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The Battle of the Doctor Bands

Don't miss the Medical Society of Metropolitan Portland's Battle of the Doctor Bands June 12 at McMenamins Kennedy School. Learn about the four groups on the bill for this first-ever event, which will benefit Special Olympics Oregon. ***—Page 5***

An art-for-all advocate

Metropolitan Medical Foundation of Oregon, MSMP honor PHAME's Stephen Marc Beaudoin

By Jon Bell
For The Scribe

It happened one night at the Aladdin Theater in southeast Portland.

Moved by the stories and images that emerged after the devastating earthquake in Haiti in 2010, **Stephen Marc Beaudoin** organized a benefit concert to raise money for Mercy Corps. Held at the Aladdin, "Songs for Haiti" featured some of Portland's biggest guns, including Storm Large and Pink Martini's Thomas Lauderdale and China Forbes.

Also on the bill was a choir from **PHAME**, the Portland non-profit which provides arts education and performance opportunities for adults with developmental disabilities. Because he wasn't all that familiar with the group, Beaudoin had been somewhat hesitant to include them. In the end, he gave them one song—and it changed his life.

PHAME Executive Director Stephen Marc Beaudoin and several PHAME students participate in the annual Walk, Roll and Stroll event. Beaudoin is credited with using art to help improve health outcomes for adults with developmental disabilities. Photo courtesy of PHAME

"They come out and they sing 'Lean on Me.' They kill it and the audience goes crazy," Beaudoin said. "I remember it very, very clearly. I had a very emotional response to it. Here were these people who were living life and loving life and just expressing themselves in a very profound way. I just said to myself, I have got to be a part of that organization."

Two months later, Beaudoin joined PHAME's board of directors. A few months more and he became their interim director, and in November 2010—just 10 months after that performance at the Aladdin—Beaudoin officially became executive director, a role he's held ever since.

The **Metropolitan Medical Foundation of Oregon**, along with the **Medical Society of Metropolitan Portland**, selected Beaudoin as this year's recipient of the **Rob Delf Honorarium Award**. The award, named after former MSMP CEO Rob Delf, recognizes an individual who exemplifies the ideals of the society.

Art a tool for empowerment, expression

Born and raised in Independence, Mo., Beaudoin, 34, said a few key themes instilled by his parents helped color his upbringing and shape his life. The first was that art matters and can be a tool for empowerment and expression. His parents also underscored the importance and potential of education, and they made sure that social justice and helping others in need were woven throughout everything they did.

Beaudoin moved to Boston in 1998 to study music at the New England Conservatory of Music. While there, he did an internship with the Boston Gay Men's Chorus and, he said, got an early clue for what he might do with his life.

"There was an organization that was working to produce positive social impact through the arts," he said. "That was something that really resonated with me."

Beaudoin also worked for the Fenway Alliance, a consortium of academic and cultural institutions, and he founded a baroque orchestra and chorus called Vox Consort. But he was having trouble finding his real direction and what he really stood for. Thinking that the

See ***BEAUDOIN,*** *page 13*

MSMP Annual Meeting coverage

Stephen Marc Beaudoin, executive director of PHAME, received the Rob Delf Honorarium Award at the Medical Society of Metropolitan Portland's 130th Annual Meeting, held earlier this month. Please look for full meeting coverage in the June issue of *The Scribe*.

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Legal Focus

Check out this month's Legal focus, which delves into coordinated care organizations and electronic medical records.
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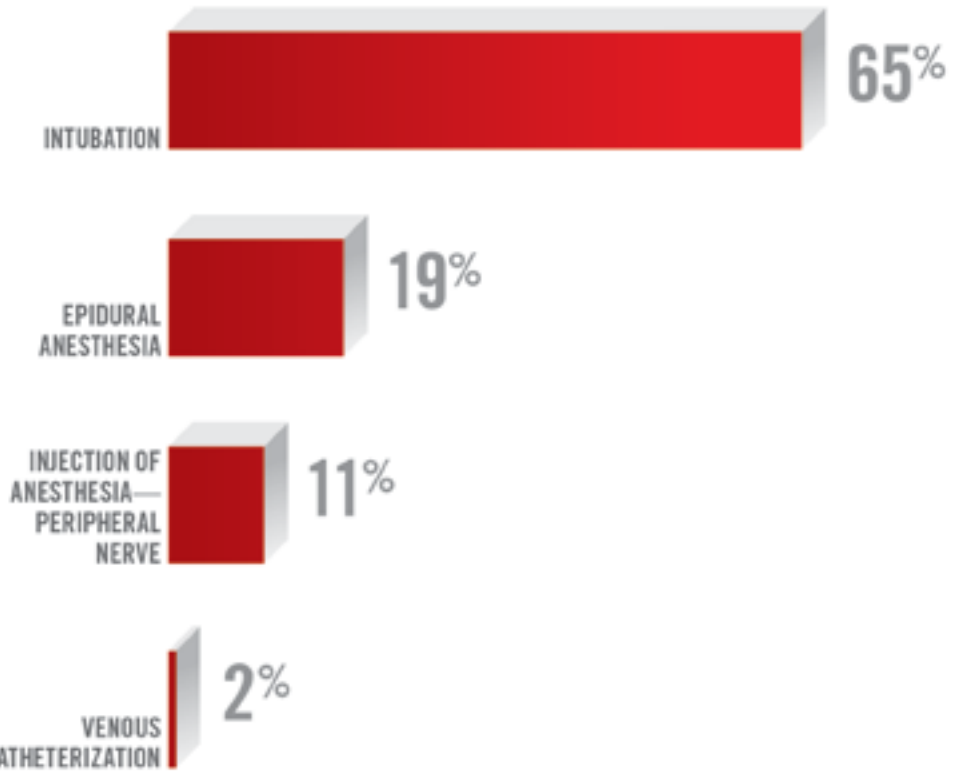

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Hitting all the right notes, for a good cause

Battle of the Doctor Bands will showcase lively mix of music benefitting Special Olympics Oregon

By Jon Bell
For The Scribe

Portland-area physicians will trade their stethoscopes for six strings at the Medical Society of Metropolitan Portland's first-ever Battle of the Doctor Bands on Thursday, June 12. Held at McMenamins Kennedy School, the free evening of music will benefit Special Olympics Oregon and feature four diverse groups. The winner of the competition gets to play at the Bite of Oregon in August.

