

OREGON HEALTH & SCIENCE UNIVERSITY

ORAL HISTORY PROGRAM

a project of OHSU's Historical Collections & Archives

an interview with:

John Moorhead, M.D., M.S.

interview conducted on: September 8, 2016

by: John Ma



Narrator: John Moorhead, M.D., M.S.

Interviewer: John Ma

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Transcribed by: Teresa Bergen

Ma: My name is Dr. John Ma, and I'm interviewing Dr. John Moorhead for the OHSU Oral History Program. It is September 8, 2016. We are in the BICC Building at OHSU. Good morning, John.

Moorhead: Good morning, John.

Ma: Let's begin with your early life in Ontario. When did you first become interested in medicine?

Moorhead: Well, my mother was a nurse. She was a pediatric nurse. She worked at the Toronto Sick Children's Hospital and so I had some influence from my mom as I was growing up. And we had a big, extended family. We'd spend a lot of time at with uncles, cousins, summers together. And I had an uncle who was a physician. So I think I got exposed to the medical field a little bit through their experiences. And I had an interest. My dad was in business, so I think I had this sort of dual interest as I was growing up. But in high school, I had envisioned that I would fit in to the medical field in some way. It had a lot of appeal in terms of working with people, helping people. And it fit with where I was at that time.

Ma: Absolutely. How did you become interested in emergency medicine?

Moorhead: Well, I was in Ontario. And through medical school at Queens University we did rotations in the emergency department. This is way back in the 1970s. And we really enjoyed doing that work. They were teaching ACLS courses to all the students. And I got interested in acute care.

And from there, I went out to Vancouver, British Columbia and did an internship in Vancouver at a trauma center. And no matter where I worked, I just loved working in all areas of the hospital. But always felt like I had a home when I got to the emergency department. I loved the people that were there, the kind of work that was going on, the teamwork. The way in which people worked together and just the kinds of people who were attracted to the area. I almost said specialty. It wasn't a specialty at that point. And I had decided that I would go ahead and take a job as an emergency physician, because I liked everything. I mean, every rotation I would do in medical school, I almost applied to that specialty because I just loved it. But you go through that sorting out process through most of your senior year. And I hadn't made a decision at that point. So the internship solidified things as I got more experience.

And there were these new training programs just starting in emergency medicine. And McGill University had one in Canada, the only one in Canada. And it's actually the longest continually running emergency residency in North America.

And so I decided I would go out and work. And I had accepted a job back in Ontario in emergency medicine when I saw an ad, I think it was in, at that time, called *JACEP*, the publication of the American College of Emergency Physicians. And I had the training program in Montreal. And I called and spoke to the residency director, who was very enthusiastic. So I ended up changing my plans and going to Montreal and doing my residency in emergency medicine. And it went on from there.

Ma: Well, what are some of your favorite memories from that internship and residency?

Moorhead: Well as I was alluding, I think, in my early career, I loved every aspect of medicine. I liked pediatrics, OB/GYN, medicine. But it was the acute care that we saw in the emergency department, and the ability to make a change in individuals' lives in very, very difficult situations. And then the way in which, as I said, the way in which people worked together in that environment as a team, had a lot of appeal. And so, like we all do, we get experience, we work with folks. We get those experiences and we make some decisions. And fortunately, if it meets our personality and it fits, it's a good long-term decision. And that was the right one for me.

And I remember mostly that, I think the word is teamwork that sticks out to me. Wherever I was, I always enjoyed going to school. I loved internship and residency. It was fun. We worked incredibly hard. And the internship, I think we were thirty-six on, twelve off, for the year. There were fifteen of us residents in this hospital, and that was the only housestaff. So we kind of were very involved in all of the care throughout the hospital. A very exciting time, working with great people. So I think that teamwork is the part that really attracted me and helped me make a decision about emergency medicine.

And then going to a great city like Montreal, an established program. But they were just getting things going. Some of the rotations that I would be going on would be the first rotation that a resident had. And so you felt like you were kind of an ambassador to your department, really wanted to do well to create good relationships with other departments. And I really enjoyed that a lot. And I worked, again, with some tremendous people, educators, and got to know a little bit about emergency medicine and what was happening in terms of efforts to kind of create a specialty and who was kind of involved in that. And I got very excited and it went from there.

But I think that wherever I was, it was acute care and it really appealed to me in all those sites.

Ma: At McGill, how were the emergency medicine residents received off service rotation?

Moorhead: Things were a little different there, the way that we trained. This was in the '70s, was quite a bit different than we do now. So I would go the week before I started a rotation. And I would say, "Hi, I'm John Moorhead. I'm the new resident. I'm in the CCU, next week I'll be starting and I'd like to run the CCU next week." I was like the second resident.

And they would go, "Oh, okay. So we'll put you in charge and you'll run the CCU starting next week." So you were creating some of it yourself with all of the structure that was of course created through the training program.

But emergency physicians, right from the get go, were very well received. The different specialties liked what we did in terms of sorting things out for them and stabilizing things so they could do what they were really interested in doing. And they really found that the work we were doing was helpful to patients and helpful to them. And so we were always viewed as people who kind of could fix things. You know, when things went wrong, we were the people who made things right. So we were very well received. The department was very well received. There was actually a section of the Department of Surgery that became its own department.

So as part of that Department of Surgery we had strong support from the department and through the university. And that was very helpful in terms of getting the program going.

Ma: Upon completion of your residency, how did you get your start at OHSU?

Moorhead: Well, I'd heard, well actually that was another sort of happenstance. While I was completing my residency, another ad in the then-called *JACEP*, from OHSU was an ad that said that OHSU had wanted to start a training program in emergency medicine. And I thought well, if they're going to start a training program, they'll need some people who've trained in emergency medicine to work with that program.

And I called and spoke with John Shriver, who was the head of the division at that time, and came out for a visit. It was a typical Oregon visit. It wasn't flashy. John was giving a talk in Hood River in the basement of a church. And so he said, "Come with me. We're going to meet with some folks in Hood River." And we met with just whoever came to our meeting to talk to them about this new concept of emergency medicine and what was going on at OHSU.

