CELEBRATING 25 YEARS AS OREGON'S LEADING NEWS SOURCE FOR THE MEDICAL COMMUNITY

U.S. Health and Human Services Secretary honors Oregon effort - Page 4

State legislator gives students a chance to reform health care - Page 14

25th Anniversary

The Portland Physician SCRIBE

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Preparedness test asks: Are you ready?

By Cliff Collins

Suppose a new type of influenza hit this area. Overnight, your patient load doubles, while at the same time you have a staff shortage caused by the epidemic.

What would you do? Is your office prepared?

That is what the NW Oregon Health Preparedness Organization and the Medical Society of Metropolitan Portland are asking physicians right now.

Over the past few weeks, the MSMP has distributed hundreds of Emergency Medical Surge Exercise materials to medical office managers in the six Northwest

Rob Delf

Oregon counties. The Medical Society is a member of the Region 1 NW Oregon Health Preparedness Organization, and serves on its steering committee.

Funding for the materials originates at the federal level, and was a response to 9/11, and the need for the medical care system to be better prepared to respond to any event that might severely strain the system's resources and capacity.

Medical office surge is defined as any event — natural or manmade — in which the ability to evaluate care for a markedly increased volume of patients challenges or exceeds normal operating capacity.

The Medical Society's role in the exercise is to help prepare physicians and medical offices for emergencies that would create great disruption in their ability to care for patients.

"Our goal is to assist every medical office to be better prepared for a medical surge event," said Rob Delf, MSMP executive director.

The MSMP, which is providing the Emergency Medical Surge Exercise materials to physicians' offices, is emphasizing that the "tabletop exercise" involves minimal time, and can be conducted in a series of short staff meetings from five to 15 minutes.

A CD-ROM version, including a PowerPoint presentation, is included so that a medical office team can collectively test its ability to respond in the event of a surge event, and modify operational protocols and policies as necessary.

The intent of the exercise is to evaluate the feasibility of physicians' offices medical surge plans, and to help medical offices develop a plan if they haven't already.

Materials are designed for administrative staff to respond. By completing the exercise, medical offices will be able to create surge plans specific to their own office and environment.

Questions help offices establish who would be in charge in an emergency, how triage would be handled, and how patients and staff could be protected from infection. They also help define contingency plans for available staff if a physician's office has to be closed.

The MSMP met with both phy-

Please see SURGE, page 3

Liability coverage costs drop for 2008

By Cliff Collins

Oregon physicians received good news with the announcements that for the third year running, doctors will see lower premium rates for liability insurance.

After six years of dramatic rises in cost -- from 1999 through 2005 -- insurance rates have stabilized, both nationally and in Oregon, with most doctors receiving lower rates for the past three years.

"The reasons are the general decline in the number of claims filed," said Mark Chambers, vice president of marketing for Northwest Physicians Insurance Co. "What we don't know is how come.

"We'd like to think this is because of patient safety efforts and doctor communication. But nobody knows exactly the reason why."

The lower rates are "a reflection of not seeing the frequency and severity of claims we saw starting in 1999 through 2005," said Paul R. Frisch, director of medical legal affairs for the Oregon Medical Association, which endorses CNA HealthPro.

Both carriers -- which combined provide coverage for the majority of Oregon doctors -- lowered premiums across the board for 2008.

Northwest Physicians Insurance saw an 8.9 percent aggregate rate decrease, effective Jan. 1. Most specialists received a 5 percent decrease in cost, but some drops were stark: Family practitioners who deliver babies saw a 20 percent reduction, and general obstetrics experienced a 15 percent reduction.

Likewise, orthopedists who perform spine surgery received a 15 percent lower premium, while orthopedists who do not do spine surgeries paid 7.5 percent less.

OMA members insured through CNA can expect an across-the-board decrease of 7.6 percent in premiums, effective May 1.

"This is another in a series of years in which the data was favorable enough that we could negotiate a rate decrease," Frisch said. "I'm (feeling) pretty positive at the moment."

He added that if the trend continues, some specialties may gain further rate reductions, and insured members can expect to receive another return of premium to doctors, which amounted to over $342,000 for 2007.

Still, "Severity continues to be a problem," Chambers pointed out, with juries remaining capable of paying out high awards. CNA also was reminded that "juries can return unexpectedly higher awards," with a large verdict last year of a failure to diagnose breast cancer, said Frisch.

However, cases such as $8.5 million and $2.5 million awards in Southern Oregon in past years are not occurring now, which suggests to Frisch that OMA-backed Measure 35 in 2004, although falling just short of passage, helped educate the public and juries that outsized jury awards adversely affect the cost of, and access to, health care.

For example, there have been reductions in the number of cases filed claiming neurologically impaired infants, or birth injuries. Also, cases of failure to diagnose cancer have fallen.

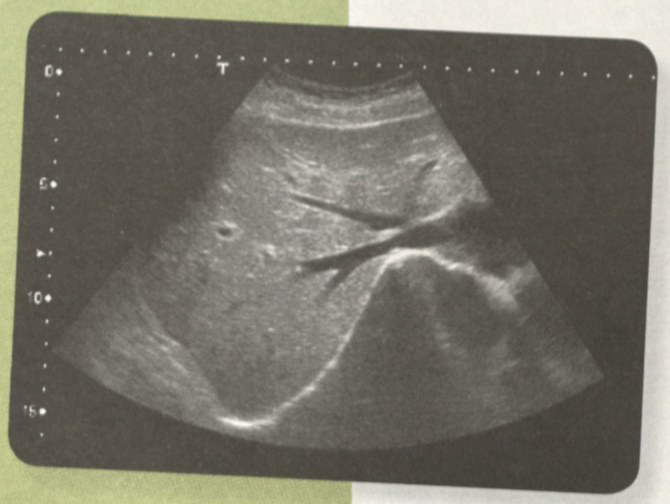
The number of claims filed, in general, has decreased across the country, not just for certain insurers, Chambers emphasized. But physicians in states that do not have liability caps -- such as Oregon, where caps were overthrown by the courts in 1999 -- generally pay more for liability coverage, he maintained.

