



# scribe

## MSMP News & Events

MSMP seeking nominations for Rob Delf Honorary Award, Board of Trustees; HIPAA training, Annual Meeting and Battle of the Doctor Bands on tap.

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A publication of the Medical Society of Metropolitan Portland

www.MSMP.org

# Health literacy boosts patient care, satisfaction

Annual conference to highlight research and evidence-based best practices

By **Cliff Collins**  
For *The Scribe*

Helping physicians aid their patients' understanding of the instructions and information they receive is the focus of a continuing effort led by **Legacy Health** to improve health literacy.

The federal government defines that term as the degree to which individuals have the capacity to process and understand basic health information

information. Such patients are less likely to follow treatment instructions, use medication as prescribed and seek preventative care, and they are twice as likely to be hospitalized.

According to the National Patient Safety Foundation, no other single issue has a greater impact on health status. Low health literacy is a leading cause of health disparities; the medically underserved, people older than 65 and people

of color are the most at risk.

At the fourth annual meeting, "**Oregon and SW Washington Health Literacy Conference 2015: Closing the Gap,**" hosted and co-sponsored by Legacy, national and local expert speakers will describe research and explain evidence-based best practices in the field. The conference is March 6 from 8 a.m. to 4:20 p.m. at the Sentinel Hotel (formerly the Governor Hotel), at 614 S.W. 11th Ave.

According to the federal Health Resources and Services Administration, or HRSA, patients with low health literacy may have difficulty:

- Locating providers and services
- Filling out complex health forms
- Sharing their medical history with providers
- Knowing the connection between risky behaviors and health

- Managing chronic health conditions
- Understanding directions and prescriptions

Legacy has made health literacy a "systemwide priority," as well as made concerted efforts to increase awareness of the topic, said **Prasanna Krishnasamy, MD, MPH**, a speaker scheduled to present at the conference and

See **HEALTH LITERACY**, page 10

### Patient Care Focus:

This article is part of *The Scribe's* special section on pages 8–10.

needed to make appropriate health decisions in order to prevent or treat illness. Studies have found that up to 50 percent of the U.S. population possesses marginal or low health literacy.

People with low health literacy have a difficult time understanding and acting on basic medical instructions and

# Steps taken to address prescription painkiller abuse, but more work remains

By **John Rumler**  
For *The Scribe*

Oregon's medical community has taken key steps to help address the state's high rate of prescription painkiller abuse, but more remains to be done, sources say.

Oregon had the highest rate in the country for non-medical use of prescription pain relievers, 5.7 percent, compared to 4.6 percent nationally, according to the 2011–12 National Survey on Drug Use and Health. Data from the **Oregon Health Authority's Prescription Drug Monitoring Program (PDMP)** showed prescribed opioid use is endemic in the state, with almost one in four Oregonians receiving at least one prescription for opioid medications in 2013.

On the national level, 41,000 people died of drug overdoses

and 17,000 of those involved prescribed opioids in 2011, the last year Centers for Disease Control and Prevention statistics are available. That same year, the CDC declared prescription painkiller overdoses—which cause, on average, 46 deaths a day—a nationwide epidemic.

Steps have been taken in Oregon and nationally to stem the tide of the epidemic. The PDMP, approved by the Oregon Legislature in 2009, became operational in 2011. The Oregon Health Authority (OHA) program tracks and monitors the controlled substances dispensed by Oregon-licensed pharmacies. The program also provides doctors with valuable information about the medications patients receive, allowing physicians to make more informed decisions when writing prescriptions.

"The PDMP has been a tremendous tool for ER doctors," said **Chip Sanchez, MD, FACEP**, president of the Oregon Chapter of the American College of Emergency Physicians. "Before, the only information we had was what the patients shared or what we had in our system. Now we can see when they filled a prescription for a controlled substance, the type of medication, quantity, and who prescribed it."

**John McIlveen, PhD, LMHC**, state opioid treatment authority for the OHA's Addictions and Mental Health Division, said the agency is seeing increased use of the PDMP. According to its 2013 Annual Report to the PDMP Advisory Commission, "By the end of 2013, almost 100 percent of pharmacies required to report data to the PDMP had uploaded information into the

system, and 98 percent of reporting pharmacies regularly reported within the seven-day statutory limit."

However, some health care professionals say the PDMP is limited in its effectiveness because participation is voluntary (see "Ask the Expert" with **Marvin Seppala, MD**, on page 7).

The **Oregon College of Emergency Physicians** initiated a strategy to combat the problem when, in 2012, it adopted voluntary guidelines for emergency room prescribing of opioids. Among the guidelines, one medical provider should provide all opioids to treat a patient's chronic pain, to the extent possible, and the administration of intravenous and intramuscular opioids in the emergency room for the relief of acute exacerbations of

See **OPIOIDS**, page 6

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## INSIDE THIS ISSUE

### Hooked on fencing



*Michael Moore, MD, who began fencing a decade ago, says the sport offers a host of challenges and benefits—and simply is a lot of fun.*

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# Lung cancer screening reduces mortality

## Legacy offers patient-centered program

Lung cancer is the leading cause of death from cancer in the United States, more than breast, colon, prostate and pancreatic cancer combined. Overall five-year survival is 16 percent. However, when diagnosed early — when typically asymptomatic — five-year survival is 70 percent.

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# News and Events

## Advance HIPAA Compliance Training Class

March 4, 1–3 PM

May 15, 9–11 AM

Don't miss MSMP's March and May Advance HIPAA Compliance Training. As recommended by ONC, OCR and AHIMA, HIPAA Compliance Training should be done annually. This class will offer updated Oregon privacy laws, discussion of how privacy laws apply to your role, and interactive case studies. A Certificate of Participation is included in this event and able to be used for employees' compliance files. To register, visit [msmp.org](http://msmp.org), or contact Sarah Parker, CMA (AAMA), at [Sarah@msmp.org](mailto:Sarah@msmp.org) for more information. •

## Battle of the Doctor Bands June 25 at Lola's Room, Portland's Crystal Ballroom

Join us for the Second Annual Battle of the Doctor Bands! MSMP is looking for bands to participate in our upcoming battle. The only criteria for signing up is that one member of the band must be a medical society member. If you'd like to battle, please read and complete the application forms at [msmp.org](http://msmp.org) under the Events section. The deadline to sign up is April 15 and space is limited!

MSMP has partnered with Project Access NOW, whose mission is to improve the health of our community by creating access to care and services for those most in need. Watch for more information about this event and where to get tickets at [msmp.org](http://msmp.org). Contact Sarah Parker, CMA (AAMA), at [Sarah@msmp.org](mailto:Sarah@msmp.org) for more information. •

## Save the date—May 5 MSMP's Annual Meeting

Mark your calendars for MSMP's 131st Annual Meeting at the Multnomah Athletic Club. Registration is required. We are excited to announce that our speaker is Sarina Saturn, who earned a PhD in neuroscience from New York University and will speak about stress and resilience. Watch [msmp.org](http://msmp.org) for more information and event updates. •

## New student section at [msmp.org](http://msmp.org)

If you are an MSMP Medical Student Member or PA Student Member, check out our new Student Only Section. We have special Student Only benefits as well as upcoming student events.

