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Nominations invited!

MSMP Board

The MSMP Board of Trustees invites your recommendations and welcomes self-nominations for positions on the new board, commencing April 16, 2013.

Rob Delf Honorary Award

The MSMP Board of Trustees created an annual award in honor of Rob Delf's long service to the organization. This award is to be given to a person or persons who exemplify the ideals of the Medical Society within the community where members practice. ***—Page 12***

After much debate, OMA backs early disclosure bill

By Cliff Collins
For The Scribe

Politics—both within organized medicine and at the state level—hung heavily in the background as the **Oregon Medical Association's** board of trustees voted Jan. 26 to endorse a proposal for a legislative bill intended to reduce malpractice lawsuits.

The bill, which resulted from a document developed last year by a state advisory group appointed by **Gov. John Kitzhaber**, would establish what is being described as a voluntary early discussion and resolution program, or EDR. It is expected to be introduced early in the 2013 Legislature. The advisory group sent to the board and Legislature a proposal containing a three-phase approach to adverse patient outcomes: early discussion and resolution; mediation; and litigation.

The path to a final decision on whether the OMA would back the bill represented one of the most unusual and contentious debates organized medicine in Oregon has seen, and the final vote reflected that. After the vote was taken of trustees present, the screen in the room at OMA headquarters showed that 52 percent voted yes and 48 percent no, according to several doctors present at the OMA meeting. Those sources said, however, that some votes came in by telephone after this count.

On Jan. 31, **Betsy Boyd-Flynn**, OMA's deputy executive vice president and chief operating officer, told *The Portland Physician Scribe*, "Our calculations show it's 57 percent to 43 percent, including the phone vote." She added that a total of 51 votes were cast, and that there are 102 OMA trustee seats.

"Now is not the time for the house of medicine to split apart," OMA President **William "Bud" Pierce** wrote in a Jan. 28 "Dear Colleague" letter sent to members following the decision.

"Even as we support this proposal for what it does, we recognize it does not do all our members could wish. While opinions on this proposal remain divided among our members, it is important to note that the system is voluntary. Those who have grave concerns about the proposed early discussion program may decline to participate in it at any time without consequence."

Kitzhaber took a strong interest in the outcome of the vote, sending a letter to OMA trustees and placing personal phone calls to some trustees, urging them to support the proposal. In his letter dated Jan. 18, the governor made clear that "your physician leadership, OMA staff and other stakeholders" had "thoroughly" reviewed and vetted "all liability reform options before reaching a consensus" on the EDR option.

Kitzhaber reminded trustees that he was honoring his commitment to the OMA to work with the Legislature toward medical liability reform, adding, "This proposal will be the only one I will support in 2013."

His intervention began last year in appointing the **Defensive Medicine and Patient Safety Workgroup**, co-chaired by Pierce and Eugene plaintiff attorney **Derek Johnson**, and submitting a 12-page proposal intended to reduce the incidence of medical lawsuits and the costs associated with them.

Kitzhaber's actions stemmed from a pledge he made earlier in 2012 that if Republican legislators, the OMA and physicians would support his plan to change Medicaid and create coordinated care organizations, or CCOs, in exchange he personally would get involved in addressing liability reform. Many doctors feared that the creation of CCOs could increase their liability exposure.

During and following the Jan. 26 vote, however, some doctors who supported the final proposal and some who opposed it all agreed that the resulting legislative bill does not represent tort reform. Instead, many characterized it as a patient safety measure.

"This was a vigorous and rigorous discussion finally about a huge issue," observed trustee **John Evans, MD**, an anesthesiologist. "The ramifications to [the **Medical Society of Metropolitan Portland**] and the OMA wait to be seen. Great weight was given to the political consequences of not supporting this."

According to several physicians present at the meeting, some doctors who spoke in favor of backing the bill warned that not supporting it might lead to ill will among legislators toward organized medicine. The thought was that to go against a proposal deemed to be partly created by physicians would make legislators unwilling to listen to the many other issues physicians have that are coming up this session and in the future.

While acknowledging that the debate about the proposal was "passionate and long," OMA president Pierce said the OMA trustees' decision to support the program was "an important first step in medical liability reform."

"We have, through our participation in shaping the proposal and through this vote, succeeded in turning the important discussion of liability reform in a new direction," he said.

"Personally, I am confident that this proposal is a good one, and that it has the potential to improve practice and patient safety in Oregon while providing an alternative to the expensive and protracted court process that currently serves neither patients nor physicians."

The OMA's board of trustees now assumes an expanded role from the past.

After the OMA discontinued its House of Delegates last April, the board took on the policy-setting functions that the House used to fulfill at its usually quarterly meetings, according to OMA COO Boyd-Flynn. Trustees now include representatives from county and specialty societies and all past presidents of OMA who choose to serve on the board, she said.

Whether a larger roster of decision-makers helped to spawn more diverse opinions, there was no shortage of differing views about what the yes vote will mean for medicine in Oregon.

Some said it would increase risks to physicians and costs to the system, while others said it would have the opposite effect in both respects.

In addition, several OMA trustees became worried last fall after a defense attorney gave a presentation stating doctors should be wary that the discussions between patients and their representatives and a

*See **OMA PRESIDENT,** page 3*

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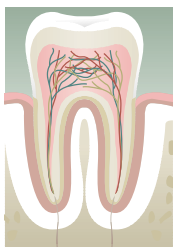
From your MSMP board member



In our ongoing series of articles from members of the MSMP board, one physician shares his thoughts on the state of oral health in patients in the U.S. The problem goes much deeper than brushing and flossing regularly, he says. In order for patients to get the care they need, physicians, dentists, and those related to both respective careers all need to work together.

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Physician Profile—Paul Thomas, MD

This month readers will meet Paul Thomas, MD, who practices medicine with an approach rooted in diversity. Not surprising, considering he lived in Africa and experienced diversity at its most basic level during his childhood. His personal history, as well as a background in both pediatrics and addiction medicine, gives his understanding towards his patients a greater depth.

