



The Scribe

A publication of the Medical Society of Metropolitan Portland

FOCUS ON WOMEN'S HEALTH & WELLNESS

'All pain is real'



Better understanding of gender differences should improve pain treatment, experts say.

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OFF HOURS

Pedal power



Jonathan Vinson, MD, finds thrills through competitive cycling.

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October 2020

OHP enrollment grows moderately; behavioral health comes under scrutiny

By Cliff Collins
For The Scribe

Oregon Health Plan officials are bracing for possible budget cuts next year, but observe that the expected deluge of new enrollees has failed to materialize.

Expectations were that the quick and dramatic economic slowdown caused by the COVID-19 pandemic would send OHP enrollment soaring, as thousands of Oregonians were laid off or saw their jobs disappear when



LORI COYNER

the country shut down earlier this year.

But Lori Coyner, the state's Medicaid director, said the plan has seen only a 10 percent increase in enrollment since the statewide emergency declaration went into effect on March 8, amounting to an additional 110,000 members as of mid-September, for a total of 1.19 million.

"Most of the increase is because we're retaining many members that ordinarily would be dropped," Coyner said. "There's been some new enrollment with COVID, but not what we expected."

Normally, if the Oregon Health Authority doesn't hear from members once their time to apply for renewal comes up, they are taken off the rolls, she explained. But during the pandemic especially, the OHP wants as much of the eligible population enrolled as possible. Retaining members who don't leave the plan voluntarily also is a requirement to continue to receive the 6.4 percent increase in federal Medicaid money allotted Oregon

through 2020, which was intended to compensate for the expected jump in enrollment due to the economy, Coyner indicated.

In addition, in order "to make it easier to enroll," the OHP is not asking applicants for proof of income, but will "ask for that information later," she said.

Another possible explanation for why new applicants haven't flocked to the OHP is that many workers who were furloughed remained on their employers' health coverage, Coyner added.

Although state economic experts anticipated a large budget shortfall to end the year, cuts to human services might end up being less than expected. According to the Oregon Economic and Revenue Forecast released Sept. 23, due to the unexpectedly large flow of tax collections during the past year, "the General Fund revenue outlook for the 2019-21 biennium is now no different than it was before the recession hit. Although the reduction in state revenues has been delayed, the pain will eventually be felt given the magnitude of the damage to Oregon's labor market."

But the report added: If the September 2020 forecast proves accurate, the general fund is "in very good shape for the current biennium," 2019-21, with "an expected General Fund ending balance of \$1.7 billion ... available to apply to the 2021-23 budget period."

The economic outlook, combined with Gov. Kate Brown's budget proposal late in the fall, will help planners determine how much their budgets for the next two-year cycle will need to be reduced, Coyner said.

"We will be working closely with the

governor's office to present the case for members to make sure we have adequate funding for the Oregon Health Plan," she said.

Effects on mental health care

With Oregon already recording among the nation's highest rates of substance use disorder, mental illness and suicides, the novel coronavirus and recent wildfires have added challenges for those charged with treating behavioral health problems.

Steve Allen, appointed last year as Oregon's behavioral health director, said social isolation and the impact on the economy wrought



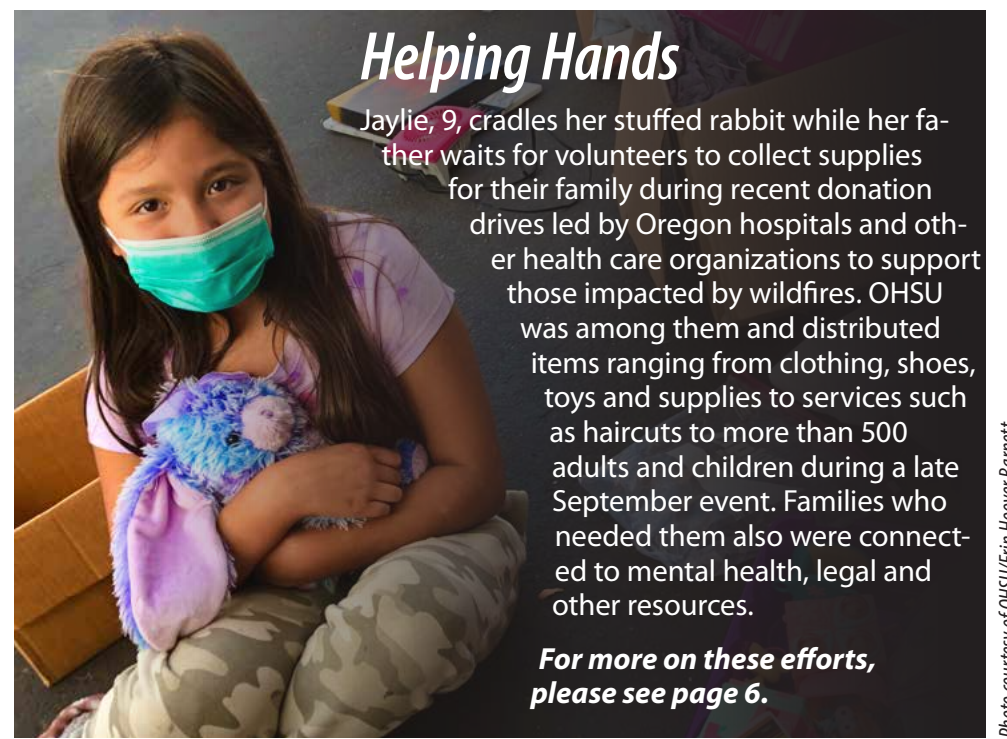
STEVE ALLEN

by the pandemic take their toll on Oregonians' emotional well-being.

What's more, services for behavioral health traditionally have depended on "human-to-human" contact and building trust relationships, which have been disrupted, he said. "It's all about the relationships." However, he pointed out that newly implemented remote connections, little used in the past for delivering mental health services, have served this year as "a true pilot test, and opened up the spigot on telehealth."

Allen, who served as co-chair of the governor's Behavioral Health Advisory Council, noted that he "was brought here to be part of reforming" the state's mental health system. That system came under sharp criticism with

See **OHP ENROLLMENT**, page 4



Helping Hands

Jaylie, 9, cradles her stuffed rabbit while her father waits for volunteers to collect supplies for their family during recent donation drives led by Oregon hospitals and other health care organizations to support those impacted by wildfires. OHSU was among them and distributed items ranging from clothing, shoes, toys and supplies to services such as haircuts to more than 500 adults and children during a late September event. Families who needed them also were connected to mental health, legal and other resources.

For more on these efforts, please see page 6.

