A PUBLICATION OF THE MARION-POLK COUNTY MEDICAL SOCIETY WINTER 2021

CHART NOTES

Women in Medicine

being a female provider in the mid-Valley

pg 6





Women in Medicine During a Pandemic

pg 13

President's Message	3	Wellness, Erin Hurley, MD	16
From the Executive Director	5	Man-Made Misery	17
From the Editor	5	Salem Health Foundations	19
Women Doctors up to 1900	6	Photo Contest Winners	21
Women Doctors after 1970	10	Photographing Fast-Moving Cars	22
Bon Voyage, Dr. York	13	My Current Obsessions	24
The Burden of Burnout	14	The Last Word	27

Serving Oregon Physicians for 50 Years

Customized Coverage for Oregon Physicians, Created by Oregon Physicians

While other insurance carriers have come and gone, CNA has been a fixture in the Oregon marketplace, helping physicians navigate the healthcare landscape for 50 years. Our tenured professionals average 32 years of experience, and our strong partnership with the OMA helps ensure you get the coverage you need. With local claim professionals and a comprehensive risk control program, CNA creates insurance solutions to help keep your practice running smoothly, year after year.

For more information, contact CNA's Portland office at 800-341-3684 or visit theoma.org/cna.

A PUBLICATION OF THE MARION-POLK COUNTY MEDICAL SOCIETY

CHARTNOTES

Marion-Polk County Medical Society
PO Box 246
Salem OR 97308-0246
P: (971) 720-1667
F: (503) 585-8547
E: info@mpmedsociety.org

mpmedsociety.org

Gender-based biases

President's Message

Doug Eliason, DO

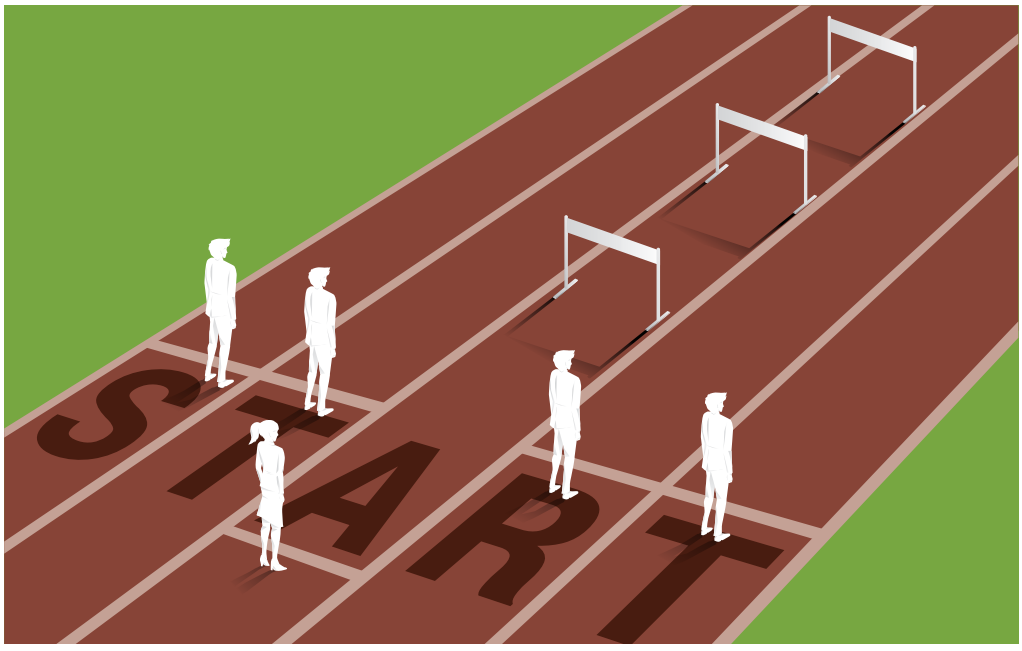
In the olden days (sorry, this is how we "mature" providers like to start conversations), being a doctor generally meant you were white and male. Women and minorities were the exception, and it showed. When I arrived for my internship, all of the male doctors were taken to the doctor's locker room. Our other doctor: Nonie O'Shea, was delivered to the nurse's locker room. Now, Nonie was not having any of that and before we knew it, she was in our locker room. We partitioned off an area for some privacy. As the year progressed, she became "one of the guys," never wanted one bit less work and always did her part. But why was she considered "one of the guys"? Why were the male interns not considered "one of the girls"? Even as we complimented her, we put her in a box defined by gender.

In this edition of *ChartNotes* you will hear about some pioneers who have helped change the face of medicine, by altering the inherent gender-based biases. I am not sure any of them started the journey into medicine to change minds and biases. Instead, they choose not to accept it and be "one of the guys."

We had a lot to learn. A few years ago, a sweet and motherly patient of mine called me out. I innocently told her to go up front and the "girls at the front desk" would schedule her referral. She looked me in the eye and told me they were women, and unless I was only going to hire women forever, I better change my statement… I was embarrassed and a little ashamed. I was also made aware how words have an impact, and what I considered innocent, in fact put a person, by their gender, into a defined box of my making.

Now, as a mature provider, I will make other mistakes, without a doubt. I am working on being more aware of how I perpetuate stereotypes by not giving proper respect in my language and my actions. The title "honey" is now reserved for my wife or daughter. I try not to link gender to job; nurse, technician, medical assistant are jobs, not chromosomal status. And I am starting a new journey to understand and respect pronouns and a person's gender based on choice, not what my eyes perceive. I want to be respectful of others and, I hope, my language reflects that.

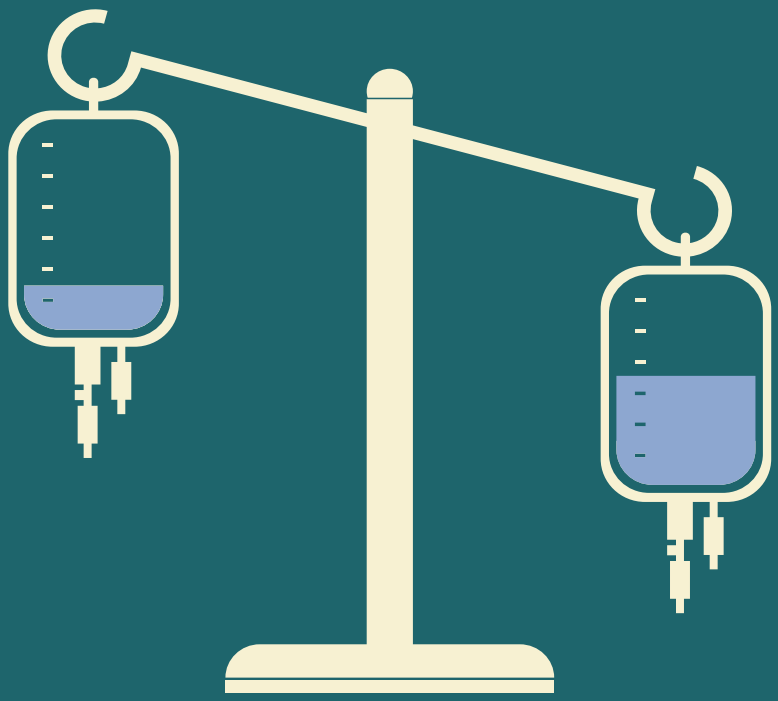
Now that you've heard my confession, please enjoy this edition of *ChartNotes*!



Working continuously to balance the

SCALES OF JUSTICE.

We're taking the mal out of malpractice insurance.
As a relentless champion for the practice of good medicine, we continually track, review, and influence federal and state bills on your behalf. All for one reason: when you can tip the scales in favor of the practice of good medicine, you get malpractice insurance without the mal. Find out more at **thedoctors.com**



The Doctors Company
TDC GROUP

From the Executive Director

G. Harvey Gail, MBA

A Season of Thanks

As we enter a season of thanks, it's time to show appreciation to those who have helped the Marion-Polk County Medical Society. Our board members, volunteers, and members all deserve a word of gratitude for everything they have done in the medical community.

First, we are thanking members with a little fun. Join us on December 5th at 5:00 pm at the Silverton Christmas Market at the Oregon Garden. Bring the family and the grandkids to this amazing event that features thousands of lights, food and craft booths, giant slides, and even Santa Claus. The event is free to MPCMS members and their families. We will have fun goody bags for the kids. Registration is on the website.

Next, we would like to thank our board members. They are fantastic volunteers with spirited energy and ideas. Between monthly board meetings, committee meetings, and insightful discussions, their dedication and hard work really shows. Board members, thank you for helping me to navigate my first year as Executive Director.

Our *ChartNotes* Editorial Committee has very thoughtful discussions of issues impacting medical professionals. They work hard to create interesting and insightful articles. Be sure to thank them, especially Dr. Nancy Boutin, our editor, for their hard work.

And thank you, members and healthcare professionals. The recent uptick in COVID-19 cases is starting to wane. You've endured yet another wave of this pandemic.

On another note, you should have received your member directories. It is quite a project to put this together, so if you have any corrections, please let us know so we can inform our members and update our data.

Finally, enjoy this issue featuring women in medicine. Happy reading and be well!

