MEDICAL ENCOUNTER EXISTS TO:

• Build community among ACH members by celebrating their creativity, diversity and energy.
• Provide voice to ACH by reaching out to communities of patients and healthcare providers worldwide.
• Support the education and research missions of ACH by highlighting innovative work occurring both inside and outside of the Academy.

Academy of Communication in Healthcare

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About the Cover Photo:
Participants at the 2018 ENRICH Healthcare Communication Course and Research Forum engage in small group activities. ENRICH Forum was held May 31—June 3, 2018 at the Hilton Downtown in Tampa, FL.
Dear ACH Members,

Recently a Task Force was established with the purpose of examining ACH’s Medical Encounter publication. Nine members of ACH joined the task force and committed to a series of conference calls to discuss the following topics: the current and future mission of Medical Encounter, the history of Medical Encounter and how that has influenced the current publication, the challenges associated with publication in current form, the opportunities for a re-envisioned publication, the audience and reach of Medical Encounter, and the possible routes for change.

As a result of the strategic discussions, ACH has decided to discontinue the publication of Medical Encounter and this is our final issue. We recognize the value that Medical Encounter has had and encourage our members to share narratives and articles through our new ACH Connect online community. In addition, we are collaborating with several other publications as a potential outlet for sharing these unique perspectives and publications. We thank Paul Haidet for his leadership as Editor of Medical Encounter, Editor Emeritus Dennis Novack and the many section Editors and contributors who made Medical Encounter possible for so long.

Russell Rothman, MD, MPP
President
Academy of Communication in Healthcare
Tell Me a Story: Teaching Internal Medicine Residents to Find and Share Their Patients’ Stories

Authors: Margaret Plews-Ogan MD, Natalie May PhD, Daniel Becker MD

The co-authors are in the Section of General Medicine, Department of Medicine, University of Virginia School of Medicine.

Funding: Arnold P. Gold foundation with matching institutional funds.

The project was approved by the University of Virginia IRB for social and behavioral research.

This work was presented as a poster at the International Conference for Communication in Health Care, New Orleans October 25, 2015.

PROLOGUE:

Patients’ stories have the power to bridge differences, evoke empathy, flesh out the person inside the list of acute and chronic medical problems, honor that person, improve diagnostic accuracy, direct treatment, strengthen teams, and reduce burnout. \(^{(1-9)}\) So why do we often find ourselves bereft of story in day to day clinic visits?

Not enough time? Appointments feel too short, paperwork feels endless, clinical issues too complex. \(^{(10)}\)

More than enough EMR? EMR-speak compresses our story-telling brains into smart sets and dot phrases. Moving into story mode is an intentional process that if not actively discouraged by “note writer” options in EMRs is also not encouraged or even mentioned in the “meaningful use” prompts that pop up when the note is closed.

CHARACTERS, SETTING AND PLOT:

The Tell Me a Story (TMAS) project claims that discovering a story or a few signature details of life beyond standard medical checklists is a clinical skill that can be taught, evaluated, reinforced, shared, normed, and deployed as a vital correction to the digitized and reductive EMR portrait.

To test these claims the TMAS project encouraged story discovery and sharing using prompts, props and attention grabbing rewards; appointed and prepared TMAS champions; developed a Minimal Clinical Evaluation Exercise (mini-CEX) that tested “narrative quotient;” \(^{5}\) kept the reverb from the project going through serial emails to attendings and residents and staff; and interviewed attendings and residents nine months into the project to confirm what worked well and what needed to work better.

University Medical Associates (UMA) is the teaching clinic for the University of Virginia internal medicine training program. There are 18 firms, 5-6 residents each, and 14 firm directors. Residents are in clinic once a week. Morning report precedes morning clinic sessions, and patient stories precede morning report.

