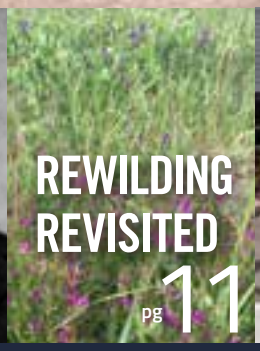
A PUBLICATION OF THE MARION-POLK COUNTY MEDICAL SOCIETY FALL 2022

CHART NOTES

Not Your Ordinary Summer Vacation

DR. JOHN MINTHORN & YOUNG HERBERT HOOVER IN SALEM

pg 8



REWILDING REVISITED

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BRAND NEW BRIDGEWAY

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LIVING WITH GRIEF

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A PUBLICATION OF THE MARION-POLK COUNTY MEDICAL SOCIETY

CHARTNOTES

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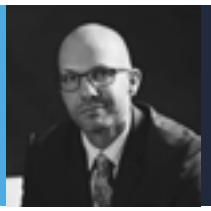
Navigating the Divide

President's Message

Keith Neaman, MD



The end of the pandemic has been predicted many times over the last two and half years, including in these pages. Each time, a new variant sweeps the globe and we cancel vacations, family get-togethers, and put the masks back on. This summer, though, the rates of BA.4 and BA.5 peaked and fell, and no current variants of concern glimmer on the horizon. And while plenty of healthcare workers called out sick for their mandatory isolation, most had mild infections. Maybe it is finally time to take a pause and talk about the impact of COVID on our medical community.

First, for all of us in medicine who came out on the other side of the pandemic, there is a dynamic tension between what was and what will be. Things have changed, our practices have changed, we've changed, and it would be foolish to ignore that. We see more patients with telehealth, meet remotely more often, and we have different priorities based on the morbidity and mortality we've seen with our patients as they have been impacted by the pandemic.

No matter how hard we worked before, we tend to gravitate now to things that are more valuable like our families, our personal sanity, and preventing burnout. Early in lockdown, with a young family and a busy practice, I didn't prioritize taking care of myself. Somewhere in the course of the past two years, I realized that a lot of people depended on me being present and healthy. Keeping myself fit, physically and mentally, wasn't self-indulgence. It was a necessity if I wanted to finish the marathon of life.

A friend introduced me to gravel biking and I took to it right away. It's midway between road biking and mountain biking, and I really love it. It lets me connect with colleagues, but at the same time, enjoy a sport. Out on a long ride, surrounded by beautiful, hard-to-reach scenery, I get my personal time, with enough quiet for introspection. I love exercising, and just a grinding of the pedals is very cathartic. I'm on the bike almost every day. I have a trainer in my house and a number of short routes I've mapped out so I can ride without taking too much time away from my wife and kids. As stretched as we've all been, everything we do requires a balancing act, and I've found mine.

Gravel biking works for me, but each of us needs to find our own way of decompressing. The medical community also needs to figure out how to reconnect after we've all been physically and psychologically remote—if not from the patients, then from one another. We need to go back and restore the connections that make MPCMS strong and resilient. I think we need more one-on-one contact, outside of Zoom, in person. We need a kind of grassroots, guerilla-type effort to connect so we can provide more holistic care for our community. The time we invest in ourselves isn't a luxury, it's a necessity if we want to be healthy and durable. Navigating the divide is my goal as president. I welcome your thoughts and ideas for ongoing success.

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From the Editor

by Nancy Boutin, MD

In This Issue

After a natural disaster, survivors emerge from their homes, look around, and take stock of the damage. Communities come together to clean up the debris, to figure out which structures are sound enough to use and which are a total loss. They begin to repair and rebuild. Since early in the COVID-19 pandemic, we've talked about "when things get back to normal." This wasn't a minor disruption and "things" aren't just going to snap back. We need to come together, assess, clean up, and repair. This issue looks at the summer we began to emerge and address the havoc created over the last several years.

In addition to the stunning number of COVID deaths, there has been tremendous collateral damage. Grief, mental illness, chronic pain, and chemical dependency have increased to record levels in communities across the country. We'll consider ways we're addressing those issues in the summer of 2022. We'll revisit people we met in issues published since early in the pandemic and see how things have changed.

We welcome back long-time contributor, Eden Rose Brown, who offers advice on making the most of a family reunion. Howard Baumann talks about the years Dr. Minthorn and his famous nephew lived in Salem. Rick Pittman shows how to plan a car trip off the interstates despite high gas prices. And, as we start to travel again, Erin Hurley reflects on how learning to navigate the airlines taught her how to navigate medical school applications.

In the last issue I got way more creative than usual—I made up a whole new medical group in town and bestowed a simpler, more streamlined last name on Howard Bauman. I apologize and I hereby give Dr. Baumann back his missing "n." And, An Ruan, PA-C, will be happy to continue working at *Capital Neurosurgery Specialists*. It must have been lonely in that other, nonexistent, office. The realization that a case of mental fog had resulted in publishing faux pas nudged me toward enjoying a restful, rejuvenating summer, although you'll see it didn't really work out that way.

We're always interested to hear from you, our colleagues. Please feel free to contact us if you'd like to talk about what's changed, what we've lost, and maybe even what we've gained through the chaos of the last several years.

CHART NOTES - FALL BIOS

NANCY BOUTIN, MD, MBA

Managing Editor

Nancy is the Medical Director of Supportive Care at Willamette Vital Health. 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 fall issue of *ChartNotes* featured activities as we come out from under COVID—ready or not. Research shows social interactions provide not only more meaning to life, but also contributes to wellness. Always, if you have any ideas for features in *ChartNotes*, contact Nancy Boutin at nancyboutin@me.com. If you or your organization has news or events to share, or an In Memoriam to share about one of our members, contact Harvey Gail at exec@mpmedsociety.org. Also, visit our website at www.mpmedsociety.org for our news submission policy. The Marion-Polk County Medical Society thanks all the medical professionals in our community for your unwavering dedication, service, and sacrifice. Be Well!

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Marion-Polk County Medical Society

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Wondering What to Do This Fall?

Out & About

BY MARY LOUISE VANNATTA, MBA, CAE, AND ADDISON ALLEMANN

Summer is over, school is starting, and the autumn colors are beginning to show themselves. Fall is one of the most beautiful times in the Valley.

Get Outdoors

Even though it is cooler, it is beautiful in our capital city in the fall. The temperatures will be perfect for outdoor activities, hiking, kayaking, and exploring the Northwest before winter's chill. The fall colors at Silver Falls State Park are gorgeous this time of year. Also, fall is migration time for birds. Minto Brown Island Park or Baskett Slough provide excellent recreation activities and birdwatching, no matter the weather.

Have Fun with Kids/Teens

It's pumpkin patch season. The Valley has dozens of places for picking the perfect pumpkin. Our favorite pumpkin patches are EZ Orchards, Fordyce, and Bauman's Farm and Garden.

Join in Holiday Fun and Festivities

September brings Oktoberfest in Mt. Angel. Polka bands, bratwurst, schnitzel, and buttery corn on the cob are on the menu. Halloween can be fun for all ages. Little children can show off their costumes and get safety tips on the Saturday before Halloween at the Salem Police Department's Halloween Dress Rehearsal (www.cityofsalem.net). For the older kids, check out the Nightmare Factory. It is located on the Oregon School for the Deaf campus, 999 Locust St NE, www.nightmarefactorysalem.com. This historical experience was enhanced when Salem was the site for ABC's *Extreme Makeover: Home Edition*. Disney and Rob Zombie came in to develop the animatronics. It opens on Sept. 30 and runs through Halloween.

For Thanksgiving, pick up a pie at Willamette Valley Pie Company on 82nd Ave off Silverton Road. In early December, you will start seeing holiday markets popping up. On Dec. 9-11, the Oregon State Fairgrounds hosts the region's largest Holiday Market.

