

Mayo Clinic Radio: Social Media and Medicine

August 16, 2014

Hosts

DD- Dawn Marie R. Davis, M.D. (guest co-host)

TM=Tracy McCray

Health & Medical Headlines

VW=Vivien Williams

Guests

MB-J. Michael Bostwick, M.D. (via telephone)

FT=Farris K. Timimi, M.D.

ARG=Alva R. Roche Green, M.D. (via Headlines)

RB= Richard A. Berger, M.D., Ph.D. (via telephone)

VW: This is Mayo Clinic Radio, the only show that gives you the chance to ask your questions to Mayo Clinic experts. We'll take you beyond the headlines to explain what developments in medicine mean to you. Join the conversation by phone, Twitter, Facebook or radio.mayoclinic.org. Now, with this week's program, here are your hosts, Dr. Tom Shives and Tracy McCray.

TM: From the Mayo Clinic Rochester, Minnesota campus, I'm Tracy McCray.

DD: And in for Dr. Tom Shives, I'm Dr. Dawn Davis.

TM: Glad to have you here.

DD: Thanks. Glad to be back.

TM: Welcome, everyone, to Mayo Clinic Radio on the Mayo Clinic News Network. It's time for another first on our program, since today's topic was barely even invented 10 years ago. Our topic today is social media and its impact on medicine. Now, smartphones keep us connected, and maybe sometimes you might even argue disconnected -- you've never spent too much time on Facebook before, have you?

DD: No, I don't have a Facebook.

TM: Oh, good for you. Yeah, in ways that we haven't imagined -- I can't even imagine from ten years ago. Did you know that 40 percent of people say social media would affect their choice of a doctor or medical facility?

DD: And 20 percent of people who own a smartphone have downloaded at least one medical app.

TM: Wow!

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DD: So today on Mayo Clinic Radio our guest is my friend, medical director of the Mayo Clinic Center for Social Media, Dr. Farris Timimi. We'll discuss how social media can be used and talk about the impact that it is having now and in the future on health care.

TM: But first, earlier this week we learned of the death of Robin Williams, tragically taking his own life. Most likely, none of us knew him. However, his death brings to the forefront discussion of mental health, suicide, depression, addiction and how we handle all of these topics. Joining us now is Mayo Clinic psychiatrist Dr. Michael Bostwick. Good morning, Dr. Bostwick.

MB: Hi.

TM: Glad to have you back again. How do we talk about suicide? This week, you know, he died on Monday and throughout the week it was interesting just to see different language that was used to talk about it from, you know, saying now he's free from this pain to people criticizing his selfish act. How is it that we talk about suicide and the impact that it makes?

MB: Well, I don't think there is one way that we will talk about suicide because it affects so many people in so many different ways. If you've experienced it as a close survivor, you have very different reaction from someone who's looking at it from afar, and people -- some people glorify the act while other people demonize it, again, based on experience, education or both.

TM: I was reading something earlier this week that said lots of times when celebrities commit suicide, there is a spike -- for instance, when Marilyn Monroe died, there was an uptick in the number of women in their thirties and forties who committed suicide. Same thing with Kurt

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Cobain. Is there a concern that that actually can happen with suicide by celebrity -- celebrities' suicide?

MB: Well, I think that the two examples you gave point out that that association has been made, a tendency to romanticize or glorify celebrities in our society, and since the topic today is social media, it seems that we are very much in tune following celebrities as if we know them, when in reality, what we know are their performances or what they care to show us or what their publicists are creating for them.

DD: Dr. Bostwick, there's been some news this week about how Mr. Williams might be suffering also from early onset Parkinson's. Can you please tell us if Parkinson's would play a role with depression nor suicide?

MB: Well, there are many risk factors for suicide and they are very broadly defined and they don't -- and because they're broadly defined, they don't predict what individual will harm themselves or kill themselves, but certainly, diseases that are painful, diseases that are associated with depression, diseases that rob you of a sense of who you are could be associated with increase in suicide, and certainly Parkinson's is one of those conditions that can do all those things.

TM: The bigger point of the whole discussion, I think, is depression and how we in this country deal with depression. Some people say take a pill. Some people say pretend like it's not happening. Ignore it. What -- how can we handle depression better in this country?

MB: Well, one of the things we first have to do -- depression is sort of a garbage word in that it's used very, very generically, but we need to focus in a bit on the kind of situation in which a

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person is morbid, in which they are agitated, in which they are unable to do the things that they would normally do when perhaps they stopped eating well or sleeping well or they're not -- tending to their responsibilities. [00:05:01]

First we need to recognize what is a serious case of depression and then get probably the best help will be psychotherapy and a medication from someone who's competent and able to do that. Reality is we don't have enough psychiatrists in the country, and most of this care is provided by harried family practitioners or internists.

DD: What could we do as a public to help de-stigmatize mental illness and depression?

MB: Well, I think we keep talking about it and keep talking about it and pointing out that it should not be a stigmatized illness. Back to your original question about how people respond, many of us have depression in our families or in our friends and we need to examine our own responses to that and try to be more compassionate and less dismissive or minimizing of this when it happens.

TM: And if someone is feeling this themselves or they're worried or concerned about a loved one, what are some of the things that people should do? First of all, let's address for yourself.