From the Editor

by Nancy Boutin, MD

In This Issue

I started my medical education at OHSU in 1979, one year behind my older sister. In the next decade I finished med school, a transitional internship, a radiation therapy residency, and served for three years as junior faculty on the Hill. I also got married, had two little girls, and moved into my childhood home after my parents relocated to Salem. With a real kitchen, a dining room, and a large backyard shaded by seven giant Douglas Fir, the house became a haven for women physician friends, mostly single, for whom OHSU was a one-to-six year stop on their way to careers elsewhere. They called my husband when they needed extra muscle or legal advice. They celebrated holidays, birthdays, and going-away parties with my extended family. They took my girls out for ice cream when they wanted a little kid-time.

One day, my older daughter was talking about one of her preschool buddies, whose two-physician parents were also friends. She wanted to know what Sean's daddy did, which I assumed she knew. I reminded her that he was a doctor. She rolled her eyes and said she wanted to know about Sean's *daddy*, not his *mommy*. When I said they both practiced medicine, she looked at me like I was trying to trick her. "He can't be a doctor," she said. "He's a *man*."

In this issue, we explore the reality of being a female provider in the mid-Valley, from the earliest days of Willamette Medical School to practicing pregnant during the pandemic, and celebrate the career of a beloved neurosurgeon. We look at how gender influences the experience of stressors in medical practice, as well as the response to that stress, followed by wellness advice from contributor Erin Hurley. I report on the frightening emergence of "new fentanyl" and "new meth" coming from countless small manufacturers in Mexico—fueled by the same societal pressures responsible for the so-called "deaths of despair." Jim Bauer, Chief Development Officer at Salem Health, details the efforts of the SH Foundations to address these pressures through a population health approach. And finally, Rick Pittman and I hope to entertain you as we indulge in our non-medical interests: cooking, Sudoku, the photography contest, and photographing fast cars. As always, Rick gets The Last Word.

Howard Baumann, M.D

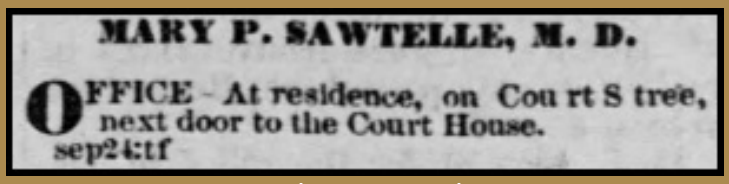
WOMEN DOCTORS OF MARION AND

When Willamette's College of Medicine first opened its doors in 1867, the University's Board of Trustees already had a policy that women should be admitted to that institution on the same terms and have the same advantages as men. Likewise, when Marion-Polk County Medical Society had its first meeting on October 14, 1870, they adopted the Code of Ethics of the American Medical Association which provided for the admission of qualified female physicians to their society.[1]

Dr. Mary Sawtelle, undated photo, from her 1891 autobiography

Willamette's first female medical student, Mary Sawtelle, was admitted in 1869. However, it was not a particularly easy year for her. During that time, she passed all her courses except anatomy but decided not to retake the exam for fear of being failed again by the anatomy professor, Dr. Elmore Chase.[2]

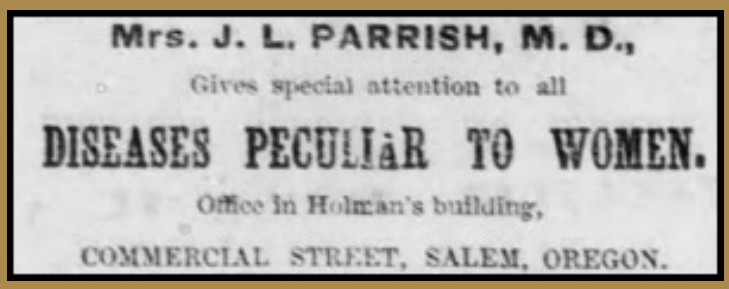
In her autobiography, Dr. Sawtelle writes that there had been: "a resolution attempting to exclude her from their class," and furthermore: "so much prejudice existed in the outside circles against women studying medicine." However, she had very complimentary words for her fellow male students, calling them her "band of brothers," thanking them for their consideration and total support. She subsequently transferred to New York Medical College and Hospital for Women where she graduated with honors in 1872. Dr. Sawtelle returned to Salem as Salem's first female doctor and set up practice for two years while her husband was finishing his medical degree at Willamette.


MARY P. SAWTELLE, M. D.

OFFICE - At residence, on Court Street, next door to the Court House.

sep24:tf

Weekly Oregon Statesman (Salem, Oregon), October 15, 1872.


Mrs. J. L. PARRISH, M. D.,

Gives special attention to all

DISEASES PECULIAR TO WOMEN.

Office in Holman's building,

COMMERCIAL STREET, SALEM, OREGON.

Weekly Oregon Statesman (Salem, Oregon), October 24, 1879.

Dr. Sawtelle specialized in women's health and pediatrics. It was during this time that she teamed up with women's suffrage activist Abigail Scott Duniway, to help advance the cause. The Sawtelles moved briefly to Portland and then to San Francisco where she remained very active in women's suffrage the rest of her life.[3]

POLK COUNTIES UP TO 1900

We should pause here to recognize that 20 years earlier in 1849, it was Dr. Elizabeth Blackwell who set the course for women physicians when she became the first woman in America to receive an MD degree in New York. Dr. Blackwell had been refused at eleven medical schools before finally being admitted to Geneva Medical College in 1847. Her sister, Emily Blackwell, received her degree soon after in 1854.[4]

The first two women students to graduate from the Willamette's College of Medicine were sisters, Dr. Ella (Ford) Robinson and Dr. Angela (Ford) Warren in 1877. Ella set up practice in Jacksonville as the first woman doctor in Southern Oregon, but unfortunately died two years later in 1879. Angela completed additional study in New York and then practiced in Portland until 1934.[5] In the early days, very few graduates, male or female, set up their practices in Salem due to the city's relatively small population (2,139 in 1870).

Dr. Clara Davidson (Courtesy of Oregon State Archives)

Dr. Sarah Dodson, youngest son Schuyler, and husband, c. 1875. (Courtesy of Berwyn Dodson Family Tree)

Over the first 20 years of Willamette's College of Medicine, a total of eight women graduated, with the class of 1879 having the most with three females receiving their degrees. One of those 1879 graduates was Dr. Jennie L. Parrish, who also became the second female physician to set up practice in Salem. However, she and her husband, the Rev.

...continued on next page

WOMEN DOCTORS OF MARION AND POLK COUNTIES

...continued from previous page

Josiah Parrish, noted for his earlier involvement with Jason Lee Mission, moved to Portland two years later. Dr. Parrish died of cancer in 1887 at age 43. She was buried in the Lee Cemetery in Salem. Noted Oregon author Jane Kirkpatrick recently wrote a well-researched historical novel about Dr. Parrish' life, medical training, and practice experiences, *All She Left Behind*.
The other two female graduates, Dr. Callie Charlton and Dr. E.L. Yeargain, set up their practices in Portland and Walla Walla respectively.[6]

In 1894, Dr. Clara (Montague) Davidson was the first female physician hired by the Oregon State Insane Asylum. She did her training at both the University of Oregon Medical School and the Woman's Medical College of Pennsylvania. OSIA had not been paying physicians commensurate with their education. She soon realized that she was being paid less than her male counterparts, and on September 1, 1895, wrote asking for a raise or the acceptance of her resignation. The board accepted her resignation. Dr. Davidson then set up private practice in Newberg where she practiced until 1905.[7]

The first female doctor in Polk County, Dr. Sarah (Cunningham) Dodson, is probably worth an article all to herself. Before she and her family traveled to Oregon by oxen-team in 1854, she had already completed a medical preceptorship in Tennessee, but did not have a medical diploma. However, from the time of her arrival, she cared for the sick from their log cabin on Salt Creek, six miles northwest of Dallas, while raising six sons and two daughters. "Doctor" or "Grandma" Dodson became legendary for her tenacious care, but also crossing dangerously swollen rivers on horseback to reach patients in need, day or night. When the Oregon Medical Board was created in 1889, she was permitted to register as a qualified physician in Oregon and she continued her medical practice for many years. Both her oldest son, Dr. Zackary Dodson, and brother-in-law, Dr. O.M. Dodson, graduated from Willamette University College of Medicine at the same time in 1877.[8]

Some of you may wonder why I didn't include local megastar Dr. Mary (Bowerman) Purvine in this article. There are two reasons: first, she didn't graduate until 1905, and second, I already plan on writing a dedicated article about this incredible early woman doctor.

1. Olaf Larsell, The Doctor in Oregon (Portland, Oregon: Binfords and Mort, 1947), pages 357, 423.
2. Jean M. Ward, "Mary Priscilla Avery Sawtelle (1835-1894)", Oregon Encyclopedia, Oregon Historical Society.
3. Sawtelle, Mary P., The Heroine of '49, a Story of the Pacific Coast (San Francisco: n.p., 1891).
4. Nimura J., The Doctors Blackwell (New York: WW Norton & Co., 2020).
5. Larsell, 415.
6. Jane Kirkpatrick, All She Left Behind (Grand Rapids, Michigan: Baker Publishing, 2017).
7. Diane L. Goeres-Gardner, Inside the Oregon State Hospital (Charleston: The History Press, 2013), p.58.
8. Larsell, 250, 414.

When your patients need more than an office visit... We'll care for them in their own home.