Support Charity Fundraisers

Fall is when our local nonprofits start holding lunches, auctions, and evening fundraising dinners. Meet new people and learn about our community's needs. Search your favorite charity or TravelSalem.com for a list of upcoming events. Liberty House, St. Francis Shelter, and Family Building Blocks are just a few examples.

Participate in Fun Runs and Walks:

Fall is the perfect time to stretch your legs and participate in fun runs and walks with the family, children of almost any age, strollers, and even your dog. Check out the website https://www.runguides.com/oregon. You can sort by date, distance, and even Boston qualifiers.

Runs, Outing, Festivals, and Annual Events

Center 50+: Boot Scoot & Brew, Sept 9, (Cityofsalem.net)

Mt. Angel Oktoberfest: Sept 15-18, 2022 (oktoberfest.org)

Oregon Humane Society: WillaMutt Strut, Sept. 18 (WillaMutt Strut - Oregon Humane Society)

St. Francis Shelter: Saddle Up for St. Francis, Crystal Springs Ranch, (www.sfssalem.org)

Alzheimer's Association: Walk to end Alzheimer's Greater Salem-Sept 17, Riverfront Park, (https://act.alz.org)

Catholic Community Services Annual Luncheon, Sept. 21, Salem Convention Center (ccswv.org).

Willamette Vital Health: Walk-n-Wag, Sept. 25, Minto Brown Island Park (www.WVH.org).

Bridgeway Recovery Services 9th Annual 5-10K/walk: Sept. 25, Riverfront Park (bridgewayrecoverywalkrun.org).

Liberty House: Champions for Children's Luncheon, Sept. 28, Salem Convention Center, (libertyhousecenter.org).

Family Building Blocks: Gala of Trees, Dec. 2, Salem Convention Center (www.familybuildingblocks.org).

Salem Community Markets: Holiday Market, Dec. 9-11, Oregon State Fairgrounds (www.salemcommunitymarkets.com).

From the Executive Director

G. Harvey Gail, MBA

You Keep Us Going

As we enter the fall, the office will be publishing our annual member directory. This is a powerful tool to that can energize the medical society members by promoting networking while also providing a convenient resource for the medical community.

We all had a great time at Dancing Date Night on July 13. Dr. Tanie Hotan and Mark Lowes were wonderful, patient teachers of Latin dance moves. Thank you, Dr. Maurice Collada, and staff, at Cubanisimo Vineyards for hosting us. Feedback was positive and we will be holding more Dancing Date Nights in the future.

Medical Society members stepped up to help our community at Family Volunteer at the Park Day on August 25. About 20 volunteers helped with landscaping at Bush Park in the rhododendron gardens. Kids had fun winning prizes by helping and identifying plants. Thanks go out to the City of Salem Parks and Rec department for providing all the tools and wood chips.

For the first time in a couple years, the Medical Society will host the New Provider Celebration on October 6. While all members are invited, we especially encourage members to invite medical professionals who are new to the area or who are potential members. The event is at Red Gate Vineyards in Independence. Nibbles will be served by Black Sheep Catering.

Also mark your calendars for our annual Holiday celebration on Sunday, December 4. This year we are back at the Salem Riverfront Carousel. This is especially fun for children. Santa and his elves will be serving hot chocolate and good cheer.

This issue of *ChartNotes* covers summer experiences. It's a "what I did on my Summer vacation" issue with a twist. Read about interesting, powerful stories of adventure, learning and service.

Attendees practice their new moves on Cubanisimo's courtyard after a bite to eat from Wild Pear Catering.

Dance instructors Tanie Hotan, MD, and Mark Lowes teach attendees bachata dance moves..

Howard Baumann, M.D

DR. JOHN MINTHORN AND YOUNG HERBERT

Herbert Hoover, about age 11, Newberg, Oregon.
(Courtesy Hoover-Minthorn House Museum)

YOUR POP QUIZ:

1. **What U.S. Presidents other than Herbert Hoover ever lived in Oregon?**
2. **Was Dr. John Minthorn ever a member of the Marion-Polk County Medical Society?**
3. **What was Herbert Hoover's childhood nickname?**

Dr. John Minthorn, 1883.
(Courtesy National Archives & Records)

Hoover-Minthorn House Museum.
(Courtesy of National Society of the Colonial Dames of America in Oregon)

The early life of Herbert Hoover was not easy. He was born in West Branch, Iowa on August 10, 1874, but by 1884 at age 10 both his father and mother had passed away, leaving Herbert and his two siblings orphans. Herbert lived with an uncle at a nearby farm for 18 months, until his mother's older brother, Dr. John Minthorn, and his wife Laura, who had just lost their own son the year before, arranged to have young Herbert travel by train to live with them in Oregon.

Herbert spent four years in Newberg between ages 11 to 15, and two years in Salem until age 17 when he enrolled as a freshman at Stanford University in 1891.

Dr. Minthorn, a Quaker, was a multitalented businessman, educator, and a physician. After serving in the U.S. Army during the Civil War, he obtained his teaching credentials at the State University of Iowa and taught school in Iowa and Michigan. He attended Jefferson Medical College in Philadelphia, graduating with honors in 1877. In 1882, while practicing in Iowa, he jumped at an opportunity in Oregon to become the second superintendent of the recently formed Chemawa Indian School, then located in Forest Grove. Three years later in 1885 he moved to Newberg where he became superintendent of the Friends Pacific Academy, the forerunner of today's George Fox University. His wife became principal of the local grammar school.

When Herbert arrived at the Portland train station in 1885, the Minthorns drove him by buggy to his new home in Newberg. Herbert was already acquainted with his aunt and uncle from his earlier days in Iowa. When Herbert was age two, Dr. Minthorn was credited by his family for having saved his life during a near fatal episode of croup. At the Newberg home Herbert was expected to help with chopping wood, all the basic farm chores, and occasionally drive Dr. Minthorn on his house calls. Herbert attended school at Friends Pacific Academy.

In 1889, the family moved to Salem when Dr. Minthorn became an owner and president of The Oregon Land Company in Salem. His real estate business dealt in the development of agricultural land and the building of neighborhood homes. Herbert worked as an assistant in the office. The company also owned the Salem Street Railway, which started with horse-

Hoover in Salem, 1955, in front of the old City Hall Clock Tower.
(Courtesy Willamette Heritage Center Collections, 1998.012.0052)

HOOVER IN SALEM

Salem House, Highland District, 1948.
(Courtesy Salem Library Historic Photograph Collections)

Salem horse-drawn streetcars at depot, 1889.
(Courtesy Willamette Heritage Center Collections, 2004.010.0841)

Dr. John Minthorn House in Salem, 2022.
(Author's private collection)

drawn streetcars that served the downtown business district and had tracks to the train station and to the fairgrounds. Herbert occasionally worked as a streetcar conductor.

Although Herbert did not officially attend high school in Salem, he did attend night school classes at the Capital Business College which was located across the street from his uncle's downtown office building. Herbert applied to Stanford University in 1891, enrolled in its first class, and graduated with a degree in geology leading to his successful career as a mining engineer.

The Minthorn House in Salem still stands at 2213 Hazel Avenue NE, on the northwest corner of Hazel and Highland Avenues. The house has been modified many times over the years, including the removal of the second floor, so that it doesn't look much like the original structure. There is a historical plaque on the corner.

Dr. Minthorn's company unfortunately became a casualty of a severe economic downturn referred to as the Panic of 1893. With business at a standstill, Dr. Minthorn reestablished himself as a physician, and moved on to other academic and business pursuits in Iowa, Kansas, and Alaska.

Ex-President Hoover returned to Salem on August 9, 1955, staying overnight at the historical Senator Hotel on his way the next day to the dedication of his boyhood home in Newberg, the Hoover-Minthorn House Museum, and to celebrate his 81st birthday. The Senator Hotel was eventually demolished in 1997, to make way for the Salem Downtown Transit Mall. During Hoover's brief time in Salem, he enjoyed viewing the beautiful trees and flowers in his old neighborhood, observed that the old courthouse had been replaced with a post office, and recalled the prior State Capitol that had burned down. He also reflected about his lifelong love for flyfishing going back to his early days in Oregon. With a twinkle in his eye, he stated that he had brought along his fly-gear, hoping for a chance to sneak down to the McKenzie River outside Eugene.