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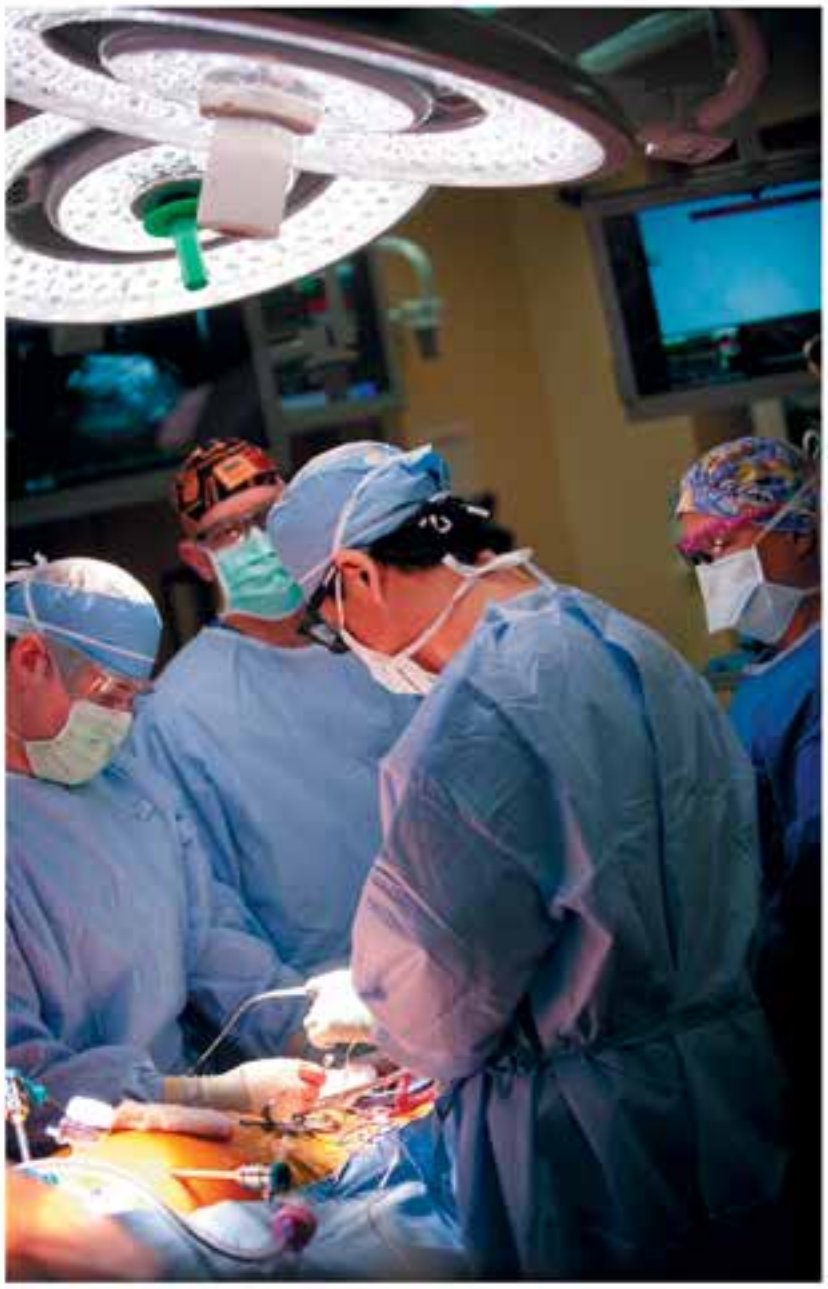

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OMA president: 'Now is not the time for the house of medicine to split apart'

***CONTINUED FROM** page 1*

physician or hospital representative could later be admissible, used in discovery and reported to the **National Practitioner Data Bank** (NPDB) and the **Oregon Medical Board**.

Trustee **Monica C. Wehby, MD**, a neurosurgeon, said attorneys and insurance carriers have told her that federal law requires reporting if money is paid to aggrieved patients, and that there is no guarantee that doctors' names won't be reported to the NPDB.

As a result of this concern, early last November the board directed the OMA to explore a voluntary system while at the same time indicating the importance that the early discussion phase with patients be kept confidential and not be used in litigation later, **Gwen Dayton**, OMA general counsel and vice president of health policy, told *The Scribe* at the time.

Thus, when Kitzhaber wrote to trustees before the vote asking them to back the proposal, he emphasized that the concerns doctors had shared had been heeded.

"The key change is that the early discussion and resolution process is now completely voluntary," he wrote, placing the last two words in boldface type.

The governor added that the proposal includes establishment of an "oversight council comprised of physicians and other stakeholders to monitor implementation."

Even if it is described as voluntary, participation in the EDR program may increase risks and costs of medical liability, particularly for high-risk specialties, said Wehby. She said there were attempts to address this point by making participation voluntary, but because the process may be initiated by anyone, including the patient or a representative, "it puts the physician in the position of having to refuse to participate, implying that he has something to hide and is not being cooperative," she said.

But **Robert A. Gluckman, MD**, an OMA trustee and chief medical office for **Providence Health Plans**, said physicians "should not have undue concern. I think it's a first step and fairly narrow in its impact."

"The bill has benefits to those who participate. It's not the final word on tort reform, but it offers the option of voluntary participation to have a speedier process if a patient has had an adverse consequence to medical care when the outcome of that medical care usually would be preventable. If it is not clearly that, this bill does not apply."

Trustee **Richard Allen, MD**, a retired obstetrician-gynecologist, agreed.

"People are more worried about this than it merits," he said. "I believe we are sending a positive message to the Legislature. I don't think this harms us."

He said he initially was concerned that the process would be mandatory, but when he was assured it would not be, he supported the effort.

He said such programs have worked elsewhere, including in Colorado, where he practiced for a number of years.

"It's not going to make you have more exposure; you may have less. It just shows concern for the patient," he added. "By making it voluntary, they took a lot of sting out of it."

In addition, said Allen, "This bill is going to pass [in the Legislature] whether we're part of this or not."

OMA trustee **Tom Hoggard, MD**, a family physician, said he does not see this as a step toward tort reform. He noted that defense attorneys and medical liability carriers were not brought in during the work group process that reviewed and developed the proposal, and at the time of the Jan. 26 vote, representatives of those two parties "unequivocally warned us this legislation was not in our best interest regarding medical liability. They warned us to oppose it. They warned us that there would be more frequent" lawsuits and higher costs to carriers.

"Obviously, this cost will have to be passed on to the insured doctors," Hoggard said. "This will particularly affect those doctors who are self-employed and pay their own insurance, and those who do not fall under the caps in place" for **Oregon Health & Science University**-employed doctors.

Two defense attorneys and two representatives from Oregon's two largest liability insurance carriers were brought in at the last minute to appear and speak briefly before the board voted. Invited to comment for this article, a lawyer who appeared did not respond. CNA's spokeswoman in Chicago, **Jennifer Martinez-Roth**, said it is too early for the company to comment about what passage of the bill would mean for medicine in Oregon.

The Doctors Company's James Dorigan, senior vice president, was out of his office and could not be reached for comment. But in public testimony last fall, he said the proposal may increase costs and delay resolution of medical liability cases. He also said no data exist that show an EDR system lessens frequency or severity of claims.

Also in testimony last fall, underwriting director of CNA Insurance **Melanie Spiering** suggested, among other points, that any EDR bill should include a four-year sunset provision. The draft of the legislative bill notes that it sunsets on Dec. 31, 2023.

OMA trustee **John C. Moorhead, MD**, an emergency physician who co-chairs the OMA's medical liability reform task force, said the intent of both doctors and trial lawyers who participated in developing the proposal was that the EDR process be confidential and could occur without attorneys present. He said the program creates for physicians and patients "the opportunity for confidential discussion without necessarily involving attorneys, and hopefully will generate patient safety."

Pierce, responding in his letter to physicians worried about whether the EDR process would remain confidential and not reportable, wrote, "We hear those concerns and respect them; we will make every effort to continue to meet with our physician community and work with them to resolve their concerns." He added that the OMA and supportive legislators will monitor the bill through the legislative process.

"Finally, it is important to note that support at this stage is not a blank check," he wrote. "Again, we will continue to advocate and work to shape the legislation to address as-yet unaddressed concerns, and if the members of the task force or OMA legislative staff feel it evolves in an unacceptable way, we will withdraw our support."

Pierce said the OMA believes this proposal will go a long way toward keeping physicians out of the courtroom.

"While this may not look like traditional liability reform, we recognize this as a step on the path to system reform," he said. "However, if it fails in implementation, we are confident we can work with our allies to fix or stop it."

Noting that he has been involved with the association since 1974, Hoggard said, "At this point the vote has been cast, and the OMA must continue to represent us as best it can. I've always been in support of this organization that does represent us all. Sometimes we don't agree with one or another or its stands or policies, but as a group we must all be in support of the organization as a whole." •

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Adventist radiation treatments get boost in precision and speed by new technology

By Jon Bell
For The Scribe

The radiation oncologists at **Adventist Health Center** have been able to add a little more punch and precision to their radiation treatments since December, when the center began using a new technology system from **Elekta** called Agility.

