MennoExpressions

A Publication of First Mennonite Church of Indianapolis, Indiana

Volume XXIII, No. 3 **February 7, 2010**

Sickness & Health

The Joy of Medicine

by Martha Yoder Maust

During my last year of residency I heard a speech by a family physician who was glad to be retiring just at the time when medicine was undergoing a lot of changes. He said he felt sorry for those of us who were just getting started.

That was about 26 years ago. Since then managed care has become more pervasive, premiums and co-pays have gone up, benefits have gone down, patients who have insurance have fewer choices, and the number of uninsured patients has gone up. The paperwork is more extensive, the privacy regulations are tighter, it's harder than ever to keep up with the new advances, and the threat of litigation looms in the background.

I hate the paperwork, I admit. I suppose every job has some unlovable parts. Aside from that, I think I have a very good job. Let me tell you what brings me joy.

I started in medicine because I loved science, and because I wanted to help people. The science continues to be fascinating. I still find myself in awe at times as I describe a body function to a patient. It is remarkable how complex the human organism is, and I love knowing something about that.

Helping people has turned out to be the strongest motivator. I work in a community health center, where many uninsured patients come for medical care on a sliding scale. Most of them are very grateful for the care they get, and grateful to be able to see one doctor consistently for years. Sometimes I can offer a cure, often a treatment, and always a measure of caring and empathy.

Of course, not all of the patients are grateful and pleasant. Some are unwashed, some are belligerent, some are whiny, some are drug addicts, and some are totally confused. Sometimes I have to mentally recite the prayer of St. Patrick to myself before I enter the room: "Christ before me, Christ behind me,…let all around me be Christ."

Even with the most difficult patients, I am conscious of being in a position of great privilege. Patients confide in me. They trust me with their bowel problems, their chest pain, their drug habits, their sexual problems, their marital problems, sometimes even their faith struggles. They tell me things they have not told their families, their spouses, or even their priests. They share all of this with me, and I receive it respectfully. I am convinced that this interaction—the telling and receiving of what is most troubling to the patient—is at the heart of our physician-patient relationship. Any healing that might happen starts at that point of vulnerability. This is a sacred trust, a humbling trust, and I strive to do my part faithfully.

This is the source of my joy.

Health Literacy

by Carolyn Martin

26% of Americans do not understand when their next medical appointment is scheduled.

78% do not understand the warnings on prescription labels

86% do not understand the rights and responsibilities section of a Medicaid application

$50-73 billion dollars were lost in healthcare expenditures due to low literacy

[Data from a 1998 presentation by the National Academy on an Aging Society]

Many of us think of ourselves as very educated. Many in this congregation have some medical association. But when you're in a medical situation yourself, it's hard to think clearly. Things go in one ear and out the other. You can't think of any questions at the moment. Maybe you're feeling rushed. Maybe you don't want to appear stupid. Our own level of literacy suddenly drops. Just think if you had a horrible accident, heard a dismal diagnosis, lacked sleep, were in an unfamiliar town or hospital or had an unfamiliar language spoken to you. Your literacy level would drop considerably.

What is Health Literacy?

"The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions." Healthy People 2010, US Health and Human Services

Unfortunately, low literacy or low health literacy is very real and very common and most of us don't even realize it. We don't know the extent people go to hide their low literacy. We don't realize the cost to ourselves or to the health care system. But if hospitals, health care workers, etc. would take the time to explain using living room language (not talking down but talking plainly) or some other literacy strategy, we could all benefit without feeling inadequate. What benefits those who need the extra help benefits us all.

Information written at a 4th grade level will allow a large part of our community to better understand their health with dignity.

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Health Literacy, cont. from p.1

For physicians and other health care workers (this includes the reception desk):

- Look for clues that may indicate a low level of reading such as holding on to the paperwork for a long time, a shortened temper, frequently missed appointments, the patient saying they forgot their glasses.
- Use living room language and/or the teach-back method to communicate health information.
- Don't just take a nod or "yes, yes" as understanding. DO NOT ASK "Do you understand?"
- Don't rush people to sign or speak quickly.
- Don't provide too much information at once.
- Offer to write down the diagnosis.
- Help patients fill out any paperwork.

Remember, low levels of literacy have contributed to the high cost of health care, medical errors, and poor outcomes.

