MEDICAL SOCIETY OF METROPOLITAN PORTLAND

The Scribe

A publication of the Medical Society of Metropolitan Portland

OFF HOURS

Havens from stress

Ballet and writing help Ashley Treece, MD, balance the demands of medicine.

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MEDICAL STUDENT PERSPECTIVES

Homing in on debt reduction

Ed Grossenbacher, MD, wanted to help OHSU Medical School students to reduce their debt load. His approach was to buy a home and offer it to medical students at no cost.

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National task force endorses new statin guidelines for prevention

By Cliff Collins
For The Scribe

Following up the 2013 release of cholesterol-lowering drug guidance by two major health groups, the national panel responsible for issuing preventive advice has seconded that opinion, with modifications.

The **U.S. Preventive Services Task Force**'s guidelines for use of statin drugs, released in November, are similar to the 2013 joint recommendations issued by the **American College of Cardiology** and the **American Heart Association** in endorsing statins as a primary preventive measure for asymptomatic patients. But the task force's guidelines are "less aggressive," noted **James Beckerman, MD**, a cardiologist and medical director for **Providence Heart Institute's Center for Prevention and Wellness**. The task force is "recommending treating people

JAMES BECKERMAN, MD

ANDREW H. FELCHER, MD

if the person is at a specific threshold of risk for heart disease," he said.

That level is set higher than that by the ACC-AHA guidelines, the latter of which were "controversial" and potentially placed millions more patients on statins, said **Andrew H. Felcher, MD**, a **Kaiser Permanente** hospitalist and director of its anti-coagulation clinic. JAMA Network reported that about 28 percent of Americans over age 40 already were taking statins by 2013, at a cost of about $17 billion.

The task force's recommendations apply to adults 40 and older with no history of cardiovascular disease and who don't have current signs and symptoms of it. The task force's explanation states: "Some individuals in this group may have undetected, asymptomatic atherosclerotic changes; for the purposes of this recommendation statement, the (task force) considers these persons to be candidates for primary prevention interventions."

The task force assigned a B grade for evidence it reviewed showing that patients most likely to benefit from statin use are those ages 40–75 who possess at least one risk factor for heart disease and a calculated 10 percent or greater 10-year risk of suffering a cardiovascular-related event. It suggests prescribing a low- to moderate-dose statin for prevention. By contrast, Beckerman pointed out, the ACC-AHA guidelines set that threshold at 7.5 percent or greater risk over 10 years for ages 40-75. The ACC-AHA guidelines also did not add the third criterion of possessing at least one risk factor.

The task force assigns a C grade for prescribing statins to patients age 40 to 75 who have a risk factor for cardiovascular disease but only a 7.5 percent to 10 percent calculated 10-year risk for an event. They are less likely to benefit from statin use. For this second group, the task force "recommends selectively offering" statins "to individual patients based on professional judgment and patient preferences."

Finally, the task force concluded that the current evidence is insufficient to assess the balance of benefits and harms of statins in adults 76 and older without a history of heart attack or stroke.

The topic of statin use is "appropriately getting attention," and the task force's guidelines are "less stringent than previous recommendations," Beckerman said. Doctors take guidelines seriously and find them useful, but don't think of them in the sense of "following a recipe," he explained.

Beckerman noted that the task force considers them guidelines, not directives or mandates, and recommends that clinicians discuss with each individual patient

*See **STATINS,** page 4*

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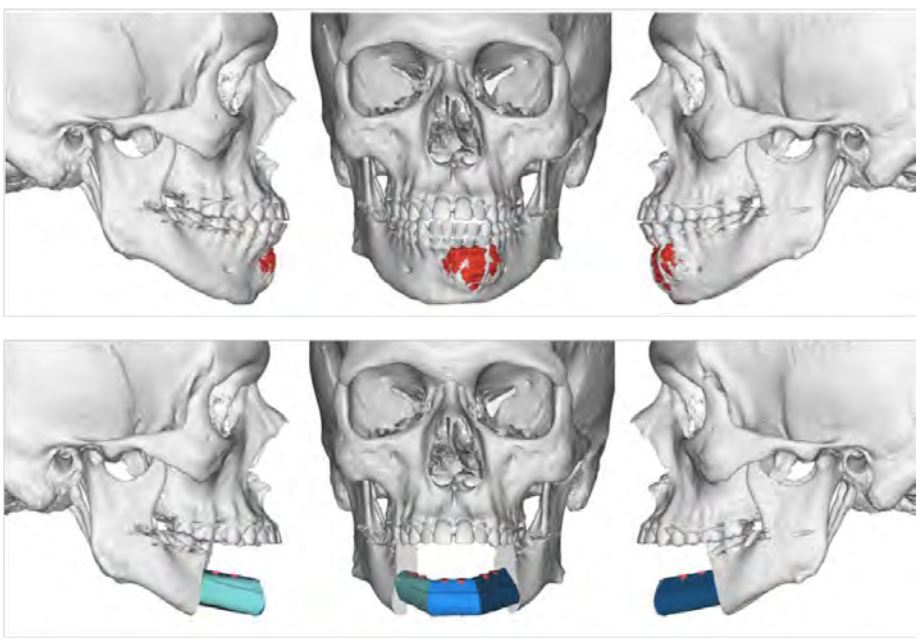

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– Please turn to page 10 for more on this procedure.

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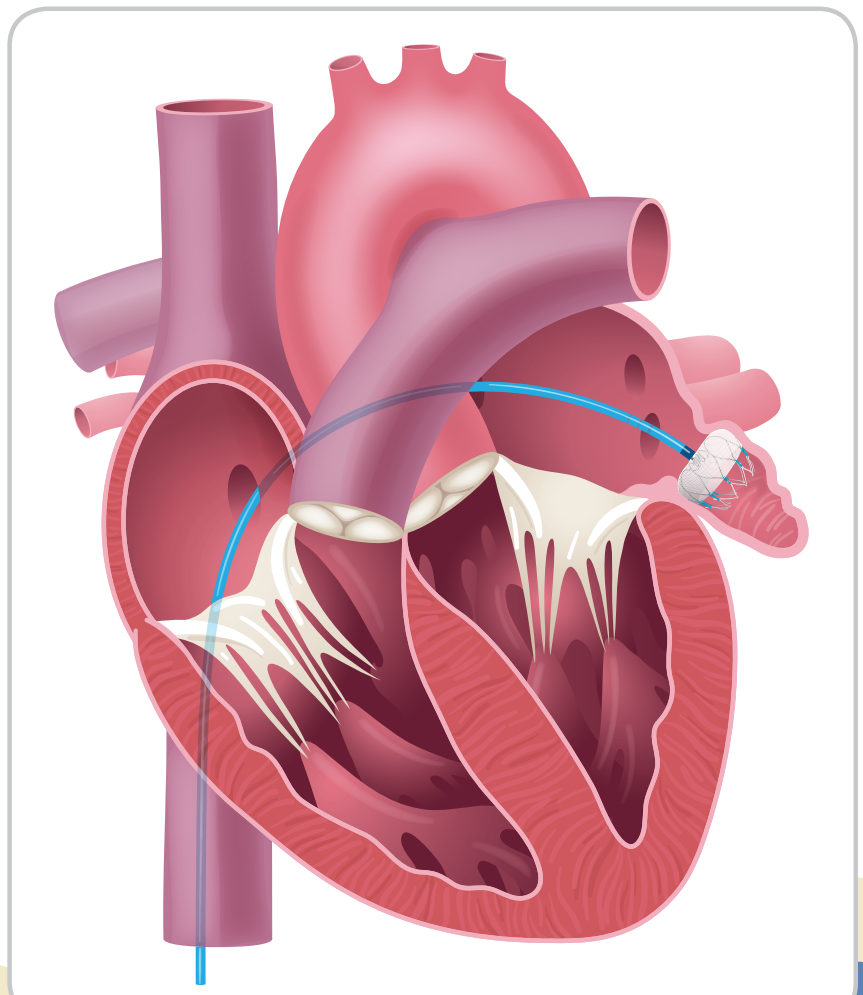

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MSMP MEMBERSHIP BENEFIT

Annual Salary and Benefit Survey Report

The Medical Society of Metropolitan Portland and Medical Society Staffing have released the *2016 Annual Salary and Benefit Survey Report*. This annual benchmarking tool captures medical office employee compensation and benefit trends in the greater Portland medical marketplace.

MSMP Group Members receive a free report. Members can purchase it for $100 and non-members can purchase for $250. For more information or to request your copy, email *paula@msmp.org* or call 503-944-1128.

