A PUBLICATION OF THE MARION-POLK COUNTY MEDICAL SOCIETY FALL 2020

CHART NOTES

Hope in the Time of Chaos

Our Chance for Change

UNDERSTANDING IMPLICIT BIAS

Implicit bias is an uncomfortable fact of life. We like to think we're better than our subconscious.

pg 4

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CHARTNOTES

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President's Message
Doug Eliason, DO

Unconscious Biases

I grew up in a Midwest town with zero ethnic diversity. We thought that since we accepted Italians, Irish and Catholics that we were open-minded. My parents were very liberal, very open and accepting people. As I entered college, I was introduced to a whole world of people and I prided myself that I was in no way biased against any race. Throughout my education, Army time, and practice I have had friends and patients of every race and again felt somewhat pleased with myself that I did not have a racist bone in my body.

Now flash forward to 2020. Black Lives Matters happens and for the first time in my life I began to wonder. Could I have unconscious biases that affect how I related to others?

The Marion Polk County Medical Society Board met to discuss what stance we, as a Board, should take. Should we make a statement or have a moment of silence and take a knee? As we discussed this, we felt that sounded more like a cop out, as it only was words, and maybe we needed deeds instead. So we decided to look inward first.

On our own, the Board each completed the Harvard Implicit Association Test. On July 28th, we met and discussed the implications. I will not share the results of any board member other than to say we were mostly surprised and disturbed when we looked at our own responses. We acknowledged that implicit biases may be inherent and may not be subject to change. But recognizing those biases can lead us to alter behavior.

In 2003, the Institute of Medicine (IOM) report came out supporting that implicit biases do impact healthcare. For more information, please see Nancy Boutin's article in this issue.

I encourage all our members to consider taking the implicit biases testing at https://implicit.harvard.edu/implicit/

Note from the Editor Nancy Boutin

The first time I heard Hamilton's Schuyler sisters sing that they felt lucky to be alive while history was happening, I had to hit pause. The idea that lucky described the experience of cataclysmic change made my eyes cross. I don't know if the song's attitude suggests the sisters' willingness to endure hardship to change the world or if, in their hubris, they anticipated retaining the status quo while other people suffered. I never expected an opportunity to gain personal insight into their situation.

And now, here we are. History is happening. I wonder what the future will say about the summer of 2020? Will today's events lead to a better world or to darker times? Too soon to say.

Writing about change in the middle of change is risky. If you guess right, you sound wise. If you get it wrong, you sound, at best, naïve. But *ChartNotes* loves a challenge.

This issue focuses on the topics facing us right now. It highlights the impact of racial disparities on the health of our community. We examine the role of implicit bias on our ability to offer compassionate and equitable care to all patients—with your Board as guinea pigs for bias testing. Rick Pittman makes his best guess at the opportunities offered by the current chaos. Howard Baumann looks back at unconventional medical treatment and the founding of *ChartNotes*. MPCMS is experimenting with ways to offer additional value to our membership. We hope our first steps inspire you to suggest more. We are in this together.

That feels lucky to me.

Understanding IMPLICIT BIAS

NANCY BOUTIN, MD, MBA

"Researchers Reveal Racial Disparities in Access to Remdesivir for Patients with Cancer and COVID-19." —Cancer Therapy Advisor, July 24, 2020

The article's punchline? Even though Black patients had, on average, more severe COVID symptoms and a higher mortality rate, they were half as likely, compared with White patients, to receive treatment with the most promising therapy. In a press release from Vanderbilt University, Jeremy Warner, MD, co-author of the largest cancer-specific observational COVID study to date, said, "It appears that Black patients were underrepresented in the clinical trials of Remdesivir, likely due to reasons other than purely clinical factors."

"Other than purely clinical factors"—specifically implicit bias on the part of treating physicians—predicted lower use of thrombolytics for Black cardiac patients in a 2007 paper published in the Journal of General Internal Medicine. In a 2012 paper, The American Journal of Public Health found that "pediatricians' implicit attitudes about race affect pain management." In a series of medical decision-making vignettes, Black children received less pain medication after surgery than White children and, the stronger the measured subconscious bias, the greater the gap. Stereotyping and biases were also called out in the massive 2003 IOM report on racial and ethnic healthcare disparities entitled "Unequal Treatment."

With complete sincerity, most providers would say that they treat all patients equally, without regard for race, nationality, sexual orientation, or other patient demographics. Studies show, however, that most physicians—*most people*—are blind to their implicit biases, constructed over their lifetimes by experience, family prejudices, exposure to popular media, and societal stereotypes.

Even Anthony Greenwald, the UW psychology professor who coined the term "implicit bias" and developed the first widely-used, validated measurement tool 25 years ago, surprised himself with his level of racial bias. After a review of data for hundreds of thousands of voluntary test-takers from Harvard University's Implicit Association Test (IAT) website, Greenwald found that 70-75% of Americans show a White racial preference, often at odds with their self-reported lack of bias. Only the Black test group showed neutral racial preference—although it would seem logical to assume they would have a positive skew for blackness.

Greenwald's first test, developed in 1998 with Mahzarin Banaji, uses a "response latency method" to measure associations. Their original study consisted of four lists of words; one positive, one negative, one names of flowers, and one names of insects. Test subjects were told to type "i" if the word on the screen was a positive word or a type of flower. They should press the "e" key if the word named a kind of insect or a negative word. On the

next text segment, the categories and/or keyboard side were switched. When the test-taker thought two categories (positive and flower) "belonged together," assigning the screen word was easy, resulting in high accuracy and speed. However, in a segment that required the tester to overcome their own natural pairing—instead, putting good together with insect and bad together with flower—it took longer to figure out where "cockroach" belonged.