In round one of this project, April-June 2014, nine firms, with 8 attendings, received enhanced TMAS preparation. Residents at large and the other firm directors heard about TMAS at a noon lecture on narrative medicine and building patient rapport, from serial emails, by direct requests for stories from clinic attendings, by endorsements from chief residents, by discussion at firm director meetings, and by the curious appearance of green and white listening cards and M&M candies labeled “got story?” in the clinic work rooms. When any attending, but in particular the 8 enhanced listener attendings, heard a good story from a resident, that resident received a small bag of M&Ms, a neon-green card with a command invitation to share the story at morning report, and a white card that prepared them for sharing the story (table 1). After sharing the story the resident received a coffee voucher for the hospital’s gourmet coffee shop. To save residents’ time we provided a loud-pink pocket sized list of story prompts, reminders of occasions that could use more story, and prompts that led back to the usual clinical agenda. (table 2). In addition, the enhanced listener attendings routinely discovered and highlighted revealing facts about patients in the process of confirming the residents’ assessments.

In round two of the project, July-December 2014, we:

1. added a mini-CEX that tested “narrative quotient”;
2. scheduled focus groups with UMA attending physicians;
3. surveyed residents by email;
4. continued handing out green cards and white cards and encouraging residents to share stories at morning report.
THE MORALS TO THIS STORY:

Story gathering and sharing can be taught (and it can be fun). We hoped to demonstrate that story gathering and sharing is contagious, that once one resident started sharing, the others would soon follow, that teaching this would be as easy as see one, do one, teach one. That was true, and many residents caught on.

Whenever I present a patient to Dr. *** he expects me to know some kind of personal detail…. the first thing he does with a patient is ask some personal detail. “You’re the one I hear is a photographer.” And patients will smile and open up… (resident)

I use this tool … in the hospital…. and I’ve noticed that patients treat residents and attendings differently, depending on whether they are open and energetic and laugh or if they’re just serious and methodical. (resident)

Plot twist: To our surprise the attendings proved even more susceptible and enthusiastic than the residents. Among the 8 designated enhanced listener attendings, 5 became champions for the project. These attendings regularly chimed in on group emails about the project. Their residents regularly shared stories at morning report. If none of the residents had a story, these attendings would share and still share their own patients’ stories. One discovered a latent talent for writing. Three participate in an informal resident reading group: not a journal club, rather poems and stories and essays worth sharing and discussing over dinner after clinic. All 5 do home visits. These attendings had also been involved in a parallel project to promote faculty development in humanism and thus had been burning this candle at both ends.

Residents get it that story listening can be woven into the clinic visit without jeopardizing management of medical problems; that attendings (some more than others) expect residents to go beyond problem and medications lists: that good doctoring depends on enriching the interactions with patients and families; that clinic notes are allowed to notice birthdays, hobbies, and pets. Celebrating good stories (the M&Ms and coffee cards and discussions at morning report) was more fun and more interesting than preaching to residents about humanism.

What I enjoyed most was the camaraderie in the workroom, “I got a story!” and then everyone wants to hear it…. there

is a community of listeners. (intervention attending physician)

We discovered that the prompts and props, cute and clever as they were, and useful in round one to trumpet the TMAS project, turned out to hardly matter when compared to the attending’s interest and personal investment in these narratives. The narrative quotient mini-Cex, like all the mini-Cex forms, felt like an after-thought and only gathered dust.

Stories change relationships. The “right” story changes the dynamic of the clinic visit.

I have seen a change in residents…. Now she (the resident) was happy… instead of feeling dominated by the hopelessness and helplessness of coping with difficult circumstances. (intervention attending physician)

It is easy to see and hear the changed dynamic: the resident and patient are smiling and laughing; everyone is pleased that after the knee injection the patient enjoyed a triumphant return to the bowling league.

It’s definitely worthwhile. You can just see the patients relax and be more at ease… it builds trust, they’re more likely to take your medical advice. (resident)

During the biannual resident-attending evaluation sessions the feedback can now raise standards for enriched patient interactions: between now and our next evaluation, work on your narrative quotient, see if you can make me and the patient smile.

Stories are not an inefficient use of clinic time. Firm directors told us that “in the moment” story sharing was more enjoyable and feasible than when the activity required forms to fill out. They felt that the project was more effective when it felt like “an invitation” rather than a mandate.

