More of her art can be found on pages 61 and 85.

Artist Fellowship from the Hawaii State Foundation

benefits of Permanente Medicine.

www.kp.org/permanentejournal

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Dorothy Faison is a senior executive in the Permanente Medical Group, PC: Permanente, Physicians and Surgeons (NWP): Ohio Region, PC, Physicians and Surgeons (NWP); Mid-Atlantic Region, PC; Northern California Region, PC; Southern California Region, PC; Southern Arizona Region, PC; Southern Nevada Region, PC; Mountain West Region, PC; New England Region, PC; and Arizona Region, PC.

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Submitting Artwork: Send us a high-quality color photograph of your art no smaller than 4”x5” and no larger than 8”x10”. Please include a cover letter explaining Kaiser Permanente association, art background, medium and a brief statement about the artwork (description, inspiration, etc). Electronic and e-mail submissions are accepted; 600 dpi resolution is required.

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In Memoriam

Doug Shearer
1962 – 2005

Being Thankful for Sunlight and Life

Some people create lists that govern their lives—to-do lists, lists of dreams, and lists of appointments. Lists provide structure. Lists help you accomplish things. Lists can also serve to remind you to schedule balance in your life—to enjoy and be thankful for what you have.

Those of us who worked with Doug Shearer, Communications Director for The Permanente Federation and an editor of The Permanente Journal (TPJ), know that Doug carried a spiral bound notebook to jot down things he wanted to accomplish each day, as well as notes from his many meetings.

His notebook tells much about him as a person. Sandwiched between the scribbled times for a meeting and work to be done are such comments as “Enjoy music on the way to work in Oakland.” “Be thankful for the beauty of yesterday’s run along the water at sunset.” “Sunlight.” “Thankful for Elizabeth and Bing—best kids in the world.”

Doug joined The Permanente Federation and TPJ editorial team in June of 2004 and quickly impressed all of us with his ability to absorb lots of data and information and make sense of it. He was a solid thought partner with a calm manner who helped others sort through issues to make sound decisions. At TPJ editorial meetings, he brought a unique perspective to article discussions that combined a policy wonk’s thorough knowledge of health issues with a creative writer’s instinct for telling a story, always expressed with a healthy mix of humor, skepticism, and enthusiasm.

Doug was originally from Mississippi and was very well read. Stacked on his desk are books that give you a glimpse of Doug: The Great Short Stories of John O’Hara, Taxi Driver, New Orleans Review, From Script to Screen: The Collaborative Art of Filmmaking, LA Confidential, Health Care Transition in Urban China, an audiotape series on The American Civil War, and a desk calendar of George W Bushisms.

The Bushisms served as great material to start off the weekly communications staff meetings. Doug’s dry, sardonic humor kept his staff motivated, and his support and follow-through created a strong team. He used his humor and strong writing skills to write for pleasure, and, at the time of his death, he was working on a screenplay.

Doug loved to surf near Bolinas in California. He said it cleared his head and the quiet of the water provided solace and a sense of peace. Living in Marin County, California, was a long way from home in Clarksdale, Mississippi, and Doug was thankful for what he had in his life—especially his wife Carolyn and their children, Elizabeth and Bing.

I don’t know if there is surfing in heaven. But I hope that Doug finds that perfect wave—in fact, I hope he surfs endlessly on a crescendo of roaring waves that resonate with the sounds of beautiful music. May he be ever thankful for that wave, as we are thankful for knowing him and counting him as a friend.

— Barbara Caruso
In this ninth anniversary issue we turn our attention to health and healing. Historically, health has meant freedom from disease, and healing hasn’t been a treatment, or even a common word, in the doctor’s approach to patients’ conditions, except for the surgeon’s reference to wound healing.

Based on the articles in this issue, I’d like to suggest that health and healing are broad in scope and multidimensional. We must increasingly define health for ourselves and for our patients in the three realms: health of mind, health of body, and health of spirit.

**Physician Health**

One of the questions I added to the Fall 2003 Northwest Permanente (NWP) Physicians’ Worklife Survey was ‘How would you rate your health in the following three areas: Mind, Body, Spirit?’ We had 500 responses out of 750 physicians, so these results are statistically significant. The rating in percentage is expressed as the top two points—‘very good’ or ‘excellent’—on a five-point scale. The results are graphically displayed in Figure 1. Physicians rated their health of mind—86%; health of body—81%, health of spirit—71%. The follow-up question was: Would you like emphasis on, or education in, the following areas? (Figure 2). Under mind, I included and they chose: psychological hardness—40%, creativity—24%, meditation—20%. Under body, they chose: fitness—51%, physical activity—44%, nutrition—23%; under spirit, they chose present in the moment—29%, discovery of meaning—19%, deep listening—12%. This was a first attempt at surveying how physicians rate themselves in mind, body, and spirit in the context of their worklife. Many physicians expressed appreciation that such a question appeared on a survey that routinely asks about clinic team practices, visits, and patient relations. They felt permission to talk about mind, body, and spirit and to include these in their clinical practice, although physicians may not yet know how to do that well. Because this survey was a statistically significant representation of NWP, I am assuming similar interest across the Permanente Medical Groups. In Spring 2004, the Northwest Healthy Eating and Healthy Active Weight (HEHAW) Group offered a conference on “Promoting Physical Activity.” This conference was a first intervention to meet the needs of 44% of Worklife Survey respondents (“Body”). In Spring 2005, this group’s follow-up conference focused on “Nutrition and Health.”

**Nutritional Health**

How is your nutritional health? I wondered about mine so I attended the first Nutrition and Health Conference, sponsored by Andrew Weil, MD, Director of the Program of Integrative Medicine at the University of Arizona School of Medicine, in March 2004. It was a remarkable experience for me. I learned a great deal about nutrition, which was personally helpful, and I returned with good information for readers of The Permanente Journal (TPJ). At the close of the meeting, there was a community symposium on the state of the nation’s health and the importance of understanding and practicing better nutrition. A Call-to-Action was read and simultaneously issued to the national media.

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Let food be your medicine, and medicine be your food.

— Hippocrates
A Life in Medicine
Anna Luise Kirkengen, MD, PhD, a primary care physician from Oslo, Norway, writes in *Encountering Particulars: A Life in Medicine*, that: “Our challenge is understanding … literally, to stand below … to be in the same place and, from there, to share somebody else’s perspective” (page 19). We, as primary care doctors, have not only the privilege of coming close, but also the obligation to come closer: to familiarize ourselves with the lives, hopes, intentions, defeats, and longings of our patients—respectfully.

Meditation, Prayer and Spiritual Healing
A special feature of this health and healing issue is *A Symposium on Meditation, Prayer and Spiritual Healing* (page 62). Five experts present the evidence for, and their experience of, incorporating one or more of these practices into their treatment approach. Marilyn Schlitz, PhD, presents the overview from her international perspective as the Director of Research and Education at the Institute of Noetic Sciences in Northern California. In *Spirituality in the Medical Encounter: The Grace of Presence*, Dr Sutherland explores enhancing the spirit of both the patient and clinician. Naomi Newhouse, CNM, recounts a spiritual encounter of a crosscultural healthy birth with the whole family present. Charles Elder, MD, demonstrates, through the current literature, the effective outcomes of meditation as an internal medicine practice. And Chaplain Kurt Smidt-Jernstrom relates his hospital practice of spirituality in assisting patients coping with serious illness and death.

Soul of the Healer
Finally, we are proud to announce the publication this summer of *Soul of the Healer: The Art & Stories of The Permanente Journal. The First Seven Years*. Motivated by our readers’ comments, we created this book to bring together the art and stories they note are so beautiful and uplifting.

The editors hope you enjoy a healthy and healing journey as you read through this issue and our subsequent publications.
A Call to Action

by The University of Arizona College of Medicine’s Program in Integrative Medicine and The Rosenthal Center for Complementary and Alternative Medicine of Columbia University College of Physicians and Surgeons

1. We believe that the population of North America is in great nutritional peril. People are consuming increasing amounts of low-quality foods. There is an epidemic of obesity and in its wake rising incidence of type 2 diabetes in younger and younger children. More people than ever are following extreme and fad diets that may pose long-term risks to health. The food served in schools, hospitals, and senior facilities promotes obesity, chronic inflammation, and accelerated development of age-related diseases. We are also concerned about food safety, given the practices of factory farming, conventional agriculture, and the genetic modification of foods. And we are dismayed to watch the successful exportation of our unhealthy foods and eating habits all over the world.

2. The current state of nutrition education of health professionals is non-existent to substandard. This is particularly true in the training of medical doctors. The scientific literature is exploding with information about optimum diets and the effects on health, both good and bad, of particular foods, components of foods, and dietary supplements, but this information does not find its way into the training of clinicians.

3. Some consequences of the nutritional illiteracy of physicians are:
   • Physicians are unable to counsel patients about an optimum diet or make use of dietary change as a primary therapeutic intervention or help patients be informed consumers of dietary supplements.
   • The medical profession is unable to act as a social and political force to counteract the commercial pressures that have led to the ubiquity of fast food restaurants and soft drink and low-quality-snack-food vending machines in public schools and hospitals.
   • The food served in hospitals and medical centers in North America—both that served to patients and that served to staff—is full of high-glycemic-load carbohydrates, unhealthy fats, and less desirable proteins. It includes processed and refined foods that are contraindicated for the prevention of heart disease, cancer, and many other chronic diseases. It must be a highest priority that our medical centers serve healthy food.
   • More than 20% of US hospitals now have fast food restaurants on their premises. This is unacceptable. How can the medical profession encourage people to make better dietary choices if it cannot itself exemplify healthy eating habits?

4. The nation is in the grip of low-carb mania, the latest dietary craze. It is important for people to understand that an optimum diet includes a balance of carbohydrates, fats, and proteins. Carbohydrates are not bad foods any more than fats are. It is important for people to understand, however, that there are good and bad carbohydrate foods, good and bad fats, and better and worse protein choices.

5. If there is any category of foods that are bad, it is highly refined and processed foods. Modern food technology tends to reduce the nutritional benefits of natural food sources and increase their health risks, as exemplified by the refining and processing of vegetable oils and the processing of whole grains into unhealthy snack foods.

6. We recommend that people decrease consumption of the following foods: foods of animal origin (other than fish), refined and processed foods, fast food, high-glycemic-load carbohydrates, and polyunsaturated vegetable oils. We recommend that they eliminate margarine, vegetable shortening, and products made with partially hydrogenated oils.

7. We recommend that people increase consumption of the following foods: fruits and vegetables, vegetable protein sources, low-glycemic-load carbohydrates (eg, beans, whole grains, sweet potatoes, winter squashes), monounsaturated vegetable oils, nuts and seeds, and omega-3 fatty acid sources (eg, oily fish or fish oils, walnuts, flax seeds, hemp seeds).

8. We recommend counseling consumers that dietary supplements are not substitutes for the whole foods that contain them. They may be useful as insurance against gaps in the diet and as natural therapeutic agents to help prevent or treat specific diseases. Pharmacists, physicians and other health professionals must be educated about their appropriate uses, benefits, and dangers.

9. We strongly support organic agriculture and better production, distribution, and marketing of organic produce to make it available and affordable to more people.

10. We call on industry to demonstrate leadership in improving the eating habits of North Americans instead of defending their current practices as “giving people what they want.” We want to see a new generation of fast food restaurants with healthy offerings, modification of snack and convenience foods to conform to current nutritional guidelines, and downsizing of portions. (Typical portions served in restaurants or packaged for individual sale are two to three times the standard serving size. Giant-sized soft drinks sold in convenience stores cost much less per ounce than small ones.) We applaud companies that have begun to do this, for example by removing sources of trans fats from processed foods. We encourage the public to patronize food companies that follow the principles set forth here.

11. We believe that the obesity epidemic in North America must be addressed by attention to physical activity as well as to eating patterns. Physical activity has gone down in our population, with many people exercising less than 30 minutes per week.

12. We must work to develop strong programs in nutrition education for physicians and other professionals, including pharmacists, who should be reliable experts on the benefits and dangers of dietary supplements. We must also work to educate consumers about nutrition and healthy eating and get this information into K-12 curriculums for our children.

13. We emphatically state our belief that healthy food can be delicious, convenient, and affordable.

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Dear Editor,

I am from Kaiser Permanente Woodland Hills, Department of Quality Improvement. I have worked for KP for 18 years in this field. I just wanted to share with you that I have just had the opportunity to read The Permanente Journal (Winter 2005) and wanted to say it is “AWESOME.” I enjoyed “Soul of the Healer” and the various quotes while reading some very informative articles. I am looking forward to future Journals.

Jacqueline Johnson, RN
Quality Management Coordinator
Woodland Hills Medical Center
Woodland Hills, CA

Let us hear from you.

We encourage you to write, either to respond to an article published in the Journal or to address a clinical issue of importance to you. You may submit letters by mail, fax, or e-mail.

Send your comments to:
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Be sure to include your full address, phone and fax numbers, and e-mail address. Submission of a letter constitutes permission for The Permanente Journal to publish it in various editions and forms. Letters may be edited for style and length.
Dr Jacobs,

Thank you for your article (Disaster relief: What can I do to help? Winter 2005: p 99)—I found it to be complete and well written. I just returned from a trip to Banda Aceh, and your article really hit on a number of important points, including footwear (I had only brought boots and found myself pulling them on and off quite a bit when visiting in people’s homes—on the other hand, it made a rather dramatic impression on the local people of the lengths I would go toward showing respect).

I used an Extream water bottle and was pleased with its performance (at least so far—I’ll be more certain after the incubation period passes).

Regarding prophylaxis—I had one member of another team have a psychotic break that was probably induced by mefloquine and triggered by the stressful conditions in Banda Aceh. It ate up a lot of time and resources and was frightening for many of the people involved. Thankfully, it resolved well for the man afflicted. However, many of the long-term relief workers gave anecdotal reports of similar problems linked to mefloquine. KP Travel Service prescribed Malarone, which many of us took without incident.

One point I would add is in regard to clothing: Most of the team were in scrubs, but I wore “technical” clothing designed for hot weather, and I was much more comfortable and less limited than they were. It is tempting to wear scrubs in a hot climate, but they actually tend to be a bit heavy and don’t provide enough protection from sun and insects. Long sleeves and pants were better suited to the terrain as well as the culture.

Record keeping was another matter that would have been better to work out ahead of time—paper was in short supply, and there had been the expectation that a record-keeping system was already in place. The nonmedical Field Coordinator didn’t have a comprehensive understanding of the needs of medical caregivers. Printing up new forms was not impossible two months after the tsunami, but it wasn’t a simple matter either.

Your article will help all involved in such missions be better prepared for what will actually happen. Can I get a copy in digital format so that I can share this information with future medical teams going out through my church?

Thanks again,
Tom Leighton, MD
Chief of Emergency Medicine
South Bay Medical Center
Harbor City, CA

—Reply
Dr Leighton:

Thank you for your letter. You have provided some excellent embellishments to my paper. Your comments on the best clothing in hot climates were especially helpful.

Thank you for commenting on the Extream water bottle. Such water filters are invaluable. I’m always amazed how many travelers trust the bottled water in the field, and I am never too surprised when they incur significant waterborne infections.

Malaria prophylaxis is always a challenge. Very necessary, but never without the risk of bothersome side effects. While most people actually tolerate Lariam (mefloquine), many do get significant gastrointestinal and psychotic problems. Although daily Malarone (atovaquone/proguanil) is promoted as a better tolerated option, I have not found the incidence of side effects to be much less than with weekly Lariam. The recommendation for Banda Aceh is daily doxycycline—100 mg daily. However, I have heard from a few individuals who took doxycycline for prophylaxis in Banda Aceh that they developed persistent lightheadedness, and one got severe vertigo. Again, no real easy answer, but when you see how rapidly falciparum malaria kills, as we did in Banda Aceh, there is no doubt that the value of prophylaxis far outweighs the risks of side effects. I have found the CDC Malaria Web page to be the best reference (www.cdc.gov/malaria/).

A pdf version of my article may be accessed on the TPJ Web site: http://xnet.kp.org/permanentejournal/winter05/relief.pdf.

Thanks again for your comments.
Lee D Jacobs, MD
Health Systems Editor
Abstracts of Articles Authored or Coauthored by Permanente Physicians

From the Northwest:

OBJECTIVE To test the long-term efficacy of brief counseling plus a computer-based tobacco intervention for teens being seen for routine medical care.

METHODS Both smoking and nonsmoking teens, 14 to 17 years of age, who were being seen for routine visits were eligible for this two-arm controlled trial. Staff members approached teens in waiting rooms of seven large pediatric and family practice departments within a group-practice health maintenance organization. Of 3747 teens invited at ≥1 visits, 2526 (67%) consented and were randomized to tobacco intervention or brief dietary advice. The tobacco intervention was individually tailored on the basis of smoking status and stage of change. It included a 30-second clinician advice message, a ten-minute interactive computer program, a five-minute motivational interview, and up to two ten-minute telephone or in-person booster sessions. The control intervention was a five-minute motivational intervention to promote increased consumption of fruits and vegetables. Follow-up smoking status was assessed after one and two years.

RESULTS Abstinence rates after two years were significantly higher for the tobacco intervention arm, relative to the control group, in the combined sample of baseline smokers and nonsmokers (odds ratio [OR]: 1.23; 95% confidence interval [CI]: 1.03-1.47). Treatment effects were particularly strong among baseline self-described smokers (OR: 2.42; 95% CI: 1.40-4.16) but were not significant for baseline nonsmokers (OR: 1.25; 95% CI: 0.97-1.61) or for those who had “experienced” in the past month at baseline (OR: 0.95; 95% CI: 0.45-1.98).

CONCLUSIONS Brief, computer-assisted, tobacco intervention during routine medical care increased the smoking cessation rate among self-described smokers but was less effective in preventing smoking onset.

From Southern California:

OBJECTIVE We sought to compare the six-month angiographic patency rates of greater saphenous veins removed during coronary artery bypass grafting with the endoscopic vein harvest or open vein harvest techniques.

METHODS Two hundred patients undergoing nonemergency on-pump coronary artery bypass grafting were prospectively randomized to either endoscopic vein harvest or open vein harvest. Follow-up angiography of all vein grafts was scheduled at six months. Graft patency and disease grades were assigned independently by two interventional cardiologists. Leg wound healing was evaluated at discharge, one month, and six months for evidence of complications.

RESULTS There were three conversions from endoscopic vein harvest to open vein harvest because of vein factors. Leg wound complications were significantly lower in the endoscopic vein harvest group (7.4% vs 19.4%, p = .014). On multivariable analysis, endoscopic vein harvest emerged as the only factor affecting wound complications (odds ratio, 0.33). Three deaths (two perioperative and one late) occurred in the endoscopic vein harvest group that were unrelated to vein graft closure. Twenty-four and 29 patients in the endoscopic vein harvest and open vein harvest cohorts, respectively, refused the follow-up six-month angiography. Therefore a total of 144 angiograms (73 endoscopic vein harvests and 71 open vein harvests) and 336 vein grafts (166 endoscopic vein harvests and 170 open vein harvests) were available for analysis. The overall occlusion rates at six months were 21.7% for endoscopic vein harvest and 17.6% for open vein harvest. Additionally, there was evidence of significant disease (>50% stenosis) in 10.2% and 12.4% of endoscopic vein harvest and open vein harvest grafts, respectively. By means of ordinal hierarchic logistic regression, endoscopic vein harvest was not found to be a risk factor for vein graft occlusion or disease (odds ratio, 1.15). Significant predictors were congestive heart failure (odds ratio, 2.87), graft to the diagonal artery territory (odds ratio, 1.76), larger vein conduit size (odds ratio, 1.32), and graft flow (odds ratio, 0.90).

CONCLUSION Endoscopic vein harvest reduces leg wound complications compared with open vein harvest without compromising the six-month patency rate. The overall patency rate depends on target and vein-related variables and patient characteristics rather than the method of vein harvesting.

From Colorado:

PURPOSE A telepharmacy service in a health maintenance organization is described.

SUMMARY: Kaiser Permanente Colorado Region’s clinical pharmacy call center (CPCC) was established in 1996 after an audit showed that the third most common type of call to the regional call center involved questions about drug therapy. The service was developed through collaboration among the phar-
From the Mid-Atlantic States: Comparison of office visit and nurse advice hotline data for syndromic surveillance—Baltimore-Washington, DC, metropolitan area, 2002.


**INTRODUCTION** Kaiser Permanente of the Mid-Atlantic States (KPMAS) is collaborating with the Electronic Surveillance System for Early Notification of Community-Based Epidemics II (ESSENCE II) program to understand how managed-care data can be effectively used for syndromic surveillance.

**OBJECTIVES** This study examined whether KPMAS nurse advice hotline data would be able to predict the syndrome diagnoses made during subsequent KPMAS office visits.

**METHODS** All nurse advice hotline calls during 2002 that were linked to an outpatient office visit were identified. By using International Classification of Diseases, Ninth Revision (ICD-9) codes, outpatient visits were categorized into seven ESSENCE II syndrome groups (coma, gastrointestinal, respiratory, neurologic, hemorrhagic, infectious dermatologic, and fever). Nurse advice hotline calls were categorized into ESSENCE II syndrome groups on the basis of the advice guidelines assigned. For each syndrome group, the sensitivity, specificity, and positive predictive value of hotline calls were calculated by using office visits as a diagnostic standard. For matching syndrome call-visit pairs, the lag (ie, the number of hours that elapsed between the date and time the patient spoke to an advice nurse and the date and time the patient made an office visit) was calculated.

**RESULTS** Of all syndrome groups, the sensitivity of hotline calls for respiratory syndrome was highest (74.7%), followed by hotline calls for gastrointestinal syndrome (72.0%). The specificity of all nurse advice syndrome groups ranged from 88.9% to 99.9%. The mean lag between hotline calls and office visits ranged from 8.3 to 50 hours, depending on the syndrome group.

**CONCLUSIONS** The timeliness of hotline data capture compared with office visit data capture, as well as the sensitivity and specificity of hotline calls for detecting respiratory and gastrointestinal syndromes, indicate that KPMAS nurse advice hotline data can be used to predict KPMAS syndromic outpatient office visits.

**CLINICAL IMPLICATION:** The anthrax attacks in 2001 highlighted the serious shortcomings of the US public health infrastructure. Improving surveillance to detect epidemics requires the cooperation of primary care providers who are the first responders to both naturally occurring and bioterror outbreaks in the community. However, public health reporting is often a provider’s last priority, secondary to the care of individual patients. When providers routinely use electronic medical record systems to document patient care, the process of reporting can be automated—information can be transmitted to health departments in near real time without interfering with the provider’s ability to care for patients. –JH


**BACKGROUND** Women aged ≥65 years are high utilizers of prescription and over-the-counter medications, and many of these women are also taking dietary supplements. Dietary supplement use by older women is a concern because of possible side effects and drug-supplement interactions. The primary aim of this study was to provide a comprehensive picture of dietary supplement use among older women in a large health plan in Northern California, USA, to raise awareness among health care providers and pharmacists about the need for implementing structural and educational interventions to minimize adverse consequences of self-directed supplement use. A secondary aim was to raise awareness about how the focus on use of herbs and megavitamins that has occurred in most surveys of complementary and alternative therapy use results in a significant underestimate of the proportion of older women who are using all types of dietary supplements for the same purposes.

**METHODS** We used data about use of different vitamin/mineral (VM) supplements and nonvitamin, nonmineral (NVNM) supplements, including herbas, from a 1999 general health survey mailed to a random sample of adult members of a large Northern California health plan to estimate prevalence of and characteristics associated with supplement use among women aged 65-84 (n = 3109).

**RESULTS** Based on weighted data, 84% had in the past 12 months used >1 dietary supplement, 82% a VM, 59% a supplement other than just multivitamin or calcium, 32% an NVNM, and 25% an herbal. Compared to white, nonHispanic women, African Americans and Latinas were significantly less likely to use VM and NVNM supplements and Asian/Pacific Islanders were less likely to use NVNM supplements. Higher education was strongly associated with use of an NVNM supplement. Prevalence did not differ by number of prescription medications taken. Among white, nonHispanic women, multiple logistic regres-
From Northern California: Development of overweight associated with childbearing depends on smoking habit: The Coronary Artery Risk Development in Young Adults (CARDIA) Study.


OBJECTIVE: To prospectively evaluate whether childbearing leads to development of overweight in women and to evaluate the role of other known risk factors.

RESEARCH METHOD: Prospective, multicenter observational study, the Coronary Artery Risk Development in Young Adults (CARDIA) Study from 1985 to 1986, examined 3,114 women at baseline and in follow-up years two, five, seven, and ten. Included were 998 (328 black and 670 white) nulliparous women, age 18-30 years, who were not overweight at baseline. Relative odds for incident overweight (BMI ≥ 25 kg/m2) associated with parity change (0, 1, or 2+) and risk factors were estimated using discrete-time survival models adjusted for baseline and time-dependent covariates.

RESULTS: Parity change-association with development of overweight depended on smoking habit (interaction, p < 0.001). In multivariate adjusted models, 1 and 2+ births vs 0, respectively, were associated with increased risk for development of overweight among never smokers [odds ratio (OR) = 2.66; 95% confidence interval (CI): 1.80, 3.93, and 2.10, 95% CI: 1.24, 3.56] and decreased risk among current smokers (OR = 0.41; 95% CI: 0.17, 0.96, and 0.36, 95% CI: 0.08, 1.65). Risk was increased for black vs white race (OR = 3.49; 95% CI: 2.59, 4.69), frequent weight cycling (OR = 1.45; 95% CI: 1.03, 2.04), and high school education or less (OR = 2.21; 95% CI: 1.50, 3.26) and was decreased for highest physical activity quartile (OR = 0.62; 95% CI: 0.43, 0.90).

DISCUSSION: Childbearing contributes to development of overweight in nonsmokers but not in smokers, where development of overweight is less likely in women who bear children. Race, education, and behaviors are important factors in development of overweight in young women.

From Hawaii: Safety and efficacy of carotid arteriography in vascular surgery practice.


OBJECTIVE: Carotid arteriography (CA) is an important method of assessing carotid artery occlusive disease and is the best method of planning for carotid angioplasty and stent placement (CAS). This study compared the results of CA performed by vascular surgeons in a contemporary series against widely recognized interdisciplinary quality standards for this procedure. Although many vascular surgeons perform CA, there is a paucity of data about its safety, efficacy, and compliance with quality standards in vascular practice. The importance of quality CA will likely increase as CAS emerges to assume a broader clinical role.

METHOD: Carotid angiograms performed by seven vascular surgeons at three institutions from September 2000 to May 2004 were reviewed. These results were compared with quality standards for the performance of CA.

RESULTS: Five hundred three carotid arteriograms were performed over 45 months. Indications for the procedure were extracranial cerebrovascular disease (86%), trauma (5%), and other conditions (9%). Indications for the procedure were appropriate in 100% of patients (as determined by guidelines document) and exceeded the recommended standard of appropriate indications in 99%. All procedures successfully provided the information required, exceeding the threshold of 98% for procedural success. Reversible neurologic deficits occurred in 0.6% (two transient ischemic attacks and one stroke) compared with the threshold of 2.5%. A permanent neurologic deficit occurred in 0.2% (one patient) compared with the published guideline of 1% after carotid arteriography. Major non-neurologic complications occurred in 1.2% (six patients), less than the standard of 2.0%.

CONCLUSIONS: The safety and efficacy of a contemporary series of CA performed in vascular surgery practice compared favorably with recognized interdisciplinary quality standards for this procedure. Ensuring safe and effective CA is likely to support the successful growth of CAS as a treatment option.
The effects of interview format on residency applicant satisfaction.
Shaffer LS, Walton DL.

OBJECTIVE Currently, there is little data on the interview format for residency in Obstetrics and Gynecology. In our community-based program, interviews are traditionally performed in groups of three-to-five applicants. Recently, our most highly regarded applicants were those who worked closely with residents and faculty during subinternships or “second look” visits. Past applicant surveys revealed dissatisfaction with the amount of time spent with residents. Was the traditional interview format giving applicants adequate exposure to our residents? Indeed, would an individual interview day result in the applicant having a better sense of our program and higher overall satisfaction?

METHODS Sixty-six applicants were interviewed for four available intern positions. Applicants were notified that individual and traditional interview formats were available during the interview period. Applicants chose the format based on their preference and availability. In the individual format, applicants shadowed the residents assigned to labor and delivery. Those in the traditional format toured the facility, were presented with a residency overview and had a question and answer session with residents and faculty. Both underwent a series of one or more formal interviews. Applicants were given a 13-item questionnaire at the conclusion of the day and asked to return it anonymously. A five-point (poor through excellent) scale and one six-item ranking of importance scale were used to evaluate the factors for applicant satisfaction during the interview day.

RESULTS Of the 66 applicants who interviewed, 28 questionnaires were returned and 25 were complete, 12 from the individual and 13 from the traditional group. All individual and 85% of traditional applicants ranked time with residents as most important during their interview ($\chi^2 = 2.0, p < 0.2$). 83% of individual and 46% of traditional applicants rated their overall day excellent ($\chi^2 = 3.74, p < 0.1$). One hundred percent of individual compared with 85% of traditional applicants responded that residents’ availability and eagerness to answer questions was excellent ($\chi^2 = 2.0, p < 0.2$). Ninety-two percent of individual versus 46% of traditional applicants rated the amount of time they spent with residents as excellent ($\chi^2 = 11.5, p < 0.001$). Finally, 83% of individual and 15% of traditional applicants rated their “sense of a typical resident day” as excellent ($\chi^2 = 11.5, p < 0.001$).

CONCLUSIONS Our applicants ranked time with residents as the most important factor during the interview. While not statistically significant, we observed that applicants in the individual format were more likely to rate the overall day and residents’ availability as excellent. Compared to those in the traditional group, applicants in the individual group rated time spent with residents and the overall sense of a typical resident’s day as excellent. Based on these results, the individual interview format may be considered to enhance applicant satisfaction and possibly to improve the “match” of applicant and program.

Effect of education on the rate of forceps-assisted vaginal deliveries in a residency program.
Crecelius AR, Brubaker KL.