FIRST CALL
Home Health Care

- Skilled Nursing Care
- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Medical Social Worker
- Home Health Aide
- Transition Coaches
- In Home Personal Care

503.371.4567

FirstCallHomeHealth.com

First Call Home Health Care can help your patients recover from illness or injury or manage their ongoing condition with personalized care in the comfort and safety of their own home.

Locally Owned and Operated. A Company you can Trust!

WOMEN DOCTORS OF MARION AND

NANCY S. BOUTIN, MD

In 1973, when Marge Thompson, MD, arrived at Salem Hospital to resuscitate the Radiation Therapy department, she became the only female physician on staff. A smattering of women had practiced medicine in Salem over the previous hundred years, and a few worked at state-run facilities in the early 70s, but Thompson walked into an all-male medical staff. Fortunately, she reports she was welcomed "with open arms." She felt particularly well-supported by hospital-based radiologists and pathologists. "Radiology chair, Bob Mueller deserves special mention, along with Pete and Sally Kelly and John and Kathy Pozar," she says. "They were all so good to me, and Kathy remains a dear friend to this day."

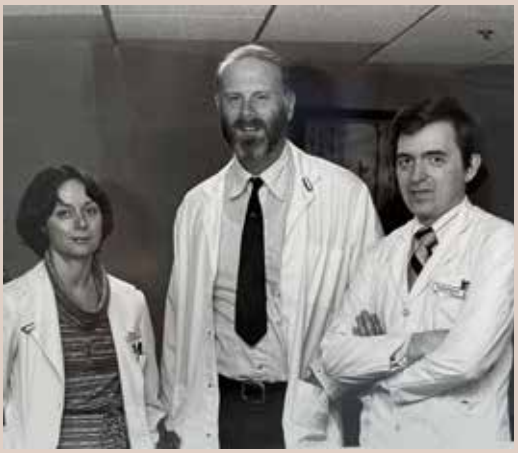
During her move, Thompson discovered it had been easier to put a VW bug into her rented U-Haul than it was to get it out. Kelly "poked around" until he located a ramped loading dock at the State Fairgrounds and saved the day. His wife appeared, as if by magic, with a luncheon tray and iced tea.

Thompson didn't need to get rescued very often; she valued her independence and self-reliance. Nor had she always felt as welcome as she did in Salem. She had bounced between undergraduate institutions and majors—from pre-vet (she realized she didn't have the brawn to wrestle recalcitrant cows and horses) to literature to pre-med (the Krebs cycle "thrilled" her). Once she started collecting brochures from potential medical schools, however, she found that about half included the message that "if you're female, don't bother to apply. We don't even want your paper."

Marge Thompson's first love.

...and the man she married

Marge and Worth celebrate an anniversary



Marge Thompson, Kirby Allen, and Ted Williamson

Although she didn't expect the University of Oklahoma to be a hotbed of progressivism, she applied at a time when they encouraged enrollment by women and students with a broader education than a straight science focus. She ticked both boxes. And, they intended to graduate everyone they admitted, if they could. Thompson's graduating class had only eight women, out of about a hundred, but the student body had been friendly and collegial. From Oklahoma, she traveled to San Francisco for a radiation therapy residency and, ultimately, sat behind the wheel of a U-haul truck heading north to Salem.

Thompson thinks her social integration would have been easier if she'd had a family. Children were the electrons that often brought adults together outside of the work environment. But that first year, Thompson didn't have time to worry about a social life, much less have one. The pent-up demand caused by the closed therapy department pushed the daily census to over a hundred

POLK COUNTIES AFTER 1970

patients once she opened the doors. By comparison, when Radiation Oncology moved into the new COM in 2000, with five full-time physicians, two new machines, and a full complement of nurses and technical staff, a census of one hundred required extended hours and felt crushing.

"Kirby Allen saved me when he came down from Tacoma. He could have demanded a pound of flesh, but he didn't. He just rolled up his sleeves and started taking care of patients."

Allen brought a family with him—including another physician, wife Amy, who had followed a more direct route to her MD degree than Thompson's.

Amy Allen, MD

Growing up up in St Louis, she went from Wash U undergrad to the affiliated medical school. She doesn't remember much pushback from professors or institutions, and joined as part of a larger female cohort, closer to 15%. Amy and Kirby met in gross lab (they liked to tell their children they bonded over cross-sectional anatomy), and married before graduation.

Kirby's military obligation and a radiation therapy residency took priority, moving the couple to Washington State. In those days, a doctor didn't need board certification and could work as a GP, so Amy had no problem finding interesting jobs—and having two babies in short order.

In Salem, Allen took positions in public health and other county agencies before she joined a busy private practice. As the only woman offering primary care in the area, Allen's panel swelled. When her senior partner retired, she was faced with more work than she could handle and three children who needed more attention, not less, than they had as preschoolers. She eventually left the practice and took a part-time job at the Oregon State Hospital.

At OSH, Allen met Ulista Brooks, MD, who graduated from University of Oregon Medical School in 1975, about the time Allen came to Salem. Unlike Thompson and Allen, Brooks grew up in a medical family—on the campus of the Oregon State Hospital. Her father, Dean Brooks, was a psychiatrist and the hospital's superintendent, her mother a nurse with a love of travel and indigenous cultures.

Brooks' residency application photo

Brooks attended U of O's Honors College in Eugene. She recalls once getting back a P-Chem test with many different grades written, and scratched out, across the front, ending with a "B+." When she went to speak to the professor about a different matter, he blurted out that she'd had the second highest score in the class, but he "just didn't feel right about giving an A to a girl."

She was admitted to U of O Medical School in a year when 10% of the entering class was female. She felt an undercurrent of "but they'll take a place away from a man—who wouldn't quit practicing when he started a family," but nothing as overt as the "don't bother to apply" notices Thompson had seen just a few years earlier.

On surgery call one night during a rotating internship in Maricopa County Hospital, she was paired with a surgery intern named Joe Hoover, who later became a revered McMinnville surgeon. They remained paired as a married couple for over thirty-five years, until Joe's death in 2010. They supported one another through their respective residencies, with two little girls, across Arizona, New Mexico, and Eastern Washington until they ended up back in the mid-Valley. As Allen had discovered earlier, plenty of rewarding medical opportunities existed for physicians whose formal training ended (or had been put on hold) after internship.

...continued on next page

Ulista Brooks, MD with Ulista Hoover, MD, and Joe Hoover, MD

WOMEN DOCTORS OF MARION AND POLK COUNTIES

...continued from previous page

Joe took the surgery job at Mac and Ulista was recruited for internal medicine by the then-current superintendent, who she'd known for years. She also found herself, in some cases, caring for *patients* she had known for years. Managing a gero-psych unit with back up from old friend, psychiatrist Mike Miller, she had long-term patients who recognized her from childhood. When one of them told a staff member he remembered watching Brooks riding a tricycle, the staffer "re-oriented" him, only to have Brooks "re-orient" the staffer to the accuracy of the patient's memory.

In the meantime, Thompson and Kirby Allen continued to build the radiation therapy practice, adding Ted Williamson, who brought a PhD in physics along with his MD. Thompson had negotiated an early contract with Salem Hospital ensuring enough independence that the partners could pursue a practice culture that offered a reasonable life style and plenty of face time with patients. Just shy of her fortieth birthday, Thompson married Salem-native Worth Mathewson, who shares her love of the outdoors, hunting, and camping. "A bad weekend," she says with a laugh, "is one where I'm not out tromping the woods—getting a little scratched and bruised in the process."

Ulista Brooks at OSH in the early 2000s

Over the next thirty years, the number of women practicing medicine in the mid-Valley mushroomed and now includes every specialty, including traditional male bastions like trauma surgery, neurosurgery, and urology. When Brooks' daughter, Ulista Hoover, graduated from medical school in 2000, the landscape looked very different from when her mother's generation attended. Woman students made up approximately half her class. Pregnant students and residents were fairly commonplace. Faculty composition was less male-dominated. Sexism, when it reared its head, was more likely to be of the microaggression variety than overt.

In 1998, Thompson and Kirby Allen retired from the practice Marge had raised, phoenix-like, twenty-five years earlier. Kirby and Amy moved to Portland where they had easy access to the music they loved. Kirby died this summer. Thompson continued to support the department with vacation coverage, between her own vacations from Canada to China. She and Worth moved to Capital Manor earlier this year, and continue to gallivant around the U.S. and Scotland to various birding sites with shotguns in tow. Brooks retired from the Oregon State Hospital just weeks before this issue went to press. She left immediately for another trip to Antarctica with the Lindblad cruise line.

It's been over fifty years since these three women decided to pursue careers in medicine. Their strength and example smoothed the way for the rest of us. Now it's up to a new generation to create a system that is more humane and healthy for everyone, patients and providers alike.

WOMEN IN MEDICINE
DURING A PANDEMIC

CHRISTINE RUE, PA-C

Adjusting to new roles can be a challenge. Adjusting to new roles as a parent and as a family practice PA during a global pandemic has proven to be extra challenging.

We welcomed our second child in May, 2021. Being pregnant during the COVID-era came with an extra set of fears. Will I have COVID during pregnancy? Do I risk exposure while working? Do we allow family members to visit after the birth? Despite Cade making his debut three weeks early, everything went as smooth as we could ask for. We were home 24 hours later, and were quickly enveloped in the blissfully exhausting newborn time-warp.

Fast forward three months, returning to work and acclimating to almost daily COVID updates, new office protocols, and patient care—all while pumping during every available break. It often feels like there is just not enough time in the day to complete charts and clean out my inbox before I'm packing up and rushing to daycare.

