



Scribe

Focus on Technology

In this issue of the Scribe, we look at the first hospital in the Portland metro area to offer MRI scans for pacemaker patients; a new procedure at a local clinic to offer relief to patients suffering from GERD; and one organization's approach to streamlining claims.

—Starting on page 10

A publication of the Medical Society of Metropolitan Portland

www.msmp.org

MSMP embarks on a new era with new goals; The Portland Physician Scribe celebrates 30 years

By Cliff Collins
For The Scribe

When A.G. "Bud" Lindstrand took over last June as chief executive officer of the **Medical Society of Metropolitan Portland**, his primary goal was to bring additional value to MSMP memberships.

The three-pronged approach he sought was to offer physicians the following:

- More resources to help them in their professional and personal lives
- Financial and business advantages and discounts
- Events they can enjoy that can benefit themselves and the community

"Our intent is to make the Society an invaluable resource and social focal point for members," Lindstrand said.

Integral to his plans to boost member numbers as well as

value is a completely redesigned and enhanced website, www.msmp.org. The site will be updated daily with general and medical news and information and includes an interactive forum feature to allow doctors to communicate with one another.

The new website continues to offer information to the public—including referrals to member doctors—but it also now gives all physicians time-saving access to medical-journal articles and economic, political and health policy news.

It includes a members-only section as well.

That aspect of the site provides information specifically for members and their families, including:

- A forum to exchange personal communications
- Business-related benefits
- Important medical and social events
- Practice-management information
- Political and health policy education
- Volunteer opportunities, medically related and others
- Self-help tips
- Links to partner organizations, such as the **Oregon Medical Association**



"We want to provide a place for busy physicians in the Portland area to come together, both actually and virtually," he said.



BUD LINDSTRAND

An objective he has set is to attain the membership of 5,000 physicians in the metropolitan area five years from now.

Lindstrand also has arranged with various companies to bring new and exciting benefits to MSMP members.

"These are essential business-related products that will provide direct financial value, as well as service value, to both individual physicians and medical groups," he said. "Our benefits far exceed, in monetary value alone, the cost of membership dues." Among those are:

- Professional liability insurance: Through partnership with **The Doctors Company**, MSMP is able to offer malpractice premium discounts up to 12 percent. Also included are The Doctors Company's premium dividend program and its unique **Tribute Plan** of financial benefit to long-term clients.

See **MEMBER BENEFITS**, page 3

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INSIDE THIS ISSUE

From your resident member



In this new year, second-year resident Rachel Seltzer shares her thoughts on the profile of the residents of the twenty-first century and all they encounter as they prepare for a career in medicine. Some descriptions in her profile may sound familiar, and some may surprise seasoned physicians. Anyone practicing medicine can identify with her thoughts.

—Page 4

History of medicine



The Scribe's medicine historian shares the background of Dr. Jessie Laird Brodie, a woman pioneer in medicine who fought for reproductive health care. Despite family and social pressures not to practice, Dr. Brodie followed her determination to become a physician. Not only did she practice medicine, she also became a tour de force in making contraception available to women.

—Page 13

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Member Benefits: Far exceed the cost of membership dues

CONTINUED FROM page 1

- A private banking program: Through partnership with **OnPoint Credit Union**, MSMP offers special benefits, including discounts on closing costs for loans, reduced lending rates, a rate boost on CDs, and personal bankers.
- Long-term care insurance: MSMP offers a program with significant discounts to assure doctors of the best possible program to fit their unique needs.
- Information vehicles: These include **The Portland Physician Scribe**, a monthly publication with news and articles concerning medicine in the Portland area and the pocket-size **Doctors' Little Black Book**, for locating physicians and other medical providers.
- Salary surveys: **Medical Society Staffing** conducts annual employee salary survey information that is available to all members at no cost.

These are **essential business-related products** that will provide direct financial value, as well as service value, to both individual physicians and medical groups. **Our benefits far exceed**, in monetary value alone, **the cost of membership dues.**

—Bud Lindstrand

CEO, Medical Society of Metropolitan Portland

In addition, the following benefits are specifically designed for group practices (all physicians in a group must be members of MSMP):

- Medical staffing services: A 10 percent discount on MSMP's own medical staffing service, Medical Society Staffing, which has been in the employee-placement business for more than 50 years. It finds and supplies staff for all levels of office needs other than physician recruitment.
- Electronic banking: Through partnership with OnPoint Credit Union and **NXGEN**, MSMP provides a special banking system for physicians' offices. Two key features of this program involve website payments and reduced processing costs.
- Bill collections and pre-collections: Through partnership with **I.C. System**, MSMP offers a 15 percent discount for collections and a 10 percent discount for pre-collections.
- IT services: Through partnership with **Pavelcomm, Inc.**, member MSMP medical groups receive a 15 percent discount on data and communication technology services.

- Special rates for medical group managers for electronic payments and merchant services.
- 401K administration: Through partnership with **Pension Plan Specialists PC**, MSMP is able to offer a 10 percent discount (a minimum of \$200) on first-year plan administration as an exclusive to medical group managers.

For all members, the Medical Society also is planning:

- Seminars and webinars to aid and enhance the professional and personal lives of physicians and their families.
- Public events that benefit medical philanthropic causes as well as providing entertainment and social interaction among doctors. Lindstrand wants MSMP to host a major, annual event sponsored by MSMP and designed to promote health and wellness. The event

should receive a high level of publicity and be designed to promote the value of medicine and member physicians to the community, focusing "on physicians' humanitarian character," he said.

- Social events "to acknowledge that physicians are, first of all, people, having a variety of interests apart from medicine," Lindstrand said. "At the same time, such interests can often be best shared with other physicians and their families."

- A variety of smaller social events for various specialty or interest groups to bring together doctors with like interests. These could include family or sports events and activities focused on arts or hobbies.

Lindstrand noted that although the MSMP has a long, rich history—it is now in its 130th year as an organization—the Society also hopes, with these many new membership offerings, to be thought of as "the new kid on the block. We want to catch physicians' attention that we are making this organization useful to them. We want to entice them to look at us." •

The Scribe marks three decades

It's the big 30 for The Portland Physician Scribe.

Launched in January 1983 by what is now called the Medical Society of Metropolitan Portland, *The Scribe* remains the principal physicians' newspaper in the Portland area.