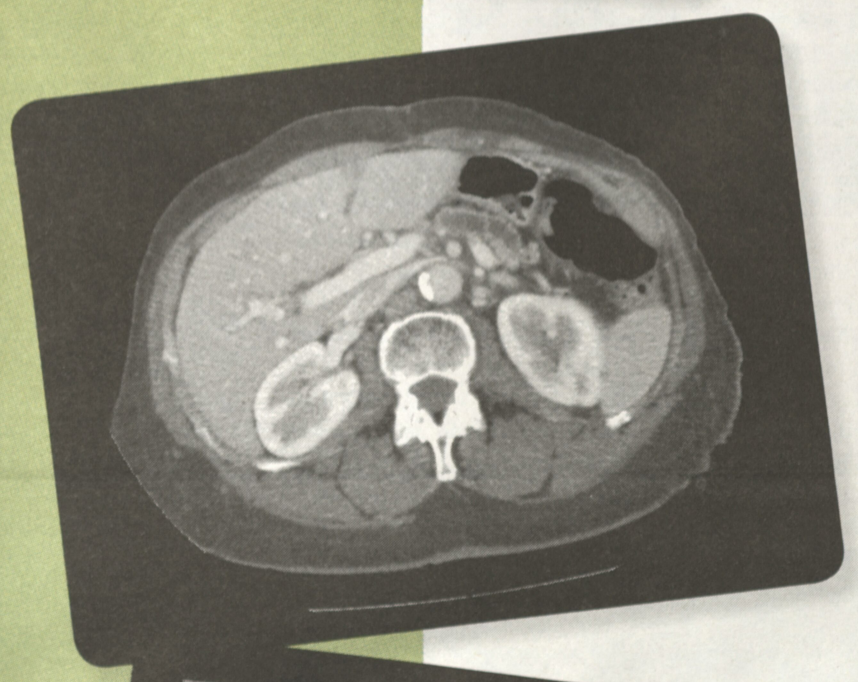
More suits including radiologists

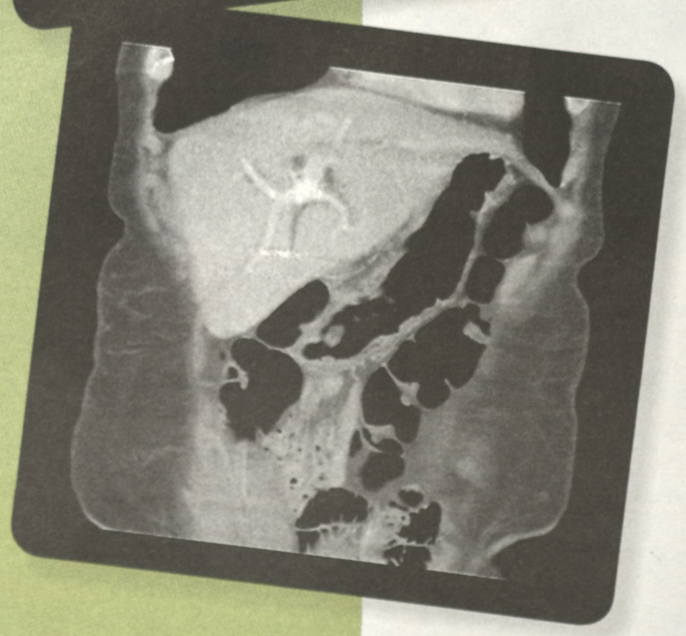
One change from past legal practices that CNA has observed: Radiologists are being named more frequently in lawsuits. This is especially true in cases of failure to diagnose breast cancer, which have seen higher numbers of radiologists named in suits in the past four to five years compared with the previous four to five years, according to Frisch.

He noted, though, a pronounced difference between interventional radiologists and diagnostic radiologists: The latter are being sued in higher numbers, whereas interventional radiologists are not. Explanations for the rise vary, but sometimes these cases happen when a referring doctor asks the radiologist to check for a problem, but "something else shows up" that the radiologist misses spotting, Frisch said.

Please see LIABILITY, page 3







From the routine to the most challenging

our multi-modality service provides the answers

History

66 year old female with fever and upper abdominal pain. Past medical history includes hepatitis C and diabetes. Labs indicate elevated LFTS.

Diagnostic Modalities

After consultation with the referring physician, an abdominal ultrasound was performed to identify potential multi-organ pathology. A renal cyst was noted on the left kidney with a thin but irregular wall. The pancreas appeared irregular and the pancreatic duct is diffusely dilated. Pancreatic atrophy was suggested. Due to the patient's body habitus, however, our radiologist concluded that intraductal pancreatic mass might be obscured on ultrasound and recommended CT follow-up.

Abdominal CT without and with enhancement identified a 6mm dilated pancreatic duct with diffuse cystic change. Two prominent calcifications were identified in the distal duct indicating obstruction.

The left kidney cyst identified on US was confirmed by CT as a complex 3.0cm cyst requiring urologic intervention.

Pathology

Pancreatic duct obstruction due to two large distal calculi stones with diffuse gland atrophy. Complex renal cyst.

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SURGE

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icians and medical office managers to gain insight into the design of the surge materials. The exercise was constructed to test the ability of an office to respond to an emergency using pre-determined strategies.

The strategies the MSMP posed questions about are based on those suggested in the literature, and are also the product of multiple meetings with physicians and clinic managers.

Last year, the Medical Society sent every office a health preparedness package, which included general background materials, a planning template, supplemental resource materials and a poster with emergency contact information. A subsequent assessment was conducted to determine what preparation activities have taken place or, in the alternative, if the office is a participant in a larger response strategy set up by various health systems in the area.

Some physicians who practice in solo or small offices may think that a medical surge would not affect them. "But a widespread emergency or epidemic would impact everyone, and every aspect of the economy and community," said Laurie Garza, a project coordinator with MSMP.

"It is critical that medical offices consider what they would do if their patient load markedly increased, coupled with staff shortages," said Delf. MSMP, as part of its professional mission, is working to create strategies and tools that are useful, easy and timely, he said.

Individual offices' responses will be kept confidential, and the MSMP will compile and analyze aggregate results and present it to the NW Health Preparedness Organization, which is hosted by the Multnomah County Health Department.

The Medical Society is asking doctors' offices to complete a one-page response form by May 31, and return it to the MSMP in a postage-paid envelope.

Sponsors hope the surge exercise will encourage offices to incorporate emergency planning into the office's culture, and to make planning a continuous effort, said Delf.

"The MSMP's objective is to assist the community's physicians in being prepared to make their offices a part of the solution if disaster strikes."

LIABILITY

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Other instances can occur when radiologists step into different areas or settings, such as when on call or when filling in for others. "Communication of urgency" sometimes accounts for problems, too, such as, "I sent it as 'urgent,' but it wasn't seen that way," Frisch added.

Chambers pointed out that because of the greater risk of spine surgery, orthopedists who do spine work already were paying more than their orthopedic colleagues who did not do spine surgery.

"In real dollar terms their savings is greater, but (their premiums) are still significantly higher than orthopedics without spine. Orthopedic experience improved through the past couple of years; spine-related improved more substantially than traditional orthopods'."