I would go in [with the resident] and demonstrate how easy it was to make a story appear. It usually took about 10 seconds: “I’ve always wondered what that hat means.” (intervention attending physician)

Rome wasn’t built in a day. Like all innovations, the TMAS project needed and still needs opinion leaders with influence and stature. It also depends, in part, on programmatic stability. Schedule changes that made for journal clubs and a primary care curriculum led to delays of weeks between finding and sharing the story. Stories have limited shelf life, and it is
important to have the attending in the room confirm the clinical and relational impact of the story.

**EPILOGUE:**

Morning report still begins with a story.

An attending recently emailed, “it’s not weird in morning report when someone tells a story. It feels normal.” Normal is what we hoped.

**TABLE 1: Sharing a Story at Morning Report**

1. What’s so great about this story?
2. What difference did it make?
3. How did you find this story?
4. What did you ask the patient?
5. What problem did the story help to solve?
6. Why did the story matter?
7. What changed because of the story?

**TABLE 2: The Pink Card: Prompts & Opportunities**

**Prompts to generate a story (versus a history):**

- Welcome back. What’s new in your world...
- Tell me again about your work.
- What brought you to this part of the world?
- If you had three wishes, what would the first wish be?
- What do you do for fun?
- What about you would surprise me?
- You are dealing with a lot. Who helps you?
- If you could do anything, what would that be?
- Tell me about a great day in your life.
- Tell me about that tattoo.

**When to look for a story:**

- to establish and deepen a relationship
- when there is a lot of strong feeling in the room
- when behaviors that need to change don’t change
- when you sense the patient does not trust you
- when you are frustrated at poor adherence or follow-up
- when the clinical stuff is easy and you have the luxury of time
- when you are curious how a patient this sick manages to be cheerful
- when you are curious how a patient this sick manages to be brave
- when there is someone in the room you have not met
- when that baseball cap is your favorite team’s
- when that T shirt is chapter one of an interesting story

**Prompts to move on from the story:**

- I have more questions and I will ask them during the exam
- I wish we had more time, but before the end of the visit I need to...
- That sounds so difficult. After the exam we can make plans to make it less difficult.
- Sit here so that you can see the recent results all lined up on the computer screen.
- Sit here so that you can see and help me correct your medication list.
- Sounds painful, and I will be very careful not to make it hurt worse during the exam.
- While I am closing the blinds so pedestrians can’t watch, you can get on the exam table.

**REFERENCES**

GETTING ACQUAINTED:

Dr. Somnath Saha

Author: Shakaib U. Rehman, MD, FACP, FACH
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Q. Please provide a narrative of your life (biography)

Dr. Somnath Saha: I was conceived in Calcutta and born in Cleveland. My parents had both just graduated from medical school, and they came to the U.S. to do their residency, my mother carrying me on the plane in utero. During their residency, I was born, then my sister, and my parents decided to stay in this country. With 2 physician parents, I basically grew up in hospitals, and from the time I started walking I think everyone including me assumed I would follow in my parents’ footsteps and become a doctor. And so I did. I was one of those dutiful Asian first-borns who walked the path I was supposed to walk, without really thinking too much about what I really wanted in life. I had a bit of an existential crisis in my 3rd year of medical school, when I finally “woke up” from being on auto-pilot. I briefly entertained quitting medical school and going to a culinary academy. I ended up spending six months abroad, soul-searching, and in the end decided to stick it out (truth be told, this was at least in part because, as a dutiful Asian first-born, I was afraid of the repercussions of quitting). Then I hit internship, a year that I had been told would be the worst of my life. But it turned out to be one of the best. Now that the weight of being judged on my performance working with patients was lifted, I realized that I actually loved working with patients. I loved being a doctor. I loved talking to people, explaining things to them, holding their hands and comforting them. I was in awe of the privilege of people allowing me to be a part of their lives. I still today thank God I didn’t have the guts to quit.