Not a Student Member? Membership is free! Visit [msmp.org](http://msmp.org) and click on the Membership tab for details. •

## Nominations for Rob Delf award, MSMP Board of Trustees needed by Feb. 18!

The Medical Society of Metropolitan Portland's Board of Trustees has created an annual award honoring Rob Delf's long service to the organization. The Rob Delf Honorary Award is presented to a person or persons who exemplify the ideals of the medical society within the community where members practice. This can be demonstrated by work projects or activities that improve the health of the community or the practice of medicine in arenas including, but not limited to, the practice of medicine; education of new members of the medical community; education of the public about health, medicine and health public policy; improving public health and emergency preparedness; advocacy in health public policy; or other community activities relating to health care and policy. This award may be given to members of the medical community, the health education community or the general public.

MSMP also is requesting nominations for its Board of Trustees, the medical society's policy-making body. The purpose of the Board is to:

1. Accurately and reasonably represent the values and priorities of the membership;
2. Oversee organizational income and expenditures;
3. Act as stewards of the membership by continually generating innovative ideas and implementing methods to improve the practice and the community of medicine; and
4. Represent members' priority legislative issues to the Oregon Medical Association, which represents Oregon physicians' priority issues to the American Medical Association.

Recent board actions include:

- MSMP and the Metropolitan Medical Foundation of Oregon's Rob Delf Honorary Award (please see above). The 2013 recipient was James Lindquist, associate director of development of Our House, who was awarded \$1,000 in recognition for exemplifying the ideals of the MSMP by improving health education within the community. In 2014, Stephen Marc Beaudoin, executive director of PHAME, was awarded \$1,000 in recognition for education of the public about health and advocacy in health public policy.
- Hosted Global Health MDs at last year's Annual Meeting, sharing their experiences of overseas volunteerism.
- Supported and endorsed the Healthy Kids, Healthy Portland initiative to add fluoride to Portland's water.

Ultimately, the leadership success of the board is a direct result of the creative and productive input of individuals and the collective participation of its members. These are exciting and changing times in medicine. Serving on MSMP's Board will allow you the opportunity to help shape the medical profession. Conversations are lively, direct and value-adding. The board meets monthly, except July and August. Attendance is important, and we require a commitment to attend at least half the meetings scheduled for the year.

We welcome nominations, with a deadline of **Feb. 18**. Please send your nominations to [amanda@msmp.org](mailto:amanda@msmp.org). •

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# 'Dream Big, Little One'

Note: Jessica Petrovich, a medical student at Oregon Health & Science University, participated in one of OHSU's science education programs, helping inspire and support underrepresented students in the sciences.

By Jessica Petrovich  
For The Scribe

"Dream Big, Little One." It is scrawled in my mother's handwriting on a scrap of paper. Underneath it she taped a small photo of me as a toddler, staring hopefully at some unidentifiable object in the background. Well aware of the risk of exposing my inner cheeseball, I have to admit that this scrap of paper has been on my fridge for the last six years. Sometimes, when I feel myself melting into a puddle of hopelessness and self-doubt 12 hours before a big exam (that's kinda my thing), I stare at it until I am convinced that everything will be okay. Everything will be okay. Everything will be okay.

Truthfully, I have experienced nothing but support and enthusiasm throughout my education. There are plenty of kids who are not as fortunate. In my "gap years" between college and medical school, I taught elementary school for AmeriCorps. Many of my students came from families that were struggling to learn English. Often, when parents were balancing two jobs just to put dinner on the table, academic resources and support were compromised.

It worried me to hear that students as young as age six didn't like science and that "math was stupid and just too hard." By the first grade, they had already resigned to the idea that they just weren't cut out for those subjects. I spent the next two years trying to change their minds. Entering medical school, I wasn't sure how I would incorporate my enthusiasm for mentoring kids, but then I found a program called On Track OHSU.

As most people would guess, medical school leaves precious little time for extracurricular activities, and deciding where to focus your energy is difficult at a school with seemingly endless opportunities. At my first On Track meeting, the program quickly rose to the top of my triage list. The program director, Katie Lenahan (a former teacher herself), expressed her overarching goal for the program: to empower students to think of themselves as scientists and future health care professionals. To convince them, no matter their background, no matter their status and no matter how stupid they may have once found math, they can make a life in science and medicine.

The afternoons that I spent with the seniors at Woodburn High School were worth every minute of my time. At our first visit, we explored different medical professions and their roles within the health care system. We came as a team of future dentists, doctors, nurses



Photo courtesy of Jessica Petrovich

and researchers so that we could share our personal stories and answer their questions specific to our programs. At our next visit, we talked with the seniors about life after high school, how to manage time in college and concerns moving forward. There are so many barriers to becoming a medical professional; it's expensive, it takes a lot of time, there are challenging prerequisites and tests, and it's easy to feel like you just aren't cut out for it. Through On Track, I hope to be one piece of a solid network for these students—both by answering logistical questions about a career in medicine and simply convincing them that, like me, they can be whatever they want to be.

You'll hear me talk about the value of the On Track program for the students, but I feel that the benefit was as much my own. As a pediatrician, it will be a joy to help my patients grow to become the people they want to be, physically, psychologically and socially. On Track lets me experience a piece of that now. Memorizing lists of cytokines has a tendency to make me lose sight of what I am doing in medical school, but afternoons with On Track bring me back to a place where I can see the forest. For a few afternoons a year, I set my flashcards and trepidations aside and spend time doing what I love—building up kids so that they can dream big. •

This essay appeared recently on the OHSU StudentSpeak blog. To reach Jessica Petrovich, please email [somdeansoffice@ohsu.edu](mailto:somdeansoffice@ohsu.edu).

## Exploring careers, making connections



Practicing physicians and medical students came together in late January to network, learn and mingle during a **Medical Society of Metropolitan Portland**-planned event at the Lucky Lab Public House in SW Portland. During the event, "Planning for your Future as a Physician: Private Practice vs. Health Systems," students interacted with a panel of physicians, learning about their experiences opening their own practice versus joining an established practice or health system. Pictured above is panelist **Bert Berney, MD**, (far left) with two of the event's attendees. Joining Berney on the panel were **Miranda McCormack MD**, **Stewart S. Newman, MD**, and **Elizabeth Sazie, MD**. Pictured below are some of the more than 40 people who turned out. To learn more about MSMP student opportunities and events, and to become a student member at no charge, please visit [msmp.org](http://msmp.org). •

Photos courtesy of MSMP



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chronic pain is discouraged.

In addition, the guidelines encourage emergency room physicians to access the PDMP, and they recommend that emergency departments perform screening, brief interventions and treatment referrals for patients with suspected prescription opioid abuse.

In another step toward addressing the opioid-addiction epidemic nationally, the federal Drug Enforcement Administration reclassified hydrocodone combination drugs such as Vicodin and categorized them with the most high-risk narcotics. Effective Oct. 6, patients need to see their doctor in person after three months instead of six to get a new prescription, and the strong opioid drugs now must be kept in special secured vaults. Under the new regulations, patients must receive hard-copy prescriptions for oxycodone from their doctor in person unless they are in a long-term care facility or under hospice care.

Hydrocodone combination pills are the most prescribed medicine in the U.S., with 125 million prescriptions filled yearly for a variety of ailments such as sprains, back problems and broken bones. Until the reclassification, the pills could be refilled up to five times and prescriptions could cover a six-month period.

"This gives doctors another tool to better regulate their prescribing," said **Dwight Holton**, head of the governor's **Prescription Drug Abuse Task Force** and CEO of the Portland non-profit **Lines for Life**. "They can make sure the drugs go to those who need it and it limits the risk of abuse."