Photo courtesy of OHSU/Erin Hoover Barnett

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SCRIBE Staff

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Scribe@MSMP.org • 360-597-4909
Deena Stradley, *Advertising Sales*
Deena@MSMP.org • 503-944-1135
Heather White, *Graphic Design*
Heather@Pixel37design.com

SCRIBE Contributors

Jon Bell, JonTBell@comcast.net
Cliff Collins, tundra95877@mypacks.net
John Rumler, Rumler@hevanet.com

SCRIBE Subscriptions

Janine Monaco Caswell Janine@MSMP.org
To update your address, or to change your subscription options, please notify us in writing. Email Janine@MSMP.org or write to: *The Scribe*, PO Box 19388, Portland, OR 97280

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Practice Manager
Northwest Women's Clinic
503-416-9930
www.nwwc.com

Nicole Christiansen, MD
Nicole D. Christiansen, MD, LLC
503-276-1290
nicolechristiansenmd.com

MSMP Senior Physicians Group

TOPIC: Aging Well: Mental and Emotional Resilience

Friday, Oct. 23

CHECK-IN: 10 a.m.
PRESENTATION: 10:45 a.m.

*If you are a **senior physician** member, we hope to see you at our upcoming meeting!*

Join us for our next Zoom meeting where guest speaker, Maureen Nash, MD, MS, FAPA, with Providence ElderPlace will be discussing resilience among older adults.

We hope you can join us!

COST: Free for MSMP members (registration is requested)

TO REGISTER: www.MSMP.org/Events • Janine@MSMP.org

EXPLORE MSMP'S WELLNESS LIBRARY – NEW CONTENT

"Preventing a Parallel Pandemic: A National Strategy to Protect Clinicians' Well-Being"

The COVID-19 pandemic has been compared with Pearl Harbor and Sept. 11 – cataclysmic events that left indelible imprints on the U.S. national psyche. Like the volunteers who flooded into Manhattan after the World Trade Center attacks, the health care providers working on the front lines of the COVID-19 pandemic will be remembered by history as heroes.

These courageous people are risking their lives, threatened not only by exposure to the virus but also by pervasive and deleterious effects on their mental health. Just as the country rallied to care for Sept. 11 first responders who suffered long-term health effects, we must take responsibility for the well-being of clinician first responders to COVID-19 – now and in the long run. This article details the five high-priority actions to protect clinicians' well-being during and after the COVID-19 crisis.

Find this and other new articles when you visit MSMP's redesigned Wellness Library: www.MSMP.org/Wellness-Library

Keywords for this article: **COVID-19, Well-Being**



Support MMFO when you shop at Fred Meyer and Amazon

It is the mission of Metropolitan Medical Foundation of Oregon (MMFO) to support activities which improve health education and the delivery of health care to the community. We believe that small grants can make a big difference. As a small foundation with limited assets, MMFO joined Fred Meyer Community Rewards and AmazonSmile. These programs donate to your favorite charitable organization each time you shop, giving a percentage of your spending to MMFO. **These programs are at no cost to you and do not affect any rebates you are receiving.**

MMFO currently has just five subscribers, and each quarter we earn roughly \$35–\$50 from these two programs. Just imagine if we had 50 or 100 subscribers supporting MMFO through these programs. Those quarterly donations could equal one mini-grant! **Will you please help us?**

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➔ **Fred Meyer:** Visit FredMeyer.com/CommunityRewards to sign up. Search for "Metropolitan Medical Foundation of Oregon" by name or use *non-profit #BH007*.

➔ **Amazon:** Shop at Smile.Amazon.com, and when you check out, simply search for "Metropolitan Medical Foundation of Oregon" by name.

Create a culture of dialogue

Listening is a great skill, used by all but rarely perfected. [Oscar Trimboli](#) does a brilliant job at uncovering and teaching the importance and power of listening. Yet, when does deep listening become *tacit agreement*?

Can we support and empathize and simultaneously respectfully challenge and offer an alternative perspective? What gets in the way of honest feedback? Many times, we say we are listening to “support,” but actually we are fearful to engage despite the consequences of silence. How does this response affect the integrity and growth of our team? How often does our silence infer false agreement?

Great leadership creates a space for dialogue, humbleness and challenging conversation. Curiosity to step beyond our comfort zone and partner with another’s wisdom.

Two elements create a culture of successful dialogue:

1. Deeply listening in a supportive way
2. Creating a safe culture for others to respond

I would argue that excellent listening does not have the same impact for change *unless* it is coupled with the invitation for subsequent dialogue.

Listening deeply

Have you recognized the importance of listening – of putting your agenda second and welcoming the insight of others? Are you genuinely open for discussion and debate, or are you listening to react and respond in an effort to impose your will?

Ideas to consider

1. “Am I listening to learn or listening to respond?”
2. Get comfortable with silence: prior to responding, **wait a full three seconds**. Allowing silence not only helps the speaker’s message sink in, but it also invites them to clarify an idea and add additional insight or depth to the discussion.

This article in [The Harvard Business Review](#) suggests the speaker elicit feedback from the listener by asking:

- “How did it feel to hear this message?”
- “How could I have presented it more effectively?”

These open-ended types of questions require the speaker to remain vulnerable, be open to suggestions, and engage the listener to challenge and actively participate – not tacitly agree!

Creating a safe culture

[Amy Edmondson](#), an author and Novartis Professor of Leadership and Management at Harvard Business School, researched the concept of “psychological safety.” She found that the highest performing medical teams had integrated trust and honest feedback, and approached conflict as a challenge rather than a threat. These teams welcomed adversity, talked about mistakes and leaned into the challenge of collaboration rather than passive listening.

My challenge to you

- When having important conversations, are you open to and asking for feedback?
- Have you created a culture that invites honest dialogue without fear of retribution?
- Are you able to separate ego from the greater good of the team and risk finding your blind spot? ■



Coach's Corner

By Shandy Welch, FNP

To reach Shandy Welch with topic ideas for this column or for assistance through MSMP's Physician Wellness Program, please email shandywelch@gmail.com.

Her weekly newsletter can be found at www.fresheyes.solutions.

She also can be contacted at 971-645-8211.

OHP ENROLLMENT, from page 1

the release of the secretary of state’s audit report in September, titled “Chronic and Systemic Issues in Oregon’s Mental Health Treatment System Leave Children and Their Families in Crisis.”

The audit found that the state’s mental health treatment system has “systemic issues that limit the state’s ability to meet the ever-growing needs of Oregonians. Auditors found Oregon’s behavioral health system for children is in crisis and failing to serve children, youth and families who are involved with multiple systems and have complex needs.”

It said the Oregon Health Authority lacks having “a documented strategic plan in place for addressing challenges identified in reports reaching back almost two decades. These challenges include: data limitations, system fragmentation, workforce capacity challenges, county oversight and unclear statutes, which inhibit the agency from making meaningful strides to improve mental health outcomes, particularly for children and youth. As

mental health issues will likely be exacerbated by the COVID-19 pandemic, and the agency faces pandemic-related budget cuts, it is imperative these critical services not be overlooked.”

“After decades of reports reiterating common flaws in the mental health system, it’s clear that it continues to fail in adequately serving some of our most vulnerable Oregonians,” said Secretary of State Bev Clarno. “The mental health system needs significant improvement, but it must be a coordinated effort across state agencies, coordinated care organizations and counties.”

The report specified, though, that the majority of work on the report was completed before the COVID-19 pandemic began to take effect: “The Audits Division recognizes that the pandemic creates substantial challenges for OHA and will affect the agency’s ability to respond to this report’s findings and recommendations.”

