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Physical Therapy & Rehabilitation

This month's Focus section includes coverage of advances in sports medicine and concussion treatment.

—Pages 8–10

Surgery center-hospital arrangements benefit both parties

By Cliff Collins
For The Scribe

When **Plaza Ambulatory Surgery Center** opened in May on the **Providence Portland Medical Center** campus, it represented Providence Health & Service's fourth ambulatory surgery center joint venture in the Portland area.

The opening also is symbolic of the growing trend for hospitals to form business partnerships with physicians who operate, and often co-own, free-standing ambulatory surgery centers. These types of joint ventures have been occurring in various parts of the nation for years, and such arrangements have been taking place with added frequency on the West Coast.

"We're seeing more and more joint ventures every year," observed **Kecia Norling**, administrator of **Northwest Ambulatory Surgery Center**, which is a joint venture with **Legacy Health**. "There are multiple reasons for it."

Both Norling and **Paul Gaden**, chief executive of Providence Portland, agree that health reform's emphasis on delivering high-quality care at a lower cost is the chief driving force at this juncture. "That's what these provide," said Gaden. Free-standing surgery centers

*See **AMBULATORY,** page 14*

The Oregon Outpatient Surgery Center in Tigard, which was formed by three doctors in 2004, became Providence Health & Services' first joint venture with a free-standing ambulatory surgery center two years later. Photo courtesy of Jesseye Arrambide/Oregon Outpatient Surgery Center

Four-legged friends make positive impacts in therapy setting

By Jon Bell
For The Scribe

Liberty Jackson always thought she would be a veterinarian, but as life so often unfolds, she ended up traveling a different path. Not, it turns out, all that far away from animals.

Jackson, 31, is an occupational therapist, and though she's not tending to the health care of dogs the way a vet would, she does practice with a canine every day. Her black Labradoodle, Tempe, is a therapy dog trained to help everyone from stroke patients and disabled children to kids having a hard time getting over a tragedy in their school.

"Dogs can be involved with such a wide variety of therapies," said Jackson, who works with

*See **ANIMALS,** page 8*

Luke and Mardene are a Portland Canine Companions for Independence service dog team. Mardene assists Luke by retrieving items he drops, turning light switches on and off, and opening doors.
Photo courtesy of Canine Companions for Independence

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Giving back through medicine, entrepreneurship

OHSU student Roheet Kakaday helps peers and those with health issues during his journey through school.

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www.legacyhealth.org/3dmammo

3-D mammography saved her life. Now, she can keep saving others.

Thanks to 3-D mammography, breast cancer surgeon Nathalie Johnson is also a breast cancer survivor. Her 3-D mammogram found the cancer her 2-D mammogram missed.

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County surveys clinicians about emergency communication

Medical society boosts e-preparedness support with apps, clinics map

By Cliff Collins
For The Scribe

Man-made disasters such as oil train derailments and explosions, along with the current Ebola virus scare in Africa, are reminders of how—if and when such events were to occur in the Portland area—it would not be business as usual for anyone involved in health care, including at the level of the medical office.

Being aware of a local situation immediately, before patients need treatment, can help providers better prepare, said **Paul Lewis**, MD, MPH, Multnomah County health officer, who also serves as tri-county health officer for Clackamas, Multnomah and Washington counties.

"Currently, Ebola rages in Africa, and imported cases in the U.S. or Portland would require enhancement of normal procedures and raise concerns far beyond more routine measles scares," he said.

Lewis is working to ensure that medical providers have accurate, timely information when such public health issues emerge. In order to do that, beginning in July, he has been asking all licensed MDs, DOs and PAs in the three counties to sign up for public health notifications to receive information, and to indicate how they would like to receive it.

In a brief, secure survey, he allows clinicians to select how they wish to be notified of important public health information for their practice. The survey link was sent to the email address providers used when most recently renewing their license.

In the first such survey, done in 2012, most clinicians chose to receive a text to their mobile phones for urgent situations, and email for routine information.

"The choice is yours," he said. "Participating in the survey will not lead to excessive emails or texts. Since 2012, we have only used the survey information four times." Once was for a hepatitis A outbreak, another was for an extensive measles exposure, and in recent weeks, notices have been sent about national Ebola alerts.

In addition, he emphasized that survey information is stored locally on secure Multnomah County servers to keep all contact information safe.

"I encourage my fellow clinicians to respond to the survey so that your public health departments can best serve you, your patients, and the community," he said.

MSMP expands medical-office disaster support

Lewis' survey coincides with work underway by the Medical Society of Metropolitan Portland, according to Aaron Troyer, manager for **MSMP's Health Preparedness Program**.

Among MSMP's efforts this year, "We are working on publishing our map of clinics online so that it can be used as a resource for both the general public and all the health preparedness stakeholders," he said. "We are also working on putting together a few apps for mobile devices."

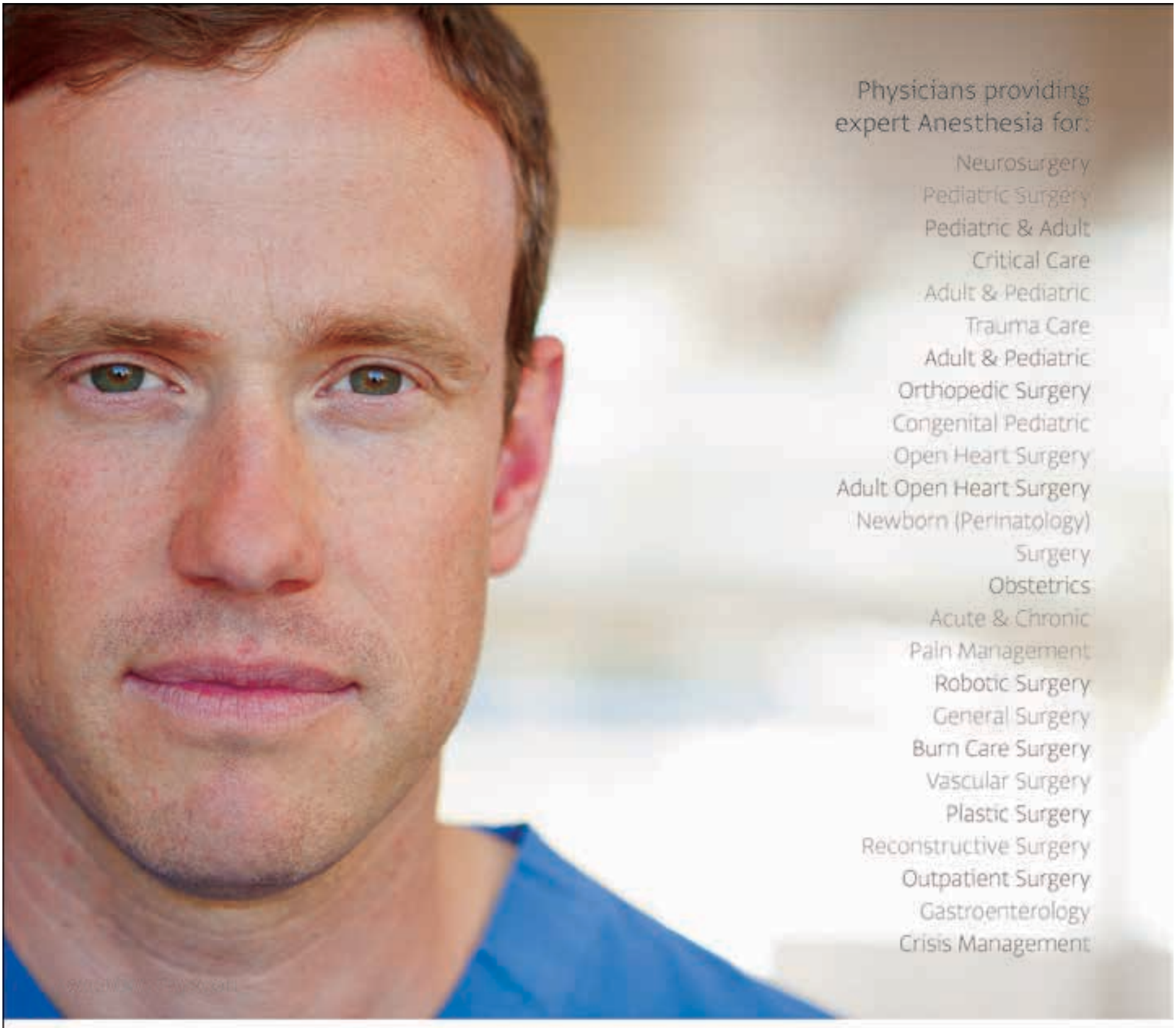
Troyer is completing work now on an app that contains county-specific information related to health preparedness, such as phone numbers and points of contact for different agencies including the state's Acute and Communicable Disease Prevention Section's program, the Oregon Poison Center, the Oregon Medical Board, the sheriff's office, county health departments, etc. It also gives users the ability to input their own clinic information, such as staff contact data and building resources.

