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JOURNAL OF THE SAN FRANCISCO MEDICAL SOCIETY

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- **CMA House of Delegates**
- **SFDPH Influenza Advisory**

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VOL. 86 NO. 10 December 2013

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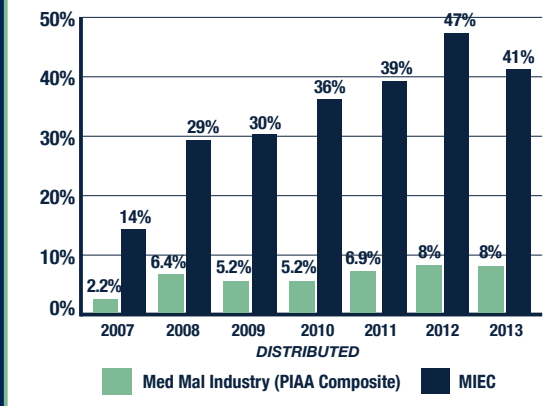

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December 2013 Volume 86, Number 10

Medicine and Performing Arts

FEATURE ARTICLES

OF INTEREST

MONTHLY COLUMNS

Welcome New Members

The SFMS would like to welcome the following members:

Jay W. Ellison, MD | *Pediatrics*
Susan D. Fracisco, MD | *Psychiatry*
William Marc Strull, MD | *Internal Medicine*
Chelsea Bowman, MD | *Internal Medicine*
Molly Martin Burnett, MD | *Neurology*
Alicia Andrea Carrasco, MD | *Internal Medicine*
Nneka Safiya Edwards-Jackson, MD | *Pediatrics*
Mai-lan Ho, MD | *Neuroradiology*
Alice Xin Huang, MD, CAE | *Psychiatry*
Christopher Lee Jones, MD | *Obstetrics and Gynecology*
Kimberly Ann Jong, MD | *Internal Medicine*
Cheryl Lin, MD | *General Surgery*
Joel Ou, MD | *Anesthesiology*
Yamini Rao, MD | *Pediatrics*
Vikram Rao, MD, PhD | *Neurology*
Catherine Anne-Marie Rottkamp, MD, PhD | *Neonatal-Perinatal Medicine*
Summer Patricia Savon, MD | *Psychiatry*
Annabelle Sparks, MD | *Internal Medicine*
Hiromi Terawaki, MD | *Internal Medicine*
Elizabeth Wahl, MD | *Rheumatology*
Priyanka Kim Wali, MD | *Internal Medicine*

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MEMBERSHIP MATTERS

Activities and Actions of Interest to SFMS Members

Covered California Workshop: The Positives and Perils of Contracting

Under the Affordable Care Act, two-thirds of California's uninsured may be covered by private insurance through a health insurance exchange purchasing pool. California's exchange, Covered California, began enrollment on October 1, 2013—with coverage beginning on January 1, 2014.

SFMS will host a workshop addressing providers' questions about contracting and reimbursement issues on January 8, 2014, at 12:00 p.m. at St. Mary's Medical Center. Learn about the risks and benefits of Covered California products that make them significantly different than current commercial products under which physicians provide care. Brett Johnson, JD, MPH, associate director for Medical and Regulatory Policy at the California Medical Association, will address issues regarding reimbursement rates offered through Covered California products and provide tips on reviewing payor contracts.

Additionally, SFMS members and their staff have free one-on-one access to CMA's practice management experts through the CMA reimbursement helpline at (888) 401-5911 or economicservices@cmanet.org. Members can obtain personalized assistance with questions about the exchange, other reimbursement issues, contracting, or general practice management issues.

Save the Date: SFMS Annual Gala

Attend the SFMS' biggest membership event of the year! Join the San Francisco Medical Society (SFMS) for our Annual Gala on January 16, 2014. Come together with many of San Francisco's most influential stakeholders in the medical community to celebrate SFMS' 146 years of physician advocacy and camaraderie.

The 2014 Annual Gala will be held at the iconic Asian Art Museum of San Francisco. Guests will be treated to an exquisite reception with elegant hors d'oeuvres, libations, and live music. Lawrence Cheung, MD, will be installed as the SFMS President.

Network with colleagues, meet SFMS leaders, and enjoy a private viewing of the Asian Art Museum's collection galleries. Please note this is a member-only event. SFMS members may purchase tickets (for themselves and guests, and/or sponsor a medical student) via the SFMS website. For more information, visit http://www.sfms.org/Events/annualgala.aspx.

SFMS Career Fair: Connecting Physicians with Local Employers

The fourth annual SFMS Career Fair connected more than ninety residents and fellows with recruiters from twenty exhibiting organizations representing a variety of practice types and settings based in the San Francisco Bay Area. Participants felt this was a wonderful opportunity to become acquainted with practice position opportunities and choices available locally in their specialties and to highlight small clinics and groups that may have been overlooked by regional or national job search events.

One event attendee commented, "Thank you for organizing an event that showcases the Bay Area's local community clinics. This event is unlike any other because of the emphasis on San Francisco Bay Area job opportunities."

For those who missed the career fair, SFMS will publish a list of available positions and recruiter contact information in our December member-only eNewsletter.

SFMS would like to thank Dr. Bobby Baron at UCSF's Graduate Medical Education Department for providing the venue for this event. We would also like to recognize our participating exhibitors and staff at the graduate medical departments of CPMC, UCSF, St. Mary's, and Kaiser Permanente for their generosity and support. Please visit http://www.sfms.org/Membership/StudentResidents.aspx for the list of the participating exhibitors.

Pledge Your Commitment to Medicine and Renew Your Membership Today

SFMS would like to thank our 1,600-plus members for their support of the local medical society this year. Because of your support and participation in organized medicine, SFMS continues to be the preeminent physician organization championing the cause of physicians and their patients as we face the many challenges of these changing times.

Please take a moment to renew your support of SFMS by remitting payment for your 2014 dues today. There are three easy ways to renew your dues again this year:

- Mail or fax in your completed renewal form.
- Renew online at sfms.org using your credit card.
- Enroll in the Easy Pay (billed in quarterly installments) Automatic Dues Renewal Plan by contacting SFMS at (415) 561-0850 or by email, membership@sfms.org.

SFMS Physician Networking Mixer a Success

More than forty San Francisco physicians participated in SFMS' November Networking Mixer at Ironside on November 14. Attendees took advantage of the opportunity to meet SFMS leaders and connect with stakeholders from within our local medical community.

SFMS would like to thank Dignity Health—Saint Francis Memorial Hospital for their support of this event and the medical society. With great attendance and positive feedback from all, SFMS plans to organize similar social networking events in the coming months. Please check the SFMS blog or follow SFMS on Twitter (@SFMedSociety) for event details.

Complimentary Webinars for SFMS Members

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

January 15, 2014: Avoiding Embezzlement: A Physician's Guide to Protecting Your Practice • 12:15 p.m. to 1:15 p.m.

January 22, 2014: Update on Medicare Physician Incentives: What's New for 2014 • 12:15 p.m. to 1:45 p.m.

CMA Medi-Cal Survival Guide Helps Physicians Understand Numerous Program Changes

Over the past year, there have been a number of changes for Medi-Cal patients and for the physicians who treat them. There will be more changes in 2014 as well. To help physicians understand the impact these changes will have on their practices, the California Medical Association (CMA) has published a Medi-Cal Survival Toolkit. The toolkit contains a summary on many of the changes, important dates, options for physicians, and links to important resources. The toolkit is available to free to members in CMA's online resource library. Contact CMA's reimbursement helpline with questions, (888) 401-5911 or economicservices@cmanet.org.

Stepping Up to Leadership: Training Program for Physician Leaders

March 6 to 8, 2014, San Diego: This course will help physicians learn best practices and explore creative approaches for resolving common problems encountered as a medical staff officer or department or committee chair. The course gives both experienced and new physician leaders the opportunity to gain practical knowledge and skills, and to learn the tools and techniques that are essential to effectively lead a medical staff. Visit http://physician-leadership.org for more information.

Classified Ads

December 2013
Volume 86, Number 10

Editor Gordon Fung, MD, PhD
Managing Editor Amanda Denz, MA
Copy Editor Mary VanClay

JANUARY 8, 2014
COVERED CALIFORNIA: THE POSITIVES & PERILS OF CONTRACTING

Join the San Francisco Medical Society for a presentation about the new Health Benefits Exchange, and what it means for physicians. Learn about the risks and benefits of Covered California products that make them significantly different than the current commercial products under which physicians provide care.

Presenter Brett Johnson, JD, MPH, Associate Director for Medical and Regulatory Policy at the California Medical Association will address issues regarding reimbursement rates offered through the Covered California products and provide tips on payor contracts.

MORRISSEY HALL

St. Mary's Medical Center

January 8, 2014, 12:00 pm – 1:30 pm

RSVP Required. Please RSVP to membership@sfms.org or (415) 561-0850 x200.

LEARN ABOUT THE RISKS AND BENEFITS OF COVERED CALIFORNIA PRODUCTS

GAIN AN UNDERSTANDING OF PHYSICIAN REIMBURSEMENT RATES WITH COVERED CALIFORNIA PLANS

COMPLIMENTARY LUNCH AND PARKING PROVIDED BY ST. MARY'S MEDICAL CENTER

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Covered California, the state health insurance exchange, is the new marketplace for more than five million uninsured Californians beginning January 1, 2014. It will serve as the cornerstone of the reform efforts called for under the Patient Protection and Affordable Care Act.

What is Covered California?

Covered California is the marketplace where Californians can compare and purchase health coverage. Through Covered California, many patients will be eligible for financial assistance to help pay their premiums and even co-pays.

Through Covered California, individuals and small businesses can compare different health insurance companies and learn whether they qualify for federal subsidies and tax credits. Californians will also be able to find out if they are eligible for low-cost or no-cost health coverage through Medi-Cal.

How will Covered California impact my practice?

The impact on physician practices will vary greatly depending on the mix of patients in your practice and the extent to which you contract with Covered California plans. Millions of previously uninsured Californians will now be eligible for health insurance through Covered California and Medi-Cal. Your patients with employer-sponsored coverage are not likely to see significant changes in their coverage.

Which patients can buy coverage through Covered California?

Legal California residents, except for currently incarcerated individuals and legal minors, are eligible to buy insurance through Covered California. If a patient has access to affordable health insurance through an employer or government program, he or she can purchase coverage through Covered California but may not qualify for financial assistance.

Which patients are eligible for subsidies through Covered California to purchase coverage?

Premium assistance is available to individuals and families who meet certain income requirements and do not have access to affordable, adequate health insurance through their employers. Eligibility for premium assistance is based on family income and the number of people in the family. The size of the premium assistance is calculated on a sliding scale, with those who make less money getting more financial assistance. Individuals with incomes up to $45,960 and a family of four with an income up to $94,200 may be eligible for premium assistance.

Will my Covered California patient be able to continue to see me?

You will have to be contracted with a Covered California plan and your patient will have to select that plan. Each health insurance plan has a specific list of doctors and hospitals that are considered in-network providers for covered services.

Patients should be advised to verify with the individual plan that a particular doctor's or hospital's services will be covered under that plan. Covered California will provide a searchable online directory so that patients can see which health plan networks contain a particular doctor or hospital.

How can a patient apply for Covered California coverage or Medi-Cal?

Open enrollment will continue until March 31, 2014, but patients must enroll in a plan by December 15, 2013, for coverage to begin January 1, 2014. In subsequent years, open enrollment will run from October 15 through December 7. Patients can apply for a Covered California health insurance plan online at www.CoveredCA.com or by calling (800) 300-1506.

Where can I obtain information about contracting and reimbursement issues relating to Covered California products?

SFMS, in partnership with the CMA and Covered California, is in the process of developing several resources to help educate physicians on the health benefits exchange and to ensure that members are aware of the important issues related to exchange plan contracting.