**Kate Woodhouse, RN**, has worked for 10 years in emergency rooms in Illinois and Oregon, and has seen firsthand the need for a shift in ER pain management. "When I first began working in emergency rooms, I was pretty naive. I took a lot at face value," said Woodhouse, a trauma-certified nurse at Southeast Portland's Adventist Medical Center.

Many of the patients' primary complaints are pain that oftentimes, even after batteries of tests, X-rays, MRIs and other procedures, is hard to confirm or even explain, she said. After seeing tests come back negative over and over again, Woodhouse started growing skeptical.

"Sometimes it's very hard to distinguish between patients who are really in pain and those gaming the system," she said.

As both an ER nurse and a patient, Woodhouse observed a wide continuum in the way patients' pain is managed. In mid-November, she had a total hip replacement and was astonished when her orthopedic surgeon provided her with a prescription for 90 five-milligram tablets of oxycodone. "I could see getting 10 or 15 tablets, but 90? That's going way overboard. That might be why so many people are getting hooked," she said.

**Jim Shames, MD**, organizer of **Oregon Pain Guidance**, a collaboration of health care providers that facilitates appropriate and safe treatment of chronic pain, wasn't surprised about the dose Woodhouse received. "Some doctors get it, but too many

don't," said Shames, board certified in addiction medicine and recognized as the Oregon Medical Association's Doctor-Citizen of the Year in 2012.

"We need to agree on a new community standard for prescribing opioids, including standards that cover emergency rooms, primary care and dental care, which are the main sources of prescribed opioids," he added. "We also need health care organizations to commit to following these standards and to monitor their own performance as part of their commitment to safe and effective care."

**David Labby, MD**, chief medical officer of **Health Share of Oregon**, said that as the over-prescription of opioids is addressed, other problems will emerge with people who substitute street drugs,

which could make the problem worse. "Decreasing inappropriate opioid prescribing won't in itself solve the overall problem. There has to be a major health-care transformation," Labby said.

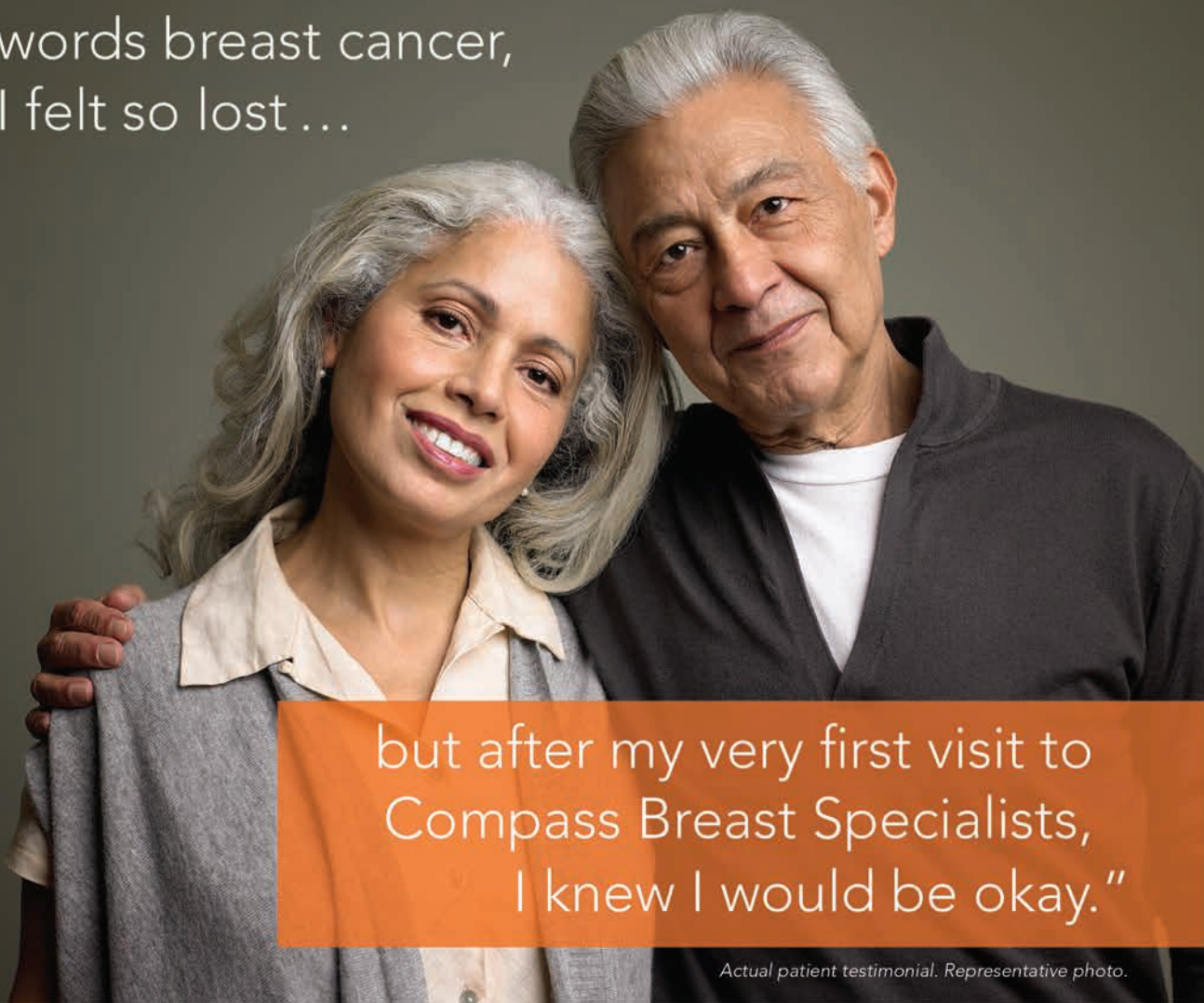
In its 2015-2018 Behavioral Health Strategic Plan, the OHA's Addictions and Mental Health Division highlights the need for this transformation as well. Among the measures of success outlined in the report, released in November, are expanded access for medication-assisted treatment for people who are dependent on opioids, and an increase in the number of physicians statewide who provide medication-assisted treatment.

Its strategies include creating an opioid task force composed of OHA representatives, prescribers, treatment

providers and other stakeholders, and providing educational materials and resources to CCOs and health care providers on best practices related to opioid dependence and treatment.

"One important point to make is that, in terms of medical usage, short-acting opioids remain the primary and best treatment for moderate to severe acute pain; however, there is significant evidence to suggest that they are not, in fact, one of the best or most effective long-term strategies for the management of long-term chronic pain," McIlveen noted. "Thus, by the very nature of opioids, the issues surrounding abuse, misuse and dependence will likely remain important issues for OHA and AMH for some time to come." •

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# Education, making prescription drug abuse a national priority key to ending epidemic



MARVIN SEPPALA, MD

Two recent developments offer insight and guidance to physicians and other health care providers regarding prescription pain medication.

Americans with chronic pain say current treatments using prescription painkillers don't work, leading to years of intense suffering, thoughts of suicide and often dependence on the medication. In addition, nearly eight in 10 people medicated for pain are willing to reduce or eliminate their current prescribed medications and try an alternative treatment for chronic pain.