OBJECTIVE To compare the rate of forceps-assisted vaginal deliveries (FAVDs) before and after intense education of patients, nurses and physicians at Kaiser Permanente Santa Clara Obstetrics and Gynecology Residency Program.

METHODS Cumulative case logs of residents’ obstetrics experience, from July 1, 1998 to June 30, 2004, were reviewed. The control group, from July 1, 1998 to June 30, 2000, represents the baseline number of FAVDs performed by residents prior to any intervention. Several attending physicians skilled and willing to teach residents FAVDs were added to our faculty in July 2000 (study group #1). In July 2002, a historical overview of FAVD training in residency and the ACOG Practice Bulletin on operative vaginal deliveries (OVDs) were reviewed with attending and resident physicians. Labor and Delivery nurses attended in-services on FAVDs. Patients received an educational handout on OVDs at their 36-week prenatal visit. Names of attending physicians interested in teaching residents FAVDs were posted in Labor and Delivery (study group #2).

RESULTS FAVDs accounted for 10.1%, 23.3% and 24.3% of OVDs in control group, study group #1 and study group #2, respectively. There was an increase in the rate of FAVDs during the study period.
from 0.9% to 3.7%. The average number of FAVDs performed by graduating residents increased from 9 to 16.

CONCLUSIONS: There was a significant increase in the rate of FAVDs at the institution from 0.9 to 3.7% after the educational process. The average number of FAVDs performed by graduating residents increased from 9 (range 5 to 13) to 16 (range 5 to 32) after a concentrated effort to increase patient and hospital staff knowledge and awareness of FAVDs. Surveyed attendings recommended an average of 21 FAVDs to be proficient, and residents came closer to that goal. The rate of FAVDs initially increased after an influx of faculty interested in instructing residents in FAVDs. The rate of FAVDs continued to increase with the education of patients and nurses. Attending physicians experienced in FAVDs are essential to bolster resident education to maintain this vital skill in the field of obstetrics.

Prevalence of neurologic sequelae, congenital cardiac malformations, and mortality of monochorionic twins.
Lee P.

BACKGROUND: It is well known that monochorionicity increases the risks of perinatal/neonatal morbidity and mortality, especially in the cases of twin-twin transfusion syndrome, and twin reversed arterial perfusion. In some cases monochorionic twins can have long-term neurologic sequelae in the absence of these two conditions. Furthermore, monochorionic twins are at increased risk of congenital cardiac malformation. Most publications on above subjects are of small numbers and selected population.

OBJECTIVE: To compare the neurologic and cardiovascular outcomes of monochorionic versus dichorionic twins.

METHODS: This is a large multicenter population-based descriptive study from the Kaiser Permanente (KP) Northern California system to look at the morbidity and mortality of the monochorionic twin pairs. A twin database maintained by the Regional Genetics/Pathology specialist was utilized in conjunction with the KP electronic records and chart review.

RESULTS: Four hundred eighty-nine twin pregnancies from 1996 to 2003 were reviewed. Mean gestational age was 35.2 weeks. In this study, number of pregnancies complicated by TTS was 16.0% and TRAP was 1.4%. Perinatal/neonatal mortality was 8.5%. Number of infants with neurologic sequelae (in particular of interests including seizure, developmental delay, cerebral palsy, audiovisual problems) was as follows: seizure was 0.5%, developmental delay was 4.7%, cerebral palsy was 1.2%, audiovisual problems was 1.4%. Number of infants with congenital heart disease was 2.5%. This study showed an association between adverse neurologic outcomes with monochorionic twins. It also confirmed previous reports of increased risk of cerebral palsy and congenital cardiac malformations in monochorionic as compared to dichorionic pregnancies. This information may be helpful in patient counseling about prognosis. Further studies comparing morbidity and mortality among monochorionic, dichorionic twins and singleton would be of interest.

Prevalence of hormone therapy use in patients with DCIS.
Habel L, Capra A, Mendez T.

BACKGROUND: The use of hormone replacement therapy (HRT) in women diagnosed with breast cancer has been typically avoided due to the concern that estrogen stimulates cancer growth. Only a few articles have reported on the prevalence of HRT use among women diagnosed with localized breast cancer. Data are also limited on use of HRT among women diagnosed with ductal carcinoma in situ (DCIS).

AIM: The purpose of this study was to describe the prevalence of HRT use among women diagnosed with DCIS.

METHODS: This is a descriptive study of 1014 female Northern California Kaiser Permanente (KP) members diagnosed with DCIS between 1990-1997 and treated with breast-conserving surgery. Cases were identified using the KP tumor registry and charts were reviewed to obtain pertinent clinical information (eg, menopausal status and symptoms, HRT use, BMI). Patients were followed through July 2002, until a subsequent cancer event developed (recurrence or other primary), or until termination of KP membership. The prevalence of HRT use among women who were or became postmenopausal after diagnosis was calculated.

RESULTS: During the median follow-up time of 63.9 months a total of 769 women were eligible for the study; 694 were postmenopausal at diagnosis and 75 became postmenopausal after diagnosis. Of the 694 women who were postmenopausal at diagnosis, 320 (46%) were current users of HRT. Sixty-six of the 320 continued to use HRT after their diagnosis and 254 stopped. Of the remaining 374 postmenopausal women with DCIS, 37 (1%) started HRT after diagnosis. Vaginal dryness was the most common reason for initiating HRT use. Seven (9%) of the 75 women who became postmenopausal used HRT for some period after their diagnosis. Hot flashes and vaginal dryness were the most common reason for use in this group. Overall, the most frequent HRT regimen used was estrogen alone.

DISCUSSION: In our population, the diagnosis of DCIS is associated with discontinued HRT use. These results are consistent with previous reports. With the recent media attention regarding the increased risk of breast cancer among HRT users (ie, Women’s Health Initiative study) it will be interesting to examine the reasons patients discontinue therapy. Given the increase in diagnosis of DCIS, it will be important to continue to examine use of HRT in this population. ✷
**Abstracts from the HMO Research Network**

**11th Annual HMO Research Network Conference**

With this issue we include abstracts from the 2005 11th Annual HMO Research Network Conference, held in Santa Fe, New Mexico that focused on “Translating Research into Practice.”

April 4-6, 2005 Santa Fe, NM

“Translating Research Into Practice—Scaling New Heights”

From HMO Research Network Member: Centers for Disease Control Patterns in weight management behavior among the enrollees of eight insurance plans

Sotnikov S, Jones R, Moonesinghe R, Etchason J. Centers for Disease Control, Atlanta, GA

During the last decade obesity has become an important driver of medical and insurance costs. Health plans are positioned to play an important role in encouraging positive changes in individual weight management behavior. How large are the variations in the incidence of obesity across health insurance plans? Which weight management techniques or combinations of techniques make some individuals more successful in achieving and maintaining their healthy weight? How does the use of these techniques differ across health plans? The 2003 ConsumerStyles survey contains self-reported data on weight and height of 5613 individuals enrolled in eight insurance plans. Individuals also reported on use of 12 weight management techniques. A body mass index (BMI) of less than 25 was used as the threshold for defining healthy weight. The difference between actual and healthy weight was used as a measure of success in weight management. A multivariate regression model was used to evaluate how that measure varied across insurance plans. Separate models were used to estimate the relationship of the measure to the types of weight management techniques employed by the individuals enrolled in each plan. The results indicated that obesity was most severe for individuals who were uninsured or on Medicaid. No statistically significant differences in the weight loss required to achieve their healthy weight was found for enrollees in Medicare, veterans’ benefits and private provider plans (HMO and PPO). Significant differences were revealed in the methods of weight management employed by individuals enrolled in different health plans. Individuals with Medicare, PPO, or HMO coverage and those without health insurance relied on exercise and high protein/low carbohydrate dieting, while those on Medicaid and Medigap were more likely to use diet pills to manage their weight. The marginal effects of health and nutrition knowledge, income, and education on excess weight were greater for persons with more severe weight problems, suggesting that targeting severely obese individuals for health and nutrition interventions may bring larger marginal benefits than a one-size-fits-all approach.

From HMO Research Network Members: Center for Health Studies, Group Health Cooperative; Henry Ford Health System; and University of Michigan

Internet-based smoking-cessation counseling: the project quit experience


**BACKGROUND** Internet-based treatment has many potential advantages, including the ability to individually tailor risk messages and health advice, and added convenience for the consumer. Tailored treatments are generally considered more salient and more effective than generic self-help programs, but it is not clear what accounts for these effects. That is, what factors are important to a successful tailored intervention? Project Quit is an Internet-based, individually tailored, smoking-cessation program. The purpose of this study is to determine the “active ingredients” of a tailored smoking-cessation intervention. Information learned from this study will be relevant to the design of other tailored behavioral interventions.

**METHODS** This project is being conducted by the University of Michigan, Group Health Cooperative (GHC), and Henry Ford Health System (HFHS). Smokers at GHC and HFHS are invited to enroll in the study. All participants receive access to a tailored online behavioral program and nicotine replacement patches. We will analyze the effectiveness of 32 different combinations of relevant tailoring variables on motivation and abstinence at six-month follow-up.

**RESULTS** Data collection is underway. Preliminary results suggest that about 4% of smokers invited to participate enroll. Demographically, participants appear similar to those in other (ie, non-Internet) cessation trials.

**CONCLUSION** Implementation of an Internet-based smoking cessation program is feasible in the health care delivery system setting, and may be a suitable adjunct to telephone-based or in-person smoking cessation programs.

From HMO Research Network Member: Kaiser Permanente Colorado Research partnerships with prevention: developing practical and generalizable health behavior interventions

Estabrooks P.

A large body of research has demonstrated that innovations are adopted at a high rate when they can demonstrate a relative advantage over the standard practice and are compatible with existing organizational values, experiences, and needs. We conducted three participatory research projects that included operational decision makers as well as staff who will ultimately deliver the proposed intervention.
Interventions to collect information on relative advantage and compatibility of new physical activity, nutrition, and weight management strategies. Each of these projects provided a case study for a participatory research model that heightens the potential of health promotion interventions to be taken to scale. As demonstrated by these case studies, interventions that were effective and were compatible with the system of care (Project 1 and 2) were adopted and implemented across Kaiser Permanente Colorado. The third intervention, although effective, did not satisfactorily fit into the current model of care and was therefore not adopted. The cases highlighted the need to ensure that health promotion interventions demonstrate both a relative advantage and that they are compatible to the existing model of care.

From HMO Research Network Member: Centers for Disease Control Knowledge of health risks, attitude about health, and prevalence of obesity and smoking Jones K, Moonesinghe R, Sotnikov S, Etchason J.

**BACKGROUND** The CDC’s chronic disease model is based on the premise that population health is a function of heredity, social circumstances, environment, medical care, and behavior. Approximately 40% of early deaths in the United States are attributed to behavioral patterns. Behavior is influenced by attitude and knowledge.

**METHODS** Data are from the 2003 ConsumerStyles and HealthStyles (CSHS) database, generated from consumer surveys of a stratified, random sample of US adults, aged 18+, over-sampled for minorities and households with children. CSHS surveys include questions regarding health beliefs, attitudes, social norms, and behaviors. We used logistic regression to analyze factors associated with obesity and smoking.

**RESULTS** The odds of being obese are significantly higher (p < 0.05) for females, blacks, people with lower educational attainment, those who exercise less than recommended, and those who perceive their weight as healthier than CDC guidelines suggest. After controlling for these and other factors, the odds that respondents who do not agree that living life in the best possible health is important (NEGATIVES) are obese increases 43% over that of respondents who agree that living life in the best possible health is important (POSITIVES). Significantly higher (p < 0.05) odds of smoking are associated with lower educational attainment. Controlling for these and other factors, the odds that NEGATIVES smoke increases 79% over that of POSITIVES. Among smokers, 46% did not agree that their smoking was a threat to their health (the percentage is higher for HMOs than PPOs (p = 0.046) and for HMOs than fee-for-service plans (p = 0.074)). Among obese respondents, 40% did not agree that their weight was a threat to their health, with no significant difference between health plan types. Among POSITIVES, 17% smoked, while a significantly higher 29% of NEGATIVES were smokers (p < 0.01). A significantly higher percentage (p < 0.01) of NEGATIVES were obese (35%) than POSITIVES (27%).

**CONCLUSIONS** These survey data reveal that misconceptions about the health effects of obesity and smoking are common and that attitudes about health affect behavior. Health plans that screen for risky health behaviors would likely benefit from screening for health attitudes and misconceptions as well.


**BACKGROUND** On average, African Americans eat fewer fruits and vegetables than all other ethnic/racial groups. We explored racial differences in participants of the pilot study for MENU, a Web-based intervention program designed to support increasing the dietary intake of vegetables.

**METHODS** Potential participants were mailed an invitation letter inviting them to the study’s Web site. Eligible participants completed an initial survey relevant to the targeted behavior change. The survey evaluated perceived general health status, change in vegetable intake as adults, and motivation, barriers, and confidence related to increasing vegetable intake.

For these analyses, respondents were subgrouped as African American (AA) or White/Other. Responses to the survey were evaluated for racial/ethnic differences by gender.

**RESULTS** A total of 530 people enrolled in this study, including 28% AA women, 35% White women, 15% AA men, and 22% White men. Women and men perceived health status equally, and both White women and men rated their health as better than AA women and men. AA and White women were similar in confidence that they could eat more servings of vegetables (68% vs 62% very confident). More AA men were very confident (63%) compared to White men (46%). For all groups, the most frequently named barrier for eating more vegetables was fear of spoilage, and the most frequently named motivation for eating more vegetables was to feel healthier (84%-90%) followed closely by weight management (70%-87%). A higher proportion of AA women and men reported eating fewer vegetables now than when young. About 40% of women compared to 66% of men who are now eating more vegetables reported some or a lot of family encouragement to eat more. Nearly twice as many AA men compared to White men said they would be motivated to eat more vegetables if recommended by their physician.

**CONCLUSIONS** Exploring differences among racial/ethnic groups is a way to better understand factors that influence dietary change. By identifying these factors, we may be able to specifically tailor intervention materials and improve efforts in changing eating behaviors.
A time for reflection
Serious introspection
A midlife pause.

So much time has passed.
Slow down, lie on the grass.
Look up at the stars
and see yourself
little once again—
ready to restart.

So now who will share
the remaining years?

How does one stop and stare
at a different reflection.

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Healing Metabolism: A Naturopathic Medicine Perspective on Achieving Weight Loss and Long-Term Balance

Introduction

Any clinician who works with patients struggling to lose weight or to maintain weight loss has observed a common paradox: that, on the basis of how much our overweight or obese patients may tell us they are eating and exercising, we believe they should be losing weight, but they aren’t. In fact, in this process of expending more energy than they consume, sometimes our patients actually gain weight. Unfortunately, clinicians may conclude—mainly out of frustration—that these patients are not being completely truthful (either with us or themselves) or that all they need is more willpower. This article introduces a framework that a naturopathic doctor (ND) may use to treat overweight or obese patients who are in this predicament.

In general, NDs consider that the equation calories in < calories out = weight loss is an oversimplification for some patients. In addition to the relation between caloric intake and activity, several other factors contribute to a patient’s overall health and, therefore, to his or her actual ability to lose weight in a sustainable and healthy way. These factors include:
- Psychological stress levels
- Exercise history
- Dietary history
- Hormone balance
- Quality and amount of sleep
- Toxic chemical exposure (for example, alcohol, tobacco, processed foods, caffeine, and pharmaceutical drugs)

All of these factors are considered to influence metabolism either directly or indirectly, because metabolism is thought to be affected by lifestyle and hormone balance and not just by heredity and caloric intake. A similar perspective has become popularized by endocrinologist Diana Schwarzbein, MD.1 Dr Schwarzbein has written several excellent, patient-oriented books on the topic of what she calls metabolic damage and healing in overweight and obese patients. In her words, a healthy metabolism has the appropriate balance between anabolic and catabolic reactions. From a naturopathic medicine perspective, the foundation for successful, healthy weight loss and maintenance is through healing the metabolism by balancing these two processes.

How Does Metabolism Become Damaged?

In the intake for an overweight or obese patient, the ND will explore, among other things, the patient’s past and current stress levels, eating habits, and exercise habits. When patients who cannot lose weight or are still gaining weight claim that they now eat very little, eat a healthy diet, or were thin or underweight when younger, we look for certain patterns. In such patients, we would expect to see a significant history of one or more of the following:
- Very-low-fat or low-fat, high-carbohydrate diets
- Low-protein diets
- “Yo-yo” dieting
- Chronic undereating
- Fasting
- Excessive cardiovascular exercise
- Traumatic or prolonged psychological stress.

Notably, six of the seven items on this list are things people commonly do to lose weight, but clinical experience suggests that these strategies are potentially harmful for some patients. When done chronically or excessively, these pursuits may contribute to metabolic damage, that is, to a metabolism in which anabolic processes cannot keep pace with catabolic reactions.

At first impression, a person would be expected to lose weight as long as his or her metabolism uses up more chemicals and energy...
than it is replacing. In fact, this weight loss may occur initially but continues for only a short period and results not from loss of fat but from breakdown of cell structures, organ tissue, bone, and muscle. In this process, the body uses up vital functional and structural proteins and fats—which are not being replaced with good nutrition—just to stay alive. Eventually, the individual reaches a plateau, where the body is exhausted and unable to respond. At this point, eating even less and exercising more intensely can have a seemingly paradoxical effect and result in gaining more weight back than was lost. In reality, this situation is not as paradoxical as it may at first appear. The body evolved very well to adapt to deprivation but not to excess, and so it tends to default toward conservation. Calories in < calories out should equal weight loss, but an individual’s metabolic balance may be a kind of factor X in this equation.

### Healing the Damaged Metabolism: The Big Picture

In her books, Dr. Schwarzbein puts forward a revolutionary perspective that is shared by naturopathic medicine but which I have not seen expressed as elegantly anywhere else, and that is: It is first necessary to be healthy in order to lose weight and not that losing weight makes for health. Healing the metabolism must happen before weight loss—or, more accurately, fat loss—can occur. Accordingly, depending on how out of balance a patient is judged to be, an ND might advise eating frequently to balance blood glucose levels, and performing resistance training (for example, weight training) to build muscle tissue before engaging in cardiovascular exercise. The rationale behind this recommendation is that cardiovascular exercise can be a depleting (catabolic) activity, whereas weight training is an anabolic activity. These recommendations would be placed within an overall, long-term plan that emphasizes:

- A balanced, whole-foods diet designed to decrease or prevent insulin resistance, improve insulin sensitivity, and spare muscle tissue
- Nutrient supplementation prescribed to replace micronutrient deficiencies and to help the body rebuild vital functional and structural proteins and fats
- Getting enough sleep: most growth hormone, a key anabolic hormone, is released during sleep and is critical for repairing the body’s tissue
- Stress management, which might explore issues such as self-image, emotional connections with food, and state of mind when eating

The ND will also treat the patient’s comorbid conditions. When the body cannot regenerate as quickly as it degenerates, certain degenerative diseases (eg, coronary artery disease and type II diabetes) can develop. Naturopathic medicine contends that these diseases are largely the consequence of detrimental lifestyle habits and are actually avoidable.

### The Hormone Connection

Naturopathic medicine has a model for assessing and treating patients affected by chronic, complex conditions, such as obesity, metabolic syndrome, and type II diabetes. This model assesses the function of physiologic systems and addresses the interplay of various factors, including gastrointestinal health, endocrine health, and psychologic stress. Gastrointestinal health and adrenal function are believed to be fundamental to overall health. Imbalance in relative or absolute levels of any hormone is understood to disturb hormone function overall. For example, ND’s consider Addison’s disease and Cushing’s syndrome as two extreme poles on a spectrum of possible and treatable adrenal gland dysfunction. Where a patient lies on this spectrum may be determined by history, physical examination, and hormone testing (for instance, cortisol, dehydroepiandrosterone, insulin, estradiol, progesterone, and testosterone).

Type II diabetes is diagnosed when fasting blood glucose levels are ≥126 mg/dL; however, we as clinicians realize that insulin resistance precedes type II diabetes and that blood glucose dysregulation precedes insulin resistance. In addition, because all hormones affect one another, chronic, prolonged stress (leading to hormonal adrenal gland dysregulation) is believed to contribute to obesity, as cortisol promotes insulin secretion, and an association exists between psychologic stress and insulin resistance. Depending on how well a patient is compensating physiologically, treatment may range from nutrient supplementation and use of botanical medicines to judicious use of bioidentical hormone therapy. An understanding of a patient’s stress level is therefore considered critical for developing a treatment program that permits healthy, long-term weight loss to occur. Stress influences sleep quality and duration, food choices, levels of insulin and glucose, and both the digestion and assimilation of food. The stress response can result in increased levels of cortisol, insulin, and triglycerides (via the mechanism of increased blood glucose and corresponding
The story we tell ourselves when eating may also affect our health. For example, we might blame ourselves for eating "bad" foods or feel guilty and shame for failing to lose weight. The goal of understanding the body-mind connection is to teach patients to become present to themselves—not in a way that incurs self-judgment but in a way that fosters self-awareness, self-acceptance, and the ability to change. None of these things are possible when the patient is not really there, when eating is an unconscious or punitive act or an act devoid of nourishment irrespective of the nutritional value of the food consumed. For the patient, becoming present may begin with the doctor’s guidance around becoming aware of the circumstances in which food is eaten, for example, hurriedly while driving, or absentmindedly in front of the TV or computer. It may proceed to paying attention to and making note of the internal dialogue that arises around food choices or cravings. It may be accompanied by breathing/relaxation exercises or recommendations to learn a mindfulness meditation. Above all, this process must be conducted with patience, gentleness, and encouragement on the part of the clinician, in an alliance that models for the patient the kind of relationship they can have with themselves.

**Conclusion**

To approach weight loss in overweight or obese patients, naturopathic medicine uses a model that addresses gastrointestinal and endocrine health along with psychologic stress levels. Especially with patients who have sincerely struggled for a long time to lose weight, the converging goal of all treatments is to bring patients into a state of metabolic balance. Treatments may include nutrient supplementation, botanical medicines, and judicious use of bioidentical hormone therapy within a long-term plan that focuses on dietary and exercise recommendations and provides guidance for becoming aware of stress and releasing it. It is possible that prolonged psychologic stress and years of detrimental lifestyle habits (such as very-low-fat diets) experienced by many of our patients contribute, in large part, to development of certain degenerative diseases, such as coronary artery disease and type II diabetes, which are essentially preventable and often reversible. The metabolism must be healed before weight loss can become fat loss and before sustainable health can become reality. This approach is the antithesis of the quick fix; but the success of the naturopathic approach is borne out by the experiences of many naturopathic doctors and other holistically oriented clinicians.

**Reference**


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**Nutrition**

It’s useful to broaden the concept of nutrition to include what we put into our consciousness.

— Andrew Weil, MD, developer of and educator on principles of integrative medicine, author of books on healthy living
Encountering Particulars:
A Life in Medicine

For 30 years, I have hoped that someone would ask me, a general practitioner, the following question: “In your opinion, what is the most important source of your ongoing professional satisfaction and your best professional contributions to your field of work, human medicine?”

My main and inexhaustible source of professional inspiration is in my everyday encounters with patients who, as individuals, present the “particulars” of his/her lived life. Each embodies these particulars quite differently, and each generously enables me to become ever more knowledgeable about what it means to live a life. The fascination of encountering such particulars is what, in my eyes, makes medicine in general worth practicing, and general practice in particular a privileged task.

Situated Humans

Human beings are suspended in webs of significance they themselves have spun.1,6 Every person, be s/he healthy or sick, patient or doctor, is situated; that is profoundly shaped and influenced by the cultural time and place s/he inhabits. To inhabit does not merely mean to be located, but rather to be embedded—in a fellowship constituted by customs, rules, rituals, conventions and—yes—habits, as such, it designates both being a part and being confirmed. In The Interpretation of Cultures, Anthropologist Clifford Geertz sees these webs of significance, the texture of cultures, as fields of an interpretative search for meaning.1 Thus, being situated involves both implicit and explicit knowledge about the meaning of life’s experiences and active and passive participation in the maintenance and construction of that meaning.

Human fellowship and cultural situatedness are the great frames for any encounter between persons, particularly in the roles of a patient and a doctor. The embodiment of life experience is the predominant topic of such encounters, though not necessarily appraised or recognized as such by the patient. Meaning and embodiment are doubly related. First, our bodies are shaped by the meaning that each of us attributes to our lived experiences. Thus, a person experiencing a threat to life or integrity without an option for defense usually will integrate this experience of powerlessness as a permanent state of insecurity. Second, because our bodies are our means of living a meaningful life, a person experiencing bodily ailments or functional impairment without an option for solution will find the meaning of his/her life threatened.

Ethics of Nearness

Medicine, and especially family medicine, must deal with this double relationship between meaning and embodiment. There we are, those of us doctors who have chosen to be on the first line. Our challenge is understanding—a prerequisite for comforting and helping, supporting, and healing. What does it mean to understand another person in his/her need? Literally: to stand below, which means to be in the same place...
and, from there, to share somebody else’s perspective. Practically: to unfold and make explicit personal experience and life details in order to grasp the significance of events, relations, and situations. These must, in turn, be professionally explored together with the patient with regard to the specific logic and rationality inherent in his/her lived body.

What such an exploration of embodied logic implies may be exemplified in Katarina Kaplan’s sickness history:

Recently authorized as a physician, Katarina was completely disabled. Her training and internship had been interrupted and prolonged by several acute and severe diseases. She had presented symptoms indicating gastric ulcer; after suffering a whiplash from an accident, she had gained sixty pounds while restoring her injury; she had been incapacitated for nearly a year by mononucleosis; and she had been hospitalized due to viral meningitis. Unknown to her doctors (who also were her colleagues), she, in addition, suffered from frequent panic attacks, binge eating, vomiting, bowel dysfunction, and abdominal pain. When finally having completed her internship, Katarina had had a breakdown, and neurologists, after several months of medical examination, had diagnosed chronic fatigue and ordered long-term rest while expressing concern regarding Katarina’s medical career.

The rationality connecting these attacks, habits, and diseases was finally disentangled in a long dialogue between Katarina and her new general practitioner: Since early childhood, and in the name of punishment, Katarina had been physically abused by her parents. But her main abuser had been her brother, who, fooling the child into dangerous situations, frequently had caused her severe harm. Later, he had battered her; and he had continued to do so even after she had left home for medical training in another town. Her state of being had, from childhood to early adulthood, been informed by fundamental insecurity, horror, and alarm. This had resulted in a heavily compromised immune system. And by the time of her graduation from medical school, her adaptability to threat had been exhausted.

As primary care doctors, not only do we have the privilege of coming close, we also have the obligation to come close: to familiarize ourselves with the lives, hopes, intentions, defeats, and longings of our patients—respectfully. And in this we are subjected to the ethics of nearness: we must remain near, and we must witness—honestly. The ethics of nearness in the medical encounter spring from “the therapeutical dyad of trust and care,” and are, as such, profoundly defined by a particular relationship that is “essentially tenuous, unequal, and asymmetrical.” On the one side, the vulnerability and appeal of the ill person; on the other, the response from the would-be healer endow this relationship with “all the characteristics of being fundamental to moral life.”

While applying an even more sophisticated technology when exploring and investigating the objectified human body, biomedicine as a field of knowledge and a basis of clinical practice renders the human subject invisible. Current biomedical research and practice does not routinely and consistently recognize a patient as a person. This means that medicine does not integrate the patient’s perspectives with regard to his/her lived experience, intentions, goals, and purposes. Consequently, the aforementioned moral core of the medical relationship between two persons is, in fact, not accounted for with regard to certain fundamental aspects.

**Phenomenology**

Peoples’ experiences, intentions, goals, and purposes represent the most central issues in phenomenology, a philosophy concerned with an understanding of human being-in-the-world. The perspectives of the human subject are at the core of its interest, and it regards the human body as the embodiment of life. Understanding the body as the embodiment of lived experience renders human bodies mind-full and interacting particulars within the different systems of values and signs that constitute human societies and human lifeworlds.

As members of societies, humans are embedded in social processes that determine their existential basics. The most central among these are trust, belonging, nourishment, respect, care, honor, and pride; their opposites are defeat, loneliness, neglect, violation, abandonment, disgrace, and shame. Because these central phenomena of social life are, in the practice of everyday life, a matter of consent, meaning, intention and purpose, the qualities of a particular experience that is embodied are never predictable only from the event as such; they cannot be fully deduced from objective characteristics. The impact of shattered trust, social abandonment, shameful exposure, or public disgrace, though regarded as disruptive in general, can be massively destructive for some individuals. Certain painful experiences can unmake the world. Neglect, abandonment, or disrespect can make persons feel lost in familiar places, and alienated in their perception of
body and self. Betrayal, particularly in times of general uncertainty, may endanger selfhood and life. 

The meaning of such a general threat to existential preconditions may be exemplified with Serena Sager’s sickness history:

An acute pain attack in her left body when Serena was nearly twenty years old resulted in a referral to the emergency clinic. However, no somatic origin of this pain could be verified. Serena reported having bad such left-sided pain in her body since she had been raped at age 16 years. She also reported to have suffered from anorexia at the age of 14 and to have been examined for left-sided pain in body and head, seizures and loss of consciousness, to have been in psychiatric care since the age of sixteen; to have intoxicated herself with suicidal intention at age 18 years; and to have suffered and been examined for pelvic pain over a period of several years. She was referred to a psychologist and was advised to see a general practitioner for general follow-up.

During extended dialogues with her new doctor, Serena was gradually able to figure out how a rape performed by an uncle had split her body perception and resulted in chronic left-sided pain, frequent seizures, and loss of consciousness. After her parents’ divorce when Serena was twelve years old, she had lived with her mother, who abused alcohol. Burdened by concealing her mother’s alcoholism and managing the household, Serena would turn to an aunt. In this “safe harbor,” in the absence of her aunt, she was raped by her uncle at age 16 years. Approaching her from behind while she was sleeping on her right side, he imprinted his heavy body on her left side. Serena, being alienated in her body and simultaneously endangered in her only safe place, increasingly experienced cramps and loss of consciousness triggered by conflicts in her family. Decoding the meanings of her pain and mental absence during the seizures enabled Serena to integrate her “sickness history,” the impact of abuse, into a meaningful life history. In doing so, she facilitated her healing.

