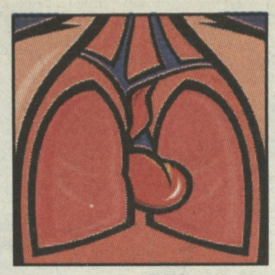
Recent M2FO grants focus on education

— Page 6



New lung cancer treatment available

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The Portland Physician SCRIBE

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Physicians asked to report possible driver impairment

By Cliff Collins

Oregon launches a new at-risk driver law this month that requires physicians to tell the state when patients are too impaired to drive, but relieves doctors of any reporting liability.

Physicians won't be held liable for civil or criminal penalties if they report a patient – or if they do not report a patient – to the state Driver & Motor Vehicle Services, confirmed Kelly Taylor, legislative liaison for the Oregon Department of Transportation. Taylor said doctors previously were not held liable for reporting, but language added this year states that they also will not be held liable if they fail to report a patient.

Moreover, cognitive or functional impairments, not diagnosis or age, are the governing criteria for determining whether drivers should give up the keys. The at-risk driver law previously on the books was brief, narrow and applied only to "lost consciousness or control," said David House, DMV spokesman.

The change comes as a result of growing concerns nationally about the impact of an aging population and the potential risks of age- and health-related impairments to drivers, their passengers, other drivers and pedestrians.

The new system meets several needs, according to Lorna Youngs, DMV deputy director: It addresses concerns among family members and friends of drivers who may need to stop driving; keeps medical testing in physicians' hands, separate from DMV knowledge and driving tests; and provides a mechanism in which a physician may inform DMV immediately of a sudden, severe impairment.

"The system also preserves the privacy of the doctor-patient relationship," Young said, adding that "it is designed to be fair, so that driving privileges can be restored when a physician cures or controls an impairment."

The new rules will begin to take effect in southwestern Oregon this month and will be phased in to the rest of the state over the course of about a year.

The new requirements allow doctors to retain clinical judgment and do not impose liability for reporting or not reporting, a factor doctors pushed for in House Bill 2986, said Colin R. Cave, MD, OMA president. Cave said if the liability portion had not been included, it would have opened up a potentially new tort area for physicians. Otherwise, the OMA has been supportive, he said. "We want the road to be safe, too."

According to DMV, the Oregon program will be a first in the nation because it is based on impairments, not age, unlike other states that restrict drivers based on age alone. Oregon's law started out to be an age bill, too, but many knowledgeable people pointed out that impairments can happen at any age, Taylor noted, and decided the law must not be based solely on diagnosis of a medical condition,but must be based on the actual effect of a cognitive or functional impairment on the person's ability to safely operate a motor vehicle.

House said the 1999 Legislature directed DMV to put together a panel to study the impact of an aging population on traffic safety. That Legislature appointed an Older Driver Advisory Committee, which recommended that impairments, not age, should be the focus of any new laws or rules. The members of the committee concluded that chronological age alone does not represent a valid or reliable criterion for assessing risk of being involved in a motor vehicle crash. Similarly, the presence of various medical conditions does not support the conclusion that a driver lacks the ability to drive.

As a result, the 2001 Legislature directed DMV to assemble a group of medical experts to determine what impairments can affect driving safety. The Legislature also enacted the committee's recommendation to replace the existing medical reporting requirements, concluding that the law was inadequate. It required only that doctors report to DMV loss of consciousness and control. However, lawmakers and physicians advised that many other physical and mental impairments could render a driver unsafe.

"A diagnosis alone does not lead to a loss of driving privileges," said Youngs. "A disease or condition does not necessarily have the same types or severity of symptoms in every person. It's the symptom or impairment that is the key, not a diagnosis, and some impairments can be controlled through medical treatment."

The Senate added an emergency clause to the bill, stating that its liability aspects will go into effect immediately after the governor signs the bill, said Taylor. In all other respects, the previous law stays in effect until the new statute takes effect in the Portland metropolitan area, which will be the last area phased in to the new requirements, effective approximately a year from now.

