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Medical liability mediation bill becomes law

By Cliff Collins
For The Scribe

A bill intended to reduce malpractice lawsuits easily passed in the Oregon Legislature and was signed into law by **Gov. John Kitzhaber** in March.

Senate Bill 483 resulted from a proposal developed by a work group Kitzhaber established last year intended to encourage voluntary early discussion and resolution. Legislative approval was assured after the respective boards of trustees of the Oregon Medical Association and the Oregon Trial Lawyers Association voted in January to back the bill. Agreement between the two organizations on previous liability reform measures over the years always had proved elusive.

OMA President William "Bud" Pierce, MD, who co-chaired the 2012 work group with a plaintiff attorney and legislators of both parties, said the bill's passage represents "a critical first step in achieving a safer health care system for all Oregonians. To really improve the system and patient safety, health care providers and patients need to have open, frank discussions about the patient's care." The voluntary early discussion and resolution process "will allow health care providers and patients to resolve adverse events without litigation," he said.

Kitzhaber's role in supporting the legislation was crucial to its passage. He had taken a strong interest in the outcome of the OMA's Jan. 26 vote, personally lobbying OMA trustees to support the proposal. He reminded them that he was honoring his commitment to physicians to work with the Legislature toward medical liability reform, adding: "This proposal will be the only one I will support in 2013."

He praised passage by the Legislature. "This bill will help resolve many serious medical events before they go to court by allowing health care providers and patients to have early discussions in a confidential setting," Kitzhaber said. "I committed last year to bring a proposal to the Legislature to ensure that our medical liability system fits within our shared vision of health system transformation, and I appreciate the Legislature supporting this effort."

The proposal developed by the work group had generated sometimes acrimonious debate among the medical community about whether the OMA should support it. Doctors critical of the bill said it did not represent tort reform, and noted that defense attorneys and medical liability carriers were not participants in the workgroup process that reviewed and developed the proposal. Some representatives of those two parties had warned physicians that the measure was not in their best interest and would cause an increase in the frequency of lawsuits and the cost to insurers.

Pierce responded that although the bill "is not liability reform in the traditional sense, it is a big step in the right direction and has tremendous potential to improve the practice environment and patient safety in Oregon while providing an alternative to the expensive and protracted court process that currently serves neither patients nor physicians."

Pierce added that comprehensive liability reform continues to be a primary policy objective for the OMA, "and we will continue to work toward that goal."

The bill is expected to cost the state $1.6 million in the coming biennium, according to the Oregon Legislative Fiscal Office. •

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INSIDE THIS ISSUE

Advancing family medicine

The Virginia Garcia Memorial Health Center is part of a new multi-state family medicine residency program considered a potential model for residency programs nationwide in that it addresses two pressing health care challenges.

—Page 6

Meet the tri-county's new health officer

The well-traveled Justin Denny, MD, returns to Portland as the new tri-county health officer, saying he relishes the opportunity to be part of a large public health team with a broad range of responsibilities.

—Page 9

A new way to prevent ovarian cancer

Legacy recommends fallopian tube removal

New evidence shows that the most common and highly lethal form of ovarian cancer — high-grade serous, formerly called papillary serous cancer — only rarely, if ever, arises from the ovary.

Careful, pathologic study of prophylactically removed tissues from patients with genetic predisposition to this cancer have identified the earliest precursors (the "p53 signature") and all of the intermediate stages of atypia up through invasive carcinoma in a consistently occurring progression — virtually always in the fallopian tube and never in the ovary.

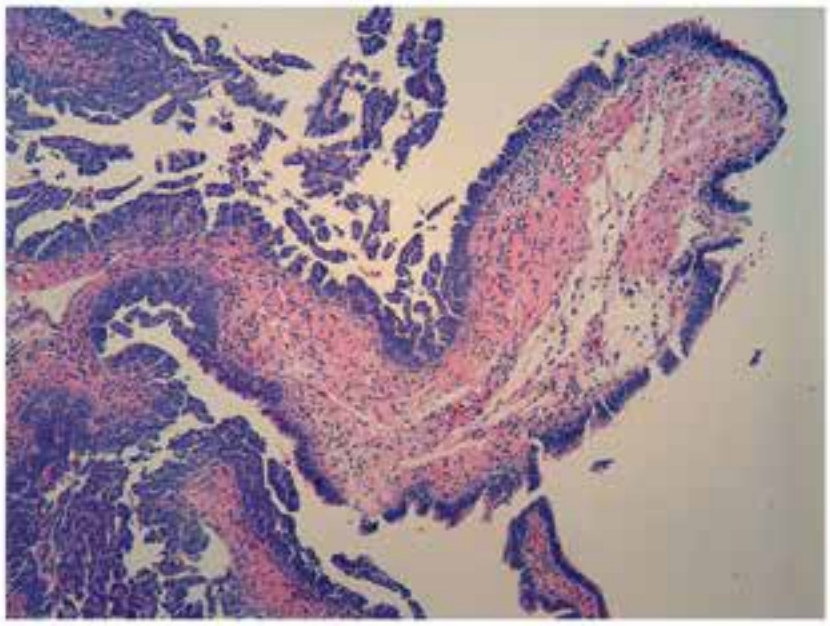
New insight

Armed with this insight, many pathologists, including Legacy Cancer Institute's Ann Smith Sehdev, M.D., have found that this same precursor lesion regularly occurs in the fallopian tubes of all of our ovarian cancer patients, including those without any genetic predisposition.

Surgical removal of at least the distal (fimbria) portion of the fallopian tubes in patients who have completed childbearing could prevent most of these malignancies.

New recommendation

Legacy Cancer Institute recommends that physicians remove the fallopian tubes during hysterectomies, tubal ligations and other routine abdominal procedures. Legacy also recommends that women who have a strong family history or known genetic mutation predisposing them to breast or ovarian cancer consider salpingectomy to reduce their risk.



High-grade serous carcinoma involving distal fallopian tube

For more on fallopian tube removal

To learn more about Legacy's fallopian tube removal recommendations and for a patient FAQ, please see **www.legacyhealth.org/preventovariancancer**.

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LEGACY HEALTH

OHSU adjusts to challenging economics

By John Rumler
For The Scribe

A series of state and federal funding cuts, a flurry of health care reforms and the looming toll of sequestration have hit area hospitals like a perfect storm.

On top of all of this, Oregon Health & Science University (OHSU) is grappling with another beast: the relentlessly escalating costs of Oregon's Public Employees Retirement System, which increased by $20 million in 2011 and is on track to go up by another $21 million in July.

As a result of these cumulative economic blows, **OHSU President Joe Robertson, MD,** announced a university-wide hiring freeze on Feb. 28.


JOE ROBERTSON, MD

"In viewing the financial landscape ahead, our leadership has determined that cautionary belt-tightening through a hiring freeze now is a prudent and necessary action," Robertson said.

OHSU earned $35.7 million in operating income through the first seven months of the fiscal year and the operating income is currently $5 million ahead of budget. However, the host of challenges that led to the hiring freeze and other cautionary measures aren't expected to go away any time soon, according to a report at the quarterly OHSU Board of Directors meeting March 21.

The university's hiring freeze comes with a caveat. As the freeze will not affect the quality of patient care, exceptions will be made for essential health care providers and, in some instances, for the replacement of staff exiting crucial university positions.

Although most hospitals depend to some extent on public funding, OHSU is much more reliant on public resources because it is a teaching and research institution. For example, more than 60 percent of National Institutes of Health research funding sent to Oregon comes to OHSU.

Since OHSU receives about 40 percent of its $2 billion budget from federal research grants and Medicare and Medicaid payments, any significant cuts in the federal budget raise huge concerns for the university's administration.

"When compared to other public institutions in the state, OHSU will take one of the biggest financial hits through sequestration cuts," Robertson said.

