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The Oregon Journal
of Orthopaedics

Volume XV June 2026



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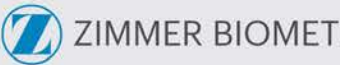


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Letter from the Editors

Welcome to the fifteenth edition of the Oregon Journal of Orthopaedics. It is an honor to highlight the cutting-edge clinical and academic pursuits of surgeons and resident physicians in programs at Oregon Health & Science University and Samaritan Health Services. As the graduates from the Class of 2025 moved on to new challenges and fellowship training, these programs welcomed excellent trainees who are eager to learn and continue the traditions of excellence in research, clinical, and operative settings.

In this edition of OJO, we will be highlighting the iconic career of Dr. Ron Turker, explore advances in the treatment of severe lower extremity injuries, examine initiatives aimed at expanding access to orthopaedic care, and highlight new ideas shaping the future of orthopaedic practice and education. We will also be highlighting new faculty, each bringing fresh perspective and furthering our commitment to excellence in orthopaedic care.

We want to thank our faculty leadership, including the Chair of Orthopaedics and Rehabilitation at OHSU, Dr. Darin Friess, the Program Directors at OHSU and Samaritan Health Services, Drs. Kenneth Gundle and Jacqueline Krumrey, respectively, and the OJO Faculty Editor, Dr. Jonathan Kark. Congratulations to the graduating class of 2026!

Faculty Editor: Jonathan Kark, MD

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Junior Editors: Caellagh Catley, MD; Samhita Swamy, MD

Samaritan Health Services Editor: Adithya Shekhar, MD

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Editors Emeriti: Yash Tarkunde, MD; Calvin Englert, MD

Letter from the OHSU Chair OHSU Department of Orthopaedic Surgery & Rehabilitation



We are proud to present the 15th edition of The Oregon Journal of Orthopaedics. Since the first issue in 2012, this journal has grown into an annual reflection on orthopaedics in Oregon. We've watched residents evolve from learners to leaders, research questions develop into meaningful contributions, and connections form between past and present generations. We hope to see you at the annual Oregon Association of Orthopaedic Surgeons meeting this year.

Since I was hired almost 20 years ago in 2006, our department has grown remarkably from 11 to 30 physicians and 2 to 24 advanced practice providers. This reflects both the increasing demand for orthopaedic care and our ability to attract and retain outstanding clinicians. To meet patient needs, we now provide services across 9 orthopaedic sections and 3 partner hospitals and clinics, delivering specialized care throughout Oregon. The Beals Resource Center helped the department publish 44 papers last year alone. Over the past six years, 19 faculty members have been promoted, and we now have two endowed scholarships supporting faculty research platforms. The Noall family has continued its long-term support of our residents and departmental library. These accomplishments demonstrate the fruits of sustained philanthropy, and we are always happy to discuss opportunities to invest in the future of orthopaedics at OHSU. Our residency program of 25 residents continues to thrive. Investments in surgical skills labs, simulation, and early clinical exposure strengthen their training, while diverse rotations and research opportunities prepare them to lead in a rapidly evolving field. In summary, our once small department is starting to look mature and robust.

This year, we celebrate an exciting milestone for the institution: the opening of the new OHSU Vista Pavilion on April 7, 2026. This expansion increases capacity, creating opportunities to care for more patients, enhance orthopaedic services, and enable more complex patient transfers. It reflects OHSU's commitment to innovation, access, and growth.

Good orthopaedic care begins with curiosity. Whether examining a patient or reviewing an x-ray, asking thoughtful questions drives improvement. This is particularly important in Oregon's stressed healthcare system, where there is never enough space to help everyone. Our responsibility is not only to individual patients but also to ensure access to care for all. OHSU takes this mission seriously. In clinics, operating rooms, calls, and meetings, it is easy to lose sight of the daily impact of our work. We help patients walk again, restore function, treat complex disease, and train the next generation to do the same. Each small task, research project, or teaching moment contributes to a larger mission of excellence in care, education, and research.

Life is about choice, and I continue to choose hope for our future. Our purpose remains constant: caring for patients, educating future surgeons, and advancing orthopaedics. As you read this issue, I encourage you to reflect on your own hopes for the steps ahead.

Darin Friess, MD, MPH
Chair, Department of Orthopaedics & Rehabilitation
Oregon Health & Science University

Letter from the OHSU Program Director



Another year passes, and it has been anything but routine. We share the privilege of caring for patients and training residents while continually seeking ways to advance knowledge and treatment. While our Triforce like missions of patient care, teaching, and research remain constant, it seems we continue to live in interesting times.

At our recent Faculty Retreat, Dr. Friess led us through a review of goals set several years ago. It was deeply gratifying to see where steady, deliberate progress had been achieved. Our research mission has expanded several fold, now encompassing more than \$8 million in funded projects—no small part due to the tireless work of our Research Manager, Rebecca Smith. Within our clinical mission, we have expanded our APP team and added nurse navigators, to clear and meaningful benefit. Across many

facets of the Department, taking pause to look back revealed real advancements and important problems solved. It also allowed us to set new goals and more clearly articulate the challenges that remain ahead.

At the retreat and since, I have reflected on how central the Class of 2026 has been to our success as a Department throughout their tenure. They are an exceptional group and will be missed as they spread across North America to top flight fellowships in Spine, Hand & Upper Extremity, Adult Reconstruction, and Pediatric Orthopaedics. As they have diligently trained and now approach graduation as independent, competent orthopaedic surgeons, this class has consistently sought out and advanced our Triforce'd missions.

From Cochrane reviews and clinical trials to database driven inquiry and grant funded work addressing our climate impact, they have contributed meaningfully to our field's knowledge base. Through service on hospital wide house staff committees, engagement in local and national advocacy, and constant dedication to teaching junior residents and medical students, this group has demonstrated courageous and sustained service. Their diligence in caring for our shared patients—day and night—has been a shining example to all and has set a high bar for those who follow. I look forward to seeing their many contributions unfold in the years to come.

As the Department continues to evolve, the Residency and our residents remain firmly at its center—and serve as the lens through which I view all our initiatives, past, present, and future.

The year ahead includes notable changes in both physical and digital spaces. Earlier this week, I toured the Vista Pavilion during its open house. This major new 14 story tower on the Hill greatly expands OHSU's capacity to care for our region. Its 128 inpatient beds feature expansive views of the Willamette River, while from above the building bears a striking resemblance to a Minecraft-style pair of pants. Soon, these pant legs will be filled with patients and will represent a fantastic addition to OHSU's ability to deliver care across the system.

Buildings, like all infrastructure, are tools—meant to be used by OHSU members to advance our shared missions. Earlier this year, following a particularly productive meeting of the AOA Council of Orthopaedic Surgery Residency Program Directors, I shared with our residents' insights on how the digital tool of generative artificial intelligence may support our work. It has been exciting to see residents and sections begin using these tools to create study guides and podcast style learning summaries. Our new Simulation Director, Dr. Dane Brodke, has leveraged AI to rapidly develop research tools and assist in organizing sessions at VirtuOHSU. Faculty have also recently gained access to an AI scribe, which has had an immediate positive impact on my own clinic days working alongside residents.

I view AI as another arrow in the quiver—a tool that may aid our work and our missions. Some applications will endure, while others will fade. As residents begin onboarding with AI scribe in the coming months, I am eager to see how they thoughtfully integrate these tools into their practices in service of learning, efficiency, and patient care.

I hope you enjoy this edition of the *Oregon Journal of Orthopaedics*—a chance to reflect on the year past and to look ahead with purpose toward what comes next.

Kenneth Gundle, MD, FAOA
Associate Professor, Oregon Health & Science University
OHSU Orthopaedic Surgery Residency Program Director
Member, Knight Cancer Institute
Staff Surgeon, Portland VA Medical Center

Letter from the Samaritan Health Services Program Director



May you live in interesting times. (Yes, this part is recycled from 2021 for those of you who eagerly read my annual soliloquy.) This is not actually a Chinese curse and is thought to have come around in England in the 19th century. It feels like a curse. We are definitely living in interesting times. I often have to just stop looking at my news feed. I won't go into politics or religion, but can't we all just get along?

The orthopaedic program in Corvallis is going through interesting times, just like the rest of the world. We are finishing our second year in a row that includes a transfer resident. The Samaritan Health system is rapidly changing. Our residents can expect

new attendings as we recruit to meet the needs of a rapidly aging population. The system is beginning a merger with MultiCare. We don't foresee a big effect on graduate medical education as a whole, but we hope a new hospital is in the future in Corvallis. Everyone is a little nervous, but we hear good things from people who currently work for MultiCare. It will be a big change.

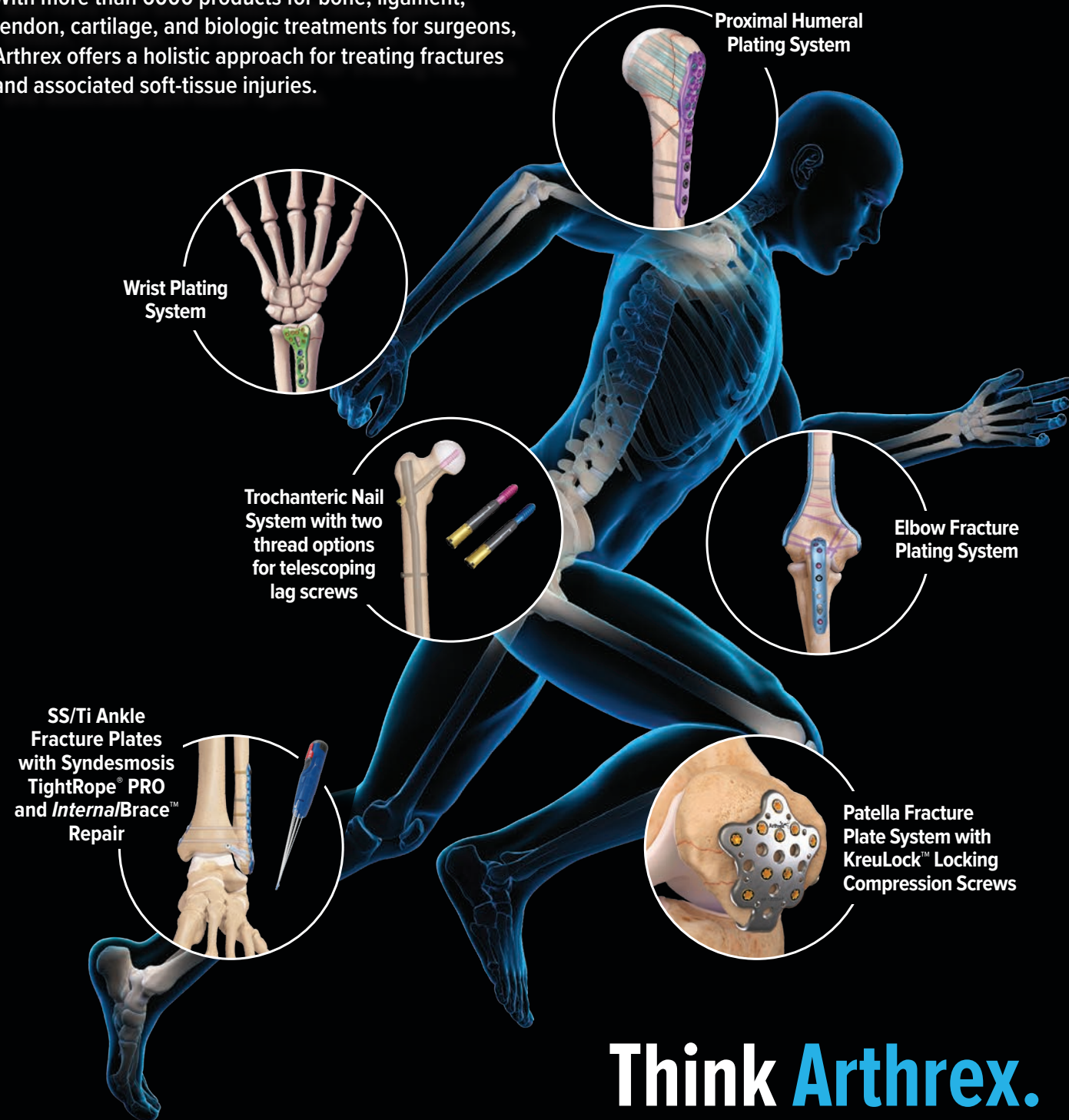
Adapting to change is part of orthopaedics – and life. When I was a resident, I worked with the surgeon who did the first total hip in Milwaukee, WI. Crazy, isn't it? My days as a resident did not include locked plating nor wound vacs. I still remember how exciting it was to place one of the early retrograde femoral nails. We put a tibial nail in the femur by entering through the lateral condyle.

My challenge to you this year is to view all the interesting times in your career as a blessing rather than a curse. Find something new in your practice and embrace it like you embraced doing that first hemiarthroplasty skin to skin. It was exciting and a little nerve-racking. Exciting and a little nerve-racking is why I love orthopaedic trauma. I've been out of training for over 30 years now, and I still see things I've never seen before. It's definitely a blessing to be doing something for so long that can still make me excited. I hope your career is the same.