Allen welcomed and agreed with the audit’s findings, and said the state has its work cut out for it in trying to address them. He cited as particular

“The mental health system needs significant improvement, **but it must be a coordinated effort** across state agencies, coordinated care organizations and counties.”

– Secretary of State Bev Clarno

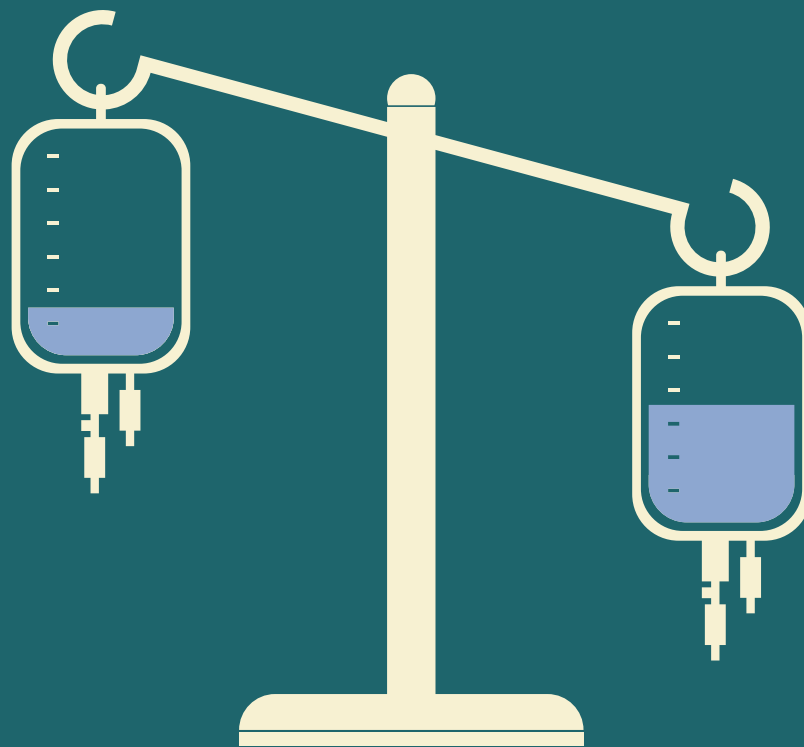
challenges the “complexity of access,” and the fact that “these services aren’t responsive enough – we don’t know if the services being provided are meaningful” to clients’ health.

“We need to have a better integrated health care system,” incorporating behavioral health services within the primary care setting, Allen emphasized. Mental health and substance use disorders have been treated as “an island to itself. We can’t live in that world anymore.” ■

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Donations support health care providers, families impacted by wildfires

Hospitals and their partners have come together to support health care workers, caregivers and families impacted by the recent wildfires.

The non-profit Oregon Association of Hospitals Research and Education Foundation (OREF) said in September it launched the Health Care Heroes Relief Fund to aid more than 100 Oregon health care workers.

In addition, with hundreds of caregivers displaced due to wildfires, **Providence St. Joseph Health** said it was awarding \$100,000 to Oregon relief agencies and not-for-profit organizations involved with disaster response.

“As fires rage across Oregon, dozens of front-line health care workers have lost their homes and their cherished belongings. Our health care heroes are there for us when we need them most. Now they need our help to stay safe and get back on their feet,” said Becky Hultberg, president and CEO of the **Oregon Association of Hospitals and Health Systems (OAHHS)**.

The Health Care Heroes Relief Fund will support Oregon hospital workers who are victims of this disaster, or who become victims of these fires or future state or federally declared disasters.

“By donating to the OREF Health

Care Heroes Relief Fund, you can help ensure displaced health care workers have access to shelter, clothing, and other essential items, and begin to help them get back what the fires took away,” Hultberg said.

All donations to the fund will be tax deductible as allowed under law. To donate, visit www.orhealthfund.org, or make checks payable to OREF Health Care Heroes Relief Fund.

OREF, established in 1989 by OAHHS, studies health care-related activities including quality patient care, operational efficiencies, cost containment, problems in rural areas, and alternative delivery methods for hospitals and related health care services. The foundation develops qualified financial resources to carry out related programs that assist OAHHS, its members and the public.

Meanwhile, Providence said that in the Portland area, \$50,000 will be split equally between the Clackamas County Service Center, Canby Center, El Programa Hispano and NW Housing Alternatives. Another \$50,000 will go to relief response in Southern Oregon and will be split equally between Medford St. Vincent de Paul and the Southern Oregon United Way Fire Relief Fund.

More than 700 Providence caregivers in Oregon were level 3 evacuated

from their homes in early September and at that point at least 30 had lost their homes, Providence said. More than 200 remained displaced.

“This has been an extremely challenging year,” said Lisa Vance, chief executive of **Providence Oregon**. “I know everyone joins me in keeping all of the people in our communities and also our caregivers in your thoughts and prayers during this very difficult time in Oregon.”

Providence Foundation’s Helping Hand fund provides financial support for caregivers during challenging times. Anyone wishing to make a contribution to the fund can do so at Helping Hand fund.

In addition to the efforts above, **Oregon Health & Science University** and its community partners collected donations of in-kind donations and gift cards aimed to help families impacted by the fires in Talent and Phoenix, in southern Oregon.

The donations, distributed to more than 500 adults and children during a late September event held in the Medford/Jackson County Chamber of Commerce parking lot, ranged from clothing, shoes, toys and supplies to services such as haircuts. Families who needed them also were connected to mental health, legal and other resources, according to OHSU’s website.

Leslie Garcia, assistant chief diversity officer in the OHSU School of Medicine, took the lead in collecting for the Oregon Latino/x Leadership Network and the League of United Latin American Citizens, Oregon Chapter, OHSU said. Others involved in the effort included Rocio Pozo

Santa Cruz, OHSU Latinos Unidos Employee Resource Group co-chair and an administrative coordinator at the Unity Center for Behavioral Health; Verian Wedeking, outreach program administrator for the Casey Eye Institute; Cathy Villagomez, administrative director in the OHSU School of Medicine Dean’s Office;



Joanna Chadd, an OHSU School of Nursing research assistant, and dozens of other Portland and Medford volunteers.

The OHSU School of Medicine Physician Assistant Program raised \$1,000 for families; OHSU Health Services reached out to vulnerable patients; the School of Nursing and OHSU Foundation quickly helped a half dozen students who lost their homes to the fires; and Garcia tapped Latinos Unidos at OHSU, dean’s office colleagues, the Latino Medical Student Association, nonprofits, companies and the community, the university said. The Casey Eye Institute equipped the event with COVID-19 precautions.

“These are hardworking families, families who propel Oregon’s economy, families already hard hit by COVID and now the ground beneath their feet is ash,” Garcia said. “We knew they needed – and they deserved – support. So much need for cultural understanding and compassion. Some lost their identification, birth certificates and others don’t qualify for federal disaster aid. I knew we as a collective could help.”

Donations are being accepted by the League of United Latin American Citizens Wildfire Relief Fund and the MRG Foundation Rogue Valley Wildlife Relief Fund. ■



LEFT: Leslie Garcia of OHSU, who helped organize a drive in Southern Oregon to help families impacted by the wildfires, helps Moises Reyes with donated clothes and diapers for his infant twins.