So John and I drove out. Had a chance to chat. Had a little dinner with the folks. Had a chat. And we came back and John had a plan for how he wanted to begin things here out of OHSU, which was really centered around starting a training program. And I was fortunate enough to, he kind of laid out the different jobs as he saw them, and said, "Where do you see yourself fitting in?"

I said, "I'm an educator. I'm really interested in the residency." And I was offered that position and literally left my residency to come out here and begin this program.

Ma: Any trepidation about moving south of the border to the United States?

Moorhead: No. None at all, actually. I find that the geography and the culture is much different west to east than it is north to south. So when I had lived in Vancouver, I'd visited Oregon, spent my vacations down here. And I felt like it was very, very similar along the West Coast. And having lived in Vancouver that year, I kind of felt like I belonged on the West Coast. And then when the job opened up in Portland, it was a great match.

Ma: Well John, you established the emergency medicine residency training program here at OHSU in 1978, which was the first of its kind in the Northwest. Please describe the work challenges and barriers in organizing the program. And how did their residency program compare to others across the country?

Moorhead: Sure. So we were amongst the first twenty programs to begin in the United States. And a paper had been published in 1973 about the status of emergency medical services around the country, and pointing out the lack of organization and the need for training programs and the rest of it to organize that important area of medical care. And actually, the federal government, through looking at that report, provided some funds for residency programs to begin.

When I came to OHSU, I realized this and had an application ready I'd send in to the government to get some of this funding. We had support for the first year so I was told "we don't need it, we won't apply this year and we'll come back next year and go for the funds". And I guess it spoke to the naiveté. We were unaware of how those sort of funding opportunities went. So we let that one go. And then UCLA and other programs were starting about the same year and they got funding and it was a help to them. Of course when we went back there the next year to look for the funding, the funding was given out to the programs that had been funded the first year and were doing a good job.

Don Kassebaum was a cardiologist, and he was the hospital director at the university hospital. And Don, at that point, looked around the emergency department, which was in the basement of North Hospital and the old county hospital. And he had some experience with pre-hospital care and I think through his cardiology experience, and then community-wide vision, reviewed cardiac complications of some kind of diseases and realized that, number one, our emergency department, which was really resident-run, there were no attendings, needed to be upgraded. The quality of care needed to be improved and we needed fulltime faculty there. And also he had a strong impetus to improve the quality of pre-hospital care. And he wanted folks to come in because these training programs put a strong emphasis on pre-hospital care, and working with the fire department and private ambulance companies to improve the quality of care, improve hospital care, for which he thought nobody really had responsibility. So it was some very good insights from Don Kassebaum who recruited John Shriver and sort of got this going in 1976.

So we followed through with that goal, and were very involved in, as you can imagine, I liken it to a startup type of a company where you have very few people. People are going twenty-four hours, seven days a week. Everybody's doing a bit of everything. But there's tremendous camaraderie, teamwork again, everybody had your back. And it was a very exciting time here. There were challenges.

And when we began our program, we wanted our residents to not only have the experience of working in a university hospital, but a community hospital. And at that time we were fortunate enough to affiliate with Portland Adventist Medical Center. Bill Whitlake was the chief there. And we had worked out an arrangement that our residents could work there. And some of our faculty. I worked there for about nine years, worked with the residents in the community setting.

So we had to do those negotiations and then as I was describing, almost like at McGill, we had to be careful in terms of the folks that we recruited, because it was so important to create a good image of this department as we started. We wanted to create good relationships with other departments. We wanted to have good people out representing us both as residents and faculty. And we were just very fortunate to attract some great people who wanted to come and participate in building that program.

It wasn't easy, but I think again that folks who worked here at that time, we'll probably get into talking about some of them, were just of that mentality. They were groundbreakers. They were innovators. Very, very hardworking folks. And worked very well together to not only recruit the residency program, but the other programs that were developed here, the Oregon Poison Center and EMS activities. And very much then began to look for opportunities to be involved in medical school education as well.

Ma: That's interesting that you mention the affiliation with Portland Adventist back then. Because now we are investigating a better relationship with the Adventist Healthcare System.

Moorhead: Yes.

Ma: So it looks like we've come full circle forty years later.

Moorhead: Well the year after I came, another resident who was at McGill followed me, wanted to come to Portland. His name was Lindsey Horenblas. And Lindsey followed me and took the directorship at St. Vincent Hospital, at their emergency department. So Lindsay came out a year, naturally a year later. We had an affiliation with St. Vincent. Our residents started rotating out at St. Vincent's, who had very, very actively started recruiting emergency medicine residency graduates. Great training assignments. It was our next affiliation and it worked out really well. And of course we have many throughout the city at this point. But we're always thankful for that first one that helped us get them.

Ma: Also as you know, our faculty continued to be very strongly involved in Portland EMS. And so you would probably trace our involvement directly to Dr. Kassebaum's leadership forty years ago.

Moorhead: Absolutely. I think it was a great vision. I'd liken it, as we said, this was 1978. Emergency medicine wasn't recognized as a specialty at that point. So there were national activities going on to help create a new specialty which would give further support to the groundwork activity that was going on at local universities and training centers. And emergency medicine had applied to become a specialty through the American Board of Medical Specialties. And had been turned down. And there are all sorts of interesting stories from the folks who were involved in that process.

When they reapplied, one of the key factors that turned in favor of emergency medicine being recognized as a specialty, was the realization that this was a group that was going to take hold of the hospital care. And no one to that point had felt a sense of responsibility for what was going on outside the hospital. And that was an extremely important point in the application to the ABMS. So similar to our department developing and to making that commitment to enhance pre-hospital care was uniquely a part of our application to become a specialty.

Ma: In a press release announcing the residency program, you stated that there were only seven physicians in Oregon who had been trained in emergency medicine, with three

working at OHSU. Tell us about some of your colleagues at OHSU and across Oregon who were practicing emergency medicine at the time.