The OMA and DMV worked together to change the wording of the bill, said Andrea Easton, OMA associate director of policy development. Taylor said organized medicine wanted reporting to be voluntary, but

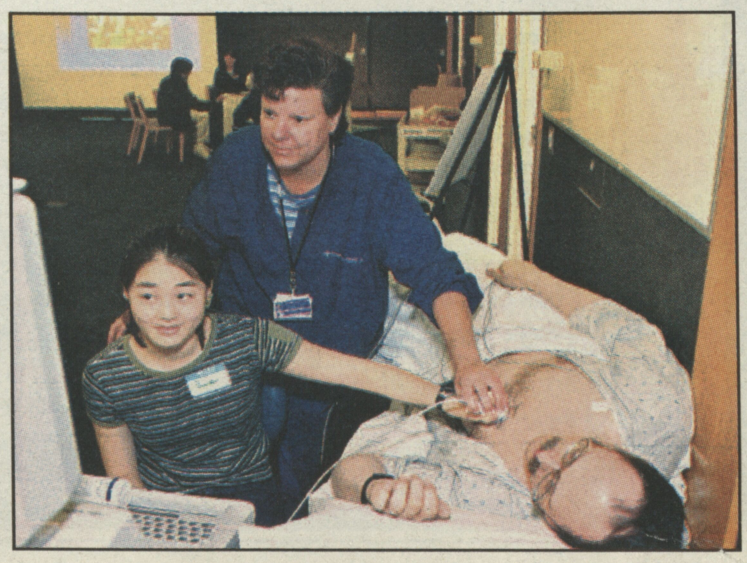
Please see DRIVERS, page 4

Students sample health careers

Students from Washington, Multnomah, Yamhill, Columbia and Clackamas Counties were recently invited to participate in a health care career fair at Providence St. Vincent Medical Center. Students had the opportunity to learn from health care professionals including nurses, pharmacists and radiology technicians.

The students participated in several activities such as to learn from staff with the intensive care unit how to resuscitate an overdose patient using a mannequin; tour an American Medical Response ambulance and perform cardiac monitoring and spinal immobilization; tour a Life Flight helicopter and use a cardiac monitor; inflate an angioplasty balloon; perform an echocardiogram and take images of a live volunteer's heart; and perform an ultrasound on a turkey to find a hidden "mass" (an olive).

Photo at right: Arlene McNett, (center), cardiovascular technologist at Providence St. Vincent Medical Center assists Jennifer Ju, (left), of Southwest Christian School, perform an echocardiogram on hospital volunteer, Mike Sheer.



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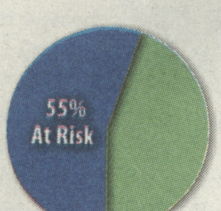
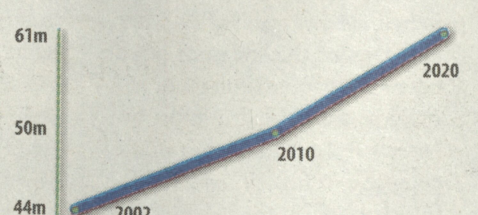
ON THE LEADING EDGE:

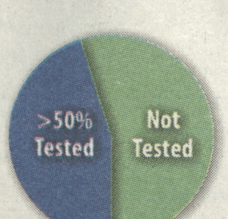
FOCUS ON: BONE HEALTH



Age 50+ at Risk



Prevalence Rate



Testing Prevalence

LOW BONE MASS EXPECTED TO AFFLICT 52 MILLION AMERICANS BY 2010

If current trends continue, the National Osteoporosis Foundation warns that osteoporosis and low bone mass will rise at alarming rates as the population ages. The condition is already considered to be a major public health threat for 55% of the population aged 50 and older. In a report published by NOF, the estimated prevalence rate of osteoporosis and low bone mass is currently 30 million for women and 14 million for men. The report goes on to project a 52 million prevalence rate in 2010 and 61 million by 2020.

The cost of this disease hovers around $17 billion annually and could climb as high as $140 billion by 2040. Given this level of economic impact and the devastating effect on quality of life caused by the disease, a major focus for the medical community must be on education, diagnosis and treatment.

It is currently estimated that less than 50% of those at risk for osteoporosis receive the simple, inexpensive test that could prevent so much pain. Bone mineral density (BMD) testing is our best method for measuring bone loss and predicting future fractures. The preferred technique for measuring BMD is dual energy x-ray absorptometry or DEXA.

DEXA scans are available at both EPIC Imaging locations. They require precise measurement and expert positioning for optimal results. Our staff has received advanced training in these techniques and places a particular emphasis on creating a comfortable experience for the geriatric patient. Until a national effort is launched to promote prevention and overall bone health, screening is our best defense for this devastating disease.

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AMA launches grass-roots effort to avoid funding crisis

The American Medical Association is asking physicians across the country to mount a grass-roots campaign to avoid another crisis in Medicare funding.

