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Parshley to lead MSMP

Marianne Parshley, MD, takes office as the 127th president of the Medical Society of Metropolitan Portland serving a two-year term.

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Maternal mortality in Ethiopia

MSMP's annual meeting features medical humanities presentation by Philippa Ribbink, MD

Philippa Ribbink, MD, obstetrics and gynecology specialist from Everywoman's Health, and a professor at OSHU, spoke on maternal mortality to the gathering of members at the 127th annual meeting of the Medical Society of Metropolitan Portland on April 19.

By Jon Bell
For the Scribe

In her first speech as the president of the **Medical Society of Metropolitan Portland, Marianne Parshley, MD,** talked about globalization and how technology and worldwide events have made people everywhere part of a "growing and emerging global commons."

"The awareness has only grown over the last 10 years," she said.

Parshley's remarks at the society's annual meeting in April set an apropos tone for the night's keynote speaker**, Philippa Ribbink, MD**, who had recently returned from a three-week stint in rural Ethiopia. An obstetrics and gynecology specialist from **Everywoman's Health** and a clinical assistant professor at **Oregon Health & Science University**, Ribbink had traveled to the African nation to provide volunteer emergency obstetrical services at a small hospital in a town called Mota.

While there, Ribbink performed surgeries on women who had walked for hours to get to the hospital. She helped deliver babies, some who lived, others who didn't. She also saw traditional midwives at work and, similar to Parshley's comments, was reminded of how globally connected people and issues are these days.

"One of the things that struck me the most when I was in Ethiopia was how relevant this is to Portland," said Ribbink, whose presentation at the evening meeting was entitled, "Maternal Mortality in Rural Ethiopia: A Community Struggles to Save Its Mothers."

Ribbink was alluding to current bills in the Oregon Legislature pertaining to lay midwives and what kind of procedures they would be allowed to perform during home births. Noting that neonatal mortality rates at the Children's Hospital at Legacy Emanuel are 10 times higher for patients who try to deliver at home first, Ribbink said she's worried about just how much midwives should be permitted to do.

"My prediction is that we're going to start seeing some of the things I saw in Ethiopia in Portland as the scope of practice of the lay midwifery community changes in Portland," she said.

Ribbink's presentation, the first to be part of the MSMP's medical humanities initiative, outlined her three weeks in Ethiopia with photographer Joni Kabana. She began with a story of one patient, a 22-year-old woman who was on her fifth pregnancy. The woman had gone into labor a day earlier, but after contractions had stopped the next morning, she walked to the hospital. By the time she arrived, her baby was dead and her uterus had ruptured. She'd lost huge amounts of fluid and blood. Ribbink herself donated blood for the woman, who ended up surviving the ordeal.

"Her husband sat next to her for days and cried," Ribbink said, "but he was afraid to give blood because he thought he was going to get AIDS."

Ribbink talked about Ethiopia in general — it's a little less than twice the size of Texas and is home to 80 million people, all but 2 percent of whom live in rural areas — and of maternal mortality, which means the death of a woman while pregnant or within 42 days of birth.

"Every minute, a woman dies in childbirth somewhere in the world," Ribbink said.

Researchers estimated that 342,900 maternal deaths occurred in 2008. Of those, more than half happened in just six countries: India, Nigeria, Pakistan, Afghanistan, the Democratic Republic of the Congo and Ethiopia. In Ethio-

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WHAT'S INSIDE THIS ISSUE

Pharmaceutical Focus: Shingles vaccine extended

The Food and Drug Administration's approval March 24 of the shingles vaccine for individuals 50 to 59 years old means that Zostavax, a live attenuated virus vaccine available since 2006 for shingles patients over 60, now can help prevent shingles in younger people.

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Project Access NOW effort exceeds fundraising goals

'Bridges to Healthcare', the second annual fundraising and recognition dinner for Project Access NOW, held April 7 at the Portland Hilton, raised a net total of nearly $50,000, compared with about $25,000 at the 2010 event, said Linda Nilsen-Solares, MPA, executive director of the organization.

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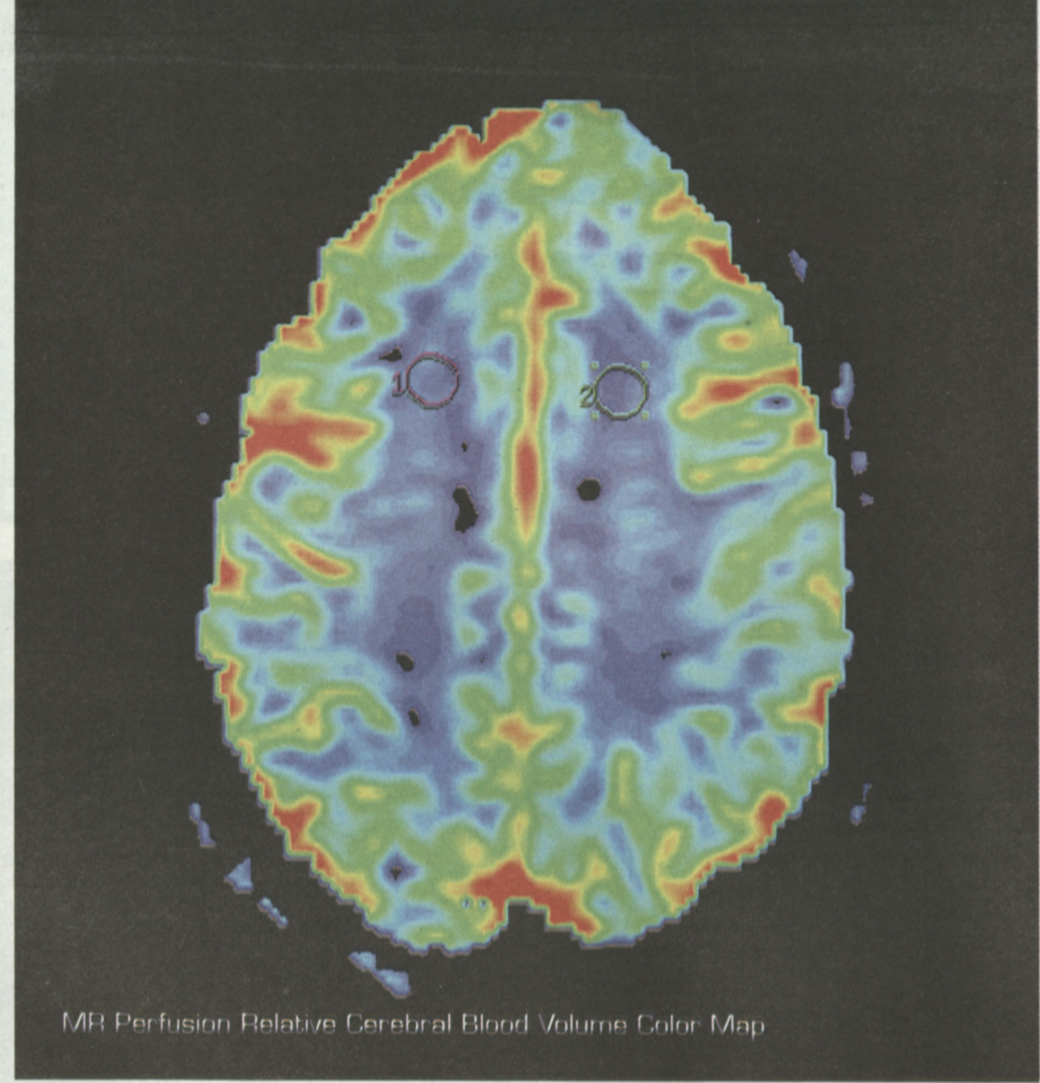