Troyer also is just starting to develop an app geared toward **Continuity of Operation Planning**—or COOP—for small, stand-alone private clinics that are not directly affiliated with a hospital or group of clinics.

These plans are used to establish guidelines and policies for alerting employees to operational changes, identifying essential mission functions, predefining alternate facilities, managing essential records, developing alternate mechanisms for communication, delegating authority, and several other key issues related to getting and keeping a clinic up and running following a catastrophic event.

In concept, the app will be a template for clinics to use to develop their own individualized COOP, he said. "Users will be able to input their own information and follow general guidelines for 'getting their ducks in a row' prior to a disaster situation." He is drawing from information garnered from several different sources—the Federal Emergency Management Agency and the National Center for Disaster Medicine, among others—to develop a template that is relevant to small clinics in the Pacific Northwest.

The MSMP also continues to maintain a section of its website, www.msmp.org, dedicated to increasing awareness of current disaster-related events and providing a plethora of health preparedness-related information and links to related resources on the Web. •



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Physician Profile

Hooked on disaster relief

For nearly a quarter century, Doernbecher's Dana Braner, MD, has responded to emergencies across the globe

By John Rumler
For The Scribe

On Nias Island, Indonesia, **Dana Braner, MD**, and his pediatric intensive care unit (PICU) team arrived at a dust-choked disaster site soon after a second devastating earthquake. Roads were destroyed, half-naked, dazed children wore surgical masks, and red flags poking out of the rubble signified dead people who were covered by debris. Coffins were scattered everywhere, with the crude wooden boxes stacked on practically every street corner.

For the past 24 years, Braner, chief of the Division of Critical Care and vice chair of Inpatient Clinical Services at OHSU's **Doernbecher Children's Hospital**, has regularly participated in global disaster relief efforts. He's served in some of the worst disasters, including those that hit the U.S. Gulf Coast, Indonesia, Honduras and Haiti (several times).

After nearly a quarter of a century of being at so many terrible situations where, it seems, all hell is breaking loose, one might assume that Braner is unshockable. Nothing could be further from the truth.

"I have daughters ages 12 and 14. Everything shocks me," he says. "The life of one child anywhere is worth the same as the lives of children everywhere."

'People amazing and deeply appreciative'

Braner, who got his start at OHSU in 1991, says he was drawn to the PICU because of the close ties developed with families and the opportunity to help kids and families on their journeys of recovery.

"We get children when they are very sick and are able to keep them until they are well and on their way to health. The PICU has longer, closer relationships with families than the Pediatric Emergency Department, and it deals with the health of a child at a pivotal moment. If we do it right, we can help the child and family to recover.

"For me, the PICU embodies the best of medicine, the team aspect and the relationships with the families."

Braner's start in disaster relief efforts came in 1990 when a colleague, **John Alan Paschall, MD**, had a medical trip planned to Colombia and could not make it. Braner filled in, performing oral-facial surgeries on youngsters with cleft palates and other disfigurements.

"I got hooked right away. The people were amazing and deeply appreciative, and it freed me of my day-to-day, highly technological practice."

More opportunities to serve overseas came in the form of disaster relief. During the first few trips Braner faced a steep learning curve, and he spent a good deal of time getting his bearings and staying focused. "We are trained to find a certain order in chaos," he says. "It might not look much like order, but it has a specific priority structure."

A takeaway early on in his overseas experiences was the importance of planning and support. "The most important lesson I learned is to have a plan and a support system. Going into a disaster with no plan and no support just makes you part of the problem."

During the Indonesia earthquake and tsunami of December 2004, Braner took on a wide variety of tasks, from providing emergency care and serving as a general pediatrician to carrying boxes of water, equipment and supplies. "I basically tried to help wherever help was needed," he says.

He filled a different role in connection with 2005's Hurricane Katrina, coordinating care between Project Hope and the U.S. Navy as well as helping to staff the ERs of some of New Orleans' decimated hospitals. This allowed many traumatized and uprooted people time to gather themselves and care for their own needs.

(above and below) **Dana Braner, MD, helps save a child during a disaster relief mission in Indonesia. Braner, whose specialty is pediatrics, says of his approach: "I see a problem and think, 'I should try to help fix that.' It's not complicated at all."**

Photos courtesy of the U.S. Navy

'The ultimate team sport'

In spite of Braner's many years of experience, he says it is difficult, perhaps impossible, to psychologically prepare for the carnage and extent of the pain and suffering at disaster sites. He still feels a great deal of trepidation before going on a mission.

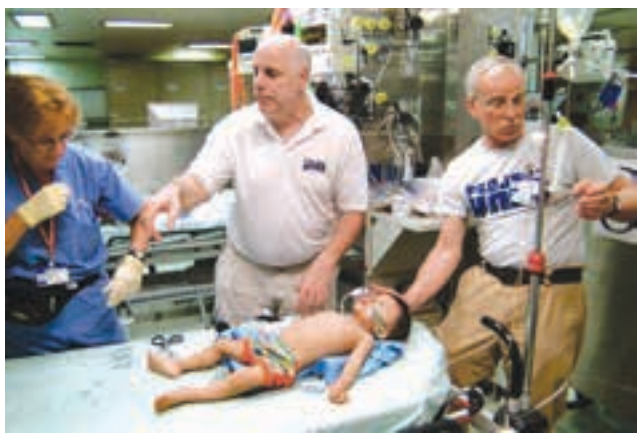
"I don't think anyone is ever prepared for the suffering of others. Each time a child dies it is a unique tragedy. Sadly, in most mass traumas there are people that your team might have saved, but for different circumstances."