For a preview of the night's musical action, The Scribe profiled the four bands who will be duking it out.

Ojos Feos

Nine years of piano lessons as a kid, countless hours spent listening to music while studying to become an anesthesiologist and 24 international surgical missions to places like Sierra Leone and Tanzania have all helped shape the musical life of Scott Brown, MD, an anesthesiologist and medical director at OAG Interventional Pain Consultants.

The result, in part, is Ojos Feos—translated as Ugly Eyes—a seven-member band that's been playing a unique musical blend they call "Afro-Latin blues with a conscience" since last August. Brown, a multi-instrumentalist who plays under the stage name Robbie Cree, is joined in the group by Ed Zancanella, Ricardo Oyarzabal, Dave Fischer, Lee Dorfman, Gaia Oyarzun and Gonzalo Villa.

"I really feel like we're doing something that no one else is doing," said Brown, who likens the band's sound to the first three albums of Santana, which fused jazz, blues and Latin influences. "It's all these different world rhythms and languages together."

The majority of Ojos Feos' songs are in Spanish, with a handful in Sierra Leone Krio and Swahili. The music is laced with African and Latin accents, and many of the songs address human rights and political issues, from the oppression of gays in Uganda to the 1961 assassination of Patrice Lumumba, a Congolese independence leader.

"Much of our music is influenced by international human rights, as several of us in the band are involved with this type of work," said Brown, who is the president and founder of Surg+Restore, a nonprofit working to establish a plastic and reconstructive surgery and burn unit in Sierra Leone.

The band, which rehearses weekly and plays out a few times a month, would love to win the Battle of the Doctor Bands, not only for the exposure of playing the Bite of Oregon, but also for the chance to further spread the message of its music.

"We want to take the band and the music as far as possible," Brown said. "We just love playing out and want people to hear our music and what it's all about."

HomeBrew

Though HomeBrew, a cover band that jams out a mix of classic R&B, blues and dance music, plays at quite a few parties and weddings, it's not a regular on the Portland club scene for one primary reason:

"There aren't too many venues for a band our size," said Gary Oxman, MD, bass player for the 11-member group that gelled into its current lineup about 15 years ago. The band plays songs from artists such as Sam & Dave, Etta James, Van Morrison and the more contemporary blues singer Susan Tedeschi.

Though it's a challenge to get everyone together for rehearsals, Oxman said having so many people and syncing them all on the same musical page is one of the true joys of being in such a large group.

"With that many people, part of the art is how to make space for each other," he said. "We've all figured out how to play with each other and around each other so that everybody's out in front some of the time, but not all the time."

Oxman, a family physician who also served as the Multnomah County Health Officer for more than 25 years before retiring in 2013, is just one of HomeBrew's musicians with a medical background. On the harmonica is Bruce Goldberg, MD, former director of the Oregon Health Authority, and on the trombone is Darren Coffman, director of the OHA's Health Evidence Review Commission. Guitarist Mark Loveless, MD, is an infectious disease physician, drummer David Panzer is a chiropractic physician, and guitar player Eric Walsh, MD, is a physician in palliative medicine. The remaining members include Maria Blum, David

See ***OFF HOURS,*** *page 13*

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Ojos Feos

HomeBrew

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Bill clarifying PA role in Oregon to take effect July 1

By John Rumler
For The Scribe

An important piece of Oregon legislation that amends certain statutes that reference "physician" to also include "physician assistant" was signed by Gov. John Kitzhaber on March 6 and will take effect July 1.

The 55-page **SB 1548** was a technical fix and clarification bill which changed more than 75 separate sections of Oregon law. In many places, the law specified medical providers only as "physicians," primarily because the law was written for prior generations, before physician assistants and nurse practitioners became common providers in the state. In increasingly frequent instances, the obsolete language was a hindrance to patient care due to misunderstandings and occasional challenges and/or misinterpretation by legal counsel, agency administrators, hospital or clinic management, insurers and others. The bill passed unanimously in both houses.

"I think of it as a housekeeping bill," said **Ted Ruback, MS, PA**, division head and program director for Oregon Health & Science University's Physician Assistant Program, one of two in the state. "It defines and accurately updates our role and the scope of what PAs do in Oregon."

Ruback founded OHSU's Physician Assistant Program, which graduated its first class in 1997 and in 2001 became a freestanding division within its school of medicine. The course consists of a 12-month didactic phase followed by 14 months of clinical rotations culminating in a master's of physician assistant studies degree. OHSU graduates 40 to 42 students annually and competition to enter the program is fierce, with upwards of 1,200 applicants in 2014.

The soon-to-be-enacted legislation also speaks to the growing trend of clinics and medical centers utilizing more physician assistants, in many cases to offset the increasing need for physicians around the nation and in Oregon.

According to the American Association of Medical Colleges, the shortage will reach 91,500 by 2020 and grow to 130,600 by 2025. In addition, the Annals of Family Medicine estimates the U.S. will need at least an additional 52,000 primary care physicians by 2025. Although some PAs do specialize, the majority are trained in primary care.

"With the full impact of the ACA yet to come, and the unequal distribution of physicians leaving many areas underserved, the role of the PA is going to become even more important in the future," Ruback said. "PAs often go to rural and sparsely populated areas that sometimes don't have or can't support an MD."


TED RUBACK, MS, PA

Including residency, it takes five to 10 years to train a physician, while the average length of a PA program is 27 months. PAs in Oregon perform physical examinations, diagnose and treat illnesses, order and interpret lab tests, perform procedures, assist in surgery, provide patient education and counseling, and make rounds in hospitals and nursing homes.

