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It's Derby time!

Join us Aug. 20 for the second annual 5k Scrub Run Derby, a family event benefiting Dollar for Portland and Doernbecher Children's Hospital. For more information, and to register, please visit www.msmp.org/Scrub-Run.

OHSU-led initiative aims to boost transplants

By Cliff Collins
For The Scribe

Oregon Health & Science University is poised to play a key role as part of a major national public-private effort to increase patients' access to solid-organ transplants.

The Obama administration announced in June a multipronged approach to coordinate and address challenges associated with organ transplantation. Related initiatives involve academia, businesses and nonprofit organizations in sponsoring and conducting research to improve availability and durability of donated organs. *The Washington Post* reported that, as part of the program, Facebook, Google and Twitter committed to a campaign to encourage people to sign up in online forums to become donors. Those companies and others will work with a nonprofit organization to use technology and social media to try to reduce the shortage of donors.

More than 30 transplant centers in the nation are involved in the administration's undertaking, which is being funded at almost $200 million overall. "That commitment is primarily in the form of more than $160 million from the Department of Defense to launch a new research institute focused on developing new manufacturing techniques to repair and replace cells and tissues that may eventually lead to organ replacement," according to the website Morning Consult.


DARREN J. MALINOSKI, MD

Also part of the steps being taken are new technology and data tools intended to increase the number of transplants and to help ensure that donated organs are matched correctly and efficiently with the identified recipient, *Nephrology News* reported.

According to the *Post*, nearly 31,000 organs were transplanted in the U.S. last year, and almost 60 percent of transplanted organs were kidneys. The "vast majority of people on waiting lists need that organ," the paper reported.

OHSU's role will be leading the portion of the program called the **Donor Management Research Initiative**. **Darren J. Malinoski, MD**, OHSU assistant chief of surgery and section chief of surgical critical care at the **Portland Veterans Affairs Medical Center**, is principal investigator of the three-year, $4.2 million initiative. He will head a research project that OHSU will conduct along with the VA, the University of California, San Francisco, and the United Network for Organ Sharing.

According to the Laura and John Arnold Foundation, which funded the grant, nationally about 22 people die daily waiting for an organ, more than 120,000 are on the organ waiting list, and the average wait time is three to five years. Since 2006, the supply of available organs has not increased significantly, and "the need continues to rise," said Malinoski. "We're trying to focus on efforts on the supply side."

*See **TRANSPLANTS,** page 17*

Bangsberg returns home to lead OHSU–PSU School of Public Health

■ *Collaboration leverages 'unique and shared strengths' to meet evolving needs*

As of Sept. 16, **David Bangsberg, MD, MPH**, will serve as the founding dean of Oregon's first urban school of public health, a collaborative project that leverages the strengths of **Oregon Health & Science University** and **Portland State University** to meet evolving public health needs locally and nationwide.

A Portland native and Lincoln High School graduate, Bangsberg studied neuroscience at New York's University of Rochester and the philosophy of science at King's College London before receiving his MD from the Johns Hopkins University School of Medicine. He also received a master's degree in public health at the University of California, Berkeley.

His academic research career began at the UC San Francisco, where he created one of the leading programs on health disparities among the urban poor in the United States. This program eventually became the first NIH Clinical and Translational Science Initiative-funded program on urban domestic health disparities. Bangsberg is internationally known for his work on social, economic and structural barriers to HIV/AIDS care in sub-Saharan Africa.

Bangsberg comes to Portland after

*See **DR. BANGSBERG,** page 12*

➢ Focus on Medical Education

This story is part of this month's special section on medical education.

Inside, we also feature an essay from an OHSU student who took part in a White House workshop focused on engaging patients as research partners.

Please see pages 8–14.

INSIDE THIS ISSUE

Finding his calling

Baseball career sidelined, Ronald Baptiste, MD, pursues the physiatry field.
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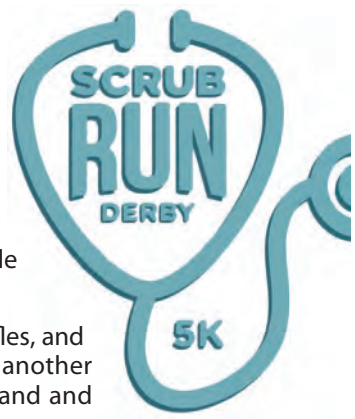
Adventist invites MSMP to host opioid education seminar

MSMP was recently invited to host a seminar on "Managing the Use of Medications in Patients with Pain" before health care providers at Adventist Medical Center. Speakers included **Joe Thaler, MD**, from the Oregon Medical Board and **Sarah Winslow, MD**, from Adventist, who both provided insightful information on the pitfalls and processes of treating patients using opiates.

We also heard from Detectives Bertrand and Leininger with the Washington County Sheriff's Office, who showed us how prescription opiates translate into heroin street use.

Thank you to everyone who participated, as well as to our partner, The Doctors Company.

5k Scrub Run Derby



9 a.m., Saturday, Aug. 20

Location: Portland Meadows

MSMP's 5k Scrub Run Derby promises to be the premier event of the summer. Look for celebrity appearances by Joel David Moore of *Bones* and *Avatar*, and live music by Wolf Meetings – winner of MSMP's Battle of the Doctor Bands.

We'll have family entertainment, local food carts, raffles, and much more. Join us after the race as we celebrate another Scrub Run Derby victory benefiting Dollar for Portland and Doernbecher Children's Hospital!

Register today before the closing bell rings at *www.MSMP.org/Scrub-Run*.

Interested in ***displaying merchandise*** or ***sponsoring a booth*** during the Scrub Run Derby?
Contact sarah@msmp.org or call 503-944-1124.

Scrub Run Derby Bib Pick-up

4 p.m., Thursday, Aug. 18

Location: Big Al's Progress Ridge
14950 SW Barrows Rd, Beaverton

Need a break from training for the 5k Scrub Run Derby? Join us at Big Al's at Progress Ridge Townsquare on Aug. 18 for the Uberthons Bib Pick-up. Pick up your packet, check your chip and claim your goodie bag!

While you're there, maybe bowl a game or two, play some arcade games, or just sit back and carb-load with a plate of Big Al's famous nachos or bacon chicken mac 'n' cheese!

It's not too late to register for the Scrub Run Derby! Visit *www.MSMP.org/Scrub-Run*.

EDUCATION

Advance HIPAA Compliance and OSHA Training

9 a.m. – 12 p.m., Wednesday, Sept. 21

Location: MSMP 1st Floor Conference Room A

This course is recommended by the ONC, OCR and AHIMA, and includes both HIPAA and OSHA learning objectives.

Cost: $75 for members of MSMP and their staff.

For more information or to register, visit *www.MSMP.org/Education*.

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Internal Medicine
Legacy Health System
1015 NW 22nd Ave
Portland, OR 97210
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- CEUs
- Speaker event
- 5k Scrub Run Derby
- OSHA/HIPAA courses
- Scribe/Little Black Book

Join today at MSMP.ORG

World Parkinson Congress to draw thousands of providers, patients to Portland

By Cliff Collins
For The Scribe

Physicians, allied health professionals and Parkinson's disease patients will benefit from attending the **4th World Parkinson Congress** convention in Portland in September, according to conference organizers.

Parkinson's disease specialists from **Oregon Health & Science University** and **Legacy Health**, as well as the locally based organizations **Parkinson's Resources of Oregon** and the **Brian Grant Foundation**, all are working together to help Portland host the meeting, Sept. 20–23, as well as to get the city "Parkinson's ready," said **Matthew J. Brodsky, MD**, OHSU associate professor of neurology, who is co-chair of the planning and steering committee preparing for the conference, along with **John Nutt, MD**, professor of neurology and co-founder and director emeritus of the **OHSU Parkinson's Disease and Movement Disorders Program**. The two physicians are deeply involved in leading planning efforts that extend beyond their traditional roles as clinicians serving Parkinson's patients.

The conference will bring together up to 5,000 people from around the world, both researchers and clinicians as well as patients and their caregivers. "It is going to be a big deal," Brodsky said. He said Portland typically does not host academic medical conferences of this scale. To have so many people living with Parkinson's disease all come together in one place for a four-day conference presents challenges, said **Holly Chaimov**, executive director of Parkinson's Resources of Oregon, a nonprofit with offices in Lake Oswego and Eugene.

> With the average age of idiopathic onset at 65, **Parkinson's**, along with Alzheimer's, **is "going to be a health crisis**, a huge need," because of "the social and economic impact. That's why **it's really critical to come up with new therapies."**
>
> *– Matthew J. Brodsky, MD*

Chaimov's group will be part of "a community effort" representing the patients' side, she said, along with the two OHSU physicians; **Lisa Mann, RN, MA**, nurse coordinator for the OHSU Parkinson Center; the Brian Grant Foundation; and **Richard B. Rosenbaum, MD**, a neurologist from Legacy. "We are working together to improve (visitors') experience," from when they arrive at the airport, to taking modes of transportation such as on TriMet, to checking in at hotels.

A related initiative is preparing hospital emergency department personnel in case they need to treat Parkinson's patients during the meeting. Chaimov said Rosenbaum and one of his colleagues will train ED staff at Legacy Emanuel and Good Samaritan medical centers about what to expect should a Parkinson's patient require medical attention. She said Portland police have advised that these two hospitals would be the closest and likely most affected, as the conference will be held at the Oregon Convention Center.