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MSMP is seeking nominations for the Rob Delf Honorarium Award, the annual award the Medical Society's Board of Trustees created in recognition of Rob Delf's long service to the organization. **The award is given to a person or persons who exemplify the ideals of the Medical Society within the community where members practice.**

This can be demonstrated by work projects or activities that improve community health or the practice of medicine in arenas including, but not limited to: the practice of medicine; educating new members of the medical community; educating the public about health, medicine and health public policy; improving public health and emergency preparedness; advocacy in health public policy; or other community activities related to health care and policy.

The award may be given to members of the medical community, the health education community, or the general public. Please visit *www.MSMP.org* or *www.MMFO.org* to submit your nomination. The deadline for nominations is Feb. 9.

EDUCATION

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Location: MSMP 1st Floor Conf. Room A

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EVENT

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Thurs., Feb. 23

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For more information or to participate as an artist or storyteller, contact Meredith Niess, MD, *niess@ohsu.edu* or Brian Ricci, MD, *riccib@ohsu.edu*, or visit *http://gimlivepdx.splashthat.com*.

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Homing in on debt reduction

Physician finds unique way to help ease medical students' financial burdens

By Jon Bell
For The Scribe

There was a time, back when he attended the University of Oregon Medical School (now Oregon Health & Science University), when **Ed Grossenbacher, MD**, lived like a bit of a pauper. If need be, he would sleep in his car, pinch all his pennies and be grateful for any extras that came his way.

"I didn't have any money as a medical student," he said. "A half a hamburger would come through the cafeteria line and I would eat like a king."

Grossenbacher made his way through medical school, served as a flight surgeon in the U.S. Army during the Vietnam War and has been in private practice in the Portland area since 1971.

He is also now the CEO and cofounder of Medical Evaluations of Oregon/Washington, a medical evaluations practice in Portland.

But he never forgot his scrappy med student days. And when, a few years ago, he saw what the average medical student carries in student loan debt—the Association of American Medical Colleges pegged it at $176,300 in 2015; the American Student Dental Association reported that dental students' average debt tops $216,000—Grossenbacher wanted to do something to help.

"It's unbelievable," he said.

Grossenbacher's approach was to buy a home on Marquam Hill near the medical school and offer it to medical students at no cost. The first three students, **Ishan Patel**, **Glenn Kautz** and **Paul Montgomery**, moved into the house in 2015 and are currently in their senior year of school. In addition to letting them live in the home rent free, Grossenbacher also picks up all the utilities and occasionally drops by with snacks and beer for the fridge.

> OHSU medical student Ishan Patel, who shares with two other students a house provided by Ed Grossenbacher, MD, noted on OHSU's website that **the arrangement "is an incredible investment in our future.** Dr. Grossenbacher has helped us tremendously by significantly lowering our debt and therefore **allowing us to keep our minds open as to the careers we pursue."**

"I think they're all very appreciative because they all could use the help to avoid some of that debt," he said.

In addition to the house, Grossenbacher has an adjacent graveled area that's large enough for five cars. He offered to let the students sell the parking spaces as a way to generate some additional income for themselves while they're in school. The students instead shared their good fortune with some of their fellow learners, offering up the spaces for free to students who are on surgical call at the hospital.

"So, they're helping out even more people that way," Grossenbacher said.

While Grossenbacher said he gets a "bounce in his heart" from helping out the three students, he would still like to do more. For starters, he'll find another cohort of students to move into the home when the current residents move out. He's also on the hunt for additional houses in the area to acquire, primarily fixer-uppers near the medical school, though he knows those can be hard to come by these days.

"All the ones up there are at a premium," he said, "but I'm optimistic I could get 20 houses."

That kind of lofty goal might take a little assistance, but Grossenbacher's already thinking about that. He started a nonprofit called the **Hippocrates Oath Oregon Foundation** to encourage and facilitate other donors who might be interested in helping out. He's also optimistic that there are supporters out there who might be looking for ways to help medical students and the good work that OHSU does.

"I need an angel," Grossenbacher said, "just some people who might be interested in helping out. If we could get a big house up there, get six or seven more students and away we go." ■

Image courtesy of Ishan Patel

Medical students Glenn Kautz (seated), Ishan Patel (back, left) and Paul Montgomery, shown here with a picture of Gilbert du Motier, Marquis de Lafayette, are housemates at a Marquam Hill residence dubbed "Marquis" that Ed Grossenbacher, MD, purchased for medical students to use at no charge. On its website, OHSU noted that the house is named Marquis after Google insisted on correcting "Marquam" to "Marquis" on the Google Document the housemates used to arrange their move in.

Those interested in finding out more about Grossenbacher's efforts can reach him through the OHSU School of Medicine Alumni Association at alumni@ohsu.edu or through his company at www.meowmed.com.

***STATINS,** from page 1*

the advantages and potential drawbacks of receiving a prescription for statins. Physicians will use the guidelines in making decisions along with their patients, he said. "That doctor-patient relationship is very special and is where (decisions) will be made."

Payers also receive the task force's recommendations seriously. Insurers generally apply those guidelines to determine whether to pay for conditions and procedures. If the medical world takes these new guidelines to heart, as it were, this could mean a substantial increase in health care costs to pay for the drugs, one of the criticisms aimed at the drugs' use. The task force does not take into account costs when making recommendations for medical services.

OHSU physician led studies review

The task force's guidelines were published in the Journal of the American Medical Association, which included a review of the evidence supporting them and several editorials presenting varying opinions of the guidelines. **Roger Chou, MD**, director of the **Pacific Northwest Evidence-based Practice Center** and a professor of medicine at **Oregon Health & Science University**, led the evidence review that the U.S. Preventive Services Task Force followed in developing its statin guidelines.

Chou and his co-researchers analyzed data from 19 clinical trials, concluding that using statin drugs provided wide-ranging prevention benefits in people who have not had a previous heart attack or stroke, without significantly increasing the risk of serious side effects. Some critics of the task force's decision cite the potential for side effects for asymptomatic individuals taking the drugs and argue that the potential benefit from statins for any single patient is small.

But Chou said, "We found that all groups studied experienced a decrease in risk of suffering a heart attack, stroke or death, and those at highest risk benefited the most." The majority of the trials used fixed, moderate doses. The number of trials analyzed "provides much-needed insight into the value of statin therapy in preventing a first heart attack or stroke, and associated deaths," he said.

Felcher, who also serves as director of guidelines, evidence-based medicine and shared decision-making for **Northwest Permanente**, Kaiser's medical group, emphasized that the task force considered the calculator used to determine risk as "imperfect" but the best we have, a description with which he agrees. That risk-estimation method, the Pooled Cohort Equations calculator from the 2013 ACC-ACA guidelines on the assessment of cardiovascular risk, uses race, gender, age, total cholesterol, HDL cholesterol, blood pressure, diabetes status, smoking status and whether the patient is taking hypertension medication. The calculator has been shown to overestimate actual risk, according to the task force.

In response to that determination, Kaiser conducted its own study, which agreed with the analysis that the earlier guidelines overestimated individual risk and "that you probably should be more conservative with your numbers," Felcher said. "We decided a risk level to recommend use of statins of 15 percent."

Kaiser's Northwest Region has been using this guideline for the past two years, and the organization designed a graphic "shared decision-making tool" to make the physician-patient discussion easier for both parties to understand. It has met with much success, he said, being employed 300 to 400 times a month by Kaiser doctors in the region. An internal survey found that 78 percent of Kaiser's primary care physicians consider that the tool is "very useful and makes the conversation easier to have," 83 percent said it made the patient more engaged in the decision-making, and 90 percent of patients approved of it. "That's something we're really proud of."

With what Felcher calls an "icon array," the graphic shows the risk to the patient of cardiovascular disease with or without statins.

The display breaks it down by age and other risk factors for cardiovascular disease, then explicates risk with no medication, with low-dose statins and with high-dose statins.

"What's cool about that is, the doctor doesn't need to know the guidelines," because the icons show the "individualized, personalized" risks clearly. He said other medical organizations, including the Mayo Clinic, have designed similar risk-assessment graphics, but "what's unique about ours is that it's embedded in our electronic medical records." The clinician doesn't have to go online or look elsewhere to find the graphic and show it to the patient, he said.

Patients gain a better understanding of the potential benefits versus harms because it is explained to them pictorially, he said. "We think this is the right way to have this conversation between doctor and patients." ■

Watch for the signs: Screen all patients for suicidal thoughts

By Robin Diamond, MSN, JD, RN
Senior Vice President of Patient Safety and Risk Management, The Doctors Company

The suicide of a patient is a tragedy for any physician.