Consequently, phenomenology is both a philosophical framework and a methodological tool for the interpretation of subjective and intersubjective issues of human life. As such, it is an adequate means for approaching the meanings of human experience with regard to sickness, disability, pain, deviation, marginalization, and suffering. Any medical interpretation of sickness reports might be fruitfully guided within such a frame of reference.

Professional Witness

Witnessing professionally means to communicate salient knowledge to the medical community about the lived body, with its particular embodiment of a particular life. This means that, as general practitioners, we also must be researchers and reporters from a very special place: from medical encounters with the details of human lives, their particulars. To do proper research and honest reporting from here, we must also be skilled in a theory and methodology other than that of biomedicine. And we must contribute to scientific knowledge in ways that account for the values that inform human life in the sense of the human sciences.

The theories and methodologies of the human sciences aim for the development of knowledge that appraises diversity, ambiguity, plenitude, difference, and particularity. As a nonabstract but rather enriching way of exploring human life conditions, we must communicate our findings in “thick descriptions." Thick, detailed descriptions, however, require time to collect—and space to communicate and publish. This is the price of insight and understanding in medicine.

Privilege and Contribution

I am convinced that the noblest professional privileges of a general practitioner and the most important contribution of family medicine to the body of medical knowledge coincide. Their nearness to particulars both nourishes the individual primary care doctor and renders research and reports from general practice unique. Such research is, in its very nature, an unfolding of the logic and rationality of embodiment. Unfolding meaning takes time and demands space. Consequently, the medical community should welcome the thick descriptions which general practice has the privilege to provide. This would, in fact, be the response to Richard Baron’s question, “Why aren’t more doctors phenomenologists?" Finally, there might be yet another important gain that, in times of increasing professional strain, would show utmost value: “In the end, it is not only the patient’s getting better that counts; it is equally, though perhaps more subtly, that the physician, no less than the patient, morally benefits from the relationship.”

... as general practitioners, we also must be researchers and reporters from a very special place: from medical encounters with the details of human lives, their particulars.

The names and contents of these stories have been altered. Any direct similarity to individuals, living or dead, is coincidental.

References
2. Zaner RM. Ethics and the clinical encounter. Lima (OH):

To Live for Yourself

No one can live happily who considers only himself. You must live for others if you wish to live for yourself.

— Lucius Annaeus Seneca, 3 BC–65 AD, Roman dramatist, poet, philosopher and orator
Preparing for Successful Surgery: An Implementation Study

By Manuel Diaz, MD
Brad Larsen, CRNA

Abstract

Objectives: To evaluate the implementation of a mind-body program for surgical patients in a community hospital, assessing patient participation, patient perception, and program impact on anxiety, pain, and quality of sleep during the perioperative period.

Methods: Two hundred thirty patients having total hip replacement, total knee replacement, hysterectomy, or colectomy participated in this investigation. One hundred fifteen patients were assigned to the control group before the start of the mind-body program and received routine care. The subsequent 115 patients were assigned to the intervention group and were given an audio CD (containing guided imagery, affirmations, and relaxation music) and a brochure three to seven days before surgery. The brochure recommended that patients listen to the CD twice a day before and after surgery. Anxiety, pain at rest, pain with movement, quality of sleep, and program participation were assessed for the first two postoperative days, and patient perception of the program was assessed at the end of the two days.

Results: Anxiety scores were lower in the intervention group on the evening of surgery. Despite a trend toward lower pain scores in the intervention group, no difference between the intervention and control groups reached statistical significance, including quality of sleep. Of patients in the intervention group, 74% listened to the CD at least once after surgery, and 37% listened to the program three or more times. Most patients who used the CD at least once rated it as helpful, and 87% said they would use it for future operations.

Conclusions: Patient response to a perioperative mind-body program was favorable. Most patients listened to the program CD at least once, and a third used the CD repeatedly, as recommended. The majority of patients who used the CD felt it had been helpful and would use it again. Program participants experienced less anxiety on the night of surgery.

Introduction

Many patients experience anxiety before surgery as well as pain and sleeplessness afterward. Pain and anxiety are frequently managed by pharmacologic means, such as opioids and benzodiazepines, but even so, pain and anxiety frequently accompany surgery.

A provocative body of literature, including numerous prospective randomized studies, demonstrates the effectiveness of simple mind-body techniques utilized before and after surgery in improving surgery outcomes as measured by decreased anxiety, decreased pain, reduced need for pain medication, and shortened hospital stays.

Bennett and Disbrow showed that autonomic behavior is subject to direct suggestion. After receiving only five minutes of suggestions and specific instructions for the early return of gastrointestinal activity, intraabdominal surgery patients experienced the return of intestinal motility in 2.6 days vs 4.1 days for control patients. Time to discharge was 6.5 vs 8.1 days with an average savings of $1200 per patient.

Ashton, et al found that CABG patients who were taught self-hypnosis relaxation techniques were significantly more relaxed postoperatively and required significantly less pain medication. Tusek, et al studied the effectiveness of using a guided imagery tape for three days before surgery and for the first six postoperative days in 130 patients having colorectal surgery. Before surgery, anxiety increased in the control group but decreased in the guided imagery group. Median worst pain score was 72.5 (0-100 scale) for the control group but only 42.5 for the guided imagery.

Clinical Contributions

Manuel Diaz, MD, (left) has practiced Anesthesiology at the KP Santa Rosa Medical Center since its opening in 1990. E-mail: manuel.diaz@kp.org.

Brad Larsen, CRNA, (right) has served as a staff anesthetist at KP Santa Rosa Medical Center since 1993. He is expanding the mind-body program to include all hospitalized and Emergency Department patients. E-mail: brad.larsen@kp.org.
Because mind-body techniques require the active participation of patients, they can only be effective if patients are receptive to such techniques ...

group. The control group used a median of 326 mg of morphine, whereas the guided imagery group used a median of 185 mg. More recently, Laurion and Fetzer looked at the effect of guided imagery or music on the immediate postoperative experience of patients having gynecologic laparoscopic surgery. Both the imagery and the music groups experienced reduced pain at PACU discharge to home compared with control group patients.

Published pain management guidelines also recognize the role of mind-body techniques in the management of postoperative pain. For example, the Agency for Health Care Policy and Research clinical practice guideline, Acute Pain Management in Adults, states that as part of preoperative preparation, one should “[p]rovide the patient with education and information about pain control, including training in nonpharmacologic options such as relaxation.”

It is not clear, however, from previously published studies to what extent the potential benefits of mind-body techniques would be realized if such programs were incorporated into routine clinical practice. Because mind-body techniques require the active participation of patients, they can only be effective if patients are receptive to such techniques and choose to actually use them. Published randomized controlled studies report high rates of patient participation, but in the context of a randomized study, patients generally agree to use the study modalities before enrolling and subsequently receive various kinds of encouragement and support. Given patients’ general lack of familiarity with mind-body techniques, one cannot assume that similar rates of participation would be seen once such techniques were offered in the context of usual clinical practice.

Our facility decided to implement a mind-body program—called Preparing for Successful Surgery—to help patients manage the stress and discomfort of surgery. The program used a CD, (entitled Preparing for Successful Surgery created by Belleruth Naparstek), which contains guided imagery, affirmations, and relaxation music. This CD was chosen because its imagery had been used effectively in prior published studies. The purpose of our study was to evaluate patient acceptance and determine clinical effectiveness of a mind-body program, incorporating several techniques previously shown effective in randomized trials, when implemented under real-life conditions in a community hospital.

Methods

Intervention

The Preparing for Successful Surgery program consists of a CD containing guided imagery (to help prepare for surgery and for healing after surgery), affirmations, and relaxation music. The CD is accompanied by a brochure describing mind-body medicine and introducing guided imagery and affirmations. Medical assistants or receptionists distribute program CDs and brochures during the preoperative clinic visit with the surgeon three to seven days before surgery. The brochure recommends that patients listen to the CD twice a day during the period leading up to surgery and twice a day after surgery until anxiety and discomfort resolve. With the exception of patients having cataract surgery, all adult patients scheduled for surgery at our 117-bed community hospital are given the CD.

On the day of surgery, at admission to the preoperative area, patients are offered a portable CD player to listen to the program CD. Outpatients return the audio equipment at discharge, whereas patients admitted to the hospital take the CD players to the hospital room and are allowed to keep them for the duration of the hospital stay. Throughout the perioperative period, listening to the guided imagery CD is entirely voluntary and is determined only by each patient’s interest.

Study Population

Two hundred thirty patients having total hip replacement, total knee replacement, hysterectomy, or colectomy surgery participated in this investigation. Of this group, 115 (50.0%) were assigned to the intervention group and did not receive the CD. The remaining 115 (50.0%) were assigned to the intervention group and were given the CD during program implementation.

Study Tools and Measures

During the control and intervention periods, study participants had baseline anxiety measured by questionnaire using a ten-point visual analog scale administered at the preoperative nurse clinic visit, usually on the same day they received the CD. Anxiety was again measured at admission to the preoperative area on the day of surgery. During the intervention period, the operating room admission assessment also asked how many times patients had listened to the CD. Patients were subsequently administered a questionnaire by nurse anesthetists the night of surgery and three times a day (morning, afternoon, evening) for the first two postoperative days. The postoperative questionnaire asked patients to report their level of anxiety, pain at rest, and pain during movement on a ten-point
visual analog scale. The morning assessment asked patients to rate the quality of their sleep, and during the intervention period, the evening assessment asked patients to record the number of times they had listened to the program CD that day. During the intervention period at the final evening assessment, patients completed a program evaluation, which included questions about frequency of CD use, program effect on preparing for surgery, anxiety, pain, sleep, and speed of recovery, intention to use the program during a future surgery, and intention to recommend the program to others as well as a space for written comments.

Statistics
The study used a controlled experimental design. Allocation to the intervention and control groups was sequential. Rates in the intervention and control groups were compared using statistical tests ($\chi^2$, Fisher exact, and Wilcoxon sign rank) as appropriate. Responses within the intervention and control groups and for the sample as a whole were compared between different time periods (eg, preoperative vs postoperative day one) using the Wilcoxon matched-pairs signed rank test.

Results
The study was conducted from July 2002 to November 2003. Before initiation of the Preparing for Successful Surgery program, 115 patients were enrolled in the control group. After starting the program, 115 patients were enrolled in the intervention group. The control group consisted of 37 total knee, 31 total hip, 27 hysterectomy, and 20 colectomy procedures, whereas the intervention group consisted of 44 total knee, 34 total hip, 23 hysterectomy, and 14 colectomy procedures. No new pain management approaches were introduced during the study period.

Upon admission to the preoperative area, study participants during the intervention period were asked how many times they had listened to the CD in preparation for surgery. Of the 79 patients who responded to this question, 53.2% reported listening to the CD at least once (35.4% listened one time, and 17.7% listened two or more times). Postoperatively, 74% of patients reported listening to the CD at least once, and 37% reported listening three or more times.

The mean anxiety levels and number of respondents at each measurement time are presented in Table 1 for each group. The results show highest anxiety levels during the preoperative interview and immediately preoperatively. Anxiety levels diminished dramatically after surgery. Anxiety scores were lower in the intervention group immediately preoperatively and on the evening of surgery, but the difference is only statistically significant on the evening of surgery.

Respondents were asked at 9:00 am on postoperative days one and two about the quality of sleep the night before (1 = poor, 2 = fair, 3 = good). Within the control group, the median sleep quality was 1.5 on postoperative day one and was 2.0 on postoperative day two. Within the intervention group, the median sleep quality was 1.0 on postoperative day one and was 2.0 on postoperative day two. No intergroup differences were statistically significant.

Postoperative median pain scores

<table>
<thead>
<tr>
<th>Table 1. Median reported anxiety</th>
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<tbody>
<tr>
<td><strong>Time</strong></td>
</tr>
<tr>
<td>Preoperative</td>
</tr>
<tr>
<td>ASU</td>
</tr>
<tr>
<td>7 pm operative day</td>
</tr>
<tr>
<td>9 am POD 1</td>
</tr>
<tr>
<td>2 pm POD 1</td>
</tr>
<tr>
<td>7 pm POD 1</td>
</tr>
<tr>
<td>9 am POD 2</td>
</tr>
<tr>
<td>2 pm POD 2</td>
</tr>
<tr>
<td>7 PM POD 2</td>
</tr>
</tbody>
</table>

POD = postoperative day.
*Intergroup comparisons at each measurement time calculated with the Wilcoxon rank sum test.

<table>
<thead>
<tr>
<th>Table 2. Postoperative pain at rest (median)</th>
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</thead>
<tbody>
<tr>
<td><strong>Measurement time</strong></td>
</tr>
<tr>
<td>7 pm operative day</td>
</tr>
<tr>
<td>9 am POD 1</td>
</tr>
<tr>
<td>2 pm POD 1</td>
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<tr>
<td>7 pm POD 1</td>
</tr>
<tr>
<td>9 am POD 2</td>
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<tr>
<td>2 pm POD 2</td>
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<tr>
<td>7 pm POD 2</td>
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</tbody>
</table>

POD = postoperative day.
*Intergroup comparisons at each measurement time calculated with the Wilcoxon rank sum test.
Table 3. Postoperative pain with activity (median)

<table>
<thead>
<tr>
<th>Measurement time</th>
<th>Control group</th>
<th>Study group</th>
<th>Statistical significance*</th>
</tr>
</thead>
<tbody>
<tr>
<td>7 pm operative day</td>
<td>7.0</td>
<td>7.0</td>
<td>p = .68, NS</td>
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<td>9 am POD1</td>
<td>8.0</td>
<td>7.0</td>
<td>p = .15, NS</td>
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<td>p = .35, NS</td>
</tr>
<tr>
<td>7 pm POD1</td>
<td>7.5</td>
<td>7.5</td>
<td>p = .65, NS</td>
</tr>
<tr>
<td>9 am POD2</td>
<td>7.0</td>
<td>5.5</td>
<td>p = .21, NS</td>
</tr>
<tr>
<td>2 pm POD2</td>
<td>6.0</td>
<td>6.0</td>
<td>p = .53, NS</td>
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<tr>
<td>7 pm POD2</td>
<td>6.0</td>
<td>6.0</td>
<td>p = .75, NS</td>
</tr>
</tbody>
</table>

POD = postoperative day.

*Intergroup comparisons at each measurement time calculated with the Wilcoxon rank sum test.

at rest for each group are shown in Table 2. A trend toward lower pain scores was observed in the intervention group, but none of the differences reached statistical significance. Table 3 shows median pain scores with activity, and again there were no statistically significant differences between groups.

In the questionnaire completed at the final evening assessment, 80.5% of patients who had used the CD indicated that they felt that listening to the CD had helped reduce anxiety, 48% felt it had helped reduce pain, 60% felt it improved sleep, and 61.8% felt it sped recovery. In addition, 87% of patients who had used the CD stated they would use it for future operations, and 93.2% stated that they would recommend it to a friend.

Discussion

The results of this study indicate that most inpatients undergoing major surgery offered a CD containing guided imagery, affirmations, and music will use it at least once preoperatively and postoperatively. The fact that most patients were introduced to the program via a brochure and brief comments by a medical assistant. It is likely that higher rates of participation and compliance would have been achieved had the program been discussed with the patient by physicians or other providers.

In terms of measured outcomes, the most significant findings were in anxiety scores. Baseline anxiety scores, as measured on the preoperative clinic visit were identical in the two groups. On the day of surgery, anxiety scores were lower in the intervention group, both at admission (3.0 vs 5.0) and on the evening of surgery (1.0 vs 3.0). However, only the difference in evening anxiety assessment reached statistical significance. Anxiety scores beyond the day of surgery were the same in both groups. This finding is not surprising, however, given how low anxiety scores were after the day of surgery, leaving little room for improvement. One can speculate that anxiety is largely an anticipatory phenomenon (fear of death, loss of control, or complications) and thus leads to the high baseline scores observed in both groups and the high scores observed at admission to the operating room and on the night of surgery in the control group. As surgery receded into the past, anxiety rapidly diminished in both groups. Sleep scores were no different between the two groups and pain scores were not significantly different between the two groups, although what differences did exist favored the intervention group.

These findings differ from those of earlier studies which showed much more dramatic improvement in postoperative pain with use of mind-body techniques. This disparity may have resulted from differences in study design. Previous studies utilized a prospective randomized design, according to which patients were asked to consent and agree to participate in a study, thus ensuring a high degree of compliance. Because our study was an implementation study, the CD was offered as part of routine care, and the decision whether to listen to it or not was left entirely up to the patient. As a result, a significant number of patients chose not to use the CD at all, and of those that did, many may not have listened to it frequently enough to obtain maximum benefit. Because our data were analyzed on an intent to treat basis, so as to avoid self-selection bias, it is possible that the beneficial effect experienced by those who used the CD as recommended was diluted by the lack of effect seen in those who did not. Unlike previous studies, the main purpose of the current study was to determine patient acceptance and to determine clinical effectiveness of a mind-body program when implemented under real-life conditions, as opposed to showing potential benefits of guided imagery, affirmations, or music per se in the context of a more rigorous experimental protocol.

Our findings indicate that patients’ perception of the program was highly favorable. Most patients felt...
that the program had helped them with anxiety, sleep, and/or pain. Almost all patients who tried it said they would use it again and would recommend it to a friend. These findings were reinforced by the highly favorable nature of the many written comments from the program evaluation.

Our program is but one of several approaches that can be employed to introduce guided imagery and other mind-body techniques to patients for use in the perioperative period. Other programs, for example, introduce these techniques in the context of a preoperative class. While this may result in patients using the techniques more frequently or more effectively, it also imposes a higher time commitment on the part of patients and may result in lower rates of participation. Facilities interested in implementing the Preparing for Successful Surgery program can obtain copies of the CD, brochures, and helpful information on implementation from Regional Health Education (510-987-3216).

Acknowledgments
The authors thank the nurse anesthetists of KP Santa Rosa for making this study possible: Maureen Bowman, CRNA; Susan Dastic, CRNA; Greg Groeneveld, CRNA; Helen Heath, CRNA; Natalie Humphreys, CRNA; Indra Johansson, CRNA; Linda Lorz, CRNA; Gale O’Connor, CRNA; Rhonda Provost, CRNA; and Ann Stevenson, CRNA.

References

Heaven

Health is my expected heaven.
— John Keats, 1795-1821, English Romantic poet
A Quarter Century of Hospice Care: The Southern California Kaiser Permanente Experience

By Mario Milch, MD
Richard D Brumley, MD

Abstract
Kaiser Permanente (KP) has been a pioneer in the development of hospice services in the United States. Since 1978, when hospice services were introduced in the KP Southern California Region, they have been gradually expanded to benefit thousands of patients and their families. However, important barriers to timely, appropriate utilization of hospice care remain. A pilot project conducted in our TriCentral Service Area has shown that palliative care—a newer development in end-of-life care—can be cost-effective in addition to being beneficial for patients and their families. Efforts are underway to emulate this model of care at other KP facilities. Availability of both home-based and inpatient palliative care services can expand the number and type of patients who, as they near the end of life, can benefit from effective symptom control and other support.

Introduction
In 1978, jointly with the National Cancer Institute, Kaiser Permanente (KP) began a demonstration project designed to elucidate whether the British model of hospice care could function within the US health care system. Now, 26 years later, we reflect on how that experiment promoted hospice care as an important benefit for KP members in Southern California. We also take this opportunity to look ahead and consider how to make services more comprehensive for patients with advanced or terminal disease and for their families. This goal is particularly important because our member population (along with the general US population) is getting older and can therefore be expected to have an increasing number of chronic, incurable conditions.

Historical Development of the Hospice Model of Care

Beginnings in England
Cicely Saunders, MD, is credited with originating the modern hospice movement in England in the 1960s. A former nurse and social worker, she became a physician (she was her own multidisciplinary team!) and was inspired to develop a better way to treat terminally ill patients. Then (and, arguably, now to an even greater extent), patients with cancer were aggressively treated in an attempt to achieve cure or remission; little attention was paid to relieving pain or other symptoms, and little emotional or spiritual support was given, particularly after the disease was designated as terminal. Dr Saunders developed the concept of addressing “total pain,” i.e., the physical, mental, social, and spiritual/existential factors affecting those faced with advanced/terminal illness. This concept eventually led to the 1967 founding of the celebrated St Christopher’s Hospice outside London and spread, worldwide, a care philosophy emphasizing comfort, quality of life, and enhancement of function for whatever time the patient had left to live. This hospice concept also redefined the unit of care, which now would include relevant family members or caregivers in addition to the patient. The concept emphasized dignity and choice and downplayed efforts to keep the person alive “at all costs,” especially when doing so would introduce a high risk of adverse side effects without any appreciable possibility of extending longevity.

While St Christopher’s and other similar freestanding hospice facilities offered inpatient care, most patients remained at home, cared for by family members, friends, or hired caregivers supervised by a hospice nurse, physician, and social worker and sometimes supplemented by a home health aide, homemaker, chaplain, volunteer, and various therapists (eg, physical, occupational, speech, music).
Hospice Care in the United States

Hospice care in the United States began as a volunteer function which gradually became professionalized. By the late 1970s, enough interest had developed to fund demonstration projects. T Hart Baker, MD, who was then Medical Director of the Southern California Permanente Medical Group (SCPMG), personally helped to apply for such funds, which were subsequently granted along with funds for three other sites around the country. George Espe, MD, was placed in charge at a Norwalk site (formerly a nursing home) that featured patient rooms with direct access to a garden; a large activities room; a playroom for visiting children; and even a viewing room for use by family members and friends. Then, as now, most patients remained at home; only a minority required short stays in the inpatient facility for symptom control or (more often) to provide respite for the caregivers. The grant money was exhausted in 1980, but KP decided to continue the service.

By the early 1980s, the momentum propelling provision of hospice care prompted expansion of Medicare coverage, and hospice legislation was enacted providing comprehensive hospice services—primarily to people aged 65 years and over with a life expectancy of six months or less. For a daily reimbursement rate (approximately $135 a day in mid-2005), hospice programs give all terminal-phase care, including medication, durable medical equipment, treatments (eg, oxygen), supplies, and visits by the multidisciplinary members of the hospice team. The care includes short inpatient stays, which are sometimes reimbursed at a higher daily rate. Palliative measures, such as chemotherapy, radiotherapy, intravenous administration of fluids and antibiotics, and total parenteral nutrition can be provided when the aim is comfort and not prolongation of life; however, hospice programs have an economic disincentive to offer these palliative measures, because they must be covered financially by the fixed daily rate of reimbursement. For patients without Medicare coverage, hospice care is financed by Medicaid, by private insurance, or by private donations.

Hospice Care for KP Members in Southern California

In the mid 1980s, the KP Southern California Region (KPSC) began offering a hospice benefit for all KP members. This introduction led to expansion of the region’s hospice programs, which have been established in five Southern California geographic areas: TriCentral/Orange County, San Diego, Fontana/Riverside, Metro Los Angeles, and the San Fernando Valley. None of KP’s expansion hospices offered a dedicated inpatient facility but instead offered inpatient care in acute hospitals and increasingly in contracted skilled nursing facilities. Norwalk eventually closed its inpatient facility when its retention became increasingly difficult to justify. Surveys show that “86% of terminally ill want to be cared for at home.”

The five SCPMG Regional hospice programs have served many thousands of terminally ill patients and their loved ones. Primarily in the home setting, where patients can retain at least a modicum of control, they have generally been helped to achieve a “good death” by means of pain management and symptom control (thus alleviating much suffering and agony) by giving them time to arrange their affairs, say their goodbyes, and, for some, to enable participation in significant family events or even long-awaited travel. Our follow-up surveys show generally high satisfaction with the interventions and service that the hospice program has provided. Commonly, we receive comments such as, “I wish we had known about hospice earlier,” or “I wish we had been referred earlier to hospice so he could have had the services longer.”

A unique feature of our hospice programs is the substantial involvement by Continuing Care physicians, who visit patients (either at their home or in the nursing home or board-and-care facility where they reside) during the first week of hospice service and on an as-needed basis thereafter (often every 30-60 days). We thus can become the patient’s de facto attending physicians, although we do not restrict patients’ access to their own primary care or specialist physicians. Most patients are grateful they need not travel to a medical office.

Barriers to Hospice Care

Substantial barriers to appropriate utilization of hospice services remain. Nationally, only about 50% of patients with cancer or other terminal conditions are referred to hospice. Pediatric referrals are particularly scarce. Patients are referred late; nationally in 2002, the mean length of stay was 48 to 51 days, whereas the median length of stay was only 26 days. In SCPMG, we are probably doing better: The mean length of stay for patients in the Metro Los Angeles hospice program is 74 days; however, a survey conducted a few years ago showed that approximately a third of the patients died within two weeks after starting hospice service.
Thus, although Medicare states that the prognostic criteria should be a life expectancy of six months or less “if the disease runs its normal course,” most patients receive hospice care for much shorter timespans.

The prognostic criteria themselves are part of the problem. All of us working in a hospice program have taken care of patients with advanced disease (eg, lung, breast, prostate, and even pancreatic cancer) who have lived considerably longer than six months. And nonmalignant disease (eg, congestive heart failure, chronic obstructive pulmonary disease, or dementia) can have a particularly unpredictable and variable course. Physicians—both in primary care and in specialties, are reluctant to discuss realistic options as the disease advances and as the patient’s condition becomes more clearly terminal. Even though chemotherapy was clearly ineffective in a particular case, the oncologist for the patient once told one of us: “I can’t stop the chemotherapy. I would be taking away hope.”

Because this hope looks for a remission or cure that will not occur, the day of reckoning comes sooner or later—and we miss the chance to switch the terms of hope so that we instead focus on avoiding suffering and promoting maximal independence. Because of this missed opportunity, some patients and families feel betrayed and angry despite their own aversion to asking probing questions or accepting the limitations of medicine. Many patients and families seek second and third medical opinions before coming to hospice and refuse to issue—or even discuss—advance directives. Moreover, at least in the inpatient setting, clinicians tend to ignore advance directives in the infrequent case where such a directive has been executed.

**Growth and Benefits of Palliative Care**

Gradually, a parallel concept of care—palliative care—has developed, defined as “comprehensive, specialized care provided by an interdisciplinary team to patients and families living with a life-threatening or severe advanced illness expected to progress toward dying and where care is particularly focused on alleviating suffering and promoting quality of life. Major concerns are pain and symptom management, information sharing and advance care planning, psychosocial and spiritual support, and coordination of care.”

In other words, palliation emphasizes comprehensive, symptom-relieving supportive service. It is the type of care offered to those for whom hospice admission is inappropriate, either because the prognosis is too uncertain or (more often) because referral is not given (by the physician) or not accepted (by the patient or significant others).

To identify patients who are good candidates for palliation, a useful concept has been to ask referring physicians, “Which patient’s death would not surprise you if it occurred in the next 12 months?” Because palliative care is rendered under the criteria developed for the Medicare Home Health benefit, patients may receive this care only if they are homebound, whereas hospice patients may be fully ambulatory. Palliative care requires a documented need for skilled services, which may primarily consist of care management for monitoring and treating of symptoms at home, along with support services for patients and their significant others. Patients receiving palliative care or hospice services receive all professional visits free of charge; however, whereas hospice patients obtain medications and most durable medical equipment and supplies (including oxygen) at no cost, patients receiving palliative care must pay for these services at rates set by their health plan coverage, and their need for oxygen must be documented.

The KP TriCentral Service Area’s Home-Based Palliative Care Program won the 2003 Volks Award for Quality. The program clearly engendered great satisfaction with the services rendered to patients diagnosed with cancer, congestive heart failure, and chronic obstructive pulmonary disease. The program also led to substantial savings, primarily by avoiding unnecessary and unwanted trips to the emergency department and hospitalization. Costs of palliative care were approximately 45% lower than for “usual care.” Switching the focus of care from the inpatient setting to the home setting was accomplished by providing 24-hour availability of services either by phone (primarily) or by home visits whenever needed. Replication of the KP Palliative Care Program beyond the TriCentral Service Area is actively being fostered, including demonstration projects underway in the KP Hawaii and Colorado Regions.

Several initiatives also are underway to promote implementation of an Inpatient Palliative Care Service, which would prospectively evaluate patients with terminal or advanced disease and thus facilitate and encourage treatment that would maximize their comfort. The service would also seek advance directives where none exist and would promote communication among patients, family members, and professionals so that available options and choices could be appropriately discussed.

The Inpatient Palliative Care Service functions also as a consultation service, helping to give advice on
obtaining adequate pain management and symptom control. The service also helps facilitate appropriate discharge planning, including referral to hospice or to other types of nonacute care.

**Conclusion**

In the past 26 years, much has been accomplished to promote optimal end-of-life care, and a “good death” is now, for many patients, more often the norm than the exception. However, too many patients are still not receiving the benefit of hospice and palliative care services and expertise as they approach death. We therefore urge a redoubling of efforts to make this care available to all our members who can benefit from it.

**References**


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**To Be Happy**

... all we need to make us really happy is something to be enthusiastic about.

— Charles Kingsley, 1819-1875, English author and clergyman
High-Quality Asthma Care: It’s Not Just About Drugs

By Harold J Farber, MD

Abstract

Asthma care is based on three simple, basic concepts: reduce triggers, use controller medicine, and take early action in flare-ups. Implementing these concepts is difficult, however, and nonadherence is common. The patient, family, and health care system tend to focus their attention on crisis care instead of on control, and long-standing behaviors are hard to change. Adherence to asthma control regimens can be improved if clinicians and their patients focus more attention on communication skills, mutual problem solving, and follow-up. Use of a stages-of-change model also can be valuable for facilitating important behavioral change.

Introduction

The basic concepts of asthma care can be considered as three lines of defense:

- Manage the environment: Identify and either remove or reduce asthma triggers in the home, school, and work environments.
- Manage the airways: Use asthma controller medications to make the airways less sensitive.
- Manage the flare-ups: Have a plan to recognize asthma flare-ups early and take appropriate action.

Although these concepts are simple, implementing them can be difficult. Lifestyle changes are required. The patient, family, and physician have to switch their focus from intermittent crisis care to daily control care. Patients may be required to conquer powerful addictions, such as tobacco addiction.

