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

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A PUBLICATION OF THE MARION-POLK COUNTY MEDICAL SOCIETY

CHARTNOTES

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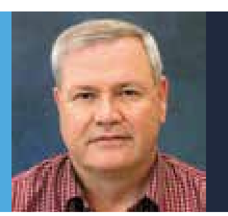
President's Message

Doug Eliason, DO



Homelessness. It is a term I have heard, seen, but only briefly experienced in my life. In full disclosure, I have never been homeless. I have lived out of a vehicle for three months, but it was thanks to a war called Desert Storm and I had a home, many thousands of miles away. After my three-month-long journey across the deserts of Saudi Arabia, Iraq, and Kuwait I told myself I would never again complain if I had food, a roof over my head, and a real bathroom with a toilet that flushed.

But many in America lack shelter, have food only when they can get it, and live with the knowledge that what shelter they do have can be gone in a moment. Homelessness is hard to explain in simple terms, even harder to solve. Wrapped up in it are all the social determinants of health with confounding issues like mental health problems and drug abuse. And our own biases.

My generation saw the last of the hobos—traveling vagabonds who knocked on your door for a sandwich before hopping a train to the next town. As a young boy, I thought this sounded romantic and exciting. Then came the hippies, living off the land and begging for food. As a young adult, I noticed that the people who lived this way were not so happy and carefree. Many showed years of hard living in their faces.

Today, as I drive by an encampment, I see garbage piled up, and I wonder, why do we allow this? I see the tents and the mess, but I do not see the faces…I do not hear the stories. I react to the visual with no clear comprehension of the WHY. And the why is part of the road to solutions.

No matter how you feel about homelessness, it cannot be ignored. It cannot be gotten rid of through enforcement. It is here and we must deal with it. This issue of *ChartNotes* will help explore some of the complex issues in our homeless crisis. I hope it opens some eyes, maybe a few hearts, too.

From the Executive Director

G. Harvey Gail, MBA

Hello, this is my first report for the medical society as Executive Director. First, I am pleased to be able to work with the medical society. This is an honor and opportunity to be part of the society's next 150 years.

As the son of a general practice physician, I have seen the challenges our medical professionals face every day. My father, Tom Gail, was a traditional small-town doctor. I recall him jumping off the tractor in our filbert orchard to run down to Newberg Hospital to deliver a baby then coming right back home and popping our Massey Ferguson into gear to finish dragging the orchard.

I am a graduate of University of Oregon, with a major in organizational behavior psychology, and I have an MBA from Willamette University. In the last ten years, my work with other medical organizations such as the American College of Surgeons and North Pacific Surgical Association has helped me understand the important work medical societies do to promote scientific advancement and enhance the careers of medical professionals. The scientific meetings I coordinate produce high-quality research that is published in the *American Journal of Surgery*. I especially like meeting the residents

Continued on next page

From the Executive Director

...continued from previous page

who are smart and fun, yet serious about helping people. I've also helped raise funds for the ACS's foundation to support medical missions in Haiti.

I enjoyed the last issue of *ChartNotes*. The focus on creativity was an insightful article that highlighted the many talents of our members. I have a vast variety of interests also. I've been rowing competitively for over 20 years. I play bluegrass banjo and I am a painter. Check out my Instagram page to see some of my recent work at @gharveygail. Mostly I paint in acrylic, but I love the challenge of oil.

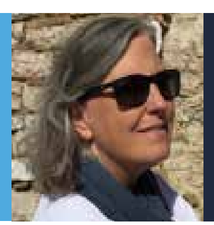
While I had an opportunity to meet many of you virtually at the annual meeting in February, I'm looking forward to connecting with everyone at future events – both virtual and in-person – once we get an opportunity to get together again.

Please contact me to share your ideas on how we can take on new challenges and opportunities together!

A Calm Day, acrylic on canvas by G. Harvey Gail

From the Editor

by Nancy Boutin, MD



As much fun as we had talking about creativity in last quarter's *ChartNotes*, the board felt the time had come to address the elephant in Salem's living room — the crisis of unsheltered residents and how the medical community can help. Just writing about the topic felt overwhelming at times, and I barely scratched the surface. Sometimes, when a problem is so pervasive, it can be difficult to think of ways to make any impact at all. A list of simple, manageable actions usually helps me take the first step. I hope you find this report and action list useful. Please let us know if you want more information, conversation, or have additional action items to share with the society membership.

In this issue, Howard Baumann completes his history of the Salem Health merger; Rick Pittman drones on about one of his hobbies—making and flying radio-controlled aircraft; and I tell you about a few of my current obsessions—photo manipulation, worm composting, and *Moby-Dick*. We introduce two new columns. Former MPMCS president Erin Hurley begins a series on wellness and board member Alyssa Schmidt shares her thoughts as a young provider. Rumor has it, she will pull in (young) board member Joe Rad for future articles. New MPCMS executive director Harvey Gail introduces himself and reports on the society's annual meeting that zoomed by in February. Our follow-up member survey has to do with Three Good Things, introduced at the annual meeting by our guest speaker.

Last, but not least, photography purist Rick Pittman presents the winner and runners-up for the first Marion-Polk County Medical Society Quarterly Photography Contest, admits that smartphone cameras are here to stay, and updates guidelines for future contests. Also, our friends at In House Graphics beg you to submit high-resolution photos to help their layout process.

As always, please contact Harvey Gail at exec@MPmedsociety.org with your thoughts, ideas, or feedback on how to make *ChartNotes* your very favorite magazine.

Member Meeting Held Virtually

G. Harvey Gail, MBA

Not exactly the celebration the Society wanted, yet after a year of Zoom it felt almost routine to have the Marion-Polk County Medical Society meet virtually on Feb. 25. More than 40 attendees made for a dynamic discussion.

A sincere thanks to sponsors, Active Recovery TMS/Neurostar, Salem Health, Willamette Valley Hospice, and South Salem Primary Care/Praxis Health. Active Recovery/Neurostar provided a $20 Grub Hub gift certificate to everyone who registered so they could enjoy a meal during the dinner-hour meeting.

President Dr. Doug Eliason welcomed the attendees, and guests were sent into virtual networking rooms where all were asked to come up with one word that means "joy" to them.

Krista Wood, executive director for the last four years, formally said her goodbyes as she has accepted a new position. She received flowers and a spa gift certificate from the board. Harvey Gail was introduced as the new director for MPCMS.

Dr. Eliason presented the **Society's President Achievement Awards**. Salem Health CMO Ralph Yates accepted the first award, and the Society donated $500 to the Salem Health Foundation. Santiam Hospital was also recognized and Maggie Hudson, President, accepted the recognition for work with victims of the Canyon wildfires. Their donation went to the Detroit Lake Foundation and will be directed towards the rebuilding of a community building in Detroit.

The guest speaker was Dr. Pritham Raj, a psychiatrist with Active Recovery TMS. He spoke on physician wellness.

At the end of the meeting, all the "joy words" shared by attendees were assembled into a "word cloud" graphic. It truly reflected how everyone feels.