The difference between "easy" test segments and "hard" test segments gives a measure of how strongly the test-taker considers an attribute to be positive or negative. Test findings have been validated not only for flowers and insects, but for skin color, BMI, various religions, sexual orientations, age, and so on.

Of course, if a tester has terrible plant allergies and a lifelong affinity for bugs, their response times will be opposite to the majority. They will be fastest for the test segments where good pairs with insect and bad pairs with flower. These associations function at the level of emotional learning and fear-conditioning in the amygdala. If you're likely to go into anaphylaxis every time you smell a rose, you should definitely stick with ladybugs. Your implicit biases will help keep you safe.

The evolutionary imperative for identifying and fearing the *other* has become counterproductive in our current environment. However, in the US, the accepted norm has always been the best, most prosperous version of White culture. Everything else is *other* and often portrayed in entertainment and advertising as dangerous or threatening. These fearful images have informed the poor, ignorant amygdala since its first awareness.

While latency response can be used to uncover preferences for vegetables vs candy or urban vs rural, it is most useful for our purposes when employed to explore implicit biases of an individual with power over others—a teacher, boss, police officer, judge, or medical provider.

Every time you hear someone say that a decision affecting a subordinate "just felt right," or "I went with my gut," or even, "based on my experience," there exists a high probability that implicit bias influenced the decision. In most cases, the decision-makers would deny, even to themselves, that the person's weight, color, or age had any impact on the determination. The affected person, though, most likely *does* sense that they've been judged by something other than their specific situation. If that person is your patient or your patient's family, you may unwittingly have damaged the therapeutic relationship and negatively impacted the outcome of your intervention.

Humans, ever-optimistic, like to think that recognizing our own biases will change how they influence us. If not, a diversity training or workshop should do the trick. Unfortunately, this does not seem to be the case. Even Dr. Greenwald, who has devoted 25 years to this topic, says he's "skeptical" that implicit biases can be overcome for more than a few minutes at a time. Data shows that priming, the act of imagining counter-stereotypical examples, can temporarily "de-bias" a person. If you are about to see a Black patient, and IAT has shown you have a significant White preference, spend a moment conjuring a visit with someone like Neil DeGrasse Tyson. You can further heighten the effect by also "visiting" the most despicable White person you can think of. Such a bias reduction exercise can even impact your IAT score. Sadly, the effect will evaporate within hours.

The most effective way to overcome implicit bias may be creation of systems to remove or reduce discretion from decision-making. If the hiring manager who said they "went with their gut" instead said, "He wouldn't have been my first choice, but he had the highest rating on (some test or task)," implicit bias was most likely overcome by predetermined objective measures. "Blind" hiring, paper-grading, or promotions based on hard data minimize the effect of unconscious bias.

In an interview published by PBS, Dr. Greenwald cites the example of blind auditions instituted by symphony orchestras in the 1970s (long-before a reality show with a similar premise premiered). At the time, major orchestras wanted to prove they weren't showing favoritism toward The Julliard School graduates and other prestigious academies. The unintended consequence of choosing orchestra members solely on the basis of their musicianship was that the percentage of female hires rose from 10-20% to 40% in a single season.

All high reliability organizations recognize that humans err. Often. We are slaves to our brain wiring and chemistry, no matter how smart or diligent or good-hearted we may be. Safe and effective organizations build systems that allow providers, whether medical, legal, or wait staff, to do their best work while protecting them from their own unconscious biases. If data show that Medicaid patients have shorter face-to-face time with the provider—despite greater co-morbidities—look for ways to assure equivalent attention. If patients are getting unequal medication management in your office, establish treatment protocols that require explanation for deviation. And then review the exceptions. If cultural barriers arise with any group on your panel, take your time to educate yourself and try to understand their perspective. Be curious. Ask respectful questions.

Implicit bias is an uncomfortable fact of life. We like to think we're better than our subconscious. Trying harder isn't enough. Like so many other things we can't change, we need to acknowledge our limitations. We need to put into place practices and policies that allow us to deliver safe, equitable, and compassionate care. We need to do it for our patients and for ourselves.

BOARD STORIES

KEITH NEAMAN, MD

Keith Neaman, MD, spent his childhood in New York and moved to Utah at age 15. He served a mission in South Korea and is fluent in Korean. After medical school at OHSU, he trained in plastic surgery in Michigan, with a hand and microvascular surgery fellowship in San Antonio. He says that when it comes to plastic surgery, he "loves it all."

He and wife Emily have been married 15 years. Boone Ryder joined sibs Dakota Jack, Lilly Sapphira, Toby Nash, and Rex Revere earlier this year. They have now used all the interesting baby names available.

He loves to play the guitar and has a longtime interest in fitness. Unfortunately, Keith broke his neck after college and had to interview for medical school in a halo!

Keith hopes the MPCMS Board will "provide a place where practitioners can connect, socialize, and collaborate on improving the lives of our patients and healthcare delivery."

DOUG ELIASON, DO

Doug Eliason, DO, current MPCMS Board President, has generated an alphabet soup of credentials during his years in the Mid Valley. He is the current ME for Marion County. He was CMO for the WVP medical group. He is a FAAFP, a CPE, and was deputy surgeon for NORTHCOM, along with many more initials.

Doug grew up in Iowa and trained for his family medicine career in "Iowa/Michigan/Virginia," before relocating to Salem in 1993.

Amateur coin collectors may be a dime a dozen, but instead of pennies and nickels, Doug collects drachmae, denarii, and other ancient coins.

Classical interests must run in the family—his daughter is an opera singer.

Doug hopes to explore new roles for the MPCMS during his time on the Board.

