Y. Stories to Save Lives

Interview Y-0028
Sabra Hammond
27 June 2018

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ABSTRACT – Sabra Hammond

Interviewee: Jane “Sabra” Hammond, P.A.

Interviewer: Maddy Kameny

Interview date: June 27, 2018

Location: Dunn/Newton Grove, NC

Length: 41 minutes

Sabra Hammond was born in 1956 in Manhasset, Long Island, NY. She remembers having a lot of freedom – taking the subway in Manhattan with friends, going to museums and musicals, and giving walking tours to others. She describes herself as a bookish child who was always interested in healthcare, encouraged by an older family member in the field. She started college in 1973, and remembers viewing pre-medicine as a cutthroat and competitive environment, so she did not initially pursue it, though she still felt she ultimately would. Sabra worked for some years as a freelance artist, writer, and editor, went to law school, and then to Costa Rica. She had a vivid dream encouraging here to go into medicine as a nontraditional student, and followed it, which brought her to P.A. school.

Sabra is permanently living in Asheville, NC, working as a *locum tenens* physician at CommWell Health. She describes the remoteness of this area as a surprise. She discusses communication strategies with patients with low health literacy. Sabra explains that there are some taboo issues, such as documentation, that patients will not discuss with her, which hinders the relationship. In addition, many patients being migrant workers means it’s difficult to assess success. Looking in patients’ eyes when explaining the illness can help, but when working with an interpreter, eye contact is less common. Interpreters may also be unwilling to translate frightening statements as directly as they are intended. Sabra gives an example of using a lock and key metaphor for describing diabetes to patients with low health literacy. This interview is part of the Southern Oral History Program’s pilot project to document health and healthcare in the rural South.

TRANSCRIPT: **Sabra Jane Hammond**

Interviewee:	**Sabra Jane Hammond**
Interviewer:	Maddy Kameny
Interview Date:	June 27, 2018
Location:	Dunn, North Carolina
Length:	42 minutes

START OF INTERVIEW

Maddy Kameny: If you wouldn't mind saying a few words just so I can kind of test out this volume, like tell me what you had for breakfast or something and I'll see if this is working well.

[0:01:38.9]

Sabra Jane Hammond: Okay. So I'm a visitor to this town, and you caught me on my last few days here.

[0:01:46.0]

MK: Oh, really?

[0:01:46.6]

SJH: I've been working here for three months as a *locum tenens*.

[0:01:50.4]

MK: Oh. So how has that been?

[0:01:55.2]

SJH: I love it, the fact that this project takes care of people who are most medically in need and has some pretty solid resources behind it. We have a lab; we have

x-ray here; we have mental health; we have referral resources, albeit not to specialists with money, for the most part, unless UNC picks up the tab. But in general, being able to do ground-level care for people who are really in need is some of the most gratifying work I've been able to since I've been in practice these last fourteen years.

[0:02:35.4]

MK: What was the name of the project?

[0:02:36.8]

SJH: Well, *locum tenens* is basically—it's Latin for "place for a time," and that's what we call temp workers in the medical field. And so they were in need of more primary care physicians or physician assistants and they brought me in from my home in Asheville, North Carolina.

[0:02:58.4]

MK: Oh, okay. Can you talk a little bit about how you got interested in healthcare?

[0:03:05.2]

SJH: I think I was always interested in healthcare. I can remember when I was a little girl, maybe five or six years old, and my then future cousin-in-law showed me, at a Passover Seder, showed me that his hands were all red, and he said, "See those? That's dilation. Alcohol dilates your blood vessels," because he was a medical student at the time or he was a premed student at the time.

And the next year I came up to him and I said, "Show me that your blood vessels are dilated in your hands."

And he said, “You don’t know it yet, but you’re going to be a doctor.” And I actually took that to heart and thought that that was always true.