Braner, who speaks French, Spanish and some Vietnamese, says learning people's customs and culture and getting to know them is not only enriching, but it also makes it possible to provide much better medical care.

He's spent so much time on naval hospital ships—including serving on one that sailed through Hurricane Rita—that he says, "I can get seasick just looking at a picture of water."

Braner works with many disaster teams, including Project Hope, those with the U.S. Navy, and members of the U.S. Disaster Medical Assistance Teams (DMATS), and points out that some of his coworkers at OHSU are even more involved in disaster work than he is. Two of those are **Jonathan Jui, MD, MPH**, current medical director of Multnomah County Emergency Medical Services, and **Terri Schmidt, MD, MS, RN**, and a professor in the Department of Emergency Medicine.

"All the doctors and specialists who volunteer for these large-scale emergencies develop a close bond," Braner says. "A single individual can't do anything. Medicine is the ultimate team sport, even more so on a disaster mission." •



Child survives against all odds

During the Indonesian relief mission, Braner and his PICU team had just poured everything into trying to save a child who ended up dying, and their spirits were sagging. Visiting a tent hospital being run by a team of Russians, they saw another youngster in extremis, seizing in respiratory failure and shock.

They placed an IV line, gave the child fluids and antibiotics, and stopped the seizures. They only had a BVM (bag-valve-mask) airway, and there was a risk the child would lose his pulse and require CPR.

"Normally, this might be a child we'd have to let go, but not this time," Braner said.

The Navy quickly dispatched a helicopter. During the flight to the ship the child had several cardiac arrests, yet the helicopter crew delivered the child and medical team to the vessel amazingly fast. Once on the ship, the child was immediately intubated. With his pH reading 6.65, a Navy radiologist inserted a central line, and the child went to the ICU where he recovered within a week. •

—John Rumler

Giving back through medicine and entrepreneurship

OHSU student Roheet Kakaday helps peers and those with health issues during his journey through school

By Barry Finnemore
For The Scribe

Roheet Kakaday didn't grow up wanting to become a doctor. Even as a student at the University of California, San Diego, a career in medicine didn't enter his mind—until, that is, he reached about the halfway point in his undergraduate studies in bioengineering and volunteered at a southern California hospital, getting to know the patients and their stories.

His pivot toward medicine was complete when, during the summer after his sophomore year at UCSD, he volunteered to help provide medical care for people with leprosy in India. For almost a month, Kakaday lived in a rural community during monsoon season, wrapping wounds, working in a cardiac clinic and improving health education. In addition to the abject poverty among the patients, the area was plagued by communist terrorists.

"It put a lot of things in perspective," Kakaday said of the experience. "The day-to-day interaction with patients confirmed that I wanted to stay in India (for the nearly four weeks), and the knowledge that I stuck with it made me realize I could handle long hospital shifts here. The stressors I felt paled in comparison to the value in connecting with folks."

After graduating from UCSD in 2012 and taking a year off, Kakaday began medical school at Oregon Health & Science University. He chose OHSU because of its reputation and growing prominence nationally, and was drawn to Portland because of its positive vibe and population of young professionals.

At first, Kakaday found it tough to regain his study habits, particularly after a year away from academics. He described med school as "college on steroids," but he soon got his feet under him and carved out time to brainstorm an idea for a company. This past January he launched **Lean On**, which pairs medical students with pre-med students who share similar backgrounds. The idea is that they form a mentor-mentee relationship, with the med students advising pre-med students, including editing their personal statements at a fraction of the cost other services charge. Lean On also has started a pre-pharmacy advising service.

While Kakaday acknowledges that admissions consulting certainly isn't new, the $49 Lean On charges for two edits has saved pre-med students it works with a total of $50,000 so far. In addition, Lean On has a broader socioeconomic reach because of its low fee. Most of the fee goes to the student advisors, and the balance to Lean On to cover operating costs. Kakaday said he has a growing network of advisers, thanks to word-of-mouth advertising, and that once advisers graduate from medical or pharmacy school they move away from Lean On and first- and second-year students take their place, ensuring pre-med and pre-pharmacy clients connect with mentors who have the freshest experience.

Roheet Kakaday, now a medical student at Oregon Health & Science University, spent time as an undergrad volunteering in India, caring for people with leprosy. He is pictured here with the 6-year-old son of an individual cured of the disease.
Photo courtesy of Roheet Kakaday

Kakaday said Lean On makes him feel like he's giving back.

"As a student, I felt like I was inputting a lot and not outputting," he noted. "I felt like I needed to have a little more concrete impact. It's nice to start a company that is doing something positive and serving people."

Kakaday said the entrepreneurial spirit was instilled in him in part by virtue of being born and raised in the San Francisco Bay area, in the shadow of Silicon Valley. He also comes from what he refers to as a "boot-strapping family." His civil engineer father started his own company, and his grandfather taught himself bookkeeping only after getting a job keeping books, a trade he ended up plying his entire working life.

In fact, Kakaday, a self-described interdisciplinarian, has flexed his entrepreneurial muscles a second time, turning a disappointing result on an electronic health records quiz into a business idea by developing a prototype of an EHR system with a simple interface he found more intuitive. He had posted his prototype on the Internet, got positive feedback from friends and even drew interest from investors. But for now, he's in a holding pattern with that effort, preferring to focus on his studies as he enters his second year of med school and, through an informatics group on technology used by physicians, getting as much insight as possible on how clinicians view and use EHRs. He also maintains a blog (www.thebiopsy.com), co-hosts a podcast about medical innovation and is a student adviser for Stanford Medicine X, dubbed the premier patient-centered conference on emerging technology and medicine.

"What resonates with me about entrepreneurship is that when you see a need or something wrong, you fix it," said Kakaday, who is leaning toward an internal medicine subspecialty. "But becoming an MD, and making a difference in people's lives every day, that impact is an unmatchable privilege." •

Multitasking—not the way to get things done efficiently and safely

Work with colleagues to ensure tasks match team members' skills, experience

This article is part of a series exploring life challenges of physicians. It is a part of MSMP's goal to better support and connect members of the region's medical community. Do you have a personal story about overcoming challenges that you'd like to share with Scribe readers? If so, please contact the editors at Scribe@LLM.com or 360-597-4909.

By Dike Drummond, MD
For The Scribe

The neuroscience is clear: Multitasking does not work. It is not a "skill" you can develop. It is not something you can possibly get good at. Multitasking is an urban myth, in my opinion. In a health care setting, it can actually threaten patient's lives.

The reason multitasking does not work is simple to explain. Your attention—the bandwidth of your awareness—has a finite capacity. There is only so much attention to go around. You get the best results when you give *all* of it to a single task or observation.