"PAs are a critical component to providing quality care to patients who need it the most," said **Oregon Society of Physician Assistants President David Greene, PA-C**. "With the passing of this law, PAs can get back to focusing on providing quality care without worrying about obstacles and outdated regulations. We are grateful to our state legislators for embracing the value of PAs and improving the way we care for patients."

According to Greene, the changes reflect today's current health care practice environment, and were relatively easy to accomplish once lawmakers understood the changing landscape of current medicine. The revisions also directly impact patient care, as several situations noted by PAs were directly addressed. One example, Greene explained, is that the bill clarified that PAs can order assistive devices for disabled people through the state PUC, as physicians and nurse practitioners have done for years.

When Ruback founded the OHSU Physician Assistant Program, PAs weren't accepted as members of the Oregon Medical Association (OMA). Now, a PA member serves on the OMA board of trustees and PAs are members in county medical societies across Oregon.

The OMA supported SB 1548 and, at the request of the Oregon Society of Physician Assistants, worked with the organization to clear up vague language in the statutes.

While the bill is a major step in clarifying the role of PAs in Oregon, Ruback said there is still room for improvement.

"The profession continues to evolve and we're enjoying increasing acceptance, but there's always a period of adjustment and some initial resistance to anything new or different."

James Ferguson is the director of rural medicine at Pacific University in Forest Grove and an associate professor in its School of Physician Assistant Studies, which has graduated 500 PAs since 1997. Ferguson, who earned his PA from Wake Forest in 1990, has practiced medicine from the South Pacific to Alaska in the U.S. Public Health Service Corps. In nearly a quarter of a century, he's witnessed huge changes in the acceptance and recognition of PAs. "SB 1548 is important because it allows us to practice at the top of our license, and it is also a reminder for us to recognize our limits," he said.

While some physicians may not have experience working with PAs, medical students now often do clinical rotations with PAs and may even obtain parts of their training from PAs, Ferguson explained. "The newer and younger physicians really value us as partners. We're generalists and we go everywhere and work in every facet of medicine as their associates." •

PAs progress professionally

With the idea of utilizing the skills and experience of returning military trained corpsmen and medics, the concept of physician assistants was originated by Charles L. Hudson, MD, in a 1961 *JAMA* article. In 1967, four former U.S. Navy medical corpsmen graduated from Duke University's PA program, the nation's first.

In 1970, Kaiser Permanente became the first HMO to hire a PA, and five years later the National Commission on the Certification of Physician Assistants was established. The number of PAs has grown rapidly since the 1990s: in 1993, 23,000 PAs worked in the United States, while today there are more than 95,000.

Likewise, in 1995, there were 61 accredited PA programs in the nation; today there are 187, graduating about 6,000 PAs annually.

The demand is likely to continue. Fifty states and the District of Columbia authorize PAs prescribing privileges, and PAs were named one of three primary care providers in the nation by the ACA.

According to the Bureau of Labor Statistics January 2014 *Occupational Outlook Handbook*, the need for PAs is projected to increase by 38 percent between 2012 and 2022. •

—John Rumler

My experience in intercultural health care

Do you have a story or perspective to share with Scribe readers?
We welcome student essay submissions. To propose a topic, or for more information, please contact the editors at scribe@llm.com or 360-597-4909.

By Shabnam Ghazizadeh

I am now in the trenches of the second year of medical school. Most hours of my day are spent juggling studying neuroanatomy and physiology with fending off anxiety about the upcoming USMLE Step 1 boards. It is exhausting to say the least. Rest is not an option, not only because there is no time, but also because of the associated guilt. The only salvation from this endless cycle is using any extra time I can find for involvements that are truly meaningful. One of these extracurricular activities is something I am particularly excited about because it is a reminder of what initially drew me to medicine.

During the ages of 12 to 18 I was responsible for accompanying my grandparents to their doctors' appointments. From dentist to ophthalmologist to cardiologist, I helped my parents out by being a translator while they were at work. It may have seemed like a part of my chores at first, but it quickly became an exciting challenge and learning experience. Even filling out the paperwork required phone calls to my mom for translations or acting out the medical words I did not know. The experience was invaluable and continues to influence every aspect of my life. I developed my love of languages and discovered my interest in patient care in those waiting rooms and doctor visits.

On the other side of almost two years of training, I am surprised that my outlook on this very influential experience has changed. Lectures on cross-cultural communication and experience working with non-English-speaking patients have made me reconsider the use of family members (especially young children) acting as medical interpreters. While I know from my personal experience that I did the best that I could, with the best intentions for my grandparents, I know that certain aspects of patient care were lost in translation. Consequently, I am happy to see that there have been strong efforts to increase access to interpreters and provide resources for improved cultural competency in health care. Many hospitals are now mandating that interpreters be available for patients at each visit, either in person or via telephone. Oregon Health & Science University has recently updated its policy and now requires providers who wish to speak to patients in a non-English language to be certified. These steps may be costly, but I am beginning to see the immense importance of this type of standardization and training.

Just last year, I went to a doctor visit where my grandmother had a professional medical interpreter. She was considering a very complicated and invasive spinal surgery associated with very high risks. I am not sure if the hospital had required it or my mother suggested it, but she was accompanied by an interpreter for the pre-op assessment visit. This two-hour experience in itself revealed to me the complex nature of intercultural medical care. I was in a unique position to witness the dynamic interactions between practitioner, non-English-speaking patient, family member and interpreter. For the first time, I learned what is meant by "a family member's conflicting agenda" in a patient visit. While both my mother and I were trying to gather information about the risks of the procedure so that we could help make an informed decision, I realize that we were less concerned about sharing that information with the actual patient. It was as if we knew we would have the opportunity to share the details with her when we got home. But what about the patient's questions and her need to know the information and risks? The only person who was an unbiased

*See **STUDENT PERSPECTIVES,** page 14*

Reducing liability factors with CCOs

Changing practice landscape raises legal questions for physicians

By Cliff Collins
For The Scribe

Coordinated care organizations intend to move health care away from fee-for-service, and yet go beyond the 1990s' managed care concept by emphasizing quality and outcomes in addition to lowering costs.