Over the years, communication between Hoover and Dr. Minthorn became infrequent. There is little written about their long-term relationship except that which they wrote themselves. For instance, Hoover wrote in his memoirs: "The doctor was a mostly silent, taciturn man, but still a natural teacher." Dr. Minthorn reflected about Herbert in 1920: "I do not think he was very happy. Our home was not like the one he left with his own parents in it and with very little of responsibility and almost no work." When his uncle died in 1922, Hoover admitted that he owed his uncle "the greatest of affection and obligation" and that "he was, in fact, my second father."

Dr. Minthorn died from cancer in Portland, Oregon on October 11, 1922, at age 76. Herbert Hoover passed away on October 20, 1964, at age 84 in New York City from complications of a cancer-related intestinal bleed.

QUIZ ANSWERS:

1. None. Hoover is Oregon's only resident-President. However, the State of Iowa also proudly claims Hoover as their sole resident-President. His birth home in West Branch, Iowa is a National Historic Site.
2. Dr. Minthorn did not practice medicine while living in Salem. There is no evidence that he advertised or practiced during that time, nor did he join our medical society.
3. Bert

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9 Whythe, 285.
10 Whythe, 284,607.

Your Trusted Counselor

By Eden Rose Brown

INCLUDE A FAMILY MEETING IN YOUR NEXT FAMILY REUNION

Along with warmer weather and lazy days spent at a pool, summertime also often includes a family gathering, such as a Fourth of July barbecue, a vacation, a reunion, or time spent at a cabin or lake house. Whatever the form, in our always-on-the-go society, getting the whole family together is a rare occurrence. Consider taking advantage of this time together to discuss your estate and financial wishes by including a family meeting in your family gathering.

What Should You Talk About in a Family Meeting?

Although there is no right or wrong answer to this question, you could cover the following topics:

▪ Who you have appointed as your trusted decision makers. You can let family members know who you have selected to be your executor or personal representative, successor trustee, and agents under financial and medical powers of attorney. You may also consider explaining the reasons why you have chosen these people to act in these roles.

▪ What specific tangible personal property family members want. A family meeting can be a great opportunity for family members to express their hope of receiving certain items of tangible personal property, such as furniture, jewelry, art, and vehicles. We are often surprised to learn the items that family members have emotional attachments to. For example, your daughter may wish to have the platter you always used to serve the Thanksgiving turkey. The family meeting is a great forum to express these wishes.

▪ Who will receive certain tangible personal property and why. Along with family members expressing their wishes to receive certain items of tangible personal property, a family meeting is the perfect opportunity for you to express who you wish to receive certain pieces of tangible personal property and why. Particularly if multiple people want the same item (such as Grandma's wedding ring), a family meeting can be a great time to discuss who should receive the item and why. Everyone is more likely to respect your wishes if you make them known, and future disputes can be avoided. You can even pass on some of the items at the family gathering so you can witness the joy that the gift brings your loved one.

▪ Your end-of-life wishes. People sometimes select a healthcare agent to act on their behalf and then never discuss with that agent their end-of-life wishes. This puts the agent in the uncomfortable position of trying to guess what the person would have wanted or being presented for the first time with the person's wishes in an advance directive or living will during a moment of crisis. Expressing your end-of-life wishes in a family meeting helps ensure that everyone is on the same page when the time comes for decisions to be made on your behalf. It may also open a discussion among other family members, so you know what they want.

Use the Family Meeting to Create a Family History

The topics discussed in a family meeting do not have to be limited to issues related to your estate and financial plans. A family meeting is also a great time to reminisce about favorite family memories. Hearing family members share their favorite memories and seeing the sparks of recollection in others is a lot of fun and can be the best part of a family meeting.

Because family legacy is about more than just money and property, we recommend video recording or having someone take notes about the memories shared so the information will be kept for future reference for all family members. A family history like this is often the most cherished family possession.

Invite Your Trusted Advisor to Conduct the Family Meeting

If you are hesitant about having a family meeting because you do not feel that you have the skill set or an adequate level of knowledge to explain the sometimes complicated legal or financial concepts involved in your plans, consider asking your trusted advisor to conduct the family meeting. After all, it is one thing to understand a concept when it is explained to you and quite another to try and explain the concept to someone else.

You may also feel uncertain about how your family will react to the estate and financial plans you have made. Having your advisor, an unrelated and objective party, there to explain your plans and their benefits and answer any questions or concerns that your family members may have can remove some of the emotional upset and criticism that could emerge.

Summertime is a common time for families to get together. Take advantage of this time to discuss your estate and financial wishes with your family in a family meeting. Communicating your plans now, while you are alive and able to answer any questions or concerns family members may have, greatly increases the likelihood of your plan working as it was designed. We would be happy to help you organize a family meeting or even conduct it for you, so please give us a call if you would like to include a family meeting as part of your family's summer gathering.

By Nancy S. Boutin, MD

Rewilding Revisited

Back in the summer of 2020, the concept of rewilding may have been new to many members of the Marion Polk County Medical Society. In that *ChartNotes* issue, Salem Health trauma surgeon Nicole Vanderheyden described her efforts to undo 100 years of ecological damage at a property on Washington's Long Beach Peninsula she had purchased several years before. She intended to increase the ability of her fifty acres to support a planned reintroduction of a threatened species of butterfly, the Oregon silverspot. Since then, *rewilding* has shown up in the news with increasing frequency as a strategy to combat climate change and slow the loss of biodiversity.

One way to return a damaged landscape to its natural condition is to simply walk away. Eventually, the land will heal by secondary intention — unless the ecosystem has been overtaken by invasive species. But even then, the area will develop into something more diverse and sustainable than a swath of emerald lawn or a sculpted garden. A more intentional style of rewilding involves replacing non-native species with the right plants in the right combinations in the right places.

Preparing her parcel to provide habitat once again for the silverspot, Vanderheyden needed to eradicate acres of European beach grass. And, she calculated, replace the grass with thousands of native plants—not exactly something she could pop over to pick up at the local nursery. So, of course, Vanderheyden started her own with help from friends. Some lived on the property to tend to the plants and animals. Some came to work weekends to fill pots in the hoop house. Some helped plant seedlings whose roots had matured sufficiently to move outdoors, sometimes several hundred at a time. She collected seeds and cuttings and continued to learn and experiment.

Vanderheyden traded native seeds through the mail with other collectors. She salvaged plants and pots from a defunct nursery in Salem. She even discovered that the elusive "early blue violet," the critical food source for the silverspot larvae, had been given to her years before under the name "Oregon wood violet." She had grown it in abundance at home in the Valley for over a decade, watching the flowers bloom in the backyard while she searched for them under a plant alias online. Unfortunately, she put 200 plants into the ground before she discovered the misidentification by an academic botanist. Not only did she still need the early blues, she had to rip out the wrong species, "which continue to cause havoc as they contaminated my stock for propagation," she says. Obviously, this business is not for the easily frustrated.

Fortunately, Vanderheyden has patience in abundance, or at least a long perspective. It took four years to see Dutchman's breeches go from seed to plant. Dark-throated shooting star seedlings bloomed after three. Chocolate lilies took five-seven years to bloom but won't be mature for ten or fifteen. On the other hand, after she first mowed the non-native grass around her Long Beach house, she scattered wildflower seeds she had collected, and the next summer had a meadow dotted with splashes of pink and purple among shades of green. Each season showed greater diversity along the paths, over the dunes, and in the fields.

In the last several years she has cared for her coastal plants through droughts, floods, ice storms, a heat dome, and even a small tsunami. But by the spring of 2021, Vanderheyden had enough seeds, seedlings, starts, bare root plants, bulbs, annuals, and perennials to start an online enterprise. On March 24, 2021, SeaDance Nursery debuted on Etsy and within hours had two "potential, substantial sales." There have been hundreds more sales since then with glowing reviews and the maximum five-star rating on the site. Not only has she made NW natives widely available, but she has also started bundling plants for specific rehab needs—starting, of course, with plants required by Oregon silverspot butterflies at all stages of development.