Those are among the results of a national survey commissioned by the Center for Public Advocacy at the Hazelden Betty Ford Foundation. The survey, released in mid-October, also found that:

- Nearly half of those surveyed (48.2 percent) take three or more pain medications
- 50.4 percent experienced lost productivity at work
- 36.5 percent faced problems with family relationships
- Doctors are prescribing addictive medicines to people with a history of addiction

Meanwhile, according to a position statement from the **American Academy of Neurology (AAN)**, the risk of death, overdose, addiction or serious side effects with prescription opioids outweigh the benefits in chronic, non-cancer conditions such as headache, fibromyalgia and chronic low back pain. The position paper was published in the Sept. 30, 2014, print issue of *Neurology*, the academy's medical journal.

Studies have shown that 50 percent of patients taking opioids for at least three months are still on opioids five years later, according to the AAN. A review of the available studies showed that while opioids may provide significant short-term pain relief, there is no substantial evidence for maintaining pain relief or improved function over long periods of time without serious risk of overdose, dependence or addiction, it said.

Statistics bear out Oregon's dubious distinction when it comes to prescription painkiller abuse. The state had the country's highest rate of non-medical use of prescription painkillers, according to the 2011-'12 National Survey on Drug Use and Health. In addition, the rate of admissions for treatment of non-heroin opioid dependence among Oregonians 12 and older increased almost fourfold between 2001 and 2011, according to data compiled by the federal Substance Abuse and Mental Health Services Administration.

Nationally, of the 22,114 deaths related to pharmaceutical overdose in 2012, 16,007 involved opioid pain relievers, according to the Centers for Disease Control and Prevention.

**Marvin Seppala, MD**, chief medical officer at the Hazelden Betty Ford Foundation, a national nonprofit substance abuse addiction treatment organization that operates 15 facilities nationwide and two in Oregon, is a recognized expert on addiction treatment, pharmacological treatments and integration of evidence-based practices.

Seppala, who received his MD at Mayo Medical School in Rochester, Minn., became aware of the "pain pill" problem in Oregon nearly 20 years ago with the spike in admissions and grew frustrated by a lack of federal response to the growing crisis. "Few people were addressing the problem even as it continued to grow and kill tens of thousands of people," he said in a recent interview.

Seppala stressed that the medical community has an important role to play in helping address what's been deemed the nation's epidemic of opioid addiction. "We need to prioritize the national medical agenda to look at this just as we did AIDS," he said. "We must educate our entire health care workforce on this issue, beginning in medical and nursing schools, and we have to prioritize addiction as the number one public health problem."

Seppala took time recently to address questions about prescription opioids, including touching on some of steps being taken to better educate health care professionals about addiction:

**Q: Why is the opioid problem so severe in Oregon compared to other states?**

**A:** We don't have a clear grasp of it, but to lead the nation in this problem, possibly suggests a medical culture of permissive prescribing of opioid pain relievers. Oregon also has an independent-minded populace with strong support for civil liberties. Perhaps that also plays a role.

**Q: In spite of initiatives, such as the state's Prescription Drug Monitoring Program (PDMP), the database designed to help health care providers and pharmacists provide patients better care in managing their prescriptions, non-medical use of opioids is increasing. What do you think would help?**

**A:** I support a mandatory requirement for use of the PDMP by physicians when prescribing scheduled substances. Studies show that in states where it is not mandatory, it is used only about a third of the time, which is not very helpful.

**Q: What makes opioid addiction such a difficult medical problem?**

**A:** These drugs are highly addictive. The euphoria is captivating while the withdrawal is terrible. Opioids may alter the brain in long-lasting ways that we don't fully understand, leading to a diminished

ability to remain abstinent. National data suggests that well over 90 percent of those who are addicted don't even know it, undermining attempts to address this issue.

**Q: To what extent are health care providers and students being educated about opioids and opioid addiction, and what strategies can be used to achieve a better understanding of chronic pain and treatment among physicians and other health care providers?**

**A:** Medical education is extremely limited regarding addiction. In general, medical schools fight over every hour in the four-year curriculum, so it is very difficult to add a new subject. The training of medical students about addiction is measured in hours at most schools, not days. They do receive lectures during their liver course about alcoholic hepatitis and they all can tell you that IV drug use is a primary cause of HIV, but they have little information about addiction as a brain disease and less about how to talk to someone with addiction or how addiction is treated.

The Affordable Care Act prioritized addiction as an essential benefit due to research showing that at least 25 percent of the health care budget in the U.S. is related to addiction. The act required accountable care organizations to provide addiction treatment services. However, most of our physicians, nurses, social workers and psychologists lack basic training to carry out even minimal interventions. Addiction is one of the most common illnesses seen in primary care and, according to studies, one of the least likely to be recognized and appropriately addressed.

Pain is the most likely reason for a primary care visit. Addiction to opioid pain relievers has skyrocketed during the past 20 years, in part due to the lack of recognition of risk associated with the prescribing of these medications. This issue is getting a great deal of attention from physicians around the country as the overdose death rate has escalated with the increased use of these medi-

cations. Good doctors, trying to ease suffering, were inappropriately prescribing these medications for chronic pain, only to learn they are not very likely to be effective over time.

Hazelden Betty Ford Foundation puts on an annual addiction conference for primary care providers. We have an American Society of Addiction Medicine fellowship training program at Betty Ford Center and we partner with the University of Minnesota and Oregon Health & Science University in training their fellows. We also provide rotations and training for other medical residents and medical students. We provide internships and residency programs for psychology trainees. We have a five-day Professionals in Residence program for medical providers who are interested in training and experience in addiction. We provide a summer medical student program that is fully funded by grants, allowing students to attend. We are collaborating with national groups to bring attention to the limited medical education in addiction, in hopes we can help bring changes to this situation. Education for medical professionals is part of our mission.

**Q: Talk about the importance of screening patients for addiction and alcoholism during primary care visits.**

**A:** Screening for alcoholism and addiction in all primary care medical settings is needed to identify those at risk for addiction and those who have addiction. Addiction is one of the most common illnesses seen in primary care, thus screening and formal examination is necessary. Screening instruments exist and can be done on a computer, with results available to the medical providers. Addiction contributes to multiple diseases, mimics many disease states, and undermines care of other illnesses. Screening can not only help those with addiction, but save a great deal of money. •

This past September, the American Academy of Neurology released a position statement on prescription opioids. As part of that, the AAN recommended that doctors consult with a pain management specialist if dosage exceeds 80 to 120 (morphine-equivalent dose) milligrams per day, especially if pain and function have not substantially improved in their patients. The AAN's statement also provided these suggestions for doctors to prescribe opioids more safely and effectively:

- Create an opioid treatment agreement
- Screen for current or past drug abuse
- Screen for depression
- Use random urine drug screenings
- Do not prescribe medications such as sedative-hypnotics or benzodiazepines with opioids
- Assess pain and function for tolerance and effectiveness
- Track daily morphine equivalent dose using an online dosing calculator
- Use the state Prescription Drug Monitoring Program to monitor all prescription drugs the patient may be taking •

# Providers shifting toward universal approach to accommodate cultural differences with patients

By Jon Bell  
For The Scribe

**Cliff Coleman, MD**, has seen it happen before: A patient comes into a clinic for a medical issue, and while Coleman's offering up advice on what the patient should do, the patient will nod in agreement, say thank you, leave the clinic and not do what Coleman has just recommended.



CLIFF COLEMAN, MD

"In many instances," Coleman said, "we'll find that they are very reticent to express any doubt or concern. They'll simply agree and then go out and not do what we've recommended." But these patients often aren't disregarding their physicians because they're not convinced the advice will work. They may instead be apprehensive based on some close-held cultural beliefs or norms that prevent them from accepting or acting on the advice of a Western doctor.