...continued on page 8

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...continued from page 6

JAMES BISHARA, MD

James Bishara, MD, grew up outside New Orleans and studied in Louisiana until Hurricane Katrina changed his plans. He completed a pediatric residency in Baltimore and a pediatric cardiology fellowship in Memphis. He has a special interest in transthoracic and fetal echocardiography.

Married to a coastal geologist, James has committed to medical practice somewhere along the edges of the country. His love of mountaineering made a return to the Gulf Coast less appealing, so he and wife Dana came to the Pacific Northwest with daughters Cosette and Marisol.

When he's not taking care of small hearts, James likes to get outdoors, a preference he seems to share with many MPCMS Board members. "I love rock climbing," he says. "Other hobbies include hiking and mountaineering. The harder the hike the better. My favorite hike was in Thórsmörk, Iceland to the site of a recent fissure eruption."

James hopes that during his time on the MPCMS Board, he will "find ways to increase provider engagement within the society."

ALYSSA SCHMIDT, PA-C

Alyssa grew up in Boise, Idaho, and moved to the opposite corner of the country for school. With a PA degree from Barry University in St Petersburg, Florida, she came to Salem three years ago to work in family medicine.

She says that joining MPCMS helped her network with providers across different specialties and better serve her patients. She reports that she went from knowing no one to now enjoying "a great group of colleagues I can call friends and mentors."

Her family currently includes two cats who help with her hot yoga practice during the pandemic. It's not the same experience as group yoga with baby goats, but sometimes you have to make do with what you have. She also gets out for socially-distanced hikes as often as possible, although the cats choose to remain at home.

Regarding her Board commitment, Alyssa says, "My goal is to get the younger generation of providers involved and invested in our community."

ERIN HURLEY, MD

California girl Erin Hurley attended medical school in Nebraska and completed a pediatric residency in Iowa after spending her internship year at OHSU.

One month into a general pediatric practice in Coos Bay, Erin met her future husband, Mike, and became a card-carrying Oregonian. They have raised their three children (one set of twins) in the Mid Valley, where Erin worked at Kaiser Permanente before joining the medical staff at Liberty House. There she specializes in the diagnosis and treatment of abused children and serves as Medical Director.

When the extended family isn't traveling to adrenalin-inducing destinations with zip lines or roller coasters, they enjoy cheering on the Oregon Ducks—which can raise adrenaline levels without leaving the ground!

Erin and her sister, both BRCA2+, have been active in the national genetically-linked cancer support organization, Facing Our Risk of Cancer Empowered.

She hopes to use her time on the MPCMS Board to increase awareness of the health effects of childhood trauma, provider self-care, and to promote healthy living.

...continued on next page

...continued from page 9

CHRIS EDWARDSON, MD

Chris Edwardson, MD, grew up north of the border in British Columbia. He left the most mountainous part of Canada for the prairie when he earned his undergraduate and medical degrees in Saskatchewan. The highlight of his training was the six months he spent in New Zealand. While he was seen as cosmopolitan, coming from a more refined part of the Commonwealth, he enjoyed the Kiwi refinement of tea time and general civility.

Married to Jeanne, a native Oregonian, Chris joined a practice in the Mid Valley early in his career and never looked back. One daughter is now a school teacher; she and her husband have three kids and live "across the creek" from Chris and Jeanne. The other daughter is a PA in Portland with four children and a second career as a pastor's wife.

Unlike some physicians, Chris has always had an interest in the business aspect of running a practice. He has embraced a "passion hobby" in real estate development, initially commercial, and now residential. He reports that a thick skin helps a lot.

Chris says the first twenty years of his practice was all about the practice. He didn't feel like he was "giving back." Now he takes pride in mentoring young providers and hopes his time on the MPCMS Board will continue to support and improve the medical community.

TY WEBER, NP

Ty Weber, NP, grew up on an emu ranch in Southwest Idaho.

He earned his nursing degree at Brigham Young University and his NP through Gonzaga University. Ty and wife Brittany have both done bedside nursing at Salem Hospital.

Ty is now a family medicine provider at Aumsville Medical Clinic and has a special interest in backs and spines.

With three small children at home, Ty doesn't have a lot of extra time for hobbies, but he does enjoy woodworking and 3D printing.

He hopes to get acquainted with more providers through his work on the MPCMS Board.

JOSEPH RAD, PA-C

Joseph Rad grew up in Erie, Pennsylvania, and attended Penn State. An avid traveler, he has visited 25 countries and "still counting"!

Joseph works with Salem Pulmonary Associates where he practices pulmonary, critical care, and sleep medicine. He has a special interest in "staying current with the latest up-to-date recommendations in COVID-19 treatments, as well as being a part of our newly developing Pulmonary Embolism Response Team."

In his spare time he also works with the hemonc team.

Joseph's family consists of two older siblings and two rescue cockatoos—who can be every bit as bossy as older siblings!

"I hope to help bring our healthcare community together," Joseph says, "with the common goal of providing the best care to our patients. I also hope to increase the awareness of the integral, essential role that Physician Assistants play in our medical society."

...continued from page 11

KEITH WHITE, MD

Keith White, MD, grew up on a farm at Whiskey Hill, near Aurora, before moving to Keizer. He went all the way to downtown Salem for college at Willamette University. Medical school and residency took Keith to Portland before he returned to the Mid Valley.

Unlike many family docs, Keith retained his obstetrics privileges throughout his career. A full time "garden laborer" since 2018, he keeps his medical skills sharp with occasional locum tenens work.

He's not a lead in a Hallmark movie, but Keith did find romance after a 35-year friendship with his new bride, Mary Ellen. Son Ryan and daughter Erin (whose high school graduation succumbed to COVID restrictions) round out the family.