As a result of these differences, Northwest Physicians Insurance now breaks down subspecialties into more specific categories. For example, he said, there also are two types of neurosurgeons: those who do "below the neck," and those who do the entire cervical and head track.

"As subspecialties continue to evolve, our categories for rate classifications continue to expand," he said. Interventional radiologists are assessed differently than traditional radiologists. "More change is on the horizon," Chambers predicted.

In addition, Frisch warned that exposure for physician assistants, nurse practitioners and nurse midwives is on the increase. "Juries don't seem to be giving them the same benefit of the doubt" as they generally do for physicians, Frisch noted. Even in the same case, juries may not hold a doctor responsible for an error, but will blame the PA.

The message for medical groups, he said, is that the public needs to be educated that, in order "to deliver care, you have to use people who aren't all physicians," and that the public needs to understand that "these folks are properly trained" for the levels of care they provide.

Feds give Oregon Health Care Quality Corp. high marks

Health and Human Services Secretary Mike Leavitt appeared in Portland March 20 to recognize Oregon Health Care Quality Corp. with a special distinction.

Leavitt designated Quality Corp. one of 14 community-based organizations around the country as "chartered value exchanges."

Leavitt said Quality Corp. has taken clear actions to organize community purchasers, health plans, providers and consumers to improve the quality of health care and address rising costs.

As a chartered value exchange, Quality Corp., along with the other groups receiving the designation, will be given access to Medicare provider performance information for their communities. These data can be combined with similarly calculated private-sector results to produce and publish payer performance results.

Previously, Medicare was not willing to release this data, and still doesn't except to the 14 groups, according to Nancy Clarke, executive director of Quality Corp. Clarke's group has had access to commercial and Medicaid data, but not Medicare, even though Medicare patients receive a large portion of health care delivered. Having this "fills a lot of holes," she said.

The value exchanges also will become part of a nationwide "learning network" through which they can share experiences and best practices, and identify areas where innovation is needed.

Leavitt, who worked the room and spent time conversing with many of the 30 people in attendance, said Quality Corp.'s designation will allow it to continue efforts to advance the four cornerstones of value-driven health care:

– Adopt "interoperable" health information technology

– Measure and publish quality information so that consumers can make better-informed decisions about their health care providers and treatment options

– Measure and publish price information about health care procedures

– Promote quality and efficiency of care by rewarding those who provide, pay for and consume high-quality, competitively priced health care.

In an opinion piece published last November in the San Jose Mercury News, Leavitt said the lack of physicians who have adopted electronic records is "not just inefficient or inconvenient; it's also dangerous."

Leavitt touted a recently announced Medicare pilot program "to encourage 1,200 small to mid-size physician practices to implement new technology to better serve their estimated 3.6 million patients."

"Right away these doctors will start to see larger Medicare payments for the services they provide, and incentives are built in to reward the most aggressive adopters of technology to improve the care they deliver," he wrote. "When the federal government puts its money where its priorities are, history shows that the private sector often follows suit."

Adoption of electronic medical records will make the health system more efficient, and "allow us to get better at paying doctors based on how well they treat their patients, not just on how many patients they treat," Leavitt wrote.

"Currently, we don't have a sense of how we are doing in terms of delivering high value health care in Oregon," explained Ralph Prows, MD, vice president and chief medical officer of Regence BlueCross BlueShield of Oregon and chairman of Quality Corp.

"A cooperative approach to measuring care value, one that focuses on improvement, is the only way this will work. All of us – doctors, hospitals, health plans, purchasers, patients, government – can and will do better with good information," he said.

Information about cost and quality, provided in the right way, can encourage a much stronger partnership between patients and their provider teams, leading to better health, added Clarke.

Specifically, Quality Corp. is focused on the following efforts, she said:

– Giving people information that helps them be better partners with their doctors in managing their own health

– Learning how doctors and hospitals can make improvements in caring for patients

– Helping purchasers get the information they need in order to buy high-value health care

– Encouraging systems to get patients' information to where it is needed for good care.

Researchers: brief smoking break intervention is not enough to quit

OHSU Smoking Cessation Center researchers are able to outline key steps for developing and implementing clinic-based systems to provide smoking cessation treatment tailored to smokers with respiratory disorders.

Smokers with lung disease require more than brief smoking cessation interventions to successfully quit, according to researchers in the Oregon Health & Science University Smoking Cessation Center report.

Their recommendations were published April 1 in the online edition of Pulmonary and Critical Care Update, a publication of the American College of Physicians (www.chestnet.org/education/online/pccu).

Although effective treatments for smoking cessation exist, and research has shown that patients who receive smoking cessation treatment are twice as likely to quit limited insurance coverage, poor adherence to practice guidelines, lack of clinician training in smoking cessation, time constraints and inadequate clinic systems to easily identify and treat smokers have limited the availability and quality of smoking cessation treatment.

"Most clinicians who treat their patients for smoking cessation provide only brief interventions, often just three short steps: asking about tobacco at every visit, advising all smokers to quit and referring them to other resources, such as quit lines for assistance and follow-up," said David Gonzales, Ph.D., lead author and co-director of the OHSU Smoking Cessation Center in the OHSU School of Medicine. "When we reviewed the data, we found that brief intervention is often insufficient for the more dependent, high-risk patients with pulmonary disease."

Patients with respiratory disease have more difficulty quitting, are more nicotine-dependent and need more intensive treatment, Gonzales and colleagues explained. They may require higher doses of medications, longer periods of treatment and more frequent follow-up than smokers in general.

And, although most try to quit on their own without assistance from their health care provider, 95 percent fail, and patients with respiratory disease have even poorer success.

To help clinicians improve tobacco cessation treatment for these patients, the OHSU research team reviewed current evidence-based treatment guidelines for smoking cessation medication and behavioral support and OHSU's own programs for treating patients in the hospitals and clinics.

They advise that when consistent, evidence-based smoking cessation treatment is tailored to the needs of patients and integrated into ongoing respiratory care, smokers can significantly improve their odds of quitting. And the key to accomplishing this, they advise, is to distribute the responsibility for enhanced treatment among several clinic staff members.

Beginning with new patient intake and continuing with review of vital signs, review of systems, treatment planning and check-out, the researchers recommend nurses, medical assistants, clinicians and clinic support staff all have roles in helping the patient stop smoking.

Including tobacco cessation treatment in each part of the clinic visit reduces demands on any one member of the clinic staff, they explained.

This approach makes it easier for busy clinics to provide effective treatment.

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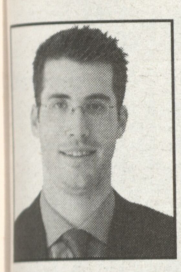
New treatments attack cancerous liver tumors

Using TheraSpheres Allows more precise Localized treatment



Jason Bauer, MD

By **Cliff Collins**

Liver cancer often is diagnosed at an advanced stage, making surgical removal of tumors impossible, but in the past few years, a new therapeutic option has emerged.