Patients with suicidal thoughts or ideation appear occasionally in physician encounters. The Joint Commission recently noted that the rate of suicide is increasing, and suicide is now the 10th leading cause of death in the United States.[1] Most people who commit suicide received health care services in the year prior to death, usually for reasons other than mental health issues or suicidal thoughts. It's a strong reminder that any patient – no matter what issue is being treated and in any setting – could be at risk for suicide.

The patient's well-being should be the primary concern, but physicians also must consider the potential legal liability that can come from failing to adequately screen patients for suicide risk and taking the proper steps when needed. The remorse a physician may face over missing signs can be compounded by legal action claiming the physician is accountable for the patient's demise. A consistent and formal screening process, plus a response plan, will protect both the patient and the physician.

Case study: Reviewing patient's full history is key

A recent case illustrates how even if the patient denies suicidal ideation when asked, the physician could be held liable for the suicide if there were other risk factors to consider. The case involved a 60-year-old woman with chronic back pain from an auto accident 10 years earlier, treated by her family practitioner over several years for pain, depression and hypertension. Prior to her death, the woman had three appointments with the doctor over nine months for insomnia, pain medication adjustment, antidepressant medication monitoring and blood pressure checks.

The notes from the last encounter state: "No energy; insomnia; denied suicidal thoughts and denied feeling depressed." Six days later, the patient overdosed on a combination of sleeping medication and anti-anxiolytics. Notes in the medical record from the next-to-last appointment said the patient "complained of insomnia; increased depression and increased anxiety; referral to psychologist." However, she did not see the psychologist and the family practitioner's office did not follow up. The defense experts said that the doctor should have considered the entire history instead of just the last visit and concluded the patient was at risk of suicide.

How to help prevent tragedies

These are some key strategies for ensuring that a physician practice or hospital is sufficiently addressing suicide risk in patients:

■ **Establish a formal policy on screening and responding to suicide risk.** Establish a policy that stipulates what screening will be done and how to respond to suspected risk. All employees should be trained. The policy should include front desk staff and other non-clinicians, who may pick up on signs that the patient could be suicidal.

■ **Implement an effective screening process.** The questions typically asked on intake can be more of a formality than a true screening. Ask specific questions that can reveal situations that might put the patient at risk for depression and suicide. Examples include asking whether the patient has recently experienced the loss of a family member, a change in marital status, a change in jobs, sleeping difficulty or loss of appetite.

■ **Connect with the patient.** If in the screening process, the patient demonstrates suicidal tendencies or it's suspected that the patient may be suicidal, refer the patient immediately to a mental health professional or ask the patient's permission to contact family members or outpatient treatment providers.

■ **Do not be deterred by HIPAA**. The patient privacy law can leave clinicians thinking that they may not discuss their concerns about suicide with the patient's family. The patient can give permission for the physician to talk to others about his or her health care, and refusal to grant that permission might be considered another sign of suicidal risk.

■ **Establish a relationship with mental health professionals for referral.** In a hospital setting, the physician should always know who is on call for patients with psychiatric risks. In other settings, the physician should establish a referral relationship with at least one or two professionals who can be called as needed. Be sure to document when and how the contact was made and any follow-up. ***Remember that simply advising the patient to seek help is insufficient.*** Contact the mental health professional directly and arrange for the patient to be seen quickly. Be sure to follow up to confirm that the patient has seen the mental health professional.

■ **Establish safety procedures for the patient who may be suicidal.** Once this risk is established, the clinician is responsible for protecting the patient from self-harm. That means keeping the patient away from sharp objects, medications and bed sheets. Having the patient wait in a typical exam room may not be safe because the patient would have access to scissors, scalpels, needles, and other such items. When appropriate, ask the patient to put on a hospital gown and remove from the room the patient's shoelaces, belt, and any other items that could be used for harm.

■ **Monitor the patient closely.** If feasible, have staff or the patient's family monitor the patient continuously, in person or on video, until the next step of care. If continuous monitoring is not possible, check on the patient frequently. Carefully document the monitoring procedure, including frequency and type as well as observed patient behaviors.

■ **Call for help if needed.** Call for additional help if the facility has no ability to isolate the patient from dangerous items or provide adequate monitoring, and also if the patient has already left against medical advice. State laws vary regarding how and when a patient may be held against their will. ■

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

In addition to her legal experience, Robin Diamond has a master's degree in psychiatric nursing from Vanderbilt University.

NOTES

[1] Detecting and treating suicide ideation in all settings. The Joint Commission. www.jointcommission.org/assets/1/18/SEA_56_Suicide.pdf. Accessed November 14, 2016.

OHSU, Oregon on forefront of wellness among students, physicians in training

Last month's *Scribe* reported that the **American Medical Association** adopted a policy in mid-November designed to ensure medical students and resident and fellow physicians have timely and confidential access to the medical and mental health services they need during medical training.

Among other strategies, AMA's new policy encourages medical schools to create mental health awareness and suicide prevention screening programs that would be available for all medical students at their discretion. The policy asks that these programs offer students anonymity, confidentiality and protection from administrative action, and provide proactive intervention for any student identified as at-risk by mental health professionals.

Kathleen Haley, JD, executive director of the **Oregon Medical Board**, is part of a national work group that is studying the issue of physician wellness and said Oregon is ahead of the curve on several fronts.

She commended **OHSU's Resident and Faculty Wellness Program**, established in 2004, and its director **Mary Moffit, PhD.** Through the program, people receive free, confidential services that include individual coaching and counseling, referrals to providers in the Portland community, educational workshops and wellness resources, and psychiatric medical consultation and medication management.

"I think that is a marker right there of Oregon being in the forefront of physician wellness," Haley said.

She pointed to the **Oregon Coalition for Healthcare Professional Enhancement**, which was established to create a statewide strategy for coordinating physician wellness initiatives and resources. In addition to Haley and Moffit, the coalition's leaders include **Henry Grass, MD**, Oregon Psychiatric Physicians Association; **Bradley Bryan, MD**, MSMP's president; **Amanda Borges**, MSMP's executive director; **Candice Barr**, emerita executive director of the Lane County Medical Society; **Bryan Boehringer**, OMA's executive director; **Mary McCarthy, MD**, psychiatrist; and **Tim Goldfarb**, president of The Foundation for Medical Excellence.

> "If all state licensing boards **focus on identifying currently impaired physicians** and encourage their licensees who are struggling with professional burnout or personal distress, depression or substance abuse to **seek professional care**, this would be a **paradigm shift that will save lives**."
>
> *– Mary Moffit, PhD, director, OHSU Resident and Faculty Wellness Program*

Haley also noted the success of physician wellness programs initiated by the Lane County Medical Society and MSMP, which are serving as national models. She said the Oregon Medical Board has designated funding in its budget package to explore the issue further and bolster telehealth resources for more remote areas of the state.

"We're definitely in the forefront, but that doesn't mean we don't have a long way to go," Haley said, adding a growing body of research shows that physician burnout has a direct impact on patient care and the Oregon Medical Board is seeking proactive strategies that address physician burnout before problems occur.

The AMA policy statement says that in order to help address concerns about confidentiality, state medical boards should refrain from asking applicants about past history of mental health diagnosis or treatment, and only focus on current impairment by mental illness or addiction, and to accept "safe haven" non-reporting, which would allow physicians-in-training who are receiving mental health treatment to apply for licensure without having to disclose it.

Haley said the Oregon Medical Board is striving for a more advanced approach in this regard and wants to strike a balance between monitoring for impairment while incorporating affirmative statements that encourage providers to ask for help when they need it.

"We want to be really clear that counseling and seeking help is not to be discouraged," she said. "We're asking about impairment and I think we're in pretty good shape moving forward, but we can always improve."

Moffit, also director of OHSU's Peer Support Program and an assistant professor in OHSU's psychiatry department, said the AMA announcement was welcome news and, if adopted by state medical boards, a long-standing barrier will be removed.

"Fear of reporting to licensing boards any treatment, psychological counseling or psychiatric care is prevalent – even in states where medical licensing boards do not require this disclosure," she said. "Here in Oregon, the Oregon Medical Board, guided by Kathleen Haley's exemplary leadership, urges physicians to seek out health care 'upstream,' recognizing that this will prevent impairment 'downstream.'"

Moffit noted that if the AMA's recommended change in policy results in increased physician trust in the confidentiality of treatment, the impact will be significant.

"If all state licensing boards focus on identifying currently impaired physicians and encourage their licensees who are struggling with professional burnout or personal distress, depression or substance abuse to seek professional care, this would be a paradigm shift that will save lives," she said.