The overall impact of sequestration on OHSU is estimated to be between $30 million to $35 million on an annual basis, including a 2 percent cut to Medicare (about $7 million) and an 8-plus percent cut to National Institutes of Health research funding, and other federal programs such as Department of Defense research funding and National Science Foundation funding ($23 million to $28 million).

A host of other challenges facing regional hospitals, including OHSU, comes in the form of various ongoing health care reforms at the state and national levels, which will also reduce payments for all health systems.

"By acting firmly now, with a hiring freeze and reductions in discretionary spending, we can ensure that OHSU continues its record of strong financial performance and secures the resources required to sustain and advance our missions," said **Lawrence Furnstahl**, OHSU's chief financial officer.

Even though OHSU was operating ahead of financial projections, the $35.7 million is less than would normally be expected given that OHSU's patient activity is running 5 percent above budget. "This is the leading edge of what we've been expecting, which is the impact of health care spending slowing nationally," said Furnstahl.


LAWRENCE FURNSTAHL

This isn't the first hiring freeze for OHSU. The university did the same thing in 2008, reducing its budget and number of employees. However, those actions were attributed to expansion costs, medical malpractice liability issues, and a decrease in federal funding for research and education.

OHSU rebounded and has added about 1,600 positions since 2009, many of them well above the average income, in spite of a stubborn economic slump. In addition, it also has become a major player in the sweepstakes for federal research grants, pulling in $359 million in 2012 alone, placing OHSU in the top 20 research universities among the 140 in the nation.

In addition to being the region's only academic health and research university, OHSU runs more than 200 community outreach programs spread across every county in the state.

Robertson is confident that the university will weather the current storm and once again be an engine that helps drive the region's economy. "With prudent management, I believe OHSU will be well positioned eventually to again provide additional high-quality jobs for the region," he said. •

OHSU's hiring freeze Q&A

Why the hiring freeze?
OHSU leadership decided to institute a hiring freeze due to a series of factors, both known and unknown, that will affect finances. Those factors include the $31 million to $33 million impact of sequestration, the ongoing impacts of health care reform and the growing cost of PERS.

Is OHSU instituting any other additional cost-saving measures?
Yes. The university is limiting travel, consulting fees and other discretionary spending in addition to the hiring freeze.

Will the hiring freeze affect any part of OHSU more than others?
The freeze will impact all segments of OHSU. However, it will not interfere with patient care. Hiring for essential patient care positions will continue.

How much are PERS costs to blame?
PERS costs are a significant part of the issue as OHSU's PERS expenses are increasing by nearly $21 million a year. OHSU is addressing the employer/employee contribution to PERS to reduce costs; however, it continues to remain an economic challenge.

Any estimates on how long the hiring freeze will last?
At a minimum, the hiring freeze will last throughout the current fiscal year, which ends June 30. It is impossible to say how long the freeze may last after that.

Hospital systems respond to fiscal crunch by trimming expenses

No other major health care provider in the region has announced plans to implement a hiring freeze, but all are reducing expenses wherever possible.

Legacy Health, which employs about 9,700, has known for years that health care reform would impact reimbursements and took steps last year to reduce staff and expenses in preparation for the changes, said **David Eager**, senior vice president and chief financial officer. "While Legacy is aware the sequester will impact reimbursements from the federal government such as Medicaid, Legacy doesn't believe it will require layoffs or other significant reductions given the work that's already been done."


DAVID EAGER

The sequester is having a direct impact on revenue at Kaiser Permanente Northwest, according to **Karen Schartman**, vice president and chief financial officer.

"We anticipated this, and began our 2013 planning with the expectation that revenues from the federal government would continue to decline, especially from Medicare," she said. "This challenge makes it even more important to continue the work we are leading to drive quality improvements that put the patient first, while delivering care in the most efficient way possible."


KAREN SCHARTMAN

KPN, which employs about 8,900 in Oregon and Washington, will continue its commitment to long-range planning as the key to good financial health, Schartman said, and to serve its community, as evidenced by the opening later this year of the new Westside Medical Center and the addition of 1,000 permanent, family wage jobs to the local economy.

Providence Health & Services, which employs 17,500 in Oregon, began a three-year process to reduce costs by $250 million in 2011 and after two years has identified $156 million in cost reductions, said senior communications coordinator **Jean Marks**. Providence has also implemented a process to review every open position and to determine whether it needs to be filled. •

—John Rumler

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Home deliveries, while on the rise in Portland, deserve careful consideration

Editor's note:

MSMP Board president-elect Brenda Kehoe, MD, and Philippa Ribbink, MD, practice together at Everywoman's Health in Portland and have teamed up to provide a two-part article about home births. In this first installment, Ribbink discusses Holland's system and how it compares to Portland. Kehoe will present her perspective in the July issue of *The Scribe*.

By Philippa Ribbink, MD
For The Scribe

Portland, with its backyard chicken coops, front-yard vegetable gardens and rooftop beehives, has a very active home delivery community. A growing number of pregnant women feel that those of us who work in a hospital have lost the connection to the essence of the birth experience, the amazing fact that a woman can grow a healthy human being in her belly and deliver it vaginally most of the time. Women who seek home delivery feel that hospital-based obstetrical care "medicalizes" pregnancy and delivery. Critics of hospital birth point out that needless medical interventions have driven the cesarean-section rate up to the 30 percent range, whereas cerebral palsy rates are unchanged.

In 2008, 3.3 percent of births were planned, out-of-hospital births in Multnomah County. The preliminary data from the Oregon Bureau of Vital Statistics indicate that this number went up to 5.2 percent in 2012. Most of those births were attended by certified nurse midwives or licensed, direct entry midwives. In 2010, 7.2 percent of the out-of-hospital births were attended to by unlicensed, direct entry midwives. Oregon and Utah are the only states that allow unlicensed midwives to attend births. The Board of Direct Entry Midwifery sets training requirements, defines the scope of practice for midwives, and also conducts investigations and imposes disciplinary action. It functions very similarly to the Oregon Medical Board, but it has no jurisdiction over unlicensed midwives.

The Dutch System

Advocates for out-of-hospital birth tend to point to The Netherlands, where up to 30 percent of women deliver at home. Even the professional society of obstetricians, the NVOG, actively supports home delivery by licensed and certified midwives. All midwives in Holland have to complete an accredited four-year program and have to be licensed to practice. A Dutch pregnant woman enters the health care system by first seeing a midwife. The midwife takes a thorough medical history and determines whether the patient has an indication for a hospital delivery. She is guided by a checklist of indications developed by Dr. Kloosterman, the Chief of Obstetrics at The University of Amsterdam. This list is still called the Kloosterman List, and a committee of midwives and obstetricians updates the checklist every 10 years based upon outcome data. If the patient does not have an indication, she stays in the care of the midwife and delivers at home or a birthing center. If she develops an indication for hospital birth during the course of her pregnancy, she gets transferred to an obstetrician. A practitioner planning to attend a birth at home with a hospital indication is subject to prosecution and could be jailed or fined, depending upon the outcome.

See ***OUR DILEMMA,*** *page 14*

OCHIN Inc. acquires Oregon Health Network

Alignment aims to better meet needs amid rapidly changing landscape

By John Rumler
For The Scribe

Oregon Community Health Information Network Inc. (OCHIN), an independent nonprofit since 1992 and a national leader in health information technology, has acquired Oregon Health Network (OHN), a nonprofit that manages and monitors Oregon's telehealth network and whose mission is to improve the quality, access and delivery of health care to Oregonians.

The two Portland-based organizations decided they could better fulfill their missions and meet the needs of the regional health care community by joining forces. The deal was effective April 1.

According to **Kim Lamb**, OHN's executive director, the nation's health care landscape is in the midst of a massive redesign effort that requires providers to retool their business, care and education models.

KIM LAMB

"The only way to achieve success in this environment is to have all members of the health care continuum streamline and simplify their efforts and offerings to ensure that every health care provider and community makes it to the finish line," Lamb said. "Through this alignment, we will help them do just that."