Keith's alter ego is a rhododendron tracker who joins expeditions to China, Tibet, and Sikkim, researching local species of rhodies. Closer to home, he serves on the Board of the Rhododendron Species Botanical Garden in Federal Way and tends his own dynamic garden.

While on the MPCMS Board, he hopes to make general meetings and get togethers as fun and entertaining as possible.

LEON HARRINGTON, MD

A Midwestern transplant, Leon Harrington, MD, spent his wonder years in Michigan and arrived in Portland in 1974 for a psychiatry residency, followed by a child psychiatry fellowship.

The Harrington family moved to Salem when Leon began inpatient psychiatric work with children and adolescents at the Oregon State Hospital. In addition to private practice, he has worked with severely disturbed young people at a number of private and public agencies.

Leon and wife Lynda, who are coming up on 50 years of marriage, have their own set of four young people, all working in service professions from law-enforcement to medicine. They also have six grandchildren available for grandma and grandpa attentiveness.

As the family's designated Tolkien nerd, Leon tries to uphold his dignity with feats of fishing, skiing, and card-playing prowess, but says he gets regularly "fleeced" by at least one of his sons.

On the Medical Society Board, Leon's goal is to provide a mental health perspective and help reduce provider burnout.

MARK FISCHL, MD

Mark Fischl, MD, lived, studied, and trained in the Seattle area until moving all the way to Spokane for his internal medicine residency. He may have never left his first practice in Moses Lake if he hadn't been recruited to Salem by fellow Sacred Heart-Deaconess resident, Gregory Lackides.

During Mark's "gap summer" between college and medical school, he spent two months backpacking through Europe using a tour book from a hometown guide—Rick Steves. While in Paris, Mark had the very unexpected thrill of a finishline-view of Greg LeMond's win over Laurent Fignon on the Champs Élysées in the closest Tour de France ever.

He says, "I recently had a chance to take my wife Deborah to Europe (when it was still allowed) and, unlike my previous trip, we did not sleep in train stations, grass fields, borrowed tents, or youth hostels. We also ate better. And possibly drank less."

In addition to his service on MPCMS Board, Mark is the president-elect of the OMA.

...continued on page 16

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...continued from page 13

NANCY BOUTIN, MD

Other than four years at Scripps College in Claremont, California, Nancy has lived and studied in the Portland metro area since arriving in 1960. She started her medical career in radiation therapy (note the outdated specialty name!) and made a mid-career change to palliative care at age 50. Despite pursuing several additional degrees (MFA and MBA) and new clinical training late in life, her family remains remarkably supportive, especially husband, Rod.

It might not surprise Society membership to hear Nancy say, "I never met a craft I didn't like." Whether quilting, soap-making, or photo manipulating, she loves to learn new techniques and share them—whether or not anyone else wants to hear about it!

She hopes to use her Board service to continue to bring the medical community into a closer, more mutually supportive family.

SCOTT BERG, DPM

Scott Berg grew up in Grants Pass and attended college in Idaho. He traveled east for medical school in Chicago and completed a podiatric residency in Seattle before returning to Oregon.

He practices at Coastline Foot and Ankle with a special interest in sports medicine.

Chicken or egg? Works at Coastline, loves salmon fishing. You decide.

Scott and wife Adrienne have been married for 15 years and have a daughter, Savannah, and son, Tommy. Scott's ambition is to visit every major league baseball stadium. The only question is: who gets to go with him?

When he's not thinking about baseball or fishing, Scott works to perfect his smoking technique—brisket, ribs, pork—and, of course, salmon.

He hopes during his time on the Board, he "will be able to mentor new providers in the area and to help them get a feel for the community."

Cover for Me.
Cover for You.

HISTORICAL TIDBITS

BY HOWARD BAUMANN, MD

TREATMENT OF NEUROSYPHILIS BY MALARIA

(Malaria Inoculation Therapy)

150 YEARS 1870-2020

Marion-Polk County Medical Society

ADVOCATE. COLLABORATE. EDUCATE.

During this COVID-19 Pandemic we have observed the off-label use of various medications, including the antimalarials chloroquine and hydroxychloroquine. Although a vaccine is looking much more hopeful, it will take time, and people are still dying. Thus, it has seemed reasonable to continue trying to treat the novel coronavirus using these relatively safe but as yet unproven drugs.[1]

Female mosquito on skin.

(Courtesy of centers for Disease Control and Prevention)

All of this talk about malaria medications reminded me of a very interesting therapy used years ago to treat patients with neurosyphilis by infecting them with malaria. This far-reaching technique involved the actual inoculation of malaria trophozoites into patients to produce a high fever that would lead to improvement, or even a cure, of this uniformly deadly disease. This therapy first caught my attention while I was helping set up a historical display of early psychiatric treatments at the Oregon State Hospital Museum of Mental Health. Dr. Julius Wagner-Jauregg, a professor of psychiatry at the University of Vienna, won the 1927 Nobel Prize in Medicine for this discovery.

Earlier, Dr. Wagner-Jauregg had noticed that many patients suffering from certain nervous diseases, including neurosyphilis, showed marked improvement after a febrile infection. Neurosyphilis, then called general paresis of the insane, or dementia paralytica, once accounted for up to 10% of admissions to psychiatric hospitals, which was also the case here at the Oregon State Hospital. When patients first appeared with the typical symptoms of neurosyphilis, they were already destined to a downhill course of insanity and death within 2 to 5 years. It was also well known that the usual syphilis therapies, including the various compounds of arsenic, cadmium, and mercury, were toxic and not very effective.