The option is SIR-Spheres (Selective Internal Radiation Therapy – also known as SIRT) and TheraSpheres each involve injecting microscopic beads containing radioactive elements.

TheraSpheres is being employed for primary liver cancer, and SIRT for metastatic liver cancer, said Jason R. Bauer, MD, an interventional radiologist at Legacy Good Samaritan Hospital & Medical Center and clinic director for ICON Interventional Consultants.

The sand like substances are administered in the same fashion, the difference being how the doctor works up the patient, including documentation.

The spheres contain a radioactive element, yttrium-90. After lodging in the tumors, they continuously deliver radiation for approximately 14 days. The spheres remain in the liver without posing any danger to the patient. The beads cannot travel from the tumor into other parts of the body, because they are too big to fit through the liver's capillary system.

The ability to localize the treatment contributes to usually minimal side effects. The procedure, with the patient under conscious sedation, lasts about an hour. The patient goes home within 24 hours.

According to Bauer, both products are covered therapies under Medicare, but SIRT is Food and Drug Administration-approved and is not under a research protocol. TheraSpheres is categorized under a humanitarian device exemption, meaning it has to be done under protocol at an approved institution, he said.

"This procedure allows a more exact delivery of radiation to liver tumors than other radiotherapy techniques, making it more effective in killing the cancer," said Bauer. "Our ultimate goal is to control our patients' liver disease. This is not a cure, but for a number of patients, life expectancy has increased and quality of life improved."

SIRT and TheraSpheres can shrink tumors more than chemotherapy alone without significant harm to normal tissue, and no effective chemotherapy is available for primary liver cancer, he explained.

The procedure employs microscopic beads containing radioactive elements. Under X-ray guidance, the radiologist threads a flexible catheter through a small incision in the groin. From there, the catheter travels to the blood vessels, allowing for targeted infusion of the beads to the malignant tumors.

The logistics surrounding the procedure are complex. Both products are made outside the United States and must be flown in: SIRT from Australia, and TheraSpheres from Ottawa, Canada.

Patients must be screened to determine eligibility, including with angiography. The products then are made at nuclear facilities, and each dose is manufactured specifically for an individual patient, so administration from start to finish must be "tightly run," Bauer said.

"The outcomes are such that it's significantly prolonging survival," although doctors can't give an individual patient an accurate prediction of how effective the therapies will be, he said. Both are in Phase III trials to determine efficacy, he said.

TheraSpheres are being used at Oregon Health & Science University. The other closest centers are in Seattle and Spokane, according to Bauer. The procedures must be administered by an interventional radiologist specially trained, and who also must perform three observed cases by representatives of the manufacturers, he said.

The bead therapies have become routinely offered in the past two to three years in most large metropolitan areas, he said, whereas three years ago, only about five centers in the nation offered them.

The procedures are contraindicated for certain patients and conditions.

According to Legacy, last year, there were more than 19,000 new cases of liver cancer in the U.S., including hepatocellular carcinoma, the most prevalent form of primary liver cancer. Average life expectancy for someone with hepatocellular carcinoma ranges from four to 18 months.

DaVinci robot makes surgery much more precise

By Cliff Collins

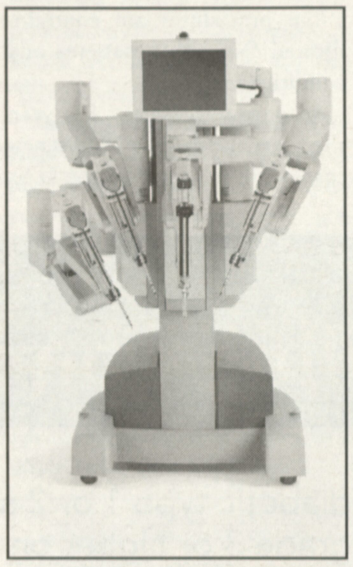
Portland physicians are using robotic assistance to gain unprecedented perception and precision in complicated surgeries.

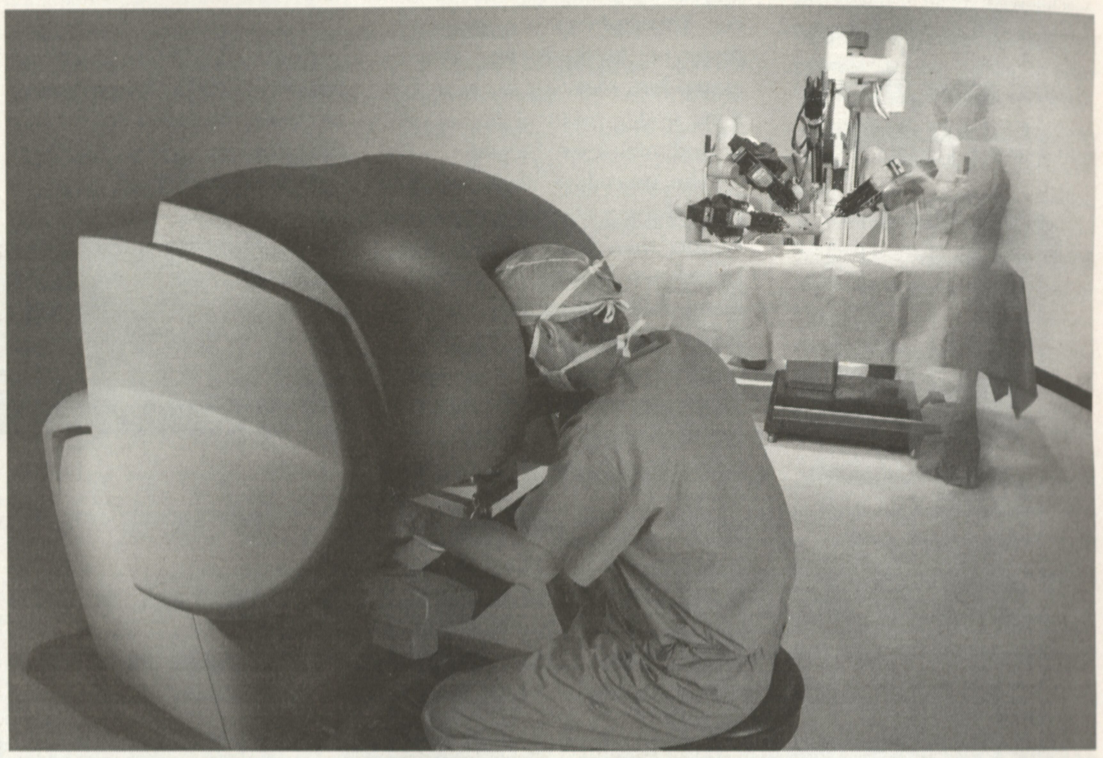
The da Vinci Surgical System has been in use nationally for nearly a decade, but did not come into mainstream use until 2001 for the function it now is most commonly used for: urological surgery for removal of cancerous prostates, said Gilbert P. Klemann, MD, a urologist with The Oregon Clinic.