"It is clear that physician well-being improves patient care. Patients may not know when their personal physician is distressed or at risk of suicide, but we do know that many of our colleagues are 'struggling in silence,'" Moffit said. ■

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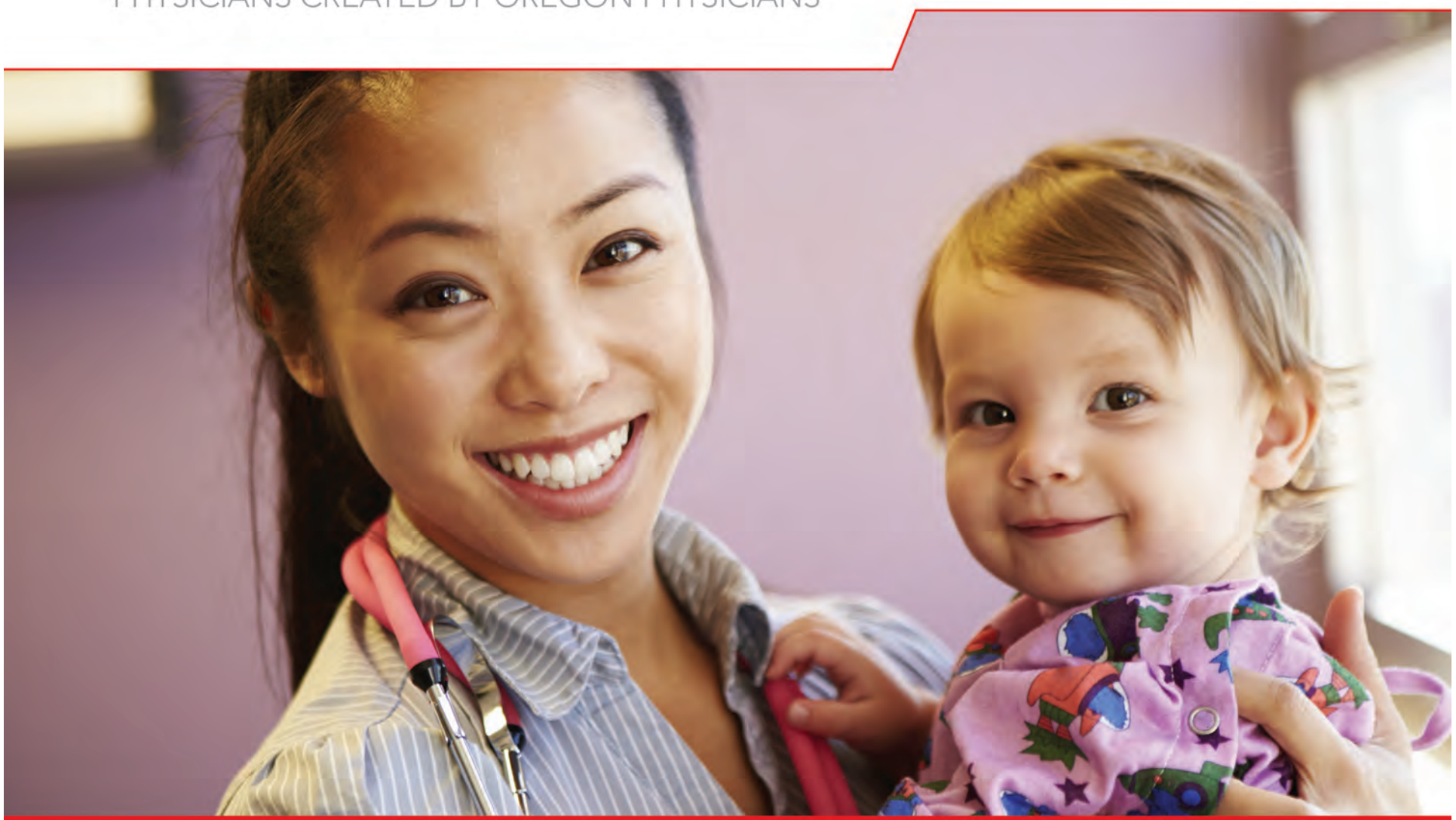

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Scribe Focus
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Each month, *The Scribe* focuses on a health topic, providing a deeper look into issues and advances that impact the area's medical community and patients. Next month, we will delve into Elder Care.

Better patient preparation, technology enhance joint replacement

By Cliff Collins
For The Scribe

Advances in pre- and post-operative care, along with improvements in materials used, have made joint replacement surgery more successful and available, even to younger patients.

"The biggest improvements in the last five to 10 years are that we've gotten much better in the rehabilitation part and particularly pre-habilitation before surgery," said **Richard A. Rubinstein Jr., MD**, who practices with **Portland Knee Clinic** and operates at **Providence Portland Medical Center**. Helping patients get in better shape beforehand translates into better outcomes, he said.

That approach, combined with good pain management that limits narcotics, has meant more patients can go home sooner, often the same day of surgery; and a home setting is the most ideal place to recover as long as the patient has a support system in place, Rubinstein said.

PAUL J. DUWELIUS, MD

Performing joint replacement operations with shorter hospital stays or as day surgeries minimizes the chances of complications such as infection and blood clots, said **Paul J. Duwelius, MD**, who specializes in hip surgery and is with **Orthopedic + Fracture Specialists**. Hospital stays that used to last four or five days now have been reduced to two to three days or same-day outpatient surgery, a change that "has been dramatic," he said.

Recent improvements in anesthesia have helped make total joint replacements in an ambulatory setting much more practicable, explained **Timothy S. Bollom, MD**, an orthopedic surgeon and sports medicine specialist in Bend. He performs 80 percent of his total joint operations at **Cascade Surgery Center**, where the average patient arrives at 7 a.m. and goes home at 5 p.m. that same day, he said.

Bollom said improvements in anesthesia are a major reason why these type of operations will increasingly be done in outpatient settings. At Cascade, the clinicians use what he referred to as "multimodal pain" management: a peripheral nerve block guided by ultrasound, combined with the non-opioid local anesthetic Exparel. In addition, improved instrument design has allowed surgeons to use much smaller incisions, which has helped decrease patients' pain, he said.

In total hip arthroplasty, the challenge of durability has been addressed in the development of a plastic material called highly cross-linked polyethylene, Duwelius explained.

The material has greatly slowed implant wear, according to the Cleveland Clinic. The advances in longevity of implants has meant younger patients can undergo total joint replacements. The clinic's website notes that in the past, the plastic surface of the prosthetic device used in hip-joint replacements often had a limited lifespan, usually due to two reasons: The implant wore down, which sometimes caused the replacement hip to begin dislocating many years after surgery; and the implant emitted microscopic particles, which the body tried to absorb. "The body also may begin to digest bone – a process called osteolysis – which leads to a weakened bone, fracture or problems with the implant." By contrast, the highly cross-linked polyethylene "virtually eliminates osteolysis for up to 10 years after the surgery. Laboratory studies using hip simulator models have shown that this material could last for decades."

> "The biggest improvements in the last five to 10 years are that **we've gotten much better in the rehabilitation part** and particularly pre-habilitation before surgery."
>
> *– Richard A. Rubinstein Jr., MD*

Duwelius, who operates at **Providence St. Vincent Medical Center**, said metal-on-metal hip replacements have fallen out of favor because they showed wear and resulted in higher rates of revision surgeries. By contrast, the new materials can last 20 years and beyond, he said.

The American Academy of Orthopaedic Surgeons reports that the same improvements have occurred with knee replacement materials. The metal parts of the implant are made of titanium or cobalt-chromium-based alloys. The plastic parts are made of ultra high-molecular-weight polyethylene. Some implants are made of ceramics or ceramic-metal mixtures. "Further improvements also are on the horizon for the metal surfaces through the use of advanced ceramic and oxidized zirconium," according to the Cleveland Clinic.

Patient selection vital to outcomes

Nonsurgical approaches also are an important aspect of treatment, said **Robert H. Sandmeier, MD**, an orthopedist and sports medicine specialist with **The Portland Clinic** who primarily treats knee disorders.

ROBERT H. SANDMEIER, MD

The majority of the patients he sees do not need surgery, he noted. "My most common treatment is to change a patient's exercise program in order to address areas that are tight or muscles that are weak and not able to support their activity," said Sandmeier, who focuses his practice on knee ligament and meniscus problems, especially anterior cruciate ligament reconstruction.

Sandmeier, who served on a committee for the American Academy of Orthopaedic Surgeons that created clinical practice guidelines for ACL reconstruction, said most patients who come into his office fit into one of three categories. The first is people who have not sustained an actual injury but are experiencing pain from overuse. These patients need to modify their exercise routine: For example, if they're having pain in the front of their knees from running, they should diversify their activities to include more balance and less repetitive motion, he counsels patients.