"It's not that they don't want to do what we recommend," Coleman said, "it's because we are not understanding where they are. We have not explored those beliefs and attitudes enough to fully understand them."

As the greater population continues to diversify, the idea and importance of cultural competency in medicine has continued to gain prominence as a way for physicians to better connect and communicate with their patients. And those connections and clear communications can often lead to better health outcomes and all the benefits that come with those.

"A growing body of evidence confirms that understanding cultural differences not only is the right thing to do, it's the smart and necessary thing to do," wrote **James Mason, PhD**, executive director of culturally competent caregiving for **Providence Health & Services' Oregon Region**, in a 2013 report called "Cultural Competence: Moving Beyond Sentiment." "This is especially true in health care, where working within our patients' cultural framework—their values, beliefs, language, customs or

socioeconomic status—can mean the difference between life and death."

Cultural competency has become prominent enough that even Oregon lawmakers have taken note. During the 2013 legislative session, lawmakers passed House Bill 2611, which allows medical boards to require cultural competence as a licensing requirement. That law goes into effect Jan. 1, 2017.

Coleman, an assistant professor of family medicine for Oregon Health & Science University, sees patients about half-time at OHSU's Richmond clinic, a Federally Qualified Health Center at Southeast 39th Avenue and Division Street. He said the patient mix there includes a large portion of white, low-income residents but also a mix of southeast Asians, Russian immigrants and a small amount of Hispanics and African Americans. He said he encounters various cultural beliefs in his interactions with patients, such as some patients who may be "more aligned" with a non-Western approach to medicine, some who are used to a more naturopathic approach or some who have a different level of familiarity with how

modern Western medicine treats chronic diseases.

Coleman also said that sometimes it's not necessarily a patient's cultural beliefs that need to be accommodated, but that the cultural differences perceived by practitioners can sometimes trigger biases—even very subtle ones—that may end up influencing how a doctor interacts with or treats a patient.

"With some patients, I may make some assumptions that they might prefer a non-Western approach or may prefer a non-pharmaceutical treatment," he said, "but those are based on subtle stereotypes that I may not have fully explored."

In addition to things like providing interpreters for patients who speak other languages and accommodating different cultural views on family or religion, Coleman said a new approach could very well shift patient-provider interactions to better incorporate cultural differences.

"By virtue of our education as physicians and providers in health care, we really are members of a different

See **DIFFERENCES**, page 9

## Dr. Chelsea Hardin has joined Surgical Associates P.C.



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**DR. CHELSEA HARDIN** is a broadly-trained general surgeon who has a particular interest in the treatment of cancerous and non-cancerous diseases of the breast. She is board certified in general surgery and is also trained in robotic-assisted surgery as well.

Dr. Hardin completed her surgical residency at Oregon Health & Sciences University in 2006. During her training, she completed a year of research in Surgical Oncology and published several research papers. She received the Martin Howard Award for the Best Surgical Research Paper, 2003-2004, the William S. Fletcher Traveling Fellowship Award, 2004-2005, and the Best OHSU Resident Research Paper Award, 2004-2005. She was inducted into the Alpha Omega Alpha Medical Honor Society in 2006.

Dr. Hardin practiced for 8 years in San Diego, California, where she co-chaired the Breast Center Leadership Team. She helped Sharp Grossmont Hospital receive the designation as a Breast Center of Excellence. Dr. Hardin is a Fellow of the American College of Surgeons (FACS). She is a member of the American Society of Breast Surgeons, the San Diego Medical Society and Oregon Medical Association.

Dr. Hardin performs a wide variety of operations including laparoscopic gallbladder, colon, splenic and intestinal procedures; laparoscopic and traditional hernia repairs; surgery for breast cancer and benign breast issues; placement of breast radiation catheters; treatment of hemorrhoids, anal fissures and fistulae; excision of skin cancers and many others.



To schedule an appointment, please call Dr. Hardin's Office: Phone: 503-292-1103 or Fax: 503 292-1433.



# Law aids patients with special needs

By **Cliff Collins**  
For The Scribe

Family lawyer **Sonya Fischer** welcomed seeing one of the numerous ways the Affordable Care Act has changed patient care for those with disabilities and special needs.

"The system before was a crisis-driven system, in that a family had to be breaking or broken in order to get assistance," said Fischer, a longtime disability rights advocate and mother of a developmentally disabled daughter. Now, a state-based program that is part of the ACA provides individual needs assessments for children with disabilities in order to determine the level of services they require. "This is huge, a big change."

She said Oregon has been at the forefront of promoting consumer-driven, collaborative approaches to taking care of people with developmental disabilities in community-based settings rather than in institutions. The state thus was highly receptive to participating in an optional personal care services state plan benefit established by the ACA called Community First Choice, known in Oregon as the K Plan. This new Medicaid state plan option provides statewide home and community-based attendant services and support to individuals who otherwise would require an institutional level of care. States accepting the option receive a 6 percent increase in their federal medical assistance percentage.

"Physicians should know that for the first time, funding for personal care workers is now available in Oregon," she said. "I do think it's important that doctors be aware of what services are available so that they can refer to the developmental disabilities program. When families are under less stress, they're more likely to be healthy."

In addition, "The ACA is a monumental change in that everybody has access to coverage," Fischer emphasized. According to the Special Needs Alliance, previously many individuals with disabilities either had no health insurance or were limited to two options: traditional Medicaid with very restrictive asset limits or, in some cases, Medicare. But through insurance exchanges established by the ACA, people with disabilities can apply for income-based subsidies to lower premiums and help them with benefits affordability.

No longer can health insurers decline coverage based on pre-existing conditions or impose lifetime limits on benefits. Moreover, children and youth now can remain covered under their parents' health insurance until the age of 26, regardless of whether they are married, living with the parents, attending school, no longer financially dependent on the parents, or eligible to enroll in an employer's plan.

In states such as Oregon, Medicaid was expanded to cover more people with disabilities who qualify for Medicaid based solely on their income, which enables them to enroll in coverage without waiting for a disability determination. The Special Needs Alliance notes that the ACA permits states to expand their Medicaid programs to insure non-disabled individuals between ages 19 and 64 who have met the citizenship requirements, are not entitled to Medicare, are not incarcerated and have income below 133 percent of the federal poverty level. "Without the ACA, this population would have remained uninsured and, unless blind or determined to be disabled, ineligible for Medicaid benefits," according to the alliance.

## ACA allows additional flexibility in services

The ACA's establishment of accountable care organizations, which in Oregon are called coordinated care organizations, or CCOs, also affected how care is delivered to people with disabilities and special needs. One category, which falls under the rubric of flexible services, allows "CCOs additional flexibility in the services they provide to their members, outside of the typical medical services we often think of when it comes to health care," according to the Oregon Health Authority's **Alissa Robbins**. These constitute non-medical services that are intended to result in better health for the patient at a lower cost.

An example of flexible services Gov. John Kitzhaber has discussed is providing an air conditioner for an elderly patient with heart failure who was repeatedly hospitalized during the summer months due to living in a hot home. Paying for a \$200 air conditioner would be far more affordable for her health plan than shelling out \$20,000 for a hospital stay. Such an action could not be done under the former way of delivering care, but can within a CCO structure.