Please join us on January 8, 2014, at St. Mary's Medical Center for a luncheon presentation about the risks and benefits of Covered California products that make them significantly different than current commercial products under which physicians provide care. For more information about this event, visit https://www.sfms.org/Events.aspx.

See the information request form on page 26.

COVERED CALIFORNIA

CMA HOUSE OF DELEGATES REPORT

Stephen Follansbee, MD, and Steve Heilig, MPH

California Medical Policy Making 2013

If the SFMS delegation to the CMA were a baseball team, we'd logically be the San Francisco Giants—no, not this year's team, but the one that went to the World Series a couple of times not long ago. Our elected team is committed, diverse, successful, and has fun amid all the serious business at hand. And, like the Giants, the team has evolved over many decades—this was its 142nd "season"!

In October more than 500 California physicians convened in Anaheim for the 2013 House of Delegates (HOD), the annual meeting of the California Medical Association (CMA). Each year, physicians from all fifty-three California counties, representing all specialties and modes of practice, meet to discuss issues related to patient care research, health policy, health economics and finance—and much more. With so many physicians and more than 100 proposed policies, the two and a half days of debate are intense and sometimes contentious. This year the SFMS took a record sixteen proposals to the CMA; we had thirteen accepted as policy. What this means in the "real world" is that CMA will now be on record and authorized by members to act in favor of proposed legislation, regulations, and so forth on these topics; and that, where relevant, CMA will advocate for the same policy nationwide via the AMA.

The full report on policies adopted is available on CMANet.org, or via request from SFMS (heilig@sfms.org). Background on our own resolutions is available, too; we'll just highlight those of ours adopted here, to give a sense of what we do. Again, there was much more, especially regarding health care reform, problems with reimbursement in this electronic age, and about the future functioning of the HOD itself. More to come on many of those, but for now, here are our own:

HIV and STDS Consent Requirements for Testing: The delegates voted to support revision of HIV consent requirements to allow all health care providers to order a test for HIV when appropriate and to encourage routine HIV testing for all patients who are evaluated for other sexually transmitted diseases. This resolution, coauthored by longtime SFMS member Marcus Conant MD, a pioneer in the response to AIDS, represented something of an ironic "full circle" for SFMS, as we fought successfully against ill-advised testing proposals back when there was no effective treatment.

Graphic Health Warnings on Tobacco Products: CMA now supports the use of graphic image labeling on cigarette and other tobacco packaging that warns of the health impact of smoking. Such efforts, showing some impact in Europe, were adopted in the U.S. but overturned by the Supreme Court as a "free speech" infringement. The collective CMA now disagrees with that interpretation.

Lowered Legal Blood Alcohol Limit for Drivers: Delegates endorsed the National Transportation Safety Board's 2013 recommendation that the legal blood alcohol limit for operating a motor vehicle be decreased from .08 percent to .05 percent or lower. This lowered limit is in effect in most of the developed world and would save more lives and prevent more injuries.

Public Funding for Gun Research: CMA supports the repeal of any restrictions on public funding for research on gun violence. "Gun control" and other such efforts have been intentionally hampered by funding and other restrictions, helping to make our nation's tragedies somewhat self-fulfilling events.

Regulation and Taxation of Ammunition: CMA supports the regulation and taxation of ammunition to improve public safety, with funds from such a tax to be earmarked to help fund health care. This works for tobacco, another lethal product.

Routine Inquiry about Firearms as Part of Preventive Health: CMA urges increased awareness of risks related to firearms, particularly in the home; seeks opportunities to make available to its members a tool kit, screening protocols, and/or checklist for routine inquiry about guns and other firearms, perhaps based upon American Academy of Pediatrics guidelines and other resources; and advises such anticipated guidance as part of health maintenance.

Ban on Menthol Additives to Tobacco: CMA supports a full ban on menthol additives in tobacco products in order to curb smoking. Menthol is the most commonly added flavor, used to "hook" more smokers, particularly among minorities.

Cell Phone Use/Texting While Driving: CMA supports increased restrictions on cell phone use while operating a motor vehicle, including texting, for anything other than a demonstrated emergency; encourages technological restrictions that prohibit such use while a vehicle is in motion; and supports increased detection efforts and penalties for violation of restrictions on use of phones while operating a motor vehicle, in conjunction with public education to decrease phone use while driving.

FDA Regulation of Off-Label Drug Promotion: CMA supports the Food and Drug Administration's authority to prohibit medication off-label detailing. Unproven, profit-driven marketing of medications needs to have limits.

Limiting the Availability of Unused Controlled Medications: CMA supports reducing financial barriers for small quantities of pain medication to be prescribed when medically appropriate; and CMA supports physician education about the quantities, diversion, and misuse of leftover prescribed pain medications in the community in an effort to try to reduce the amount of excess prescription pain medication available to be diverted.

Restrictions on Marketing in Hospitals and Medical Centers: CMA supports policies, duly adopted by a medical staff or facility governing body within its scope of authority: (1) that govern the level and content of contact between physicians and pharmaceutical, device, and other medical product representatives in hospital and medical center settings in order to minimize undue external influence over medical judgment and patient care as necessary and appropriate for the particular medical staff or facility; and (2) that promote education, training, operative orientation, or coaching as the focus of such contact; and CMA urges the California Hospital Association to support such policies. This resolution sparked much debate: "But I get all my continuing education from pharma representatives!" (actual quote)

Restrictions on Physician/Patient Free Speech: CMA opposes any and all attempts to restrict physician discussion with patients of any issue relevant to the patient's health and safety. This might seem obvious, but proposals and actual laws limiting discussion of guns, abortion, environmental toxins, and more have proliferated around the nation.

Retention of Senior Members: CMA will work with county medical societies to draft measures to ensure that members are aware of membership options available to them as they decrease their practice hours or retire.

SAN FRANCISCO REPRESENTATIVES 2013

Stephen Follansbee, MD (Chair)
William Andereck, MD
Elizabeth Andrews, MD
Gary Chan, MD
Lawrence Cheung, MD
Mihal Emberton, MD
Roger Eng, MD
George Fouras, MD
Steven Fugaro, MD
Gordon Fung, MD,
Katherine Herz, MD
Leslie Lopato, MD
Keith Loring, MD
Robert Margolin, MD
Stephanie Oltmann, MD
Adam Schickedanz, MD
Judy Silverman, MD
George Susens, MD
H. Hugh Vincent, MD
David Pating, MD
Eric Tabas, MD

SFMS delegate (and San Francisco Medicine *editor) Gordon Fung serves on a reference committee (center).*

"After a decade and a half, I leave the House of Delegates with some sadness, as the delegates with whom I have worked over these years have become friends. The House as a forum for discussing resolutions presents an interesting mix of important issues and occasional self-serving ones. I am proud to say that the SFMS has never submitted the latter type.

"I truly believe the SFMS is and has been the conscience of the CMA as we annually write serious resolutions for the betterment of our profession and our patients' care. Our resolutions often become CMA policy and are sent on to the AMA for national action. I thank the SFMS for the opportunity to have taken part in this exciting adventure." —George Susens, MD

"The most exciting moment of the weekend was the instant that the electronic voting devices designed to make the votes clearer sparked open revolt when they didn't register 20 percent of the audience's responses! Back to the old-fashioned method of ayes and nays. We'll reboot and try again next year." —Adam Schickedanz, MD

"It's been thirty-some years since I first set foot in CMA's House of Delegates. One would expect that after that long, often hearing the same resolutions time and again, being repeatedly frustrated with failure to achieve our goals—like Sisyphus pushing that rock up the hill—one would give up. It is a tribute to those who continue to fight the battles, not surrendering until they eventually succeed. Rather than being inured to it, I am so invigorated by their unbowed spirit and so proud of the collective body that strives to make things better for patients and their doctors.

"The faces change over time. New young delegates bring renewed vigor and vision. It is, after all, their future that is at stake. SFMS should be extremely proud of its delegation for its work representing its views over the years. From it have come an inordinate number of resolutions that have ultimately gone to AMA for national action and driven national policy—on HIV/AIDs, smoking, food safety and labeling, product safety, physician-patient rights, child safety, reproductive rights, reimbursement, medical savings accounts—just to name a few.

"I feel blessed and fortunate to have been a part of this energizing process—it is through this avenue that the issues of importance to San Francisco and California physicians become state and national policy." —H. Hugh Vincent, MD

SAN FRANCISCO MEDICAL SOCIETY

Annual Gala

• January 16, 2014 •

Be a part of the biggest membership event of the year!

Come together with many of San Francisco's most influential stakeholders in the medical community to celebrate SFMS' 146 years of physician advocacy and camaraderie.

President-Elect Lawrence Cheung, MD and the San Francisco Medical Society request the pleasure of your company at the

Asian Art Museum

Network with colleagues, meet SFMS leaders, and enjoy a private viewing of the Asian Art Museum's 2nd floor galleries




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200 Larkin St, San Francisco, CA 94102 · Thursday, January 16, 2014
6:30 p.m. to 9:00 p.m. · Black Tie Optional

Guests are treated to an exquisite reception with elegant hors d'oeuvres and libations

Invitations will be mailed out in early December to SFMS members
For more information: www.sfms.org/events.aspx

This is a member-only event. SFMS members may purchase tickets (for themselves and guests, and/or sponsor a medical student) via the SFMS website.

PRESIDENT'S MESSAGE

Shannon Udovic-Constant, MD

Meaning and the Practice of Medicine

As January approaches, I always find myself reflecting on the year that is rapidly coming to a close. I look at my kids who are growing so fast and think about the fact that another year has sped by. This year has special meaning to me, as my service as president for this amazing medical society comes to an end. I have truly enjoyed getting to meet with many of San Francisco's physicians at different events and meetings. My San Francisco physician colleagues constantly inspire me.

The year draws to a very rewarding close as we completed a strategic planning process that was energizing and will provide great direction to our medical society's efforts over the coming years. As with all strategic planning, the real work starts in the implementation phase. You will be hearing more details in the coming months about the direction in which we will be going, but the focus will be to provide more services to help busy physicians perform their work more easily and also to be more involved in our community with public policy and advocacy efforts.

As we embark on our strategic planning efforts, I anticipate rolling up my shirtsleeves and getting down to work. In this vein I challenge each one of you to make a commitment to do something this year that will increase the meaning in your work.

I have written in my President's Message over the past year about some ways to do this:

- Get involved in an advocacy effort to improve public health.
- Become a leader at your institution or at the medical society.
- Teach a medical student.
- Mentor.
- Find ways to use technology to provide more efficient or higher-quality care.
- Provide healthy recipes in your waiting room or attach to a prescription for more fruits and vegetables.
- Thank your colleagues for the care they provide to your patients.

I guess that many of you are reading this and thinking, "I don't have time for this." I completely understand. Yet I would argue that increasing the meaning in your work is the best use of your time.

I recently signed up to do something that was on my bucket list—run a half marathon. I realized that if I was ever going to do this, I needed to do it now, because my knees aren't getting any younger. For those of you who don't know me, I am not a long-distance runner. Before this I was a purely "get my allotted minutes of cardiovascular exercise done and get back to all the other work that I need to do" type of runner. This translated into running two or three miles a few days a week. When I signed up for the Nike women's half marathon, my husband looked at me a bit skeptically. I printed off the novice-training schedule and started doing it. Amazingly, I completed the race—and in a time that I was proud of. The reason I tell this story is because the part that was eye-opening for me was that when I prioritized this training, I found the time in a schedule that I thought was too full. Although I won't continue to train for half marathons, I will continue to prioritize exercise in those small time windows that I found.

As this issue of the magazine focuses on performer health and the illnesses and injuries of artists and performers, I think about our profession and the articles that have recently been written about physician burnout (Shanafelt et al, *Arch Internal Med* Aug 20, 2012, doi:10.1001/archinternmed.2012.3199). There is good science showing that if physicians can get back to the meaning of medicine in their day-to-day lives, their burnout symptoms will improve. This brings me back to my challenge to you: Find something to add meaning to your work, or take a cue from my recent adventure and find time for your own wellness.