The second types of patients he sees have a meniscus tear or ACL injury, both of which are on the increase in the Portland area, especially among female athletes such as soccer players, he said. These injuries generally often get worse if not repaired, because younger people have a normal hard meniscus that requires significant trauma to tear. By contrast, the over-50 patient has a softer meniscus, and its threadlike tissue frays and pulls off, and often self-resolves. "A whole lot of (those) people get better." MRIs show that between 15 percent and 20 percent of patients older than 50 have a tear in their meniscus, yet they don't experience problems with it, he said.

The third group has degenerative arthritis. Sandmeier advises them to attain a healthy weight, emphasize good nutrition and avoid repetitive activities that cause pain. He may discuss with these patients having full joint replacement for those whose pain is not alleviated by physical therapy and medication. Partial replacement often feels better because it preserves more of the natural knee, but no evidence exists that partial replacements last longer or make a second operation easier or more likely to be successful, he said.

"The full replacement is probably more predictable," and especially with joint replacements, predictability is important, he said.

Rubinstein and Sandmeier agreed that the particular type of implant used is less important than appropriate patient selection and the skill and experience of the surgeon. Rubinstein added that these factors trump the technique employed by the surgeon, such as whether robotics are used. In addition, he said, "Most manufacturers make excellent total-knee systems," and there are no independent data showing that one is better than another.

Studies show that obesity is associated with increased length of hospital stay, increased readmissions and higher costs. A study presented to the orthopedic academy found that of 13,250 patients undergoing total hip or knee arthroplasty, patients with higher body mass index experienced a higher overall complication rate compared with patients of normal weight.

Sandmeier said these factors mean that patients with a body mass index over 40 may have trouble finding a surgeon who will do joint replacement. "I think you are going to find more people who are stuck," he said. ■

Services on the increase for transgender patients

By Jon Bell
For The Scribe

The biggest news in the transgender world these days, at least in terms of major headlines, may be North Carolina's bathroom law, which since March has placed restrictions on which public restrooms transgender people can use.

But there's a different kind of focus elsewhere when it comes to the transgender community, especially in Oregon – improved and increased medical care and surgical options. And one of the primary drivers of that increase and improvement is the fact that more and more insurance plans are offering coverage for gender transition surgeries, hormone therapies and other care.

"There has been an exponential demand in these services since insurance carriers have started covering these procedures," said **Hema Thakar, MD**, a plastic and reconstructive surgeon at **Legacy Medical Group–Reconstructive Surgery**. "I have always provided these services, but it comprises a large part of my practice now."

In the past, a large portion of Thakar's patients were women who had had breast cancer and were in need of reconstructive surgery after a mastectomy. That experience led to her offering the same kind of surgery, known as "top surgery," to both male and female transgender patients interested in breast and chest reconstruction.

Oregon Health & Science University has in recent years also expanded its surgical offerings for the transgender community. This past summer, the hospital brought on **Jens Berli, MD**, to help add services through its Transgender Health Program. Surgeries at OHSU include everything from facial feminization surgery to top surgery, hysterectomy and gender transition surgery.

In addition to more insurance plans covering certain surgeries for transgendered people, Thakar said she has noticed that there are fewer denials of coverage from insurance companies these days. That said, she noted that the field is one that is still considered emerging even as it becomes more mainstream across the medical community.

"This is definitely an emerging area of practice," she said. "Transgender care is getting more and more attention at a national level. Both the American College of Surgeons and the American Society of Plastic Surgeons featured sessions regarding transgender care this past year."

As the practice area becomes more widespread and well-known, Thakar said it will only improve and advance. Already, she said, a major trend is to focus more and more on patient outcomes and satisfaction.

"In terms of top surgery, research is starting to focus on long-term results," she said. "The positive thing about transgender surgery coming out of the shadows is that we will be better able to follow our patients' outcomes and long-term results."

KARIN SELVA, MD

At Legacy, Thakar is part of the larger Transgender Services offerings that the health system has for transgender patients. Surgery-wise, Legacy also offers gender transition hysterectomy and post-operative care from **Megan Bird, MD**. It also has a range of services geared toward the transgender community, including primary care, gynecologic care and an even more emerging field, transgender care for youth. In 2014, Legacy launched its Transgender Clinic, which offers medical, mental health and support services for what it calls "gender non-conforming youth up to 18 years of age."

Karin Selva, MD, is a pediatric endocrinologist who sees patients in the Legacy Transgender Clinic a few days each month. That, she said, is already an uptick from when the clinic opened two years ago.

"Since we opened the T Clinic in 2014, the rate of referrals has at least doubled every year," Selva said. "We have increased our access and opportunities to see our patients fourfold since opening."

As in the surgery space, Selva said practitioners are not having as hard of a time getting insurance to cover "pubertal suppression." She also said there have been improvements made in the psychological issues with gender-affirming therapy.

In the world of hormone therapy, Selva said there's been a shift away from using shots to inject agents that suppress puberty and toward implants, which releases the medicine over a longer period of time. For estrogen, providers have moved to transdermal agents – patches – instead of oral ones, because of their effectiveness and ability to mimic physiologic levels in the blood stream. Testosterone is now given through subcutaneous injections, just as insulin is given, which is much more convenient and less painful for patients.

Selva said it can still be a challenge for patients in general to find mental health support or primary care providers who are comfortable taking care of transgender patients. But that's changing, especially in pediatrics.

"Many area general (pediatrics) offices are asking for training and wanting to learn how to respectfully take care of these patients and their families – in terms of general pediatric care and support," she said.

Similarly, Selva said there is a lot of interest in the pediatrics field, particularly in a place like Portland where the practice is "accepted and even revered."

"I have not come into negative opinion from my field in doing trans medicine," she said. "If anything, most people say thank you and are appreciative. It is so rewarding from both a patient perspective and medical colleagues." ■

"The positive thing about transgender surgery coming out of the shadows is that we will be better able to follow our patients' outcomes and long-term results."
– Hema Thakar, MD

Providence patient receives life-changing procedure with 'Jaw in a Day'

By John Rumler
For The Scribe

Oral, head and neck cancer, the sixth most common cancer according to the National Institutes of Health, can be a cruel disease, impacting a person's ability to talk, eat, swallow and sometimes even breath. In extreme cases, facial disfigurement can be so severe that patients choose to isolate themselves. Nationally, every 10 minutes a new case is discovered and every 45 minutes someone dies from OHN cancer.

The American Academy of Otolaryngology–Head and Neck Surgery estimates that about 110,000 patients in the U.S. are diagnosed each year with a form of this disease and treatment costs are pegged at about $3.2 billion.

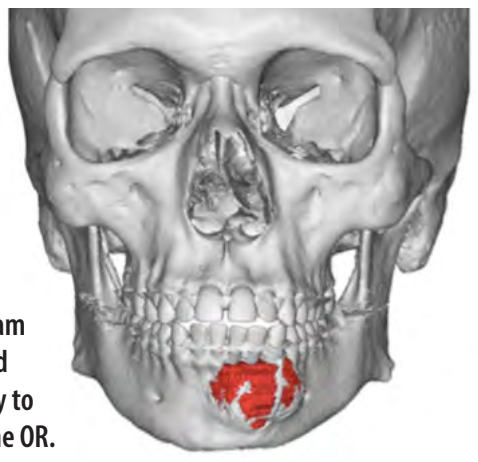
Fortunately, doctors and scientists are finding new ways to treat this serious and challenging condition. Under medical director **Bryan Bell, MD, DDS, FACS**, the **Providence Oral, Head and Neck Cancer Program** has established itself as a national leader and pioneer in developing and utilizing 3-D computer technology to optimize positive outcomes in complex oral surgery reconstructions. The **Providence Oral, Head and Neck Cancer Clinic**, which opened in December 2012, is a center for OHN cancer research and currently has 10 clinical trials open to enrollment.

The clinic successfully performed a revolutionary procedure in August at Providence St. Vincent Medical Center. The procedure had been attempted by only a handful of medical institutions in the world and, until last summer, none on the West Coast.