Other examples of flexible services Robbins offered include providing temporary housing for patients needing a clean environment post-surgery; a vacuum cleaner to help patients with asthma manage their condition; medical or non-medical equipment; and an exercise class for patients with hypertension, obesity or diabetes. Such services must be justified by the health care provider as necessary to help manage a health-related condition.

These services don't generate a traditional medical claim, but the Oregon Health Authority has developed a way

for CCOs to pay for these services within their global budgets, and to report these services to the OHA, according to Robbins. Currently, this periodic reporting isn't at the patient level, but at the aggregate level. The idea is that providing these alternative ways of dealing with and alleviating health problems improves the patient's health and saves money by avoiding costly, repeated emergency room visits or hospital admissions.

Second is the category of special transportation needs. Beginning this year, the OHA—which previously provided Oregon Health Plan members non-emergency medical transportation to doctor, therapy and related appointments—transferred to CCOs the responsibility for contracting for those services. Health Share of Oregon and FamilyCare, the two CCOs that cover OHP members in the Portland area, jointly contracted with Access2Care, an affiliate of American Medical Response, to provide members with those services.

Under the name Ride To Care, it offers free rides to approved health care appointments for OHP members in Multnomah, Clackamas and Washington counties who have no other transportation options. Ride To Care replaced the non-emergency medical transportation service operated previously by TriMet. When members call to schedule a ride, they need to identify their special needs so the drivers will know to provide assistance boarding and exiting the vehicle. Depending on their need, members may be assigned public transit, taxi or wheelchair lift-equipped vehicles. The two CCOs also offer gas-reimbursement programs and volunteer drivers. •

## DIFFERENCES from page 8

cultural group," he said. "Really, what we are teaching now in the medical school is that every single encounter is a cross-cultural one. Doing so will help us move away from the old model that says there's not a real cultural difference unless there's something challenging in the way."

In fact, OHSU is currently about six months into a major overhaul of the curriculum in its medical school that will reshape the instruction to do just what Coleman said: treat every visit as a cross-cultural one, and that clear communication throughout is important for every single patient.

"Learning how to be patient-centered is going to help us really cut through what turn out to be significant cultural differences with all our patients," he said. "Taking a universal approach will potentially help us limit biases and improve outcomes for every patient." •



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## HEALTH LITERACY from page 1

medical director of medical home transformation for Legacy Medical Group. He offered two examples of patients who were affected: A middle-aged patient had been experiencing uncontrolled diabetes for two years. Krishnasamy assumed she was following directions, and he kept trying to determine the right insulin dose for her. Finally, "We got her an insulin pen," he said. "Her diabetes is well-controlled now." Second, he had a patient who was mildly developmentally disabled and suffered from asthma attacks. Nothing seemed to be helping, so Krishnasamy asked him to bring his inhaler with him into the office, and to demonstrate how he was using the device. It ended up, "Nobody had taught him how to use it; the inhaler was not getting to his lungs."

Physicians just assume that the instructions they give patients are getting across, but too often that is not the case, he explained.



PRASANNA KRISHNASAMY,  
MD, MPH



KEVIN S. BREGER,  
MD, PHD

One of the ways the conference will try to help practitioners address that gap is by instructing attendees in the use of plain language and the teach-back method, according to **Kevin S. Breger, MD, PhD**, medical director of Legacy's Internal Medicine Service at Legacy Emanuel Medical Center. Teach-back refers to explaining instructions in plain language and asking the patient to repeat back to you what you instructed.

"Anybody in health care should be using this technique," he said. "It's been shown to improve patient understanding, and it's a key component in reducing readmissions." In studies, use of the teach-back method also has been shown to improve patient satisfaction dramatically, he added.

Breger said Legacy has trained 5,000 clinical staff across its system in how to do teach-back. "The reaction has always been positive. It feels like the right thing to do, communicating with patients using plain language." Doctors have been receptive, as well, he said.

"In principle, physicians are accepting of it," though some have told him they were concerned about how much time would be needed to employ it in their patient interactions, he said. "I try to explain that it might initially take more time, but you're making an investment on the front end to save time on the back end.

Those physicians who do teach-back consistently have told me it is largely a positive thing."

HRSA advises ways health care professionals can help increase patients' comprehension:

- Use simple language and short sentences, and define technical terms
- Supplement instruction with appropriate visual materials, such as videos, models or pictures
- Ask patients to explain your instructions or demonstrate the procedure
- Ask questions that begin with "how" and "what," rather than closed-ended, yes-or-no questions
- Organize information so that the most important points stand out, then repeat the information
- Reflect the age, cultural, ethnic and racial diversity of patients
- For limited English proficiency patients, provide information in their primary language
- Improve the physical environment by using universal symbols
- Offer assistance with completing forms

Krishnasamy also suggests to doctors, in relating to patients, "Don't ask, 'Do you have any questions?' but ask, 'What questions do you have?'" He said another strategy Legacy Medical Group follows is what are termed universal precautions, which borrows from the same concept as routinely wearing gowns and masks when appropriate: Doctors should assume that all patients may have difficulty understanding terminology and instructions; and clinicians should ensure that systems are in place to promote better understanding for all patients, not just those assumed to need extra assistance.

Breger said the conference will be "eye-opening and informative," and doctors can gain valuable insights from it. "We would like to encourage physicians to attend," even if they can spend only part of the day at it, he said. "The conference has been a huge success," with 500 people attending each year and generating waiting lists.

The keynote address, "Health Literacy and Chronic Disease: An Update," will be given by **Dean Schillinger, MD**, from the University of California, San Francisco. Legacy is accredited by the Oregon Medical Association to sponsor continuing medical education for physicians. Legacy designates this live activity for a maximum of six AMA PRA Category 1 credits. Physicians may claim credit commensurate with the extent of their participation. CME credit certificates are provided for other professions. Registration deadline is Feb. 19. For a conference brochure, and to register online, see [www.legacyhealth.org/healthliteracy](http://www.legacyhealth.org/healthliteracy) conference. For registration questions, contact Diana Netter at 503-413-6177, 503-413-6644 (fax) or [dnetter@lhs.org](mailto:dnetter@lhs.org). •

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# Research shows physician wellness results in improved patient care, community health

By **Melody Finnemore**  
For *The Scribe*

From medical errors to poor relationships with patients, several studies have shown the adverse impacts of physician stress, burnout and depression. But a growing body of evidence also points to physician wellness improving patient care and overall community health.

**Tait Shanafelt, MD**, director of the Mayo Clinic Department of Medicine Program on Physician Well-being, has conducted a robust body of research about physician well-being and its impact on patient care. Through his work with the program, which is a clinical laboratory evaluating personal and organizational factors that contribute to physician satisfaction, Shanafelt details the stress, burnout, depression and suicidal thoughts experienced by many physicians and nurses.

The Mayo Clinic's Program on Physician Well-being website states that along with studies demonstrating the adverse effects of physician "distress," an emerging body of evidence has found positive outcomes associated with high well-being. Among these outcomes, care providers with a positive mental quality of life and a sense of meaning in their work demonstrate greater empathy, engagement, discretionary effort and better quality of patient care.

"Physician well-being is important to both patients and the physicians themselves. Indeed, physician well-being is crucial to the health of our entire system of medical care delivery. Health care organizations have a strategic interest in cultivating an environment that both immunizes against distress and promotes resilience over the course of a career," the website states.