Earlier this year, AMA and its members' collective efforts produced a major victory for physicians when President Bush signed into law legislation that replaced a 4.4% cut for 2003 with a modest increase of 1.6%. Congress stepped in and restored funding lost from the system because the 1998 and 1999 targets didn't adequately reflect GDP and beneficiary enrollment. The 2003 conversion factor is 6% greater than it would have been, and resulted in a $3,700 gain, on average, per physician for 2003 Medicare payments.

The Centers for Medicare & Medicaid Services (CMS) told Congress that the legislation enacted in February would produce positive updates for the next few years. But recently, CMS issued a letter stating, "While we had previously estimated positive updates for 2004 and later years, we now estimate updates will be negative for 2004-2007, with a 4.2% cut in 2004."

According to a memo from Michael D. Maves, MD, MBA, President of the AMA, this new projected cut is not the result of a deliberate decision by Congress. It is the unintended consequence of an unsound and unworkable Sustainable Growth Rate (SGR) formula. The SGR cuts payments if growth in Medicare patients' use of services exceeds GDP growth.

At the same time, however, the government induces greater use of physician services through new coverage decisions, quality improvement initiatives and a host of other quasi-regulatory decisions that are good for patients but not reflected in the SGR. The Medicare Payment Advisory Committee (MedPAC) established by Congress recommends replacing the SGR with an update process similar to the approach used for Medicare hospital updates. For 2004, MedPAC has recommended an update of +2.5% instead of the projected -4.2% cut.

The House Ways and Means, House Energy and Commerce and the Senate Finance Committees are developing Medicare reform legislation that will include prescription drug coverage, other reforms and provider payment provisions. The House and Senate are operating under a budget resolution that allocates $400 billion for new Medicare spending.

The AMA predicts that it will be difficult for Congress to fund a new prescription drug benefit and other initiatives within the $400 billion spending cap. Replacing the SGR with the MedPAC recommendation will cost tens of billions of dollars (actual cost varies subject to a host of factors). The AMA also believes that many members of Congress will initially be reluctant to allocate funds this year to another physician payment fix because the Congressional Budget Office scored the 2003 correction as costing $54 billion over ten years. A number of pundits said physicians would not get the 2003 fix but we succeeded by mounting an aggressive lobbying, grassroots and media campaign.

"It's time to kick the 2004 campaign into high gear," said Maves in a memo to the nation's state medical associations and medical societies."The House leadership intends to bring Medicare legislation to the floor by Memorial Day with Senate floor action possible before the Fourth of July recess."

"Every physician in the country should immediately urge Congress to replace the SGR with the MedPAC recommendation and to adopt the MedPAC-recommended 2.5% update for 2004. We need to generate a high volume of contacts for every Representative and Senator. Members of Congress serving on the House Ways and Means, House Energy and Commerce and Senate Finance Committees are the top priority," said Maves.

The AMA provided the following "talking points" to assist physicians in making their case to their elected officials:

- Medicare reduces payments to physicians and other practitioners whenever program expenditures for their services exceeds a set target or Sustainable Growth Rate (SGR). This formula is unfair and unworkable and must be replaced with one where payment updates keep pace with practice cost increases.
- Because of the formula, Medicare cut payments to physicians and other practitioners by 5.4% in 2002. Another 4.4% cut for 2003 was replaced with a modest 1.6% increase only after Congress stepped in and restored funding lost from the system because 1998 and 1999 targets didn't adequately reflect GDP and enrollment.
- At the time, Congress thought it had averted multi-year payment cuts. A few weeks later, however, the Centers for Medicare and Medicaid Services (CMS) issued a letter stating, "While we had previously estimated positive updates for 2004 and later years, we now estimate updates will be negative for 2004-2007" with a 4.2% cut in 2004.
- The SGR is a flawed public policy that defies economic theory, imposes automatic, arbitrary pay cuts never intended by Congress, and threatens patient access to medical care. MedPAC, the Congressionally-created Medicare Payment Advisory Committee, recommends replacing the SGR.
- The SGR cuts payments if growth in Medicare patients' use of services exceeds GDP growth. This position is simply untenable. Physicians have ethical obligations to individual patients whose medical needs do not shrink whenever the economy slows.
- The SGR formula requires Medicare actuaries to predict the unpredictable, leads to constantly changing government cost estimates and creates volatile and unexpected payment swings that undermine medical practices' ability to make rational business decisions and remain financially viable.
- Targets tied to GDP implicitly assume that physicians will restrict care to Medicare beneficiaries in times of significant technological advances and/or economic slowdown. At the same time, however, the government induces greater use of physician services through new coverage decisions, quality improvement initiatives and a host of other quasi-regulatory decisions that are good for patients but aren't recognized in the SGR.
- No other Medicare provider group is subject to the SGR; yet CMS data indicates that 2002 increases in Medicare spending for durable medical equipment, hospitals, home health, skilled nursing facilities and hospices all exceeded the increase in physician spending.
- From 1991-2003, payment rates for physicians and health professionals fell 14% behind practice cost inflation as measured by Medicare's own conservative estimates. Even the 1.6% increase for 2003 was only about half the 3% rise in practice cost inflation estimated by CMS.