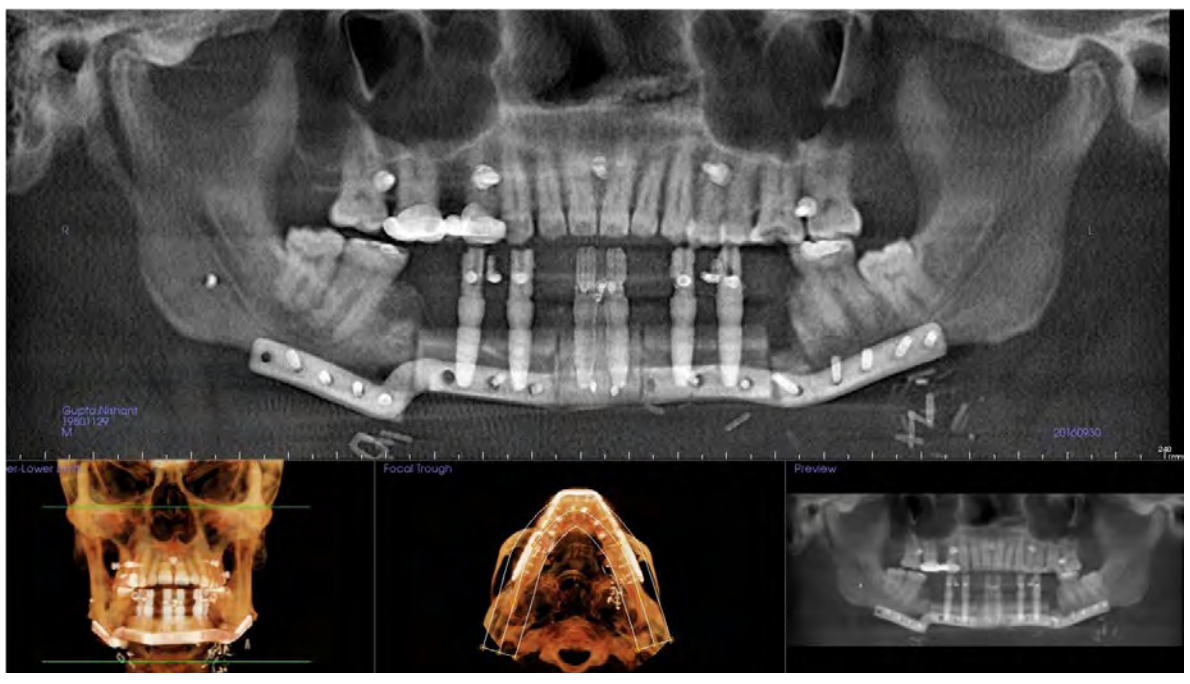
When Joe Smith (not his real name), a married man with young children, first saw Providence doctors last May, he had a rapidly growing, benign tumor on his jaw. The ameloblastoma had already done extensive structural damage and was now disrupting his ability to eat. Benign tumors make up a minority of Providence OHN cancer surgeries, and this type of tumor was relatively rare. The advantage to the surgical team was, because the

A LOOK INSIDE Jaw in a Day

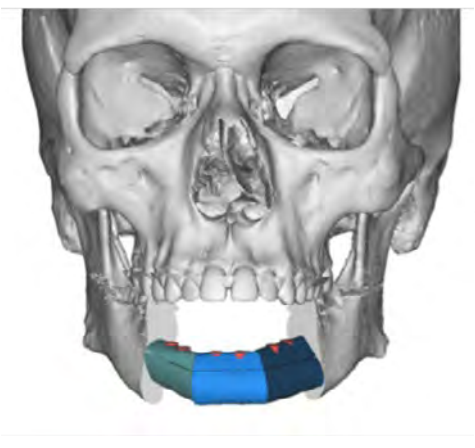
Fibula image source and author: Andross. License: CC-BY. All other images courtesy of Brian Bray, DMD.



The patient had a rapidly growing, benign tumor on his jaw. The ameloblastoma had done extensive damage and was hindering his ability to eat. The medical team planned and simulated the procedure virtually to ensure its success in the OR.



A post-operative radiograph of the patient shows the three segments of the fibula as well as the six implants and abutments. The dental prosthesis cannot be seen because acrylic in radiolucent is not seen on an X-ray.



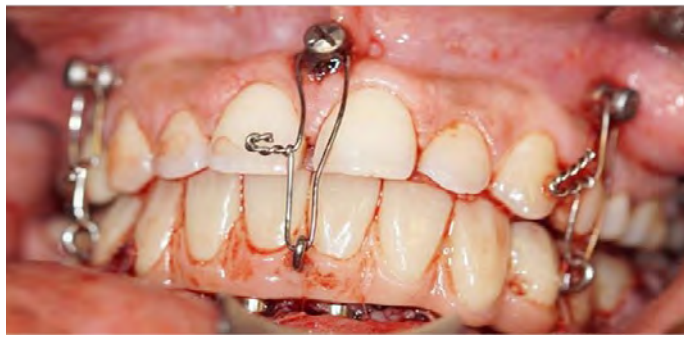
CAD image of the planned fibula graft. Six implants were involved, two per section of the fibula graft.

The new jaw is sculpted out of one of the patient's fibulas, with dental implants added while it's still attached to the patient's leg.

Standard treatment *in cases like this would be up to a* **one-year process.**

With Dr. Hirsch's trademarked process, the entire operation is **over in 12 hours.**

Benefits of the procedure include: reduced expense, reduced hospital and healing time, and less risk of infection or complications.



A dental prosthesis was stabilized in the mouth with wire ligatures for healing. Smith underwent post-operative speech therapy to learn how to use his lips around the new teeth he received during the procedure; he was able to share a meal with his family within several weeks of the surgery.

tumor was non-malignant, it had ample time to plan the procedure and to have the surgical jigs and prosthetics fabricated. Ameloblastomas, however, continue growing aggressively and, in countries without access to health care, can grow to the size of soccer balls.

The standard treatment in cases like Smith's is to first remove, rebuild and replace the damaged jawbone. Then, after sufficient healing, dental implants are added to the reconstructed jaw. Finally, after more healing, teeth are attached to the dental implants. The whole process would have taken about one year, instead of the 12 hours it actually required.

The prolonged process is psychologically traumatic for patients, explained **Ashish Patel, MD, DDS**, a surgeon with the Providence OHN Cancer Clinic. "Imagine having part of your face removed and rebuilt and that all of your lower front teeth are missing."

Known as Jaw in a Day (JIAD), the surgery will replace the standard procedure, which was done in several stages and could take a year or longer to complete. The Virtual Surgical Planning system, a state-of-the-art digital CAD/CAM technology, allows physicians to create personalized surgical plans and design patient-specific surgical guides, models and instruments. The benefits to the patient are reduced expense, reduced hospital and healing time, and less risk of infection or complications.

Providence was on the inside track to the innovation because it was co-developed by **David Hirsch, DDS, MD, FACS**, an oral and maxillofacial surgeon and former Providence OHN fellow, who now has a registered trademark on JIAD. At NYU, Patel assisted on two cases with Hirsch and co-authored the first paper on the technique with him in 2012.

"Since I had firsthand experience learning from the surgeon who developed it," said Patel, "I felt very comfortable doing it at Providence."

Bell said he worked with Hirsh and others to develop protocols for the virtual surgical planning for head and neck reconstruction and to validate its accuracy. "Hirsch and I were among the first in the world to establish a routine work flow process for virtual surgical planning and computer-aided head and neck surgery," he noted.

Throughout Smith's 12-hour procedure, Patel partnered with **Allen Cheng, MD, DDS**, who removed the blood vessels and diseased jawbone, which took about two hours. Meanwhile, Patel carefully sculpted a new jaw out of one of Smith's fibulas, a delicate process as he needed to avoid damaging the surrounding blood vessels and tissue for the living transplant. "You have to preserve the blood supply to the bone," Patel said, "or the graft won't take in the jaw."

The procedure, known as a "fibula free flap," is becoming adopted in leading head and neck centers around the nation. An unusual aspect of the procedure was that while the newly sculpted jawbone was still attached to Smith's leg, Patel put six dental implants into the fibula bone.

Prosthodontist **Brian Bray, DMD**, then activated the implants and applied a complete dental prosthesis on top of them. Finally, Patel transplanted the entire new jaw and attached teeth into the patient's mouth, connecting the tiny blood vessels via microsurgery. He salvaged all of the patient's upper teeth.

The new jawbone was attached to the remaining portion of the healthy jawbone using plates and screws made of titanium alloys. "Because we planned this virtually," Cheng said, "we could fabricate the hardware precisely to the shape of our patient."

Patel created the U-shaped jawbone from the straight leg bone, and then placed dental implants into that leg bone in exactly the right position to ensure that the teeth would be in the correct place so Smith's bite would be perfect – and it was.

None of this could have been done without precise computer planning and modeling. "It was incredibly complex and challenging to do all of that in a single procedure," said Patel.

Patel and his team spent hours on computers in the weeks leading up to Smith's surgery, planning every detail within a millimeter of accuracy and designing 3-D-printed models and cutting guides to carry out their plans precisely in the operating room.