"Multiple clinical studies have shown that the da Vinci ... offers patients shorter hospital stays, less pain, scarring, risk of infection, blood loss, transfusions and faster recovery," said Lance T. Marr, MD, also a urologist with The Oregon Clinic.

"Time will show if it has better (long-term) outcomes, but it makes a lot of things easier," said Klemann. The early data show earlier return of urinary continence and potency, he added, both crucial elements of prostatectomies. The risk of incontinence and impotency are "the most devastating" potential side effects of prostate removal, and occurrence can vary between 5 percent and 20 percent, Klemann said.

Both doctors perform the da Vinci surgeries at Legacy Good Samaritan Hospital & Medical Center, as does urologist Bruce A. Lowe, MD, who has performed many of the procedures and is sold on their effectiveness.





"With the da Vinci robot, patients undergoing surgical management of prostate cancer can expect excellent continence rates, 98 percent being continent with a faster return of urinary control than seen with open procedures and improved recovery of sexual function," said Lowe. "Many of my patients have been back on the golf course, fishing or hiking 10 days after their operation as opposed to four weeks with an open procedure."

The surgery is performed through five small, pen-sized holes in the abdomen. The surgeon sits at a console in the operating room and guides the da Vinci robot. A surgical assistant provides retraction and exposure, and passes instruments. A slender camera inserted into the patient's body through a surgical port transmits a high-definition, panoramic view to a monitor for the surgeon to see.

Because of the advanced technology developed for the robot, which mimics the actions of the human wrist, it is able to work in very narrow areas. In addition, the system allows the surgeon's hand movements to be scaled down, filtered and translated into precise movements.

Because the technology permits such precision, it is being adopted for other uses, including for bladder and kidney tumors. Over the past two years, gynecologists have been using it for advanced gynecologic oncology and pelvic reconstructive surgery, said R. Scott Rushing, MD, a gynecologic oncologist with Northwest Cancer Specialists.

"The HD vision gives you such incredible views," he said. "It's wonderful for endometrial and cervical cancer."

Many of the patients are going home the next day instead of the traditional three to five days in the hospital, according to Rushing. In addition, recovery time has shortened to approximately two weeks, as opposed to the standard four to six weeks for women who have open surgeries, he said.

Doctors say that, like anything new, it takes some time to learn and to gain proficiency. "The main drawback is, you lack tactile feedback," Rushing noted. But using it is easier than laparoscopic surgeries' stiff, rigid instruments, which he compares to "chopsticks in 2D."

But it cannot be used for some cases, such as advanced ovarian cancer that would require "debulking," Rushing said. Likewise, added Klemann, certain patients are not well-suited for prostatectomies via the da Vinci, such as morbidly obese individuals or those who have undergone previous abdominal surgeries.

Also, "patient preference definitely goes a lot into decision-making" about which options – surgical and nonsurgical – are selected for prostate cancer treatment, he said.

With the latest-generation da Vinci devices, such as Good Samaritan recently added, which is more compact and has smaller arms than an earlier version, cardiothoracic surgeons are starting to regain interest in using the technology, Klemann noted. The device originally was intended for open-heart surgery, partly because using the da Vinci negates having to cut into the ribs, he explained.

Rushing now is using the da Vinci for 90 percent of the hysterectomies he performs on patients who have endometrial cancer. "I am seeing an increase in the number of lymph nodes I can remove versus a typical open or laparoscopic surgery. This means a more thorough cancer staging procedure for my patients."

Gynecologists have only a couple of years of data so far on outcomes, so they do not know yet what the long-term results will look like, Rushing said. But so far, surgeons are seeing less morbidity using the device, he said.

Hospitals both large and small are adding them to their therapeutic arsenal, but the da Vinci is an expensive technology, and "not a guaranteed moneymaker," Klemann emphasized.

The device and setup costs total about $1.6 million, and instruments must be replaced after being used in only nine procedures, he said. Also, support personnel must be trained specifically for surgeries that employ the robot, he said.

LifeFlight expands reach further south, into Gorge

Life Flight is expanding its 30-year presence in the Portland-Vancouver metropolitan area to the Southern Willamette Valley and Columbia River Gorge to bring life-saving medical helicopter service to all communities within range of its new bases of operation.

Life Flight's new bases at the Eugene Airport and The Dalles Airport will increase the availability of emergency medical helicopters and fixed-wing aircraft in those regions - reducing the transport time of critically ill and injured patients to area hospitals.

"This is great news for the growing communities in those areas," said Michael Griffiths, Life Flight Network Executive Director. "Additional Life Flight bases at the Eugene Airport and The Dalles Airport will not only greatly enhance access to air ambulance service for the communities surrounding those airports, it will have the added benefit of increasing access to Life Flight helicopters in the Portland-Vancouver metropolitan area. Positioning helicopters in the Gorge and Southern Willamette Valley will increase the availability of Life Flight helicopters currently located in Hillsboro and Aurora. With increasing traffic congestion on our freeways, it is getting even more challenging to get patients where they need to go in the shortest amount of time possible."

Life Flight plans on beginning service at both of their new bases by mid June.

Life Flight headquartered in Aurora and was the first hospital-based air ambulance on the West Coast and only the fourth such service in the nation. Celebrating 30-years of continuous service, Life Flight has safely transported over 31,000 patients.

Life Flight Critical Care Nurses and Paramedics are trained in the emergency transport of high-risk obstetrical patients as well as critically ill and injured pediatric and adult patients.

Life Flight Network is owned and operated by the consortium of Legacy Emanuel Hospital & Health Center, Oregon Health & Sciences University and Providence Health System.

Medical Teams, firms aid Liberian children

In a country where a mild cold, a painful ear infection or the onset of pneumonia carries a potential death sentence, this partnership is bringing critically needed medicines to families that have little hope.

In recent weeks, Medical Teams International has shipped more than $5.5 million in donated medical supplies from Abbott Labs and Henry Schein, including basic but lifesaving antibiotics, syringes and sterilizing equipment. Henry Schein's $550,000 in donated medical supplies will help children in Liberia and Gaza. Abbott Lab's $5 million contribution of medicines is being used to help people in Lebanon, Jordan and Mexico.