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MEMBER SURVEY

Three Good Things

Nancy S. Boutin, MD

During his remarks on physician wellness, guest speaker Dr. Pritham Raj described a mindfulness practice called Three Good Things. This validated tool came out of the Duke Center for Healthcare Safety and Quality in hopes of preventing provider burnout. Test subjects were instructed to write down three things that went well during the day and how they had influenced the outcome. Randomized controlled studies five years ago demonstrated that after only 14 days subjects showed improved mood and sleep quality *greater* than if they'd started an SSRI. Surprisingly, the gains persisted an entire year.

Dr. Brian Sexton from the Duke Center says that the brain is hard-wired to notice and remember negative things. For much of human history, the ability to recognize and remember danger has saved lives. "Negativity," he says, "is like Velcro, while positive experiences are like Teflon."

We have to practice remembering the affirming, recharging events and emotions we experience before they slide away. Early in the pandemic, Duke Health encouraged workers to practice a transition-to-home ritual that included TGT, in an attempt to combat COVID fatigue.

Several MPCMS members reported that they had tried TGT at home with good success. Natasha Tiffany, MD, of Oregon Oncology Specialists, said that she and husband Geoff have added it to their dinnertime routine. When she proposed TGT to her two kids, 15 and 18, she expected them to "roll their eyes and say, 'here goes Mom again.' But the kids really like it," Tiffany says. "Even their friends join in when they come over and my parents join when they come to dinner. We find out things about each other's days that we wouldn't have known."

Even before the school lockdown, one of Tiffany's teens had experienced a lot of loss associated with the 2018-2019 string of high school suicides. She struggled with grief, undoubtedly complicated by the impact of the pandemic and resulting isolation. "It's really helped her to realize that good things happen and we tend to brush them aside to focus on the bad things. It's helped me, too. As a physician, I come home and worry about my patients or things that didn't go well. I forget about nice things—the card from a family or the patient who says how happy they are that I'm their physician. It's been really positive."

For more information, go to www.hsq.dukehealth.org. There are several apps to help keep you on track. The one that appears most closely related to the Duke study is at darlingapps.com. They are all available at the usual app stores. But writing the good things on a piece of scratch paper with a nub of pencil would work, too.

MARION-POLK COUNTY MEDICAL SOCIETY QUARTERLY PHOTO CONTEST (MPCMSQPC)

Grand Prize

Submitted by **Jennifer Lee Smith**, ANP ($50.00 Gift Certificate)

Florida Keys Oct 2020

Comment: Beautiful composition. Technical component falls down; not enough resolution to make into a large print, but the highest resolution photo submitted.

RICK PITTMAN, MD, MBA

Thanks to the folks who sent in photos for the first Medical Society Photo Contest. I had hoped my article on the pinhole camera would spark the attention of photographers using SLR cameras but in this inaugural edition of the MPCMSQPC, four out of five members sent in smartphone camera photos. At least we did not ask you to do your own darkroom work. That's another whole level of art and expertise!

Here's the thing--photography is all about the light. The tiny lens and pixels of a smartphone camera are, well, tiny. Such cameras do not work well in low light. And even if there are enough pixels, emailing an image with suboptimal resolution makes it impossible to use for a high-resolution magazine cover. And we would love to highlight your images on the cover of *ChartNotes*.

I blame the miscommunication on myself and should have been more specific, but it makes a good point. I listened and have modified the rules going forward. In the meantime, I hope you enjoy the photos the board selected as our favorites.

Sam Datta, MD Family Medicine

Comment: Great composition of fall colors. Technically, resolution too low for magazine publication.

Richard Boughn, MD Family Medicine.

Comment: Eerie photo of Gothic Architecture. The cloudless sky almost looks like it was photoshopped. In spite of being the only DSLR photo selected, the resolution is too small for magazine publication.

Congratulations and thanks to all the participants.

Joseph Rad, PA-C Oncology

Comment: Wonderful photo of Valley of Kings, Egypt. Technically good but washed out looking. I really like the 3D feel.

One of the photos submitted was a beautiful composition of Mt. Hood, taken from Mount St. Helens with an iPhone. Unfortunately, the technical aspect makes it unusable for our purposes. If this shot had been taken with a DSLR and a prime lens with proper management of the aperture, f-stop, and shutter speed along with proper white balance adjustment, it would be a great candidate for a cover photo. Lovely as it is, this looks more like a watercolor than a photograph.

REQUEST FOR PHOTOS: We will use two categories but still choose only one Grand Prize winner—sort of battle of the smartphone camera vs real cameras. From the many submissions I anticipate, we will pick two from each category. Any photo has the chance to be chosen for the Grand Prize.

When in question, use the highest quality your camera will take. Good magazine cover photos will usually have at least 5-10 megapixels per photo and this could go much higher if the image is raw.

There will be one Grand Prize winner and three runners-up. Jettisoned are the categories of nature, wildlife, etc. Just be aware that we cannot publish photos that identify people or other sensitive information (e.g. license plate number.)

All photos will be judged on: composition (remember the rule of threes) and technical quality/resolution. So, if the photo is sharp, 350 DPI, and with beautiful colors, but otherwise uninteresting, it will not be chosen. Neither will the great composition if we can't enlarge it. Keep in mind that, among other things, we are looking for a spectacular image for *ChartNotes*. A $100 gift certificate awaits the cover photo winner.

Marion-Polk County Medical Society Quarterly Photo Contest

- Contest is limited to photographs taken and submitted by current MPCMS members.

- Please state the title of your photo (keep file names short), where the photo was taken, what camera you used, the specifics of the camera settings if applicable, and any other information you would like to include about the image.

PHOTO SUBMISSION

This time please submit low-resolution images to my email address. If your photo is selected in the preliminary round, we will request a high-resolution image and will provide a Dropbox link for upload. Remember, we are looking for great photos taken at high resolution.

Send low-resolution preliminary images to my email address rpittman@silverfallsderm.net.

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Overwhelm

Wellness

Erin Hurley, MD

As medical providers, most of us are people pleasers. We say yes to our patients, work, partners, kids, kids' schools, places of worship… you get the picture. What does that lead to? A plate overflowing with to-dos and activities accompanied by a sense of overwhelm. Did you know there is a way out of this vicious cycle? It starts with awareness of your current state, a clear vision of what you would like to happen instead, knowledge that you are the one making choices, and a commitment to change.

For most of my medical career, I found myself living in a continual state of overwhelm. Too much to do with too little time, always busy and on the go, and finding it difficult to relax or slow my racing mind. When I gave up one activity, I said yes to two more. It was clear to my family I took on too much, so why did I think I could manage it all? Was I bored? Think I was the only one qualified? Needed a boost for my self-esteem? The message finally got through to me that if I wanted to be my most productive, energetic, and fully-present self, I needed to create space and buffers in my life and offload my overflowing plate. But was that possible as a medical provider, parent, and spouse?

It turns out it was. I was surprised at how much I needed to move off my plate to find some wiggle room and bigger blocks of time to slow down, rest, and fully connect with people. I had help from my high-performance life coach, learned from individuals with different perspectives and healthier lifestyles, and grew my mindset by listening to books, podcasts, and webinars on a daily basis.