If I've learned one lesson over the last 18 months of practicing, it would be the value of flexibility. We've had to learn how to pivot and adjust expectations, from changing work schedules,

Christine, Lucas, Halle (2.5) and Cade (6 months) Rue

developing telemedicine, and a drive-through COVID testing site. Also, being a working mother requires managing a sick toddler with cancelled daycare, and sleep regressions, all while maintaining a profession. Staying flexible allows for the unexpected to not derail our day and for resiliency to develop. Ultimately, I believe these stressors make me a more empathetic, experienced provider— not to mention a more well-equipped mother.

BON VOYAGE, DR. YORK

NANCY S. BOUTIN, MD

Of all the things you could say about Julie York, MD, of Capital Neurosurgery Specialists, one thing stands out: the way she embraces change. And challenge. And adventure. Okay, that's three things, but they go together. Her coworkers and patients use words like "compassionate," "smart," "generous," "talented," "reliable," "funny," and "kind," but those first three descriptors got her from Pennsylvania to the mid-Valley.

As a freshly-minted U of Penn electrical engineer, York made the jump to General Dynamics in Fort Worth, where she designed aerospace electrical systems—and met her husband, John. He recalls that one morning, on the way to work, she announced that she'd like to make a career change. She was thinking about medicine. . .

By the end of her first year at Baylor College of Medicine, she'd decided on neurosurgery—exchanging one variety of complex electrical systems for another. John says that between Fort Worth and Salem they moved frequently, going from school, to residency in Salt Lake, to a combined ortho/neuro fellowship in

Julie York, MD

Seattle, to an academic appointment at Loyola University Medical Center. When she decided to leave academia for private practice, they started looking to move again. A friend in Portland alerted them to Bob Buza's upcoming retirement.

The couple interviewed in Salem in 2005 and "fell in love with the area," according to John. "But we really fell for Salem after we got here—the town, the people, the patients, and especially the welcoming, collegial neurosurgical community. You don't find that everywhere," he says. "It's our first real home, where we put down roots."

...continued on next page

BON VOYAGE, DR. YORK

...continued from previous page

A year or so after they arrived, the Yorks threw a reverse welcome-to-town bash in a downtown venue, even bringing their favorite band from Seattle for the event. Megan Wolfram, York's PA since 2010, says she still hears about what a great party she missed. At the time, York said she just wanted to say thank-you to the medical community for embracing the pair. The medical community says it would have been difficult not to do so.

Sandra Shore, former NTCU nurse manager at Salem Hospital, recalls that York "put patients at the center of her care and listened closely when they spoke." Shore says York sought the input of the whole team to really understand the patient's needs. "I always appreciated working with her. She's a gem."

Salem Health Surgical Services Officer, Deni Hoover, agrees, calling York a "tremendous contributor" to neurosurgical care in the mid-Valley. "Her patients appreciate her calm and compassionate approach. The hospital community is grateful for her responsiveness and excellent surgical care, in good times and through the pandemic, the ice storm, and all the other challenges."

The people who work most closely with York express even greater gratitude. Wolfram, who says the OHSU PA program leans toward primary care, credits York for teaching her "everything (she) knows"—not only about the brain and spine, but also efficiency, kindness, and how to be the type of provider she would want for her family. "Now that I'm working with another surgeon, using the skills she taught me, I think Julie sees the legacy she's created here at Capital Neurosurgery."

Melanie Son, a long-time patient care coordinator in the practice, says York is "like family," and "finds ways to make others feel valued and special. She cares about our health and our happiness—she mentored my young daughter, even giving her a white coat with her name embroidered on it. Dr. York's generosity made our office group crave to be just as giving of our time and energy as she is." Also, she says, "the laughs are endless. Dr. York encourages us to embrace our quirkiness and step out of our comfort zones."

The practice administrator for Capital Neurosurgery Specialists, Heather Born, echoes her colleagues' assessments. She contacted MPCMS executive director, Harvey Gail, to pitch this profile because York is making another career change.

With the successful launch of CNS and the inevitable pandemic soul-searching, York decided she'd accomplished what she'd set out to do, had offered excellent, compassionate care to her patients, and had been a productive member of the medical community. She gave herself permission to retire while she and John have the time and good health to enjoy things they love outside of work. In January, they will travel to Mexico to eat great food, swim with the fish, explore local art, and generally decompress. As the world opens back up, they intend to travel—a lot. They can also be found working in their garden, cooking for fun, visiting friends, and living without a call schedule.

Best wishes for the next adventure, Dr. York.

THE BURDEN OF

BY NANCY BOUTIN, MD

Kathleen Harder, MD, Salem Clinic internist, sees evidence of burnout among female physicians all around her. She sees it in her women colleagues, in online groups for physician moms, and, she believes, in the complaints that come before her at the Oregon Medical Board.

Burnout did not start with the pandemic. The annual *Medscape* survey of physician wellness, conducted in the autumn of 2020 during the height of the pre-vaccine pandemic, drew 12,000 physician respondents. They skewed toward over-fifty and male, although it should be noted that older age seems to protect against burnout.

Seventy-nine percent of those self-reporting symptoms said the symptoms began before the pandemic, leaving twenty-one percent to identify COVID-related stress as an initiating factor. Almost half said burnout has had a "strong/severe" impact on their lives, a quarter reported moderate impact, and the rest noted little or no impact. Twenty percent had either experienced suicidal ideation or declined to answer the question.

There has always been a greater number of women physicians admitting to burnout than men, but this year, the disparity widened; fifty-one to thirty-six. Not surprisingly, critical care and infectious disease doctors moved to the first and third positions, up from the middle third of listed specialties.

Men and women both ranked work-life balance, compensation, and combining parenthood/work as the top three workplace issues. However, within each category, men cared more about balance and money than women, and women were three times as likely to be worried about parenthood than their male colleagues.

In a *New York Times* article in February, 2021, author Andrew Jacobs introduced the concept of a "parallel pandemic" caused by trauma and exhaustion among frontline workers. The journal *Occupational Medicine* identified adverse psychological effects on front-line physicians caused by moral injury from ethical dilemmas regarding resource allocation as contributing to depression and suicide. Work-related stressors and the demands at home create a toxic combination for a group already behind on rest and self-care. During the period of inadequate PPE and lack of vaccine, many frontline workers self-isolated from loved ones, further exacerbating a crippling sense of isolation.

In September, 2019, the AMA reported on a study from the National Academy of Medicine (NAM) regarding factors contributing to burnout among female physicians. The first is "work-life integration." The authors have apparently moved beyond the concept of "balance." Given the lag time between data-collection and publication of findings, the information did

BURNOUT

not include the added stress of managing the unique family needs caused by lock-down, limited childcare, and distance learning.

The NAM cited pre-pandemic research showing that women with full time jobs spend an additional 8.5 hours per week on childcare and "domestic activities." If their partner also works, the women put in two hours of "domestic work" each day, while men in the same situation showed an increase of only forty minutes over baseline.

Other factors influencing burnout included gender bias and discrimination; lack of autonomy and lack of control over workload (due in part to cultural expectations of women as caregivers); and sexual harassment, both direct and indirect.

Seventy percent of women reported gender discrimination—higher among women of color—especially related to pregnancy and maternity leave. For a number of reasons, women providers had less control over setting workload boundaries, from employers and from patients. Women providers spend, on average, two minutes more per patient encounter then their male counterparts, amounting to one hour additional face-time per thirty patients.

Complaints to the Oregon Medical Board are the ultimate, "Let me talk to your manager." OMB Medical Director David Farris says that unless the physician reports burnout as the inciting factor in whatever behavior contributed to the complaint, it flies under the radar. But that's a Catch-22—many victims of burnout don't recognize their problem and others fear to admit the weakness.

Harder, former head of the Investigation Committee and current board chair, believes the increased complaints about women physicians are related to burnout, with allegations of rudeness, lack of caring, or some other way of failing to meet patient expectations. Anonymous respondents to the *Medscape* survey reported their depressed emotional state manifested as exasperation and frustration with patients, poor note taking, and unusual errors—the kinds of things reflected in the excess patient complaints Harder has reviewed. She also sees women retiring early, changing specialties, or pursuing a career outside of medicine.

A meta-analysis of forty-three articles from four databases on physician burnout showed men tend to demonstrate burnout as depersonalization, or disengaging from work and patients. Women, on the other hand, disengage more slowly, leading to emotional exhaustion. A male physician who seems aloof may be less likely to upset or offend a patient than a female physician who fails to adequately fulfill her caregiver role.

A paper published in the journal *Medical Care*, by researcher Timothy Hoff, recommends that organizations "ameliorate the factors that give rise to feelings of emotional exhaustion." A great idea, made impractical by the demands of the pandemic.

Further, even physicians working in organizations with anti-burnout programs may not take advantage of the offerings. Only thirty percent of the *Medscape* respondents said they would seek out organized help, if offered. Some minimized symptom burden; some said they didn't have time. Fear of disclosure or lack of trust in mental health professionals also prevented seeking assistance.

Almost half of the physicians who had not sought help for their burnout/depression said they could "manage the situation without help from a professional." For suggestions to self-manage, please see the article in this issue by MPCMS board member and wellness coach, Erin Hurley, MD.

Wellness

Erin Hurley, MD

Reflections on my career as a woman in medicine....