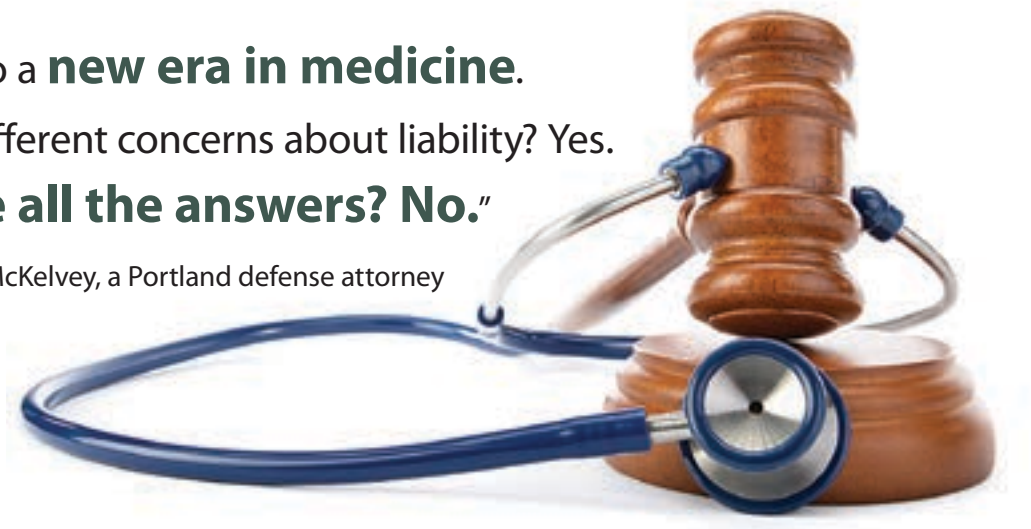
However, CCOs—otherwise known outside of Oregon as accountable care organizations, or ACOs—also may present new liability challenges. Does contracting with a CCO or practicing within a CCO team-based approach open up different legal risks for physicians that didn't exist before?

"We're going into a **new era in medicine**.

Are there definitely different concerns about liability? Yes.

Do we have all the answers? No."

—Connie Elkins McKelvey, a Portland defense attorney



A July 10, 2013, article in the *Journal of the American Medical Association* suggests that it does. CCOs rely on shared risk, promising to return to providers part of any savings achieved through delivering efficient care for a population of patients. But, as was also true under previous managed care arrangements, that objective of cost containment potentially could increase legal liability, according to the authors.

"When cost-saving efforts play a role in medical decision-making, there is an inevitable tension between cost containment and medical liability," they wrote. This tension can be exploited by plaintiffs' attorneys to charge that care was compromised or withheld to save money.

"We're going into a new era in medicine," said **Connie Elkins McKelvey**, a Portland defense attorney who has represented doctors and health care providers for three decades. "Are there definitely different concerns about liability? Yes. Do we have all the answers? No."

CCOs are so new that not enough time has elapsed for insurers and providers to grasp what liability risks are involved. One factor is that the Affordable Care Act emphasizes prevention, and patients now have higher expectations about their physicians' ability to diagnose conditions sooner and to offer mitigation more effectively, she said. Secondly, the ACA removed a major legal protection under a federal law known as the Employee Retirement Income Security Act, or ERISA.

According to *Medical Economics* magazine, in 2004 the U.S. Supreme Court gave managed care organizations some immunity against state-law tort claims by recognizing federal preemption of these claims for employer-provided health insurance plans that are subject to the requirements of ERISA.

"ERISA doesn't apply under the ACA," McKelvey noted. Thus, participants in a CCO no longer would have the protections afforded by that law. In its absence, medical liability claims "would be judged by state-based standards, which do not consider federal cost-containment goals when determining whether a medical decision was appropriate," the *JAMA* article authors noted. If a plaintiffs' attorney discovered documents leading to a claim that the right care wasn't provided in order to save costs, "that's a huge concern," added McKelvey.

What this might mean for physicians' personal risk is unclear, she said. She expects more plaintiffs now will sue the entity, and that entity will be held vicariously responsible in lawsuits claiming that the care should not have been delegated to the team. As *Medical Economics* put it, the simple threat of greater liability could end up making physicians in CCOs "hesitant to consider costs in their clinical decision-making."

In the CCO team-based approach, the physician's role often changes from what it was traditionally. He or she may see certain patients for only 60 seconds, or not at all if a doctor's services aren't required for a patient's particular case. Yet that doctor is the head of the team, and may be held responsible for their actions.

Robin Diamond, senior vice president and chief patient safety officer for The Doctors Company, said physicians or any other clinicians can take certain steps to minimize their risk in an integrated delivery system such as a CCO. She noted that doctors might assume that the entity will meet all their administrative needs, and thus they don't have to worry and can concentrate only on patient care.

But paying close attention to contracts is essential, and doctors should review contracts thoroughly before signing on.

"It's important for physicians to understand how their role is going to change," she said. "Ask a lot of questions about what they're expected to do." Note what the contract holds them responsible for, and carefully examine policies and rules that pertain to evidence-based protocols. Physicians should keep copies handy of what those protocols involve, because that's what their performance will be judged on, Diamond pointed out. Also essential is to document everything so that the physician gets credit for the care provided to the patient.

She said many doctors come into a CCO from small practices where they are used to having autonomy and making their own decisions. As a result, Diamond said, doctors need to inquire about whom they will be working with, such as nurse practitioners, and whether those clinicians will "be in charge of certain patients, or am I to see all patients?" Also ask whether the physician is going to be working with nonlicensed personnel such as patient navigators and, if so, whether the doctor is taking on additional risk.

Coordinated care places great emphasis on "the patient-centered idea," making sure patients are involved in their own care, she said. Therefore, the physician must demonstrate through documentation that patients were involved in education about their disease and what they should do to follow up.