Some recent lessons came from the book *Essentialism* by Greg McKeown. I owned the paper version for three years, but it took me Audibling it (is that a word, or did I just make that up?) and I regret not completing it sooner. Lesson: Be selective, save yes for only the best options, not just the good ones, as every yes comes with a cost. This means saying no to most opportunities and requests. If that makes you feel guilty, find creative ways to say no — "I'd love to help, but the timing doesn't work." "Can I make a donation instead of joining the committee?" or "Let me discuss this with my family first and I'll get back to you if can help." Essentialism also encourages you to ask, "What's important now?"

If it is not essential to do now, then don't. And while you are building this new skill of saying no, can you learn to say no guilt-free? Guilt usually does not serve any great purpose, and the more we can let go of it, the less energy it will steal.

When you say no to enough things, your pace slows, and you can finally find time for new healthy habits. Try some activities like meditation, tapping, exercising, reading, coloring, playing music, dancing, or taking a nap to name a few. Unlike binge-watching Netflix or scrolling through your social media feed (things that steal your time and energy and do not give back), the suggested activities can boost your mood, energy, and creativity, especially when done on a consistent basis. Then when it is time to tackle those few tasks you said yes to, instead of dread and overwhelm, you can do so joyfully with gratitude for your ability to help out.

Resources:

(some are free, some have a monthly, annual, or lifetime cost)

Meditation apps:
Calm, Headspace, Insight Timer, Simple Habit.

Tapping apps:
The Tapping Solution.

Calming apps:
Breethe, Colorfly coloring app.

I hope you can find some ideas that will serve you until next time. Feel free to email me for more information at transformationaldoc@gmail.com.

HISTORICAL TIDBITS

BY HOWARD BAUMANN, MD

PART TWO

1969: THE YEAR OF THE MONSTER MERGER

It wasn't easy, but it finally happened! After nearly 50 years of traveling on parallel paths while serving the citizens of Salem, two competing hospitals: The Salem General Hospital and The Salem Memorial Hospital officially merged on October 1, 1969. Few of us remain today who remember that day, but there are some of us "old goats" who started practice not long afterwards who can still remember the various ramifications, both pleasant and not so pleasant, of that union.

These two hospitals were founded under totally different premises. Salem General Hospital, initially called Salem Hospital, was a community-based hospital when it was founded in 1896. They would change their name to Salem General Hospital in 1927. Salem Memorial Hospital was a totally religious-based hospital when founded by the Mennonite Church in 1916, then called Salem Deaconess Hospital. They changed their name to Salem Memorial Hospital when they converted to a community-based hospital in 1947. There were several name and site changes along the way, as you will see.

Part Two will delve more into the nitty gritty of the actual merger.

North Tower of Salem Memorial Hospital in 1968.
(Courtesy of Salem Public Library)

Time for a Merger

1968 For better or for worse, the time had arrived for Salem's two community hospitals (Salem General Hospital and Salem Memorial Hospital) to merge. The history of these two hospitals up to this point is detailed in the Part One article.[i] By 1968, community leaders had come to realize that Salem could no longer afford two competitive full-service acute hospitals. The specialists in town were tired of serving on two house staffs and wanted one acute hospital, such as the gynecologists, who were delivering babies at both hospitals. However, most of the primary care physicians had strong loyalty to one hospital or the other, usually the one closest to their office, and thought their hospital should be the favored one.[ii] A negotiation process was started in 1968, which saw Ted Stang being hired as an Assistant Administrator to help Memorial Director, Irwin Wedel. Graciously, Ted has allowed me to lean on him for his valuable insights and clarifications of events for this article.[iii]

1969 The initial letter of intent was signed by both boards in January 1969. Now the two hospitals were officially "engaged to be married". The actual merger (marriage) occurred on October 1, 1969, when a corporate contract was signed. However, the newlyweds were not particularly enamored with one another. For instance, the two women's auxiliaries refused to talk to each other, and a group of 12 upset Memorial doctors threatened to pack up and start their own for-profit hospital in town. The honeymoon probably could have gone smoother, if more outside experience had been available, but hospital mergers were distinctly unusual back then.[iv]

The first item of business was to rename the two hospitals, in this case: Salem Hospital, Memorial Unit and Salem Hospital, General Unit respectively. The latter unit also included the Morse Maternity Building, which was located across the parking lot, connected to Salem General by a tunnel. It was agreed that a combined board would have 15 members, 10 from Memorial's prior board and 5 members from the General, commensurate with the bed count. Irwin Wedel was named

Executive Director and General's Robert McGlynn became Associate Director.

To add to the complexity, the two hospitals were not equals: Memorial Hospital was fiscally stronger, having added its North Tower in 1968, expanding its beds to 265 total, compared to General's 110 beds. Salem General was operating at a loss, had started laying off employees, and had to abandon plans for upgrading their 1924 hospital building.

1970 A poll in 1970 showed that a majority of doctors in town (55%) still favored a single acute hospital, but there remained a deep divide among certain physicians. A lot of work still needed to be done, and to facilitate the process, the Board hired an outside consultant ("marriage counselor") from New York, John Steinle and Associates, to analyze the strengths and weaknesses and to give recommendations. In the meantime, Irwin Wedel assigned a combined unit manager for each department of the hospital. Ted Stang was one of those and was assigned as the administrator of medical records, pharmacy, lab, and x-ray at both units. Likewise, Mary Wade, RN, was appointed as vice president of patient care at both units. Mr. Wedel purposely moved his desk and office to the General Unit to be more responsive to the concerns of their staff and employees.[v]

1971 On January 21, 1971, the Steinle firm concluded that the Memorial Unit should be designated as Salem's single acute full-service facility and that the General Unit should be phased out. They based their decision on Memorial's more central location, transportation routes, more existing core services, better-quality buildings, and suitable land for development even though the General Unit had more available land.[vi]

The Board of Trustees realized that some form of compromise was needed to smooth things out, and on April 1, 1971, they voted to go ahead with expansion of the Memorial Unit to a 420-bed acute care unit, and that the General would

Irwin Wedel at Salem Hospital,1968.
(Courtesy of Salem Public Library)

remain as an intermediate facility to provide maternal services for the city, and that they could retain a few surgical and medical beds. These decisions remained contentious and debated for many years.[vii]

End of an Era

1987 Just like at one time, it was time for a merger: it was now time for a change in direction. In 1987, the Board of Directors realized the need to upgrade their in-house rehab services, voted to close down the General Hospital, and modernize the aged building with a 4.1-million-dollar improvement to become Salem Hospital's Regional Rehabilitation Center, which included Easy Street training and a large therapy pool. All of Morse's maternity services were transferred to the Memorial Unit, and the Morse Building became a multipurpose facility.

2016 To complete the circle, I need to mention something about the final days of the General Unit buildings on Center Street. It started in 2016 with the demolition of the old Morse Building, and not much later, the demolition of the Rehab Building, which had recently been replaced by Salem Health Rehabilitation Center on the corner of Mission and Church Streets SE.