ABOVE: Adidas donated 300 pairs of tennis shoes to help people who lost their belongings during recent wildfires.

Photos courtesy of OHSU



COVID-19 is changing liability risks, litigation in health care

By Bill Fleming

The Doctors Company

Across the spectrum of care, health care delivery is changing as the COVID-19 pandemic continues, creating additional pressures to maintain patient safety and shaping new liability risks for hospitals, group practices and solo physicians.

Understanding how these new risk exposures are unfolding – and how adverse events may be litigated in a courtroom environment also under strain – is the first step to taking protective measures. Mr. Fleming offers his expert insights:

What kinds of lawsuits do you expect to see linked to the COVID-19 pandemic?

Extraordinary circumstances and a steady stream of directives (and revisions thereto) from state and local governments have pressed physicians, practices and hospitals to practice medicine in ways they never have before – or to not practice medicine, when certain elective forms of care have been suspended by government action, often to conserve personal protective equipment (PPE) and other resources. In spite of reasonable efforts under difficult conditions, it's likely that some adverse events will be traced to this time.

It is important to note that "elective" in this context does not mean unnecessary or optional. It includes important screening and diagnostic procedures such as colonoscopies, some cancer and cardiac surgeries, and most dental procedures. Delay of elective procedures may be a source of increased litigation – many biopsies for cancer, for instance, have lately been delayed, and delay in diagnosis was already one of the most expensive areas of litigation pre-COVID-19.

Other delays in care may be linked to access issues. Telemedicine has been a lifesaver for many during this crisis, but some vulnerable patients may lack access. Infrastructure can also present a barrier to telemedicine care, as some do not have sufficient internet bandwidth for video visits.

Moreover, circumstances have forced physicians to use telemedicine in ways they usually might not. Telemedicine is ideally an adjunct to in-person care, and therefore not the best option for a first visit with a new patient, but during peak infection risk, exceptions had to be made.

Among our infrequent telemedicine claims pre-COVID-19, misdiagnosis of cancer was the top allegation, and I can't imagine that risk of misdiagnosis has decreased, given the spike in telemedicine usage under nonoptimal conditions.

Also, I anticipate that some COVID-19-related cases will focus on shortages of PPE – those claims may come from patients or employees.

As you've said, providers are delivering care differently during COVID-19. How do these changes diminish or increase risks?

In the crush of managing a public health crisis, many hospitals and practices have had to take temporary measures that impact patient safety: Some of these measures mitigate certain risks but may amplify others.

Health care providers in hard-hit areas are working longer hours, sometimes with insufficient PPE, sometimes in large tents put up in parking lots or other overflow sites. In surge locations, staff from other departments may be covering in the emergency department (ED) or intensive care unit (ICU) – this could increase the risk of communication gaps. All of these resource-stretching measures, taken together, may add up to a risk profile that is more than the sum of their parts.

While responding to health directives from state and local governments, as well as advisories from the Centers for Disease Control and Prevention (CDC) and other trusted sources, hospitals and practices will continue to experience unavoidable delays in treatment to all patients. Testing delays do not help.

In addition, by patient preference, many routine checkups and tests have been delayed, not to mention routine procedures. Adverse events linked to these delays could affect physician liability.

What can physicians and practices do to protect themselves during the pandemic?

Conscientious documentation becomes a witness for the physician in the courtroom. In the COVID-19 era, practices may benefit from documenting not only individual patient interactions, but how the practice is following CDC infection control guidelines and recommendations from state and local health authorities at particular points in time. This could be as simple as jotting a daily note in an electronic calendar.

How are courtroom changes during the pandemic challenging defense teams?

In a recent medical malpractice suit, a physician member of The Doctors Company, with assistance of counsel and The Doctors Company's support, secured a defense verdict despite many changes in the courtroom environment that could have posed problems if we had not been prepared to adjust.

We've seen firsthand how physicians facing a court hearing during COVID-19 need a legal team that is prepared for changes in depositions, jury selection and the trial itself. For instance, depositions may be completed by video, with multiple screens for the attorneys, parties and exhibits, and jury selection may take place partly via written

communication. During trial, showing evidence must be done differently, so defense teams need solid technology skills in settings where counsel can publish exhibits to the jury using large screens.

Some courts are taking 15-minute breaks every hour for better ventilation and cleaning. This breaks the momentum when an attorney is speaking with a witness, reduces the overall trial time per day, and prolongs the trial duration. Taking time out of a practice to participate in an extended trial can further stress a stretched practice.

Litigation stress places a burden on physicians at any time. How is this different during the pandemic?

Individual trials are taking longer, compounding delays from the existing backlog. This keeps physicians in limbo – and could even affect their credentialing. As previously reported by RAND, pre-pandemic, on average, physicians were already spending more than 10 percent of their careers living under the shadow of an open malpractice claim.

It is true that at any time, even the best of physicians could find themselves facing an unexpected lawsuit. And states around the country handle cases differently. That's why our members are supported by legal teams with deep roots and expertise in members' local venues. In addition, knowing that the stress of malpractice litigation affects physicians deeply, and knowing that preparation is the key to victory, we support our members through in-depth litigation preparation.

Like the COVID-19 pandemic itself, pandemic-related risk exposures are fluid. Physicians, practices, hospitals and systems are facing rapid changes in liability exposures at the same time as the day-to-day business of health care is changing under their feet. The Doctors Company is prepared to assist our members through lawsuits during these unprecedented times so that, even with changes in the courtroom, members can present their best defense. ■

Bill Fleming is chief operating officer with The Doctors Company.

For more resources and information from The Doctors Company, please visit www.thedoctors.com.

The guidelines suggested here are not rules, do not constitute legal advice and do not ensure a successful outcome. The ultimate decision regarding the appropriateness of any treatment must be made by each health care provider considering the circumstances of the individual situation and in accordance with the laws of the jurisdiction in which the care is rendered.

Antwon Chavis, MD, works with young patients to develop healthy habits early in life

By Melody Finnemore
For The Scribe

Antwon Chavis, MD, distinctly remembers when he decided he wanted to become a doctor. It was in his childhood after his older brother, now 36, was diagnosed with autism. Public awareness about autism was not as widespread as it is today, and the diagnosis and health care that followed had an indelible impact on Chavis.



"I remember thinking, 'When I grow up, I want to be a doctor.' I like helping people and making a difference and making people feel better," he said.

Chavis credits his parents with teaching him how to care for both special needs and typically developing children throughout various stages of childhood, instilling in him the importance of patience, the value of every accomplishment and bringing out the best in others.

An Iowa native who grew up in an Air Force family, Chavis earned a degree in psychology at Iowa State University and, in 2013, a medical degree from Meharry Medical College in Nashville, Tenn. As he considered where he wanted to complete his residency, Chavis decided he wanted to

go to a city he'd never been to before. He chose Oregon Health & Science University in part because he knew Portland would be welcoming to him as a gay man.