The two companies believe the new alignment will complement both operations and enable them to better address the immediate needs of the providers, hospitals, patients and health care educators who are reshaping Oregon's rapidly changing coordinated care landscape.

"OHN's infrastructure and knowledgeable staff are a perfect complement to OCHIN's executive health care resources, data analytics and clinical improvement expertise," said **Abby Sears**, OCHIN chief executive officer. "Together, we will have an immediate impact on health care delivery and service."

ABBY SEARS

Dick Gibson, MD, founding OHN board chairman, said since the inception of OHN the organization's leadership and board have realized the need to expand services and/or align with other organizations.

"I am proud of the work and progress that the OHN has achieved and I look forward to the next stage in OHN's development," said Gibson, who is also the chief health care intelligence officer for Providence Health & Services.

OCHIN was established in 2000 through a partnership with CareOregon, the Oregon Primary Care Association, Multnomah County Health Department, Clackamas County Health Department and Virginia Garcia Health Clinics.

Originally focusing on safety net clinics and small practices, OCHIN expanded to include private practice providers and specialists. Today, it operates in 14 states supporting 70 health center networks and more than 4,500 medical providers serving upwards of 2.5 million patients.

OHN is a member-based organization providing a variety of technical and support services to its 228 member facilities, including enhanced broadband connectivity, health best practices, hosted services and advocacy.

Two years after it was founded in 2007, OHN received $20 million from the Federal Communications Commission — the largest single allocation in the FCC's history—to build a "telehealth network" throughout the state and to link more than 300 health care facilities in urban, rural and frontier communities through broadband connections.

The FCC funding was a part of the $417 million Rural Healthcare Pilot Program dedicated to building statewide and

See ***PARTNERSHIP,*** *page 10*

First-ever program helps Virginia Garcia, other CHCs meet primary care needs

By John Rumler
For The Scribe

The Virginia Garcia Memorial Health Center, a nonprofit primary health care provider serving the low-income and uninsured populations of Washington and Yamhill counties, is working extra hard to make up for its shortage of primary care physicians.

It is far from alone.

Nationwide, an estimated 13 percent of all primary care positions in community health centers and federally qualified health care centers (FQHC) are unfilled. Those figures are projected to drastically worsen for Oregon in 2014, when the 17 percent of the non-elderly uninsured in the state is reduced to 11 percent due to the Affordable Care Act.

The good news for Virginia Garcia, and five other community health centers in the U.S., is that help is on the way.

Thanks to a first-ever multistate residency program—which focuses on the primary care specialty of family medicine—Virginia Garcia will add two residents per year starting this July, with a goal of six total in the program at the end of three years. The residency period for a family physician is three years, the internship being the first year of a residency.

The A.T. Still University of Health Sciences School of Osteopathic Medicine in Mesa, Ariz., and the Wright Center for Graduate Medical Education in Scranton, Pa., cooperatively developed and run the program, which is funded by a $4 million U.S. Health Resources and Services Administration grant.

The program will place a total of 29 medical school graduates per year, over three years, at community health centers in at-risk and medically underserved communities around the country.

"Community health centers provide rich educational experiences for those passionate about the health of America's most vulnerable citizens," said **Gil Muñoz,** CEO of Virginia Garcia Memorial Health Center. "We are thrilled to be among those giving the incoming residents an opportunity to enhance their training, not only by serving a diverse patient community, but also by being part of a medical model that is redefining the way health care is delivered in the United States."

The fledgling program is a model for residency programs across the country in that it addresses two of the nation's major health care challenges: the shortage of primary care physicians trained to work with America's most vulnerable populations, and the potential changes in federal funding that may leave thousands of new doctors without a place to complete their training.

Out of $360 billion in total health care cuts, the Obama administration targeted a $9.7 billion reduction in federal Graduate Medical Education funding as a part of its plan to reduce the federal budget by $4 trillion during the next decade. In addition, the National Commission on Fiscal Responsibility and Reform proposes a $60 billion cut over 10 years in Medicare support for Graduate Medical Education.

The cuts will likely force teaching hospitals to lay off staff, close training programs and eliminate some services that operate at a loss. In the face of these cutbacks and the looming effects of the sequestration, any help or assistance for medical students or interns is critically important.

The jointly run program aims to create a pipeline of doctors trained to work with underserved rural and urban populations and in team-based practices that emphasize keeping entire communities healthy.

Unlike most residency programs, which take place in and are managed by individual hospitals or medical centers, the Wright Center-ATSU collaboration is a multistate but centrally run effort spread among health care organizations in Arizona, Ohio, Oregon, New York, Washington state and Washington, D.C.

The new residency program with which the Virginia Garcia Memorial Health Center is involved will, in part, address the shortage of primary care physicians trained to work with vulnerable populations.
Photo by Larry Rosencrantz

The residency program will deliver an innovative curriculum with a strong community focus combined with comprehensive training and unique opportunities for participants.

With research showing that new doctors tend to practice in the communities where they have completed their residencies, there is a glaring need to create opportunities for residents to train in these underserved and often poverty-level communities.

Christine Rontal, executive director of the Virginia Garcia Memorial Foundation, said the value of the multistate initiative program to community health centers such as Virginia Garcia is it gives them the opportunity to utilize resources from different sites that don't exist at their own facilities.

"We will be taking advantage of an already up and running residency program in the Wright Center and a medical school in ATSU School of Medicine which allows us to broaden our reach without having to create the administrative superstructure de novo," she said.

All residents will be based at Virginia Garcia Hillsboro but they will rotate to the four different clinics for additional teaching opportunities. An important question is, will the residents stay permanently or will they complete their internship and move on?

"Our goal will be to keep the residents that we have invested the time and energy in developing in them the skills of being competent physicians," Rontal said. "We hope to be competitive in those efforts, but we will be happy to be part of the solution of more primary care physicians in FQHCs in the region."

Thomas McWilliams, DO, associate dean for Graduate Medical Education at A.T. Still University, helped develop the new program. "These residencies will serve as a model for a new paradigm for training physicians to function effectively within a rapidly evolving health care system," he said. "Physicians trained in these programs will become leaders in shaping medicine in this country and will be a force to improve the health of individual patients as well as the overall health of their communities."

President and CEO of the Wright Center, **Linda Thomas-Hemak, MD**, said, "The Wright Center has acted as a teaching health center GME consortium spreading our rich tradition of academic excellence in an educational infrastructure throughout northeastern Pennsylvania. We are privileged to have the opportunity through collaboration with A.T. Still University to nationalize our efforts."

Besides Virginia Garcia, the other community health centers participating in the program are: the El Rio Community Health Center in Tucson, Ariz., the Lutheran Family Health Centers in Brooklyn, NY, HealthSource of Ohio in Milford, Ohio, HealthPoint in Renton, Wash., and Unity Health Care in Washington, D.C.

The Virginia Garcia staff was "overall very excited about the opportunity" when they learned they would benefit from this new program, and "somewhat anxious about trying something new and different," Rontal said. "I've gotten about ninety percent positive feedback from our medical and ancillary staff." •

Childhood immunizations under the microscope as Legislature considers SB 132

By Melody Finnemore
For The Scribe

As Senate Bill 132 wends its way through the legislative process, it creates a prime opportunity to address not just the bill's pros and cons, but the common myths surrounding childhood vaccinations.

At 5 percent, Oregon has the highest rate of kindergartners who are not vaccinated. The rate of children who aren't vaccinated has more than doubled in the last decade, according to the Oregon Pediatric Society (OPS). The OPS also reports that Oregon had more than 800 cases of pertussis in 2012, the highest rate since the 1950s. And the non-medical exemption rate was as high as 76 percent in some Oregon schools during the 2011–12 school year.