Now, only grass and trees remain where these buildings once stood, leaving behind memories, and a proud history of many years of service to our community. During the first 10 years of my practice after I arrived in Salem, I saw patients at the General, did an occasional procedure, enjoyed walking the connecting tunnel, and watch my son born at Morse. Like Ted and myself, I'm sure many of you old geezers have great stories to tell, and maybe we should do that sometime.

[i] Howard Baumann. 1969: The Year of the Monster Merger, Part One. *ChartNotes*, Spring 2021, 6-7.

[ii] John McMillan, A Century of Service. Salem Hospital 1896-1996 (Salem, Oregon: Salem Hospital, 1996), 73-77.

[iii] Ted Stang, MA in Hospital Administration, retired in 2001 after serving as Vice President of Professional Services and Director of the Salem Hospital Foundation. Ted was voted as Salem First Citizen in 2001.

[iv] Capital Journal, 5 Dec 1969. Doctors Consider Building Own Hospital.

[v] McMillan, 78-81.

[vi] Capitol Journal, 2 Feb 1971. Hospital Decision is Critical

[vii] Capitol Journal, 5 Apr 1971. For Two Hospitals.

LIVING IN THE MID-VALLEY W

How the medical community can help

BY NANCY S. BOUTIN, MD

A 40-something-year-old man sits in the gathering twilight on the sidewalk across from Rudy's Steak House, his back against JC Penney, a flat Walery's box on the blanket beside him. "Know anybody who wants some pizza?" he asks a passerby. "I only ate two pieces." He gestures toward the box, his eyes slightly unfocused.

The man seems altered, whether from mental or physical illness, chemicals, or exhaustion. It's not clear how the pizza came to be here. The man doesn't ask for money. He doesn't look threatening—he just wants to share his windfall.

Homeless is a catchall phrase that includes families who move in with another family related by blood or friendship; families living in their cars, in motels, or in shelters of one kind or another; couch surfers; tent dwellers in the woods, in city parks, or on sidewalks; and the men and women who sleep in the doorways of downtown businesses or under bridges and overpasses.

The number of people sitting or lying on Salem's sidewalks has swelled in recent years, despite efforts to get them to *move along*. Estimates put the number of "campers" within the city's urban growth boundary between 1,000-2,000, including about 100 who have no shelter but a blanket or sleeping bag. These people are simultaneously some of the most visible and invisible members of our society.

Salem Health emergency room doctor Trevor Phillips campaigned for, and won, a Salem city council seat on a platform that included support for recommendations by the Downtown Homeless Solutions Task Force. "It's the top priority identified by the people of Salem," he says. On his campaign website, Phillips wrote, "I recognize the City doesn't have the resources to provide everyone in need with a home, but we can find the resources to treat everyone with dignity while also ensuring our downtown is welcoming for all."

The causes of homelessness are deep, complex, and longstanding, made worse by the widening gulf between the haves and the have-nots. Housing costs climb while living-wage jobs become more difficult to find for anyone disadvantaged by fate, circumstances, or unfortunate early life decisions. Salem's unhoused population represents the part of our economy not reflected in record-high Dow Jones earnings. The chronically homeless often display a combination of mental illness, chemical dependency, and overwhelming physical health issues —all commonly caused or exacerbated by adverse social determinants of health, including childhood or military trauma. Life expectancy for the chronically unsheltered is cut by 25-30 years compared with the rest of society.

As complex as the roots of homelessness may be, the solutions are even more tangled. So the question becomes, how do the needs and wants of the unsheltered community intersect with those of the medical community? What opportunities do we have, as providers and citizens, to improve the health and well-being of Marion and Polk counties? Should we work through our organizations, as individual healthcare providers, or simply as friends and neighbors? Should we look for immediate interventions? What about the near-term? Do we need to think more strategically about long-range solutions, even if we are not lawmakers or civil servants?

The answer is "yes" to all. The topic of homelessness is too vast to cover adequately in a single article. It can be overwhelming even to figure out how to help. Below are a few suggestions offered by and for people with a proven desire to serve, the ability to problem-solve, and personal resources.

That would be us.

VITHOUT A HOUSE

Process improvement wonks ask, "What can you get done by Tuesday?"

Understand and acknowledge that the unhoused face barriers to accessing healthcare.

According to Tim Murphy, CEO of Bridgeway Recovery Services, people living on the streets may not even know what services are available. "Getting that information is often word-of-mouth," he says, "and it comes with lots of warning."

People with legal problems, civil or criminal, may fear putting personal information into "the system." Transportation may be difficult. There may be embarrassment going into a shiny clinic unwashed and wearing dirty clothes. Leaving belongings unattended in an encampment is a good way to lose them. They may risk missing out on a spot or a meal if they don't get back in time. Navigating hospitals or clinic spaces can challenge any patient and the processes of appointments and paperwork can overwhelm almost anyone.

Many homeless patients have insurance through the Oregon Health Plan. Most of the rest are eligible for OHP. Although the Salem Free Clinic used to serve large numbers of homeless patients, now they primarily act as a bridge to primary and specialty care, linking individuals with OHP and other services. Currently, the working poor, who don't qualify for Medicaid and can't afford out-of-pocket healthcare, make up the bulk of the Free Clinic's clientele. But that's a topic for a future article.

In your own practice, find ways to lower barriers and make access less difficult for your patients experiencing homelessness. Make sure someone on your staff has time to deal with the complex needs that probably don't exist for the rest of your patients. Don't fire patients for missing appointments or chronic lateness. Be patient. Be empathetic. Be compassionate.

Donate

When Salem Health Medical Group community service committee chose the homeless population as their outreach focus, committee chair and OB hospitalist Lisa Rice quickly realized lots of people are doing this work already. Many good ideas have yet to implemented, but somebody, somewhere in our community is working on it. No one needs to reinvent anything.

The City of Salem website has a long list of organizations working on behalf of the homeless. A few that stand out include the Salem Leadership Foundation with their Church@the Park, headed up by DJ Vincent; ARCHES, with

Continued on next page

How we can help

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advocate-leader Jimmy Jones; Union Gospel Mission; Salvation Army; and United Way. Those focused on children include Family Building Blocks, Liberty House, The Boys and Girls Club, as well as programs run by larger organizations such as UGM's Simonka Place and the Salvation Army's Kroc Center. In addition to Marion Polk Food Share, many churches, medical clinics, and social service agencies have food pantries on-premises.

Donate things

Every agency involved with homeless outreach will accept needed items—or direct you to one that will. Tents, tarps, blankets, and sleeping bags, new or gently used, are always in demand. Coats, jeans, and shoes in good condition can also be used. Socks and underwear must be new, that should go without saying, and are always in short supply. Toiletries for hygiene kits are welcome, but some sizes might be preferred over others. Food pantries always need high-quality canned protein and other food options. Some of the agencies serving meals and/or take-away boxes may have wish-lists, too.

