North Coast Physician

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"Breadcrumbs"

Jennifer Heidmann, M.D.

When I think about what we can do as humans to be healthier, it is useful to make a list of to-do's, like breadcrumbs leading us to safety lest we get lost down some path lined with ice cream sundaes, cigarettes or big, comfortable couches.

Some things we can control. We can commit to moving our bodies, eating actual food (as opposed to the junk variety), getting mammograms and colonoscopies and pap smears, and avoiding drugs and alcohol.

But what if we do all of those things and still get sick? It is a reasonable question that invokes the injustice of life. Life is not inherently fair.

We know more now about intergenerational trauma affecting health, as well as life circumstances we cannot control that impact our health outcomes. Descendants of people who were traumatized may carry some of that trauma in their genes, perhaps making them more susceptible to illness. Likely, strength is also transmitted through those genes, and an ability to survive despite circumstances.

We also know that the social constructs set up around race, gender and economic status significantly impact both individual health and entire populations. If you live in a neighborhood without access to healthy food choices, or where there are not enough doctors to provide primary care, you may have a higher risk of heart disease, diabetes and hypertension.

If you are a Black man and live with the constant fear that you might get shot when out on a run, you might be less inclined to exercise. Insidiously, feeling in danger because of your perceived societal status can produce stress that can increase inflammation in cells and reduce strength of immunity.

This doesn't mean our bodies are different physiologically — race is a social construct, and a human is a human is a human. The injustices we pile on one another across socially constructed differences cause health disparities.

We can despair about all of this, but I recommend doing so only for a few minutes. Despair does not help, but it can force us to acknowledge the suffering we all face, and how we are interconnected. Like with other big issues, you have to name a problem before you can make any progress on solving it.

When my father was put on the list for a heart transplant at age 60, he questioned whether this was the best use of resources. His family and doctors thought it was, but his question still resonates with me to this day. He was not saying his life was not valuable; he was acknowledging the hard fact that while he was getting a brand new heart, many people cannot afford even basic health care.

While some of us can enjoy care from some of the finest medical doctors in the world, others are ignored because of implicit societal biases.

For example, doctors don't listen as well to women as men. We have the highest maternal mortality rate of any wealthy nation, and Black women in the U.S. are about three times more likely to die from pregnancy-related issues than white women. The factors are more about who we are as a society than specific gaps in care: before you will receive the same gold standard of care that my father received all those years ago, your doctor must first acknowledge your suffering and take you seriously.

And to offer a gold standard level of care, we as a society need to be real about resources. The pandemic has pointed out just how closely we ride on the edge of structural stability in health care. As a system geared toward profit, the model is for staffing that is just enough or a little less than enough for demand, and then to glean as much profit as possible from procedures and medications.

But that money does not generally go to the doctors, PAs and nurses who treat you, and certainly not to aides and caregivers. As a physician, I am fortunate in my level of income, but I can also tell you I will be paying off my medical school debts far into my 60s. Most of what we pay for medical care goes into corporate financial pots. Meanwhile, when I admit my next COVID-19 patient, I just hope there will be a hospital bed, and a fresh N95 mask for me to wear.

Our societal to-do list for good health needs to go beyond exercise, diet and regular check-ups. We need to acknowledge the injustices built into our healthcare system, which is just a mirror of our society in general. What if we decided we want to do better for each other? And what if

"Breadcrumbs", Continued Page 22

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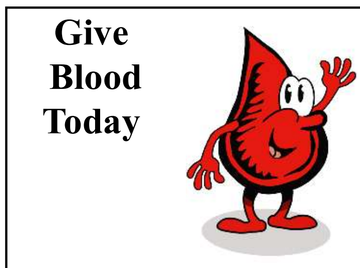
"Breadcrumbs", Cont. From Page 4

we realized that the person walking down the street with mental health or substance abuse struggles is us, could easily be us or someone we love? And even if that person is no one we know, we should recognize that their health reflects the health of our very community at large, so we have to try to do better. Looking the other way is not a plan.

Breadcrumbs make for good directional tools until some raccoon comes along and eats them. It is time to lay down a more substantial trail to follow that will be a whole new foundation for the direction we choose to go as a society, so that good health is a reachable destination for everyone. Institutional bias against whole groups of people is not a sustainable way into the future. What small steps can we each take every day to create a healthier world for all?

—

Dr. Jennifer Heidmann *is medical director and primary care provider at Redwood Coast PACE (707-443-9747), Humboldt Senior Resource Center. This column is reprinted with permission from the December 2021 issue of Senior News. Send comments to seniornewseditor@humsenior.org.*



"Syphilis", Continued From Pg 6

the first two trimesters.

2) Patients should be screened for syphilis at delivery, except those at low risk (ii)who have a documented negative screen in the third trimester.

3) Emergency department (ED) providers in local health jurisdictions with high-CS morbidity (iii) should consider confirming the syphilis status of all pregnant patients prior to discharge, either via documented test results in pregnancy, or a syphilis test in the ED if documentation is unavailable.

4) All people who are or could become pregnant entering an adult correctional facility located in a local health jurisdiction with high-CS morbidity (iii) should be screened for syphilis at intake, or as close to intake as feasible.

5) All sexually active people who could become pregnant should receive at least one lifetime screen for syphilis, with additional screening for those at increased risk.

6) All sexually active people who could become pregnant should be screened for syphilis at the time of each HIV test.

In accordance with these screening guidelines and in response to the increasing number of CS cases in the northern region of California, CDPH supports efforts to expand syphilis screening and treatment including but not limited to the following:

- Use opt-out strategies when offering syphilis screening
- Offer syphilis screening to all individuals at the time of pregnancy diagnosis
- Perform pregnancy testing for any person who tests positive for syphilis and could be pregnant
- Incorporate syphilis screening into routine emergency department care for all patients who are pregnant
- Use rapid syphilis screening tests to screen all incarcerated persons at the time of intake or as close to intake as possible
- Offer rapid syphilis screening at locations frequented by people who inject drugs, including drug treatment and syringe service programs
- Include rapid syphilis screening as part of street medicine or homeless outreach programs
- Continue to screen men for syphilis per CDC/CDPH STDCB screening guidelines, (iv) including in any of the settings described above

To ensure appropriate treatment of all individuals diagnosed with syphilis, the CDPH STDCB also encourages the following:

- Empirically treat persons who have a preliminary positive treponemal or non-treponemal syphilis test while awaiting confirmatory testing, especially if patient follow-up is uncertain
- Arrange field delivery of Bicillin-LA where necessary to reach patients with syphilis who have difficulty accessing routine healthcare services

Additionally, since syphilis can be challenging to recognize or adequately treat, providers should reinforce their knowledge of the clinical presentation and treatment of syphilis, including via the National STD Curriculum, or via virtual syphilis training videos available from the California Prevention Training Center

STD programs and providers in the northern region of California are encouraged to enact as many of the above recommendations as possible, as we work together to find creative solutions aimed at reversing the concerning trajectory of increasing CS and syphilis. As a remind-

"Syphilis", Continued on Pg. 23

MICRA

MICRA online resource center: https://www.cmadocs.org/micra

MICRA Utube Video: https://www.youtube.com/watch?v=kr6qcNP_Kms&ab_channel=CaliforniaMedicalAssociation

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OFFICE FURNITURE FOR SALE. Large desk, lamps (table & floor), black 2-drawer file cabinets, Cannon printers (3), etc. Contact: Niki Moore, Soper Family Psychiatry. (707) 798-0145.

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http://www.hdncms.org/Physician_Educational_Calendar.html

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