Now a pediatrician at Doernbecher Pediatrics Clinic, Chavis said he appreciates the opportunity to inspire children and families about adopting good health habits. He also enjoys working with kids because it allows him to form special relationships with families while having a positive effect on the health and safety of the community.

"Every day is a little different. I like going in and seeing a baby born to a first-time parent and providing support to them, and also adolescents who are taking over their own health care and want to know how to stay healthy," he said. "Plus, I get to hang out with kids all day."

In conversations with families during the COVID-19 pandemic, Chavis has encountered many parents hungry to learn about how to provide adequate distance learning, and he said COVID-19 has created a lot of good conversation about health and illness prevention that extends to other illnesses and influenza, vaccines and hand hygiene.

'A brave advocate can change the world'

He said families are also talking about how to raise children who are advocates for other races, particularly since parents are spending more time with their children now and there is a lot of thought around making the most of that time.

Antwon Chavis, MD, and his partner, Nate, are foster parents to a 5-year-old daughter, whom they began fostering when she was 2. Chavis says fostering represents "something I could contribute to the community and to Portland." Photos courtesy of Antwon Chavis, MD



"The BLM movement is personally important to me, so I make sure to ask all families about their experiences," Chavis said. "For infants and toddlers I ask about 'playroom diversity.' Do their dolls look like them? Are the protagonists in their books both boys and girls? Children can recognize different races very early, and we should expose them to as many different races as we can as they are also learning the difference between 'right and wrong.'"

Chavis also noted that kids should see black and brown characters being superheroes, moms and dads, "and adventurous kids getting into shenanigans. Older kids and teens should learn how to be activists when they see people in their environment being treated unfairly. Minority teens should learn how and when to stand up for themselves. All teens should know how and when to protest, and who in their lives they can turn to if they see unfair treatment. A child of any race who learns to become a brave advocate can change the world."

Another dynamic to arise during the pandemic is that both families and providers are seeing the use and convenience of virtual medicine. He foresees improvements to the services and resources provided to patients, and that providers need to learn how to best utilize those because telehealth and virtual medicine aren't likely going away anytime soon.

Also an assistant professor of pediatrics in OHSU's School of Medicine, Chavis said teaching allows him to help develop new providers who are good with families. "I want them to know the right answers or where to find them, but if they can't calm an anxious family or scared child then we have work to do. Google knows all the right answers, but no one wants Google as their doctor," he said.

His work has also impacted his personal life. Chavis and his partner, Nate, are foster parents to a 5-year-old daughter and began fostering her when she was 2.

"In pediatrics we see all sorts of kids who bounce around different homes and we learn about their trauma, so we wanted to be a stable place for them to land," he said. "I always thought about being a parent, but fostering made more sense as something I could contribute to the community and to Portland."

The Chavis family also has what Antwon Chavis describes as two "obese cats who hate their new diets." In addition, the family is fostering two kittens. When he's not herding cats, Chavis likes to crank up the headphones and listen to hip-hop music, enjoy concerts and other shows, travel and hike. ■



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"All pain is real, and all pain is an output of the brain and nervous system and affected by an integrated super-system. The treatment of pain is the treatment of the entire person ...

If we treat the whole person in front of us, we should see all pain as real, and biases begin to melt away as we work with our patients to understand their experience."

— Nora Stern, MS, PT

Oregon Pain Management Commission chair and director of Portland's Know About Pain



Better understanding of gender differences should improve pain treatment, experts say

By Cliff Collins
For *The Scribe*

The question of whether or why women experience pain differently than men remains open, but finding the answer could help clinicians treat all patients more equitably.

That's the conclusion of the authors of several studies that have examined whether bias exists in the medical field in regard to female patients who report chronic pain.

Some studies of gender differences in experiencing pain found that women tend to feel pain more of the time and more intensely than men.

"Although the specific etiological basis underlying these sex differences is unknown, it seems inevitable that multiple biological and psychosocial processes are contributing factors," according to a 2013 study in the *British Journal of Anaesthesia*. "Recent years have witnessed substantially increased research regarding sex differences in pain. The expansive body of literature in this area clearly suggests that men and women differ in their responses to pain, with increased pain sensitivity and risk for clinical pain commonly being

observed among women."

In a 2012 study published in the *Journal of Pain*, researchers studied data from more than 11,000 patients whose pain scores were recorded in electronic medical records at Stanford Hospital and Clinics between 2007 and 2010. They asked patients to rate their pain on a scale of 0 to 10, assessing sex differences for more than 250 diseases and how the genders perceived those. "For almost every diagnosis, women reported higher average pain scores than men. Women's scores were, on average, 20 percent higher than men's scores," according to the study as reported in *Scientific American*.



NORA STERN,
MS, PT,

Clinicians were taught for years that pain is a result of damage to tissue, said **Nora Stern, MS, PT**, who chairs the Oregon Pain Management Commission and is director of Know About Pain, a pain consultation and education company in Portland.

"Pain was thought to be purely related to tissue injury, (perceived

by the) pain receptors in the brain," she explained. That orientation led clinicians to believe that there is "real pain," but also patients whose pain is imagined or psychosomatic. "The bias comes" in separating the emotional side of pain and the physical, when both "physical and emotional are part of pain. It's inappropriate and poor practice to separate them."

Many women's pain is dismissed because of that, Stern said. "You should never dismiss the emotional" aspect, because the pain experience "warrants a full evaluation.

Sometimes it is related to injury and sometimes not. What I would emphasize when looking at the concept of bias is to understand that pain is a multifactorial experience."

According to an article in *Consumer Reports*, evidence shows that women's pain is also often less thoroughly investigated, especially initially, when the cause of pain is unknown: A 2008 study of nearly 1,000 patients in an urban emergency room found that women waited an average of 16 minutes longer than men to get medication when reporting abdominal pain



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and were less likely to receive it.

If clinicians approach a patient with complex pain solely from “a biomedical perspective,” they may be “frustrated by the lack of findings and could dismiss the person living with pain as having less legitimacy,” Stern said.

“Some research suggests that more women (than men) have chronic pain. Do they have more pain, or do they go to the doctor more and get diagnosed more?” asked **Kimberly M. Mauer, MD**, medical director of Oregon Health & Science University’s Comprehensive Pain Center and an associate professor of anesthesiology and perioperative medicine. “I don’t know if they truly have more pain or go to the doctor more often.”

OHSU’s pain center sees more female than male patients, but as Stern pointed out, more women than men seek health care in general. The most common conditions seen at Mauer’s center are low-back pain and fibromyalgia.

“Fibromyalgia has been accepted as a diagnosis that can be treated,” Mauer said. “I’m glad, because it affects a lot of people. It did take a while for it to get accepted.”

Pain experts now generally believe that pain is in fact a “biopsychosocial experience based on actual or perceived threat,” Stern said. “However, practice change takes time, and it is still common for clinicians, perhaps unintentionally, to dismiss pain experiences that cannot be explained by testing and radiological studies, such as fibromyalgia, a condition more common in women. This condition is now seen as a complex pain experience which is centrally mediated, or centrally sensitized, and is better understood and better treated through a biopsychosocial lens.”