Below are some web resources for health care workers:

http://www.ama-assn.org/ama1/pub/upload/mm/367/healthlitclinicians.pdf

http://www.ama-assn.org/ama/no-index/about-ama/8035.shtml

http://www.ama-assn.org/ama/no-index/about-ama/9913.shtml

For patients:

- Bring someone along that you feel could help as an extra ear and be an advocate for you.
- Don't be afraid to ask the clinician to repeat what they said.
- Write or have the clinician write down the diagnosis, medication, procedure.
- Don't forget, feel free to contact a hospital librarian. They can't diagnose but they can look for information on health topics that's easier to read and understand.

Remember, you have the right to understand your health. Below are some web links that you might find helpful regarding health literacy as well as health information.

For health information, the best is www.medlineplus.gov. Medical librarians use strict guidelines when selecting websites to include on Medlineplus. Little, if any advertising is allowed. It's all arranged according to diagnosis, overviews, etc. from authoritative websites. Medlineplus does not create the information but selects and arranges it.

For health literacy:

http://www.npsf.org/askme3/

http://www.mlanet.org/resources/medspeak/index.html

Defined:

In 8th grade we were asked to complete a 'values survey,' choosing from a long list the 10 or 20 things/ideas we valued most, and ranking them. From a class of 30, I was the only who didn't value health. I remember standing in the classroom, across the room from everyone else ("everyone with health in your top three go to this side" the teacher had instructed); it was the first time I recognized that chasm. There were so many more important things on my list: friends, family, pets, music, nature, freedom, world peace. How could health be so vital?

I was also bald and in a body cast at the time. To that point, life had been one long chain of minor medical conditions; my childhood cardiologist (for a heart murmur) had found the scoliosis early, after a couple years in a brace I had surgery in 8th grade to correct part of the curvature (hence the body cast), and the time in the hospital had led to the unusually early diagnosis of a benign brain tumor (hence the baldness). Add allergies and asthma to the mix, and I was a mess - not someone with anything life-threatening, but with a long and impressive list of problems. For the first 16 years of my life, that list defined who I was. I was the miracle kid (no one expected the tumor to be benign), the weak one, the one to be watched and protected.

Most of my life, I have alternated between resting in the refuge of weakness and struggling to develop a stronger attitude toward my own health. The extremes have always been there - periods of good habits and vegetarian, bike-riding friends and periods of laziness and too much fast food; periods of Cadillac healthcare plans and one terrifying uninsured month after being turned down by three different insurance companies; a sense of self-pity that I can't stand up straight, and a desire to spend more time stretching; a desire to give in to illness and a determination to make use of my mental, emotional, spiritual, financial and physical resources to improve things.

The key to good health, or rather, the way I keep myself moving in the right direction is to focus on what I really, really want for myself. Deep down, I want balance and longevity. Deep down, I'm happiest when I'm reveling in a vegetarian stew or the clarity of mind and body after a workout. I remember the day I was trying to treat myself, and I picked up an orange and a chocolate bar. It took half an hour of debating (no, really – I stood in the supermarket for half an hour going through the pros and cons) before I realized the orange was what I really wanted. The chocolate bar was my intellectual ideal of indulgence, but the fruit was more honestly irresistible.

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***MennoExpressions* is published five times a year by First Mennonite Church, appearing bi-monthly on the first Sunday, October-June. Any correspondence should be sent to the editor at 4601 Knollton Rd., Indianapolis, IN 46228, U.S.A. Email: fmc@indymenno.org**

Diagnosis

By John Hofstetter and Aimee Mayeda

Is a diagnosis a benefit or limitation, a boon or a bane? Usually, we take the symptoms of our illness to our doctor. We want his or her diagnosis and a treatment that will resolve our medical problems.

Capturing the symptoms

On the plus side, a diagnosis can be what we desperately need. To have something go wrong with your body and to not know either what is happening or why it is happening is terrible. A physician's diagnosis at its best can put your symptoms into a recognizable form – give them a name, an organization, and surround them in a wealth of scientific data. It can help you corral illness and manage it psychologically and physically. You feel like you know what to expect. Unfortunately diagnosis can also bring with it some downside as well.

About five years ago, John began to have infrequent but very disturbing bouts when he suddenly felt light-headed and cold. His heart felt like it was beating erratically but harder than usual. He had a bad feeling in his lower chest. Was this a heart attack? As he got more anxious, the symptoms got worse.

One especially terrifying episode occurred in the middle of a 3-hour airplane flight. Luckily, by the time we landed, the symptoms cleared up. More often episodes started in the middle of the night.

During one episode we visited St. Vincent's Emergency Room. But as we waited our turn the symptoms went away. The doctor could not explain what had been wrong – there was no diagnosis.