MB: For myself, how do you mean it?

TM: Oh, that if someone is feeling depressed.

MB: Well, first of all, you pay attention to it. You ask questions about it. You indicate that you're available and want to support and help that person. You ask directly whether they're thinking of -- life isn't worth living, whether they're thinking that they might want to do something to

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escape their life and specifically you ask about the pain that they're in, emotional pain. I think we put a great deal of emphasis on physical pain and regard it as being legitimate, but somehow emotional pain is not regarded with the same seriousness, with the same degree of legitimacy.

TM: And if someone this week who is feeling depressed notices this and hears a lot of this conversation and says, okay, I hear you now, I need to get some help for myself, what steps should that person take?

MB: Well, one of the things is to, first, find out what resources are available to them in their local community. I would actually recommend starting by talking to a family member or a friend so at least you're not alone with what you're feeling. Perhaps enlist their support in trying to find a doctor or a therapist or both so that you can work with to try to get a handle on the depression.

There are lots of treatments that are available and can singly or in combination be helpful. It's also useful if the agitation or the overwhelming sense of despair is present to really try to get someone who can assess that person and make sure there isn't something even more, underlying complications to their depression.

DD: I know there are times when family or friends try to help somebody who they feel is depressed or anxious or going to hurt themselves and oftentimes that person will backlash at them and so the person backs off, thinking that they've overstepped their bounds or invaded that person's personal space. Any advice about that?

MB: Well, I think a discussion that we each have to have with ourselves is whether rejection by a depressed and potentially suicidal patient is -- is worth the possibility of their death. What I see

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are people who regret, in the wake of suicide, not having done as much as they feel that they could have done rather than saying, well, you know, it was their right; they could -- they could just sort of do it. My own belief is that people -- we can't stop necessarily people from killing themselves, but we certainly can try to help reduce the risk of it going to that suicidal state.

TM: And possibly recognize -- I know the last time that you were here this was brought to my attention that there might be something that temporarily has changed, for instance, a medication that has some side effects or something that might be going into the whole thought process that people should be aware of.

MB: Oh, absolutely. Also people who are deep into the throes of addiction, people who, in fact, may have an undiagnosed illness, whether it be a mental illness or a physical illness with mental components. I think one of the things that we do in this country is make a distinction, which is really quite arbitrary and dangerous between mental and physical pain and mental and physical illness.

TM: Very good. Dr. Michael Bostwick, thank you so much for your time today.

MB: My pleasure.

TM: All right. It's time --

DD: Thank you.

TM: Yeah, it's time for a short break. Coming up, we're going to talk with Dr. Farris Timimi about the impact of social media on medicine.

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DD: Don't forget that you can listen to Mayo Clinic Radio at any time on iHeartRadio, and you can also tweet us anytime at #MayoClinicRadio.

TM: We'll be back right after this.

[Break] [00:10:00]

TM: Welcome back. Our guest today is the medical director for Mayo Clinic Center for Social Media, Dr. Farris Timimi. Great to have you here, Dr. Timimi.

FT: Oh, thank you. It's a delight to be here this morning.

TM: I have to admit that I have toyed with the idea of doing a show on social media -- I don't know -- for a year, I suppose. A year ago I asked you, hey, we should probably do something. But I didn't really even know how to go about doing it because it's such a broad range of things that can go into there. And then Dr. Davis said, well, if I'm going to be on, we should talk to Dr. Timimi. So here you are. I didn't have the courage, but Dr. Davis did.

DD: Dr. Timimi teaches me so much about social media that I figure he could help others too.

TM: That's true. But the most interesting part of this, I suppose, for our listeners who don't know is that you were not educated to be a social media expert. Tell us what you do at the Mayo Clinic besides social media.

FT: No. My primary practice is advanced heart failure, sort of the pre-transplant population. But fundamentally, this is how people communicate in the current era.

TM: Sure. So how did you go from -- well, I shouldn't say go from -- add that onto the plate? Have you just always been someone who's a techy kind of a person?

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FT: No. I've always been interesting in how to bring the patient perspective into the care process.

TM: Okay.

FT: I have been intimately involved in the formation of patient/family advisory councils --

TM: Okay.

FT: -- which are ways to bring patient's perspective on policy and procedures into the clinical practice because we do better when our patients speak with us --

TM: Sure.

FT: -- on how to do better. And I've done that for the last ten years and, frankly, this is just that conversation in the digital era.

DD: And it's allowing patients to talk to each other, right? Because a lot of times when I see patients in the clinic, I think, oh, I have another patient that you would be so great to know and you guys could collaborate, but with patient confidentiality issues, we don't connect them necessarily, and now patients can connect with each other and feel like they're not alone with their medical condition.

FT: You're absolutely right. One of the fundamental concepts of social media, in particular, is those whom geography would isolate, social media gives companionship. So if you're the only one in your community suffering from a rare disease and you're challenged, how to care for my child, how to meet their needs effectively, what tools do I need, you can't find someone in your community --

TM: Sure.

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FT: -- but you can find someone online.

TM: You can find it and you become your own community.

FT: Precisely.