Diamond encourages physicians to ask as many questions as possible ahead of time, preferably including querying doctors who already are part of a CCO what the expectations are of physicians in that entity.

Defense attorney McKelvey observed that because the legal landscape has not yet played out with coordinated care, both plaintiffs' attorneys and lawyers who defend doctors probably now are weighing what legal obligations will be expected under CCOs, and anticipating risks.

"It's coming," she said. •

Welcome New Members

R. Scott Brown, MD
Oregon Anesthesiology Group
Interventional Pain Clinic
1849 NW Kearney #201, Portland, OR 97209
Specialties: Interventional Pain and Anesthesiology
Graduated: Medical College of Wisconsin, 89

MaryAnn Conrad, MD
Summit Research Network
2701 NW Vaughn St #350, Portland, OR 97210
Specialty: Internal Medicine*
Graduated: Univ. of Washington MEDEX NW, '91

Amanda M. McClure, MD
Northwest Center for Colorectal Health
9155 SW Barnes Rd #231, Portland, OR 97225
Specialties: General Surgery and Colon and Rectal Surgery
Graduated: Michigan State University College of Human Medicine in East Lansing Michigan, '08

Shannon M. Mitchel, MD
Accelecare Wound Professionals
Specialties: Wound Care, General Surgery, Urgent Care, and Occupational Medicine
Graduated: Univ. of Texas San Antonio School of Medicine

Enrique Gomez Morayta, MD
Healthy Living Internal Medicine, LLC
Specialty: Internal Medicine*
Graduated: Universidad Veracruzana

Norina Mohd Nordin, MD
Northwest Vascular Consultants
9701 SW Barnes Rd #140, Portland, OR 97225
Specialty: Vascular Surgery
Graduated: McGill University

Jimmy Unger, MD
Kaiser Permanente
9800 SE Sunnyside Blvd, Clackamas, OR 97015
Specialty: Pediatrics*
Graduated: Univ. of Texas Southwestern Med School, '80

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Taking time to understand EMRs from the start can save on legal headaches down the road

Ask the Expert

As an attorney who specializes in defending physicians and health care systems against medical malpractice lawsuits, Chip Horner has seen the positive impacts of electronic medical records (EMRs) as well as the risks they create. Horner, a partner in Hart Wagner's Portland office, spoke with *The Scribe* about these risks and how physicians can avoid malpractice suits because of them.

The Scribe: **What are some of the malpractice liability risks physicians face when they begin using EMRs?**

Horner: Perhaps the most significant challenge is simply the change in underlying format or structure.

Consider the classic paper chart. These are often in a single file in a single office with each patient file physically separate from others. A few aspects of the patient's care, such as hospital records, radiology, pharmacy or billing records, may be maintained separately from the main chart or in a different location altogether. Generally, when requested, the chart can be taken off the shelf and photocopied. Occasionally, the original chart may be produced at deposition or trial.

In contrast, under an EMR system there is no longer a single chart on the shelf; information is no longer physically stored page by page, patient by patient. Instead, each piece of electronic information is separately managed within a server or other computer system. When viewed by a health care professional, requested pieces of medical information are displayed on a computer screen, in a format chosen by the user. Consequently, the location of information changes.

Clinicians must be aware of what information is available, and where to find it, to ensure continued quality care. For example, knowing where outside records are stored, how incoming phone or email messages are created and acted upon, or how to find scanned patient questionnaires will ensure information is not simply "stored" in the EMR, but can actually be accessed and used by health care providers.

Not knowing an outside record, lab result or other clinical detail was present in a chart can present medical-legal challenges. Like any new tool or system, it is important to take the time necessary to become proficient at finding the information necessary to provide patient care.

Along with format and layout differences, another critical difference between paper and electronic charts is timing. Electronic records often have very exact timestamps attached to them. But, this does not necessarily signify the time a particular event took place. Instead, it only reliably reflects the time an event was recorded into the EMR. Providers generally have little or no ability to alter these timestamps and, instead, must record the information when they are able to access a computer terminal. It can be important to document within the chart when an act took place, rather than simply when it was recorded.

Often when care is transferred from one EMR system to another (and in litigation), paper copies of an EMR are prepared and produced. But, each EMR system produces paper copies in a different form. Because of these inherent differences, it is also important, when reviewing printed medical records from an EMR system, to become familiar with the layout and organization of the paper records, ensuring you understand when and how such information is being provided. Whatever the system, key records are often scattered throughout the lengthy EMR printout. For example, in hospital records, vital signs or patient assessments may be contained in multiple areas, spread over multiple pages. The format of a printed EMR is not intuitive. It is, nonetheless, important to take the time and effort to understand all of the sections of any EMR you receive, and identify all of the pertinent records or comments.

Similarly, EMR systems may contain multiple references to the same event. A medical order, for instance, may appear in a nursing end-of-shift summary, a separate medication administration log, and in individual notes from health care providers who ordered the medication or referenced the order. This does not mean that the medication was given three (or more) separate times; instead, the information was recorded in three (or more) separate areas. To the reader who is not familiar with the layout and format of these records, however, these entries can incorrectly suggest multiple dosages of a medication.

The Scribe: **What advice do you give physicians about how to understand and manage their EMRs?**

Horner: Take the time to understand your system. Each EMR is slightly different, but like any new skill, it is important to become comfortable navigating your EMR and knowing where to find the information you need. Learn to record pertinent information in a consistent way so that you and your colleagues will be able to find and understand the information later. Whether it is a check box, a flowsheet or a narrative section, be sure that you agree with the final result that appears on screen.

Likewise, while you may be able to access important information from other screens (such as past medical history or recent laboratory results), be sure to review this information, confirming any necessary details, as it is now information within your chart note. Obviously patients change over time. Don't let "old" details remain if they are no longer applicable.