At the paper's birth, Medical Society executives generally modeled the paper after the **American Medical Association's American Medical News**, a tabloid-format periodical that concentrates on socioeconomic and political news for doctors.

Many *Scribe* editions also focus on specific topics such as physical therapy or the business of medicine that are useful to doctors' practices. In addition, *The Scribe* covers new developments in local research along with personal achievements by physicians and contributions they make to medicine and the community.

After *The Scribe's* inaugural year as a monthly, the publication converted to being produced twice a month. In July 2012, it returned to monthly release in order to increase its page count and advertising base in a challenging economic environment.

In recent years, each issue of *The Scribe* has been available both in print as well as online (at www.msmp.org), and the paper is mailed to every physician in the metropolitan area.

MSMP CEO Bud Lindstrand said the Medical Society will continue to publish the print version of the newspaper, because physicians, health care administrators and other members of the medical community read it and want it available in that convenient form.

"Everywhere I go, I get responses of how valuable *The Scribe* is to people," he said.

At the occasion of *The Scribe's* 25th anniversary five years ago, then-MSMP Executive Director Robert Delf explained that the paper was originally produced in-house using a "wet process," with every page manually typeset and pasted on large sheets of paper. Each edition then was sent off to a contracted printing company. It was a highly labor-intensive process, and making corrections required a manual reformatting of a whole page or even at times an entire edition.

With the advent of computers, word processing and publication software, the process took far less time, with resulting improved graphics capabilities and easier editing.

During the newspaper's three decades, it has witnessed the Medical Society's headquarters move to its third location over that time span; seen 15 different individuals hold the position of editor; and benefited from the services of numerous freelance reporters, several of whom have contributed to **The Oregonian** and other regional and national publications. Current editor **Ekta R. Garg** is serving her second stint at *The Scribe*, having previously worked as editor from November 2005 to January 2008.

The newspaper's articles have not always made people comfortable. In addition to its target audience of physicians, the paper has been closely—sometimes nervously—read by state and local health officials, as well as hospital administrators.

Some of the latter have praised stories they viewed as favorable or at least balanced, while sometimes the same individuals squirmed when stories appeared that they would as soon have not wished to see the light of day.

Lindstrand said *The Scribe* has never dodged controversial or difficult topics as long as subjects and people were treated accurately and fairly, because MSMP members want issues that affect doctors explored candidly, and in depth.

"*The Scribe* is here to stay," he said. "It's a reliable, informative source of news that physicians depend on." •

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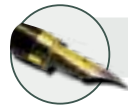
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From your MSMP Resident Member

Residents of 2013: Who are we?

By Rachel Seltzer
For The Scribe

If octogenarian physicians remember their residency, they likely remember taking up residence at the hospital. They went to college, then medical school, then completed their one year of post-graduate medical training, called "internship." A minority continued on to complete a residency. Some interrupted their education to serve our country. The majority had few obligations. They lived at the hospital, working 36 hours straight, with 12 hours off between shifts. They were paid very little, outside of room and board.

Forty years later, the majority of physicians were completing residencies. By the 2000s, many were completing subspecialty fellowships.

Now we are the current wave of residents. Some are in our twenties, some in our thirties (and some in our forties!). The average age of my class on the first day of medical school was 26. We were the oldest class in the country. We came straight from college or did research for a short time. We had graduate degrees. We had partners, and families, and children of our own. We had run marathons, climbed mountains, volunteered in the Peace Corps. We earned a doctorate in pharmacy. We were a former Miss Oregon. We were a professional soccer player. We were a single parent. We were midwives, engineers, and Navy flight medic instructors. And so we began medical school when we were 26.

We grappled at every accessible spark of opportunity. We did lab research, translational research, clinical research, outcomes research, qualitative research and policy research. We started and led interest groups, changes in medical education in Oregon, and changes in health services delivery. We became triathletes, husbands and wives, fathers and mothers. In June of 2011, we became physicians.

Today, we are your residents. We often work 80 hours over 6 days per week. That is what we document, anyway. We work straight through most holidays, unless we're lucky. We learn about humility and navigating hierarchies.

"If I speak I am condemned. If I stay silent I am damned!" though we are not *Les Misérables*. We learn how to make clinical decisions, and we become more confident in our abilities. We learn to be providers. We learn how to delegate and work in teams to provide the most efficient, effective care for our patients. Thereby we learn to spend less time with patients and ensure adequate documentation, communication, thoroughness and learning.

If we haven't already, we learn how to make room for date night once a week, to get home in time to kiss the baby good night, how to plan way ahead if



Today, we are your residents. We often **work 80 hours over 6 days per week**. That is what we document, anyway. We work straight through most holidays, unless we're lucky. We **learn about humility** and navigating hierarchies.

Christmas is at *his* folks' house next year. We learn how to manage upwards of \$100,000 in student loans and understand that we probably can't afford a house for a while, unless it's coming out of someone else's income.

Nannies are expensive. Presents are handmade. Airline credit rewards are fantastic. Beer is cheaper than wine. Some days it feels like we're finally getting the hang of it; other days it's never enough.

If we have children, we feel guilty for missing so much of their childhood. If we're single, we either resign to bear children with an increased risk of Down's Syndrome or adopt, or we accept that not having children is okay too. Luckily for women physicians, we have many role models: strong, successful women in medicine with children, and strong, successful women without. It seems there is joy and fulfillment in many paths.

We go to work, as a medical student, then a resident, maybe a fellow for 9 to 14 hours almost every day for 6 to 14 years. We seldom volunteer anymore, seldom lead change, create organizations, or write; go to our children's tee-ball games, join the family for holidays or vacations, or create. We will. Once our 3 to 12 years of formal post-graduate training is done, once we turn 35, we will. Our former assistant dean, Dr. Ed Keenan, used to remind us about the value of delayed gratification.

Who am I now? We shall see. "There is a life about to start when tomorrow comes." •

Rachel Seltzer is a graduate of Oregon Health & Science University and is now a second-year Family Medicine and Preventive Medicine resident there. She has served on the MSMP Board of Trustees for three years.