Oregon law currently requires children in childcare and school to submit a form verifying they have received required vaccines. Parents who choose not to vaccinate their children submit a form stating their exemption. The new law would require those parents to also submit either a provider signature or a certificate verifying that they have received education about the risks associated with not immunizing their child. In 2011, Washington passed similar legislation, resulting in a 25 percent decrease in immunization exemptions, according to the OPS.

MSMP Board member **Lydia Villegas, MD**, says the bill's weaknesses include the option that allows parents and caregivers—and their family physicians—to take the "path of least resistance" by opting for their health care provider's signature indicating they have been educated about the need for childhood immunizations.

"Many people will just get the signed paper rather than watching the educational video, and it may defeat the purpose," Villegas said, adding that a visit to the doctor's office to discuss childhood immunizations may not be covered by insurance for many. In addition, the definition of the religious exemption is somewhat nebulous as it currently stands.

Ultimately, legislation such as SB 132 promotes vaccinations that protect children from preventable diseases such as measles, mumps, rubella and the flu. Villegas said the key is to ensure more parents become educated about vaccinations before choosing to exempt their children.

"The Internet education video is a way for more parents to really know before declining the vaccine," she said. "It might show them what the research says and help them make more informed decisions."

There are many myths about childhood vaccines that cause parents and caregivers to choose exemption over immunization. Here are the top six misconceptions, according to the Centers for Disease Control and Prevention:

- Diseases had already begun to disappear before vaccines were introduced because of better hygiene and sanitation.
- The majority of people who get a disease have been vaccinated.
- There are "hot lots" of vaccine that have been associated with more adverse events and deaths than others.
- Vaccines cause many harmful side effects, illnesses and even death.
- Vaccine-preventable diseases have been virtually eliminated from the United States.
- Giving a child multiple vaccinations for different diseases at the same time increases the risk of harmful side effects and can overload the immune system. •

William Moss, MD

By Jon Bell
For The Scribe

William Moss, MD, wrote the book on radiation oncology. Literally.

The former chair of the Department of Radiation Therapy at Oregon Health & Science University, Moss wrote "Radiation Oncology: Rationale, Technique, Results" and had it published by the medical and textbook company Mosby in 1959. The book became a bestseller in the medical world and went on to see no fewer than eight additional editions, some edited later by other physicians. The ninth and latest edition, published in 2010, is now available as an e-book.

"It was for a time the only book that dealt specifically with radiation treatment of cancer," said Moss, now 94. "That made my name in the field."

Though he's been retired since late 1989, Moss has fond memories of his time in medicine. OHSU still awards the William T. Moss, MD Annual Excellence in Teaching Award, and his name is one that still holds a place among pioneers in radiation therapy for the treatment of cancer.

The Scribe: **Can you share a little bit about your background?**

William Moss: I was born in Ardmore, South Dakota, in 1918, but after about five years, after my father had died, we moved with my mother to Rock Hill, South Carolina, to be with my mother's sister. That's where I was reared. After high school, I went to The Citadel and graduated from there in 1939. Then I decided to go to medical school at Washington University in St. Louis.

The Scribe: **What got you interested in medicine?**

Moss: Well, it was always something I was interested in. I hate to brag, but I was really good in human anatomy. When I was at Washington University in St. Louis, I had a professor who offered me a fellowship if I would help the first-year medical students with their dissection. So for two years, I helped medical students in the lab with cadavers, circulating around to see if they needed help and if they knew what they were doing. I did that half-time while I was in school to help pay for my medical school, so that really helped keep me interested and involved.

The Scribe: **How did you get into cancer treatment?**

Moss: After medical school, I had an internship at Barnes Hospital in St. Louis, which is a famous hospital. Then I did a year at the Missouri State Cancer Hospital (now called the Ellis Fischel Cancer Center), but after that I had to go into the service. I became a captain in the Air Force and served in Guam for two years, just after World War II, when the Japanese were still occupying the island. When I came back, I returned to the Missouri State Cancer Hospital and became a resident in training in radiation oncology. When I was in medical school, I rotated out to the hospital for a one-month period to learn about cancer and radiation. I liked it so much that when I finished school and my internship, I applied for additional training and got that.

The Scribe: **Was all your training in Missouri?**

Moss: No, my chief at the state hospital said you've got to go to Europe and learn about radiation therapy. That's where a lot of the advances were happening. I got a National Cancer Institute fellowship and went to Manchester, England, where I studied radiation therapy service for one year. After that, I earned a continuation of my grant and did six months at the Curie Institute in Paris, and then became chief of radiation at the Missouri State Cancer Hospital.

The Scribe: **What brought you to Oregon?**

Moss: I got a letter from the University of Oregon Medical School (now OHSU) asking me to come to Portland and give a few lectures at the medical school. While I was here, the dean called me into his office and said, "We want you up here," so I accepted the offer. I came to Oregon (in 1974) to be the chair of the Department of Radiation Therapy, and I served there until I retired.

The Scribe: **Are there any highlights that stick out for you from your career in medicine?**

Moss: During all that time early on, I collected materials and thought about writing a book. So I ended up writing a book about cancer treatment with radiation, which was one of the only books then (1959) that dealt specifically with radiation treatment of cancer. I can't claim it to be the first, but it was definitely one of the earliest. It went on to see six or eight editions over about 30 or 40 years, so that really sticks out for me.

The Scribe: **How about your life outside of medicine and since you retired?**

Moss: I married a girl named Rose Daily and we were married for 67 years. She passed away a few days ago. We had six kids, one is a physician, one is a nurse. In terms of hobbies, I can't say I had any big hobbies. I read a lot, wrote a lot. Writing the book was kind of my hobby. I wasn't out playing tennis or anything like that. Where I live now, at Mary's Woods in Lake Oswego, I still read a lot. I belong to a writing group that meets every other Saturday. We usually write stories about our lives. I've written things about my childhood and all that. It's a very benign life. •

Welcome New Members

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Specialty: Family Medicine
Graduated: OHSU '83

Judith M. Kemp, MD
Judith M. Kemp, MD, LLC
6244 NE Brighton St, Hillsboro, OR 97214
503-615-3100
Specialty: Family Practice
Graduated: UTMB '01

Robert Mullen, MD
Rose City Clinic, LLP
5635 NE Alameda St, Portland, OR 97213
503-282-0979
Specialty: Internal Medicine
Graduated: George Washington University '82

MEDICAL SOCIETY OF METROPOLITAN PORTLAND

Right at Home

Justin Denny, MD, the new tri-county health officer, returns to Portland with a healthy dose of enthusiasm, international experience

By Cliff Collins
For The Scribe

Justin Denny, MD, MPH, has lived and worked all around the world, but he considers himself back at home since he returned to Portland last summer.

Denny, who had taken his dual residency in family medicine and public health and preventive medicine at Oregon Health & Science University from 1998 to 2001, is the new tri-county health officer, covering Multnomah, Clackamas and Washington counties. He follows **Gary L. Oxman, MD, MPH**, who retired at the end of January. (Please see sidebar.)

Denny, who was born in England because his father was in the U.S. foreign service, moved often with his family during his growing-up years. Among places the family lived were Washington, D.C., Israel and the Philippines. "About every four to eight years, we moved," he recounts.

Despite or because of these circumstances, Denny had no trouble deciding on medicine as a career. "I always gravitated toward people and science," he says. "I always loved both."

After completing his undergraduate and medical degrees in Virginia, he later worked in clinical practice in Portland, both family medicine and emergency medicine, and in 2002 obtained a master's degree in public health at OHSU. Denny's first public health job was as medical director and health officer for Clark County, Wash., and for Washington, Clackamas, Columbia, Wasco and Sherman counties in Oregon.

"Public health always has been a calling to me," he explains of his choice of specialty. Despite the many advances and innovations American medicine has achieved, we still fall behind other countries in prevention, he says, which places plenty of importance on public health's role.