Again last year we visited St. Vincent's ER. This time there was a diagnosis: atrial fibrillation. That is the name tag for the condition where the atrium, the top part of the heart, beats more than twice its normal rate; the bottom of the heart beats more slowly, but irregularly. The heart beating in this disorganized way keeps blood from being pumped effectively.

Fortunately, this diagnosis led to treatment that got John's heart back to normal: his heart suddenly reverted to a safe rhythm during an overnight stay in the hospital on medication. He immediately felt better. The doctor told us if his heart hadn't resumed normal rhythm by the next day, he would have given it an electrical shock to "reset" it.

Getting a diagnosis was reassuring. A comforting name tag captured the confusing, intermittent, unpredictable. The doctor told us what to expect, what treatment could work. To know what we had been dealing with for so many years and that there were treatments felt good. It was a relief. We didn't need to make up other terrible scenarios.

However, getting the diagnosis led to limitations. The doctor could not explain why atrial fib happened – disappointing. He predicted repeated episodes, but beyond staying indefinitely on a strong heart medicine, he gave no preventative. John might have to limit vigorous activity, but otherwise cautiously resume regular activities.

A diagnosis can lead both doctor and patient into a mire of limitations. The doctor easily falls into the trap of seeing each patient as an idealized form of an illness and communicates his or her expectations based on that story. Diagnosis carries the illusion that the condition is under their control, but may not take into account a patient's individual experience of illness.

Loosening up the diagnosis

John decided to try to loosen the limitations accompanying the diagnosis. Reasoning that episodes happened only every few months and counter to recommendations, John stopped daily heart medicine.

Then, in the weeks that followed, we found reports on the Internet linking atrial fib with gastro esophageal reflux (GERD), a severe indigestion. All the reports were from patients, not doctors. They wrote that atrial fib went away when they controlled GERD. At first, managing a heart condition by treating one's stomach seemed like nonsense. However, one sufferer claimed it was sensible because the esophagus sits alongside the atrium and GERD irritates the esophagus. It also resonated with John's recollection – before episodes, his GERD would get worse.

Avoiding lots of food he likes, raising the head of our bed, taking antacids and other acid-controlling meds -- John began to aggressively treat GERD. And Success! He has had no more episodes of atrial fib.

Surprisingly, when we returned to the doctor, he couldn't hear our success. Didn't it fit his understanding of his diagnosis? Not using the medication displeased him. Now John had the diagnosis called "non-compliant patient."

Dealing with a new diagnosis

Now John and I are dealing with a new diagnosis: aging. We search for the lessons our experience with the diagnosis of atrial fib teaches us. The words in any diagnosis are a blunt tool enabling communication and efficient, coordinated action. Having a diagnosis is helpful; we easily accept that we are wiser than when we were younger. But the diagnosis of aging can be very limiting, especially in our culture. We can be locked into expectations without really considering them: that our memories will fail, that our stamina will be limited. To prevent words from choking off our personal experiences, growth, and fulfillment we must decide daily what this diagnosis means.

Aging

by Mary Liechty

We all have traits that define us, even some by which we are solely known. Recently I have been thinking about the process of aging and how it redefines us against our will. How we handle that says a lot about who we are underneath all the definitions.

Take my grandfather, for example. He was known as a philosopher. Carl T. Habegger had an eloquent manner of speech. He loved to explore ideas, to consider thoughts outside the usual ones. I defined him as a kind and loving wordmeister who loved to put concepts into vocabulary pictures. I used to just listen to his words and feel them wash over me and around me and through me. There was something in them that made me hopeful, positive and calmed. If people could express themselves like grandpa, then the world could only improve.

This tender man who loved his words suffered a series of strokes as he aged, leaving him with aphasia. No longer could he weave those beautiful phrases. I was pained for him as I thought about what this loss would mean to him. Who was he now, without that defining vocabulary?

Then, slowly, I began to know the man under the definition. Grandpa-without-words had a glint in his eye. He would attempt a thought, it would come out horribly botched, and unbelievably, he would laugh. If you told him that he had just said, “I am going to the cemetery” (instead of the kitchen), he would smile, give a large guffaw, and keep that glint as he looked you in the eye and headed to the kitchen.

When I brought a boy home, he was determined to shake the fellow’s hand. If the young man gave a solid hand-shake, he would turn to me and smile, grunting approval. If the handshake was less than satisfactory, grandpa would catch my eye and grimace. I had no doubt about his opinion.

Grandpa chose to claim the soul within himself that took joy in forming phrases, and simply bypass the words. He chose to be joyful and let his spirit shine right through the aphasia. Never had I understood him so well.

