities are complex, how much can one hear and process? Patients and families hear what they want to hear. Sometimes, with non-English-speaking patients, we have to talk through interpreters. These conversations can take time and are easier if a trusting relationship exists between the physician and the patient. But establishing such a relationship is often impossible in

today's disconnected health care delivery system, where a patient is admitted by an emergency physician and cared for by a hospitalist, neither of whom knows the patient. Patients, families, and physicians yearn for black and white instead of the many shades of gray.

A wife tells me that she and her husband did not understand that heart bypass surgery might cause damage to the brain and result in some dementia. Now, she watches over the retired engineer in the same way she did her children. She resents the medical team and is angry about the outcome.

An elderly woman tells me she is not using the cream I had prescribed at an earlier visit. She had seen me for a vaginal itch. After an exam, I prescribed estrogen. Thirty years of menopause had thinned her skin causing discomfort. When she came in for a follow-up, I asked if the cream was helping.

"I'm not taking it," she said. "I read the entire package insert, and it said I could get cancer."

I explained that was true, but at 79 cancer was unlikely. "You won't be using that much and cancer is a long process. The increased comfort may be worth it."

Physicians are in an untenable position. It is impossible to cover every risk, to anticipate every possible outcome, to have exactly the right words for a patient and his or her family.

I confess, in reality, it is much easier to be the medical deity. Explaining the probability of a certain risk happening is a complex discussion, often too complex for some patients to understand, and it takes time. As the medical deity, I am cloaked in authority and presumed control. I know what is good for the patient, and that is what we will do. The patient will not question my wisdom or omniscience.

Playing the medical deity, however, does not work today. No physician can or should determine what is best for a patient. There are endless possibilities, and patients and families may have values and goals that are different from our own. Some are motivated to eat right and exercise religiously; others prefer to pay for a pill. Some are ready to die; others are willing to keep trying for a miracle. Given finite resources, we must help patients make the tough decisions realizing they involve messy conversations and negotiations. Perhaps that is where we start, one imperfect human to another in an imperfect world. **MM**

Therese Zink is a professor in the department of family medicine and community health at the University of Minnesota.



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Parallel Worlds

By Fran Lebajo Wu

Mr. X didn't speak English. I'm not sure it would have helped if he had; he seemed so somnolent whenever we would round on him, rarely opening his eyes. Sometimes I wondered if he was trying to ignore me. As a medical student, I did not have much authority, nor did I pretend to. Besides, I looked like I could be his daughter. Was it humiliating to be seen half-naked by someone who might be the same age as his own daughter? I thought of my father and decided that it was.

We came every day. I think we grew on him, and especially on his family. They saw us as often as he did, if not more. There was never a moment when he was alone in his hospital room. His family brought him home-cooked food every day. This was different from the way it was with other patients. I thought, This is the way it should be. Or at least, this is the way I grew up believing it should be. His family was there so often that they started to treat his hospital room as if it were their own space. When we arrived, they would clear things out of the way, move the walker, push the chairs aside, stand up. It was as if they were welcoming us into their home.

My mother would welcome the friends I brought home from school by clearing a place for them to sit and offering them food. "Sit down! Please have some grapes. Would you like a Coke?" It

was her way of making guests feel welcome, even if they said they weren't staying long, and even if they said they weren't hungry. But sometimes my friends couldn't understand my parents, either because of their accent or because of their unconventional way of viewing the world. I often had to play the interpreter.

If there was no interpreter available, Mr. X's children would do the job. Their father, whom I imagined to be a stoic, proud man who made sacrifices for his family so that they could survive, was now too weak, too sick, and probably viewed as too simple to understand the finer details of his hospitalization. Perhaps he was encephalopathic and was otherwise a different man. Not only was there a language barrier, but also there was a cultural barrier and likely an educational barrier. The hierarchy had turned upside-down, and the children were now the ones in power, acting as middle-men between their parents and the doctors and influencing decisions.

I went to my mother's oncology appointment to smooth the lines of communication. "Doctor, can you please explain our options? My mother does not want traditional chemotherapy." I could feel the doctor's suppressed exasperation. My mother was foreign. She appeared to be ignorant. I was American-born, spoke Eng-

A medical student discovers threads of her own story in that of an immigrant patient.

lish well, and was in medical school. I could be reasoned with. What person in their right mind succumbs to cancer without a fight? The doctor didn't understand. My mother grew up in a village without electricity or plumbing. She lived a simple life, and she wanted to die a simple death at home, not in a hospital. She was not afraid of death. She understood what she was doing and believed chemotherapy would make the last moments of her life miserable.

Mr. X was going to get a second chance at life—a liver had become available and was on its way. Transplant surgery was scheduled for that night or early the next morning. This was the exciting part of medicine. Mr. X's family was excited, too; numerous family members had gathered in his room and in the halls. The hospital staff did not look favorably on their presence, and attributed Mr. X's brief episode of tachypnea and tachycardia to their disruptiveness. Mr. X's son tried to calm his father by telling a story about the first time he kissed a girl. The story seemed too normal, and thus, out of place.

Over Christmas, my family got together and did the normal things we do during the holiday season. However, we could not ignore the fact that our mom needed a wheelchair to get around. We made a point of doing as much as possible together because we didn't know if these would be our last moments with her. We held out hope, though. I had a dream in which she was standing at the kitchen sink, washing dishes, and singing—a familiar scene, but one that had not been played out for several months. Perhaps I wanted to believe that some day I would see my mother doing something as ordinary as washing dishes again.

I had a dream about Mr. X the night the liver became available. I dreamed that the next morning I found him, post-transplant, awake and alert. When I arrived at the hospital, my resident told me the real story. Mr. X had quickly gone into septic shock and had been transferred to the ICU. A new liver was now out of the question. I was crestfallen.

I passed by the ICU a couple days later and found Mr. X's

family crowded into the hall. I spotted his son and asked how everything was.

"We are going to take the life support off," he told me. "The family is here to say goodbye. Thank you for all your help."

It was hard to hold back tears. But I was comforted to learn that Mr. X's family would be allowed to dress him in traditional clothing and say goodbye before taking the machines offline. At least, I thought, they had been allowed a semblance of what they knew as normal in death, despite what modern medicine dictated. I was thankful that Mr. X's children were there to make his wishes known.

A week after I dreamed about her standing at the kitchen sink, my mother died at home, as she wished. My sister and brother were at her side. I would like to think that we, her children, made things easier for her by communicating her wishes despite what the doctors recommended. But it was only through her resolve that we could do this for her. Throughout everything she remained realistic about the prospect of death and held her ground about staying at home with minimal treatment. She had a strength and peace that was not of this world.

The final moments of life are some of the most intimate of the human experience. And now I have experienced these moments both as a daughter and as a future physician. Negotiating two very different worlds—that in which my mother raised me and that of biomedicine—I learned to appreciate how they could each make perfect sense and still be at odds with one another. Seeing my own experience reflected by one of my patients only months after my mother's death magnified the need for me, as a doctor, to put my patients and their families first by valuing their wishes even if I do not always understand the culture behind them. This way, physician, patient, and family member can face death the same way—with respect and hope.

MM

Fran Lebajo Wu is a fourth-year medical student at the University of Minnesota.

Tackling a Taboo

The first step toward alleviating burnout is talking about it.

By Patricia J. Lindholm, M.D.

Although I have felt burned out a number of times during my career, it culminated one night about 15 years ago. As a family physician in a small community, I had full-time clinic hours, did obstetrical care, had an inpatient hospital practice, and saw nursing home patients. In addition, every week I was required to work one or two 12-hour overnight shifts in the ER. That particular night I was on call to staff the ER when an obstetrical patient of mine was admitted in active labor. As I waited for the delivery, I was paged to the ER because a patient was experiencing an acute myocardial infarction. There was no other physician in the hospital at that time. It was an impossible situation. The workload was excessive, and I had no control over it.

My efforts seemed futile, and my work was not satisfying. I did not have enough hours in the day, intellectual energy, or down time to succeed in my work or in my family life. I became somewhat gruff and short with patients and co-workers. I began to think that patients should just “buck up” and deal with some of their problems without bothering me when I needed sleep or a break. I realized that I had lost the empathy that had led me to enter medicine. I began to contemplate leaving my profession.

It is clear to me now that many physicians feel they are stuck on an ever-accelerating treadmill. I think of my colleagues in various specialties whose patients’ problems do not occur on a 9-to-5 schedule. Many of them also are struggling to meet increasing “productivity” expectations, to handle the

added tasks of seeking prior authorizations and making formulary appeals, or to learn to use a new electronic medical record system. They continue to work sleep-deprived on relentless schedules, while relationships with their family members and friends suffer. How often are our colleagues “putting up a good front” in the interest of getting through another day or night? And how can we see past the façade to understand that someone may be crying for help?

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The Signs of Burnout

Not to be confused with stress, which is an unavoidable fact of life, burnout has been called “erosion of the soul.” It is a condition that has the following dimensions:

- depersonalization (we feel disconnected from or lack empathy for others—in the case of physicians, patients and/or co-workers);
- a perceived lack of effectiveness in our work, which can lead to cynicism; and
- emotional exhaustion.¹

The risk of burnout increases when we are consistently overworked and feel that we lack control over the extent to which the load exceeds our capacity. For physicians, it might manifest in a number of ways:

- Frequently failing to respond to phone messages or pages from the hospital, clinic, or emergency room;
- Refusing to complete medical records in a timely fashion;
- Showing up late for work;

- Belittling or insulting colleagues, nurses, and other staff;
- Storming out of a busy clinic or ER and leaving patients waiting; or
- Making disparaging remarks about a colleague to a patient.

Some who experience burnout spiral into depression and experience the self-loathing that can go with it (that seems to be a particular talent of mine). We feel that we have betrayed our own values and ideals, lost our ability to be empathetic, and become cynical. We conclude that we have failed in our vocation.

Mayo Clinic researchers Dyrbe and Shanafelt have found that about 30 to 40 percent of practicing physicians are experiencing burnout.² Others have found that levels of burnout among physicians range from 25 to 60 percent. Clearly, this problem is serious and prevalent. Yet, we have been reluctant to discuss it with our colleagues.

A Delicate Subject

For a number of reasons, physicians rarely admit that they are burned out. We fear the stigma associated with admitting any weakness or lack of dedication. In addition, professionally, many of us are loners. We appear to work in teams but, in reality, are each in our own silos, trying to keep our heads above water. We see our own patients, do our own paperwork, and exchange superficial pleasantries as we quickly move from one exam room to another or through the hospital. Most of us do not have access to employee assistance programs, especially if we are self-employed or a partner in a group. Even if we have access, we are reluctant to use the services of a counselor. And so we tend to suffer in silence. Consequently, physicians can feel isolated and helpless.

Reaching out to a colleague who appears burned out can seem even more risky. We fear that the person may become angry or defensive. It's not surprising that I do not recall being approached by a colleague in respect to my own experiences with burnout.

I have learned, however, that talking to colleagues about this topic can be done. Indeed, many physicians are hungry for an opportunity to share their feelings.

Several years ago, a chaplain colleague and I decided to see if we could start a physician peer support group. Each of us was experiencing a degree of personal and professional distress and could detect distress in others among us. We could see the need for having a safe place where physicians could express what they were feeling and receive support. But we struggled with how best to broach the topic with our colleagues. Chaplain Brad and I met over several weeks to discuss how to put together the group, what to do in the group, who to invite, etc. It seemed that the safest way to start was to extend personal invitations to people we felt might benefit.

Still, bringing up the subject of burnout made me anxious. I worried that these colleagues might take offense, or worse, that I might be the only one who had "needs." After all, it's one thing to work professionally in the care of a mutual patient or quality-improvement process. It's another thing altogether to have a

heart-to-heart conversation. But the issue was important to me. And I could sense that others were suffering alone, as I was. In the end, I invited individuals whom my intuition told me might need to talk. In each case, I went to the person's office, shut the door, and gently stated that I was vaguely aware of some distress in their lives and that I wanted to get some colleagues together who could support each other. To my immense relief, my invitations were gratefully accepted.