Moorhead: Well, there were people practicing emergency medicine, but they weren't all trained folks. And there had been an attempt two years previously to start a training program at Providence Hospital. And Greg Lorts was involved. Duane Beitz was a trauma surgeon over there. And they had an attempt to organize a residency. And Greg was actually the first resident. And I think probably, at that point because we weren't recognized, emergency medicine wasn't recognized as a specialty, there was some accreditation of training, but it came through the American College of Emergency Physicians. And they would do site visits and do accreditation. And Providence made that initial application. But it tapered out after about a year or so. And so created really the niche for us to start our training program.

So Greg was working at Providence. And the folks at St. Vincent with Lindsay, Dave Craig, Steve Wright, those folks got recruited from Fresno and from Denver, West Coast, to come and work there. At OHSU, John Shriver was an internist. He had been here and knew Don Kassebaum and he'd gone into practice in Salem. And Don reached out to John and asked him to come back and begin this whole effort.

Marc Bayer had been a resident in Denver and came to Portland just before I did to OHSU and was the person who started the Oregon Poison Center. And he was a trained toxicologist and that was his interest. So that's how the Oregon Poison Center got its start. And Mark and John kind of put that together and got a bit of funding to begin that tremendous program that is so vital to the community right now.

People, as we talk about EMS, we also were starting a paramedic training program. And Knut Eie, a real interesting fellow, a Norwegian, had been recruited to come to the States on a skiing scholarship in Utah, and then done paramedic training. And got recruited to come to OHSU and start this paramedic training program. So he was a paramedic. And still lives in Portland. And we became just best friends. He was one of the most energetic guys. I mean, I remember this, "24/7, John, 24/7" would be Knut's modus operandi. And we would spend the day and often work till dinner at night and then come back and work the two of us. We had lots of energy at that time. But Knut was really instrumental not only getting our training program, but developing relationships within the community.

And Keith Neely was recruited right after that, a paramedic who was just a fabulous individual and a wonderful EMS advocate and instructor. And Keith's vision was coordinating all of this pre-hospital care with the communication system. And of course was responsible for our communication system and now the medical communications center, and where there's medical control for pre-hospital care through the emergency department. And then started the process of collecting data and allowed us to do some research and see just what was going on here so we could learn from it.

Joe Bander was a very interesting individual. He was an internist. And so when I came, when John was recruited here, he was not only asked to be the chief of the Division of Emergency Medicine, which is worth a comment here, but was also asked to run the medical intensive care unit. And John had recruited Joe Bander. And Joe served as the director of the intensive care unit. Joe then later left years later and took MICU chief job in Detroit. And still practicing, I believe.

So we had the critical care involvement, pre-hospital care, the poison center was going. I mean, it was a very active group.

So just a word about this, I forgot what it was. We said we'd get back to it and I wanted to make a point.

Young: Was it about the division?

Moorhead: It was about the division. So let's go back to that for a minute. Because this was really a stroke of genius on the part of Don Kassebaum. So paralleling some of the struggles that were going on with emergency medicine becoming a specialty. At the national level, everyone recognized that there was a unique area of medicine that hadn't been organized. But it turns out behind the scenes, everyone thought it should be part of them. So the internal medicine community thought that the emergency medicine group should be part of internal medicine. And the surgeons thought we had a natural affiliation and that we should be part of surgery. Very similar to the department at McGill, for example, as part of the department of surgery.

And this had, you'd seen this occurred around the country. Emergency medicine was part of medicine, part of surgery, a little bit independent. So those activities were going on nationally. Dr. Kassebaum was very, very bright. Did not take on any of those traditional departments by saying, "Let's just start a new department and give them equal stature." He created an interdepartmental division. Which sounds like gobbledy gook but allowed us to function as a separate unit within the hospital and the medical school. Not part of the traditional department, but yet, not yet given department status.

The flipside was that our leadership were able to participate in all of the leadership activities in the hospital and in the medical school, as if we were all a department chair. And so it was well, I think a stroke of organizational genius in terms of creating this department. And actually, that experience was written up and published and created a model for other departments around the country to create their emergency medical organization. So I think it was worth a note that again, it was another vision of Dr. Kassebaum working then with John Shriver that created this structure that really, I think, was responsible for an independent group to get together on these activities we were talking about.

And I've read that some of the concepts that may have occurred if we had, again, been part of a different department. So that was very helpful to those of us creating new programs within the university structure. So I thought that was worth a special note.

Ma: You alluded earlier to some of the struggles and barriers that EM faced when trying to get specialty status within the American Board of Medical Specialties. What are your recollections of those times?

Moorhead: Well, you had to go through the official process, which was demonstrating that you had a unique area of medicine that was not already covered by a traditional specialty. That training programs existed. That there was a literature regarding the kind of work that was being done in that area. That here were textbooks being published. A real academic basis. It was a really stringent standards. Which I think has held up well over the years in terms of BMS function. And emergency medicine, I think, intuitively made a

lot of sense to the other specialties. Because they were the ones that had to vote on creating this new specialty. But as I said, there was some, a little bit of paternalism going on in that they could see this maybe developing, you know, and thought maybe it should be part of their area

So there were formal activities going on, demonstrating the academic aspects of that and meeting all of these other qualifications. And then there were the things that happened, the sort of political aspects that happen in terms of negotiating for something like this. And national leaders from places around the country. The original folks that created the specialty in 1968, who had been involved through the American College of Emergency Physicians. And then as part of their vision in creating a specialty, knew that we needed formal recognition through the American Board of Medical Specialties. And helped put together that application and shuffled it through the various stages of being accepted by the BMS.

A lot of very interesting stories have been written up in some textbooks and some historical publications about the early days of the specialty. Wonderful reading. Really likening the whole process that was going on locally here and around the country in terms of the kinds of activities that were being created and some of the struggles. And natural affiliations that were developing, really focused on clinical care, providing good care and good training for folks to go out and work with the community.

Ma: What are some of your favorite memories of the people who were involved in that early movement?