I think that is why I was so disturbed when Grandpa’s health finally dictated that he would require 24 hour nursing care. He was positive about going into the nursing home, but it was a tough move for him. I would go visit him and stand outside the door, listening to a well meaning aide talk to him in a baby voice as she fed him, assuming that his lack of language skills meant a lack of thought. I would often go in and ask if I might finish the feeding task. Grandpa would look lifeless behind his eyes. Once the aide was dismissed, however, I could feed him without the babying and the light would begin to return. I could acknowledge his courage and his frustration, then give him a few gems about the world outside. His eyes would focus again. The glint was there – frustrated and resigned, but there.

Grandpa often said, “won’t it be exciting to die? THEN we will know the answers!” I wonder what he knows now.

My mother, grandpa’s daughter, is 90 years old now. She has been defined in many ways, one as an independent, high-energy woman who walked so fast few could maintain pace. She was also defined as a musician, a singer, a woman with a voice like an angel, a teacher of others.

As mother has aged, she has lost good use of her legs. She walks, but with a walker and very slowly. For a woman who has always been accustomed to setting the pace, this is a significant change. It has compromised her significant independence.

Mother has also lost a large percentage of her hearing. When one hears poorly, one cannot sing well. It is hard to pick out pitch and choose a harmony.

Mother has refused to allow a full re-definition of herself. Yes, she is slowed in her pace, but she can choose to ask for help. She attends a large number of the sporting events at Bluffton University in spite of her mobility problems by allowing others to pick her up and deliver her. The athletic department has reserved a seat for her at each event.

Many who lose hearing withdraw from the world around them. Mother has decided she would rather participate in that world in spite of the fact that she will have to clarify many things and miss some of the jokes. She, the musical perfectionist, has determined she will sing even if her hearing prevents her from landing on the perfect pitch and her voice croaks a bit. And she continues to grab teaching opportunities as they present themselves; in preparation for teaching, she continues to keep an active mind and remains a learner.

Certainly, I have learned that aging is not for wimps. Ask me sometime about my father’s favorite poem about the “golden days.” It is not printable. How we respond to aging makes all the difference. Dad responded with humor – slightly off color. It got him through and gave us a few giggles, too.

As participants in this world we also have a responsibility to find the individual within the body that is declining. Do you talk to the person in the wheelchair, or to the person pushing that chair? Do you assume the person who is sick in bed cannot hear you, or do you speak directly to them? How do we give dignity to the mind inside the failing anatomy?

I am not yet aged, but I am aging. My hair is grey, my joints hurt, I take medications for issues commonly associated with bodies that have lived for quite some time. What choices do I need to make about this process?

As I teach, I notice students respond to me differently than they used to…at least when they first see me. I work for a health education center in Indianapolis and am sent out to teach various health topics in nearly every school in central Indiana. Last year, in a middle school, I arrived and waited for a group of 7th graders. As they arrived I heard one, “Oh no…she’s OLD! This is going to be boring!”

I find it takes me an extra few minutes these days to prove to the young people that I might have something to say. They are skeptical for the first five minutes. I have even had conversations with younger co-workers about what they feel is “appropriate” for me to teach as I age.

See **Aging,** page 6

Does Prayer Work?

It depends on who you asked.

by Becky Oberg (originally published November 9, 2009 on examiner.com)

Writer Hugh Miller called prayer "so mighty an instrument that no one ever thoroughly mastered all its keys." Apparently even science can't call all the tunes.

While prayer studies cover numerous medical concerns, the most well-known may be the ones involving cardiac patients.

The first study on the effectiveness of prayer was published in England in 1872, but Americans did not start researching the subject until 1988, according to Wikipedia.org. In that study, San Francisco cardiologist R.C. Byrd found that patients who received prayer to the Judeo-Christian God required fewer medical interventions while hospitalized. A 1999 study in Kansas City, Mo. found similar results, but did not specify the type of prayer.

According to PubMed.gov, a service of the National Institutes of Health(NIH), a 2001 study at the Mayo Clinic study found prayer had "no significant effect". A study by Duke University reached similar conclusions.

One study, published in the American Heart Journal in 2006, found negative results. The researchers concluded that while prayer itself had no effect on a cardiac patient's recovery, patients who knew they were being prayed for had slightly higher instances of complications.

The discordant results of the prayer studies haven't affected prayer's popularity among Americans. According to NIH, prayer for one's health is the most popular form of complementary and alternative medicine(CAM), with 43 percent of all CAM patients using it. Prayer by others for one's health is the next most popular form of CAM, with 24.4 percent using it.