TM: I only -- I know the answer to this because I've listened to you talk about it before, but I'll ask, who is leading this charge, the patient or the hospital?

FT: You know, I think fundamentally --

DD: Great question.

FT: -- we are following the patients.

TM: Right.

FT: They have had the courage to share, the courage to explore, and I think we're realizing, as professionals, is our job is to walk with our patients. That's what we do. We walk with them on their journey from illness to recovery. In the current era, they are journeying online.

DD: And we learned from them on social media.

FT: Absolutely. Absolutely.

DD: Our patients teach us every day, I would say.

FT: No, that's very apt.

TM: So what is it that is a struggle for hospitals and for physicians? Because there's some physicians like yourselves who are engaged -- Dr. Timimi, you are leading Dr. Davis along -- there are some who think, I don't have any time in my day at all to be monitoring a Twitter account or to be

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doing something like this. Explain, when you say, using -- how a physician would use social media, explain what that looks like.

FT: I would stress to you that the concept of we shouldn't participate is fairly universal in health care in the United States. Our survey data suggests that 60 percent of hospitals block all their employees of the firewall.

TM: 60 percent!

FT: 60 percent. So they'll have a Facebook account and a Twitter account for the institution --

TM: Sure.

FT: -- but their employees are not allowed to participate. And by doing that, they actually cheat themselves of their human bandwidth, their capacity for engagement. And you look at --

TM: And why -- why do they do that?

FT: Well, they're afraid of privacy violations. They're afraid of time wastage. They're afraid of reimbursement. But they don't understand that that those issues could be addressed aptly through social networks. You know, I have a six- and an eight-year old. We see Chris in Pediatrics here in town. He takes great care of us. And in the spring when we see Chris, he talks about how to pick a bike helmet. He does that conversation 25 times a week. It's got to be a Y over the ear, it's flat against the forehead, a fingerbreadth beneath the chinstrap. If we film Chris having that conversation with an iPhone instead of doing that conversation 25 times, he could simply put a QR code on his door and say, when you get in the room, watch my video about how to pick a bike helmet. We've made Chris more efficient.

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TM: Sure.

FT: Moreover, if someone in our community who may not have access to a pediatrician has the opportunity to see a video of relevance online, we can touch one child's life and save that child from catastrophic injury and we can do so in a fashion that costs absolutely nothing.

DD: Well, and I don't know how you feel, Farris, but when we go to the doctor, especially if we're nervous about something and we're busy and we've got other things to do or we're getting bad news or news we don't understand, we try to listen to the doctor and we try to take notes and answer -- ask all the right questions. But there are so many questions that we have afterward or things that we write down that then we don't understand what we wrote down and if the physicians have things on social media or the health care team has a repository of data, then you can go back and say, ah, that's what they meant or that's the question I should have asked.

FT: Moreover, when I see the pediatrician, if I'm there with my son and my wife can't be, I can share content with her and so she's a part or an engagement without actually physically being there. It allows for asynchronous engagement, which extends that conversation beyond me and my provider. [00:15:08]

TM: And if you were to -- with Chris, the pediatrician, I'm sure he's fine if you take out -- and say, oh, Colleen needs to hear this and you start recording, in that -- are there hospitals, are there doctors who say, oh, no, you can't do that here.

FT: No. Now, if you're recording the encounter, they're not practices that preclude that --

TM: Okay.

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FT: -- at least not here. What I'm talking about is the repetitive content that Chris shares --

TM: Okay.

FT: -- and its capacity to be more efficient by moving that content online.

TM: Sure.

FT: And by doing so, extending the conversation between Chris and I to my family, my community who support the recovery of my child. You had asked about making him more efficient. That's the way we make Chris more efficient. Moreover, if there is a nuanced conversation to have with a patient that's difficult to have -- we talk about conversation elevation -- you can use social tools to begin that conversation well before the encounter.

DD: And when we talk, it's verbal, but a lot of things we have to explain, we have to draw out or you really need a visual clue and social media also helps with the visual aspect because when videos demonstrate things or there's artistic illustrations, I find that for myself, and hopefully for patients, it connects the dots and comprehension increases.

FT: It does. It allows for repetition, and it allows for sharing.

TM: Another way to look at how social media affect medicine I would suppose is something that you -- I experienced this spring, when you get a diagnosis with something and you try to explain to family and friends what it is and then everybody googles, googles it. I would Google it to see what it is or I'd go find a diagram to show what it is or -- how has that changed medicine?

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FT: So the three most common activities that occur online in the United States are emailing -- we spend a lot of time emailing -- general internet search, and the third most common activity is looking for health care information.

TM: Sure.

FT: So -- which makes sense. If you get untoward or uncomfortable news, you will go to Google or Bing to try to find content of relevance.

TM: Sure.

FT: The opportunity we have as providers is to put content of value in the path of the patient where they spend the majority of their time.

TM: Sure.

DD: And I think one question that people have is that people try to be very aware and they don't want to be duped by going online and reading something that's false because I think the consumer is aware that there's a lot of things online that are not true, and when it comes to health care, they definitely don't want to believe or go down a path that is false. So what tips can you give to the people about how to find legitimate health care sources?