Moorhead: Well, nationally folks like George Podgorny and John Wigenstein from Detroit, and some of these pioneers. Ken Graves. There's a group of about ten or twelve of them that had gotten together in literally a hotel in Michigan in 1968. And they were the ones that had this vision of emergency medicine. And fortunately, being involved early on with our training program gave me opportunities to represent the university and be a part of some of these organizations and meet some of these folks. And they were just tremendous and inspiring. I mean, meeting and working with people who had the original vision for the specialty is very invigorating and like it does for us now when we get to national networking with our colleagues and come back energetic and who fought for another year of activity. But it was pretty unique with folks who were creating something that had never been there before.

Ma: The OHSU Division of Emergency Medicine was established in 1977. And it became an official academic department in 1991 with you serving as the inaugural chair. You mentioned earlier Dr. Kassebaum's involvement with the organizational structure and how that was a key moment. What were some of the other key decisions and moments during the 1970s and 1980s?

Moorhead: Well, one activity that helped me was the creation of a sabbatical program within our department. And it was supported by all of the faculty and had support from the university. We got a university-wide sabbatical program. And Bob Norton, who had come to the department to work both in the intensive care unit and the emergency department had taken a sabbatical the year before I did. And creating a medical transport

system to evacuate patients literally from around the world. Had gone over to Europe to create an office for this company.

I had an opportunity in my sabbatical in 1987 to go back to New York, to NYU, and do a master's of health policy program. It was a combined health policy and health management program. Lived there and going to school fulltime as a student again. Probably changed my life in terms of my perspective on things, and my interest in creating an interest in health policy and more on the management side of things as well as my background with clinical and education.

And having come back, it's often the formal training, but it's the language and I think respect for having dedicated a year of my life to doing that activity. I came back and worked within the hospital directors at that point, Ken Goldfarb, Bill Collins was the hospital administrator directly working with emergency medicine, and very involved in the EMS community. Worked with tremendous support.

So we had started to work on some new programs within the department. At that point, John Shriver elected to go to Yale on the East Coast, to begin an organization of emergency medicine at Yale. And so when John left, I was asked to be an interim chief. And began to negotiate. And at that point, John Benson, who had been the dean, had transitioned to John Kendall. And we started working with John to do a search and look around for new leadership.

Through that process and discussing the whole situation, doing some strategic planning as you do when you go through a search like that, having discussions with Dr. Kendall, he was tremendously supportive of our move at that point to becoming a full department within the medical school. And so part of, then, the ongoing negotiations involved the creation of this and a separate department academically. And I was fortunate to be offered the job and the academic department sort of came with it. So it was an opportunity to take our organization to its rightful place with the other departments and create our department. And so that happened in 1991. It was personally very gratifying and wonderful for our organization and our folks to feel like all that hard work that had gone on for the last thirteen years had been recognized. And I think gave a tremendous satisfaction to everyone here that was working in emergency medicine and emergency services.

Ma: Did the dean offer you a Chair's package at that time?

Moorhead: That was the incentive package. That was by far the most important thing he could have done for us. And we're indebted to Dr. Kendall for doing that. He was very innovative. Things were very tight. It wasn't the same size of an organization that we enjoy these days. And we worked hard for everything we got as we do now. But John Kendall was truly supporting us and our efforts, and I'm really thankful to him for that support in terms of establishing an academic presence here. Which we've used as a base to now continue to go forward.

Ma: Who were some of the players around the campus who really advocated and supported emergency medicine during the decision process?

Moorhead: I think when I came here, part of the experience, I think what identifies emergency medicine as just the key word, but if you're interested in emergency medicine, you have to be interested in acute care. It defines our specialty. It's the front end of every aspect of care. Folks with a stroke or heart attack, an injury, obviously come to the emergency department and are prepared to treat that broad spectrum age group of individuals.

And one of our challenges when starting a program was that we could not create a focused experience for our residents in trauma. Trauma was starting to get organized within the community. But there were several hospitals in Portland – five, in fact – that were serving as trauma centers. One was Portland Adventist, Providence, Emanuel, and St. Vincent. And so trauma patients were taken at all of five hospitals. Portland was not that large a community. And so there was not that intensive special to trauma. And we realized that.

We created an affiliation with Denver General Hospital to start our program. And so the faculty there, who we became very close with, Peter Rosen, a leader, national leader and was head of the group at Denver General. Vince Markovchik at Peter Pons and John Marks and those folks, tremendously supportive. So we developed a relationship that allowed our residents to go to Denver and get an intense exposure to patients with traumatic injuries.

At the same time, we were working locally, and one of the impetuses was not only to improve care, but to be able to provide education in this area of trauma. And as we evolved and became a Level 1 Trauma Center with the Department of Surgery and the Department of Emergency Medicine provide the natural affinity. And so working with [Rich] Mullins' predecessor, Don Trunkey, was tremendously helpful to our department and to the folks who worked here. Don often commented that he would be doing trauma call at night and he'd look around the hospital and the only faculty were emergency physicians and the trauma surgeon. And Don was a tremendous mentor for me, an individual that supported the work of our department. And just one of the most remarkable individuals I've ever met. But to our department, he was tremendously helpful. Always open. I had never had this kind of a leadership position before. And I think I was sent to a AAMC weeklong program to become a department chair. Fortunately, I'd done this training program in New York. But individually, I had to sort of look around as you do for mentors and people who've done this before who could give you some guidance. And Don was an individual who I went to, tremendous response. And our departments had natural affinity.

And we worked together, then, to work with the community and develop the trauma system that we have here. That has, our department, their department has done research, worked together to run educational programs and demonstrated the value to the community of improving care.

But the way that we worked together was always very collaborative. And the support from the Department of Surgery was instrumental in working through issues within the institution to improve and better coordinate care for patients that we were seeing. So he's someone that stands out to me that was just extremely helpful. And without him probably we wouldn't have accomplished some of the things we were able to do.

Ma: The OHSU department of—should we take a break? How are we doing?

Moorhead: Sure. [Pause]

Ma: Okay. So John, early on, was there a certain personality type that was attracted to emergency medicine?