But when I got to college, at that time—I started college in 1973, and doctors were making a lot of money back in those days and premed programs were incredibly competitive because the people now who are being cutthroat to get to Wall Street or be in the top firms or whatever, they were competing with each other in classes, and they were doing horrible things. They would slice chapters out of the reserve reading in the library and destroy each other’s notebooks and homework, and they weren’t enjoying their education. They were there strictly to compete for the very best grades so that they could get into medical school, and I said, “That’s not for me,” and I filed in the back of my head, “Well, someday I’m going to be a doctor.”

Always seemed to be true, but my life took a different path and I went through several different professions until I wound up working successfully as a freelance writer, artist, and editor, and I had a very successful business of my own until I went away to Costa Rica in 1997, probably. And I had a dream while I was there, and in that dream I met a council of people and they told me I was going to medical school and I argued with them. I said, “I haven’t had a science class since high school.”

And they said, “That doesn’t matter.”

And I said, “I defaulted on my loans from law school and I don’t have any money.”

And they said, “That doesn’t matter.”

And I said, “I’m older, and medical schools don’t like nontraditional students.”

And they said, “That doesn’t matter.”

And I said, “Okay. I’m going to medical school.”

And so, mind you, this would have put me in my mid-forties or my early forties. I’d have to do the calculation for you. But it was really rather late in life to start going back, and I did. I went and I did my premed courses, and, in fact, I did get into a medical school and I kind of balked at the $250,000 in loans, and so I wound up going to PA school where I only had to take out about almost $70,000 in loans. And I graduated in 2004, and from the moment I had that dream, when I woke up, it was like I’m in love. I had a secret and I was in love, and I am in love with medicine.

[0:06:23.0]

MK: That’s amazing. I love that story. [laughter] Can you talk about your childhood?

[0:06:30.3]

SJH: I grew up up north on Long Island just outside of New York City, and I spent my time—a lot of the time, people were less frightened about what their kids did back then, and so my mother would drop us kids off at the Queens Line at the subway and we would go into Manhattan. And I was a culture buff, and I would go in and I would go to Broadway musicals and I went to the museums and I would walk Fifth Avenue.

And I used to, by the time I was in college, be able to give people a walking tour of Manhattan that would start at the top and finish at the bottom, all the way to Chinatown. I can’t imagine anymore, but I used to know all of those places and go there, and I thought that Manhattan was the place to be. It was heaven. That was where I was heading for, a great big city, great big world. And that waited until I was in law school

and went to the countryside on a cabin on a frozen pond with my karate class and saw the stars for the very first time, and I became a wannabe country girl ever after that.

[0:07:45.6]

MK: So you told me that you live in Asheville, but you're here visiting Dunn

[0:07:51.5]

SJH: There are many like me, the *locum tenens* group. It's a little bit like being in the French Foreign Legion. If you're there, there's a reason why you're there, but they are the traveling crew of temporary medical workers, and we take jobs where we're needed. We cover vacations, we cover gaps between hiring and people getting trained up or when they're having difficulty hiring something. And so, yes, my home is in Asheville, and I take jobs sometimes in the—you can see from the beadwork that's about to die on my dying stethoscope, sometimes on Indian reservations, and I go from place to place and I work for a few months at a time at different locations.

[0:08:40.6]

MK: How has it been adjusting to the culture here?

[0:08:43.8]

SJH: Well, I've been living down South since 1991, so I don't think there's any great culture shock here in terms of the mainstream culture. My first week here, I started to run out of gasoline, and when I realized and I went on my map on my phone and I realized that I was more than eight miles from the closest gas station, that was a little bit of a—that was a surprise, and I felt like I don't think, other than when I was out at the Indian reservations, I didn't think I'd ever been eight miles from a gas station before. But

other than that, the culture here, if you're talking about Dunn and Newton Grove and so forth, I don't think there's any great surprises in that.

The culture, in terms of patient population we're taking care of, that's a little surprising. One always has difficulty convincing patients that they're on a medicine for the rest of their lives, that they must take care of themselves, that they need to understand their disease process in order to maintain their health. But here we have people who are sicker and poorer and more apt to drop their medication regimen, so we have severe diabetics who may be here only part-time, and they come back and I know they've been on medicine and they come back with a hemoglobin A1c of 11, let's say, which is a very high, bad blood sugar number.