"It's a new way of delivering the radiation," said **Aaron Hicks, MD**, a radiation oncologist at Adventist, "and we're the first in the Northwest to offer it—second on the West Coast along with **[the University of California, Davis]**. It's something that we're excited to be able to offer our patients."


AARON HICKS, MD

The new technology delivers external beam radiation via a device known as a linear accelerator or linac. The radiation comes out of the head of the machine to the patient, who lies on a table below.

In older systems, radiation oncologists could shape the beam somewhat using a system of beam-shaping "leaves," but not to the greatest level of precision. The less an oncologist is able to precisely target the radiation at a tumor, the more likely it is that surrounding organs and healthy tissue can be damaged.

During the past 10 or 15 years, Hicks said advances in technology have afforded more precise beam shaping. More recent devices have utilized 10 mm leaves that move within the open field of the machine head to shape the beam and conform it around a tumor. The Agility system has 160 "interdigitating"—or interlocking—tungsten leaves, measuring 5 mm, that block portions of the radiation beam to accurately target the patient's tumor.

"The technology has really come a long way over time," Hicks said.

The leaves also move together during a treatment, which allows for a faster delivery of radiation and helps limit the chance of motion inside the body. As a result, patients spend less time on the treatment table.

"We've already seen a remarkable decrease in the time in the delivery of the treatment," Hicks said. "When it used to be 15 to 20 minutes a treatment, now it's just five to 10. Over a six-week course of treatment, that really adds up."

In addition, the way the leaves move together helps cut down the "transmission rate," which is the rate that radiation leaks around the leaves.

Hicks said the Agility system likely has the lowest transmission rate of all the existing technologies. He also said the Agility system can be used on just about any patient with any kind of tumor.

We've already seen a remarkable **decrease in the time in the delivery of the treatment**. When it used to be 15 to 20 minutes a treatment, now it's just five to 10. Over a six-week course of treatment, **that really adds up**."

—Aaron Hicks, MD, *radiation oncologist at Adventist*

At Adventist, the Agility system will work in conjunction with other cancer-fighting tools already in use. Among those: Volumetric Modulated Arc Therapy, which finds the source of the radiation beam rotating around the patient while the target area is continuously irradiated; and Image Guided Radiation Therapy, which uses various imaging techniques—including 2-D, 3-D and 4-D imaging—to better target and monitor tumors during a radiation treatment.

Hicks said the latter is essentially like creating a CT scan just before the treatment to ensure that the treatment plan is implemented accurately.

While the Agility system didn't require any training for physicians, Elekta representatives did some training for Adventist.

Looking ahead, Hicks said the technology of the Agility will likely evolve for even greater patient outcomes. "I expect continuing advances in delivery," he said. "The goal is to deliver [the radiation] precisely, quickly, and in a way that spares the nearby tissue as much as possible—all for the best outcomes in our patients." •

Working towards improving oral health in Oregon

By R. Bryan Bell, MD, DDS, FACS
For The Scribe

In 2000, the **Surgeon General of the United States** issued the first report on Oral Health America, which was followed by the Surgeon General's 2003 National Call to Action, in which numerous disparities that exist in oral health and disease patterns, oral health care delivery, and oral health education were defined.

These disparities are particularly manifested in children without access to preventive dental care; adults and children entering our nation's emergency rooms and trauma systems; and in patients undergoing cancer therapy, who are unable to afford or obtain access to specialized dental services.

Statistics from the National Institute of Dental and Craniofacial Research

- Dental caries alone is the single most common chronic childhood disease—5 times more common than asthma.
- Poor children have twice the rate of dental caries compared to more affluent children, and their disease is much more likely to be untreated.
- More than 51 million school hours and 164 million hours of work are lost from children and employed adults respectively due to dental-related illness.
- Cleft lip/palate, one of the most common birth defects, is estimated to affect 1 out of 700 live births in the United States. These and other birth defects result in missing teeth and facial deformity that can be functionally and emotionally devastating to children and adults.
- There are striking inequities in dental disease based upon income, due in part to the lack of access to specialized dentists trained in cleft and craniofacial care.
- There were 936,482 emergency department visits related to dental conditions in 2009.
- It has been estimated that as many as 15% of the most severely injured patients evaluated at U.S. trauma centers have significant facial injuries, of which half have catastrophic dental injuries that will require complex reconstruction and prosthetic rehabilitation.
- More than 400,000 patients undergoing cancer therapy in the U.S. will develop oral complications annually.
- 40,000 Americans will be diagnosed with oral and pharyngeal cancers in 2013, just over half of whom will be alive in five years. Dental rehabilitation is a critical component of restoring the oral cancer patient to form and function.
- For every adult with health insurance, an estimated three lack dental insurance.
- Dental services are mandatory for children in Medicaid, but it is optional for adults and varies from state to state.
- Medicare does not provide coverage for routine dental care.

The social impact of oral diseases in children and adults is substantial and is made more complicated by a complete separation of dentistry from medicine by virtue of having disparate and fundamentally isolated delivery models. While preventative dental service and prosthetic dental rehabilitation are important for health-related quality of life, they are typically elective, fee-for service procedures (unless accompanied by pathology or infection) that are provided by office-based private practitioners.

Most dentists have opted out of **Medicare/Medicaid** programs, as well as most medical insurance programs, in order to maintain a reasonable level of reimbursement. While this has resulted in a much-celebrated economic model of health care delivery, it has also produced significant access to care issues that are just now being widely identified.

These access-to-care issues are particularly acute for individuals who experience catastrophic oral problems related to cancer or trauma.

For example, a patient undergoing a composite resection of the floor of mouth and mandible for oral cancer will have his reconstructive surgery paid for by medical insurance. But because complete oral rehabilitation is considered "dental," they are not covered by "medical" insurance.

The reverse is also true as dental insurances consider these problems "medical." Therefore, the patient, who just lost a part of his jaw, will go without a dental implant supported prosthetic rehabilitation unless he can pay the out of pocket expense—usually between $25,000–$50,000.

As a consequence, the patient is rendered an oral cripple for the rest of his life. This is equivalent to a person undergoing lower extremity amputation for a sarcoma and insurance not covering the lower limb prosthetic. Why shouldn't we prioritize complete oral rehabilitation the way we prioritize complete limb rehabilitation?

Another unfortunate fact is that most physicians have little knowledge or understanding of oral diseases.

While the oral manifestations of systemic diseases are common and often severe—it is estimated that more than 400,000 patients undergoing cancer therapy in the U.S. will develop oral complications annually, and 40,000 Americans will be diagnosed with oral and pharyngeal cancers in 2013—it is unusual for a medical student to receive more than a cursory review of oral health problems during training.

Once in practice, oral diseases only become notable to an individual physician when he or she encounters the occasional patient who attempts to obtain needed dental/oral health care services because of infection or injury and who, because they have medical insurance but not dental coverage, seek the advice of their family doctor.

The reasons behind the access-to-care issues in dentistry and oral health care in general are complex and some historical perspective is required if a durable solution to this problem is to be implemented.

Historical Perspective

At the turn of the 19th century, a health care policy debate in the United States centered on the numerous proprietary medical and dental schools that existed at the time, which contained significant disparities in qualified faculty, staff, facilities, and curricula.