FT: I think that's a very -- I think that's a great question. There was a recent study looking at YouTube videos that talked about high blood pressure and found that a third of the YouTube videos surveyed had information that was either wrong or would be harmful to the patient. And frankly, when I talk to other hospitals and providers about that --

TM: A third --

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FT: A third.

TM: -- of the videos were wrong.

FT: A third.

DD: And that scares people out of social media.

TM: Oh, my goodness!

FT: But it's our obligation, it's our opportunity. That's our window of opportunity. Our obligation as health care providers is to put information of value to fill that void, to leverage what we do, to put credible content, to have conversations of value. So --

DD: So they should look for a brand they trust?

FT: They should look for a brand they trust, and providers, physicians need to understand that these conversations occur, whether they're part of them or not. Whether you participate or not, these conversations occur. Of time spent online in the U.S. right now, 1 in 4 minutes is spent in the social network; 1 in 7 minutes is spent in Facebook. So if we're not part of those conversations, they will occur with us there or with us not being there, and our opportunity to be the moral authority on an issue, to put valuable information in the path of the patient at need has never been more heightened or more aware.

TM: Dr. Davis, you had said people put some credence in what they see online except for sometimes, oh, this is all crazy. And people will say, oh, well, that's because everything online is real, sarcastically. How -- do you really think that people believe most of what they read online?

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DD: I think some people do, absolutely. And if they've never been duped or don't know they're being duped, then they just trust.

TM: Sure.

DD: I think people by nature are very trusting, well-meaning individuals --

TM: And they go looking for maybe something that will -- if you have an idea, your preconceived notion, they go looking for something that will affirm that.

DD: That validates that, correct. Like, for example, in my practice, atopic dermatitis or eczema is very common. It's one of the most common referrals to my practice. And most people feel that atopic dermatitis is caused by food allergies. But only 30 percent of people with atopic dermatitis even have a food intolerance or allergy and they're not even causal necessarily.

TM: So Dr. Timimi had mentioned the videos. I know I've seen -- I've seen some of the videos that you have done. Are you also, Dr. David, recording videos for patients to access about --

DD: Yes.

TM: -- atopic dermatitis?

DD: Yes, and YouTube, I would say, is the most common modality that I have right now for my patients on educational tutorials. And Mayo Clinic has a site that they put YouTube videos on --

FT: We do.

DD: -- and then you can consult Mayo Clinic.org also for videos.

FT: Yeah, we do. We have around 3700 videos in our YouTube rotation on a wide variety of topics.

And again, we do so because you're absolutely right. [00:20:01] The second most common

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search engine used in the U.S. after Google is YouTube. So if we don't have content of value to fill the void, then the void is filled by others who may not have the same commitment to patient education.

TM: How do you use -- personally for yourself, for cardiology, as -- you're a cardiologist. Do you have videos talking about different topics or what do you do?

FT: Absolutely. For example, we have a pilot we're starting in the heart failure practice, looking at patients who have heart failure, who are admitted with a devastating disease that has a high risk of being readmitted within 30 days to the hospital, and if you're readmitted with heart failure, you have a high chance of dying. And the most common reason for readmission is a lapse in compliance with the diet, which can be very onerous to do, and with medication, which can be quite demanding. And it's scary being hospitalized. You're terrified. You're being dismissed on the day of dismissal. You're overwhelmed with information. We are producing a series of 30 brief videos -- you'll be prescribed a series from that 30 that are related to your diagnosis that you can share with your family --

TM: Sure.

FT: -- with your grandson who may go to the store for you, with your husband who may not be there at the clinical encounter, to try to extend the conversation beyond the moment of encounter to try to address readmission rates.

TM: And -- yeah, go ahead.

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FT: So these opportunities are not -- are not dependent on the age of the patient. These are -- this is an older population because penetrance --

TM: That's right. --

FT: -- for social media is incredibly quite high.

TM: I was going to say, too, that some -- I don't know about you guys, but sometimes I need to hear something more than once for it to kind of sink into my thick skull.

DD: Abso -- your skull isn't thick.

TM: Sometimes it is. Sometimes it is.

DD: I won't tell your husband that you admitted that to the public.

TM: Yeah, I'm sure he's too busy to be listening right now. You're listening to Mayo Clinic Radio. Coming up, this week's health and medical news with Vivien Williams, and right after that we're going to hear from Dr. Richard Berger with an example of how social media has made an impact on health care. Please re -- we welcome your tweets too at #MayoClinicRadio. This is Mayo Clinic Radio on the Mayo Clinic News Network.

VW: Hi, I'm Vivien Williams with headlines from the Mayo Clinic News Network. Are you a workaholic or know somebody who is? Well, a study from the University of Bergen shows that more than 8 percent of the Norwegian workforce is addicted to work to the point where it becomes a health issue. Now, here are a few signs that you might be a workaholic. You always try to free up time to work more, you get stressed if you can't work, and others tell you to cut back. And the study says workaholics tend to have these personality traits. They were agreeable and altruistic,

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neurotic and intelligent with big imaginations. They say workaholism is not a formal diagnosis yet, but because it may have psychological and physical outcomes, there is need for proper treatment. And this was published in the journal *PLOS ONE*.