Multiple studies have shown that physician acceptance of new Medicare patients is declining and that this trend will accelerate if payments are again cut. The time has come to adopt MedPAC's recommendation to replace the SGR with an annual update system like those of other provider groups so that payment rates will better reflect actual increases in practice costs, starting with a 2.5% increase in 2004.

ASSESSING OLDER DRIVERS

(Continued from page 1)

agreed to make it mandatory as long as doctors were not on the hook for liability related to reporting or not reporting. The amended bill "reduces their exposure to tort if they don't report," said Easton. "The amendment was, if the provider does not make a report, they are immune from liability."

According to Taylor, the two big questions to be decided were: Who is required to report, and what is required to be reported. DMV says about the first part:

• Primary care providers. A physician or health care provider acting in the capacity of a person's primary care provider.

• A physician or health care provider providing specialized or emergency health care services to a person who does not have a primary care provider.

• An ophthalmologist or optometrist providing health care services to a person who does not meet DMV vision standards.

What must be reported: cognitive and functional impairments that are defined as severe or uncontrollable to a degree that precludes, or may preclude, the safe operation of a motor vehicle; and the impairment is not able to be corrected by medication, therapy or surgery, or by a driving device or technique.

Functional impairments, including sensory impairments, affecting the following areas: vision, peripheral sensation of the extremities, strength, flexibility, motor planning and coordination.

For example, a strength impairment may affect a driver's ability to maintain a firm grip on the steering wheel, which could compromise ability to maintain lane position or execute turns. Or, in the case of sensory impairment, "If you can't feel your foot, that can be extremely dangerous" for driving, Taylor pointed out.

Cognitive impairments affecting the following areas: attention, judgment and problem solving, reaction time, planning and sequencing, impulsivity, visio-spatial, memory, lapses of consciousness or control.

DMV said older drivers still will comprise the bulk of this at-risk group. The agency said research confirms that as people age, their ability to drive a car may be compromised by changes in vision, attention, perception, decision-making, reaction time and aspects of physical fitness and performance. The process starts at about age 55 in most people. Increasing age, coupled with declining functional capability, chronic illness or effects of medication can significantly increase a driver's risk of a crash.

According to DMV, a random survey conducted among Oregon adults last year found that 77 percent believed doctors and medical professionals should be required to report medically impaired drivers to DMV. The federal Administration on Aging reports that growth in the overall population of people age 65 to 74 years of age is expected to remain relatively constant until 2010.

But the National Highway Traffic Safety Administration estimates that elderly traffic fatalities will increase to more than 23,000 annually, or 63 deaths per day, by 2030. Oregon projections are similar. In 2001 there were 97 Oregon traffic fatalities involving drivers age 65 and older. By 2015 this number is estimated to increase to 132 fatalities per year, and could jump to 188 fatalities per year by 2025.

The American Medical Association is now accepting applications for its Training of Trainers program, which is part of the Older Drivers Safety initiative. The AMA, with support from the National Highway Traffic Safety Administration, is currently developing the program, which is based on the AMA's Physician's Guide to Assessing and Counseling Older Drivers.

The program is designed to educate physicians and other health care professionals on the issue, in addition to helping them assess and counsel patients for their medical fitness to drive. The AMA is inviting geographical and medical specialty societies to organize multidisciplinary teams and attend the workshop to receive the training and materials necessary for hosting local training sessions. The AMA provides additional information at its Web site: www.ama-assn.org/go/olderdrivers.

BME seeks acupuncture committee member

The Board of Medical Examiners is seeking to fill a physician position on the Acupuncture Advisory Committee that expires June 30, 2003. The Committee is composed of two physicians, three acupuncturists, and one member of the Board who may be a physician (MD/DO) or a public member. The term of office is for four years and members be reappointed to serve not more than two terms. The Committee meets twice a year, in March and September.