...continued on page 12

Revisiting Rewilding

...continued from page 16

While the uninitiated may think of "gardening" as something that happens in spring and summer, the work of collecting, propagating, planting, and selling goes on year-round. Most of Vanderheyden's customers sound very sophisticated in their reviews. However, she noted during the early days of the Omicron spike that she had sent half a dozen or so packages of fernleaf biscuitroot seed to buyers in central Utah. She didn't believe any part of the plant influenced viral illnesses—like COVID-19, for example—but they likely wouldn't hurt anyone. She doubted though, whether "buyers have paid attention to the fact that this plant needs 3-5 years to reach a size large enough to harvest."

This summer, Vanderheyden has taken her show on the road, selling seeds and plants at places like the Salem Art Fair. But with all her knowledge and experience, she can still be surprised. One evening before leaving Long Beach for Salem, she posted, "I'm sitting alone in my beach house working on the computer when, all of a sudden, there is a whole lot of rustling and popping going on in my sunroom. For a second I thought it sounded like a fire starting. I get to the room to realize it is the lupine seed pods I collected into a paper bag and left in the sun to dry. They had started popping to release their seeds which set off a chain reaction of pods popping. You can see how when they pop, they twist, shooting out their seeds a fair distance."

While it's easy to be a little overwhelmed by all of Nicole Vanderheyden's interests and accomplishments, it is reassuring to hear her confess, "Today I have concluded there is not enough time in my life for everything I want to get done."

However, we're eager to watch her try.

Bush Park Volunteer Opportunity

Work piles from weeding and trimming. MPCMS had 18 people clear weeds and reestablish a trail in the SE corner of Bush's Pasture Park, Salem.

Dr. Keith Neaman, MPCMS President and his wife Emily Neaman.

Zayne Webber, age 2, son of Ty Webber, hard at work. When his older brother Reese was asked, "Has he been farmin' long?" he said, "no, just about 5 minutes."

Dr. Keith White and Dr. Jay Jamieson tackle the weeds. Thanks to Dr. White for this great idea for a volunteer activity.

Brand New Bridgeway

AN INTERVIEW WITH CEO TIM MURPHY

NB: Tim, one of the first things I did this summer was to attend the opening of a lovely new building at 750 Front Street. It had a Bridgeway sign out front. Can you tell me about that?

TM: That would be the celebratory opening of the brand-new clinic for our outpatient mental health and chemical dependency clients. We were able to collocate services that had been scattered around town as we grew over the years.

NB: What prompted the consolidation?

TM: Putting everything together makes it easier to access for our patients and clients, and having our staff together makes it easier to offer more services, different groups, different things that people might need. We have treatment providers who are double-credentialed in mental illness and chemical dependency to break down the separation that's been going on for decades. But we also offer medical and dental care of OHP patients. One of our supporters asked when we were going to offer Bingo!

NB: That's a lot. Was it just too much to expand the main building over near Lancaster?

TM: Historically, addiction clinics and, oftentimes mental health clinics, were located on the fringes of town or the fringes of a hospital campus. The concern has been the privacy for people seeking drug and alcohol services. There's been a lot of stigma about going to treatment, and we're trying to address that by making it as natural as going to the dentist. The whole idea was to put Bridgeway in the middle of town, available, accessible and to reduce the stigma of seeking and receiving services.

NB: The stereotype I have, based on a tiny bit of experience, is that clinics for dependency diagnoses feel kind of dark and unsavory. Your building is beautiful—light and airy with very nice art on the walls. There are some exam rooms, but also a lot of offices and meeting rooms that are very welcoming.

TM: We're trying to normalize treatment. We put up a big sign in the parking lot that says "Bridgeway" and light it up all night long. It says, "Hey, Bridgeway is here. It's an integral part of the health of our community. It keeps our community healthier, keeps our community safer." We want that to be well known, well understood.

NB: How did you choose this location?

TM: We know Front Street is going to be developed. During the coming five years it will be open to the river and we think we're at a really nice location. There is easy access by the Cherriots bus line, and we are near other services like Union Gospel Mission and Arches. It fits with the service array that's being offered downtown right now.

NB: And not far from the free clinic. Do you have a large population of unhoused clients?

TM: Although people might suppose they are a large segment of our clientele, most of the patients we serve are employed with OHP or commercial insurance. We do get some uninsured people in our detox clinic who are overusing alcohol or drugs. When they've completed their detox stay, we try to make sure they leave with the Oregon Health Plan intact. We're successful at that and it opens up opportunities for them to get medical care. When you don't have an address, it's hard to get connected. We work with other community partners, Community Action being the largest, to meet the needs of the homeless.

NB: It must feel good to get a project like this done. Construction has been a challenge with supply chain issues and finding enough skilled workers.

TM: We're not done. In early 2023, we plan to start the second phase of this, which is a new building that will connect with the current one. We'll add to our 18,000 square feet with new detox space and a primary care clinic. We expect to complete within the year.

NB: Primary care?

TM: One of the unique stories about Bridgeway is we were the first primarily behavioral health clinic that added primary care. There are a lot of primary care clinics that have been adding behavioral health, but we did the opposite for a whole bunch of reasons. We started a number of years ago with 2 1/2 days a week. Now it's a full practice with 900 current patients on our panel. We have one PA and two part time MDs. We're looking to add a PA who has an interest in Behavioral Health.

NB: How do patients get to your clinic?

TM: They're usually already receiving services from us for mental health and/or chemical dependency and have some concerns about their physical health or pain issues. Because they have OHP, they have access elsewhere, but sometimes they feel uncomfortable in a "regular" clinic. And some providers feel inadequate to meet the needs of someone who, along with their heart disease or diabetes, has chemical dependency. We offer a solution.

NB: Do you get many referrals for medical care from community providers?

TM: We get some, and we would welcome more. With the new developments in the treatment of chemical dependency, we're seeing how complex it is and the role it plays in a person's general health and well-being. There's a lot of talk about integrated care so with our expertise in chemical dependency it makes sense to consolidate an individual's care in one clinic.

NB: Does that include psychiatric care?

TM: Yes. But we find that our docs, who have practiced in rural settings, are more comfortable managing psych meds than most psychiatrics are with primary care meds. So, they take over prescribing. We do get consultations with OHSU for some of our patients with severe symptoms who need multiple medications.

NB: Do the referred patients stay with you forever?

TM: We include the referring PCP in our treatment plan and send a treatment summary at the end. Then it's up to the patient and their doc where they receive ongoing medical care.

NB: What else do you want the medical community to know?

TM: First, that the concern that "you can never get a patient into Bridgeway" has been addressed. We can now usually admit a patient in one-to-two days.

Second, Bridgeway is the largest clinic providing chemical dependency service in the community and we're the only one providing medically managed withdrawal in the three counties. We have doctors who round every day for every one of our detox patients.

NB: And, you have a beautiful new building. Even if you don't yet have a space for Bingo!

Wellness

Erin Hurley, MD

Travel, and how it helped me become a physician.

My unique travel history started when I was 17 years old and my mom married a commercial airline pilot. The summer after I graduated high school, my stepdad took his entire new family—wife and four kids plus his own daughter—to Europe. This was no small feat. My stepdad had employee passes which allowed us to travel at low cost, but we flew as standbys. Which meant we only made the flight if there were open seats for all of us. It's frustrating to miss an out-bound flight, but down-right complicated to get stuck anyplace else. Thus began my travel adventures to every continent but Antarctica. I learned to be independent and travel internationally on my own before I turned 20.