OHSU sees record year for technology transfer, business development, and number of patents

By Jon Bell
For the Scribe

From a balance training device and stem cells derived from blood vessels to a promising new startup business and a treatment for tooth hypersensitivity, the **Technology Transfer and Business Development (TTBD) office at Oregon Health & Science University** had a busy 2012. So busy, in fact, that the year turned out to be record-breaking in terms of industry-sponsored research agreements, patents and non-disclosure agreements executed with private companies.

In its 2012 fiscal year running from July 1, 2011–June 30, 2012, the office completed 81 industry-sponsored research agreements. Those agreements resulted in a record \$12.8 million worth of funding for researchers working on everything from macular degeneration to brain stroke therapy.

The office also had 33 patents issued—another record. The patents covered a wide range of technologies and processes, among them: methods for producing an immune response to tuberculosis; inactivating pathogens for vaccine production; and even a “bike gutter” to help people wheel their bicycles up and down stairs.

A prototype of the bike gutter was actually placed on a staircase at the **OHSU Kohler Pavilion** in the summer of 2011.

With a total of 144, OHSU’s TTBD office also set a new record this year for the number of non-disclosure agreements it executed with private companies.

The agreements are a sign that the companies are expressing real interest in collaborating with OHSU researchers on various technologies in the works. On top of that, OHSU also completed 553 material transfer agreements—the most it ever has—which are required when research materials transfer between entities, 117 new inventions and 35 research collaboration agreements with other institutions.

Also falling under the TTBD office umbrella this year is **Ivey Creek LLC**, a startup launched by **Robert Duvoisin** and **Catherine Morgans**. The business will develop an immunoassay and a vaccine for the diagnosis and treatment of metastatic cutaneous melanoma.

Andrew Watson, interim director of the TTBD office, said the record-setting

year came about largely due to OHSU’s increased focus on and investment in the effort.

“About a year-and-a-half ago, the university decided that if they really wanted to have a good technology transfer office, they would need to invest more in it,” he said. “We had an increase in staff, with the hope that it would lead to increased commercialization and agreements, and it has.”



Watson said the office initially planned to increase from 14 staff members to 27. It didn’t add all of those positions, but there are now at least 22 on staff.

“That’s been a real big part of it,” Watson said. “Just having more hands on deck has been important.”

In addition to the staff increase, Watson said the office also has been reorganized in a way that finds staff members working on “key deliverables” to help achieve the overall mission. The combination of the two should lead to more good years in the future, he added.

“It might not be in the same areas that it was this year, but I still expect some good results,” Watson said. “I’d be sort of shocked if it didn’t happen.”

While the TTBD office works with a wide range of researchers in various fields at OHSU, Watson said that lately some promising technologies in ophthalmology have been coming out of the university’s **Casey Eye Institute**.

He also said OHSU is hopeful that new recruits to its **Knight Cancer Institute** will spearhead some advances in the cancer space.

Other areas of strength for OHSU in terms of technology transfer and business development also include infectious

diseases, the development of vaccines and neurology.

The OHSU Brain Institute, in fact, is one of the top three institutions in the nation for **National Institutes of Health** funded neuroscience research.

Although Watson expects continued success for OHSU’s TTBD office, he said there are a few challenges in today’s funding and research environment.

way until the investment community understands that eventually the pipeline will dry up if they don’t invest in startups. But with the economy coming around in the U.S., maybe in a few years things will change.”

Additionally, in March 2013, the America Invents Act kicks in and will switch the way rights are granted for patents in the U.S. from a “first to invent” system to a “first to file” one.

“That’s been a challenge over the years. It will probably stay that way until the investment community understands that **eventually the pipeline will dry up if they don’t invest in startups**. But with the economy coming around in the U.S., maybe in a few years things will change.”

—Andrew Watson, *Interim director, TTBD office at OHSU*

For starters, venture capitalists often are reluctant to invest in early stage startups, preferring instead to wait until a technology is in the clinical trial phase before committing. That makes it more difficult for early stage technologies to receive funding unless it comes from angel investors or federal small business grants and funding opportunities.

“That’s been a challenge over the years,” Watson said. “It will probably stay that

Although the verdict is still out on whether the change will hinder or benefit inventors, Watson said the legislation is “the biggest change to U.S. patent law since the 1950’s.” As a result, the TTBD office at OHSU has already begun educating faculty and “key inventors” on how the new law might impact their work and research.

“This is a big deal,” Watson said. •

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Questions remain as OMA board set to weigh liability reform proposal and concerns

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

An advisory panel appointed by the governor has submitted recommendations for a proposed bill in the 2013 Legislature intended to make malpractice lawsuits a last resort.

Many questions remain about what the final bill will encompass and whether organized medicine will back it. Although the **Oregon Medical Association** Board of Trustees agreed to explore the concept **Gov. John Kitzhaber** laid out last year—known as early discussion and resolution, or EDR—the board did not make a commitment to endorse the end result.

However, the governor and several OMA leaders, including **OMA president William “Bud” Pierce, MD**, and the OMA’s medical liability reform task force, have urged the board to accept the proposal developed by the **Patient Safety and Defensive Medicine Workgroup**, which Pierce co-chaired with plaintiff attorney **Derek Johnson**.

The OMA task force said the work group’s proposal has the potential to improve the liability climate in Oregon and represents a collaborative approach to reduce lawsuits, lower administrative costs and improve the patient experience.

But some OMA trustees and rank-and-file members have balked. They’ve expressed concerns that recommendations that were supposed to emphasize the voluntary nature of an EDR, as well as confidentiality of discussions between parties, constitute neither. Some also fear the legislation is being rushed through too fast and could harm physicians.

Several OMA trustees became worried after a defense attorney gave a presentation to them last fall in which he stated that doctors should be wary that the discussions between patients and their representatives and a physician or hospital representative could later be admissible, used in discovery and reported to the **National Practitioner Data Bank** and the **Oregon Medical Board**.

“To call this task force and the potential legislation to come out of it tort reform is a stretch,” said **John Evans, MD**, a past president of the OMA and a past president of the **Medical Society of Metropolitan Portland**.

“It does nothing to reform the legal system around malpractice claims. It does open up many levels of exposure of physicians. I continue to canvas physicians on this issue, and there is a great deal of angst related to the huge downside of this proposal. I have yet to hear that the critical issues of protection from reporting to the data bank and non-use of discussions in future lawsuits is protected.”