While it may initially slow your workflow, taking time at the start to become comfortable will avoid inconsistencies, charting abnormalities and, in the end, lead to a more efficient practice. •

Compassion fatigue: A call to action

By Dike Drummond, MD
For The Scribe

For anyone in the helping professions, compassion fatigue is a common occurrence and a clear signal to take better care of your own needs.

Compassion fatigue is when you find yourself challenged to care about your patients in the way you know is proper and expected in your position. One of the key components of quality health care is the ability for you to connect with your patients and for them to sense that connection. Compassion fatigue cuts you off from the people who need you the most…and it extends well beyond just your patients.

Cynicism, sarcasm and feeling put upon are the first signs:

- If you find yourself being cynical or sarcastic about your patients, you have compassion fatigue. It can come in the little voice in your head, mumbling under your breath or "venting" to your colleagues or staff.
- If you find yourself feeling like your patients/staff/institution are deliberately trying to wear you out or drive you crazy, you have compassion fatigue.

Recharge your emotional bank account

Being a doctor or other helping professional is the perfect compassion fatigue formula. Caring for others with difficult, often chronic illnesses is a draining emotional experience. Think of yourself as having an emotional bank account. You simply can't get to the end of an office day with the same amount of emotional energy in your account as when you started. Your job is draining…even on a good day.

It is up to you to recharge your emotional bank account, on your own time. That's where the double whammy hits. At the same time your job is draining, you have been conditioned throughout your medical training that your needs come last.

For many of the doctors I work with, they find it very difficult to know how they might recharge themselves. Their needs have not been on their radar for years, even decades.

It's like the oxygen masks on an airplane—you have to put your own mask on first.

The key to avoiding compassion fatigue is taking care of your own emotional needs first. You can't give what you don't have. You can't get water from a stone. If your emotional needs are not being met, you can't be there emotionally for your patients when they need you the most. In too many cases, no one teaches medical students or residents how to ensure their own emotional needs are met. It's every doctor for themselves.

Here's the unspoken tragedy: If you can't be emotionally present for your patients because of compassion fatigue, you can't be there for your spouse, significant other, children or friends, either. Everyone loses when you allow yourself to be tapped out at work. And this is just the start of a slippery slope.

Compassion fatigue is one of the three signs of physician burnout, along with physical exhaustion and a sense that your work doesn't make any real difference.

When you notice compassion fatigue, I suggest you see it as a call to action and engage in some exquisite self care.

I imagine you have not taken enough time for yourself or the most important people in your life lately. Your emotional bank account may be even worse than empty—you may be overdrawn and in a major negative balance. Here are a few keys to address this urgently.

Make recharging part of your life

These non-work activities are key to keeping your emotional bank account full and to you being the best you can be. Be sure to schedule these recharging activities into your life every month from now on. That means:

- Choose your rechargers
- Schedule them
- Do them
- Celebrate them

Begin to treat recharging activities as equally important as your call schedule. Don't skip or scrimp because these things don't feel as important to you as taking care of other people's needs.

Do a great job with every patient you see, and:

- Cut your work hours back to minimum
- Only chart what is necessary Stop worrying about complete sentences and punctuation
- Strongly consider some time off
- Take care of your needs first (remember the oxygen mask)
- Get some rest
- Get some exercise
- Do something fun you have put off for a while
- Then spend some quality time with your significant other and children

That's just your training and conditioning talking, and it's what got you to this point of compassion fatigue in the first place.

Remember the oxygen mask and get your needs taken care of first. Taking exquisite care of yourself is the foundation for taking care of others, and it's the only way you can be emotionally available for your patients and your family and avoid even deeper levels of burnout. •

Dike Drummond, MD, is a family physician, entrepreneur and business coach. He provides burnout prevention and treatment services to physicians, other health care professionals and health care organizations through his website, www.thehappymd.com.

This article is part of a series exploring life challenges of physicians. It is a part of MSMP's goal to better support and connect members of the region's medical community. Do you have a personal story about overcoming challenges that you'd like to share with Scribe readers?

If so, please contact the editors at scribe@llm.com or 360-597-4909.


Is there a doctor in the house? (Yes, 11 of them)

Second of two parts

The story so far. . .

Talents run in certain families. In medicine, in Portland, there are the Rosenbaums. The *Scribe's* April edition published the first of a two-part profile on the three-generation family of 11 doctors, which has distinguished itself nationally and regionally (to read part one, please visit msmp.org, click on the News and Publications tab, then "Scribe" and go to page 14 of the April issue).

The family's story has humble beginnings, with Sam and Bessie Rosenbaum emigrating to the United States from what is now Ukraine. Their two sons, Ed and William, did something their parents did not—acquired a college education—and became physicians. Several of *their* children subsequently went into medicine as well, including James Rosenbaum, MD, who now chairs OHSU's Division of Arthritis & Rheumatic Diseases, serves as the Edward E. Rosenbaum (named for his father) Professor of Research, and heads its Uveitis Clinic. He is also executive vice president and chair of the renowned Legacy Devers Eye Institute at Good Samaritan Medical Center.

Medicine runs in the Rosenbaum family

By John Rumler
For The Scribe

Although Ed never encouraged his children to become doctors, Jim and the other boys sometimes made hospital rounds with him. "The love and respect my dad earned from his patients made a huge impression on me. That seemed like a gratifying path for life," Jim said.

As a doctor, Jim enjoys the intellectual challenges derived from diagnosing, treating and empowering patients. As a researcher, he savors the opportunity to discover or describe an observation that might benefit humanity. He dislikes the ever-increasing bureaucratization that infringes on the patient-doctor relationship, but realizes that a portion of it is inevitable.

Jim's wife, Sandra Lewis, a Stanford Medical School graduate, is a cardiologist with offices in Portland and Vancouver, Wash. The couple has two daughters, Jennifer and Lisa, who both graduated from the University of California at San Francisco School of Medicine.

Jennifer studied computer science at Brown University, then earned a master's degree in education and taught high school math in Oakland, Calif. Now she is an intern at Providence Portland Medical Center. "I tried to do everything else but medicine, but I couldn't run away from it," she said.