Q. How did you become interested in doctor-patient communication and the academy?

Dr. Somnath Saha: My path into the world of doctor-patient communication was not a direct one. As a resident and fellow, I became interested in the issue of racial disparities in health care, and I was particularly interested in how racial disparities in the healthcare workforce (i.e., lack of diversity in the health professions) might contribute to racial disparities in healthcare delivery. I began doing research on the relevance of physician race in doctor-patient interactions. So I was primarily focused on racial disparities but also interested in communication. Then I met my partner in crime, Mary Catherine Beach, whose research focus was the reciprocal of mine. She was primarily focused on doctor-patient communication but also interested in racial disparities. As a communication researcher, she had already found ACH and encouraged me to join. My conversion happened when I went to the ICCH in Charleston in 2007. I had a poster that I thought no one would come to. But I ended up during that poster session talking to people from 7 different countries about their perspectives on race and disparities, and I had some of the most fascinating conversations I’d ever had at an academic meeting. I haven’t missed an ICCH since.

Q. What are the lessons learnt from your years of teaching and practice?

Dr. Somnath Saha: I’m still learning lessons all the time, but one thing that I learn over and over again is just how powerful and meaningful stories are. Hearing even a short, simple story about a patient’s life can transform her from a bag of organs to a whole person, from the CHfer in room 104 to Gloria. I’ll admit it’s hard, when I’m busy, to take time to ask for and listen to people’s stories, and I am not always great about doing it. But when I do, my time almost immediately becomes more fulfilling and meaningful. It’s like exercise. You struggle to find the time to fit it into your day, but then when you do, you feel so much better that you wonder why you don’t prioritize it.
Q. How can young clinicians, investigators and other healthcare workers be more effective, productive and happy?

Dr. Somnath Saha: As people working in health care, we all have the privilege of having day jobs where we get to do work that satisfies part of our souls. Not everyone has that privilege, and we shouldn’t squander it. It is very easy to get sucked into tasks and projects that we don’t find meaningful. I often find myself doing things that I don’t feel much conviction about, while things that I care deeply about sit on my desk waiting. Of course we all have to do scut from time to time, but the advice I give to my mentees (and that I try to follow myself), is to periodically look at your portfolio of activities and ask where each one is, in relation to your center. That requires knowing where your center is. So I also advise people to write down a list of their core values, and craft a mission statement. Then use that as a guide, and prioritize your activities so that the majority of them are close to your center.

Q. What is the future of ACH in your vision?

Dr. Somnath Saha: I think the pendulum of health care is swinging back towards the values ACH has worked to preserve. Over the last couple of decades, the movement to improve quality of care has been successful in many ways. But one of the unintended consequences, in my opinion, has been the displacement of good communication and relationships. Quality and performance measurement have focused on disease-specific metrics, clinical reminders, and checklists. This mechanization of medicine has improved care in some ways, but it has also cut into the time we have to establish meaningful relationships with patients, to listen to their stories and know them as people. It has become clear, though, that neither health professionals nor patients want health care to be mechanical, and people are now rediscovering what ACH members have always held to be true, that good relationships are at the core of good health care. ACH is positioned to lead the way as the pendulum swings back in our direction.

Q. How can we enhance the reach of ACH?

Dr. Somnath Saha: ACH is a small academy and probably always will be, because it is a highly focused group, which is one of its strengths. To enhance its reach — both in the sense of reaching constituents, and in the sense of having an impact on health care — one thing ACH could do is to integrate more with other professional organizations. ACH was born out of the Society of General Internal Medicine and has a close relationship with them. There is an annual ACH abstract session at the national SGIM meeting. Relationships like that could be cultivated with other like-minded organizations and professional societies. This is being done to some degree, with the help of ACH staff. But it would help for ACH members who are involved in other organizations to build relationships so that ACH can promote its mission through partnerships with others with bigger numbers and greater leverage.