References for this article are on page 6.

The Solution

by Robin Helmuth

The 'solution' to the health care 'crisis' is very complex and I won't even pretend to know any or all of the answers. However, my perspectives are a blend of being a physician for 25 or more years, being a patient multiple times, having parents on Medicare, having family members on Medicaid and having family members without any insurance. Some components of a "workable" health care plan to consider:

1. Elected and appointed government officials at all levels must NOT have access to any health care/insurance plans which are not accessible to the general population.

2. Elected and appointed government officials at all levels must pay for health care in the same manner as they require the general population to do.

3. U.S. hospitals and staff should not be required to provide medical care for all persons who show up for evaluation. Most other countries won't treat U.S. citizens unless there is a guaranteed pay or. In essence, we cannot provide and pay for health care to the world. I'm all for community based/volunteer 'free' clinics.

4. Medical malpractice/ insurance laws should be reformed to allow emergency departments to truly discern between urgent/emergent and convenience/non urgent medical needs without threat of being sued for 'abandonment.' If these laws aren't changed, then the emergency departments should be permitted to expect up-front payment.

5. Some of these components may seem harsh, but health care facilities need to be financially viable today in order to be able to provide care for future patients.

6. Last, government and lawmakers should work on areas in which they have a proven track record of being successful and efficient - and, health care is not one of them.

Aging, cont. from p. 4

I realize that sometimes others will try to limit us and underestimate us as we get older, at least in western society. How will I respond to the expectation that I become boring and unable to relate to certain sets of people?

I could become outrageous. Isn't that what the poem , "When I get Old I Will Wear Purple" is about? I could become defiant. Or I could become defeated. I could hide away. That is my natural tendency as an introvert (yes, I am an introvert.)

Or I could work harder to lose weight and improve my muscle tone. (I work at that…really, I do!) I could continue to challenge myself to learn and grow. I could see it as a mission to teach children that people with grey hair do have interesting things to say!

The point is that I have choices. I can see myself as still growing, not as "already grown." I can think, process, and act on what is possible.

How we respond is often a choice, but not always. Few physical declines can be more difficult than in the case of Alzheimer's or another type of dementia. I worked in an Alzheimer's research clinic. When the brain is being robbed of the core personality, the individual affected will eventually be unable to find him or herself. They can no longer choose to respond in one way or another. It seems and feels remarkably unfair.

So while I have the ability to choose, I must challenge myself to choose growth, and joy.

Doing anything else would certainly be in opposition to my heritage!!

Defined, cont. from p. 2

The people I surround myself with (and have since college) have nudged me in the right direction. Almost all my best friends have been vegetarians. They have been hikers and backpackers and runners. They have been people who love hosting friends for a meal of glorious tilapia on the grill or fabulous homemade beans & rice. I usually fall short when I compare myself to them, but at least I'm aiming high.

When I think about the constant battle to stay on healthy ground, I'm thankful that my instinct is to do what's best for me. I'm honestly the most happy when my habits are healthy. Which leaves me with my stiffest challenge – to view myself as worthy of being happy.

Sickness and Health is a battle in so many ways. It's a battle against nature (or against elements people have introduced which disrupt the natural order of things), against societal norms, against conflicting political opinions, against time. In the pages of this issue are a handful of stories detailing the battle and the ways people find to keep fighting.

Food for Thought

By Devon Miller

Meatloaf! Yes, meatloaf, I am sure all of us have eaten it at some time or other. There is good meatloaf as well as bad meatloaf. Food magazines are currently focusing on meatloaves, meatballs, etc. Oakley's Bistro featured meatloaf when they opened their restaurant in 2002 and is still being served eight years later. We made meatloaf with added soy protein to enhance food value and make the meat stretch further. Our recipe today is Sherrill Glick's version which is a mixture of extra lean beef and turkey. It also is "healthy" reduced fat, moist, and delicious. Enjoy making Sherrill's version

Sherrill Glick's Applesauce Meatloaf

1 pound ground beef
1 pound ground turkey
1 1/3 cup applesauce
1 cup bread crumbs
1 teaspoon salt
1 teaspoon seasoned salt
4 eggs beaten
1 cup of chopped onion
8 ounces of mushrooms chopped
½ cup ketchup
½ cup brown sugar
¼ cup mustard

Sauté mushrooms and drain. Mix the first eight ingredients. Spoon into an ungreased loaf pan and set aside. Combine ketchup, brown sugar and mustard. Spread over meat mixture. Bake 350 degrees for one hour.

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