Parkinson's Resources of Oregon is leading 30-minute Parkinson's disease awareness and training presentations to Portland police officers and staff from Portland International Airport and at least 10 hotels that will be hosting the visitors. Chaimov said the local residents will be made aware that patients may react slower, show confusion at times, have slurred or stuttered speech if fatigued, or experience mobility problems.

Brodsky said several satellite meetings will be held in town in conjunction with the conference, as well as a number of social activities that will be part of the conference agenda, such as a movie night and music and dance programs. "Dance therapy for Parkinson's patients is regarded as a valuable tool," he noted. Chaimov added that her organization's annual fall Sole Support for Parkinson's awareness walk will take place two days before the conference.

Sponsors are hoping that many Northwest physicians will attend. Brodsky, who lectures on Parkinson's disease around the world and has authored myriad peer-reviewed publications in the field of movement disorders, said numerous portions of the conference will be of interest and applicability to doctors.

He especially pointed to the first day, Sept. 20, Pre-Conference Course 3: "Scientific and Clinical Research Advances," which will summarize updates in the field. In addition, the first morning plenary session, Sept. 21, should be of special interest: "Targeted modulation of motor and mood circuits using deep brain stimulation: Complementary studies in Parkinson's disease and major depression."

An area of his own research interest centers on deep brain stimulation and its relation to minimizing its side effects and improving patient outcomes. Brodsky's other research interests focus on preclinical detection and neuro-protective interventions for Parkinson's disease.

At one of the sessions, on Sept. 21, he will be speaking on the topic "Nutrition and malnutrition in Parkinson's patients, and their prevalence, importance and ramifications." Other sessions will address topics such as sleep and living alone with Parkinson's.

"Biomarker research in the disease has definitely progressed in the last five years," Brodsky said. In genetic research, imaging and other research to determine the pathology of the disease, "there have been some really exciting discoveries." In addition, "There has been an explosion of research in outcomes of nonmedical therapies such as exercise," and a number of new dopamine-replacement therapies have become available, he said.

Former Portland Trail Blazers player **Brian Grant**, who has Parkinson's disease, will participate in panel discussions.

The conference, sponsored by the **World Parkinson Coalition Inc.** and held every three years, is true to its name: It will be global, Chaimov noted, with 59 countries represented so far. "It's quite an honor" to have the meeting here, one she attributed to efforts by Travel Portland in promoting the city to organizers, but also to OHSU's reputation and work in movement disorders, in addition to the support offered by her organization, which is independent and not affiliated with any national group.

According to OHSU, its Parkinson's program is one of 26 National Parkinson's Foundation-designated national centers of excellence for Parkinson's disease care, education and research.

Brodsky said with the average age of idiopathic onset at 65, Parkinson's, along with Alzheimer's, is "going to be a health crisis, a huge need," because of "the social and economic impact. That's why it's really critical to come up with new therapies." ●

Registration and additional program information can be found online at wpc2016.org.

Cruising for a cause

■ *Surgeon creates motorcycle fundraising ride to help defeat breast cancer*

As you read this, motorcycle enthusiasts – health care providers among them – are poised to crisscross Oregon, taking in the coast, valleys, high desert and Columbia River Gorge on two wheels.

The multiday ride is for fun and camaraderie, of course. But raising awareness and funds for the early detection and treatment of, and research into, breast cancer is a central focus of the inaugural three-day tour called the **Mammary 500**.

The event is the brainchild of **Marcos Barnatan, MD**, a vascular surgeon with **Legacy Medical Group–Vascular**, and LMG Clinic Manager **Scott Dillinger**. They created the Mammary 500 after members of NW Moto MDs, a group founded and headed by Barnatan that's comprised of physicians and other medical providers who are motorcyclists, expressed a desire to raise money and awareness for an important cause.

For Barnatan and his family, the cause is personal. His wife, Timothea, was diagnosed with advanced breast cancer in 2013, and went through chemotherapy, radiation and multiple surgeries. Barnatan, who called his wife his inspiration, said the Mammary 500 will have met one of its key goals if it encourages just one person to self-examine, talk with their provider about a mammogram and detect any possible cancer in the early stages.

Photo courtesy of Marcos Barnatan

Marcos Barnatan, MD, shown here during last fall's Distinguished Gentleman's Ride to help raise awareness about and fund a cure for prostate cancer, led the way in creating the first annual Mammary 500 this month. The event, in which participants ride through Oregon on motorcycles, is a fundraiser for breast cancer prevention, treatment and research.

The notion behind the ride was, "What can we do that's fun and can make a difference and contribution to our community?" Barnatan said.

In the weeks leading up to the Aug. 12–14 event, participants raised money for the **Legacy Health Tumor Bank**, which collects donated tissue for cancer-related research that scientists use to study how cancer cells work, the causes of cancer and markers that predict who will respond to treatment, among other things.

Mammary 500 riders on the first day will travel from Portland to the Oregon Coast, where they will eat a group dinner, then on the second day they'll head east and make their way through the Willamette Valley and over the Cascades to Prineville. They'll explore the state's high desert on the third day before traveling to The Dalles and through the gorge to Portland.

The event's mode of travel has long been a keen interest of Barnatan's. Having lived in Spain, where motorcycle riding is immensely popular, his affinity for two-wheeled machines was virtually assured.

"Spaniards have a huge passion for motorcycle riding," Barnatan said. "Soccer and motorcycle riding – one or both."

He was about 18 when he started

*See **FUNDRAISER,** page 6*

Baseball career sidelined, provider finds another calling in physiatry

By Jon Bell
For The Scribe

It was 2004 and **Ronald Baptiste, MD**, was in the prime of his baseball life.

Then a left-fielder for the Orlando Shockers, a collegiate summer league team in Florida, Baptiste had grown up excelling at the game. Born and raised in Saudi Arabia, he even appeared in the Little League World Series in 1994 with the Arabian Little League team. In one game of that series, he struck out 10 hitters and slammed a two-run homer. He went on to play for Rollins College, making it all the way to the semifinals of the Division II College World Series in 2004.

Representing the Shockers in the summer of that same year, Baptiste stepped up to the plate in the home run derby. Before a crowd that included scouts looking for talent to take to the big leagues, Baptiste put on a show – and won the slugfest.

But not long after, a long-nagging elbow issue – lateral epicondylitis, better known as tennis elbow – and trouble with his shoulder drove his baseball career straight to the bench, for good.

"Basically my baseball career was done," said Baptiste, who even flew to Alabama to see renowned orthopedic surgeon James Andrews about his injuries, to no avail. "I felt as though I'd lost a part of myself, so I had to think about what else I could do in my life that would bring meaning."

For Baptiste, that became the pursuit of medicine. He enrolled in medical school at Howard University College of Medicine, originally thinking he would become a surgeon.

"I thought I wanted to become a surgeon to help figure these kinds of injuries out," he said. "I just felt like they weren't catching these injuries in people early enough."

During a break before his third year of school, Baptiste had a revelation while on a trip to Argentina. There, he saw quite a few people with disabilities, including one man who climbed up a cliff with a pair of wooden crutches. He also got his first glimpse of physiatry, which is a field dealing with physical medicine and rehabilitation for patients with physical injuries and disabilities.

> "Basically **my baseball career was done**. I felt as though I'd lost a part of myself, so I had to think about **what else I could do in my life that would bring meaning**." *– Ronald Baptiste, MD*

According to the American Academy of Physical Medicine and Rehabilitation, physiatrists treat conditions that afflict the brain, spine and nerves. They also focus on bones, joints, ligaments, muscles and tendons. Treatment methods are similar to internal medicine, but they also often include procedures such as electromyography, nerve conduction studies, joint injections and others.

Baptiste, who has been a physiatrist with Providence for about a year, said he was intrigued by the practice's preventative approach.

"It's often really about seeing someone early on in an injury or when it just happens," he said. "It's also targeted to prevent you from getting hurt."

In addition, Baptiste said he likes the way physiatry involves patients in their own rehab whenever possible.

"I think people really want something that they can do on their own," he said. "They want the education, they want to hear what is wrong with them and then what they can do to get better. We are a very important piece of that."

Elbow and shoulder issues ended Ronald Baptiste's baseball career, but he pivoted toward a career in medicine, specializing in physiatry. He said of the field: "It's often really about seeing someone early on in an injury or when it just happens. It's also targeted to prevent you from getting hurt."

Photos courtesy of Ronald Baptiste

As a field of practice, physiatry isn't as widely known as some more common practices.

"Until I went to Argentina, I didn't know anything about it," Baptiste said. "It's still not very well known in a lot of places."

One of the places where it's not widely known is the Pacific Northwest. But physiatry is very prominent in other locales. Baptiste, who did a residency at the University of Texas Southwestern Medical Center, said the practice is big in that state, in large part because of its abundance of rehab hospitals, which often have more than 100 rehabilitation beds.

Baptiste said physiatry is also big around military bases, in large part because of how many veterans returned from World War II in the 1940s with serious injuries, including musculoskeletal damage. In fact, according to the AAPMR, the U.S. War Department and the Navy were big early proponents of establishing physical medicine and rehabilitation as its own specialty in the late 1930s and 1940s.

Though it may not yet be widespread in the Pacific Northwest, Baptiste said physiatry is growing quickly here. Not only is population growth fueling that, but the fact that residents here are often very active has ramped up awareness, as well. Baptiste's own practice at Providence – there is a **Providence Physiatry Clinic** on both the east and west sides of Portland – has been growing quickly. Last year, there were two providers in the practice; now there are five, and as of mid-July, the practice was essentially booked into October.