Moorhead: Yeah. It was interesting. I think people used to call us adrenaline junkies or cowboys. And it often felt like that's the way it was when we were working. It's just so busy, you had so few people and you were working so hard at your job, you felt like you were flying by the seat of your pants sometimes. So the specialty attracted people who had to be quick thinkers, decision makers. And folks who worked hard while they worked hard, and probably played hard while they played hard. And you found people who were different from the maybe the traditional mold, particularly academics, because it was folks that were, their shift was a defined time period when you were doing your clinical activity, there was a defined time period when you were doing other teaching and research activities. But outside of that, you were climbing a mountain or you were running a marathon. Very active folks. So Oregon was a great opportunity to recruit this kind of individual, because of what Oregon offers. So a lot of the early people were, fit into that sort of stereotype. And I think as we've evolved, it's become much more traditional.

There are, my background is in psychology. We used to do personality tests to just sort of look at the different specialties and how personality types help individuals to fit into a particular medical specialty. It was very interesting, because as we did this work we found that physicians that most closely resembled emergency physicians in their personality type were actually OB/GYN doctors. I guess, I tell this to students who are looking at emergency medicine as a career to help them understand that its people who like to work with all age groups, who do a little bit of medicine and a little bit of surgery. But who, again, work in a team situation. Probably the two classic teams, the OB/GYN setting, the operating room, and the emergency department, where individuals just work together to get the work done. Not so much hierarchy as we might see in other areas. But in emergency medicine just people who worked hard, always oriented to getting the best result for the patient. It didn't matter who did what. You just worked together as a team. So it was interesting that that was the particular view of the folks early on in the specialty. Now we're much more broad and we have, I think, a broader representation of sort of the population who's interested in emergency medicine, emergency medical services, emergency medicine research. But there's still some of that personality type I think that persists now. We like each other in emergency medicine. We get along. It's folks who are really pretty similar sort of folks.

Ma: What also strikes me about this specialty is it's very physical. That's what I describe to medical students is that it's more than just cerebral. We certainly do our share of thinking, but it's also a very physically taxing specialty. We're always moving, we're always lifting, we're always doing something. And there are physical demands, which make it unusual.

Moorhead: Well there are, and it means you have to have and be able to have all your faculties available to you. There are physical demands and mental demands. I think the physical ones, it's impossible to work in this specialty if you've unfortunately lost a limb or had some medical or traumatic event. And that's why emergency physicians were high up on the list of physicians and medical providers who got disability insurance. It's something I always have taught our residents: make sure you get your coverage. This is a risky business. It's physically demanding. You're exposed to patients who are very sick. Accidents happen. People get stuck with needles. There are infectious exposures to all sorts of patients.

I think it's, the physical is a big part of it. But the number of decisions that an emergency physician makes in one day is incredible. I don't know if we've counted them. I think people actually have counted them. It's just incredible. And it's one of the reasons at the end of the day where really you are physically tired and you're mentally challenged to continue to make all those decisions. Not just clinical, but organizational. Our work is constantly evolving because we don't know what one day will bring. And it can change from minute to minute and hour to hour. And it's challenging, but it's part of the intrigue and appeal of the specialty. And the folks that work there enjoy that. Enjoy sorting out the resources and trying to match them with the needs of individual patients at the time that they need them. That's all part of the specialty, that it sort of goes beyond just the technical skills and the knowledge in terms of making an emergency department work efficiently and effectively for patients.

Ma: I think the other thing that makes emergency physicians unique is our commitment to treating patients with a high quality of care regardless of their ability to pay. I know in my twenty-five years of practice, I've never looked at a patient's insurance status before seeing them, and I'm sure you haven't, either. And I think that's what sort of bonds a lot of emergency room physicians.

Moorhead: Well, it does. And I think it brings up another real, an important landmark in the evolution of the specialty. Hospitals are, have some financial motivation. They have to keep operating to offer services to the community. There was a practice early on in the middle twentieth century where patients were screened when they came to the emergency department when they were in active labor. And if they did not have insurance coverage, they would be told to go down the street to a public hospital.

And part of the early research and learning about this specialty was that there were problems. Patients did not get good outcomes when they were shuttled off and care was delayed. And there was a national effort to create legislation that would make this practice go away. And it was called EMTALA, the Emergency Medicine Act of Labor and Treatment Act. And it is landmark legislation that basically prohibited what was called patient dumping, and mandated that every emergency patient who presented to an emergency department in the United States would have a, what's called medical screening exam, would have an evaluation to determine whether they needed acute resuscitative activities, and needed to be stabilized before. Then an agreement could be made for continuity of care or for whatever reason, access to specialty service, if that could be done. But it had to be done in a way that was patient-centered and provided them better care, not just for financial reason. That changed the practice of emergency

medicine and was instrumental in terms of emergency medicine quality of care improving over time.

Ma: So John, the OHSU Department of Emergency Medicine celebrated its twenty-fifth anniversary this year as an academic department at OHSU. How has our emergency department sort of matured? And how does that maturation parallel the specialty over the years?

Moorhead: It's been tremendously gratifying to just be part of it and to see how our department has matured. I think that after I became chair we created an academic department. It was clear that two areas that needed attention were greater involvement in undergraduate education and to expand the research base in emergency medicine and the activities here. Jerris Hedges was recruited to head up our research activities and took our whole academic and research activity to just another level. Jerris had come from University of Cincinnati, had come from the Northwest and wanted to come back to Portland. And we were really fortunate to attract him to come here. Was an academic leader. And came here and organized our research activities. And is probably known nationally as one of the foremost mentors for emergency medicine researchers in the country. And stimulated a whole effort to expand the research base, which had been sort of episodic, non-focused. And became very focused on the health policy activities, and recruiting people like John McConnell, Keith Neely, who we've mentioned, and folks to do policy research on the delivery of emergency medical services to work with the department of surgery in demonstrating that the organization of trauma had improved the quality of care for patients.