If you are doing one thing (say, reading an MRI report on one of your patients) and you add in a second activity at the same time (say, taking a phone call and trying to continue to read the MRI report), your available attention for each individual activity has instantly been cut in half. You are now half as good at reviewing an MRI report—and your phone conversation will have half the quality it would if that was the only thing you were doing.

Congratulations—your multitasking (just two tasks in this case) has allowed you to instantly do a half-assed job. Unfortunately, we are just getting started.

Here is the mathematical relationship between multitasking and quality:

$$\frac{\text{Attention}}{\text{\# of Tasks}} = \text{Quality}$$

There are two unfortunate consequences to this equation:

1. When you multitask you really do look stupid—and you do a ½- or ⅓- or ¼-assed job of whatever multiple tasks you are trying to accomplish at one time.
2. In health care, where even little mistakes can have big consequences, multitasking is downright dangerous.

But what can you do when there simply *are* too many tasks and not enough time in the average office or hospital day?

Try these three field-tested tools instead:

1. Batch Processing

As you go through your day, put similar tasks in piles and process the piles one at a time in batches.

Carve out protected time so that the batch is the only thing you are doing. The similar activities help you maintain your focus as you move through the tasks one at a time.

*See **MULTITASKING,** page 15*

***ANIMALS** from page 1*

Tempe in the Vancouver School District. "Fine motor skills, sensory goals, social anxiety. There is just such a spark in a dog and they're able to help so many people."

Though incorporating dogs for various therapies isn't new, it is a practice that has grown over the years and become more and more mainstream. Therapy Dogs International, a nonprofit organization that regulates, tests and registers therapy dogs and their handlers, had registered nearly 25,000 new teams by 2012, and another similar organization, Therapy Dogs Inc., has about 12,000 teams in the U.S. and Canada.

For Jackson, who's been practicing for about four years, occupational therapy became her focus because she'd learned how therapists had been incorporating dogs into their practices. She studied at Pacific University in Hillsboro, with a large focus of her work being the use of therapy dogs.

When she began practicing, Jackson got Tempe, a professionally-trained therapy dog who knows at least 50 different commands, to do everything from getting a tissue out of a box for a sneezing child to helping a disabled person get undressed. At the command, "squish," Tempe will lay on someone and snuggle them, and she'll stand close to patients who need to work on motor skills so they can reach out and pet her.

Highly skilled Canine Companions for Independence facility dogs, such as Millie (pictured), are carefully selected and provided free of charge to assist professionals in a variety of settings.

Photo courtesy of Canine Companions for Independence

"Dogs are great because they give clients something to reach for," Jackson said.

Sometimes it's not necessarily what Tempe has been specifically trained to do that can be beneficial as well. Out in public with the dog once, Jackson said Tempe kept pestering her about a particular woman. Tempe looked at the woman, then looked at Jackson, over and over, gradually growing more agitated. Unbeknownst to anyone nearby—save for Tempe, it turns out—the woman had chronic obstructive pulmonary disease. Tempe had been trying to tell Jackson that something was wrong for 10 minutes when the woman went into a full-on respiratory attack.

"She's very in tune with physiological changes with people," Jackson said. "She's a good barometer for the human experience. She's just able to pick things up about people in a way that others aren't able to."

In addition to therapy settings such as those that Jackson and Tempe work in, dogs have become fairly prominent in other areas as well.

Canine Companions for Independence is a California-based nonprofit that breeds, raises and trains assistance dogs that it then pairs with handlers or people with disabilities. The organization has matched more than 4,500 dogs with people since its founding in 1975 and currently has 32 graduates in Portland.

In addition to training dogs used for therapy, which Canine Companions calls facility dogs, the organization also trains them for other work. Service dogs work with adults who have disabilities but who are able to handle the dogs themselves. Hearing dogs help people who are deaf or hard of hearing, and skilled companions work with family members or caregivers to assist disabled youth or adults.

"There is a huge range of things that dogs can do, and the client base we work with is really broad," said Angie Escudero, Northwest region development associate and instructor for Canine Companions. "We have over 60 different kinds of disabilities that have been in our program, but I say the most common ones are cerebral palsy, multiple sclerosis, spinal cord injuries, hearing loss and muscular disorders."

The dogs that Canine Companions puts to work are all Labradors and golden retrievers, or a mix of the two. Volunteer puppy raisers raise the dogs, they're trained until they're two, and then they work for anywhere between 10 and 12 years. Canine Companions matches dogs with clients and provides the dogs free of charge. There's currently a waiting list of 400 people nationwide, and Escudero said it can take between a year-and-a-half to two years for approved clients to get matched with a dog.

Some of Canine Companions' Oregon puppies are actually raised by inmates at the Coffee Creek Correctional Facility in Wilsonville.

As more and more service and assistance dogs have come into use, particularly in public places, Escudero said more people have tried to get their own dogs into places where dogs normally wouldn't be allowed.

"You have people who know that assistance dogs are allowed in public and so they want to take their pet dogs into those places, too," she said. "Unfortunately, that jeopardizes the access rights of people who truly do need their dogs with them in public places."

Canine Companions has started a pledge against service dog fraud to help curb the practice. It's also holding an informational event and fund-raiser in Portland on Sept. 13. Called the DogFest Walk 'n Roll, the event—a community dog walk and celebration—will be held on the University of Portland campus. For more information, visit www.cci.org. •

"Dogs can be involved with such a wide variety of therapies. Fine motor skills, sensory goals, social anxiety. There is just such a spark in a dog and **they're able to help so many people."**

—Liberty Jackson, occupational therapist

Liberty Jackson, an occupational therapist, shares a lighthearted moment with her Labradoodle, Tempe, a therapy dog trained to help everyone from stroke patients and disabled children to kids having a hard time getting over a tragedy in their school.

Photo courtesy of Derrin Battles

Sports medicine advances through improved collaboration with physical therapy

By Melody Finnemore
For The Scribe

Sports medicine—for seasoned pros, weekend warriors and student athletes alike—has advanced significantly during the last decade. While technology plays a key role in that evolution, something more basic has propelled the field: greater collaboration and improved communication with physical therapists.

"As sports physicians, we don't have the opportunity to watch athletes play or work out. We're more confined to seeing them in our office," said **Don Roberts, MD**, an orthopedic surgeon with **Rebound** who specializes in knee disorders. "The trainers and the physical therapists who work with them have the opportunity to see them in a setting where they can watch for abnormal gait patterns, running and jumping. That communication between athletic trainers, physical therapists and physicians has really helped guide rehabilitation."


DON ROBERTS, MD

Roberts, team physician and orthopedic surgeon for the Portland Trail Blazers since 1994, also was team physician for the gold-medal-winning men's and women's basketball teams at the 2012 London Olympics and has cared for Olympic athletes at the U.S. Olympic Training Center.

During his care of both pro and amateur athletes, particularly in recent years, Roberts has witnessed athletes of all calibers returning to their sport more slowly after an injury to ensure their rehabilitation has been as effective as possible.

"Today, athletes are returning to sports more slowly because physicians realize that some muscle patterns haven't fully recovered. When they do return, their function is better and it's safer to return to their sport and, hopefully, prevent further injury," Roberts said.