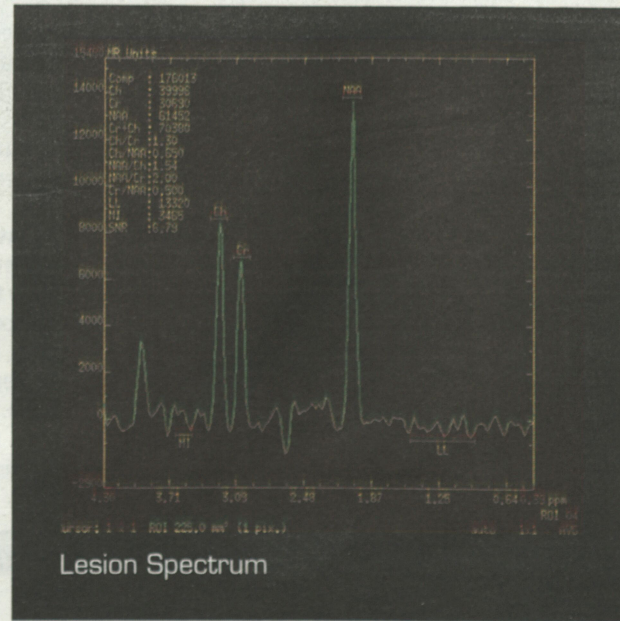
The Importance of 3.0T Imaging in Neuroradiology: a case study

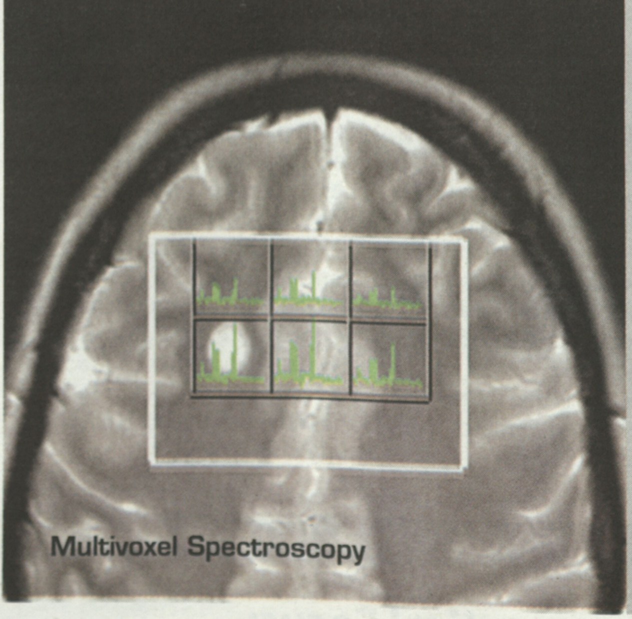
This young woman had recent excision of a subcutaneous benign nerve sheath tumor. Brain MR imaging done at a regional major hospital system discovered an enhancing lesion located in right frontal lobe white matter. She was referred to EPIC imaging, for preoperative 3.0T MR imaging for a planned brain biopsy. At EPIC, under the direction of Neuroradiologist, Dr. Kenneth Curtin, stereotactic planning images were obtained and additional advanced imaging techniques: Diffusion Tensor Tractography, Dynamic Susceptibility Weighted Perfusion Imaging and Multivoxel Spectroscopy were acquired.

These additional images show the T2 hyperintense lesion located in the right frontal lobe white matter. The advanced imaging reveals an abnormal spectrum over the lesion with increased choline at 3.2 ppm but preservation of the NAA peak at 2.0 ppm. Although this spectrum is abnormal, it is not a tumor spectrum.

The perfusion images show that the lesion does not have elevated relative cerebral blood volume (rCBV), which would be expected in a primary brain tumor. The rCBV ratio was 1.1 with primary brain tumors generally having values greater than 1.75.

On the basis of these advanced techniques, the favored diagnosis was a demyelinating lesion and her brain biopsy procedure was canceled. She subsequently developed additional brain lesions and is being treated for multiple sclerosis.





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New president will enhance physician 'community and connections'

Marianne C. Parshley, MD, is inaugurated as the 127th president of the Medical Society of Metropolitan Portland

By Cliff Collins
For The Scribe

Doctors must unite if medicine is to survive and thrive in the rapidly changing health care environment.

That is one of the themes the **Medical Society of Metropolitan Portland's 127th president** is emphasizing as she embarks on her just-begun presidential term.

"It's important for physicians to come together as part of the community of physicians, because health care is changing," said **Marianne C. Parshley, MD**, who was inaugurated April 19 at the MSMP's annual meeting. Through organized medicine, doctors can play a larger role in shaping change than if they stay separated in "silos," she said.

Those who practice medicine naturally share a commonality. "Most do this, or started doing this, for the reason of helping patients. And because of that, we've got a lot to share and compare with each other's practices that enrich all of us," she said. "If physicians concentrate on caring for patients and the things that bring us together, we will be successful."

Marianne C. Parshley, MD, began her two-year term as president of the Medical Society of Metropolitan Portland with her inauguration at the organizations 127th annual meeting in April.

Becoming a doctor

Dr. Parshley, an internal medicine physician with **Providence Medical Group's Gateway** office, knew from an early age that she wanted to be a doctor. "I think I started realizing that in high school, and confirmed it in college," she said. Her father, **Philip F. Parshley, MD**, also a member of **MSMP**, is a retired burn surgeon and former medical director of the **Oregon Medical Board**.

Born in Boston, Dr. Marianne Parshley lived in Kansas while her father was in the service, before the family moved to Portland when she was in the first grade. She graduated from Lincoln High School, and then followed her father's footsteps in going to Dartmouth College for both undergraduate and medical degrees.

However, the elder Dr. Parshley had completed his medical studies at Harvard Medical School, because Dartmouth did not have a four-year program until Dr. Marianne Parshley became a member of the first four-year class, she explained.