Q. What would be your message to all of us?

Dr. Somnath Saha: Do work that you are passionate about, that you are particularly suited to do, and that contributes to the betterment of the world in some way. Then you’ve won the game. (Loosely stolen from Steven Covey)
Dr. Dave Kern

Author: Shakaib U. Rehman, MD, FACP, FACH
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Q. Please provide a narrative of your life (biography)

Dr. Dave Kern: Born in Cincinnati, and attended magnet public high school (Walnut Hills) where I learned about eastern colleges. Went to Princeton where I majored in biology, then Harvard Medical School. Wanted to be a doctor from an early age (though also liked the idea of architecture). Developed interest in primary care in medical school, interned at Pres-St. Luke’s (Rush) in Chicago, then spent from 1972-74 at a 5-doctor inpatient and outpatient medical center on the San Carlos Apache reservation in Arizona. In 1975, my significant other (Susan Gauvey) and I traveled in western and eastern Europe (then behind the “Iron Curtain”) and Egypt, marrying in England where I had spent a year abroad in medical school. Moved to Baltimore to complete my internal medicine residency at Baltimore City Hospitals (now Johns Hopkins Bayview) and do a Robert Wood Johnson Clinical Scholar fellowship. Because of great colleagues and opportunities at Hopkins, and my wife’s work, we never left. My career has been as a clinician-educator, focusing on medical education and curriculum development. My wife (a lawyer and judge) and I are now retired, working part-time. We have three grown children, the oldest (“G-K”) a research manager at Hopkins, Kevin a med-peds resident at Geisinger, and Lizzie a professional musician in NYC/London (www.elizabethhuntermusic.com).

Q. How did you become interested in doctor-patient communication and the Academy?

Dr. Dave Kern: We obtained a HRSA grant for a primary care residency in 1979, which required training in communications skills and the psychosocial domain of medical practice. Randy Barker and I developed our skills in this area working with social scientists, one of whom suggested we attend an ACH course (then the Task Force on Physician and Patient of SGIM). I was hooked. ACH helped me develop personally and professionally and connect with wonderful colleagues and friends. It provided the support and mentorship that helped me develop as a teacher, scholar, leader, and person.

Q. What are the lessons learnt from your years of teaching and practice?

Dr. Dave Kern: Listen. Connect. Partner. Attend to emotions. Be open and seek input and perspectives from diverse individuals and groups. Never stop learning. Do what is right, but also be aware of external requirements and constraints and try to mesh the two.

Q. How can young clinicians, investigators and other healthcare workers be more effective, productive and happy?

Dr. Dave Kern: Identify wonderful mentors. Do not hesitate to approach, ask help from leaders in your field. Most will be generous and offer help. Follow your energy and passion. Don’t let others tell you that your desired path is the wrong one. Seek mentorship from those who will help you succeed. Become involved in your national professional organizations, and network broadly. Volunteer for activities in ACH if health care communication is one of your interests. Work hard and collaboratively, and take time to balance your life

Q. What is the future of ACH in your vision?

Dr. Dave Kern: Becoming the professional home for an even more diverse group of educators and researchers of communication in health care. Engaging patients and the patient perspective more in our educational and research work. Increasing our influence/reach: using our collaborative expertise in communication to help to improve the provision of healthcare services and to improve morale and teamwork within the healthcare workforce.

Q. What would be your message to all of us?

Dr. Dave Kern: Leave the world a better place because of your input. Listen, love, never stop growing, smell the roses.
The Wedding of Seemingly Disparate Interests

Author: Eric Ardman

I never had any real intention of learning Vietnamese beyond completing my first trip to Vietnam. I have been learning Vietnamese for almost four years now. Four years ago, I didn’t have any longitudinal career or personal goals that required speaking Vietnamese; now, I’m in medical school and hope to one day work in Vietnam as a clinician and in the public health sector. My interest in Vietnam initially stemmed from a curiosity about American history post-World War II. Coincidentally, I stumbled upon a flyer about a University of Miami program promising to provide a language partner to help students learn “exotic languages” for free. When I signed up to learn Vietnamese, I thought I was getting some peace of mind for when I shipped off to Vietnam. Maybe I’ll be able to ask some directions and order a beer. Turns out I got more than I bargained for. In reality, I was being given the opportunity to forge a key that would grant me access to another world and drastically alter my life forever. Let me explain.