So that whole academic focus, research focus, was tremendous. Again, in recruiting individuals who could come and work here, obviously be part of the clinical activity and teaching activity, but expand the sort of third leg of the stool in terms of research activities. Expanded it and Bob Lowe coming here and Craig Newgard and that whole group have just taken that incredibly. But Jerris, somebody like Jerris needed to come here and take control of that activity and provide the leadership that was necessary. So that's just been fabulous to see that growth within the department.

Ma: Well as you know, our research section ranks in the top three every year across the country as far as NIH funding is concerned. So that's got to be incredibly gratifying for you seeing that sort of maturation process and the growth of our research.

Moorhead: Well the individuals here, the department, it's tremendous for the department. And it's a very appropriate recognition of the effort that's gone on for many years and the individuals who have worked very, very hard in terms of creating these opportunities and funding to do these studies. Tremendously gratifying. But Jerris took, it needed someone of his stature to come here and take that leadership. And of course he became the next chair of the department. So that was just wonderful, and a natural sort of evolution for the department academically to move in that direction.

I think the most satisfying thing, again, are the people. It always used to be, come to Portland, Oregon, you could work and almost any job would get filled in about a week because it's a great place to live. But eventually people have to be happy in what they're

doing. And people who come here and train here don't leave. Because it's a great group. We've had, I think, good leadership and good camaraderie. That teamwork that I talked about right at the beginning of forming all of our activities has continued through the years and still exists within our department. It's just a great feeling to feel not only that you're part of a clinical team that works together in terms of patient care, but a team that supports each other, education, research and clinical activity, community service, that works together and supports each other. Has been a central, I think, realization amongst the people who come here. So when we have students rotate with us, when our residents come to look at doing training here, it's something they always remark on. They just think the people who work here are incredibly talented. But they always remark on how well people work together in this department. And that's tremendously gratifying.

As we've graduated residents now since 1980, and they've gone out into the community, most of our emergency departments within the community are staffed with our graduates. And that just feels wonderful to know that the care throughout the state and even the Northwest has improved that much from really well-trained people going up there and improving the quality of care, which is really what it's all about.

Ma: What's also interesting is that each year twelve to fifteen percent of the graduating medical students from OHSU elect to go into emergency medicine as their specialty. As a faculty member who's been so focused on education over the years, that also has to be very satisfying to see.

Moorhead: It is. It's wonderful. It's a tremendous specialty. It's extremely rewarding. Personally I enjoy every day I go to work. I learn something. I feel like I give something. It was the right decision for me. So I think as students learned about emergency medicine and saw how medicine was changing, this was a specialty that had tremendous appeal to students. For the same reasons that we went into and created the specialty. And so it's nice to see that's not just a spike one year or two. It persists over time, the interest. And it's been great to see at OHSU a consistent level of interest in emergency medicine amongst the medical school graduates. Yeah.

Ma: John, you've served as an attending physician at OHSU Hospital and Doernbecher Children's Hospital. What's your favorite memory of both hospitals during the nearly 40 years that you worked at OHSU?

Moorhead: Well I think, I referred to the organization of trauma as being tremendously satisfying. That was an area within this community that national studies had demonstrated that by organizing trauma services, you improve the quality of care for folks. And being able to participate in creating that system that, 1987 created the Oregon Trauma System, the first statewide system in the country, was tremendously gratifying. And there's a whole story behind the trauma, you know, the Don Trunkey and Dan Lowe, followed by Rich Mullins and that whole group participated in. Interesting point that as that was being organized, and there was obviously some sort of jockeying within the community to see how that would fall out, I think one of the key times that helped that whole effort was the support from Kaiser Permanente. That although they were responsible for insuring about a third of the population, they put patient care first. And

they realized that what it took to create a trauma center from patient care through rehabilitation, education and research, and realized that you needed Level I trauma centers.

And they threw the support behind the effort to consolidate trauma at two centers in Portland. And that was a key decision that enabled the whole effort to organize and regionalize trauma care. That was tremendously satisfying.

I think the other is, we had an opportunity in 1997 to open a new emergency department as the Mark Hatfield Research Building was being constructed. So we were given the ground floor of the building to create a new department of emergency services. And at that time, it was obviously an upgrade of all of our facilities, and a tremendous effort by everyone involved. Our nurses, paramedics in the community, our docs, the people who train here, to have a vision of the design for that department. Had to fit within a template.

But one of the offshoots was creating a separate place for us to care for children. And I think now the Doernbecher Emergency Department was sort of a landmark time in that evolution where we were able to physically create an environment that was much more conducive for treating children. Have physicians dedicated to treating children separate from an adult emergency department was tremendously helpful in terms of the evolution of our service, and created just a wonderful area for treating kids. And it has improved the quality of care, I believe, for children in the region.

So I remember speaking at the time that we opened the department, that that creation of that department was a realization of the hospital of the role that emergency medicine played within the healthcare service. That so many more patients that were admitted to hospital were coming through the emergency department. The impressions that individuals have, patients coming to OHSU have, start when they arrive at the emergency department. And by providing good care, we start up front to improve outcomes for patients, improve their experience and their satisfaction. So that was, again, another landmark and creating a separate area for children was tremendously gratifying and still is to be able to offer that special area of care. So those are two areas that I think were noteworthy along the way.

Ma: John, you're considered a pioneer in emergency medicine advocacy. And I've described you as being the single most influential emergency physician in Oregon history. Please discuss how you've advocated for emergency medicine within our state and across the country.

Moorhead: Well, that's very kind. I had a vision and saw through my experience as a medical student and through my training what was then the standard of care in terms of providing emergency services. And although it was an improvement over what had been, there were clearly opportunities to improve that care. And I think that's where I've tried to devote my career is across the training, supporting research, and getting out and doing advocacy for policy changes that support regionalization of services, legislation that would ensure that no patient would ever get turned away from an emergency department for financial reasons. Improving quality, improvement, looking at the way in which care was being delivered and looking for opportunities to improve really is where I focused my whole career. And so locally through efforts working with the university and

university hospital, Doernbecher Hospital, and then working out in the community to look at some of the policy issues that influence how care is delivered, how best to support patients who come to emergency department for care. But the individuals who work there, to a better degree than previously, because if you've got healthy people and you focus on wellbeing, you deliver better care. And so it really encompasses the various activities I've been involved in through education, through advocacy, through American College of Emergency Physicians and the Oregon chapter, through the Oregon Medical Association, to better help emergency medicine coordinate with all of the other specialties in improving care. And then working with the American Board of Emergency Medicine, and ABMS, to ensure that the standards that were created for physicians were not a one-time effort but were career-lasting, and ensure that physicians kept up in our specialty just the way they should in all of our specialties. And thereby hopefully extending this continuous quality improvement in our service over a long period of time.