Jacqueline Krumrey, MD
Program Director, Samaritan Health Services Orthopaedic Surgery Residency

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OHSU Residency Core Faculty

Adult Reconstruction

Foot & Ankle



Thomas Huff, MD
Fellowship Director



Ryland Kagan, MD



Kathryn Schabel, MD
Director Comprehensive
Joint Replacement,
Section Head



Lara Atwater, MD



James Meeker, MD
Section Head

Orthopaedic Oncology



Yee-Cheen Doung, MD
Vice Chair; Director of
Clinical Operations



Kenneth Gundle, MD
Residency Program
Director



Duncan Ramsey, MD, MPH

Pediatrics

Podiatry

Research / Basic Science



Matthew Halsey, MD
Section Head



Muayad Kadhim, MD



Trish Ann Marie Otto, DPM



Brian Johnstone, PhD
Section Head

Physical Medicine & Rehabilitation



Hans Carlson, MD
Section Head

Nels Carlson, MD
Assistant Dean of Continuing Professional Development

Jesse Day, MD

Ian Logan, MD

Upper Extremity



Adam Mirarchi, MD
Fellowship Director

Omar Nazir, MD
Director of Wellness & Health; Section Head

Robert Orfaly, MD, FRCS(C)
Quality Medical Director

Spine



Jonathan Kark, MD

Clifford Lin, MD
Fellowship Director, Section Head

Travis Philipp, MD

Jung Yoo, MD
Director of Spine Center

Sports Medicine (Surgical)

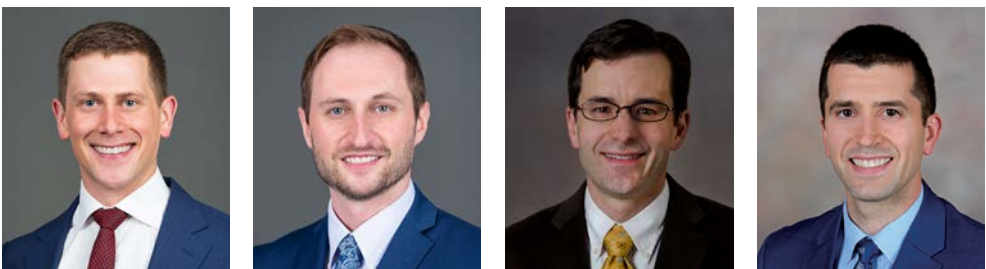


Jacqueline Brady, MD
Associate Residency Program Director

Dennis Crawford, MD, PhD

Andrea Herzka, MD

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Dane Brodke, MD

Graham Dekeyser, MD

Darin Friess, MD, MPH
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Orthopedic + Fracture Specialists Residency Core Faculty



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Brett Andres, MD

Residency Faculty

Portland VA Medical Center Residency Core Faculty



Mark Berkson, MD
Section Chief for
Orthopedic Surgery



Kenneth Gundle, MD



Ryan Wallenberg, MD



Linda Zhang, MD

Shriners Hospital for Children Residency Core Faculty



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Krister Freese, MD



Kathryn Fuchs, MD



Heather Kong, MD



Dominique Laron, MD



Bryan Menapace, MD



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MD

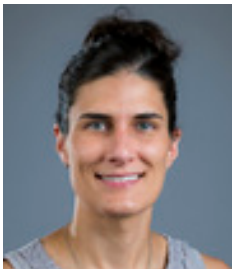


Michelle Welborn, MD



Natalie Zusman, MD

Samaritan Health Services Orthopedic Surgery Core Faculty



Kelli Baum, DO



Erin Campaigniac, MD



Wael Ghacham, MD



Lauren Hansen, MD



Jacqueline Krumrey, MD
Program Director



Jason Lin, MD



Christopher McCrum,
MD



Cay Mierisch, MD



James Ryan, MD



Nicholas Tedesco, MD



Peter Tsai, MD

OHSU Program Fellowships 2025-2026

Sports Medicine Primary Care



Trevor Gohl, DO

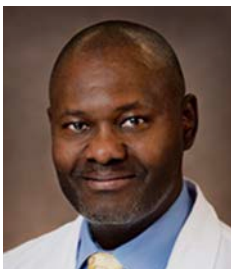


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Dustin Biron, MD

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Dardiny Saint-Clair, MD

Spine



Lily Wood, MD

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Featured Articles

Saluting Dr. Ron Turker

By David Chen and Kaleb Roach

As a farewell to Dr. Ron Turker, one of OHSU's most esteemed pediatric orthopedic surgeons, we sat down to reflect on his more than three decades in medicine. Here's a summary of our conversation.

Journey to Orthopedics

Dr. Turker was born and raised on Long Island, New York, and completed his undergraduate education at SUNY Binghamton before earning his medical degree from SUNY Upstate Medical University. Initially committed to a career in pediatric general surgery, he spent significant time training with pediatric surgeons and pursuing away rotations in the field but ultimately did not match.

In 1987, he began what was supposed to be a two year preliminary general surgery position at what he described as a "trial-by-fire" hospital on Chicago's South Side. During this time, he developed an interest in orthopedics and built relationships with the department's faculty. In May of 1988, funding issues forced the hospital to reduce its general surgery positions, leaving Turker without a job for the upcoming year. With less than a month to go, the orthopedic surgery department hired Turker to fill a newly vacated position. Hence, the pivot to orthopedic surgery training in Chicago.

Although his specialty changed, his interest in caring for pediatric patients remained strong. He went on to complete a pediatric orthopedic fellowship at Shriners Hospital for Children in Chicago and, reflecting on his unconventional path, describes himself as an "accidental orthopedist."

Early Career

Dr. Turker began his career at the University of New Mexico, where he spent five years before

moving to Oregon in 1998 to join OHSU and the Shriners Portland staff. At the time, the OHSU orthopedic department was in a period of rebuilding, with a small team of surgeons managing a high clinical volume. As one of the few surgeons comfortable treating pediatric patients, Dr. Turker assumed an extraordinary call burden, taking pediatric call nearly every night for his first several years, often in addition to adult call to support the broader service. As the program began to rebuild, call responsibilities became more manageable and eventually transitioned to shared coverage with his colleague, Dr. Stephen Renwick. Even then, every other night call felt "kind of insane" by today's standards.

Dr. Turker described his surgical style as "bare bones," shaped in part by his international orthopedic work, where limited resources demanded adaptability and technical creativity. He credits his mentor, Dr. John Lubicky, former chief of surgery at Shriners Chicago, as a major influence. Lubicky, whom he describes as a "beast of a surgeon," approached cases with meticulous planning and multiple contingencies, a mindset Dr. Turker carried throughout his career. This emphasis on preparation, adaptability, and follow-through became central to his surgical philosophy.

Equally important was a strong sense of ownership in patient care. Dr. Turker emphasized being consistently available to patients and colleagues, taking responsibility for both successes and complications. He describes caring for children as a "gift given and received", particularly in witnessing their growth and recovery over time. In practice, his approach was always to engage with the child first

before asking the kids whether they thought their parents “might have questions.” For Dr. Turker, meeting patients where they are, both emotionally and clinically, was often more challenging than the technical demands of surgery, but ultimately the most important aspect of his role.

Legacy

Over the years, Dr. Turker has had an incredible impact on his patients, and it’s no surprise that he continues to hear from those whose lives he touched through his empathy and surgical skill. When asked to recall any particular cases that have resonated through the years, Dr. Turker mentioned scrolling through Facebook recently and seeing his own signature tattooed on a woman’s forearm. A former patient, now in their 30s, had gotten a replica of his signature inked over one of her incisions. This is just one small testament to the well of goodwill Dr. Turker has cultivated throughout his career.

And still, while patients were at the center of his practice, Dr. Turker never gave up teaching the next generation of doctors. Even as he navigated career transitions through different hospitals and institutions, residents and medical students could count on his thoughtful approach to education. “It’s a huge gift to be able to teach, to be challenged,” he reflects. “I would say teaching was the thing that kept me getting up in the morning and going at it.” Today, there are countless attendings across the country—active and retired—that have benefitted from Dr. Turker’s mentorship.

Wisdom for the Next Generation

For the medical students and residents following in his footsteps, Dr. Turker’s advice is rooted in the same adaptability that defined his own journey. He emphasizes that while it is vital to have a clear direction, one must

remain open to reorienting and redirecting when the path shifts. Looking back, he admits he could not be happier with where he landed; had he stayed a rigid course, he might never have found the freedom to perform the international work he so enjoyed—work that took him to such far-flung corners of the world as Colombia, Jordan, and Ukraine.

To sustain a long career, he urges young physicians to stay humble in both their pocketbooks and their egos. He warns of the immense pressure the modern system places on one’s moral compass, advising that the greatest power a doctor has is the ability to “speak with their feet.” By living simply and paying down debt early, a physician gains the financial independence required to vote with their presence or, conversely, their absence. In his words, “live small to live large”.

The Next Chapter

Even in retirement, Dr. Turker hasn’t truly moved “beyond” medicine; rather, he has moved into the fight for its future. His current energy is dedicated primarily to healthcare advocacy and reform, working alongside groups such as the Patient Revolution (Mayo Clinic) and People Power Health (Harvard). He is a man on a mission, talking to anyone who will listen and utilizing every medium available, from film to books to short-form pieces, including his debut health care novel, *The Wandering Jew of St. Salacious*.

His latest project is to promote and distribute a new investigative documentary, *Suck it up, Buttercup*. He hopes to take it across Oregon, to venues large and small, and spark dialogue about the state of American medicine today. To heal the growing rift between doctors and the people they care about most, their patients.

We look forward to following Dr. Turker’s activities—and you can too—at www.ronturker.com

Meet the New APD: Dr. Lara Atwater on Mentorship, Wellness, and Training

By Michelle Hernandez

From the long and demanding hours to triumphant breakthroughs, residency is a journey of extremes. The challenges are relentless, but so are the moments of growth and discovery. While medical knowledge comes from constant studying and skills from repeats and practice, it’s the mentors that walk alongside residents who often leave the biggest impact. This past winter, Dr. Lara Atwater—a mentor, physician, and advocate whose own journey through medicine has been shaped by both the rigor of training and the warmth of mentorship— was named the new residency Assistant Program Director. Dr. Atwater attended medical school at Georgetown University, completed her orthopedic residency at Johns Hopkins University, and later completed a foot and ankle fellowship in Baltimore, Maryland.

For Dr. Atwater, the decision to step into this new role was unexpected yet welcomed. She admits it wasn’t something she actively pursued but she is honored to have been asked and is grateful to be taking on the new role. Already part of the undergraduate medical education (UME) team, Dr. Atwater was the perfect fit for this role. She found that her skills translated naturally into supporting residents. “Having knowledge of undergraduate medical education helps me connect the dots for trainees,” she explains. “I understand where they’re coming from, the challenges they’ve faced, and how to guide them forward.”

This new role also carries a personal resonance. During her own residency, Dr. Dawn Laporte shaped not only her career path but her view of what mentorship should be. “I really idolized

my program director,” she recalls, describing that relationship as foundational and important in her life, and viewing this opportunity to give back in a similar way as a pinnacle moment in her career.

Dr. Atwater’s main objective stepping into this new role is simple—support Dr. Gundle and the residents as best as she can and while prioritizing active listening. She strongly believes that listening to feedback and being responsive is the most important part of her new role. She highlights and acknowledges that residency training is always evolving, and what works today might not work tomorrow, so being attentive and adaptable is very crucial.

As she steps into her new role, Dr. Atwater is mindful of the balance between serving as both a medical student advisor and Assistant Program Director—positions that, while complementary, can carry potential challenges. She recognizes that her new title may subtly shift how medical students perceive her. Although she has been noted as a safe and approachable advisor, she understands that some students may now no longer feel comfortable fully disclosing things as before. Despite this, she remains committed to fostering a supportive environment, advocating for students and approaching each situation objectively. She also highlights the department’s thoughtful approach in establishing an alternative advising option with an incoming faculty member this fall, ensuring that students continue to have access to specialty-specific advising. Ultimately, while the role may change how others perceive her, her core mission remains unchanged: to guide trainees with honesty, fairness, and a commitment to their growth.

Regarding residents, her support extends far beyond coordinating schedules, navigating resources, or reviewing evaluations. It entails creating a safe space to share concerns, seek advice, and navigate challenges. Dr. Atwater hopes to provide that support by being present for residents, acknowledging that training is tough and prompting trainees to seek additional support when needed. Her strong integration with the UME office brings a deep familiarity with campus-wide resources, positioning her to connect residents with the support they need to thrive.

Approachable, humble, and candid, Dr. Atwater embodies what many hope to find in a mentor, with the willingness to share her experiences and perspectives. “I want residents to know I wasn’t a perfect resident,” she says. “I made mistakes, struggled, and learned from them—and I’m always willing to share those experiences if it can help someone else.” That openness is shaped in part by her experience as a mother of three and a woman in orthopedics—perspectives she draws on to support residents navigating identity, confidence, and professional growth. She believes that having someone who has been through similar experiences can be incredibly valuable and is the kind of informal support that often makes a meaningful difference for residents.

—

When it comes to work-life balance, Dr. Atwater is quick to acknowledge that the department already does a great job promoting wellness and balance for residents, while also recognizing that maintaining this balance is not always easy. When she isn’t juggling all her various roles,

Dr. Atwater does her best to prioritize her own balance and wellbeing—recognizing that while it can be difficult, it is essential. She and her husband carve out time twice a year to step away from daily responsibilities, unplugging completely and recharging without phones or distractions. For Dr. Atwater, these intentional practices are not just personal—they serve as a model for trainees navigating high-pressure environments, reinforcing the importance of making time for self-care even when it feels impossible to do so.

Her number one piece of advice for residents is simple but often needs reminding: “one step at a time.” She encourages residents to focus on the moment rather than becoming overwhelmed by the anxiety of what could go wrong. “You put one foot in front of the other. That’s all anyone can do,” she says.

Though new to the role of Assistant Program Director, Dr. Atwater brings several years of experience in leadership and mentoring future physicians. Her passion for guiding trainees is one of the main reasons she chose a career in academic medicine. She strives to help trainees navigate the complexities of training, find their footing, overcome challenges, and ultimately shape their own paths in medicine.

With her dedication to mentorship, openness, and thoughtful leadership, Dr. Atwater is poised to leave a positive impact—not only on the residents she guides in her new role, but on the culture of the program itself.

A Path Shaped by Community

By Shrey Sharma

Dr. Julia Silver, a third-year orthopaedic surgery resident at OHSU, traces her interests in preventing firearm injuries back to her time in New Orleans, where she completed her Master of Public Health in epidemiology at Tulane University. Through community-based work, she gained a deeper understanding of the gap between healthcare systems and the populations they serve.