Thank you for the privilege of serving as president of the SFMS this year. I look forward to continuing to be active and involved in the coming years as I serve in my role as the San Francisco representative to the California Medical Association Board.

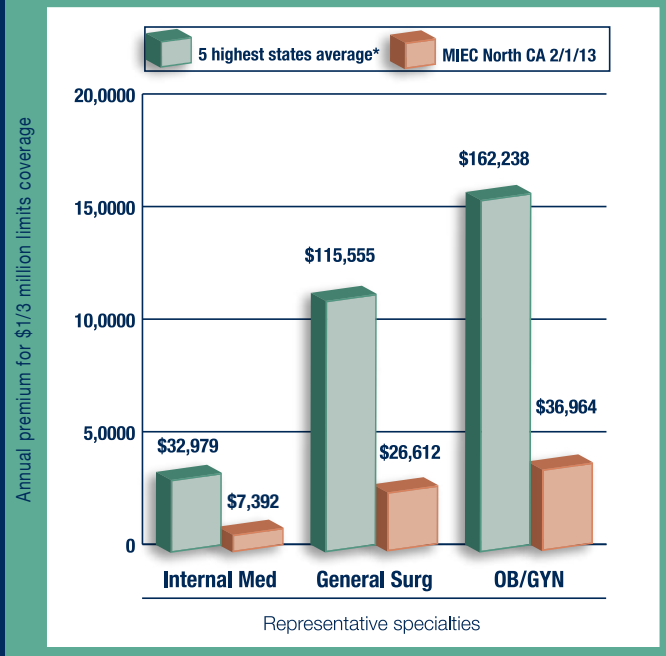
I hope that you will join me in efforts to continue to find the meaning in this amazing work that we do as physicians because, as the Red Hot Chili Peppers say in their song "Can't Stop," "This life is more than just a read-through."

Speak As One to Protect Your Profession and Your Patients!

A trial lawyer-backed initiative would:

- Quadruple non-economic damages in malpractice lawsuits, from $250,000 to over $1.1 million
- Reduce access to care- especially for our most vulnerable patients
- Drastically increase malpractice insurance rates
- Increase health care costs by billions
- Increase frivolous litigation and put more money in trial lawyers' pockets

Physician owned insurers malpractice premium comparison



*Depending on the specialty the Highest States were selected from FL, IL, MI, NY, PA, CT & DC

Graph prepared by Medical Insurance Exchange of California, the first physician-owned professional liability insurance carrier in California, founded by SFMS and five other Northern California county medical societies.
Source: Medical Liability Monitor Annual Rate Survey - October 2013

Protect MICRA, California's Premier Tort Reform For Patient Protection*

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* Medical Injury Compensation Reform Act of 1975

EDITORIAL

Gordon Fung, MD, PhD

Performing Arts and Medicine

The first publication to summarize the occupational diseases of musicians was Bernardino Ramazzini's *Diseases of Tradesmen* in 1713. While there was sporadic interest in performing arts medicine during the 1800s, the first book devoted to the subject, Kurt Singer's *Diseases of the Musical Profession*, was published in 1932.

During the 1960s and 1970s, both physicians and performers became more interested in arts medicine. When pianists Gary Graffman and Leon Fleisher publicly discussed their career-ending hand problems in the early 1980s, a huge, previously unknown group of injured musicians was brought to light. Since that time, publication in the field has dramatically increased, numerous conferences have been held, and clinics catering to the needs to performers have been set up in various large cities. Although we still do not have all the answers to the problems faced by performing artists, arts medicine is now a recognized discipline, reaching out to performers, arts educators, arts administrators, and instrument manufacturers.

The above paragraph is the abstract from the article "Odyssey: The history of performing arts medicine" by S.E. Harman in the *Maryland State Medical Journal* (March 1993; 42(3):251-3). It seems that every time we may have found something new and innovative, going to the library—or, today's equivalent, doing a Google search—proves us wrong. At the San Francisco Medical Society's Editorial Board meeting, we were brainstorming for a fun edition for the holiday season and thought that many people would like to know more about the specialty that some individual physicians have chosen: treating performing artists. We came up with a few names of people who had taken care of some of our opera greats, some who are sport teams physicians, and others who cared for circus performers, and we spread out our requests for articles. Then I did a search to find out if there was a specialty area of medicine that might address this field. And, as you have seen, I read that the field's original textbook was written in 1713. I guess I missed it while in medical school or subsequent medical training. I think everyone knows performers are people who specialize in their art form, and that they are not immune to the diseases of everyday people. But who would imagine when experiencing a concert performance or circus show that the performers are at special risk for injuries specific to their chosen art.

I have talked to otolaryngologists who say that during the opera season they leave a few spots open on their schedule for singers who need to have a clear voice and to "take care of any sore or raspy throat trouble, whatever the cause" that may occur just before opening night or performing night. And I was aware of sports team physicians who get to travel with their teams to competitions at national and international venues. Since I love travel, I was really envious of those positions. But I was never aware of the full range of problems that can afflict every instrumentalist in an orchestra or physical performer in a circus or gymnasium. And, as with professional sports, we only see the people who made it, not some of those were injured in training and never made it to the stage.

This holiday season theme takes a deeper look at the performing arts and delves into the issues facing actors and performers themselves. Dr. Renee Emunah and Gary Raucher start out the magazine with a discussion about the connection between theater and therapy. It is challenging for some people to express themselves to resolve their issues. And yet acting requires that every emotion be expressed to the fullest for others to experience. Is this therapeutic for the actors, or just the work of a professional? Christopher Hills Eaton writes an article about circus arts for health—a fun path to fitness. Isa Isaacs talks about an injury that led her to fire dancing and how it has helped her. Everyone is looking for the job that is not really a job but a passion or vocation, one that gives you more than you put in by keeping you healthy and fit; and when we see performers on stage, they usually looked so poised and polished. How can they be anxious? Yet if they are, can they afford to have their edge taken away by taking beta-blockers or tranquilizers to calm themselves? Dr. Eric Maisel discusses several nonpharmacologic "natural solutions" to manage performance jitters. And last but not least, is performing arts medicine ready to be a separate specialty? At this time it is usually considered a section of occupational medicine. Dr. Ralph Manchester discusses the current state of the field and next steps to get recognized for the special training and experience needed to be a qualified specialist in the field.

As usual, we hope that you enjoy this issue. And from the Editorial Board and staff of the San Francisco Medical Society, happy holidays and here's to looking forward to an awesome 2014!

THEATER AND THERAPY

What's the Connection?

Renee Emunah, PhD, and Gary Raucher, MFT

Psychologist and drama therapist David Johnson cites theater as "a lie that reveals itself as a lie, and is therefore honest." The connection between theater and therapy is informed by paradoxical relationships: disguise and revelation, stage performance and life performance, acting as a way of reaching emotional truth.

People respond emotionally to evocative circumstances, whether real or imaginary. Who has not, at some time, felt deeply moved, angered, edified, or exhilarated by circumstances portrayed within a play, film, or TV show? What is true for an audience is doubly true for actors, who must tap into the emotional life of the "fictions" they portray in order to convincingly enact them. Actors frequently speak of needing to find the emotional truth within a script.

Interestingly, the brain does not appear to make distinctions between emotion rooted in reality versus fiction. Neurocognitive researchers at London University demonstrated in an MRI brain scan that renowned actress Fiona Shaw, when reciting emotion-laden dramatic verse, activated very different parts of her brain than when reciting randomly assigned numbers. Notably, the infraparietal sulcus, a portion of the brain used for complex imaginative associations often linked to emotional experience, lit up only when Shaw recited the poetry (*The Guardian*, November 23, 2009). Likewise, mirror neurons, which are seen as the neurological correlate of our human capacity for empathy, are equally activated whether we witness people in actual or in fictitious situations.

The connection between pretend states and emotional health has long been apparent to psychiatrists. D. W. Winnicott, for example, famously introduced the concept of the transitional object, the notion that children form a temporary and transitional attachment to some toy or object as an imaginary surrogate for their caregiver's affection. Kids routinely enact little dramas with their dolls or teddy bears—until they internalize the positive emotional associations their play represents. Winnicott's ideas about transitional phenomena apply equally to later developmental stages. For adults, fulfilling certain roles in life (for some, the role of parent, for example) can activate positive emotional associations, whereas other life roles (for example, badgered employee) may produce stress through association to prior negative experiences.

The therapeutic benefits of drama have been noted since ancient times. Aristotle described catharsis as the emotionally purgative impact on audiences witnessing tragic drama in fourth-century BC Greece, and that term remains in use today. So, in one sense, it is not surprising that several contemporary movements look beyond theater-as-entertainment and leverage the emotional benefits of drama. From corporate executives learning the ABCs of spontaneity through theatrical improvisation classes to personal growth groups using role play to practice responding to real-life challenges, the fields of applied and interactive drama are rapidly expanding. Young children and actors are no longer the only groups experiencing the healthful benefits of dramatization and acting.

Of particular interest to the healing professions is the field of drama therapy, the application of carefully considered drama-based techniques toward specific psychotherapeutic objectives, which naturally vary by population. Drama therapy is integrative in its theoretical roots and its praxis. It merges evidence-based psychotherapeutic practices with the humanistic and expressive benefits of an arts practice. Drama therapy enables people to express themselves freely through role play, improvisation, and other forms of acting within a supportive environment focused on therapeutic goals.

The therapeutic potential of drama is related to the powerful outlet it provides for safe emotional expression. With ever-increasing research on the mind-body connection and on the potentially deleterious effects of stifling emotions, drama's greatest gift to health may be its capacity to help a person attain fluency in emotional regulation. All of the arts provide a creative means for accessing and communicating internal emotions, but drama provides a particularly direct approach—via the use of the voice and body—to express feelings. The fictional aspect, that is, the opportunity to "become someone else," affords tremendous permission and freedom to express dormant, feared, or deep-seated emotions. A person can convey rage, love, yearning, disappointment, passion, grief—and in so doing experience release and relief, all without real-life consequence.

Acting not only supports the capacity to express a wide range of emotion but also a capacity to contain or master emotion. While acting, people access real feelings, but they also sustain some distance from them through awareness that the enacted circumstances are at some remove from the "real." This paradoxical state of dual consciousness enables people to self-observe in action while flexing affective muscles. They become proficient in getting in touch with, responding to, and letting go of emotion.

Another therapeutic facet of drama is its capacity to facilitate awareness concerning the various roles that people "play" in daily life. Social scientist and role theorist Erving Goffman has examined how individuals become habituated to particular roles and constricted within the "scripts" of set routines. Acting enables them to try out new roles, responses, and behaviors. We are inherently multifaceted creatures, but we shortchange our rich complexity as we become dulled in the performance of workaday tasks and familiar relationships. Like actors, we need

to keep our roles "fresh." The opportunity to act in new ways and to step out of our own shoes through drama helps expand our sense of self, and it helps us empathize with and connect in more fulfilling ways with others. Flexibility, perspective, and compassion—all of which are naturally honed in dramatic work—are critical aspects of our humanity and also vital traits for our shared planetary future.

Increased awareness of the healing potentials of drama led to the emergence of drama therapy as a formalized field in the U.S. with the founding of the National Association for Drama Therapy in 1979. Prior to that, J. L. Moreno had established a related discipline, psychodrama, as the first form of group therapy in the 1920s. While there is much interrelationship and overlap between these fields, there are also clear distinctions. Drama therapy emphasizes group process (indeed, drama as an art form is largely interactive), whereas psychodrama tends to focus on one "protagonist" even in a group session. Drama therapy capitalizes on the aspects of play and pretending that are inherent in drama, whereas psychodrama entails direct reenactment of real-life issues. Drama therapy's approach to a person's core themes and issues is gradual and modulated; the starting point is more one of liberation from actual issues. Drama therapy is one of the creative arts therapies (art therapy, music therapy, dance/movement therapy, poetry therapy)—all of which focus on eliciting people's strengths, creativity, and resilience.