"That's important for everybody. Whether you are a weekend athlete or a high-school basketball or soccer player, you're going to live with your injured joints for a while. So our goal is to make sure they return to their sport with minimal impacts."

Jonathan Greenleaf, MD, an orthopedic surgeon with **Sports Medicine Oregon**, cares for amateur and pro athletes, including members of the Portland Timbers and Thorns soccer teams. He said he also has seen greater collaboration among physicians and physical therapists, which has benefited athletes of all calibers.

"The big thing that has changed over the last ten years is that we're really taking a team approach to both the treatment of injuries and injury prevention," Greenleaf said, adding the treatment and prevention of knee ligament injuries, particularly anterior cruciate ligament (ACL) injuries, have been in the spotlight.

"That's been a huge advance and something we have really pushed to have available for the general public," he said.

Functional movement evaluation, or functional movement screening, is an enhanced treatment in which physicians and physical therapists evaluate a patient's flexibility, strength and balance and incorporate the results into their recommendations for the patient's treatment regimen, Greenleaf said.

Rehabilitation advances include using evidence-based science for treatment options. Physicians and physical therapists can pinpoint these options by developing prospective treatment regimens to get people back to their sports and, more importantly, their normal function. These functional guidelines are directed by body movement and capacity rather than a designated amount of time for a return to sports, Greenleaf said.

"Technological advances have been helpful, but not as much as individualizing treatment and using pre-injury evaluation to avoid injuries," he said.

Mark Colville, MD, also a Rebound orthopedic surgeon who specializes in knee injuries, is head team physician for the Portland State University and Winter Hawks hockey clubs and is a consulting team physician for Concordia University's athletic teams. His practice also focuses on preventing injuries before they occur.


MARK COLVILLE, MD

When injuries do happen, Colville works with physical therapists to ensure athletes have plenty of time to rehabilitate before returning to their sport. This includes functional coordination activities that use the athlete's body weight for natural balance rather than machine weight that isolates the muscles.

When athletes do sustain an injury, Roberts said he recommends a switch to an alternative activity such as rowing or swimming. These activities allow athletes to rehabilitate knees and ankles in a safe way while introducing them to a new sport and giving them a way to remain competitive and get stronger while they heal.

"This is especially great for people with long-term injuries that take a long time to recover," he said, adding rowing and swimming give athletes a way to see their progress as their muscular and cardiovascular strength improves during rehabilitation and gives them a leg up on the competition upon their return. •

"As sports physicians, we don't have the opportunity to watch athletes play or work out. We're more confined to seeing them in our office. The **trainers and the physical therapists** who work with them **have the opportunity** to see them in a setting where they can watch for abnormal gait patterns, running and jumping. That **communication** between athletic trainers, physical therapists and physicians has really **helped guide rehabilitation."**

—Don Roberts, MD, orthopedic surgeon with Rebound

As concussion awareness grows, treatment options focus on slower steps toward recovery

By Melody Finnemore
For The Scribe

Diana Robinson has dealt with a host of health issues during her lifetime. Among them, four concussions—the most recent of which happened last spring when she reached for a coffee cup, fell and hit her head.

"My balance went first and then my short-term memory," she said. "It was like having your IQ suddenly drop several points."

Robinson found that she would drive to do errands and then forget how to get home. She would sit in her car shaking until she could calm herself enough to drive.

"Everything from the concussion forward was hit or miss about whether I would remember it or not," she said.

During physical therapy, Robinson struggled to remember four-number sequences. She found working on a computer to be as exhausting as physical exercise, and cooking was nearly impossible because it combined both mental and physical activity.

"It's just like if you have a cold or a flu and you try to go to work, it's going to be harder to heal," she said.

Robinson turned to **Laurelhurst Physical Therapy Clinic**, where she was introduced to myofascial release therapy for the tightness and pain she suffered during the fall that caused the concussion. The slower mental processing she experienced is another common symptom of concussions, and one that fascinates **Suzanne Trebnick**, PT, OCS, COMT, co-owner of the Portland clinic that treated Robinson.

"We've treated concussions for years, but it really hasn't been clearly understood until recently," said Trebnick, who has practiced physical therapy and rehabilitation since 1972.

Among the facts that are better understood today is that there are several myths surrounding concussions and their treatment. The myths include the notion that one has to lose consciousness in order for a concussion to occur.

"Only about 10 percent of people who have concussions lose consciousness," Trebnick said. "If you fall off your bike and you see stars, that's a concussion. Whiplash can cause one, too. Anytime you hit your head and your brain bounces off your skull, that's brain trauma that can cause a concussion."

Her concussion patients range from a young soccer player who does headers to a bicyclist who had an accident and an older patient who fell down some stairs and hit her head.

"The soccer player did lose consciousness for a very brief period of time. The biker saw stars. The older patient said they didn't go completely unconscious or see stars, but they felt numb and didn't feel quite right. So it can be different every time," she said.

Physical therapist Suzanne Trebnick, right, treats patient Missy Decker with vestibular exercises. Her eyes are closed as part of the exercise.
Photo courtesy of Suzanne Trebnick

Another myth is that people with concussions should be woken up every 20 minutes. A better treatment, she said, is to wake the person every couple of hours.

"Let them rest—they need that rest. Every two hours is fine," she said. "The biggest precaution is don't overload the brain or the nervous system because they have been compromised. If you have a concussion, the number one initial treatment is rest. They have to get the symptoms to subside."

Trebnick said common symptoms include blurry eyesight and nausea as well as trouble focusing and sleeping. People with concussions may be overly emotional, and headaches are common. Often, treatment of the neck is required because head injuries can involve the neck as well. Trebnick treats many of her concussion patients with mobilization or stabilization of the spine. In addition, physical therapy programs often involve eye tracking and a vestibular component to help patients regain their balance, she said.

Over several decades of treating concussions, Trebnick said she has learned not to push patients to rehabilitate too quickly mentally or physically. "The key factor is the slower mental processing. The synapses in the brain are taking longer to connect, and we need to acknowledge that. You can't speed that up—that's the brain healing."

Trebnick said that as the medical profession has become more sophisticated in diagnosing concussions, she has been pleased to see a series of diagnostics required for athletes to return to their sports after suffering a concussion.

"If a kid fell down on a basketball court or had an injury even 10 years ago, they just let them keep playing," she said. "Now if there is a head injury they are removed from the court immediately and they aren't allowed to play again until they can pass a series of tests."

For her part, Robinson, who recently took a brief break from her physical therapy regimen, continues to improve both mentally and physically. •

Edward Keenan remembered as treasured and talented leader, mentor, friend

Edward J. Keenan, PhD, closely associated with Oregon Health & Science University for many years and president of **The Foundation for Medical Excellence** since 2008, died Aug. 14. He was 65.

Keenan was remembered for his profound and lasting contributions to Oregonians' health, to mentoring innumerable physicians, and as an advocate for medical students. Colleagues described him as curious, passionate, intelligent, warm and endearing, with the ability to both share his vast knowledge and learn from every person with whom he interacted.