The Acupuncture Advisory Committee reviews all applicants for licensure and limited licenses; recommends to the Board: standards of professional responsibility and practice for licensed acupuncturists; standards of didactic and clinical education and training for acupuncture licensing; standards for clinical supervisors and trainees; and licensing examinations. The Board prefers that the physician members practice acupuncture or have an interest in acupuncture.

If you are interested or would like more information, please contact Diana Dolstra, Licensing Administrator at 503 229-5873 x223 or Diana.dolstra@state.or.us before July 14, 2003

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Metropolitan Medical Foundation celebrates 11 years

This year marks the 11th anniversary of the Metropolitan Medical Foundation of Oregon. It was started in 1992 by a group of interested physicians and others.

The original group consisted of Cathy Krieger (current President), Jim Fenimore and John Kendall, MD, a past President of the Medical Society of Metropolitan Portland.The late Jim Fenimore was founder and former president of Fenimore Associates, Inc, a local independent insurance company. He provided the "seed money" to get the foundation started.

Contributions from Medical Society members have enabled the foundation to fund multiple "mini grants" and requests that are reviewed by the Foundation Board. Fenimore's daughter, Jill, has served as president for most of the years of the foundation's existence and has only recently stepped down.

The current board consists of Cathy Krieger, John Kendall, MD, Jim Prihoda, MD, Nancy Graham (a past president of the Auxiliary), Keith Marton, MD (President-elect of the Medical Society), Rob Delf, Executive Director of MSMP, and George Caspar, MD.

The foundation board meets every other month to review requests from various local groups and organizations that are engaged in activities that improve health education or the delivery of health care.

Over the past year the foundation, fondly refered to as M2FO, awarded more than 15 "mini grants" ranging from $100 to $500 per request. The last five awards were:

- $500 to the Multnomah Education Service District to fund a six-week stress management program for students at Centennial High School
- $500 to fund an obesity intervention and nutrition pilot program at Portland Public Schools
- $500 each for three education programs sponsored by the Medical Society and designed for physicians, residents, medical students anf family members, on medical marriages, stress and burnout, and rediscovering the soul of medicine.

"I urge all of you to make a contribution, large or small, if you have not done so already," said Caspar. For more information about the foundation, call Rob Delf at 503-222-3164..

Providence Child Center gets new name

For 57 years, the Children's Nursing Center at Providence Child Center has been the only facility in the Northwest caring for children with profound disabilities and complex medical needs on a long-term and short stay basis. In recognition of the significant changes in medical technology and care provided to these special children, the Nursing Center is being renamed the Center for Medically Fragile Children at Providence Child Center.

"The children who reside here have severe developmental and physical impairments due to metabolic disorders, birth defects, tragic accidents and other circumstances," said Sharon Salmonson Brown, RD, NHA, center director. "The name 'Center for Medically Fragile Children' conveys a more thorough and accurate description of the children who we care for. This new name will enable health care providers, social service professionals and families who are in need of our services to find us."

The Center has 58 beds dedicated to children from birth to 21 years of age in need of long-term chronic care, short-stay respite, post-surgical care and end-of-life services.

Group to set standard for Continuity of Care Record

The ASTM International, Healthcare Information and Management Systems Society (HIMSS), and Massachusetts Medical Society have joined forces to begin work on a standard for the Continuity of Care Record (CCR), which will enable healthcare providers to base future care on relevant and timely patient information.

"We want to end the situation where doctors must either start from scratch or act blindly because they don't have the patient's relevant past history, allergies, or the details of medications" said Thomas Sullivan, MD, president of the Massachusetts Medical Society, the organization initiating the development of the CCR standards.

The working group contends that as an ongoing record of care, the CCR should be created or updated at the end of every healthcare encounter and available for review by the next provider, no matter what and where the healthcare setting might be. As a result, that provider would use the CCR to guide the care process for the patient. The patient also could request a CCR printout to provide valid and current information for another healthcare provider.

"This initiative with ASTM and the Massachusetts Medical Society is just one of the Society's strategies in place to achieve interoperability," said Pat Wise, HIMSS director of EHR Initiatives. "The Society is involved in this and other collaborative efforts within the industry to bring stakeholders together to realize the universal health record.

The new standard is being developed by the standards development organization ASTM Committee on Health Informatics, which is chaired by Peter Waegemann, CEO of Medical Records Institute. He noted, "The goal of electronic health records can be achieved with the vision of a continuous care record that will reduce medical errors and costs and increase the quality of care."