Now, depending where you live, the school year is about to start or already has. Mayo Clinic experts would like to help lighten the load, starting with the backpack. Here is Dr. Alva Roche Green.

ARG: Do you guys remember going to high school and having that 20-pound backpack on your back? We now know that that's really bad for children's posture and their back. They end up having back problems down the line. So we recommend that children have no more than 10 percent of their body weight in their backpack. For a child that weighs a hundred pounds, that's ten pounds. So children need to learn to prioritize what they're putting in their backpack, and if they find that they need to bring home more than the recommended weight, getting a rolling backpack may be a good idea.

VW: And here are some other tips to make sure your child has a healthy start to the school year. Make sure they wash their hands for 60 seconds, at least, to prevent spreading germs, remind kids about stranger danger, help them get good night sleep, and encourage good eating habits.

And now finally, here is some news about breast cancer. Researchers found that post-menopausal, overweight or obese breast cancer patients who have hormone therapy and who use nonsteroidal, anti-inflammatory drugs, such as aspirin or ibuprofen, have significantly lower breast cancer recurrent rates. The findings suggest a new possibility for reducing the incidence

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of recurrence among these women and they say this research is very preliminary and they plan additional larger studies to learn more about adding nonsteroidal, anti-inflammatories to breast cancer treatment. And this was in the journal *Cancer Research*.

Okay, so you're outside and even though days might be getting a little shorter, the bugs are still biting. Insect repellent works, but it only works if used properly. The type of repellent you use depends on the type of insect you're trying to ward off. The CDC says use repellents with picaridin IR3535 or oil of lemon eucalyptus for mosquitoes, and use repellent with 20 percent or more DEET for both ticks and mosquitoes. And remember, it only works if you wear it.

And that's a look at headlines from the Mayo Clinic News Network. I'm Vivien Williams.

You are listening to Mayo Clinic Radio on the Mayo Clinic News Network. [00:25:03]

TM: Welcome back to Mayo Clinic Radio, information you want from specialists who know, on air, online and on iHeartRadio. And you can listen to us live right now by going to our flagship station's website. Go to KROCAM.com and push Listen Live.

DD: It's time for you to join in on our conversation, please. You can contact us by telephone at 507-282-1234 or please tweet us at #MayoClinicRadio.

TM: Joining us now as we talk about social media and medicine and the impact of social media on medicine is Dr. Richard Berger. Good morning, Dr. Berger.

RB: Well, good morning. It's great to be here. Thanks for asking me.

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TM: I love any excuse to get you on the program because your story is so interesting. Explain to us how social media has impacted medicine.

RB: Well, it's been something that personally has been transformative for my practice, but, more importantly, transformative for a group of people that previously could not find an answer to their -- the pain that they -- that they were experiencing, keeping them from doing the things that they enjoy, but also the things that they had to do for their -- for their work. We're talking about ulnar-sided wrist pain. Now, this is pain on the pinky side of the wrist, and there are a number of causes, but there was a large group of people that were suffering with this that could not find an answer to their pain. It was just something they had to deal with and sometimes requiring a change in job or with professional athletes actually having to drop out of their competitive career.

About ten years ago, I was lucky enough to discover an answer for this that has been very successful in the treatment, and it's based upon a simple physical exam that anybody can perform. This does not typically show up on imaging like MRI, but the end result is about a 95 percent success rate compared with what we had before, which was less than the chances of guessing a flip of a coin. And this was something that I took out on the conference circuit with international and national conferences, trying to educate other surgeons about this. I also taught our own hand surgery fellows about this. But it wasn't until social media that this really took hold, and we have a growing number of patients that are now finding solutions.

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TM: Okay. So typically, from when you present to one of -- one of your meetings, one of your annual meetings, to when something comes to fruition, that's -- how many years does that usually take?

RB: Oh, it's actually years. I would -- I would guess that for something new like this, it's probably going to take perhaps ten years before it actually grabs hold.

TM: And that means that before a patient will learn about this and then come to see you and say, hey, I need -- I think I have this problem.

RB: That's correct.

TM: Okay. So explain -- explain how this first happened with this ulnar tear.

RB: Well, it was through a series of successful outcomes that we finally were able to publish the results of this, and that was another venue to get the word out, but it happened that there was a very famous baseball player -- who's famous now. He wasn't so famous then -- Jayson Werth -- who had been released by the Los Angeles Dodgers because for a year and a half he was suffering with this pain and he couldn't bat. He couldn't perform. And he found out about the surgery that I was doing. He had a successful outcome, ended up going with the Phillies, and now he's got a very large presence with the Washington Nationals, shall we say.

And Lee Aase at the time, with Public Affairs, and now with the Center for Social Media, came to me with the idea of, well, let's do some interviews with Jayson. And so he met up with Jayson in the locker room, produced some YouTube videos, as well as engaging Twitter. We had

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an article that was published in the *US-- USA Today*, and they sponsored a Twitter session with me and this thing just virtually, in the medical world, I think, would be considered going viral.

TM: Sure. And I think the best part about this story is the gal who had the wrist pain, her mom is the one who saw it, and was she on Twitter or where did she see it? A YouTube video?

RB: It was a YouTube video.

TM: Okay.