Dogs and cats may be important asthma triggers for a patient yet may also be very important members of the family. Exposures may occur at work, at school, or at leisure activities. To provide effective asthma care is to facilitate important lifestyle changes.

Nonadherence to asthma control treatment is extremely common. Nonadherence to asthma control therapy is one of the most common reasons for poor asthma control and for recurrent asthma crises.

Reliance on crisis care—measured by overuse of quick-relief medication—is associated with increased risk for asthma-related Emergency Department visits, hospitalization, admission to the intensive care unit, and death. In contrast, risk for these events is reduced by regular use of asthma control medications, especially inhaled corticosteroid agents.

Despite these facts, crisis care is what comes naturally: Most people don’t want to take medicine when they feel well. They also don’t want to change their long-established habits. If a situation is not “in our face”—presented to us as an immediate, major problem—we don’t want to deal with it. Many “more important” things command our attention.

Even within our health care system, crisis care gets the glory; long-term control care is treated as the poor stepchild. Hospitalization, Emergency Department visits, and urgent care receive the lion’s share of asthma care dollars. Someone in respiratory distress commands our immediate attention. But those of us who are passionate about asthma care often have to fight for resources to advance long-term asthma control. The argument is frequently made that if we divert resources for long-term control care, we won’t have sufficient resources for crisis (urgent) care. But what would happen if we applied this same “logic” to airline safety? Focusing on crisis care instead of on long-term asthma control is not just the counterproductive behavior of patients and their families—health care systems do it too.

Implementing an approach to asthma control starts in the physician’s office but does not end there: Asthma-friendly communities also are needed. What is the quality of our housing stock? How pol-
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With their health beliefs, care expectations, individual lifestyle priorities, or any of these. Patients or parents may misunderstand the role of the medicine. Patients or parents may believe that any medicine they can’t feel can’t be working. Cost may be a barrier. Other possible factors may be steroidophobia, having a disorganized lifestyle, or insufficient parental supervision. Taking medicine to stay well might not rate a high enough priority with the patient, parent, or household.

Strategies for Improving Asthma Control

Compliance and Outcomes

Follow-up, Cultural Awareness, and Communication

Follow-up is important. Single-session educational programs do not substantially improve outcomes. Progress and success must be monitored and reinforced. Communication skills are important. In a study of Medicaid-insured children with asthma, Lieu et al found that physician practice sites which had policies and procedures promoting cultural competence had greater adherence to asthma controller use and also generated greater patient satisfaction. Policies and procedures considered as promoting cultural competence included recruitment of ethnically diverse and bilingual nurses and providers, attempts to minimize cultural barriers through printed materials, offering crosscultural or diversity training, offering communication skills training, and evaluation of the level of cultural competence among providers.

In a randomized controlled clinical trial, Clark and Gong found that an asthma training program for physicians that included training in asthma clinical practice and in how to create a partnership with patients led to physician behavior changes, improved patient satisfaction, and decreased health care utilization. These results were accomplished without requiring any more visit time.

The training was focused on helping physicians to create interactive conversation; to create a supportive atmosphere; to reinforce self-management actions; to engage and to share in the process of solving problems; to strengthen patients’ skills in using medicine; and to build patients’ confidence that their asthma can be controlled.

Ten communication behaviors were emphasized in the course:

- Show nonverbal attentiveness.
- Give nonverbal encouragement.
- Give verbal praise for things done well.
- Maintain interactive communication.
- Discover underlying worries and concerns.
- Give specific, reassuring information.
- Tailor medication schedule to the family’s routine.
- Reach agreement on a short-term goal.
- Review the long-term therapeutic plan.
- Help patients to use criteria for making decisions about asthma management.

Using a Stages-of-Change Model

A “stages-of-change” model is often helpful for implementing shared decision making (see sidebar). This model postulates that people go through five stages in implementing behavior change: precontemplation, contemplation, preparation, action-implementation, and maintenance. The goal of health professionals is...
to help patients to negotiate these stages of change.

At precontemplation, patients do not intend to change their behavior. At contemplation, patients intend to change their behavior within the next six months but have not yet made a commitment to action. At preparation, patients intend to implement behavior change soon (within one month), perhaps having tried previously without success. At action-implementation, patients have recently (within the past six months) made the behavior change, and risk of relapse is highest. At the maintenance stage (six months to five years post change), risk of relapse is still present, although not as high as during action-implementation.

To help patients (and parents) negotiate these stages, messages must be stage-matched. Discovering why the patient is stuck at a particular stage will enable the clinician to find the key to moving the patient forward. Starting with a differential diagnosis of what may be causing the patient to be stuck at a particular stage, the clinician can probe to identify factors that are important for this person and for the family. The differential diagnosis lets the clinician know what to probe for; realistic plans can then be made as part of a shared decision-making process.

The Precontemplation Stage. The patient or parent (or both) do not intend to implement a desired behavioral change. The goal is to move them to contemplation. Discussing action/implementation when a person is at precontemplation may not be fruitful. Stage-matched interventions could include discovering barriers, discussing the value of a proposed change, and finding what the patient or parent is willing to do. When the desired behavioral change is daily use of asthma controller medicine and the patient is at precontemplation, barriers may include unpleasant taste; misunderstanding the role of the asthma controller medicine; not perceiving a benefit to regular use of asthma controller medicine; not perceiving harm in the frequent use of crisis-care medicine; fear of adverse effects of the medicine (steroidophobia); or believing that the medication regimen is too difficult or complicated to fit into their lifestyle. Barriers to removal of a pet may include emotional attachment; home security; or not perceiving the harm. Barriers to secondhand smoke elimination may include not perceiving the harm; belief that current efforts to limit exposure are effective; dependence

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**Stages of Change Model**

- **Precontemplation**
  - Description: Does not intend to implement desired behavioral change
  - Goal: Move to the contemplation stage
  - Stage-matched intervention:
    - Discover barriers to behavioral change
    - Discuss value of change
    - Find out what patients and parents are willing to do

- **Contemplation**
  - Description: Intends to implement behavioral change within next six months but not now
  - Goal: Move to the preparation stage
  - Stage-matched intervention:
    - Assist to identify and overcome barriers
    - Use problem-solving techniques for overcoming obstacles
    - Build confidence

- **Preparation**
  - Description: Plans to implement behavioral change soon (within the month)
  - Goal: Move to the action stage
  - Stage-matched intervention:
    - Identify specific changes to make
    - Make specific plans for implementing change
    - Role-play changes

- **Action-Implementation**
  - Description: Behavioral change recently made (within the past six months)
  - Goal: Maintain behavioral change
  - Stage-matched intervention:
    - Ask about strategies to overcome difficulties
    - Ask about lapses and discuss ways to recover from them
    - Provide positive reinforcement

- **Maintenance**
  - Description: Behavioral change made more than six months ago. Temptation to relapse is less than initially but is not zero.
  - Goal: Maintenance of behavioral change
  - Stage-matched intervention:
    - Ask about any lapses or temptations to relapse
    - Provide positive reinforcement

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Discovering why the patient is stuck at a particular stage will enable the clinician to find the key to moving the patient forward.
on a smoker for housing or child care; and belief that the tobacco addiction cannot be overcome.

Understanding the barriers to moving past precontemplation can guide discussion about what the patient or parents are willing to consider doing. For example, if the barrier is unpleasant taste, discussion may focus on minimizing the bad taste or on changing to a medicine with a less unpleasant taste. If the patient or parent does not perceive a benefit of using asthma controller medication or misunderstanding its role, consider discussing that role, goals of therapy, harm from frequent crisis care, and expected benefits of therapy. If fear of medication side effects is the case, candid discussion of potential side effects, of risk vs benefit, or of medication or dose alternatives may help. And when giving away a pet is not an option, discussion could focus on exploring what the family is willing to do.

The Contemplation Stage. This stage is when the patient or parents, or both, are considering making a particular behavioral change within the next six months but not immediately. They are aware of the advantages of this change but are also aware of its difficulty. The goal is to move them to preparation. A stage-matched intervention would focus on helping them to identify and overcome barriers, would use problem-solving techniques to eliminate obstacles, and would build their confidence that they can make a change that has beneficial results.

At contemplation, barriers to daily use of asthma controller medication might include living between two households and not having a supply of medicine at each location. Stage-matched interventions could include such measures as prescribing a separate medication supply for each household; administering medication at a time when a parent can supervise its use; or moving the asthma controller inhaler to a convenient location (such as near the toothbrush).

Stage-matched interventions to reduce secondhand smoke exposure could include setting up a smoking area in the backyard and keeping the child inside when an adult is smoking outside. If the adult wants to quit but does not know how, the smoking cessation strategies could be discussed, written information about smoking cessation could be provided, or the adult could be referred to a stop smoking class or helpline (such as the California Smokers Helpline, 1-800-NO-BUTTS).

Stage-matched interventions to reduce exposure to pet dander could include having the pet live at a friend or neighbor’s home, or perhaps the pet could be kept in the garage or outside.

Solutions will differ for each family. Finding out what the patient and parent(s) are willing to do as part of a shared decision-making process is critical.

The Preparation Stage. The patient or parents, or both, intend to implement the behavioral change in the immediate future, usually defined as within the next month. The goal is to help them move to action. Stage-matched interventions are designed to identify specific, needed changes and to facilitate the development of plans for implementing the change.

At preparation for taking asthma controller medicine daily, a stage-matched plan might designate an accessible place to keep the medicine and might select a routine time for taking the medicine (eg, before brushing teeth, before meals, or when getting dressed or undressed). For smoking cessation, a stage-matched plan might include obtaining the needed prescriptions and signing up for a smoking cessation class. For reducing exposure to smoke from an indoor woodburning appliance (fireplace), plans might include purchasing sweaters or an electric heater. And for reducing pet exposure, plans could include identifying the friend or animal shelter that will receive the pet or perhaps placing a pet house in the backyard.

The Action-Implementation Stage. The patient or parent has made the behavioral change recently, ie, within the past six months. The goal at this stage is to maintain the behavioral change. In a stage-matched intervention, the clinician might ask about strategies to overcome difficulties, ask about lapses, and discuss ways to recover from them. The clinician might ask how the patient remembers to take the asthma controller medicine and when it is to be taken. Consider asking about forgotten doses. Anticipate difficulties: Discuss situations where taking controller medicine may be difficult, such as when the patient feels well or when the family or child’s routines change (such as during vacations). For smoking cessation, discussion could focus on how to deal with cravings, friends who smoke, or
other potentially difficult situations. Even after the patient has reached the action-implementation stage, follow-up is important. Relapse into nonadherence is common, and the consequences are often not immediately apparent.

The Maintenance Stage. Patients who have reached the maintenance stage must exert some effort to prevent and respond to relapse but not as much as was needed at action-implementation. The maintenance phase has been estimated to last from six months to five years. Stage-matched interventions could include asking about lapses or temptations to relapse and providing positive reinforcement. Intervention could also involve a plan to reevaluate the child’s asthma control and medication needs at regular intervals.

Conclusion
Knowledge is important, but knowledge alone does not change behavior. We know how to control asthma in most cases. The difficult part is the implementation—by the patient and family, by the health care provider, and by the health care delivery system. When facilitating behavioral change, determine the stage of change (precontemplation, contemplation, preparation, action-implementation, or maintenance). Provide stage-matched messages. Remember the principle of KIS, an acronym for the cautionary expression, “Keep It Simple!” The more things added to the patient’s prescribed regimen for asthma control, the less likely that any of it will get done. Simplify and prioritize the changes. Focus messages on the patient’s and caregiver’s stage of change.

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Sandra R Wilson, PhD, of the Palo Alto Medical Foundation Research Institute reviewed the manuscript and provided helpful suggestions.

References
Medicine is becoming more and more challenging. After a particularly difficult and frustrating day, I drove home with visions of vacations and respite to be greeted by this scene. I was reminded of the calming, nourishing, and ultimately rejuvenating effect a simple thing like sunset and home can have.

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Malnutrition in the Elderly: A Multifactorial Failure to Thrive

By Carol Evans, RNP, MS, MA

Poor nutritional status and malnutrition in the elderly population are important areas of concern. Malnutrition and unintentional weight loss contribute to progressive decline in health, reduced physical and cognitive functional status, increased utilization of health care services, premature institutionalization, and increased mortality. Nonetheless, many health care practitioners inadequately address the multifactorial issues that contribute to nutritional risk and to malnutrition. A common assumption is that nutritional deficiencies are an inevitable consequence of aging and disease and that intervention for these deficiencies are only minimally effective. Nutritional assessment and treatment should be a routine part of care for all elderly persons, whether in the outpatient setting, acute care hospital, or long-term institutional care setting.

A conventional, disease-specific perspective may not always lead clinicians to the underlying cause of malnutrition and weight loss. For example, an 85-year-old woman with a three-month history of intermittent abdominal pain, nausea, diarrhea, and gradual weight loss, had been living independently in a mobile home park. Her daughter, who lived nearby, brought the woman home for some meals and prepared leftovers and meals for her to warm in the conventional or microwave oven when she was alone. The initial medical examination showed no underlying cause for the weight loss and abdominal symptoms. The patient was given medication for the abdominal discomfort and was encouraged to add over-the-counter nutritional supplements to her daily diet, yet the patient’s condition continued to decline. A referral to the Kaiser Permanente (KP) case management program for the frail elderly led to a home visit—and to a revelation about the abdominal symptoms: The case manager discovered that the elderly woman’s refrigerator was noisy and had been disturbing her sleep. The woman had attempted to address this problem by unplugging the refrigerator each evening at 8 pm when she prepared for bed. When informed of this situation, the family replaced the refrigerator, and the abdominal symptoms and weight loss subsided.

Although only 1% of older adults who are independent and healthy are malnourished, the Health and Nutrition Examination Survey (HANES) data indicated that 16% of community-dwelling Americans older than 65 years consumed fewer than 1000 calories per day—a statistic that would place these persons at high risk for undernutrition. The nutritional risk increases in the community-dwelling elderly who are sick, poor, homebound, and have limited access to medical care. Malnutrition can become a major concern. The incidence of malnutrition ranges from 12% to 50% among the hospitalized elderly population and from 23% to 60% among institutionalized older adults. When not directly attributable to underlying disease, weight loss in the institutionalized elderly is most commonly due to depression, use of anorexigenic drugs, and dependency on staff for feeding.

Malnutrition is often due to one or more of the following factors: inadequate food intake; food choices that lead to dietary deficiencies; and illness that causes increased nutrient requirements, increased nutrient loss, poor nutrient absorption, or a combination of these factors. Nutritional inadequacy in the elderly can be the result of one or more factors—physiologic, pathologic, sociologic, and psychologic (Table 1). The difficulty for the clinician is in identifying the underlying factors contributing to the problem and how to intervene effectively.

A physiologic decline in food intake has been seen in people as they age regardless of chronic illness and disease. Physiologic changes that decrease food intake—often referred to as the anorexia of aging—involves alterations in neurotransmitters and hormones that affect the central feeding drive and the peripheral satiation system. Loss of lean body mass and the

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decreased basal metabolic rate observed in persons of advanced age also may influence appetite and food intake. Sensory decline in both olfaction and taste decreases the enjoyment of food, leads to decreased dietary variety, and promotes increased dietary use of salt and sugar to compensate for these declines.5

Underlying pathology and medical treatment can directly cause anorexia and malnutrition. Disorders of the gastrointestinal system—ranging from problems with dentition and swallowing to dyspepsia, esophageal reflux, constipation, and diarrhea—are related to poor intake and malabsorption of nutrients. Many diseases (eg, thyroid, cardiovascular, and pulmonary disease) often lead to unintentional weight loss through increased metabolic demand and decreased appetite and caloric intake.7 Chronic illnesses such as diabetes, hypertension, congestive heart failure, and coronary artery disease are treated with dietary restrictions and with medication that affects food intake. Because sugar, salt, and fat contribute to the taste of food, dietary restrictions may make food unpalatable. Drugs affect nutritional status through side effects (eg, anorexia, nausea, and altered taste perception) and through alteration of nutrient absorption, metabolism, and excretion.8

Socioeconomic status and functional ability are often major indicators of nutritional status. The cost of housing and medical expenses (most notably, medication) often competes with the money needed for food. When financial concerns are present, meals are often skipped and food that is purchased may not provide a nutritionally adequate diet. Declines in functional status both physical and cognitive, affect a person’s ability to shop for food and to prepare meals. Loss of instrumental skills related to activities of daily living (eg, shopping, transportation, meal preparation, housekeeping, taking medications, managing finances, using the telephone) leads to dependence on others. Nutritional problems are further compromised by inadequate social support networks and by resultant social isolation, which commonly leads to apathy about food and therefore decreased intake.

Late life can be a time of multiple losses. The older person has experienced change and loss through retirement, disability and death of friends and family as well as change in financial, social, and physical health status. These changes may lead to depression, a well-known cause of anorexia and weight loss. Even transient depressed mood (as with bereavement) can cause clinically significant weight loss. Depression is often unrecognized in older persons, many of whom are seen for distinctly somatic complaints. Malnutrition may be a presenting symptom of depression in the elderly.

Assessment of nutritional status and weight loss should start with questioning the patient about any history of weight loss during the past three months and past year and about the the patient’s perceived nutritional problems. Including a family member or caregiver is helpful for obtaining an accurate history. A thorough general assessment should consider the following:

- Severity of nutritional compromise and rate of weight decline;
- Patient’s living situation (living independently, alone, in an assisted living facility, or in a skilled nursing facility);
- Functional status, specifically including mobility, ability to shop and prepare meals, ability to feed self;
- Mental and psychologic status, including depression and any decline in memory or cognition;
- Dietary assessment: intake of food and fluids in the past day; availability of food and types of food

Malnutrition may be a presenting symptom of depression in the elderly.

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<tbody>
<tr>
<td>Decreased taste</td>
<td>Dentition</td>
<td>Ability to shop for food</td>
<td>Depression</td>
</tr>
<tr>
<td>Decreased smell</td>
<td>Dysphagia, swallowing problems</td>
<td>Ability to prepare food</td>
<td>Anxiety</td>
</tr>
<tr>
<td>Dysregulation of satiation</td>
<td>Diseases (cancer, CHF, COPD, diabetes, ESRD, thyroid)</td>
<td>Financial status low socioeconomic</td>
<td>Loneliness</td>
</tr>
<tr>
<td>Delayed gastric emptying</td>
<td>Medications (diuretic, antihypertensive, dopamine agonist, antidepressant, antibiotic, antihistamine)</td>
<td>Impaired activities of daily living skills</td>
<td>Emotionally stressful life events</td>
</tr>
<tr>
<td>Decreased gastric acid</td>
<td>Alcoholism</td>
<td>Lack of interactions with others at mealtime</td>
<td>Grief</td>
</tr>
<tr>
<td>Decreased lean body mass</td>
<td>Dementia</td>
<td></td>
<td>Dysphoria</td>
</tr>
</tbody>
</table>

CHF = congestive heart failure; COPD = chronic obstructive pulmonary disease; ESRD = end-stage renal disease.
consumed; methods used for meal preparation; and identity of person or persons preparing the patient’s meals;
• Medical and surgical history, including gastrointestinal, cardiac, respiratory, and renal disease, recurrent infection, and psychiatric illness;
• Current use of medication.

The physical examination should be narrowly focused on information obtained in the medical history and must assess the patient’s current weight and body mass index (BMI); oral cavity, especially the dentition and ability to swallow; and gastrointestinal as well as respiratory systems.

Diagnosis of a specific problem focuses intervention on treatment of the underlying cause. Often, however, a team approach is needed to address problems of nutrition and weight loss. Nurses, dieticians, a speech therapist, an occupational therapist, and social services staff can contribute important components to the treatment of malnutrition. Terri Franklin, a registered dietician for outpatient services at the KP Walnut Creek Medical Center, states that she can help improve nutrition and stabilize weight loss for failure-to-thrive patients who are referred to her. Terri believes that dieticians are somewhat underutilized in the outpatient setting, but she does receive a substantial number of referrals for frail elderly patients. She states that certain clinicians regularly send e-consults to the dieticians but that other physicians never issue such referrals.

Susan Feledy, RN, case manager for the Complex Chronic Conditions Case Management Program at the KP Redwood City Medical Center, encourages referrals when the patient clearly has medical, psychologic, and social issues that need to be addressed. The ability of case managers to meet with the patient and family and to make a home visit if indicated can often make a big difference in improving the health of a frail elderly person. Determination of appropriate referrals is often based on the patient’s cognitive status and whether the patient can understand and implement recommendations of each specialist. Social services should be included if the patient has financial concerns or questions regarding independent living.

Interventions appropriate for addressing nutritional deficiencies may include one or more of the following actions:
• Remove or substantially modify dietary restrictions (ie, liberalize the patient’s diet);
• Encourage use of flavor enhancers and frequent small meals;
• Offer liquid nutritional supplements for use between (not with) meals;
• Improve protein intake by adding meat, peanut butter, or protein powder;
• Treat depression with antidepressants that do not aggravate nutritional problems;
• Remove or replace medications that have anorexia-producing side effects;
• Evaluate swallowing as well as functional ability to manage eating;
• Obtain a social services assessment of living situation of community-dwelling adults.

The hospital and skilled nursing facility settings present additional factors that influence nutrition. The nursing staff of these facilities can assess the ability of a hospitalized patient or nursing facility resident to chew and swallow foods of various consistencies, to feed himself or herself, and to perform the necessary tasks of eating. Interventions in the institutional setting include the following actions:
• Ensure that patients are equipped with all necessary sensory aids (glasses, dentures, hearing aids).
• Ensure that the patient is seated upright at 90°, preferably out of bed and in a chair.
• Ensure that patients residing in a long-term care facility eat in the dining room.
• Ensure that food and utensils are removed from wrapped or closed containers and are positioned within the patient’s reach.
• Remove or minimize unpleasant sights, sounds, and smells.
• Allow for a slower pace of eating; do not remove the patient’s tray too soon.
• Consider ethnic food preferences and permit families to bring specific foods.
• If the patient must be fed, allow adequate time for chewing, swallowing, and clearing throat before offering another bite. Rapport between patient and feeder is critical.
• Demented patients may need to be reminded to chew and swallow and may benefit from availability of “finger foods.”
• Encourage the family to be present at mealtime and to assist in the feeding.

Several medications have been used to stimulate appetite, but they should not be considered frontline treatment. Megestrol acetate, dronabinol, and oxandrolone have been used to treat cachexia and anorexia in patients with AIDS and cancer. Limited studies have pro-
duced mixed evidence regarding the long-term effectiveness of these agents in the geriatric population.\textsuperscript{11} As a nurse practitioner working in long-term care facilities, I often address the issue of weight loss that continues after nutritional support measures have failed; in this situation, three primary options are evaluated on the basis of discussions with the patient and family: 1) palliative care measures, 2) appetite-stimulating medication, or 3) enteral feeding. (A group of KP nurse practitioners working in community skilled nursing facilities in Northern California are currently conducting a research study to determine the effectiveness of megestrol acetate on weight loss in custodial nursing home residents who have not responded to nutritional supplementation.) No drug has received US Food and Drug Administration approval for treating anorexia in the geriatric population.

**Conclusions**

The elderly population is affected by many causes of malnutrition, which can be reversed if it is addressed early. Management of malnutrition in the elderly population requires a multidisciplinary approach that treats pathology and uses both social and dietary forms of intervention. Nutritional deficiencies are more common among hospitalized patients and nursing home residents. If intervention elicits only minimal response, the clinician must confer with the patient and family regarding end-of-life choices, including nutritional intervention. Unintended weight loss and malnutrition that do not respond to intervention are often important clinical indicators of worsening health status.

**References**


**Opportunities**

Problems are only opportunities in work clothes.

— Henry Kaiser, 1882-1967, American industrialist

This “Moment in History” quote collected by Steve Gilford, KP Historian
After a Solstice Storm

By Marie Mulligan, MD

does the earth weep and wail
    when an old oak
is ripped from her belly
during a December storm?
or does she patiently welcome
    its sagging flesh
back into her own?

— spring of winter
    2002

Marie Mulligan, MD, is a family practice physician in the Headache Clinic at the KP Santa Rosa Neurology Department. She is currently on leave, studying Spanish in Mexico.
Chronic Pain is a Chronic Condition, Not Just a Symptom

By Christine E Whitten, MD
Kristene Cristobal, MS

Conservative estimates indicate that 60 million Americans suffer from some type of persistent or recurrent pain sufficient to significantly affect their lives.1

The Kaiser Permanente (KP) member population includes many patients with chronic pain, and this cohort is generally characterized by a high level of utilizing medical services. Compared with other conditions addressed by the Care Management Institute (CMI), chronic pain more adversely affects quality of life, functional status, and productivity.1

Recent measurement of the KP chronic pain cohort2 by CMI showed chronic pain in 5.1% of adult KP members. This incidence can be compared with the incidence of other conditions diagnosed in the KP population: diabetes, in 7.7% of the population; depression, in 6.5%; coronary artery disease, in 3.2%; persistent asthma, in 2.0%; and heart failure, in 1.6%.

According to the recent CMI Annual Population Care Management Report,3 about a third of patients with moderate to severe impairment from a chronic condition would benefit from care management, and another third would benefit from case management (Figure 1). About 50% of these impaired patients require only support for self-care. As Figure 1 shows, patients who are moderately to severely impaired by chronic pain often demonstrate poor pain control, clinically significant deconditioning and physical impairment, and often a lack of coping skills. A state of learned helplessness may develop and substantially alter a person’s lifestyle.

The population with chronic pain has a high incidence of comorbid conditions. For example, 27.7% of members with chronic pain also had documented depression during 2000, whereas 6.5% of all adult members had depression. Compared with utilization by nonafflicted KP members, utilization of resources by KP members with chronic pain is much higher.

For example, this utilization2
• is 3.7 times higher than the HEDIS inpatient admission benchmark
• is 2.7 times higher than the HEDIS emergency visit benchmark
• includes four times more outpatient visits
• produces pharmacy costs that are 3.5 times higher.

Chronic pain is a chronic condition with its own pathological changes, its own set of clinical and behavioral characteristics, and its own subset of effective approaches to treatment regardless of etiology.

To promote healing, we teach acutely injured patients to rest passively and to focus on their pain as a gauge of when to become more active. However, treating chronic pain in the same way you treat acute pain is a prescription for failure. Ironically, the patient

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Figure 1. Illustration shows levels of care needed by patients impaired by chronic medical conditions. Percentages indicate proportion of patients with indicated level of need and are taken from the 2002 Annual Population Care Management Report3 of the Kaiser Permanente Care Management Institute. Reproduced by permission of the Kaiser Permanente Care Management Institute, Oakland, CA.

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Kristene Cristobal, MS, is the Care Management Institute’s National Project Manager for Chronic Pain and the Project Manager for Culturally Competent Care. E-mail: kristene.cristobal@kp.org.
with chronic pain should not focus on pain but instead should focus on adequate pain control to allow improved functioning and independence. Care plans should aim to simplify medication regimens, decrease pain-related behavior, increase patient and family coping skills, improve sleep, restore daily activities (such as household chores and social engagements), and resume vocational activity. Use of a multimodal approach has proven highly effective in both the KP Northern California Regional programs\(^4\) and the KP Northwest Region’s Vohs Award-winning program.\(^5\)

Help your patients with chronic pain to return to improved function and independence by following four basic principles of pain management. These principles include

- good communication between patient and clinician
- support for the active role of the patient in treatment
- optimal medication management
- use of a multimodal approach (Figure 2).\(^6\)

Higher-Acuity Patients Need More Aggressive Medical Management

As with any medical condition, pain can be graded across a continuum as presenting low, moderate, or high risk of poor clinical outcome on the basis of the patient’s affective, behavioral, and physical functioning; use of medications; comorbid conditions; and ability in self-management. The earlier you identify and treat a higher-risk patient, the more likely you will be to prevent development of pathologic changes, and the better the clinical outcome will be. You must therefore recognize which type of patient you have in your office, because how you treat these patients can—and should—vary so that their care is optimized.

Example 1: Patient at Low Risk for Poor Clinical Outcome (level 1)

Chris trips over a box left in the hallway at home. The fall results in a twisted ankle and a scraped knee. Chris is angry with the person who left the box in the hall. Chris is also somewhat anxious about whether the ankle will interfere with driving to work the next day. Some mild spasm may be evident in the ankle and lower leg.

Chris should be evaluated and treated as indicated in the following grid:

<table>
<thead>
<tr>
<th>Pain issues</th>
<th>Interventions</th>
<th>Multimodal approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injury</td>
<td>Massage</td>
<td>Complementary and Alternative Medicine (CAM)</td>
</tr>
<tr>
<td>Anger</td>
<td>Ice</td>
<td>Physical modalities</td>
</tr>
<tr>
<td>Some anxiety</td>
<td>Gentle stretching</td>
<td>Medical prescription</td>
</tr>
<tr>
<td>Slight spasm</td>
<td>NSAIDs</td>
<td></td>
</tr>
</tbody>
</table>


Example 2: Patient at Moderate Risk for Poor Clinical Outcome (level 2)

Joe has a long history of low back pain and has had two back surgeries in the past five years. Joe trips over a box in the hallway. The fall results in a twisted ankle and pain radiating from the lower back down the outside of the injured leg. Joe is very angry with the person who left the box in the hall. The last time something like this happened, a two-week period of bed rest was followed by the second back surgery.

Joe should be evaluated and treated as indicated in the following grid:
Chronic Pain is a Chronic Condition, Not Just a Symptom

Example 3: Patient at High Risk for Poor Clinical Outcome (level 3)

Pat has a long history of low back pain and fibromyalgia. She had multiple back surgeries during a 20-year period; relief from the last surgery lasted less than one month. Because of pain, Pat has trouble sleeping. She trips over a box in the hallway. The fall results in intense burning pain in the entire leg, extending from the lower back through the buttocks and down the leg to the foot. She is very angry with the person who left the box in the hall and is almost in a state of panic: The last time something like this occurred, the pain and spasms led to five days in the hospital, and since that time—nearly a year ago—the pain has never been fully controlled. She has lost so much time at work that she worries that she might lose her job.