In a paper in the journal *Pain Research and Management*, researchers did a literature search of 77 pertinent articles relating to research on sex differences for pain. They found “there is a lack of knowledge about the influence of gender in the patient-provider encounter. Women dominate most

diagnoses related to chronic pain, and research has consistently shown differences between the sexes, like the perception, description and expression of pain, the use of coping strategies, and the benefit of different treatments. There are convincing findings that biological differences contribute to the observed sex differences,” including both genetic and hormonal factors.

The article, titled “‘Brave Men’ and ‘Emotional Women’: A Theory-Guided Literature Review on Gender Bias in Health Care and Gendered Norms towards Patients with Chronic Pain,” showed that “studies have found that women’s pain responses are affected by menstrual cycle, pregnancy and oral contraceptive use, which confirms that hormones are related to pain response. In addition, the response to opioid receptor antagonists may generate a difference between men’s and women’s experiences of pain. However, more research is needed to fully understand the underlying biological mechanisms.”

The paper added that psychosocial factors also have been identified as explanations for sex differences.

“Men are more stoic,” said Mauer, or at least that is the general societal perception.

“Awareness about gendered norms is important,” the Pain Research and Management study concluded, “both in research and clinical practice, in order to counteract gender bias in health care and to support health-care professionals in providing more equitable care that is more capable to meet the need of all patients, men and women.”

“All pain is real, and all pain is an output of the brain and nervous system and affected by an integrated super-system,” Stern said. “The treatment of pain is the treatment of the entire person, and our job as clinicians is to be detectives with the patient, and to move towards greater function and greater self-efficacy. If we treat the whole person in front of us, we should see all pain as real, and biases begin to melt away as we work with our patients to understand their experience.” ■

IBS affects more women than men; treatments highly individualized

Irritable bowel syndrome (IBS) affects up to one in five women, and young women are most likely to experience it. Stephanie Gapper, RN, a nurse at Oregon Health & Science University’s Digestive Health Center, shares insights about IBS – the condition caused by a change in gut-brain communication – and managing it.

Is IBS different for women?

We know it affects more women than men; about twice as many women. Some women have more IBS symptoms at the beginning of their period each cycle, due to hormonal changes. IBS with constipation, or with alternating constipation and diarrhea, is more common in women than in men.

How is IBS diagnosed?

People with IBS can be frustrated with this process. They continue to have symptoms, but tests, like colonoscopy or MRI, show that everything is normal. This doesn’t mean that IBS is a “diagnosis of exclusion,” (a diagnosis given when every other possible cause isn’t the answer) though! IBS is caused by a change in the brain-gut connection, not by visible problems in the body. To be diagnosed with IBS, you must have abdominal pain at least once a week, on average, accompanied by a change in frequency or appearance of your stool.

IBS and IBD are similar acronyms. How different are they?

They cause some similar symptoms, like abdominal pain and changes in bowel movements, but the underlying causes are very different.

IBD is inflammatory bowel disease. This is an autoimmune disease – the immune system is attacking the gastrointestinal tract. The treatments for IBD are also very different.

How is IBS treated?

Treatment of IBS is very individualized, and depends on your symptoms. Common treatments include looking at how to reduce stress, dietary changes, cognitive behavioral therapy and medication.

Keeping a food diary can help you determine if your body is sensitive to certain foods. IBS is not a food allergy, but specific foods can often trigger IBS symptoms. A low FODMAP diet is often helpful for IBS patients. It limits certain types of carbohydrates that can be harder to digest, leading to symptoms.

The full version of this Q&A originally appeared on the OHSU Center for Women’s Health website.

MSMP MEMBER EXCLUSIVE

Don’t miss this article!

Oregon voters will decide next month whether the state should create a program to allow licensed service providers to administer psilocybin-producing mushroom and fungi products to adults 21 and older. This month’s Members Only feature delves into supporters’ and opponents’ positions surrounding Measure 109.

To read more, please visit www.MSMP.org/MembersOnly.





“I was very fortunate to have access to excellent medical care, but many people aren’t as lucky. **It’s extremely satisfying for me to be able to share my story and to help and inspire women** so they can be the greatest advocates for their own health and well-being.”

– Nandita Gupta, MD, FACC

Medical journey inspires career

A heart-surgery patient as a child, cardiologist becomes a physician-researcher-healer, women’s health advocate

By John Rumler
For The Scribe

Heart disease is by far the leading cause of death among women, according to the American Heart Association, claiming the life of one in three women. Every 80 seconds a woman in the United States dies of some form of heart disease, with about 400,000 lives lost annually.

Working feverishly to improve these disturbing statistics is **Nandita Gupta, MD, FACC**, who was born in Delhi, India, with a congenital heart defect.

“The majority of those women who die are wholly unaware that they are at risk for heart failure,” Gupta says. “Sadly, 80 percent of the deaths are preventable.”

When she was 8 years old, Gupta underwent corrective surgery to repair a hole in her heart. While recovering for several weeks in the intensive care unit, she became so inspired and impressed by her physicians and entire medical team that she decided to become not only a doctor, but also a cardiologist.

In January 2020, Gupta, an assistant professor of cardiology at the **OHSU Knight Cardiovascular Institute**, became the medical director of newly launched Cardiovascular Services at OHSU Health Hillsboro Medical Center, formerly Tuality Healthcare. She also sees patients at the OHSU Center for Women’s Health (CWH) on Marquam Hill, one of only 11 “Centers of Excellence” in the nation, an honor bestowed by the U.S. Department of Health and Human Services.

CWH Director Johanna Warren, MD, says Gupta is a humble and quiet person and a great collaborator who works diligently to improve the health and well-being of her patients.

“Dr. Gupta is incredibly passionate about women’s health. It is personal with her. She is also so versatile and multitalented she can notice something in the clinic, take it to the lab and then take it back to the patient.”

Gupta began medical school while still in her teens and graduated with a medical degree from the University of Delhi. She moved to the United States in 1998 to complete an internship and residency at Albert Einstein College of Medicine in New York.

With many options open to her, Gupta came to OHSU on a cardiology fellowship. “My husband (also a cardiologist) and I thought Oregon would be an ideal place to raise a family, plus we were attracted by the excellent reputation of OHSU’s cardiology department.”

Board certified in internal medicine, general cardiology, echocardiography and nuclear cardiology, Gupta has published science/research papers and abstracts exploring gender differences in heart disease. She has presented her findings to national

audiences such as the American Heart Association (Role of Epoxyeicosatrienoic Acids in Syndrome X in Women, 2011).

Gupta also served as the chair of Oregon’s chapter of Women in Cardiology in 2015–’16, and was named a Top Doctor in *Portland Monthly* magazine for 2019–2020.

Building awareness

“Everything changes when you’re having a baby, including your heart and blood circulation,” Gupta says. “The changes are so consequential that medical experts see pregnancy as a stress test as there are a lot of new demands on your body during pregnancy.”

While a complication-free pregnancy and birth shows that a woman’s body can pass that stress test, problems such as gestational diabetes, preeclampsia and premature birth are warning signs, explains Gupta.

“If you have any type of adverse pregnancy conditions, you are more at risk for heart disease or a cardiac event 10 or 20 years down the road.”