During the last three years, our group has grown from four physicians to 10. We meet twice a month and have formed a true community. We do not try to "fix" each other. We just listen to each other's stories respectfully and compassionately and offer support. The group is so confidential that only the members know the identities of the other participants.

Beginning the Conversation

I'm convinced that if I could start a conversation with colleagues about burnout, other physicians can do the same in their practice communities. A good way to start is to simply listen intently to a colleague in the moments you see them in the doctors' lounge or after meetings. Being a generous listener is one of the best ways we can help each other. Sometimes, sharing your own experience can free others to acknowledge their difficulties and begin to discuss them.

I have had a number of opportunities to speak to groups of physicians about burnout. At the end of these talks, it's not unusual for someone from the audience to thank me for opening up about my experience and my depression—topics that were once considered taboo. I also have been blogging about the issue of burnout. I have been surprised many times to hear who has been reading my blog and how they have appreciated the resources I share.

We need to realize that burnout has professional implications for physicians, that when we are burned out, we are not at the top of our game, and thus our patients and the people we work with suffer as well.

If we physicians do not heal ourselves, we will be unable to heal our patients or our health care system. We need to start by making burnout and the way we are feeling something we can all talk about.

MM

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The New Language of Medicine

Terms from commerce have found their way into medicine. How will this affect the next generation of doctors?

By Pamela Hartzband, M.D., and Jerome Groopman, M.D.

During our first year of medical school, we spent countless hours learning new words, memorizing vocabulary as if we were studying a foreign language. We discovered that some words that sounded foreign actually represented the familiar: rubeola was measles, pruritus meant itching. Now, we find ourselves learning a new language of medicine filled with words that seem familiar yet feel foreign. Patients are no longer patients, but rather “customers” or “consumers.”¹ Doctors and nurses have been transmuted into “providers.” These descriptors have been widely adopted in the media, medical journals, and even on clinical rounds. Yet the terms are not synonymous. The word “patient” comes from *patiens*, meaning suffering or bearing an affliction. Doctor is derived from *docere*, meaning to teach, and nurse from *nutrire*, to nurture. These terms have been used for more than three centuries.

What precipitated the increasing usage of this new vocabulary in medicine? We are in the midst of an economic crisis, and efforts to reform the health care system have centered on controlling spiraling costs. To that end, many economists and policy planners have proposed that patient care should be industrialized and standardized.² Hospitals and clinics should run like modern factories, and archaic terms such as doctor, nurse, and patient must therefore be replaced with terminology that fits this new order.

The words we use to explain our roles are powerful. They set expectations and shape behavior. This change in the language of medicine has important and deleterious consequences. The relationships between doctors, nurses, or any other medical professionals and the patients they care for are now cast primarily in terms of a commercial transaction. The consumer or customer is the buyer, and the provider is the vendor or seller. To be sure, there is a financial aspect to clinical care. But that is only a small part of a much larger whole, and to people who are sick, it's the least important part. The words “consumer” and “provider” are reductionist; they ignore the essential psychological, spiritual, and humanistic dimensions of the relationship—the aspects that traditionally made medicine a “calling,” in which altruism overshadowed personal gain. Furthermore, the term “provider” is deliberately and strikingly generic, designat-

ing no specific role or type or level of expertise. Each medical professional—doctor, nurse, physical therapist, social worker, and more—has specialized training and skills that are not recognized by the all-purpose term “provider,” which carries no resonance of professionalism. There is no hint of the role of doctor as teacher with special knowledge to help the patient understand the reasons for his or her malady and the possible ways of remedying it, no honoring of the work of the nurse as a nurturer with unique expertise whose close care is essential to healing. Rather, the generic term “provider” suggests that doctors and nurses and all other medical professionals are interchangeable. “Provider” also signals that care is fundamentally a prepackaged commodity on a shelf that is “provided” to the “consumer,” rather than something personalized and dynamic, crafted by skilled professionals and tailored to the individual patient.

Business is geared toward the bottom line: making money. A customer or consumer is guided by “caveat emptor”—“let the buyer beware”—an adversarial injunction and hardly a sentiment that fosters the atmosphere of trust so central to the relationship between doctor or nurse and patient. Reducing medicine to economics makes a mockery of the bond between the healer and the sick. For centuries, doctors who were mercenary were publicly and appropriately castigated, the subjects of caustic characterization in plays by Moliere and stories by Turgenyev. Such doctors betrayed their calling. Should we now be celebrating the doctor whose practice, like a successful business, maximizes profits from “customers”?

Beyond introducing new words, the movement toward industrializing and standardizing all of medicine (rather than just safety and emergency protocols) has caused certain terms that were critical to our medical education to all but disappear. “Clinical judgment,” for instance, is a phrase that has fallen into disgrace, replaced by “evidence-based practice,” the practice of medicine based on scientific data. But evidence is not new; throughout our medical education beginning more than three decades ago, we regularly examined the scientific evidence for our clinical practices. On rounds or in clinical conferences, doctors debated the design and results of numerous research studies. But the exercise of clinical judgment, which permitted

assessment of those data and the application of study results to an individual patient, was seen as the acme of professional practice. Now some prominent health policy planners and even physicians contend that clinical care should essentially be a matter of following operating manuals containing preset guidelines, like factory blueprints, written by experts.² These guidelines for care are touted as strictly scientific and objective. In contrast, clinical judgment is cast as subjective, unreliable, and unscientific. But there is a fundamental fallacy in this conception. Whereas data *per se* may be objective, their application to clinical care by the experts who formulate guidelines is not. This truth, that evidence-based practice codified in clinical guidelines has an inescapable subjective core, is highlighted by the fact that working with the same scientific data, different groups of experts write different guidelines for conditions as common as hypertension and elevated cholesterol levels³ or for the use of screening tests for prostate and breast cancers.⁴ The specified cutoffs for treatment or no treatment, testing or no testing, the weighing of risk versus benefit—all necessarily reflect the values and preferences of the experts who write the recommendations. And these values and preferences are subjective, not scientific.⁵

What impact will this new vocabulary have on the next generation of doctors and nurses? Recasting their roles as those of providers who merely implement prefabricated practices diminishes their professionalism. Reconfiguring medicine in economic and industrial terms is unlikely to attract creative and independent thinkers with not only expertise in science and biology but also an authentic focus on humanism and caring.

When we ourselves are ill, we want someone to care about us as people, not as paying customers, and to individualize our treatment according to our values. Despite the lip service paid to “patient-centered care” by the forces promulgating the new language of medicine, their discourse shifts the focus from the good of the individual to the exigencies of the system and its costs. Marketplace and industrial terms may be useful to economists, but this vocabulary should not redefine our profession. “Customer,” “consumer,” and “provider” are words that do not belong in teaching rounds and the clinic. We believe doctors, nurses, and others engaged in care should eschew the use of such terms that demean patient and professional alike and dangerously neglect the essence of medicine. **MM**

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Inaccuracy in Patient Handoffs

Discrepancies between Resident-Generated Reports and the Medical Record

By Michael J. Aylward, M.D., Tyson Rogers, M.S., and Peter G. Duane, M.D.

■ A handoff is the transfer of a patient's care from one provider to another. It usually involves both a verbal and written exchange of information. Although written handoff sheets are critical to good patient care, there is little data on the quality of information they contain. We conducted a study to assess the accuracy of handoff sheets used in one Minneapolis internal medicine residency program. We compared the accuracy of information about code status, medication allergies, medications, and problems recorded on the handoff sheet with that in the patient's medical record. We found errors were common in resident handoff sheets. Only 83 (19%) of 428 handoff sheets contained no errors. The most common error was one of omission on the medication list (69% of the handoff sheets contained a medication omission). The percentage of patient handoff sheets with code-status errors was 5.7%, and the percentage with medication allergy errors was 2.8%. Important problems were omitted from the problem list in 22% of cases.

Communication among physicians is central to the safe and effective care of hospitalized patients. The work of caring for these patients is distributed over a number of providers, hence the rotating night call system that is a component of many residency programs. This system has made the transfer of patient information between physicians necessary and important. A handoff is the transfer of care of a patient from one provider to another.

Because of the resident duty work-hour restrictions mandated by the Accreditation Council for Graduate Medical Education (ACGME), a great deal of emphasis has been placed on efficient and effective handoffs among residents. As additional restrictions take effect, the ability to perform thorough, accurate handoffs will become even more critical.

Several studies have shown that

poor continuity of care leads to more adverse events among hospitalized patients.^{1,2} For example, research has shown that mistakes related to medications made during the handoff are potentially harmful.^{3,4} Furthermore, care provided by physicians other than those on the primary team has been found to prolong hospital stays and increase the cost of care; this may be a consequence poor-quality handoffs.² The Joint Commission has identified improving handoffs as a national patient safety goal, citing problems with communication as "the single most frequent cause of medical errors."⁵ In addition, the ACGME has designated interpersonal and communication skills and professionalism as core competencies of physicians.⁶ The ability to complete an effective handoff encompasses these competencies.

The term "handoff" is synonymous with "sign out" and "check out." How-

ever, it does not imply cessation of patient care or relinquishing responsibility for the care of a patient. Handoffs usually include a verbal as well as a written component. The verbal component is often done informally in a busy work environment. The written component, the handoff sheet, is a document that is typically passed from the primary team to the covering team. The information in the handoff sheet should be succinct, accurate, legible, relevant, and informative.³

In most residency programs, transfer of care is an ad hoc process. Residents and medical students typically maintain patient lists in a spreadsheet or word processing template that they update daily. Patient information comes from the computerized medical record, a physician's personal note-taking system (eg, index cards), or a physician's memory. Updating the written information is often the last thing a resident does before going home for the day.

We conducted a study to assess the accuracy of information contained in the handoff sheets in one Minneapolis internal medicine residency program.

Methods

The University of Minnesota's internal medicine residency program is ACGME-accredited and includes categorical, medicine/pediatrics, and preliminary residents. There are 23 categorical, 10 medicine/pediatrics, and four prelim-

inary residents in each class. All residents rotate through three tertiary care teaching hospitals—the University of Minnesota Medical Center, Fairview in Minneapolis; Regions Hospital in St. Paul; and the Minneapolis Veterans Affairs Medical Center (VAMC). The Minneapolis VAMC was the site chosen for our study because of its robust electronic medical record system and centralized access to handoff sheets. The Minneapolis Veterans Affairs Internal Review Board approved the study.

The medicine teaching services at the Minneapolis VAMC consisted of five general medicine teams, three cardiology teams, and one intensive care team. Each medicine team, as well as the ICU team, included an attending physician, a senior resident, an intern (a first-year resident), and one or two medical students. One general medicine team had a first-year psychiatry resident who functions as a medicine intern. The three cardiology teams were each composed of a senior resident and an intern; the teams shared an attending physician. The cardiology and ICU teams provided cross-coverage on call nights. Interns typically handed off their team's patients at the end of a workday and provided cross-coverage duties on a call day. The team that was primarily in charge of a patient's care updated the handoff sheet.

The handoff sheets they used were electronic spreadsheets. Their format and content were left to the discretion of the residents. A single handoff sheet may have contained information on as many as 16 patients. At the end of the day, each handoff sheet was updated manually, printed out, and given to the resident who was covering that night. The following morning, the resident returned the handoff sheet to the primary team and updated them on events that occurred during their absence.

In a pilot study, we compared information listed in all of the domains on the handoff sheets (demographic information, patient location, code status, medication allergies, problem lists, and medication lists) with that in the medical record over one week. Using information from the pilot, a physician focus group identified

the most important handoff sheet domains: code status, medication allergies, the problem list, and medications. Criteria for assessing accuracy were established based on clinical importance, feasibility, and a review of the literature.

For the full study, we collected data from the four domains identified by the focus group for two nonsequential complete call cycles for each team during January and February of 2006. The time frame was chosen so that interns would have gained about six months of experience with cross-covering and creating handoff sheets since starting their program. Different residents were working during the two call cycles. Each day of the call cycle, the handoff sheets were printed out in the morning, ensuring that they were identical to those carried by the intern the night before. Information from each of the four domains on the handoff sheet was compared with that in the medical record.