After my sophomore year of college, I combined travel with medical volunteering on a medical mission to Malawi, Africa. First, my mom and I spent a week in Kenya on safari. When she flew home, I flew to Lilongwe, Malawi. I had the phone number of the leader with SIMS (Students for International Mission Service) and was to call them when I landed. After I collected my luggage, I began calling the number from the pay phone in the arrivals area, but no one answered. After a couple of hours, I asked for assistance from the friendly staff nearby. They suggested I take a cab to the address I had been given. When I arrived, no one answered my knock at the door. The gardener kept repeating "fourteen, fourteen." I assumed he meant the family would return at 1400 hours, but then realized he meant the 14th of the month, which was days away! He suggested I ask for help next door.

This type of mishap may be commonplace for missionary families, but a surprise for me. Lesson learned. Try plan A, if that does not work, have a backup plan or two. Luckily, the missionary dentist's wife with the adorable toddler, took me in, fed me, and put me in the guest house for the night. As luck would have it, another missionary traveler who knew his way around Malawi arrived the next day, and accompanied me to my final destination several hours south. After a comfortable, air-conditioned bus to Blantyre, we transitioned to the local bus, with no air-conditioning and live chickens and small farm animals among the riders!

I learned many things from my travel adventures. I learned that even when the airlines have oversold a 747 by 180 seats and the gate agent dismisses you, don't leave. Instead, wait until the plane takes off without you, because many times I still got a seat. If you show up an hour before your international flight from Sydney instead of the recommended 2-3 hours (due to a public transportation strike the night before), and the check-in counter is empty, don't give up. When the first employee you find tells you to try again tomorrow as the flight is "closed," look instead for someone willing to work with you for a better outcome. I asked a second airline employee for their assistance, and they personally escorted me through security and ensured I made the flight. Never give up.

My travel adventures also helped me get into medical school. As an underclassman, my premed advisor told me medical schools were not interested in students "like me." I had a C+ in my first physics class because I valued getting together with friends, participating in sorority events, and joining the ski team as much as doing my classwork and studying. Other Bio-Med majors were gunning for the top twenty-four positions in the program so they could skip their senior year, and immediately start medical school through a UCLA extension program. They spent all their time studying at the library or working in a lab, with no extracurricular activities. That wasn't me.

Instead of listening to the advice of a stranger telling me to give up my dream, I did what I had learned at the Sydney Airport.

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Wellness

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I found someone willing to work with me for a better outcome. I turned to my sister's medical student boyfriend, Gary. Just like that second airline employee, he personally escorted me through the remainder of my undergraduate studies. Like me, Gary had not been the typical straight-A pre-med, but he had other attributes that made him a good candidate. He proved to be the perfect mentor, adding hard work as well as humor to my journey.

Gary insisted I turn my C+ in Physics to an A. He recommended I volunteer for a medical clinic, which is how I ended up on my adventures in Africa. Gary encouraged me to run for leadership positions, so I campaigned for, and became, Vice President of my sorority. Gary granted me permission to enjoy my undergraduate years *and* pursue my dream of becoming a doctor. He role-modeled how to study by trapping me in his dad's office in Westwood for hours before letting me take a break. My grades improved each term until I got a 4.0 my senior year. Gary advised me to take a gap year like he did, so schools would see my improved GPA and I could repeat my MCATs. I had an amazingly year full of fun classes at a junior college, work, and more travel adventures. Fortunately for me, Gary's premed advisor had provided the advice he needed to become a doctor, and then Gary did the same for me.

Living with Grief

Cheryl MacDonald, Medical Director at Willamette Vital Health, never saw the fall 2021 *ChartNotes* featuring mid-Valley doctors reflecting on their marathon-running experiences. In the article, she recounts sprawling on her parents' living room floor after her first long run. Her mother told her she should quit; "it's too hard." MacDonald said the word *quit* didn't exist in her vocabulary and hearing it out loud only cemented her resolve.

The night *ChartNotes* went to production, MacDonald received a phone call that put her powers of resolve to the test. One of her 23-year-old twin daughters had taken a walk after work, headphones on, listening to her favorite playlist, when she was struck at high speed and died instantly. MacDonald said the grief was so overwhelming that "everything in my life stopped for a time. I didn't have the capacity even to do things that previously brought me joy." She recognized that she had become part of a collective grief enveloping the entire country, the entire world.

Never in our lifetimes have the grief-stricken been so isolated and grief so common. COVID and COVID-adjacent deaths have filled the newspapers and social media in numbers difficult to comprehend, while for over a year fear of the disease blunted the usual gatherings and rituals that helped survivors cope. Funerals moved outdoors or live-streamed, every hug became a decision. In some cases, death spawned death with families waiting to see if their pain had created a super-spreader event.

Although Meghan didn't die of a COVID infection, MacDonald wonders how much of her daughter's distraction that day came from the effects of two years of isolation, anxiety, and trying to work in a public-facing job even before vaccines became available. "I feel tremendous sadness that she never saw us coming out from under all that. Not that it's over, but at least it feels better."

As the chance of a fatal course of COVID for those at average risk fell, MacDonald's aunt and uncle in Nova Scotia opened the ancestral home, a rural farmhouse off

Celebrating Uncle Hugh's birthday at the Celtic Interpretive Center

Cape Breton

The twins' first trip "down home."

the grid, for one of their every-other-year-or-so clan reunions on Cape Breton Island. Forty members traveled from all over the US and Canada to gather for *céilidh* music, dancing, food, single malt, and stories.

For MacDonald, the trip brought back precious memories of the first time she took the twins "down home," as everyone calls it. "It was the first international trip for Meghan and Mariah. Meg fell in love with the nature, the beauty, the hiking, the music. . . She already played strings, but she picked up a violin and started playing it by ear. We bought her one while we were there. My father's oldest brother had passed, and he had asked to have the ashes scattered at sea off the coast of Cape Breton. So, we piled on a fishing boat, playing Scottish music all the way out. We had a ceremony, and a toast, and Meg loved it.

"When my cousin started planning the first reunion post-COVID, she asked if we wanted to bring some of Meg's ashes 'down home.' The more we thought about it, the more we thought it was a spectacular idea. In the weeks after her death, during the wake and funeral, I had been numb, just trying to get through. It was a totally different experience on the boat, I sensed her spirit there with her brother, sister, and closest cousins. At one point, my uncle put his arms around me and told me to let it go. And I did. To finally just fall apart, not thinking about what anyone thought, was a great relief and release. And acceptance, in some ways.

"I've been through a year of 'firsts' and the anniversary is coming up. The numbness has worn off and the knowledge of the reality, the permanence is, in some ways, more painful.

"I think, as a culture, we don't really understand how long it's acceptable to grieve. Now, I have a constant, chronic ache. I expect it to evolve and change over time, but I am able to find joy again. When I run, I feel Meg with me—doing something we always loved to do together. There are new babies in the family—my stepdaughter's little boy is learning to walk, and my son and daughter-in-law are expecting. My other son is engaged. Mariah is coming to Oregon to start a new journey. The fog is finally lifting a bit."

Over the past year, MacDonald and her family have found ways to live with the grief of losing Meghan. Yes, there were times she wished she could just quit; everything was too hard. But, as she said a year ago, the word simply isn't in her vocabulary.

Watching My Friend Pretend Her Heart Isn't Breaking

By Rosemerry Wahtola Trommer

On Earth, just a teaspoon of neutron star
would weigh six billion tons. Six billion tons.
The equivalent weight of how much railway
it would take to get a third of the way to the sun.
It's the collective weight of every animal
on earth. Times three.
Six billion tons sounds impossible
until I consider how it is to swallow grief—
just a teaspoon and one might as well have consumed
a neutron star. How dense it is,
how it carries inside it the memory of collapse.
How difficult it is to move then.
How impossible to believe that anything
could lift that weight.
There are many reasons to treat each other
with great tenderness. One is
the sheer miracle that we are here together
on a planet surrounded by dying stars.
One is that we cannot see what
anyone else has swallowed.

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BY NANCY S. BOUTIN, MD

Assessing Opioid Risk

People who suffer from chronic pain often say two things: "My pain is real" and "It's not in my head."