Dr. Wagner-Jauregg's first studies on neurosyphilis patients used bacterial organisms to produce a fever, but he soon switched to a safer and more effective approach using Plasmodium vivax due to its ability to cause a high cyclical fever into the 103°-106° range. Following treatment, the malaria infection could be terminated with a course of quinine sulfate. The results of his 1917 study were striking, with six of the nine patients showing extensive remission. This study also brought attention to the fact that the patients presenting with the earliest stages of neurosyphilis had the best chance of a lasting response.[2]

Wagner-Jauregg (right of center in dark jacket) watching a neurosyphilis patient get a malaria inoculation in 1934.

(Courtesy Institut für Gescjocjte der Medizin, Vienna, Austria)

His subsequent studies showed a remission rate of 85%, and a partial remission of 12%. Other medical center studies, including at the Mayo Clinic, showed similar outcomes. The downside to this treatment was a patient death rate of 9-15%, mainly due to complications of the induced malaria itself.[3]

Malaria inoculation was carried out in one of two ways. The first and most common was direct intravenous administration of 5-10cc of blood from an already infected individual, titrating to infuse one million parasites. The second method was direct mosquito inoculation (3-6 anopheles mosquitos in a cage to the upper extremity and axilla). Following 8-12 fever cycles, the patient was treated with quinine sulfate to treat the malaria.

Malaria inoculation was also used here at the Oregon State Hospital. Available information from Oregon State Biennial Reports showed an average of 42 inoculations per year between 1932 and 1938. Unfortunately, I could not find outcome data. This form of therapy effectively ended with the introduction of penicillin in the mid-1940's.

Because I started this article referring to our current COVID-19 pandemic, I wanted to remind you that two past ChartNotes articles have dealt with other pandemics in Oregon. The first article covered the 1870s Cholera Pandemic, and the other the Spanish Influenza of 1918-1919, which found McKinley Elementary School here in Salem serving as a hospital.[4,5]

1 Sanders JM, et al. Pharmacologic Treatments for Coronavirus Disease (COVID-19): A Review. JAMA. April 13, 2020, published online.

2 Nobel Lectures, Physiology or Medicine 1922-1941, Elsevier Publishing Company, Amsterdam, 1965.

3 O'Leary PA. Treatment of Neurosyphilis by Malaria. JAMA. 1927;89(2):95-100.

4 Baumann HW. Asiatic Cholera Threatens Salem. ChartNotes. Summer 2017, pages 12-13.

5 Baumann HW. McKinley Elementary School Stepped into the Gap. ChartNotes. Summer 2019, pages 10-11.

BY HOWARD BAUMANN, MD

OUR EARLIEST JOURNALS

(Appeared in *ChartNotes*, a publication of the Marion-Polk County Medical Society, January 2015)

This article is about the first three medical journals published in Marion and Polk Counties, which were also the first three ever published in Oregon. The time set for all this is during the decade that followed the Civil War, when scientific medicine was starting to actively evolve. We will also catch up on some of the medical articles of interest at that time, including some gossip.

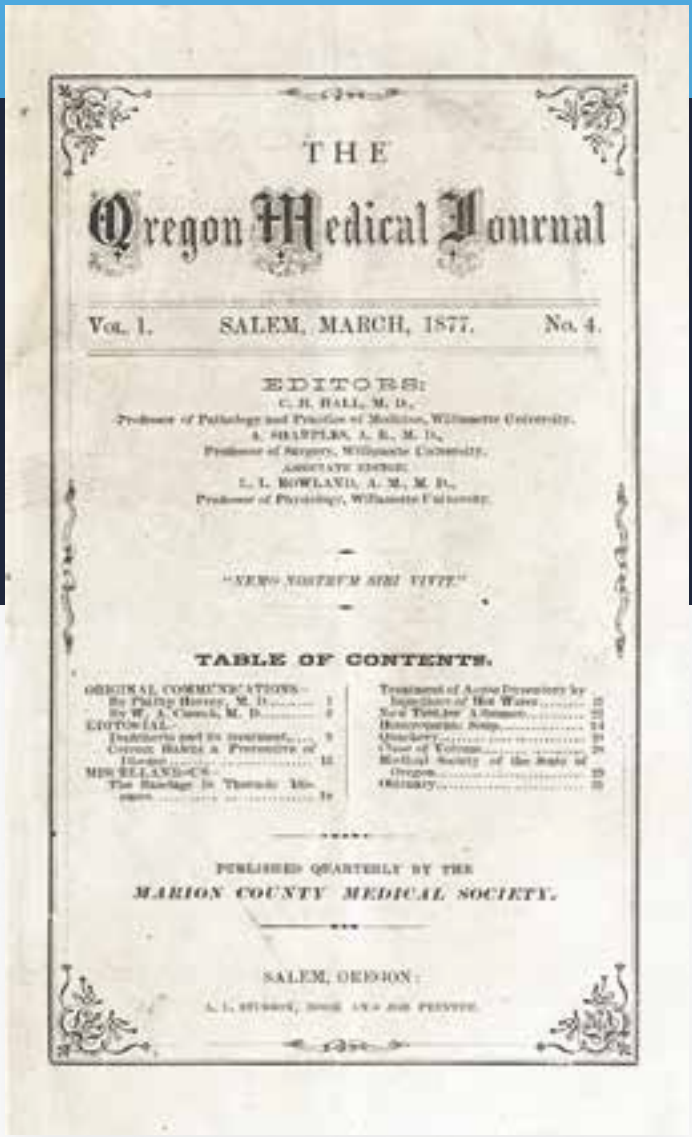

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TABLE OF CONTENTS.