Shanafelt's research references four studies conducted by St. Paul Insurance Company that showed medical departments with greater stress had more malpractice claims, while a reduction in employee stress at one hospital resulted in a 50 percent decrease in malpractice claims. When a stress-reduction program was implemented in 22 hospitals participating in the studies, malpractice claims fell by 70 percent compared to hospitals that did not have a stress-reduction program.

The American Medical Association conducted its own research in a 2013 study with the RAND Corporation, and found that patient health topped the list of factors that contribute to physician satisfaction. Noting that professional satisfaction can be a huge determinant of overall wellness, the AMA designed its Professional Satisfaction and Practice Sustainability initiative to help physicians regain and maintain a sense of joy in their work.

In addition, the AMA's Improving Health Outcomes initiative focuses on reducing prediabetes and high blood pressure through screening and prevention for physicians. Another AMA effort, the Accelerating Change in Medical Education initiative, strives to implement curriculum that includes coping mechanisms, business management and other skills for medical students to carry into their careers so they will have greater personal and professional satisfaction.

Following last fall's International Conference on Physician Health in London, AMA President **Robert Wah, MD**, addressed physician well-being in a column published last September.

"There are so many facets to physician health: physical, mental, emotional, personal and professional. At the same time, physicians juggle many responsibilities and pressures—our patients, our practice, our family and friends, keeping up with important medicine news and regulations, maintaining personal interests and a social life, the constant buzz of our mobile devices. So taking time to focus on our personal health is quite a challenge," Wah wrote.

"But if we're in poor health, how can we counsel our patients on improving their health? Poor physician health affects us all—from our peers to our trainees, patients and the health care system as a whole, not to mention our own families," he added.

Some factors that contribute to physician burnout include an overwhelming workload and increased clinical demands; lack of control and autonomy; inefficiencies; decreased time with patients; an inability to find meaning in one's work; lack of personal time; and isolation, notes Shanafelt, a fellow in hematology and oncology and a professor of medicine at the Mayo Clinic.

In 2012, Shanafelt led a group of authors in a nationwide study of burnout among U.S. physicians that was published in the *Archives of Internal Medicine*. In an interview with *Bloomberg Businessweek* in August of that year, Shanafelt said he worries about burnout because "burned-out physicians are more likely to make mistakes." He also expressed concern that more doctors would cut back their hours or retire early, further exacerbating the physician shortage predicted by the Association of American Medical Colleges.

Research in several publications, including the *Journal of the American Medical Association*, the American Psychological Association's *Health Psychology*, the *Annals of Internal Medicine* and the *Annals of Surgery*, directly tie physician burnout to patient satisfaction and compliance, medical errors and professionalism.

Locally, promoting physician wellness is a priority for the **Medical Society of Metropolitan Portland**. In conjunction with its May 5 Annual Meeting, MSMP will introduce its Physician Wellness Program (please see January's *Scribe*, at [msmp.org](http://msmp.org), for program details). Another example of local efforts is headed by the Foundation for Medical Excellence,

a nonprofit that promotes quality health care and sound health policy. It hosts an annual Physician Well-Being Conference and offers educational programs for physicians and other clinicians that encompass the doctor-patient relationship, difficult interactions, professionalism, well-being and patient safety. •



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# Moore finds endless challenges, rewards in fencing

By John Rumler  
For The Scribe

Internal medicine specialist **Michael Moore, MD**, found fencing the roundabout way. His oldest daughter, Isabelle, was fascinated by the swordplay in "Peter Pan," and subsequently began a fencing class at age 9. Noticing the hot, sweaty, ruddy-faced youngsters panting after the classes, Moore realized the health benefits. He then observed the blade play and thought it looked like a lot of fun.

foil is a descendant of the light court sword. Foil focuses on the basics of footwork, attacks and defense.

"The different weapons attract athletes of different mentalities and personalities," Moore explains. "I did foil for about four years and switched to épée, which fits my personality better. My conditioning, or lack thereof, and bad fencing habits make épée a little more forgiving than fencing foil."

The épée, a descendent of the dueling sword, weighs 27 ounces, is stiffer and has a larger hand guard. The third

"Fencing is very open and creative in that there are a multitude of ways to score," he says. "The best fencers have many arrows in their quivers and change styles against different opponents and even show different styles in the same bout."

creating a total of nine bouts. The time limit of a bout is either three minutes for five touches or nine minutes for 15 touches.

"The cardio workout of fencing is great for endorphins and you can also work out frustrations by hitting your opponents, without injuring them," Moore says.

**"Fencing is very open and creative in that there are a multitude of ways to score."**

—Michael Moore, MD

Raoul Rodriguez fenced in college and shared a dorm with Moore at the University of Texas upwards of 30 years ago. The two men are now frequent fencing partners as they live only a few blocks apart. Rodriguez, a financial planner, describes Moore as a dedicated fencer who participates in tournaments around the country.

"Doc is serious about fencing, yet he's got a great sense of humor and is very open-minded. He's helpful and encouraging to other fencers and is an all-around awesome person."

Most fencing competitions are individual, but there are also team events. This usually consists of two teams of three fencers, often with an alternate. The fencers face each of the opponents on the other team,

Simon Abram became the youngest fencing master in France in 2006 at age 21 before coming to Oregon to instruct fencing at Northwest Fencing Center in 2009 and lead them to a Foil Team U.S. National Championship.

Abram says Portland is one of the nation's best fencing cities because of the caliber of fencing schools—with three excellent facilities in Beaverton alone. Also, Mariel Zagunis, of Beaverton, is the first female fencer in history to hold four world championship titles in one season.

One of Moore's favorite instructors, Abram says, "Doc is passionate about fencing. He's not just a skilled fencer, he's special to our community because he'll often stick around all day supporting and helping others. We love having him here." •



Michael Moore, MD, (fencing, facing camera), has been fencing for about a decade and says the sport offers many benefits, including incorporating mental and physical discipline and problem solving.

Photo courtesy of Ryan Hutchison/Northwest Fencing Center

Moore, who specializes in diagnosing and treating cross symptom illnesses at Westside Internal Medicine in Southwest Portland, learned from one of the coaches that adult fencing classes were available and the first lesson was free. "They gave me a weapon and just curling my hand around the grip, I was hooked. I've told them many times since then that they're no better than drug dealers," Moore says with a laugh.

Moore took his first fencing class about 10 years ago, at age 38, at the **Northwest Fencing Center** in Beaverton. His younger daughter, Caroline, 12, also fenced for a few years and although both she and Isabelle have drifted from the sport, he is as enthusiastic as ever and just participated in a major regional competition, the "Battle in Seattle," in late January.

Fueled by the Pirates of the Caribbean movies and the success of the U.S. Fencing Team, which brought home six medals in the 2008 Olympics in Beijing, fencing is steadily gaining popularity in the United States, especially in high schools. The sport attracts an equal number of females and males.

Moore started fencing foil, as do most beginners. Thirty-five inches in length and weighing less than one pound, the

weapon, the saber, is a modern version of a cavalry sword. It is similar to a foil, but has a blade and is a slashing and thrusting weapon.

Hand-eye coordination and balance are essential, but fencing also requires regular training and practice to become proficient, Moore says. "Taking private lessons will help hone your skills and refine your particular style of fencing." The time required to become skilled varies widely, Moore says. "I have been at it for 10 years and am a good, solid club fencer. When I was working hard at it, I was able to break into the top 20 in the country in my age group."

Moore explains why fencing is often described as "physical chess."