In fact, *all* pain is real and it's *all* in our heads. The electrical impulse running up an afferent neuron is not felt as pain. It must be processed in the brain, with complex interplay at the spinal cord level, before it is perceived as *an unpleasant sensory and emotional experience associated with actual or potential tissue damage.*

During training we learned that there are different acute pain phenotypes—nociceptive, visceral, and neuropathic—with different drivers and different approaches likely to relieve it. They all produce a similar physiologic response; tachypnea, tachycardia, diaphoresis, and elevated blood pressure. Chronic pain is different, they said, and "because the body gets used to it," you can't expect to see the typical physiologic or affective response. And yet, during the era when providers were held responsible for "managing" all pain, we were expected to treat chronic pain in the same way we treated acute pain. We have all seen the devastating results.

In the early 2000s, to identify patients at risk for opioid dependence, researchers developed and validated tools with names like ORT, DIRE, and SOAPP-R. Unfortunately, each presents challenges in terms of reliability, validity, sensitivity, and predictive value for opioid use disorder. Nevertheless, best practice mandated providers administer one of these tests to every patient before prescribing opioids. There is little evidence that any of these screens was done consistently nor were there easily available alternative treatments, in part because the understanding of chronic pain phenotypes only hit its stride in the last decade.

Paul Coelho, Salem Health pain clinic physician, presented data about the diagnosis and treatment of high impact chronic pain (HICP) in the Summer 2020 issue of *ChartNotes*. Since that time, and building on his early data, he has analyzed over 2300 patients presenting to the clinic on chronic opioids for chronic pain, a significantly larger sample size than those used to create the above-noted alphabet soup of risk assessment tools currently available. The pain clinic MA administers two brief, validated instruments to every new patient, the Pain Catastrophizing Scale (PCS) and the Fibromyalgia Symptom Questionnaire (FSQ). The final score for each screen falls into a quartile for that tool ranging from low to high. Patients are then grouped in a 2x2 fashion: low value for both, high value for both, high only for PCS, or high only for FSQ, and followed for outcomes including pain relief on stable doses, ability to taper off opioids, and suicide.

As useful as it may be to diagnose HICP, which is found in approximately 8% of patients, the average provider is likely more interested in how to risk-stratify those opioid-naïve adults who present to the clinic with acute pain. Unfortunately, a physical pain driver does *not* protect against developing opioid dependence in patients at risk for one of several central pain syndromes due to genetics or other occult sensitizer. The old screens haven't proven effective.

Coelho is collaborating with Stasinos Stavrianeas, Ph.D., at the Oregon Research Institute, and others, to translate the findings from his cohort of opioid-dependent patients into a protocol to benefit those opioid-naive patients who may be most impacted by inappropriate opioid prescribing. Just as a poorly performed procedure may lead to life-long difficulties in some surgical patients, exposure to opioids prescribed for an acute event may lead to life-long difficulties in some pain patients.

Instead of the old paradigm of nociceptive, neuropathic, visceral, and chronic, the groups are distributed into four groups based on their level of central vs peripheral inputs. Those with Nociceptive/Physical score low on both PCS and FSQ. Common pain drivers are cancer and arthritis. Mental health factors are minimal. The pain responds to NSAIDs, opioids, and procedures. Nociplastic/Central scores high on both tools and are commonly

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Chronic Pain

...continued from previous page

diagnosed as fibromyalgia and chronic low back pain or headache. Mental health factors are significant. The pain responds to tricyclics and serotonergic agents, but not to procedures. Neuropathic, due to nerve damage or entrapment such as diabetic neuropathy or carpal tunnel syndrome, responds to all the above noted medications and decompressive procedures and mental health issues are minimal. Finally, the mixed phenotype shows both a recognized pain driver and high scores on PCS and/or FSQ. They may or may not respond to both medications and procedures and may or may not include mental health issues.

Any good medical screen must be easy to administer, with high sensitivity and specificity, and reproducible over time. In addition to the two widely available questionnaires, Coelho's team considers age (60 and above vs below 60), number of opioid prescribers in the prior twelve months as documented in the PDMP, and a diagnosis of bipolar disorder (only self-reported 50% of the time in Coelho's clinic, but usually noted in the patient's medical record.)

Stavrianeas notes that for PCS and FSQ to contribute to an individual's experience of pain, they must identify durable traits rather than short-term states, which was demonstrated in a paper by Roberts et al in 2007. Though not immutable, an individual's personality evolves over a lifetime by, on average, 1%/year—and whether it's toward a more positive, optimistic person or more pessimistic is hard to predict, particularly if they are not engaged in a practice such as mindfulness or an evidence-based therapy. In either case, the patient's pain phenotype is unlikely to change for a decade, at least.

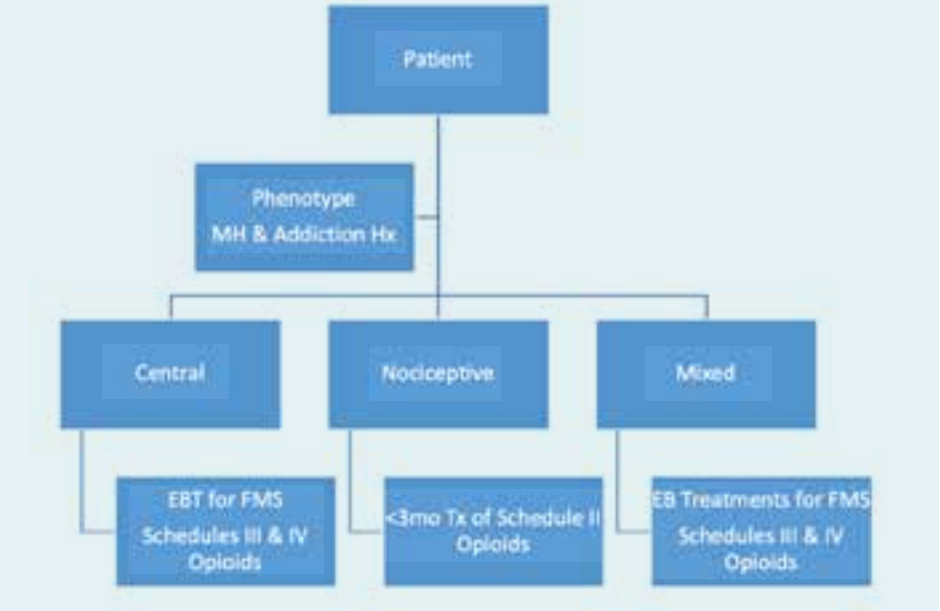
Additionally, while any mental illness predicts for centralized pain, bipolar disorder exerts an out-sized influence compared to other diagnoses. The population prevalence of bipolar disorder is ~3% but the prevalence in the SH pain clinic is 14%. Suicide attempts in bipolar disorder are 20-30-fold higher than in the population as a whole and life-time addiction history is 5-6-fold higher. *If bipolar disorder is present in chronic pain, a strong argument can be made to avoid Schedule II prescribing due to risk of suicide and addiction* per Hashmi et al in 2013.

"Back in the 1990s," Coelho says, "risk happened in the clinic, with doctors prescribing ever-higher doses of opioids. But now risk walks into the clinic. In fact, substance use disorder may be a symptom of a larger problem, rather than the problem itself. It is a proxy for high allostatic load—combined life stress—physical, emotional, financial. They're barely making it, under a lot of stress, perhaps with histories of trauma

Four Pain Phenotypes

Nociceptive/Physical	Nociplastic/Central	Neuropathic	Mixed
Primarily due to inflammation or tissue damage in the periphery	Primarily due to a central disturbance in pain processing.	Damage or entrapment of peripheral nerves.	Due to a mixture of central and peripheral processes.
NSAID/Opioid Responsive	Tricyclic neuro-active compounds and serotonergic agents.	Responds to both peripheral and central pharmacotherapy.	May respond to a cautious Combination of central and peripheral pharmacotherapy.
Responds to procedures.	Does not respond to procedures.	Can respond to decompressive procedures.	May have a measured response to procedures.
Behavioral factors minor.	Behavioral factors prominent.	Behavioral factors minor.	Behavioral factors are a contributor.
Examples: Osteoarthritis, Rheumatoid arthritis, cancer pain.	Examples: FMS, cLBP, cHA, IBS.	Examples: carpal tunnel syndrome, diabetic neuropathy.	Examples: FMS or Elevated PCS with demonstrable OA, CA, etc.