"In a lot of ways, what made Ed a marvelous leader was not how smart he was, but his genuine ability to connect with people and include them in his mission. And that's rare," said Lauretta Young, MD, medical director for OHSU's **Resiliency Program**, who collaborated with Keenan on initiatives encompassing medical education, student and physician resiliency, and organizational professionalism. "When you were with him, you had his full attention."

Young, who as part of a health care master's of business administration class she teaches at OHSU uses Keenan as an example of an effective leader, recalled lunches with him in which they brainstormed trainings to help clinicians build skills to thrive on the job as well as help organizations develop the practices that allow health care providers to flourish.

"The depth of his knowledge of the issues facing medicine was really profound," Young said, adding: "He had a habit, when he would be really passionate about something, of pulling his glasses down and looking at you, and you'd see the twinkle in his eyes."

OHSU President Joe Robertson, MD, said Keenan's contributions were many. "Ultimately, what I think I and many others will remember him most for are his contributions to medical education. For a generation of medical students, Ed was the face of medical education. When they think about medical school, their mental image is going to contain a picture of Ed. He was concerned about every aspect of their lives."

Mark Richardson, MD, dean of OHSU's School of Medicine, called Keenan "a great contributor" to the school "in almost every way you can think of," including as a scientist, educator and friend.

"For me, Ed was always grounded, always had good humor, and always had a great approach to problems," Richardson said. "He was just a wonderful person…and leaves an indelible mark."

Keenan was widely admired by students, and had a gift for quickly establishing personal relationships and for big-picture thinking, Richardson noted. Keenan was instrumental in changing the school's admissions to make the scoring process more holistic, and in seeing the school's role in training practitioners to serve Oregon's population, including rural and underserved communities.

Keenan's ability to see the big picture, Richardson added, was a major reason why he made the transition so well from the medical school to The Foundation for Medical Excellence. The Portland nonprofit is dedicated to promoting excellence in medicine, improving the quality of health care, and advancing sound health policy through education programs, collaborative initiatives and research.

A native of Shelton, Wash., Keenan earned bachelor's and master's degrees in biology from Creighton University, and his doctoral degree in pharmacology from the West Virginia University School of Medicine.

Keenan, who joined OHSU in 1975, created the Hormone Receptor Laboratory and served as its director until 1994. He then was appointed associate dean for medical education in the School of Medicine, where he developed and encouraged new innovations in training doctors.

In his memory, Shelley and Alex Keenan have established the **TFME Edward J. Keenan, PhD, Medical Student Scholarship** fund to support scholarships for medical students. Contributions to the fund can be made to The Foundation for Medical Excellence, One S.W. Columbia #860, Portland, OR. 97258, or at the foundation's website, www.tfme.org. •

Resident's culinary past adds flavor to his medical future

By Jon Bell
For The Scribe

For **Shai Rosenfeld**, a resident in family medicine at **Providence Health & Services**, the rewards of practicing medicine are very similar to those of one of his favorite pastimes: cooking.

"The parts I liked about cooking were so much about the personal connection and adding value to people's lives and providing a service," said the former line cook and sous chef. "I feel like medicine gives me the opportunity to do that in a more fulfilling way."

Born and raised in New York, Rosenfeld learned to appreciate food and good cooking early on. As is the case in many Jewish families, food played a big role in Rosenfeld's family, particularly around holidays and family gatherings. He said his mother works wonders in the kitchen, and he grew up cooking alongside her.

"She's just a really intuitive cook," Rosenfeld said. "She has a good feel for food, and I think I got that sense from her."

After floundering in college during his first go-round, Rosenfeld dropped out and headed into restaurant work, including a stint at Nobu, a renowned Japanese restaurant in New York City. While still in New York, he also went through a two-year certificate program at the Culinary Institute of America. Then it was on to New Orleans and restaurants there that melded New Orleans flair with European hints of southern France and northern Italy.

SHAI ROSENFELD

"I was pretty passionate about the food culture in New Orleans and had a lot of personal connections there, too," he said.

In addition to his long history of food appreciation, Rosenfeld said he liked—and still likes—cooking for other reasons, too.

"I really like it so much because it's very tactile and real and tangible," he said. "It's something that adds value and joy to people's lives. Everyone loves to eat good food, right?

"It's also fun because it's kind of dangerous; there are lots of sharp, hot things, it's fast-paced and requires a lot of focus."

Even so, life in the professional kitchen, as with many careers, can begin to wear anyone down, and that's what happened to Rosenfeld.

"After a while in kitchens, it feels like a grind and loses some of that sense of fulfillment," he said. "It starts to be about something else. It's like a lot of things—once you do it for a living, you lose the pleasure of it."

Burned out on cooking by 2004, Rosenfeld turned to medicine. He earned a bachelor's degree in cellular and molecular biology from Portland State University and started medical school at the Tulane University School of Medicine. He is set to graduate in May.

Rosenfeld said he doesn't foresee himself burning out on medicine the way he did cooking.

"In medicine, there is such an immediacy and the reality of what people are going through and what they get out of the healing process adds a lot," he said.

Though his professional days in the kitchen are behind him—for now, anyway—and though he has less time in his busy resident's schedule for cooking, Rosenfeld said he still loves to cook for his family whenever he can. His favorite dishes are simple, healthful recipes that are easy and efficient. He enjoys cooking Japanese dishes and Asian food in general, since those styles steer clear of excess grease and aren't so centered around meat. Rosenfeld is also a big fan of the Mediterranean diet.

Rosenfeld said he's looking for a job in the Portland area that will allow him to integrate his love of good, healthy food into his practice, where he'll be able to concentrate on the prevention of disease, food as medicine and integrated medicine.

A father with young kids, Rosenfeld said it's too early to tell if his own children will take to cooking the way he did. His 3-year-old son does, however, enjoy mixing, stirring and playing with water, and he's already gotten the inevitable run-ins with the stove out of the way.

"I don't know if he'll be into it or not," Rosenfeld said, "but, you know, for what I'm able to do now, it's just fun to have fun with cooking again." •

Spanning the city, for a good cause

A sun-splashed day greeted the nearly 18,000 participants of the Aug. 10 Providence Bridge Pedal, including bicyclists who participated as members of the Medical Society of Metropolitan Portland team. Among the team members were, from left, Brenda Kehoe, MD, president of the MSMP; Jim Kehoe; Amanda Borges, MSMP executive director; Mariena Gardner; Aaron Troyer, MSMP website administrator and health preparedness program manager; and Mike Troyer.

MSMP raised money for Special Olympics Oregon via the bridge pedal, the community event that crosses multiple Portland spans, as well as through the appearance of Love You Longtime at the Bite of Oregon, held the same day. Love You Longtime performed at the Bite as a result of winning MSMP's Battle of the Doctor Bands. •

Photo courtesy of MSMP

***AMBULATORY** from page 1*

PAUL GADEN

are "much less expensive" than operations performed in a hospital, he said.

"The model for ambulatory surgery centers is a perfect fit for our CCOs and health care institutions focusing on high-quality health care at an affordable price," said Norling. "Surgery is an expensive industry, so it only makes sense to focus on companies' keeping it affordable."