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SALEM, OREGON:

Last issue of the OMJ, March 1877. *(Image courtesy of Oregon Health Sciences University Historical Collections and Archives)*

Depending on how one categorizes medical journals, the first journal was started in 1866 by Dr. J.C. Shelton, a Salem homeopathic physician who graduated from an irregular (botanic) medical school, which advocated natural remedies, and tried to steer patients away from those "poisonous patented medicines." We are not sure of the extent of its popularity, but this bimonthly journal lasted about two years.[1]

The second journal, the Oregon Medical and Surgical Reporter (OMSR), was launched in 1869 as a product of the Willamette University College of Medicine. The editors were Dr. Eugene Fiske and Dr. Horace Carpenter. Dr. Fiske graduated from Harvard Medical School, and was Professor of Pathology and the Practice of Medicine. Dr. Carpenter had been a surgeon with the First Oregon Infantry during the Civil War, and was the first Dean of the Medical School. This journal, although initially well received, also had to disband after two years, due to the relatively small number of subscribers and advertisers. The editors had asked the newly formed Marion County Medical Society to take over publication, but without success.[2]

Finally, six years later and with not much fanfare, the Oregon Medical Journal (OMJ) officially started in June 1876, published on a quarterly basis by the Marion County Medical Society. The original OMJ editors were: Drs. Charles Hall, Abram Sharples, and Levi L. Rowland. Dr. Hall was in the second graduating class of the Medical School, was Professor of Pathology, and later would twice be president of the Oregon State Medical Society (now the OMA). Dr. Shaples was a graduate of Jefferson Medical College, had been a Civil War surgeon, and was Professor of Anatomy. Dr. Rowland, also a College of Medicine graduate, was later to be Dean, and would eventually serve as the fourth superintendent of the Oregon State Insane Asylum.[3]

The editors of these journals gave us a window to view important scientific developments during this time, among them: a) an update on the antiseptic techniques recently promoted by Joseph Lister, b) a new test for detecting blood in liquids or cloth using a mixture of tincture of guaiac and turpentine.[4] This, of course, was long before commercial stool guaiac testing would become available in the late 1950s, and c) the merits of hydrate of chloral (chloral hydrate).[5] This sedative, which had just been released, would also turn out to be one of Mary Todd Lincoln's favorite sleeping pills, and today is still listed as a schedule IV controlled substance in the United States.[6]

Along with the articles, the actions of one of the editors might give you pause for thought. Dr. Fiske was abruptly dismissed after he wrote an editorial endorsing a letter that had been sent to the OMSR that was both critical of the qualifications of the students at the Willamette University College of Medicine, and questioned the medical ethics in general of doctors in Oregon and Salem. Dr. Fiske was later reinstated after printing a formal apology.[7]

As far as the OMJ goes, the times remained tough and it lasted only four issues. The next publication by the Marion-Polk County Medical Society, at least that we know about, was The News Bulletin of the Marion-Polk County Medical Society, first published sometime in the late 1960s or early 1970s. By the way, if any of you have any old publications from our Society, please consider a kind donation of them to our archival collection. Next in sequence, of course, came ChartNotes in 1998. Some of you may remember that a special collection: The ChartNotes Collection: The Doctors of Marion and Polk Counties, Vol. 1 and Vol. 2, was published in 2008, and edited by Nancy Boutin, MD.[8]

Finally, and as a side note, Historical Tidbits has just celebrated its one-year anniversary. Hopefully you have learned something of the early days of the Marion-Polk County Medical Society, including our birth, our first president, and peripheral events of that time. Now you can also be proud of yet another first for our Society: The Oregon Medical Journal, the first medical society journal in Oregon.

1 Olaf Larsell, The Doctor in Oregon (Portland, Oregon: Binfords and Mort, 1947), 401. This was the Oregon Physio-Medical Journal. Dr. Shelton graduated from the Physio-Medical College of Cincinnati.
2 Larsell, 402-403.
3 Larsell, 404-405.
4 Larsell, 403-404.
5 H. Carpenter, Oregon Medical and Surgical Reporter, (1871), I: 346.
6 Jean H. Baker, Mary Todd Lincoln: A Biography (W.W. Norton & Co., New York, N.Y., 1987), 331-334.
7 Larsell, 402-403.
8 Nancy Boutin, MD (editor), The ChartNotes Collection, Vol. 1 and 2 (Marion-Polk County Medical Society, Salem, Oregon, 2008).

THE MEDICAL COST OF STRUCTURAL RACISM

BY NANCY BOUTIN, MD, MBA

Back in the olden days, when some of your Board members were trainees, medicine was an interaction between one patient and one doctor. There were no quality indicators, no dashboards, and public health was some mysterious thing followed by the county health department. Nowadays, we are expected to manage the well-being of groups of people, whether the diabetics on your panel or the community in your hospital's catchment area. The Institute for Healthcare Improvement (IHI)'s Triple Aim, adopted widely throughout the country, defines quality as care that improves the patient experience, decreases per capita cost, and improves the health of populations. While we have been aware for many years of disparity in healthcare access and outcomes, the COVID-19 pandemic revealed the disproportionate burden of the virus on vulnerable populations. Protests in the wake of George Floyd's death have emphasized the role of structural racism in creating underlying conditions that put Black and Brown communities at the highest risk.

One of the foremost experts on anti-racism, Ibram X. Kendi, Ph.D., recognizes that *racism* has become so emotional, so political, and so pejorative, that the very word creates an impediment to useful dialogue. Kendi offers a way of thinking about racism that does not depend on what's in a person's heart, family, friend group, or even their DNA. Instead, racism is about action or inaction. To paraphrase: racism is found in laws, rules, policies, regulations, and/or guidelines that promote one racial group over another, resulting in inequity. In Kendi's view, an antiracist is someone who opposes inequity. He rejects the concept of "not racist" because, in the words of Elie Wiesel, "Neutrality helps the oppressor, never the victim."