Demographic information, allergies, a medication list, and summary of care provided, plus a short care plan with recommendations for the next step in patient care, are included in the CCR. "The CCR contains most of the relevant information that is necessary when a patient is seen by a healthcare provider," said Claudia Tessier, a consultant in healthcare documentation and co-chair of the CCR workgroup with Sullivan.She said the final standard should be confirmed before the end of 2003.

Founded in 1898, ASTM International is a not-for-profit organization that provides a global forum for the development and publication of voluntary consensus standards for materials, products, systems, and services. Over 30,000 individuals from 100 nations are the members of ASTM International. Formerly known as the American Society for Testing and Materials, ASTM International provides standards that are accepted and used in research and development, product testing, quality systems, and commercial transactions around the globe.

The Healthcare Information and Management Systems Society is the healthcare industry's only membership organization exclusively focused on providing leadership for the optimal use of healthcare information technology and management systems for the betterment of human health. Founded in 1961 with offices in Chicago, Washington D.C., and other locations across the country, HIMSS represents more than 13,000 individual members and some 150 member corporations that employ more than 1 million people. HIMSS shapes and directs healthcare public policy and industry practices through its advocacy, educational and professional development initiatives designed to promote information and management systems' contributions to quality patient care.

The Massachusetts Medical Society, with more than 18,000 physicians and student members, owns and publishes The New England Journal of Medicine, the Journal Watch family of professional newsletters, and AIDS Clinical Care, and produces HealthNews.

New lung cancer therapy available

On May 6, 2003 the FDA approved the first in a new class of anti-cancer therapies. Iressa was approved for the treatment of non-small cell lung cancer that has progressed despite treatment with standard chemotherapy drugs. Last year, it was reported in two separate clinical trials that the quality of life substantially improved in more than one third of lung cancer patients after they began taking Iressa, a pill that is administered once a day.

Iressa is one of a growing number of "targeted" agents that have been developed to battle cancer. These drugs take advantage of characteristics acquired by cancer cells that normal cells in the body do not have. This helps direct the drugs to the cancer cells and avoid many of the side effects of less specific chemotherapy drugs.

Iressa blocks a receptor on cancer cells, the epidermal growth factor receptor (EGFR). EGFR is involved in a series of events that allow cancer cells to multiply. It is thought that blocking EGFR interrupts a process that is necessary for cancer growth. Other proteins in the cell interact with EGFR and these have also been "targeted" by other new drugs that are currently in development.

Although clinical trials using Iressa with standard chemotherapy in the initial treatment of lung cancer failed to show an improved outcome, the FDA approved the drug based on the quality of life studies in patients with no other treatment options available.

Northwest Cancer Specialists has made the drug available to over 80 individuals with non-small cell lung cancer in the Portland/Vancouver area during the last three years. Appropriate patients have participated in the initial randomized trials as well as an Expanded Access program sponsored by Astra-Zeneca.

"Although this is far from the 'magic bullet,' it is yet another important step forward in cancer treatment," said David A. Smith, MD, Medical Director for Research at Northwest Cancer Specialists. He added that many of the clinic's physicians have significant experience with this new drug and are available to answer questions.They can be reached at 503-803-4993.

Collins Medical Trust invests in local projects, research

The Collins Medical Trust has announced the appointment of Elizabeth Eckstrom, MD, MPH, as Trustee. Eckstrom is Associate Program Director for Internal Medicine at Legacy Health System and an Assistant Professor of Medicine at Oregon Health & Science University. She received her MD at the University of Wisconsin-Madison and holds a Masters in Public Health from the University of Washington-Seattle.

Eckman joins the trust's other trustees, Truman W. Collins, Jr., and James R. Patterson, MD, who is also a member of the Medical Society of Metropolitan Portland.

"We are a very small trust with total annual giving in the $300,000 range so we maintain a somewhat discrete profile," said Nancy L. Helseth, Administrator of the Collins Medical Trust. "However, we are always looking for good medical research and medical education projects in the State of Oregon."

The Collins Medical Trust was established in 1956 by Truman W. Collins as a tax-exempt charitable trust under the laws of the State of Oregon. The Trust's purpose is to aid, further, promote, develop, encourage and sponsor research, experiment and work in the cause, cure and treatment of human disease or in any field of medical research, and to aid, further and promote medical education.

With that purpose as a guide, and having knowledge of the desires and concerns of the Collins, the Trustees over the ensuing years have established the general guidelines under which grant requests are considered.

For additional information and applications for grants, contact Helseth at 503-227-1219 or nhelseth@collinsco.com.