Her time in New Orleans, a city that has been heavily affected by gun violence, shaped both her professional and academic interests. She had always been interested in orthopaedics, stemming from her background in dance and early exposure to musculoskeletal care. Over time, she began to see firearm injuries as an opportunity to apply her interests in surgery and public health in a tangible way.

Expanding the Role of Orthopaedics

During her training, Dr. Silver cared for multiple patients with firearm-related wounds, many of them being young people from marginalized groups. Witnessing these injuries firsthand reinforced how closely a patient is tied to their social factors, often turning preventable issues into critical medical crises.

Orthopaedic surgeons play a key role in the immediate care of gunshot wounds, from the first evaluation in the trauma bay to the final surgery. However, involvement often ends when the patient is discharged. Dr. Silver states that by directly addressing the social factors influencing negative health outcomes, the field of orthopaedics is given a chance to grow, especially in the areas of prevention and patient education. She notes that conversations around firearm safety and prevention can be done in the same way that doctors talk about other

health risks, such as osteoporosis and smoking cessation. Providers have the opportunity to frame these discussions with patients around safety and risk reduction without making them take a side on larger political issues.

Research and Collaboration

Dr. Silver has partnered with the OHSU-PSU School of Public Health to integrate orthopaedic perspectives into multidisciplinary firearm injury research. Her projects with Dr. Kathleen Carlson, the director of the Gun Violence Prevention Research Center, and Dr. Graham DeKeyser, orthopaedic trauma surgeon, focuses on finding gaps in care and improving postoperative outcomes for patients after firearm-related orthopaedic injuries. A key area of focus for her and her team is continuity of care following discharge. Initial research indicates that a significant number of patients, especially young men enrolled in Medicaid, are unaccounted for in follow-up within the first month post-surgery. This represents a critical gap as these patients are at increased risk for further complications and reinjury.

Her research also explores the role of hospital-based violence intervention programs. These programs link patients with community health workers at the time of hospitalization and provide ongoing care and support after discharge. By establishing early trust and maintaining engagement, they aim to meet not only medical needs but also address social needs that affect recovery.

Advocacy and Education

In addition to her research, Dr. Silver has also contributed to medical education through helping facilitate a mandatory firearm injury prevention skills lab for second-year medical students. This

novel session began three years ago at OHSU and introduces practical strategies for discussing firearm safety and goes over relevant laws and case-based scenarios with students before the start of their clinical years. The goal is to normalize these types of conversations in clinical practice. Physicians can help patients with firearm safety by treating it like other screening topics, such as smoking or alcohol use, offering guidance and resources in a way that feels both practical and patient-centered.

She also highlights the importance of improving data collection and research infrastructure in this area. Healthcare systems can better understand patterns of injury and find ways to intervene by keeping better records of gun-related injuries and outcomes.

Looking Forward

Dr. Silver plans to keep working at the crossroads of orthopaedics and public health

throughout her career. She is especially interested in multidisciplinary efforts that bring together clinicians, public health researchers, and community groups to work to address firearm injuries on a larger scale. She was also recently appointed as a Research Fellow for the Gun Violence Prevention Research Center, further supporting her work in this space.

Her work shows that orthopaedic care can extend far beyond the operating room. For patients experiencing firearm-related injuries, recovery is shaped by a complex set of medical, social, and environmental factors. Taking the time to understand these factors and connect patients with appropriate resources can play an important role in improving outcomes. Dr. Silver’s work demonstrates that orthopaedic surgeons are uniquely positioned to be a part of that effort.

FLAP ATTACK at OHSU: Accelerated flap coverage versus standard timing in the treatment of severe lower extremity injuries

Interview with OHSU’s Orthopedic Trauma Surgeon Dr. Graham DeKeyser

By McKenzie Hopfer

The Flap

When a patient sustains an open fracture to the lower extremity, the race against the clock begins. From the time the patient arrives to the ED to initiating antibiotics and debriding the wound in the OR, the orthopedic trauma team needs to move swiftly to stabilize the fracture and determine if the soft tissue requires flap coverage. As the clock keeps ticking, the infection risk keeps climbing. In the United States, the average time from injury to flap coverage is 10 days with infection rates of 20-35%. In contrast, the UK national guideline (NICE guidelines) emphasizes flap coverage within 72 hours of injury.

The Attack

With the UK reporting infection rates less than 10%, Dr. Lily Mundy, a plastic and reconstructive surgeon at Johns Hopkins University, recruited colleagues Dr. Sheila Sprague at McMaster University & Johns Hopkins University and Dr. Mark Gage at R Adams Cowley Shock Trauma Center to be co-Principal Investigators in a randomized controlled trial to better understand how the timing of surgical flap coverage impacts clinical status in patients with open fractures and/or dislocations below the knee. In the FLAP ATTACK trial, enrolled patients are randomized to receive either accelerated flap coverage (within 72 hours from injury) or standard flap coverage (within 5 to 15 days from injury). The trial will assess how the timing of flap coverage affects all-cause mortality, risk of amputation, re-operation rate for infection and/or flap

complication, and number of days in hospital six months after randomization. Nine clinical sites around the world, including OHSU, are actively recruiting patients while dozens of other sites are currently gearing up to initiate the trial.

OHSU’s Participation and Collaboration

Dr. DeKeyser is leading OHSU’s FLAP ATTACK by building a multi-disciplinary collaboration across Departments to ensure surgeons, staff and resources are available to perform the accelerated flap coverage. Prior to the trial, OHSU’s injury to flap coverage time aligned with the US standard of 7 to 14 days. To provide the opportunity for participants to receive accelerated flap coverage, patients are enrolled and randomized by OHSU’s Orthopedic Trauma team either before or soon after the initial debridement to accelerate communication with Plastic Surgery about the assignment of a standard or accelerated flap. With most flap surgeries taking between 8-10 hours, the enrollment phase needs to be swift so personnel and resources are available. Since the initiation of the trial in November 2024, Dr. DeKeyser and colleagues have been flexible and creative to ensure accelerated flap coverage is possible within 72 hours of injury. Dr. DeKeyser emphasized that some of the biggest impacts from the trial so far have been the increased collaboration with plastics and the call schedule adjustments to allow for sharing operating rooms. Additionally, the accelerated flap coverage has underscored how critical the initial debridement is and has motivated teams to be even more thorough and concise during the initial washout.

More to Come from the Flap Attack

Although OHSU has enrolled 5 out of 39 participants in the FLAP ATTACK trial (3rd leading enrollment behind Johns Hopkins and the Shock Trauma Center), it has been difficult to enroll patients. Enrollment can be delayed for patients with open lower extremity fractures since they often have multiple injuries that are life-threatening. Dr. DeKeyser notes that asking patients with a life-changing injury if they want to be involved in a research study can be overwhelming and difficult to understand. As we learn more from the trial about the clinical outcomes of accelerated flap coverage, communication about its potential benefits

may ease these conversations with patients. With funding from the National Institutes of Arthritis and Musculoskeletal and Skin Diseases (NIAMS), Canadian Institutes of Health Research (CIHR), Orthopaedic Trauma Association (OTA) and Foundation of Orthopedic Trauma (FOT), and participation from clinical sites around the world, this trial aims to show how accelerated flap coverage can reduce mortality, reduce injury-related amputation, reduce unplanned reoperations, reduce length of stay, improve clinical outcomes and improve patient satisfaction and quality of life. Now that is a FLAP ATTACK!

Learn more at: <https://flapattack.com/>

Checking in with Shriners

By David Chen

It has been five years since the Oregon Journal of Orthopaedics last ran a feature on Shriners Children's Portland, and it is high time for an update! As a pediatric orthopedic hospital situated on Marquam Hill alongside OHSU and the VA, Shriners cares for thousands of children every year, from local families across the Pacific Northwest to those who travel from across the country and around the globe. The hospital is a vibrant hub of educational activity, regularly hosting MS1 students and PGY-2 residents from OHSU for rotations and conferences. Following its 2024 centennial, the hospital is now leveraging its 100-year legacy to redefine the boundaries of pediatric orthopedics through several ambitious research and outreach initiatives.

The Sports Consortium

At the heart of the hospital's innovation is the Shriners Sports Consortium, a collaborative network of 14 care centers dedicated to advancing pediatric sports medicine through research and education. In Portland, much of this work centers on the state-of-the-art motion analysis center—one of the only facilities of its kind in the state. Led by Dr. Bauer, in collaboration with Clinical Research and Motion Analysis, Shriners Portland is currently driving several studies aimed at refining how young athletes recover from injury.

A primary focus of this work is redefining “readiness” for a return to play. In one study evaluating patients with adolescent idiopathic scoliosis following posterior spinal fusion, researchers found that post-operative athletes showed improved trunk and pelvic obliquity. Interestingly, these physical improvements did not translate to significant differences from their preop assessments in PRISM return-to-sport test scores or PROMIS pain and mobility measures.

A similar approach is being applied to ankle fractures, where preliminary data suggests the standard 12-week recovery mark may be too early for a safe return. By analyzing ankle, hip, and knee biomechanics, the team is working toward more rigorous, evidence-based clinical guidelines.

To make this high-level analysis more accessible, the team is also exploring the future of wearable technology. While traditional lab-based motion capture is highly effective, it remains expensive and time-consuming. Researchers are currently assessing the validity of wearable Inertial Measurement Unit systems as a cost-effective alternative. Because these sensors require less data processing and can be used “in the wild” during actual sports maneuvers, they offer the potential to bring sophisticated biomechanical tracking out of the lab and directly onto the field.

Shriners is also translating this expertise into community action. Recently, Jessica Martschinske ATC/L received an ESPN Take Back Sports Innovation Challenge grant, which funded a public event titled “Insights from the Experts in Sports Safety” on January 14, 2026. Held at Lewis and Clark, the panel brought together social workers, clinical sports psychologists, athletic trainers, and local coaches to discuss the pressures of youth sports. About 50 parents and coaches engaged in a lively discussion regarding the drivers of early specialization—ranging from college scholarship expectations to club team culture and peer pressure.

Advances in Biomarkers: The “CXM” Breakthrough

Shriners has been at the forefront of researching Type 10 collagen (CXM) as a powerful new biomarker for bone growth. Because CXM is a direct measure of longitudinal bone growth and

endochondral ossification, it is particularly useful in pediatric research. This work began in 2017 under Dr. Bill Horton and has been significantly advanced by Dr. Michelle Welborn, the Diane Ruth Abramson Professor of Pediatric Orthopedic and Burn Surgery.

In 2025, Dr. Welborn and her team published a major study involving 254 patients, which identified CXM as a significant independent predictor of height velocity. The clinical appeal of this biomarker is its simplicity; it can be obtained via a simple finger-prick blood test! The impact of this work was recently recognized at the 2025 Scoliosis Research Society annual meeting, where it received the John H. Moe Award for the Best Basic Science/Translational E-Point Presentation. The research is ongoing, with current studies looking at growth cessation and risk staging in children with scoliosis.

Understanding Idiopathic Toe Walking

Another major multi-center initiative is being led by Dr. Jeremy Bauer, Division Chief of Clinical Research and Hip, and focuses on children who walk on their toes without a known medical etiology. This study addresses a long-standing challenge: determining whether “tip-toe” walkers are best served by non-invasive serial casting or surgical lengthening of the Achilles tendon. By leveraging the in-house motion lab, the team can quantify exactly how these treatments change a child’s gait cycle with 3D precision.

Notably, the study is also investigating the potential genetic underpinnings of the condition. By looking at patient genomics, the team hopes to uncover why certain children respond better to one treatment over another, potentially allowing for a “precision medicine” approach. Initial findings from this work were presented at the 2025 Gait and Clinical Movement Analysis Society Annual Meeting, receiving a Best Paper award. Upon the study’s completion, it will be the largest of its kind, providing much-needed consistency to a historically fragmented area of literature.

Activities on the Horizon

The coming months will prove to be an exciting time for Shriners as research teams push ahead into rare conditions and cutting-edge technology. Dr. Krister Freese, division chief for arthrogryposis and upper extremity, is leading an effort to create a registry for arthrogryposis and to develop a new validated measure for upper extremity function in these patients. In the realm of cerebral palsy, Dr. Bauer and a team from Emory University are investigating the use of AI and computer vision for the assessment of gait on children with cerebral palsy. Dr. Sienko is investigating how large language models may help standardize GMFCS classifications for children with cerebral palsy within the Shriners Children’s network by combing through the patient chart, a potential game changer in data harmonization. These efforts aim to improve the quality-of-care Shriners provides and thereby the quality of life for patients.

From Barrier to Bridge: How the OWL Clinic is Reshaping Orthopaedic Access

By Steven Shelofsky

For many patients with advanced joint disease, the path toward treatment is not limited by pain, willingness, or disability, but rather is limited by a number. The Body Mass Index (BMI) has long been used as a threshold for surgical eligibility, creating a paradox for patients: those who would benefit most from joint surgery are often deemed ineligible.

Historically, these patients were left in a difficult position. They would meet with a surgeon to discuss debilitating pain but were unable to get signed up for surgery until they lost weight. They were provided with limited structure and an unclear path forward. This created a gap in care, delaying treatment for patients who were suffering and creating frustration for both patients and providers alike.

The Orthopaedic Weight Loss (OWL) Clinic was created to address this gap.

Identifying the Gap

The origins of this clinic can be traced back to a simple yet persistent clinical dilemma: orthopaedic surgeons routinely encounter patients who are suitable surgical candidates in every respect except for their BMI. While the rationale for these BMI thresholds is rooted in evidence-based risk mitigation, the absence of a structured path forward created a disconnect between surgery and patient care.

This was the starting point for conversations between Jaymey Sweeney, R.N., M.N., F.N.P.-C, and Nany Puzziferri, MD, MS. in late 2024. These two, among orthopaedic faculty and collaborators across disciplines, including endocrinology, bariatric surgery, nutrition, pharmacy, met opportunity with action. By June 2025, these discussions resulted in

a focused effort to build a program to help patients achieve perioperative optimization and improved long-term musculoskeletal health. This marked the beginning of the OWL Clinic.