As an undergraduate at Dartmouth, she and other female students comprised only 12 percent of the total student body, as the Ivy League schools slowly began to admit more women. An upside was that she met her future husband there.

She selected primary care rather than a surgical specialty like her father practiced. "I chose internal medicine because what I really wanted was a longitudinal relationship with patients," she said. She spent her residency at **Providence Portland Medical Center**, where she eventually served as chief resident.

On April 7, Dr. Parshley was inducted as a **Fellow of the American College of Physicians** at its annual meeting in San Diego. "I work to provide comprehensive medical care to the whole patient, recognizing that health is affected by all parts of an individual's life," she said.

She and her husband have three children, and in her off hours Dr. Parshley enjoys spending time with her family and hiking, skiing, gardening, knitting and reading.

Referring to primary care, she said, "It's gotten tougher as time has gone by, tougher because of the structure of medicine and the way it's reimbursed." Still, she would not switch places with any other profession: "I love what I do. I can't imagine doing anything else." Even for her vacation time, she has gone on overseas medical missions such as to El Salvador and Nicaragua.

Presidential goals

As **2011-13 MSMP president**, Dr. Parshley said she wants to continue the work of the past two presidents -- **Glenn S. Rodriguez, MD** and **John Evans, MD** -- and she supports the Medical Humanities initiative begun by Dr. Rodriguez.

She also wants to attract more young physicians to MSMP by speaking more in their language: the language of technology. "If we're going to engage the younger physicians, we need to connect with them on a level where they can communicate." With that goal in mind, the MSMP Board of Trustees will continue to explore taking full advantage of social networking sites and technological devices, she said.

MSMP will look for ways to build a sense of "community and connections" among physicians and bring them together, "so that, in this new era of global awareness and technological change, we can serve our larger community better," Dr. Parshley said.

Dr. Rodriguez, immediate past president, said the past year's board was "a diverse group" that brought varying points of view and spent a great deal of time on strategic plans for the MSMP. Last November, the board sponsored a well-attended membership dinner devoted to the theme of state health policy.

During the past year, MSMP also changed its bylaws to extend the president's term from one year to two years, and increased the number of at-large board members from six to eight.

As if to underscore Dr. Rodriguez's emphasis on what he called the "history and continuity and tradition of the profession," past MSMP presidents from each decade going back to the 1970s were in attendance at the April annual meeting, he noted.

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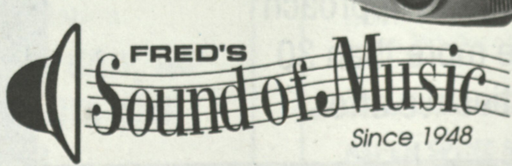

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MSMP Annual Meeting: Gynecology physician speaks on maternal mortality

CONTINUED FROM / Page 1

pia, the lifetime risk of dying in childbirth is 1 in 27; in the United States, it's 1 in 4,300. Infant mortality in Ethiopia is 77 per 1,000 live births; in the U.S., it's 6.

Ribbink said poor infrastructure is partly to blame for the conditions in Ethiopia. However, people there also delay seeking care for several reasons, the first being simple geography.

"It's a mountainous country, there are not a lot of roads," Ribbink said. "It's simply hard to get to the hospital.

People who live in the countryside often don't have enough knowledge about the dangers of childbirth, and there are cultural barriers to seeking health care in the first place. In addition, there isn't the medical capacity in the country's hospitals even when patients do show up.

According to Ribbink, in all of Ethiopia, there are just 167 OB-GYNs. The city of Chicago alone has more than that, she said.

In addition to charitable efforts— Ribbink and several colleagues have set up a nonprofit organization, **Global Soul International** (www.globalsoulinternational.org), to help out in Mota and other areas —the Ethiopian government has outlawed child marriage and begun providing trained anesthetists. There are also efforts to better educate traditional birth attendants and institute national protocols established by the World Health Organization.

It's a start, Ribbink said, but "we have a long way to go before this generation is safeguarded from maternal mortality."

Every minute, a woman dies in childbirth somewhere in the world. What we are doing is a start, but we have a long way to go before this generation is safeguarded from maternal mortality.

-- PHILIPPA RIBBINK, MD
Obstetetrics & Gynecology Specialist
Everywoman's Health

Providence researcher lands major cancer grant

Michael Gough, PhD, will use grant to study metastatic cancer

Providence Cancer Center researcher Michael Gough, PhD, has received a Career Catalyst Research Grant from Susan G. Komen for the Cure to study the possibility of ending metastatic cancer.

Despite advances in all treatment modalities for breast cancer, metastatic disease – the spread of cancer to other parts of the body -- remains the ultimate challenge. Dr. Gough's work in the field of cancer research explores how the human immune system protects and supports cancer cell growth following cytotoxic therapies such as radiation and chemotherapy. Cells that are not killed during treatment have the potential to move to other parts of the body.

The grant will be used to study how to redirect immune processes so that a patient's own immune system can target and destroy residual cancer cells that remain following treatment. It will also explore ways to enhance the efficacy of chemotherapy and radiation therapy in order to eradicate microscopic pockets of disease and eliminate the chances of cancer cells spreading.

Finding funding for studies such as this is increasingly challenging, according to Walter J. Urba, MD. PhD, director of cancer research for the Robert W. Franz Cancer Research Center in the Earle A. Chiles Research Institute at Providence Cancer Center. With reduced funding from the National Institutes of Health, researchers are competing to find other sources of support. Providence Cancer Center is the only Oregon institution to receive research funding from Komen in the organization's 2011 fiscal year.

Komen Career Catalyst Research Grants are awarded to scientists in the early stages of their careers to further research independence and to explore novel approaches that will lead to substantial progress in breast cancer research and reductions in breast cancer incidence and/or mortality within the next decade. Dr. Gough's team will receive $450,000 over three years. Funds become available in June 2011.

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Volunteers celebrate the success of coordinated donated care

Bridges to Healthcare' doubles donations to nearly $50,000 for Project Access NOW at recent fundraising event

By Cliff Collins
For The Scribe

Project Access NOW's second annual fundraiser was an overwhelming success, raising double the amount of money from last year's inaugural event.

Called **'Bridges to Healthcare'**, the fundraising and recognition dinner, held April 7 at the Portland Hilton, raised a net total of nearly $50,000, compared with about $25,000 at the 2010 event, said **Linda Nilsen-Solares, MPA**, executive director of Project Access NOW, a nonprofit organization started in 2007 with the help of the **Medical Society of Metropolitan Portland** and its physician and executive leadership.

Honored at the April dinner, which was hosted by **Joey and Emily Harrington**, was the **Hospital Equity Group**, a committee composed of financial-department representatives from each hospital. This group meets with Project Access NOW three or four times a year to share and compare data, with the objective of ensuring that no one hospital receives too many patient referrals, and that as equitable of a balance as possible is achieved, she explained.