Once grown and degreed, Denny continued the peripatetic ways of his upbringing. In 2007, he went to work for the European Centre for Disease Prevention and Control in Stockholm. Most recently, before returning to the Beaver State, Denny worked from 2008 to 2012 in Thailand and Laos for the World Health Organization and the U.S. Centers for Disease Control and Prevention. He and his wife, Paula Dougherty, had adopted a girl from Thailand, and they wanted to experience Southeast Asian culture, he says.

Denny speaks Spanish, Swedish and Lao, and gained many valuable perspectives from his overseas travel and jobs. The contrasts he observed between the United States and foreign countries help him appreciate American culture's emphasis on a "friendly, can-do spirit," while highlighting how our individualistic mind-set can leave some people isolated and disconnected from any community.

He says patients in the area of Laos where he worked earned only 10 or 15 cents a day, but generally were more healthy as a group than ER patients he treated at Legacy Good Samaritan Medical Center. The strong "social cohesion" of Southeast Asian culture may have made a difference, he thinks, because orphans and the disabled were taken in by families. "People take care of each other," he says. "That contributes to health enormously."

That is why one of the aspects that attracted Denny to his new position in Portland was the promise of health care transformation, where patients are treated via medical homes and fragmented care is avoided. Treating people for primary care in the ER is "ill-placed" by comparison, in addition to being expensive, he notes.

The tri-county health officer has a broad range of responsibilities, from coordinating programs with other counties, to preparing and responding to emergencies, to inspecting restaurants and preventing disease outbreaks. And Multnomah County has some of the most affluent citizens in Oregon, as well as the most impoverished and disadvantaged, he adds. "It's a big job with many challenges."

But the county also brings the asset of a large public health team, larger even than that of the state's, Denny says. "Public health is a team sport. If you make many decisions in isolation," you aren't doing the job the right way, he says.

In crises and controversies, public health officers can find themselves in the spotlight. Denny welcomes the opportunity of working with the media, because it's a good way to get messages out about public health, he says.

"Communication is an art you have to work on. In difficult, challenging circumstances, you have to take time to communicate them. I look forward to that."

He also realizes he has big shoes to fill following Oxman in this position. "Everywhere I go I find Gary's fingerprints everywhere," he says.

However, Denny has many ties in the community, including having benefited from mentors such as **Bruce Goldberg, MD**, formerly of OHSU family medicine and now head of the Oregon Health Authority; **Alan Melnick, MD, MPH**, an OHSU associate professor and health officer for Clark, Cowlitz, Skamania and Wahkiakum counties in Washington; and **Mel Kohn, MD**, state public health director.

"I know a lot of people," Denny reflects. "A lot of folks I can't say enough about. I can't tell you how privileged I feel to be in that role."

He likely has given up his nomadic ways for good, too, and says he and his family are here to stay. Dougherty is a teacher and, in 2002, won Portland Public Schools' Teacher of the Year. Denny is an avid jogger, and he also plays clarinet and the guitar, though he claims he is no threat musically to break into the lineup of Oxman and Goldberg's venerable rhythm-and-blues band, HomeBrew.

As for the politics that accompany his new job, Denny isn't worried. He admits there is much too learn about "hospital systems and personalities," but he imagines all of that will be peanuts compared with working for the United Nations. In the U.N., the political bureaucracies, he says, are "enormous." •

Justin Denny
Home: Portland
Family: Wife, Paula Dougherty, a teacher; and daughter, Pimnipa, 12.
Hobbies: Jogging and playing the clarinet and guitar.

Oxman, MD hangs up his spurs after three decades

One trait never changed about **Gary L. Oxman, MD, MPH:** From when he began working with Multnomah County in the 1980s until he stepped down Feb. 1, his appearance—the wavy hair and Fu Manchu mustache of an Old West sheriff—remained the same.

Oxman served as Multnomah County medical director and later as health officer from 1984 until 2006, when he became tri-county health officer for Multnomah, Clackamas and Washington counties until his retirement at the end of January.

Those who have known and worked with him say another characteristic about Oxman was unwavering: his self-effacing approach to his job. He long has refused to take individual credit for Health Department accomplishments.

"I didn't do anything alone," he says now. "Everything I did was with colleagues in the department or colleagues in the community."

> **"I didn't do anything alone.** Everything I did was with colleagues in the department or colleagues in the community."
> —Gary Oxman, MD, MPH

Maybe so, but a lot of good got done during the 29 years he served in that department. Oxman, a longtime member of the Medical Society of Metropolitan Portland, was honored by the county when Multnomah County commissioners declared Jan. 17 "Gary Oxman Day," recognizing that Oxman may have done more to save lives and improve the health of Portland-area people than just about anybody.

A Minneapolis native, Oxman is the youngest son of a psychologist and a speech pathologist. He graduated from the University of Minnesota Medical School and practiced as a family physician for five years in Portland before moving into public health. He worked under then-health officer **Charles Schade, MD**, taking over that position in 1987 at age 35 after the colorful Schade retired.

Accomplishments under Oxman's tenure are many. Besides the routine work of public health, they include addressing racial and health disparities, early HIV prevention, emergency preparedness, addictions treatment and curtailment of heroin addicts' deaths, workplace smoking, and health care transformation.

"I've really had the privilege of being involved," says Oxman, who will continue to do some consulting work for the county during the coming months. "It's a great department doing great work, and I was privileged to have worked there." •

—Cliff Collins

Providence's Van Pelt to continue health care involvement in retirement

By Barry Finnemore
For The Scribe

Greg Van Pelt recently announced his retirement after 38 years with Providence Health & Services, but the decision does not mark the end of his involvement in health care.

Van Pelt, recognized for his focus on collaboration, commitment to community health services and leadership in health care reform, said he'll continue to contribute to the field.

"I'll take a few months off and see what the fall brings. I'm not ready to sit around and make birdhouses," he said good-naturedly. "I have a lot of passion and interest in how our community, and our health care community, evolves."

Van Pelt spent all but about six months with Providence during a career book-ended by serving as an administrative intern and as Providence's Oregon chief executive. In an interview, he said he's filled with gratitude for the opportunity to have worked with a great organization, dedicated clinicians and nurses, and inspiring volunteer board members.

During the course of nearly four decades, Van Pelt served in a variety of capacities. He was administrator of Providence St. Vincent Medical Center, led Providence Health Plan during major growth, brought hospitals in Seaside and Newberg into the Providence fold, and partnered with leaders to develop obstetric services at Providence Portland and to develop a Neonatal Intensive Care Unit at Providence St. Vincent. He also was the founding chair of the Ministry Leadership Center, a national model dedicated to preserving the heritage of Catholic health care through ongoing leadership formation.

Van Pelt was pivotal in opening the Virginia Garcia Memorial Health Center, which serves those who face barriers to medical care in Washington and Yamhill counties, and collaborated with health leaders to create the maternity care program Healthy Start. He has been instrumental in health care reform, including as a member of Gov. John's Kitzhaber's health care transformation work group and helping develop Health Share of Oregon CCO to expand health care access. He also is on the board of the Oregon Health Leadership Council, chairing its Oregon Health Plan redesign and financial sustainability work group.

Van Pelt said he's been privileged to explore with major health systems and providers in the private and public sectors ways to improve care and reduce costs through collaboration and identifying respective strengths.

Colleagues described Van Pelt as charismatic, diplomatic and tactful, saying he excelled in every capacity while keeping a focus on Providence's mission and values.

"Our mission has never changed, but the community which we serve has changed," Van Pelt said, noting the tremendous impacts of a down economy, the growing number of uninsured Oregonians and the diversity of communities. "With all the changes in regulations, policy, technology and economics, one thing that stays true is our clinical partners' commitment to patient care. Easing their way so they can care for the people we serve, I think that is our greatest challenge."