Equality states that everyone is given an equal share, while equity requires a more needs-based approach. In the US, we tend to focus on equal opportunity, rather than resource allocation. "To each according to his needs," may sound frankly Marxist to some, which, depending on their political persuasion, may be considered a negative or a positive.

Many members of the MPCMS came from working-class families, or impoverished families, or immigrant families. We worked hard to overcome obstacles to get where we are today. It's natural to think that others should be able to accomplish as much as we did. Of course, we were born with intelligence, an aptitude for problem-solving, and a lot of stamina and/or stubbornness. Additionally, few of us pushed against systemic or structural racism along the way. We present a high bar for comparison under any construct. We need to meet our patients where they are, not where we think they should be.

The concept of social determinants of health has gained tremendous traction in the last twenty years. For a long time, we assumed that disparity in health outcomes hinged on access, but as more people were able to afford insurance, it became clear that the ability to "go to the repair shop," in the words of IHI's Don Berwick, MD, was not the whole answer.

In fact, in a wide variety of studies, medical care accounted for 10-25% of a person's overall health. Genetics had a similar effect. Depending on how you cut the pie chart, "lifestyle," added to access and genetics, only totaled half of the health equation. Social determinants, often those present during childhood, accounted for 50% of an adult's health status, including chronic disease, cancer, mental health diagnoses, substance use, and premature death.

In 2008, a UCSF study showed that adjacent zip codes had widely differing life expectancies. A paper from the Department of Public Health at NYU Langone showed that, in US cities with the highest levels of racial and ethnic segregation, life expectancy varied from 25-to-30 years from one neighborhood to the next. Marc N. Gourevitch, MD, MPH blames "longstanding, systemic racial and ethnic inequalities."

Ronald L. Copeland, MD, FACS, Kaiser Permanente's Chief Equity, Diversity, and Inclusion Officer and Senior Vice President of National Diversity and Inclusion Strategy and Policy, agrees. "The existence of institutional racism and discriminatory practices in various systems, including health care, serve as root causes of inequities that drive recurring and disproportionate health care disparities. Systemic racism, therefore, is a determinant of health."

In the wake of Barack Obama's election in 2008, some hoped that the US had evolved into a post-racial America. Events have disproven that hope. "Policies and regulations" continue to favor White citizens over citizens of color, while the effects of previous policies like Jim Crow and redlining persist. An LA Times Opinion editor, Matthew Fleischer, calls the Los Angeles freeway system "the most racist California monuments," built with malice aforethought to destroy racially diverse neighborhoods and to assure de facto segregation in Los Angeles.

The irony of Portland's progressive reputation and blatantly racist past inspired a 2016 *Atlantic* magazine article. From the founding of Oregon's White Utopia, to the influx of Black workers during WWII, to the turbulent 60s and beyond, the piece looks at how Portland and the state have treated minorities. As in Los Angeles, the building of the I-5 freeway through the middle of the Albina neighborhood offered an opportunity to disrupt a vibrant Black community. Further urban renewal projects like the Memorial Coliseum and expansion of Emanuel Hospital, required displacement of more Black homeowners—who had nowhere to go. Restrictive covenants in both Los Angeles and Portland severely limited relocation options. The article also cited a PSU/Coalition of Communities of Color report from 2014. "Oregon has been slow to dismantle overtly racist policies. African Americans in Multnomah County continue to live with the effects of racialized policies, practices, and decision-making."

These policies, Copeland's racist determinant of health, cause or exacerbate the other social determinants like poverty, food insecurity, substandard housing, pollution, and violence. The impact of childhood trauma on an individual's lifetime health garnered attention in the healthcare arena at about the same time as social determinants. The two are closely related, interrelated, but not precisely the same.

...continued on next page

The Adverse Childhood Experience (ACE) score identifies events that heighten allostatic load in a developing body. Maturing organs, bathed in a wash of cortisol with resulting inflammation, may be primed for chronic disease in adulthood. One ACE point goes for having a close family member in prison. Mass incarceration, disproportionately Black or Latinx, confers an ACE point on children who are statistically more likely to be exposed to other traumas, i.e. living with social determinants. Further, research suggests that the effects of trauma can be transmitted epigenetically. Abuse experienced as an enslaved person, terror caused by hate crimes, or privation due to general racist policies, may impact the health substrate of new generations in utero and beyond—which may lead to chronic illness, early death, and another turn of the cycle.

As it became evident that a) underlying conditions conferred a higher likelihood of severe COVID symptoms, possibly due to a "cytokine storm" i.e. uncontrolled release of proinflammatory cytokines, and that b) Black and Brown communities were hardest hit, a certain level of victim-blaming ensued. Given our knowledge that social determinants and ACE lead to increased levels of diabetes and obesity, we should have seen that blame—if there was any—belonged to a system that had already victimized those communities.

Writing last year, Daniel E. Dawes, PhD, author of The *Political Determinants of Health*, (the determinants of the determinants), anticipated 2020, saying, "Sometimes extemporaneous interceding factors also severely impact our health and well-being and may result in the premature death of individuals and communities. The storm that represents the brutal forces that roll in unexpectedly and cut your life short, such as violence or natural disasters—the effects of which can be mitigated or worsened by political systems—illustrate this point." He discusses the government's disparate response to hurricanes that impacted predominantly White communities vs. POC. The response, he said, "was significantly different because those communities were valued differently."

If COVID had targeted 30-year-old White men and women instead of the elderly, infirm, and communities of color, would the White House have mounted a different response to the pandemic? No way to know. . .

Dawes also points out that "Political systems at all levels should take note that the lives of its citizens are inextricably intertwined and that, when one community is negatively affected, other communities will also be negatively impacted."