A worksheet was created to facilitate abstraction of data from the handoff sheets and medical record. Unique confidential patient and team identifiers were used. Code status and medications were coded as being correct, having errors of omission, or having errors of content. An error of omission meant that information was in the medical record but not on the handoff sheet. An error of content meant that information on the handoff sheet was not in the medical record or was incorrect. The total number of medications prescribed was also noted. Medication allergies were coded as correct or omitted.

Abstraction was performed every morning during the study period by a physician who was not involved in patient care. Entries regarding code status, medications, and medication allergies on the handoff sheets were compared with those in the computerized order system. The problem list was compared with progress notes made by nurses, residents, interns, and attending physicians during the previous two days. The criteria for a problem-list discrepancy was the omission of a major problem that potentially or actually required intervention. These criteria were designed by the authors to capture omis-

sions with practical relevance to a cross-covering intern. The day of the week and the day of the call cycle were also captured.

Because residents often intentionally omit a number of medications from handoff sheets, we generated a list of medications that, if omitted from the handoff sheet, would not be counted as errors. On that list were vitamins, psyllium, Maalox, acetaminophen, iron, all stool softeners and laxatives, calcium, sublingual nitroglycerin, guaifenesin, and all inhaled and nebulized medications. These medications are commonly prescribed and generally do not lead to adverse outcomes. Several of the medications, including sublingual nitroglycerin, are on the hospital's admission order set.

We determined error rates for each team in each domain. For code status and medication allergy status, we identified the percentage of handoff sheets that were discrepant from the medical record. For the problem list, we used the percentage of days in which there was a discrepancy between the problems listed on the handoff sheet and those in the medical record. We expressed medication errors as a ratio (the number of drugs omitted from the handoff sheet and the number of content errors divided by the correct number of medications). We then determined the mean discrepancy rate for each domain (Table).

Results

A total of 428 patient handoff sheets were created by 36 residents over the course of the two nonconsecutive call cycles. The handoff sheets contained information on 186 patients. One handoff sheet was deleted, and its information was not captured because of a computer error.

Eighty-three (19%) of the 428 patient handoff sheets were completely without error. The percentage of patient days with a code status handoff error was 5.7%, and the percentage of patient days with a medication allergy error was 2.8%. Important problems were omitted from the handoff sheet 22% of the time. Examples of problems omitted from the problem list include changes in mental status, urinary tract infections, knee effusions, pneu-

Table

Discrepancies between Manually Created Handoff Sheets and the Medical Record

Domain	Mean discrepancy rate	Variation among 18 teams
Code status	5.7%	Nine teams with no errors, six teams had one error, three teams had two errors
Medication allergy	2.8%	13 teams had no errors, four had one error, one had two errors
Problem list	22%	Ranged from 0% to 45%
Medications (omissions + content)/ medications	16%	Ranged 6% to 40%
(omissions/medications)	11%	Ranged from 6% to 23%

monias, congestive heart failure, acute renal failure, line infections, anemia if transfused within 48 hours, alcohol withdrawal, atrial fibrillation or flutter requiring rate control, and spontaneous bacterial peritonitis.

The most common error on the handoff sheet was an omission on the medication list (69% of the handoff sheets contained medication omissions). Twenty-six percent had one medication omission, 44% had more than one, and 5.6% had more than six medication omissions. The rate of discrepancies between the handoff sheets and the medical record is shown in the Table.

Handoff sheets were likely to have an error on the first day rather than on subsequent days. Eighty-three percent of code-status errors, 100% of medication allergy errors, 66% of problem-list discrepancies, and 89% of medication discrepancies occurred on Day 1 of observation. When there was a patient handoff error on the first day of observation, it was significantly more likely that there would be additional errors on subsequent days, as compared with when there was no error on the first day: 100% vs. 1.6% for code status errors, 80% vs. 0% for medication allergy errors, 74% vs. 23% for problem-list discrepancies, and 96% vs. 43% for medication discrepancies. The *P*-value for all comparisons was <0.001 using a chi-square test. Day of the week was not associated with increased errors. Errors tended

to occur more frequently later in the call cycle, but this became significant only for medication allergy errors (*P*=0.005), which were most common for patients admitted on the last day of the cycle.

Discussion

Our data show that errors are common on manually created resident handoff sheets. The most common ones involved medications and problem lists. Although code status and medication allergy errors were less common, their potential consequences can be serious. A previous study showed that residents began resuscitation on patients whose code status was DNR based on inaccurate information on handoff sheets.⁴ More concerning is the case of a patient who wishes to be full code and no attempt at resuscitation is made. It is unlikely that a handoff sheet would be the sole source of advanced directive information in such a situation. However, a patient’s code status may influence how a physician views that patient (eg, providing less aggressive medical care to someone who is DNR/DNI). Regardless, the fact that the information is believed to be important enough to communicate to covering providers dictates that it be correct.

For one of every six medications listed on the handoff sheet, there was a discrepancy with the medical record. In all cases, the patient was either on a different medication or a medication was listed that the patient was not taking. Multiple errors

regarding medications were common. For example, 44% of handoff sheets omitted more than one medication the patient was taking, and 5.6% omitted more than six medications. A clinically significant problem was omitted from the problem list 22% percent of the time. The high error rates in the medication and problem lists are likely because the information in these domains often changes during the course of a patient’s hospitalization. Code status and medication allergies rarely change during a hospitalization.

The first day that a patient is handed-off is a critical point. Virtually all of the code-status errors, all of the medication allergy errors, and most of the medication and problem-list errors on the handoff sheets occurred on the first day of admission. The first-day errors are likely the result of the fact that completing the handoff sheet is a low priority for residents on busy admitting days. The first day is also when the bulk of data must be entered into the document.

The persistence of errors and the occurrence of new ones speak to the residents’ failure to update handoff sheets. The reasons residents do not update handoff sheets are myriad. Fatigue, interruptions, and workload all likely contribute to making errors. Also, handing off 16 patients is more complex than handing off only a few. The level of involvement of the senior resident or the attending in the creation of handoff sheets may also affect the error rate.

Few articles in the medical literature describe what constitutes the “best practice” for handing off patient care. The handover process in the aviation and aerospace industries, which also have complex work environments, is more regimented and structured than it is in hospitals. The airline industry has long used checklists for preflight and inflight processes. In the aerospace industry, handovers are scheduled events, and no interruptions are allowed. Audio flight controller loops, checklists, and the involvement of the incoming controller in identifying potential problems facilitate the process.⁷

Physicians can apply several lessons

from these industries to ensure that patient handoffs are accurate, standardized, useful, and succinct. First, the importance of the handoff needs to be recognized, and a formal curriculum to improve handoff skills should be implemented.⁸ The curriculum should emphasize the importance of the initial handoff and the need for thorough daily updates after that. The majority of internal medicine programs in the United States do not provide any handoff education to their residents.⁹ Residency programs instead use lectures and coaching by attending physicians to improve resident handoffs. At the University of Minnesota, all internal medicine and medicine-pediatrics residents attend a handoff workshop during their orientation.¹⁰⁻¹² Second, sufficient time should be given to the process, and interruptions should be limited.⁸ Third, handoff sheets should be standardized and their creation automated to decrease human error. Ideally, handoff sheets would be automatically created from within an electronic medical record and then printed out or updated online. More systematic creation of handoff sheets results in fewer adverse events, and standardizing the forms results in better-quality handoffs.¹³⁻¹⁸ Since this study, the Minneapolis VA has implemented a system for automatic creation of hand-off reports from the medical record. Although a standardized handoff sheet may decrease the likelihood of errors during the handoff, care must be taken to not make them overly prescriptive, as that may inhibit information exchange.⁸

Our study has several limitations. Patient outcome data were not collected, and, therefore, it is not clear whether errors on handoffs had any effect on patient outcomes. In addition, our audit did not capture the verbal component of the handoff, which may have provided more information than what was available on the handoff sheet. Another limitation was the fact that even though the residents involved in our study are representative of those in the residency program as a whole and the handoff process is consistent with that used at other teaching sites, our audit consisted of a discrete sample of residents

at a single institution during a limited time period.

The abstraction was done entirely by one of the authors, which may have led to bias or errors. Bias may have played a role in the assessment of problem-list omissions; however, the other measures are objective comparisons between the medical record and the handoff sheet. Errors also may have been introduced during the manual abstraction process. Our data reveal the quantity of errors in written handoffs, but they provide only circumstantial evidence about the severity of those errors.

Statistically, counting the same error multiple times can confound and inflate the percentage of errors. To account for this, we summarized errors across days for each patient. An uncorrected error and a corrected error followed by a new error counted equally. Furthermore, during a call cycle, a given intern will be cross-covering once, so any errors introduced onto the handoff sheet will be novel to that intern. Counting an error multiple times has validity from the perspective of the interns, each of whom will use the information on the handoff sheet to make clinical decisions. Finally, the VAMC's medical record system might have ameliorated some handoff errors because it provides easy access to patient information.

Conclusion

Patient handoffs are an important part of inpatient care especially in the context of resident duty-hour restrictions. Our study found that manually created handoff sheets provide inaccurate information or even fail to provide critical patient information to covering teams. Standardizing handoffs, automating the process, and emphasizing their importance may improve handoff accuracy and patient care. **MM**

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Meeting the Needs of Somali Patients at the End of Life

By Keith M. Swetz, M.D., Abdi A. Jama, M.D., Onelis Quirindongo-Cedeno, M.D., and Lena Hatchett, Ph.D.

■ Given the large number of Somali refugees living in Minnesota, it is likely that Minnesota physicians will encounter Somali patients, some of whom will have serious illnesses. Although our knowledge of Somali expectations about health care is growing, little has been written about the Somali people's views of treatment for life-threatening illnesses or their ideas about end-of-life care. After encountering a Somali man with advanced cancer in our practice, we attempted to learn about the Somali view of death and dying and the kind of treatment Somali patients might want during their final days. We share what we learned so that others might provide more culturally competent end-of-life care for Somali patients in the future.

Since the early 1990s, Somalis have been fleeing civil unrest in their homeland and relocating to the United States. During each of the last 10 years, between 2,000 and 13,000 Somali-born immigrants have become U.S. citizens.¹⁻⁴ At least 30% (32,000 according to 2010 U.S. Census data) of Somalis living in the United States now live in Minnesota, with many making their homes in the Twin Cities and Rochester.^{5,6} This number may underrepresent the number of Somalis in Minnesota, as some Somalis may not have fully established a place of residence and others may come to Minnesota as a result of cross-state or secondary migration after resettling in the United States.

Because the state has such a large Somali population, being able to provide culturally competent medical care to these newcomers is of critical importance. Not surprising, there has been growing interest among physicians and

other health care providers in how to best serve this population. A number of studies have examined what providing culturally competent care for this population means. Some have explored specific aspects of care. For example, one published in this journal focused on Somali refugee women's attitudes about health and their preferences regarding care¹; another focused on tuberculosis prevention and treatment.⁷ In addition, there is a growing amount of general information about providing culturally competent care, and a handful of reviews of Somali culture and history are available (Table 1). However, little has been written about providing culturally appropriate end-of-life care to this population.

Articles that focus on Islamic attitudes toward end-of-life care and common Islamic views of death and dying are often not specific to Somali patients.^{8,9} Indeed, much of the medical literature

regarding end-of-life care for Muslims focuses on Arab populations and misses the sociocultural variations among Muslims in Africa including Somalis.

Our intent in this article is to provide information that others have not. We share the story of a patient who inspired us to learn about the Somali people's beliefs regarding death and dying, and we discuss what we learned about providing end-of-life care to Somali patients.