I was not expecting my language skills to get me far during my first trip to Vietnam in the summer of 2013. I had only been learning Vietnamese in the Directed Independent Language Study (DILS) program for six months, and it was a difficult language. My only real goal was to make sure I could read which areas were marked “Danger: Unexploded Ordnance.” But my very basic language skills gave me a glimpse into a country and culture so vastly different from my own. This was made very clear to me during my taxi ride from the airport after landing in Hanoi. I asked the driver about his favorite foods. “Thịt chó,” he replied. I made a puzzled face so he explained further, “Bark! bark!” Ah, I see. His favorite food is dog meat. Little exchanges like these were so exciting. The more people I talked to, the more places I visited, and the more customs I learned about, the more I came to feel a connection to Vietnam which I had not felt with any place else. I came back to America wanting to continue my learning, but with my initial goals for studying Vietnamese accomplished, doing so proved to be much more difficult than I expected.

Learning without any tangible goals was one of the hardest challenges I faced. Where do I go next with this? What is the point of learning a language that never seemed to be useful outside of Vietnam? I couldn’t even find a single person, apart from my language partner, with whom I could converse in secret about professors during class or cute girls at parties. I felt very alone in my learning. My drive to continue was subsequently revived when my language partner invited me to her wedding in Hanoi the following summer. Once again, I found myself in the middle of somewhere so different than anything I had experienced before. The wedding banquet had hundreds of guests and ten mouth-watering courses. I sat with some university students and made conversation as we stuffed ourselves. The wedding was an ideal reflection of my time in Vietnam: vibrant, delicious, and warm. After the wedding, I traipsed around Vietnam for a few weeks, sightseeing and making new friends, some of which I still keep in contact with. Ultimately, I began to envision a life for myself in Vietnam, for I felt that I was home.

This newfound feeling of home did little to alleviate the frustration of learning a new language. I saw my grueling, imperceptible daily progress as failure, through and through. I had good days, where the words flowed like water and I felt that fluency, a perceived impossibility when I started, was coming up over the horizon. I was expressing my feelings, making jokes, and forging relationships with people solely in Vietnamese. Bad days were interspersed between like barbed wire, where the words were like cement and carrying on a two minute conversation was exhausting. I cannot tell you how many times I’ve wanted to quit learning Vietnamese. This still happens occasionally, but part of what keeps me going is the support and encouragement of my friends, mentors, and even strangers. During my third trip to Vietnam, I had almost reached my breaking point. I was lucky to find support in a old Russian expat, Natasha. Natasha runs a gallery hidden in plain sight in the bustling Old Quarter of Hanoi that pays tribute to her late-husband, a prominent Vietnamese artist during the early days of Liberation. Drawing from her vast breadth of experience and wisdom, she talked me down from quitting Vietnamese on more than one occasion. I am forever grateful. I have come to understand that learning a language, or really anything, does not have to be a solitary journey of one person and a text book. Seventeen...
years of structured school had made me biased to the “what” and “how” of learning. However, through DILS and my time in Vietnam, I’ve developed some skills that facilitate learning on my own, by any means available, and prevent me from being too hard on myself on those supposed “bad days.” Self-compassion is a godsend. 

This past summer I interned at the Center for Supporting Community Development Initiatives (SCDI), an NGO that supports ‘key populations’ in Vietnam, e.g. drug users, sex workers, and men who have sex with men and transgender (MSMTG) populations. My project was to create a workshop for a handful of leaders from the MSMTG community to educate them further about topics ranging from HIV/AIDS prevention and treatment to drug use and mental health. The project brought me deeper into the fray of current public health issues that Vietnam faces. I learned more about the burgeoning MSMTG community and their fight for recognition by the government and mainstream culture. Stories of rejection and ostracization are numerous, but so are stories of finding new family, new friends, and a new sense of freedom not unsimilar to stories found here in the US. Through the project, I met with experts from the US embassy and the UN, among others, who have shown me that it is more than possible to wed my interests in public health and Vietnam. Allowing others to show me the world has made me understand just how bountiful the possibilities are for someone who knows a second language.