Van Pelt said the ethic of caring for one person at a time while building a better health care system has been the motivating force during his career. He was raised in St. Louis, one of five siblings. As a youngster, he was no stranger to the hospital, where he was treated for everything from broken bones to tonsillitis. The health care field fascinated him, allowing Van Pelt to combine his study of economics with an interest in social services.

"I'm not ready to sit around and make birdhouses… I have a **lot of passion and interest** in **how our community,** and our **health care** community, **evolves.**"

—Greg Van Pelt

"I was drawn to that idea of caring for one person at a time while also working on social structures and systems that improve the larger community," he said.

Van Pelt said no one factor led to his decision to retire, but he noted in part recent successes with state health care reform legislation. "We have an opportunity … to create greater access to health care, greater affordability and to achieve greater health outcomes for the community. That's exciting. We're making dents. It's easy to talk about, but hard to execute, and we're really in the midst of that hard work."

He also cited a "well-positioned" Providence leadership team in his decision to retire.

"I think it's something inside you that says, 'Maybe now is the time,'" he said. "But I believe that somehow I'll stay involved in health care." •

Greg Van Pelt

Home: Portland

Family: Wife, Joan; son, Andy, chief operating officer, Oregon Association of Hospitals and Health Systems; daughter, Emily, a cardiac intensive care nurse; and seven grandchildren, with another on the way.

Hobbies: Spending time with family and visiting the Oregon Coast.

Partnership: Will improve patient care and lower healthcare costs

CONTINUED FROM *page 5*

regional broadband telehealth networks spanning the USA.

The network was designed to be inter-operable with the Oregon Public Safety and Emergency Management networks as well as Oregon government and education networks. The concept for OHN originated with the Telehealth Alliance of Oregon and the original proposal resulted from a collaboration of more than 150 individuals and agencies throughout the state.

The ongoing project has enabled patients to receive access to state-of-the-art health care in otherwise underserved areas. The new telemedicine network enhanced collaboration among providers by allowing the secure and confidential sharing of access to electronic medical records. OHN is scheduled to fully complete the statewide project in May 2014.

OHN has seven full-time positions and reported revenue of $1.2 million in 2012. OCHIN employs 170 and earned $22 million in 2012. Two years ago OCHIN signed the largest office-space lease in Portland, of more than 38,000 square feet, when it moved to its headquarters at 1881 S.W. Naito Parkway.

"The only way to achieve success in this environment is to **have all members of the health care continuum streamline and simplify their efforts and offerings** to ensure that every health care provider and community makes it to the finish line. Through this alignment, **we will help them do just that.**"

—Kim Lamb, *Oregon Health Network executive director*

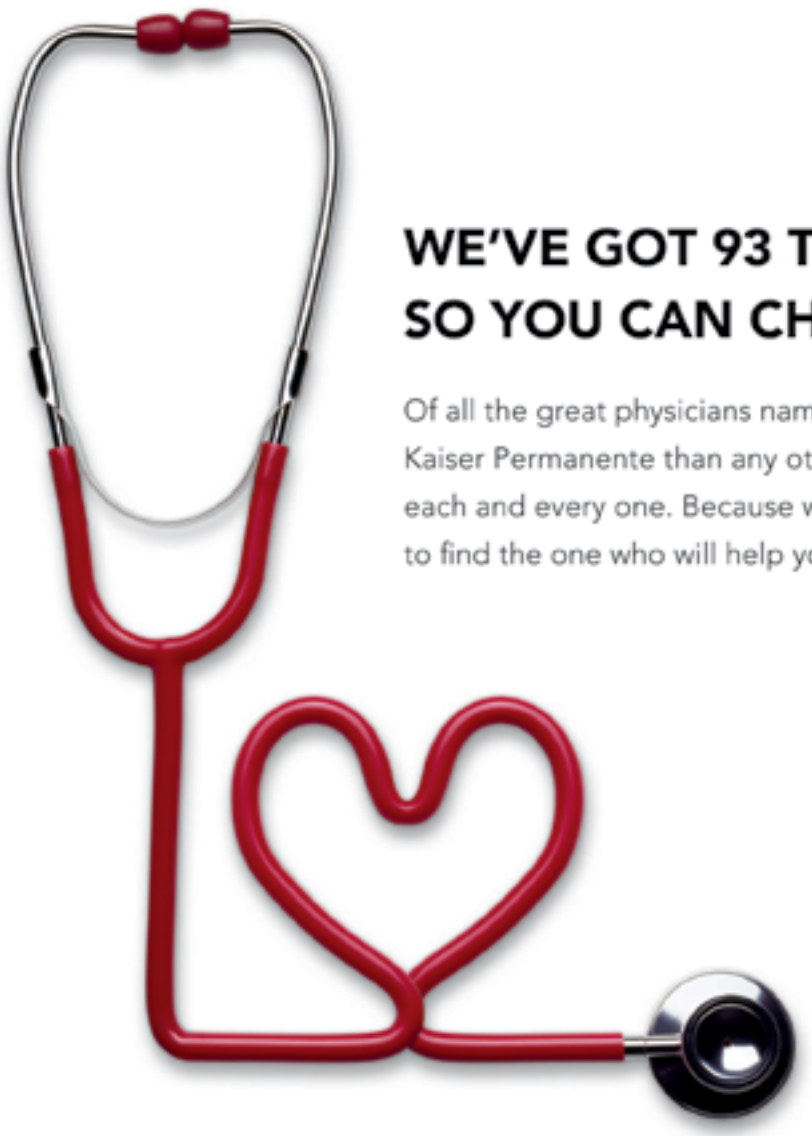
The Oregon Association of Hospitals Research and Education Foundation submitted the application to the FCC.

OHN also laid the foundation for improved emergency preparedness applications for hospitals, clinics, private practitioners, public health, emergency medical services and tribal partners who previously could not communicate across jurisdictions during day-to-day operations and large-scale incidents.

The improvements to the health care communities in rural and isolated areas were immediate and drastic as OHN replaced the old copper T1 telephone lines with fiber optic cable, enabling the transfer of electronic data including digital imaging and other diagnostic information.

The combined business services of the two partnering companies will include health information technology and related advocacy, connectivity, hosted services, consulting, federal and state program funding, management and administration, and research.

"Uniting forces and collaborating with health care and external partners will improve patient care and lower healthcare costs," said **Bob Marsalli**, OCHIN board chairman. "I am proud of OCHIN and OHN for making this extraordinary alignment decision." •



WE'VE GOT 93 TOP DOCS.
SO YOU CAN CHOOSE ONE YOU'LL LOVE.

Of all the great physicians named in *Portland Monthly*'s 2013 Top Docs issue, more practice at Kaiser Permanente than any other nonacademic health organization. So we'd like to congratulate each and every one. Because we know having more great doctors to choose from makes it easier to find the one who will help you achieve total health.