And don't forget children's items. Not only are there children living in shelters, but they also live in cars and tents. School is hard enough without the extreme stressors of unstable housing and food insecurity. During the 2019-2020 school year, 21,000 students in Oregon were considered homeless. Three-quarters of homeless students lived in shared housing, 10% were unsheltered, and the rest stayed in shelters or motels. Satya Chandragiri, MD, president of the school board reports 1,100 homeless students in the Salem-Keizer district, although that may be an underestimate. And not all homeless school-age children attend school. In May 2020, HUD counted 1,590 unaccompanied homeless youth, some as young as twelve, living in Oregon. Seventy-five percent of those were unsheltered and not likely enrolled in school.

Keep your eyes open for food drives, coat drives, backpack drives. Almost any kind of drive will move your leftover items to someone who needs them.

Ellen Bennington, Portland homeless advocate and daughter of former Salem Health Psychiatry medical director Maggie Bennington-Davis, carries useful items in her car. As she interacts with unsheltered people she's able to hand out whatever she has available—a granola bar, a tarp, a pair of clean socks. She also organizes cooking parties with family and friends. At Christmas and during natural disasters like the wildfires and the ice storm, when getting to services might be more complicated than usual, she took meals directly to encampments.

Donations of service and resources are welcome at a number of Salem area organizations.

(The City of Salem website has a long list of organizations working on behalf of the homeless. The examples below are just a few of them.)

Church@the Park

The ARCHES Project

Union Gospel Mission

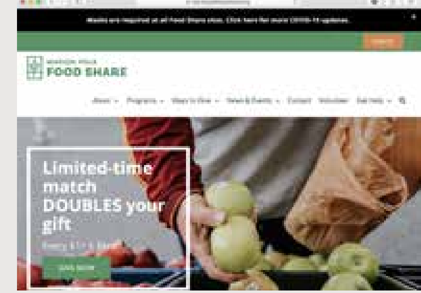
Salvation Army

Family Building Blocks

Salem Free Clinics

Liberty House

Marion Polk Food Share



Salem Warming Center

Donate money

Of course, there's always cash. A little online research will reveal which organizations most closely align with your interests and how well they do their job. CharityWatch, Charity Navigator, and BBB Wise Giving Alliance make the research easier. Nobody wants to be scammed by a fake, fraudulent, or inept "charity." You can write a check or click the donate button inevitably found on the organization's website. While they welcome one-time gifts of any size, a recurring commitment helps them plan for the future. You can also encourage others to donate with you—for birthdays and other special occasions or when they want to show appreciation for something you've done. Facebook makes it easy to solicit friends to donate to a charity you've selected. It's good for the charity, but benefits also accrue to Facebook behind the scenes. Why not cut out the middleman? If someone asks, "Can I pay you for fill-in-the-blank?"—using your vacation home, quilting you did for them, or watching their dog, you can always say, for example, "Why don't you send a few dollars to the food bank?"

And although food pantries welcome your canned goods, they can make your dollars stretch farther than you can.

We've all seen people sitting by the side of the road with signs that say, "anything helps." If you're uncomfortable handing cash to a stranger, but want to help, try a card for a nearby grocery store or fast food place. A bus pass would be a godsend for some people or a pre-paid phone card.

Bennington suggests sticking with cash. "No one judges me if I spend my money unwisely or if I have a messy house. People experiencing homelessness are still people, just like me. Why do we hold them to a higher standard?"

Donate time

There is no shortage of providers in our two counties who volunteer in various community health activities, including screenings, education, and direct patient care. Many have spent vacation time on medical missions. Some providers have been known to go to the encampments for outreach to an existing patient or to offer some specific healthcare service. At this point, I do not find any organized

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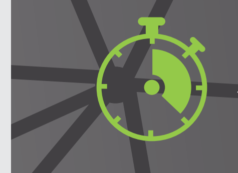
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How we can help

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mobile health initiatives in our area that accept volunteer providers. If you know of any, please contact the medical society and we'll get the word out to our membership.

When retired Salem Clinic physician Jim Byrkit researched which charities he wanted to support financially, he also realized they could make good use of his time as well. Byrkit has plenty of experience donating his medical expertise at the Salem Free Clinic, but he has other skills to offer also and wanted "to get boots on the ground. I enjoy building things."

That's how Byrkit found himself "swinging a hammer" and helping to build pallet homes at a secure site in NE Salem, paid for by the city and managed by Church@thePark. The units are intended as transitional housing, with support for the occupants to find employment and permanent housing as soon as possible.

In early May, the first 20 tiny houses opened for occupancy. The pallet homes have electricity and lights with two beds that can fold up during the day. They have locking doors for personal safety, as well as the ability to secure possessions while the occupant is working, getting medical care, or managing any of the other activities of daily living that are hard to accomplish if you have to worry about finding shelter. "The homes are well-constructed," Byrkit says. "And they are mostly aluminum, so you can hose them off if you need to."

After many years of contributing his medical skill locally and on mission trips, Byrkit has found a new way to serve and he's having a great time doing it. "This is the most fun I've had in my life," Byrkit says with a smile, "being able to get out and help people." After a pause, he adds, "I hope more of our colleagues get bit by the philanthropy bug."

See the person

Lisa Rice recommends taking it a step further. Rice has been involved in homeless outreach since her undergraduate days. She earned her BA, MD, and completed her residency at Creighton University. The first paragraph of the Creighton website homepage ends with the sentence, "Here, students learn to become leaders through service to others."

Rice's SHMG community service committee worked with local agencies and planned to participate in Community Homeless Connect 2020, whose tagline promised, "Connecting neighbors and providers, counting those who need to be seen, changing the conversation." COVID put those plans on indefinite hold, but the words spoke to Rice's core values.

"This is a group of people who tends to be forgotten," she says. "They're very visible, but a lot of times people don't see them. When we try to put ourselves in other people's situations, it humanizes them. Driving down the Parkway, you see the tents, but do you really think about the fact that someone is actually staying there overnight in 30-degree weather? Something that would be very easy for us becomes difficult for the unsheltered. We tell a patient to take some ibuprofen. 'Well, where am I going to get that? How am I going to store it? How am I going to keep it from being stolen by somebody else?' There are all these things we never think about."

While Rice acknowledges the importance of collecting cans and tents, she doesn't think that goes far enough. "I would like us to do things where people interact with their community. I was so excited about Community Homeless Connect and definitely want to participate when they reschedule. I worked in a free clinic for the homeless as a student, a resident, and then I staffed it as an attending. It's such a different experience when you sit and talk to people instead of buying things for them—although that's important, too."

"You don't get to people's hearts," Rice says, "until you get face-to-face."

A lot can happen in a year

A year ago it would have been difficult to imagine the events of the last twelve months. Perhaps the next twelve will offer more solutions than problems, but overcoming entropy takes work. Many potential solutions have been suggested to address aspects of the homeless crisis in the mid-Valley. Some have proven effective elsewhere. We need to examine the proposals and decide where to exercise our influence through advocacy, lobbying, and financial support. We also need to understand the physiologic factors that predispose a person to become unsheltered and address those problems individually and collectively. We need to decide where to apply a band-aid and where to employ more radical interventions.