Speaking of physical activity, Baptiste himself keeps plenty busy. He said that when he stopped playing baseball 12 years ago, he was a fit 220 pounds. Soon, however, he had climbed to 265 pounds. But as he got more into his medical career, he decided to change course.

"I figured that, as a physician, I need to be the epitome of what patients want to see in their provider," he said. "This is what my patients expect. I think it was also important for my own personal health. And I took some of that grievance (from losing his baseball career) and made myself better."

During the ensuing decade or so, Baptiste ran half marathons, became a regular swimmer and competed in triathlons. His bike, he said, just turned 10. And though he's not playing baseball anymore, Baptiste still takes in a game or two every now and then, and he still has friends who play.

"I also have one son, and a daughter on the way, so family does keep me busy," he said. "But I still love the game. It's a fascinating, beautiful game."

FUNDRAISER, *from page 5*

riding. Barnatan rode a Vespa back and forth to medical school in Madrid from 1980 to '86, an affordable and fun way to get around, he said. "When you're in medical school, you can't afford much more than that."

Fast-forward to today. Barnatan continues to ride, for fun and for important causes. He owns a Harley-Davidson and a Suzuki. His two sons, ages 18 and 20, also share his passion for motorcycling, and together they take one or two motorcycle trips a year.

Barnatan said his wife does not ride motorcycles but was planning to join the Mammary 500, probably for a couple of evenings during the ride.

Barnatan said the most significant challenge of this first annual ride has been spreading the word about it. The event's registration fee was $500 ($650 for two riders and one bike), and registered riders set up online fundraising pages. Participants who met a fundraising goal of $1,500 were eligible for prizes, including the grand prize of a motorcycle tour donated by High Desert Adventures, the Mammary 500's principal sponsor who served as the event's registration portal. Medical imaging firm NOVADAQ also is a sponsor.

Barnatan said he hopes the inaugural Mammary 500 begins to build momentum for additional support, sponsors and participation in the future. "Our intention," he said, "is to carry this on on an annual basis."

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White House reflections

Patients passionate about partnering to advance medicine

By Roheet Kakaday

I have been lucky to somehow accomplish a number of milestones in my lifetime: graduate college, enter medical school, build a company, spearhead a premier medical technology conference, pen a blog with over 10,000 followers and, now, in what seems like the largest stroke of luck, receive an invitation from the White House, under the direction of President Barack Obama's Office of Science and Technology Policy (OSTP), to assist in the newly launched Precision Medicine Initiative.

Just recently, I traveled to Washington, D.C., to attend The White House OSTP and Stanford Medicine X joint workshop on "Engaging Patients as Partners in Research." When I first received the invitation a month prior, embellished with the official logo of White House, I had to do a double-take and then verify the legitimacy of the sender. Indeed, everything checked out and I had been officially invited. Mom was the first to know.

After I received my official appointment badge, passed through security and entered the White House campus, a chill ran through me. I was entering arguably the most powerful building in the world, in which decisions are made that have effects and ripples everywhere. The gravity of my involvement was not lost on me. Determined to represent myself and OHSU's innovative ethos well, I strode past doors that read "National Security Council" and "Office of the Vice President" with a resolve I hoped didn't betray how giddy I was inside. Once all 50 or so guests assembled inside our conference room, the workshop kicked off.

"Look around you," DJ Patil, chief data scientist of the United States Office of Science and Technology Policy, encouraged. "We are in a room that has been used to negotiate international treaties … and now there are sticky notes on the wall!" Everyone burst out laughing and applauded. In this room, Stanford Medicine X and the White House had convened some of the most powerful and influential names in medicine, technology, patient advocacy and politics to solve one problem – engaging patients more broadly and rigorously in the research process.

And the twist? No one knew who anybody else was. In clever fashion, the guest list was kept secret, the agenda was sealed and everyone's name tags had no mention of their titles. Why? To generate a more equal playing field, where all participants were valued, irrespective of their title. Hierarchy was nonexistent, and everyone came from a place of naïvety – the birthplace of creativity. A blank sheet with all the potential.

Photos courtesy of Roheet Kakaday

OHSU medical student Roheet Kakaday traveled recently to the nation's capital to attend the White House Office of Science and Technology Policy and Stanford Medicine X joint workshop on "Engaging Patients as Partners in Research."

> Ultimately, the **concept of patients as partners** in research is a larger reflection of what we medical students strive to uphold – the sanctity of the patient-physician relationship. The discussions in the White House echoed, sometimes verbatim, the tenets we were taught in first and second year of medical school ... **partner with your patients, understand their backgrounds and help them achieve their goals** from the health care system.

For the next six hours, we used design principles to hash out our ideas, moving from room to room among the White House offices. At the end of the half-day, we had generated six different ideas that could propel patient engagement forward in the world of research. Workshop participants enrolled in the ideas they thought they could contribute to.

At that moment, I figured the workshop had completed, but participants in the workshop began to introduce themselves, their titles, their expertise and then generously offered their time to aid everyone else in the room. As it turned out, I was sitting down next to CEOs, CTOs, VPs, editors-in-chief of prominent medical journals, founders, advocates and other incredibly accomplished and influential individuals. I chuckled as I remembered that, unlike my fellow participants, I had a pediatrics shelf exam to make up the following week. Medical school stops for no one.

I think the biggest takeaway I have from this experience is witnessing the passion patients have for contributing to science and contributing more than just their time as subjects, but acting as partners in everything from hypothesis generation, to methodology creation, data gathering, analysis, dissemination and recognition. Even more basically, patients wish to know whether or not their participation, at whatever engagement level, had any sort of contribution to the world of science. In essence, patients want to have a more meaningful impact on medical issues.

Ultimately, the concept of patients as partners in research is a larger reflection of what we medical students strive to uphold – the sanctity of the patient-physician relationship. The discussions in the White House echoed, sometimes verbatim, the tenets we were taught in first and second year of medical school during our Principles of Clinical Medicine course – partner with your patients, understand their backgrounds and help them achieve their goals from the health care system. The mix of medical professionals – from MDs, NPs, to PharmDs and more – in attendance reflected OHSU's own efforts in fostering interprofessional collaborations at every level of education and decision making.

After seven hours of collaboration, we disbanded. Business cards were exchanged. Keep-in-touches and goodbyes wished. A transformation happened at this workshop – we formed a tribe of progressives indelibly tethered by our collective link to the White House and to the spirit of Medicine X.

And the cherry on top? I ended the night bowling on the president's own bowling alley. Yes, I did get a strike. Miracles do happen.

Roheet Kakaday is a medical student at Oregon Health & Science University. This post originally appeared on OHSU's StudentSpeak blog.

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Institute aims to strengthen health care leaders' abilities in rapidly changing industry

By Barry Finnemore
For The Scribe

Established and emerging health care leaders will come together in the coming months for an institute that, through hands-on, interactive sessions and opportunities for collaboration across disciplines and organizations, is designed to strengthen their ability to lead in a rapidly changing field.

The **Northwest Healthcare Leadership Institute** is presented by **The Foundation for Medical Excellence**, the Portland-based nonprofit that promotes quality health care and sound health policy. The impetus for the institute, noted **Barry Egener, MD**, the foundation's medical director, is not simply to deliver facts, but to help develop leaders "who can adapt to whatever the future holds."

"The truth is, none of us knows what is coming down the pike in health care; the future is really unknowable," he said, adding that the institute will address everything from adaptability and personal and organizational resilience to the ability to understand others' perspectives and cultivating collaboration. "This is focused on developing the person."

The institute, open to board members, medical executives, clinical chiefs, medical directors, service line leaders, department managers and others, is organized into two cohorts: a "foundational leadership cohort" for emerging leaders who've had clinical or technical training but minimal leadership training and experience; and the "experienced leadership cohort" for current leaders, or "leaders of leaders."

Egener said a cornerstone of the institute will be its inter-organizational focus, for while area health systems and organizations have their own leadership training programs, the reality is that organizations today are collaborating and working with governmental and community entities to address health needs and deliver the best possible care. "Population health and social determinants of health can't be solved by any particular organization, but by a collaboration of organizations," he added.

Participants, Egener said, "will be rubbing elbows with peers, grappling with the same challenges but within different systems that have different missions."

The institute also dovetails with a key focus of the foundation: provider well-being and organizational professionalism. An important outcome, according to the institute's brochure, is for graduates to "recognize how personal values, resilience and leadership behaviors impact organizational performance and health."

Research shows an increase in burnout among providers. For example, the 2015 Medscape Physician Lifestyle Report found that 46 percent of physicians had burnout, a major increase from the Medscape 2013 Lifestyle Report, in which burnout was reported in slightly less than 40 percent of respondents. In Oregon, the 2014 Physician Workforce Survey found that 78 percent of respondents said stress and burnout were a significant issue, compared with 61 percent in the 2012 survey.

"People burn out in health care, leaders no less than others," Egener said. "They need to be aware of how they are doing and aware of how their colleagues and others in the organization are doing. One of the main focuses is on developing healthy organizations, not just medical professionals, but all employees of an organization."

The institute will address this issue in part by participants completing the Neurozone Brain Performance Diagnostic, which Egener described as "taking one's emotional temperature at the moment and understanding how you're doing in terms of well-being."