Karen Smith Mularski, MD
Nancy F. Tsai, MD
Parsa Shahinpoor, MD
Robert E. Dexter, MD
Thomas A. Lorence, MD
Steven J. Spindel, MD
Alicia M. Ahn, MD
Christine Choo, MD
Daniel S. Tamashiro, MD
Elizabeth A. Frederick, MD
Jane O. Drummond, MD
Janet M. Leigh, MD
Adrianne C. Feldstein, MD
Richard D. Baertlein, MD
Anthony C. Cirino, MD
Antony M. Poothullil, MD
Duncan Hodge, MD
Eric E. Bosworth, MD
Colin R. Cave, MD
Lawrence A. Dworkin, MD
Robert J. Krum, MD
Jennifer L. Bass, MD

Bradley M. Anderson, MD
Robert Lawrence, MD
Clayton T. Horan, MD
Kristina M. Ruybalid, MD
Marc R. Lutz, DO
Kathy A. Crispell, MD
Timothy D. Jacobson, MD
Yong T. Shin, MD
Shari A. Sanders, MD
Virginia M. Sytsma, MD
Susan D. Gass, MD
Fred Cirillo, MD
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Andrew H. Felcher, MD
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Jennifer Gilmartin Garnand, MD
Keith H. Bachman, MD
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Marcia J. Dunham, MD
Sean E. Jones, MD
Stephanie P. Detlefsen, MD
Thomas D. Harburg, MD
David H. Ruud, MD
David J. van de Lindt, MD
Han-chun Liang, MD
Rory E. Green, MD
Stuart L. Oken, MD
Micah L. Thorp, DO
Greg R. Zarelli, MD
Gregory L. Clark, MD, PhD
Stephen T. Gancher, MD
Charles J. Wrobel, MD
Ann Stanek, MD
Fabio Cappuccini, MD
Kimberly F. Luft, MD
Luanne B. Nilsen, MD
Richard C. Cohen, MD
Wendy Lin, MD
Daniel A. Ladizinsky, MD
Anthony J. Domenigoni, DPM
David M. Schmidt, MD
Jonathan A. Rettmann, MD
Praseeda R. Sridharan, MD
Katelyn A. Deming, MD
Atanu Prasad, MD
Brian J. Markey, MD
Joshua R. Hill, MD
Robert T. Speirs, MD
Vandana Khurma, MD
Stephen F. Lieberman, MD
Homayon Hajarizadeh, MD

KAISER PERMANENTE® thrive

Wright, MD, promoted to senior VP for Providence's five-state region

By Cliff Collins
For The Scribe

During **Craig Wright, MD**'s nine years working with Providence Health & Services, the number of members of the health system's employed Providence Medical Group increased by multiples.

In 2004, the group was comprised of about 150 physicians, mostly in primary care. Today, Providence Medical Group employs nearly 700 doctors statewide, across most specialties, including hospitalists.

Now Wright, a family physician who most recently served as chief executive of physicians and clinical services for Providence in Oregon, has been promoted. In April, he assumed his new post, in Seattle, as senior vice president of physician services for all five states where the health system operates: Alaska, California, Montana, Oregon and Washington. The position is newly created.

"I'm excited for this role, because it does allow physician leaders to be at the corporate-office level, to have a clinical voice, specifically a physician voice, at the system office," Wright said. "The successes we've had with our medical group, I want to develop that over the system."

He wants to position the medical group "at the system level to be a bigger representative of our organization," and to emphasize "the importance of our medical group," he said.

The health system employs 3,600 doctors in medical groups within eight different hospitals systems across its five-state region. Providence Medical Group in Oregon and Seattle's Swedish Medical Group are the largest member groups, both of about comparable size, he said.

The Providence system has employed physicians for the past 15 years, but he thinks Providence in Oregon "was early in seeing the value of that, developing physician strategy and the value of our medical groups," Wright said.

Wright has moved up the administrative ladder at Providence. When he first joined Providence, he focused primarily on Providence Medical Group. About four years ago, his role expanded to include operational accountability for ambulatory outpatient and home services. For the past two years, he also gained responsibility for service line development, clinical programs and quality improvement.

"I'm excited for this role, because it does allow **physician leaders to be at the corporate-office level, to have a clinical voice**, specifically a physician voice, at the system office."

—Craig Wright, MD
Senior vice president of physician services for Providence in Alaska, California, Montana, Oregon and Washington

During most of his tenure in Portland, Providence Medical Group's growth was organic, he said. But in the last 18 months, the group also has expanded through acquisitions, such as of large, previously private-practice cardiology groups.

Wright's goals for his new post are to "represent the medical group, and move the medical group into the center stage of strategy," he said. In addition, he will work on "developing physician leaders and engaging our clinicians and staff"; define what are the best quality initiatives in the employed practices; and strive to integrate further the employed practices and the hospitals.

He received his undergraduate degree from Pacific Lutheran University in Tacoma and his medical degree from the University of Washington School of Medicine. Wright previously practiced family medicine in Seattle for 14 years, led Medalia Healthcare and was a medical director for Swedish Physicians.

His wife also is a family doctor, practicing in Portland.

In a related development, Providence has named **Mike Waters** to serve as chief administrative officer of physician services for the five-state region. Waters' job represents a new position and new responsibilities. •

Correction:
Due to an editing error, Erin LeBlanc, MD, MPH, was misidentified in the March issue. *The Scribe* regrets the error.

Conferences address breast cancer, health literacy

By Jon Bell
For The Scribe

Physicians and other care providers are a little wiser when it comes to health literacy and various issues around breast cancer thanks to two conferences recently hosted by Legacy Health.

Legacy Cancer Institute partnered with **Susan G. Komen for the Cure–Oregon and SW Washington** to present the annual Breast Cancer Issues Conference in Portland on March 8. The conference, which drew physicians, residents and providers, covered a range of topics, from legal concerns around diagnosis to sexuality after cancer.

The other conference was Legacy's second annual "Health Literacy Conference: Toward a Culture of Clarity" on March 1 in Portland. The event aimed to teach health care professionals valuable techniques to improve health literacy—essentially understanding basic health information and guidelines—among patients.

Health Literacy Conference: Toward a Culture of Clarity

Minot Cleveland, MD, found himself in an interesting position in March.

Rather than taking on his usual role of physician at Legacy, where he is also medical director for employee health, Cleveland climbed into the patient role for a hip replacement.

"I think it's a good thing that every once in a while health care providers become the patient and see the world from the other side of the sheets," he said.

The experience was a valuable one, and not just because Cleveland now has a new hip. Being on the patient side also allowed him to get a firsthand glimpse of the importance of health literacy and how key it is for physicians to communicate clearly with their patients—and for patients to understand them.

"When you become a patient, you're stressed, you're a little more vulnerable," Cleveland said. "It's very likely your health literacy will drop."

Through presentations, educational sessions and more, Legacy's conference on health literacy aimed to prevent that.

"The main thing I got out of the conference was an incredible sense of awareness and the impact on the patients that we see," said **Robert Vissers, MD**, medical director for emergency services with Legacy. "I gained some tools, there were some great stories, and the fact that it was sold out after only the second year . . . suggests that this problem is huge."

Sessions at the conference covered everything from talking in plain language and conveying complicated data to writing techniques and diversity.

The term health literacy is relatively new, but it's a communication issue that providers have been targeting for years. The nonprofit Institute of Medicine defines health literacy as "the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions."

Kevin Breger, MD, a hospitalist with Legacy, gave two, 80-minute seminars on the teach-back technique, whereby a physician relays information to a patient and then has the patient explain it back to make sure it's fully understood.

"Basically, you explain something to the patient in easy-to-understand terms, then ask them to repeat the information so you both are on the same page," he said.

The technique works well for anything from prescriptions to follow-up appointments to exercise instructions. One of the keys to it, Breger said, is to use clear language and not muddle up communication with medical jargon.

Additionally, he said patients will rarely admit that they don't understand something. Likewise, he added, physicians may not always know that their messages aren't getting through.

"I think we're all under the delusion that we are communicating effectively," Breger said, "but research has shown that patients only remember about half of what we tell them. Yet they'll say that they understand it all."

In addition to the teach-back method, other ways to help improve patients' health literacy include:

- Devise a list of simpler substitute words. For example, instead of saying "myocardial infarction," say "heart attack."
- Instead of asking patients if they understand the information, ask them, "What questions do you have?"
- Engage family members in the process for a layer of redundancy.
- Remember that health literacy is fluid. A patient in great pain or under a lot of stress may understand information better the next day, when their condition has improved.

Breast Cancer Issues Conference

Melinda Muller, MD, clinical vice president of primary care at Legacy, gave one of the primary presentations at the conference. Titled "Life After Breast Cancer: Allaying the Fears, Managing the Concerns, Evaluating the Risks," the talk was designed to offer some perspective to primary care providers on what they need to be doing after a patient has been diagnosed and treated for breast cancer.