"Fencing is a sport in which you try to capitalize on your opponent's mistakes. You lull them into a sense of complacency or into a thought pattern so you can change tactics, timing or tempo. When they make a distance or timing mistake, you can score."

Although raw athleticism is helpful, being crafty is almost as important. Moore says some people possess an uncanny ability to control distance, (between them and their opponent) and to disguise their attacks.

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# Partners in life and practice

A husband and wife care for patients at the same clinic—and love it

By Jon Bell  
For The Scribe

**Shahram Hosseinion, MD**, met his future wife to be at the medical equivalent of a fraternity house.

Now a family physician at **Hawthorne Wellness Center** in Southeast Portland, Hosseinion landed at Oregon Health & Science University's student co-op house in Portland in 2001. Just a few days earlier, a medical student from the Czech Republic named Eva Randulova, who had grown up in a family of doctors, a veterinarian and an herbalist, had also arrived at the house.

"I figured she was a college student and didn't realize she was a medical student as well," said Hosseinion, who grew up always knowing he wanted to be a physician. "The fact that she was such a light-hearted person—and it turned out she was actually a medical student—was actually part of what intrigued me about her."

Fast-forward nearly 14 years and the two are now a married couple who both practice at Hawthorne Wellness Center. **Eva Hosseinion, MD**, also specializes in acupuncture, Chinese herbal medicine and qigong, an ancient Chinese healing method that involves physical postures and breathing techniques. In light of this month's biggest holiday, *The Scribe* talked to the husband and wife about their approaches to medicine, the ups and downs of having a spouse in the same field—not to mention the

same practice—and what they do when they're not focused on medicine.

**The Scribe:** Do you find that you have similar approaches to medicine, similar philosophies and ideas about it?

**Shahram Hosseinion:** Yes and no. There are obviously very large differences because of the very different backgrounds of our current field of practice. It turns out that through my training and practice, I have been very interested in integrative and natural medicine, so I've always held an open-minded perspective to evidence-based alternative treatments. Because of Eva's training in Western medicine, she is obviously very familiar with the efficacy of evidence-based Western medicine, so she carries that perspective with her in her practice of Chinese medicine. So from somewhat opposite sides, we have a common ground where we meet in the middle.

**Eva Hosseinion:** We both look at the person as a whole. We both believe that an integrative approach to medicine has the most beneficial outcome for the patient.

**Are there benefits to having a spouse in the same field?**

**SH:** The benefits are that she understands my struggles, stresses, and is understanding when I'm taking a late-night call or our personal life is interrupted by a patient need. The challenge is talking shop at home too much; we have to make special efforts to limit ourselves.



Eva Hosseinion, LAc, MSOM, MD,  
and Shahram Hosseinion, MD

**EH:** We understand the challenges the other has, and can support each other. I agree that we can talk shop too much, which can be a problem.

**Do you ever work together directly? Is there ever any kind of competition or competitive nature between you when it comes to your practice?**

**EH:** Yes, we work together on occasions where we share patients. Because we both understand the limitations of our professions and we both want to provide optimal care in every respect, our patients benefit from comprehensive integrative care in those instances.

**SH:** In those cases, our discussions in coordinating patients' care are very collaborative and not competitive. When we have differences of professional opinion—which isn't very often—it becomes a personal relationship issue that we have to work out between ourselves. That's always interesting, but I don't feel

like it gives us more fuel for interrelationship issues to work out than most couples would have on their own, anyway. I have to say it is quite fun when we do share patients, which interestingly is not necessarily that often; we get to each report on our progress with our patients and it puts a different spin on talking shop!

**How do you keep from bringing your work home with you, or do you?**

**EH:** It's healthy to maintain a healthy balance between home and work life and not mix the two too much, even though it can be fun at times.

**SH:** To a degree, talking shop at home is an important way for each of us to decompress and share our exciting moments with someone who really gets it, so that's very valuable. There is a line that can be crossed where it goes from therapeutic to invasive, though, just like medicine—the difference between a medicine and a poison is the dosage!

**How about when you're not at the Hawthorne Wellness Center; how do you spend your off hours together (or apart?)**

**SH:** We enjoy skiing, playing in the park with our dog, running, or socializing with friends. We each have times/days we spend doing sports or socializing with others as well, though, just like any other couple.

**Anything else that's unique about your medical and marital situation?**

**EH:** It's a special feeling when patients know both of us; it creates a more familiar connection between all of us, especially when there's been longer continuity of relationship. •

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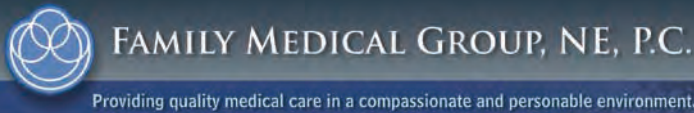
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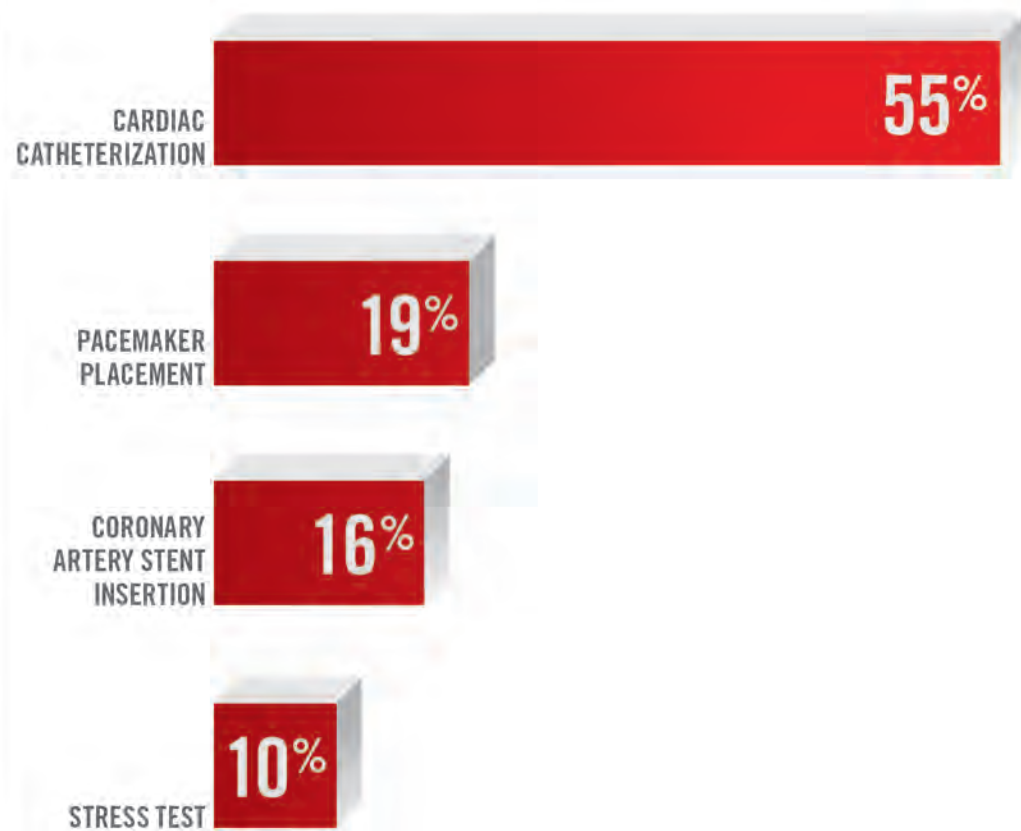
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