Hospital participation and financial and in-kind donations have been crucial to the success so far of Project Access NOW. "Hospital were aware that the donated care from physicians is large, so (hospitals thought), 'We need to support that,'" said Nilsen-Solares. "Our success depends on every hospital system participating." **The Oregon Association of Hospitals and Health Systems** "has helped us tremendously," too, she said.

Since connecting the first patients to volunteer providers beginning in March 2008, Project Access NOW has enrolled 7,000 patients, who have been seen by close to 3,000 volunteer providers, the "vast majority" of whom are physicians, she said.

Project Access NOW -- the "NOW" stands for Northwest Oregon and Washington, but also refers to giving health care when it is needed -- is dedicated to building access to care for low-income and uninsured people in the Portland-Vancouver area by coordinating a network of volunteer providers, clinics and hospitals.

According to the organization, the metropolitan area is home to more than 300,000 uninsured people. Fewer than half of those receive basic medical care through safety-net clinics; most of the rest either go to the emergency room, or do without care. Before Project Access NOW, patients who needed additional care such as X-rays, prescriptions or a specialist did not know whether they would be able to get these services at a cost they could afford. If they could find someone willing to help, they would have to fill out the same forms they'd already completed at the clinic, again and again, for each provider.

With Project Access NOW, patients complete a single eligibility

See PROJECT ACCESS NOW/ Page 9

Hospital Equity Committee of Project Access NOW was honored at the organization's recent fundraiser. Member include, from left to right, Priscilla Lewis, Project Access NOW Board Member; Tim Fleischmann, Tuality Healthcare; Mark Perry, Adventist Medical Center; Scott Johnson, Legacy Health; John Nusser (standing in for Joe Ness), PeaceHealth-SW Washington Medical Center; William Olson, Providence Health & Services; Diana Gernhart, Oregon Health Sciences University. Not pictured are Adam Nemer, Kaiser Permanente and Robin Moody, Oregon Association of Hospital & Health Systems.

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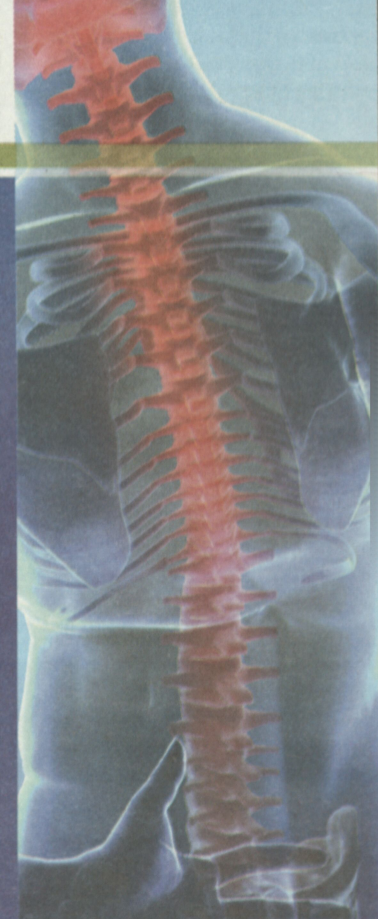

Dr. Warren Roberts is returning to the Portland area with the opening of his new practice, Aspen Spine & Neurosurgery Center. Dr. Roberts will have three locations including the main location in Tualatin and two satellite locations in Sherwood and Tanasbourne.

Dr. Roberts has performed a wide variety of procedures, including complex spine, vascular, tumor, and skull-base. Dr. Roberts' primary focus is treating patients with spinal disorders, including neck pain, whiplash, back pain, compression fractures, spinal stenosis, degenerative disk disease, disk herniation, and spondylosis/spondylolisthesis.

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– Dr. Warren Roberts

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FOCUS ON PHARMACEUTICAL

FDA approves vaccine to prevent shingles in patients 50-59

A recommended vaccination schedule for adults has yet to be developed, but shows promise in application for younger adults

By Cliff Collins
For The Scribe

The Food and Drug Administration's approval March 24 of the **shingles vaccine** for individuals 50 to 59 years old means that Zostavax, a live attenuated virus vaccine available since 2006 for patients over 60, now can help prevent shingles in younger people.

However, approval of a vaccine does not equate to a recommendation by the government, pointed out **Ronald J. Dworkin, MD**, an infectious diseases specialist at **Providence Portland Medical Center**. The first step in availability of a vaccine is FDA approval for safety and efficacy. The next step is that the Advisory Committee on Immunization Practices -- known as ACIP -- which is appointed by the Department of Health and Human Services, must "review all vaccines and come up with recommended schedules for adults," he said.

That second process usually takes several months. ACIP decides if the vaccine should be widely recommended, partly based on a cost-effectiveness analysis, which includes lost work time and impact on quality of life, Dr. Dworkin said. Medicare and private insurers want to know this information -- which is based on what are called "quality-adjusted life years" -- so that they can decide whether to cover the vaccine, he explained. Incidence of shingles in adults under age 60 is lower than in those over 60.

"What's important is, who's going to pay for it?" he said. "If the ACIP says it is recommended, that would have sway over most health insurers. They would feel they should probably cover it. That's one of the criteria they use."

According to the FDA, shingles affects approximately 200,000 healthy Americans each year between the ages of 50 and 59, but about 1 million Americans overall. One in three people who have had chickenpox will get shingles at some point in their lives, said Dr. Dworkin, who is a member of the **Medical Society of Metropolitan Portland**.

It is a disease caused by the varicella-zoster virus, which is a virus in the herpes family and the same virus that causes chickenpox. After an attack of chickenpox, the virus lies dormant in certain nerves in the body. For reasons scientists

> **One in three people who have had chickenpox will get shingles at some point in their lives.**
>
> RONALD J. DWORKIN, MD
> Infectious diseases specialist at Providence Portland Medical Center

don't fully understood, the virus can reappear in the form of shingles, more commonly in people with weakened immune systems and with aging.

"The likelihood of shingles increases with age," said **Karen Midthun, MD**, director of the FDA's Center for Biologics Evaluation and Research. "The availability of Zostavax to a younger age group provides an additional opportunity to prevent this often painful and debilitating disease."

Shingles is characterized by a rash of blisters, which generally appear in a band on one side of the body and can cause severe pain that may last for weeks. But about 20 percent of cases develop into a prolonged, painful condition called post-herpetic neuropathy, which can last for years, Dr. Dworkin said.

FDA approved the vaccine based on results from a multicenter study conducted in the United States and four other countries on approximately 22,000 people who were 50-59. Half received Zostavax, and half received a placebo. Study participants then were monitored for at least a year to see if they developed shingles. Compared with placebo, Zostavax reduced the risk of shingles by approximately 70 percent.