Workshop on communication styles, finances

The Portland Medical Community Managers will host an all-day workshop on June 11 at the Oregon Medical Association. "Communications Styles and Financial Issues" will run from 9 a.m. to 4 p.m.

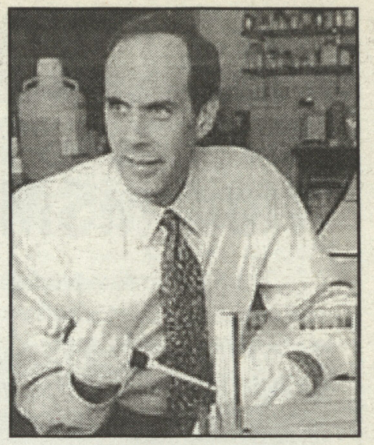
The morning presentation is titled "Workplace Communication Styles," an interactive session to discover your preferred communication style at work, strengths and weaknesses of your style, and how it interacts with others. You will be shown strengths and weaknesses of styles, feedback from the other styles' views and what you can do to stretch your style for a more compatible workplace team. The presenter wil be Marti Ayers, MS, PhD, a consultant specializing in workplace communications with emphasis in working with health care professionals.

In the afternoon, "Cash Management: What's in it for Me" will be presented by Anne Marie Flora, Vice President of Pacific Northwest Bank. "Merchant Card Banking Services: Understanding the Details" will be presented by Tony Yazzolino, also a Vice President at Pacific Northwest Bank.

The final session will be "Identity Theft: The Problem and How to Protect Yourself" presented by Detective George Burke from the Portland Police Bureau Detective Division.

Registration is $90 for the full day and $50 for half. Checks may be sent to Karen Stone, 11211 SE Sunnyside Rd., Clackamas, OR 97015 by Wednesday, June 4, 2003, or call Stone at 504-698-7777.

Druker receives ASCO's highest honor



Brian Druker, MD

Brian Druker, MD, JELDWEN Chair of Leukemia Research at the Oregon Health & Science University Cancer Institute and an investigator of the Howard Hughes Medical Institute, was given the American Society of Clinical Oncology's (ASCO) 2003 David A. Karnofsky Memorial Award at its annual meeting on May 31.

ASCO is the world's leading professional organization representing physicians who treat people with cancer, with membership numbering nearly 20,000 professionals from 100 countries. The Karnofsky award is ASCO's highest honor, given for innovative research and developments that have changed the way oncologists think about the practice of oncology.

"ASCO sets the standards for cancer care worldwide and leads the fight for more effective cancer treatments," said Druker, who presented the Karnofsky Memorial Lecture on "Imatinib as a Paradigm of Targeted Therapies" at the opening ceremony. "I am truly honored to receive this award."

Druker's research focuses on chronic myelogenous leukemia (CML) and tyrosine kinase inhibitors. He approaches CML from the inside out, studying the molecular origin of the disease as a means of developing the most effective treatments. His work, which has validated this paradigm, has changed the face of cancer therapies, leading to an effective and nontoxic treatment that targets cancer cells while leaving normal cells unharmed.

In collaboration with scientists at Novartis, Druker developed imatinib mesylate, commonly known as Gleevec. In 2001, the FDA broke a record for cancer therapy approval by fast-tracking Gleevec, approving it in less than three months for patients who failed interferon treatment.

The FDA approved Gleevec in 2002 as an effective treatment for gastrointestinal stromal tumors (GIST), a deadly form of intestinal cancer that, until then, had been difficult to treat. Earlier this year an editorial published in the New England Journal of Medicine dubbed Gleevec the "gold standard" treatment for CML. Recent studies also have found Gleevec to be effective in treating hypereosinophilic syndrome, a rare and often fatal blood disorder. This year Gleevec became the frontline therapy for the treatment of CML and earned the FDA's approval for use in children, the first approval of a new pediatric cancer drug treatment in more than a decade.

Druker's current research focuses on understanding and predicting how individual CML patients respond to Gleevec and determining mechanisms of resistance if it occurs. He is also applying the Gleevec paradigm to another type of leukemia, acute myeloid leukemia.