From the outset, the goal was never simply weight loss, but rather to reframe obesity as a chronic, biologic disease requiring comprehensive, multidisciplinary, evidence-based management.

A New Model of Care

At its core, the OWL Clinic provides a structured, multidisciplinary pathway for patients navigating weight-related barriers to orthopaedic care.

Patients are typically referred by orthopaedic providers, though referrals may originate from a variety of sources, including self-referral. Following intake, patients complete a detailed health history and are enrolled in a free, group-based nutrition class led by a registered dietitian. This initial step ensures that all patients receive a foundational understanding of nutrition strategies before advancing further in their care.

Next, patients meet one-on-one with a provider to develop an individualized plan through shared decision-making. This plan may include pharmacologic therapy (often with GLP-1 receptor agonists), referral for bariatric surgery, continued nutritional counseling, or behavioral health support. Diagnostic labs are frequently incorporated both to guide clinical management of this multidisciplinary pathology and to facilitate insurance approval for evidence-based therapies.

This stepwise approach has become a clearly defined, actionable, and well-supported process for both patients and providers.

What Sets OWL Apart?

Weight loss programs are far from a new concept. However, the OWL Clinic sets itself apart in both structure and philosophy.

Central to this model is a multidisciplinary team. This approach gives due respect to the fact that obesity is a complex condition influenced by metabolic, behavioral, endocrine, and environmental factors.

The clinic is also deeply rooted in evidence-based care. Providers are affiliated with the American Board of Obesity Medicine, and the program actively contributes to ongoing research efforts, including randomized trials and prospective data collection. Educational and advocacy initiatives, such as involvement with national obesity organizations, further reinforces this group's commitment to advancing the field.

Most important is the clinic's emphasis on creating a stigma-free environment. By reframing obesity as a multifactorial disease, the OWL Clinic shifts the conversation away from blame and toward partnership.

Impact on Orthopaedic Care

Although formal outcomes data are still being collected, the early impact of this program is evident in its effect on access to care. Patients who might have previously been turned away or given unrealistic goals for weight loss are now offered a clear and achievable pathway toward surgical eligibility. This not only improves the likelihood of eventual operative intervention but

also engages patients earlier in a process that benefits their overall health and the longevity of both native and prosthetic joints.

For orthopaedic providers, the clinic offers a tangible solution to a longstanding challenge in perioperative optimization. Rather than serving as gatekeepers, surgeons can now guide patients toward a structured program designed to optimize outcomes and expand access to care.

Looking Ahead

The OWL Clinic continues to grow and evolve, with future integration of programs such as culinary medicine and exercise science on the horizon. The implementation of shared didactic clinic followed by individual patient appointments may help create a sense of community and togetherness in the weight loss journey, reinforcing that patients are not alone in this challenging path.

With continued growth of the care team and ongoing research efforts, the clinic is well-positioned to serve as a model for similar programs nationwide.

A Shift in Perspective

The OWL Clinic represents a shift in how orthopaedic care approaches one of its most persistent challenges. Rather than viewing BMI as a barrier, the clinic reframes it as an opportunity to meet patients where they are and collaborate with an interdisciplinary team for the sake of long-term health improvement. In doing so, access to surgery is expanded, and care for patients with obesity undergoes an ever-necessary evolution.

Osteochondritis Dissecans Lesions of Trochlea: Report of Two Patients and Review of the Literature

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Running Head: Osteochondritis Dissecans Trochlea Lesions Case Report

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Key Words: osteochondritis dissecans, OCD, trochlea, elbow, sports, pediatric orthopaedics, upper extremity

Introduction: Osteochondritis dissecans (OCD) is the separation of articular cartilage and subchondral bone.¹ The etiology, pathogenesis, histology, and diagnostics of OCD are incompletely understood. OCD most commonly occurs in the knee joint (61.7%), followed by the ankle joint (25.4%), and elbow joint (12%).² OCD of the elbow is a common injury in children and adolescents, especially those who participate in athletics.^{3,4,5} Patients may present with pain, loss of range of motion (ROM), crepitus, and mechanical symptoms.^{4,6} In the elbow, OCD lesions most

often occur at the capitulum, but they can occur at the humeral trochlea in rare instances, accounting for 2.5% to 7% of lesions.^{4,6,7} In the trochlea, the most common location for an OCD lesion is in the lateral trochlea accounting for 77% of lesions.⁴

Treatment for OCD of the elbow is guided by clinical and radiographic findings and includes conservative and surgical treatment.^{2,4-6,8} There are no standardized procedures for treatment of OCD of the trochlea and often non-surgical conservative treatment is the initial treatment.^{5,6} For osteochondral segments that are intact, conservative treatment is recommended.⁸ Conservative treatment may include physical therapy, activity modification, and elbow immobilization.^{4,5,9} If conservative treatment fails, or if osteochondral segments are displaced or detached, symptomatic loose bodies are present, or fracture of the articular surface occurs, then surgical treatment is indicated. When surgical intervention is required, there are two broad approaches: arthroscopic and open surgeries.⁴ In open procedures, debridement or drilling/microfracture are the most common procedures.⁴ OATS (osteoarticular transfer system) is a well-established technique used in the knee that can also be applied to the elbow.⁴

A recent systemic review from 2022 only found a total of 75 reported cases of OCD of the trochlea.⁴ This study aims to increase the volume of literature on this rare condition by adding two more cases of OCD of the trochlea which were successfully treated surgically with two different techniques.

Case Reports:

Case 1:

A 13-year-old male patient presented after feeling a pop in his right elbow during a push-up. He had no pertinent past surgical or medical history. At the presentation, the elbow lacked 20 degrees of extension and pain was noted over posterior olecranon area. No swelling, popping or clicking was noted during the physical exam. Non-operative treatment of activity modification was pursued with a scheduled three month follow up. Pain persisted and the patient chose to pursue operative treatment prior to three-month follow-up. Preoperative magnetic resonance imaging (MRI) showed an osseocartilaginous lesion of the distal humeral trochlea with surrounding marrow edema signal and no loose bodies (Figure 1).



Figure 1. Pre-operative MRI of OCD lesion in humeral trochlea of right elbow of Case 1.

Diagnostic arthroscopy found no synovitis and an overall intact articular cartilage with slight fraying of coronoid cartilage. The cartilage and OCD lesion were visualized in the trochlear region where there was a 10mm x 10mm area of abnormal cartilage but no detachment or fragmenting. Therefore, intraarticular debridement of this area was not indicated. Extraarticular drilling and decompression was then performed through the trochlear lesion using a 4.5 mm drill. The area was then curetted to remove residual necrotic bone, and the area filled with demineralized bone matrix (DBX, DepuySynthes,West Chester PA).

Postoperative strengthening with physical therapy started at two weeks. At the six week follow up visit the patient reported no pain, had full ROM and x-ray imaging appeared normal (Figure 2). His one-year postoperative MRI showed healed and well ossified OCD with tendonitis and edema in the mobile wad attachment (Figure 3). The patient reported lateral elbow pain different from his preoperative complaints with sport activity such as basketball and soccer and physical therapy was recommended for tendonitis.

Case 2:



Figure 2. 6-week post-operative X-Ray imaging of Case 1.

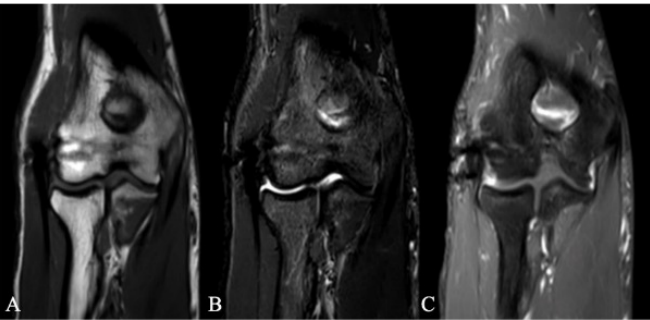


Figure 3. 1-year post-operative MRI imaging of Case 1.

A 16-year-old female who played basketball and volleyball presented with persistent right elbow pain. Her elbow ROM without pain was 0 to 150 degrees. She had no significant medical or surgical history. The right elbow pain began nearly a year prior to her referral to orthopedic surgery. Her first Xray and MRI (June 2022) findings at an outside hospital were initially reported to be consistent with cubital tunnel syndrome (Figure 4).

One year after the initial MRI, her right elbow pain persisted and the patient and family sought a second opinion (March 2023). Review of the MRI and plain Xray identified a 1 cm x 1 cm lesion at the ulnotrochlear junction on MRI consistent with trochlear OCD lesion of her right elbow.

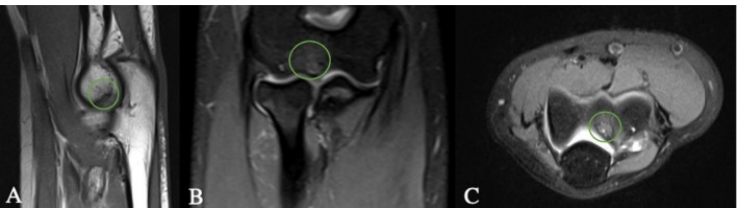


Figure 4. Preoperative MRI imaging of OCD lesion (green circle) in Case 2 procedure 1 in (A) sagittal, coronal (B), and axial (C) planes.

The patient and her family initially elected for conservative measures with minimal success. Due to persistent lack of ROM, the patient elected for operative intervention. An elbow arthroscopy with an open decompression and bone grafting of lesion debridement for the patient's elbow trochlear OCD lesion was performed (May 2023). Drilling into the lesion was performed and DBX was then used to fill the void.

At both the two and four months post-operative visits, the patient reported persistent mild surgical site pain at the medial elbow site, but no notable joint pain after the procedure and she maintained full ROM. At her first post-operative volleyball competition she reported pain that improvement over a 10-day period. Four months post-operative X-rays showed a well-healed drill hole and reduced OCD lesion (Figure 5). The pain was attributed to increased activity, and it was recommended that she continue as tolerated.



Figure 5. Postoperative X-Ray imaging of OCD lesion (green circle) for Case 2 procedure 1 in coronal (A) shows the well healed drill tract (black arrows).

One-year post-operatively, the patient had pain with activities and at rest. She maintained full ROM with no pain laterally over radial head but did have pain anteriorly over the antecubital fossa. Xray demonstrated new finding of loose osteochondral lesion in the trochlear area. The previous drilling tract was well healed with no evidence of new lysis in the trochlear area. An MRI with contrast

confirmed the nearly nondisplaced osteochondral fragment with underlying fluid signal along the radial margin and the trochlea as well as minor signal alteration in the ulnar nerve at the level of the cubital tunnel (Figure 6).

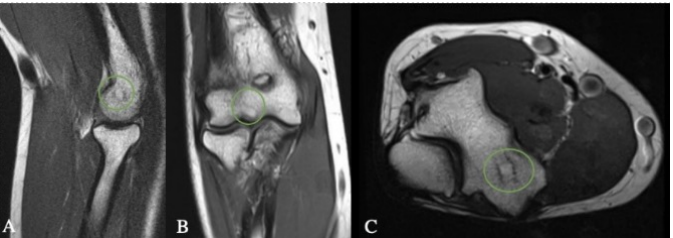


Figure 6. Preoperative MRI imaging of OCD lesion (green circle) for Case 2 procedure 2 in sagittal (A), coronal (B), and axial (C) planes.

An open decompression and microfracture of lesion for the patients elbow trochlear OCD lesion was performed (May 2024). The OCD lesion (12 mm x 5 mm) was observed on the lateral edge of the posterior trochlea. The bone was then removed, and the base of the lesion was curetted until no further cartilage remained and then a microfracture of the lesion was performed (Figure 7).

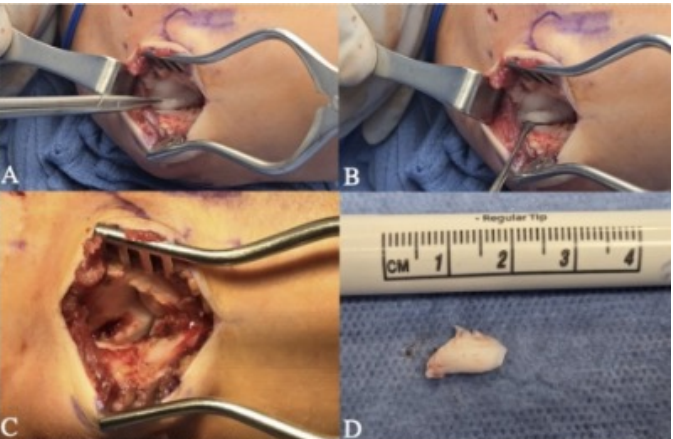


Figure 7. Relevant intraoperative imaging with OCD lesion specimen from Case 2 procedure 2. Open view of trochlea lesion (A), active removal of lesion (B), trochlea with lesion removed (C), and excised trochlea lesion measuring nearly 1.5 cm (D).

At her two week follow up, she had no pain at rest and slight discomfort with activities. She also had decreased ROM including slight loss of extension and her flexion was at 110 degrees. The surgeon recommended strength training and she began occupational therapy. One month postoperatively

the patient had full ROM, no pain, and well healed incisions. Five months postoperative, the patient was satisfied with the result and had full ROM with well healed incisions. She experienced no pain with day-to-day activities and was playing volleyball with only minor pain after tournaments which resolved with ice and anti-inflammatories. Xray imaging demonstrated no loose bodies or arthritis, the drill hole and OCD trochlear area were well healed (Figure 8).