When I was in medical school in the early 1990s, I remember talking to my driver from the auto shop about school. He shared that his daughter had been accepted to medical school, but she became pregnant, and was not allowed to start. It reminded me of when my mom was a flight attendant in the early 1960s. At that time, you could not be married or get pregnant as a flight attendant. My mom secretly married and remained working for the airlines until she could no longer hide her pregnancy with my oldest sister, and she was forced to give up her dream job. Did the same rules apply to the male-dominated field of commercial airline pilots? Not a chance.

We have come a long way since then, with many women entering male-dominated fields including medicine, and women are no longer being kicked out due to marriage and pregnancy. As the percentage of female physicians rises, many of the traditional cultural aspects of medicine and rites of passage now appear to be outdated and no longer appropriate. Is "pimping" the medical students, a great source of stress, embarrassment, and insecurity really necessary for students to learn? I still remember my medical school pal John secretly saving me when I was in the hot seat getting peppered with questions from the attending physician. When asked what a linear aspect on an X-ray of the chest was, John, who was standing behind me, subtly ran his finger down my own scapula to give me the answer.

Is it also necessary to have adages such as "show up for work unless you are dead," popularly used, especially in residency? Is it any wonder why the statistics change within months of entering medical school and continue throughout our careers—as our mental health, depression, and burnout scores take a significant turn for the worse? One paper I read said that male physicians commit suicide at a rate 40% higher than the average population and female physicians a striking 130% higher. When we are subjected to unhealthy conditions throughout our training, when are we supposed to learn to take care of ourselves, our health, our wellbeing, and our relationships? It should be no surprise that physicians also have an elevated risk of divorce. We signed up for medicine because we wanted to help and heal others, but many of us were oblivious to what I call the collateral damage that this career can bring.

Could the influence of women in medicine help create a new culture that is free of guilt when providers take time off for illness or vacation? A culture that celebrates births instead of begrudgingly allowing maternity and paternity leave? Could a new culture encourage providers to take their earned time off at regular intervals to give them something to look forward to and time to replenish their diminishing reserves? Could a successful career in medicine be one that encourages providers to step away from their desk and actually take a break during lunch, instead of using that time to catch up on reports and patient care? What if setting clear boundaries between work and home was no longer the exception but the rule? What if, when a healthcare provider had a day off, they were no longer expected to check patient labs, answer patient emails, and still be reached by phone if there was a need? What if there was enough time during the workdays to complete charting and that day's work so there was nothing to take home? What if when you were home, you could fully focus on tending to your own needs and those of your family without additional interruptions or time demands from work? Is that really such an impossible ask?

If you have attended one of the wellness workshops I have hosted this year, read my prior articles, or otherwise spent time with me, you know that I believe the time is now to start setting better boundaries, paying more attention to our relationships, and tending to our wellbeing. After twenty years in health care, it took working with a coach to help me create the consistent change and support the choices that would create better outcomes. I could not figure out how to do it alone. I realized I could help and support other medical providers get out of chronic exhaustion and overwhelm, and I became certified as a coach. In addition to serving on the board of directors for the Marion-Polk County Medical Society, earlier this year I began serving on the board of directors of the Oregon Wellness Program (OWP). This program was started locally after a cluster of physician suicides occurred in Eugene several years ago. The OWP is now a statewide network providing free confidential counseling to physicians, PAs, NPs, podiatrists, and now dentists. Please know that you are not alone, reach out if you need support, and keep asking until you get it. If I can be of help, you can find me at transformationaldoc@gmail.com.

Man-Made Misery:

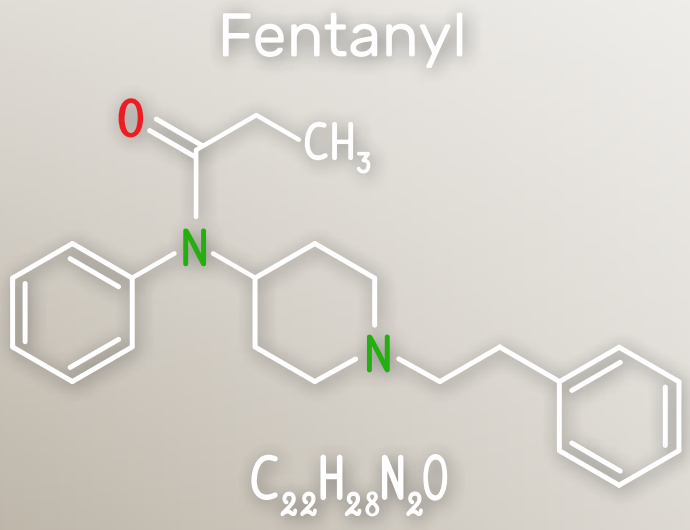
the rise and risk of synthetic psychoactives

BY NANCY S. BOUTIN, MD

Spoiler alert: If you don't want to know what may be in the "oxycodone" pill someone gave your patient/neighbor/child at a party or why the methamphetamine user in the ED today is so different from the one you saw five years ago, stop reading now.

Drug trafficking has been a part of American life for as long as there have been laws against specific drugs and drug classes. Anyone willing to make a buck off human misery has been able to obtain and sell illicit substances since well before Prohibition. Sadly, we in the house of medicine have unknowingly contributed to the creation of an apparently insatiable demand over the last twenty years by prescribing, and then deprescribing, massive quantities of opioids. Additionally, society has designed its own Rat Park experiment by isolating low-income Americans, often rural, and sending away the jobs that traditionally supported families who lacked a highly-educated wage earner—the segment of society that accounts for the "Deaths of Despair."

We know the risks to individuals and to society of prescription opioids diverted to the street, but the new synthetic psychoactives pose much greater dangers. While overdose curves from heroin and prescription opioids have flattened or decreased in recent years, deaths from illicit fentanyl have increased more than 1,000%.



Since 2013, headlines have tracked fentanyl overdose deaths in places like Appalachia, Chicago, and Boston. Tom Petty, Prince, several rappers, pitcher Tyler Skaggs, former Bruin Jimmy Haynes, actor Michael K. Williams—and tens of thousands other Americans—have died with fentanyl in their blood. And make no mistake, only a thimble-full of the drug came from prescription patches. The tsunami arrived as counterfeit pills from Mexico and China.

Paul Coelho, MD, at Salem Health's Pain Clinic, says the problem has arrived in the mid-Valley and he has the drug screen data to prove it. "In the last six months we've picked up seven positive UDS, and had two non-fatal overdoses. We hadn't seen a single case prior to that."

This September, Sam Quinones, journalist and author of *Dreamland: the True Story of America's Opiate Epidemic*, spoke with members of the Regional Overdose Prevention Project in Marion, Polk, and Yamhill Counties, hosted by Willamette University. *Dreamland* covers the resurgence of heroin that followed the rise of prescription opioids. Insightful Mexican drug traffickers "followed the pills," understanding that when the opioid-dependent patients lost their legal source of mu receptor agonists, they would need a relatively cheap replacement.

Even more insightful traffickers, he says in his new book, *The Least of Us*, realized the advantages of synthetic alternatives: fewer steps in the supply chain than are needed to grow, harvest, and process cannabis or opium poppies; less bulk to smuggle; the ability to create demand that hadn't previously existed. As a bonus, fentanyl powder could be pressed into pills, a form familiar to and trusted by the American consumer.

Of course, legitimate fentanyl doesn't come in pill form, but oxycodone "Blue 30," sure does. At roughly a dollar per milligram, recreational oxycodone is on par with wine and liquor. However, if you are an addict requiring several hundred milligrams every day, the cost becomes prohibitive. Yet it takes only pennies to make counterfeit "oxycodone," i.e. fentanyl, from cheap chemicals easily obtained through ports on Mexico's West Coast.

For one thing, to achieve "prescription-strength" illicit fentanyl, the pure form needs to be cut 50:1, an apparently unheard of dilution in the world of street drugs. The favored mixing equipment is reported to be the Magic Bullet blender,

...continued on next page

SYNTHETIC PSYCHOACTIVES

...continued from previous page

which does not blend powders well. A pill pressed from such a mix may be all fentanyl (at 50-fold strength), no fentanyl, or anywhere in between. Distribution of active drug within a single pill will be uneven, which is why two people sharing one pill may get very different results—including overdose and death.

Further, illicit fentanyl powder may be added to any other street drug during manufacture—turning a recreational stimulant-user into an unwitting opioid addict. Ditto the risk of opioid overdose.

The story of the "new" methamphetamine follows a similar script. With the crackdown on ephedrine availability, drug manufacturers in Mexico found workarounds with other toxic chemicals including cyanide, sulfuric acid, and hydrochloric acid. The patchwork of "Breaking Bad" meth labs in the US is being replaced by a pipeline from Mexico with a more sophisticated distribution system. If that's not bad enough, the new, ephedrine-free meth has a very troubling effect. Rather than making the user social and outgoing, it turns the user inward, paranoid, and sometimes violent. They are harder to reach—harder to help.

Quinones has data to show these individuals make up one end of the spectrum of homelessness, accounting for many of the most difficult problems posed by the population—both within the encampments and as they interface with the wider community. An article he wrote for the October 10, 2021 issue of *Atlantic Magazine* offers a deeper dive into the matter.