The SCRIBE

welcomes letters to the editor and opinion pieces to be considered for the First Friday Forum

For more information contact Liz Clark at 503-546-9884

New MSMP members

The Medical Society of Metropolitan Portland recently welcomed three new members:

Herbert J. Tirjer, DO
Clackamas Urology Clinic
8800 SE Sunnyside Rd., Ste. 115
Clackamas, OR 97015
Graduated: Chicago College of Osteopathic Medicine 1980

Kristen Flemmer, MD
364 SE 8th Ave., Ste. 300
Hillsboro, OR 97123
Specialty: Family Practice/Obstetrics

Efraim Vela, MD
10330 SE 32nd Ave., Ste. 226
Milwaukie, OR 97222
Specialty: Obstetrics/Gynecology

Legacy has new doctor, new building on way

Michele Metrick, MD, recently joined the staff at Legacy Emanuel Children's Hospital. Metrick is board certified in pediatrics and neurology - special competency in pediatric neurology - and is a fellow with both the American Academy of Pediatrics and the Academy of Neurology.

Metrick received her doctorate from the Chicago Medical School and completed her pediatric neurology residency at the Medical College of Wisconsin. In addition, she completed an epilepsy fellowship with the Minnesota Comprehensive Epilepsy Program. Before joining the staff at Emanuel Children's Hospital, Dr. Metrick worked at Northwest Kaiser Permanente as a staff physician in neurology and at OHSU as a clinical assistant professor of neurology. She also has served as director of pediatric neurology at Lutheran General Children's Hospital in Park Ridge, Ill.

Metrick is interested in the treatment of epilepsy and other neurological ailments in children. She has published several manuscripts and given numerous lectures in these areas and is committed to providing high-quality service to children with neurological disorders, their parents and primary physicians.

Legacy Health System has begun construction on the first new hospital in the state of Washington since 1979. The site for Legacy Salmon Creek Hospital is located near the southeast corner of 20th Ave. and NE 139th Street in Vancouver.

The project is expected to cost $220 million. The medical office complex will be completed in winter 2004 and the hospital will be completed in summer 2005. The facility will provide family wage jobs for about 900 employees.

Clark County is the fifth-largest county in the state, yet it has the lowest ratio of beds of any of the top five counties. Until now, Clark County residents have been served only by Southwest Washington Medical Center, which is undergoing an expansion to increase its capacity to serve residents.

Real Estate *Showcase*

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CLASSIFIEDS

PRACTICE OPPORTUNITIES

THE PORTLAND CLINIC
is an independent full-service medical clinic with private physicians representing multiple specialities. We are seeking BC, BE physicians to join our well established practice in the following specialties:

Dermatology
Family Practice
Gastroenterology
Internal Medicine
Orthopedics
Radiology
Convenient Care

Send CV to: Colleen Ritt, Physician Recruitment
The Portland Clinic, LLP
800 SW 13th Ave.
Portland, Oregon 97205
Fax: 503-274-1697
Phone: 503-221-0161, ext. 2139
E-Mail:CRitt@TPCLLP.com
Visit our web site:
theportlandclinic.com

PRIMARY CARE
Providence Health System is seeking BE/BC Primary Care physicians to join employed or private practice groups in various areas of Oregon.
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Interested candidates please send CV to MaryBeth Cruz, Director of Physician Recruitment, Providence Health System, 1235 NE 47th Ave., Suite 288, Portland, OR 97213.
Tel: (503) 215-6389
Fax: (503) 215-6561
mcruz@providence.org
Equal Opportunity Employee

PRACTICE OPPORTUNITIES

INTERNIST WANTED
Growing 13 internist primary care group seeks full or part-time internists. Respond to Gregg Coodley, MD, Fanno Creek Clinic, 2400 SW Vermont, Portland, OR 97219 (fax 503-768-9232)

INTERNAL MEDICINE PRACTICE FOR SALE
Stable, well-established patient population and established staff. Location–Forest Grove, OR. Hospital–Tuality Community. Excellent mutual physician coverage, nights and weekends. Will provide every assurance to patients to insure successful transition. Terms negotiable.
503-357-7135

PRACTICE OPPORTUNITIES

DERMATOLOGIST WANTED
Primary Care group seeks part or full time Dermatologist–existing dermatological practive. Please respond to Larry Reed, 2400 SW Vermont, Portland, OR 97219 (fax 503-768-9232)

FOR SALE

View property. Sylvan exit. 1234 SW 57th. .84 acre. Dividable. Home with 3384 sq. ft. includes 6 Bdrm, 4 Ba, office, bonus room with outside entry. Fast access to OHSU and Providence St. Vincent's Hospitals. $569,000. Flexible terms. 503-223-5464.

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Nurse Practitioner with established practice in adult medicine to share space with a solo practice (Allergy, Asthma, Immunology). Excellent referral base. Bright and light office space in the Gresham area. Contact Amy at 503-666-5025.

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