RB: And there were also increasing communications going on between patients. But what's happened with this is that the patients are now empowered to actually do their own physical examination. They -- they know more about this sometimes than their -- than their doctors do, and they'll take this to their doctor, saying, I think I've got this. And maybe the doctor hasn't heard about this yet, but they'll very often pick up on the videos and learn about themselves. But the other thing is when patients come to me through the social media venue, which is a large percentage of them, they all tell me that they -- that they actually feel like they know me before they actually get here. So that level of trust is already established.

TM: You're like a rock star.

RB: Well, I don't know about that.

TM: So did the YouTube video, did you explain in that YouTube video how to do this exam?

[00:30:04]

RB: Yes. Yes, absolutely. And that's what has really empowered these -- these patients. They've -- a large percentage of them have been told that there's nothing wrong, that it's in their head; they

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just need to learn to live with it. And it's a very, very demoralizing process that they go through.

So when they see a glimmer of hope and they say, wait a minute, I've got this, I know I do, it's

very empowering to them and what they do then is they search out a caregiver that's familiar

with this and can actually help them through this.

FT: That's such a powerful story, Dr. Berger. I think it highlights the power of an electronically facile, engaged patient --

RB: Yes.

FT: -- who can be the lived expert over their own disease.

RB: Yeah, exactly. Exactly, Farris.

DD: And I think it provides a lot of assurance to patients that they're really not alone, because I think that's just the best example in social media about validation because I think every human being wants validation that they're not alone.

TM: Well, and as you said previously, when you discovered, oh, it's this tear that's going the opposite way -- that's why nobody's figuring it out -- and you would present it at a group meeting, it would take years before maybe a physician who was paying close enough attention to your speech would have a patient come in and he would click it together and go, oh! I bet this is what Dr. Berger was talking about. Now that you have a patient who is coming in, saying, this is what I think I have, watch this video, I think this is me, the patient can actually be educating that physician.

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RB: Oh, and that's exactly what happens. The patients are driving this transformation to the point where I've actually had surgeons from out of state come with their patients to observe --

TM: Wow, that's fascinating!

RB: -- their surgery with me so that they can learn how to do this with other patients that they have with similar symptoms.

DD: And Tracy, I think you bring up a very good point. Physicians spend a lot of time on the road at conferences educating each other to help educate one another --

TM: Sure.

DD: -- about differences in the subspecialty practices, but we don't necessarily have as many opportunities --

TM: Sure.

DD: -- traditionally to teach the public.

TM: Sure.

RB: That's absolutely right.

FT: And I think it's also -- it's also -- just to take a step back. Remember the database we providers use, PubMed, which is a repository for publications related to medicine that are relevant and important. It has 23 million publications in it and, on average, gets one new publication every minute. So I think providers swim in a sea of information that can be overwhelming. On the other hand, all that information is transparent and publicly available. And if you're a patient suffering from a disease, in isolation and alone, having access to that data can change your

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outcome and make you the lived expert of your disease, and I think you've highlighted how partnering with patients online is a powerful way to do it.

TM: Do you suppose that this would have happened as quickly, Dr. Berger, if Jayson Werth didn't have this tremendous baseball contract that he was going to be losing because he had been told it was all in his head?

RB: Well, I think he certainly highlighted the problem. We've had subsequently a large number of professional athletes that are exactly in the same situation. What was fortunate about Jayson is that he saw that perhaps he could be some type of a catalyst in actually spreading the word about this and he personally was already engaged in social media and so it was -- it was just a perfect fit. He had the -- the right condition, the right outcomes, the right personality, and a developing notoriety so that potential patients or people with this ulnar-sided wrist pain could identify with his situation. They say, I'm just like Jayson.

DD: So Dr. Berger, I agree, and I think having a hand issue or a wrist issue is not necessarily embarrassing, especially when you're a professional athlete. And, you know, being in the media and showing that you're going through this rehab and surgery to fix your defect so that you can play again shows dedication to your sport and your career.

But either for you or for Farris, what do you do for the patients that have a medical condition that people consider embarrassing, like a women's health issue or a men's health issues where they want to be an advocate, but they don't want to out themselves because they're embarrassed about their pelvic floor dysfunction or their impotence --

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TM: Sure.

DD: -- or something like that? Any advice or directions, since you guys are delving in the social media?

FT: I think there are clear opportunities for closed social networks, for people to have private conversations and support groups. We've seen that be profoundly successful in body dysmorphia --

TM: Okay.

FT: -- and young women who have weight issues and concerns, to allow them to have a private platform for sharing. And as you've implied, peer-to-peer companionship can be difficult if you have a disease that has stigma associated with it, and allowing people to have an opportunity to share and a platform that they're familiar with is a powerful thing to do.

TM: Yeah, a professional baseball player might be able to make a bigger splash for that, right, Dr. Berger?

RB: Right.

TM: Well, thank you so much for your time. We appreciate you joining us today. It always is a pleasure.

RB: Thank you so much, and thanks for taking on this important topic.

TM: Yeah, very good.

RB: It really is transformative.

TM: Thank you, Dr. Berger. [00:35:00]

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DD: Take care.

RB: Thank you.