*See **JAW IN A DAY,** page 14*

Havens from stress

Ballet, writing help Ashley Treece, MD, balance the demands of medicine

"I feel at home there, next to the barre and dancing across the floor. When I used to teach creative dance and ballet to foster children, I would tell them that when you come to class, you leave all your other thoughts and worries behind because dance requires all of your attention."

– Ashley Treece, MD

By John Rumler
For The Scribe

Practicing medicine is more stressful than ever. According to the 2014 Physician Workforce Survey, 78 percent of Oregon doctors said stress and burnout were a significant issue. Fortunately, physician wellness groups, pioneered by the Lane County Medical Society and embraced by the Medical Society of Metropolitan Portland, now are available to help many providers.

Physicians such as **Ashley Treece, MD**, have created their own stress-busters to help balance their lives and provide a healthy escape from the daily pressures that might otherwise take a toll.

Treece describes her ballet time as a space where all else stands still, and where her mind, body and spirit are all focused on, and rejuvenated by, dancing. "In many ways, it has become a way for me to process and escape the many toils of everyday doctoring," she says.

Growing up in Clovis, Calif., near Fresno, Treece knew from a very young age that she wanted to be a doctor, for, as she puts it, "the fairly classic purpose of helping people." Her mother was a RN and young Ashley found her mom's work infinitely more interesting than her dad's office job.

However, it was not until late in medical school that she decided on pediatrics. "It was where I felt most comfortable, most challenged and most useful. I loved that the young patients were rarely alone; there was always family or community for them to rally around."

Treece started ballet training when she was 5. Her mom placed her in a class because she was always dancing around the house. Her debut performance was at age 6. "I was a monkey in the 'Little Match Girl,' jumping in and out of hula hoops. I especially remember the bright red lipstick I had to wear for the first time."

The studio Treece attended, Cynthia Merrill Dance Studio, was family friendly and not ultra-competitive, so she learned to enjoy ballet and dance without high stress. At 14, she volunteered to help teach creative movement classes to young children. When she turned 16, she began working for the studio, teaching dance classes to 4- to 10-year-olds and choreographing their performances.

By high school, she was spending nearly all her free time at the studio. If she wasn't dancing, she was teaching. "During performance times, we all ate, drank and slept dance," she recalls. "I loved performing and choreographing."

After high school, Treece decided to leave ballet behind to focus on her studies, but after several months she experienced a withdrawal so she took several on-campus technique classes. Since then, despite various injuries, she's never strayed away.

"I feel at home there, next to the barre and dancing across the floor. When I used to teach creative dance and ballet to foster children, I would tell them that when you come to class, you leave all your other thoughts and worries behind because dance requires all of your attention."

At the University of California, Irvine, where Treece earned a bachelor's degree in genetics, she made friends with a fellow student (who is also a doctor) whose family took in high-risk foster children. Treece gave the kids ballet lessons twice a week.

"They all got ballet shoes and outfits and we used the upstairs railing as a ballet barre and cleared the room for dancing. I love teaching kids to focus their energy."

After earning her MD at the University of California, Davis, Treece moved to Oregon in 2011 and completed her residency in pediatrics at Oregon Health & Science University. She is now employed at the East Portland Pediatric Clinic.

While Treece has experimented with yoga, Pilates and other forms of exercise, she found them incomplete or tedious because they did not engage every part of her body and mind. "One thing I love about ballet and dance is that it moves and exercises your entire body."

Rebecca Castro, RN, met Treece more than 20 years ago and danced with her in a production of "The Little Mermaid." They have been best friends ever since, sharing a love of ballet. Castro will serve as the maid of honor in Treece's upcoming wedding.

"Ballet is an interesting choice for Ashley, since she's sensitive to criticism and ballet instructors are notoriously critical. She's also the most loyal and affectionate person I've ever known," says Castro, who lives in Oakland. "I'm not the first or the only person to point out that building a tolerance for criticism helps lay the foundation for a successful career in medicine."

Treece, who takes advanced ballet classes at BodyVox and the Classical Ballet Academy, also finds satisfaction in writing, something she's been involved in since being a staffer for her school newspaper. Although she had little time during med school, she resumed writing during her residency. "It helped me to process all the pain and confusion that I dealt with in the hospital, and then I started wondering if I could turn it into something more."

So, Treece submitted one of her essays to a national writing competition and surprised herself by taking first place. "It felt great to rediscover my voice. Although I may be quiet in person, I can be vociferous in my writing."

She's continued writing poetry and essays, taking classes at Portland Community College and joining a writing group that is still going strong after two years. "Although starting in a real practice and some life changes have cut into my time, I will continue writing as it is an essential part of me that needs to stay alive."

While Treece has considered teaching ballet again or owning a studio, she is a full-time pediatrician with little spare time. "I'd love to work someplace like The Aspire Project, which I found online. It would be wonderful to help get kids with less opportunities involved in dance."

Castro, who visited Portland a year ago and took a ballet class with Treece, says she could definitely see her friend teaching ballet someday. "As a teenager, Ashley loved teaching young kids in our studio. She is a child at heart herself, and teaching children helped guide her to a career in pediatrics." ■

(Above) Rebecca Castro, RN, and Ashley Treece, MD, shown here in California, share a friendship as well as a longtime love of dance. Castro recalls that Treece relished teaching dance to youngsters. *Photo courtesy of Jordan Holsen*

(Center of page) When she was 16, Ashley Treece performed in a production of "The Wizard of Oz." *Photo courtesy of Cynthia Merrill School of Performing Arts*

Construction starts on new Multnomah County Health Department HQ

Multnomah County commissioners broke ground in mid-December on a new headquarters for the Multnomah County Health Department. The nine-story **Gladys McCoy Headquarters**, situated in Portland's Old Town/Chinatown, promises to transform the dynamics and economics of the iconic Union Station neighborhood, according to the department.

At least 500 health professionals, including physicians, nurses, pharmacists, laboratory employees and administrators, plan to move from other scattered sites into the new facility in early 2019. The Health Department director and directors of Integrated Clinical Services, Mental Health & Addiction Services, Public Health and the Tri-County Health Officer will be located in the building.

Multnomah County Health Department's new Gladys McCoy Headquarters

"For more than 150 years, Multnomah County has prevented disease, promoted wellness and provided medical care for the most vulnerable. This building will carry that mission forward for the next 80 years," said Chair Deborah Kafoury. "Our community deserves a modern, efficient nerve center for that critical work."

The Health Department, the largest safety net health provider in Oregon, has sought to leave its current location at 426 S.W. Stark St. The current headquarters is located in a 1923 former department store that was never designed to meet current and future needs.

The new 157,000-square-foot building will bring together employees from the current headquarters and others in leased space. Commissioner Loretta Smith led a resolution to carry the Gladys McCoy name from the current site to the new building. McCoy was the first African American elected to office in Oregon.

"Gladys McCoy championed what was best for people in this community and honoring her brings her values forward," Smith said.

The building will include street-level windows with art and light to activate the block.

"We see this as a great civic building that will bring vibrancy and security to the neighborhood, and connect Old Town/Chinatown to the Pearl District," said Eugene "Gene" Sandoval, a partner at ZGF Architects, which designed the building.

The building cost is estimated between $93 million and $95 million. More than one-third of the cost is covered by $26.9 million in tax increment funds from building in the River District Urban Renewal area and $9.5 million from an agreement with the Portland Development Commission. The land, a half block from the Bud Clark Commons, was acquired at no cost from Portland's Housing Bureau.

"The Portland Development Commission supported this to boost the economic development of the Broadway corridor," said Scott Andrews, former PDC chair, who first began talking about the project in 2009. "This continued investment is expected to bring more than 4,000 jobs and 3,000 residents to the River District."

Commissioner Diane McKeel thanked county staff, general contractor/construction manager JE Dunn Construction, and the county's owner's representative, Shiels Obletz Johnsen, which she said steered the project through delays and "hiccups."

Helen Ying, chairwoman of the Old Town/Chinatown Community Association, said her organization testified its support to the Portland Planning Commission and City Council, and has met with Health Department staff to understand their work.

As excited as neighbors are about the building, she said, "we're more excited that the Health Department staff is going to be here everyday, their shoes on the ground, walking around.

"We are simply thrilled." ■

OHSU taps University of Missouri Health Care executive

Oregon Health & Science University said recently it appointed **Mitch Wasden, EdD**, as chief executive officer of OHSU Healthcare and executive vice president of OHSU, effective March 1. Wasden comes to OHSU from MU Health Care (University of Missouri Health Care), where he is chief executive officer.