The problem, as Dr. Dworkin noted, is that the vaccine is expensive compared with other routine vaccinations, and is not covered under Medicare Part B, only Part D. Part D is for pharmaceutical benefits that patients have to sign up for in order to receive. Since the vaccine became available for those over 60, fewer than 10 percent of eligible patients have received it, he said.

Last year, Annals of Internal Medicine reported that researchers surveyed almost 600 primary care physicians and found that fewer than half strongly recommended the shingles vaccine, because of the cost to patients.

According to The New York Times, although only one dose is required, the vaccination costs $160 to $195, 10 times more than other commonly prescribed adult vaccines, and insurance carriers vary in the amount they will cover.

"Medicare is not paying for it upfront," said Dr. Dworkin. "They're forcing patients to pay out of pocket; they're paying it more like a drug." Medicare patients then must submit the necessary paperwork in order to receive the vaccine in their doctor's office.

Moreover, many private insurers also require patients to pay out of pocket first and apply for reimbursement afterward, according to the Times. "It's a complicated reimbursement process that stands in stark contrast to the automatic, seamless and fully covered one that Medicare" uses for influenza and pneumonia vaccines, the newspaper noted.

For additional information about the vaccine visit zostavax.com

TRANSITIONS

Announcements of hiring, appointments, movement, career and leadership changes of physicians and administrators in the Portland Metro area.

Peter G. Bush, former Vice President of Physician Services for Southwest Washington Health System, has been appointed to a new position with **PeaceHealth Medical Group (PMG)** as Director of Strategy and Integration. In his new systemwide role, Peter will lead the development of the SMG/PHMG integration planning and the early development of the PHMG strategic plan. Bush started with Southwest in June 2008 and has led the development of Southwest Medical Group from a medical group of 30 primary and surgical care providers to a multispecialty medical group comprised of 90 providers from 12 different medical specialties and 300 employees. Also effective immediately, Southwest Medical Group's **Jonathan Dykstra, MD**, SMG's lead physician and **Kurt Litvin**, SMG's Executive Director —will operate as a leadership "dyad."

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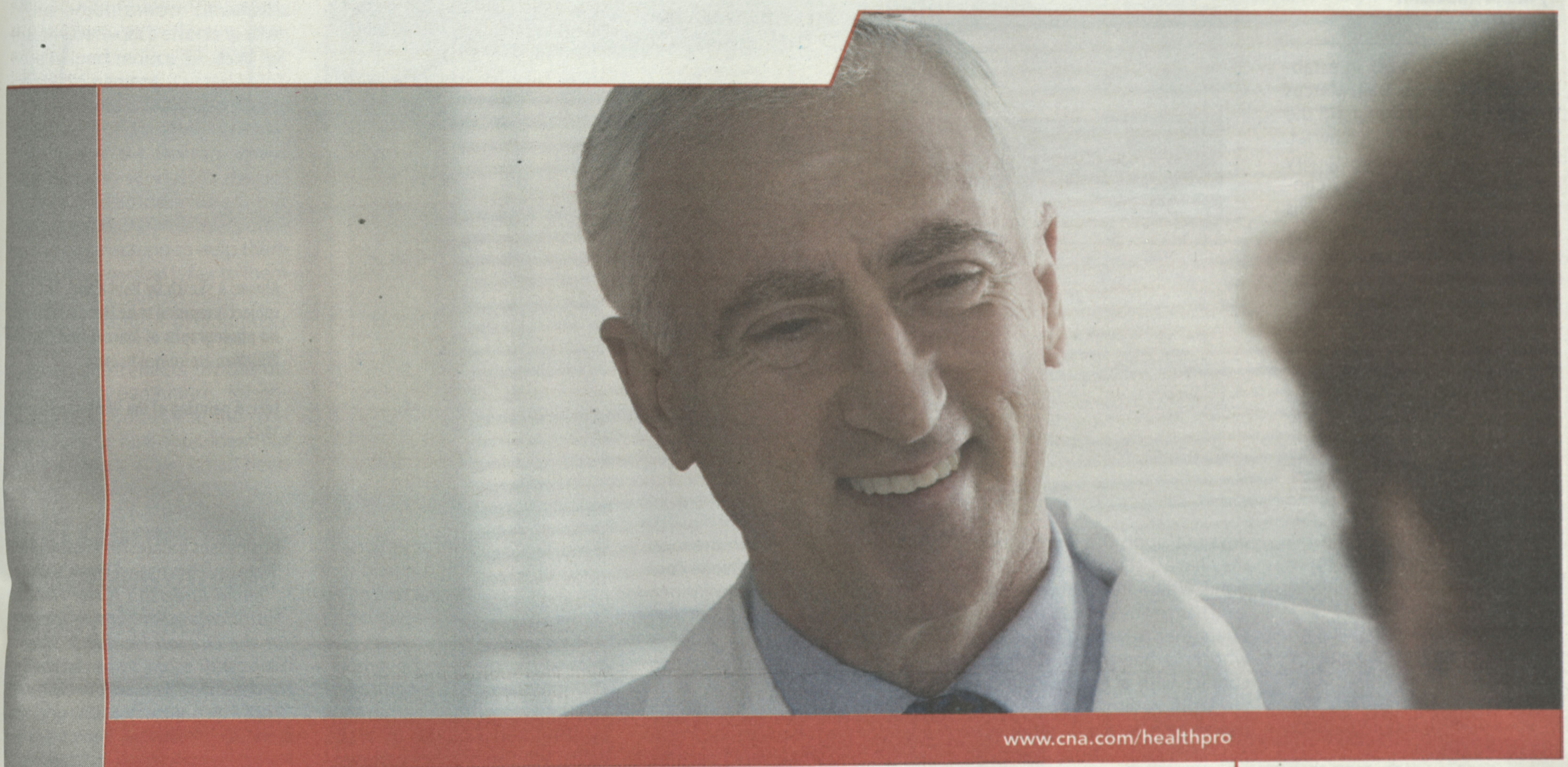