TM: We did get a tweet that -- someone saying, I'm not sure what will end up happening with social media. I used to work in a hospital where Google and YouTube were both blocked.

FT: Right.

TM: I can see, you know, sometimes you might go to some sites that maybe your workplace doesn't want you at, but I can't imagine that Google and YouTube would be some of them.

FT: You'd be surprised how many centers block all their employees. I spoke at a center in the southern United States that had 38,000 employees. They had a very active presence on social media. All of the employees were blocked but one, blocked at the firewall, which, one, is an error. In the smartphone -- in the smartphone era, we can easily bypass a firewall.

TM: Sure, right.

FT: And two, those employees are a powerful asset for that institution for partnering with patients.

TM: Sure.

FT: And so the key is to provide them orientation, guidelines and training that are meaningful to allow them to change the dynamic. Think about the pertussis vaccine. So pertussis vaccine came out in the 1950s. We went from 120,000 cases a year in the United States down to around a hundred -- around 1,000 cases in 1976. We stayed below 10,000 cases a year for 37 years in the United States and --

DD: Until.

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FT: Until -- until we chose as a profession not to be the moral authority online and allowed others to do so. Our silence in social platforms has allowed Jenny McCarthy to be the moral authority on that issue.

TM: On vaccines.

FT: And it's catastrophic.

TM: Right.

FT: The American Pediatric Association has 60,000 members. If each one of them this year made one tweet, one blog post, one Facebook post, how many lives could we touch and save?

TM: Yeah, the impact of someone saying, I think that vaccines are wrong, without a medical rock star, coming in to say, actually, no, they're good --

FT: Right.

TM: -- this is a good thing, that is a -- that is a big deal.

FT: I think it's the impact of our silence as a profession.

TM: So you're almost saying that it is your duty as a professional to be engaged in social media.

FT: I think -- I think our moral authority as a health care professional is to journey with our patients.

TM: Let's talk for just a moment because I thought it was so fascinating and, of course, no surprise to you at all, but how the Ebola outbreak was predicted by social media basically.

FT: Right.

TM: Explain that to us.

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FT: So it's fascinating. If you look at -- if you look at a variety of diseases and look at how people search and what they search for, social networking can predict a variety of influenza-like illnesses, atypical infections like Ebola. There was an earthquake in West Virginia that did not have significant magnitude three years ago, but the social network propagation moved faster than the earthquake wave did.

TM: Wow!

FT: And there's a group at the World Health Organization that are looking at word analysis in Third World countries on social networks to identify when there's significant stress, based on hunger, food deprivation, unemployment and are diverting resources to that community before a crisis occurs and have found that if they can intervene six weeks before someone hits that break point by identifying on a social network, they can have significant impact. What it reflects is these are where conversations occur. These are where people are talking right now.

DD: And what about support group sites for patients? Also, that's another aspect of social media, like Caring Bridge, for example, if somebody has a terminal illness. Any thoughts on that?

FT: Frankly, it is one of the most powerful and most moving interventions I've seen in social networking. Caring Bridge, I think, has been breathtaking in what it's offered, and it gets back to what we talked about initially. People who are isolated by geography can find companionship online, and that's such a powerful thing when you're alone, when you're scared, when you're at risk, and it changes lives.

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DD: And when you're ill and you need somebody to help you go to the grocery store, it's way easier to get on your Caring Bridge site and say, gee whiz, I wish somebody could just get these five items at the grocery store --

TM: Oh, certainly.

DD: -- than trying to call or chase a friend and you can't get out of your house to go down there just because you feel poorly --

TM: People are coordinating meals or, you know, I've lived in this town for over 20 years and people that come from my hometown to Mayo Clinic for care, that little pipeline back and forth of, how's it going at Mayo -- and, you know, my mom saying, go in and invite them out for a cup of coffee, you know, just this whole thing. It's interesting how Caring Bridge has changed --

FT: It has.

TM: -- that whole process.

FT: So I've got a good friend named Lucien Engelen who lives in the Netherlands and he wanted to develop an app for the iPhone to tell you where an AED is if someone has a cardiac arrest. So Lucien thought, well, if I develop an app, I've got to apply for funding from the hospital, I've got to get approval for the money, hire a developer. Instead, he tweeted, I need to make an app. Within four hours he had four developers who volunteered to make it. The app was completed in two days.

Now, the app tells you where an AED is, but Lucien does not know where AED's are. So he releases the app for free in the Netherlands and tells the crowd, everyone who's on Twitter,

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hey, if you see an AED, photograph it. We'll geo-tag the location. Tell me when that building is open.

So now, if you have a cardiac arrest in his country, you pull the phone out, hit a button, it'll say the closest AED is in the building across the street. That building is open from 8 to 5 on Monday through Friday. All this was created and produced and made using social networks online.

TM: We have just a couple of minutes left and I want to go back to a question that I should have asked at the very beginning, which is, you are the medical director for Mayo Clinic Center for Social Media. Let's talk about the Center for Social Media, because you are helping to train and pass out the word on, get involved with social media. Tell us a little bit about it. [00:40:14]

FT: I think our most powerful asset as an institution, both at the Mayo Clinic and in health care, in general, are our employees, our human bandwidth. Helping them become strategic and tactical online and be professional online is the Center for Social Media's primary obligation. We want these tools to change the dynamic of health care. To do so, we've got to provide training, guidelines and orientation, both for our employees locally and nationally for people who do not work with us. That is the primary obligation at the center.