Some of the problems that Gupta pointed out include preeclampsia, which affects 5 percent of pregnant women; and gestational diabetes, which up to 10 percent of pregnant women have. More than 10 percent of infants in the United States are born too early, she says.

“Depending on how severe your condition is in pregnancy, your risk of heart disease may double, triple or even quadruple. Many women who’ve experienced heart attacks in their forties and fifties had early warning signs that were overlooked or ignored.”

Unfortunately, the connection between problems in pregnancy and heart disease risk later in life is, to a large degree, still under the radar. “Most women and even many pregnancy care providers are unaware of this,” Gupta says, “so they fail to refer their patients who’ve had these problems to a cardiologist.”

Gupta is steadily building awareness in several ways, including through her research on gender differences in cardiac pathology, with the American Heart Association’s Go Red for Women movement (the American Heart Association’s initiative to increase women’s heart health awareness) and through the Women’s Heart Program (WHP), a clinic at the OHSU Center for Women’s Health that she reopened last month, where she collaborates with pregnancy caregivers and other women’s health care providers.

The clinic, which serves all women’s cardiac care needs, not just pregnant or postpartum patients, is a reincarnation of a similar clinic at the center that was directed by Shimoli Shah, MD, but was interrupted when Shah departed OHSU to join the Mayo Clinic.

A large segment of the public is unaware that heart disease is different for women than it is for men, with

the differences extending to symptoms, risks and outcomes, says Gupta.

The WHP provides patients with woman-centered cardiovascular care, which is part of the CWH's overarching goal to provide comprehensive women's health care under one roof. It is targeted at women who have, or are at risk for, heart disease, including those who've had an adverse pregnancy outcome, gestational diabetes mellitus, preterm birth, preeclampsia, and/or women with other risk factors such as high blood pressure or diabetes. The WHP can assess heart risk, monitor it on an ongoing basis, and help patients with prevention/treatment plans.

"Addressing and identifying postpartum risks is a major focus of the clinic because adverse pregnancy outcomes have such a huge impact on a woman's short- and long-term risk of cardiac events," Gupta says.

The WHP is mainly a health care clinic, but Gupta is also helping to lead and promote the local chapter of Mended Hearts, a woman-centered survivorship program offering peer-to-peer mentoring, advice and support since 2016.

Executive director of the American Heart Association Oregon & Southwest Washington, Leslie McCall met Gupta several years ago at an OHSU Go Red for Women event, where Gupta moderated a panel discussion.

McCall says she was immediately struck by how personable Gupta was and how passionate she was about women's health. "I knew right away that she'd be a great advocate for Go Red for Women. Dr. Gupta's passion for women's heart health is extraordinary," McCall says. "She gives so freely of her time to volunteer with

us, which is a testament to her personal commitment to improving women's health."

Gupta, now a member of the local Go Red for Women executive leadership team, frequently speaks at regional American Heart Association events, helping to raise awareness and providing education about heart health.

The president of OHSU Health Hillsboro Medical Center, Lori James-Nielsen, RN, BSN, MHA, met Gupta about 18 months ago when she was in conversations with OHSU about finding a medical director and leader for its cardiovascular service line.

"We needed someone to help us build a world-class cardiac program at Hillsboro Medical Center," James-Nielsen says. "Dr. Gupta's vision to build a state-of-the-art, patient-centered program with a special focus on women and heart disease was exactly what we were looking for. She brings a passion to patient care and excellence in service that is unparalleled."

After a career in medicine spanning nearly a quarter of a century, it is clear that the heart defect, surgery and recovery that lit a fire under Gupta so many years ago is burning stronger than ever.

Even while balancing multiple medical duties, conducting research, volunteering, working on a health care MBA and raising two sons, she is fully focused and totally committed to her mission.

"I want to give back," says Gupta. "I was very fortunate to have access to excellent medical care, but many people aren't as lucky. It's extremely satisfying for me to be able to share my story and to help and inspire women so they can be the greatest advocates for their own health and well-being." ■

“Dr. Gupta is incredibly passionate about women’s health.

It is personal with her.

She is also so versatile and multitalented she can notice something in the clinic, take it to the lab and then take it back to the patient.”

– *Johanna Warren, MD, director of the OHSU Center for Women's Health*

Study: ADHD risk may be linked to inflammation during pregnancy

A unique, new study by Oregon Health & Science University's Center for ADHD Research outlines a potential candidate marker of attention-deficit/hyperactive disorder risk.

In what OHSU called a first-of-its-kind study in humans, OHSU investigators reported that maternal inflammation, measured by higher levels of prenatal cytokines, or small proteins that aid the immune system, during the third trimester of pregnancy, may be associated with elevated ADHD symptoms in children between 4 and 6 years old.



HANNA GUSTAFSSON, PHD

"This finding is promising, and may be the first step to opening the door for low-cost prevention for children at risk for ADHD," said **Hanna Gustafsson, PhD**, an assistant professor of psychiatry in the OHSU School of Medicine and the study's lead author.

The study was published online in the journal *Brain, Behavior and Immunity*. OHSU noted that more than 6 million U.S. children and adolescents have been diagnosed with ADHD, according to the Centers for Disease Control and Prevention.

OHSU researchers monitored 68 children from 62 women from the second trimester of pregnancy until the child was 4 to 6 years old. At 24 and 37 weeks of gestation, the women provided a blood sample to measure inflammation markers, and completed questionnaires to assess mood and stress level. Subsequent postnatal surveys and interviews, completed by the women as well as school teachers of their children, rated child behavior and clinical symptoms of ADHD. Overall reported data supports the team's hypothesis that cytokines are one pathway through which maternal prenatal distress may influence child behavioral risk.

Gustafsson cautioned that the effect is not likely to be confined to ADHD as the only outcome and that repeating the study with more participants will be necessary to further confirm the team's preliminary yet intriguing results.

"In the future, if these results hold, the exciting possibility is that a simple blood test obtained from expectant mothers may be able to help predict whether their unborn child will be at risk for ADHD several years later," she said. "It may also suggest that safe anti-inflammatory treatments, administered to women during pregnancy, may help to limit a child's risk for long-term developmental disability, even before they are born." ■





Three grants expand large genetic testing study at Kaiser research center

Three new grants will fund studies at the **Kaiser Permanente Center for Health Research (CHR)**, expanding a large genetic testing study called Cancer Health Assessments Reaching Many, or CHARM.

CHARM is a nearly \$11 million, four-year study that seeks to understand what health systems can do to ensure equity of access to genetic testing and counseling among all patients. More than 800 patients in Portland and Denver who are diverse in race, ethnicity, income, primary language, health literacy and insurance status have been enrolled. The study specifically recruited Spanish speakers, developed culturally tailored and translated materials for them, and provided interpreters for genetic counseling visits.

CHARM is screening healthy adults ages 18 to 49 in primary care clinics to help identify those at risk for Hereditary Breast and Ovarian Cancer (HBOC) syndrome and Lynch syndrome – two hereditary cancer syndromes that lead to an increased risk of breast, ovarian, colon and endometrial cancer. CHARM offers patients screening for these syndromes and, if screening indicates patients are at risk or meet other criteria, they are offered additional genetic services, including exome sequencing, to further assess risk.