Some centers were developed independently by surgeons, such as the **Oregon Outpatient Surgery Center** in Tigard, which was formed by three doctors in 2004 and became Providence's first joint venture with a free-standing center two years later, said **Jonathan Greenleaf, MD**, medical director.

"We're partners" with Providence, said Greenleaf, an orthopedic surgeon. "The physicians actually manage the center." The board is a blend of physician owners and representatives of the health system. "It's worked out to be a good balance."

Oregon Outpatient's major incentive to hook up with Providence wasn't to seek capital, he said. Instead, "We wanted to be able to expand our base of patients as much as possible." He said Providence Health Plan has a lot of sway over where patients go for care, and the insurer did not include Oregon Outpatient as "in-network" for that health plan—but it became so after the joint venture, which was a motivating influence for the doctors to agree to the business arrangement.

> "The **model for ambulatory surgery centers is a perfect fit** for our CCOs and health care institutions focusing on **high-quality health care at an affordable price**."
>
> —Kecia Norling, administrator of Northwest Ambulatory Surgery Center

Providence also furnishes the center with statistical studies, but the doctors handle their own management. In the center's inaugural year, it used an outside management firm, but then took over managing itself, to save costs, Greenleaf said.

The Oregon Outpatient doctors do most of their surgeries at the center—including recently starting to perform knee and hip replacements there—but some patients who have other, concurrent conditions or limitations must be operated on in a hospital, he said. In addition, the center doesn't accept certain insurance plans.

By contrast, Northwest Ambulatory Surgery Center, located in Northwest Portland, uses a national management firm, United Surgical Partners International, and that company actually approached the doctors' center, in 2007, about forming a partnership with it and with Legacy, Norling said.

"We weren't looking to sell," but the management firm already had formed a partnership with Legacy, and "Legacy was looking for a way to develop a relationship with the surgeons who had opened up their own surgery center," she said.

The partnership was a win for all parties, she said.

For the surgery center, it offered the credibility of associating with a hospital system and enhancing the center's position with managed care. Also, Legacy negotiates on behalf of the center with insurers. "Definitely, Legacy has done their job with contracts."

Plus, affiliating with an experienced management firm, which operates 200 facilities, two-thirds of which are in joint ventures with hospitals, has been a boon for Northwest Ambulatory, she said.

The partnership gives Legacy a continuing relationship with the center's physicians—there are 17 surgeon-owners, 25 surgeons operate there, and 35 employees work there—and has helped Legacy gain some market in the ambulatory surgery arena. "Always, if you can keep your relationship with your surgeons, it's good for the hospital," she said. Hospitals lose some business to the centers, but by joint-venturing with them, hospitals at least earn a percentage of the centers' profits.

"Legacy is there when we need them," said Norling. The health system respects the surgeons' decisions and how they want to run the center, she added. Orthopedist **Ira M. Weintraub, MD**, is medical director. Legacy also has one other surgery center joint venture: East Portland Surgery Center.

Providence Portland's Gaden pointed out that freestanding centers also offer both physicians and patients convenience and dependable scheduling, whereas the availability of a hospital operating room might not be as predictable. Because "all they do is outpatient surgery," and procedures tend to be "less-acute-type cases," ambulatory centers can run more efficiently, he said.

Health reform's emphasis on treating patients in the least-expensive setting means "there is a very large outmigration of services" from hospitals to ambulatory settings, Gaden said. "I think Providence is one of the health systems that is very proactive with this. We are putting a lot of strategy into ambulatory services, delivering care as close to your home as possible and as convenient as we can."

Providence's newest center, unlike its others, is situated adjacent to Providence Portland, in Providence Professional Plaza. Plaza Ambulatory Surgery Center involves a partnership among 28 physicians, Providence Health & Services and Regent Surgical Health Inc., a national management company. The center includes surgeons specializing in podiatry, pain management, otolaryngology, orthopedics and hand surgery, urology, neurology and general surgery. Anesthesiologist **Craig S. Derby, MD**, is the center's medical director.

Providence's other ambulatory centers include the **Surgery Center at Tanasbourne**; the **Center for Specialty Surgery**, located in Southwest Portland; and Greenleaf's Oregon Outpatient Surgery Center.

One of the problematic elements of these joint ventures from the ambulatory surgery centers' viewpoint is that health systems increasingly are employing physicians, and not all hospital systems allow their employed surgeons to work at ambulatory surgery centers, pointed out Norling, a fact that reduces the centers' volume.

For independent physicians, there also is a tradeoff with joint ventures, Greenleaf noted.

"With any partnership, you give up some of your autonomy," he said. Doctors can't make decisions "based solely on the physicians' interests," but instead also must share decision-making with the "global interests of the hospital." Providence owns 51 percent of the center.

But Greenleaf said both parties come to agreement on most decisions, to the benefit of each, as well as patients. •

***MULTITASKING** from page 7*

2. Use your Team

Being a workaholic/lone ranger/ perfectionist is part of our conditioning. It is what drives a lot of our multitasking urges. Every doctor I have ever coached works too hard because they have not learned how to lead their team with maximal effectiveness.

If you are doing any activity... take a second to ask why am I the person doing this?

Does this activity take the skills, education and experience of a physician? If not, who on my team could be doing it instead? Ask your team the same questions about every task that makes you want to multitask in your day.

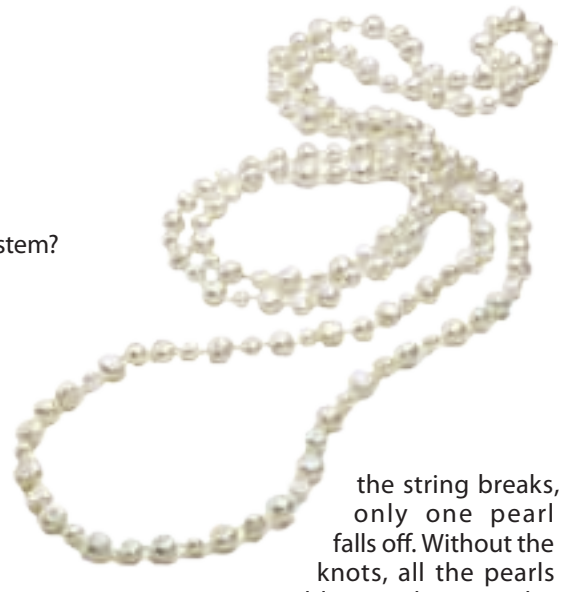
Then delegate and systemize everything you can.

Make sure you and every member of your team is assigned tasks matched to their skills and experience. If that seems overwhelming from the vantage point of your current situation, pick one task that is a sticking point and work these questions with your team at your monthly staff meeting.

- What is our goal for this task?
- Who is doing it right now?
- How is that going?
- What would work better?
- Who would be the person completing the step now?
- How would we measure this new way of doing things?
- When will we start this new system?
- When will we meet again to see how it is going?