The institute will have four daylong sessions for each cohort on Oct. 21 and Oct. 22, Nov. 11 and Nov. 12, Feb. 3 and Feb. 4, and March 3 and March 4, including an evening dinner program connected with each session. Curriculum will build upon itself and connect between each session. Session one is titled "Conscious Leadership: Leading with Intention & Attention," session two is titled "Facilitating Collaboration: Coming Together Without Coming Apart," session three is titled "Healthcare Economics: Balancing the Big Picture with the Bottom Line," and session four is titled "The Illusion of Control: Transforming How We Manage Change."

In addition to the sessions, participants will apply what they learn in each session to a leadership project at their workplace. Egener said participants will choose their projects and have guidance, including one-on-one time with institute faculty.

He said the foundation was aiming for about 15 participants for each cohort, and applications were due by Aug. 15.

Institute core faculty includes Egener; **Lisa Goren, MS**, physician engagement consultant and executive coach; and **Steve Kinder, MPA**, with Oregon Health & Science University's Division of Management. Guest faculty and keynote speakers are **Joni Mar, MCC**, Healthcare Executive Coaches & Consultants; **Krista Hirschmann, PhD**, director practice engagement, Lehigh Valley Health Network; **Lisa Bielamowicz, MD**, executive director and chief medical officer, the Advisory Board; and **Anthony Suchman, MD**, founder and senior consultant with Relationship Centered Health Care. ●

WHAT: The Northwest Healthcare Leadership Institute, presented by The Foundation for Medical Excellence

WHEN: Four daylong sessions, held in October, November, February and March in Portland

TO LEARN MORE: Visit *www.tfme.org* and click on the Education tab.

OHSU continues commitment to rural education, gives students more options

By Jon Bell
For The Scribe

Before he joined **Oregon Health & Science University** in 1990, **Paul Gorman, MD**, had been a primary care physician in Astoria, the Columbia River city whose main claim to fame is that it was the first permanent U.S. settlement along the West Coast. While he was there, Gorman was also the chief of medicine at Columbia Memorial Hospital, a small critical-access hospital that serves the town of about 10,000 people.

Astoria may not be the first town that comes to mind when the word rural comes up, but located west across the Coast Range, at the mouth of the mighty Columbia, it is indeed a rural outpost.

For Gorman, who has been OHSU's assistant dean for rural medical education since May 2015, the time he spent practicing in a rural area was key to getting a real feel for how health care works outside of an urban setting.

"You can train at the big academic hospital," he said, "but unless you are actually working and learning in a smaller hospital, you don't know what it's like."

Gorman has brought that sensibility with him to OHSU, which incorporates a rural component into the medical education of every student who passes through, in part to help boost interest in rural practices. That entails, at the very least, a four-week clerkship in a rural location, one that is essentially 10 or more miles away from a city with 40,000 or more people.

Having that rural component is beneficial for a number of reasons. In an interview with The Scribe, Gorman talked about those benefits, the partnerships that OSHU has in rural communities across the state and where rural medical education in Oregon is headed.

The Scribe: ***Can we start with a quick overview of rural medical education at OHSU and where we are?***

Gorman: For about 25 years or so, we had a rural requirement, where every student was required to do a Rural and Community Health Clerkship. It was a five-week program at a rural facility. It was a very successful program. When we revised our curriculum, starting in 2012, we said, let's overhaul the curriculum for the 21st century. One of the big things that came out of that was a continuing commitment to rural education, but with a new twist. Every student is to do a rural rotation, but now they have many more options. They are now four-week rotations and can be in any discipline, whether that's surgery or obstetrics – whatever the rural population needs and what the community can support.

The Scribe: ***Are there other requirements that pertain to rural education?***

Gorman: This is not specifically for rural, but the other new requirement is that every student must do a continuity rotation that is eight weeks in the same place. That gives them greater continuity with patients, it's also continuity with teachers and it's continuity with a system. When a physician is new to a place, he doesn't really know how it works.

We also have a rural enrichment experience, where students get to meet real clinicians and students in rural settings to see what opportunities there might look like. A student who wants to be a cardiologist or a surgeon might not recognize that you can practice those specialties in rural areas, so that is one of the ways to make them aware of what the options are.

The Scribe: ***Does OHSU have a lot of partnerships in place for these rural programs?***

Gorman: Yes, we have quite a few. Historically, many of our partnerships have been with individual practitioners, but today, far more physicians are employed by large health systems, like PeaceHealth and Mid-Columbia Medical Center in The Dalles. In some smaller towns it's with smaller practices.

The Scribe: ***What kind of benefits come out of those partnerships?***

Gorman: I think a lot of clinicians like teaching and they like to pass on what they know. I also suspect and believe that the practice of health care is better when there is teaching going on.


Paul Gorman, MD

The Scribe: ***Are there any unique partnerships that stand out?***

Gorman: Well, we value all of them. We are developing some new ones. We have one with Yellowhawk Tribal Health Center in Umatilla County. They are very interested in interprofessional training that comes about. They also would love to see some tribal members go through the educational pipeline and return and practice there.

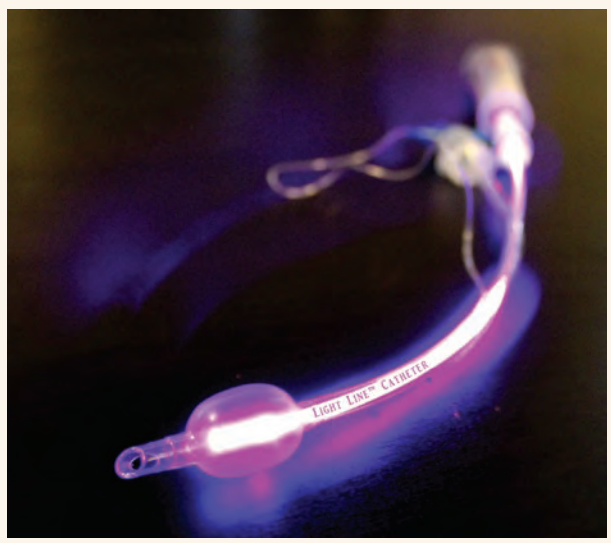
The Scribe: ***What are some of the biggest challenges when it comes to rural education?***

Gorman: I think one of the biggest is just the complexity of modern care. There's also a lot of pressure in rural settings to maintain a high level of patient (volume). There are a lot of people who need care, and having a student in that setting can slow it down. There's always the challenge of distance in rural areas as well, though if you are someone who is used to that, it's not an issue.

The Scribe: ***What's on the horizon for OHSU's focus on rural education?***

Gorman: I think we've got the opportunity to build new ways of training that don't confine students within four walls for four weeks. Some schools have programs where students take care of the same patients for much longer, and it's not so much discipline-focused, but integrated across an entire spectrum. That might be something that works well in a rural setting. ●

OHSU student receives AMA award for catheter sterilization technology



Mitch Barneck, MS4, won second place at the AMA Healthier Nation Innovation Challenge in Chicago for a visible spectrum light sterilized catheter that could significantly reduce catheter-associated infections. As a University of Utah bioengineering student, Barneck and fellow students developed the bacteria-killing catheter LIGHT LINE Catheter™, which uses high-intensity narrow spectrum light to sterilize indwelling catheter sites.

The student-run company formed by Barneck and others, **Veritas Medical**, has previously won numerous awards and competitions and has raised nearly $500,000, including a grant from the National Science Foundation I-CORPS program, NASA, and a prize from the U.S. Patent and Trademark Office.

Barneck and colleagues took second place out of 117 entries from physicians, residents and medical students across the nation. Winning teams received a share of $50,000 in prizes and access to the AMA's network of accelerator and entrepreneurship partners.

Barneck intends to proceed with regulatory clearance through the FDA/CE. Clinical trials using the Foley catheter model will begin later this year in the University of Utah Burn Center, and early next year at the Neuro Intensive Care Unit at Intermountain Medical Center. ●

DR. BANGSBERG, *from page 1*

serving as director of MGH Global Health at Massachusetts General Hospital, the largest teaching hospital of the Harvard Medical School. Under his leadership, the MGH Global Health has transformed from a single program to an institution-wide global health initiative that now includes programs in medical technology innovation, global disaster response, cancer care, obstetrics/gynecology, radiology, pathology, infectious diseases and community health. Bangsberg's resume also includes serving as a professor of medicine at Harvard Medical School and the Harvard T. H. Chan School of Public Health, and he is a visiting professor at Mbarara University of Science and Technology in Uganda and the Vellore Institute of Technology in India.

He recently shared his goals for the new School of Public Health, why the collaboration is important for Oregon, and what he enjoys doing when he's not working.

The Scribe: ***What drew you to medicine as a career? It sounds like it was a field that interested you from a relatively young age.***

Bangsberg: My interest in science was sparked by two high school teachers, Mr. John Flenniken and Ms. June Conway, as well as Dr. Ted Molskness at OMSI. John taught chemistry and June taught health occupations at Lincoln. Ted directed the student science program at OMSI. John's class was notoriously one of the most difficult classes.

I was enrolled in his class filled with juniors and seniors because of an administrative error and was scared to death. John taught me I could accomplish more than I thought possible if I worked steadily every day. In June's class, I worked in a nursing home, shadowed cardiologist Dr. Alan Ames, was a teacher's assistant in a program for disabled children, and watched autopsies at OHSU. June taught me all the smarts in the world don't mean much unless they are applied to the human condition. Ted created an intellectually supportive and creative space for me to hang out, learn about science and design my first research studies. Ted taught me the joy of discovery.