It impacts all of us when a significant segment of our population cannot reach its potential. "This unequal treatment," Dawes writes "has resulted in inequities in health, education, employment, housing, criminal justice, transportation, and a host of other variables that collectively affect our ability to attain outstanding health outcomes, to achieve higher life expectancies, and to ensure the opportunity for all groups living in the United States to meaningfully contribute to strengthening our democracy."

Healthcare is rife with examples of "penny wise and pound foolish." Failing to provide medical care and a healthy environment for all young people means that we will pay more later. One insurance executive said that, with a two-year average enrollment cycle, it was hard to see a return on investment 20-40 years in the future.

Nevertheless, in "Economic Burden of Health Inequalities in the United States," LaViest, Gaskin, and Richard estimated that deferred care for racial and ethnic minorities (their trips to the "repair shop") cost, conservatively, $300 billion per year in 2009. Another study the same year by the Joint Center for Political and Economic Studies, estimated that eliminating health disparities for minorities would have reduced direct medical care expenditures by $229.4 billion and reduced indirect costs associated with illness and premature death by approximately $1 trillion during 2003–2006.

In 2014, Don Berwick gave an IHI conference keynote called, "A Report from Xanadu." In the address, he spoke eloquently about the need for America to address the social determinants of health by repairing or reimagining all manner of social justice issues. He advocated for overhaul of the criminal justice system, for early childhood interventions, affordable childcare, safe neighborhoods, and universal access to medical care.

Five years later, with the Affordable Care Act (ACA) undermined and under constant threat, he spoke about "Quality, Mercy, and the Moral Determinants of Care." It is safe to say, he had no room under that umbrella for racist laws, rules, policies, regulations, and/or guidelines. There was no room for inequity.

Instead, Berwick said this: "Healers are called to heal. When the fabric of communities upon which health depends is torn, then healers are called to mend it. The moral law within insists so. Improving the social determinants of health will be brought at last to a boil only by the heat of the moral determinants of health."

As we, members of the Marion and Polk County Medical Society, continue to advocate for addressing the social determinants of health, we should be mindful of the political and moral determinants, as well. We must look at policies and regulations with an equity lens and remove structural racism wherever we find it. Together, we can build a more equitable and just healthcare system for our patients and our community. Together, we can mend the fabric.

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HOPE IN THE TIME OF CHAOS

Chunhua is an elderly Chinese woman who makes the one-mile journey to the river every day. A stick balanced on her shoulders suspends a large pot for water on each end. Every day, the pot over her left shoulder leaks through a small crack so that by the time she returns to the village, it is only half full. For many seasons this happens daily. One day the cracked pot spoke to the woman- "I am ashamed of myself, because this crack in my side causes water to leak out all the way back to your house."

The old woman smiled; "Did you notice that there are flowers on your side of the path but not on the other pot's side? I plant seeds on your side of the path, and every day while we walk back, you water them. Every spring, I have been able to pick beautiful flowers to decorate the table."

When life hands you a bunch of lemons, you make lemonade.

"A crisis can be a real blessing to any person, to any nation. For all crises bring progress. Creativity comes from anxiety as the day comes from the dark night." A. Einstein

Adversity is a given. It is how you deal with adversity that will determine your ability to carry on from day to day during these chaotic pandemic times. Concepts of good arising out of bad have been prevalent in our society since the dawn of time. There are good things that have come out of the coronavirus pandemic. In India, the Himalayas had been hidden for over 30 years due to smog. Air pollution is down across the globe including China, Dubai, Abu Dhabi, Italy, to name a few. The disuse of the Venetian waterways has allowed us to see the dolphins in the clear water. In the Summer 2020 edition of *ChartNotes* I shared with you a quote from the 2008 movie The Day the Earth Stood Still, "...if earth dies, we die; if we die the earth lives."

With the decrease of global movement, the earth is beginning to heal itself. Satellite images have revealed a massive fall in global nitrogen dioxide. Images by the US space agency NASA are clear indicator of decreasing NO2 levels. In February, the concentration of nitrogen dioxide fell drastically in Wuhan, China, coinciding with the lockdown of the city which was the epicenter of the COVID-19 pandemic. The importance of atmospheric NO2 and mortality rate of COVID-19 is explained in this article. https://www.sciencedirect.com/science/article/pii/S0048969720321215

In the Fall 2019 issue of *ChartNotes*, I suggested that the future would include AOC as president and telemedicine kiosks on every corner. I doubt that AOC will ever be president, but Medicare and other 3rd party payers now reimburse for Telemed visits and most of my patients really love it. In my opinion, this is the most important good to come out of this crisis.

I am on the fence about forcing home schooling, because I believe that schools serve as one of the most important socializing components in our society. On the other hand, intensive involvement in the education of your children cannot be bad.

Magical things are happening. Andre Bocelli gave a free concert at Duomo di Milano with a message of love, healing and hope. Many artists are giving free Zoom concerts. Take out and curbside delivery is becoming the norm and masks are finally getting the reputation they deserve. For the first time in modern history, every scientist in the world is working on the same problem, and we may have a vaccine in record time!

So, if you are feeling sorry for yourself and those around you, look inward and remember to smell the flowers. Perhaps the best thing to consider is that we will be better prepared for the next pandemic.

1 From the parable of the cracked pot origin/author unknown. Chunhua means spring flower in Chinese.

CHARTNOTES - WRITER BIOS

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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.

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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. From those working tirelessly with COVID-19 positive patients, to those working behind the scenes to secure PPE, operationalize tele-visits or simply respond to emails and phone calls - your role is invaluable and appreciated. As we plan future issues of ChartNotes, we would like to share your experiences during this pandemic. How has it affected you, your practice, your relationships with your patients? How are you moving forward? If you would like to share your story/experience please contact Nancy Boutin at nancyboutin@me.com or Krista Wood at krista@mpmedsociety.org.

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