Ma: Okay. So John, you've also been very active in our state professional organizations. Could you discuss your work with organizations such as the Oregon chapter of ACEP and the Oregon Medical Association?

Moorhead: Sure. My early entrée into organized medicine was really through Oregon ACEP and getting involved in the activities of the Oregon chapter of the American College of Emergency Physician, the two roles, big roles, that that organization plays, are educational in creating statewide conference and educational opportunities for emergency physicians around the state, and advocacy in terms of ensuring that emergency medical services gets the support that we need to deliver high-quality care. And over time, the regionalization of trauma care, the continued regionalization of emergency medical services for cardiac care, for stroke care, for pediatric care, now for patients with psychiatric issues, has been an ongoing evolution and really is gratifying to see. And Oregon has played a role in all of those activities.

I think as we participate with the other specialties in the evolution of care and how our whole care delivery system is changing, I personally think for the better, but we'll see, it's still important to carry the message of patients coming to the emergency department at a time of tremendous need, fear, anxiety, and fight for policies that allow us to deliver the best care we can for those individuals. And continuing to place value on what emergency physicians provide to the whole care delivery system.

It used to be looked at, as we talked about doctors, cowboys, delivering this acute care. Sticking in a chest tube, intubating somebody, saving people's lives. Tremendously valuable, and will always be sort of the focus of kind of what we do. But getting into the organization policy issues and realizing that influencing those decisions can better create systems that will improve care. And again, working with great people in the community has been tremendously gratifying. And OHSU has always supported that activity, been at the center of it, helped with EMS and all these other areas of care delivery.

When we, one other area I will mention, and it really started when we created our new facility, was the creation of an observation area. And I bring this up from a policy standpoint, because I think we had some good vision there in creating an area where patients who need more resources, investigation or treatment than we typically provide in a short episode in the emergency department, but don't need to be in the hospital and go

through that full admission process, can be very efficiently put in a setting where their evaluation management can be focused for conditions that generally will turn around within a day or two and then be discharged at a hospital.

I think came from the early studies looking at those kinds of units showed that they were very appropriate settings. They provided good care. They were very well accepted by patients. But it became obvious that if emergency physicians were running those units, they operated very differently than if other physicians were operating those units. Emergency physicians, because they're attuned to making quick decisions, focusing care and providing an efficient workup, evaluation and management of a particular condition, that's just our orientation. And it expanded into an observation unit, which made, expanded the episode of care, and provided a very efficient way to manage a large number of conditions. That was very, very helpful in terms of providing care to a whole section of patients that traditionally would have been admitted to the hospital.

Those kinds of decisions, and providing that efficient workup and treatment for patients is clearly what we do, and can't be lost in terms of a system that's evolving. Because it serves patients well, it's efficient, it actually helps to even save money versus sort of traditional care. So it's just another way that emergency physicians help and provide value to the care delivery system.

So we've advocated for these new areas and efforts, and we've advocated for policies that would support those. So through Oregon ACEP, and then getting involved with the Oregon Medical Association, and being involved with an organization, again, that had statewide scope, was very natural, because OHSU has always had a statewide scope. And then working with emergency physicians statewide, and then all physicians statewide, seemed kind of a natural environment to work in, and I enjoyed it very much. And enjoyed the physicians who participated.

One of the activities I tried to bring to both of those organizations was the involvement of young physicians in mentoring physicians as they go out into practice and prepare themselves for a career. And to provide them support as they worked in the community. And so we tried to reorganize those organizations to realize that we were helping to create systems for the people who were students and residents now who would be out in practice in years. And that's an orientation I've taken to everything that I've worked on in terms of community service is creating an environment for the people who are in training that will better serve them when they own a practice in five or ten years from now. Because we want them to have the support that they're going to need no matter what the system looks like, so that they can do what they want to do and just take care of patients and provide good patient care. So that's been very satisfying to work in those organizations with that kind of a focus.

Ma: You've also held several national leadership positions – the president of the American Board of Emergency Medicine, president of the American College of Emergency Physicians, and you're currently the chair of the American Board of Medical Specialties. How have these leadership roles helped to enhance emergency medicine standing within the house of medicine?

Moorhead: Well, I think it's been very interesting to see how national organizations have evolved and how emergency physicians have gradually become more and more involved,

and assumed some of these leadership positions and opportunities. I think it's a reflection of how we work day to day, that we help to coordinate, we help to work as a team, we help to bring in physicians from different perspectives. When we work at national organizations, it's reflective of the kind of work that we do clinically. Brings people together, coordinates efforts and tries to focus it on a patient or on a specific policy or issue. And it's just very gratifying that these opportunities have been available and we've been able to participate in them. It just takes the work we were talking about at the state level and just expands it nationally. But I've tried to take the same focus into those activities that I've taken locally. And it's been tremendously gratifying to work with folks who share that vision for the future and take steps to get us there.

Ma: If I recall correctly, you're only the third emergency physician to chair the American Board of Medical Specialties. Is that correct?

Moorhead: That's correct. Harvey Meislin, who was the chair at Arizona, John McCabe, who's the president of SUNY Upstate, and myself are the three that have held that position. And I mean, I get to work on the national level with all of the organizations responsible for coordinating medical care, with people who've served as deans and now involved with their boards. I've just been very, very fortunate to work with a tremendous number of people from around the country. It's just a real pleasure.

Ma: What do you see as some of the major challenges, both for emergency medicine in the future and for all medical specialties, in your role as the ABMS chair?