3. Sequential mono-tasking or "beads on a string."

This is a personal work habit. To explain it best, think about a fine pearl necklace. A high-quality pearl necklace has knots between each pearl. This way, if the string breaks, only one pearl falls off. Without the knots, all the pearls would cascade onto the floor and bounce away.



The activities of your day are like the pearls on the necklace. You can arrange them to come one at a time.

Your breath is the knot in between each pearl. You use your breath as a release between each activity. Exhale and release the task and feelings you just finished and turn to face the next activity with a clean attitude and your full attention.

You can learn this "squeegee breath" mindfulness technique and much more at www.thehappymd.com/stress-relief-for-doctors-one-minute-stress-relief.

When you find yourself multitasking now:

- Breathe
- Come back to just one activity (the one you are most qualified for)
- Let the other activity go for now until you get to its position on the string of pearls
- See if it can be batched or delegated in the future
- And, breathe again •

Dike Drummond, MD, is a family physician, entrepreneur and business coach. He provides burnout prevention and treatment services to physicians, other health care professionals and health care organizations through his website, www.thehappymd.com.

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Physicians embracing, exploring new practice models, poll finds

While physicians remain happy about their choice of a medical career, that doesn't mean they are content to be controlled by government mandates and declining reimbursements, according to a recent poll.

In its annual Great American Physician Survey, sponsored by Kareo, Physicians Practice polled physicians nationwide on their medical careers, their personal lives, and the politics affecting both work and home. In this year's survey, 1,311 physicians responded that they remain happy being a physician—26 percent rated their happiness as an eight on a scale of one to 10—but also indicated a growing dissatisfaction with fee-for-service medicine.

Of the respondents, 35 percent indicated they either work at or would consider switching to a "concierge" practice and charging patients a membership fee for services. Fifty-three percent indicated they would consider or are already working in a direct-pay practice that does not accept insurance at all. Both questions indicate a growing interest by physicians to escape from federal mandates, payer interference and other issues which could impede treating patients. When asked about their biggest frustration with being a physician today, 39 percent indicated "too much third-party interference."

The 2014 survey also examined aspects of defensive medicine and personal health, inquiring whether physicians order additional (and perhaps unnecessary) tests to avoid malpractice suits and asking how they rate their own fitness as examples for their patients.

"In our past surveys, a larger majority of physicians always showed a hint of skepticism toward concierge and direct-pay practices as unethical or not something they would pursue," said Keith L. Martin, group editorial director for Physicians Practice. "But now, with growing stressors from flat payer reimbursements to health care reform mandates, physicians are feeling pressed to maintain quality patient care and keep their practice running. The bottom line, as our survey indicates, is that these professionals love medicine and they love helping others—it's just the path to get there is rockier than in the past." •

Kaiser: 'Landmark' study helps obese women limit weight gain during pregnancy

It sounds counterintuitive to ask women to gain no weight while they are pregnant, but that's just what a novel study conducted by researchers at the Kaiser Permanente Center for Health Research did to try and help women who are already obese reduce their risk of complications during pregnancy.

More than half of women in the U.S. are either overweight or obese when they become pregnant and many of them gain more than the recommended amount during pregnancy. Excessive weight gain can lead to complications for mom and baby, and puts the child at higher risk of being obese later in life.

The Healthy Moms study found that by attending weekly group sessions, keeping food diaries and setting specific calorie goals women who are already obese can limit their weight gain and retain less weight after the baby is born. Women who participated in the program were also less likely to have large babies, which can make delivery more difficult and lead to problems for mom and baby.

Kaiser calls it a landmark study because most interventions that have asked women to limit weight gain during pregnancy have failed, and because current guidelines from the Institute of Medicine suggest that women who are obese gain between 11 and 20 pounds during pregnancy; the goal of this study was for the women to maintain their weight throughout pregnancy. •

Oregon Bioscience Association to host 2014 annual conference

"Oregon Bio 2014: An Industry Inflection Point" is the theme of the Oregon Bioscience Association's 2014 annual conference, which will take place Sept. 15–17. Keynote and featured speakers include nationally renowned thought leaders in the commercialization economy, product and therapeutic development, industry research and development sectors.

*See **NEWS BRIEFS,** page 18*

NEWS BRIEFS *from page 17*

"It's time, as an industry, that we start to examine both the growing commercialization opportunities and the innovation that already exists here in Oregon for the development of bio devices and biotechnologies," said Oregon Bioscience Association Executive Director Dennis McNannay. "We believe the 2014 program clearly demonstrates Oregon's bioscience industry is at an inflection point."

The three-day format not only provides attendees with the opportunity to discover industry R&D and investment opportunities, but also allows them to develop strong investor relationships, explore partnering opportunities and learn about important industry trends helping shape the market for their products. From the exciting progress of the Knight Cancer Challenge and its fundamental impact on Oregon to exciting new markets being driven by the new generation of biosensors, the Oregon Bio 2014 provides something for everyone.

Day one will focus on bio-entrepreneurship. Attendees will learn about the breadth and depth of local research and entrepreneur opportunities. They also will hear from national experts on the industry trends driving venture capital investing and how companies can react to the changing times, economic fluctuations and health care trends.

Day two will focus on "Lessons on Inflection Points," and will explore how companies, organizations and bio leaders can navigate the fast pace of industry growth and change. Presentations and peer-to-peer networking will focus on how new business models are being tried and implemented.

Day three, titled "Biosensor/Data Processing Day," highlights the emergence of the latest generation of biosensors and the new market this technology enables.

To register, please visit https://oregonbio.org/registration-fees or call the association at 503-548-4432. •

Survey shows nearly half of nursing school grads concerned about bullying

For those entering the workforce, typical top-of-mind issues include opportunities for growth, benefits and job security—but nearly half of those entering the nursing profession voice another concern: being bullied by colleagues.

According to a recent Kaplan survey of more than 2,000 nursing school graduates from the class of 2014, 48 percent say they are concerned about being the victims of workplace bullying or working in a hostile working environment. The survey found that 39 percent personally knew nurses who were victims of workplace bullying or a hostile working environment.

One widely cited study (*American Nurse Today*, "Break the bullying cycle," by Terri Townsend, MA, RN, CCRN, CVRN, January 2012) found that approximately 60 percent of nurses left their first nursing job within six months because of bullying issues or because of a hostile work environment. And studies conducted during the past decade show there's a financial cost to this for medical providers, ranging from $22,000 to over $64,400 per turnover.

"Workplace bullying is a disturbing dynamic in the nursing profession and our survey shows that nurses entering the workforce have a justifiable degree of anxiety about the issue," said Susan Sanders, DNP, RN, NEA-BC, vice president of nursing at Kaplan Test Prep.

She noted that changing cultural norms within the nursing profession will require involvement from nursing graduates and leaders and health care and academic institutions.

Kaplan's survey also found that 79 percent of nursing school graduates think nursing schools should provide workshops and special training about how to handle workplace bullying or a hostile working environment.

The online survey was conducted in August of 2,012 nursing school graduates who prepared for the NCLEX-RN® exam with Kaplan. Kaplan is currently surveying nursing school and medical school administrators for additional insight on the issue. Results will be released later this year. •

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