Drama therapists work in a wide range of settings, with all age groups. With children, drama therapy is an obvious fit: Children express themselves through play naturally. Erik Erikson said, "To play it out is the most autotherapeutic measure childhood affords us." While adolescents typically resist talking about their issues, they will easily engage in action-oriented methods; in fact, drama therapy channels teen "acting out" into acting. With seniors, drama therapy facilitates storytelling, reminiscence, and honoring of life experience. Many drama therapists work in psychiatric facilities, and both authors of this piece first honed their skills as drama therapists in psychiatric hospitals, where they were astounded by the degree to which schizophrenic and depressed patients would present very different behaviors while acting.

Beyond institutional settings, drama therapy is used in private practice (with individuals, couples, families, and groups) and in community settings. In psychoeducational applications, such as school anti-bullying programs, drama-based approaches to social and emotional intelligence are burgeoning. There have been applications in the medical field as well, not only in children's hospitals ("Child Life" programs) but also in work with physicians and care givers to provide a haven for spontaneity, play, and release of the tensions that accumulate in dealing with other people's life-and-death issues. Drama-based approaches have also been used to help medical personnel better ascertain patients' emotional needs, practice delivering difficult news, and strengthen empathy and ability to build rapport.

There are two long-standing accredited and approved master's-level training programs in drama therapy in the U.S., one at the California Institute of Integral Studies (CIIS) in San Francisco and one at New York University. A few newer programs have also recently emerged. The program at CIIS attracts students from around the world, many of whom come with professional experience in acting but are drawn to the psychological and transformative aspects of theater. Using experiential, practical, and theoretical approaches to pedagogy, the program takes students on an intellectually and personally intensive journey, exploring the interface between theater and therapy and developing the skills to become competent, ethical drama therapists.

The beginning of this article alluded to the paradoxical nature of drama, in linking emotional veracity to fictional circumstance. Paradox is ultimately a form of integration, and perhaps the essential hallmark of drama as therapy is its capacity for integrative synthesis. Drama therapy—merging the healing arts and aesthetics; the body, mind, and emotions; the real and the imaginal—is a potent form of integrative healing.

Renee Emunah, PhD, RDT, BCT, is director of the Drama Therapy Program at CIIS and author of the book Acting for Real. *Gary Raucher, MFT, RDT, BCT, is a professor at the CIIS Drama Therapy Program and a drama therapist and marriage family therapist in private practice. For more information on the Drama Therapy Program, contact jaitken@ciis.edu.*

"By the Way, Ms. Jones…"

By Sean Bourke, MD

Roughly 70% of patients are overweight, but counseling them to action can be challenging. Since a trusted physician's advice can be just the catalyst to spur meaningful change, how we handle the conversation matters.

SPEAK WITH CONVICTION

Physicians are uniquely able to inform patients of weight-related health risks and direct them toward solutions, enhancing motivation and follow-through. Those counseled by doctors are more likely to understand the risks of obesity, the benefits of weight loss, and move toward readiness for weight loss,[1] emerging more than twice as likely to attempt weight loss in the following year (OR 2.5).[2]

… AND A DOSE OF SENSITIVITY

Prejudice toward obesity is commonplace in our culture; we physicians need to be mindful of our own. Would it surprise you that 50% of physicians view obese patients as "awkward, unattractive, ugly, non-compliant?[3] Or that 60% erroneously cite a "lack of motivation" as the cause of obesity.[4]

Obesity is now the number one cause of preventive death in our country. Ensure your conversations resonate meaningfully with patients:

- Avoid judgment words like "obese," "fat," or "morbidly obese." Try more neutral words: "weight" and "unhealthy weight."
- Recognize the patient's struggle. "I notice you're up ten pounds since your last visit. Is that a concern to you? Are you aware of the health risks associated with as little as 10-20 extra pounds?"

OFFER ACTIONABLE SOLUTIONS

Sustainable weight loss and improved health is not about any "diet," but the result of lifestyle and food strategy changes assimilated over time. This is best accomplished under consistent professional guidance and the evidence-based support not easily provided in a primary care setting. According to studies, physicians both feel ill-equipped to manage weight loss, and typically provide insufficient guidance on weight management strategies.[5]

In primary care, conditions better served in the realm of a cardiologist, endocrinologist, or gynecologist, are referred to optimize care. If the solution doesn't exist in our traditional practice model, we should likewise direct patients toward viable medical weight management solutions.

References:
1. Acad Med. 2004 Feb;79(2):156-61. 2. Arch Intern Med. 2011 Feb;171(4):316-21. 3. Obes Res 2003 Oct 11; (10): 1168-77. 4. Obes Res 2005 Apr 13(4): 787-95. 5. Acad Med. 2004 Feb;79(2):156-61.

CIRCUS ARTS FOR HEALTH

A Fun Path to Fitness

Christopher Hills Eaton

Thanks to the growing popularity of international production companies like Cirque du Soleil, the circus arts have become a hot trend in exercise and fitness. No longer the animal-centric carnivals and sideshows of the past, the athleticism of the contemporary circus is attracting more recreationalists to the sport than ever before.

Circus Center, located in San Francisco's Cole Valley neighborhood, provides opportunities for students to train recreationally in the circus arts. With nearly 100 classes a week, ranging from classical mime to handstands, aerial conditioning and flying trapeze, we have more ways than ever for students (young and old) to exercise in a fun, exciting, and unique way. What does training in the circus arts actually provide?

The circus arts offer three forms of anaerobic exercise: supported (activities interacting with the ground), suspended (activities requiring hanging or suspension above the ground), and flight-based (activities accomplished while airborne). All three types of workouts require full range of motion and core strength. The wide range of physical movements also contribute to building cardiorespiratory fitness, strength, vascular fitness, and sensorimotor skills.

Acrobatics, such as tumbling and handstands, are full-body exercises that require upper body strength and balance. They promote positive blood flow and core and bone strength. Even the simplest tumbling exercises, like cartwheels and roundoffs, involve the transfer of energy, weight, and balance from the feet onto the hands and back again. Such exercises can help overall body awareness and functional flexibility; meanwhile many detrimental body conditions such as a poor posture must be overcome to successfully tumble.

Other circus art forms require the performer to adapt body and movements to a particular apparatus. The aerial arts, including the trapeze, tissu (aerial silk), and rope, require immense upper body and core strength; and they cultivate muscle groups in the back muscles, glutes, and thighs. The suspended nature of aerial apparatuses helps decompress joints and elongate muscles.

Finally, if laughter is the best medicine, clowning fits the bill. Physical and mental coordination are required for elements of physical comedy, balancing, and, of course, juggling. In fact, a recent study in the journal *Nature* showed that juggling can actually increase the amount of gray matter in the mid-temporal area and the posterior intraparietal sulcus—the visual and motor activity centers of the brain.

There's also significant literature to support the positive effects of humor on the brain. Laughter relaxes the whole body, boosts the immune system, triggers the release of endorphins, and improves blood flow and blood vessel function, which can protect the heart.

Circus Center supports Clown Zero and its Healing Through Humor program in residence at UCSF Benioff Children's Hospital. It also uses circus arts to help develop sensory integration for children with special needs. Learning and remembering sequences of movement are helpful tools in solidifying sensory processing and fending off dysfunctions in the tactile, vestibular, and proprioceptive systems. One student, for example, found that training in static trapeze helped him cope with the effects of Asperger's syndrome.

Wendy Parkman, one of the original founders of Circus Center, has integrated the circus arts into the physical education and theater programs at the Urban School. Her Circus Techniques class teaches high school students introductory tumbling, trapeze, and clowning to encourage timing, balance, and pushing their creative limits.

People used to think of the circus as an activity at the fringes of society. Today, circus is emerging as a respected art form, requiring strength and mental fortitude. It is also a fitness option for ordinary people, one that can provide exceptional health benefits within a unique and fun environment.

Circus Center is located at 755 Frederick St., San Francisco, California, 94117, and can be reached online at http://www.circuscenter.org.

ANXIETY AND PERFORMANCE ART

Natural Solutions

Eric Maisel, PhD

All of the following have reported extreme performance anxiety: Richard Burton, Maria Callas, Pablo Casals, Laurence Olivier, Luciano Pavarotti, and Carly Simon. The list could go on and on.

Casals explained, "I've never conquered that dreadful feeling of nervousness before a performance. It is always an ordeal. Before I go on stage I am tormented." The actor Paul Lynde confessed, "I have never gotten over being terrified in front of an audience." From the actress Maureen Stapleton: "I get scared that something is going to fall down or that there's going to be an explosion. I'm nervous every night . . . and opening night is a nightmare!"

Public speaking is the world's number-one phobia. That should help put the enormity of this problem in perspective. Many performers deal with this terrible anxiety by avoiding performing, by using street drugs and alcohol, by using prescription drugs (often passed from one performer to another), and by white-knuckling the anxiety. Below are fifteen nonmedical, nonchemical strategies that can help performers manage and reduce their experience of performance anxiety.

1. Attitude choice

You can choose to be overly vigilant to changes in your environment and overly concerned with small problems, or you can shrug such changes and problems away. You can choose to approach life anxiously or you can choose to approach it calmly. It is a matter of flipping an internal switch—one that you may find it in your power to control.

2. Improved appraising

Incorrectly appraising situations as more important, more dangerous, or more negative than they in fact are raises your anxiety level. You can significantly reduce your experience of anxiety by refusing to appraise situations in such ways.

3. Lifestyle support

Your lifestyle supports calmness or it doesn't. When you rush less, create fewer unnecessary pressures and stressors, get sufficient rest and exercise, eat a healthy diet, take time to relax, include love and friendship, and live in balance, you reduce your experience of anxiety.

4. Behavioral changes

What you actually do when you feel anxious makes a big difference. There are many unhealthy and dispiriting ways to manage anxiety—and many efficient, healthy, and uplifting ways, too.

5. Deep breathing

The simplest anxiety management technique is deep breathing. By stopping to breathe deeply (five seconds on the inhale, five seconds on the exhale), you stop your racing mind and alert your body to the fact that you wish to be calmer.

6. Cognitive work

Changing the way you think is probably the most useful and powerful antianxiety strategy. You can do this straightforwardly by noticing what you are saying to yourself; disputing the self-talk that makes you anxious or does not serve you; and substituting more affirmative, positive, or useful self-talk.

7. Incanting

A variation on strategies 5 and 6 is to use them together and to "drop" a useful cognition into a deep breath, thinking "half" the thought on the inhale and "half" the thought on the exhale. Incantations that might serve to reduce your experience of anxiety are, "I am perfectly calm" or "I trust my resources."

8. Physical relaxation techniques

Physical relaxation techniques include such simple procedures as rubbing your shoulder and such elaborate procedures as progressive relaxation techniques (slowly relaxing each part of your body in turn). Doing something physically soothing probably does not amount to a full anxiety-management practice, but it can prove highly useful in the moment.

9. Mindfulness techniques

Meditation and other mindfulness practices that help you take charge of your thoughts and get a grip on your mind can prove useful as part of your anxiety-management program. The contents of your mind create anxiety, and the better a job you do of releasing those thoughts and replacing them with more affirmative ones, the less you will experience anxiety.

10. Guided imagery

Guided imagery is a technique with which you guide yourself to calmness by mentally picturing a calming image or a series of images. You might picture yourself on a blanket by the beach, walking by a lake, or swinging on a porch swing. You can use single snapshot images or combine images to such an extent that you end up with the equivalent of a short relaxation film that you play for yourself.

11. Disidentification techniques

"Disidentification" is a core idea of the branch of psychotherapy known as psychosynthesis. Rather than attaching too much significance to a passing thought, feeling, worry, or doubt, you remind yourself that you are larger than and different from all the

stray, temporal events that seem so important in the moment. By making these linguistic and thought changes, you fundamentally reduce your experience of anxiety.