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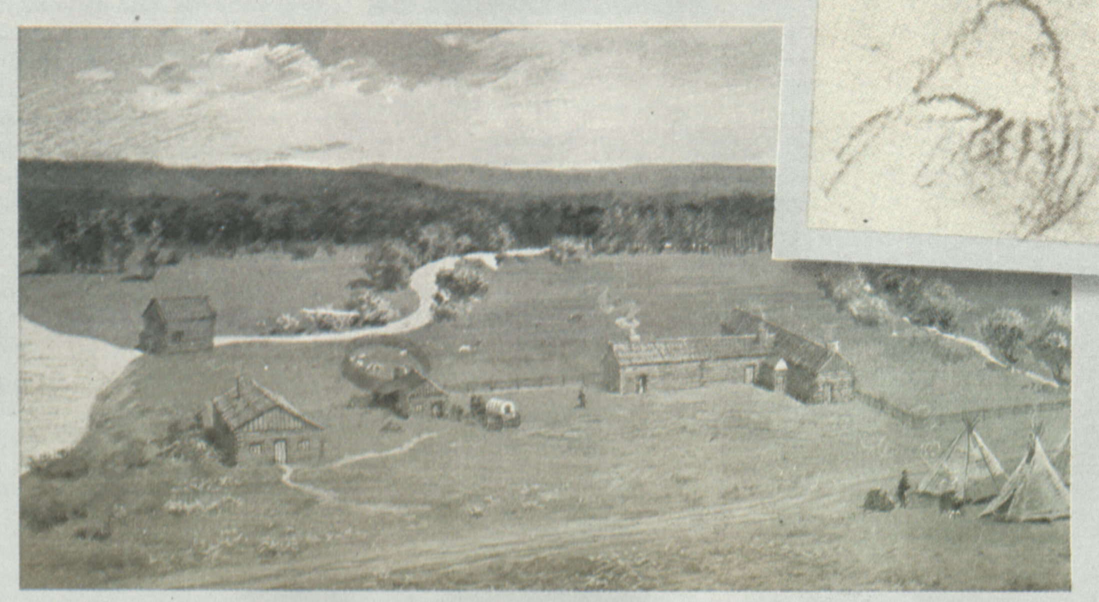
Marcus Whitman

Frontier Doctor

By Maija Anderson
OHSU Historian



Above: A sketch by Paul Kane, 1847. The subject is reputed to be Marcus Whitman. No photographs of Marcus and Narcissa Whitman are known to exist.

Left: A painting of the Whitman Mission, 1843

Famous for his work in establishing the Oregon Trail, Marcus Whitman is a major figure in the history of the Pacific Northwest. While his work as a missionary is well known, Whitman's chosen career was medicine. His experience as a frontier doctor provides unique insight into the historic conflicts that arose during the settlement of the American West.

Whitman was born on September 4, 1802 in upstate New York. He had a deeply religious upbringing, and had originally hoped to pursue a career in ministry. For financial and possibly health-related reasons, he instead studied medicine through apprenticeship to a local doctor. His studies culminated in a degree from the well-regarded Fairfield Medical College in 1832.

His faith continued to guide his medical career. Whitman applied to the American Board of Commissioners for Foreign Missions, an agency which sought to place missionaries among the Native American tribes. Though he lacked religious training, he was accepted as a missionary doctor. In 1835, he accompanied missionary Samuel Parker to the Western frontier, seeking Native American tribes that might be responsive to missionary activities. Whitman also practiced medicine among both the indigenous population and settlers.

HISTORY OF MEDICINE

The infections and contagious diseases that accompanied the frontier environment challenged pioneer doctors such as Whitman. On his journey west, Whitman treated a group of fur traders for cholera. Whitman wrote in a letter, "For the last twelve days have been attending upon Mr. Fontanille's men; the cholera has raged severely among them; three only have died…It is not strange that they should have the cholera, because of their intemperance, their sunken and filthy situation. They have been removed for some days out upon the Bluffs where they have a clean, healthy situation." Whitman also removed a 3-inch arrowhead from the back of another traveler, Jim Bridger, who had been shot during a conflict with a group from the Blackfoot nation. Samuel Parker described it as "a difficult operation, because the arrow was hooked at the point by a large bone and cartilaginous substance had grown around it. The Doctor pursued the operation with great self-possession and perseverance, and his patient manifested equal firmness."

After his first missionary experience, Whitman returned to New York. In 1836, Whitman married Narcissa Prentiss, a fervently religious schoolteacher who shared her new husband's enthusiasm about missionary work. Along with a group of traders and other missionaries, the couple traveled west on May 25, 1836, departing from St. Louis. On this journey, the Whitmans established missions and settlements in present-day Washington and Idaho. Whitman also practiced medicine among both the indigenous populations and the settlers.

The Whitmans' missionary efforts during this time were largely unsuccessful: They failed to engage socially with the local Cayuse population, let alone convert or acculturate them. When their mission was closed in 1842 through board action, Marcus Whitman headed east to plead his case. The decision was reversed, and in 1843 Whitman led a wagon train back to the West, establishing what would become the Oregon Trail.

Marcus Whitman's medical and missionary efforts now focused on the growing community of white settlers in the Walla Walla Valley. This only increased the alienation of the local Cayuse population. Like most of his contemporaries, Whitman disdained the practices of tribal healers, whom he described as "conjurers" and "sorcerers" working at odds with the medicine he practiced.

The Cayuse had a mutual distrust of Whitman's own healing traditions. In 1847, an epidemic of measles struck the area. Lack of immunity among the Cayuse led to the death of around half their population. Their high mortality rate in contrast to that of white settlers, fed suspicion that Whitman – as healer and minister - was causing these deaths.

On November 29, 1847, a group of Cayuse sought to avenge these deaths by killing the Whitmans and twelve other settlers, and burning down the mission buildings. The Whitman Massacre led to the further tragedies of the Cayuse War, a protracted and bloody conflict between the indigenous population and the government and local settlers.

Whitman's life as a missionary and doctor was characterized by conflict and tragedy; however, he was regarded in later years as a hero in the pioneer movement. Though his legacy is controversial, he is now commemorated by Whitman College in Walla Walla; Whitman County in eastern Washington; and schools and businesses located in Washington State and his native New York.

Maija Anderson is the Head of Historical Collections & Archives at the Oregon Health & Science University, and can be reached at andermai@ohsu.edu or 503-418-2287.

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Project Access NOW: Fundraiser nets $50,000 for volunteer organization

CONTINUED FROM / Page 5

form for most services. They find out right away what services are available through Project Access NOW's care coordination, pharmacy benefits and large network of volunteer providers Patients are more likely to get the care they need, and their use of costly, inappropriate alternatives such as hospital emergency rooms becomes less frequent.

The organization calculates that the network's efforts to date have helped reduce ER visits for care by 36 percent.

Project Access NOW also makes the process of donating care easier for physicians. Doctors always have donated services to the uninsured and underinsured, but previously there was no coordinating organization to help them do this in a way that is fair to them and does not pile too many referrals on a handful of volunteer physicians.

When she reflects on the organization's beginnings, Nilsen-Solares recognizes that the concept was "a nebulous idea. We were selling a vision. It had been accomplished in other communities, but not here," she said.

"It's most gratifying to help bring good will to create this system of donated care. It went from a vision to a tangible reality: donated care that is dignified, convenient and efficient. It's an honor to be involved in this. We create the environment; we just make it possible for other people to give."