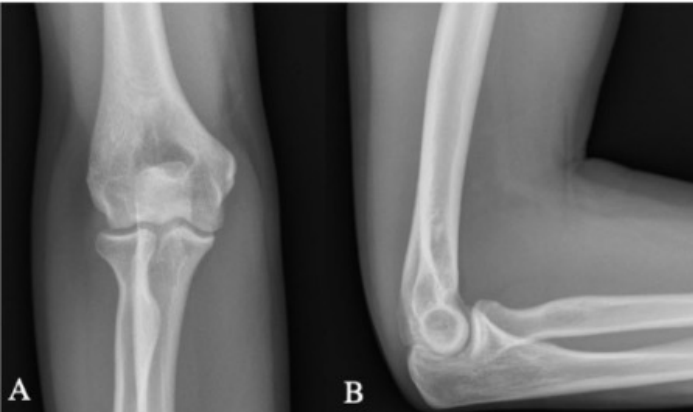


Figure 8. Postoperative X-Ray imaging for Case 2 procedure 2.

Discussion:

OCD of the trochlea in the elbow is rare, accounting for 2.5-7% of lesions in the elbow^{4,6, 10, 11}. Non-operative treatment is pursued initially in 86% of cases and 76% of those achieve a full recovery⁴. If symptoms do not resolve an operative approach is taken yet there is little consensus on the best method of operative treatment given the heterogeneity of the data does not allow for control comparison.⁴ The presented cases report two instances of OCD of the trochlea which were repaired using extraarticular drilling and decompression. In both cases, the patients failed nonoperative treatment as pain and decreased ROM remained. Postoperatively the OCD lesion presented in the first case was healed and well ossified based on MRI with the patient reporting full recovery of ROM. While pain remained with certain physical activities the patient sought physical therapy for treatment of tendonitis. The clinical outcomes

of this case were considered satisfactory and add to sparse available literature on repair of OCD of the trochlea.

The second case involved a prolonged pathology course including a repeat operation. The first operation was thought to be a success with no complications. The recurrent pain was shown to be a new loose osteochondral fragment which required revision surgery. The repeat resection was of a higher complexity than the previous surgery and was completed without complication resulting in improved clinical and radiographic outcomes. By five months postoperatively, the patient had full ROM, no pain with daily activities, mild volleyball tournament-related discomfort, and X-ray evidence of a well-healed trochlear OCD lesion. This case is an important addition to the literature, as it demonstrates the potential complexity of surgical intervention involving repair of OCD of the trochlea.

For OCD lesions of the elbow debridement and drilling are two of the most common forms of surgical repair and were chosen as the intervention in these cases.¹² The lack of literature allows for little consensus on the best operative management of elbow trochlear repair. These cases provide two examples of operative treatment of OCD of the trochlea with varying surgical outcomes after initial surgical intervention.

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New Faculty Spotlight:

A Q&A session with Dane Brodke, MD, MPH

Hometown: Salt Lake City, UT
Medical School: University of California, San Francisco
Residency: University of California, Los Angeles, Orthopaedic Surgery
Fellowship: R Adams Cowley Shock Trauma Center, Orthopaedic Trauma

Tell us a little about yourself.
I was exposed to orthopaedic surgery early on by my dad who is a spine surgeon at the University of Utah. I skied a ton growing up, first on racing teams and then freestyle telemarking at Alta, so I always felt most at home near snowy mountains. I then spent 14 years in California for school/training. I met my wife Sasha, and some of my best friends at Pomona College. I also studied abroad in Kathmandu, Nepal where the mountains made Utah's look like anthills! At first, I thought I would pursue a neuroscience PhD, but while I loved science research, I missed working directly with people. In med school, I felt like I was missing the broader perspective on US healthcare so I took a fifth year to get an MPH in health policy. That year, I started some access-to-care projects in orthopaedic trauma that ultimately helped lead me to the field.

What brought you to OHSU?
I was attracted to OHSU by the potential to work with fantastic partners, a strong trauma system with an interesting and complex case mix, and a department and residency program with a strong culture and sense of identity. I have always wanted to work in academia because I love research and teaching. Further, I love the sense of community inherent when you have learners of all levels striving to improve their knowledge and their craft. I also wanted to live in the western US which is home for me.

What have you been most proud of so far in your career?
Surgically, there are almost no words for how rewarding it is to perform a difficult fracture repair and then see the patient nonchalantly walk comfortably into your clinic 3 months later. As I am writing this, I am 6 months into practice, and I did not fully anticipate how incredibly touching and rewarding that experience would be.

Do you have any research projects or areas of interest that you are pursuing?
My focus currently is using smartphone data to better understand patients' real-world recovery from injury. Existing tools, such as in-office surveys, are time-limited and error-prone. This greatly limits our insight into the recovery process, and our ability to understand systematically how we can improve recovery through treatment. Within the last decade or so, a remarkable change in society has occurred; nearly all people now have an advanced chip connected to a high-fidelity accelerometer at all times. If we can harness the data produced by these devices, there is a profound opportunity to learn more about our patients' mobility and advance both diagnostics and treatments.

What is your go-to OR music?
Right now, I am on a Hozier kick but anything upbeat and soulful or slightly dancy always flies!



New Faculty Spotlight:

A Q&A session with Muayad Kadhim, MD

Hometown: Damascus, Syria
Medical School: Damascus University
Residency: Damascus Hospital – Syrian Board of Medical Specialties
Fellowship: University of California San Francisco, Benioff Children Hospital: Pediatric Orthopaedics Fellowship; University of Pittsburgh Medical Center: Hand surgery fellowship; Louisiana State University, Children's Hospital of New Orleans: Pediatric Orthopaedics fellowship; Dalhousie University, IWK health center: Pediatric Orthopaedics fellowship; Sinai Hospital of Baltimore: Limb lengthening and reconstruction fellowship

Tell us a little about yourself.
I was born and raised in Damascus, Syria, with family roots in both Iraq and Syria. Coming from a family deeply involved in medicine, I developed an early interest in the field. After completing orthopaedic surgery residency training in Damascus, I pursued subspecialty training in pediatric orthopaedics, including fellowships at multiple institutions across the United States and Canada.

What brought you to OHSU?
Portland has long been of interest to me, given Oregon's renowned natural beauty and temperate climate. I have always aimed to establish an academic career in pediatric orthopaedic surgery and was enthusiastic about the opportunity to join an outstanding faculty and staff at OHSU.

What drew you to your subspecialty?
The variety of routine and complex conditions motivates me to continually refine my judgment and technical expertise, especially when evaluating infants and young children.

What have you been most proud of so far in your career?
There is a special satisfaction in helping children

recover, regain function, and return to their daily lives. I take pride in fulfilling this role and contributing to children care.

What are some goals you have for your practice?
My goal is to provide thoughtful, high-quality care for every child I treat, ensuring that families feel supported and confident in the care we provide. I also aim to continue learning as a surgeon and to integrate new knowledge and techniques into practice. Over time, I hope to contribute to the field through research and mentorship, improving outcomes for children and supporting the development of future pediatric orthopaedic surgeons.

Do you have any research projects or areas of interest that you are pursuing?
I am eager to engage in research projects that advance patient care and support evidence-based practice. I look forward to developing a meaningful research portfolio over the coming years.

Do you have any advice for the graduating chiefs?
Stay connected with your mentors and do not hesitate to seek guidance when needed. Be deliberate in your learning, take notes of "dos and don'ts" and maintain a record of instructive cases. Most importantly, remember that you will be the one standing before patients and their families, entrusted with their care.

What is something you wish you had learned earlier in training?
I have come to appreciate that anatomy and surgical approaches are fundamental to successful surgery. Without a deep understanding of normal anatomy, a surgeon's ability to perform procedures safely can be limited.

What do you do when you aren't at the hospital?
I enjoy walking, hiking, working out, and cooking.



New Faculty Spotlight:

A Q&A session with Ian Logan, MD

Hometown: Aloha, OR

Medical School: Saint Louis University School of Medicine

Residency: University of Washington, Physical Medicine & Rehabilitation

What brought you to OHSU?

OHSU offered personal and professional opportunities that were impossible for me to pass up. Personally, this is a homecoming for me and my family. Having grown up in Aloha, OR (the Portland suburbs) I'm very excited to return home after being away for over a decade. Professionally, I'm looking forward to building a physiatry practice in my home community that is focused on neurological conditions, in particular traumatic brain injuries and spinal cord injuries. After meeting the faculty and leadership of the department, I felt incredibly supported to create a practice that would balance my interests and serve the needs of the community.

What drew you to your specialty?

The diversity and collaborative nature of the field. PM&R is a unique field where the primary aim is to enhance or restore functional abilities leading to increased independence and improved quality of life for patients with physical and/or neurological impairments or disabilities affecting the brain, spinal cord, or musculoskeletal systems. Additionally, I played collegiate basketball and was very excited to find a medical specialty with such an emphasis on teamwork. I'm frequently collaborating with orthopaedics,

neurosurgery, trauma surgery, physical therapy, occupational therapy, speech therapy, and psychology among others.

What are some goals you have for your practice?

My current goals are to develop robust inpatient and outpatient neurological physiatry and rehabilitation medicine services here at OHSU. On the inpatient side, I'm partnering with the trauma, orthopaedic, and neurosurgical teams to optimize functional outcomes after TBI and SCI by assisting in the management of neurogenic bowel and bladder, spasticity and contracture prevention, disorders of consciousness, agitation and paroxysmal sympathetic hyperactivity after TBI. In the outpatient setting, I want to ensure that Oregonians with TBIs and SCIs have access to longitudinal physiatry care for ongoing coordination of their rehabilitation.

Do you have any advice for the graduating chiefs?

More of a reminder than advice: The learning never stops.

What is something you wish you had learned earlier in training?

To provide the highest quality care for your patients you must take care of yourself first. Find balance between your work, your family and friends, and your hobbies and interests.

What do you do when you aren't at the hospital?

These days I'm spending most of my time at home with my wife, daughter (born in December 2023), and our golden retriever.

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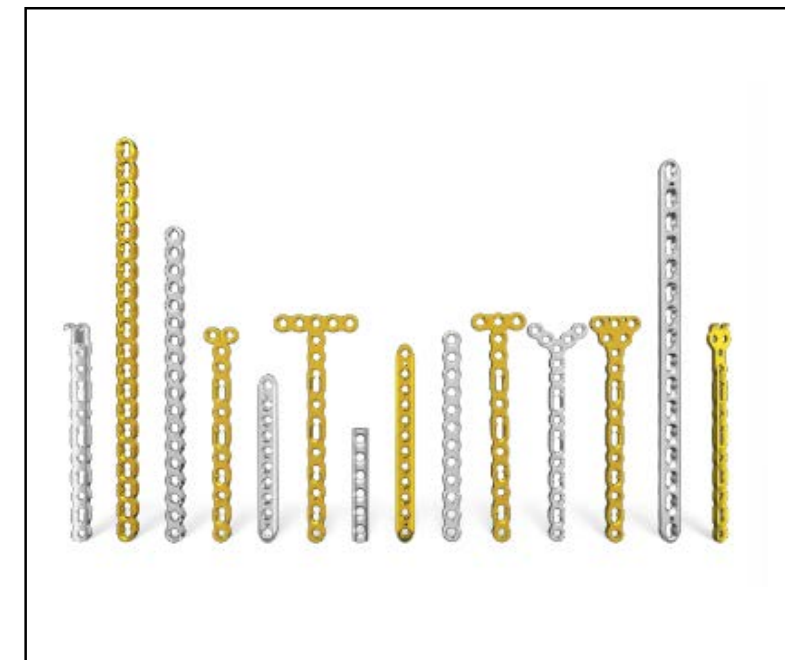


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Outcomes of Posterior Lumbar Interbody Fusion: A Comparative National Database Study of Bariatric Surgery, Morbidly Obese, and Non-Obese Patients

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BACKGROUND

Obesity is associated with increased perioperative risk following spine surgery. Bariatric surgery (BS) has been proposed as a preoperative optimization strategy; however, its impact on outcomes after posterior lumbar interbody fusion (PLIF) remains unclear. This study evaluates postoperative outcomes in patients undergoing PLIF with prior BS compared to morbidly obese (MO) and non-obese (NO) cohorts.

METHODS

A retrospective cohort study was performed using the PearlDiver Mariner database, identifying patients who underwent single-level open PLIF between 2016 and 2020. Patients were stratified into BS, MO, and NO groups. Outcomes included 90-day readmission, revision surgery, medical and surgical complications, intensive care unit (ICU) utilization, and length of stay (LOS). Multivariable logistic regression adjusted for demographic and clinical covariates. Kaplan–Meier analysis assessed revision-free survival over five years.

RESULTS

A total of 75,821 patients were included (316 BS, 16,685 MO, 58,820 NO). On unadjusted analysis, both BS and MO patients demonstrated higher rates of revision and 90-day readmission compared to NO patients. Kaplan–Meier analysis showed significantly lower revision-free survival in BS and MO cohorts (p < 0.0001). However, after adjustment, BS was not independently associated with revision surgery, medical complications, ICU utilization, or other postoperative complications. BS remained independently associated with increased 90-day readmission (OR 1.79, p = 0.0004). MO patients demonstrated higher complication rates and longer LOS compared to NO patients.

CONCLUSIONS

After adjustment for confounding variables, bariatric surgery was not independently associated with most postoperative complications following PLIF, though it remained associated with increased 90-day readmission rates. These findings suggest that observed differences in unadjusted analyses may reflect underlying patient characteristics rather than bariatric surgery itself, while highlighting readmission as an area of ongoing concern.

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Surgical approaches for inserting hemiarthroplasty of the hip in people with hip fractures

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BACKGROUND

The optimal surgical approach for hip hemiarthroplasty remains uncertain. This study systematically reviewed and meta-analyzed randomized controlled trials (RCTs) and quasi-RCTs to evaluate the effects of different surgical approaches on clinical outcomes after hip hemiarthroplasty.

METHODS

We searched 11 electronic databases and 9 additional sources for grey literature, including studies from inception to March 2023, without language restrictions. Trials comparing surgical approaches for hemiarthroplasty as treatment for hip fractures in older adults were included, while studies involving high-energy mechanisms or total hip arthroplasty were excluded. Core outcomes included activities of daily living (ADL), health-related quality-of-life (HRQOL), mobility/functional status, mortality, and pain. Secondary outcomes focused on complications, operative details, and postoperative care. Meta-analysis was performed using RevMan Web, and evidence certainty was assessed with GRADE methods.