Pat should be evaluated and treated as indicated in the following grid:

<table>
<thead>
<tr>
<th>Pain issues</th>
<th>Interventions</th>
<th>Multimodal approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injury</td>
<td>Massage</td>
<td>CAM</td>
</tr>
<tr>
<td>Anger</td>
<td>Ice</td>
<td>Physical modalities</td>
</tr>
<tr>
<td>High anxiety level</td>
<td>Gentle stretching</td>
<td>Medical prescription</td>
</tr>
<tr>
<td>Generalized leg spasm</td>
<td>NSAIDs</td>
<td>Self-management</td>
</tr>
<tr>
<td>Lowered level for activation of pain systems</td>
<td>Relaxation/meditation</td>
<td>CAM</td>
</tr>
<tr>
<td>Hypersensitivity of central and peripheral nervous systems induced by longstanding, poorly controlled pain</td>
<td>Trigger-point therapy</td>
<td>Physical modalities</td>
</tr>
<tr>
<td>Depression</td>
<td>McKenzie stretches</td>
<td>Medical prescription</td>
</tr>
<tr>
<td></td>
<td>Antidepressant drugs</td>
<td>Self-management</td>
</tr>
<tr>
<td></td>
<td>Anticonvulsant drugs</td>
<td>Cognitive behavioral therapy</td>
</tr>
<tr>
<td></td>
<td>Opioid drugs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Prophylaxis for side effects, especially constipation or nausea</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Self-care education and flare-up management plan</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Consider cognitive behavioral therapy referral</td>
<td></td>
</tr>
</tbody>
</table>

What worked for Chris was not sufficient for Joe, and what worked for Joe was not sufficient for Pat. Unless the patient is treated as a whole entity, the chances of a successful outcome become diminished despite receipt of good medical care. For up-to-date recommendations for delivering multimodal care, see the Evidence-Based Guidelines and Technical Review for Chronic Pain Management in Primary Care.7

Why is Good Pain Management Critically Important?

The past decade provides extensive information—not only about how the pain system works but also on how plastic the nervous system is in response to painful stimuli and injury. From the moment of injury, repeated pain signals produce a cascade of physical and chemical changes in the nervous system—especially activation of the N-methyl-D-aspartate (NMDA) receptor. These neuropathologic changes create new synaptic contacts, changes in neurotransmitter types and balance, receptor type and sensitivity, and can even lead to cell death. All these changes can cause pain that is prolonged, severe, or both. This sensitization of the nervous system—called “wind-up”—can become permanent if pain continues.8

During wind-up, pain is felt as more severe than previously. Stimuli that were not previously painful (eg, light touch or temperature change) can become painful. An example of wind-up is the phenomenon of undamaged skin near a laceration becoming painful to touch. In most patients, wind-up resolves as the injury heals; however, these changes persist in some patients. The more severe the pain and the longer it persists, the more likely the change will become permanent.9

Research shows that possible risk factors for development of chronic pain include unrelieved moderate or severe acute pain, previous episodes of acute pain, poor coping skills, and psychologic distress. Good pain control may prevent development of chronic pain and will certainly help prevent progression of problems related to fear, stress, guarding, loss of elasticity, and muscle atrophy due to pain.

Assessing Pain: Room for Improvement

As is true for managing any condition, good assessment is key. The goals of assessment are to...
• obtain the physical and historical information needed to reach a diagnosis
• guide treatment
• begin planning long-term management
• allow early identification of the patient at high risk for poor outcome so that a more aggressive care plan can be pursued
• reassess the patient’s medical response to the care plan and to monitor for side effects and complications of therapy.

Assessing Patients With Pain in Your Busy Practice

The most important first step is to ask patients if they have pain. This step may seem self-evident, but pain is too often not discussed or assessed in any routine manner. Many studies done during the past 25 years have consistently shown that lack of assessment can lead to inadequate pain management.5,11 In one study of resident physicians’ skills in assessing cancer pain, more than half of the resident physicians failed to perform simple assessment of pain characteristics such as intensity.12 Research shows that when clinicians do not obtain overall pain ratings from patients, the pain—especially moderate to severe pain—is likely to be underestimated.11,13-15 These studies were done in cancer patients; and if pain assessment and treatment is done inadequately for cancer patients—cases where presumably the complicating issues of regulatory oversight and fear of substance abuse are minimal—imagine how insufficient this assessment and treatment must be for patients with pain unrelated to cancer! More than 40% to 50% of patients treated in routine medical practice settings fail to achieve adequate relief from primary pain, despite the current availability of effective treatments for pain.16 Assessing pain and tracking trends in progress over time can be done reasonably as a two-step process (Figure 3, top).17

The Numeric Rating Scale (NRS) is a validated tool used to assess severity of pain. This severity is defined as whatever the patient says it is—not how you as clinicians perceive the severity on the basis of patient behavior. However, all have seen patients who rate their pain as being a 10—a number typically associated with hospitalization—despite their continued ability to function. Often, patients fear that using a smaller number will lead to their pain being given less priority. Teaching patients how to effectively use the NRS is a first step toward making your patient your partner in their care. For more guidance on this topic, see Christine Whitten et al, Pain Management Doesn’t Have to Be a Pain: Working and Communicating Effectively with Patients Who Have Chronic Pain.18

Tracking trends in functional progress is as important as evaluating the pain score. Functional information gives an objective barometer of pain’s impact on life activities, guides future management decisions, expands the conversation with the patient (beyond asking “How’s your pain?”) and is useful for setting goals jointly with the patient. Tracking progress in this way also helps fulfill documentation for regulatory requirements related to prescribing opioid therapy.

Using KP HealthConnect, clinicians will soon easily track and record pain scale and functional scale (just as is done currently for patients’ vital signs). The basis of your care plan—ie, typical characteristics of pain sought while obtaining the medical history—can be remembered by using the mnemonic PAIN BASE (Figure 3, bottom).17

• Place/location of pain
• Amount/severity of pain
• Interactions: What aggravates the pain?
• Neutralizers: What alleviates the pain?
• Breakthrough pain: How often?
• Activities: Are they limited by pain?
• Side Effects: constipation, nausea, dizziness, sedation, dry mouth?

Pertinent physical examination is a critical part of any evaluation for pain. Having these facts makes the resulting treatment plan more likely to succeed.
The Brief Pain Inventory (BPI) is another assessment tool for optional use by clinicians. This tool has the benefit of crosscultural reliability and validity and is available in multiple languages, including Spanish, Chinese, and Tagalog. Although not required, use of such tools better documents the severity of pain and its persistence.

Risk Factors for Development of Chronic Pain: Care Management Institute Chronic Pain Guideline

In patients with acute herpes zoster, acute low back and neck pain, or acute musculoskeletal pain, the likelihood of having chronic pain is increased by several risk factors:

- Unrelieved moderate-to-severe pain (an evidence-based determination)
- Age: moderate risk for patients aged >60 years; severe risk for patients aged >80 years old (an evidence-based determination)
- Self-perceived risk of a chronic problem developing (an evidence-based determination)
- Previous episodes of continuous low back pain (an evidence-based determination)
- Psychosocial factors: psychological distress, stressful life events, depression (an evidence-based determination)
- Poor functional status or high level of disability (an evidence-based determination)
- Lack of active coping skills, eg, realistic goal setting, pacing, realistic beliefs about condition (an evidence-based determination).

As these risk factors show, many of the criteria for moderate-to-severe risk relate to pain-related distress and to the patient’s ability to function (Figure 4). How can you screen for this risk and identify patients at higher risk? One way to check for signs of inability to cope in the course of long-term management is to look for these signs—sometimes called the “dysfunctional D’s”—which include the following:19

- Distress: anxiety, conflictual feelings, anger, hostility, resentment, and alienation
- Depression
- Deficits in the following: impulse control, assertiveness, attention, concentration, memory, and judgment
- Disturbed sleep resulting from pain or from other pain-related distress
- Disability
- Deconditioning.

Be on the Lookout for Neuropathic Pain!

Neuropathic pain is defined as abnormal processing of sensory input by the peripheral and central nervous system. This abnormality may be the critical process in development of chronic pain. You should suspect neuropathic pain when a patient describes the pain as burning, shooting, lancinating, “pins and needles,” or “a strange feeling” (dysesthesia). Allodynia is diagnosed when normally nonpainful sensations (eg, light touch or temperature changes) are painful. Sunburn is a good example of a condition causing allodynia. In clinical practice, neuropathic pain is common in painful diabetic neuropathy and in postherpetic neuralgia and may occur as a result of orthopedic injury. However, physical examination of the patient may show no obvious cause of the pain.

Neuropathic pain is an important symptom to recognize, because delayed or otherwise ineffective treatment can result in chronicity and in permanent change in the nervous system.

Neuropathic pain often responds more fully to adjuvant medication (eg, antidepressants or anticonvulsants) than to opioid analgesics.20 These adjuvant classes of drugs can remodulate the hypersensitivity changes of the nervous system by simultaneously limiting excitation and enhancing inhibition.20 Some patients with chronic pain achieve effective analgesia with low doses...
of the drugs, whereas other patients with chronic pain need antidepressant levels. Benefit may be seen within two weeks after initiation of treatment or may be delayed for several weeks. Opioid analgesics may be needed; if so, higher doses may be necessary because of changes in the nervous system that produce resistance to the effect of the drugs. Neuropathic pain is rarely relieved by nonsteroidal antiinflammatory drugs (NSAIDs).

Patients suspected of having complex regional pain syndrome (CRPS, previously known as reflex sympathetic dystrophy, RSD) who do not respond rapidly to adjuvant treatment should be referred to a pain specialist. Signs of possible CRPS in an extremity include

- allodynia, hyperesthesia, or both
- abnormal skin color
- temperature greater than or less than 1°C compared with the unaffected limb
- edema
- pseudomotor activity (increased sweating or dry skin).

When suspected neuropathic pain does not respond to treatment, early referral to a pain specialist is recommended.

**Fears of Addiction and Monitoring for Abuse**

Addiction is defined as a psychic compulsion to continue taking a drug on an ongoing basis—and despite harm—to obtain effects other than pain relief. Addiction is a major problem in the general population, but most patients are not at risk for substance abuse. Patients at low risk include middle-aged or older patients with no prior drug or alcohol abuse and a stable family and social history. Concerned about potential addiction, many clinicians fear prescribing opioid analgesics; however, the actual risk of opioid abuse is comparable to the incidence of alcohol abuse in the general population.

When considering long-term opioid use for chronic, noncancer pain, you must assess your patient’s potential for and risk for abusing these drugs. Cancer experts also are beginning to recognize that addictive disease can be a problem in some cancer patients because these patients are living longer and therefore, receiving long-term analgesic drug therapy even if not cured. You should be cautious about prescribing long-term opioid analgesics for young patients, patients with severe psychological pathology (eg, personality disorders or schizophrenia), and patients with a history of chemical dependency. Before initiating long-term opioid therapy, clinicians can use the CAGE-AID tool to assess for risk of addiction or whether a patient may already be addicted to alcohol or drugs. The CAGE-AID questionnaire is an assessment tool which helps to identify patients who may be at risk of substance abuse of alcohol or drugs. The CAGE-AID questionnaire asks whether a patient has ever:

C: Wanted or needed to Cut down on drinking or drug use?
A: Been Annoyed or Angered by others complaining about the patient’s drinking or drug use?
G: Felt Guilty about the consequences of the patient’s drinking or drug use?
E: Taken a drink in the morning as an “Eye opener” to decrease hangover or withdrawal?

The questionnaire can be Adapted to Include Drugs.

A single positive response suggests that the clinician should exercise caution in prescribing opioids to the patient; two or more positive responses suggest the need for increased vigilance by the physician prescribing opioid analgesics to the patient.

If long-term use of opioid analgesics is considered appropriate, do discuss the pros and cons of this therapy with patients and document their informed consent. Some physicians find useful a written agreement of the opioid therapy plan with specification of the conditions under which opioid analgesics will be prescribed. An easy-to-use template of an opioid therapy plan will be readily accessible for your use in KP HealthConnect.

Monitoring your patients receiving opioid therapy is of paramount importance. More common than addiction is the phenomenon of “pseudoaddiction.” Patients who are receiving an inadequate dose of opioid medication often “seek” more pain medications to obtain pain relief. This is called pseudoaddiction because it is often mistaken for the true drug-seeking behavior of addiction. Other common signs of pseudoaddiction and inadequate analgesia include

- requesting analgesics by name
- demanding, manipulative behavior
- clock watching
- taking opioid drugs for an extended period
- obtaining opiate drugs from more than one physician.

Whereas pseudoaddiction resolves when the patient obtains adequate analgesia, true addictive behavior does not. Consultation with an addiction medicine specialist is recommended if you observe any of the following “red flags” for addiction or substance abuse:

- multiple dose escalations or noncompliance despite warnings
- multiple episodes of prescription loss
Chronic Pain is a Chronic Condition, Not Just a Symptom

Reassess your patients periodically for adequate pain control and side effects. If pain is continuing, check to see if they are taking their medications correctly and following the prescribed care plan before you try a new approach or increase medication dosage. Patients might not volunteer the information that they have stopped taking a medication because of a side effect, fear, cost, or the disapproval of a family member or friend.

Treatment of pain is an expected part of good medical management, and all physicians should therefore address the problem to the best of their ability. Sometimes, however, despite your best efforts—and just as for any medical condition—consultation will be needed. This need will vary, depending on the physician’s knowledge and skills and on availability of support systems for monitoring pain.

For patients with chronic pain lasting more than three months and unresponsive to conventional treatment, consider referral to a Pain Management Program. Moderate-to-high-risk patients with either acute or chronic pain unresponsive to an optimized multimodal treatment should be given this referral early to try to minimize development of nervous system hypersensitivity.

Treatment may include medical evaluation and consultation, highly technical interventional and implantable techniques, and cognitive-behavioral intervention as indicated. However, because internal services vary from region to region, you should educate yourself about your local resources for pain management within and outside KP. Intranet resources include our National Clinical Library. Click the “National” tab and search for “chronic pain” in the Google field. Internet resources...

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Table 1. Risk stratification characteristics for patients with acute and chronic pain

<table>
<thead>
<tr>
<th>Goals of treatment</th>
<th>Mild risk (level 1)</th>
<th>Moderate risk (level 2)</th>
<th>Severe risk (level 3)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Provide routine care, self-management education, support for coping</td>
<td>• Enhance self-care skills and abilities; provide clinical management using care paths and protocols for patients who have begun to show deterioration in functioning, increased medication usage, or onset of moderate deconditioning</td>
<td>• Restore the most severely impaired patients to their highest level of functioning. • Using professional expertise and supervision, reinforce learning by providing appropriate, supportive environment and structured experiences</td>
</tr>
<tr>
<td>Characteristics</td>
<td>• Absent to mild depression, anxiety symptoms • Adequate functioning in most areas • Absent or minimal physical impairment • Minimal or no current use of pain and/or sedative hypnotic medications</td>
<td>• Mild to moderate depression, anxiety symptoms • Deteriorating functioning in most areas • Moderate physical impairment and deconditioning • Inadequate medication management due to incorrect dosing/selection or because pain generator is increasing</td>
<td>• Moderate to severe depression, anxiety symptoms • Severely deteriorated functioning • Severe physical impairment and deconditioning • Habituation to analgesics and/or sedative medications • Indications of domestic violence or sexual abuse • Inadequate medication management due to incorrect dosing/selection, or because pain generator is increasing • Coexisting addictive disease</td>
</tr>
</tbody>
</table>

consider using cognitive behavioral therapy (CBT) for any patient who presents a challenging pain management situation or who has poor social, occupational, physical, or psychological function. This includes patients who have poor social, occupational, physical, or psychological function. CBT is a psychotherapeutic approach delivered in a series of group and individual sessions focusing on the interrelation of cognition, mood, behavior, and symptoms. Contrary to popular misconception, CBT is not a health education class. Based on complex theory of personality and psychopathology, CBT includes an integrated program of well-defined therapeutic strategies and techniques (interventions) for use by trained psychotherapists.

Of great importance is that you assure your patient upfront that using CBT does not mean that the patient is not real or that the patient has a psychological problem. Educate the patient that every illness has psychological as well as physical components and that a comprehensive approach is intended to help the patient to regain function. Referring to a common experience—such as asking if the patient has ever “worried themselves sick” or gotten a headache when stressed—can often point out the “mind-body” connection.

Remember that CBT represents only one modality for treating chronic pain. Unless their pain is already optimally controlled, patients with this diagnosis are likely to benefit from full consultation at your Pain Management Program.

Summary

Pain exists on a continuum, and acute pain sometimes leads to chronic pain as it molds the nervous system and your patient’s life. To treat these patients effectively, clinicians should not expect success from simply prescribing medication; early, effective pain management is the best preventive therapy for chronic pain. For patients who already have chronic pain, multimodal treatment is key and must address not only pain relief but also the negative impacts of chronic pain and analgesic medications on the patient’s life, sleep patterns, psychosocial distress, conditioning, retreating, and pacing. Under your care, with optimal pain management, your patients can get their lives back.

Disclosure Statement

The author(s) have no conflicts of interest to disclose.

Acknowledgments

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The Wheel of Life

Please subdue the anguish of your soul.
Nobody is destined only to happiness or to pain.
The wheel of life takes one up and down by turn.

— Kalidasa, circa 5th century, Indian dramatist and poet
Bariatric Surgery in the KP Northwest Region: Optimizing Outcomes by Using a Multidisciplinary Program

By Keith H Bachman, MD
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Abstract
Although bariatric surgery can be an appropriate treatment option for extremely obese patients, uncertainty exists as to how to optimize treatment outcomes. This article describes a coordinated multidisciplinary program designed to educate and behaviorally prepare patients for bariatric surgery and to support long-term behavioral change.

Key aspects of our program include adequate preoperative obesity-related assessment, including nutritional, psychosocial, and physical assessment; emphasis on preoperative behavior change; changing the inpatient surgical treatment care path to decrease the length of hospital stay; and providing long-term management by using enhanced clinical decision support that includes Intranet-based practice resources embedded in the electronic medical record. Self-care is facilitated through group classes and support groups.

A multidisciplinary bariatric program optimizes short- and long-term postoperative success and maximizes the safety and cost-effectiveness of bariatric surgery.

Introduction
Bariatric surgery can be an appropriate treatment option for severely obese patients with obesity-related medical or functional problems and is a covered benefit for many Kaiser Permanente (KP) members. Despite the popularity of weight loss surgery, little information is available to guide programs toward improving the quality and cost-effectiveness of care. This article describes the KP Northwest Region (KPNW) bariatric surgery program, which we believe is a model of multidisciplinary collaboration that efficiently delivers excellent patient care to a high-risk population. Since 2001, over 200 Health Plan members in KPNW have participated in our preoperative program and subsequently had bariatric surgery. To better understand this process from a Health Plan member's perspective, we asked one of our program participants for her perspective on how bariatric surgery and the preparation for it has changed her life. She told us:

I knew I needed to make some changes. I felt my health slipping away. Walking caused pain—by the time I was able to get to my car in the parking lot at the end of the day, I would be in tears. A fall where I could not get up without help "woke me up." I weighed 325 pounds on a 64-inch frame. I developed health conditions related to weight. I was tired, in pain, and had little energy. About ten years ago, I went to my doctor for a check-up. He told me, "come back when you have lost weight." Needless to say, I never went back. I had been through bariatric surgery before—I had a stomach stapling—but eventually regained the weight. I knew I had only one more chance.

A Problem of Quality
The prevalence of extreme obesity is increasing rapidly as are the human and economic costs of obesity-related diseases, such as diabetes, hypertension, weight-bearing joint disorders, sleep apnea, and lipid abnormalities. Disability, work loss, and daily pain also are strongly associated with extreme obesity.
Disability rates for basic activities of daily living are fourfold higher in the severely obese population.\(^1\)

Unfortunately, obesity and severe obesity are common in KPNW member population; 37% of adults in this population are obese, and 7% have been identified as both severely obese (BMI > 40) and as potential candidates for bariatric surgery. Research data from the KP Northern California Region indicates that health costs are 80% higher in KP members with severe obesity as compared with members whose weight is normal.\(^2\) Traditional clinical weight management strategies and primary care-based management approaches have shown only limited effectiveness in severely obese patients. The primary care approach is limited by the comorbid disease burden, inadequate obesity assessment in this context (ie, due to short visit length), and high rate of psychosocial distress in this population.

Roux en y gastric bypass surgery is considered an appropriate treatment option for selected patients. Despite the many successful outcomes seen in academic centers, \(^3\)--\(^4\) few programs in respected hospitals have either closed or have temporarily suspended operations as have prestigious programs in respected academic centers.\(^7\)

In this environment, KPNW Severe Obesity and Weight Management Program was founded in 2001 and is supported by a collaborative team from the Departments of General Surgery, Internal Medicine, Health Education, Nutrition Services, Social Work, Physical Therapy, and Inpatient and Ambulatory Nursing. The program is designed to serve the needs of three stakeholders: severely obese members contemplating bariatric surgery, clinicians struggling to manage the obesity-related disorders of their patients, and administrative concern about meeting members’ needs in a clinically effective, cost-efficient manner. From the outset of the program, our work has been guided by the following philosophy:

- An expert, coordinated regional multidisciplinary team will best serve our patients.
- Severe obesity is a complex multifactorial condition in which food is often used as a coping mechanism for stressors.
- Detailed individual assessment, psychosocial management, and physical rehabilitation are prerequisite to surgical intervention.
- Preoperative education and behavioral change result in safe, effective weight loss and maintenance.

**The Importance of Preparation**

The bariatric program participant continued her story:

I was nervous about attending the introductory class called “Options for Severe Obesity.” I was a little less nervous after I went—the team obviously took this decision seriously, answered my questions, and it turned out that a lot of other people were struggling with the same issues. I was nervous again when I had individual consultations with the dietician, social worker, and physical therapist. I didn’t believe the physical therapist, Tamara, when she told me I would be able to get active and that I needed forearm crutches. She told me to get into the water to do aerobics. It wasn’t easy, but I did it—and over the next year before surgery, I got stronger and healthier. I lost some weight too. And it turns out that no one really cares what you look like in a swimsuit at six in the morning!

The goal of our preoperative preparation program is to ensure that the surgery is done for informed and prepared patients while improving their health, helping them to achieve greater insight into obesity,
Understand the role of weight and food in a person’s life is important.

Understanding the role of weight and food in a person’s life is important. Every patient is different: the typical duration of preoperative preparation ranges from 6 months to 18 months.

An extensive preoperative questionnaire is the basis for evaluating patients’ baseline quality of life and functional status; this questionnaire thus provides information necessary for improving the bariatric program’s quality. The questionnaire contains validated screening measures of common obesity-related conditions including sleep apnea, binge eating, depression, and adverse childhood experiences. In an obese person, any of these issues may be driving the obesity and may affect management strategies.

**Psychosocial Preparation**

A critical first step in preparing an obese patient for bariatric surgery is to adequately assess the psychosocial factors and life events that may have contributed to the patient’s weight problem. Depression and eating disorders (e.g., binge eating or night eating) have been well established as factors that may lead to overeating and to weight gain. Recognition of these problems can be a foundation for behavioral change and treatment. Review of the patient’s weight history often alerts the clinician to major life events (e.g., childbirth, divorce, depression, or addiction transference) that coincide with the patient’s excessive weight gain. Adverse childhood experiences such as physical, emotional, or sexual abuse, frequent humiliation, and growing up in the presence of substance abuse are common—both in our member population and in the wider population—and may result in excessive weight gain. Adverse childhood experiences that may have contributed to the patient’s weight problem. Depression and eating disorders (e.g., binge eating or night eating) have been well established as factors that may lead to overeating and to weight gain. Recognition of these problems can be a foundation for behavioral change and treatment. Review of the patient’s weight history often alerts the clinician to major life events (e.g., childbirth, divorce, depression, or addiction transference) that coincide with the patient’s excessive weight gain.

**Physical Preparation**

Physical preparation results in improved mobility and strength, and this conditioning promotes earlier ambulation after surgery and more successful preoperative weight loss and sets the stage for postsurgical maintenance of weight loss. Having a physical therapist as an integral part of our bariatric team has been critical for achieving these goals. Before bariatric surgery is scheduled, all patients are required to work toward establishing a 60- to 90-minute daily home exercise program that includes moderate aerobic activity; warm-up and cooldown exercises; and stretching and strengthening exercises. Properly fitting, shock-absorbing footwear is
recommended for patients who can tolerate walking. Water aerobics—even just “water walking” in accessible pools—are excellent activities that are well accepted by bariatric patients. Owing to the excessive forces on joints, higher-impact activities, such as running and jumping, must be avoided. Patients receive education about avoiding overheating and heat exhaustion (possible consequences of the insulating properties of excessive adipose tissue).

Many severely obese people have major physical challenges—degenerative joint disease, plantar fasciitis, asthma or respiratory insufficiency of obesity, and deconditioning are common examples—that may preclude traditional exercise routines. Obese people may also have psychologic barriers and negative attitudes about activity (ie, because of previous injury or pain experienced during activity) or may fear the humiliation they expect to suffer if they are seen exercising. Patients who cannot progress gradually to these exercise regimens are referred for individual physical therapy for assessment and for development of a management plan. This treatment facilitates individual assessment of rehabilitation potential and may include positioning for sleep, body mechanics training, methods of optimizing independent mobility, pedal edema management, use of adaptive equipment, pacing, and graduated progression of the home exercise program. The ultimate goal is to find safe, sustainable physical activities that can be incorporated into daily life and daily routine on a long-term basis. Specific criteria are used for assessing physical rehabilitation potential, and bariatric surgery candidates must have “fair” or “good” rehabilitation potential before they can be scheduled for bariatric surgery.11

**Nutritional Preparation**

Most patients presenting for bariatric surgery have proved to be “expert dieters” but may nonetheless lack the behavioral skills or basic nutritional knowledge needed to maintain a lower body weight. All members contemplating bariatric surgery are strongly encouraged to attend the KPNW Health Education Service’s “Freedom from Diets” research-based weight management program. This program uses a nondiet, behavioral approach to improve eating and everyday fitness. The program emphasizes alternative (ie, nonfood) strategies for coping with stress and for preventing “emotional eating.” During this program and throughout the preparation process, patients learn to set specific, attainable goals for food and exercise management. Use of four to six daily low-fat, low-sugar, hypocaloric meals often leads to modest weight loss—one to two pounds weekly—and mentally prepares patients for the frequent meal times needed after surgery. Structured meal times help patients to manage their clinical or subclinical problems with binge eating. After patients attend the program, group classes, the program dietician individually assesses program members’ progress and fine-tunes strategies until members show confidence in sustaining the types of behavior necessary for maintaining a healthier body weight. Immediately before surgery, group classes are used to discuss and solve problems related to postoperative dietary progression.

**Medical Preparation**

Optimization of patients’ medical status usually parallels their efforts at behavioral change. Before surgery can be scheduled, chronic diseases—diabetes and hypertension, for example—must be controlled, and patients must be current with scheduled health maintenance examinations. Sleep apnea is prevalent in the severely obese population, and perioperative risk is thought to be reduced by adequate preoperative management of this condition. All patients are screened for sleep apnea as part of their preoperative questionnaire and are referred for overnight sleep study if indicated. Nonsteroidal antiinflammatory medication is stopped before surgery, because these drugs present a risk for bleeding and stomach ulceration. Other pain management strategies are then substituted.

**Outcomes of Preparation: Improved Health and Readiness**

The success and usefulness of the preoperative preparation process has been obvious: Presurgical weight loss has been as much as 125 pounds and has averaged a mean 19 pounds per patient. Patients participating in the bariatric program have had improvement in all dimensions of health: comorbid medical conditions, pain, functional level, exercise tolerance, mood, and stress levels. Moreover, several patients achieved such benefit from the preoperative preparation that they subsequently opted not to pursue surgery! For most patients, education and preparation have contributed to smooth, uneventful hospitalization, allowed patients to know what to expect after surgery, and ensured that patients are physically ready to move around and start a liquid diet on the first postoperative day. Despite concern that the preoperative process is slower than they would like or the perception that preparation is a “barrier” between them and bariatric surgery,
most program participants who have had the surgery recognize that the extensive preparation was valuable, necessary, and critical—both for positive initial results and as foundation for long-term maintenance of weight loss (L DeBar, PhD, MPH, personal communication, April 2004).

**Improving the Inpatient Experience**

Our patient said also of her experience with the bariatric program:

Surgery went smoothly for me. The inpatient RNs knew what to do and helped me a lot. It wasn’t fun, but I knew what to do. I had surgery on Wednesday, started drinking a nutritional supplement—one ounce every 15 minutes—beginning on the next morning, and was walking the halls and went home on Friday. Once I got home, it was rough for a few days, but I got through it.

Bariatric care at the KP Sunnyside Medical Center was regionalized to improve consistency and quality. After a needs assessment was completed, various improvements were made through collaboration between surgeons, operating suite staff, nurses, anesthesiologists, and hospital administration. Equipment (including special tables, instruments, and retractors) were obtained to meet the needs of patients receiving bariatric surgery. An orientation handout for all staff and a postoperative order template was developed by the operating suite team to improve coordination before, during, and after surgery. Inpatient units obtained needed equipment (e.g., wheelchairs, commodes, beds, and linens) designed for the safety and comfort of bariatric patients. Sensitivity toward obese patients has been promoted via inservice training sessions for nursing staff and for other inpatient staff.

Within nine months and using rapid-cycle CQI and critical-incident analysis, changes in perioperative and postoperative care led to reduced length of hospital stay, improved pain management, and a safer and more sensitive inpatient environment (Figure 2). Introduction of wound infusion devices that are used with local anesthesia rapidly eliminated epidural anesthesia as a supportive analgesic technique. Observations by nurses led to earlier transition to oral pain medication and feeding; and these results led to earlier ambulation and discharge. Because of the physical conditioning that precedes surgery, patients in the bariatric program are mobile and ambulatory during their inpatient stay, but a lift team is nonetheless available on an as-needed basis. For all these reasons, safety concerns of personal injury were allayed early in the program, and no staff have been injured. As expected for a high-risk patient population, major complications have occurred:

- For 9% of patients, the hospital stay has been six days or longer, and 18% of patients were ultimately readmitted to the hospital because of complications of bariatric surgery, including protracted postoperative vomiting, pulmonary emboli, wound infections, or elective readmission for incisional hernia repair.