"A lot has happened to the woman, so there has to be some attention paid to the care coordination around everything that happened," Muller said. "The other thing is that there can be a lot of fears, concerns and risks. Those need to be addressed, too."

In addition to helping recovering cancer patients deal with things such as new medications and their possible side effects, primary care physicians may also have to play catch-up on the management of any chronic conditions. Those may not have been optimally managed during cancer treatment.

"The patient may have had breast cancer, but she still needs to stay up on her diabetes or maybe it's time for a colonoscopy," Muller said. "It's about paying attention to the rest of you."

In addition, Muller said breast cancer survivors often are dealing with emotional concerns and fears. Many are on edge about whether every single lump they find is cancerous. They also may be depressed. It is the physician's role to help patients work through these issues.

"You're helping the patient gauge whether something is normal or whether they need to see their oncologist, whether the side effects of their medications are what are making them feel bad, those kinds of things," she said. "A lot of it for physicians is common sense stuff, but I think it's an important reminder."

Paul Frisch, adjunct instructor at the University of Oregon School of Law, gave a talk about the legal concerns surrounding late or deferred diagnosis of cancer, and three other providers covered sexuality after breast cancer in a third session. The keynote speaker for the conference was **Kimberly Allison, MD**, an associate professor of pathology at Stanford University. A breast cancer survivor herself, Allison talked about her experience in a speech titled, "Understanding Breast Cancer: A Breast Cancer Pathologist Learns from Life on the Other Side of the Microscope." •

Our dilemma: Difficult to draw conclusions about safety

CONTINUED FROM *page 5*

Is home delivery safe in Portland?

Many practicing obstetricians and midwives have deep concerns about the safety of home delivery in Oregon, not just because the state of Oregon allows unlicensed midwives to attend a planned home delivery. It's also because the scope of practice of licensed, direct entry midwives in Oregon includes home delivery of twins, home delivery of patients with previous cesarean sections and home delivery of a breech baby, all indications for a hospital birth in The Netherlands.

In the 1990s, most obstetricians stopped delivering breech babies vaginally in Oregon, and many hospitals stopped allowing patients a trial of labor after cesarean section. Direct entry midwives were the only ones who offered to attend those births. A group of direct entry midwives in Oregon successfully lobbied the Legislature to increase their scope of practice to include patients with previous cesarean sections and breech vaginal deliveries because of patient demands.

Many of the more experienced direct entry midwives do not feel comfortable delivering twins or breech babies at home or in a birthing center, and do not feel comfortable letting pregnancies progress beyond 42 weeks. However, they also face a public that truly does not understand the potential complications of childbirth and views any mention of hospital-based obstetrical care with skepticism.

The response of the medical establishment

"Home birth is like the rain," says **Dr. Duncan Neilson**, Chief of Obstetrics and Gynecology at Legacy Emanuel Medical Center. "You can get mad at it, but it is still going to happen." Emanuel's policy of accepting patients that were planning an out-of-hospital birth, without judging their choice, makes patients and their midwives feel welcome in the hospital. By lowering the threshold to transfer a patient to the hospital, some of the complications associated with home birth can be avoided. Oregon House Bill 2380, which passed in 2011, protects both physicians and hospitals from legal liability if an injury occurred as a result of care provided from a direct entry midwife.

The hospital policies are also changing in other ways to actively try to lower our cesarean-section rate. Last year, Oregon Health & Science University started allowing breech vaginal deliveries again in select patients and Legacy Emanuel may follow suit. The hospital-based obstetrician model is gaining acceptance in Portland, which will allow more patients a trial of labor after a cesarean section and will allow more twin patients to deliver vaginally. Most hospitals in the area have restricted elective inductions, which many believe have contributed to our increased cesarean-section rate.

Our Dilemma

Whether or not home delivery is a safe option in Portland at all is a big question and one that cannot be answered without assumptions and conjecture at the present time. While the Oregon Board of Vital Statistics has been collecting data on home birth and freestanding birth centers since 2008, is it difficult to draw conclusions about the safety of out-of-hospital birth because the report only records the final method and place of delivery and the outcome. As a result, a fetal death in labor occurring while a patient is being transferred to a hospital is accounted for as a fetal death that occurs in the hospital. This should change with the above-mentioned HB 2380, which will require the Oregon Public Health Division to add two questions to the Oregon Birth Certificate to determine planned place of birth and birth attendant, and to report annually on birth outcomes, including death, by location and attendant type.

More information will also be gleaned from a report to be released in the summer of 2013 based on a perinatal fatality case review of term births intended to occur out of a hospital conducted by the Oregon Public Health Division in 2012. This report will cover key findings of live term births by planned place of birth and planned birth attendant, term fetal and neonatal deaths by planned place of birth and planned birth attendant, and maternal characteristics of births by planned place of birth. We have a duty to our patients to understand their choices and needs, but we also have a duty to protect the lives of mothers and babies. Armed with data, we can educate women about the possible risks of out of hospital birth. However, unless the hospital-based obstetrical community starts to celebrate the joy of birth while managing the risks, we will continue to lose patients who will choose a home delivery over a hospital birth. Any complications associated with these deliveries are better handled in the hospital than at home. •

Philippa Ribbink, MD, graduated from Cornell Medical College in 1991 and completed her OB/GYN residency at the University of Vermont in 1995. She was board certified by the American College of Obstetrics and Gynecology in 1997.

The Medical Society of Metropolitan Portland

requests your presence at the

129th Annual Meeting

We are pleased to invite the members of the Medical Society of Metropolitan Portland to join us in celebrating the installment of our 129th president, **Brenda Kehoe, MD**, followed by the announcement of the 2013 Officers and Trustees.

Partake in a private viewing of the Center for Modern and Contemporary Art galleries, savor food and spirits amidst the ambiance of live piano—and of course, hear from our prestigious speaker, **Dr. Louise Aronson**.

Dr. Louise Aronson is an associate professor of medicine at the University of California San Francisco. She holds an MD from Harvard Medical School and an MFA from the Warren Wilson Program for Writers and has recently published her first book, ***A History of the Present Illness***, to renowned acclaim from both the medical and literary communities. Dr. Aronson will be signing copies of her book following her presentation. Each attending member will receive a complimentary copy of *A History of the Present Illness*.

WHEN: **April 16, 2013**

WHERE: **Portland Art Museum**
1219 SW Park Ave, Portland OR 97205

5:00–6:30 pm Registration & Gallery Viewing
6:00 pm Dinner Begins • **6:30 pm** Meeting Begins
7:00 pm Speaker, Louise Aronson, MD, MFA

No cost for members and one guest

Please **RSVP** by calling **503-944-1138**
or email **aislynn@msmp.org**

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Westside Pediatric Clinic, P.C. is looking to hire a FT, Board Certified Pediatrician or Pediatric Nurse Practitioner. Salary is negotiable. Please fax CV and salary requirements to 503-297-1043 attn: Jill B.

OTHER MEDICAL OPENINGS

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Requirements: Board-certified physician with active, unrestricted professional license in the State of Oregon, State of Washington license desirable; minimum of five years of medical practice experience – Family Practice or Internal Medicine specialty preferred; Master's Degree in Business Administration, Health Services Administration or Public Health a plus; excellent interpersonal and team skills; demonstrated public speaking and presentation skills and knowledge of and commitment to quality improvement principles, methods and tools required; experience in physician leadership roles desirable.

Contact: Members of the Acumentra Health team share a passion for improving the quality of healthcare in our communities. Our culture is marked by a dedication to client service and a spirit of collegiality. We foster teamwork and balanced individual lifestyles. We offer a generous benefit package and competitive salary. For a complete job description and to apply online, visit www.acumentra.org and select Employment. Application materials may also be mailed to Acumentra Health, 2020 SW Fourth, Suite 520, Portland, OR 97201, attention HR, or FAX to 503-279-0190. Send materials to the attention of Judith Wilson. Acumentra Health is an Equal Opportunity Employer.

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