The Carnegie Foundation for the Advancement of Teaching commissioned **Abraham Flexner** to report on the overall quality of health education. The results were published in 1910. As a result of the so-called "Flexner Report," many medical schools closed and quality standards were implemented and incentives provided that resulted in a significant expansion in the number of medical and dental schools housed within North American universities.

In 1926, **William J. Gies** authored the tenth of the series of reports supported by the Carnegie Foundation. This report focused on dental education and supported science-based health professional education that included basic sciences.

Specifically, the report recommended that: dental education and science must be comparable to medical education in quality and support; dental educators must perform in teaching and research comparable to the best of a good university; the preparatory education/requirements for medicine and dentistry should be comparable; and the training be provided in both a clinic-based as well as a hospital based environment.

Thus a "special relationship" between medicine and dentistry was forged in which medicine abrogated oral health care to dentistry. Implied in this paradigm of regionalized care was that dental schools would be part of the greatest universities housed within medical schools and that dentistry would be the anatomically based practice of medicine and surgery. Dentists would have full patient care responsibility within their scope of practice, could prescribe, supervise, be licensed, have hospital admitting privileges, and that the professions would have a common biomedical education.

Currently the "special relationship" between medicine and dentistry has eroded substantially. Furthermore, dentistry suffers from the same fragmentation that characterizes most universities: a disconnect between the clinical sciences, the basic sciences, and the various health care disciplines.

Such educational and clinical "silos" prevent cross-fertilization among patients, students, residents, practitioners, clinical researchers and basic scientists. A prime example of this is the fact that most dental offices and dental schools have no access to the electronic medical records of their associated hospitals or health centers.

Change and Opportunity

In 2010, the **United States Congress** passed and **President Obama** signed into law the **Patient Protection and Affordable Care Act** ushering in a new era of change and opportunity for all providers of American health care. Now that the law has withstood legal challenge, political leaders in Oregon are forging ahead with **Coordinated Care Organizations** as a means to increase access to health care and reduce treatment costs.

Dental Care Organizations are also being formed, coincidentally, as pediatric hospitals, trauma systems and cancer centers find themselves precariously perched on a platform between two diverging professions—medicine and dentistry—as the quality, quantity, purpose, education and training of the health professional workforce again becomes a major policy issue in the United States.

In order to create an improved health care delivery model for the future, it is imperative that the academic and political leadership of our professions take a proactive approach in moving educators, practitioners, governmental agencies, professional societies, educational foundations, industry, insurers, and patients toward improving oral health in the United States.

The formal integration of dental services into Oregon's hospitals and health systems, its emergency rooms and statewide system of trauma, and within its academic and community cancer centers is a step in the right direction. •

Dr. Bell is medical director of the Oral, Head and Neck Cancer Program and Clinic at Providence Cancer Center; attending surgeon on the trauma service at Legacy Emanuel Medical Center; affiliate professor at OHSU; and maintains a private practice at Head and Neck Surgical Associates in Portland, Oregon.

OHSU physicians join national health care teams to provide leadership during Hurricane Sandy

By John Rumler
For The Scribe

When hurricanes, earthquakes and disasters strike, **Terri Schmidt, MD**, and **John Jui, MD**, both members of the **Oregon Disaster Medical Assistance Team** (Oregon DMAT) pack their bags and go. Late last year, they headed to New York City and spent a good part of November assisting in areas that were hit hardest by Hurricane Sandy.

Jui is Oregon DMAT deputy commander while Schmidt is the chief medical officer.

The two physicians, both fixtures at **Oregon Health & Science University**, have a long track record of assisting after disasters, but Hurricane Sandy presented its own unique challenges.

"I've never been to a hurricane before where a week later there was a snowstorm, so you have hurricane damage and then you have snow all over the ground," Schmidt said.

Hurricane Sandy, nicknamed Superstorm Sandy by the press and several federal agencies because of its unusual merge with a frontal system, caused a total of 253 fatalities and was the second costliest Atlantic hurricane in U.S. history after Hurricane Katrina.

The hurricane affected 24 states, including the entire Eastern Seaboard, with some of the worst damage inflicted on New York and New Jersey. The total damage in the U.S. is estimated at $65 billion with 131 deaths, including 53 in NYC and 37 in New Jersey.

The carnage and destruction in its wake was unforgettable to those who experienced it firsthand.

"We saw people in their houses with kids and the whole family was without food, water or heat," Jui said.

The **National Disaster Medical System** (NDMS) did not ask the Oregon DMAT to deploy a traditional 35-member team to the disaster site as it was not their month "on call," but asked instead to augment with teams of other responders.

Schmidt initially worked with the Ohio-5 DMAT because they needed an ER physician to help at their field site, while Jui assisted at a mobilization center.

When the Oregon team mobilized two additional larger medical task forces, at the request of NDMS, Schmidt and Jui received extensions to be able to stay on and provide command component roles, said **Helen Miller, MD**, team commander, NDMS, Oregon DMAT.

"We are proud of our ability to be flexible in serving the rapidly changing situations that arise at these missions," said Miller, a pediatric emergency medicine physician at OHSU and an adjunct faculty member in the department of emergency medicine for 15 years. "It's always a challenge to adjust to the diverse and ever-changing patient needs at disaster sites."

"We run to the burning buildings"

Schmidt joined Oregon DMAT in 2003 because of her desire to help others in need.

"In disasters, it is often the people who are already at the fringes of society, such as the homeless, people with serious medical conditions, those without family resources or without the means to leave a disaster area who are disproportionately impacted," she said. "At the same time, anyone who happens to be in harm's way can be impacted. Being able to help is an honor."

One of the best parts about volunteering, Schmidt said, is being on the front line of new experiences. She also enjoys the deep camaraderie and savors the challenges of working with a team to solve problems and figure out creative ways to do things with limited resources.

Schmidt said that she could not volunteer to help at disasters without the support of many people in both her professional and personal life.

"When we are activated to a mission, it is often with little or no warning," she said. "This means that other people have to step in and work shifts that we were scheduled to work. Many people may be impacted and often get little credit."

*See **SANDY,** page 8*

Sandy: Volunteers provided around-the-clock health care

CONTINUED FROM *page 7*

Superstorm Sandy struck New York on October 29, and Schmidt got a phone call on November 4 asking if she could go to New York. She left Oregon that same evening.

For the first few days, Schmidt and two team members worked with a team from Ohio and stayed in a lower Manhattan hotel. The subways were just beginning to run again and the hotel had reopened on generator power, so the volunteers had the good fortune to be sleeping in hotel beds but only had intermittent hot water and no heat.

"It wasn't too bad, because there was enough heat in the buildings from all the people to only seem cold at night, plus there were blankets," she said.

"It was not the tents of Oregon back country camping," she said, "but the large tents you used to see on [the old television show] *M.A.S.H.* that are insulated and heated."

The meals ranged from snacks the volunteers brought along to military "meals on wheels," often supplemented by home-cooked food provided by members of the community. One spirited group set up an impromptu kitchen and provided delicious barbecue for all the emergency responders.

Usually volunteers are deployed for a maximum of 14 days, but they can extend their commitment. When Schmidt first left for Sandy to join another team, it was with the understanding that if Oregon deployed she would join them.

> Our **team is incredibly bonded** to each other. I have said that **I would go anywhere with them** and think that I have done so. One team member said that **we were like litter mates**, and we are!
>
> —Terri Schmidt, MD, *Oregon Disaster Medical Assistance Team*

After several days, all were assigned to a mission on Long Island where the hospital had been severely damaged by the storm and there was no available health care outside of the federal DMAT field hospital that was set up.