12. Ceremonies and rituals

Creating and using a ceremony or ritual is a simple but powerful way to reduce your experience of anxiety. Pavarotti's pre-performance ritual involved looking for (and always finding, as they were abundantly provided!) a good-luck bent nail backstage.

13. Reorienting techniques

If your mind starts to focus on some anxiety-producing thought or situation, or if you feel yourself becoming too wary, watchful, and vigilant—all of which are anxiety states—one thing you can do is to consciously turn your attention in another direction, orienting yourself away from your anxious thoughts and toward a more neutral stimulus. For example, instead of focusing on the audience entering the hall, you might orient yourself toward the notices on the bulletin board in the green room.

14. Discharge techniques

Anxiety and stress build up in the body and techniques that vent that stress can prove useful. One discharge technique that performers learn to employ to reduce their experience of anxiety before a performance is to "silently scream"—to make the facial gestures and whole-body intentions that go with uttering a good, cleansing scream without actually uttering any sound (which would be inappropriate in most settings). Jumping jacks, push-ups, and strong physical gestures of all sorts can be used to help release the "venom" of stress and anxiety and pass it out of your system.

15. Recovery work

You can deal with mild anxiety without having to stop everything. But if your anxiety is more serious, and especially if it permeates your life, then you must take your anxiety-management efforts seriously, as seriously as you would take your efforts to recover from an addiction. One smart way to pay this kind of serious attention is by using addiction recovery ideas—for example the idea of identifying triggers, those thoughts and situations that trigger anxiety in you. Just as you might "work your program" to stay sober, you work your program to stay calm and centered.

These anxiety-management techniques work—but, of course, only if a performer actually practices them and uses them. If he or she does practice and use them, they can make a world of difference!

Eric Maisel, PhD, is the author of more than forty books on creativity, meaning, and mental health. His titles include Secrets of a Creativity Coach *(2014),* Mastering Creative Anxiety, Performance Anxiety, Making Your Creative Mark, Coaching the Artist Within, *and* The Van Gogh Blues. *He is widely regarded as America's foremost creativity coach, blogs for* Psychology Today *and* Fine Art America, *writes a monthly print column for* Professional Artist Magazine, *and leads workshops nationally and internationally. Visit http://www.ericmaisel.com for more information.*

PUBLIC HEALTH UPDATE

SFDPH Influenza Advisory

Based on California Department of Public Health (CDPH) surveillance data as of 11/1/2013, statewide and nationwide influenza activity continues to be sporadic. It is not yet known which influenza strains will predominate during the 2013–2014 influenza season.

Actions Requested of All Clinicians

Report to SFDPH Disease Control at (415) 554-2830: (1) outbreaks of undiagnosed influenza-like illness (ILI) in large-group or institutional settings; (2) individual lab-confirmed cases of seasonal influenza only if they meet specific reporting criteria listed in the advisory.

Treat patients with suspected or confirmed influenza who are hospitalized for severe illness or who are at higher risk for influenza-related complications. Use oseltamivir or zanamivir. Treat early and empirically, without relying on lab test results.

Encourage and facilitate influenza vaccination for all persons six months of age and older and pneumococcal vaccination for those at increased risk of pneumococcal disease.

Implement infection control precautions as described on page 3 of the advisory.

Influenza Vaccines

2013: Fourteen U.S. trivalent influenza vaccines contain an A/California/7/2009 (H1N1)-like virus, an A/Victoria/361/2011 (H3N2)-like virus, and a B/Massachusetts/2/2012-like virus. Quadrivalent vaccines are newly available this year and include a B/Brisbane/60/2008-like virus. Two other new formulations include Flucelvax, grown in canine kidney cells rather than eggs, and FluBlok, a trivalent recombinant vaccine. Intranasal, high-dose, and intradermal formulations continue to be available. A complete listing of 2013–2014 flu vaccine products is posted at http://sfcdcp.org/fluvaccine.html.

If your facility does not offer flu vaccine, patients can be referred to the AITC Immunization and Travel Clinic (TravelClinicSF.org) at SFDPH.

Note for Health Care Workers

By order of the San Francisco Health Officer dated 10/4/13, all hospitals and skilled-nursing and other long-term care facilities in the City and County of San Francisco must require their health care workers to receive an annual flu vaccination or, if they decline, to wear a mask in patient care areas during the influenza season. In addition, California law (Health & Safety Code §1288.7/Cal OSHA §5199) mandates either flu vaccination or the signing of a declination form for all acute-care hospital workers and most health care personnel, including clinic- and office- based staff.

THE ART OF FIRE DANCING

Healing through Movement

Isa Isaacs

In 1998, I discovered a way to move my body that transformed me. Previously I was happily employed in a job that required hours at the computer, hunched over a desk. I was also immersed in my passion for playing the piano. One day, my arms decided they'd had enough. When debilitating repetitive strain injury (RSI) set in, I had to give up piano or give up my work. Seeking new creative musical outlets, I turned to dance, and eventually I discovered poi. Poi is an art, a meditation, an exercise, and sometimes a performance. It involves swinging a weighted ball on a chain or rope around the body in an artful, flowing way. A skilled practitioner can light the ball on fire, making the performance more dramatic for both dancer and audience.

The injury that led me to Poi was a blessing in disguise, transforming my sedentary lifestyle into one that incorporates movement on a daily basis. My practice involves three elements: flexibility through yoga; cardiovascular physical activity through dance; and the use of muscles, development of bilateral coordination, conditioning, and exploration of strength, endurance, and precision through spinning poi. Artists practicing this form report, anecdotally, myriad benefits: increased muscle tone and endurance, strengthened cardiovascular health, and enhanced body awareness. They say the practice increases ability to handle adrenaline responses, balances bilateral motor skills, increases range of motion and flexibility—particularly spinal flexibility in more advanced practitioners—improves coordination, reduces stress, develops discipline and courage, encourages creativity, and increases self-esteem and self-awareness. For me, it did all of this while lessening the painful symptoms of RSI. I reduced the impact of tendonitis in my arms and increased my wrist strength.

As I got more involved with this art, I became involved in the Burning Man community, which led to me found the world's first poi-fire dancing school, Temple of Poi in 2002. The school has been transformative for others. One client came to us with a heart murmur, seeking a gentle exercise that would not cause cardiovascular stress. He went from engaging in no physical activity to performing with fire. Another client, deeply impacted by diabetes, was eventually led to tears of joy as she accomplished things with her body previously unknown to her. An adult male client said, "I wish they had poi in gym class," because it was the first physical activity that allowed him to feel bodily freedom. A woman forced to retire from ballet for physical reasons came to us after a double hip replacement and used poi to rehabilitate and find her way back to the stage—this time twirling fire.

If you watched me spin now, you'd never believe I had been a 315-pound couch potato. You would never believe that the girl who tripped over her feet all the time could have become deft, graceful, and physically impressive with movement. Our clients have been as young as nine years old and as old as eighty-two. One of my protégés taught poi to a ninety-one-year-old occupational therapy client who later performed in front of thousands of people in San Francisco's Union Square.

The beginning student experiences high repetition with low weight, developing the shoulders, upper arms, chest, and upper back and can control how much weight is swinging to increase or decrease muscle development and endurance. Also, the student must train to work with the weight of the fire which not only includes the wicking that creates the weighted ball spinning around the artist, but also includes the fuel that is absorbed into the wicking, (thus adding more weight). As the artist improves in skill, he or she has the opportunity to increase the use of the body. At first this looks like expansion of body movement and improved spinal flexibility caused by a classification of moves we call "flowers." These moves involve extensive use of the core muscles as the arms swing like a swimmer might around the sides of the body. The poi may turn at a rate of 120 rotations per minute, which makes for a substantial number of repetitions and develops muscles over time. However, the artist is focused on quickly moving poi heads and may not realize how much of a workout it is until the practice is complete. In the later stages the artist begins to explore the execution of these moves while dancing, adding another dimension of aerobic exercise to the experience.

I can honestly say that taking on a daily practice has been the best thing I ever did for myself physically. Previously, I would wake up in pain every day. However, by challenging my body and committing to this form of movement, I am more relaxed and have less stress; my strength, balance, and endurance are stronger than ever; my posture is better; I'm leaner; and my RSI hasn't flared up in over a year. Although I'm statistically closer to death than birth, I feel happier and healthier than ever before.

Isa Isaacs, better known by her stage name Glitter-Girl, founded Temple of Poi (TempleOfPoi.com), the world's first poi fire dancing school, which has been awarded three Best of the Bay awards, including "Best Dance Studio". Isaacs has performed for a variety of media outlets and produces the Western Hemisphere's largest fire dancing showcase, held annually in Union Square. Photo credit: David Yu.

ROCK MEDICINE

Pioneering Care at Concerts for Four Decades

David E. Smith, MD, Glen Raswyck, and Leigh Davidson

"Take care of the individual right now. Return him or her to their friends or family and do away with the necessity of either hospitalizing the individual or getting involved with the law."

—George R. "Skip" Gay, MD, founder and former director

In 1972, legendary concert promoter Bill Graham asked the Haight Ashbury Free Clinics to staff a medical care tent at his Grateful Dead and Led Zeppelin outdoor events. As a businessman, Bill knew that one could not continually produce events that forced the local government's emergency infrastructure to deal with drug reactions because the "powers that be" would soon pull the permits, so he helped facilitate and support the clinic in a quid pro quo relationship (his benefit concerts saved HAFMC's existence on more than one occasion).

In many ways, the volunteers simply moved the medical clinic to the stadium, and while they provided first aid and emergency medical care to the injured and ill, they were also prepared for adverse psychedelic reactions (APRs).That was the start of a vision that was formalized in 1973 by Dr. George "Skip" Gay. Forty years later, Rock Med is still going strong and setting the standard in event medicine.

Although we still primarily handle concerts, we have branched into many other events as well, including: all 49er home games patron care, the 2013 San Francisco Pride event, the 2012 San Francisco Giants World Series Champions Parade, the Mountain Play on Mt. Tamalpais, and many more. No matter the event, we strive to provide the same high standard of care and follow our founder's philosophy in everything we do. The precept of "do no harm" is one we fully embrace in the care of each patient. It doesn't matter to us what a patient has done to be with us; it only matters that we get that patient treated and back where they belong.

The Rock Medicine protocol consists of screening, or triaging, patients according to their medical problem. Once staff establishes that the patient is not in any physical distress from injury or illness but is suffering from an adverse psychedelic or other drug reaction, the patient is taken to the "space station." Whenever possible, this area is located as far as possible from the cacophony of noise and crowds endemic to a rock concert. Here the volunteer staff, while continually monitoring the patient's vital signs (blood pressure, pulse, respiration), starts to "establish control, rapport, trust, guide, reassure, reestablish the reality base, and then return control to the patient." Some patients need only one of these interventions for a short period; others require all of them and a lot of time.

In many cases, the best Rock Med can do is get patients back to the mental state they were in before they ingested their drug of choice. Unfortunately, these individuals sometimes need much more mental health care than can be offered in a concert setting.

The next-to-worst-case scenario is that the patient needs physical restraint. Rock Med has developed procedures through trial and error, and group experience, for safe methods to "take down" a patient and physically restrain him or her. A team approach secures patients from injuring themselves and those around them, using some of the principles of Professional Assault Response Training (PART). This type of restraint allows the staff to "feel" when the patient starts to relax and no longer needs to be restrained, then being ready for the talk-down stage of recovery. Leather and cloth straps, while useful when transporting a patient in an ambulance, just escalate the patient's mental distress in the Rock Med setting. Foam mats placed on the floor (or ground) offer the safest place to restrain people. While it can be uncomfortable for clinicians, there is no danger of the patient falling off the floor (although there were times at Grateful Dead shows when the patients did seem to actually float above the ground).