And there's some difficulty penetrating into that cultural headset, and I know that's partly because we have different educational backgrounds, but there's also a different set of expectations, perhaps, that they have in medicine. And although I can't ever confirm it talking directly to them, there are frequently stories that I can't know and I'm not allowed to know. They won't say, "Well, I'm undocumented," and they won't say, "I'm a migrant."

And they'll come in and they'll clearly need medications, and I'll say, "Where have you been?" And they say, "Oh, well, I live in—" such-and-such a country, "but I'm just here visiting," as if they're just coming to stay with their children for a while. And I know they're coming here to work.

So I have to find other ways to try to reach them in order to get them to comply with their medication, and I have to do a lot of talking about their diseases from scratch in order to try to get their attention, but I don't know whether I've reached them or not for

sure. If I came back the same time next year and saw the same people, I might have a better idea whether I had succeeded.

[0:11:51.7]

MK: What are some of those ways that you have to talk about the disease to—

[0:11:57.6]

SJH: Well, diabetes, we start with basically understanding diabetes. Would you like to hear my diabetes—

[0:12:09.5]

MK: Go for it.

[0:12:10.9]

SJH: —as if you were a diabetic? Okay. So, sugar, which we call glucose, is the best fuel and the only fuel that most of the cells in your body want to use, but in order to keep those cells from burning up because of having too much fuel in the cell, the cells are locked, and the key to the door which opens up the cells is insulin. At some point in their lives, a diabetic will either lose the ability to make the insulin or they will have had so much sugar floating around that there were more locks put on the door and they become insulin-resistant. Now that you are a diabetic, your body needs help getting the sugar from outside the cell to inside the cell, and when your blood sugar goes up, it means that the sugar hasn't gone inside the cell, so it's an indirect way of our measuring how your disease process is going.

I would use probably much simpler words, but I'm trying to go fast with you. If that sugar stays outside of the cell and floats around in the bloodstream, it does harm. It does harm to the inside of your blood vessels, and that causes heart disease and the

possibility of stroke and a decrease in circulation that ultimately winds up costing people sometimes their feet or their legs. It causes damage to the back of their eyes and causes blindness, and it causes kidney disease. It makes people old before their time and it leads to their untimely deaths.

[0:13:57.5]

MK: And how do people react to that?

[0:14:03.1]

SJH: Well, if I can look them in their eyes and I talk to them—I'm talking to you more on your level. I try to read their level of education, and I'll go slower and I'll use simpler words, but I'm essentially giving you the concepts of that. If I can look in their eyes and I can talk to them and I can gauge who they are, I almost always get someone who is more compliant and who may have some difficulty understanding the medications, but is more willing to work with me.

Unfortunately, when I'm working here, I work with a translator. I very rarely get to see my patients' eyes. They look into the translator's eyes, not into mine. The translators are using even simpler language than I am, and what I am saying is very often—I understand enough Spanish to know that what I'm saying is not what's being said. It's a much cruder form of what is being said, and so I'm not able to adjust my language and adjust my tone as well when talking to people.

And when I start—if I feel like this is someone who only will respond to the most primal kind of motivations, then I am more likely to say things like, "This will kill you." And the translators don't want to say that, and so I think my success rate is probably considerably lower when I'm working in translation, and I am somewhat frustrated, but I

have a goodly percentage of patients who are coming back and adjusting their medications with me and are coming to see me and whose blood sugars have gone down from the greater-than-400 on the day they walked to every day being under 200 most of the day, and that's quite a success.

[0:16:04.0]

MK: Yeah, absolutely. How was health and healthcare addressed for you when you were growing up in your family?

[0:16:11.3]

SJH: I came from a very medically literate family, and we went to a doctor for care and we had insurance most of the time, and if something was wrong, it was expected to be taken care of. There was a consciousness about the cost of medical bills and medicines, but it was considered to be *the* thing, and the important thing. And my mother used to joke that she'd gotten her medical degree from *Reader's Digest* [laughs], and so she was always going around diagnosing and discussing things, medical and whatever. So health was like good food and culture. It was a thing that was known and talked about and considered to be a baseline part of who we were.