Case Study

A 41-year-old Somali man, who immigrated to the Twin Cities about 13 years ago, presented at our emergency department for evaluation of advanced lung cancer that had metastasized to the spine. He was subsequently admitted to our inpatient service. During the previous 10 months, the patient had been treated elsewhere with chemotherapy and radiation therapy and was becoming increasingly weak. He was having difficulty walking and was in severe pain. He came to our institution for a second opinion regarding his diagnosis and the extent of his disease, and to learn about any remaining treatment options. The patient and his wife strongly believed that his weakness stemmed from prior radiation and that his chronic back pain was the result of

Table 1

Key Resources Regarding Somali History and Culture and Cultural Competence

Author (Date)	Title	Available at
Putnam and Noor (1999)	The Somalis: Their History and Culture	www.cal.org/co/publications/cultures/somalis.html
Centers for Disease Control and Prevention (2010)	Promoting Cultural Sensitivity: A Practical Guide for Tuberculosis Programs that Provide Services to Persons from Somalia	www.cdc.gov/tb/publications/guidestoolkits/EthnographicGuides/Somalia/chapters/SomaliTBBooklet.pdf
Lewis et al. (1996)	Somali Cultural Profile	http://ethnomed.org/culture/somali
Hospice Minnesota (2007)	Serving Somali Patients and Families in End-of-Life Care	http://mnhpc.org/wp-content/uploads/2009/12/Somali-End-of-Life-Care-Guidelines1.pdf
Stratis Health (2007)	Culture Matters: The Cultural Competency Initiative	www.stratishealth.org/documents/CC_Somali_121907.pdf
Betancourt et al. (2002)	Cultural Competence in Health Care: Emerging Frameworks and Practical Approaches	www.commonwealthfund.org/Publications/Fund-Reports/2002/Oct/Cultural-Competence-in-Health-Care--Emerging-Frameworks-and-Practical-Approaches.aspx
U.S. Department of Health and Human Services, Office of Minority Health	National Standards on Culturally and Linguistically Appropriate Services (CLAS)	http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15

an injury and not his cancer.

During the initial three days in our hospital, his attending physicians wanted to do as much as possible to improve his quality of life. The man was having significant pain and thus was very receptive to titration of his medication for pain. In addition, we performed neurologic exams that suggested worsening spinal cord involvement from his cancer.

We tried to talk to him candidly about his disease. However, he was unwilling to use an interpreter (which is our standard practice for patients who are not proficient in English) and instead wanted to communicate through his son, who was about 18 years old. We honored this request on most days, which may have limited our ability to have a detailed conversation; but nevertheless, we kept the patient engaged to the extent he was comfortable discussing his situation. He openly talked about his work and family with the physicians and social workers; however, when questioned about his medical condition, he would defer to his wife. He did not appear to be open to discussing the severity of his medical

situation, nor did he wish to discuss end-of-life preferences. The social worker reported that he responded to her questioning, “I don’t know, I don’t know, talk to my wife.” Other providers were met with a similar response.

After radiation therapy at our hospital, we suggested the possibility of ongoing rehabilitation for his weakness, given his spinal tumor. His wife resisted our efforts to transfer him to a regional rehabilitation hospital, insisting that her husband was too weak to be moved. After two weeks in our facility, the man did agree to go to the rehabilitation facility. A follow-up appointment with oncology was scheduled for several weeks later to discuss advanced-line chemotherapy. The patient never made it to that appointment. He died three weeks after discharge from our hospital. We do not know the details surrounding his death.

Despite providing treatment that was consistent with the patient’s stated preferences, his discharge and subsequent death left something to be desired. Efforts to meet the patient where he was were made, but team members would have liked to

have made a greater connection with him and to better appreciate the lens through which he viewed his situation. It is likely that our team will encounter a situation similar to this one again, given that we see a number of Somali patients. For that reason, we wanted to understand how to provide better end-of-life care to those patients.

Beliefs about Illness and Dying

To better appreciate the sociocultural complexities of caring for Somali immigrants, we reviewed the Somali Cultural Profile, which provides both general historical and geographic information about Somalia as well as information about cultural values and traditions.¹⁰ We also interviewed physicians and other health care workers who are Somali immigrants regarding attitudes toward death and dying and palliative care and hospice.^{10,11} We found no articles in the medical literature that focused specifically on end-of-life issues in Somali culture.

We learned that death and dying are generally accepted as being a natural part of life in Somali culture; death is recognized as inevitable and is considered a predestined fate. Understanding these views in the context of Islamic traditions is helpful, as the vast majority of Somalis are Sunni Muslims.¹⁰ Whether death is the result of a progressive disease or an acute event, it is commonly believed to be the will of God (Allah). Some refer to “return to God” instead of “death” to describe their belief about what happens to one’s “soul.”¹¹

The belief that death is a normal, inevitable part of life often leads Somali immigrants to avoid getting preventive care, as they may take a “why bother” approach to preventing the unpreventable. Although most Somalis are unfamiliar with preventive health measures, most are familiar with vaccinations, as they tend to be used to prevent overtly manifesting, infectious diseases.¹²

Somali immigrants know about diseases that have overt signs or symptoms, that are treatable, that tend to affect younger people, that can be evaluated with available resources, and that are communicable. These include malaria, tuberculosis,

diarrheal illnesses, and hepatitis—all of which are common in their homeland. There is, however, a general lack of understanding about noninfectious diseases with less-overt symptoms such as cancer or cardiovascular disease. This may be changing as more Somalis see loved ones diagnosed with these diseases and understand that they sometimes are preventable or treatable.

When Somali patients are confronted with a diagnosis of cancer or stroke or another serious illness, providers may encounter varying degrees of acceptance. Cancer, for example, is sometimes regarded as a disease that does not affect Somali people. This belief may lead Somali patients to request a second opinion or delay seeking care.

Intensive Care Utilization and Advance Care Planning

Because resources are limited in Somalia, most medical care (ie, intensive care) is reserved for younger patients who have a reasonable chance of recovery. Given this, the concept of life being sacred at all costs and being extended through aggressive use of technology can seem strange to Somalis. How patients and their families perceive intensive care measures will vary largely based on whether they believe the measure will be effective. Hemodialysis or ventilator use, for example, might be accepted if the patient or family consider the patient's condition reversible. It would be less likely for a family to buy into long-term life-sustaining therapies if they did not allow the patient to be at home. In addition, Somali patients and families may have a limited understanding of what life-sustaining technologies can do.

It is generally accepted in our society that there is no moral, ethical, or legal difference between withholding or withdrawing life-sustaining treatment.¹³ Somali patients or families might feel differently. They may have more difficulty withdrawing treatments once they are started than withholding them in the first place. And although removal of some life-support technology or medications may be accepted, Somalis may be quite resistant to

Table 2

Communication Models for Eliciting Patients' Perspectives Related to Illness

The LEARN Model	Kleinman's Explanatory Model
<p>LEARN is a mnemonic that represents a guideline for conducting medical interviews with patients from other cultures.</p>	<p>These questions are designed to elicit a patient's perception of their illness.</p>
<p>L Listen with sympathy and understanding to the patient's perception of the problem</p>	<p>1. What do you think caused your problem?</p>
<p>E Explain your perceptions of the problem</p>	<p>2. Why do you think it started when it did?</p>
<p>A Acknowledge and discuss the differences and similarities</p>	<p>3. What do you think your sickness does to you?</p>
<p>R Recommend treatment</p>	<p>4. How severe is your sickness? Do you think it will last a long time, or will it be better soon in your opinion?</p>
<p>N Negotiate treatment</p>	<p>5. What are the chief problems your sickness has caused for you?</p>
	<p>6. What do you fear most about your sickness?</p>
	<p>7. What kind of treatment do you think you should receive?</p>
	<p>8. What are the most important results you hope to get from treatment?</p>

withdrawal of long-term enteral nutrition because feeding is viewed as an ordinary and necessary part of life. Patients or families from any culture may experience distress if they are required to make decisions about whether to withhold treatment, but it is helpful to understand the general root of this belief, which in the case of Somalis may be based in Islamic faith.¹⁰

Although Somali patients may find it difficult to make a decision about treatment, they may be quite accepting of truthful information regarding a poor prognosis caused by a terminal illness. However, specific predictions (ie, having six months to live) may not be as well-received, as they may seem contrary to the idea of a predestined future.

Few Somalis have participated in formal advance care planning such as completing a living will or advance directive. So what can providers do to make sure their patients' wishes are being honored? Because they regard physicians as respected members of society and often look to them for help when making decisions about care, Somali patients expect medical providers to put forth formal

recommendations regarding a plan of care. In doing so, providers may ask if anyone in the family is a medical provider and enlist that person's help. They also might enlist the elders in the family. Either way, they need to be patient, as the need for collaboration can delay decisions about care.¹¹

Finally, providers should be mindful of the extent to which an individual patient and his or her family are acculturated. In many Somali families, members of the younger generation are caring for their parents and grandparents. This dynamic can be challenging as members of different generations may have very different views of health care and life and death. Health care providers should explore with each patient and family their understanding of the patient's medical problem, the goal being to develop a treatment plan that is mutually acceptable and culturally sensitive. Cross-cultural communication tools such as the LEARN model and Kleinman's explanatory model can help facilitate these conversations (Table 2).^{14,15}

Palliative Care and Mitigation of Suffering

Although Somali immigrants generally believe death is a part of life, experiencing or witnessing physical or psychological suffering can be distressing to patients and families alike. Therapies that relieve suffering may have a higher relative value compared with aggressive interventions, particularly if treatments that increase comfort allow a terminally ill patient to be at home rather than in the hospital. Efforts to manage symptoms, particularly overt or distressing ones such as pain or difficulty breathing, are generally welcome. Although opioids and oxygen are not readily available in Somalia, they are commonly accepted if they are needed for comfort. Because Somali immigrants have a high prevalence of post-traumatic stress disorder and other psychiatric or depressive disorders, it is especially important for providers to recognize and address emotional as well as physical causes of suffering.¹⁶

Hospice and palliative care do not exist in Somalia, so physicians should be certain that patients and their family members are on the same page regarding the goals of care. In Somalia, the expectation is that parents raise children, and children, in turn, care for parents when necessary. This may mean that recommendations for placement in a skilled nursing facility or inpatient hospice will not seem palatable to families. A treatment plan that allows for children and the community to care for terminally ill parents or elders at home and that allows for Islamic prayers and prescripts to be carried out in accord with customs would be favored over a prolonged hospitalization or placement in a nursing or hospice facility.

Conclusion

The Somali people represent an important patient population in Minnesota and in many urban centers in the United States. Given the fact that this is a growing population, it is likely that more physicians will encounter Somali patients, including those who may be nearing the end of their lives, in their practices. We hope this review will assist them as they seek to provide better end-of-life care for these patients. **MMA**

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Whose Best Interest?

By Ryan M. Antiel, M.A., Jon C. Tilburt, M.D., M.P.H., Fredric W. Hafferty, Ph.D., Michael D. Brennan, M.D., and Paul S. Mueller, M.D., M.P.H.

■ In the summer of 1910, William James Mayo, M.D., delivered the commencement address at Rush Medical College in Chicago. In his speech, he uttered words that have become the cornerstone of Mayo Clinic's model of care: "The best interest of the patient is the only interest to be considered, and in order that the sick may have the benefit of advancing knowledge, a union of forces is necessary." In this article, we reflect on issues raised by Mayo's speech that strike at the very heart of our professional identity and ask two questions: Is medicine's foremost concern the best interest of the patient? And has medicine really united over the last century in the service of patients?

In June of 1910, William James Mayo, M.D., delivered the commencement address at Rush Medical College in Chicago. He urged his audience to consider the need for physicians to work together.

As we grow in learning, we more justly appreciate our dependence upon each other ... the very necessities of the case are driving practitioners into cooperation. The best interest of the patient is the only interest to be considered, and in order that the sick may have the benefit of advancing knowledge, a union of forces is necessary.¹

That same month, Abraham Flexner delivered his now-famous report on the state of medical education and called for a more uniform and scientifically grounded approach to the training of physicians.² A few years later, in 1915, Flexner delivered an address, "Is Social Work a Profession?," to the National Conference of Charities and Corrections in Baltimore.³ In this speech, Flexner compared a number of occupations, in-

cluding pharmacy, nursing, medicine, social work, and business, to identify the qualities and characteristics of a "profession." Flexner's report and subsequent address generated considerable discussion and ultimately helped redefine the structure and content of U.S. and Canadian medical education. Although Mayo's commencement address received less national attention than Flexner's talk, the philosophy Mayo articulated complemented that of Flexner and became the cornerstone of the model of care practiced at Mayo Clinic.