One of her favorite aspects of the recognition dinner is to see volunteers and supporters make connections among themselves, she said.

"Portland is still a small enough town that people know each other. You hear people (at the dinner) say, 'Oh, you're part of this, too?' It's grass roots; people don't know who else is involved. It's fun to see this," said Nilsen-Solares. "It's an organization that attracts good people, and that says something. And we've got the best people, there's no question about that."

For more information visit: projectaccessnow.org

Oral cancer education offered to physicians

Providence Cancer Center will be offering educational sessions for physicians Wednesday, May 18, at the Center at 4805 NE Glisan in Portland. Sessions include:

- "Contemporary surgical management of oral, head and neck cancer: Optimizing function and esthetics in the technological age" (physicians/health care professionals); **R. Bryan Bell, MD, DDS, FACS** medical director, Providence Oral, Head and Neck Cancer Program; Providence Cancer Center Amphitheatre; Noon-12:20 p.m.
- "Advances in radiation therapy for oral, head and neck cancer" (physicians/health care professionals); Steven Seung, MD, medical director, Gamma Knife of Oregon, Radiation Oncology, The Oregon Clinic; 12:40-1p.m.
- "Update on the indications for chemotherapy in the definitive and adjuvant setting for oral, head and neck squamous cell carcinoma" (physicians/health care professionals) Eric Bernstein, MD, Medical Oncology, Providence Oncology and Hematology; 12:20-12:40 p.m.
- "Oral, Head and Neck Cancer Therapy in the 21st Century: Enhancing treatment outcomes through multidisciplinary care" (public/health care professionals/dentists); **R. Bryan Bell, MD, DDS, FACS**, medical director, Providence Oral, Head and Neck Cancer Program; 2-3p.m.

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A 'mindful' method for stress reduction

Gregory Esmer, DO, offers MBSR -- a clinical education treatment approach for treatment of chronic illness

By Cliff Collins
For The Scribe

The psychological concept of mindfulness, presented in a secular, health care context, is becoming more popular as a therapy for chronic illness and pain.

So says **Gregory Esmer, DO**, a Portland physician who has a keen interest in promoting mindfulness, or more specifically, **Mindfulness-Based Stress Reduction -- or MBSR** -- a clinical education treatment approach for chronic illness.

Dr. Esmer, who is with **Osteopathic Advantage** and is a member of the **Medical Society of Metropolitan** Portland, recently presented a research paper on which he was the lead author: "Mindfulness-Based Stress Reduction for Failed Back Surgery Syndrome: A Randomized Clinical Trial." His presentation was part of a special conference on alternative and complementary medicine held in April at **Oregon Health & Science University.**

Patients who have undergone back surgeries but still experience back or leg pain are challenging to treat. "Repeat surgeries have diminishing returns. That's one reason I wanted to look at this population of patients," he said. "They are really in need of a more conservative treatment paradigm."

This is where MBSR comes in. Mindfulness has long been associated with religious practices, particularly Buddhism. But since **Jon Kabat-Zinn, PhD**, founded the Mindfulness-Based Stress Reduction program in 1979 at the University of Massachusetts to treat the chronically ill, interest in it as a secular health care concept has spread, Dr. Esmer said.

The factor that has most inhibited its growth has been a lack of teachers, but that is starting to change. After he completed his residency and arrived in Portland in 2006, no one was teaching it in the Pacific Northwest, he said. Now several are, although he said that so far, he is the only physician teacher.

He defines mindfulness as "awareness where thoughts, emotions, and physical sensations are accepted as is." *Psychology Today* phrases it this way: "Mindfulness is a state of active, open attention on the present. When you're mindful, you observe your thoughts and feelings from a distance, without judging them good or bad. Instead of letting your life pass you by, mindfulness means living in the moment and awakening to experience."

Use of MBSR has grown because the public wants it, Dr. Esmer said. "Patients are really receptive to these kinds of more broadly defined wellness approaches. I see it as part of an evolution, that we're simply meeting a need."

He will be leading an eight-week course in MBSR beginning May 11. "It's intended for anyone who has chronic medical issues," he said. "It's more of a wellness-type approach, not specific to any diagnostic category," and is suitable for any patient in which chronic stress plays a significant role in the person's illness.

Part of the reason for the course he is teaching is to "allow physicians to address this aspect of a patient's case in a new way," he said.

Researchers are examining the psychological concept of stress hardiness, which refers to individuals who live in stressful environments and yet thrive and remain well. The idea is to try to ascertain whether those people possess certain traits that can be taught to others. "We're seeing people report improved quality of life," Dr. Esmer said. In the study he led, patients reported that they were "getting on with the business of living," taking fewer pain medications and functioning better without pain, as well as sleeping more soundly.

"Stress is a deep and basic problem," he concluded. The purpose of employing MBSR is "to have a better life, even if there is an unfortunate symptom."

Greg Esmer, DO, will teach "A Course in Mindful Living" on Wednesday evenings from 6:30 to 8:00 from May 11 through June 29, and on Saturday, June 4, from 9 a.m. to 12 p.m. For additional information or to request a course brochure: 503-230-2501. To view Dr. Esmer's study visit: www.jaoa.org/cgi/content/abstract/110/11/646