[0:17:05.9]

MK: Do you have a sense of how your parents, how they grew up with the culture of health?

[0:17:12.6]

SJH: My father had an older brother who became a doctor, which was a very big and important thing then, and so health was considered important to them too. I don't remember really talking to them about—except for small anecdotes. But my father was

born after his father had gone away to a sanitarium for a long time with tuberculosis, so in those days, that's how they treated TB. And it was before the age of penicillin, so I remember the stories about the first time he was allergic to penicillin, and I remember my mother's stories about she worked in a medical office and worked an x-ray machine, or the equivalent of an x-ray machine, without any protection. So I know little bits of the stories about what their exposure to medicine was, but I think that the respect for medicine and medical education that I got from them was probably something they were raised with as well.

[0:18:25.8]

MK: What did your parents do?

[0:18:30.2]

SJH: My father was a machinist who worked in the garment industry in New York back when fabric and garments was actually made in Manhattan, and my mother was a school secretary.

[0:18:42.1]

MK: What did you do for fun when you were a kid?

[0:18:46.2]

SJH: I would go to the city. I would go to museums and things like that. I was a nerd child. [laughs]

[0:18:56.8]

MK: Do you have any memories of friends or siblings or neighbors, like things that you guys would do together?

[0:19:03.1]

SJH: That's a hard one. You know, when I was grade school, my best friend lived next door, and my parents would remark on it or her parents would, because we were both readers and we would go to one house or the other and then we would sit next to each other and we would read. [laughs] So I don't know if that answers your question.

[0:19:30.7]

MK: Yeah. So did you live close to things to do in the city?

[0:19:38.2]

SJH: Right. It was probably a ten-minute drive to the subway and then a subway ride into Manhattan, and so I went to see—nowadays, Broadway tickets are thousands of dollars, literally. In those days, they were maybe thirty or forty dollars for a seat, but if you went the same day, you could go to the tickets booth in Times Square and stand on line with all the other people who wanted cheap tickets and you'd get tickets for half price or less, so you could see Broadway shows.

[0:20:13.7]

MK: Wow. Which ones did you see?

[0:20:16.8]

SJH: I saw the original cast of *Hair*, I saw *Jesus Christ Superstar*. I had tickets from my uncle to see *Fiddler on the Roof*. I saw some experimental theatre in the sixties I can't remember the names of. I probably saw many, if not most, of the musicals that were around in the late sixties and early seventies.

[0:20:40.9]

MK: What about your grandparents? Did you grow up around them?

[0:20:44.4]

SJH: I grew up on Long Island, and my grandparents, both sets lived in Brooklyn at the time, so, no, we were really not an extended family. And I would see them when they would come for visits or we would go to see them, and so there wasn't a lot of intergenerational—and my mother was an only child. My father was the youngest of four brothers and he was kind of the afterthought baby, and I was the youngest in the family and I was, as my Grandma Sarah [phonetic] used to say, the baby's baby. And so there was not an awful lot of family togetherness.

[0:21:16.3]

MK: Had your family lived in New York for generations?

[0:21:21.3]

SJH: My grandmother's family—my grandmother was, I think, second generation, and she came from German and Czechoslovakian Jewish origins. My grandparents were married in what we used to call Russia and was somewhere in what became the Soviet Union, somewhere on the Russian border, and after they were married and had kids, my grandfather came via Ellis Island by himself and established himself as a tailor here in New York and then went back and got his family and then sent money over and brought his whole family back over. So my father was the only one of his brothers who was actually born in the New World.

[0:22:08.8]

MK: Wow. Where did you hear those stories from? Your parents or your grandparents?

[0:22:12.7]

SJH: Or my uncle as well. My uncle late in his life, late in his very long life, became interested in genealogy and, in fact, went back to the old country to find the town that had been there where my grandparents were, which had been a Jewish town with a yeshiva, and now had either no Jews or single-digit number of Jews, and the name of the town had been changed from a Jewish name to a Christian, and it had basically been wiped out in World War II.