Although no standards yet exist for reporting complications, postoperative mortality rates have been consistent with national norms.

**Maintaining Long-Term Success**

Our bariatric program considers that “success” in bariatric surgery is defined as enabling patients to achieve their own goals for their health; creating a safe operative experience and weight-loss process; and avoiding near- and long-term complications of bariatric surgery (including weight regain). We consider “extreme-obesity-status-post-bariatric-surgery” as a chronic medical condition with unique physiology and as a risk factor for later development of medical problems, including iron-deficiency anemia, vitamin B12 deficiency, and osteoporosis. Excessive weight regain also continues to be a concern and can be avoided with healthy eating and adequate physical activity. Strategies learned by patients during their preoperative preparation support other coping mechanisms unrelated to eating. Focus groups have indicated that patients who most effectively internalize the preoperative preparation have more successful long-term outcomes (L DeBar, PhD, MPH, personal communication, April 2004). From a systems standpoint, elements of the chronic disease model—eg, use of support groups to enhance self-care, use of safety-net registries, and use of clinical practice guidelines—are helpful for managing long-term risk and for promoting optimal health outcomes.

The program dieticians and case manager actively follow patients for two years postoperatively via for-
Bariatric Surgery in the KP Northwest Region: Optimizing Outcomes by Using a Multidisciplinary Program

The visits by the dietician and case managers support positive behavioral change, monitor development of problems such as vomiting or excessive weight gain or weight loss, and help patients to follow their prescribed diet as they progress through the postoperative period and beyond. After patients receive initial surgical postoperative care, primary care practitioners address most care-related needs of the patients. Practice management guidelines and laboratory templates (embedded in the electronic medical record and available on the KPNW’s Intranet) efficiently support primary care clinicians in their work with patients who have received bariatric surgery. The bariatric team continues to be available for postoperative patients on an as-needed basis and leads four monthly support groups throughout KPNW for members and families involved in all phases of the bariatric program.

Our patient recently updated us on her progress. She told us:

Tomorrow will be a year since my surgery and about two years since I was referred to the program. I’m really appreciative of the team for supporting and helping me through the process pre- and postoperatively. I’ve lost more weight than I thought I would, and my health has improved too. I still work at it—I do my water aerobics five times weekly at 6 am and need to be careful with my diet. I somehow think that if I had been as prepared and knew what I know now at the time of my first operation, I might have not needed to go through bariatric surgery again. I have a bright future now and am so grateful for all you have done for me. You have given me my life back! ♦

Acknowledgments
The authors acknowledge other members of the Severe Obesity Team and Kaiser Sunnyside Medical Center Staff whose efforts are invaluable in providing high-quality care to our Health Plan members in KPNW. Team members include Louis Kosta, MD; André R Leger, MD (Surgery); Lynn Larson Debar, PhD, MPH (Center for Health Research); John R Crawford, MPH (Health Education); and Jenna Barlow, PA-C (Primary Care). We also acknowledge Gayle Livingston for allowing us to share her story.

References
How Can We Reduce the Incidence of Contrast-Induced Acute Renal Failure?

Report of a Case

A 60-year-old female with history of diabetes mellitus type II, hypertension, coronary artery disease, and chronic kidney disease (baseline serum creatinine level 1.5 mg/dL, and GFR 38 mL/min) was admitted to the hospital with a non-ST elevation myocardial infarction. In preparation for cardiac catheterization, the patient received N-acetylcysteine (Mucomyst). She then underwent catheterization with the placement of two stents.

The next day, the patient had decreased urine output (900 mL/day). From a baseline level of 1.5 mg/dL, measured on the first hospital day, the creatinine level increased on subsequent hospital days to 2.0 mg/dL, 3.3 mg/dL, 3.8 mg/dL, and 4.9 mg/dL, respectively. Neither the patient’s medical history nor review of her medical chart showed any evidence of periprocedural hypotension or use of nephrotoxic medication. Thus, this rapid onset of acute renal failure after cardiac catheterization was probably secondary to contrast-induced nephropathy. The nephrology service was then consulted for treatment of acute renal failure and for possible initiation of renal dialysis.

Contrast-Induced Nephropathy

Contrast-induced acute renal failure is defined as creatinine level increased at least 0.5 mg/dL or >25% above the baseline level. Patients are usually not oliguric and characteristically have low levels of urine sodium because of impaired ability to concentrate urine. Although described to occur within 24 to 48 hours after exposure, the renal failure usually peaks within 3-5 days after completion of the procedure and is most often self-limiting.

The incidence of contrast nephropathy varies from 5% to 38%, depending on the risk factors of the patient.

Contrast nephropathy may account for more than 10% of hospital-acquired cases of acute renal failure, but fewer than 5% of these patients will require dialysis. More commonly, serum creatinine level rises only moderately, and the clinical significance of this mild renal impairment is unclear.

The differential diagnosis of contrast-induced nephropathy includes renal atheroemboli, volume depletion, and interstitial nephritis. In most cases, onset of atheroemboli-associated renal failure occurs incrementally days to weeks after completion of the procedure. The course is more prolonged and is accompanied by little or no recovery of renal function. Physical examination may show other signs of embolic phenomena, including levido reticularis and embolic lesions. In addition, urine eosinophils and decreased complement levels may be present. Clinically, volume depletion can be distinguished from contrast-induced nephropathy. In both cases, urine electrolyte testing will show low urinary sodium levels, but documented hypotension and negative fluid balance are more suggestive of volume depletion.

The mechanism of contrast-induced nephropathy remains unclear. One theory proposes that alterations in nitric oxide metabolism lead to renal vasoconstriction and thereby cause decreased renal perfusion and acute renal failure. Another theory hypothesizes that contrast medium is directly toxic to the renal tubules. In either case, the damage may be mediated by formation of free radicals in the acidic tubular environment.

Treatment and Prevention of Contrast-Induced Nephropathy

Supportive treatment should be given until the acute renal failure resolves. As mentioned earlier, fewer than 5% of patients will require dialysis. Prevention is key and should focus on limiting risk factors (Table 1). A helpful approach is to opt for noncontrast studies whenever possible (ie, MRI, ultrasonography, noncontrast CT). The damage associated with contrast agents can be minimized also by using lower doses of contrast
medium and by using low-osmolal or iso-osmolal non-
ionic contrast agents. Iso-osmolal nonionic agents have
shown the lowest incidence of contrast-induced neph-
ropathy\(^4\) but are expensive and not yet in wide use.
Studies have evaluated use of vasodilators (eg,
dopamine and fenoldopam) for preventing contrast-
induced renal failure\(^5,^6\) but have not shown a clinically
significant decrease in contrast-induced acute renal fail-
ure in patients receiving these treatments. Other attempts
at prevention—ie, use of mannitol- and furosemide-in-
duced diuresis as well as prophylactic hemodialysis given
after contrast administration—also failed to be effective.\(^7,^8\)
Recently, promising results were produced by a study\(^9\)
of periprocedural continuous hemofiltration adminis-
tered to prevent contrast-induced nephropathy, but
larger studies are needed to confirm these results. Two
other treatments—oral N-acetylcysteine administration
and bicarbonate infusion—have received substantial
attention and have also produced promising results.

**Table 2. Results reported by Alonso, et al\(^{10}\)**

<table>
<thead>
<tr>
<th>Group</th>
<th>Incidence of radiocontrast induced nephropathy</th>
</tr>
</thead>
<tbody>
<tr>
<td>N-acetylcysteine</td>
<td>35 of 444 patients (7.8%)</td>
</tr>
<tr>
<td>Control</td>
<td>82 of 441 patients (18.6%)</td>
</tr>
</tbody>
</table>

**N-acetylcysteine**

Studies of N-acetylcysteine used to prevent contrast-
induced nephropathy have produced mixed results. A
meta-analysis by Alonso et al\(^{10}\) attempted to reconcile
previous findings but showed large disparities between
study designs. The most important disparities were in
N-acetylcysteine dosages and hydration protocols used
for different patients. Most patients received N-
acetylcysteine 600 mg twice daily for two days, start-
ing on the day before the procedure. The authors\(^{10}\)
concluded that N-acetylcysteine reduces the incidence of
contrast-induced acute renal failure and may have a
greater renal-protective effect in high-risk patients
(Table 2). To prevent one case of contrast-induced acute
renal failure, the number needed to be treated with N-
acetylcysteine was eight.\(^{10}\)

**Bicarbonate Infusion**

Use of iso-osmolar crystalloids has been the main-
stay of hydration protocols for preventing contrast-
induced nephropathy. Merten et al\(^{11}\) recently compared
periprocedural use of two substances—sodium bicar-
bonate and isotonic sodium chloride—and hypoth-
esized that alkalinizing the tubular environment with
bicarbonate infusion would reduce formation of free
radicals and would decrease the incidence of acute
renal failure occurring after exposure to contrast agents.
In that study,\(^{11}\) 119 patients were randomized to re-
ceive infusion of either normal saline or sodium bicar-
bonate before and after administration of the contrast
agent. One hour before this administration, patients re-
ceived either sodium chloride or sodium bicarbonate
as a bolus of 3 mL/kg over one hour; infusion of the
same substance then continued at a rate of 1 mL/kg/hr
for six hours. Interim analysis showed that acute renal
failure was developing at a higher rate in the group
receiving sodium chloride, and the study was halted.
Subsequently, all patients received sodium bicarbon-
ate and were enrolled in a registry so that their progress
could be monitored. The results are shown in Table 3.
The absolute risk reduction of nephropathy for patients
receiving sodium bicarbonate infusion was 11.9%. To
prevent one case of contrast-induced acute renal fail-
ure, the number needed to treat with sodium bicar-
bonate infusion was 8.4.\(^{11}\)

**Conclusion**

Acute renal failure sometimes occur after administra-
tion of contrast agents. This failure is usually associ-
ated with only slight elevation in serum creatinine level
and is often self-limited. Treatment of contrast-induced
nephropathy focuses on assessing risk factors. More-
over, treatment with N-acetylcysteine as well as hydra-
tion with sodium bicarbonate appears to have a renal
protective effect in high-risk patients.

Future research will investigate further questions in
this field. Researchers have not yet clarified whether a
synergistically protective relation exists between N-
acetylcysteine and bicarbonate infusion in preventing
contrast-induced nephropathy. In addition, research-
ers will probably examine the effectiveness of prolonged
preprocedural bicarbonate infusion and oral bicarbon-
ate supplementation for preventing contrast-induced
acute renal failure.
To conclude the opening case, the patient’s creatinine level peaked at 4.9 mg/dL on the fourth day after catheterization. The creatinine level returned to baseline over the next several days while the patient received supportive care only. Although the hospital stay was longer than originally anticipated, dialysis did not become necessary.

Disclosure Statement
The author(s) have no conflicts of interest to disclose.

References

Table 3. Results of study comparing bicarbonate infusion to sodium chloride for preventing contrast-induced acute renal failure

<table>
<thead>
<tr>
<th>Group</th>
<th>Incidence of acute renal failure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sodium Chloride Infusion Study Group</td>
<td>8 of 59 patients (13.6%)</td>
</tr>
<tr>
<td>Bicarbonate Infusion Study Group</td>
<td>1 of 60 patients (1.7%)</td>
</tr>
<tr>
<td>Bicarbonate Infusion Registry Group</td>
<td>3 of 191 patients (1.6%)</td>
</tr>
</tbody>
</table>

Things Make Sense

Hope is not the conviction that things will turn out well, but the certainty that things make sense regardless of how they turn out.

— Vaclav Havel, Czech writer, dramatist and former President of Czechoslovakia
“causa mortis”

oil and mixed media on hammered copper
9.7” x 7.5”
2003

By Dorothy Faison

More art by Dorothy Faison can be seen on the cover and page 85.
A Symposium on Meditation, Prayer and Spiritual Healing

At the 2005 Kaiser Permanente National Primary Care Conference in Maui, I convened a distinguished panel, diverse in disciplines, to address the topic of meditation, prayer, and spiritual healing. The following symposium is an edited transcript of that session. 

*Meditation* in the form of a relaxation response was first brought to conventional medicine by Herbert Benson, a Harvard cardiologist in the 1970s. *Prayer? Isn’t that something people do in church or on their knees by their bedside? Spiritual? Is that different from religion? How is it experienced now? *Healing?* The only reference to healing when I went to medical school was wound healing. Can meditation, prayer, and spiritual healing be part of clinical practice? And what are the outcomes of their use?

This panel was brought together in Maui to illuminate the areas of mind, body, and spirit in clinical practice. We feel that this subject is so important that we are publishing it in this issue on health and healing.

❖

Ode to Physicians

By Tom Janisse, MD

At day’s end, who do I see in my patient’s eyes as I look in to listen? Automated chart note? CPT 99214? or overbook five?

I view in her face Mrs Yinder’s twitch, Mrs Olive’s tear, Mr Sila’s droop, Mr Garren’s wink; all visit for care.

Close air clouds our face.

A spot of blue! Ryan, blinks then winces, clutches his ear, his sole concern. I too am a parent, a child, and a patient.

Insight for me now at another day’s end: Can that be enough to feel therefore I am? My schedule, my watch, my palm pilot don’t hold my heart.

My heart holds my head in my hands.

What I give in visit after visit after visit all day long I take home. Ryan meets my son, Mrs Yinder greets my wife, Mr Sila calls my dad across the country. With these people at wit’s end at home I feel fulfilled.

Is this Tuesday? Thursday? It’s day’s end.
Meditation, Prayer and Spiritual Healing: The Evidence

Marilyn Schlitz, PhD, is the Vice President of Research at the Institute of Noetic Sciences and Senior Scientist at the Research Institute of the California Pacific Medical Center. She completed a bachelor of philosophy degree from Monteth College, Wayne State University, a master of arts in social and behavioral studies from the University of Texas, San Antonio, a PhD in social anthropology from the University of Texas in Austin, postdoctoral fellowship in cognitive sciences laboratory, Science Applications International Corporation, and a postdoctoral fellowship in psychology at Stanford University. She has published more than 200 articles in the area of consciousness studies and is the co-editor of Consciousness and Healing, Integral Approaches to Mind-Body Medicine, by Elsevier. She conducted research at Stanford University, Science Applications Internal Corporation, the Institute of Parapsychology, and the Mind Science Foundation. She has taught at Trinity University, Stanford University, and Harvard Medical School, and has lectured widely, including at the United Nations and at the Smithsonian Institution. She served as a Congressionally appointed advisory member for the National Institutes of Health Center for Complementary and Alternative Medicine and is on the board of trustees for the Esalen Institute and on the board of directors for the Institute of Noetic Sciences. She also serves on the scientific program committee for the Tucson Center for Consciousness Studies.

Dr Schlitz: This is a remarkable time in human history—never before have so many world views, belief systems, and ways of engaging reality come into contact. On one hand are the remarkable successes of science and technology: an orbiting space station, cloned sheep and cats, and a computerized chess champion that has outsmarted even the best of the human chess champions. On the other hand, through the Internet, awareness of the world’s wisdom and spiritual traditions has expanded: we now have access to practices that were once isolated in the Himalayas or deep in the Amazon and available only to a very small group of adepts. Today we are experiencing a convergence of these different ways of knowing, science on one hand and diverse religious, spiritual and cultural traditions on the other. Nowhere is this more clear than in the case of medicine.

There are various ways of responding to the unprecedented convergence we now experience. One is conflict; we need only turn on our radios to see how widespread this response is at a global level. Another response is co-option, where one tradition—typically the Western technological, scientifically based rationalist model—overpowers indigenous wisdom, often in very covert ways. A third response takes the form of creativity: As differences come together, we have the opportunity to birth new ideas and new ways of being together as a collective humanity.

My focus this morning is on the research perspective that lies at the interface of science, spirituality, and medicine. How can science begin to offer insights into these wisdom and spiritual practices? And how are these wisdom practices influencing science and medicine in ways that may lead to a more integral approach to health and healing?

Primary Areas of Evidence

There are five primary areas of data or evidence: the crosscultural data, survey studies, public health research, basic science related to mind-body medicine, and clinical studies of distant healing.

Crosscultural Perspectives

Indigenous cultures hold no separation between healing and a connection to the sacred. If you examine various traditions, it is only within our own culture that we make this demarcation between what is the rationalist approach and what is our deep engagement with the mystery. From the survey studies, it is clear that people are hungry for a deeper sense of meaning and for a connection to their spirituality. Seventy-three percent of adults believe praying for someone else can help cure their illness; this is based on a CNN poll. Fifty percent of patients wanted physicians to pray with them. This says something about what people are calling for, how people will feel happier, more contented, how they feel satisfied in terms of the therapeutic encounter. A recent survey published

Spirituality Symposium
by the National Institutes of Health looked at the ten most common complementary and alternative practices or modalities that are used by Americans today, and they found that of the top ten, three involved prayer: prayer for self, 43%; prayer for others, 24%; and prayer groups, a very common modality for people to engage in.

**Public Health Studies**

In terms of public health research, through the use of epidemiological methods and tools, we are beginning to understand the correlations between spiritual and religious practice and physical outcomes. Jeff Levin, a social epidemiologist, notes that more than 1600 studies have been conducted examining the correlation between religious and spiritual participation and health. The evidence is overwhelming. Findings persist regardless of religious affiliation, diseases or health conditions, age, sex, race or ethnicity, or nationality of those studied. This finding is positively correlated with education. People who have a strong educational background believe that these kinds of practices and principles are important for health and well-being.

**Basic Science on Mind-Body Medicine**

So let’s talk about the mind-body connection. From cross-cultural perspectives, it appears that people believe in and practice spirituality in the context of healing and, in fact, don’t make a separation. Within the Hawaiian Kahuna tradition, healers and religious spiritual practitioners are one and the same. It’s clear from the correlational studies within the epidemiology data that positive relationships exist between religious and spiritual practice and health outcomes on a variety of different conditions. We hear so much about the placebo effect as a mind-body piece for example. In our new book, *Consciousness and Healing,* we consider an integral approach to medicine in that health and consciousness is not only a part of this mind-body connection but also is a part of our connection to our relationships—our interpersonal relationships—our relationship to the environment, and our relationship to the transpersonal or the spiritual. Harris Dienstfrey, contributor to *Consciousness and Healing,* writes, “The mind as a source of medicine is waiting to be explored.”

It is very interesting to me as a researcher that the placebo effect is something that we tend to put aside. It’s the control condition. And yet if we really wanted to understand the innate capacities of the body to heal, wouldn’t we want to focus in there and look at the ways in which our body can take an inert substance and produce a physiological change? More so, this inert substance knows the whole cascade of responses that are necessary to lead to a particular kind of outcome. How does that happen? It is a profound mystery and one that needs to be explored more fully.

**Wound-Healing Study**

We received an NIH grant to look at the effects of prayer and spirituality on wound healing; research we are conducting at California Pacific Medical Center. This is a three-arm clinical trial with women, primarily breast cancer patients, who are undergoing reconstructive surgery after mastectomy. We have recruited healers from across the country to participate in this study—people who believe they can use their minds, their prayers, and their intentions to influence other people at a distance.

These healers include: Chi Gong masters, Johrei practitioners, Reiki practitioners, Carmelite nuns, Buddhist monks, and Christian groups. All the healers in our research study keep a daily log that describes their practice and their experience. People report making use of techniques such as directing healing energy toward the distant person, using some kind of focusing tool, such as a photograph, to focus their attention on the distant person, or making use of petitionary prayer to call on divine help from supernatural forces.

The women who come into the surgery unit are randomized into two blinded arms: Either they receive distant healing or they don’t. In the third arm of a distant healing or prayer and intention healing group, patients are called every day and are told that they are getting healing. The outcome in this study is the rate of wound healing by measuring collagen deposition in a little Gore-TEX® patch inserted in the groin area, a standardized location.

We’re also looking at a variety of psychosocial measures. This is an example of bringing spiritual and religious practices, what we call compassionate intention, into a laboratory setting and looking at the role of expectancy and placebo as it relates to the particular outcome measure. We are framing the possibility that our intention can actually influence the physical well-being of another person, even if that person is unaware of that intention.

**Distant Healing Research**

In the recent National Center of Complementary and Alternative Medicine (NCCAM) survey study I mentioned, a significantly high percentage of the population makes use of prayer for other people. Many people believe that if I pray for you, you will become better, or if you pray for me I’ll become better, and yet
we know very little of the mechanism to explain how this might happen. So this is a frontier area for research. To date, more than 180 studies have been done in this area, with more than half of them producing significant results. In these experiments, one person through their intention tries to influence the physiology or the physical condition of a target system, such as cell cultures, animal models, and there are human studies. As of March 2004, there have been nine controlled clinical trials looking at intercessory prayer (compassionate intention at a distance). Six of these have produced statistically significant positive results. For a complete list of these studies, one can visit the distant healing research site at the Institute of Noetic Sciences Web site (www.noetic.org).

As an example, Dr Elizabeth Targ at California Pacific Medical Center did a series of trials looking at AIDS patients. She selected AIDS as a condition because, at the time of the study, it was very resistant to conventional allopathic medical intervention. Patients were randomized into standard care alone or they got standard care plus a booster, which was this intercessory prayer at a distance. This was a blinded study. In both a pilot study and a confirmation study, the prayer groups had statistically significant improvements in outcome, suggesting that the intervention has clinical relevance.

**Compassionate Intention and Cancer Patients: The Love Study**

Anyone who works with cancer as a condition knows that partners of cancer patients can feel very disempowered. There is very little to do to help your partner. The Love Study is another project that is relevant to the translation of basic science into clinically relevant outcomes. Specifically, one of our goals was to promote psychological robustness in the partner of the cancer patient.

We trained the cancer patient partner in compassionate intention. When the training program was over, we conducted a distant healing experiment in our lab at the Institute of Noetic Sciences. We monitored the patient's physiology, looking at autonomic measures: skin conductance, respiration, heart rate, and EEGs. One person was situated in a 2000-pound electromagnetically shielded room to rule out any conventional explanations that might account for the results. We asked the couple to exchange meaningful items—a psychological activity that helps them stay connected. For example, a man gave his wife his boots and she gave him her doll, which they held while doing the experiment. The job of the partner of the cancer patient, at random times throughout a session, is to try to calm his partner's physiology. This is a “proof of principle” type study to show that physiological changes occur as a result of this kind of exchange. The man watched a closed-circuit television as his wife’s image intermittently appeared on the screen. Neither he nor she knew when those viewing periods were going to occur. The experiment is based on a randomized double-blind-type protocol.

This study can be seen in light of other studies using this same testing paradigm. A study published in the *British Journal of Psychology* examined 35 studies that looked at whether the intention of one person can interact with and influence the physiology of another person. They found a statistically significant positive difference across the studies.

We feel we have established the proof of principle that there is some kind of nonlocal or transpersonal exchange of information between two people. So, now the question for all practitioners is: How does that relate to our practice? How do we bring these ideas of spirituality and compassionate intention into our practice, and how do we begin to see whether or not it helps clinically?

**Practical Application**

In the introduction to *Consciousness and Healing*, Ken Wilber notes that the most important aspect of this integral approach to medicine is the transformation that happens in the healer. Rather than thinking about this as something outside of ourselves, how do we really bring these principles into our own lives. Key to an integral approach is not the content of the medical bag, but the holder of the bag: one who has opened herself or himself to the multidimensional nature of healing, including body, mind, soul, spirit, culture, and nature.

**Spiritual Education**

Today, 101 medical schools incorporate patient spirituality in their curriculum, up from 17 in 1995. This fact suggests that these principles are being incorporated into medical education, albeit at an elective level. Some hospitals such as UCLA Medical Center encourage physicians to include spiritual histories in patients' charts. This acknowledges that in fact these kinds of principles are being incorporated into mainstream medicine. Harold G Koenig, MD, who works at Duke University, recommends that physicians ask every patient if they consider themselves spiritual or religious. Doctors should encourage prayer and religious participation if that is a source of comfort. Religion has the power to heal, and we
have an obligation to value that power alongside medicine.

**Conclusion**

By way of conclusion, each of us in some way represents both the hospice worker who is helping in a very loving, kind, gentle way to let the old paradigm die, to watch and release it from its own suffering, and at the same time, each of us acting as midwives for the birth of something new. As these different cultures and different world views converge, we can begin to see the birthing of a creative solution to many of the problems we face today.

**References**


**Fly!**

You and I are made for goodness, for laughter, for joy. We’re made for transcendence. Fly!

— Archbishop Desmond Tutu, b 1931, South African cleric and activist
Meditation

Charles Elder, MD, received his BA, MD, and MPH degrees at Boston University and completed his internship and residency at the University of Michigan in 1990. He joined the Northwest Permanente Medical Group as a primary care internist in 1991. He has offered a natural medicine consultative group clinic for six years and established the KP Northwest Integrative Medicine Service last year. He organizes the Northwest Permanente Complementary and Alternative Medicine Journal Club, is cochair of the regional natural products committee, and is clinical lead for the interregional CAM domain. He is a clinical investigator at the Center for Health Research, is principal investigator for two NCCAM NIH-funded clinical trials, and has published several papers on the topics of integrative and Ayurvedic medicine.

Dr Elder: The glaring discrepancy between our patients’ needs and what we are capable of offering them within the confines of allopathic care represents an underrecognized root cause of chronic dissatisfaction among adult primary care clinicians. Complementary and alternative medicine (CAM), including the spirituality, prayer, and spiritual healing discussion that we’re having today, can offer us practical tools to help bridge this chasm. The following discussion focuses on meditation: the mechanics of meditation, the evidence base to support its use, and the practical recommendations we can offer to patients.

We can understand “science” as denoting any branch or department of systematized knowledge considered as a distinct field of investigation or object of study. That “science” connotes empiricism is not an a priori truth but rather a provincialism of our age. An authentic meditation technique, then, can be properly understood as a scientific pursuit, with the object of systematic study being consciousness or the self. Meditation does not represent a mood-making or counterculture phenomenon but instead a specific set of simple but sophisticated techniques having definable physiologic markers and clinical results. Mantra meditation represents one technique, where the meditator sits comfortably with eyes closed and focuses his or her attention on a specific mantra or sound. This procedure serves to guide the mind from active awareness to a more tranquil state rooted in pure consciousness. Once this restful state is achieved, however, thoughts may frequently “bubble up,” diverting attention back toward the external world. The meditator responds by gently returning focus to the mantra and so on, back and forth. The technique thus represents a simple yet specifically directed procedure.

The physiology of meditation has been exhaustively studied. When meditating, patients exhibit decreases in heart rate, respiratory rate, blood pressure, and cortisol levels, as well as increased serotonin availability and reduced free radical burden. In one classic study published by Keith Wallace, MD, in the journal Science, subjects demonstrated reduced O2 consumption, reduced respiratory rate, and increased galvanic skin resistance during meditation practice. In another paper published in American Psychologist, meta-analysis data comparing meditation with simple eyes-closed rest suggested increased basal skin resistance, reduced respiratory rate, and reduction in plasma lactate in the meditating groups. Thus, the literature clearly describes distinct physiologic changes that occur during meditation.

Let’s next consider some of the clinical trials data. A paper published about ten years ago in Hypertension compared patients with mild hypertension, randomized into three groups: an attention control group receiving standard patient education, a physical stress reduction group receiving training in the progressive relaxation technique, and a meditation group receiving instruction in Transcendental Meditation. At three months, this single-blinded study showed statistically and clinically significant reductions in systolic and diastolic blood pressure in the meditating group compared with control.

In another study published in the American Journal of Cardiology, 21 patients with documented coronary artery disease were tested at baseline by exercise tolerance testing and were assigned either to meditation instruction or to a wait-list control. After eight months, the meditation group had a 14.7% increase in exercise tolerance, an 11.7% increase in maximal workload, an 18% delay in onset of ST-segment depression, and significant reductions in rate-pressure product at three and six minutes and at maximal exercise compared with the control group.

In addition to cardiovascular disease, studies have suggested beneficial clinical effects for meditation in numerous other clinical conditions, including anxiety...
disorders and substance abuse. For example, meta-analysis data have shown a significant effect size for meditation compared with other standard behavioral interventions in the context of both alcohol and tobacco abuse. Finally, numerous studies in the literature suggest that regular meditators use less health care. One study, for example, compared five years of medical insurance utilization statistics of approximately 2000 regular meditators with a normative database of approximately 600,000 members of the same insurance carrier, showing the meditating group to have lower medical utilization rates in all categories.

At a practical level, what can we offer our patients? Some KP Regions offer training in various stress management protocols through the Health Education Department, and most larger cities offer additional community resources. In Portland, I sometimes refer my patients to the Portland Transcendental Meditation Center for meditation instruction or to the Oregon College of Oriental Medicine for classes in Qigong.

In summary, meditation represents a sophisticated mental technique that is associated with a definable physiology and can render significant positive clinical effects. Through the use of meditation and other evidence-based CAM modalities, as adjuncts to usual care, primary care clinicians may be able to affect a sizeable number of patients we might otherwise be unable to reach.

References

All The Answers

It is reasonable to expect the doctor to recognize that science may not have all the answers to problems of health and healing.

— Norman Cousins, 1915-1990, writer, editor, citizen-diplomat
Spiritual Moments

Naomi Newhouse, MS, CNM, completed her graduate study at the University of California San Francisco in 1995. She served as chair of the TPMG nurse midwifery peer group for six years and is a California Health Care Foundation Fellow. As a board member of the California Nurse Midwifery Association, she has been actively involved in moving legislation to support midwifery statewide. She has personally delivered more than 3000 babies and practices clinical midwifery at three TPMG sites. She and her husband, David Newhouse, MD, are busy raising their two children, Daniel and Elizabeth.

Ms Newhouse: Growing up in a small rural community, I had the opportunity to watch the lives of many friends and community members unfold over time. I knew why Mrs Jones had horrible headaches and why her daughter was often sick. By watching, I learned that what is wrong with our lives soon becomes what is wrong with our bodies and our minds.

This realization drew me to midwifery and sculpted my practice. The care I provide is patient centered. I ask questions and listen hard. The expert is sitting in my office. Working with thousands of women over the years, I have come to appreciate that the patient is intimately acquainted with her circumstances and knows what will or will not be effective. She ultimately holds the responsibility for any choices made, and she will bear the consequences. This is all about her.