One more complicating factor to the synthetic psychoactive story, according to Quinones, is that the ease of manufacture has moved the economic model in Mexico from a set of hierarchal cartels into a "Wild West, free market." Taking down the El Chapos will have little effect on the flow of dangerous drugs into the US. We have to change the environment so that the potential market dries up—which was the ultimate lesson from Rat Park and the optimistic conclusion of *The Least of Us*.

Quinones' talk with the mid-Valley OD group and be seen through Willamette University's link at

https://willametteuniversity.zoom.us/rec/share/auA56nLSy9KRKeTFx9p2adGCgLSzR9_qdVD3qiGy4f3Xl5o046jCDf_Wh725MW4.pPOKtrGk4FaHIb5M

Salem Health Foundations and Population Health

JIM BAUER, MBA

Over the years, the Salem Health Foundations have served the patients of the Salem and Dallas hospitals. As the communities have grown larger and their health needs more complex, the Foundations have broadened focus to population health within our mission. To enact tangible change takes discipline and direction. Our population health work uses the four-component population health framework proposed by Dr. Stephen Shortell, dean emeritus of the School of Public Health at the UC Berkeley. His work proposes that improvement comes when effort is strategic, structural, cultural, and technical. It's our strategy to learn, to seek useful resources that improve understanding, to find effective partners, and to focus on initiatives that make a difference.

Strategy: We are listening across a wide platform of relationships with intent to connect people with intentional effort to provide support. We have formed a genuine partnership with PacificSource, our local CCO, where we collaborate to build strategy for population health improvement. Salem Health Foundations uses the Marion-Polk County Health Assessment documents to strategically target opportunity for improvement. The assessment helps reveal what makes our community health unique. Within our communities, we employ strategy to make a disciplined effort to learn from individuals and focus groups.

Structural: Structural effort starts with a sincere desire to find effective partners. Making the structure a resilient one comes from finding partner expertise, to select useful priorities for collaboration, and ensure that effort hits its mark. One example is the Foundations collaborating with a local low-income housing non-profit to ensure internet access for all residents, including children. Quality internet access was a barrier to studies for kids, and to health care and social services resources for parents. Another example is Salem Health participating with a wide range of local voices—including multi-county public health, our local CCO, all area hospitals, and advocacy organizations for Latinx community members, and many others—to unite in an organized

...continued on next page

Photo caption...

Photo caption...

Photo caption...

Photo caption...

SALEM HEALTH FOUNDATIONS AND POPULATION HEALTH

...continued from previous page

structure to improve the health trajectory around diabetes for area Latinx youth. Both examples show how aligning good partners into structure enables decisions and effort that truly effects change. A structure of relationships provides opportunity to collaborate. Structure feeds a population health learning system. The structural system allows gathering a variety of teachers and learners together, especially when focusing on a specific population health improvement plan.

Cultural: When COVID hit, cultural differences appeared to increase the complexity of distributing vaccine broadly. The Foundations went to school on how to bring care to local underrepresented communities by partnering with organizations within those communities. COVID testing, flu shots, and education became pathways of understanding and relationships. Caring people and thoughtful effort combined to illuminate unique cultural needs. The Foundations funded posters and flyers to encourage vaccination in six languages, as well as Spanish and Russian language radio and TV ads. We have learned, and continue to learn, about the nuanced cultural experiences that affect health care delivery, public health, community, social services, and access. Going forward, this learning will affect and influence shared goals and future action.

Technical: Better data allows better outcomes for our region. Any population health effort needs accurate information and a good method to share information. For instance, our regional population health is affected by the destructive cycles of addiction. The complexity of the problem is often hidden, confounded by poverty, and recently made more destructive by access to cheap fentanyl that can kill with small doses. Salem Health Foundations builds connections between those who can gather data inside the pathway of care and those with expertise to credibly analyze the data. This will enable actionable information to be offered back to providers, care givers, public health officials, payers, and even legislators, in a form useful to their particular needs.

The health of our population in Marion County and Polk County will improve using the four pillars of strategy described by Dr. Shortell. We have learned that useful strategy gets the right ideas to the surface, good information from a structure allows us to address issues and act on priorities, careful consideration of unique circumstances can positively affect the pathways to care, and a disciplined technology approach will inform good choices and enhance credibility. For the betterment of population health, the Salem Health Foundations are ready to lead activities that collect and analyze information, and turn it into accessible, useful data that better informs a wide variety of partners about pathways for improving the delivery and acceptance of care.

Photo contest winners

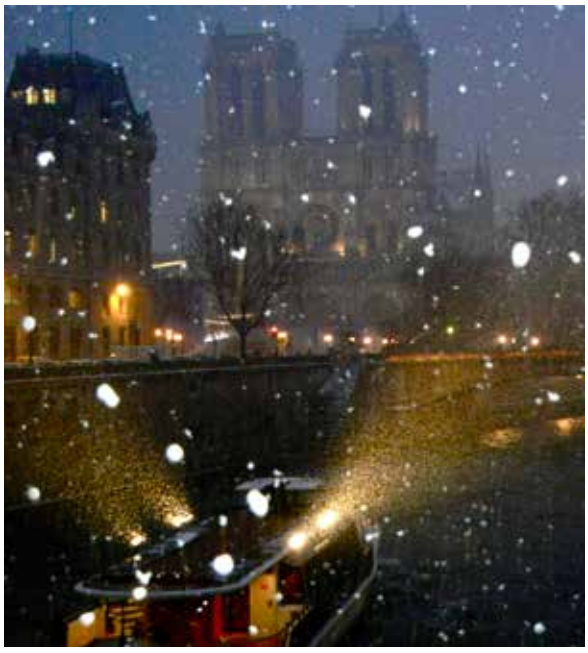
Grand Winner—Sheila Sund ($50)

Runner ups: Hal Boyd and Everett Mozell ($15 for each winning photo). Everett claimed two of the four spots. Thank you to everyone who submitted photos this time. We received more than 50 photos from 13 people.

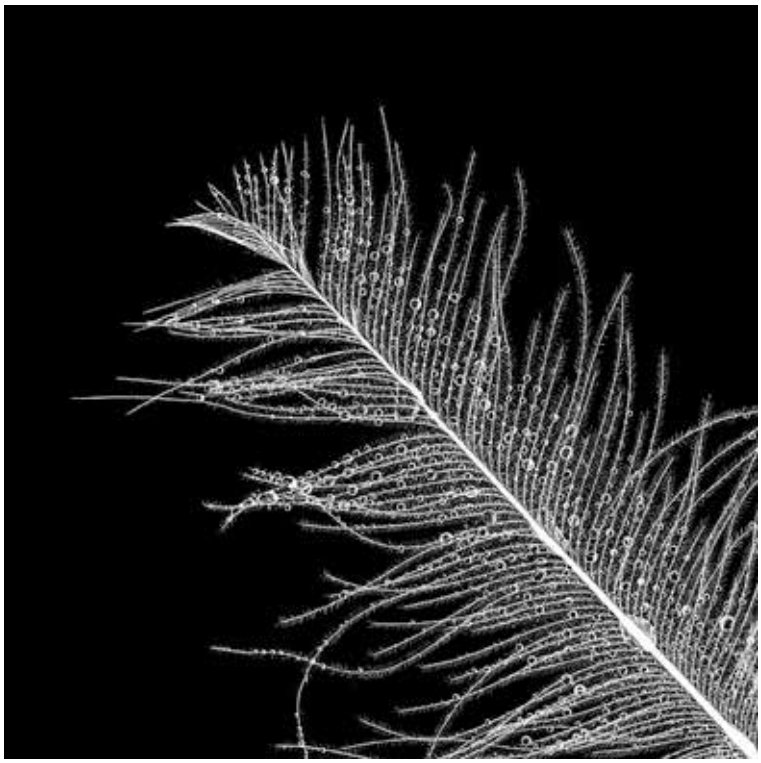
To begin, we eliminated the smartphone photos-maybe we will have a separate contest for the low resolution cameras.

Photos were thinned to 12 entries. MPCMS staff and editorial board then voted. It was very close and the top entries were only separated by 1 or 2 votes! Great job photographers.

Hal Boyd, March /6/2015 7:52 am. Canon PowerShot SX60HS F/5; 1/250 sec; ISO 160 : LENS FL 17mm.



PARIS IN WINTER: Everett Mozell
Jan 20, 2013, CoolPix S8 100 f\4.1; 1/30 sec. ; ISO 800 FL 12 MM.



DOWNY DROPS: Sheila Sund
Camera: Canon EOS 5D Mark III.
Lens: Canon 100mm f/2.8L Macro
Exposure 1/20 sec, f/13, ISO 800 ▪ Tabletop photography set-up with tripod

GREENLAND: Everett Mozell
Noritsu Koki (Scanner) ; So probably came from a slide, or film—perhaps a scanned photo.

Watch for an email regarding next issue's photography contest. Also, please answer the SurveyMonkey looking for the life-long learners among us, whether they earned an advanced degree, became a master gardener, or learned conversational Finnish.

Photographing Fast-Moving Cars

RICK D. PITTMAN, MD, MBA

In my spare time, I serve as club photographer for the Oregon Porsche Club. It is a fun hobby and satisfying to see my photos in both local and national publications, calendars, and the like.