Educate yourself and your staff

If you're not already an expert, educate yourself about trauma and other social determinants of health. I started with *The Body Keeps the Score* by Harvard psychiatrist Bessel van der Kolk, MD, and the 2014 IHI keynote address, *A Report From Xanadu: Healthcare and the Health of Communities* by IHI President Emeritus, Donald M. Berwick, MD. It's available on YouTube, but watch the one-hour version, not the five-minute clip. There are lots of good books on SDOH and the long-term health consequences. In the words of Dr. Berwick, stop asking your patients, "What's the matter with you?" and start asking, "What matters to you?" A related question would be, "What happened to you?"

Educate yourself about trauma-informed care and universal precautions. Then educate your organization and your staff.

If you're not already an expert, educate yourself about the underlying causes of chronic pain. (Hint: see trauma and SDOH

above.) Yes, it's real pain, but effective treatment requires non-pharmacologic interventions. Opioids do more harm than good in the long run. Understand how your appropriate, though generous, opioid prescription for acute pain may lead to dependency in a susceptible patient. Learn how to assess the risk and ask for expert help when you need it—before you and your patient get in trouble.

Find out about efforts at the local, city, and state levels to fund improving the health of people experiencing homelessness. Add your voice as a medical expert. DJ Vincent hopes you will advocate for grant proposals before the Salem Health Foundation and other medical entities to fund community health workers in managed campsites. "We want to bring services closer to the people who need them," he says.

Support more shelter options

City council member Trevor Phillips, MD, says that thinking about providing shelter has evolved in the last few years as the housing crisis has intensified. "Five years ago, the idea of allowing an encampment in a city park would have been a non-starter," he says. "But unmanaged campsites are not the solution for a whole host of reasons."

Managed tent camping sites

After visiting the 50-tent encampment at the State Fairgrounds Pavilion managed by Church@thePark late this winter, Phillips says he and his fellow councilors had a eureka moment. "We realized—this really works. We had our proof of concept."

Housing approximately 100 people, 10-15% of them going to work daily, the pavilion offered social distancing, safe storage of possessions, and respite from the elements. The campers included children and pets. Vincent said the February-March pilot exceeded their expectations in almost every area. According to an article in the Salem Reporter, "Six households secured permanent housing and another ten transitioned to more stable shelter. Forty households got connected to resources like the Oregon Health Plan, nutritional assistance, and other needs."

Phillips estimates that four or five sites similar to the fairgrounds would meet much of the current need—not everyone wants to go to a managed site—and says that 40-50 tents create an economy of scale. The biggest obstacle remains location, location, location to find an available space that meets regulatory requirements for safety and insurability.

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How we can help

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Managed car camping

Church@thePark manages parking for 100 vehicles, with 50 on a waitlist. Ditto the obstacle to finding an appropriate location for a second lot suitable for that number of vehicles. Eighteen months ago, the city of Salem approved more limited private-car camping for organizations who applied and took financial and organizational responsibility for providing toilet and staffing resources.

Pallet homes

The first twenty houses opened this spring. The waiting list demonstrates a desire for many more. Like car camping, they require space, but not a large empty building, and might be easier to site than managed indoor tent camping. Eugene and Cottage Grove have taken the pallet home idea much further—piloting tiny-house, supportive communities built on the Village concept with rents as low as $350/month.

Shelters

When the new UGM building opens later this year, the number of men's beds there increases from 150 to 300. No data is currently available on a proposed expansion of other indoor shelters in the community.

Group homes

Many different group home situations exist in the mid-Valley, from adult foster care to halfway houses. DJ Vincent thinks a self-governing group-living situation, especially for the hard-to-house mentally ill offers a great opportunity. As with all homeless solutions, most community members support sheltering unhoused individuals, but they want it "not in my backyard." And it's difficult to find a space that isn't in somebody's backyard.

Each of the suggestions to increase shelter requires community input as well as funding, either private, non-profit, or governmental. They are not permanent solutions, but available shelter offers possible transition to more stable or permanent housing for the individuals involved. It provides a humane path to shrinking the encampments and clearing the sidewalks while putting vulnerable people in proximity to the resources they need.

Adopt strategies to mitigate harm in the community

The 17th century English philosopher, Thomas Hobbes, asserted that "Life in the state of nature is nasty, brutish, and short." He could have been talking about conditions faced by the chronically homeless, who have been largely excluded from the modern social contract. Although none of the strategies below deal with the root causes of homelessness, each offers a chance to make life a little less nasty and short for our fellow citizens.

Mobile response unit

Calls to 911 about events at encampments or on the street are often due to physical or mental health emergencies, not criminal activity. Communities like Eugene that have put an appropriately-

staffed mobile crisis response van under the same umbrella as fire and police, alongside the police, have enjoyed great success. It is not "de-funding the police," it is matching the response to the need. Look up Cahoots at White Bird Clinic for more information. During weather emergencies, such a mobile unit could be a literal life-saver. ME Doug Eliason says he's struck by "the lethal combination of substance use and homelessness when the weather turns bad. People with altered sensorium don't even realize they're getting cold and they end up dying."

Primary care physicians typically complete death certificates, and there is no specific coding for homelessness, so Eliason can't track the death rate among the unsheltered. ARCHES' Jimmy Jones estimates 30 deaths from all causes since the beginning of COVID and supports Senate Bill 850 that would make reporting explicit.

Sobering center

Many communities have replaced the "drunk tank" at the police station or local ED with a medically supervised sobering center for individuals who need to safely recover from the effects of alcohol or other intoxicants. The costs are lower than spending hours in the ED and safer than going to the police station. For more information, go to the website for the American College of Emergency Physicians.

Navigation center

Health and Social Service systems are complex and convoluted. Redundancies and gaps abound. Rules change from one agency to another. It's hard enough to sort through the labyrinth if you're a highly-trained physician. Now try to imagine you are simultaneously managing hungry children, mental illness, time constraints, poor coping skills, lack of phone or transportation, or substance use. A quick survey of the internet shows conflicting opinions about the success of navigation centers, but it depends on how you define success. If you expect navigation to end all homelessness, it will never be successful. If success means matching individuals with available resources and support to improve their health and well-being, then the answer is "yes" more often than "no."

Mobile medical van

Given all the barriers to access noted above, taking healthcare to people experiencing homelessness makes tremendous sense, especially since many have active (or potential) insurance coverage. Chronic medical problems, acute illness and injury, and premature death plague those living in encampments or on the streets.

The medical community has some familiarity with certain aspects of mobile care. Dallas doctor Chris Edwardson staffed a medical/dental van as part of a homeless ministry in Portland some years ago and found the experience "meaningful." Alluvium Mobile Health offered home visits in the early days of COVID and testing later on. The Salem Free Clinic saw patients in makeshift clinics held in high school gymnasiums before they moved into Broadway Commons. Medical Teams International hosts van-based dental clinics in Salem and other parts of the Mid-Valley with support from local volunteers. With that level of experience, it ought to be fairly straightforward to implement a mobile medical van if infrastructure and funding were in place.

Mobile mental health services

As difficult as it has been to access mental health services in the mid-Valley historically, COVID has increased demand and pushed new appointment slots out for months, even for patients with commercial insurance. Given the known co-morbidities of mental health and chemical dependency in the chronically unhoused, these services might be even more relevant than a mobile medical van.