SHPC Age ≤59 Opioid Naive Algorithm

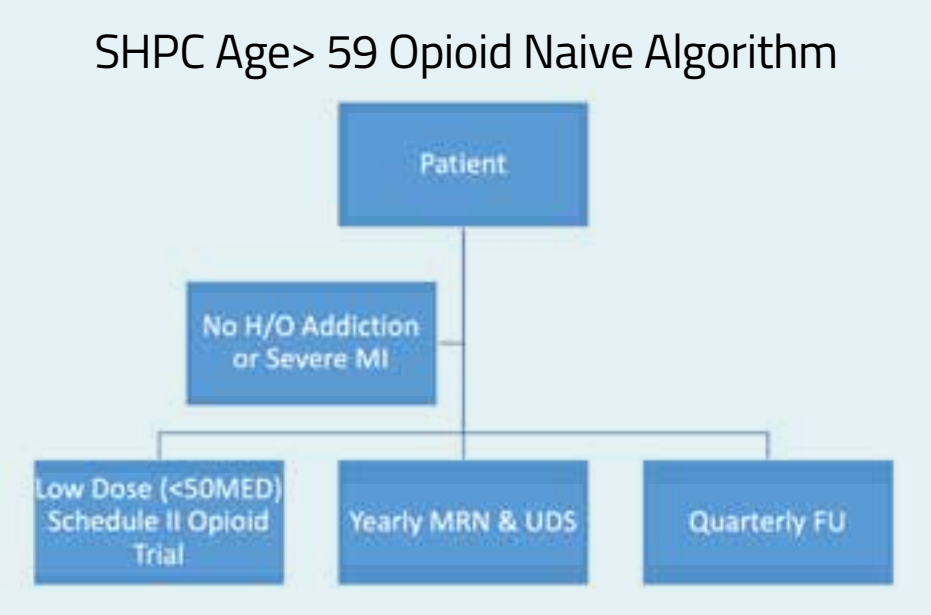


with comorbidities of mental illness particularly, but not exclusively, bipolar disorder."

While Coelho's findings have not yet been confirmed by a randomized clinical trial, the neurophysiology is well-recognized, and summarized in an article in the summer issue of *ChartNotes*, specifically the functional MRI results of Tor Wagers, Ph.D. Coelho's screening is simple and risk-free. Patients are surprisingly forthcoming about their pain catastrophizing and their fibromyalgia symptoms, possibly because the pain they perceive is such an all-encompassing reality to them, even if in the past it wasn't considered "real pain" by some providers. Tailoring a treatment approach to the whole person, which is certainly a worthy goal, may take a few more minutes than writing the prescription many of them may think they want.

But with the MA administering and scoring the PCS and FSQ, a quick check through the EHR, and a stop at Oregon's PDMP, identifying the patient's risk *once* in a course of therapy isn't onerous.

Treatment options, in addition to the algorithms available here, are available through the Oregon Health Administration at https://www.oregon.gov/oha/hpa/dsi-pmc/pages/module.aspx



BY NANCY BOUTIN, MD

MY CURRENT OBSESSIONS

I'm a hospice physician and, for many years before that, an oncologist. I view death philosophically and with great equanimity. My family of origin is down to three members and if I ever took bereavement leave, I simply worked from home. I always told people I was an "instrumental griever"—a person who doesn't mope around but uses grief to fuel useful action.

Circle of life. Dust to dust.

And then in July my dog died. Not even my dog: Chunky, our daughter's elderly, caramel-and-white bulldog, came to live with us when grandbaby number two arrived. At Chunk's age, we expected her to be with us six months. Tops. We would be her hospice home as she quietly rolled toward the eternal care unit. We noticed right away, though, that she had no intention of going anywhere quietly. She snored, and snuffled, and pitter-patted across the hardwood. Teenaged girls would screech their cars to a stop, jump out, and race over to pet her. Grown-up strangers regaled us with their bulldog stories.

Three and a half years later, after spending the whole of lockdown sitting next to me on the couch while I worked remotely, Chunk crossed the proverbial rainbow bridge. I had watched her lose muscle mass, vision, continence of bladder and bowel. She got confused and lost in familiar places. I recognized the sting of anticipatory grief—I even told her I'd miss her when she was gone—but nothing prepared me for the rush of tears that swamped me later every time I came across one of Chunky's toys, her smell, or her favorite lounging place in each room. No amount of useful action slowed down the water works.

During my early days in palliative care, I spent months puzzling over the purpose of grief. Nociceptive pain alerts us that something—a hot stove, an incised wound, an infection—poses a threat to our physical integrity. It forces us to move away from danger before irreparable harm occurs.

But why does evolution favor the pain of grief? Does it warn us of a threat to our emotional or psychological integrity? Does it force us to repair a void left by loss? In every close relationship, we exchange bits of ourselves, what we do and how we feel, with someone else. What happens to that bit when the other person no longer exists? We have all seen new widows or widowers who needed to learn to pay bills, cook dinner, or figure out the grandkids' birthdays because the deceased had always taken care of "that."

Tasks are one thing, but we also depend on our intimates to help modulate feelings. Who do you turn to when you're down? That friend who can always lift your mood. Someone who sees you as beautiful, intelligent, or funny, no matter what. The person who appreciates the things you do for them. A bereft colleague once told me that after caregiving for a blind, curmudgeonly relative for years, she didn't know "who she was" after he died.

"He didn't *define* you," I said. "He *demonstrated* who you are. He didn't take that with him. You still have compassion, and kindness, and grace you showed him to share with someone else."

Shortly after our conversation, she left for a long-planned trip to New York and said the universe put several older, low-vision men and women in her path. She helped them cross streets, find addresses, and hail cabs. She came home feeling good again.

When Chunky died and my reactions blind-sided me, a friend said she'd heard the pain of losing a pet mimics the pain of chemical withdrawal. That nugget sent me to the internet where I found studies proving that

dogs elevate their humans' emotions by inducing oxytocin—the "tend and befriend" neurotransmitter—at surprising levels. It makes sense that pack animals evolved a way to strengthen the bonds between members, and my husband and I were definitely Chunk's pack. We knew she made us happy without a clue about the neurochemistry at play.

Oxytocin, also called "the cuddle chemical," is such a powerful mood-modulator it can be used to treat the nasty side effects of withdrawal from drugs like heroin, alcohol, and nicotine. In human relationships, oxytocin levels fall during a breakup, leaving the newly single person depressed and blue. I had ridden out the pandemic on a river of oxytocin and now I felt as low as if I'd been jilted—my dealer gone for good.

So, what eases the side effects of oxytocin withdrawal? Experts say hugs, giving someone a gift, and gazing into the eyes of a dog all increase hormone levels. Is the solution for my blues, then, to get another dog?

No, thank you. Not for a while. Chunky isn't an interchangeable widget; she will always be an important part of our family, our stories, our shared history, or as my five-year-old granddaughter asked, "When Chunky-bear died, did she become one of our ancestors?"

Maybe so.

She demonstrated something to me about myself. I am *not* "not a dog person." I am susceptible, for better or worse, to the effects of oxytocin — which as a mother, I should already have known. As bad as I felt at that moment, I wouldn't feel sad for the rest of my life. I loved Chunky, but she did not take the secret sauce of my happiness with her when she died, not permanently. My brain would eventually right its chemical balance, one way or another.

I may not have come much closer to understanding the purpose of grief, but at least I understand the chemistry. Some people say we are stardust. I say we are our neurotransmitters. Understanding the *how* of my grief made it easier to tolerate.