Older sister Lisa (please see sidebar) completed a residency in internal medicine at Massachusetts General Hospital, and is now a fellow in cardiovascular medicine at New York-Presbyterian/Weill Cornell.

The oldest of the Rosenbaum's second generation, Bob (William's son), never stopped to think about choosing a career. "There was no question in my mind. The Rosenbaum fathers were examples of how wonderful a career in medicine could be," he said.

Bob considered ophthalmology and ENT and worked in both departments at Johns Hopkins Medical School. He then found out about a neurology program at the Mayo Clinic from uncle Ed, enjoyed the electrical aspects of EEG and EMG, and did his residency there before enjoying a satisfying career at both Legacy Good Samaritan and Providence Portland Medical Center.

Now retired at 68, Bob volunteers with Habitat for Humanity and other charities, takes art classes at Portland State University and, at the time of this interview, was in Italy with his wife, Jean, taking a three-week immersion Italian language course. "The best aspects of medicine to me were the people and the puzzles," he summarized.

Younger brother Thomas received his medical degree from OHSU and is a neurological surgeon at both Legacy Good Samaritan and Providence Portland Medical Center. By his own estimate, he has performed upwards of 13,000 surgeries during his 35 years in medicine.

Still working full time at 67, practicing spine surgeries only, Thomas says he became a physician largely by accident. "As a freshman in college, I was stating my major and I had no preconceived notions, so my dad suggested I put down medicine."

Thomas' first interest was cardiac surgery, but he decided to take a six-week fellowship in neurosurgery at the Mayo Clinic, as his brother and uncle had trained there.

The aspect of medicine he appreciates most is the feeling of accomplishment from "the significant difficulty of the daily practice and the need to give it your all." What he least enjoys is the loss of that freewheeling college student who selected a career that consumed him.

"The greatest joy and the least joy are the same," Thomas said.

Steven Rosenbaum, 38, Lisa and Jennifer's cousin and president of Portland-based Pop Art Inc., an interactive marketing/software firm, said he was always supported to follow his own career path.

For such a group of high achievers, Steve said his family is mellow and laid back. "Medicine and public policy dominated the conversation when I was growing up, but for being such a medical family, everyone is pretty well rounded."

When he was growing up, being a doctor simply held no appeal to him but, "I do feel a twinge of regret sometimes when I think about what it would be like to be a doctor, but overall, I'm very happy with my life," Steve said. •

Jennifer Rosenbaum, MD, is flanked by her parents, Sandra Lewis, MD, and James Rosenbaum, MD, at her medical school graduation.
Photo courtesy of the Rosenbaum family

Lisa Rosenbaum, MD: A critical lens

It's likely that none of the Rosenbaum clan is having a more profound effect on health care than Lisa, who was strongly influenced by her grandfather, Ed, and his critical view of Western medicine in his book, "The Doctor," published by Random House in 1988.

The two dreamed of writing about medicine together, and although Ed passed away five years ago, Lisa is carrying the torch by writing about hot-button topics such as duty hours, shared decision making, and health care economics.

Lisa has published upwards of a dozen articles in the *New England Journal of Medicine*, edits the health care section for the *New Yorker* online, and has written essays for *The New York Times*, *Huffington Post*, the *Journal of the American Medical Association* and *The Boston Globe*.

Lisa, who lives in New York, knew early on that her family was different. She recalls being asked in the first grade what her parents did for a living. "I was the only one in the class, probably the entire school, who had a mom and dad who were both doctors."

While she never seriously considered a career outside of medicine, Lisa said she was supported and encouraged, but never pushed, to become a doctor. In spite of an outrageously hectic schedule, she keeps in near-constant touch with her family.

Medicine today, Lisa said, with ever-increasing demands from government and insurance and other bureaucratic encroachments, is a far cry from the medicine her grandfathers loved.

Still, if she had children, she would definitely encourage them to pursue a career as a physician. "It's unbelievably rewarding. Medicine isn't a job, it's a way of life, a deep joy, and I am blessed to live with it every day." •

—John Rumler

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Battle of the Doctor Bands: A fun venue for a good cause

OFF HOURS *from page 5*

Crow, Dick Zimmerman, Robyn Dunn and Doug McCleary.

Oxman said the band's name comes from some of the members' interest in brewing beer but also from the idea of bringing multiple elements together to ferment into something new.

"Like most bands, we play better when we're playing out somewhere," he said of HomeBrew's desire to enter the Battle of the Doctor Bands. "It gives us an opportunity to focus and rehearse. And this will be a fun venue for a good cause."

Love You Longtime

What started as a jam at Norman Willis' annual summertime house party morphed late last year into Love You Longtime, a four-piece rock 'n roll band with a sound somewhere between Tom Petty and The Eagles. And thanks to Willis' son, who saw a note in *The Scribe* about the Battle of the Doctor Bands competition, the band will be rockin' out with the other three groups.

"This is a good opportunity to get in front of an audience at a really great location," said Willis, MD, a radiation oncologist and medical director of Meridian Park Radiation Oncology.

Though he played the saxophone in elementary school, it wasn't until a few years ago that Willis started playing guitar. He began writing his own songs three years ago and solidified the lineup of the band after last summer: Dan Stanton plays lead guitar, Ken Mann plays bass and Richard Parker is on the drums.

As for the band's name, "love you long time" is a line from the Vietnam War movie "Full Metal Jacket." Willis said he wanted something that was a little bit edgy but that also conveyed some of the band's passion for music.

"I wanted to also express the affection the band has for the audience," he said. "We are going to play and sing our hearts out as an expression of what we feel for the music and for the audience."

Love You Longtime plans to play three original songs and one cover tune in the competition. Oxford said the cover tune will be a Tom Petty song, but not one that everyone knows.

"We try not to do the most obvious cover songs," he said, "but people will like it."

The Moderator Band

Too old to rock and roll? Not Michael Powers, MD, who at 55 is one of the youngest members of the Moderator Band, a rock and roll group he and some friends formed in medical school in 1982.