Neurosurgeon **Michael Dorsen, MD**, emphasizing that he was commenting only on the proposal that had been released and that he did not know what

changes may have taken place in the wording since then, said if the initial discussions between physician and patient include the patient’s attorney, “I think this was biased, to say the least. It really represents a fishing expedition for the attorney, a free discovery tour to see whether” the case would be worth pursuing in litigation.

Pediatrician **Robert A. Mendelson, MD**, also said he had seen no wording later than the work group’s final recommendations, but that he, too, was concerned that aggrieved patients could select a plaintiff attorney as their “representative” in early discussions. Referring to the recommendations, Mendelson, a co-author of the book *Medical Legal Issues in Pediatrics*, added, “There was no input, as far as anyone could see, from the defense bar.”

“The OMA and the plaintiff lawyers are moving forward with the **early discussion and resolution proposal** and are actively engaged in discussion and negotiation on the terms of the proposal.”

—Gwen Dayton, *OMA general counsel and vice president of health policy*

An OMA official told *The Scribe* on Dec. 5 that she could not comment on specifics of any language in the bill until the board of trustees votes on the final proposal.

“Negotiations are ongoing on liability reform, and we likely will not have a final answer on the OMA’s position or what the bill will look like until our upcoming board meeting on Jan. 26,” said **Gwen Dayton**, OMA general counsel and vice president of health policy.

“The OMA and the plaintiff lawyers are moving forward with the early discussion and resolution proposal and are actively engaged in discussion and negotiation on the terms of the proposal.”

As described in the cover story of the September issue of *The Scribe*, the work group was appointed by Kitzhaber and was comprised of Pierce and Johnson; two Republican legislators and two Democratic legislators; a public member; and a health system administrator.

The panel followed a three-phase approach to reform: early discussion and resolution, mediation and litigation.

Members sought to achieve three principles:

- Improve the practice environment to allow physicians to learn from medical errors and improve patient safety
- More effectively compensate individuals who are injured as a result of medical errors
- Reduce the collateral costs associated with the medical liability system, including insurance administration, litigation and defensive medicine

The work group met three times and submitted its final recommendations to the Legislature last September. Resulting legislation will be introduced in the 2013 legislative session, according to the **Oregon Health Authority’s** website.

In public testimony to the work group, **Cara Steinkeler, MD, Kaiser Permanente’s** physician director of risk management and patient safety, urged that the mediation process not be mandatory.

James Dorigan, senior vice president of **The Doctors Company**, said the work group’s proposal may increase costs and delay resolution of medical liability cases. He said no data exist that show an EDR system lessens frequency or severity of claims.

Melanie Spiering, underwriting director of CNA Insurance, suggested, among

programs and the expansion of ongoing ones in several states,” according to the AMA paper.

It added that these expanded efforts will help to answer some of the key questions about these programs, including: whether they will increase the frequency of liability claims; whether they can succeed in states without traditional liability reforms; whether they can be expanded outside of large integrated health system settings; and whether they will be sustainable when the liability climate worsens in a state.

The paper summarized some of the national concerns the AMA has heard from doctors:

- Notifying patients of medical errors could lead to an increase in claims and an increase in subsequent costs.
- Physicians have expressed reservations about establishing an EDC program in a state that does not have traditional liability reforms that could provide “a financial backstop” if a patient does decide to pursue a claim.
- Worries exist about establishing an EDR program in states that do not have an apology inadmissibility statute that could afford the physician protection for portions of the disclosure.
- Doctors are worried about reporting mechanisms such as the National Practitioner Data Bank and state licensing boards, because increased disclosure to patients could lead to more claims against physicians, which in turn could trigger NPDB or state licensing board reporting requirements.
- Some reform advocates have expressed concern that EDR programs will distract from the goal of achieving caps on non-economic damages at the federal and state levels.

Monica C. Wehby, MD, an AMA trustee and a past president of both OMA and MSMP, advocates that instead of moving to an EDR system, Oregon should adopt a plan called a certificate of merit, which she thinks is a much better idea.

This would require that in order for a case to proceed, a board-certified physician who is still practicing in the same specialty state that the standard of care was not met, she said.

The AMA’s model bill for such legislation additionally reads that the expert’s opinion “must conclude that the failure to use such reasonable care directly caused, or contributed to the cause, of the damages claimed.”

According to the AMA, about half of the states have in place some form of certificate of merit.

All documents from the state related to the Early Discussion and Resolution proposal are posted at:
www.oregon.gov/oha/OHPR/Pages/PSDM/index.aspx

Sitting correctly, movement during workday important for good health in long-term

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

“Active sitting” may sound like an oxymoron, but it’s one aspect of the importance of keeping active during the day.

“Active sitting is sitting that encourages movement,” explains **David Kahl**, owner of **Ergo Depot** (www.ergodepot.com), a Northeast Portland-based

company that features ergonomic furniture such as height-adjustable desks and chairs.

Researchers, pathologists and other specialists whose work requires them to be sedentary much of the time, as well as all physicians who employ desk workers as part of their practice, can especially benefit from furnishings that can be made to go up or down, he says.

Take the short, round, black stools many doctors sit on when examining patients. If the doctor’s height, or the height of the stool itself, causes the sitter’s knees to be higher than they should be, that scenario can create health problems over a long period of time.

“The general principle is, if you’re able to have your knees below your hips, that makes it easier to have better posture

for your back,” says **Greg Esmer, DO**, who specializes in neuromusculoskeletal medicine. “The lower back can have trouble otherwise.”

Sitting correctly, as well as incorporating movement while we work, are beneficial, says Esmer, a member of the **Medical Society of Metropolitan Portland**.

“I’m interested in how posture contributes to our overall health. It has to do with exercise and stability and our ergonomics throughout the day.”

When he sees patients, he inquires what they do at work, including what type of chairs and desks they use if they are office workers. Chairs that allow you to sit at varying heights, or even to partially stand as with a bar stool, likely are helpful, he says.

In his practice, Esmer uses a height-adjustable chair he purchased from Ergo Depot. Patients often ask him about it, and he sees this as a way of modeling healthful behavior at work.

“I will **jump rope for two minutes** here and there during the day,” he says.