In the worst-case scenario, where, due to the individual's size and/or mental state the patient is deemed a danger to him- or herself and the clinicians, he or she is medicated by the staff physician. Based on the clinical experience of the authors over decades, the most effective method of controlling anxiety and perceptual abnormality has been to administer lorazepam 2mg with haloperidol 2 mg intramuscularly, in combination with supportive, nonjudgmental talk-down. The dose can be repeated at one-hour intervals based on clinical judgment and patient behavior. These patients are usually discharged to responsible friends or relatives; hospitalization is rarely required.

Rock Medicine continues to treat concertgoers at hundreds of shows every year, far and wide. Our chief medical officer is David Relman, MD, professor of medicine at Stanford and chief of infectious diseases at the VA Palo Alto Health Care System. We are doctors, nurses, EMTs, and paramedics. We are volunteers, we are caregivers, and we invite interested clinicians to join us. Please see http://www.rockmed.org/.

David E. Smith, MD, pictured above with George Harrison (1973), is founder of the Haight Ashbury Free Medical Clinics, which, like Rock Med, is now a part of HealthRIGHT360. Smith is also a longtime SFMS member. Glen Raswyck and Leigh Davidson are former administrators at Rock Med and the HAFMC.

PERFORMING ARTS MEDICINE

The Case for Specialty Certification

Ralph A. Manchester, MD

The idea of specialty certification in performing arts medicine (or performing arts health care) has been discussed for a long time among professionals in the field. An article by Pascarelli and Bishop[1] published nearly twenty years ago mentioned the perceived need for certification and some of the obstacles to creating it. The Performing Arts Medicine Association (PAMA) took a step in this direction at the Thirty-First Annual Symposium on the Medical Problems of Performing Artists by offering a preconference workshop, "The Essentials of Performing Arts Medicine Course: From Classroom to Stage."[2] This full-day educational session was attended by several dozen performing arts medicine professionals and led by experts from several disciplinary backgrounds in both music and dance. While PAMA has no plan in place currently to offer specialty certification in performing arts medicine, educational offerings such as this one are often part of the requirements to become certified in an interdisciplinary specialty area.

What are the key reasons for choosing to create specialty certification in health care for performing artists? Specialty certification can benefit the individual who acquires it, the field and organization that sponsor it, and the public at large. The specialty-certified professional stands to gain status and recognition in his or her field and may be able to increase income by seeing more patients with particular problems and/or charging more for the services provided. Specialty certification may qualify the individual for a desired position or a higher salary. The American Board of Preventive Medicine describes the benefits of specialty certification as follows:

Board certification status is the culmination of a physician's training and says to the public and to your colleagues that you have achieved the "gold standard" of accomplishment as you begin practice in your chosen specialty. Being "Board Certified" in today's world of the practice of medicine is also looked at by credentialing organizations, hospitals, medical groups, insurers, and the public as a surrogate for measuring competence in your field.[3]

The professional field can also enhance its status by offering specialty certification, and the organization that sponsors certification may be able to generate revenue in excess of the cost of offering it. The public stands to benefit if the certification process is valid and identifies individuals who have expertise in specific topics that are of concern to them.

Are these benefits likely to accrue in performing arts medicine? The benefit for any performing arts health care professional will depend on his or her specific circumstances, but it will probably take time (years to decades) for any significant financial benefit to occur. That would likely require recognition of specialty certification in performing arts medicine by third-party payers in the U.S. and by national health care systems in other countries. Benefits to the field and to the organization that sponsors certification might happen sooner if significant numbers of performing arts health care professionals go through the certification process and acquire the credential. The public (especially those who are performing artists) may benefit the most, as it becomes easier to identify physicians and other health care professionals who have expertise in the care of musicians, dancers, and others.

What are the costs and risks of establishing specialty certification in performing arts health care? The initial costs would probably be substantial in terms of both time and money. PAMA and/or another organization would have to convene a group of experts who would establish criteria, compose a curriculum, and write an examination. Most specialty certification exams are administered online using an outside vendor. The organization might need legal counsel in order to avoid problems later on, and down the road there might be legal liability despite the most careful planning.[4] The sponsoring organization might have to carry liability insurance in case it is sued by a practitioner who was denied certification or by a patient who had a bad outcome after being treated by a certified practitioner.

The sponsoring organization will have to sort through a number of issues that are relevant to performing arts health care. First, a decision will need to be made as to whether certification will cover all forms of the performing arts (music, dance, theater, circus arts, rhythmic gymnastics, etc.) or will be limited to just one or two areas, perhaps with multiple exams to cover all types of performing arts. Certification in sports medicine for physicians, for example, covers all types of sports.[5] However, some if not many health care professionals who provide care for performing artists have contact with only musicians or only dancers. It will be difficult for those professionals to acquire enough knowledge to pass an exam that covers a discipline with which they have no experience, and the credibility of the credential itself could be brought into question if it seems to make a claim for expertise that doesn't really exist.

Second, professionals from a wide variety of disciplines play important roles in the health care of performing artists, but specialty certification is typically discipline specific. For example, while the American Board of Family Medicine (ABFM) offers a "certificate of added qualifications" for physicians who are trained in family medicine, emergency medicine, internal medicine, pediatrics, and physiatry,[5] they don't offer that certificate to nurse practitioners, physician assistants, physical therapists, or any other professionals. The sponsoring performing arts medicine organization would likely have to work with several other health professions organizations to make certi-

fication available to the majority of us. (The ABFM does have a thirteen-page outline of a sports medicine curriculum on its website[5] that could be adapted for performing arts medicine.)

A third issue is the international reach of performing arts health care. The journal this article was originally published in, for example, is the official publication of three performing arts health care organizations, based in three different countries. At least one of those organizations, PAMA, has members in more than a dozen countries. It is unclear how specialty certification that is granted by an organization chartered in one country would be applied to a member who is practicing medicine, for example, in another country.

Finally, the near-total absence of fellowship training programs for physicians in performing arts medicine is a significant obstacle to widespread acceptance of special qualification in a subspecialty area in the U.S. and probably in other countries as well. The ABFM offers a certificate of added qualifications in five subject areas (sports medicine, geriatric medicine, adolescent medicine, hospice and palliative medicine, and sleep medicine), and all five have recognized fellowship training programs, completion of which is a prerequisite to certification.[5] Without approved fellowship training programs, the variability in the knowledge and expertise of professionals in the field tends to be much greater.

So what options do we have as we look ahead? On the one hand, the prospect of establishing a critical mass of performing arts medicine fellowships for physicians, physical therapists, or any other discipline as the only pathway to specialty certification seems dauntingly difficult and might take a decade or more to accomplish even under optimal conditions (which don't exist now). On the other hand, offering certification based on simply passing an online examination after taking an online course seems ill-advised in my opinion, although this is fairly common for some professions.[6]

A "middle of the road" approach might make sense if now is the time to act. Both the Canadian Academy of Sport and Exercise Medicine7 and the American Board of Preventive Medicine[3] offer specialty certification for physicians without requiring completion of a recognized fellowship training program. The Canadian organization (thanks to Dr. Roger Hobden for bringing this to our attention) requires licensed physicians who are members of the Academy to have been in practice for two years, who have attended at least one national or provincial sports medicine conference, and who have spent at least fifty hours covering sporting events in the two years prior to taking a certification exam. The examination is not inexpensive ($1,500 Cdn) or quick (six hours). It consists of twenty stations, each of which requires the examinee to handle a common situation in sports medicine. The alternative pathway offered by the ABPM requires licensed physicians who have completed residency training and been in full-time practice of preventive medicine for two years to submit evidence of courses and experience in order to sit for their exam in occupational medicine, aerospace medicine, or general and preventive medicine. The Society of General Internal Medicine recently announced its TEACH Certificate,[8] which is a one-year program for its members leading to certification as a medical educator.

While none of these models would work perfectly in performing arts medicine, they provide examples of how we could find the right balance between rigor and feasibility. It's up to the leaders of the performing arts health care organizations—with input from all of us—to decide if, when, and how to proceed. If it is done right and we can find the resources to support it, all parties stand to benefit.

Ralph A. Manchester, MD, is editor or Medical Problems of Performing Artists (MPPA)*, a journal covering the unique medical issues of musicians, dancers, and other performers. This article was reprinted from September 2013 issue of* MPPA*. Visit http://www.sciandmed.com/mppa for more information.*

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Available online at: http://www.sciandmed.com/mppa/journalviewer.aspx?issue=1201&article=1995.

HEALTH POLICY PERSPECTIVE

Jack Lewin, MD

A Sinking Ship or Just a Stormy Sail: Reflections from the "Far East"

The Affordable Care Act (ACA) has had a rough (bad bloodied nose) experience so far. Both the Obama administration and potential ACA enrollees got rolled on the botched rollout of the healthcare.gov exchange website, with apologies flying rampantly.

Then the President backpedaled on the "you can keep you own coverage" issue for those whose existing policies were canceled—in order to meet the higher standards of the ACA. This week several ACA-supporting states announced they are holding back on shutting down their high-risk pool coverage as planned, until they see if the ACA is really going to work (doubts abound). Whatever your politics, it's a mess.

But the ACA ship isn't sinking at this point. The law certainly won't be repealed. It will continue to be implemented. It could potentially become insolvent over the longer term because not enough healthy people sign up for the exchanges—leaving soaring premiums if only sicker and older folks participate. But that won't likely happen either. The website debacle was sad and ridiculous. But that will get fixed, like all the IT nightmares we've all faced so many times before in the awkward start-ups of new things in the cyberworld since Y2K. This one was conspicuously awkward, as has been hyperacknowledged. The White House has been unfortunately slow to seek the kind of outside help from those (like Amazon, big insurers, etc.) who know how to do this kind of website stuff effectively for mass audiences, but HHS will inevitably find its bruised way to making it work here.

On the other hand, this isn't where the ACA's vulnerability really lies. Its failure would be in not making quality health care effectively available to those who don't have it today, and in not making it affordable those who do. And the ACA has to promote better prevention. And it has to foster a ferreting-out of the enormous waste in our nonsystem. These are the key issues that resulted in its surprising passage through Congress.

This ACA ship basically has to sail—or we all sink (on both sides of the aisle). We can redesign (amend) the ship as we go forward to make sure it will sail effectively. But a few reflections on the heated issues of the past month are worth mentioning here:

• The IT debacle was a bad show, but it will get fixed. But maybe not in a month, so enrollment and tax penalty implementation needs to be extended out to allow robust enrollment to occur before making the exchanges operational.

• The people who had their coverage canceled because of the ACA's higher standards: What about those poor souls? Well, about 12 million people are covered in the "individual insurance" market, where the coverage cancellations occurred. But only approximately one-third (4 million) of them had this problem. Eight million of them will get better and cheaper coverage through the ACA and are due to be happy. The 4 million (out of 330 million Americans), who had high-deductible, limited-benefit individual coverage and whose policy costs are going up would be even more unhappy if they got sick and experienced how much out-of-pocket money they would owe under their current policies—the ACA limits such out-of-pocket spending liability. (And, of course, the men quoted in the news who were mad as hell about having to pay for pregnancy benefits may have missed in their sex education classes the fact that men often have a role in the development of pregnancy). Whatever, these kinds of minimum-benefit and high-risk policies should be improved upon—everybody needs to pay their fair share of health costs—which is why many states are unhappy with the backpedaling on this issue. High-deductible plans work for those who can afford to pay for the deductibles—but not for those who can't when they need health care.

• Despite all the naysaying, I believe the young and healthy will sign up for ACA coverage over the next year—maybe not immediately, but because most of them will end up with cheaper coverage than they are thinking is available to them, and because having health insurance is reassuring, let's face it. Every insurance program starts out with this struggle—sicker people seek coverage before healthy people do. The exchanges need to start focusing on promoting health and well-being, not just treating disease. And, in fact, more than half of the under-40-year-olds (6-7 million) among the young uninsured, according to multiple economic analyses, will end up paying next to nothing for their coverage in the lowest-cost "Bronze" plans in the exchanges when their subsidies are added in. It would seem logical that these folks will ultimately sign up, right?