The three grants that will expand CHARM are funded by the National Human Genome Research Institute, the National Cancer Institute and the National Institute on Minority Health and Health Disparities.

"When we submitted three supplemental funding requests in May 2019, we were optimistic that at least one of them would get funded. We had no expectation that all three would be awarded," noted **Katrina Goddard, PhD**, co-principal investigator of CHARM and director of CHR's Translational and Applied Genomics Department. "The approval of all of these grants reflects the interest funders

have in genetic testing for hereditary cancer syndromes and the work that the CHARM study is doing to reach patients from minority groups or those with lower levels of education or income."

CHARM is testing several new approaches to screening for hereditary cancer syndromes. One is a web-based risk-assessment tool that asks patients about their personal and family history and can assess risk without an in-person visit. **Kathleen Mittendorf, PhD**, a CHR research associate, is leading a two-year study to evaluate the effectiveness of the risk assessment tool, which was designed for patients of all literacy levels.

Improving identification of risk is important, CHR said, because these hereditary syndromes greatly increase a patient's chance of developing cancer, and diagnosis means patients can be monitored and even receive preventive treatments such as surgery.

Although some exome sequencing is effective for genetic diagnosis, one barrier to its use has been the need to help doctors understand and adopt this technology. Exome sequencing is more complex than standard genetic testing, and its results and methods are more complicated to convey to patients, CHR said.

The second new study will identify ways to improve how patients and their doctors make choices about using exome sequencing. **Elizabeth Liles, MD, MCR**, a Kaiser Permanente Northwest primary care doctor who is board certified in internal medicine, and a CHR investigator on the CHARM team, will lead this study.

Liles will test a web-based tool that helps patients identify their values to see if it helps them decide what results they want to receive from exome sequencing. Although CHARM's main goal is to identify increased cancer risk, screening might also identify risk for other conditions, such as heart disease, which patients may or may not want to

know about.

"We want to know if helping patients identify their own values makes them more selective about the types of results they choose to receive," Liles said.

Exploring barriers

Methods used now to identify patients who should be referred for genetic counseling and testing rely on their knowledge of family history of cancer, including cancer type and the age of onset in close relatives. When patients don't know their family cancer history, it becomes difficult to assess their hereditary cancer risk. This could lead to missed opportunities for life-saving interventions and to share hereditary risks with the patient's family, CHR said. Due to stigma and intolerance that may lead to strained or estranged family relationships, people who identify as lesbian, gay, bisexual, transgender, queer, non-binary or another identity may have limited knowledge of and access to family cancer and other health history information.

The third new study, led by **Jessica Ezzell Hunter, PhD**, a CHR investigator on the CHARM team, will involve interviewing LGBTQ+ individuals to explore their knowledge and experiences, as well as barriers to knowing family cancer information that could lead to health disparities for this group.

The new approaches the CHARM study is testing could enable health care providers and systems to offer genetic screening, testing and counseling to more patients, CHR said. CHARM – involving Denver Health, Kaiser Permanente Colorado, Kaiser Permanente Northwest, Seattle Children's Research Institute, Columbia University, the University of California at San Francisco, Dana Farber Cancer Research Institute, Emory University and the University of Washington – also could provide a model to increase equitable access to genomic services for all patients. ■

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Physician
**Jonathan
Vinson, MD,**
finds thrills through
competitive cycling

By Jon Bell
For The Scribe

It might be hard to picture these days, but there was a time not all that long ago when the streets of downtown Portland around the North Park Blocks would be cordoned off and closed to traffic. Thousands of cheering spectators would line the sidewalks on either side. And then, scores of speeding cyclists would come racing around the corner in a blurred streak of pedaling fury, one after another – zip, zip, zip – and then they'd be gone. Until they came back around on another half-mile lap, and then they'd rip by once again.

Over and over it went until, after usually a few crashes, some dropouts and a couple disqualifications, one rider would cross the finish line and take the crown.

The race was known as the Portland Twilight Criterium. It attracted some of the fastest pro riders from around the country – one year saw a prize pot worth \$10,000 – as well as a tier of riders who may not have been professionals, but who were competitive and fast nonetheless. Among those latter riders was **Jonathan Vinson, MD**, a specialist in family medicine obstetrics at Providence Medical Group–Lloyd Center.

“That was an amazing race that would attract national-level racers,” he said. “It was really big. There were tons of spectators, it was at dusk, it was really fast. It was even a little dangerous. I just loved it.”

The Portland Twilight Criterium hasn't been run in recent years. Vinson, too, has seen his competitive racing days dwindle a bit after a good 10-year run between 2005 and 2015, thanks largely to the busy life of a physician and family man who's also a flight surgeon in the Oregon Air National Guard. But he still dons a race number and saddles up for

a few bike races each year.

“I still go out a few times a year to help other people feel good about themselves,” he said.

An eye on stage racing

Vinson, who grew up in Georgia, had been riding bikes his whole life long before he got into racing. A graduate of Amherst College, he had considered studying medical sociology in grad school at UCLA but changed course when one of the only faculty in the field there died suddenly.

“It was really problematic,” he said, “and it got me thinking of what I wanted to do in my life, so I started thinking about med school.”

That led Vinson first to Emory University School of Medicine, then to a residency at Oregon Health & Science University. While there, he also enlisted in the U.S. Air Force and served three years as an active duty officer, practicing family medicine while being deployed overseas. He found himself joining group bike rides and spent his last year of active duty “racing my face off.”

When he returned to Portland, the cycling scene here was cranking. Save for mountain biking, Vinson said he dabbled in just about everything, from tandem races with his wife and daughter to track racing, velodrome, criteriums – single-day bike races on a circuit – and lots of cyclocross, which is bike racing on a short course featuring pavement, grass, hurdles and mud. In fact, some of Vinson's favorite races, other than the Portland Twilight Criterium, have been the cyclocross races at Alpenrose Dairy in Southwest Portland.

Even though Vinson doesn't race as much as he once did, thanks to the COVID-19 pandemic, he probably couldn't race any more this year even if he wanted to.

“There is nothing going on with cyclocross this year,” he said. “It's such shoulder-to-shoulder

racing. In fact, there's really no sanctioned racing happening in 2020.”

That's left Vinson and other cyclists without many competitive options. But they can still ride recreationally and conjure up the dream races they'd like to ride in when the pandemic is behind us. Vinson said for him, that would likely be getting into stage racing. The Tour de France is the most well-known of such races, but Vinson said at the amateur level, there are three-day stage races that consist of a time trial on a Friday, a road race on Saturday and a criterium on Sunday.

“The whole weekend is a big race made up of smaller races of different disciplines,” he said. “If I had nothing but time, I'd probably want to try that.” ■



Jonathan Vinson, MD, has participated in a wide range of cycling events, including with his daughter (top). Vinson, who enlisted in the Air Force, is shown (above) on a medevac trip from Antarctica to New Zealand aboard an LC-130 airplane, along with an aeromed tech and patient.

Photos courtesy of Jonathan Vinson

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