DJ Vincent, who has been a touchpoint for homeless outreach in our community, calls substance use "a multiplying factor" for the challenges faced by the clients he serves. He puts chemical dependency services in his top three requirements for breaking the cycle of homelessness. "We believe if people get the treatment they need, they move on to self-sufficiency much faster," Vincent says. "Every person who makes a positive human connection and gets connected with resources can work on their addiction. It gives them a chance to find a job or get housed. All of that matters."

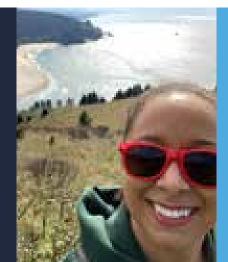
Tim Murphy, Bridgeway Recovery Services CEO, says his team has the expertise and the will to offer mobile care in addition to their current slate of treatment options. "We'd do it tomorrow if we could figure out the funding."

The long haul

Any provider who has worked at Salem Health or attended its Physician Leadership Institute has at least a passing familiarity with Toyota Production System or Lean. One of the foundational concepts of Lean is that the individual is rarely to blame for a failure, it's almost always the system. To solve the problem of homelessness in the long term, we need to solve some of the biggest systemic problems in American society, because homelessness is a symptom of a larger disease.

To take back our streets and our parks, we need to address poverty and the lack of affordable housing, shore up the middle class, educate people for decent-paying modern jobs, and protect our children from trauma and other adverse social determinants of health. We need to increase equity and dismantle institutional racism. We need to end the opioid epidemic and address the despair that disables and kills white middle-aged working-class men and women.

In the short term, we need to work across all the artificial boundaries that divide us: county, state, and city; governmental and faith-based; medical systems; public and private organizations. In the words of Bridgeway's Tim Murphy, "The growth of homelessness in Salem is becoming a public health crisis. It is absolutely treatable and preventable. But that requires a measure of collective will coming from all levels of the community. It requires all levels of leadership operating collaboratively. At this point, we are working siloed and it's not getting us anywhere."



From Where I Stand

Alyssa Schmidt
MPH, MCMSc, PA-C

Serving the Homeless in Primary Care

Before attending PA school, I knew I had a passion for vulnerable populations. I got my Master's in Public Health and thought, "Now I have the tools I need to change medicine!" I was quickly slapped in the face with real life. It was difficult to meld my need to help people in lower socioeconomic status classes and practice medicine. More and more, we learn that practicing medicine requires us to take a step back as providers and use the lens of social determinants of health. Studies show that American homeless patients are more likely to have many co-morbidities, challenges accessing care, transportation and scheduling challenges, substance abuse, and mental illness including trauma.

We need to ask about their barriers to care: Is their medication too expensive? Is this easily remedied with a GoodRx card or the $4 med list? Do patients need help with a bus pass for transportation? Does our social worker have resources to remedy this? Often, without looking too hard, you find staff willing to help with answers and resources.

Jumping to conclusions about substance abuse is not helpful. When I started practicing I was naïve about drug use. After building a relationship with me, one patient explained that he mixed meth with heroin and injected it in his neck. After he told me the truth about his lifestyle, I was better able to treat his co-morbidities and to discuss clean needles and disposal with him.

Salem has a growing homeless population that is not going to change any time soon. To better serve our community, we need a multidisciplinary team including a behavior specialist or social worker that we can partner with. In my practice (Pre-COVID), having an LCSW help with counseling and resource management was a lifesaver. It showed that not only did I care, but my team cared. Time is not a luxury we have; hopefully, your homeless patient has OHP coverage and can visit more often, if you can't have a longer visit.

Patient-centered care with a focus on empathy and patience will help us build rapport with patients experiencing homelessness. By making sure patients have a quality relationship with their primary care provider, we can lower healthcare costs/ED visits and ensure quality care for one of our most vulnerable populations in Salem. Don't give up!

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BY NANCY BOUTIN, MD

MY CURRENT OBSESSIONS

My family will tell you that, for me, the barrier between interest and obsession is whisper-thin. Lockdown has cut my commute from 40 minutes to a short walk between kitchen counter and kitchen table. My social life occurs almost exclusively by screen. Travel? Forget it.

This time-management scramble has provided me the opportunity to ~~explore~~ obsess over new interests. I hope you find something that piques your curiosity.

The Poor Man's Photoshop

Okay, I don't know how much it would cost to buy Photoshop or whether the apps I use cost significantly less. I do know that my first introduction to Photoshop made it seem so anti-intuitive that I walked away, never to try again. Not that I wasn't interested. I definitely wanted to make birthday cards that superimposed my friend's face on Christie Brinkley's body or turn my grandsons into a pair of sloths, but I never found enough motivation or time to sign up for the Adobe course.

Years later, I accidentally wandered into photo manipulation. During a wine-and-watercolor class, another student told me that she loved, loved, loved a very low-cost app called Waterlogue. The developers say it has "an exceptionally uncomplicated user interface" and turns photos into images that look like, well, watercolors. Problem solved. In a nano-fraction of the time required to paint a pathetic-looking field of lavender with a brush, I created six amazing "watercolors" of lavender fields from the *France* album on my cell phone.

In no time, I had watercolor portraits from each phase of my granddog's life. Every interesting landscape I had ever photographed turned into a Hopperesque masterpiece. And Heaven help you if you sent me a vacation snapshot. It undoubtedly came back as a greeting card printed on 140-pound art paper with deckle edges. Later, I stumbled across similar apps that turned photographs into oils, line drawings, or cartoons. I wrote picture book stories for my grandkids and illustrated them with drawings created from family photos or web images.

I slipped down the proverbial slope when Facebook pegged me for a patsy and bombarded me with ads for Photofox, now Photoleap. With nothing but a picture, your finger, and a touch screen, you can erase people, backgrounds, foregrounds, add

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elements, and merge images. Suddenly, I had sloth grandsons, bemittened Bernie Sanders at family gatherings, and my granddog lounging on a beach chair in Tahiti. My picture book illustrations no longer depended on anyone's travel history. Instead, my granddaughter can consort with green giraffes on the savannah, my grandson can time travel, and Godzilla can walk down Center Street.

All I need now is my own time machine to get back the hours I've obsessively spent erasing photo elements in search of the perfect composite image.

TIPS:

- The basic functions of Photoleap are free and do most of the things I want.
- Your finger works, but a squishy "eraser" touch screen stylus works better.
- If you put your image on a background color, it's easier to see the edges emerge.
- High-res images make a much crisper final product.
- Use the same filter on your two images for a better match.
- There are short tutorials online to compress your learning curve. Trial and error takes time—believe me!

Worm Ranching

I failed utterly at composting. My postage stamp yard didn't support a vigorous pile and neither did my stop-and-go project approach. An eco-conscious friend introduced me to worm composting when she brought me a quart container of Red Wrigglers from her own ranch.

Worms are by far the most forgiving animals I've ever had. Despite terrible neglect on my part, they keep producing amazing organic fertilizer, and more worms, year after year. I've settled on the $1 five-gallon bucket from Home Depot as my container of choice. I keep several, starting new buckets when necessary and consolidating old ones as able.