[0:22:50.8]

MK: Have you been back to that area?

[0:22:54.7]

SJH: I have not. I have not. Growing up in the post-World War II generation, it's interesting, there's a sense of separation, I think, and we all grew up knowing that Jews had been exterminated during World War II and we all have—I bet all of my friends know exactly where their passports are and know where their Anne Frank room is in their house. I certainly do. But on the other hand, it wasn't until I was much older that it really occurred to me that other people have relatives in Europe and know who they are and have a sense of continuity of New World and Old. I didn't have that connection and I didn't understand that I had lost that connection.

[0:23:43.3]

MK: What do you mean by Anne Frank room?

[0:23:44.9]

SJH: If you had to go into hiding, where in your house or apartment could you wall off in to make a secret room and be hidden from the powers that be.

[0:24:01.4]

MK: So was that still kind of talked about in your community, like, in New York or—

[0:24:08.7]

SJH: You know, I had a conversation, I'm trying to think, not that long ago with a friend just to confirm that, yeah, she had that too. It wasn't even something that we talked about a lot. We all read *The Diary of Anne Frank* growing up and we probably talked about it when we were kids, and it's not something that's talked about a lot, but I have had those conversations recently. It was something that marked us, something that made a pattern, that we had a sense that it could happen here, it could happen to us.

[0:24:44.3]

MK: Do you have any memories of either positive or negative experiences with healthcare providers?

[0:24:54.5]

SJH: I had a lot of illness when I was a child, so I remember both my pediatrician and the internist who took over fairly young, and I remember having good relationships certainly with the internist, that he would talk to me in a way that was about medicine. I was a smart kid, and he would talk to me in the way that it was about medicine. And I guess I liked going to the doctor. It was a place where I thought that—I felt that going to the doctor was kind of a grownup thing. It was the sort of privilege that you get from growing up.

[0:25:41.9]

MK: Hmm. And then later in life?

[0:25:45.8]

SJH: Well, later in life, interestingly, before I had the dream telling me to go to medical school, I had no insurance, which is a big American thing, and beyond that, I was very much involved in New Age ideas, and so I had a chiropractor and I had a naturopath and I had a Chinese doctor who did herbalism for me when I was sick, who I swear could cure anything with three bags of tea. And I had not been to conventional medical care in probably a decade before I had the dream telling me to go to medical school.

[0:26:26.7]

MK: So do you still kind of incorporate some of those ideas or did—

[0:26:31.6]

SJH: I do, to the best that I can. At the very least, I incorporate the holistic understanding. I will occasionally tell people that their problems really are problems that need to be solved from a Chinese medicine perspective. And I feel sad that the medicine I know how to practice pretty much all comes out of a bottle from a manufacturer, so that I don't actually have an herbal background or herbal training—but I do, at least, I see that my medical practice is balanced by the thought that less medicine is better, and more natural is better, and don't over-diagnose, and treat and use home remedies if possible.

[0:27:25.3]

MK: Have you noticed any home remedies of patients that you didn't know existed?

[0:27:30.9]

SJH: That I learned from here?

[0:27:32.1]

MK: Or anywhere.

[0:27:33.4]

SJH: I'm forever teaching them about neti pots and arnica. Those are the two that I bring into the practice most commonly. I'm not sure that—I'd have to think about that, but nothing's coming to mind of a home remedy that I learned from a patient.

[0:27:52.5]

MK: Do you remember any from your childhood?

[0:27:55.6]

SJH: Hot water with lemon and whiskey for a cough [laughter], which these days I add Tabasco sauce to because that spice will dry up your mucus membranes temporarily. And I like to joke that if you're getting a cold, go out for a—this'll be for privileged people, but that the yuppie cure for a cold is go to a Japanese restaurant, because you get hot tea and even the sake is hot, and the wasabi, which is a mustard, member of the mustard family, will clear your sinuses.

[0:28:35.8]

MK: Let's see. How do you care for yourself at the end of a long day?