“I find that it **supports productivity**, as opposed to getting in the way of it.”

—Greg Esmer, DO



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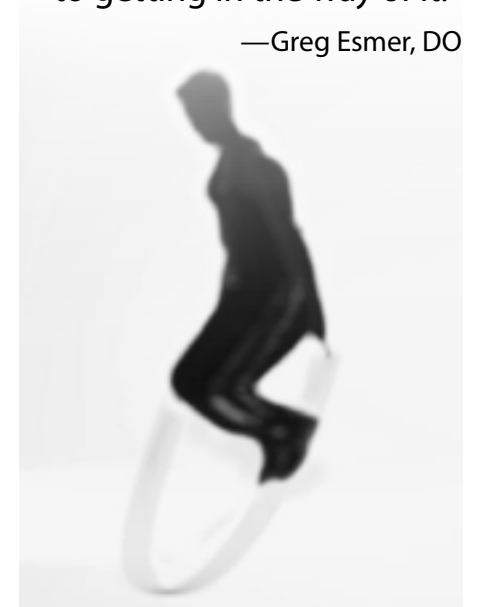
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Providence Brain Tumor Center medical directors, from left: Edsel Kim, M.D., head and neck surgery, The Oregon Clinic; Daniel Rohrer, M.D., cranial services, Comprehensive Neurosurgical Consultants; and Pankaj Gore, M.D., cranial services, The Oregon Clinic



He also keeps moving during the workday.

“I will jump rope for two minutes here and there during the day,” he says. “I find that it supports productivity, as opposed to getting in the way of it.”

According to the **Mayo Clinic**, studies have linked sitting for long periods of time with obesity and metabolic syndrome, a cluster of conditions that includes increased blood pressure, high blood sugar, excess body fat around the waist and abnormal cholesterol level. Too

See **ACTIVE SITTING**, page 8

Active sitting: Saddle-type or kneeling chairs aid movement

CONTINUED FROM page 7

much sitting also seems to increase the risk of mortality from cardiovascular disease and cancer.

Sit-stand desks and chairs allow you to sit at various heights or even stand during the day while still doing desk work.



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“Many people, **once they get these, never go back.**

The body feels alert and natural.”

—David Kahl,
owner of Ergo Depot

Kahl sells desks that can be raised or lowered electrically.

“Many people, once they get these, never go back,” he says. “The body feels alert and natural.”

He also advises that chairs that allow you to relax your arms at your side are preferable, because with an armrest, “you’re putting your arms and shoulders in an unnatural position.”

Saddle-type or kneeling chairs encourage leg and arm movement by opening up the angle of the hips. Sitting at a 130-degree angle is better than 90 degrees, according to Kahl.

By sitting with an open-hip angle, rather than a traditional knee-tilt position with legs parallel to the ground, the spine naturally creates its S-shaped curve, supporting your upper body, he says. He stocks special lab chairs for people who do scientific work such as dealing with potential chemical spills, because the chairs’ exterior is covered with a material that is easy to clean and impervious to chemicals, he says.

A 2004 technical report from the **Human Factors and Ergonomics Research Laboratory** at **Cornell University** compared electric height-adjustable desks with fixed-height desks.

A total of 33 computer workers in two companies worked at each type of

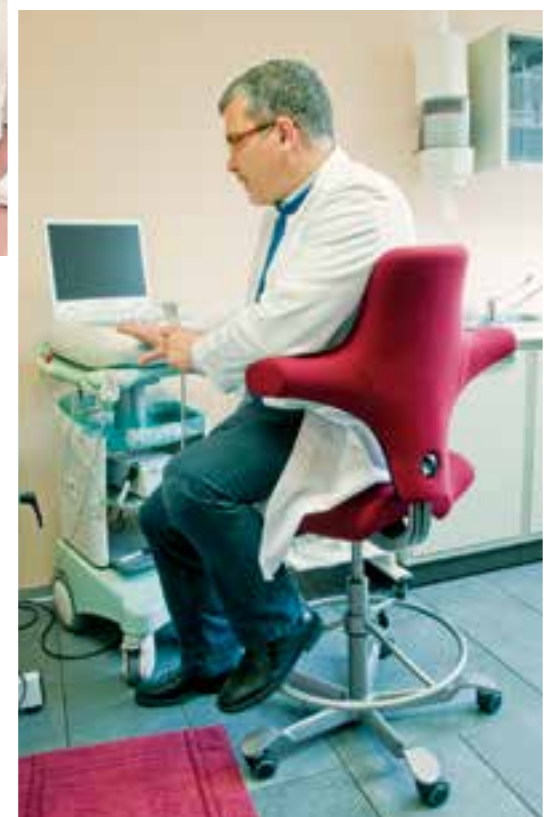


HAG Capisco chair

Photos courtesy of ErgoDepot.com

desk for between four and six weeks. Participants completed extensive survey questionnaires immediately before and then four to six weeks after using the height-adjustable desks.

Results showed substantial decreases in the severity of musculoskeletal discomfort for most upper body areas, and productivity ratings improved. Participants indicated a strong preference for using the electric desks. •



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The Oregon Clinic one of 25 centers in the U.S. to offer new procedure for GERD

By Jon Bell
For the Scribe

A simple bracelet of tiny titanium beads has the potential to end the suffering of countless people who live with one of the most prevalent gastrointestinal afflictions, gastroesophageal reflux disease. And two surgeons at **The Oregon Clinic** are among the handful of physicians at just 25 centers in the U.S. who can turn that potential into reality through a new minimally-invasive surgical procedure.

"This new treatment is really a breakthrough and I'm really excited about it," said **Christy Dunst, MD**, an esophageal surgical specialist at The Oregon Clinic. "There is a large population of patients out there who could really see an improvement in their quality of life because of this."



CHRISTY DUNST, MD

Gastroesophageal reflux disease, commonly referred to as GERD, occurs when the barrier mechanism that normally prevents gastric juice and bile in the stomach from entering the esophagus has weakened or become incompetent. The result is a burning pain and fluid in the chest and throat.

People with GERD can find themselves in various states of pain and discomfort. In more severe cases, complications such as position-related regurgitation with aspiration and Barrett's esophagus can develop.

Many people who experience GERD—some estimates suggest that 10 percent of the population in Western countries are affected—take over-the-counter or prescription antacid medications.