RESULTS

We included 27 studies (23 RCTs, three quasi-RCTs, and one combined RCT/quasi-RCT) with a total of 3369 participants. The quality of evidence was rated as low or very low for core outcomes. The anterior approach was associated with earlier independent ambulation (RR 1.64, 95% CI 1.15-2.34) and a lower risk of dislocation (RR 0.20, 95% CI 0.05-0.90) compared to the posterior approach. It also resulted in fewer instances of leg length discrepancy and a lower likelihood of early Trendelenburg gait (RR 0.13, 95% CI 0.04-0.40) compared to the lateral approach. The posterior approach was linked to more dislocations (RR 3.12, 95% CI 1.47-6.67), more postoperative blood transfusions (RR 1.47, 95% CI 1.04-2.08), more reoperations (RR 1.59, 95% 1.02-2.44) at 6-24 months compared to the lateral approach.

CONCLUSIONS

Overall, current evidence does not definitively support one approach over another. However, differences in mobility, mortality, and complications may guide shared decision-making as appropriate. Future studies should aim to improve evidence certainty through higher-powered trials, adherence to established reporting standards (eg. Consort, Cochrane), the use of core outcomes for hip fractures, and follow-up to at least four months.

Midterm Outcomes Following Intravenous Zoledronate Administration in Elderly Patients with Hip Fragility Fractures: A Cohort Study

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BACKGROUND

Geriatric hip fractures are associated with high morbidity and mortality, and secondary fragility fractures represent a recognized complication in this population. Despite evidence supporting bisphosphonate therapy for secondary fracture prevention, osteoporosis remains underdiagnosed and undertreated following hip fracture. Intravenous (IV) zoledronate offers logistical advantages given its annual dosing schedule, permitting in-hospital administration. Our institution previously implemented a quality improvement (QI) initiative that significantly increased rates of inpatient zoledronate administration and formal osteoporosis diagnosis in eligible hip fracture patients. The purpose of this study was to evaluate midterm (1-2 years) outcomes of patients enrolled in this initiative. Specifically, we investigated whether IV zoledronate receipt was associated with differences in one-year mortality, two-year readmission, two-year additional fracture, or ongoing bone supportive medication (BSM), which includes denosumab and bisphosphonates, use.

METHODS

This is a retrospective cohort study of patients aged 65 years and older admitted with fragility hip

fractures between January 2021 and December 2022 at a single academic institution. Patients were eligible for bisphosphonate therapy if they had a creatinine clearance of at least 35 mL/min, no severe dental disease, no prior bisphosphonate use, and an estimated life expectancy exceeding two years. Primary outcomes were one-year mortality, two-year readmission (length of stay 2 or more days), two-year additional fracture, and ongoing BSM use (prescribed 3-24 months post-surgery). Unadjusted and adjusted logistic regression was used to assess associations between zoledronate receipt and each outcome, adjusting for age, sex, BMI, ASA classification, smoking status, and index vitamin D level.

RESULTS

A total of 115 patients were included; 59 (51%) received IV zoledronate. One-year mortality was 23% overall and did not differ significantly for patients receiving zoledronate compared to those who did not (20% vs 27%; adjusted OR 1.80, 95% CI 0.59-5.88, p=0.29). Two-year readmission occurred in 37% of patients and was also not significantly associated with receiving zoledronate (adjusted OR 0.82, 95% CI 0.34-1.98, p=0.66). Two-year additional fracture occurred in 16% of patients with no significant

association (adjusted OR 1.05, 95% CI 0.34–3.36, p=0.93). Receipt of ongoing BSM was significantly higher in patients who received zoledronate (adjusted OR 0.17, 95% CI 0.04–0.57, p=0.006), with 12% of the zoledronate group and 25% of the no-zoledronate group receiving BSMs within 24 months of index fracture.

CONCLUSIONS

IV zoledronate administered during the hip fracture index admission was not significantly associated with differences in one-year mortality, two-year readmission, or two-year additional fracture, though the study was underpowered to

detect clinically meaningful differences in these outcomes. Zoledronate receipt was, however, associated with significantly lower odds of receiving additional bone supportive medications in the 3 to 24 months following surgery. Given evidence that a single zoledronate infusion may suppress bone turnover for up to five years, this finding may reflect appropriate clinical decision-making rather than a gap in osteoporosis care, though limitations in EMR-based prescription ascertainment preclude definitive conclusions.

Level of Evidence: III (Retrospective Cohort Study)

A Multi-Institutional Cost Analysis of Reusable Versus Disposable Surgical Gowns

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IMPORTANCE

Reusable surgical gowns have been demonstrated to have a lower environmental impact than disposable gowns. However, the relative costs of these gown types in the United States (US) are not well studied.

OBJECTIVE

To determine the relative cost of using a reusable versus a disposable surgical gown at multiple institutions.

DESIGN, SETTING, AND PARTICIPANTS

This multicenter cost analysis was conducted between January 2022 and March 2026 at 3 US hospitals. Inclusion criteria were active reusable gown use, ability to provide disposable gown cost data, and willingness to participate in the study. Site visits were performed to collect cost data and observe reusable gown processing workflows.

MAIN OUTCOME AND MEASURES

The primary outcome was cost per use of reusable versus disposable surgical gowns at each participating hospital. We hypothesized no difference in cost between the gown types.

RESULTS

Reusable surgical gowns had a cost advantage

at Seattle Children’s Hospital (\$2.67 versus \$3.14 per use) and at Harborview Medical Center (\$3.15 versus \$3.35). Both facilities use the same local facility for laundry and sterilize their reusable gowns in house. Meanwhile, reusable surgical gowns were more expensive than disposable gowns at Penn Presbyterian Hospital (\$3.64 versus \$3.19), which relied on a non-affiliated third-party vendor to supply and reprocess its reusable gowns. After several decades of favoring reusable gowns, Penn Presbyterian Hospital transitioned back to disposable surgical gowns in 2025.

CONCLUSIONS AND RELEVANCE

In this multi-center cost analysis, reusable and disposable surgical gowns were competitively priced. The cost difference between gown types was less than 50¢ at all included hospitals. Reusable gowns were cheaper at the Seattle-based hospitals that had local reprocessing infrastructure; however, they were more expensive Penn Presbyterian Hospital, which was dependent on an external vendor located out of state. These findings suggest that reusable surgical gowns are a cost-competitive alternative to disposable gowns. Importantly, local laundry facilities like that in Seattle may be integral to the cost-effective expansion of reusable textiles in US hospitals.

Is Timing of Total Hip Arthroplasty and Lumbar Spine Fusion Associated With Risk of Hip Dislocation?

Sebastian Welling, MD^a, Spencer Smith, BS^a, Jung Yoo, MD^a, Travis Philipp, MD^a, Mark Mildren, MD^b, Ryland Kagan, MD^a



Sebastian Welling, MD
Hometown: Juneau, AK
Medical School: University of Washington School of Medicine
Fellowship Plans: Spine, Spine Institute of Arizona

BACKGROUND

In patients with concomitant hip and lumbar spine disease, the question of which surgery—total hip arthroplasty (THA) or lumbar spine fusion (LSF)—to address first has not been adequately answered. We aimed to evaluate the risk of dislocation after THA in patients with LSF first or after THA.

METHODS

Retrospective review utilizing the PearlDiver database querying Current Procedural Terminology codes for LSF in the year prior (LSF first) or in the year after primary or revision THA (THA first). International Classification of Disease codes identified postoperative hip dislocation as our primary outcome variable. Demographic data collected included age, sex, and obesity. Dislocation rates were described as a proportion of the cohort and compared with chi-square tests.

RESULTS

We identified 280,857 primary THA and 42,314 revision THA cases from 2012–2019. Of these, 2090 underwent primary THA and LSF, and 283 underwent revision THA and LSF within a year of each procedure. No differences in age, sex, or obesity between groups were noted. No difference in rate of all-time dislocation for primary THA was noted for the LSF first 51/1429 (3.6%) compared to the THA first 30/661 (4.0%) groups ($P = .34$), or for revision THA with LSF first 48/204 (23.5%) compared to THA first 27/117 (23.1%) groups ($P = 1.0$).

CONCLUSIONS

There was no difference in the risk of dislocation after primary or revision THA if LSF occurred prior to or after the THA. These findings can help surgeons as they counsel patients with concomitant lumbar spine and hip degeneration.

PGY-4 Class



Amador Bugarin, Jr., MD
Hometown: Norwalk, CA
Medical School: UCLA - Charles R. Drew University of Medicine and Science, Los Angeles, CA



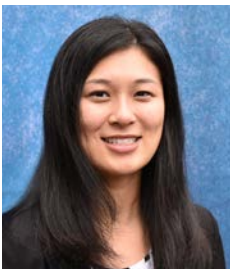
Calvin Englert, MD
Hometown: Windsor, CO
Medical School: University of Rochester School of Medicine & Dentistry, Rochester, New York



Isaac Lapite, MD
Hometown: Eugene, OR
Medical School: Case Western Reserve University School of Medicine, Cleveland, OH



Yash Tarkunde, MD
Hometown: Sugar Land, TX
Medical School: Washington University School of Medicine, St. Louis, MO



Stephanie Zhao, MD
Hometown: Beaverton, OR
Medical School: Oregon Health & Science University, Portland, OR

PGY-3 Class



Nicholas Collar, MD
Hometown: Deerfield, WI
Medical School: Medical College of Wisconsin, Milwaukee, WI



Hanne Gehling, MD
Hometown: Walla Walla, WA
Medical School: Oregon Health & Science University, Portland, OR



Tasha McKibben, MD
Hometown: Eatonville, WA
Medical School: Oregon Health & Science University, Portland, OR



Julia Silver, MD
Hometown: Salem, OR
Medical School: Tulane University, New Orleans, LA



Josh Yuan, MD
Hometown: Portland, OR
Medical School: Case Western Reserve University School of Medicine, Cleveland, OH

^a Department of Orthopaedics and Rehabilitation, Oregon Health & Science University, Portland, OR, USA
^b Slocum Center for Orthopedics and Sports Medicine, Eugene, OR, USA

PGY-2 Class



Caellagh Catley
Hometown: Superior, CO
Medical School: Washington University School of Medicine in St. Louis



Madison Hayes-Lattin
Hometown: Portland, OR
Medical School: Tufts University School of Medicine



Brett Jones
Hometown: Seattle, WA
Medical School: Elson S. Floyd College of Medicine, Washington State University



Maia Shoham
Hometown: Palo Alto, CA
Medical School: Stanford University School of Medicine



Samhita Swamy
Hometown: Memphis, TN
Medical School: University of Tennessee Health Science Center

PGY-1 Class



Cesar Cornejo Ochoa, DO
Hometown: Leon, Mexico and Portland, OR
Medical School: Western University of Health Sciences - COMP-NW



Varun Gopinath, MD
Hometown: Portland, OR
Medical school: Saint Louis University School of Medicine



Jai Prasad, MD
Hometown: Austin, Texas
Medical school: UT Southwestern



Braedon Urie, MD
Hometown: Purcellville, Virginia
Medical school: Rush Medical College



Morgan Williams, MD
Hometown: Dallas, TX
Medical school: Meharry Medical College

The Use of a Novel Antiseptic Irrigant Solution in Combination with Vancomycin Powder Significantly Reduces the Risk of Surgical Site Infections in Orthopedic Trauma Patients.

Robert Wood, DO, Jeremy Brown, DO



Robert Wood, DO
Hometown: Erie, PA
Medical School: Lake Erie College of Osteopathic Medicine
Fellowship Plans: Sports Medicine and Shoulder Surgery, University of Missouri



Jeremy Brown, DO
Hometown: St. Petersburg, FL
Medical School: Rocky Vista University
Fellowship Plans: Pediatric Orthopaedics, Phoenix Children's Hospital

OBJECTIVES

This study aims to evaluate whether using a novel antiseptic irrigant solution combined with vancomycin powder can effectively reduce the incidence of surgical site infections (SSIs) in orthopedic trauma patients. Specifically, we seek to determine if this combined approach significantly decreases SSI rates compared to using vancomycin powder alone. The study also aims to assess the safety and efficacy of the phosphate buffer solution, particularly its ability to reduce biofilm formation on surgical implants without causing cytotoxic effects. Ultimately, our goal is to provide insights into potential clinical practice changes that can enhance infection prevention strategies in orthopedic trauma surgeries.

METHODS

This retrospective study analyzed 450 orthopedic trauma surgeries for lower extremity fractures at a Level Two hospital in Oregon, USA, between January 2021 and October 2023. Patients were stratified based on intraoperative irrigation with

either vancomycin alone or vancomycin combined with a phosphate buffer irrigation solution. Data analysis included demographic characteristics, operative details, and occurrences of SSIs within 90 days postoperatively.

RESULTS

Among the 450 surgeries analyzed, 18 (8.1%) SSIs occurred in the vancomycin cohort compared to 3 (1.3%) in the vancomycin and Phosphate buffer cohort. Adjusted logistic regression revealed an 89% reduction in the odds of SSIs in the vancomycin and Phosphate buffer cohort (OR: 0.11, 95% CI 0.02-0.35, $P=0.001$), adjusting for age, tobacco use, operative time, and procedure type.

CONCLUSION

This study underscores the promising role of combined vancomycin and Phosphate buffer irrigation in reducing SSI rates in orthopedic trauma surgeries. Further prospective studies are warranted to validate these findings and explore optimal infection prevention strategies in diverse surgical settings.