"All the medical offices on the island were closed both because of damage, and many of the providers had evacuated the area," Schmidt said. "The pharmacies were closed, there was a 6 p.m. curfew, and many of the roads were not passable."

The volunteers provided around-the-clock health care, attending to everything from minor injuries (Schmidt stepped on a nail while cleaning up debris and needed a tetanus shot) to ambulances loaded with critically ill patients. Schmidt worked with other doctors in a tent caring for patients, and they also slept in tents furnished with cots and sleeping bags.

When Schmidt had only a few days left, Team Oregon was activated and she joined as deputy commander. "I stopped being 'one of the docs in the tent,'" Schmidt explained, "and became part of the command staff directing other physicians."

When the team returned to their hotels in Manhattan, they continued to perform a wide range of services, including providing medical support to shelters for nursing homes and other patients with special medical needs. They also helped care for a variety of displaced pets, helped staff the Long Beach DMAT hospital and even accompanied the National Guard, going from door to door to assess the medical needs of survivors.

Schmidt estimates that she has assisted at about ten disasters beginning with Hurricane Ivan in 2004. One of her most inspiring memories is of the Haitian people and their resilience after the January 2010 earthquake there, which killed 316,000 people, injured another 300,000 and left 1 million homeless.

"We hired local people as interpreters and support staff," she recalls. "Even though many of them had lost everything, in the afternoon they would sit under mango trees and sing."

Schmidt joined OHSU in 1977 and has served on the faculty of the department of emergency medicine since 1988. She worked in the emergency department until 2009, and since then she's served as an attending physician on the inpatient palliative care team.

She is also director of the **Oregon Physician Orders for Life Sustaining Treatment** (POLST) Registry.

The rewards of volunteering are huge, she says.

"Our team is incredibly bonded to each other," Schmidt says. "I have said that I would go anywhere with them and think that I have done so. One team member said that we were like litter mates, and we are!"

To anyone considering joining the DMAT team, Schmidt asks: "How would you do living with 35 to 50 people in very close quarters for two weeks? How do you adapt to new situations? Do you have a sense of humor? When you see a burning building, would your tendency be to run toward it or away from it? We run to the burning buildings!"

"A critical human element in a time of need"

An OHSU faculty member since 1982, Jui is currently a professor in the department of emergency medicine. He joined the Oregon DMAT team in 2000 to help those affected by disasters and also to learn more about disaster preparation, as he is also the Emergency Medical Services Medical Director for Multnomah County.

He served as the group's team leader during the two-week deployment and directed activities such as providing medical support to South Nassau Community Hospital, to Red Cross shelters, to veterinary teams providing animal care, and to the outreach teams that performed door-to-door assistance in the Rockaway and Coney Island communities, which were among those most severely impacted by Hurricane Sandy.

The rewards for assisting individuals in this type of response, especially regarding the patients and providers are direct and immediate, Jui said.

> The **contribution of the OHSU faculty** to this response **cannot be overstated**. It truly is a team effort.
>
> —John Jui, MD
> *Oregon Disaster Medical Assistance Team*

"It provides a critical human element in the time of greatest need," he said.

Jui previously served at numerous disaster sites including the terrorist attacks of 9/11, many hurricanes including Katrina, Ivan, Frances, and Gustav, and the American Samoa tsunami.

He also served at the 2004 Olympic Games and President Obama's 2008 presidential inauguration.

He is extremely grateful to his emergency medicine colleagues who fill in for him when he must depart abruptly.

"The contribution of the OHSU faculty to this response cannot be overstated," Jui said. "It truly is a team effort."

To anyone considering joining the ODMAT team, Jui says: "Your motivation and flexibility and patience are key factors. The willingness of your family and your colleagues for you to suddenly go away for two weeks is also very important."

Oregon's DMAT deployed a total of 34 personnel including nurses, pharmacists, a physician assistant, paramedics, EMTs, a mental health nurse practitioner and a safety officer who were a part of the team. Other physicians that served at Superstorm Sandy included Rob Cloutier, MD, (OHSU); Patricia Ramos, MD, (Kaiser Sunnyside); and Sandra Dunbrasky, MD, (Ontario OR). •

For more information, go to
www.phe.gov/ndms

Welcome New Members

Marilyn J. Booth, MD
Marilyn J. Booth, MD
3305 19th Ave, Forest Grove, OR
503-357-7194
Specialty: Family Practice, OB/GYN
Graduated: U of O Health Sciences Center '79

Kim Webster, MD
Rejuvenation Medical
2525 NW Lovejoy St #408, Portland, OR
503-973-5545
Specialty: Family Medicine
Graduated: UNSOM '82

Paul Thomas, MD

By Jon Bell
For The Scribe

Paul Thomas, MD, had a childhood unlike many people.

Born in Portland in 1957, he moved to Zimbabwe with his parents, who were missionaries, when he was just a few years old. There, Thomas grew up as the only white child in the entire village. Although the nearby schools were segregated, Thomas' parents enrolled him in the village school for a few years until the higher-ups found out and made him attend the segregated school from fourth to eighth grade.

"I went to school all day with my white friends, and when I got home I'd play with all my black friends," Thomas said. "Growing up there, it really was a phenomenal childhood."

Fast-forward through high school in Swaziland, an undergraduate degree and a master's in biology from the **University of the Pacific**, medical school at **Dartmouth Medical School** and a pediatric residency at the **University of California, San Diego**, to find Thomas today a board-certified pediatrician who's also board certified in integrative and holistic medicine and addiction medicine. He runs three clinics: **Integrative Pediatrics**, a general pediatrics clinic; **Fair Start**, an opiate detox clinic; and **Pediatric Urgent Care**.

The married father of 10 children—three biological, seven adopted—talked recently with *The Scribe* about why he got into pediatrics, his unique approach to medicine, which blends traditional practices with alternative approaches, and one of the touchier topics in medicine today.

It was during my pediatrics rotation that I just really fell in love with pediatrics. **I loved the kids and I loved the parents, too.** Parents are just genuinely concerned and interested in the well-being of their children.

—Paul Thomas, MD

The Scribe: Did you always know you wanted to get into medicine?

Paul Thomas: Because of my parents being missionaries—and my dad was a minister—I always thought I was going to be a minister, too. But by high school . . . I was asking myself, how am I going to be able to play that role? I always had been drawn to a helping profession, though, so I had that idea and I just held onto it.

What drew you into pediatrics?

Thomas: During the third and fourth year of medical school, you rotate through all the major disciplines. It was during my pediatrics rotation that I just really fell in love with pediatrics. I loved the kids and I loved the parents, too. Parents are just genuinely concerned and interested in the well-being of their children. It's very sincere. To me, working with adults, you often see how people neglect their health through poor diets or smoking. It seemed somewhat futile compared to the joy of kids. I knew, hands down, that this was what I was going to do with my life.

You're board certified in pediatrics but also in integrated holistic medicine. What's behind that?

Thomas: It's part of a journey that began for me in about the year 2000. I, like most pediatricians, had been seeing an increase in autism—and no good explanation for it. Also, it seemed like our ability as physicians to care for these kids, to make a healing difference in them, was fairly limited. We can offer Applied Behavioral Analysis [a common treatment approach for autism] and speech and language support, but, really, I wasn't seeing that there was a huge impact being made either in causes of autism or really helping those families getting their kids well. That's what led me to consider other ways of looking at things, including getting certified in integrated and holistic medicine.