When people ask me why I am learning Vietnamese, I never know what to tell them because my reasons for doing so have become so varied and numerous, many of which are near impossible to express in words. They range from the concrete career goals to the abstract. Maturation and self-improvement, broadening perspective, empathy, and self-compassion are all goals I’m working towards through learning a language. Learning Vietnamese has become a part of my identity, inseparable from my passion to understand this world, my community, and my view of myself. So when people ask I tell them I’m just following my nose.
Three Poems on Illness

Author: Ateret Haselkorn

ONE
I have observed illness closely.
Health leaves the body much
like piano scales returning to their lowest note,
making it harder for us to remember
what we sounded like at our peak.
It’s as if illness snuffs out a flame,
reducing our identity to an outline of trailing smoke.

TWO
Illness and I have spoken at length
and now any pause is as uneasy as
the silence after a door is slammed.
Life fluctuates between fear and gratitude
like a frail man grasping a handrail,
teetering on a steep journey
towards what used to be.

THREE
Illness broke a window in my neighborhood
and I swept up the pieces while listening for sirens.
We live on the border of infirmity,
determined to ignore the sounds of malaise
with our own song.
We hear our melody as a pulsating heart.
We wait for each beat to fill the silence.

COMMENTARY
I once interviewed a hospitalized man who had
suffered a stroke. I wanted to learn about his experience of care and to translate his voice into ideas for improvement that I would share with the hospital. The conversation was halting and alternated between lucid moments in which he was charming and informative, and instances in which he forgot where and who he was. It seemed that he was fluctuating between an existence in which he was fully present and one where he was an outline of his former self. When I left the room, I had to consciously remember him at his full potential instead of focusing on the times in which he seemed to be missing.

Months later, on another project, I interviewed people who were hospitalized with cancer. Their rooms were decorated with photos of their healthier days - family celebrations, fishing trips, and professional portraits. From these conversations I learned that, with time, the clinical team, the family, and even the patient himself needed mementos from the days before he was sick. Cancer was so powerful it could make people forget the semblance of health.

What I learned is this - you don’t have to become severely ill to learn about the tenuous nature of health and the impact of infirmity. Interviewing people who are sick, and the dedicated providers who care for them, is enough. The ultimate lesson I strived to learn was how to move forward well; in other words, how to find the balance between enjoying good health without taking it for granted or living in fear of what might come.

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For You

Author: Fae B. Kayarian

At first, I felt more like a gawky invader than a volunteer musician upon entering your egg-shell room in my mute pants and iron blazer. Your family stood like stone chess pieces, cold and somber, arms heaving with weeping-willow aches, swaying at the feet of your bedstead.

My ukulele squirmed from my bag and your eyes flickered opaque under the armor of pain and resolute that the cancer clawed through. So I played the song I knew the best and promised we would travel to a place way up high, where blue birds fly, to somewhere else, somewhere over a rainbow.

Your sobs were the lyrical accompaniment that carried my Garland chorus in crashing, ghost-form waves. Yet I continued strumming my Ode to Oz, upon seeing your eyes that had set themselves free and true. I have never played for anyone like I played for you.

I have never played for anyone like I played for you. Your granddaughter clutched your face as I poured over the chamber of sound letting your crying echo in every corner of my memory and fill the clinic hallways with deep blue. I have never played for anyone like I played for you.

At the end of the song we all returned to the room, and came back to our side of The Rainbow. I said goodbye and, in return, your eyes told me that you knew I have never played for anyone like I played for you.

COMMENTARY

The reason I get up in the morning is to visit patients in the hospital. There is something about sitting beside a patient and witnessing their human vitality that brings me the deepest fulfillment I can imagine. Each visit stays with me, latches on to my being, and becomes embedded in the stitching of my own human narrative. As a hospital volunteer, I have shared moments in silence and in laughter, in joy and in grieving, all moments that celebrate the human connection between a visitor and a patient.

This particular poem describes the story of a patient I visited one unassuming Sunday morning on the Neuroscience Step-Down unit. This patient let me into her room for a visit, where I was immediately welcomed by her family, all pale-faced and drained of energy. It was evident that the prognosis was not what they had hoped for, but they had still ushered me into their hospital room with warm, sincere hospitality. Seeing how sick this woman was and how broken her family had become left me at a loss for words. Not knowing what to say, I let music provide the comfort that I alone could not. With her permission, I played my favorite song, “Somewhere Over the Rainbow”.