At a glance, it appears that the medical profession today is struggling with Mayo's ideas. In the United States, at least, medicine looks more like a loose collection of vendors in a marketplace of products and services than a unified profession.⁴ Physicians trade in relative value units and formulate business plans and market strategies. Reconciling what some have called the "two opposing orders"—the physician's covenant to uphold patients' interests and the necessity of economic survival—appears to be no small task.⁵ And some have asked whether medicine has become "payout-

centric" rather than "patient-centric"?⁶

In this article, we revisit remarks that William Mayo made more than 100 years ago that strike at the very heart of our professional identity and ask two questions: Is medicine's foremost concern the best interest of the patient? And has medicine really united over the last century in the service of patients?

100 Years Ago

Between the late 1800s and early 1900s, medicine experienced a series of exponential changes. The educational requirement for becoming a physician shifted from high school and a two-year course to college followed by four years of medical education. At the same time, medical practice was becoming more grounded in science with "hypothesis, supposition, and fancies" being replaced by "demonstrable facts."¹ (Interestingly, Mayo expressed concern about the "dependence upon the laboratory and special investigations" hindering new physicians' clinical observation skills.) As a result of these changes, the scientifically competent, highly trained, altruistic physician was in great demand compared with what Mayo described as the "ill-prepared men of low ethical standards and often commercial instincts" of an earlier era.

During a time when physicians historically had worked independently of others, Mayo envisioned that teamwork, in a multidisciplinary sense, would transform medicine into a more patient-centered endeavor. Indeed, around the

turn of the 20th century, laboratories, radiologists, physicians, and surgeons were being combined in multispecialty group practices. According to Mayo, “a spirit of unity which was unknown to the previous generation” was starting to prevail. He believed a more rigorous, technical, and specialized medical profession would require physicians to coordinate their work and cooperate with one another. He remarked that the “sum-total of medical knowledge is now so great and wide-spreading that it would be futile for one man to attempt to acquire ... even a good working knowledge of any part of the whole.” Serious teamwork was needed for “specialism” to work well.

It should be noted that the prototype that emerged from Mayo’s vision of group practice was not embraced by all. Physicians resisted group practice for a variety of reasons; chief among them was profit.⁷ Many physicians complained that group practices cut payment rates. Although initially a for-profit entity, Mayo Clinic was placed under the ownership of a nonprofit foundation in 1919; and in 1923, the former Mayo partners, including William Mayo and his brother Charles, became salaried staff. In so doing, Mayo Clinic was criticized for “underselling” its local competition.⁷

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Medicine as a Profession—Then and Now

In his Rush Medical College commencement address, Mayo called for a professional culture that implicitly linked the needs of the patient with the character of physicians. He considered attributes such as excellence, accountability, reflection, and, importantly, altruism as central to medical professionalism. In his 1915 address, Flexner echoed Mayo’s words regarding altruism in medicine.

According to Flexner, a “true” profession possessed six characteristics. It must be intellectual in nature, consist of an ever-expanding learned body of knowledge, be practical in the object of the knowledge, require educational training, create a sort of caste, and finally be altruistic in motivation.³ Altruism, by definition, requires

self-sacrifice for the well-being of others. Flexner highlighted altruism in particular in showing how the profession of medicine differed from trades such as plumbing. “It must in fairness be said that the medical profession has shown a genuine regard for the public interest against its own, that it is increasingly responsive to large social needs.”³ In short, for Mayo and Flexner, the core of the physician’s professional identity was an altruistic desire and orientation to serve those in need.

Although professionalism recently has been endorsed as a core competency of medical education,⁸ what the term means and requires continues to be questioned and debated.⁹ Several formal statements on medical professionalism call forth the idea of altruism;^{10,11} however, in recent years, altruism has become suspect.¹² Medical students question its relevance to contemporary medical practice.¹³ Furthermore, tools that assess professionalism often lack a measure of altruism.^{14,12} In contrast to Mayo and Flexner, who both saw altruism as fundamental to medical professionalism, contemporary interpreters of professionalism tend to stress “entrepreneurial professionalism” or “lifestyle professionalism.”¹⁵ Entrepreneurial professionalism emphasizes commercialization, technical competence, and professional dominance. Lifestyle professionalism emphasizes autonomy, flexibility, and personal morality. Both interpretations could be construed to imply the opposite of altruism.

Professionalism so conceived poses a serious challenge to Mayo’s and Flexner’s ideas. Indeed, the absence of altruism from physicians’ self-identity has led some to conclude that altruism is professionalism’s “missing hero.”¹² What prompted the recent shift away from altruism as a tenet of professionalism?

.....
The Love of Money

The ethos of medicine has changed since Mayo’s and Flexner’s day. Today, multiple interests compete for the attention of both physicians and their patients.¹⁶ The demands (financial and time) of physician training, the reimbursement structures, the complex relationships between

physicians and industry, and other factors complicate physicians’ thinking about their professional identity. Medicine has become commodified, and physicians are now referred to as “providers” and patients assume the role of “consumers” who shop for goods and services.¹⁷ This recent emphasis on health-care-as-market and doctor-as-vendor is viewed by many as necessary for increasing physician effectiveness and improving the quality of care.¹⁸ Yet it may prove to be a prelude to the erosion of medicine’s identity as a true profession. It is at least worth asking if Mayo’s words of 100 years ago condemn or exonerate modern medicine, especially with regard to its emphasis on money.

Recent reports suggest that a persistent focus on money has major ramifications for human motivation, a phenomenon from which medicine is not immune. An article in the journal *Science* explores the research on the effect of money on human psychology.¹⁹ It describes nine different experiments that showed that when money is involved, people are significantly less likely to offer help to others. And with money as an incentive, people demonstrate a preference to work alone. This dynamic can have insidious effects in medicine and even undermine cooperation among physicians for which Mayo called.

In their article “Money and the Changing Culture of Medicine,” Hartzband and Groopman make a distinction between “market exchanges” and “communal interactions” and discuss the implications of the former on medicine.²⁰ They note that a market exchange simply requires payment equal to the value of the goods or services provided. In a communal interaction, however, the members of a profession understand that one will offer a service regardless of payment. Medical practice involves both market exchanges and communal interactions. But Hartzband and Groopman conclude medicine has tipped too far toward the market exchange model, making the “collegiality, cooperation, and the teamwork” that Mayo envisioned appear ever more unattainable.²⁰

Our generation is not the first to

struggle with the economics and financing of medicine. Mayo Clinic itself was not immune to the economic pressures caused by the devastation of the Great Depression. Yet, at the August 11, 1930, faculty meeting, William Mayo reminded his colleagues that money was not their chief concern: “We must not permit the material side to encroach upon our ideals I believe the heart of the Clinic has been more responsible for its extraordinary usefulness to the people and the confidence that the people have in it than any other factor.” In Mayo’s view, at the heart of Mayo Clinic, and by extension all of medicine, was the radical idea that patients come first, even in hard economic times.²¹

Does Altruism Still Have a Place?

In light of the current economic climate and efforts to reform the health care system, physicians understandably are concerned about the financial viability of the organizations they work for. No health care organization is immune from the fear and panic that economic hardship creates. Perhaps it is not surprising that in the debate about health care costs and reform, physicians have largely avoided discussion of altruism in the practice of medicine. A rare exception is Howard Brody, M.D., Ph.D., who expressed concern in a 2010 *New England Journal of Medicine* article that physicians were placing their own interests, and especially their financial interests, above the needs of their patients.²² One recent survey showed that one in three practicing U.S. physicians objects to limiting reimbursement for expensive treatments and procedures in order to expand access to basic health care for those lacking insurance coverage.²³ Furthermore, physicians in the most lucrative specialties, including procedural and surgical specialties, are the most likely to object to making the sacrifices necessary for reform. In the face of such apparent self-interest, Brody’s criticism seems all the more poignant. If physicians are to maintain their professional identity, serious sacrifices, including revisions to how and how much they are paid, must be part

of the equation.

The enduring legacy of Mayo’s vision—nonprofit, multidisciplinary, salaried group practice—frequently has been held up as a model to be emulated in contemporary debates about health care reform.²⁴ Although such a model does not eliminate physician self-interest as a concern, it may at least buffer the physician from the issue of compensation so that he or she can better focus on the best interest of the patient.

Physicians should be well-compensated, but the profession as a whole also must consider the subtle-but-significant difference between making a living and exploiting professional power for personal gain. In the words of William Mayo, our professional success will “not [be] judged by commercial standards, but by the ideals which have ever been held by the long line of worthy men of medicine who have preceded you.”²¹

In the end, we should not let how medicine is practiced become a business question to be answered by financial analysts and managers. Nor should our own entrepreneurial or lifestyle desires drive how the business of health care is run. Rather, physicians collectively should claim their professional identity rooted in history and endeavor, even at personal expense, to uphold the best interests of every patient. We may no longer be able to say that the best interest of the patient is the *only* interest to be considered. However, the best interest of the individual patient must, at the very least, be the foremost and primary interest of the practicing physician. Without that, medicine will cease to be a profession. **MM**

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Talking to Sexually Abused Children

Tips for Physicians

By Kathleen McDowell, M.A.

■ A child who has been sexually abused typically is not going to be forthcoming about the abuse. Therefore, it can be difficult and time-consuming for a physician who suspects sexual abuse to get the child to disclose what is happening. This article reviews strategies that can help physicians establish a trusting relationship with a child that may enable them to speak openly about what is going on in their lives.

Jolynn just turned 7 years old. Her mother has brought her to the doctor today because she has been complaining of stomach aches. Jolynn is sitting on the exam table when Dr. Johnson enters. She notices that the girl is sullen and is looking at the floor. Her mother notes that Jolynn does not sleep well and wakes up looking tired.

Scott is 12 years old. His school principal caught him smoking pot. Upset, his father brought Scott to his pediatrician to talk about the issue and the fact that he also has gotten into altercations with other children. As Dr. Smith enters the exam room, he notices that Scott looks very anxious.

Both doctors examine the children, asking first about physical concerns. Then Dr. Johnson asks Jolynn how long she has experienced stomach pain, and Dr. Smith asks Scott when he first smoked marijuana. Both doctors ask the children if anything is going on at home that they should know about. Each child looks at their parent, then at the doctor, and says nothing.

Each physician proceeds with the appropriate examination. Seeing no physical issues to address, each physician asks the parent if they know what is going on. Is their child under any stress? Is their child being bullied? Is there any abuse happening? Is someone touching them sexually? The parents say that nothing is going on. But is that the full story?

Most of the time that will be the full story. Jolynn may have exaggerated about her stomach aches in order to miss school. Scott may simply have succumbed to peer pressure and tried pot. However, there are enough exceptions that physicians need to consider the possibility that both children have been sexually abused. An estimated one in four girls and one in six boys will have experienced an episode of sexual abuse before they turn 18.¹ Of those who have reported abuse, 34% are under 12 years of age, and one in seven is younger than 6.2 In addition, 96% of reported female rape victims under the age of 12 know their attackers.² Twenty percent are fathers, 16% are

other relatives, and 50% are acquaintances or friends.³

A child who has been sexually abused typically is not going to be forthcoming about the abuse. She may feel she is in a no-win situation. Does she tell her secret in order to get the acts to stop and risk betraying the family? This is often the case if the assailant has threatened to harm her, her family members, or her pets if she tells. Because it can be difficult and time-consuming to get children to disclose abuse, physicians will likely have to exercise both suspicion and sensitivity if they are to tease out the source of the child's troubles.

The Psychological and Physical Effects of Abuse

There are a number of reasons for physicians to put forth the effort. For one, they and other health care providers are mandatory reporters of sexual abuse. In Minnesota, the law requires those who work in health care, social services, child care, mental health, education, law enforcement, and corrections, and the clergy, to report suspected child abuse and maltreatment. According to Minnesota Statute 646.556, when sexual abuse of a child is suspected, the responsibility of reporting falls to the person who suspects it. Physicians and others have 24 hours to make a verbal report and up to 72 hours to file a written report with either the county's child protection unit or law enforcement.