"These medical donations are the difference between life and death for so many children in impoverished countries," says David Beltz, director of commodity support at Medical Teams International. "It's heart breaking for our staff and volunteers to know that children suffer needlessly or die because they don't have a $10 treatment course of antibiotics. With partners like Abbott Labs and Henry Schein, we can use these medicines to bring healing and hope to future generations."

Last year, Medical Teams International surpassed $1 billion in humanitarian aid shipped around the world.

"Diarrhea is one of the top killers of children under the age of five," explains Beltz. "Without essential medicines, we are helpless against this disease. We're grateful to our corporate donors for helping us make a difference for so many children around the world."

'Society lady' Mae Whitney Cardwell broke barriers for female physicians in early era Portland

'HISTORY OF MEDICINE IN OREGON'

By Sara Piasecki
For The Scribe

When the Portland City Medical Society first convened in 1884, the group brought itself to order and quickly passed its By-Laws, including one notable clause: to ban women, in perpetuity.

Eternity has, perhaps, never seemed so short: in 1892, Dr. Mae Harrington Whitney was elected as the society's first female member, throwing open the doors to generations of women physicians. In the July 1905 issue of the Medical Sentinel, the editors were moved to comment that "at the time of the organization [of the Society] women were not admitted as members. Today women are among its most honored guests. Truly, 'the world do move.'"

As a member of the Oregon State Medical Society since 1885, Whitney was an active member of the medical community in Portland. From 1893-1903, she served as treasurer of the OSMS and was vice president of its House of Delegates in 1904; in 1894, she was the Oregon delegate to the American Medical Association convention in San Francisco. As contributing editor of the Medical Sentinel, Whitney regularly highlighted information from OSMS meetings, including addresses and scientific papers, and reported on the activities of medical groups outside of the state. She routinely presented papers at meetings of the OSMS, such as "Technology of Antiseptic Surgery," and she had articles and papers published in state and national journals, including the provocatively titled "Women as risks," published in the Medical Examiner and Practitioner (1905: xv, 534-537).

Born in Pennsylvania in 1853, Whitney came to the West Coast in 1887, and graduated from Cooper Medical College five years later. She took a second M.D. from the Willamette University Medical Department in 1885, and received additional training in New York from 1888-1889. Returning to Portland in 1889, she joined the medical staff of the Portland Hospital in Sunnyside and, with Dr. Reese Holmes, began a training school for nurses there. In April of 1895, Whitney married Dr. J.R. Cardwell, Portland's first resident dentist and himself an active member of the city's dental community.

Her experience in the male-dominated medical societies of the city led Whitney Cardwell to become in 1990 a founding member and first president of the Medical Club of Portland, a society created exclusively for women physicians. She held various positions within the club, and served as president a second time, in 1925.

In 1903, Mayor George Williams appointed Whitney Cardwell to the city's Board of Health, making her the first woman to hold such a position. She served until 1905, when Mayor Harry Lane appointed a new board, including another prominent woman physician, Dr. Esther Pohl Lovejoy.

A constant advocate for women's rights, Whitney Cardwell was also a charter member of the Portland Women's Club, hygiene liaison to the Oregon Congress of Mothers, staff member of the Florence Crittenton Home and the Boys' and Girls' Aid Society, and one of the first members of the Oregon Child Welfare Commission. In addition, she was active in the suffrage movement in the state, and served as one of five vice presidents of the College Equal Suffrage Association's Portland Chapter in the 1912 suffrage campaign.

During World War I, Whitney Cardwell and three colleagues –Drs. Katherine Manion, Mary MacLachan, and Emily Balcom—challenged the United States Army's denial of officer status for medical women. Presenting themselves for duty at the Vancouver Barracks, the women were ultimately denied officer status by the Surgeon General, but the action was a powerful test case and an important component in the broader movement for full participation of women physicians in the armed forces.

Whitney Cardwell retired from practice in 1926 and left Portland to return to her Eastern roots. When she died in 1929 in Pennsylvania, the Portland Oregonian hailed her as "an outstanding member of her profession and a pioneer in women's activities in the world of medicine." Her efforts to advance the status of women in both the medical profession and society at large left an indelible imprint on Portland society and secured her place among the most prominent figures in the city's medical history.

Sara Piasecki is the History of Medicine Librarian at OHSU Historical Collections & Archives, and can be reached at piasecki@ohsu.edu

Emanuel Children's Hospital wins $100,000 FEMA grant

Legacy Emanuel Children's Hospital is among six children's hospitals nationally to receive a $100,000 grant from the National Association of Children's Hospitals and Related Institutions.

Chosen from among 44 grant applicants, Legacy Emanuel is the only children's hospital in the Northwest to receive a grant made possible by the U.S. Department of Homeland Security under FEMA's Assistance to Firefighters grant program. Other recipients are: Children's Hospital of Michigan, Detroit; University of Iowa Children's Hospital, Iowa City; St. Louis Children's Hospital, St. Louis; Rainbow Babies and Children's Hospital, Cleveland; and Monroe Carell Jr. Children's Hospital at Vanderbilt University, Nashville.

Recipients will use grant proceeds to establish a safe escape program for families of children with disabilities and special health care needs. Hospitals will integrate Safe Escape into newly established or expanded hospital-based safety stores where families can access safety equipment and injury prevention education, so that they can prepare for safe escape during emergencies. Emanuel Children's Hospital administrators intend to consolidate all safety programs for children under the Safe Escape Program.

"We are proud to be a recipient of a grant that offers families with children who have special health care needs or disabilities the ability to keep their kids safe in an emergency," said Carla Harris, Chief Administrative Officer for Legacy Emanuel Children's Hospital. "Parents we reach through the Safe Escape Program should feel a greater sense of security knowing that they can safely evacuate their children in an emergency."

Through the Safe Escape Program, families would have an opportunity to meet with a trained hospital staff member to assess their home life, emergency evacuation concerns and their children's health condition. A hospital staff member will also help families select needed products and will teach them how to use equipment effectively to maintain their family safety.

Trial puts treatment for obesity to the test

By Peter Korn

Pamplin Media Group

Sign-ups begin this week at Portland's Oregon Health & Science University for a clinical trial on a radical new treatment for obesity.

The new technology involves implanting in participants a flat, silver dollar-size device that will send signals to their brain reducing their appetites and increasing their sense of being full — no matter how much they've eaten.

The device uses technology called neuroblocking. Implanted beneath the skin next to the stomach, and powered by an external battery pack worn on a belt, it sends signals up the body's vagus nerve to the brain.

The vagus nerve provides communication between the brain and the digestive system.

According to Bruce Wolfe, the professor of surgery at OHSU's school of medicine who is conducting the trial locally, the foundation of the experimental therapy came decades ago, when physicians treating patients for ulcers observed that cutting the vagus nerve reduced patients' appetites.