[0:28:51.1]

SJH: That's a hard one. The hours are *very, very* long here. I haven't—the three months I've been here hasn't been long enough for me to work out more than just, get on the phone with friends and try to decompress. I try not to make alcohol too much of a habit because I'm not burning it off. When I don't live so far from home, I have a daily yoga habit, but the days have been too long and the rooms too small for me to continue it much by myself.

[0:29:33.8]

MK: So did you move from New York—where were you in between New York and North Carolina?

[0:29:40.5]

SJH: I moved from New York to college in Rochester, New York, and London and law school in Boston and a job in Connecticut, where I stayed for about ten years, and then to Atlanta for a job. And when I was very early in my time in Atlanta was when I discovered Asheville, and I knew from the moment I set foot in Asheville that that was where I wanted to live. But Asheville's the kind of place where you kind of have to bring your own job, bring your own career in order to make it, and so it took me from about 1993 until 2005 'til I got a job in Asheville. And Asheville is where I have stayed, except when I go away to travel for work.

[0:30:29.0]

MK: How did you know that Asheville was where you wanted to stay?

[0:30:32.0]

SJH: It was, at the time, a small town with big-town sophistication. It is, sadly, now no longer undiscovered and no longer a small town.

[0:30:46.4]

MK: So Atlanta was your first exposure to the South, then?

[0:30:51.8]

SJH: It was.

[0:30:52.1]

MK: How was that?

[0:30:54.2]

SJH: I got into Atlanta when it was big, but nowhere near as big as it is now. I moved initially to Alpharetta and I had a cottage on a horse farm surrounded by horse farms, and when I moved out a couple of years later, it was a cottage on a horse farm surrounded by tract homes. And the traffic grew exponentially in the ten or so years that I spent mostly in Atlanta. So my relationship with Atlanta started with kind of "A nice town for a city. It's got transportation," whatever, and ended with, after I graduated in 2004, after I graduated from PA school, to "I would not have this on a plate," because I stayed there while I was looking for a job and it could take me an hour and a quarter to go from my hotel room to a friend's house that was less than three miles away.

[0:32:00.9]

MK: Were there any cultural differences that surprised you either there or in North Carolina?

[0:32:08.5]

SJH: People say that southerners are nicer than Yankees, and I'm going to tell you, frankly, it's not true. Southerners will talk to you on line at a cash register. They will make small talk with you as a stranger, and you might very well get a "drop dead" look up North, which is one of the reasons I can't ever move back there. But my memory of the culture when I was growing up was that it was also a very inclusive culture, that a stranger would be taken in as like, "Oh, you're from out of town. You should join us for the holidays." And southerners are much more clannish, and even if they will talk to you on the cash register line, you are still an outsider and it wouldn't cross their mind to bring you into a family gathering.

[0:33:05.2]

MK: Um, what do you see—we talked a little bit about challenges facing this community. Like, you mentioned the diabetes and health literacy.

[0:33:18.3]

SJH: Mm-hmm.

[0:33:20.4]

MK: Do you see any assets that this community has that we can maybe leverage?

[0:33:24.5]

SJH: Well, this facility, in particular, is extraordinary, to have a clean, well-run, well-staffed place where medicine can be practiced, and the pharmacy there. Those are amazing things. And obviously it's well known in the community, which means that people are more likely to get medical care if they know that they can come here, and I think they come here in confidence, knowing that, for example, their documentation status isn't going to be exposed and they're not at risk here. I've had many, many patients in the last three months who would not show up for imaging appointments or radiology or something, and especially who would not show up for specialist appointments or who were afraid to go to the emergency room when they seriously needed emergency treatment, because they are afraid of the institutions elsewhere. The reputation this place has a refuge is huge.

[0:34:27.4]

MK: What do you think is the future of healthcare?

[0:34:32.1]

SJH: [sighs] Ideally, complete collapse of the current system in the United States. I think that the *only* way out is to start from scratch and be like every other industrialized

nation on Earth and have universal healthcare. And it is deeply distressing to be practicing medicine in this country where, no matter where I am, whether it's here where people are very poor but get sliding-scale medicine and treatment, or I am in an affluent suburban community somewhere outside the city of Asheville or outside of anywhere, I rarely have an appointment with a patient where cost does not become part of the discussion. And it's not only disheartening, it's stressful.