One of the most important elements of photographing fast-moving cars is the use of the depth of field—this allows the subject to be in focus within a larger range. Remember—a pinhole camera has an infinite depth of field. Here are some other tips:

- choose a location that gives you a wide-angle view of the moving car while the car is in the same focal plane. e.g. the inside of a left curve.
- use continuous focus mode and 3D focus mode if your camera allows.
- if the camera autofocus is too slow, go to manual focus and chose a specific spot on the car's trajectory that will put it in focus when the car enters the turn. Shooting fast moving cars in turns can yield some impressive results.

- Choose a small aperture for increased depth of field. Worth repeating. Choose a small aperture for increased depth of field. Remember from several editions of *ChartNotes* ago we talked about the unintuitive inverse relationship between the f–stop NUMBER and the size of the hole the lens is looking through.
- The shutter speed settings are crucial, as well. For the start of the shooting, choose a high shutter speed and follow the car with the camera (panning). Note: if your lens allows, set the image stabilization to the panning mode. While this will not yield the sought-after background blur, it will get sharp pictures of the car. As you dial down the shutter speed, it is best to utilize the auto iso function in order to keep the exposure correct.
- With more feel for the situation, begin to dial down the shutter speed towards 1/60. Slower, if your camera has image stabilization. This is the tricky part as it can yield wonderful shots with the car and driver sharp, and the background blurred, but can also increase the number of blurred shots if taken when the car is outside of the focal plane.

- I find that the 100-400 mm telephoto lens with a circular polarizing filter is the best combination for photographing fast-moving vehicles from a safe distance. The polarizing filter removes the window glare that obscures the occupant(s).

BY NANCY BOUTIN, MD

MY CURRENT OBSESSIONS

Life Lessons of Sudoku

If you haven't spent the last forty years under a rock, you are familiar with Sudoku. Maybe you have played a few rounds or you may be a Sudoku master. If you're unfamiliar, here's the skinny: it's a puzzle comprised of eighty-one squares organized into nine rows and nine columns. A superimposed 3x3 grid organizes the squares into nine boxes. When the puzzle is solved, each row, column, and box will contain one copy, and only one copy, of the digits from one to nine. The puzzle creator will have pre-populated some of the squares with digits before it gets to you—a few filled squares for a hard puzzle and lots of filled squares for an easy one.

If you're like me, you probably assumed Sudoku came from the mysterious East, perhaps a meditative practice created by Buddhist monks searching for enlightenment. It actually has roots in the mysterious 18th century Switzerland as part of Leonhard Euler's work on "Graeco-Latin Squares," published in 1782. Sudoku first appeared in puzzle form as "Number Place" almost 200 years later, with modifications by Howard Garns. Only then did it travel to Japan where it got a new name and a final polish.

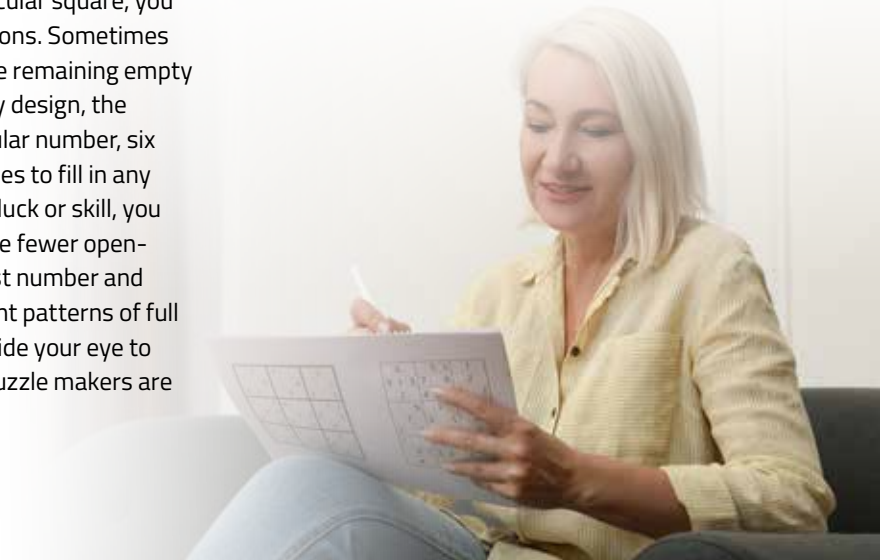
Sudoku does not require any mathematical ability. It's about patterns and pattern recognition. It could just as easily be played with nine different letters, or colors, or any other symbol.

To find the right digit for any particular square, you need to rule out all the wrong options. Sometimes there's a gimme—maybe only one remaining empty square in a row, column, or box. By design, the squares destined to host a particular number, six for example, will be the easiest ones to fill in any given puzzle. When you find it, by luck or skill, you can "run the board." Then there are fewer open-square options for the next easiest number and those squares will fill, too. Different patterns of full and empty squares will quickly guide your eye to the next "loose thread." But the puzzle makers are devious. While they give you some numbers that will make the others fall like dominoes, they also pick a couple to devil you to the end of the game. Beware. Those squares are a trap, a real time sink.

Playing Sudoku online poses different challenges from the paper version. You can't make a mistake that leads to the creation of a Gordian knot as you can with a pencil. If you try, the number screams red from the screen. Three mistakes and the game's over. On the other hand, the digital version keeps time of your play and compares your prowess to other players. This is where, for me, Sudoku transforms from a pleasant diversion to a life lesson.

To complete a puzzle quickly, you have to be on the lookout for easy solutions. You can't get pulled into trying to solve one tough square to the exclusion of all those teetering dominoes. It takes self-discipline to fill in the blank squares with the tools you have, when the problem children call your name. But the easy-to-fill squares narrow down future wrong options and make the tough nut easier to crack. I have often overlooked a key gimme on the board, because I couldn't take my eyes off the problem square.

Sometimes, in real life, we have no choice but to take on the most complicated issue in front of us. But how many times do we miss the easy wins while engrossed with an insoluble problem? And how many times would that seemingly insoluble problem untangle if we took the time to rule out all the wrong options before we started? Maybe I should go meditate on that for a while.



Yogurt "Incurred"

(Thank you, autocorrect. I'll take it.)

For easy, no-fuss homemade yogurt, all you need is ultra pasteurized or UHT milk, some active culture, an Instant Pot, a strainer, and time. See below for details. Regular milk works, too, but requires more time and attention.

And while I am obsessed with homemade yogurt, the current obsession is the curd that goes with it. I don't know how long I had a jar of lemon curd on my shelf with little idea how to use it. I suspect it got so far past its "use by" date that it went into the trash. I don't know what possessed me to make lemon curd last Easter, but when I stirred a scant teaspoon into my yogurt, I think I heard angels singing.

It didn't take long before I had made curd out of every citrus except kumquat (too difficult to juice) and yuzu (too difficult to find right now). The biggest standalone vote-getter so far has been ruby red grapefruit. As usually happens, internet research led to experimentation. I mean, lime is good, but lime-basil is better. And what about fresh ginger or black pepper? If I added fresh mint, would I have Mojito curd? I wonder about Pina Colada…

Epicurious offers a basic recipe online and suggests moving past citrus to other tart fruit—like cranberry. I can attest to raspberry and kiwi berry. Peach was okay (a different online recipe) but bland. Probably should have been paired with citrus or tart berry to make it brighter.

I found an English company that sells coffee curd, so I tried making that. Yum. Without the citric acid, coffee probably needs corn starch thickener, which the Epicurious recipe calls for and which is easy enough. Can mocha or pumpkin spice latte curd be far behind? How about Earl Grey? And if cocoa works, why not chocolate peanut butter or chocolate mint? You can see how these obsessions roll.

Curd is not just for yogurt. It can be spread on scones or toast. It makes a great filling for layer cakes, tarts, or bars. And it stays good in the refrigerator for at least a month, but we've never gone that long. By the next issue of *ChartNotes* I may have found or developed a whole new direction for the uses of curd—or I may have moved on to the next new current obsession. Only time will tell.

Yogurt

- Any quantity or fat content ultra-pasteurized or UHT milk, follow the instructions on your Instant Pot.
- Stir in a tablespoon or two of any fresh, live culture yogurt (if you start with berry, your first batch will be a faint pink, but will work just fine).
- Fermentation will take anywhere from six hours to twelve. Longer means tangier.
- Chill for at least four hours.
- Drain the whey as long as needed to achieve the yogurt thickness you like. (FYI, the tang is in the whey.) I use giant coffee filters, but cheesecloth or a reusable strainer from the internet work. If the yogurt gets too thick, stir some whey back in.
- See the tofu article for uses of whey.