In 20 to 40 percent of GERD cases, however, medication is not effective. That's because medications are designed to lower the acid level of gastric juice, which eliminates the burning sensation for sufferers.

However, because GERD is the result of a mechanical problem, people still feel the fluids in their esophagus, even though the acid has been reduced.

"The medication does nothing to prevent the progression of the disease," Dunst said.

The other treatment for more severe GERD is surgery. Known as laparoscopic Nissen fundoplication, the traditional surgery finds a surgeon rebuilding the barrier using parts of the patient's own stomach.

While the procedure is effective, there are standard surgical risks as well as possible side effects, including difficulty swallowing and increased bloating. Up to 10

percent of patients may also experience a recurrence and require more surgery.

Caught between ineffective medications and an invasive surgical procedure, many GERD patients opt to simply endure as best they can.

"For many people, their disease falls somewhere in the middle," Dunst said. "It's not severe enough for them to accept those complications, but they're not happy with their medications either. So they're in limbo and just suffering."

Enter LINX and the procedure known as laparoscopic magnetic sphincter augmentation.

"The majority of patients are doing great, and there have been no complications. Most of them are off their medication and happy."

—Christy Dunst, MD
Esophageal surgical specialist at The Oregon Clinic

The procedure involves implanting the band of beads around the gastroesophageal junction to augment the existing barrier and basically keep it closed. Because the device is magnetic, however, the bond is temporarily broken any time the person swallows food, belches or vomits.

Dunst said she first came across it in 2005 at the **University of Southern California** through one of her mentors. She was one of the surgeons who

participated in a large clinical trial that saw around 100 patients receive the device. Thirteen clinics were part of the trial, including The Oregon Clinic.

After their surgery, the patients were followed closely and underwent endoscopy and had x-rays to monitor the device. Physicians had been concerned that the LINX would slide around—it doesn't because of the nearby anatomy—or erode, which never happened.

"The majority of patients are doing great, and there have been no complications," Dunst said. "Most of them are off their medication and happy."

The device underwent a full premarket approval process with the **U.S. Food and Drug Administration** and received official approval in March 2012.

According to Dunst the LINX procedure is less invasive than the traditional procedure, requiring four or five small incisions to access the bottom of the esophagus and no disruption to the native anatomy.

The traditional procedure usually takes close to an hour-and-a-half; the LINX takes 45 minutes at most. Patients are given a

local anesthetic and can leave the hospital in well under 24 hours, whereas the traditional procedure usually requires a longer stay.

Before the LINX procedure, patients were required to go on a soft diet for a few weeks up to a few months while their swelling improved. With LINX, physicians want the device to open and close naturally from the beginning so that it "scars in" properly, according to Dunst.

As a result, patients start off on their normal diet after surgery and only shift to a soft diet around six weeks later if they have any difficulty swallowing.

Since FDA approval in March, Dunst has performed the procedure on one patient. She said about 10 others are on a waiting list. One of the biggest holdups is getting preauthorization from insurance companies.

"They're always skeptical about new things," said Dunst, whose colleague at The Oregon Clinic, **Lee Swanstrom, MD**, also can perform the LINX procedure. Swanstrom specializes in esophageal diseases, minimally invasive surgery and endoscopy.



LEE SWANSTROM, MD

"We're just really glad that patients who are disenchanted with the idea of the traditional surgery now have another option for treatment," Dunst said. "This is really innovative and just has the potential to help out a lot of people."

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Tuality pioneers MRI scans for pacemaker patients in the Portland metro area

By John Rumler
For the Scribe

Pacemakers and magnetic resonance imaging (MRI) scans both are indispensable tools on the medical landscape; however, in spite of all the benefits they provide, when the two devices are used together the results can be damaging and even life-threatening.

But thanks to recent advances in technology, those risks and contraindications are a thing of the past at **Tuality Healthcare**, a non-profit community-based health care organization in Hillsboro, Oregon.

Tuality is the first hospital in the Portland metropolitan area with a diagnostic imaging staff that is certified to perform MRI scans for patients who have the new **Medtronic Revo MRI® SureScan®** pacing system.

"From a medical standpoint it's a huge breakthrough, because previously patients who needed an MRI but had a pacemaker could not get one; it was simply a contraindication," says **Vincent Reyes, MD**, a cardiologist affiliated with Tuality. "It is a huge plus, particularly for patients [who] need some definition of soft tissue trauma or identification of problems that can be diagnosed by MRI."



VINCENT REYES, MD

Patients with traditional pacemakers cannot undergo MRI scans because of potential heart tissue damage or interference with the pacing circuitry. Magnetic fields from an MRI scan can interact with the circuitry causing pacemaker failure or malfunction.

The new Medtronic pacing system's circuit design is immune to magnetic interference and the pacemaker's leads have also been engineered to mitigate heat around the heart tissue making it safe for MRI.

Tuality Healthcare is the first hospital in the metropolitan area not only to implant these pacemakers but also to perform this specialized scanning. MRI scans use powerful magnetic fields to produce highly detailed images of internal structures within the human body. Physicians use this technology to diagnose cancer, stroke, muscle injuries, bone disorders and other diseases.

This revolutionary new technology is the first MRI-safe device approved by the **U.S. Food and Drug Administration (FDA)**. Tuality Healthcare is registered as an MR Imaging Center on the Medtronic website, and Tuality imaging staff members are certified to safely scan patients with this new pacing technology.

Medtronic certification means staff members have completed training in specific FDA specifications and requirements to safely scan patients with the new Revo pacing system.



Cathleen Dehen of Portland has the new Medtronic pacing system and was one of the first patients to have an MRI scan at Tuality Healthcare to determine the source of her knee pain.



CATHEEN DEHEN

"I was a little nervous at first, because I think I was just the second time they've done this," said Dehen. "But I was reassured and felt comfortable so I finally got my MRI done, and now I can go to my doctor and find out what is wrong with my knee."

Founded in 1983, Tuality Healthcare operates two hospitals in Washington County, **Tuality Community Hospital** in Hillsboro and **Tuality Forest Grove Hospital**.