In addition, sexual abuse takes a toll on physical and mental health. Some of the long-term mental health effects of childhood sexual abuse include post-traumatic stress disorder (PTSD), depression, anxiety, and low self-esteem.⁴ These feelings and disorders can manifest in self-destructive behaviors. Children who have been abused may exhibit sexual promiscuity or turn to alcohol or other drugs to manage or decrease a flood of negative emotions or to boost positive feelings.⁵ They also may experience difficulty learning, exhibit eating disorders, and have suicidal thoughts.⁶

Childhood sexual abuse has an effect on physical health

as well. Research has shown that there are connections between childhood sexual abuse and gastrointestinal, reproductive, and pain-related issues; heart and liver diseases; and diminished immune system capacity.^{4,7} The gastrointestinal problems patients may experience as either a child or adult include irritable bowel syndrome, nonulcer dyspepsia (indigestion), and chronic abdominal pain.⁸ Girls and women who have suffered sexual abuse also are at greater risk for sexually transmitted diseases, pelvic inflammatory disease, multiple yeast infections, premenstrual syndrome, early hysterectomy, excessive menstrual bleeding, genital burning, painful intercourse, dysmenorrhea, and menstrual irregularity than those who have not.⁹ People who have experienced child sexual abuse are also at greater risk for weight gain and obesity. For example, women who had reported sexual or physical abuse as children were twice as likely as those who had not to experience obesity and depression in middle age, engage in binge eating, and report dissatisfaction with their body.¹⁰

Childhood sexual abuse also has an impact on brain development. Magnetic resonance imaging has shown the potential for structural abnormalities in the brains of children who have been abused. For example, children subjected to trauma were found to have reduced gray matter volume in areas related to visual memory.¹¹ Children who have been neglected and abused have a smaller corpus callosum with poor integration of the cerebral hemispheres compared with those who have not been abused.¹² And chronic or overwhelming stress has been shown to lead to decreased grey matter volume in the hippocampus.¹³

..... Detecting Abuse

A child who is not disclosing sexual abuse may show a number of signs and symptoms that should raise a physician's level of suspicion. Among the physical signs of sexual abuse are injuries and bruising in the genital area; pain, discoloration, bleeding or discharge from the genitals, anus, or mouth; and persistent or recurrent pain during urination or bowel movements.¹⁴ But often, the signs of sexual abuse are not visible, and a physician can only probe based on a hunch or the behavior described by a parent or guardian or exhibited in the exam room (Table). (Note that it may be a warning sign when the parent continues to answer for a child who is capable of responding for themselves.)

In these cases, the physician's challenge is to get the child to open up. This may be difficult, as the child may view the physician as yet another adult they need to fear or cannot trust. There are, however, a number of ways health care providers can put a child at ease and earn their trust:

- **Create a safe environment.** Make sure the environment is private, quiet, and familiar to the child. Let the child know that you are concerned and that you will do all that you can to keep them safe.
- **Pay attention to what is and is not being said.** How does the child respond when you are doing an examination? Does he flinch? Does he cower? How does he or she look at the parent? Is there a sense that the child feels safe and com-

Table

Potential Signs of Child Abuse

A child of any age:

- Has nightmares or difficulty sleeping without an explanation
- Seems distracted or distant at odd times
- Has a sudden change in eating habits such as refusing to eat, a loss of or drastic increase in appetite, or difficulty swallowing
- Has sudden mood swings (depression, rage, fear, insecurity, or withdrawal)
- Develops new or unusual fear of certain people or places
- Makes statements that their body is repulsive, dirty, or bad
- Shows unusual interest in or avoids things that are sexual in nature
- Refuses to go to school

Younger children:

- Behaves like a younger child (bedwetting or thumb sucking)
- Resists removal of clothes for bath, bed, toileting, diapering
- Has wetting and soiling accidents unrelated to toilet training

Adolescents:

- Engages in self-injury (cutting, burning)
- Has inadequate personal hygiene
- Abuses drugs or alcohol
- Is sexually promiscuous
- Runs away from home
- Exhibits signs of depression, anxiety
- Attempts suicide
- Shows fear of intimacy or closeness

Sources: Stop it Now! (www.stopitnow.org) and American Academy of Child & Adolescent Psychiatry

fortable with the parent? If you suspect sexual abuse may be occurring and that the parent may somehow be involved or that the child may be uncomfortable discussing it with the parent present, ask to have a conversation with the child without the parent in the room. If you do interview a child privately, be sure to have another professional in the room.

- **Be mindful of your tone and facial expression.** Is your tone inviting, safe-sounding, slow-paced, gentle? Or is it clipped, as though you are rushing to get to the next patient? Also,

remember to use kind eyes.

- **Ask simple questions about physical signs** such as, “That looks painful. Do you want to tell me how you got it?” or “Do you want to talk about that bruise you have?” Don’t ask leading questions such as “Did you get that bruise when someone hit you?” Also, avoid “why” questions, which can add to the child’s confusion and will not offer helpful information.
- **Consider the child’s age.** For young children, use simple terms and phrase your questions accordingly. For teens, consider asking the parent to leave the room and then use age-appropriate terms and ask about age-appropriate issues. Are they smoking, using drugs or alcohol? Are they being bullied or experiencing violence? Is someone touching them in ways that make them uncomfortable?
- **Refrain from correcting the child.** If you do not understand a term a child uses to describe a body part, ask the child to explain further or point to the body part. Let them use their own words. And let the child know when you understand them.
- **Let the child know that it is O.K. to feel hurt, angry, confused, or scared.**
- **If the child indicates that he or she has experienced sexual abuse, let him know that you believe him,** as it is quite rare for a child to lie about such abuse. Then tell the child you will be contacting the people who will be able to help. Protecting the child is your primary responsibility. You can discuss your concerns and your duty to report child abuse with the parent or guardian after interviewing the child. In addition, you might provide a referral for the child to a specialist or counselor.
- **Remember to respect the child’s privacy.** Refrain from asking too many details, as they will need to share their story later on.
- **Keep your emotions in check** so that you don’t inadvertently convey disapproval of the child, the parents, or the situation. Do not express judgment or blame the child or the parents.
- **Let the child know they did the right thing by letting you know about the abuse.** And let them know they are *not* to blame. They may feel guilt or fear punishment for disclosing this information.

The most important aspect of communicating with children about something as deeply personal and painful as sexual abuse is to really listen to what the child is saying. Then, make every effort to help the child feel safe.

If a child reports sexual abuse that is unsubstantiated or not supported through assessment, consider making a referral to a mental health or sexual abuse professional. Remind the child that you are their advocate, that your door is always open and that you are willing to be there as a confidant and a resource, no matter what.

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Conclusion

After examining and talking to Jolynn, Dr. Jones suspected she was being sexually molested by a family member, and he reported her case to child protection services. Scott finally told Dr. Smith that he was being abused by a neighbor; Dr. Smith contacted the authorities.

Of course, not every child exhibiting behaviors and symptoms similar to these two children is being sexually abused. However, when there is a change in a child’s behavior or when physical symptoms can’t be explained or resolved with conventional treatment, it may be that something is going on with them either at home or at school. For that reason, it is important for physicians to take the time to ask appropriate questions in a nonthreatening way and consider making referrals to mental health and other services to address further concerns.

A child may hope that a physician can figure out their problem without their having to explain what is happening and betray a family member or divulge a secret that the perpetrator told them to keep. If a child is not forthcoming, it may be that he or she is doing what is needed to avoid further abuse. For that reason, health care providers need to view children who are behaving oddly or badly with compassion and speak in ways that will help them reveal what is troubling them.

MM

Kathleen McDowell is a family sexual violence consultant in Minneapolis whose area of focus is the long-term health issues associated with child sexual assault.

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2011 Index

By Author

A

- Adams ME, Levine SC:** First New Otologic Disorder in a Century: Superior Canal Dehiscence Syndrome (The), November, 29.
- Adkinson C:** Hyperbaric Oxygen for Treatment of Problem Wounds, September, 41.
- Agarwal Z:** Foggy Night, May, 60.
- Agarwal Z:** Unknown Suffering (The), August, 56.
- Amer H, Carlsen BT, Dusso JL, Edwards BS, Moran SL:** Hand Transplantation, May, 40.
- Antiel RM, Tilburt JC, Hafferty FW, Brennan MD, Mueller PS:** Whose Best Interest?, December, 47.
- Augustson J, Patow C:** Health Care and the Environment: Local Champions, Global Impact, April, 40.
- Aylward MJ, Rogers T, Duane P:** Inaccuracy in Patient Handoffs: Discrepancies between Resident-Generated Reports and the Medical Record, December, 38.

B

- Bartholomew JR, Schaffer JL, McCormick GF:** Air Travel and Venous Thromboembolism: Minimizing the Risk, June, 43.
- Belani KG:** Postoperative Nausea and Vomiting in Pediatric Patients, March, 38.
- Bell H:** Air Care, June, 8.
- Bell H:** Drug Rep Debate (The), October, 31.
- Bell H:** Personalized Medicine, February, 22.
- Berlinger NT:** Meniere's Disease: New Concepts, New Treatments, November, 33.
- Boeke M, Griffin T, Reidenberg DJ:** Physician's Role in Suicide Prevention: Lessons Learned from a Public Awareness Campaign (The), January, 44.

C

- Carter BA, Wiberg C:** Minnesota's Prescription Monitoring Program: How to Identify Patients Who May be Abusing Controlled Substances, October, 55.
- Chan DC, Simonetto DA, Rogstad Dk, Juang JE, Leise MD, Hauser SC:** Uncommon Cause of Chronic Diarrhea and Peptic Ulcer (An), February, 51.
- Chase J, Averbeck BM, Walling L, Lim K:** MN Community Measurement Responds, January, 7.
- Christenson G:** Why We Need the Arts in Medicine, July, 49.
- Crosby A:** River (The), July, 40.

E-F

- Eggen M:** New Twist on License Renewal, April, 5.
- Falkowski C:** Illegal Drug Impersonators: The Synthetic Drug Abuse Boom, October, 52.

- Farley D:** Well-Oiled Machine (A), January, 32.
- Farley HH:** World-Class Act, April, 5.
- Firpo MT, Wagner J:** Stem Cell Research in Minnesota: Here Today, Gone Tomorrow?, May, 34.
- Fischer PR, Sohail MR:** Children and Airplanes: Are We Having Fun Yet?, June, 33.
- Freeman TI:** ACO Dilemma: Should We or Shouldn't We? (The), May, 48.
- Frisch S:** Hotel Management, September, 6.
- Frisch S:** Life in Pictures (A), July, 14.
- Frisch S:** Pilot Practices, June, 12.
- Frisch S:** Rare Encounter, December, 6.

G

- George P, Belani KG, Shukla A:** Postoperative Nausea and Vomiting in Infants and Young Children following Urologic Surgery, March, 41.
- Gillespie NH:** Consideration of the Tonsil Question (A), November, 26.
- Gourley B, Boyle-Vavra S, Jones M, Holmes M, Ruf R, DeVries A:** Comparative Genomic Sequencing of an Isogenic Pair of Clinical MRSA Isolates Obtained during and after Daptomycin Treatment Failure, February, 50.
- Guida K, LaVenture M:** EHR Adoption and Use: Results from the 2010 Minnesota Ambulatory Clinic Survey, April, 33.

H-J

- Halaas GW:** Best Care (The), February, 30.
- Hansen R, Hansen E:** Radiation Exposure and Air Travel: Should We Worry? June, 40.
- Harden L:** Driving While Low, August, 8.
- Harden L:** New Leaf (A), July, 18.
- Harden L:** Not Your Grandmother's Auxiliary, September, 10.
- Harrison T:** Pediatric Chronic Pain: There Is Hope, March, 48.
- Hartzband P, Groopman J:** New Language of Medicine (The), December, 36.
- Haugan K:** Mid-Career Crisis, January, 30.
- Hernandez BS:** Don't Assume the Worst, October, 38.
- Hofeldt RL:** Shoulder to Lean On (A), January, 47.
- Hoffmann D:** Out-Dated Drug-Rep Dress, November, 6.
- Hubbard JE:** One-Star Doc Responds (A), June, 5.
- Hustead ST:** If Only They Had Known Her, July, 12.
- Huyser M:** How Do I Help You Understand?, December, 64.
- Iglehart JK:** Bundled Payment for ESRD—Including ESAs in Medicare's Dialysis Package, May, 38.
- Imig M:** Mission Hospital, June, 56.
- Jensen AC:** Hospital Geeks, April, 11
- Joyce JJ:** Issue Calls for Reasoned Discussion, Not Politics, June, 5.