The Scribe: ***What led you to focus on health disparities and barriers to care?***

Bangsberg: I enrolled in the MD/PhD program in neuroscience at Johns Hopkins Medical School in 1986 with a full scholarship. I studied neuroscience in college and planned to devote my career to discovering new approaches to engineering neuroplasticity as a neurosurgeon. The unconscionable, if not unimaginable, structural violence and resulting health disparities of East Baltimore put an end to that plan.

A new disease, AIDS, was killing gay men, injection drug users and their sexual partners. Many of the people dying were the same age as me. I gave up my scholarship and dropped out of the neuroscience PhD program to focus on frontline urban health care. My first clinical experience was providing HIV counseling and testing at a free gay men's sexually transmitted disease clinic. It didn't take me long to realize that racism, homophobia, addiction, mental illness, poverty, and other forms of structural violence compounded suffering due to AIDS. I spent the next 20 years trying to reduce suffering related to HIV and complex health disparities in the urban poor in New York City and San Francisco.

I launched my first research study in sub-Saharan Africa because one of my students at UCSF, Cheryl Liechty, who grew up in Swaziland, suggested that the most important issues around HIV and poverty were in Africa. I was reluctant at first, but she was persistent and also correct. My first trip was in July 2000 and I've returned every 1 to 3 months since. We first studied adherence to HIV therapy because most public health leaders thought that poor people there couldn't or wouldn't take their medications, and missing medication would generate new strains of drug-resistant HIV that would start in Africa and spread globally.

One of my proudest professional moments was when President Bill Clinton described our research findings as "the nail in the coffin on the debate as to whether poor people in Africa can take their HIV medications" in front the international leaders in HIV treatment and public policy at the International AIDS Conference in 2006.

The Scribe: ***What do you see as the role of the OHSU–PSU School of Public Health in terms of educating future practitioners as well as addressing public health issues?***

Bangsberg: My interest in science and education is very much directed at reducing health disparities and there is no single magic bullet. Any significant and durable progress requires a multidisciplinary approach that combines biomedicine, behavioral and social science, health services research, health policy and advocacy.

Let me give an example. In 1996, biomedical scientists discovered medications that transformed HIV from a terminal to chronic disease with a normal life expectancy. It took 20 years of behavioral science, social science, health services research, public policy research and advocacy for the majority of people living with HIV globally to benefit from that discovery. Most diseases require the same long, slow multidisciplinary push to achieve a population-level impact and will require complementary expertise in biomedicine, social science, community health and health policy from both OHSU and PSU.

By leveraging the unique and shared strengths of both universities, the School of Public Health will be poised to meet the evolving public health needs of Oregon and beyond.

The Scribe: ***What do you see as some of the most serious public health issues, and in what ways are they being addressed effectively today? In what areas does more work need to be done, and how can that be accomplished?***

Bangsberg: Oregon, like much of the U.S., is faced with an epidemic of malnutrition (especially over-nutrition), inactivity, obesity and associated health consequences such as diabetes, heart disease and cancer.

Many health problems are caused and/or exacerbated by economic disparities and other forces that marginalize individuals and their communities. Food insecurity, homelessness and access to quality education are some of the public health issues closely linked to marginalization and poor health. Better access to mental health and substance use care will be necessary to reverse the rising rates of drug-related deaths and suicides in Oregon.

As a longtime global health practitioner, I look forward to leveraging the energy and interest of Oregon youth to improve the health of the global communities most important to Oregon. I especially look forward to the ideas not yet imagined, but sparked by creating a vibrant and interactive academic community.

The Scribe: ***What are your thoughts on returning to Portland in this role?***

Bangsberg: I spent much of my youth on the PSU and OHSU campuses. My mother graduated from PSU and my stepfather, James Manning, was a professor in PSU's business school. My first college class was a PSU algebra class that I audited in eighth grade. My first job in high school was in an OHSU genetics lab as a research assistant. I used to alternate studying in the OHSU and PSU libraries in order to better imagine what it would be like to be a student at these universities.

It seems almost too good to be true that I will be leading the first school that formally combines the best of these universities to reduce health disparities in my home state.

The Scribe: ***What is the biggest lesson you've learned in your career so far?***

Bangsberg: Be good to your people because public health is a team sport. People are willing to dedicate their lives to a public health mission if they know their contribution matters and they are proud to be on your team. Making the work fun helps, too.

The Scribe: ***Can you share with readers a bit about your family and what you enjoy doing away from the office?***

Bangsberg: My wife of 26 years, Lynn O'Kelley, is a medical illustrator. We met at Johns Hopkins Medical School when she was completing her master's in medical illustration. We have two daughters, Brooklyn O'Kelley-Bangsberg and Madelyn O'Kelley-Bangsberg. Brooklyn is in her final year at Smith College and Madelyn will start Reed College in the fall. My father, mother, brother and his family, as well as uncle, aunt and cousin, all live in the Portland metro area.

I'm glad Portland is a great biking city because I would only consider a job where I can bike to work. I spent much of my youth skiing on Mount Hood and look forward to night skiing with my brother.

I love sailing. I've sailed to Nova Scotia, Block Island, Bermuda and the British Virgin Islands. My mother, who lives in a houseboat on the Willamette, bought me a used 22-foot sailboat several years ago to lure me to visit Portland more often. Her strategy worked. ●

NUNM sees increase in partnerships, residency opportunities

By Melody Finnemore
For The Scribe

For **Corina Dunlap, ND**, the opportunity to participate in a residency at **A Woman's Time** clinic in Northwest Portland has been an invaluable complement to her education at the **National University of Natural Medicine** (NUNM).


CORINA DUNLAP, ND

Now in her second year of residency, she calls it an "exponential process" of learning that has allowed her to gain more information about the specialty areas she would like to focus on in her practice as a naturopathic physician and participate in rotations with MDs.

"It's great because we can make this bridge and figure out how to complement each other and better serve our patients," Dunlap said of her rotations. "It's very helpful that I get to see what a standard workup would be to give a diagnosis so we're all on the same page when we give a diagnosis."

Conducting the same workups as MDs improves consistency in patient care for people who prefer an integrated approach, she noted. For example, she and the MDs she joins on rotation collaboratively monitor how a patient's disease is progressing and provide a holistic treatment plan and united standard of care. Dunlap focuses on natural treatments and, when prescription medication is needed, she has a network of MDs to provide that.

In addition, the residency program has accelerated her education, allowing her to learn more about different types of pathologies. She focuses on her initial specialty interests in hormone care, gynecology and endocrinology while also building her expertise in fertility, which has been fostered by the NUNM residency program. In addition, NUNM's residency program allows Dunlap to train with other NDs, many of whom provide hormone treatment plans for transgender people and patients experiencing perimenopause.

"I see about 40 patients a week, and that would not have been the case if I'd gone directly to work from school. I would have had to build my practice slowly," she said.

Dunlap is one of an increasing number of students participating in NUNM's residency programs, which have grown nearly 40 percent in the last two years. This is largely in response to a mandate by some insurance companies that require NDs to have completed three-year residencies to be considered as primary care providers, according to the university.

As part of this growth, NUNM has increased its partnerships with affiliated sites throughout Oregon and beyond, giving more residents an opportunity to gain real-world experience at external practices as part of their education.

Leslie Fuller, ND, associate dean of residencies, said NUNM has about 20 to 25 residents in affiliate settings each year. The residency program is typically a year long, though sometimes it extends to two or three years. The program begins in September and runs through the following October. The affiliate sites are nationwide, in locations such as Vermont, Virginia, Michigan and Atlanta, but one-third to half of them are based in Oregon.

"The sheer number of sites is growing," Fuller said. "When I graduated eight years ago, we didn't have nearly as many opportunities as we do now. We had several, but the growth we're seeing is phenomenal."

Fuller noted that **Tori Hudson, ND**, medical director for A Woman's Time and a NUNM clinical professor, has played a key role in helping to develop residency opportunities. The programs are an essential tool to introduce residents to primary care from inside a practice setting, she added. ●

COLE KIMBALL, AIF

Financial planner: Let career goals guide loan strategy

Several strategies can help medical students and residents manage their debt, including significant student loans, and save for the future. **Cole Kimball, AIF**, chief investment officer and financial advisor for **Finity Group** in Portland, offers advice on meeting short- and long-term goals.

The Scribe: ***What are some practical steps medical students can take to reduce their expenses during medical school while most rely so heavily on student loans?***

Kimball: One of the biggest steps that residents can take is to stay ahead on their high-interest-rate debt. The easiest way to find oneself meaningfully behind financially while in training is to take on significant consumer or credit card debt that accrues interest much faster than their student loans, which typically have more favorable terms. Paying off a credit card in full at the end of the month is a small habit that makes a big difference over time.

Carefully considering your options for living arrangements can also make a significant difference. It can be tempting to find yourself a nicer apartment than you had during your undergrad years, but a few more years living in a modest place with a couple of roommates can save thousands of dollars over the course of medical school.

The Scribe: ***What state and/or federal policy/program changes have occurred recently that have had or will have the most significant impact on borrowing conditions and the student debt outlook for medical students?***

Kimball: A big item looming on the horizon will be in October 2017, when the first borrowers pursuing the Public Service Loan Forgiveness (PSLF) plans finish their 10th year of payments and, in theory, see the remainder of their direct federal student loans forgiven. Many changes have been proposed to this program during the past few years, but no concrete changes have been made at this point. When we see the first borrowers finish up, we'll have a much better idea of what that program looks like in practice, and what strategic changes folks still pursuing it should consider.