DD: And you have a boot camp, a training.

FT: We do. We have a social media residency. It's a one-day program that's tactical. Here are the tools and the toolset. Here's how to use them. We also have a social media summit the third week in October that's more strategic. Here's the why of how to do it.

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DD: So really, somebody who is social media phobic, could go to your boot camp, residency, and it's one day.

FT: Absolutely.

DD: So it's not intimidating.

FT: Not in the least, and what's surprising is most of -- many of our attendees are not health care professionals. We did a boot camp recently in Arizona, and a third of our attendees were librarians who wanted to learn how to redefine their role in the digital era.

TM: Sure, justify their existence.

DD: It makes perfect sense.

FT: Right.

TM: Okay. So we have about one minute left. What is the direction that social media will go? What is the future for social media and medicine?

FT: I really see an opportunity for frank partnership, for frank transparency, for patients and providers to work together to improve outcomes. You know, using the analogy of the bike helmet --

TM: Sure.

FT: -- it's a simple analogy, but doing so can save and touch lives in our community and can do so at little or no cost. I see more opportunities for partnership and engagement in the future. I see a new era with tools that are used strategically and appropriately.

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DD: And it's really an opportunity for providers and for the public to pay it forward. I think people like paying it forward.

TM: Well, because they feel if you go through something terrible and then you share it, it might actually help someone. This is where all of these support groups have popped up.

FT: Incredibly well said.

TM: Yeah, I think every time we do a show, we become aware of a support group that finds the show and then tweets it out to their whole group of people. It's amazing. Dr. Farris Timimi, thank you so much for being here.

FT: Thank you for the opportunity. I appreciate it.

TM: Yeah. And if people want to learn more information about the Center for Social Media, how do they find you?

FT: Google Social Media Health Network. You'll find us there.

TM: Google it.

FT: Yes, ma'am.

TM: Of course. You're listening to Mayo Clinic Radio on the Mayo Clinic News Network. Coming -- coming up, we'll tell you about next week's program. Stay with us.

[Break]

TM: Welcome back. Next week on Mayo Clinic Radio we're going to change spots. Dr. Shives will be back.

DD: And I still be here.

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TM: Because I'm going to be gone next week. I'm glad that you're pulling a two-week in a row for us.

DD: We're going to party without you.

TM: I am actually going to try to listen though because if you are going to be here, you're going to get a chance to needle Dr. Tom Shives because next week's topic is women's health with Dr. Stephanie Faubion.

DD: And he wants to be an expert, I'm sure.

TM: It was his suggestion. He does love it. He does.

DD: And we love Dr. Faubion, and she's full of great information.

TM: That's right, and we just recent -- we just mentioned sometimes there are situations that you maybe don't want to talk about on social media, but that's where something like this is very important because, you know, perimenopause -- I don't even know what that is, so I've got to Google that, you know.

DD: I don't want to have it.

TM: That's right. And then there's hormone therapy or bioidentical hormone therapy or there's night -- night sweats and hot flashes and --

DD: What to do in menopause with all those hot flashes. Do you take estrogen? Don't you? How does this affect my sexual life?

TM: Absolutely. And Tom's favorite, vaginal dryness. I always say we have to talk about that, Tom, and he goes, do I really? It's a big deal.

Mayo Clinic Radio: Social Media and Medicine

August 16, 2014

Hosts

DD- Dawn Marie R. Davis, M.D. (guest co-host)

TM=Tracy McCray

Health & Medical Headlines

VW=Vivien Williams

Guests

MB-J. Michael Bostwick, M.D. (via telephone)

FT=Farris K. Timimi, M.D.

ARG=Alva R. Roche Green, M.D. (via Headlines)

RB= Richard A. Berger, M.D., Ph.D. (via telephone)

DD: But we'll be here. It's a very big deal, and women have the questions and we're going to talk about it.

TM: And not afraid to ask, yes. We hope you'll join us.

DD: For more information on topics that we discussed on this program, please visit our website, radio.mayoclinic.org, where you can access a podcast of today's program, as well as our previously-aired Mayo Clinic Radio episodes, or feel free to visit us at mayoclinic.org, where we have 3,000 physicians, scientists and researchers that are on cutting edge Mayo Clinic to share their expertise on how to empower you to manage your own health.

TM: You've been listening to Mayo Clinic Radio on the Mayo Clinic News Network. Our senior producer, Ron Petrovich; our associate producer and phone screener, Audrey Caseltine; and our technical director is Rich Peterson. Theme music, performed by Chip Davis of Manheim Steamroller. For Mayo Clinic Radio and Dr. Farris Timimi, I'm Tracy McCray.

AD: And I'm Dawn Davis. Thanks for joining us.

VW: Any medical information conveyed during this program is not intended as a substitute for personal medical advice, and you should not take any action before consulting a health care professional. For more information, please go to our website, radio.mayoclinic.org. Please join us each week on this station for more of the medical information you want from Mayo Clinic specialists who know.

[End of program]