From the first strums of the chorus to the last pluck of my strings, the patient looked up at the ceiling and audibly sobbed. There were times during the song when she wept just above a whisper, and others when she was practically screaming with grief. A handful of instances, I almost stopped playing all together, in fear that I was causing her distress or pain. Yet, each time I looked to her, she returned my gaze and pleaded for me to continue the music, to keep playing. Out of all the visits I had ever experienced, few had been as raw, as heart breaking as this visit. All the while, her family sat alongside her and duet of my ukulele and her crying.

Looking back on this visit, I have realized that, for her, the music was a medium of grief and resilience, it was a way for her to vocalize her pain. Therefore, I want to dedicate this poem to her, and to thank her for letting me play for her on that day. It is an honor and blessing to say that I have never played for anyone the way I played for her. Thank you and bless you.
Debora Paterniti and I once wrote an article called “Building a History Rather than Taking One.” I was quite proud of this article, because it had what I thought was a unique perspective and innovative take on the data-gathering phase of the medical encounter. The journal that published it enlisted Frederic Platt, one of the early giants in the medical communication literature, to write an editorial about it. I reveled in Deb’s and my success in “making a difference,” one of my core aspirations at that point in my career.

About three months after the article came out, I received a letter from a “Dr. Shochet” in Florida. Dr. Shochet was retired, and had received a copy of Deb’s and my article, and wrote a brief note congratulating us, and offering an article of his own that he thought I would find interesting. In the envelope was a yellowed reprint of an article, from a journal that no longer existed, and published in 1965 (the year I was born). As I read through the article, I broke out in a cold sweat. The ideas in this article were exactly the same as the history building article! It was so close that, at best, it felt like Deb and I really had not said anything new, and, at worst, looked like we had plagiarized this forgotten paper. I had a friend, Rob Shochet, a fellow ACH member at Johns Hopkins and whose name was spelled the same as the Dr. Shochet from Florida, so I called him up.

“Rob, do you know a Dr. Shochet who is retired and lives in Florida?”
“Yeah, that’s my dad.”
“Rob, your dad found a copy of the history building article…”
“Yeah, I gave it to him.”

“ROB, it looks like we plagiarized an article of your dad’s! Did you know about this? What do I do? Should I retract the article? Am I guilty of scientific misconduct? WHAT DO I DO?!??”

“Oh, relax – Dad wanted you to know that the really important ideas never go away, they get carried forth from generation to generation, and he wanted to congratulate you on carrying this particular idea forward.”
LETTER FROM THE EDITOR

It was in that moment that I had a life and career-altering realization. I had been so fixated on changing the world that I lost sight of the fact that making a difference is not necessarily something writ large, but perhaps being part of a community that nurtures, keeps, and carries forward the really important ideas.

*Medical Encounter* has been a community carrying forward important ideas since the early 1980s. If you read back through the archives (an activity I highly recommend), you will find some of the biggest ideas in the communications literature being worked out in our little newsletter before they hit the prime time. It has been my honor to be one of the stewards of this community, and I look forward to participating in our ongoing conversations as we transition to a more dynamic, interactive, and online community. Now, everyone can carry the important ideas forward! I am forever grateful to Alyce, Beth, Fred, Aanand, Gretchen, Mike, Jack, Monica, Kit, Chris, Shak, Adriaan, and the rest of the editorial board who have participated over the years, and to the ACH staff who have tirelessly worked to do all of the mundane but critically important tasks that have made our publication a reality for so long. I also want to thank Dennis Novack, the originator of *Medical Encounter*, who has been a guide, mentor, and believer in the publication from the beginning.

While it wasn’t strategically planned, it is not lost on me that our last issue has “narrative” as such a strong theme running through all of its columns. Times change. Publications come and go, but the ideas and stories do not. What is important is not so much the medium of our community, but rather our community itself, and the stories we share. Let’s go and carry those stories, those big ideas, into the future!

Peace,
Paul Haidet

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