PGY-5 Class



Jeremy Brown, DO Hometown: St. Petersburg, FL Medical School: Rocky Vista University Fellowship Plans: Pediatric Orthopaedics, Phoenix Children's Hospital	Kristin Toy, MD Hometown: Steamboat Springs, CO Medical School: University of Toledo College of Medicine Fellowship Plans: Orthopaedics, Columbia University	Robert Wood, DO Hometown: Erie, PA Medical School: Lake Erie College of Osteopathic Medicine Fellowship Plans: Sports Medicine and Shoulder Surgery, University of Missouri
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PGY-4 Class



Delon McAllister, MD Hometown: Irvington, NJ Medical School: Georgetown University, Washington, DC	Marielle Ngoue, MD Hometown: Yaounde, Cameroon Medical School: University of Texas Austin Dell Medical School, Austin, TX	Carson Twiss, DO Hometown: San Francisco, CA Medical School: Pacific Northwest University of Health Sciences, Yakima, WA
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PGY-3 Class



Jackson Barber, DO Hometown: Kalispell, MT Medical School: Pacific Northwest University of Health Sciences, Yakima, WA	Adithya Shekhar, MD Hometown: Newark, CA Medical School: California Northstate University College of Medicine, Elk Grove, CA	Jorge Perera, DO Hometown: Cape Coral, FL Medical School: Lake Erie College of Osteopathic Medicine, Bradenton, FL
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Resident Directory 2025-2026

Samaritan Health Services Residents (PGY-5 to PGY-1)

PGY-2 Class



Jaydeep Dhillon, DO
Hometown:
Houston, TX

Medical School:
Rocky Vista
University College of
Osteopathic Medicine,
Englewood, CO



Daniel Schanz, DO
Hometown:
Amity, OR

Medical School:
Michigan State
University College of
Osteopathic Medicine,
East Lansing, MI



Kaitlin Williams, DO
Hometown:
Houston, TX

Medical School:
Rocky Vista
University College of
Osteopathic Medicine,
Englewood, CO

PGY-1 Class



Galo Bustamante, MD
Hometown:
Portland, OR

Medical School:
Ohio State University,
Columbus, OH



Michael McGehee, DO
Hometown:
Tyler, TX

Medical School:
Edward Via College of
Osteopathic Medicine,
Blacksburg, VA



Austin Yu, MD
Hometown:
Pasadena, CA

Medical School:
Albany Medical
College, Albany, NY

OHSU Orthopaedic Program Alumni Directory

GRADUATE	FELLOWSHIP TRAINING	CURRENT PRACTICE LOCATION
2025		
Kate Hutchison	Trauma – Indiana University	
Mackenzie Kelly	Adult Reconstruction – University of Utah	
Phillip Lam	Hand, Upper Extremity, and Microsurgery – University of Maryland	
Sarah Lindsay	Orthopaedic Oncology – University of Toronto	
Kyle Minkel	Sports Medicine – Mammoth Orthopaedic Institute	
2024		
Naomi Turner	Arthroplasty – Washington University, St. Louis, MO	Essentia Health St. Joseph's, Brainerd, MN
Michelle Lawson	Orthopaedic Trauma – Indiana University, Indianapolis, IN	University of Iowa, Iowa City, IA
Danielle Peterson	Orthopaedic Trauma – University of California, Davis, Sacramento, CA	MultiCare Tacoma General Hospital, Tacoma, WA
Frank Rodgers	Arthroplasty – University of Chicago, Chicago, IL	SSM Health, Madison, WI
Laura Sokil	Foot and Ankle – Mercy Medical Center, Baltimore, MD	University of Wisconsin, Madison, WI
2023		
Loren Black	Orthopaedic Trauma – Harborview Medical Center, Seattle, WA	Saint Alphonsus Regional Medical Center, Boise, ID
Derek Bond	Hand, Upper extremity and Microvascular – University of California Davis	Hillsboro Medical Center, Hillsboro, OR
Elliott Cole	Sports Medicine and Shoulder Fellowship – University of California San Francisco (UCSF)	Regenerative Orthopedic Center, Tualatin, OR
Jamil Kendall	Adult Reconstruction – Midwest Orthopedics at Rush University	Parkview Orthopaedic Group, Palos Heights, IL
Connor Pihl	Hand & Upper Extremity – OHSU, Portland, OR	Eastside Orthopedics and Sports Medicine, Milwaukie, OR
2022		
Sam Cheesman	Hand – University of New Mexico, Albuquerque, NM	Regenerative Orthopedic Center, Portland, OR
Ryan Hadden	Hand and Upper Extremity – Brown University, Providence, RI	Olympia Orthopaedic Associates, Olympia, WA
Sam Moulton	Sports Medicine & Shoulder – University of California San Francisco, San Francisco, CA	Proliance Orthopaedics and Sports Medicine, Greater Seattle Area, WA
Erik Woelber	Adult Reconstruction – Rothman Orthopaedic Institute, Philadelphia, PA	Juneau Bone and Joint Center, Juneau, AK
Natalie Zusman	Pediatric Orthopedics – Children's Hospital Los Angeles, Los Angeles, CA	Kaiser Permanente, Portland OR
2021		
Torgom Abraamyan	Sports Medicine – Southern California Orthopaedic Institute, Van Nuys, CA	Kaiser Permanente, Woodland Hills, CA
Trevor Barronian	Total Joint Arthroplasty – Rothman South Jersey, Atlantic City, NJ	Olympia Orthopaedic Associates, Olympia, WA
Jason Laurita	Adult Reconstructive Surgery – Houston Methodist Hospital, Houston, TX	Sterling Ridge Orthopaedics & Sports Medicine, Houston, TX
Michael Robbins	Hand/Upper Extremity – University of Utah, Salt Lake City, UT	Orthopedic Associates of Northern California, Chico, CA
Sean Sterrenberg	Arthroplasty – Reno Orthopedic Clinic, Reno, NV	CHRISTUS St. Vincent Orthopedic Specialty Clinic, Santa Fe, NM
2020		
Nikolas Baksh	Spine – New York University, New York, NY; Orthopaedic Oncology – Memorial Sloan Kettering Cancer Center, New York, NY	Loyola University Medical Center, Maywood, IL
Taylor Lara	Adult Reconstruction – Florida Orthopaedic Institute, Tampa, FL	Saint Alphonsus, Boise, ID
David Putnam	Adult Reconstruction – OHSU, Portland, OR	Kaiser Permanente, Hillsboro, OR
Duncan Ramsey	Orthopaedic Oncology – Massachusetts General Hospital, Boston, MA	Oregon Health & Science University, Portland, OR
Grant Sun	Foot and Ankle – Baylor University, Dallas, TX	The Orthopaedic Specialty Clinic at TOSH, Salt Lake City, UT
2019		
Courtney Bell	Adult Reconstruction – Rothman Institute, Egg Harbor Township, NJ	Neuroscience and Spine Associates (NASA), Naples, FL
Shanjean Lee		VA Sierra Nevada healthcare System, Reno, NV
Elizabeth Lieberman	Adult Reconstruction – Washington University, St. Louis, MO	Orthopedic + Fracture Specialists, Portland, OR
Peters Otlans	Sports Medicine – Jefferson University, Philadelphia, PA	Proliance Southwest Seattle Orthopedics, Burien, WA
Travis Philipp	Spine – New York University, New York, NY	Oregon Health & Science University, Portland, OR

GRADUATE		FELLOWSHIP TRAINING	CURRENT PRACTICE LOCATION
2018			
Hannah Aultman	Hand & Upper Extremity – University of Chicago, Chicago, IL	Orthopedic & Fracture Specialists, Portland, OR	
Karlee Lau	Hand & Upper Extremity – University of Alabama, Birmingham, AL	University of Alabama, Birmingham, AL	
Dayton Opel	Hand & Upper Extremity – Cleveland Clinic, Cleveland, OH	Orthopedic & Spine Centers of WI, Madison, WI	
Derek Smith	Hand Surgery – Mary S. Stern, Cincinnati, OH	Desert Orthopedics, Bend, OR	
Benjamin Winston	Arthroplasty – Tahoe Reno Orthopedic Clinic, NV	Kaiser Permanente, Hillsboro, OR	
2017			
John Cox	Adult Reconstruction – Scripps Health, San Diego, CA	Kaiser Permanente, Antioch, CA	
Ryland Kagan	Adult Hip and Knee Reconstruction and Hip Preservation – University of Utah, Salt Lake City, UT	Oregon Health & Science University, Portland, OR	
Joseph Langston	Adult Reconstruction – Melbourne Orthopaedic Group, Melbourne, Australia	Kaiser Permanente, Lone Tree, CO	
Michael Rose	Sports Medicine – Steadman Hawkins Clinic, Denver, CO	The CORE Institute, Phoenix, AZ	
Ryan Wallenberg	Orthopedics – St. Vincent Hospital, Portland, OR	VA Portland Health Care System, Portland, OR	
2016			
Jake Adams	Adult Reconstruction – Mayo Clinic, Scottsdale, AZ	Integrated Surgical Services, Phoenix, AZ	
Kirsten Jansen	Adult Reconstruction – Indiana University, Indianapolis, IN	VA, St. Louis Healthcare System, Saint Louis, MO	
Tom Kowalik	Trauma & Adult Reconstruction – Orthopedic + Fracture Specialists, Portland, OR and Sydney Australia Arthroplasty & Trauma	OHSU Hillsboro Medical Center, Hillsboro, OR	
Jared Mahylis	Shoulder & Elbow – Cleveland Clinic, Cleveland, OH	Henry Ford Health System, Detroit, MI	
Farbod Rastegar	Spine – Cleveland, Cleveland, OH	Cincinnati Elite Orthopaedic and Spine, Cincinnati, OH	
2015			
Alex DeHaan	Adult Reconstruction – Tahoe Reno Arthroplasty, Reno, NV	Orthopedic + Fracture Specialists, Portland, OR	
Troy Miles	Adult Reconstruction – UC Davis, Davis, CA	Shasta Orthopaedics, Redding, CA	
Dustin Larson	Hand and Upper Extremity – University of New Mexico, Albuquerque, NM	Olympic Medical Physicians Orthopaedic Clinic, Port Angeles, WA	
Vivek Natarajan	Pediatrics – Childrens Hospital of Pittsburgh, PA; Spine – Oregon Health & Science University, Portland, OR	Institute For Orthopaedics and Neurosciences, Roanoke, VA	
John Seddon	Foot & Ankle – Melbourne Orthopaedic Group, Melbourne, Australia	UCHealth Orthopaedics Clinic - Briargate, Colorado Springs, CO	
2014			
Zachary Domont	Sports Medicine – University of Pennsylvania, Philadelphia, PA	Advocate Medical Group, Lincolnshire, IL	
Jia-Wei Kevin Ko	Shoulder & Elbow – The Rothman Institute, Philadelphia, PA	SEATTLE Joint Surgeons, Seattle, WA	
Trevor McIver	Spine – Spine Institute of Arizona, Scottsdale, AZ	St. Cloud Orthopedics, Sartell, MN	
Richard Myers	Trauma – R Adams Cowley Shock Trauma Center, Baltimore, MD	Sentara Orthopaedic Trauma Specialists, Norfolk, VA	
Brent Roster	Foot & Ankle – University of California Davis Medical Center, Sacramento, CA	Missoula Bone & Joint, Missoula, MT	
2013			
Adam Baker	Foot & Ankle – Northwest Orthopedic Specialists, Portland, OR	Kaiser Permanente, Hillsboro, OR	
Michael Kuhne	Trauma – Orthopedic Trauma Institute (UCSF), San Francisco, CA	Enloe Medical Center, Chico, CA	
Laura Matsen Ko	Adult Reconstruction – The Rothman Institute, Philadelphia, PA; Adult Reconstruction and Trauma – Providence St. Vincent, Portland, OR	SEATTLE Joint Surgeons, Seattle, WA	
Jacqueline Brady (Munch)	Shoulder Surgery, Sports Medicine – Hospital for Special Surgery, New York, NY	Oregon Health & Science University, Portland, OR	
Daniel Wiekling	Foot & Ankle – Melbourne Orthopaedic Group, Melbourne, Australia	Southern Oregon Orthopedics, Grants Pass, OR	
2012			
Dawson Brown	Sports Medicine – Southern California Orthopedic Institute, Van Nuys, CA	WestSound Orthopedics, Silverdale, WA	
Peter Fredericks	Trauma – Indiana Orthopedic Hospital (OrthoIndy), Indianapolis, IN	UCHealth, Colorado Springs, CO	
Matthew McElvany	Shoulder & Elbow – University of Washington, Seattle, WA	Kaiser Permanente, Santa Rosa, CA	
Cuchulain Luke Rust	Foot & Ankle – Orthopaedic Associates of Michigan, Grand Rapids, MI	Rebound Orthopedics, Vancouver, WA	