So would you say that you use kind of a blend of more traditional medicine and some alternative approaches?

Thomas: Yes. [The integrated holistic medicine certification] has just given me a few other tools to use. We all have our little tool chests, and I've found that the combination has been very rewarding. I'm still largely a mainstream AAP [**American Academy of Pediatrics**] practice, but I've added a few things that add great benefit. It can be very helpful to look at things like nutrient deficiencies, allergies and food sensitivities. For many kids, these can make a huge difference. What I feel is key to good health and wellness is good nutrition and minimizing our exposure to toxins.

How do you go about getting patients to avoid their exposure to toxins?

Thomas: You drink filtered water and eat organic food. If you live in an old home, you have to really be aware of exposure to lead paint. Don't eat fish, because even though we need the antioxidants, there are high levels of mercury and pesticides. Silver fillings are half mercury.

Another source of toxins is the aluminum that is found in some vaccines. Unfortunately we're stuck with using some of those vaccines, because otherwise you can't protect kids from disease. Like the pertussis outbreak last year. It was one of the worst in the past 25 years. Clearly we want to vaccinate children against pertussis. I just wish it didn't have the aluminum in it.

You also have a detox clinic, and it's for teenagers and people under 30?

Thomas: Yes, I'm also board certified in addiction medicine, which is a fairly new recognized specialty. The clinic is for teens and people in their 20s to help them get off opiates. That's a hard addiction to overcome.

What led you to get into addiction treatment?

Thomas: Addictions have danced with my family a little bit, so I have a personal interest for that reason. My wife is an addiction nurse, so that really seemed to be a combination that would allow us to really help people out.

You're obviously busy with all of your medical work. If and when you get free time, how do you like to spend it?

Thomas: I like to make educational YouTube videos, and I do some blogging for our site. That's sort of still work, but it's also enjoyable. I also like the coast, and once a year we go to Maui to swim with the turtles. I love to snorkel.

Have you ever been back to Africa?

Thomas: Three years ago, I took my family back to Africa to see the village where I'd grown up. It was a great, great trip. •

Dr. Paul Thomas with his family.

Dr. Paul Thomas (*front row second from left*) and his staff.

Newly-retired obstetrician helped new mothers, delivered babies for 35 'fun' years

By Cliff Collins
For the Scribe

Some obstetrician-gynecologists give up delivering babies well before they hang up their stethoscopes for the last time.

Not **Thomas O. Flath, MD**, who delivered right up to the day he retired, at the end of 2012.

"That's really the fun part," he says of obstetrics. "It's a special event to participate in that."

After 35 years as a practicing physician, Flath called it a career at the age of 65. But like many other doctors, he had trouble actually carrying through his plans to retire.

"This was my fourth attempt," he admits. "Probably for the last four or five years I've been thinking about it."

Partly he was wary, because he had a grandfather who retired at his age, then died a month afterward, and Flath had seen others do similarly.

But Flath's father, a dentist, retired at 65 and lived to be 90. Flath hopes to emulate his dad's example, and tries to exercise each day. He notes that since he still has his own hips and knees, he wants to take time to enjoy that fact, and to relax.

Flath is glad he doesn't have to get up at 5 a.m. every day, and "for the first time in years," he doesn't spend his vacations worrying about his patients and what's going on at the office.

Instead, he and his wife excitedly anticipate having six grandchildren by this May, the oldest being just 4 years old. The couple also has a home at Sunriver, and Flath plans to get out a long-stored fishing boat once good weather hits.

"My plan is to focus my attention on my family and continue to stay active in our community by volunteering," he says. "I don't see a rocking chair in my future anytime soon."

Flath, who completed his working years with **Women's Healthcare Associates**, saw many changes take place during the years of his practice, both in medical and business arenas.

One of the biggest was that within his specialty, many subspecialty fellowships developed over time, such as oncology, endocrinology, urogynecology and maternal-fetal medicine.

After obtaining his medical degree from the **University of Iowa**, he completed his residency at **Oregon Health & Science University**.

At first, "I actually wanted to be a family physician," he remembers. He then considered internal medicine, while taking an elective one-month rotation in obstetrics just because he thought knowing how to deliver a baby was useful for any doctor.

My plan is to **focus my attention on my family** and continue to **stay active in our community by volunteering**. I don't see a rocking chair in my future anytime soon.

— Thomas O. Flath, MD

He discovered to his surprise that he loved obstetrics, caring for "young, healthy patients with, for the most part, happy outcomes," and he decided to focus his career on that field.

Flath, a member of the **Medical Society of Metropolitan Portland**, began practicing in 1977, with **Portland Women's Clinic**. Initially, the group included just five doctors, and it was "real family-oriented," where the members sat around a table and made decisions, he says.

But growth eventually became "necessary" in order for independent physicians to retain clout with health systems and insurers and to avoid being bought out by larger entities, such as hospitals, he says. Thus, in 1991 his group merged with **Lloyd Center Women's Clinic**, which became **Women's Clinic** in 1993. In 2011, **Women's Clinic** and **Women's Health Center of Oregon** joined Women's Healthcare Associates, which now includes nearly 90 providers throughout the metropolitan area.

With that merger, Flath finished his career among some of the physicians he first trained and practiced with years before. He and his group at **Emanuel Medical Center** were staff members at the medical school, and trained many residents at Emanuel.

During these three-month periods, "we get to know them very well," he says. "We were super lucky and could cherry-pick the very best when it comes time to recruit."

About the time Flath turned 60, he found that taking night calls was tougher than when he was younger. Recovering took him two or three days, and even though he felt mostly normal the day after working the night, "studies show you function as if you're drunk," in terms of reactions and decision-making, he says.

So he negotiated with his clinic to reduce his salary in order to not take night calls for the past few years.

"It was well worth it," he says. "I'm the first one in our group able to do that. Before that, either you're in 100 percent or not."

He says some medical groups and types of specialists make allowances such as this, and he thinks doing so is a good idea.

"It can extend your career by five, six years, easy."

Flath has mixed feelings about the current state of American medicine. On the one hand, he says, "We have a tremendously dysfunctional health system in this country. We're 37th in the world in general health." People who have enough money can buy good care, but many others get left out, he says.

Conversely, he is astounded at the myriad technological developments that have occurred over the span he has practiced.

"Robotic surgery is amazing," he says. Physicians can perform complex operations that used to require long recovery times, but now many patients can go home practically the next day. Also, the advances in cancer care have been astonishing, he adds.

Daniel C. Schrinsky, MD, Women's Healthcare Associates' chief medical officer, completed his specialty training at OHSU the same year as Flath.

"We've been part of the same professional community for decades," Schrinsky says. "When we began discussing merging practices two years ago, it was a no-brainer. It has been an honor to share this part of our careers."

With Flath's retirement, he adds, "The women's health care community is losing a very valuable and distinguished member." •

OSU study focusing on Asian ethnic group debunks assumptions about cancer screenings for women

By John Rumler
For the Scribe

Cervical cancer rates for Hmong women are among the highest in the nation, three to four times higher than among the broader population of Asians, Pacific Islanders and non-Hispanic white women, while cervical and breast cancer screening rates for this population are remarkably low.

During the past several decades, the medical community has speculated that the Hmong's unique culture, patriarchal society, and historical experience contributed to their wariness of Western medicine in general and more specifically regarding the group's reticence towards breast and cervical cancer (BCC) screening.