Another point is that as overall interest rates in the U.S. continue to rise, costs of student borrowing will likely go up along with them. This will impact the costs faced by all types of student borrowers, and have a particularly large influence on how attractive private student loan refinancing programs are, as rates may reach a point where a debt that seemed to have a high interest rate in 2015 may seem much more favorable by 2018, 2019, etc.

The Scribe: ***What are some specific factors graduating students who are entering residency should consider when developing a financial strategy, both short and long term? For example, should they focus mostly on paying down debt, setting aside money for "emergency" savings, contributing to a retirement account, or is it ideal to dedicate a certain amount to each?***

Kimball: Ultimately, this will be different in each situation. The core concept that guides our advice here is opportunity cost – the idea that we all have limited resources, and when we decide how to allocate our money we should be cognizant of the most efficient option available. For example, an individual with $3,000 of credit card debt at a 15 percent interest rate might be more concerned with their $200,000 of federal student loans at 6 percent, but we would encourage them to focus more on the credit card. Despite the smaller balance, dollar-for-dollar funds applied to the higher interest credit card balance will have a more positive impact over the long run.

If an individual will vest in their employer's retirement plan, and thus have the ability to take any employer "matching" contributions with them if/when they leave, this is one of the first areas we would encourage taking advantage of. A dollar-for-dollar match on contributions is like an automatic 100 percent rate of return on an investment – not something that would be available in any other area of the plan.

Finally, putting some of the proper risk-management strategies in place is important to consider. After spending years in medical school and paying hundreds of thousands in tuition, taking every reasonable step to protect one's future income potential is vital.

The Scribe: ***What about repaying student loans, and refinancing those loans after completing a degree? What factors should graduating students or recent graduates consider, particularly in the broader context of their short- and long-term financial and lifestyle goals?***

Kimball: Future job plans are a huge factor here. Depending on the setting they would like to work in, two residents with the exact same student loan situation might be best served taking very different approaches to paying off their debts. If one wants to practice in a private setting, refinancing programs can be a great fit. If an academic practice setting is more appealing, programs like PSLF might be more appropriate.

For those considering the PSLF route, getting signed up for the program and beginning income-driven contributions while in residency can provide a significant leg up. Since payments in those programs are based on earned income, they are much lower for residents than for attending physicians. Each payment that one makes in residency can potentially save thousands of dollars down the line.

The Scribe: ***What two or three pieces of advice would you give those entering residency for managing education debt? What about income-based repayment, loan forgiveness (including for working in underserved and rural areas) and debt consolidation programs?***

Kimball: Not to be too cheesy, but the first is to let one's career goals guide their student loan strategy, not the other way around. Our clients tend to have the happiest and most profitable careers when they find the work setting that is the best fit for their personality and aspirations and back-solve debt elimination from there.

Income-driven repayment plans can be a great strategy for those interested in pursuing the PSLF program. As mentioned previously, in those situations starting payments earlier rather than later can generate significant savings in the future. Consolidation can be useful in these scenarios as well, as it can make loans that were previously not eligible for the PSLF program eligible. That being said, it is important to review your situation carefully to see if this would be beneficial before moving forward with any consolidations, as these are irreversible.

Consolidation is not a one-size-fits-all strategy, since for those not pursuing the PSLF program, it can serve to limit your flexibility to address individual loans at higher interest rates first. Refinancing privately is a tricky proposition since it is usually not affordable for residents given that full payments are expected to begin immediately after refinancing. While there are some refinancing programs specifically geared towards residents, in the environment we have now they often do not offer much room for improvement over the interest rates on federal student debt. That said, for someone who has a private student loan and/or loans that were taken out years ago, now may be a good time to look at refinancing that block of their loans. For those interested in the PSLF program, it's important not to refinance privately since loans need to retain their federal direct status in order to be eligible.

In the end, there are a lot of options and different routes to tackle your student debt. We would recommend moving slowly and gathering as much information about your situation as possible, as many of the choices are irreversible. ●

This article is the last in a three-part series.

UWS student chapter to host national leadership conference

The **University of Western States** chapter of the **Student American Chiropractic Association** (SACA) is slated to host the 2016 National SACA Leadership Conference on the Portland campus Sept. 23–25.

The conference will include presentations by prominent speakers in chiropractics about their accomplishments and how they achieved success. Other speakers will discuss dealing with roadblocks in the profession and how they were overcome.

"This type of training is outside our education on how to be a doctor, diagnosing and treating," **Jacqueline Carlisle**, UWS SACA chapter secretary and leadership conference chair, said. "It teaches us how to embrace change and push for the evolution of the profession and ourselves."

SACA's leadership played a big role in bringing the event to the UWS campus. Carlisle, along with **Rebecka Dunn**, leadership conference vice-chair, completed a proposal themed "Innovate, Integrate, Motivate."

"This conference theme proposal focused on integrating with other health care providers after graduation," Dunn said. "We want students to become leaders in their communities and be able to work with other health care providers, not only to better the profession but to improve our health care system as a whole."

The proposed topic of integrated health care was one factor that propelled the UWS proposal to be chosen, according to a university news release. Another factor that led to the decision to host at UWS was its success as a chapter during the past year. ●

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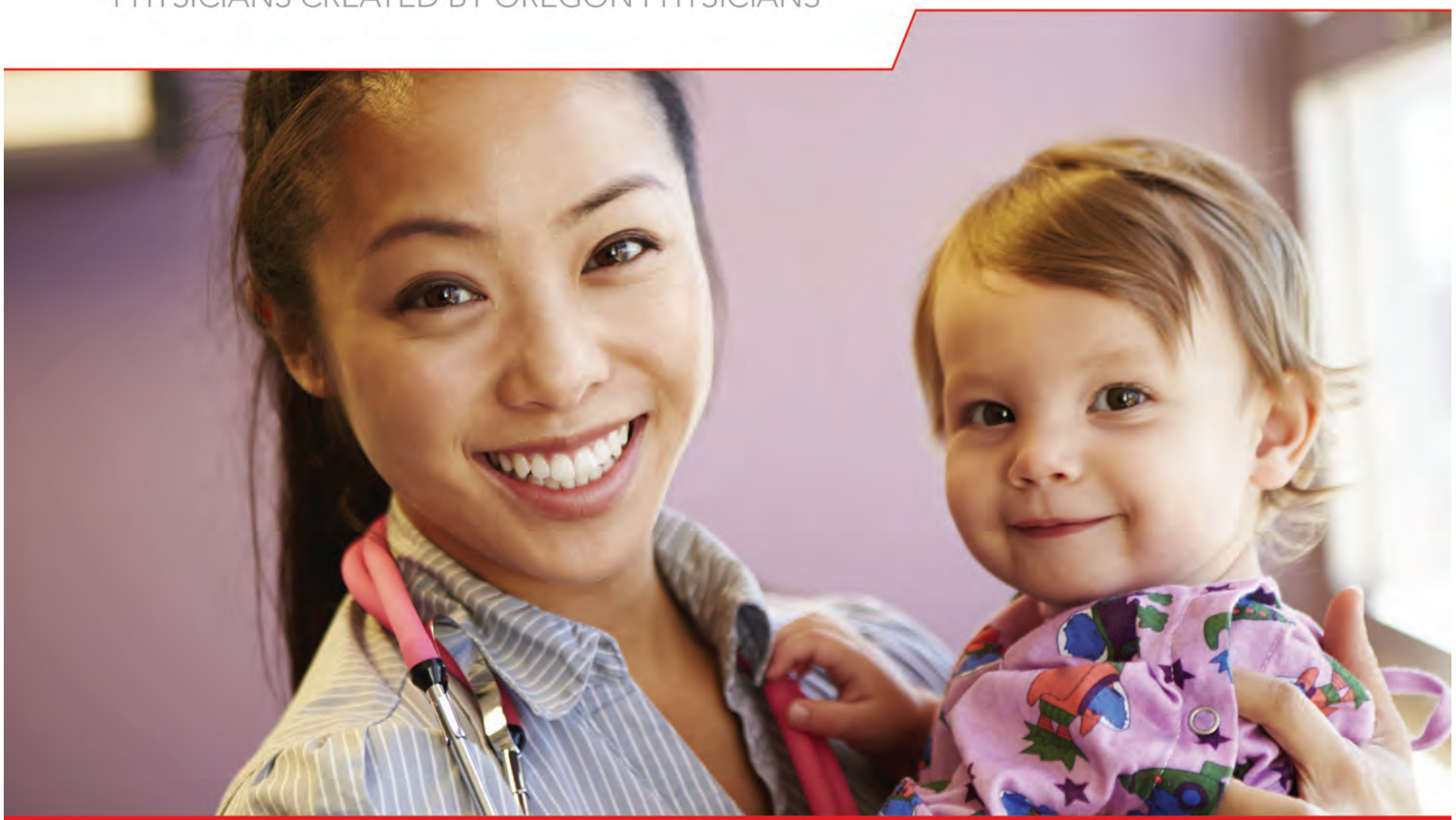

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Obesity: A national health crisis and a threat to safe patient care

By David B. Troxel, MD
Medical Director, The Doctors Company

Chances are good that in your practice, you treat obese patients. Obesity continues to be a national crisis: Current research has found that 35 percent of men and 40.4 percent of women in the United States are obese.[1] The obesity crisis not only contributes to growing health costs, but also raises serious patient safety risks.

Patients who have experienced an adverse medical event leading to a medical malpractice claim are frequently noted to be obese (based on documented height and weight). A review of 7,065 claims from 2011 to 2013 by The Doctors Company, the nation's largest physician-owned medical malpractice insurer, revealed that 28 percent were identified as having one or more comorbidities, and obesity was the most common (8.3 percent of total claims and 19.2 percent of total claims with a comorbidity). When closed claims were analyzed, 26 percent of claims that resulted in indemnity payments listed obesity as a comorbidity.