Moorhead: Well, the ABMS role is one of trying to coordinate the various specialty boards in terms of a more cohesive way to provide programs for physicians as they have practiced during their career. I think everyone feels very good that we have excellent training at the undergraduate level. There's an accreditation system, the training is standardized pretty much around the country. We now even have osteopaths and allopathic physicians sharing the same standards.

We have tremendous standards for our graduates. Our residency programs are just first class. Wonderful people. And their oversight, with some great standards for training.

The standards for people in practice has not been as organized and certainly hasn't been transparent to the public. So I think we've evolved a program for doctors to not only go through that initial accreditation, be certified in their specialty, feel very, very good about their accomplishment, but hopefully evolve a program that helps them to kind of keep up in their area, whether it's emergency medicine or another specialty area, in a way that's focused on the kind of work that they do, that's not burdensome to them, that helps them to learn and keep up as reasonable in terms of its time commitments and financial implications for physicians. These programs have evolved, each specialty evolved their own program. There wasn't a lot of coordination. And now our effort is to try and open up these programs, make them transparent for the different specialties to learn from each other, adopt best practices and standardize this. Listening to diplomats, because this environment is overwhelming at the current time for practitioners. Physicians and all providers are totally overwhelmed.

A study that was just released yesterday showed that physicians in practice spend fifty percent of their time in front of an electronic medical record. And when they go home, they spend one to two hours on electronic medical records. It's a very different way of practicing than 1978, when we created a residency here. It creates all sets of different challenges for individuals.

I still think it's a tremendously satisfying, important, wonderful area, and encourage people to look at medicine as a career. But it is changing. And it's challenging for practitioners to not feel overwhelmed with dealing with electronic medical records, how they get paid and a system that's become less efficient than we'd like to see. So that system needs to change.

And physicians and providers feel just overwhelmed with the sense of burden that they feel to meet everyone's obligations. We always feel like that in the emergency department because we're the fishbowl. Everyone looks at us. But I think physicians in general feel that way. And so we want, we're doctors. We're creating a program that should be more helpful to physicians. Help them in their career to keep up and not feel like an additional burden that they have to sort of undertake.

So coordinating efforts from the different specialties, coordinating responsibilities and appropriate regulations for doctors to look at and standards. But trying to create one set of standards that meets a variety of responsibilities, so that doctors will feel that that program is helpful, useful to them, and not so burdensome, is something that we're currently challenged with and working very hard to accomplish for all physicians practicing across the country. And that's just an activity that will lead to greater provider satisfaction. And again, will focus on improving the quality of care for patients.

Ma: And how about with emergency medicine, specifically? What do you see as the big challenges for our specialty?

Moorhead: Emergency medicine will always do well, because we provide an essential service for individuals. If left to the community, we would be right at the forefront, because they recognize the value of what we do for them and their families in times of tremendous need. So the public understands what we do. They see us as champions for individuals. We're not out for any kind of financial issue. We're there totally devoted to patient care and doing the best we can for patients and their families. But as you go through a reorganization that needs to occur in terms of the whole care delivery system to make it better coordinated and more efficient, we just need to ensure that folks who make policy decisions make decisions with the full understanding of how it affects all the different specialties. But for emergency medicine, sometimes we feel like we get a little bit taken for granted. And I don't think, we just need to ensure that everybody recognizes the value that emergency medicine plays within the whole system.

So there's continuing financial pressure on all of medicine to become much more efficient. I think that emergency medicine is a leader, because I think we're the most efficient area in the healthcare delivery system. That's why patients, when they need acute workup or evaluation, get sent to us in the emergency department. Because there's a realization we can provide that efficiency within the system.

We need to ensure that as the general healthcare system evolves, that emergency physicians are recognized for the value that they play.

Our training programs are tremendously well-organized, run, very high quality. Because they're very popular with medical students, the number of programs have expanded dramatically. As I said, we were in the first sort of twenty programs. There are now at least 161 programs, maybe a few more at this point. And the number of residents in those programs has increased across the country. So we've had almost unlimited appetite for increasing and satisfying this demand from the medical students who are very interested.

But what is the right number of emergency physicians that the new care delivery system needs is a question that we really haven't answered, and having had the opportunity to participate in workforce research within the specialty, we are going to reach a time that potentially we will saturate the marketplace. And we need to be cognizant of that. It shouldn't be the focus of our efforts. But we need to be aware that these opportunities will not be out there.

And as you see students going through medical school and then training as an emergency physician, going out in practice with the debt that they often hold, part of our job and part of our responsibility is to ensure that they'll have a great job out there for them, that they'll be able to deliver the service that they've been trained to provide.

So we have to be aware of the environment that we practice in, the frustration of physicians, the change in healthcare. It seems pressures come from everywhere to always be doing better and improving. In emergency medicine, I believe that we're kind of used to feeling that way. We have a natural desire to improve and better coordinate services. So I think that's there.

So I'm very optimistic about this specialty. It's a wonderful area of medicine. It's appealing to medical students, tremendously satisfying in terms of the quality of our educational programs. And the service that we provide is improving all the time.

Emergency medicine used to be an area that people trained in for three or four years, went out into practice, that was their career. Different from other areas like pediatrics or internal medicine, surgeons, who specialize their care, we've become much more specialized. And so we have physicians in toxicology and pediatrics and emergency medical services. And now areas like ultrasound, which have taken our whole clinical, I mean, it's another great example of how emergency medicine has evolved, to take this technology that obviously you are a leader in terms of developing and writing and educating about, to provide care that can only be considered at the forefront of what we possibly can do for patients with acute conditions. So the technology is evolving, the use. It's one of, I think, the biggest accomplishments that I see with the clinical practice of emergency medicine in terms of changing our ability to provide service to patients. And so as we, as that has been organized effort to create an academic entity and great recognition for people who train, again, it's another evolution in terms of education, research, and patient care that is being led by emergency physicians nationally. Tremendously, again, satisfying to see all of those efforts undertaken by just great people in the field.

Ma: John, thank you very much for your time. This interview has been both very educational, and a lot of fun.

Moorhead: It's been great. Thank you.