K

- Kiser K:** 25 Ways to Use Your Smartphone, April, 22.

Kiser K: Big and Getting Bigger, February, 12.
Kiser K: Body Electric (The), July, 16.
Kiser K: Drug Test, October, 20.
Kiser K: Flight Fellows, June, 7.
Kiser K: In His Own Words, May, 8.
Kiser K: iPad Project (The), April, 12.
Kiser K: Magic for Sinus Sufferers?, November, 10.
Kiser K: Matchmaker (The), May, 12.
Kiser K: Perfect Blend, August, 6.
Kiser K: Rx for Rural Pharmacies, October, 12.
Kiser K: Scaling Back, January, 12.
Kiser K: Sleeper Career, March, 6.
Kiser K: Study Break, July, 20.
Kiser K: Too Much Information, December, 12.
Kiser K: View from a Thousand Feet, June, 6.
Kiser K: What Breaks the Bond?, December, 14.
Knopp R: Empathy in 10 Minutes: A Medical Oxymoron, February, 28.
Konia MR, Belani KG: Anesthesiology Education: A New Emphasis, March, 29.
Koranne R: Role of the Long-Term Acute Care Hospital (The), September, 38.
Kralewski JE, Dowd BE, Xu YW: Differences in the Cost of Health Care Provided by Group Practices in Minnesota, February, 41.
Kuppe P: What You Can Do Now to Prepare for ICD-10, April, 37.

L

Lawson KM: Demystifying Mindfulness, January, 37.
Le M: Operation, September, 56.
Ledger K: Battling Burnout, January, 24.
Ledger K: Doctor, What's the Story?, December, 22.
Ledger K: New Transplant Patient (The), May, 24.
Ledger K: Safety First, March, 22.
Ledger K: Slowing the Revolving Door, September, 24.
Lindholm PJ: Tackling a Taboo, December, 34.
Link C: Infertility 628.2, July, 46.
Lowen JT: Body and Soul, September, 12.
Lowen JT: Disruptive Docs, January, 16.
Lowen JT: Home Alone, February, 8.
Lowen JT: Music to Their Ears?, November, 8.
Lowen JT: Pharmaceutical Pipeline, October, 16.
Lowen JT: Pressure Work, June, 15.
Lowen JT: Shave, a Haircut—and a Kidney? (A), May, 10.
Lowen JT: Sweet Debate, August, 20.
Lowen JT: Wingmen in the ED, April, 6.

M

Majhail NS, Warlick ED: To Cry or Not to Cry: Physicians and Emotions at the Bedside, January, 40.
Manahan B: Eight Suggestions for Promoting Physician Well-Being, January, 34.
Mazze R, Akkerman B, Mettner J: Overview of Continuous Glucose Monitoring and the Ambulatory Glucose Profile (An), August, 40.
McDowell K: Talking to Sexually Abused Children: Tips for Physicians, December, 50.
Mellor MA: I Believe, You Believe, July, 45.
Mettner J: Cancer Gone Viral (A), November, 22.
Mettner J: Due Process, February, 10.
Mettner J: Ill Will, January, 14.
Mettner J: Is There a Doctor on Board?, June, 25.
Mettner J: Paths to a Cure, August, 24.
Mettner J: Running Short, October, 8.
Mettner J: Virtual Visits, April, 8.
Meyer CR: Deciding Factors, December, 29.

Meyer CR: Fixes for Failing Organs, May, 4.
Meyer CR: Fouled-Up System (A), October, 4.
Meyer CR: Gadget Guy's Take on Technology (A), April, 4.
Meyer CR: Lives of My Cells (The), April, 56.
Meyer CR: Mysteries of the Head and Neck (The), November, 4.
Meyer CR: Next Round for Reform (The), February, 4.
Meyer CR: Public Service, September, 32.
Meyer CR: Re-engineering Diabetes Care, August, 4.
Meyer CR: Reinventing the Sick House, September, 4.
Meyer CR: Romancing the Sky, June, 4.
Meyer CR: Rural Medicine Revisited, January, 49.
Meyer CR: Seeking the Spark, July, 10.
Meyer CR: Shady Business, October, 40.
Meyer CR: To the Edge and Back, March, 4.
Meyer CR: Working on Wellness, January, 4.
Meyer CR: Working with Words, December, 4.
Miksaneck T: Seven Reasons Why Doctors Write, July, 47.
Moore EJ, Price DL: Robotic Surgery for Head and Neck Cancer, November, 37.
Msambichaka L: Diabetes in Tanzania, August, 30.

N-O

Nelson S: Home Care Can Reduce Readmissions, November, 6.
Niesen AD, Hebl JR: Multimodal Clinical Pathways, Perineural Catheters, and Ultrasound-Guided Regional Anesthesia: The Anesthesiologists's Repertoire for the 21st Century, March, 31.
Nesvold JH, Westman KF, Yawn BP, Anderson B: Reducing COPD Readmissions in Minnesota, October, 6.
Norrgard B: On Seeing Beauty, January, 56.
Olson A, Schultz S, Khalid H, Kornfeld-Kaplan Y, McCabe J, Lick S, Jorgenson M, Skarda P: Improving Utilization of Palliative Care in End-Stage Heart Failure, February, 50.
Orr J: More on In-Flight Emergencies, August, 5.

P

Peota C: Abbott's Pain Patrol, March, 14.
Peota C: Anti-Smoking Prophet, March, 10.
Peota C: Beacon in the State (A), August, 12.
Peota C: Family Medicine's Fan Club, December, 15.
Peota C: Futurist (The), September, 22.
Peota C: Learning from Experience, May, 16.
Peota C: Media Master, April, 15.
Peota C: Midnight Runner, June, 22.
Peota C: Novel Approach, November, 15.
Peota C: New Look at an Old Standby, November, 12.
Peota C: Reframing a Conversation, December, 9.
Peota C: Reinventing the ER, February, 6.
Peota C: Uniform Design, July, 22.
Peota C: Visual Cues, July, 17.
Peota C: Why They Regrow, November, 14.
Pereira EC, Shaw KM, Snippes Vagnone P, Harper J, Lynfield R: Review of Multidrug-Resistant Enterobacteriaceae (A), October, 44.
Plotnikoff GA: Drug-Nutrient Interactions: A Case and Clinical Guide, October, 60.
Price JL: We Need to Talk, February, 56.

R

Raju A, Sorge LA, Lounsbury J, Sorensen TD: Expanding Role of Minnesota Pharmacists in Primary Care (The), October, 49.
Reinke MB, Edwall G, Nygaard P, Zakelj J: Collaborative Psychiatric Consultations: Guidance for Primary Care Providers Who Prescribe Psychotropic Medications for Children, October, 57.

- Rettig RA:** Special Treatment—The Story of Medicare's ESRD Entitlement, May, 36.
- Rosario IC:** Obstructive Sleep Apnea: A Review and Update, November, 44.

S

- Sam-Agudu N:** Tularemia in Two South Dakota Children, July, 52.
- Sang R:** A Turning Point, September, 30.
- Santilli J:** Bethany, House of God, July, 44.
- Scanlon M:** The First and Last Days of Medicine, May, 32.
- Scherrer PD:** Safe and Sound: Pediatric Procedural Sedation and Analgesia, March, 43.
- Schoenbaum M:** Critical Access Hospitals: Hubs for Rural Health, September, 34.
- Schommer JC:** Going Over the Patent Cliff, October, 42.
- Schwartz P, Leyendecker J, Conlon M:** Hyperacusis and Misophonia: The Lesser-Known Siblings of Tinnitus, November, 42.
- Sequist ER, Montori V:** The Minnesota Partnership to Conquer Diabetes, August, 45.
- Segovis CM, Rethlefsen ML:** Social Networking Savvy, April, 30.
- Shores W:** Hospice, July, 43.
- Silversmith J:** Accountable Care Organizations: A Primer, February, 38.
- Silversmith J:** Five Payment Models: The Pros, the Cons, the Potential, February, 45.
- Skogen BJ:** Thanks for the Respect, November, 6.
- Slaughter A, Kersey JH:** Philanthropy and Scientific Medicine: The History of the the University of Minnesota's Cancer Institute, September, 47.
- Sonier JJ, Blewett LA:** Payment Reform: The Lynchpin of Health Care Reform, February, 33.
- Spoelhof GD:** We Can Do More than Assume the Worst, November, 6.
- Steinkraus LW:** When Is It Safe To Fly? Addressing Medical Conditions in Pilots, June, 36.
- Stoll L:** Kids Need Restraints, July, 12.
- Stowman AM, Bothun ED, Belani KG:** Discomfort, Delerium, and PONV in Infants and Young Children Undergoing Strabismus Surgery, March, 39.
- Sunni M, Mays R, Kaup T, Nathan B:** Recognizing and Managing Type 2 Diabetes Mellitus in Children: An Algorithm for Primary Care Providers, August, 34.
- Swetz KM, Jama AA, Quirindongo-Cedeno O, Hatchett L:** Meeting the Needs of Somali Patients at the End of Life, December, 43.
- Swetz KM, Kuczewski MG, Mueller PS:** Surrogate Decision-Making and the Need for Advance Care Planning: Issues Raised by the Al Barnes Case, April, 43.

T-V

- Terzic A, Edwards BS, McKee KC, Nelson TJ:** Regenerative Medicine: A Reality of Stem Cell Technology, May, 44.
- Van Loon J:** A Waste of Time, October, 72.

W-Y

- Warner MA:** Evolution of Safety in Anesthesiology (The), March, 27.
- Warnock E:** Unspoken Words, July, 38.
- Waytz PH:** Superb Issue, April, 5.
- Weingarten TN, Shi Y, Mantilla CB, Hooten WM, Warner DO:** Smoking and Chronic Pain: A Real-but-Puzzling Relationship, March, 35.
- Wentworth A:** Pumpkin Face, November, 64.
- Westra R, Skube S, Zant M:** HOPE Clinic: A Place to Care, November, 49.
- Weymiller A, Simonson G, Liebow M, Goodwin K, Taylor G:** Minnesota Diabetes Plan 2015: Stemming the Tide on an Epidemic and Improving Patient Care (The), August, 47.

- Wilson M, Beyder A, Beckman T:** Gout Encephalopathy: An Under-Recognized Complication of Crystalline Arthritis? February, 49.
- Wu FL:** Parallel Worlds, December, 32.
- Yawn BP:** Problem of Rigidity (A), January, 6.

Z

- Zink T:** End of the Medical Deity (The), December, 30.
- Zink T:** My Fat Ass, August, 32.

By Article Type

Book Review

- Meyer CR:** Deciding Factors, December, 29.
- Meyer CR:** Public Service, September, 32.
- Meyer CR:** Rural Medicine Revisited, January, 49.
- Meyer CR:** Shady Business, October, 40.