In a culture where we are conditioned to ignore our own voice, my greatest challenge is to create a “sacred space” or “safe space” where a woman can tune in and hear what her heart is trying to tell her. As I regard the value of her voice, she regards the value of the message and moves to make the necessary changes.

By its very nature, birth creates this space for you. New life is emerging, the lights go down, and the sacred takes center stage. This is the woman’s moment. Holding the space without bias or judgment and keeping her and her infant safe is the essence of the work I have come to love.

Each family brings their unique perspective to birth: a perspective affected by culture, religion, and personal experience. Last year, I had the pleasure of working with a family from Afghanistan. When I say family, I mean a family of 12. The entire family had immigrated the year before and took turns supporting the laboring couple. They prayed continually but would stop as soon as a nurse or other clinician entered the room. When I assumed care, I mentioned how important prayer was in my life and encouraged them to feel comfortable praying in my presence and in the presence of our supportive staff. When the family began to feel more comfortable, I noticed that the mother relaxed considerably. I encouraged the family to become more involved with her direct care, showing them where they could access supplies to keep her more comfortable and asking them how they felt about her progress. Soon they were sharing their experiences and their concerns. The young mother quickly progressed, and the female members of the family moved with us to the largest delivery room. They stayed with the laboring woman throughout the delivery, praying out loud continually and offering encouragement as the woman worked hard to deliver her first son. The only man present was the father of the baby. Standing off to the side and close to the wall, he smiled occasionally, comfortable with the support his wife received from family members. After I completed the delivery, I felt someone’s hand in the back pocket of my scrubs. Quickly taking off my gloves, I turned to see the father of the baby remove his hand from my backside.

I was shocked to discover he’d placed two hundred-dollar bills in my back pocket; and turning to the family, I knew immediately that they were expecting me to accept their gift graciously. The nurse and I exchanged a worried glance, and I began to tell them as carefully as I could that I could not accept their money. They were completely offended and physically turned away from me. Hours spent making them comfortable had ended in failure. Thinking fast on my feet, I lifted my hands in Birth bears witness to the creative power we all possess. It’s a time of transformation, an opportunity to remind a woman how powerful she can be.
the air and exclaimed in a loud, plaintive voice that accepting money was against my religion! To my great relief, they quickly turned to face me and graciously nodded their acceptance and understanding.

Birth bears witness to the creative power we all possess. It’s a time of transformation, an opportunity to remind a woman how powerful she can be. Many, many times, I have whispered into the ear of a new mother that she should remember what she did here today. When it gets tough, she should remember how strong she is. Honoring her ability to self-create, to transform her life, plants the suggestion that she can mobilize and realize changes that will benefit her and her family. These women will track me down just to tell me they’ve finished their GED, started college, left an abusive partner. For those who will hear their own voice, who will value what is true for them above all else is the gift of vitality and the power that comes with it. What is right about her life will soon be what is right about her body, mind, and spirit.

Nurturing Spiritual Growth

Although the act of nurturing another’s spiritual growth has the effect of nurturing one’s own, a major characteristic of genuine love is that the distinction between oneself and the other is always maintained and preserved.

— M Scott Peck, b 1936, author, nationally recognized authority on the relation between religion and science
Pastoral Spiritual Care

Kurt Smidt-Jernstrom lives in Canby, Oregon, with his wife and two children and enjoys work, cycling, fishing, boating and choral singing. He received his theological education at Fuller Theological Seminary in Pasadena and at the Graduate Theological Union at Berkeley, California. He took his chaplaincy training and internship at Stanford Medical Center, UCLA Medical Center, and Legacy Emanuel Hospital in Portland, Oregon. An ordained minister in the United Church of Christ, he has served as pastor of a local church, as interfaith chaplain at a care center, as pastoral counselor of Kaiser Permanente Hospice, and is a chaplain at Kaiser Sunnyside Hospital in Portland. He is a member of the KP Regional Ethics Committee; a board-certified chaplain through the Association of Professional Chaplains, and a doctoral candidate at the University of California, Berkeley.

Mr. Smidt-Jernstrom: I am going to begin by listing my three main points: First, it is possible for healing to occur (healing in the broadest sense, meaning a reintegration of body, mind, emotion, and spirit that enables one to live life fully, with a sense of equanimity), whether or not physical symptoms actually improve. Second, supporting and fostering this healing process is something you can do in the clinic setting. Finally, to provide effective spiritual support, it is helpful to reflect on one’s own spirituality.

At the outset, I would like to offer a couple of definitions that may be helpful as we discuss spirituality. I often make a distinction between spirituality and religion. Spirituality is an aspect or condition of human being, concerning:

- relationships (involving love and intimacy)
- meaning and purpose for being
- letting go of the crippling past (forgiveness)
- openness to the future; hope.

Religion is:

- a system of beliefs and formal practices that are practiced individually or in community, usually as a focus for finding meaning in life, understanding death, and maintaining hope for the future.

As a hospital chaplain, I provide spiritual and emotional support (and occasionally religious support as a Protestant Christian clergyman) to patients, sometimes to families, and occasionally to hospital staff. One of the tools I use in providing this support is active listening (listening to a person nonjudgmentally and compassionately) to try to understand that person and not necessarily to fix a problem. Another tool I use is a supportive presence; in other words, the nonverbal aspects of communicating interest and compassion when attending to another. Maintaining a supportive presence is important in any patient encounter but becomes especially important when working with someone who is struggling with cognitive impairment and who finds it difficult, if not impossible, to communicate verbally, not to mention engage in a reflective process. Prayer (and to a lesser extent, meditation) are other tools I use to provide spiritual support and to help enable a person to cope with illness or injury or sometimes dying. I work, as best I am able, within patients’ belief systems, helping them to tap into their own spiritual resources.

Prayer and meditation are practices that can aid the ability to cope by enabling a person to modify the perception of a stressor. (I have a graphic image that shows the relation between prayer, meditation, and various coping behaviors.) For instance, some people have told me that in their struggles with chronic illness or pain, they have learned to “befriend” their illness or to “dance” with their pain. These metaphors seem to indicate a certain ability to cope with various stressors.

A woman I worked with recently had lymphoma. The cancer itself plus the side effects of various medical interventions left her, at times, physically, emotionally, and spiritually exhausted. Throughout her life, she had prided herself on her physical condition and appearance and so occasionally became distressed at the disfigurement that occurred as a result of the chemotherapy and the progression of the cancer. For all this, she refused to let her illness (and eventually her dying) keep her from participating in family and community life. Until quite near her death, she was attending family gatherings, grandchildren’s school events, and church. She had a very deep faith that she drew upon continually for inner strength. A saying that she gave me shortly before her death is an indication of how she was able to modify the way she perceived some of the powerful stressors she experienced.
LIFE'S JOURNEY
Life is not a journey to the grave with the intention of arriving safely in a pretty-well-preserved body, but rather to skid in broadside, thoroughly used up, totally worn out and proclaiming:

WOW!
WHAT A RIDE!

This coping or healing can be fostered and supported in the clinic setting by using spiritual support tools, such as active listening—listening CARE-fully, sensitively and respectfully—and attending to spiritual concerns when they are mentioned. Occasionally, a patient will explicitly mention a religious preference, belief, or spiritual concern. In that case, it is helpful to follow-up. When I talk with patients, I always listen for openings that give me the opportunity to follow-up on spiritual issues or concerns.

Some people like to take a spiritual history using one of various spiritual assessment tools. One popular assessment that has been peer reviewed and listed in medical journals was developed by Christina Puchalski, MD. You might find this or other assessments helpful in developing your mental template and your own way of broaching spiritual issues. Good opportunities to conduct a spiritual assessment might be when a person is admitted to the hospital, or perhaps during a new patient visit, or during a medical maintenance visit.

Sometimes the presentation of spiritual issues can be complicated, and one needs to tease them out. For instance, I worked with a young woman who had ovarian cancer and who was very angry. By listening carefully and by establishing a nonjudgmental presence, I offered her the opportunity to talk about and reflect upon her anger, which in turn, allowed her to begin to understand the effects that her anger had on others as well as herself. (Editor’s note: Mr Smidt-Jernstrom wrote about this in a story to be published in a future issue of TPJ.)

Referrals are another way of offering spiritual support. When addressing spiritual concerns threatens to go beyond the time constraints of an office visit, it may be helpful to suggest a referral to a chaplain or social worker. In addition, in the KPNW, we have health consultants to whom patients can be referred, and those consultants can link people to various groups who are open to reflecting on spiritual concerns as they relate to the patient’s own illness or condition.

Finally, to provide effective spiritual support, it is beneficial to reflect on one’s own spirituality. Some may be novices at that, and so I have included a short list of questions to reflect upon that can serve as starters (Table 1). They prompt reflection on spirituality in general as well as on one’s own spiritual journey. ❖

Table 1. A short list of questions/discussion points for reflection

<table>
<thead>
<tr>
<th>Discuss the following thoughts and questions about spirituality:</th>
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<tbody>
<tr>
<td>• What are some of the barriers to discussing spirituality/spiritual issues in general and/or with those you care for?</td>
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<tr>
<td>• It is often helpful to distinguish between religion/religiosity and spirituality</td>
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<tr>
<td>• Spirituality is elusive. It’s not my mind or my feelings, although it’s part of them. It’s that part which holds together all the rest. Spirituality refers to an acknowledgment, belief, or conviction that there is more to life than the material … People are looking for commonality—for common ground.</td>
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<tr>
<td>Various ways of describing spirituality:</td>
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<tr>
<td>• Journey—with metaphors such as traveling, destination, or crossing over</td>
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<tr>
<td>• The business of living—the work one has to do, unfinished or unresolved business, pride in what has been accomplished</td>
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<tr>
<td>• Relationships—with metaphors for healing, estrangement, and separation</td>
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<tr>
<td>• Interpersonal—issues such as fear of suffering or questions of forgiveness, shame, and guilt</td>
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<tr>
<td>• We all perceive life in our own way. Difficulty arises when we cling to a world of perception as though our own perception is the ultimate reality</td>
</tr>
<tr>
<td>• We all ask such questions as: Why? Why me? Why now? Questions for which there are no answers. What’s required is not a seminary education but sensitivity and ears that can hear and being comfortable with not knowing</td>
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❖ Brad DeFord remarks at National Hospice Organization’s annual meeting in Salt Lake City, Utah; 1992.

b Don Dinsmore remarks at Hospice Organization of Wisconsin annual meeting; 1993.

References
Spirituality in the Medical Encounter: The Grace of Presence

Elizabeth Sutherland is a naturopathic doctor. She received her bachelor’s degree in biopsychology from Tufts University and her naturopathic medical degree from the National College of Naturopathic Medicine in Portland. She completed a two-year postgraduate fellowship through the Kaiser Permanente Center for Health Research and is currently a research associate with that organization. She is a clinical investigator on the NIH-funded study, Alternative Medicine Approaches for Women with TMD, and the principal investigator on two pilot studies that examine the experiences of chronic pain patients at the Kaiser Permanente Northwest Pain Clinic who received an energy healing intervention. Her research interests center on developing methodologies to study the doctor-patient relationship and transformational change, and she has published in this field. In the past, she studied Classics at Cambridge University.

Dr. Sutherland: It is easy to think of spirituality as a domain that is distinctly separate from the practice of medicine. If spirituality is considered to have a place in the medical setting at all, it is usually envisioned as a discussion between doctor and patient where the doctor gingerly approaches the topic of the patient’s religious beliefs to better assess the patient’s available social support. Sometimes, this discussion takes place when the doctor feels s/he has reached the limits of medical knowledge and doesn’t know what else to do, as with a patient facing the diagnosis of a terminal disease or other life crisis. The goal of the discussion may then be to refer the patient to a chaplain or other religious expert.

While this type of discussion is vital and admirable, it is possible for the doctor-patient relationship itself to be a profoundly spiritual encounter, even if the topic of religious beliefs is never broached. I lived within a spiritual community for several years where meditation and introspective work were built into a rigorous schedule. The real emphasis of the practice, however, was that spirituality is grounded in everyday life, not separate from it; that, by our nature, we are spiritual beings, and that connection is, in a sense, the fundamental unit of life. The practice involved becoming aware of this connection and consciously serving it. In the medical setting, spirituality can be defined as the practice of cultivating awareness of a larger and larger context. This may sound like a kind of “off-label” use of the term spirituality, but when we practice cultivating awareness of a larger context, in essence we take a step back and begin to contemplate both ourselves and the patient, each as a whole person. Practicing medicine as a spiritual encounter is really a lifelong work of meditation and introspection, which can be expressed as three steps:

1. Cultivating awareness of wholeness within oneself
2. Seeing wholeness in another
3. Connecting from the sense of wholeness within oneself to the sense of wholeness one perceives within another.

The language may sound abstract, but if connection is a constant principle of life, then we are just acknowledging and consciously participating in that connection process. A way to step into practicing medicine as a spiritual encounter is to listen for the meaning of a patient’s experience, instead of listening only for the reporting of symptoms. Think of this as our attention span, not how many minutes we can concentrate with our minds, but how far we can open our hearts and simply behold ourselves and another person in a given moment. This is deep listening, a facet of spirituality with concrete benefits.

Deeply listening is not just a nice

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**Sidebar: The benefits of listening deeply**

**For the patient**
- Improved medical outcomes through better diagnosis
- Improved satisfaction leading to greater adherence to treatment

**For the doctor**
- Greater job fulfillment
- Less stress-related illness and burnout
- Personal expansion and growth
thing to do. It is in itself an agent of healing and transformation. Deep listening is an internal orientation of you, the doctor, that becomes experience and then a state you transmit to the patient. (See Sidebar: The Benefits of Listening Deeply.) It may feel like doing nothing, but it can make all the difference in the world. Knowing one is truly heard and understood gives a sense of self-value and a greater ability to bear whatever is going on. The culture of medicine has become so fraught with time constraints, performance measures, and litigation that it loses sight of the two people who are in the room participating in an experience together. Medical training essentially trains doctors to take the person (that is, themselves and the patient) out of medicine. To help bring the person back into medicine, consider two concepts:

**The First Law of Theo-Dynamics**

*Sometimes, the least is what you know; the most is who you are.*

**The Second Law of Theo-Dynamics**

*How much time you actually spend with the patient is less important than the quality of your presence.*

I use Theo here to represent the spirit and creative power of wholeness or completeness that resides within each of us. Being present and deeply listening brings the person, the humanity, back to the medical encounter and turns it into a therapeutic relationship. The practice of medicine is a spiritual encounter in which the doctor as person is an integral part of the medicine, acting as a catalyst in the therapeutic relationship to reconnect the patient with his/her inherent capacity to be whole. Spirituality in the medical context is about the doctor as expert human being rather than religious expert. This can take the form of holding for patients the vision of their wellness when they are unable to connect with it themselves. It can mean realizing that fear of giving the patient false hope may in fact be directing the patient toward false despair.

**How to Practice Medicine as a Spiritual Encounter**

Begin every visit with a spiritual orientation toward your patients. This means wanting to know the meaning their experience has for them. (It may help to hold inside of yourself the thought: “I want to know who you are.”) Begin with an invitation: “How can I help you?”

If a patient reports to you what is in his/her medical records, redirect: “I know all of that. I want to know what is going on for you.” A patient may cry because this is the first time anyone has ever asked this. If the person cries, it is actually a good sign. You don’t have to do anything. Just wait a few seconds. The patient will tell you what is really going on, making connections s/he has perhaps not understood until now.

In the presence of your deep listening, you have created the space for self-awareness. Stop talking. Listen. Listen beyond the mere reporting of symptoms. Remember, listening from your heart is a state of deep acknowledgment that you will transmit to your patients.

Even if you only have a few minutes, the patient will feel heard, hopeful, and understood because you have deeply listened. Get comfortable doing nothing. Get comfortable letting a patient leave without a prescription. Listening may be all the medicine your patient needs in that moment.

**Conclusion**

Spirituality is found in the human condition; it’s in the connection between people. It takes a relatively small investment to connect. It’s not the time spent; it’s the quality of your presence. Connection is the human face of medicine; the human face of medicine is spiritual medicine. Listening beyond the reporting of symptoms will transform your practice and will transform you as a person.

——

The time will come
When, with elation,
You will greet yourself arriving
At your own door, in your own mirror,
And each will smile at the other’s welcome
— From “Love after Love,” by Derek Walcott

**Reference**

Spirituality Symposium: Panel Discussion

Dr Janisse: I want to thank our panel for their thoughtful, informative, and entertaining presentations. I would like to open this discussion up for questions.

Time

Audience member: I love connecting with my patients, and it’s always the time issue. Once you start connecting with them, they really want to open up and let it all out as though you were from the behavioral science department. So what do we do with that? Do you have something specific that you stay with and focus on with the patient, and how do you stop them without invalidating them when they start to go on and on?

Dr Sutherland: Because I practice on the fringes of medical society, so to speak, I have the luxury of spending sometimes an hour, sometimes an hour and a half with patients, and maybe I’ll ask two questions in that time. The first question I’ll ask is, “How can I help you?” At which point they’ll either tell me what’s in their chart, for example, “I’ve just been diagnosed with ovarian cancer.” I’ll say that I already know that. What I’m interested in is what is your experience: I want to know your story. Or they’ll cry, and that’s when I know I’m really doing good work. They’ll cry because no one has ever asked them, how can I help you. So, how can I help you? And then maybe I’ll ask, “What else?”

What we’re really talking about is the cultivation within you, the practitioner, of certain qualities. How you describe these qualities, I think, is whatever resonates with you. Dr Schlitz talked about compassionate intent. I talk about being fully present and deeply listening. So this is something, as I think all of the panelists have mentioned, that a practice we do all the time. Hopefully we’re successful with it in that moment with a patient, but it’s not something that we can turn into a technique. When you practice it all the time, you can step into it immediately because it’s a state that is always there so you can connect with it.

When you have that demeanor, your patient is going to feel you’ve really spent a lot of time with them even if it’s only seven minutes. You probably heard about a statistic recently that surgeons who don’t get sued spend more time with patients than surgeons who do. Do you know how much more time they spend with patients? It’s not 90 minutes. Three minutes. Three minutes, but it was something about their demeanor. So in terms of how to redirect a patient when you’re running out of time: One, is the fact that you have listened so deeply that patient is going to feel acknowledged so then whatever you say (because you will in that state allow the words to come to you rather than forcing words), they’ll still feel acknowledged. You can say to them: I think what you’re saying to me is so important that I really want to continue exploring this with you. We’ve run out of time, so I’d like you to make another appointment. This leads to you, the practitioner, getting comfortable doing nothing, because when you think you’re doing nothing that’s actually when the healing is happening. To send that patient away without a prescription, maybe the only thing you say to them is: In the coming week, in the coming month I’d like you to spend ten minutes on your own thinking about your experience right now and see what it brings up for you and then tell me about it when you come back.

Mr Smidt-Jernstrom: I would add to what Dr Sutherland has said, only that you can communicate compassion and understanding and it doesn’t necessarily take a long time. I can appreciate that there are times that you feel this particular patient has just given you something you don’t have time for, and that’s when handoffs are good, like referrals, as a way of redirecting. You can say, “This is really important, and I’m wondering if you might be willing to talk with someone else about this.”

As I mentioned about doing a spiritual history, I know of a physician, for instance, who asks his patients: “What are you doing for yourself besides taking your pills?”

Dr Elder: I think the presence of the clinician is, in itself, healing. What we can do that doesn’t take a lot of time is just be ourselves and take care of ourselves. Then, when the patient comes in sick, s/he will pick up on that energy, and that is itself therapeutic. The other point is that it doesn’t take a lot of time to make positive comments to the patient, because we forget how powerfully we communicate to the patient through...
Applying Meditation in Clinical Practice

**Audience member:** How do you think we could use meditation, and in what conditions and situations would this be particularly valuable?

**Dr Elder:** There’s a lot of data supporting the use of meditation in cardiovascular disease, that’s number one. Number two, in substance abuse. Number three, depression and anxiety. Learning these techniques isn’t inexpensive but is cost-effective in the long run when you consider that, for example, the average cost of being on a drug is about $1500 a year per drug. So, if we can give patients alternatives to medication, we can go a long way in terms of being cost-effective.

**Dr Schlitz:** Also, just as a resource, on the Institute of Noetic Sciences Web site is a meditation bibliography, called *The Psychological and Physiological Correlates of Meditation*. There are different illness categories and the research.

**Mr Smidt-Jernstrom:** Practically speaking, oftentimes I suggest a focus on breathing as a way for people to clear their mind and slow their breathing. Sometimes people find a certain phrase helpful, and they use it over and over. Sometimes music. A single parent I work with in the hospital focuses on her youngest child and uses that as a starting point for her meditation. It could be a walk in the woods.

**Ms Newhouse:** In the Diablo Service Area in Northern California, we have a trainer in a technique called mindful meditation, developed by Jon Kabat-Zinn. It’s non-sectarian. It’s available in a course for physicians and also for patients, for example those with chronic pain. Dr Kabat-Zinn initially worked with chronic pain patients in his clinic to discover their own power of healing and has had a lot of success through applying this technique.

**Audience member:** I was very interested in the cardiologist who says a prayer before he goes into the procedure. It reminded me of the JAHCO standard now to have a time-out in the OR before every case. It’s an incredibly powerful thing that when the patient is draped, prepped and getting ready for the procedure, the surgeon has to quiet everybody down, tell a brief history of the patient, then the circulating nurse and the anesthesiologist give their important points about that patient. It’s a powerful moment.

**Dr Schlitz:** This moment also allows a renewal for the practitioner because it’s a two-way interaction. How they can find, and we can find, our centering so that it’s a more responsible engagement.

**Mr Smidt-Jernstrom:** Recently, I met a young woman who had surgery, and she had listened to some wonderful meditation tapes and read a book on meditation. She came up with a list of statements that she wanted her surgeon to read to her before she went under anesthesia. The list contained such things as “You will only have minimal blood loss during surgery” and “You will recover completely and quickly from this procedure.” There were six things, and the surgeon read them all.

**Audience member:** How long is the meditation that you would suggest patients do? For a lot of people with their busy lives, trying to start meditating would probably take some practice.

**Dr Elder:** Twenty or 30 minutes of practice, once or twice daily, has been generally recommended for the techniques that we have studied at our Center for Health Research (including Transcendental Meditation and Qigong). In our studies, patients have generally reported 80-90% compliance. Some patients have told us that they find the mind-body practice time efficient because they can get so much more done with the rest of their day.”

**Dr Schlitz:** In Jon Kabat-Zinn’s work, it’s ten minutes, and it’s just a simple centering exercise that’s distilled from a number of different practices, so it can be a deeper immersion in the practice or it can be something so simple as just connecting to your core self and relaxing.

**Presence At Death**

**Audience member:** Although I’m an endocrinologist, I still take hospital call, and I’m amazed in this day and age that I still have to declare people dead. When I enter the room, the family is there, and the patient’s dead. I’m entering that sacred space, if you will. That’s when I take my time-out—before I enter that room—because I don’t know this patient at all, never met them.
I’m not their personal physician, I’m the hospitalist, and it still gives me goose bumps. I would do that until I stop practicing medicine. And when I entered medicine I never thought I would. I thought I would be afraid of death and would not honor it. We’ve talked today about birth, which is a beautiful thing, but the time of death is also when we can be present with the family. That is incredibly healing for the family. I just know that’s true.

Dr Schlitz: Both birth and death are the transitional phases where the sacred comes and goes, so they're similar. They are so related, it's almost hard to divide them, and honoring that space doesn't take a lot of time. It's about your willingness to just center your spirit for a moment before you walk into that space, and the more aware you are of what is going on in your own heart and mind and being able to put that aside for a moment. When you're interfacing with critically ill patients or with patients who are very upset or in a state of crisis, holding that sacred space can be done in short fashion, and it begins with how in touch you are with your spirit. When they see you get centered, they get it right away. You can feel it, you can feel them zoom in on you.

Dr Sutherland: I wanted to give my talk today the title: "What is spirituality? Or what do you do when you think you have nothing to offer?" And we’ve been talking about profound experiences, people who are dead, patients who are facing death or birth. I'd just like to say again that spirituality is the human condition. It’s something that’s with us all the time and we can connect with it all the time. In the Tibetan tradition, they have mantras, which are like prayers, for everything. There is a mantra for going to the bathroom, and this is not making something sacred profane; it’s saying that everything’s sacred.

Negative Effects?

Audience member: I went to medical school at Columbia with a surgeon named Emmett Oz. Whatever happened to his work about giving suggestions during surgery?

Audience member: He is still out there. People now believe that thinking positive things about our patients can have a positive impact, then the reverse is probably true, and so we need to be very mindful of that.

If we believe that thinking positive things about our patients can have a positive impact, then the reverse is probably true, and so we need to be very mindful of that.

Dr Schlitz: That is such a good point. That's why research in this whole area is so critical. We just don't know enough. It's a whole new sort of discipline. When you consider something as benign as prayer, we just don't know enough about in what conditions it is helpful and in what conditions is it harmful.

Dr Sutherland: Because of this, it’s safer to keep yourself as the instrument, because if you’re listening, if you’re being fully present, I really don’t think you’re going to do any harm.

Mr Smidt-Jenström: I think it is important to remain patient-focused. I always work within the belief system of the patient to enable them to tap into their own spiritual resources.

Dr Elder: Your point emphasizes the importance of thinking good thoughts about our patients, because in the course of a busy day, when we’re seeing two dozen patients, we can come to a point when we’re not at our best and we start having thoughts that aren’t entirely positive about our worklife and the people whom we serve. If we believe that thinking positive things about our patients can have a positive impact, then the reverse is probably true, and so we need to be very mindful of that.

Dr Sutherland: What we’re doing when we’re with a patient is inviting them; we’re not demanding. We’re not saying, you know, I’m loving you unconditionally, what’s your problem? Because we can do that. We can think our intent is loving kindness and it’s putting energy into another person that they may not want. So you have to hold within yourself that: I want to know who you are. Let everything you do be an invitation.

Dr Janisse: Well, thank you all for coming. And a special thanks to the panel for bringing knowledge, experience and wisdom to this relevant subject.

Reference

soul of the healer

“Mr Statue.com”
photograph
By Beverly Brott, MD

Dr Brott is a full-time hospitalist at the Kaiser Sunnyside Medical Center. She loves to travel and has visited Thailand, Laos, Cambodia, Myanmar, China, Hong Kong, Guam, Micronesia, the Philippines, India, and Nepal.
Dr Brott’s photo galleries can be found on the Internet at: www.globalviewphoto.com.
Abstract
Standardized patients have been utilized for nearly 40 years in teaching medical curricula. Since the introduction of this teaching methodology in the early 1960s, the use of standardized patients has steadily gained acceptance and is now incorporated into medical education across the country. This “standardization” was useful for teaching and evaluating medical students and residents. However, as this modality expanded beyond medical schools to include seasoned physicians, the limitations of “one-size-fits-all” clinical scenarios became apparent. In teaching clinician-patient communication (CPC) courses to practicing physicians, we have discovered that flexibility and improvisation on the part of the actor enhances the educational experience. The term “care actor” more accurately describes this role than standardized patient. The care actors in our CPC courses have become integral contributors to the education process, serving not only as simulated patients but also as coaches and collaborators. This article outlines the history of standardized patients in medical education and presents a three-part framework for effectively using care actors to teach clinician-patient communication: setting the stage, skill practice, and providing feedback.

Introduction
Standardized patients have been used effectively to teach communication and physical examination skills to medical students, residents, and practicing physicians for nearly four decades. This modality has become one of the most pervasive and highly touted of the newer teaching methodologies in medical education. Originally, patients presented their own medical problems. Eventually, actors were trained to simulate problems with a pre-defined set of historical, emotional, and physical criteria. Usually, these encounters would occur within the confines of a structured teaching or evaluation process.

Although a scripted and standardized patient scenario often worked well for students or residents early in their training, more experienced physicians seemed to learn better in situations that allowed increased flexibility and customization. The advancement of the role of the standardized patient to that of a “care actor” for teaching clinician-patient communication skills has been a marked improvement. The care actor takes on a more active and collaborative teaching role. The physician presents the care actor with a realistic clinical scenario based on a clearly stated communication goal. The physician and coach also set the level of emotion and affect for the care actor (eg, “really angry,” “slightly scared,” “moderately frustrated,” “somewhat withdrawn”). The care actor then portrays the case in a manner geared toward the stated learning objective.

The Standardized Patient
Howard S. Barrows first began to use “programmed patients” while teaching third-year neurology clerks at the University of Southern California (USC) in 1963 and published his early experiences a year later. Although today he is often referred to as the “father” of the standardized patient, Barrows was, at the time, maligned by some medical educators, who were skeptical of the practice. After learning of Barrows’ innovation, the LA Herald-Examiner ran a headline exclaiming that “Hollywood Invades USC Medical School,” and the San Francisco Chronicle reported that scantily clad models were “making life a little
more interesting for the USC medical students.10 These reports made widespread acceptance of this teaching methodology all the more difficult in the beginning.

By definition, a standardized patient faithfully reproduces a scripted clinical scenario, often with predetermined learning objectives in mind. The objective is to have the actor play the role with as little variability as possible. Standardized patients are particularly useful in teaching medical students, who lack clinical experience to formulate realistic scenarios on their own. With standardized patients, an instructor scripts the “case” in advance with learning objectives in mind. A weakness of this modality is that the standardized patient may have a hidden agenda that can thwart the physician/learner’s primary focus.

Standardized patients have been incorporated successfully in many medical schools, including the University of Colorado and the University of Hawaii.9-10 Studies have shown a high level of acceptance and have concluded that they are helpful for instruction.9-10 Medical students and residents, as well as practicing physicians, reportedly have difficulty differentiating between standardized and “real” patients.11 Our own experience mirrors those of other institutes in that the use of the standardized patient is popular and effective.