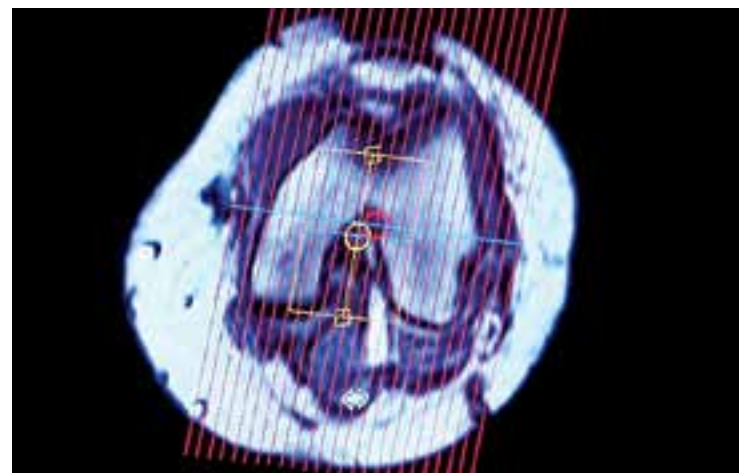
In addition, Tuality operates the **Tuality Healthcare Foundation**, **Tuality Health Information Resource Center**, the **Tuality Health Alliance**, and the **Tuality Health Education Center**.

Images are screen captures from a YouTube video published by Tuality Healthcare. View the video at: www.youtube.com/watch?v=x0Majnc6yLA&feature=youtu.be

"It's a **huge breakthrough**, because previously patients who needed an MRI but had a pacemaker could not get one; it was simply a contraindication. It is a **huge plus**, particularly for patients [who] need some **definition of soft tissue trauma** or identification of problems **that can be diagnosed by MRI.**"

—Vincent Reyes, MD

Cardiologist affiliated with Tuality



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FamilyCare, Inc. streamlines, outsources avalanche of Medicare, Medicaid claims

By John Rumler
For the Scribe

FamilyCare, Inc., a Portland-based non-profit health plan serving **Medicaid** and **Medicare** members, set a goal earlier this year to upgrade its claims processing system, which handles a whopping 720,000 claims annually.

"We wanted to improve the speed and accuracy of our claims processing to better serve the providers in our network and ultimately our members," said **Jesse Gamez**, chief operations officer of FamilyCare.



JESSE GAMEZ

So this summer, FamilyCare began the first of three phases in outsourcing Medicaid claims processing to Salem-based **Performance Health Technology** (PH Tech), a company specializing in processing claims for health plans.

Such transitions can be bumpy and disruptive, but PH Tech specializes in health claims management using web-based technology to expedite their claims processing for Medicaid and Medicare, the same market that FamilyCare, Inc. serves.

"We wanted to make FamilyCare's transition as smooth and as seamless as possible for them and for their providers," said claims administration manager **Amy Bruce**, of PH Tech's Northern Region.

The new system streamlines FamilyCare, Inc.'s ability to process claims by reducing re-work, explained Gamez.

"As provider satisfaction is a key driver for us, when we weren't fulfilling the need to process claims expeditiously, we knew had to do something about it. Our goal is to process 80 percent of our claims in 14 days and 95 percent in 30 days," said Gamez.

In phase one, which began in July, FamilyCare, Inc. started outsourcing their Medicaid mental health provider claims to PH Tech. In phase two, which started August 1, they began outsourcing their Medicaid physical health claims, and now they are in the third and final process of transitioning the Medicare claims, which should be complete by the beginning of 2013.

Gamez says there often was insufficient information coming in on claims. As FamilyCare was converting from paper files to electronic, there was a lot of wasted time going back and forth to acquire the necessary information to process the claims.

"Also, the more touches there are, the

more room for error there is, so we were seeking a new claims management system to improve provider satisfaction, to deal with a backlog and process them quicker, and to make the whole process seamless," Gamez said.

The advantages of the new system are numerous, Gamez explains, as PH Tech has special expertise in processing physical and mental health claims.

The program is set up so participating FamilyCare network providers and

high volume non-panel providers are granted access to PH Tech's secure web tool, **Clinical Integration Manager** (CIM).

In addition, the system requires providers to enter information regarding

See **CLAIMS**, page 13

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Dr. Jessie Laird Brodie: “A Woman of Distinction”

By Maija Anderson
OHSU Historical Collections & Archives
For the Scribe

Portland-area physician **Jessie Laird Brodie** was a local, national, and international force in reproductive health care. Through her medical practice and organizational leadership, she was a health pioneer for more than 30 years.

Jessie Laird was born in Detroit on May 5, 1898. Her father was a physician trained at **Detroit Medical College**. The family moved to the Willamette Valley when Jessie was a child. She remembered life as the daughter of a country doctor, and her father’s influence on her career.

“I often held a coal oil lamp and passed instruments to my father for minor surgery on a kitchen table. Whenever I broached my ambition about becoming a doctor, Dad said definitely that no daughter of his would ever be subjected to the treatment women medical students received when he was in school—I must be a teacher, he said.”

His daughter would eventually change his mind.

In 1920, Jessie graduated from **Reed College** with a degree in biology. While completing her college studies, she worked as a laboratory technician and assistant for **Charles Sears** and **Laurence Selling** at **University of Oregon Medical School**. After graduation, she was appointed to become a teacher in an experimental program under the **National Board of Education** and the **American Social Hygiene Association**. Identifying Oregon as a state that was progressive in the field of sex education, the organizations appointed Jessie Laird

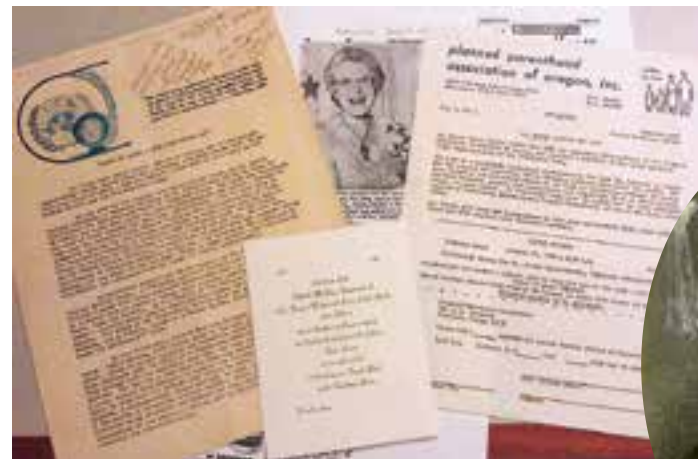
Brodie among others as the first to teach the subject in school settings.