Red Wrigglers are top feeders, which means when they go to work on your potato peels, onion skins, and corn cobs, the top few inches will look like beautiful soil while the rest of the bucket looks like, well, old kitchen scraps. Scoop off the top layer every 2-4 weeks and let it mature in another bucket. A sheet of brown paper bag or cardboard laid across the scraps seems comforting and increases the time worms spend at the surface.

If you want to "harvest" the worms, put mature castings into a shallow container in full sun. Skim off the top inch or so of fertilizer every 15 minutes. The worms will burrow down until they concentrate in the bottom of your bin. If you just want to share with a friend or start a new bucket, simply scoop up handfuls of castings. It doesn't take many worms to start a new colony and there are likely worm eggs present even if you don't see many adults. Starting a bucket with a top layer of mature compost also discourages flies and slugs from intruding.

Worm castings are organic and go a long way in your garden, without adding chemicals. Did I mention worms are very forgiving? I once got a colony drunk on fermenting fruit and another time I fed them a whole shredded novel by a mean author. Once, I had to round up a herd that escaped onto my patio after a heavy rain. And yet they keep producing, despite everything.

TIPS:

- Drill small air holes in the top of your bucket/lid combo and drain holes in the bottom.
- If you want to collect the "worm tea," set your worm hacienda into an intact bucket—but empty it occasionally. Otherwise, let the nitrogen-rich liquid run into the nearby soil.
- Layer kitchen scraps and shredded newsprint/copy paper.
- Some experts say worms are vegan, others disagree. But meat scraps turn rancid. Ewww.
- Don't poison your bucket with wrapping paper dyes or cleaning products on paper towels.
- Egg cartons, berry boxes, and paperboard prevent your compost from compressing into anaerobic sludge. Corncobs are especially good.
- Keep buckets under cover in the rainy season and away from your backdoor in fruit fly season.
- Cover your scraps—before and during the composting—to prevent becoming a fly hatchery.

Moby-Dick

I struggled through *Moby-Dick* this spring and plan to read it again this summer. The white whale will not defeat me!

I expected a straightforward narrative and got anything but. *Moby-Dick* is (choose your metaphor) a patchwork, a stew, a prism that splits reality into fractured bits of story, philosophy, poetry, natural history, and political commentary. The narrator, "Call me Ishmael," says it is not an allegory, but much of what he says is unreliable, so you decide. Expect a heavy dose of Shakespeare, Bible, and 19th-century prose. A good audiobook helps.

I made my first dive into 600+ pages of "the greatest American novel" with a six-week guided group. One of the members said *Moby-Dick* changes with each reading and "is the book you need now." It may be the book *society* needs "now," given how its popularity has waxed and waned over the last 170 years.

Published a decade before the start of the Civil War (and eight years before the discovery of Pennsylvania crude signaled the decline of whaling), Melville lived in a divided United States. Citizens were polarized by opposing beliefs about race, the role of government, and who should determine the course of America—ordinary people or titans of industry? These topics are not mentioned explicitly in the novel, but neither are religion, sexuality, ecology, or demagoguery. And yet, they all simmer below the surface.

Despite the insightful comments by my group and our guide, I really didn't "get it." Then I picked up a slim book at the New Bedford Whaling Museum called *Why Read* Moby-Dick? by Nathaniel Philbrick. I wish I'd seen it first.

If you've never read Melville's classic, or even if you have, give it a go. If a dozen or so society members want a guided read, we may be able to arrange it—possibly as a fundraiser. Let Harvey Gail know if you're interested at exec@mpmedsociety.org.

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RICK PITTMAN, MD, MBA

Last Word

It is as though we have grown wings

—H. Hughes

But I Drone On

In 1986, during my transition from general surgery residency to vascular surgery fellowship, I had some time on my hands. So, I joined the AMA—the Academy of Model Aeronautics. I learned how to build, fly, and maintain radio-controlled aircraft (RCA), one of those hobbies that consume you, especially for anal-compulsive people like most physicians. I enjoyed it so much that I became a lifetime member of the AMA, L245968.

I learned that wind was the biggest enemy, especially for a maiden flight. It was the one thing that would keep a model aircraft on the ground. Personally, I will not take any model aircraft up for the first time if winds are gusting more than 10 mph. It's exasperating to wait all week to fly when the weekend turns out to be a good one for windsurfing. "*...it is doubly hard for an aviator to stay on the ground waiting for just the right moment to go into the air.*" Howard Hughes.

As my practice and family grew, time for an all-consuming hobby disappeared. In about 1999 I hung up my transmitter—and did not take it down again until 2020. Extra time during the pandemic led me back to my love of RCA and I quickly realized how many things have advanced over the last twenty years. The brushless motor and LiPo battery technology have made electric model aircraft possible, including drones. Think Tesla in the sky where torque is king.

Along with the technical advances come new popularity and new regulations. Everyone reading this knows something about drones and how pervasive they have become (if not, well, you probably don't have a cell phone either). There used to be a rule about how many could be in the air at any time, but it was difficult to regulate. Now, any unmanned aerial systems (UAS) > 250 grams must be registered with the FAA. In 2018 there were an estimated 1.4 million registered UAS with

a projected number close to three million by 2023.

Unless you have special clearance, any drone you fly today has to (legally) remain within visual line of sight (VLOS). This is very different from the military drones you may have seen on tv, flown thousands of miles away, and operated from somewhere near Las Vegas. As of April 21, 2021, Big Brother (the FAA) requires that all UAS—and this includes fixed-winged radio-controlled aircraft—contain an electronic module called Remote ID that identifies the craft, owner, location, altitude, and control station or take-off location, *in real-time!*

Like all regulations, there are pros and cons. Certainly, if everyone adheres to these rules, the skies will be safer. One silver lining is that, if you are a member of the AMA *and* you fly at an AMA sanctioned site (there are several locally—I am a member of the Dallas Wingdingers), Remote ID is not required.

If you have been thinking about getting a drone, now may be the time to join the AMA. While you will still need to register with the FAA, you can fly at a sanctioned AMA field without Big Brother watching.

I took the photo of the Willamette Valley that appeared in the last *ChartNotes* from a drone. For the next edition, I will return to tips on photography with special emphasis on the finer details of submitting photos for magazine publication, and the nuances of DPI, PPI, Pixels, CMOS sensors, full dig. sensor vs. cropping sensors in digital cameras. Stay tuned.

CHART NOTES - WRITER 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 would like to thank all of the medical professionals in our local community for your unwavering dedication, service and sacrifice. As we the emerge from the COVID-19 pandemic our focus shifts to getting back to normal. But what was normal a year ago may never quite be the same. A shift toward telemedicine, virtual education and how we gather for professional and social situations will likely continue. As this ordeal is lifted its time to reflect. In future issues of *ChartNotes* we will address how it has impacted you both personally and professionally and your patients. We would love to hear your story and experiences. Contact Nancy Boutin at nancyboutin@me.com or Harvey Gail at exec@mpmedsociety.org.

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