Increased risks: complications and access issues

Obese patients commonly have a variety of comorbidities. Many are associated with a metabolic syndrome, such as hypertension, dyslipidemia and hyperglycemia, which increases the risk of stroke, ischemic heart disease and diabetes mellitus. These patients also have increased risk of obstructive sleep apnea (which often contributes to opioid-induced respiratory depression), susceptibility to nosocomial and postoperative infections, and weight-associated wear and tear on joints that can lead to osteoarthritis. Additionally, bariatric surgery can be associated with both surgical and metabolic complications.

In addition to the risks of comorbidities, health care facilities also face risks if they are unprepared to accommodate obese patients. An inability to fit a morbidly obese patient into a conventional MRI machine or CT scanner is a unique problem necessitating use of an open MRI or CT. Health care facilities that are unable to accommodate morbidly obese patients in their MRI machine or CT scanner or if their MRI or CT isn't available at night or on weekends should have transfer agreements with open facilities in place so there are no delays in urgent MRIs or CT scans. The failure to transfer an obese patient to a facility with an open MRI machine or CT scanner in a timely fashion may result in a delay of diagnosis and/or surgical treatment – and, ultimately, in a malpractice claim.

The following is an example of such a claim:

A 41-year-old female, 6 feet 2 inches tall, weighing 390 pounds, was initially seen by a neurosurgeon in November with complaints of neck and low back pain and tingling in her hands. She had no deep tendon reflexes in her arms and decreased sensation in her left hand. She had been diagnosed three years earlier with an L4–5 radiculopathy and spinal stenosis. An MRI two years prior had shown C3–4, C5–6 and C6–7 disc herniation with moderate cord compression at C3–4.

The neurosurgeon ordered an MRI and, based on the findings, performed an anterior interbody discectomy with fusion at C3–C4, C4–C5, C5–C6, and C6–C7 in January. Her symptoms improved following surgery.

In early February, she was readmitted through the ER with a six-day history of right-sided neck pain, fever and a discharge from the surgical wound. Cervical x-rays were done, and an epidural abscess could not be ruled out. She was seen by an infectious disease specialist and started on empiric vancomycin and amikacin. The neurosurgeon debrided the wound with placement of a drain and noted that there was purulent material in the deep soft tissues. A culture revealed methicillin-resistant Staphylococcus aureus (MRSA). One week later – afebrile, moving all extremities and ambulating well – she was discharged. Two weeks later, the wound was healing nicely without drainage, and she was continued on antibiotics.

On April 22, she was readmitted with complaints of not feeling well for three days, generalized body pain and difficulty urinating. A hospitalist noted confusion. She reported being seen at another hospital and diagnosed with a urinary tract infection. She was afebrile.

On April 23, she was again seen by the neurosurgeon because her legs had given out and she had fallen several times. He suspected spinal epidural abscess and ordered a cervical MRI. However, the MRI at this hospital could not accommodate a patient of her size, so it could not be done. The hospital did not have a transfer agreement in place with an open MRI facility. She was seen by the infectious disease specialist, who suspected a gram-positive bacteremia of unclear source. He ordered a blood culture and started her on IV vancomycin.

On April 24, the hospitalist made arrangements to transfer her to an open MRI facility. When he saw her again on April 25, he noted decreased strength in both upper extremities. Nursing notes indicated an unsteady gait and a limited range of motion.

On April 26, the neurosurgeon noted lower extremity weakness with bilateral loss of sensation. The blood culture came back positive for MRSA. The infectious disease specialist noted that the patient had left arm weakness and trouble moving her legs. His progress note stated "Needs MRI – if transfer is necessary to accomplish this, it should be done as quickly as possible." The neurosurgeon again requested an MRI. However, two attempts on April 27 to transfer the patient by ambulance to outside facilities were unsuccessful because she was too large for the gurney. On April 28, the neurosurgeon was told that the MRI could not be completed (four days after he had ordered it), and on April 28 she underwent a CT myelogram – which showed significant anterior epidural compression extending from the L2–3 to the L3–4 vertebral interspace, a suggestion of compression of the lower cervical cord–thoracic cord junction, and flattening of the cervical cord from C6-T1.

On the morning of April 29, she developed decreased movement and sensation in both lower extremities. The next morning, the neurosurgeon performed a wide decompressive laminectomy from C3 to T1. Somatosensory-evoked potential monitoring during the procedure showed no activity in the lower extremities. Two weeks later, the patient was transferred to a skilled nursing facility with paraplegia and a neurogenic bowel and bladder.

Steps to accommodate patients of all sizes

Practices should have appropriately sized furniture in the waiting areas and exam rooms to meet the needs of obese patients. They should also have equipment – such as blood pressure cuffs, needles and wheelchairs – designed for obese patients.

Weight assessment tools are handy, and practices may want to consider providing weight education to patients. It's key to understand the importance of talking about weight with patients – the conversation should take place early for better prevention and treatment. Many factors can arise that inhibit a practitioner from speaking frankly about weight with a patient. As obesity rates continue to increase, it is worthwhile for doctors and other health care professionals to recognize that they might have their own barriers to such communications.

Sensitive treatment of obese patients involves attending to their needs for comfort, safety and respect. Obesity can be viewed as one of the many chronic health conditions afflicting patients. The person, not the obesity, should be the focus of treatment. As with any patient with a chronic health condition, a relationship with respectful caring forms the bedrock of medical care.

Contributed by The Doctors Company. For more patient safety articles and practice tips, visit www.thedoctors.com/patientsafety.

[1] Trends in obesity among adults in the United States, 2005 to 2014. JAMA. 2016;315(21):2284-2291. doi:10.1001/jama.2016.6458. *http://jama.jamanetwork.com/article.aspx?articleid=2526639.* Accessed June 9, 2016.

TRANSPLANTS, *from page 1*

The overall goal of the combined White House-led initiatives is to raise the number of transplants by 2,000 annually.

The foundation's grant "aims to increase the number of organs that each donor is able to give," Sam Mar, manager of venture development, wrote on the foundation's website. "One organ donor has the potential to save up to eight lives," but we now are transplanting only about three organs per donor, he said. The Donor Management Research Initiative "will build the rigorous research and scientific evidence base needed to maximize the number of organs per donor and ultimately increase the number of lives saved."

The Obama administration announced in June **a multipronged approach to coordinate and address challenges** associated with organ transplantation.

Related initiatives involve academia, businesses and nonprofit organizations in sponsoring and conducting research to **improve availability and durability of donated organs**.

An irony associated with the shortage of organs from deceased donors is the improvements that have taken place in injury prevention and medical care. Malinoski pointed out that helmet and seatbelt laws and advanced ICU and trauma care have meant "fewer patients are dying in such a way that they can donate." That is, fewer people are "determined to be dead by neurological criteria," he said.

Malinoski, who is a trauma surgeon, said OHSU probably was tapped to lead the initiative because it has built a lengthy track record in publishing research in the medical literature on organ donation and ICU management, and how those affect the donor side.

The initiative's focus will be on expanding the **United Network for Organ Sharing's quality registry** by creating a national database of organ donors linked to recipient outcomes.

"We will try to create a standardized database that can be used for quality assurance and research purposes," he said. The initiative also will oversee the conduct of trials. Because not enough organized research has been done involving deceased-donor organ management, "there has been a lack of infrastructure and oversight to do trials, and there has not been much funding," Malinoski explained. "So we're really grateful for (the foundation's) interest. We hope to do more research and create a path for others to follow, and engender more work."

Existing regulations on organ donation are for living donors, not deceased donors, he said. "None of my work involves living donors; it involves deceased donors." That means that when a patient who wishes to be an organ donor dies in the ICU, the medical staff continues to do aggressive care to preserve the patient's organs. Research needs to focus more on managing the body after the patient dies. Transplant centers apply criteria to determine whether an organ is acceptable to donate, and the centers may turn down an organ because of poor quality, he said. "If you can improve how the organ is functioning to make it suitable for transplantation," the result may be the ability to add one more organ per donor, which would be the objective, he said.

Kidneys are the most commonly used organ. Depending on the type of organ, most must be used within five to eight hours, he said. "The entire transplant system has been developed to accommodate these short (turnaround) times." The idea of research is to be able to take organs thought not to be usable and make them transplantable. One area of research focuses on increasing how long an organ is usable. If the time limit could be extended to 10 or 12 hours, more organs would be recoverable, he said.

Malinoski noted that transplant centers – both those inside the same metropolitan area and across the country – work together along with the United Network for Organ Sharing. Organs from OHSU may go anywhere, and those received may come from all over the U.S. As explained on UNOS' website, when a patient is added to the list, a transplant hospital adds a patient's medical information into UNOS' computer system. When a deceased organ donor is identified, UNOS' computer system generates a ranked list of transplant candidates, or matches, based on blood type, tissue type, medical urgency, waiting time, expected benefit, geography and other medical criteria.

"The goal of the initiative is to demonstrate we can do national research involving deceased donors," Malinoski said. "We've created our own levels of oversight. The government needs to come through with guidelines for ethical considerations to ensure that everyone is protected and that procedures followed are appropriate," he said. ●

National transplant facts

About **22 people die daily** waiting for an organ

More than **120,000 are on the organ waiting list**, and the average **wait time is three to five years**

Source: Laura and John Arnold Foundation

In memoriam: Michael Dorsen, MD

Dr. Michael Dorsen died suddenly July 4 at age 71. He was born June 25, 1945, to Frederick and Gisella Dorsen in Sydney, Australia. He attended Sydney High School and received his degree in medicine from the University of Sydney in 1969.