Neuromodulation technology until now has been used to treat epilepsy, pain and depression, Wolfe said. But its use for appetite control is new.

So far, the technique has been tested in only a handful of patients, all outside the United States. OHSU is one of 13 sites across the country where clinical trials for what is called the Empower Study will be taking place.

Wolfe sees great potential for the new therapy, if it proves successful. "The market could be almost unlimited," he said.

Wolfe said people who enroll in the five-year OHSU trial, which is free of charge, might experience considerable weight loss if the technology's preliminary data proves accurate.

But there is a catch.

Because the trial will follow research protocols that call for a "control" group, in the first year, one out of three patients won't actually be getting the neuroblocking therapy.

The device will have been implanted, they will wear the special belts 15 hours a day, but they will be part of the placebo group against which the other participants' weight loss will be measured.

After the first year of the study, if data shows participants with operable devices are losing more weight, all participants will have their neuroblockers turned on, according to an EnteroMedics spokeswoman.

William Raum, an endocrinologist at the Obesity Institute at Portland's Legacy Good Samaritan Hospital & Medical Center, said he is on the verge of conducting a trial for a similar competing device. He says that history has taught physicians that medical interventions that help people lose weight don't necessarily help people keep it off.

Raum said that when lap band surgery — which places a band around the stomach to reduce its capacity — was introduced for weight loss, it was expected that surgeons would be able to remove the bands after six months or a year. But physicians discovered that patients quickly gained back the weight they had lost, Raum said.

Neuromodulation devices, Raum said, are being devised as lifelong treatments. Raum said the expectation is that they may not be as effective in terms of weight loss as current weight loss surgery — either lap band or gastric bypass surgery — but the surgery itself for implanting the devices is much less invasive.

According to Wolfe, that could make the potential market for neurotransmission treatment of obesity enormous. EnteroMedics estimates there are 13 million potential candidates for the device in the United States alone.

In Oregon, six of 10 adults are either obese or clinically overweight.

Even with those numbers, Wolfe said, the use of weight loss surgery is low.

With appetites neurologically suppressed and a constant feeling of being full, users of neuroblocking technology might be expected to face nutritional deficits.

But Wolfe said that previous technologies for obesity show that to be an unnecessary concern.

"People eat for reasons other than appetite," Wolfe said. "It's a very complicated human behavior."

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040408_Scr

State approves entry of new psychiatric hospital

By Cliff Collins

The state expended much of its 45-page order granting a certificate of need to Ascend Health Corp. by listing arguments why it should not be allowed to open a for-profit, free-standing psychiatric hospital.

Many of the reasons echoed those some large area hospitals had voiced, including that:

- Adding more psychiatric beds wouldn't necessarily translate into greater patient access.
- A for-profit facility with no emergency room and not qualified to receive Medicaid payment would cherry-pick insured patients at the expense of nonprofit hospitals.
- The proposed facility would not possess the capability to accept and treat patients who have concurrent medical needs.
- It would not have a physician on site 24 hours a day and would have no security staff.

Ultimately, though, the Department of Human Services granted a certificate of need on March 19 to Ascend, a Delaware-based company formed in 2004 by three venture capital funds. The facility, at the site of what was the Cedar Hills Hospital until that closed in 1993, can open as a private psychiatric hospital, but must meet several specific conditions, DHS said.

Perhaps most important to area hospitals are the provisions stating that Ascend must accept admissions and transfers without regard to patients' ability to pay; that Ascend participate fully in the area emergency management and pre-hospital system; and that it, according to language in DHS' order, "will provide care to the uninsured in the same proportion as the psychiatric units of community hospitals located in the service area."

"Legacy is pleased that the state of Oregon has recognized the clinical and financial burdens borne by community hospitals in providing inpatient psychiatric care to the uninsured," Legacy Health System stated in a prepared comment following DHS' announcement. Legacy, along with Providence and Adventist health systems and the state hospital association, had opposed a certificate of need approval.

"We wholeheartedly endorse the Public Health Division's imposition of conditions on the certificate of need that will require Ascend ... to participate fully in the emergency medical services system and to accept admissions of patients without limits or restrictions based upon the patient's ability to pay," Legacy said.

DHS also reduced the approved number of beds Ascend will be able to open to 36, down from the 77 the company originally had requested. The department concluded that only 36 new inpatient acute care beds would be needed by 2010.

Questions about new beds

In the past few years, emergency physicians and psychiatrists have lamented the loss of available psychiatric beds in the metropolitan area. Doctors say patients have had long waits in the ER, and often have to be sent long distances, even out of state, for inpatient care.

Even so, mental health advocacy groups and some hospitals had questioned whether the new facility would help or hinder access to services for mentally ill patients.

The DHS order noted: "While acknowledging a need for additional inpatient psychiatric capacity in the Portland area, three current providers of inpatient psychiatric care ... (Legacy, Providence and Adventist) also expressed concern that the Ascend proposal would not alleviate current problems with the provision of mental health services in Oregon, but would exacerbate them while also reducing the ability of existing community hospitals to care for this patient population."

Instead, what is needed, the hospitals contended, are more community-based resources for patients after discharge, and adequate reimbursement for unsponsored patients.

The Oregon Association of Hospitals and Health Systems stated in testimony prior to the certificate of need approval that all 17 Oregon hospitals with inpatient psychiatric units lose money on the beds. Hospitals said they feared that Ascend would draw insured patients who otherwise would be treated in existing hospitals' psychiatric units.

"The greatest need is access for uninsured mentally ill and a large group of non-dual eligible Medicaid patients and the proposed facility will not meet this need," they told DHS. Since a large number of mental health patients enter care through hospital emergency departments, Ascend's plans not to include an ER worried some hospitals.

The DHS order acknowledged that Ascend's "lack of an emergency room has the potential to leave the majority of uninsured or underinsured patients to be cared for by established general acute care hospitals."

Ascend projected that 60 percent of its patients would be insured, and 40 percent would have coverage under Medicare or Medicaid, with a small number of self-pay patients. The company predicted it would provide 3 percent charity care and 5.2 percent in bad debt.

Legacy had pointed out that a substantial percentage of mental health patients are covered under Medicaid, which pays hospitals even less than for general medical services. In 2007, Medicaid comprised 58 percent of psychiatric payment for Good Samaritan and Emanuel hospitals.

DHS stated that as a free-standing facility, Ascend would not be eligible for reimbursement for Medicaid patients: "Patients with co-occurring medical conditions would need to be sent" to Providence St. Vincent, which is less than one mile away.