Wasden replaces Timothy Goldfarb, who served as interim chief executive officer from August to December 2016, after Cindy Grueber returned to her role as chief operating officer, having served as both interim CEO and chief operating officer of OHSU Healthcare since Peter Rapp became CEO of OHSU Partners in January 2016.

MITCH WASDEN, EdD

Wasden's primary responsibilities will be to lead and manage all aspects of OHSU Healthcare operations, including financial performance and the continued delivery of high-quality care and services. In parallel, as a member of the OHSU Partners Leadership group, Wasden will be responsible for executing the strategy, vision and goals of OHSU Partners within the OHSU Healthcare system. Wasden also will work with other OHSU executives to support and further OHSU's research and education missions within the clinical enterprise.

As chief executive officer for MU Health Care, Wasden provides executive leadership and vision for the health system's hospitals, clinics, and ancillary and support services. In this role, he oversees the health system's network of specialty hospitals, including Ellis Fischel Cancer Center, the Missouri Orthopaedic Institute, the Missouri Psychiatric Center, University Hospital and Women's and Children's Hospital, and a network of more than 50 outpatient clinics. MU Health Care employs nearly 5,600, including 550 physicians specializing in approximately 70 specialties and subspecialties.

Wasden joined MU Health Care as chief operating officer in June 2012 and was appointed chief executive officer in January 2013. He previously served as chief executive officer for Ochsner Medical Center in Baton Rouge. His previous experience also includes positions as chief operating officer and vice president of Tympany Medical Inc. in Stafford, Texas, and vice president of clinical services for Ochsner Health System in New Orleans.

Collaborative behavioral health center opens

The **Unity Center for Behavioral Health**, a collaboration between **Adventist Health, Kaiser Permanente, Legacy Health and Oregon Health & Science University**, opened this month on Legacy's Holladay Park campus in Northeast Portland.

Unity Center is a patient-centered care environment for adults and adolescents experiencing a mental or behavioral health crisis. Patients receive immediate psychiatric care, may be assessed and treated onsite short term, and are introduced to continuing care options.

In related news, muralists Rather Severe and Blaine Fontana last month created two murals in Portland to raise awareness about depression. The project, a partnership with Kaiser, aimed to bring hope and encouragement to people with depression, Kaiser said.

The muralists were joined by foster and at-risk youth from Color Outside the Lines, a nonprofit that empowers and inspires foster children and at-risk youth by providing opportunities for self-expression and creativity.

Kaiser supported the murals as part of its "Find Your Words" campaign, which aims to remove the stigma around depression and mental illness. According to the National Alliance on Mental Illness, about one in five U.S. adults experiences mental illness in a given year, and one in five children 13 to 18 have or will have a serious mental illness.

Photo courtesy of Branded Arts

Community Partnership Program funds 10 new cancer research projects

The Northwest Sarcoma Foundation in Portland and the American Lung Association of the Mountain Pacific in Tigard are among 10 community-led projects across Oregon that received grants from the **OHSU Knight Cancer Institute** in the latest funding cycle for its **Community Partnership Program**.

Other organizations that received funding in this cycle were Bay Area Hospital in Coos Bay, Oregon State University, South River Community Health Center in Winston, Cascade Health Alliance in Klamath Falls, Eastern Oregon University in La Grande, Family YMCA of Marion and Polk Counties in Salem, the Hood River County Prevention Department and Roseburg's YMCA of Douglas County.

To date, Community Partnership Program grants have funded 53 projects in 34 of Oregon's 36 counties, with 89 percent of projects targeting rural communities. A variety of projects have been funded, including expanding cancer screenings, prevention through healthy behaviors and survivorship support. The program, launched in October 2014, helps communities conduct cancer-related projects targeting a range of cancer types and audiences.

The program offers multiple funding tiers to help organizations begin at the "idea phase" of a project, then build and test an effective solution for a cancer-related problem within their community. Organizations with funded projects connect with other nationally based trainings designed to increase their capacity and knowledge for developing evidence-based programs, provide them with networking opportunities and collaborate with OHSU faculty.

Kaiser Permanente grant funds transportation for cancer patients

The **American Cancer Society** and **Ride Connection** have collaborated for a number of years to support the Road to Recovery transportation program, and increase the level of services provided to cancer patients in the tri-county area.

A grant provided by **Kaiser Permanente** allows the organizations to continue offering rides to and from life-saving treatments, even when volunteer resources are limited. When American Cancer Society volunteer drivers are unavailable, Ride Connection will step in and provide the necessary rides, which will result in 100 percent ride request fulfillment in Clackamas, Multnomah and Washington counties.

"It is not unusual for cancer patients to need radiation therapy every weekday for six to seven weeks," said **Courtney Clark**, mission delivery program manager for the American Cancer Society. "A patient receiving chemotherapy might report for treatment weekly for up to a year. In many cases, a patient is driven to hospitals or clinics by relatives or friends, but even these patients must occasionally seek alternative transportation…That's where Road to Recovery comes in."

Both Ride Connection and the American Cancer Society are contributing staff and volunteer time to operate the program. Many of the thousands of Oregonians who learn they have cancer need assistance in ensuring they get to and from treatment.

Ride requests are coordinated and scheduled through the Ride Connection Service Center and the rides are provided by volunteer drivers using their own vehicles. "Road to Recovery volunteers arrange their own schedules, with some volunteering as little as one afternoon a month and others driving patients as often as twice a week," Clark said. "If you have a car and some spare time, you can help someone keep a potentially life-saving appointment."

For more information on how to volunteer, please visit www.cancer.org/volunteer.

***JAW IN A DAY,** from page 11*

Prior to the procedure, the team completed a simulation of the surgery in a virtual environment to ensure that the actual surgery would be successful. As a result, the surgical procedure was executed flawlessly, Patel said. "We were able to remove all of the tumor, to rebuild the jaw exactly the way we'd planned it, and to place the implants and prosthetic in the perfect position."

Bray pointed out the critical nature of extensive planning and communication pre-surgery: "During the design process Dr. Patel, Dr. Cheng and I were able to meet virtually on a GoTo Meeting with the medical modeling team to design the fibula graft. I was able to meet with the lab technician, **Lee Culp, CDT**, the same way to design the prosthetic teeth. This entire process required approximately four weeks."

Smith underwent post-operative speech therapy to learn how to use his lips around the new teeth he received during the procedure; he was able to share a meal (soup) with his family within several weeks of the surgery. Bray, who has seen Smith several times for follow-up care, said the biggest complications would be rejection of the graft and infection of the surgical site. Neither occurred. Smith also received physical therapy for leg strengthening and walking.

"The doctors did such a wonderful thing," Smith said. "I just wanted to get on with my life. Being able to get this done in one day, instead of having to go through multiple surgeries, was great."

Providence's OHN program treats patients with benign and malignant tumors of the oral cavity, tongue, pharynx, nose, para-nasal sinuses, salivary and thyroid glands, and tumors at the base of the skull. Because of the numerous challenges, a multidisciplinary approach is needed. The Providence team utilized physicians, dentists, nurses, speech pathologists, audiologists, nutritionists and social workers.

"This technique is truly a marriage of two disciplines, medicine/surgery and dentistry, drawing heavily from knowledge of both which is the hallmark of our specialty, oral and maxillofacial surgery," Bray said.

JIAD will be used much more often at Providence, Patel said. "It will not only become the standard of care for patients with benign tumors of the jaw, but it will also be expanded to patients with malignant tumors as well." ■

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- To learn more about Pacific Medical Group, please visit our website at **www.pacificmedicalgroup.com**.
- To apply, submit CV and cover letter to Trudy Chimko, HR Manager, by email: **careers@pacificmedicalgroup.com**, or fax: **503-914-0335**.

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Since 1937, Broadway Medical Clinic has been providing patient centered care in the same Hollywood neighborhood location of NE Portland. Every physician who has, and continues to practice at Broadway Medical Clinic believes the patient comes first. Broadway Medical Clinic shows its commitment to patient-centered care by employing registered nurses who work directly with the physician and his/her patients, providing advice, care planning and care coordination.

Interested physicians should send their CV to **JKCooper@bmcllp.net** or fax to **503-382-7706.**

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The Medical Society of Metropolitan Portland's Physician Wellness Program provides free confidential counseling removing all barriers that typically prevent physicians from seeking help.

- Appointments within 24 hours of request, including before or after office hours
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- Private setting—counseling in a dedicated, confidential room within the Medical Society offices
- Open to all physicians and PAs at no cost
- No information disclosed to others without the physician's written consent
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To schedule an appointment, call our private wellness line at:

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