Selected in the Vietnam War draft, Michael served in the Royal Australian Air Force. He was the first Australian Air Force doctor to undertake the Space Medicine Program in Houston and on his return to Australia, was the first to undertake the Australian Space Medicine Program. While in Houston, Michael was accepted into the Baylor College of Medicine residency program. At Baylor, he worked closely with the famous surgeon Dr. Michael DeBakey and completed his neurosurgical residency in 1978.

Michael's 43-year neurosurgical career took him to Denison, Texas; Austin, Texas; and Corvallis, before finally settling in Portland. He served at Legacy Emanuel Medical Center, where he became chairman of the department of surgery. He was board certified by the American Board of Neurosurgery and was a fellow of both the American Association of Neurological Surgery and the American College of Surgeons. Michael served as a trustee with the Medical Society of Metropolitan Portland from 2008 to 2013.

Michael enjoyed traveling, hiking, Thanksgiving dinner, the Beatles and being an active alumnus of the University of Sydney. He was always grateful for the personal and professional opportunities that the U.S. afforded him. He is survived by his wife of 15 years, Edith; sons, Matthew and Marcus; brother, Victor; nephew, Simon; and niece, Catherine. He will be dearly missed by all.

In lieu of flowers, please donate to organizations that help battered women, support rape victims or promote the education of women or girls. Thank you. ●

Discovery may impact diabetes treatment

A new study led by nationally prominent stem cell scientist **Markus Grompe, MD**, has determined the existence of at least four separate subtypes of human insulin producing beta cells that may be important in understanding and treating diabetes. The findings were published online in July in the journal *Nature Communications*.

Markus Grompe, MD

"This study marks the first description of several different kinds of human insulin producing beta cells," said Grompe, primary investigator, director of the **Oregon Stem Cell Center** at OHSU and the **Papé Family Pediatric Research Institute** at **OHSU Doernbecher Children's Hospital**. "Some of the cells are better at releasing insulin than others, whereas others may regenerate quicker. Therefore, it is possible that people with different percentages of the subtypes are more prone to diabetes. Further understanding of cell characteristics could be the key to uncovering new treatment options, as well as the reason why some people are diabetic and others are not."

Diabetes affects more than 29 million people in the United States. It is caused by the dysfunction or loss of insulin producing beta cells, which help the body to achieve normal blood sugar levels. Previously, only a single variety of beta cell was known to exist. However, using human pancreatic islets, or clusters of up to 4,000 cells, Grompe and colleagues discovered a method to identify and isolate four distinct types of beta cells. They also found that hundreds of genes were differently expressed between cell subtypes and that they produced different amounts of insulin. All type 2 diabetics had abnormal percentages of the subtypes, suggesting a possible role in the disease process.

Additional research is needed to determine how different forms of diabetes – and other diseases – affect the new cell subtypes, as well as how researchers may take advantage of these differences for medical treatment, OHSU said in a news release.

Compass selected for care delivery model

Compass Oncology has been selected by the Centers for Medicare & Medicaid Services as one of nearly 200 physician group practices and 17 health insurance companies to participate in a care delivery model that supports and encourages higher quality, more coordinated cancer care.

The Oncology Care Model encourages practices to improve care and lower costs through episode- and performance-based payments that reward high-quality patient care. It is one of the first CMS physician-led specialty care models and builds on lessons learned from other innovative programs and private-sector models. As part of this model, physician practices may receive performance-based payments for episodes of care surrounding chemotherapy administration to Medicare patients with cancer, as well as a monthly care management payment for each beneficiary.

Through its affiliation with the US Oncology Network, Compass Oncology has been engaged in an internal program developed by the US Oncology Network to prepare for the OCM by building and testing processes that will be required for success. This program reinforces its commitment to deliver high-quality, evidence-based cancer care.

Compass Oncology is the largest multispecialty medical practice in the Pacific Northwest dedicated solely to providing state-of-the-art, comprehensive care for patients with cancer or diseases of the blood. The Medicare arm of the OCM includes more than 3,200 oncologists and will cover about 155,000 Medicare beneficiaries nationwide.

Cancer is one of the most common and devastating diseases in the United States. According to the National Institutes of Health, based on growth and aging of the U.S. population, medical expenditures for cancer in 2020 are projected to reach at least $158 billion (in 2010 dollars), a 27 percent increase compared with 2010. A significant proportion of those diagnosed are over 65 years old and Medicare beneficiaries.

Study finds early, late menopause can increase type 2 diabetes risk

Women who begin menopause before age 46 or after 55 have an increased risk of developing type 2 diabetes, according to a study of more than 124,000 women enrolled in the Women's Health Initiative, a large national trial aimed at preventing disease in postmenopausal women.

The study, led by **Kaiser Permanente** researcher **Erin LeBlanc, MD, MPH**, was published in late July in *Menopause*, the North American Menopause Society's official journal.

According to the society, the average age of menopause is 51. The study found that women who had their final menstrual period before age 46 were 25 percent more likely to develop type 2 diabetes, compared to women who had their final period between ages 46 and 55. Women who had their final period after age 55 had a 12 percent increased risk of developing diabetes.

After menopause, estrogen levels decline. These low estrogen levels have been linked to increased body fat and appetite, decreased metabolism and high blood-sugar levels. Previous studies linked early menopause to an increased risk of diabetes, but this study is one of the first to show that later menopause also puts women at higher risk.

"Our study suggests the optimal window for menopause and diabetes risk is between the ages of 46 and 55," said LeBlanc, lead author and an investigator at the **Kaiser Permanente Center for Health Research**. "Women who start menopause before or after that window should be aware that they are at higher risk, and should be especially vigilant about reducing obesity, eating a healthy diet and exercising. These lifestyle changes will help to reduce their risk for type 2 diabetes."

The study also found an association between the length of a woman's lifetime reproductive cycle and her risk of developing type 2 diabetes. Women with the shortest lifetime reproductive cycles (less than 30 years) were 37 percent more likely to develop diabetes than those with medium length reproductive cycles (36 to 40 years). Women with the longest reproductive cycles (more than 45 years) were 23 percent more likely to develop diabetes compared to women with medium length reproductive cycles.

The differences in risk were reduced, but remained statistically significant after adjusting for several factors, including age, race, BMI, birth control use, hormone replacement therapy, number of pregnancies, physical activity and alcohol consumption.

Study participants were part of the Women's Health Initiative, a large national study of postmenopausal women focused on strategies for preventing heart disease, bone fractures, and breast and colorectal cancer.

TPC study: Portlanders' healthy behaviors outpace U.S. average

A recent study by **The Portland Clinic** shows Rose City residents are more likely to engage in healthy behaviors and live a more health-conscious lifestyle than their peers nationwide.

"Portland Healthy Habits: 2016" shows about 73 percent of Portlanders surveyed exercise regularly, while only about 56 percent of Americans do so.

The study sought to understand how Portlanders approach health and wellness and which healthy lifestyle choices were most popular. While trends suggest Americans are paying closer attention to how lifestyle impacts health – ditching sugary drinks and cigarettes, for example – the survey shows Portlanders place more emphasis on nutrition and exercise.

"It's a point of pride that our residents put such a high emphasis on their physical fitness," said **Amanda Borges**, executive director of the **Medical Society of Metropolitan Portland**. "There are a lot of ways that this city is taking a leadership position compared with communities around the country. You can see this in the variety of nutrition-conscious restaurants that are bustling in all corners of our metro area and the vast array of physical activities available in all of our neighborhoods. Prioritizing a diet of healthy options and regular exercise is just one of the many ways we are setting ourselves apart as a region where people want to live."

This health-conscious lifestyle does more than trim waistlines and increase energy.

"Lifestyle choices like exercising regularly and eating a balanced diet can have the single largest impact on our health," said **Dick Clark**, CEO of The Portland Clinic. "We've seen countless patients benefit from these healthy patterns – either arresting chronic medical issues or maintaining overall health. It speaks volumes about the culture we have cultivated in Portland that our citizens put such an important focus on their health, and our doctors and nurses are proud to help their patients make smart wellness decisions every day."

General exercise, such as visiting the gym, was the most popular way to stay fit in Portland (36 percent). Walking was second (27 percent). The city's natural spaces also make other outdoor activities such as running, hiking and bicycling popular.

Other findings:

- Aligning with national averages, 54 percent of respondents confirm they monitor their nutrition to improve physical and/or mental health. About half of respondents eat fruits and vegetables every day, and nine out of 10 eat produce several times a week. However, recent national statistics show that, even if fruits and veggies are part of a regular diet, we still need to eat more.
- About 6 percent of Portlanders follow a plant-based diet, compared to about 4 percent nationwide. Just under half of respondents drink some form of caffeine daily. In contrast, about two-thirds of Americans grab a cup of joe.
- While 80 percent of Americans eat fast food at least once a month, only about 60 percent of Portlanders do. About 35 percent of Portlanders eat processed snacks multiple times a week.
- 55 percent of homes report having at least one family member with a chronic health condition, many of which can be treated and prevented with lifestyle changes. Obesity and arthritis (21 percent) were most common, followed by asthma (16 percent) and diabetes (15 percent).

The full press release can be found online at *www.theportlandclinic.com*.

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