We forget—we watched doctors on TV. That's another thing. Where did my medical culture come from? It came from watching medical programs on TV when I was a kid, okay? We watched those programs on TV and we know that they're all over-dramatized and this and that, but in the office, in the day-to-day, it's very easy to forget that medicine really is life and death, and that while the opportunities to save someone don't come along every day and you never do it by yourself, the opportunity to kill someone through a careless decision or a bad decision happens every single day. It's serious business and it is appropriately stressful.

The fact that I have to juggle all of my decisions with cost factors in mind takes something that is appropriately stressful and makes it into something that is inappropriately stressful. And then we multiply that times the documentation quota that goes along with our proving that we're doing medical care, which completely distorts the process from charting what's important to charting what Medicare and Medicaid have said give you enough points in order to be reimbursed. And so it takes a job that is an art and a science and it turns it into bean-counting tinged with fear for your patient because of the cost.

[0:37:06.8]

MK: What makes it worthwhile?

[0:37:10.9]

SJH: When I can help someone and when I can connect with people. Every single appointment that I go in to, I try to see into their heart and into their eyes and try to understand the world from their point of view and try to give them something that will make their lives a little bit better. It's hard being in this body. This meat suit that we wear is subject to wear and tear. It's painful, it's cranky, it's difficult, and to one degree or another, almost every patient that comes into the medical office is saying to me, "I hurt, and if I tell you enough facts about this hurting and that hurting, maybe you can make it so that it's not painful for me to be in this body and alive." And for the most part, that's not true. I can't change that, but I can give them the little things and the perspective that will help them adjust, and I can help them find the things that either right now are affecting them most or that, like cigarette smoking, for example, are the things that are going to make it very, very uncomfortable to be in the meat suit in the future.

[0:38:28.3]

MK: Is there anything else I didn't touch on or anything else you want to talk about?

[0:38:34.2]

SJH: I want to talk about our relationship with emergency rooms, because we have the cost. I've mentioned the cost factor. I've mentioned the fear of being deported if you go to the emergency room. But I want to give you an example or two of what's that like. I had a lovely young woman come to me after four weeks of tonsillitis where her tonsils were so swollen that they weren't touching anymore, they were overlapping and

they were pushing backward into her airway and forward into her oral cavity, and she was miserable with pain and she had waited four weeks to come here because of her fear about cost. I gave her antibiotic and a steroid and I made her come back in two days, thinking this is already a risky problem.

And she came back two days later with her hands and her feet and her face swollen and covered with hives, which was probably an antibiotic reaction, but potentially a serious complication of the infection, and although the tonsils were a little less swollen, they were still big enough to be threatening her airway. And I had to convince her to go to the emergency room, knowing that the odds were if I gave her another shot and a different antibiotic and some antihistamines, that she would not be in a life-threatening situation, but that I couldn't go by odds that she didn't have a deep neck infection or something else, that the possibility, the very real possibility that she had a potentially fatal condition required her to be evaluated in the emergency room, and I did so knowing that the price of that emergency room night, where they did eventually do a CAT scan, discover that she didn't have a deep infection, sent her home, that the price of that night in the emergency room could very well be the difference between whether this very bright, young, ambitious girl was going to go to junior college or spend her life continuing to be a waitress and working off debt.

[0:40:50.6]

MK: That's a lot to think about every time you see a patient.

[0:40:56.9]

SJH: Yeah, it is.

[0:40:59.9]

MK: I want to be respectful of your time because I know you might have a patient, but if there's anything else you want to say—

[0:41:07.4]

SJH: I think I've said a lot. [laughs]

[0:41:09.8]

MK: It was really, really great talking to you.

[0:41:13.7]

SJH: Same here. Thank you very much for this—

[End of interview]

Edited by Emily Chilton, October 24, 2018