An Asian ethnic group originating from the mountainous regions of China, Vietnam, Laos and Thailand, the Hmong first came to the United States in the 1970s as refugees from Southeast Asia where they ardently supported the U.S. military during the Vietnam conflict. About 3,600 Hmong now live in Oregon, with the majority centered in the Portland metro area.

The health care system itself was suspected of posing barriers to the Hmong, especially in view of the group's low literacy rates, yet no definitive studies have probed these assumptions.

Oregon State University researchers, **Sheryl Thorburn** and **Jennifer Kue**, a member of Portland's Hmong community, and now an assistant professor at **Ohio State University**, have taken on the challenge.

Their study, "Breast & Cervical Cancer Screening Among Hmong: Social, Cultural & System Factor," published online in ***Health Education Research***, is the first study to look at the role of Hmong patriarchal and family influences on women's breast and cervical cancer screening. It is also one of the only studies conducted with Oregon's Hmong population.

Lead author and principal investigator Thorburn, a professor of public health at Oregon State University, had previously studied the influence of discrimination and other social, cultural and health care system factors.

Kue, who also had researched the prevalence of hepatitis B in Hmong communities and the low degree of screening and vaccination, was co-investigator and project coordinator of the **National Cancer Institute**-funded study.

Kue and her family came to the United States as refugees from the Vietnam War after the fall of Saigon in 1975. She gained visibility and experience as a caseworker and researcher at the **Portland Asian Family Center** where she worked for 10 years.

"Jennifer is highly committed to her community and passionate about improving their health and well-being," said Thorburn. "She was a critical link between the research team and the Hmong community."

Thorburn and Kue's two-year study had two main phases.

First, they conducted 20 key informant interviews with community leaders, health care providers and other persons of influence in the Hmong enclave.

OSU Hmong research team: Karen Levy Keon, Patela Lo, Jennifer Kue, and Sheryl Thorburn conducted the first study of Oregon's Hmong population in regard to their attitudes on cancer screening. (Photo: OSU College of Public Health and Human Sciences)

Building on those results, the pair then conducted in-depth interviews with 80 Hmong men and women living in Multnomah and Marion counties.

The research was conducted with the assistance of a community advisory committee, composed of nine Hmong community members and leaders. This guiding principle of community-based research was a huge factor in enabling the researchers to penetrate the tightly-knit Hmong people.

Questions addressed issues such as medical mistrust, historical discrimination, cultural beliefs and familial relations. Along with a team of bilingual interviewers, the researchers explored topics such as perceptions of and experiences with the U.S. health care system; men's influence on women's decisions; levels of health literacy; and wariness toward hospitals and treatments.

The majority of Hmong women and men reported that women make health decisions independently, and that, in general, breast and cervical cancer screening was not discussed in the household.

These findings shed a new light, as previous research suggested that patriarchal influences as well as suspicion of Western medicine could be contributing factors to a lack of cancer screening among women, and that men could be dominating the most critical decisions about the medical conditions of Hmong women.

However, those earlier studies did not survey both men and women.

Kue was surprised at the amount of autonomy reported by both male and female respondents.

"Hmong culture places a heavy emphasis on communal decision-making and it is still male-dominated, so I expected men to have more influence," Kue said. "The Hmong in our study were very open to using Western medicine, trusted it and had positive things to say."

There also seemed to be greater use of health services among the Oregon Hmong interviewed, as no less than 75 percent of women in the study had had a clinical breast examination at least once; 79 percent of women 40 and older had received a mammogram at some point in their lives; and 84 percent of women had gone to the doctor for a Pap smear.

In comparison, the few national studies conducted of Hmong women show low rates of breast and cervical cancer screening, ranging from 27 to 74 percent.

Both Thorburn and Kue hope this study lays the foundation for much more research on the Hmong community, especially to identify the specific factors that are responsible for the high cervical cancer rates in the Hmong population.

While the results were unexpected and encouraging, Kue said that it does not mean that significant health barriers do not exist.

"It isn't enough to get screened once, because we want women to get screened regularly," Kue said. "There have been so few studies done of the Hmong that it can be difficult to draw conclusions."

"We do know that this is a population at high risk, but there is still so much to learn. Hopefully our work will help guide future research."

Thorburn said the study helps researchers who follow up to shape their research.

"Without this exploratory study, people might have held a lot of assumptions that may not be correct," she said.

"This tells us it's not men deciding whether or not women get screened, because women of all ages said they have control and make the decisions about their health."

Karen Levy Keon and **Patel Lo**, formerly with Oregon State University, and **Ann Zukoski** with **Rainbow Research** contributed to the research project. •

In Memoriam—Dr. Daniel Bachman

March 26, 1926—November 9, 2012

Member of the **Medical Society of Metropolitan Portland** since 1985, Dr. Bachman began his medical career of research, teaching and practice in rheumatology and internal medicine after bravely serving his country in WWII and returning home to graduate from the **University of Oregon Medical School** in 1952. He practiced in accordance with the highest level of competence, ethical standards, and dedication to service.

He passed on his passions for learning, independent mind and capacity to wonder at the natural world to his three children. He leaves a surviving spouse, Judith Bachman. •

Announcing the Rob Delf Honorary Award

The Board of Trustees of the Medical Society of Metropolitan Portland has created an annual award in honor of Rob Delf's long service to the organization. This award is to be given to a person or persons who exemplify the ideals of the Medical Society within the community where members practice.

This can be demonstrated by work projects or activities that improve the health of the community or the practice of medicine in arenas including but not limited to the practice of medicine; education of new members of the medical community; education of the public about health, medicine and health public policy; improving public health and emergency preparedness; advocacy in health public policy; or other community activities relating to the healthcare and policy. This award may be given to members of the medical community, the health education community, or the general public.

The Board of Trustees is interested in receiving nominations for this award to be made at our annual meeting in April. We welcome nominations until the deadline of February 20, 2013. Please send your nominations to amanda@msmp.org. •

Nominations invited for MSMP Board

The MSMP Board of Trustees will consider recommendations for positions on the new board, commencing April 16, 2013. We invite your recommendations and welcome self-nominations.

The Board of Trustees is the policymaking body of the society. The purpose of the board is to see to it that the Medical Society of Metropolitan Portland:

1. Accurately and reasonably represents the needs and desires of the members of the organization
2. Oversees cost and expenditures
3. Initiates appropriate actions to achieve excellent results
4. Continues to generate creative new ideas and ways to enhance the practice of medicine and the community of medicine

The board represents the members of MSMP and the profession in determining and assuring exceptional organizational performance. Toward that end in recent past sessions of the board, a grant was approved for the enhancement of humanities in medicine. The intent of the grant is to bring art, literature, music, and the international culture of medicine to the members.

Ultimately the leadership success of the board is a direct result of the imaginative and productive input of individuals and the collective participation of its members. These are exciting and changing times in medicine. Involvement on the board of the medical society will allow exceptional individuals to be a part of shaping the future.

The board meets monthly except July and August. Conversations are lively, direct, diverse and important.

The board will consider all recommendations and present its list of nominees in March. If you have an interest in serving on the MSMP Board of Trustees or know of a colleague who has expressed an interest in serving, please contact Amanda Borges at 503-944-1129 or amanda@msmp.org by February 20, 2013. •

Correction

In the article written by student member Nathan Hamblin in the December 2012 issue of *The Scribe*, Hamblin was incorrectly listed as a "physical assistant" student. Hamblin is a second-year physician assistant student. The Scribe staff regrets the error •

Radiologist spends seven months serving patients, exploring new culture in New Zealand

By Dawn Weinberger
For the Scribe

Mary Burry, MD, is very familiar with the ins-and-outs of international service.