• Special deals being considered for big labor worry me. Labor worries that the ACA offers cheaper options for their beneficiaries in the exchanges than they offer in labor-sponsored coverage—which could discourage union membership. They need to get more competitive, then. Everyone should pay their fair share of health care costs, which we all incur. No special carve-outs are right.

OK. It's clear we're still caught up in partisan rancor around the ACA; but rather than recognizing that this nation can't afford its status quo in health spending, we're fiddling. Popular or not, the ACA is taking on a major part of this problem. The American Medical Association, not known for liberalism, supports the ACA—because just supporting the status quo is scary, an option for tea drinkers only.

Harvard's David Cutler made this compelling but missing observation about the ACA amid the current rants about it over

this past week: He noted that, for multiple reasons, the ACA has stimulated a force of change in health care that has already had huge and irreversible effects in reducing health care spending, in improving care efficiency and coordination, in fostering experimentation on quality improvement, in promoting prevention, and in producing reductions in unnecessary hospital readmissions. The law's warts and pimples will be amended over time as needed, but these kinds of long-overdue changes will not be reversed, website glitches aside.

Finally a "Doc Fix"! Really?

All the stars are aligned. Congress has proposed that the impending 25-30 percent cuts resulting from the SGRrrr (Sustainable Growth Rate Medicare physician payment formula, expressed as a growl) be abolished at last! Everybody's for it. The AMA has done a powerful job of lobbying to repeal the SGR. The National Coalition of Health Care, advised by MGMA and many physician groups, but also by many other powerful business and consumer constituencies, is also at the center of the effort of killing the SGR. Congress is under pressure to do it. They know they can't let these cuts happen. The House of Representatives proposes the SGR be abolished in exchange for a ten-year freeze on physician Medicare payments. AMA asks that doctors get at least a 1 percent increase each year. If something isn't done, the accumulation of the deficit attributed to putting off the cuts prescribed by the flawed formula will balloon out of control, making it ever harder to abolish and replace it. It's time to get rid of it.

But, unfortunately, it's not. The "nuclear option" exercised this week to eliminate the filibuster in the Senate won't promote much collaboration—as if there were much to protect. And, even without that, this Congress is not close enough to agreeing on how to pay for the $140 billion "pay-for" to eliminate the SGR. The National Coalition on Health Care has proposed ways to Congress to achieve these savings without using third-rail issues like hospital cuts or home health or other patient co-pays. There are ways to finance this. Everybody says that this is the year to eliminate the SGR.

But I say Congress will kick the can down the road again—and just postpone the cuts for yet one more year, leaving a worse looming mess to deal with in 2014. But I do think we're getting close to a fix. 2014 may really be the year when this happens, if we can keep the momentum going. The stars really are aligned—but this current Congress isn't.

John C. (Jack) Lewin, MD, a former state director of health and CEO of the CMA and American College of Cardiology, is now president and CEO of the Cardiovascular Research Foundation in New York City and chairman of the National Coalition on Health Care in Washington, DC.

CHOLESTEROL CHAOS?

Jack Lewin, MD

Who should take statins to prevent heart disease? After the long-awaited release this week of the American Heart Association and ACC guidelines on cholesterol management and coronary heart disease prevention, you must have noticed the media furor about whether the new guidelines were overreaching. A number of prominent cardiologist critics of the announcement feel the new guidelines promote overprescription of statins to people with low risk of heart disease.

It's a controversial issue for sure. HIPAA privacy protections aside, let's take my personal situation on this: I am a nonsmoker with no family history of atherosclerotic heart disease, and with normal blood pressure. I have mildly elevated cholesterol (about 220), with a mildly elevated LDL ('bad' cholesterol subgroup) of 120, but with a very favorable HDL ('good' cholesterol) at over 100. Basically, given this profile, I'm not at high risk and basically am not a candidate for statin therapy—and I wouldn't in good conscience recommend statins to a patient with a similar clinical pattern. But wait, here's the rub: I take a generic (very inexpensive) statin anyway. I feel good about getting my LDL cholesterol down well below 100. What I'm doing could be not only unnecessary but might turn out someday to be a wrong decision. I'm kind of an experiment of my own making here. So why do I do it (yet certainly not recommend it to you)? I guess it's a combination of hypothetical scientific logic, creative intuition, and a reasonable clinical gamble.

Statins are generally tolerated without side effects for most people, including me—although some people have liver issues and muscle and other problems as side effects that need to be taken seriously. But statins, besides lowering LDL (bad) cholesterol, are fairly powerful anti-inflammatory agents that might logically prevent cellular inflammation that can lead to heart disease, diabetes, and possibly even cancer. These potentials are not scientifically proven beyond their known benefits for people with significant cardiovascular risks. But some researchers believe statin benefits may someday be shown to reach further, preventing damage to major blood vessels where cholesterol plaques that cause heart attacks and strokes typically form, thus providing protection of the microvasculature and preventing deterioration of the brain and other organ systems. This is, again, hypothetical, not proven. But many cardiologists and other physicians at relatively low risk for coronary heart disease have been taking statins "off label." I am not endorsing this—it's similar to the propensity of millions of people to take various vitamins and minerals that lack scientific assurance of benefit. The risks may outweigh the benefits when the evidence is finally in.

Back to the issue at hand: the new guidelines recommend broadening statin therapy for people with known risk factors for coronary disease, even if their cholesterol or LDL numbers are not (yet) significantly out of range. There is logic behind this—people with diabetes, higher LDL cholesterol levels, and other risk factors typically progress over time toward development of coronary artery disease—and the new recommendations aim to head that off. Some critics interpret this as an abandonment of focusing on managing high LDL levels to therapeutic targets, but I don't see these recommendations as changing any of that. They instead aim to start earlier with statin therapy for people with risk factors to head off progression of coronary disease. It seems logical.

So why did these apparently controversial new guideline recommendations manifest now? I guess it's a combination of hypothetical scientific logic, creative intuition, and a reasonable clinical gamble. . . .

COVERED CALIFORNIA

INFORMATION REQUEST FORM

The California Medical Association (CMA) and the CMA Foundation have been awarded a grant from Covered California, the state's new health benefit exchange. The purpose of the grant is to help medical professionals and their health care teams learn more about Covered California and to help their patients learn more about the new coverage options and financial assistance available through Covered California.

The CMA Foundation, in partnership with the local county medical societies, can provide you with educational materials to distribute to patients who ask for information about Covered California. We can also provide in person educational sessions for your medical office team and provide educational materials specifically for physicians and their practice staff.

If you are interested in receiving resources for your office, please complete the form below and return to the CMA Foundation.

☐ - Yes, I would like information on Covered California.

Date Requested: _____/_____/_____ Name: _____

Name of Physician Practice: _____

No. of Staff: _____ Specialty: _____

☐ - I am interested in Covered CA education for my staff ☐ - I am interested in Covered CA materials for my patients

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San Francisco Medical Society
Advocating for Physicians and Patients

The San Francisco Medical Society (SFMS) has been a champion for community health issues since its inception in 1868. As the only medical association in San Francisco representing the full range of medical specialties and interests, many projects and activities that have begun here have gone on to have implications for the state and the nation. Beyond the broad and deep resources devoted by the CMA to representing physicians in the halls of state politics and in providing many useful practice management resources, here are some highlights from the SFMS community health agenda.

SFMS Community Health Activities

Universal Access to Care: SFMS leaders have long advocated that every San Franciscan should have access to quality medical care, with ongoing, vigilant efforts to preserve programs and prevent cuts in Medi-Cal reimbursement. Our representatives served on the Mayoral Task Force that designed the Healthy San Francisco program, and SFMS joined in the lawsuits to preserve that program as well. SFMS members advocated for, and even created, community clinics dating back to the original Haight-Ashbury Free Clinics in the 1960s.

Anti-Tobacco Advocacy: SFMS advocates were in leadership roles in the banning of tobacco smoking in San Francisco restaurants, ahead of the rest of the state and nation; we advocate for ever-stronger protections from secondhand smoke, for removal of tobacco products from pharmacy settings, for higher taxes on tobacco products, and more. SFMS signed onto an amicus brief in support of upholding San Francisco's law banning the sale of tobacco in pharmacies.

HIV Prevention and Treatment/Hepatitis B: The SFMS was at the center of medical advocacy for solid responses to the AIDS epidemic, being among the first to push for legalized syringe exchange programs, appropriate tracking and reporting, optimal funding, and more. SFMS is a partner in the Hep B Free program in San Francisco and in educating physicians and patients on prevention and treatment of hepatitis B.

Schools and Teen Health: SFMS helped establish and staff a citywide school health education and condom program, removed questionable drug education efforts from high schools, and worked on improving school nutritional standards; it provides ongoing medical consultation to the SFUSD school health service. In addition, SFMS has authored a resolution allowing minors to receive vaccines to prevent STIs without parental consent.

Environmental Health: SFMS's many efforts include establishing a nationwide educational network on scientific approaches to environmental factors in human health and advocating for the reduction of mercury, lead, and air pollution exposures.

Reproductive Health and Rights: SFMS has been a state and national leader in advocating for women's reproductive health and choice, including access to all medically indicated services.

End-of-Life Care: SFMS leaders have developed numerous policy and educational efforts to improve care toward the end of life, including promulgation of the Physicians Orders for Life-Sustaining Treatment medical order.

Rebuilding and Preserving San Francisco General Hospital: SFMS spokespersons took a lead in both advocating for full funding of the seismic rebuild and acting on the mayoral committee to advise where and how that would best occur.

Blood Supply: SFMS has long been a partner of the Blood Centers of the Pacific and continually seeks to help increase donations there.

Organ Donation: SFMS has been a leader in seeking improved donation of organs to decrease waiting lists due to the shortage of organs, via education and new polices regarding consent and incentives for organ donation.

Operation Access: SFMS is a founding sponsor of this local organization providing free surgical services to the uninsured and has provided office space, volunteers, and funds.

Drug Policy: SFMS has been a leader in exploring and advocating new and sound approaches to drug abuse, including some of the first policies regarding syringe exchange, medical cannabis, and treatment instead of incarceration. We were integral in the development of the CMA's landmark report on decriminalization and regulation of cannabis.

Medical Ethics: SFMS has developed and promulgated forward-looking policies and approaches regarding end-of-life care, patient directives, physician-assisted dying, and other topics of interest to patients, physicians, policy makers, and the general public.

Partnerships: SFMS works closely with many local specialty and health organizations, such as the San Francisco Department of Public Health, San Francisco Emergency Physicians Association, San Francisco Pediatric Council, San Francisco Community Clinic Consortium, West Bay Hospital Conference, Chinese Community Health Care Association, and others.

"I was an SFMS member for almost fifty years until I retired and always saw them as an important and often progressive voice in organized medicine on many crucial issues." **—Philip R. Lee, MD, UCSF Chancellor Emeritus and U.S. Secretary of Health**

"The SFMS helped save the Haight Free Clinic from the start, and I've been a loyal member ever since. So much of state and national impact has come from here and the SFMS has helped in many ways." **—David Smith, MD, founder, Haight-Ashbury Free Medical Clinics**

SFMS: An advocate for physicians and their patients

MEDICAL COMMUNITY NEWS

KAISER

Robert Mithun, MD

The Medical Weight Management program (MWM) at the San Francisco Medical Center began in May 2010, and within the first year the team started five cohorts. As of January, 2013, the staff now runs six programs a year, with each group consisting of up to twenty-one participants.

The MWM program features low-calorie meal replacements, medical supervision to ensure that weight is lost safely, weekly group sessions to motivate participants, and behavioral skills to help participants develop long-lasting health habits. MWM is one of many Kaiser Permanente weight-management programs. To learn more about others, visit www.kp.org/healthyweight.