And now I need to do something useful. Maybe I'll make a photo book for everyone who loved Chunky-bear. I am, after all, an instrumental griever.

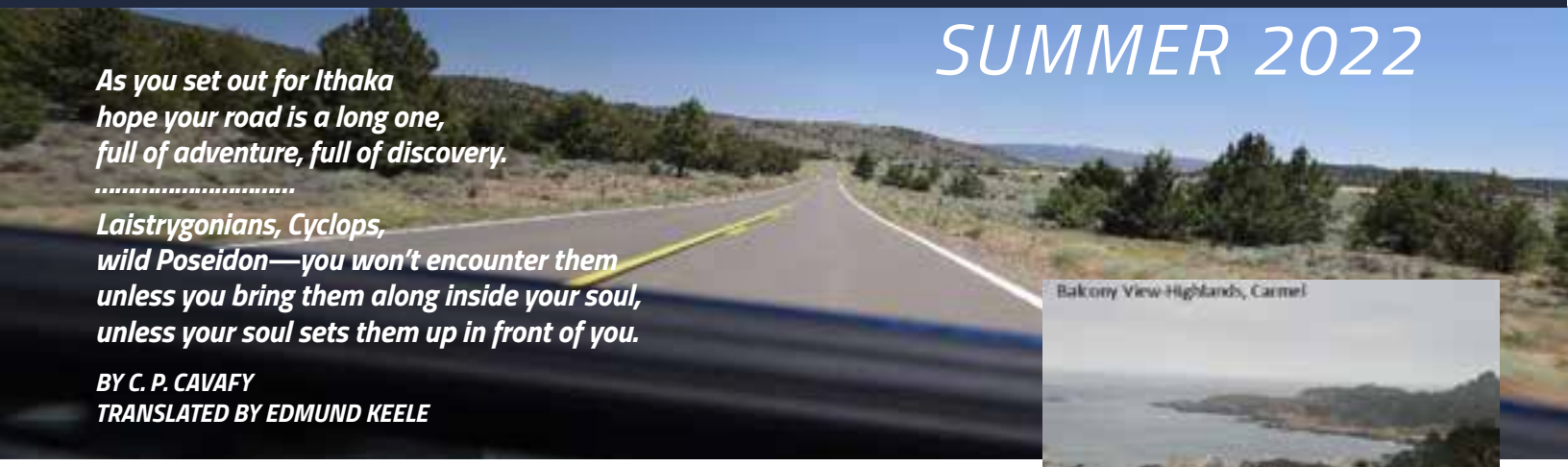
Sometimes.

RICK PITTMAN, MD, MBA

Last Word

2 Weeks, 2 Lanes, 2200 Miles in a 2-seat Convertible.

SUMMER 2022



As you set out for Ithaka
hope your road is a long one,
full of adventure, full of discovery.
.....
Laistrygonians, Cyclops,
wild Poseidon—you won't encounter them
unless you bring them along inside your soul,
unless your soul sets them up in front of you.

BY C. P. CAVAFY
TRANSLATED BY EDMUND KEELE

Inspired by Cavafy's words, my wife and I departed on an incredible 16-day journey that would take us from desert to ocean, through mountains, with multiple changes in weather, road types, and temperatures that ranged from 36 degrees to 104 degrees. To find adventure and discovery, we fervently pursued two-land highways and out-of-the way stopovers with a goal of 150 miles per day. To hell with wi-fi.

The short distances allowed a completely different perspective than racing along the I-5 corridor, and gave us freedom to explore the country. Until you experience a trip like this you will never appreciate two lane highways the way we do. The road from Chiloquin to Susanville was smooth, fast and ...empty! Plans to visit Lassen National Park changed when we realized if we got to Susanville by 2:30 pm we could see *Maverick* on the big screen, and we're glad we did. (ya gotta see it!)

How does one plan a two-week-plus road trip in a two-seat sports car, keeping in mind the essence of Cavafy? *It is not about the destination; it is about the journey.*

First we set up road rules:

#1: If the temperature is 58-98 degrees F with little to no precipitation, the top is down.
#2: Rule #1 can be broken.
#3: Avoid highways whenever possible.
#4: Tolls and ferries are okay if #3 is followed.
#5: Stay off the well beaten paths.
#6: Visit "cool" places.
#7: Hook up with friends along the way.
#8: Pack light—use fast-dry clothing
#7: Pick out safe places to stay preferably with inhouse restaurant

Once you and your adventure partner agree on the rules, choose your own Ithaka. Decide where you want to go and who/what you want to see. Plot a rough map. You can change it as you plan.

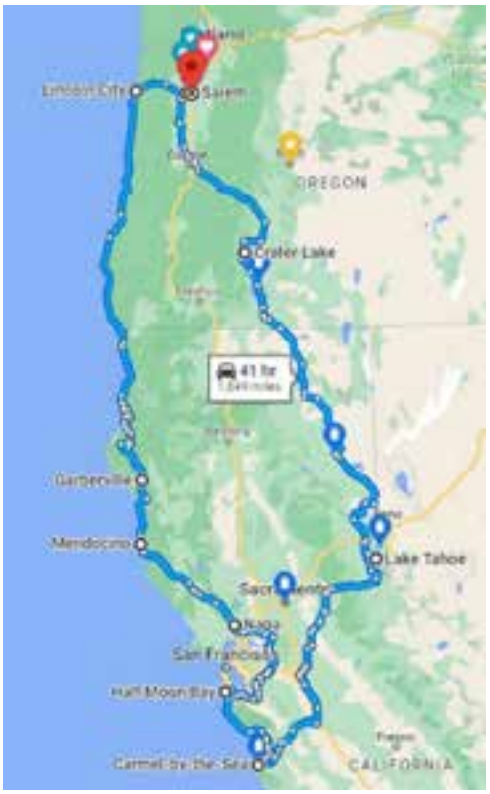
Our goal— 2,000 miles in two weeks. Stops were chosen for various reasons. We planned the last part of the journey in order to drive the coastal highways. Then the research begins.

1. Perform online research before you make reservations for available lodging along your chosen route. Do this at least six months in advance. Book several rooms in the same area while you refine your search. You have plenty of time to cancel.
2. Decide if wi-fi is important.
3. Look up reviews and read them.
4. Use satellite images of the venues.
    a. What are the surroundings? (remember you'll be off the road most traveled.)
    b. Is the parking secure?
    c. Can your car be seen from the nearest well-traveled road? (preferably not.)
    d. Are there lights in the parking lot?
    e. Cancellation policy?
5. If you golf, learn how to use four clubs without a driver.
6. NO Luggage. Use five-cent plastic bags—easier to pack.
7. Carry car wash supplies.

In Part II we will explore the uniqueness of each leg of our journey. Stay Tuned.

Our itinerary:

Town	Lodging		Reason to stop
Chiloquin, OR	Sleep Inn & Suites	1	Enroute to Tahoe
Susanville, CA	Diamond Mountain Casino & Hotel	1	Enroute to Tahoe
N. Tahoe, CA	Parkside Inn at Incline	3	Visit high school friend
Sacramento, CA	Comfort suites	1	Enroute to Carmel
Carmel, CA	Carmel Highlands	2	Return for 33rd anniversary 7/15
Benecia, CA	Holiday Inn	2	Visit brother
Napa, CA	Funk's Paradise on the River	2	Visit high school friend
Point Arena, CA	Wharf Master's Inn	2	Heading home
Garberville, CA	Benbow Inn	1	Heading home
Bandon, OR	Best Western	1	Heading home



In the end, we traveled 2,176 mi @51mph average and 21.6 mpg, consuming approximately 100 gallons of gas @ ~ $6.60/gal.

For more photos from our trip see our SmugMug site

PASSWORD= cali2022 (lowercase)

https://westhillsphotographysalem.smugmug.com/RDP-2022/2022-CALI-ROAD-TRIP-RICK-JEN/

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RETURN SERVICE REQUESTED