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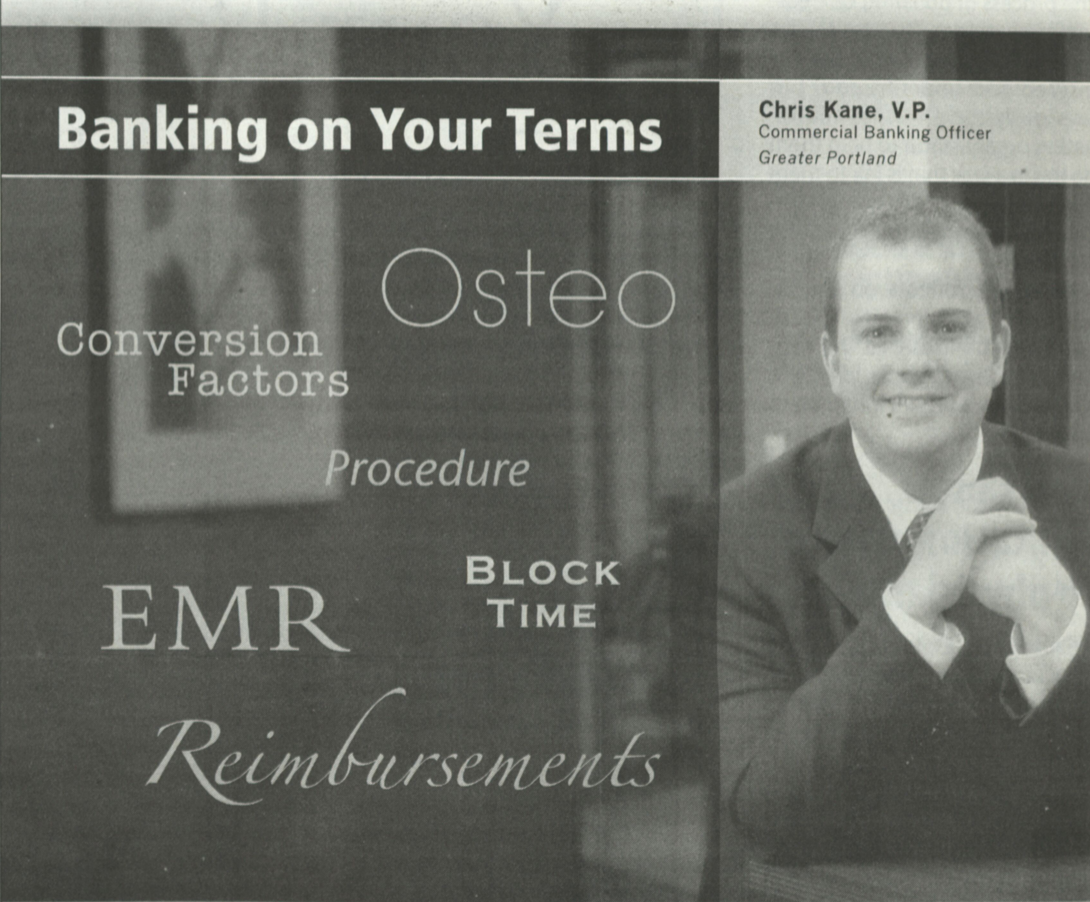

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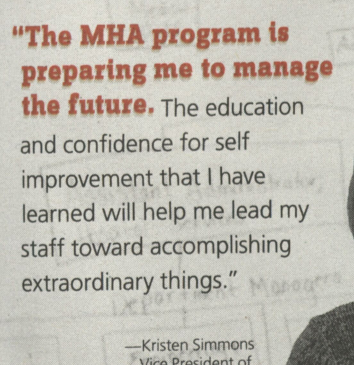

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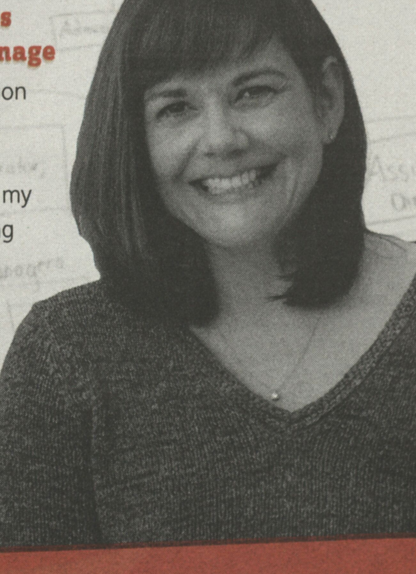

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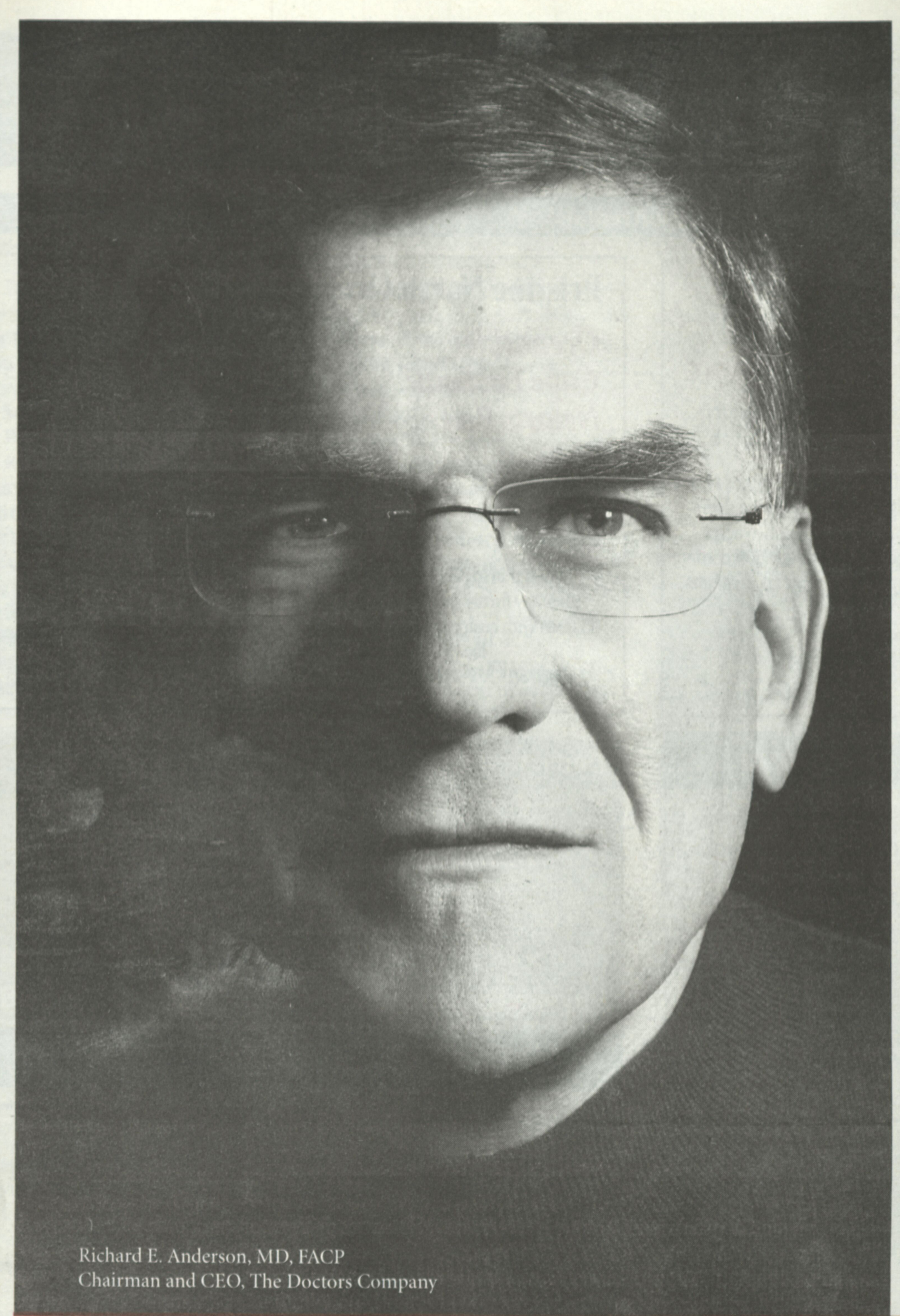
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