For more than 20 years, she and her husband **Tom Hoggard, MD,** have traveled all over the world with organizations like **Mercy Corp** and **Medical Teams International** , providing much-needed medical care to people in impoverished or disaster-stricken places.

Mary loves serving in this capacity, she says, but this past June she had the opportunity to try something new—three months in Whakatane, New Zealand, filling in for vacationing medical staff. She jumped at the chance to spend some time in the tiny town at the east end of the small island country.


MARY BURRY, MD

"I had talked to some other doctors who had worked in New Zealand and they said it was fun," says Burry, a Portland-based radiologist and past president of the **Medical Society of Metropolitan Portland**. "Next thing I knew, I was [there]."

Three months wound up turning into seven months, giving Burry even more time to get to know a new medical culture and to explore the beauty of the island.

She returned to Portland on January 26 with the experience of a lifetime, a wealth of memories and a newfound perspective on just how different things can be outside of the United States.

"It was kind of amazing," she says, adding that working in New Zealand felt a lot like how she imagines an old-fashioned medical practice. Not so much in terms of technology, although that certainly comes into play, but more in terms of the attitude of patients and doctors. Not to mention the relaxed schedules.

"I'm used to working 7:30 a.m. to 6 p.m. [at home]. In New Zealand, I start[ed] between 8:30 and 9 a.m. and I [was] done by 5 p.m.," she says, "And everyone [took] lunch and tea breaks."

Burry goes on to explain that Whakatane doctors typically work just three-and-a-half days each week. They don't work nights or weekends. In other words there are no on-call docs—all patients head to the ER for after-hours medical concerns.

And physicians take 30 vacation days a year. Plus, they receive 12 paid public holidays and two weeks of paid educational leave. The arrangement is so appealing, in fact, that Burry says many U.S. doctors decide to practice in New Zealand permanently.

"The stress level is a fraction [of] what it is at home," she points out, adding that there are "no malpractice problems because they have a different way of looking at outcomes."

There is, however, a trade-off.

As a public system pre-paid through taxes, things often get tied up in bureaucracy. Out-of-pocket expenses are essentially non-existent, though patients can choose to pay out of pocket for more rapid treatment at one of New Zealand's private hospitals if they wish.

Wait time for a routine ultrasound can be as long as 10 months. Combine that with a culture of people who are slow to act on health concerns, and it isn't uncommon for a troubling diagnosis to come too late to treat.

And when that happens, patients just seem to accept their fate, Burry says. She often wondered why they didn't see a doctor sooner, but she quickly came to realize that they simply have different expectations than the typical patient in the United States.

"They just know that life is unfair, and they don't think that it *should* be fair," she says. "They are much more accepting of the reality of things."

She recalls one particularly stoic patient, a young woman she encountered this past December. Diagnosed with advanced-stage breast cancer, the woman could not move her right arm—it was at least three times its normal size. The cancer had spread to her bones, and her prognosis was not good. Nonetheless, she had a smile on her face.

"She was very pleasant," Burry says. "I was amazed to see her like this. She was like 'this is the way it is and there isn't much they can do.'"

Burry says that while she learned to work within their system, she did, at times find it frustrating and heartbreaking, especially when patients weren't able or chose not to get treatment in time.

"It [was] interesting being in such a small town. You know everybody. It is real," she says, recalling a patient she saw in her radiology clinic who wound up passing away.

Despite the challenges, Burry left New Zealand with a positive impression of the country's medical customs. And the people.

The stress level is a fraction [of] what it is at home… there are **no malpractice problems** because they have a different way of looking at outcomes.

—Mary Burry, MD

"I'm anxious to see my family, but [was] sad to leave," she says. "I've made a lot of really nice friends."

She says she would be happy to return for another tour of duty, but not without her husband who, aside from a short visit, stayed home in Portland this time around.

"I think [serving in New Zealand] is a great thing for people to do," she says. "Although some might like it so much that they won't come back." •

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- Rates based on the experience of Oregon physicians

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scribe CLASSIFIEDS MARKETPLACE

To place your classified ad, please contact Dustin at LLM at 503-445-2234.

PHYSICIAN OPENINGS

Family Practice or Internal Medicine Physicians: Pacific Medical Group is a busy, independent, private practice with five provider-owned clinic locations in the Portland metro and surrounding area, that boasts a provider satisfaction rate of 86%. Looking for full-time dynamic providers to join and expand our progressive practice.

- Outpatient only
- Opportunity to be a shareholder, and participate in an incentive pay plan after first year
- Competitive salary, sign-on bonus, and benefit package
- Fully automated EMR software

If you are seeking an opportunity to build and grow a solid practice that is both professionally satisfying and financially rewarding, this may be the right opportunity for you. To apply, submit CV and cover letter by email to careers@pacificmedicalgroup.com, or by fax to 503-914-0335.

Pediatrician: Small pediatric clinic on the west side looking to hire a part-time, Board Certified Pediatrician for two days per week, including vacation coverage, locum coverage and possible weekends. Salary is negotiable. Please fax CV and salary requirements to 503- 297-1043 attn: Jill D.

Lacamas Medical Group, PC

Family Practice, Urgent Care & Occupational Medicine

Progressive Family Practice group in Camas, WA is looking to add provider for our growing, office based, independent practice. The position will take over an existing young women and family practice panel. Willing to consider part time or job share type of arrangement.

Logician EMR and onsite lab and digital x-ray.
Open Access model for scheduling.

Partnership potential after one year.

Compensation is base plus productivity bonus, CME and Professional dues, Health, Dental and vision, 401K.

Please call or email Attn: Scott Jonason
Lacamas Medical Group, PC
3240 NE 3rd Ave, Camas, WA 98607
360-838-2440
sjonason@lacamasmedicalgroup.com

OTHER MEDICAL OPENINGS

Northwest Occupational Medicine Center, a Multidisciplinary clinic in Beaverton, is seeking a part-time or full-time Physiatrist (PM & R), Occupational physician, or Family practitioner with an interest in sports medicine. For further information please contact Brad Lorber, MD at mleland@nwomc.com or call 503-684-7246.

Family Nurse Practitioner: Needed for busy Integrative Family Practice located in Sherwood, Oregon. We offer family care for infants–elderly. Our clinic is comprised of 9 providers.

- Ideal candidate will have at least 2 years clinical experience practicing as a primary care provider and believe in providing quality care to their patients and is able to coordinate patient care with other providers. Must have strong interest in Integrative Care.
- Must have current, unencumbered licensure with the State of Oregon as a Certified Practitioner with Prescriptive Authority.
- Must be flexible with working hours.
- Full time (minimum 36 hours per week clinic hours).
- Our clinic is open extended evenings and Saturdays.
- We provide a highly competitive compensation package.

Please send your resume and cover letter ATTN: Sarah Ahlschlager, Clinic Administrator; sahlschlager@sherwoodfamilymedicine.com.

SPACE AVAILABLE

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.

SERVICES

VACATION RENTAL

Oregon Coast Vacation Rental: The Inn at Otter Crest. Condo with the best view on the Oregon Coast. Sleeps up to 10. Full kitchen. Deck. Can rent part or entire condo. Onsite swimming pool and children's playground. Newly remodeled. Sorry, no pets allowed.
Call for details and pricing, 503-312-5548.

The Scribe

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