Obesity in the United States affects millions of people, with one-third of Americans overweight and one-third obese. In northern California, 650,000 Kaiser Permanente members are considered obese. The MWM team has treated close to 300 participants, all of whom have completed thirty weeks of the eighty-two-week program with the average weight loss of forty-eight pounds at thirty weeks. The Medical Weight Management Program stands out from many of the commercial weight-loss programs in several ways. We run weekly group sessions for eighty-two weeks. For the first eighteen weeks of the program, participants are medically monitored while on full meal replacement. The group sessions focus on lifestyle and behavior change for the long term. The approach used is based on SMART, an acronym for Setting a goal, Monitoring your progress, Arranging your world, Recruiting a support team, and Treating yourself.

An excellent example of our success is a participant who began the program in August 2011 and still consistently attends weekly group sessions. She has maintained her initial weight loss and significantly reduced her body fat. By addressing our patients' weight problems, we are extending their lives, working to curb the country's current obesity epidemic, and helping them to become happier, healthier, and transformed.

SFVAMC

Diana Nicoll, MD, PhD, MPA

The San Francisco VA Medical Center (SFVAMC) may not be the first hospital that leaps to mind when thinking about the treatment of performers and artists, but veterans of the U.S. military frequently have a creative side to their private and post-military professional lives. Our veterans have the same breadth of interests, hobbies, and passions as the rest of the population.

They are also experiencing the same increased need for orthopedic care that is a national demographic trend. One patient, a former military band member and professional drummer, was losing his ability to perform his regular gigs due to severe hip pain. A former Army nurse and part-time ballroom dancing instructor was finding it increasingly difficult to stay on her feet (and toes) because of arthritis in her knee. A Vietnam war-era veteran, who discovered landscape painting as his passion later in life, could hardly continue to do what he loved because of worsening elbow pain and stiffness.

The common thread among these patients, and for a majority of patients seeking orthopedic care within the VA system, is an epidemic of degenerative joint disease. Not surprisingly, joint replacement is one of the most common surgeries performed at the SFVAMC. Our facility is one of just a small number of VA hospitals nationally that offers ankle and elbow replacements, in addition to more commonly performed replacements of the shoulders, hips, and knees. We also provide care for veterans needing joint preservation procedures such as hip arthroscopy, cartilage repair/replacement, and correction of limb deformities.

After successful surgery at the SFVAMC, each of the veteran patients mentioned above was able to return to the performance activity he or she most valued. We are proud to help all of our patients stay as active as possible so that they may pursue their creative interests.

UCSF

Michael Gropper, MD

Bariatric surgery is widely recognized as the most effective treatment for severe obesity, with efficacy that is superior in terms of both magnitude and durability of weight loss. Unfortunately, regaining weight or insufficient weight loss (WR/IWL) following surgery occurs in nearly 20 percent of cases. The negative consequences of this on the bariatric patient's health and quality of life are significant, with many returning to obesity-related comorbidities. WR/IWL is becoming more frequent with the cumulative number of bariatric procedures performed, and its etiology is likely multifactorial, possibly including behavioral and physiologic alterations as well as issues related to surgical anatomy.

At UCSF Medical Center, novel treatment options are being offered to help treat this growing problem. In addition to reeducating patients about the dietary requirements necessary for weight loss, treatment may also include restoration of initial bariatric restrictive anatomy or revision bariatric surgery, often performed laparoscopically. With innovative devices being used by bariatric surgeons Stanley Rogers, MD, and Matthew Lin, MD, these revisions may now also be performed using a novel incisionless endoscopic approach called endoluminal suturing. Performed under anesthesia, this option may allow restoration of the restrictive anatomy necessary to reverse WR/IWL without a surgical incision. Initial clinical trials show high patient satisfaction, with favorable preliminary safety and efficacy outcomes. Longer-term studies being conducted at the UCSF Bariatric Surgery Program will be necessary to determine whether these effects will be sustained.

Endoluminal suturing is offered in conjunction with the UCSF longitudinal, multidisciplinary approach to bariatric surgery that includes dietary counseling and behavioral changes, both of which are essential for enduring results. For more on weight-loss surgery at UCSF, visit www.ucsfhealth.org/bariatric.

CPMC
Michael Rokeach, MD

The American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP®) has recognized CPMC as one of 37 ACS NSQIP-participating hospitals that have achieved meritorious outcomes for surgical patient care. As a participant in ACS NSQIP, CPMC is required to track the outcomes of inpatient and outpatient surgical procedures and collect data about patient safety and the quality of surgical care improvements. CPMC was commended for achieving the distinction based on outstanding composite quality scores in the nine areas of review. Risk-adjusted data from the July 2013 ACS NSQIP Semiannual Report, which presents data from the 2012 calendar year, were used to determine which hospitals demonstrated meritorious outcomes. ACS NSQIP is the only nationally validated quality-improvement program that measures and enhances the care of surgical patients. For the first time, physicians may be able to predict organ rejection in patients who have received a transplant for liver, kidney, heart, or lung disease and develop novel drugs for improving transplant outcomes. The advancement in transplant medicine arises by way of new research from California Pacific Medical Center Research Institute (CPMCRI) and the Stanford University School of Medicine, in collaboration with colleagues in Belgium. "We identified a set of eleven genes implicated in the immune response underlying acute organ rejection after solid organ transplantation, and these key genes can be manipulated to discover new drugs for treating transplant patients at a fraction of the current cost needed for pharmaceutical drug design," said Minnie Sarwal, MD, PhD, co-senior author of the study and a senior scientist at CPMCRI. The other senior author is Atul Butte, MD, PhD, an associate professor of pediatrics at Stanford and director of the Center for Pediatric Bioinformatics at Lucile Packard Children's Hospital at Stanford. The study of gene expression data was published in the *Journal of Experimental Medicine.* Dr. Sarwal and colleagues analyzed the genes of 1,164 biopsy samples, from eleven hospitals across six countries, from publically available tissue samples of patients who had undergone transplantation of the heart, lung, kidney, or liver.

BROWN & TOLAND
Fiona Wilson, MD

Brown & Toland Physicians opened My Health Medical Group, a nationally recognized patient-centered medical home (PCMH) practice, in March 2012. After more than 18 months in operation, My Health Medical Group is helping redefine and shape how Brown & Toland physicians deliver medical care in San Francisco and the East Bay.

Our objective when opening My Health Medical Group was to achieve the triple aim: improve the patient experience, improve the quality of care of populations, and bend the cost curve. We have done just that. We improved the quality of care while reducing the total cost of care by 15.7 percent for commercial patients and 8.7 percent for senior patients.

In addition to the care delivered by our providers, we also put into place "population health" programs to improve care and reduce costs. Individual teams, each consisting of a physician, nurse practitioner, medical assistants, a care manager, and a data analyst, work together using registries to improve the care for patients with diabetes, hypertension, and those who were identified as high-risk or vulnerable (patients with multiple active chronic problems, who taking multiple medications, and with a history of hospitalizations).

Besides being the first practice in San Francisco to earn national recognition as a Level 3 PCMH from the National Committee for Quality Assurance (NCQA), My Health Medical Group also received the 2013 Patient-Centered Medical Home of the Year award from the California Academy of Family Physicians. We want to use our practice as a test bed and then share the new and best practices with the Brown & Toland network.

Our future plans call for expanding and refining our programs and services to bring patient-centered care to more patients.

SUTTER PACIFIC MEDICAL FOUNDATION
Bill Black, MD, PhD

Keeping kids safe from athletic injuries is a top priority for our pediatricians at Sutter Pacific Medical Foundation. It's important to gather information about their activities during a routine office visit—before a patient shows up injured. Our pediatricians have developed effective techniques for making patients realize what's at stake when they play soccer, ride a skateboard or bicycle, or take up some other sport.

Basic precautions include wearing appropriate protective gear—helmets and shin guards, even sunscreen. Sun protection is necessary to reduce skin cancer risk, even with dark-colored skin. Pursuing different sports at the same time is helpful so young limbs are not overused by repetitive movements.

Cindy Greenberg, MD, advises patients to stretch, and, if an injury occurs, she likes to get them in physical therapy soon so they hear from another expert about exercise.

Teenage girls often need to strengthen the surrounding musculature of the knee joint since the ACL, like other ligaments, can become weak as estrogen levels rise during puberty.

If patients do experience a head injury, they must not engage in sports until well after symptoms disappear. That includes not watching TV or videos, reading, or being on the computer. They can resume these activities after symptoms disappear but should stay away from contact sports for two weeks.

"I make them promise to be true to themselves, and if something hurts or they are dizzy, they need to come off the field and not go back until they are evaluated," Greenberg said.

Young athletes need to hear the message about rest and recuperation so they don't risk another injury or, worse, permanent damage.

Zea Malawa, MD, tells patients, "You need to recover completely so you don't go on to long-term physical problems that later limit you from being active. I remind them they have two legs and two arms, but only one head."

SFMS Election Results

2014 Officers

One-year term

President-Elect | Roger S. Eng, MD
Secretary | Richard A. Podolin, MD
Treasurer | Man-Kit Leung, MD
Editor | Gordon L. Fung, MD

2013 President-Elect Lawrence Cheung, MD, will automatically succeed to the office of President. 2013 President Shannon Udovic-Constant, MD, will automatically succeed to the office of Immediate Past President.

Board of Directors

Seven elected for three-year term 2014-2016

Benjamin C.K. Lau, MD
Ingrid T. Lim, MD
Keith E. Loring, MD
Ryan Padrez, MD
Adam Schickedanz, MD
Rachel H. Shu, MD
Paul J. Turek, MD

Nominations Committee

Four elected for two-year term 2014-2015

James L. Chen, MD
Patricia J. Galamba, MD
Vanessa E. Kenyon, MD
Amy E. Whittle, MD

Young Physicians Section Delegate

Two-year term 2014-2015 | Stephanie Oltmann, MD

AMA Delegate

Two-year term 2014-2015 | Robert J. Margolin, MD

AMA Alternate Delegate

Two-year term 2014-2015 | Gordon L. Fung, MD

Delegates to the CMA House of Delegates

Two-year term 2014-2015

Delegates

Ameena T. Ahmed, MD
Roger S. Eng, MD *(serves automatically as President-Elect)*
George A. Fouras, MD
Katherine E. Herz, MD
David R. Pating, MD

Alternates

Brittany Blockman, MD
Keith E. Loring, MD
Richard A. Podolin, MD
Judy L. Silverman, MD
Elizabeth K. Ziemann, MD

PAC Contributors

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Take a closer look at your dental plan

It's Open Enrollment time for the San Francisco Medical Society sponsored Group Dental program. This plan is designed to help you, your family and your employees minimize the out-of-pocket expense of regular dental care.

This program helps you maximize your out-of-pocket savings by using network dentists, but also allows you to use any dentist you like and receive lower benefits. Following are many valuable benefits that can save you money:

- **Annual Benefits of $2,000** per person for dental care, using network providers ($1,500 if you use non-network providers).
- **During Open Enrollment only,** members may join as an individual or as a group with your employees.
- **Low, calendar year deductible of $50** per person ($100 per calendar year maximum for families).
- **Pay no deductible** on oral exams, x-rays and routine cleanings.

Remember, the open enrollment period is available once per year. To be eligible for coverage, applications must be received during the special open enrollment period ending on January 1, 2014.

Call a Client Service Representative at **800-842-3761** for more information. Or visit **www.CountyCMAMemberInsurance.com** to download a brochure and application.

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Photo Courtesy of San Francisco Ballet © Erik Tomasson

RETURNING PATIENTS TO THEIR PASSIONS

California Pacific Medical Center's orthopedics program launched its Short Stay hip and knee replacement program in 2012. In 2013, CPMC was recognized by the American College of Surgeons National Surgical Quality Improvement Program as one of 37 ACS NSQIP participating hospitals that achieved meritorious outcomes for surgical care. Helping your patients return to their creative pursuits, faster. It's another way we plus you.

Sutter Health
CPMC
We Plus You

cpmc.org/jointcare