Epicurious Curd recipe

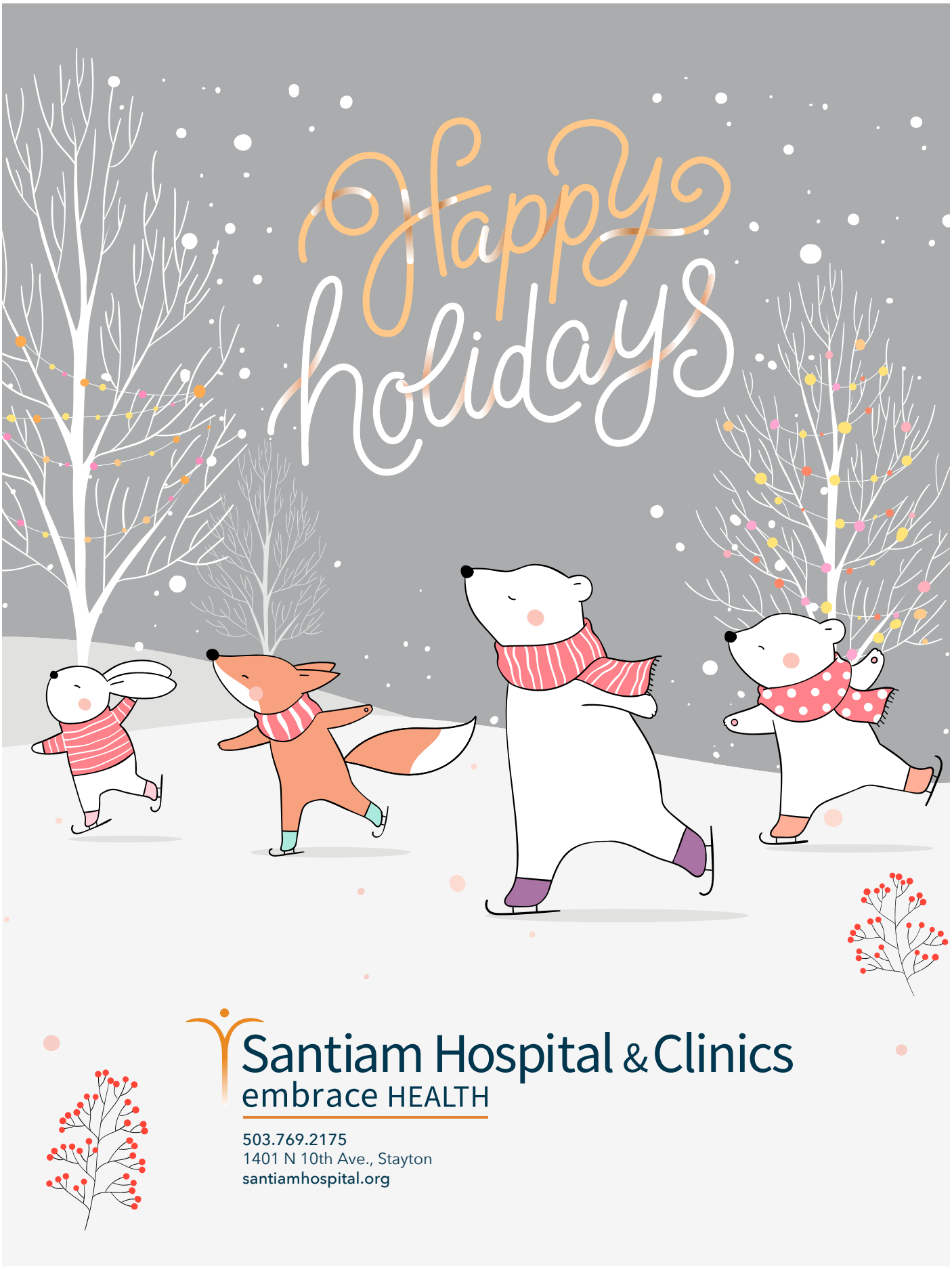
- 3/4 cup granulated sugar
- 0-3 teaspoons corn starch (depending on the acidity of the flavor)
- 2 whole eggs and two egg yolks (I remove the white protein tethers from the yolk)
- 3/4 cup juice, puree, or other liquid
- 1 T of zest (for citrus)

Mix well, cook over a double boiler, stirring constantly until thickened, about 10 minutes

- 1/2-1 cube of butter, cut into 1 tbsp slices. To taste.
- 1/8 t salt. Delete if using salted butter.

Add butter, one slice at a time until incorporated.

Cool. Should be silky. The coffee flavor benefitted from a quick mix with the immersion blender.



Santiam Hospital & Clinics
embrace HEALTH

503.769.2175
1401 N 10th Ave., Stayton
santiamhospital.org

RICK PITTMAN, MD, MBA

Last Word

Women Make Better Leaders

"I am absolutely confident that if every nation on earth was led by women for two years, you would see a significant improvement across the board on just about everything.... living standards and outcomes." [1]

Leaders are the soul of any organization. Leaders are responsible for the culture, health, wealth, and future of any organization, no matter how big or small. If I could distill the essence of a great leader into a small phrase—it is the willingness to sacrifice personal needs for the good of the whole. In an interview with a Marine general, author Simon Sinek asked why some teams were able to trust each other enough put their lives on the line and the general replied, "Officers eat last."

Trust. It is in our genes to believe that someone has our back, yet roughly 50% of people distrust their leader. 65% of leaders stress or alienate their employees. 70% of Americans would be happy to take a pay cut if someone would fire their boss. It is because we are still following the stereotypes of history, choosing leaders who are charismatic, confident without competence, and so in love with themselves that they lack integrity.[2]

Human beings are social animals. In the days of the hunter-gatherer, the main attribute of a good leader was to protect the tribe from their harsh physical reality. The people trusted their leaders, even to death. Being a leader is like being a parent—they put their own interests aside to protect those under their care. Whether we like the concept or not, females make better parents than males. This is even more true in the wild.

In 1953, 66% of Americans preferred a male boss. In 2019 only 23%. Male managers give themselves higher leadership effectiveness than female managers do, but in the same studies, subordinates always ranked female managers higher.[3] What incompetent managers lack (male or female), and what many female managers have more of, is the proper amount of emotional intelligence, and a leadership style that is transformational for her subordinates, blended with a dose of reality[4] . Today only 13% of the 6,000 or so hospital CEOs are female.[5] Salem Health is fortunate to have one.

There are now decades of research showing that women leaders outperform their male counterparts, especially during a crisis. Companies with more females at the helm do better; leaders typically account for around 30% of the variability in group's performance. Countries led by women appear to have managed the COVID crisis better than their male counterparts.[6]

Personality predicts leadership style. Leadership style predicts employee attitudes and team functioning. Attitudes and team functioning predict organizational performance. Managerial failures are due to dysfunctional interpersonal proclivities that coexist with talent, ambition, and good social skills, "but prevent people from completing the essential tasks of leadership and building teams."[7]

Equality isn't about exceptional women getting ahead, it is about smoking out the incompetent managers, male or female. 87% of Hospital CEOs are men, and while we could invoke the Peter Principle, we don't have time. Imagine a utopian meritocracy+ where people are not promoted because of their race, gender or otherwise.

The next time you attend a company picnic, banquet, or the like, observe if your leaders eat last.

1 Paraphrased B. Obama, Asher, S. (December 16, 2019). Women are better leaders than men. BBC News. Retrieved from: https://www.bbc.com/news/world-asia-50805822

2 Gender differences in narcissism. Psychological bulletin 141 Grijalva, E, et.al. 2015

3 Agreement in self-others' ratings of leader effectiveness. International journal of selection and assessment, 2009

4 Gender and leadership style. Psychological Bulletin, 108 Eagly, AH, et.al. 2003

5 https://www.healthcareitnews.com/news/boosting-prevalence-and-power-female-health-it-executives

6 Denmark, Finland, Iceland, New Zealand, Germany, Slovakia and Taiwan. "What do countries with the best coronavirus responses have in common? Women Leaders. https://www.forbes.com/sites/avivahwittenbergcox/2020/04/13/what-do-countries-with-the-best-coronavirus-reponses-have-in-common-women-leaders/?sh=4b1cc7483dec

7 Hogan and Kaiser. Review of general psychology. 2005, volume 9, number 2.

*Leaders Eat Last Title of leadership book by Simon Sinek 2014

**Otherwise known as charisma

+ Meritocracy in simple words means a system where promotion is based on ability and talent rather than on class privilege, wealth, gender, race, etc.

CHART NOTES - FALL BIOS

NANCY BOUTIN, MD, MBA

Managing Editor

Nancy is the Medical Director of Willamette Valley Palliative Care. She has contributed articles to *ChartNotes* off and on for twenty years. She is very happy to be back at the keyboard.

RICK D. PITTMAN, MD, MBA

In private vascular surgery practice for 28 years before obtaining a MBA from OHSU/PSU, Dr. Pittman works full-time as a vein and wound care specialist in the Silver Falls Dermatology Clinics and spends his spare time in the garden, behind a camera or in the workshop restoring cars.

HOWARD BAUMANN, MD

Howard Baumann retired in 2010 after 34 years practicing gastroenterology at Salem Clinic. He is a member of the American Association of the History of Medicine, the Society for the History of Navy Medicine, and is a Board Member of the Oregon State Hospital of Mental Health. He contributes regularly to *ChartNotes* and Historical Tidbits.

THANK YOU MEDICAL PROFESSIONALS

The Marion-Polk County Medical Society thanks all of the medical professionals in our community for your unwavering dedication, service and sacrifice. In the last issue of *ChartNotes* we featured our athletic endeavors. In a very real way, this pandemic has been a marathon requiring stamina, endurance and training – just like the race. Unfortunately, we don't get medals or trophies. But you deserve recognition, especially thanks. Marion-Polk County Medical Society continues to support and encourage you through fun activities like our Holiday Lights event December 5th and through wellness workshops and thoughtful articles in *ChartNotes*. if you have any ideas on how we can help, we would love to hear from you. Contact Nancy Boutin at nancyboutin@me.com or Harvey Gail at exec@mpmedsociety.org

150 YEARS 1870-2020

Marion-Polk County Medical Society

ADVOCATE. COLLABORATE. EDUCATE.

Marion-Polk County Medical Society
PO Box 246
Salem OR 97308-0246

RETURN SERVICE REQUESTED