"We're rockin'," said Powers, a pediatric pulmonologist and a professor at Oregon Health & Science University. "It's a lot of fun, and it shows my students that even this old professor guy can have a life outside of medicine."

Named after a structure found in the right ventricle of the heart, the Moderator Band plays cover tunes from the likes of Bruce Springsteen, David Bowie, the Beatles and others. Five of the band's seven members are physicians: Powers, a lead vocalist; Brenda Kehoe, MD, also a vocalist and current president of the Medical Society of Metropolitan Portland; Rob Skinner, MD, drummer; Steve Urman, MD, rhythm guitar; and Bob Bailey, MD, bass. Jim Kehoe plays keyboards and guitar, and Bill Rashid plays lead guitar.

Powers said the band rehearses in the Kehoes' basement every Wednesday night. They have played a few different fund-raisers and benefits over the years, including for the Oregon Food Bank and the Nick Wilson Charitable Group. At one such benefit a few years ago, the Moderator Band packed a downtown Portland bar to the rafters, proving just how much they're still rockin'.

"The kegs even ran out of beer," Powers said, noting that the gig was held on the same night as Portland's infamous naked bike ride. "It was a lot of fun." •

PHAME: Producing positive health outcomes for students

BEAUDOIN *from page 1*

best way to figure that out would be to move across the country to a cool city he knew very little about, Beaudoin headed to Portland.

"I moved here with a handful of contacts and no family and no job," he said. "That required me to figure myself out and what values were critical to me."

He wandered a bit between some consulting jobs, but it wasn't until the night he saw the PHAME singers perform that Beaudoin really locked in on something.

She said Beaudoin has been so effective as executive director because he is so committed to the cause.

"He has so much charisma and so much passion for the idea that art should be accessible to everyone, that art can benefit everyone's lives," Thomas said. "It's infectious. It's hard not to be carried along with that kind of momentum and not want to be a part of it."

Beaudoin said he was honored to receive the Rob Delf award, which includes a $1,000 honorarium. He plans to donate that back to PHAME.

"He's **elevated the programs and the students and the visibility of PHAME** in the community. It's really given people an opportunity to see how impactful these programs can be."

—Laurie Dunn Thomas, PHAME board member

'An amazing transition'

Founded in 1984, PHAME now offers more than 20 classes in two 15-week terms for around 100 adults each year. Classes for winter term 2014 included everything from creative writing and costume design to acting, musical theater and playwriting. In his time with PHAME, Beaudoin has been credited with raising the organization's profile, boosting its annual budget by 350 percent and expanding offerings so that it now serves more students than it ever has.

"Watching Stephen come into this organization was just an amazing transition," said **Laurie Dunn Thomas**, one of PHAME's board members who's been connected to the organization for more than 20 years through a sister who takes classes there. "He's elevated the programs and the students and the visibility of PHAME in the community. It's really given people an opportunity to see how impactful these programs can be."

He said he sees a connection between PHAME and the medical community because PHAME is focused on producing positive health outcomes for students who live with Down syndrome, brain injuries, cerebral palsy and other conditions. In fact, PHAME has begun working with some new community partners to begin measuring the kinds of positive impacts it has on its students' lives.

Beaudoin, who invited and encouraged MSMP members to experience a PHAME performance for themselves, also said he truly appreciated having a respected organization like the MSMP acknowledge the importance of PHAME and what it does.

"How exciting for an established group like the medical society to say that we, too, recognize that art is essential to our community," he said. "That's exciting." •

To learn more about PHAME, please visit phamepdx.org

STUDENT PERSPECTIVES *from page 7*

aid to the patient was the interpreter—who never failed to translate every word from the patient to the practitioner and back.

It was also very clear that the practitioner's training and experience with intercultural medical care was a crucial aspect of this interaction. Unfortunately, in the visit with my grandmother, the practitioner seemed most concerned with speeding up the process. From asking the question, to getting the translation, then getting the response, then getting the translation, then answering our separate concerns, it was clear that she was impatient and only wanted to hear the answers to her paperwork. It is obvious that multiple components, including provider training, qualified interpreter access and patient education, are essential to improving quality care in intercultural settings.

> "The **interplay** between patients, family members, interpreters and practitioners is a collaborative effort that **requires patience, practice and training**."
>
> —Shabnam Ghazizadeh, Oregon Health & Science University student

Last year I joined the leadership of a student-led initiative to help medical students develop skills in intercultural medicine. We are very pleased to have launched the Intercultural Longitudinal Health Elective this year, which has assigned students proficient in languages including Spanish, Korean and Mandarin to non-English-speaking patients with chronic illnesses. These students will follow their patients over the course of the year at every appointment, acting as their liaison for medical care to help navigate cultural and language barriers. This experience will give students the opportunity to work closely with non-English-speaking patients in a direct care setting in order to increase their comfort and competency for working with intercultural patients in their future practices. It will also give non-English-speaking patients with chronic illnesses a resource in the maze of physician visits and a familiar face that will improve their longitudinal health care needs.

In addition, in March we held the second annual OHSU Bilingual Provider Training Event. This interdisciplinary event is designed to educate students who are interested in providing medical care in non-English languages in the future. Via lectures and small-group sessions, we highlighted challenges and techniques for future bilingual providers and encouraged students to make cultural competency a core part of their patient care. We also hope to increase awareness about the collaborative effort of delivering intercultural care via talks from OHSU's Language Services department, interpreters and physicians to prepare students to meet these demands as future health care providers.

Intercultural medicine is an area that has increasing application in our diverse country. The interplay between patients, family members, interpreters and practitioners is a collaborative effort that requires patience, practice and training. I am very excited to be part of such an initiative that will help patients, like my grandmother, have access to the resources and knowledgeable providers that will deliver the best health care for their unique needs. •

Shabnam Ghazizadeh attends Oregon Health & Science University. This essay first appeared on the OHSU StudentSpeak blog.

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