The Care Actor

In recent communication skills courses incorporating the Four Habits model,12 it has been useful to collaborate with actors to focus on physicians’ self-determined learning goals. This methodology, adopted in part from the “Communication Skills Intensive” program co-developed by Terry Stein, MD, of The Permanente Medical Group in Northern California and the Bayer Institute for Healthcare Communication, has proved highly effective. The skill practice sessions are learner-focused: The physician chooses a communication skill to practice and then creates a relevant clinical scenario in partnership with a coach and a care actor. The care actor is given direction by the physician regarding the clinical setting, presentation, emotion, affect, and degree of difficulty. Because there are clearly identified goals and objectives in mind, a successful practice session can be readily achieved.

In addition, the opportunity exists for the coach or learner to “stop, rewind, and try again” if desired.

Pitfalls

In our experience, the use of care actors has been overwhelmingly positive. Surveys completed by physicians attending our courses have uniformly praised the skills and teaching ability of our care actors. However, there are potential downsides to this methodology: First, there are no randomized, controlled trials proving the effectiveness of standardized patients in teaching clinical or communication skills. Although CPC appears to improve, there is no scientific proof per se. Second, the success of this methodology depends, in part, on the commitment and skill level of the actors. We are fortunate to have a highly dedicated group of actors who meet with us regularly to discuss and clarify their roles and to enhance their coaching and feedback skills. Our care actors spend many hours in specialized training and practice in portraying various disease states and in improvising clinical scenarios. Finally, actors’ salaries are not insignificant. Although we budget accordingly, the financial commitment should not be overlooked.

A Model For Skill Practice

We have found that a three-stage model facilitates teaching of CPC with care actors: setting the stage, skill practice, and providing feedback. This model increases the success of the learning session and reduces unhelpful and distracting variability.

I. Setting the Stage

Thoughtful planning in the beginning can reduce later problems. The
The key to a successful communication skill practice session is proper set-up. Setting the stage includes the following:

1. Assure confidentiality and trust.
2. Assist the physician/learner in selecting a communication skill he or she wishes to practice; for example, planning the visit or demonstrating empathy.\(^1\)
3. Assist the physician/learner and care actor in developing a case relevant to the physician’s specialty. The scenario should be straightforward and not an exact reconstruction of “the worst case imaginable!” It is important to remember that the practice session should focus on a small portion of a clinical interview, not an entire history and physical examination.
4. Check to see that the care actor understands the clinical scenario as well as the emotion, affect, and communication goal.
5. Check with the physician/learner about “ground rules” including stopping the session when the goal has been achieved, permission to interrupt/redirect, and willingness to “stop, rewind, and try again.”

It is also useful to assign other group participants specific observation tasks. For example, one observer might watch for body language and nonverbal communication. Another observer might write the first five words of each sentence the practicing physician says, thus allowing him/her to identify repetitive words (ie, “uh-huh,” “okay”) or closed-ended sentences.

II. Skill Practice

The coach restates the communication goal at the beginning of the practice session for clarity (eg, “Bill, you said you’d like to try a statement of empathy with this angry patient that you’ve outlined for us. Specifically, you want to identify and acknowledge the patient’s emotion, pause briefly, and then proceed with the interview. At that point, we’ll know that you’ve been successful. Okay? Let’s begin …”).

The scenario begins with the care actor portraying the role and the physician embarking on the interview. It is in the nature of many clinicians to start down the “biomedical pathway.” If the physician begins asking a series of closed-ended or biomedical questions, (eg, “Have you had a fever?” or “Is the pain throbbing or stabbing?”), it may be worthwhile to interrupt and redirect back to the stated communication goal. Once that goal is achieved, the session may be ended.

III. Providing Feedback

The practicing physician self-evaluates first. The communication goal should frame this. (“So, Bill, recalling that your goal was to try a statement of empathy with this patient, how do you think it went?”)

Then the care actor gives feedback also framed in terms of the goal. (“Mrs Smith, how did it feel when Dr Jones used empathy to demonstrate understanding and concern?”)

The care actor will then provide feedback from the patient’s perspective. After surveying the group for specific feedback, the coach summarizes and provides his/her own comments.

Conclusion

In teaching CPC to practicing physicians, the more-flexible care actor concept is preferable to the less-flexible standardized patient. Given the experience of most physicians, as well as their diverse specialties, learning and enhancing communication skills seems to work best when they are allowed to customize the scenario to create relevant learning situations. Care actors, trained in improvisation, facilitate the exercise by portraying patients similar to those seen routinely by these physicians. Focusing on setting the stage, the practice session, and providing feedback helps assure a successful educational experience.

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### Standardized Patient

- Actor portrays a standard and scripted role
- Preplanned with little variation
- Case usually written by instructor ahead of time
- Education objectives are instructor-generated: “I want you to learn …”
- Good for students and early learners with little practical experience
- Useful for evaluation and testing purposes
- Case scenario may involve “hidden agenda” to uncover

### Care Actor

- Flexibility and improvisation on part of the actor
- Actor partners with learner to create a realistic and relevant scenario
- Increased learner input into the exercise (creating the case, choosing communication goal)
- Education objectives are physician/learner generated: “I’d like to try …”
- Actor has collaborative role in facilitation, feedback, and education
- Flexibility and customization good for seasoned physicians of varied specialties
- Transparent case scenario with no hidden agendas
Acknowledgements
The authors would like to thank the following for their creativity and input:

- Terry Stein, MD, Director, Clinician-Patient Communication, TPMG Physician Education & Development; Glenna Kelly, Community Programs Manager, Educational Theater Programs, KP Colorado; Sue Niedringhaus, Special Projects Coordinator, Educational Theater Programs, KP Colorado; Becky Toma, Production Manager/Technical Director, Educational Theater Program, KP Colorado; and Renee S Harper, Training and Meeting Assistant, CPMG.

References

The Meaning of Life
Each man must look to himself to teach him the meaning of life.
It is not something discovered; it is something molded.

—Antoine de Saint Exupéry, 1900-1940, French poet, pilot, and author
KP’s National Transplant Network Honored by US Senate and Local Governments

The US Senate, the City of Oakland, and Alameda County in California all proclaimed April 28, 2005, National Transplant Network Day in celebration of the tenth anniversary of Kaiser Permanente’s (KP) National Transplant Network (NTN).

The NTN provides KP members with access to a network of solid and bone marrow transplant programs located at “Centers of Excellence”—medical facilities outside the KP system that meet or exceed the NTN’s stringent site selection criteria and that are known nationally for their transplant programs. In 2004, the NTN managed 563 transplants for KP members.

In addition to managing transplants for KP members, the NTN also promotes and encourages communitywide awareness of organ donation. To learn more, visit KP’s National Transplant and Contracting Services Intranet site: http://scm.kp.org/scm/ntacs or http://ncap.kp.org/scm/ntacs/index.cfm.

KP Honored for Contributions to Minority Access to Health Care

KP received the 2005 Mary Eliza Mahoney Award, presented each year by the National Minority Health Month Foundation to an individual or organization for outstanding contributions toward ensuring that minority communities have the best possible access to health care. The foundation’s board was particularly impressed by the Care Management Institute’s work on a diabetes study conducted with the foundation. The board cited KP’s genuine commitment to exploring new avenues to ensure better health outcomes for minority patients.

Born in 1852, Mary Eliza Mahoney was America’s first African-American professional nurse. Since its inception in 1999, the National Minority Health Month Foundation has promoted the building of coalitions and evidence-based solutions designed to eliminate health care disparities.

Southern California Permanente Medical Group (SCPMG)

Benjamin K Chu, MD, Named President of the KP Southern California Region

Benjamin K Chu, MD, was named President of the KP Southern California Region earlier this year. Dr. Chu brings more than 25 years’ experience to KP. He comes to KP from the New York City Health and Hospitals Corporation (HHC), where he served as President of the $4.2 billion organization with 11 acute care hospitals, 40,000 employees, and 7000 contract physicians. Under his leadership, HHC implemented clinical information systems throughout the organization, initiated systemwide process redesign initiatives in ambulatory care, oversaw a $1.2 billion capital rebuilding program, developed communitywide cardiovascular and cancer screening programs, and spearheaded the growth of HHC’s managed care plan to cover more than 220,000 plan members.

Physician Receives Community Service Sabbatical Award

The Kaiser Foundation Health Plan and Hospitals Board of Directors has selected Altaf Kazi, MD, a pediatrician at KP’s West Los Angeles medical facility, as the recipient of the 2005 David M Lawrence, MD, Community Service Sabbatical Award. The sabbatical award is named for former Chairman and CEO David M Lawrence, MD, and was created to honor a KP physician or employee who has made an outstanding contribution to the health of a specific KP community. The award includes a fully paid sabbatical of up to three months and a $10,000 contribution to the recipient’s community service project.

Dr. Kazi has volunteered more than 350 hours each year since he became involved in community service more than ten years ago. He is chairman of the University Muslim Medical Association (UMMA) board of directors and continues to see patients at the clinic, which provides medical care for more than 12,000 underserved residents of South Central Los Angeles. In addition to
his work with UMMA, Dr. Kazi helps coordinate an annual health fair for the homeless in downtown Los Angeles, provides free sports physical exams for underserved children at an annual football camp, volunteers monthly as a pediatric attending in the resident clinic at Children’s Hospital Los Angeles, and serves as a “community-based” preceptor for University of Southern California medical students during their pediatric clerkships.

**Physician Committed to Training Others on Innovative Procedure**

Seth Kivnick, MD, was selected an Everyday Hero and is featured in the Everyday Heroes Gallery at the Walnut Center for his work establishing a surgical team to implement laparoscopic hysterectomies at the West Los Angeles Medical Center. He took the initiative to learn about the procedure from two physicians, John Kennedy, MD, and Clem Hoffman, MD, both of the KP San Diego Medical Center, and then led training for the OB/GYN staff. The new laparoscopic procedure is now performed on an outpatient basis and reduces pain, minimizes scarring, and requires a much shorter recovery time.

**Colorado Permanente Medical Group (CPMG)**

**KP Colorado Pediatrician Honored for Dedication to Early Childhood Intervention**

Al Mehl, MD, a pediatrician at KP Colorado’s Rock Creek Medical Offices, received the Frances Owens Communities Helping Young Children Award for his dedication to early childhood intervention causes. Dr. Mehl was one of the first pediatricians in Colorado to embrace a statewide initiative for newborn hearing screenings. Based on his work, both the Joint Committee on Infant Hearing and the Academy of Pediatrics adopted a recommendation for universal newborn hearing screening, prompt diagnosis, and early intervention.

**Donna Lynne Named President of the KP Colorado Region**

Donna Lynne, BS, MP A, PhD, was named President of the KP Colorado Region, bringing more than 20 years’ experience to KP. She comes to the organization after serving for seven years as Executive Vice President and Chief Operating Officer of Group Health Incorporated (GHI), a not-for-profit health insurance company with $2.5 billion in revenues and 2300 employees providing health insurance and related services to more than 2.5 million members in New York State. Dr. Lynne had also assumed the additional role as President/CEO of GHI’s newly acquired for-profit HMO.

**Northwest Permanente (NWP)**

Andrew Lum, MD, nominated as Regional Medical Director

The Northwest Permanente Board of Directors has unanimously nominated Andrew Lum, MD, as Regional Medical Director. Dr. Lum joins KP Northwest from the KP Colorado Region, where he served as Associate Medical Director for Primary Care and Service. He was instrumental in implementing the KP Colorado Region’s award-winning clinical information system.

Board-certified in Internal Medicine, Dr. Lum has been a Permanente physician since 1989. He served as Physician-in-Charge of the Santa Clarita medical facility, SCPMG, before moving to Colorado in 1994.

**The Southeast Permanente Medical Group (TSPMG)**

Georgia’s Provider Site Launched

The Georgia Region has launched a new provider Web site, which was developed for anyone who does business with KP and TSPMG. This includes TSPMG practitioners, associate providers, community providers, affiliated hospitals, ancillary health care providers, and administrative staff who work for KP network providers. The provider site has the same consistent look and structure as the national Web site, http://providers.kp.org/ga.

TSPMG Announces Leadership Changes to the Associate Medical Director Team

To prepare for the strategic work required for the KP HealthConnect implementation and other projects, a number of leadership changes were announced by Bruce Perry, MD, Medical Director of TSPMG. William Boddie, MD, will assume the role of Associate Medical Director for Professional Development and Human Resources. Lee Jacobs, MD, will assist Dr Perry on special projects as he shifts to a larger clinical practice and focuses more time on his humanitarian efforts. Robert Schrainer, MD, will assume the position of Associate Medical Director for Specialty, Hospital and Ancillary Care. In addition, Robert van der Meer, MD, was named Assistant to the Medical Director for Risk Management.
“nil admirari”
watercolor and charcoal on Sennelier paper book
11” x 8”
2003
By Dorothy Faison

More art by Dorothy Faison can be seen on the cover and page 61.
announcements

Upcoming Symposia

National Surgery Symposium
Wednesday–Friday
August 31–September 2, 2005
Fairmont Orchid Hotel
Kohala Coast, Hawaii
For more information or to receive a brochure, contact Physician Education at 626-564-5360.

National Asthma Symposium
Friday and Saturday
October 7–8, 2005
Ritz Carlton, Pasadena, California

7th Annual Cardiovascular Medicine and Surgery (COAST) Conference
Friday–Sunday
October 7–9, 2005
Palace Hotel, San Francisco, California
Visit our Intranet Web site for more information at: http://kpsymposia.kp.org or call 626-564-5338.

Call For Material Related To Sidney R Garfield, MD

The Permanente Journal plans to devote a special centenary issue in April 2006 to Sidney R Garfield, MD, and his legacy. We are seeking any material of historical interest related to Dr Garfield's career, including photographs, sound recordings, letters, work documents, and anecdotes. In particular, we hope to hear from people who knew Dr Garfield personally and who may possess unique artifacts not already archived by KP Heritage Resources or other historians.

To share materials, please contact:
Tom DeBiley
Heritage Resources, Kaiser Permanente
1800 Harrison St, 18th Floor, Oakland, CA 94612
Phone: 510-625-4844 (Tieline 8-428-4844)
Fax: 510-625-5949 (Tieline 8-428-5949)

To provide an overview of the principles of Permanente Medicine, The Permanente Federation has produced a brochure on the Permanente Medical Groups. The brochure includes a profile of each of the Permanente Medical Groups, as well as a profile on The Permanente Federation. To learn more and see a pdf of the brochure, visit The Permanente Federation Web site: http://kpnet.kp.org/permfed.

For a brochure or registration information, please visit: www.kpprimarycareconference.org or e-mail: primary.care.conference@kp.org or call 1-510-625-6374.
“Military Medicine”

Across
1 Greek Muse of poetry
6 Wing-shaped
10 Said a farewell
14 Connection, or center
15 Composer Schifrin
16 Always
17 Put out some effort
18 Modern music miracle
19 Russian river
20 Low-ranking components?
23 ___ mater
26 Girl’s name related to Agnes
27 Reputed Scottish lake dweller
28 All in one piece
30 Rail or bus stop (abbr)
31 “The ___”
32 Explosive part of an early pregnancy?
36 Advanced type of filter (abbr)
37 Paddle
38 Expense
42 Frantic raids?
47 7th Greek letter
50 ___-de-sac
51 Refreshing winter drink (2 wds)
52 Showing more effect of the sun
54 Theater or church suffix
56 Poetic above
57 Operation by an officer?
60 Golfer’s need
61 Common term in a bibliography
62 Weird
66 No, to a Berliner
67 Demolish
68 Sharply dressed
69 Sea eagle
70 Let go of, as dead skin
71 The ones here

Down
1 Chemical suffix
2 Mystery writer Stout
3 Guitar, in slang
4 Frequent urologic procedure (abbr)
5 One who hides his head
6 Still breathing
7 Bolivian city (2 wds)
8 Plenty (2 wds)
9 Furry disease vectors
10 Lugosi and others
11 Not inclined to
12 Significant constituent of a tooth
13 Completely wiped out
21 Word for a divider of numbers
22 ___ moss
23 Essential core
24 Regarding, as in a legal document (2 wds)
25 At the summit
29 Acetaminophen, for short
30 ___ Lee
33 Furuncle
34 Fond Du ___ (Wisconsin city)
35 Jazz singing style
39 Eight (prefix)
40 ___-Ball, amusement park game
41 Russian despot
43 Maple genus
44 Sucklers
45 “Of ___ I Sing”, Gershwin musical
46 Deluge
47 Weasel prized for its fur
48 One who rips apart
49 ___-de-sac
50 Refreshing winter drink (2 wds)
51 Low-ranking components?
52 Operation by an officer?
53 English metaphysical poet John
54 Touch lightly, as a pitch might hit a batter
55 Stared salaciously
58 Home of the Jazz
59 Stangy assent
63 Highway (abbr)
64 “Baby ___ You” (Beatles’ title)
65 Ophthalmologist’s concern

Kenneth J Berniker, MD, is a Board-certified Emergency Physician at the KP Vallejo Medical Center. Dr Berniker has long enjoyed solving crossword and cryptic puzzles, and now creates his own. The challenges in creating the puzzles include: completing the grid with usable answers and perhaps a theme, generating interesting clues of suitable difficulty, being error-free in framing questions and answers, and injecting humor. Have fun, and please send him your comments. E-mail: kenneth.berniker@kp.org.
Consciousness and Healing: 
Integral Approaches to Mind-Body Medicine 
Marilyn Schlitz, Tina Amorok, and Marc S Micozzi, editors

Review by Doris Lora

“... the goal of integral healing is to bring into awareness a health and healing model that, in addition to using the best strategies of physical science, recognizes “personal relationships, emotions, meaning, and belief systems as fundamental points of connection” to the physical body.

Doris Lora is a member of the Institute of Noetic Sciences and has been a clinical psychologist, professional musician, and owner of an autobiography-writing service. Contact Ms Lora at dloralin@aol.com.


I

Consciousness and Healing: 
Integral Approaches to Mind-Body Medicine 
Marilyn Schlitz, Tina Amorok, and Marc S Micozzi, editors

Review by Doris Lora

“I only had a heart,” the Tin Man laments in The Wizard of Oz. All the while he is unaware of the deep compassion already infusing his own behavior. Lest we think that modern medicine has completely lost its heart—and its practitioners their humanity—in a system gone mad, a recently released book highlights the research and insights of healing experts who not only speak from their science, but also from their compassionate hearts.

Opening with Ken Wilber’s brilliant introduction calling for “more effectively setting the stage for the extraordinary miracle of healing,” followed by Marilyn Schlitz’s eloquent, articulate statements inviting us into the emerging consensus of an integral medicine, Consciousness and Healing had my adrenaline pumping within the first few pages.

Schlitz and her coeditors Tina Amorok and Marc Micozzi state that the goal of integral healing is to bring into awareness a health and healing model that, in addition to using the best strategies of physical science, recognizes “personal relationships, emotions, meaning, and belief systems as fundamental points of connection” to the physical body.

To that end, these essays and accompanying DVD geared to the academic and layperson alike offer both a sympathetic critique of the prevailing medical paradigm and a variety of well-researched alternatives that specify the role of conscious awareness in healing. Contributors range from such experts in the medical field as Deepak Chopra, Dean Ornish, Candace Pert, Larry Dossey, Jon Kabat-Zinn, Stanislav Grof, and Rachel Naomi Remen to a multiethnic group of scientists, philosophers and healers, including William Braud, Thomas Berry, Willis Harman, Michael Lerner, Brian Swimme, Honglin Zhang, Sogyal Rinpoche, Nancy Maryboy, and IONS’ own James O’Dea.

How many physicians and nurses realize that they do not need formal training in “spirit nurturing,” a key ingredient of integral medicine? As hinted at in this collection of essays, being a “human, comma, being” automatically forges a heart-to-heart connection with each patient. Healing happens by being present and letting go. Add to this a physician’s up-to-date medical knowledge and modern medicine’s technological wizardry, and we have the potential for dynamite integral healers.

This book demonstrates connection and cooperation between all health providers and their patients, which oils the mechanism of courageous change. Contributors compassionately report their careful observations of what works and what doesn’t in the healing arts. Through this approach, conventional and complementary healers alike are encouraged to step up to the uncertain adventure of transformation of consciousness, a concept that made less daunting and esoteric as one experiences the heartfelt personal accounts, simply daily exercises, and multitude of empirical data this book offers.

For the past half-century, the teaching of internal medicine in America has been dominated by two widely recognized textbooks: *Cecil Textbook of Medicine,* and *Harrison’s Principles of Internal Medicine.* Serious competition has just arrived upon the scene with the two-volume set, *ACP Medicine.* Not only is this outgrowth of the former *Scientific American Medicine* a heavyweight competitor in its own right, it has the special advantage of being an official publication of the American College of Physicians (ACP). Moreover, the ACP promises that it will reissue the bound set every 18 months to keep it current. Alternative formats exist and are to be updated more frequently.

All three of these major texts are well bound and well printed; they are equally well designed. Each devotes several opening chapters to subjects related to the practice of medicine, such as ethics, geriatrics, and preventive medicine. The editors and authors of all three texts are equally prestigious. *ACP Medicine* is unique in having a section on bioterrorism and in its variety of formats and free add-ons. By comparison, *Harrison* has a significant segment dedicated to underlying principles of disease, much in the manner of the old MacBride’s *Signs and Symptoms* that had chapters on the pathophysiology and interpretation of cough, fever, pain, etc. *Cecil* has the most comprehensive section on preventive medicine.

The clear purpose of these internal medicine texts is to provide current and helpful information on bio-medicine and disease.

- Obesity is discussed more or less equally in the three texts. What minor attention is paid to etiology focuses on the inevitably essential intermediary mechanisms, not on the adverse life experiences we found so commonly causal in our Weight Program at Kaiser Permanente (KP) San Diego, where we have treated, successfully and unsuccessfully, more than 26,000 adult obese patients. No implication is drawn from the fact that every anorexigenic agent ever used (except fenfluramine) has had antidepressant activity.

- Hereditary hemochromatosis is interestingly and concisely presented in *ACP Medicine,* which supplies a helpful table of additional causes of iron overload. Surprisingly, no mention is made of the significant dissociation between phenotype and genotype in this fairly common homozygous mutation but much less common clinical disease. Genetic analysis is considered in *ACP Medicine* the gold standard for diagnosis, thus blurring the important distinction in genetics between the presence of a laboratory marker and the existence of clinical disease or the probability of its ultimate appearance over time. Lastly, no mention is made of using quantitative phlebotomy to replace liver biopsy as the simplest technique for determining iron load. *Cecil,* though published four years earlier than *ACP Medicine,* more clearly makes the distinction between genotype and clinical disease. I found the *Cecil* presentation more helpful clinically than that in *ACP Harrison* helpfully explains potentially confusing genetic terminology (eg, haplotypes and penetrance) on the indexed pages for hemochromatosis, thereby integrating it seamlessly. These two topics are not indexed in *ACP* or *Cecil.*

- Fibromyalgia is briefly described in *ACP* and is helpfully related to depression and sleep disor-

*ACP Medicine*
David C Dale and Daniel D Federman, editors  

Review by Vincent J Felitti, MD

2 vols, 2859 pages; 
$219.00
der. It is equally briefly described in Cecil. Harrison has a distinctly longer description, but one that is icily biomedical. Its approach is epitomized in the sentence, “Several causative mechanisms have been postulated to explain abnormal pain perception.”3:p 2055

In essence, this sampling suggests that George Engel’s concept of the need for a biopsychosocial approach to diagnosis and treatment has not made much headway in the quarter century since his widely acclaimed article in Science.1 Review of the Psychiatry section in ACP Medicine shows that my conclusion is probably not due to sampling bias. We learn: “Psychological models for the etiology of mood disorders, especially depressive disorders, have also (sic) been proposed.”3:p 2054 The focus on depression in ACP is on intermediary mechanisms, not basic causes. Any sense of understanding human beings is absent. Harrison is similar, only shorter. Fifteen of its >2700 pages are devoted to “Mental Disorders.” In Cecil, psychiatry has been reduced to a nine-page section of neurology. Although tremendously important for pharmacotherapeutics, these etiologic conceptualizations of depression lack the insight and understanding proposed by Alan Barbour in his superb book, Caring for Patients,6 where he helps us see that depression is not a disease but a normal response to abnormal life experiences.

Each of these three internal medicine texts represents the best of current mainstream American medical thinking ... While it is easy to find fault with anything this big, it is even more important to acknowledge that the editors have taken on a monumental task in bringing together the knowledge of the various contributing authors; this is a huge intellectual endeavor. We are in their debt, even while wishing for more. ACP Medicine is sufficiently good to want it to become even better.

Finally, ACP Medicine has some advanced features worthy of note because they may be the harbinger of future approaches in medical texts. A monthly e-newsletter and a useful PDA download for diagnosis and treatment are available free from the publisher at www.acpmedicine.com/dxrxpromo1.htm. ACP Medicine is available in several formats:

- A two-volume hardbound set of books with three months of free online access ($219)
- A multi-CD-ROM version that is updated quarterly ($329)
- Two loose-leaf volumes updated monthly, with one year of online access ($349)
- An online full-text service allowing digital searches ($179)

ACP Medicine has joined Harrison and Cecil as the major American texts in internal medicine. Many physicians will see ACP Medicine as having the best start on meeting the future needs of clinicians seeing adult patients as we move into a digital era.

References
Section A.

Article 1. High-Quality Asthma Care: It’s Not Just About Drugs

In order to improve patient satisfaction and decrease health care utilization, appropriate physician communication behaviors:
   a. show nonverbal attentiveness
   b. discover underlying worries and concerns
   c. discuss the severe harm they are causing their child when they do not adhere
   d. tailor medication schedule to the family’s routine

An appropriate-stage matched message for an individual at the precomtemplative stage of change includes the following. Which statement is the only correct one?
   a. role play behavior change
   b. discover barriers to the behavior change and find out what the patient/parents are willing to do
   c. build confidence
   d. ask about lapses and discover ways to recover from them

Article 2. Chronic Pain is a Chronic Condition, Not Just a Symptom

Treating chronic pain will be successful if the focus is on:
   a. decreasing pain behavior
   b. increasing medications to eliminate pain most of the time
   c. simplifying medication regimens
   d. increasing patient and family coping skills

Adequate pain management results from:
   a. the use of a pertinent physical examination
   b. being aware of the difference in pain ratings of the provider and the patient
   c. the provider’s ability to estimate pain
   d. the objective use of appropriate tools such as a pain scale and a functional scale

Article 3. Bariatric Surgery in the KP Northwest Region: Optimizing Outcomes by Using a Multidisciplinary Program

Which of the following conditions is NOT common in patients presenting for bariatric surgery?
   a. physical disability related to degenerative arthritis
   b. sleep apnea
   c. clinical or subclinical binge eating disorder
   d. psychosis

Which of these conditions is NOT a common sequela of bariatric surgery?
   a. anemia due to iron deficiency
   b. worsened diabetes status
   c. dumping syndrome
   d. emesis in the first few months after surgery
   e. emotional adjustment issues related to weight loss

(Continued on next page)
(Continued from previous page)

Article 4. How Can We Reduce the Incidence of Contrast-Induced Acute Renal Failure?

Which of the following is NOT a risk factor for contrast nephropathy?
- a. diabetic nephropathy
- b. volume of contrast received
- c. gender
- d. congestive heart failure

Which one of the following statements regarding contrast nephropathy is true?
- a. the majority of patients who develop contrast nephropathy require dialysis
- b. according to a recent study, the addition of bicarbonate to hydration fluids is associated with an absolute risk reduction of 11.9%
- c. the use of fenoldopam has been proved to be effective in preventing contrast nephropathy
- d. according to a recent meta-analysis, the number of patients needed to be treated with N-acetylcysteine to prevent one case of contrast nephropathy is 800

Objectives

1) to inculcate the use of evidence-based medicine as part of the science of medicine. 2) to stress the art of medicine via enhanced patient physician communication, improved care experience for patients, and more satisfying care giving experience for physicians and staff through better teamwork. 3) to review appropriate updates on the diagnosis and treatment of clinical conditions. 4) to describe infrastructure and systems improvements that lead to improvements in outcomes and patient care experiences.

Section B.

Referring to the CME articles and to the stated objectives, please check the box next to each statement as appropriate.

<table>
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<tr>
<th>Article 1</th>
<th>Article 2</th>
<th>Article 3</th>
<th>Article 4</th>
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<td>Strongly Agree</td>
<td>Strongly Disagree</td>
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<td>4</td>
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</table>

The article covered the stated objectives.

I learned something new that was important.

I plan to use this information as appropriate.

I plan to seek more information on this topic.

I understood what the author was trying to say.

Section C.

What change(s), if any, do you plan to make in your practice as a result of reading these articles?

__________________________________________

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Section D. (Please print)

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32 Malnutrition in the Elderly: A Multiafactorial Failure to Thrive
Carol Evans, RN, MS, MA

This presentation emphasizes the importance of taking a multiaxial approach to treat pathologies and uses so- cal and dietary forms of intervention when addressing malnutrition in the elderly.

41 Chronic Pain is a Chronic Condition: Not Just a Symptom
Christine E Whitson, MD

This second article in a con tinuing series on pain management emphasizes the importance of helping patients return to work and function.

52 Bariatric Surgery in the KP Oregon Region: Optimizing Outcomes by Using a Multidisciplinary Approach
Keith H Bachman, MD

As a provider in bariatric surgery, the KP Southern California Permanente Medical Group launched our program.

65 Q A Quarter of Hospice Care: The Southern California Permanente Experience
Mario Milich, MD, Richard D Brumley, MD

This article describes the KPVMF multidisciplinary hospice program and its short- and long-term outcomes.

76 Corridor Consult
How Can We Reduce the Incidence of Contusion-Induced Acute Respiratory Distress Syndrome?
Baudwin Hornada, MD

Jay Agarwal, MD, Arielle C Abcar, MD

A case study illustrates the importance of reduced acute renal failure, its treat ment, and its prevention.

81 Review Board
C linical Permanente Medical Group, PC (CPMG)

A Multi-Plan, Jr.

This article describes the CPMG, multidisciplinary approach that treats pathologies and uses so- cal and dietary forms of intervention when addressing malnutrition in the elderly.

91 CLINICAL CONTRIBUTIONS
High-Quality Asthma Care: Not Just About Drugs.
The importance of communication, mutual problem solving and follow-up is emphasized in this thoughtful and important article on long-term asthma care.

Resources available at cpmpublishinggroup.com