Clinical and Health Affairs

- Adams ME, Levine SC:** First New Otologic Disorder in a Century: Superior Canal Dehiscence Syndrome (The), November, 29.
- Adkinson C:** Hyperbaric Oxygen for Treatment of Problem Wounds, September, 41.
- Amer H, Carlsen BT, Dusso JL, Edwards BS, Moran SL:** Hand Transplantation, May, 40.
- Antiel RM, Tilburt JC, Hafferty FW, Brennan MD, Mueller PS:** Whose Best Interest?, December, 47.
- Augustson JL, Patow C:** Health Care and the Environment: Local Champions, Global Impact, April, 40.
- Aylward MJ, Rogers T, Duane P:** Inaccuracy in Patient Handoffs: Discrepancies between Resident-Generated Reports and the Medical Record, December, 38.
- Bartholomew JR, Schaffer JL, McCormick GF:** Air Travel and Venous Thromboembolism: Minimizing the Risk, June, 43.
- Belani KG:** Postoperative Nausea and Vomiting in Pediatric Patients, March, 38.
- Berlinger NT:** Meniere's Disease: New Concepts, New Treatments, November, 33.
- Boeke M, Griffin T, Reidenberg DJ:** Physician's Role in Suicide Prevention: Lessons Learned from a Public Awareness Campaign (The), January, 44.
- Carter BA, Wiberg C:** Minnesota's Prescription Monitoring Program: How to Identify Patients Who May be Abusing Controlled Substances, October, 55.
- Chan DC, Simonetto DA, Rogstad Dk, Juang JE, Leise MD, Hauser SC:** Uncommon Cause of Chronic Diarrhea and Peptic Ulcer (An), February, 51.
- Falkowski C:** Illegal Drug Impersonators: The Synthetic Drug Abuse Boom, October, 52.
- Fischer PR, Sohail MR:** Children and Airplanes: Are We Having Fun Yet?, June, 33.
- George P, Belani KG, Shukla A:** Postoperative Nausea and Vomiting in Infants and Young Children following Urologic Surgery, March, 41.
- Gourley B, Boyle-Vavra S, Jones M, Holmes M, Ruf R, DeVries A:** Comparative Genomic Sequencing of an Isogenic Pair of Clinical MRSA Isolates Obtained during and after Daptomycin Treatment Failure, February, 50.
- Guida K, LaVenture M:** EHR Adoption and Use: Results from the 2010 Minnesota Ambulatory Clinic Survey, April, 33.
- Hansen R, Hansen E:** Radiation Exposure and Air Travel: Should We Worry? June, 40.
- Harrison T:** Pediatric Chronic Pain: There Is Hope, March, 48.
- Koranne R:** Role of the Long-Term Acute Care Hospital (The), September, 38.

- Kralewski JE, Dowd BE, Xu YW:** Differences in the Cost of Health Care Provided by Group Practices in Minnesota, February, 41.
- Kuppe P:** What You Can Do Now to Prepare for ICD-10, April, 37.
- Lawson KM:** Demystifying Mindfulness, January, 37.
- Majhail N, Warlick ED:** To Cry or Not to Cry: Physicians and Emotions at the Bedside, January, 40.
- Mazze R, Akkerman B, Mettner J:** Overview of Continuous Glucose Monitoring and the Ambulatory Glucose Profile (An), August, 40.
- McDowell K:** Talking to Sexually Abused Children: Tips for Physicians, December, 50.
- Moore EJ, Price DL:** Robotic Surgery for Head and Neck Cancer, November, 37.
- Niesen AD, Hebl JR:** Multimodal Clinical Pathways, Perineural Catheters, and Ultrasound-Guided Regional Anesthesia: The Anesthesiologists's Repertoire for the 21st Century, March, 31.
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- Terzic A, Edwards BS, McKee KC, Nelson TJ:** Regenerative Medicine: A Reality of Stem Cell Technology, May, 44.
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- Wilson M, Beyder A, Beckman T:** Gout Encephalopathy: An Under-Recognized Complication of Crystalline Arthritis? February, 49.

Commentary

- Christenson G:** Why We Need the Arts in Medicine, July, 49.
- Firpo MT, Wagner J:** Stem Cell Research in Minnesota: Here Today, Gone Tomorrow?, May, 34.
- Hartzband P, Groopman J:** New Language of Medicine (The), December, 36.
- Iglehart JK:** Bundled Payment for ESRD—Including ESAs in Medicare's Dialysis Package, May, 38.
- Konia MR, Belani KG:** Anesthesiology Education: A New Emphasis, March, 29.
- Lindholm PJ:** Tackling a Taboo, December, 34.
- Manahan B:** Eight Suggestions for Promoting Physician Well-Being, January, 34.
- Rettig RA:** Special Treatment—The Story of Medicare's ESRD Entitlement, May, 36.
- Schommer JC:** Going Over the Patent Cliff, October, 42.
- Warner MA:** Evolution of Safety in Anesthesiology (The), March, 27.

Editor's Note

- Meyer CR:** Fixes for Failing Organs, May, 4.
- Meyer CR:** Fouled-Up System (A), October, 7.
- Meyer CR:** Gadget Guy's Take on Technology (A), April, 4.
- Meyer CR:** Mysteries of the Head and Neck (The), November, 4.
- Meyer CR:** Next Round for Reform (The), February, 4.
- Meyer CR:** Re-engineering Diabetes Care, August, 4.
- Meyer CR:** Reinventing the Sick House, September, 4.
- Meyer CR:** Romancing the Sky, June, 4.
- Meyer CR:** Seeking the Spark, July, 10.
- Meyer CR:** To the Edge and Back, March, 4.
- Meyer CR:** Working on Wellness, January, 4.
- Meyer CR:** Working with Words, December, 4.

End Notes

- A Look Back, March, 56.
- Agarwal Z:** Foggy Night, May, 60.
- Agarwal Z:** Unknown Suffering (The), August, 56.
- Huyser M:** How Do I Help You Understand?, December, 64.
- Imig M:** Mission Hospital, June, 56.
- Le M:** Operation, September, 56.
- Meyer CR:** Lives of My Cells (The), April, 56.
- Norrgard B:** On Seeing Beauty, January, 56.
- Price JL:** We Need to Talk, February, 56.
- Van Loon J:** Waste of Time (A), October, 72.
- Wentworth A:** Pumpkin Face, November, 64.

Face to Face

- Peota C:** Futurist (The), September, 22.
- Peota C:** Midnight Runner, June, 22.

Feature Story

- Medical Imaging, July, 30.
- Minnesota Firsts, May, 29.
- Bell H:** Air Care, June, 8.
- Bell H:** Drug Rep Debate (The), October, 31.
- Bell H:** Personalized Medicine, February, 22.
- Frisch S:** Hotel Management, September, 6.

Frisch S: Life in Pictures (A), July, 14.
Frisch S: Pilot Practices, June, 12.
Frisch S: Rare Encounter, December, 6.
Harden L: Driving While Low, August, 8.
Harden L: New Leaf (A), July, 18.
Harden L: Not Your Grandmother's Auxiliary, September, 10.
Jensen AC: Hospital Geeks, April, 11.
Kiser K: 25 Ways to Use Your Smartphone, April, 22.
Kiser K: Big and Getting Bigger, February, 12.
Kiser K: Body Electric (The), July, 16.
Kiser K: Drug Test, October, 20.
Kiser K: Flight Fellows, June, 7.
Kiser K: In His Own Words, May, 8.
Kiser K: iPad Project (The), April, 12.
Kiser K: Magic for Sinus Sufferers?, November, 10.
Kiser K: Matchmaker (The), May, 12.
Kiser K: Perfect Blend, August, 6.
Kiser K: Rx for Rural Pharmacies, October, 12.
Kiser K: Scaling Back, January, 12.
Kiser K: Sleeper Career, March, 6.
Kiser K: Study Break, July, 20.
Kiser K: Too Much Information, December, 12.
Kiser K: View from a Thousand Feet, June, 6.
Kiser K: What Breaks the Bond?, December, 14.
Ledger K: Battling Burnout, January, 24.
Ledger K: Doctor, What's the Story?, December, 22.
Ledger K: New Transplant Patient (The), May, 24.
Ledger K: Safety First, March, 22.
Ledger K: Slowing the Revolving Door, September, 24.
Lowen JT: Shave, a Haircut—and a Kidney? (A), May, 10.
Lowen JT: Body and Soul, September, 12.
Lowen JT: Disruptive Docs, January, 16.
Lowen JT: Home Alone, February, 8.
Lowen JT: Music to Their Ears?, November, 8.
Lowen JT: Pharmaceutical Pipeline, October, 16.
Lowen JT: Pressure Work, June, 15.
Lowen JT: Sweet Debate, August, 20.
Lowen JT: Wingmen in the ED, April, 6.
Mettner J: Cancer Gone Viral (A), November, 22.
Mettner J: Due Process, February, 10.
Mettner J: Ill Will, January, 14.
Mettner J: Is There a Doctor on Board?, June, 25.
Mettner J: Paths to a Cure, August, 24.
Mettner J: Running Short, October, 8.
Mettner J: Virtual Visits, April, 8.
Peota C: Abbott's Pain Patrol, March, 14.
Peota C: Anti-Smoking Prophet, March, 10.
Peota C: Beacon in the State (A), August, 12.
Peota C: Family Medicine's Fan Club, December, 15.
Peota C: Learning from Experience, May, 16.
Peota C: Media Master, April, 15.
Peota C: New Look at an Old Standby, November, 12.
Peota C: Novel Approach, November, 15.
Peota C: Reframing a Conversation, December, 9.
Peota C: Reinventing the ER, February, 6.
Peota C: Uniform Design, July, 22.

Peota C: Visual Cues, July, 17.
Peota C: Why They Regrow, November, 14.
Segovis CM, Rethlefsen ML: Social Networking Savvy, April, 30.

Letters

Chase J, Averbeck BM, Walling L, Lim K: MN Community Measurement Responds, January, 7.
Eggen M: New Twist on License Renewal, April, 5.
Farley HH: World-Class Act, April, 5.
Hoffmann D: Out-Dated Drug-Rep Dress, November, 6.
Hubbard JE: One-Star Doc Responds (A), June, 5.
Hustead ST: If Only They Had Known Her, July, 12.
Joyce JJ: Issue Calls for Reasoned Discussion, Not Politics, June, 5.
Nelson S: Home Care Can Reduce Readmissions, November, 6.
Nesvold JH, Westman KF, Yawn BP, Anderson B: Reducing COPD Readmissions in Minnesota, October, 6.
Orr J: More on In-Flight Emergencies, August, 5.
Skogen BJ: Thanks for the Respect, November, 6.
Spoelhof GD: We Can Do More than Assume the Worst, November, 6.
Stoll L: Kids Need Restraints, July, 12.
Waytz PH: Superb Issue, April, 5.
Yawn BP: Problem of Rigidity (A), January, 6.

Medicine, Law, and Policy

Freeman TI: ACO Dilemma: Should We or Shouldn't We? (The), May, 48.
Hofeldt RL: Shoulder to Lean On (A), January, 47.

Perspective

Crosby A: River (The), July, 40.
Farley D: Well-Oiled Machine (A), January, 32.
Halaas GW: Best Care (The), February, 30.
Haugan K: Mid-Career Crisis, January, 30.
Hernandez BS: Don't Assume the Worst, October, 38.
Knopp R: Empathy in 10 Minutes: A Medical Oxymoron, February, 28.
Link C: Infertility 628.2, July, 46.
Mellor MA: I Believe, You Believe, July, 45.
Miksaneck T: Seven Reasons Why Doctors Write, July, 47.
Msambichaka L: Diabetes in Tanzania, August, 30.
Sang R: Turning Point (A), September, 30.
Santilli JD: Bethany, House of God, July, 44.
Scanlon M: First and Last Days of Medicine (The), May, 32.
Shores W: Hospice, July, 43.
Warnock E: Unspoken Words, July, 38.
Wu FL: Parallel Worlds, December, 32.
Zink T: End of the Medical Deity (The), December, 30.
Zink T: My Fat Ass, August, 32.

Retrospective

Look Back (A), March, 56.
Gillespie NH: Consideration of the Tonsil Question (A), November, 26.

How Do I Help You Understand?

By Michelle Huyser

AUTHOR'S STATEMENT:

I grew up on the Navajo reservation in Window Rock, Arizona. I am half Navajo. I have participated in many discussions about racism and consistently have felt the same way after every one: lacking the words to express how I feel but not the passion. I tried to capture some of that sentiment as I wrote this poem after participating in cultural awareness activities as part of the Rural Medical Scholars course last year.

How do I help you understand that this conversation means more to me than it does to you?

That the outcome of this conversation holds more weight for my people than it does for yours.

How do I help you understand that you can choose to have this conversation but I am automatically a spokesperson for all those like me?

That the words I choose in this conversation are the words I learned so that I can participate in the realm created for you.

How do I help you understand that every time you make a joke about this, it makes me feel uncomfortable in my own skin?

That by making that joke, you are exercising your power again without even realizing it.

How do I help you understand that the words I choose can be manipulated in every conversation I have, or you have, with another person about this topic?

I inherited that pressure; I did not choose it.

How do I help you understand that it does go both ways, but when you say that to me it feels more like an excuse than an explanation?

For every one example you give me, I can give you a hundred.

How do I help you understand that I don't have an answer, but I want to be heard?

Michelle Huyser is a second-year medical student at the University of Minnesota-Duluth.