Tuality supported approval

Tuality Healthcare testified in favor of the certificate of need approval. Last November, Tuality's Dick Stenson, president and chief executive, stated that Ascend approached Tuality and asked for an endorsement of the company's plans. Ascend also offered Stenson the assurance that it would take its fair share of Medicaid and indigent patients, including involuntary patients.

Tuality decided to back the proposal, "on the expectation that Ascend's presence would facilitate appropriate treatment of psychiatric patients who are backlogged in our emergency department," Stenson said.

In its application to the state, Ascend pledged to accept qualified patients without regard to their ability to pay, including patients brought in by police.

DHS stated in its approval order that Ascend additionally must become part of the EMS system, and accept admissions and transfers without restriction for ability to pay, adding that the facility must readmit patients who are court-committed after their hearings.

Ascend also is required to submit annual reports to the state's Certificate of Need Program detailing the amount of charity care the facility provided.

The company expects to hire up to 10 psychiatrists, and will employ primary care doctors during the day; but no physicians will be present during the night. In addition, Ascend will not be hiring security guards, a point the hospital association questioned prior to state's approval:

"OAHHS believes that not having on-site security endangers the well-being of clients, staff, law enforcement and the community."

In response to those concerns, DHS is asking Ascent to submit a safety plan to the Addictions and Mental Health Division before opening, and then annually to report safety documentation to the state.

Dermatologists honored by national group

By Cliff Collins

Two Portland physicians were among eight doctors named Feb. 5 as honorary members in the American Academy of Dermatology. Acknowledged at the academy's 66th meeting in San Antonio, the honorees received the award for their lifetime dedication and distinguished service to the academy and its mission.

Frances J. Storrs, MD, director of the contact and occupational skin disease clinic at Oregon Health & Science University, has served the academy as a member of the board of directors, member of the executive committee, president of the Sulzberger Institute for Dermatologic Education and chairwoman of the long-range planning committee.

She also is a past president of the Oregon Dermatology Society and served as a board member of the American Contact Dermatitis Society, and is a past member of the board of directors and historian of the Women's Dermatologic Society.

Storrs has received the Alexander Fisher Lectureship Award from the American Contact Dermatitis Society and the Rose Hirschler Award from the Women's Dermatologic Society.

Walter G. Larsen, MD, of Portland Dermatology Clinic, is a clinical professor of dermatology at OHSU and has served the academy as a member of the board of directors, and as secretary-treasurer and assistant secretary-treasurer. He was a member of the editorial board for the Journal of the American Academy of Dermatology and was editor-in-chief of the American Journal of Contact Dermatitis. He also is a past president of the Pacific Northwest Dermatological Society and of the Oregon Dermatology Society.

Both Storrs and Larsen are members of the Medical Society of Metropolitan Portland.

Emergency doctor tabbed "hero" for professional contributions

Richard F. Edlich, MD, director of trauma prevention, education and research at Legacy Emanuel Hospital & Health Center, has been named a "Hero of Emergency Medicine" by the American College of Emergency Physicians. The campaign recognizes emergency doctors who have made significant contributions to emergency medicine, their communities and their patients.

Edlich was trained in plastic surgery at the University of Virginia, and then worked as acting director of the University of Virginia Health Science Center's emergency room. There, he and others coordinated development of an emergency medical system that has been replicated nationwide.

The system included state legislation for sexual assault victims, public access by 9-1-1, rescue-squad training, emergency radio communication systems, trauma centers, poison control centers, an emergency medical plan for the president of the United States, a national telecommunications system for the deaf, and Virginia's first air medical transportation system.

Homework could end up in the hopper

Mitch Greenlick will have PSU students draft health policy bill

By Peter Korn
Pamplin Media Group

Mitch Greenlick has heard more than a few people say, "There outta be a law." Or something along those lines.

Now state Rep. Greenlick, D-Northwest Portland, is going to give those people a chance to make their own law, providing it has something to do with health care.

A few months ago Greenlick was asked by Portland State University's Professional Development Center to teach a springtime continuing education course.

Greenlick was a hard sell at first, according to Lori Silverman, program manager for the center. Eventually Greenlick consented, with a novel idea for the course.

Greenlick, who directed a Kaiser Permanente health research center for more than 30 years and has taught at the Oregon Health & Science University medical school, proposed that his class would not simply rely on lecture and discussion.

Instead the class will, if all goes well, find a problem in health care that needs to be addressed by a law, and craft the legislation for Greenlick to introduce at the next legislative session. Greenlick just happens to be chairman of the Legislature's health care committee.

The class goal makes perfect sense to Greenlick.

"Usually when I teach a class I try to have a real-life example that's involved," he said. "So I thought, Maybe if they can get an idea, we can craft a bill and introduce it and see how it flies."

Silverman is delighted. "I guess you could say for the professional development center this will be a first, and pretty exciting," she said.

Greenlick's class will be the second in a health care leadership series offered by the PSU center. The four-hour classes will take place on four Friday afternoons beginning April 18.

Silverman said that the first session, which focused on health care management ethics, attracted 10 students, ranging from physicians and nonprofit advocates to executives for pharmaceutical companies. She expects a similar turnout this time, though anybody can sign up for Greenlick's course as long as they are willing to pay the $995 tuition.

Greenlick, who previously has taught in the PSU sociology department, said each of the four classes would involve a little lecture from him, a guest lecturer and a lot of discussion.

The guest lecturers should be able to provide advice. They will include Lorey Freeman, a health care specialist with the legislative counsel; Sandy Thiele-Cirka, a health care committee administrator; and Bruce Goldberg, director of the state Department of Human Services, which oversees public health.

But is four classes enough time to draft a bill?

"There will be homework," Greenlick said. He also said that he is not expecting the class to produce the final language of a proposed bill. That job would fall to legislative counsel if a worthy proposal comes out of the class.

Greenlick said he hopes, if the course is successful, that students don't think their work is complete when they hand the proposal over to legislative counsel.

There will be, after all, a lot of lobbying in Salem if the bill is to become law.

"I would hope they'll come down and help it get passed," Greenlick said.

PSU's Silverman said the class presents an opportunity for people who might be frustrated in dealing with the health care system.

"If I were sitting in a management role and I were frustrated by something, isn't this a great opportunity to act?" she said. "And maybe I can influence the class to pick my topic."

Greenlick said one of his goals is to show the students that government isn't all that hard to understand.

"What I'd really like to do is demystify the process of creating public health policy," Greenlick said. "People think it's this mystical thing. You don't always pass what you want to pass, but it's actually pretty straightforward."

Silverman said that she intends to limit the class to 15 students. Anyone interested can register online at www.pdc.pdx.edu/healthcare .

Peter Korn is a reporter for the Portland Tribune newspaper.

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