In 1921, she married **F. Walter Brodie**, a fellow Reed alumnus who was planning to attend medical school. Earning an MD from UOMS in 1926, he went on to practice as an obstetrician and gynecologist. The couple raised three children: sons Laird and Alan, and daughter Eleanor Jones.

After her wedding, Brodie was forced out of teaching because of strict rules against the employment of married teachers. While saddened to leave a profession that she had loved, she recognized the opportunity to pursue her childhood dream of becoming a doctor. She graduated from UOMS in 1928, one of three women in a class of 52.

Brodie interned at **Multnomah County Hospital** and was a pediatric resident at **Doernbecher Hospital**. Her experiences there strengthened her conviction that Oregon had a great need for family planning services. One day, she delivered a baby to a couple that had little means to support the 15 children they already had and no plans to prevent future pregnancies. Brodie advocated for contraception and planned pregnancy as a sensible alternative to abortion, illegal for most of her career, and high rates of infant mortality and child poverty.

Brodie began her medical practice as a pediatrician, focusing on adolescent gynecology. She worked from a home office so she could raise her children while pursuing her profession. She also began working on family planning campaigns at the state level, serving as the social hygiene chair for the state PTA and League of Women Voters. Her activism was instrumental in passing a 1935



Clippings and correspondence from Jessie Laird Brodie’s career.

Digital scan of graduation photograph of Jessie Laird Brodie, University of Oregon Medical School, 1928.



Images courtesy of OHSU Historical Collections & Archives

Oregon law to control the advertising, sale and quality standards of contraceptive supplies. This made Oregon the first state with a positive contraceptive law: Rather than restricting the availability of contraceptives, the law ensured that they would be of good quality and represented accurately in advertising and sales.

In the 1940s, Brodie began organizing at the international level. In 1947, she helped found the Pan-American Womens’ Alliance in Mexico City. She remained a prominent member of the organization for 20 years, serving as president from 1954–1956. She was the first president of the **Portland United Nations Association**, and was elected as the Northwest representative to its national executive board in 1958.

By the end of the 1950s the Brodies had decided to retire and began transitioning their medical practice to younger partners. Jessie Laird Brodie was invited to serve as president of the **American Medical Women’s Association** in New York City. She became president in 1959–1960 and then served as executive director for three years. During this time Walter Brodie volunteered as an English teacher, helping foreign medical students learn conversational English.

The Brodies always considered Oregon to be their home. After a few years in New York, they were able to return. In 1965, Jessie Laird Brodie was appointed as the founding executive director of the **Planned Parenthood Association of Oregon**. Starting in a single room borrowed from a counseling center, under Brodie’s leadership the organization grew to include two Portland clinics and family planning services in eight county health departments.

In 1967, Brodie made yet another dramatic career change. Resigning from Planned Parenthood, she accepted a position as Latin American field representative for the **Pathfinder Fund** (now **Pathfinder International**). Brodie’s work focused on fostering emerging family planning programs so that they could eventually qualify for large-scale government aid or NGO support.

For her contributions to world health, Brodie received an honorary doctorate from Reed College, the Woman of Distinction Award from the Soroptomist Federation of America, and the Brotherhood of Christians and Jews Achievement Award. Later in life she spent time at the family home near Carver on the Clackamas River where she enjoyed cooking and wildlife.

Brodie passed away in 1990 at the age of 92. Her autobiography, *Dr. Jessie: The Odyssey of a Woman Physician*, was published posthumously in 1991.

Claims: New system reduces times on tasks

CONTINUED FROM page 12

consultation referrals and other services into PH Tech’s CIM. The system provides automatic approval for those services that do not require medical review, and at the time providers enter information regarding the referral the system provides immediate authorization.

If the service requires medical referral, then providers will receive a notice that their request is pending and FamilyCare will process the authorization request.

The web-based technology greatly reduces the administrative time spent as FamilyCare, Inc. can connect to its providers through CIM. The automatic approval decreases time on the

phone with the health plan administrators, and CIM allows providers to check eligibility and authorization status independently as well as online claims status.

It also provides a direct line of communication to claims and authorization personnel via email.

FamilyCare has provided training in-person and via webinars on the system with its staff as well as having PH Techs available to assist providers, and as a result they are now processing payments quicker and meeting the objective of 30 days.

It is a classic case of short-term pain for long-term gain, Gamez said.

“This happens with change within any organization and internal redesigns of systems,” Gamez said. “Working with PH Tech closely helped immensely. We not

only co-existed with them through the whole processing, having techs and reps on sight, but we also worked through the transition of staff. Many of our employees interviewed with PH Tech for positions as our goal was to manage any reduction in forces associated with claims processing.”

Beth Welty, program manager at **Children’s Health Alliance**, a provider of pediatric services for FamilyCare members, agrees that the changes brought a significant improvement in the claims processing.

“Using this technology for managing claims gives providers better access to the patients referral and authorization information, which allows for easier and more comprehensive follow-up care,” Welty said.

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Medical Office Space for Lease, Tualatin, Oregon. 6485 SW Borland Road @ Meridian Park Hospital. Located on campus of Legacy Meridian Park Hospital, the available space is 1,236 square feet. The lease rate is a competitive lease with tenant allowances for improvements. Space includes reception area, waiting room, nurse's station and three exam rooms, one of which is a minor procedure room. Days of use for the suite are negotiable. Rent includes full service, net of gas and electric. Janitorial services are included with easy parking and freeway access. Beautifully maintained building, excellent location, ready for immediate occupancy. For more information, please call Jessica at 503-692-5005.

Office Space for Lease, Hillsboro. 2,018 sq ft medical office space in Orenco Station. Looking for someone to take over lease ending December 2015. Current monthly lease \$3100; terms are negotiable. Willing to lease fully furnished. All exam rooms and offices have natural lighting. Original build-out 2003; painted/redecorated 2010. Convenient parking. Walking distance to Orenco Station MAX station, New Seasons, and many restaurants. Email jujufung@gmail.com or call 503-330-6910 for more information.

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