GRADUATE		FELLOWSHIP TRAINING	CURRENT PRACTICE LOCATION
2011			
Matthew Harrison	Foot & Ankle – Oakland Bone & Joint Specialist Clinic, Oakland, CA; Middlemore Hospital, Auckland, New Zealand	Alta Orthopedics, Santa Barbara, CA	
Jayne Hiratzka	Spine – University of Utah, Salt Lake City, UT	Southern Oregon Orthopedics, Medford, OR	
Jackson Jones	Adult Reconstruction – Harvard Medical School's Brigham and Women's Hospital, Boston, MA	Reno Orthopedic Clinic, Reno, NV	
2010			
Matthew Bradley		St. Louis Spine and Orthopedic, Town & Country, MO	
Gregory Byrd	Hand – Beth Israel Deaconess Medical Center, Boston, MA	Olympia Orthopaedic Associates, Olympia, WA	
Adam Cabalo	Spine – Spine Care Medical Group, Daly City, CA	Southern Oregon Orthopedics, Medford, OR	
Patrick Denard	Shoulder – Centre Orthopédique Santy, Lyon, France and San Antonio Orthopaedic Group, San Antonio, TX	Southern Oregon Orthopedics, Medford, OR	
Gary Kegel	Hand – St. Luke's-Roosevelt Hospital Center, New York, NY	Kaiser Permanente – Capital Hill, Seattle, WA	
2009			
Stephan Prô	Sports Medicine – Santa Monica Orthopaedic and Sports Medicine Group, Santa Monica, CA	OrthoKansas, University of Kansas Health System, Lawrence, KS	
Khalid Shirzad	Foot & Ankle – Duke University, Durham, NC	Northwest Orthopaedic Specialists, Spokane, WA	
Abner Ward	Hand – SUNY Stony Brook; Sports Medicine – Southern CA Center for Sports Medicine, Long Beach, CA; Shoulder & Elbow – Alps Surgery Institute, Annecy, France; Shoulder & Elbow – Schulthess Klinik, Zurich, Switzerland	Yosemite Bone and Joint, Inc., Merced, Turlock, Modesto, and Manteca, CA	
2008			
Kate Deisseroth		VA Medical Center, Lebanon, PA	
Andy Kranenburg	Spine – San Francisco Spine Institute, San Francisco, CA	Southern Oregon Orthopedics, Medford, OR	
Kenna Larsen	Hand – University of New Mexico, Albuquerque, NM	Tanner Clinic, East Layton, UT	
2007			
William Magee	Sports Medicine – TRIA Orthopaedic Center, University of Minnesota, Minneapolis, MN	Providence Northeast Washington Medical Group, Colville, WA	
J. Rafe Sales	Spine – San Francisco Spine Institute, San Francisco, CA	Summit Spine, Portland, OR	
Joseph Schenck	Sports Medicine – Perth Orthopaedic Sports Medicine Clinic, Perth, Australia and Arthroscopic Surgery and Computer Navigated Total Joint Arthroplasty – Sir Charles Gairdner Hospital, Nedlands, Western Australia	Oregon Surgical Institute, Portland, OR	
Robert Tatsumi	Spine – LA Spine Institute, Santa Monica, CA	Oregon Spine Care, Portland, OR	
2006			
Catherine Humphrey	Trauma – Vanderbilt University, Nashville, TN	University of Rochester, Rochester, NY	
Amer Mirza	Trauma – Harborview Medical Center, Seattle, WA	Summit Orthopaedics, Portland, OR	
Mark Wagner		Orthopedics Northwest, Portland, OR	
2005			
Patrick Dawson	Upper Extremity and Sports Medicine – Congress Medical Associates, Pasadena, CA	Cascade Orthopaedic Group, Tualatin, OR	
Suresh Kasaraneni		Scott Memorial Hospital, Scottsburg, IN	
Christopher Untch	Davis Monthan Air Force Base, Tucson, AZ	Arizona Orthopedics, Tucson, AZ	
Corey Vande Zandschulp	Trauma – Ortholndy, Indianapolis, IN	Summit Orthopaedics, Portland, OR	
2004			
Benjamin Kam		Kinetic Orthopedics, Colorado Springs, CO	
Britton Frome (Polzin)	Hand – University of Texas Southwestern, Dallas, TX	Summit Orthopaedics, Portland, OR	
2003			
Jennifer Miller	Sports Medicine – Congress Medical Associates, Pasadena, CA	Idaho Sports Medicine Institute, Boise, ID	
John (Jeb) Reid	Sports Medicine – Taos Orthopaedic Institute, Taos, NM	Asante Orthopedic Surgery and Sports Medicine, Ashland, OR	
Eric Shepherd	Trauma – UC Davis Medical Center and Auckland City Hospital, NZ	Santa Barbara Orthopedic Associates, Santa Barbara, CA	

GRADUATE		FELLOWSHIP TRAINING	CURRENT PRACTICE LOCATION
2002			
Michael Binnette	Spine – University of Washington, Seattle, WA		Maine Medical Partners, Scarborough, ME
Kevin Kahn	Trauma – Vanderbilt University, Nashville, TN and Universitatsspital, Zurich, Switzerland		Rebound Orthopedics, Vancouver, WA
Tamara Simpson	Trauma – Orthopedic Trauma Institute (UCSF), San Francisco, CA and Hennepin Medical Center, Minneapolis, MN		Cascade Orthopaedic Group, Tualatin, OR
2001			
Michael Gustavel	Sports Medicine – San Diego Arthroscopy and Sports Medicine, San Diego, CA		Gustavel Orthopedics, Boise, ID
James Hayden	Oncology – Massachusetts General Hospital, Boston, MA		Oregon Health & Science University, Portland, OR
Todd Ulmer	Sports Medicine – University of Washington, Seattle, WA		Adventist Health Orthopedic Clinic, Portland, OR
2000			
Mark Metzger	Joint, Spine & Tumor – Harvard Medical School, Boston, MA		
Lorenzo Pacelli	Hand & Microvascular Surgery – Hand Center, San Antonio, TX		Scripps Clinic Torrey Pines, La Jolla, CA
Edward Perez	Trauma – R. Adams Cowley Shock Trauma Center, Baltimore, MD		Broward Health, Fort Lauderdale, FL
1999			
Anthony I. Colorito	Sports Medicine – Cincinnati Sports Medicine and Orthopedic, Cincinnati, OH		
John M. Kioschos	Shoulder and Elbow Surgery – Florida Orthopaedic Institute, Tampa, FL		
Jill A. Rider-Graves			
1998			
John D. Curtis			Medical West Orthopedics, Bessemer, AL
Darrin F. Eakins	Sports Medicine and Knee – Royal N Shore Hospital, Sydney, Australia		
Ronald D. Wobig	Sports Medicine and Knee – Louisiana State University, Lake Charles, LA		Beaver Sports Medicine, Corvallis, OR
1997			
Dennis J. Davin			
Kevin M. Lee			Upper Valley Orthopedics, Rexburg, ID
Ronald L. Teed			
1996			
Knute C. Buehler	Lower Extremity Reconstruction – Scripps Clinic and Research Foundation, San Diego, CA		The Center Orthopedic & Neurosurgical Care, Bend, OR
Thomas J. Croy			Providence Newberg Specialty Clinic, Newberg, OR
Marc R. Davidson	Sports Medicine – The Hughston Clinic, Columbus, GA		Advantage Orthopedic and Sports Medicine
1995			
Douglas R. Bagge			Cortez Orthopedics, Cortez, CO
Robert A. Foster	Hand and Microvascular Surgery – University of Minnesota, Mineapolis, MN		Texas Orthopedics Sports & Rehabilitation Associates, Austin, TX
Gregory A. Voit	Hand and Microvascular Surgery – University of New Mexico, Albuquerque, NM		
1994			
Robert J. Grondel	Sports Medicine and Shoulder – Mississippi Orthopaedic & Sports Medicine Clinic; Trauma – Emanuel Hospital, Portland, OR		Orthopaedic Institute of Henderson, Denderson, NV
Allen L. Hershey	Lower Extremity Reconstruction – Scripps Clinic and Research Foundation, San Diego, CA		Precision Orthopedics and Sports Medicine, Salinas, CA
Brian J. Padrta	Foot and Ankle – Florida; Orthopaedic Institute, University of South Florida, Tampa, FL		Northwest Orthopaedic Specialists, Spokane, WA
Mark R. Rangitsch			Cheyenne Orthopaedics, Cheyenne, WY
1993			
Blaine A. Markee			
Dean K. Olsen			TRIA Orthopedics Burnsville, Burnsville, MN
Andrew H. Schmidt	Adult Reconstruction – Hennepin County Medical Hospital, Minneapolis, MN		Hennepin County Medical Center, Minneapolis, MN
1992			
Edward C. Pino	Sports Medicine – Cincinnati Sports Medicine, Cincinnati, OH; Foot and Ankle – Michigan International Foot and Ankle Center, Detroit, MI		Kaiser Permanente, Denver, CO
Stephen S. Tower			Alaskan Arthroplasty Initiative, Anchorage, AK
Michael R. Van Allen	Hand and Microsurgery – University of Alabama, Birmingham, AL		South Portland Surgical Center, Tualatin, OR

1991
Ronald R. Bowman
William H. Dickinson
Richard A. Rubinstein

1990
Gregory T. Bigler
Adrian B. Ryan
Theodore S. Woll

1989
James R. Hazel
Asa E. Stockton
Keith J. Ure
Robert G. Zirschky

1988
John D. DiPaola
Jeffrey E. Flemming
Morris Hughes
Michael B. Wyman

1987
Dale G. Bramlet
Scott B. Jones
Stefan D. Tarlow

1986
Mark J. Buehler
Wendell D. Ferguson
Paul A. Switlyk

1985
Stanley J. Neitling
Daniel N. Ovadia

1984
Steven J. Bruce
Kenneth A. Hermens
Wendy M. Hughes

1983
Michael J. Grundy
Paul J. Mills
John C. Schwartz

1982
Julie Isaacson
James D. Livermore
John S. Toohey

1981
Christopher A. Blake
Wayne K. Nadamoto
Samuel K. Tabet

1980
Lenart C. Ceder
Jonathan H. Hoppert
Robert W. Jordan

1979
Brian Laycoe
Donald Peterson
James Robbins

1978
Lyle Mason
Edgar K. Ragsdale
Enoch D. Shaw

1977
David L. Noall
Byron K. Skubi
Robert K. Smith
Theodore J. Vigeland

1976
Wayne C. Kaesche
Walter A. Smith
Stephen J. Thomas

1975
Randy W. Crenshaw
John O. Hayhurst
Patrick T. Keenan
Kelsey C. Peterson
Ned R. Schroeder

1974
Thomas W. Hutchinson
Robert J. Porter
Frederick L. Surbaugh

1973
James L. Baldwin
David A. Haaland
Craig MacCloskey

1972
Michael S. Hmura
Grant D. Lawton
Michael R. Marble

1971
Charles B. Bird
Robert G. Chuinard
Jim Dineen
Ilmar O. Soot

1970
Philip J. Fagan
Robert J. Foster
Art Hauge
Edwin A. Kayser
Gerald T. Lisac
Ira M. Yount

1969
Thomas E. Fagan
Michael H. Graham
George W. Ingham
Joseph P. Klein
Scott Struckman

1968
Benjamin F. Balme
James D. Kunzman
James D. Nelson
Frederick D. Wade

1967
Michael S. Baskin
John W. Gilsdorf
John W. Thompson

1966
Charles A. Bonnett
McGregor L. Church
Don D'Amico
Fred G. Grewe
Howard E. Johnson

1965
Arthur L. Eckhardt
John Hazel
Richard L. Mercer

1964
Robert F. Corrigan
Richard C. Zimmerman

1963
Donn K. McIntosh
Michael R. Rask

1962
Phaen Gambee
Norman D. Logan
Keith A. Taylor

1961
Rodney K. Beals
Thomas A. Edwards
George Keyes
Ralph E. Peterson

1960
Charles A. Fagan
Calvin H. Kiest
Betty J. Hohmann
Robert W. Straumfjord
Bud Yost

1959
Raymond A. Case
James V. Harber

1958
Richard G. Gardner
William D. Guyer

1957
Hadley F. Fitch
Richard S. Gilbert

1956
William E. Hummel
Joseph R. McProuty
Jack B. Watkins

1955
Edward A. Attix
Max M. Bocek

1954
Howard I. Popnoe
Dale D. Popp

1953
Donald D. Smith

1952
Melvin L. Makower

1951
Bob Maris
William E. Snell
James W. Weed

1950
Ralph Thompson

1949
Howard Cherry
Boyd G. Holbrook
Richard J. Hopkins

1948
Robert F. Anderson
George W. Cottrell
Carl L. Holm

1947
Edward A. LeBold

1946
William P. Horton
Clyde D. Platner
Faulkner A. Short

1945
Joseph H. Gill

1943
Paul G. Hafner

1942
Rodney Begg
Harold E. Davis

1940
Leslie S. Porter

1938
Arthur M. Compton

1935
E.G. Chuinard

1931
Harry Leavitt

1929
D.G. Leavitt

1928
Leslie C. Mitchell

1925
John LeCocq

1924
Leo S. Lucas

OHSU Annual Beals Lectureship



Rodney K. Beals, MD

The Beals memorial lectureship is an annual event established in honor of the late Rodney K. Beals, MD, Professor Emeritus in the Department of Orthopaedics & Rehabilitation at Oregon Health & Science University, who taught orthopaedics for more than 50 years. Dr. Beals was a lifelong “Oregonian” and spent his entire professional career practicing orthopaedic surgery in Portland, OR. Dr. Beals was a committed clinician, master surgeon, revered educator, and accomplished researcher. It was not only out of respect for his scientific accomplishments, but for his humble guidance and mentorship that the OHSU Department of Orthopaedics & Rehabilitation established the annual Beals Memorial Lecture Series.

Dr. Beals attended Willamette University for his undergraduate training, graduating in 1952, and received his medical degree from the University of Oregon Medical School (precursor to OHSU) in 1956. He completed his internship at Minneapolis General Hospital followed by a General Surgical Residency in San Bernadino County Hospital in California. He ultimately completed his training in Orthopaedic Surgery at the University of Oregon Medical School in 1961. Dr. Beals immediately joined the faculty and rapidly rose through the ranks at OHSU, serving as Head of the Division of Orthopedics from 1981 to 1994. Dr. Beals also served as the first chairman for the Department of Orthopaedic Surgery at OHSU in 1994. At the age of 77, he remained an active member of the Orthopaedic faculty at OHSU until the time of his passing on August 7, 2008.

Dr. Beals was an accomplished researcher throughout his career. He was nationally recognized for his research on skeletal manifestations of growth disturbances in children. He authored more than 150 peer-reviewed publications. Dr. Beals was also a revered educator. During his tenure at OHSU, he helped train more than 150 orthopaedic surgeons in residency. He also helped thousands of patients and mentored countless numbers of medical students. Throughout his remarkable career, Dr. Beals represented and personified excellence in medicine and orthopaedic surgery.



Visiting Professor 2025
Eric Klineberg, MD

Professor and Vice
Chair of Orthopaedic
Surgery

Milton “Chip” Routt
Endowed Chair of
Spinal Surgery

UTHealth Houston,
McGovern Medical
School

BEALS DAY, MAY 2026
VISITING PROFESSOR

Eric Klineberg, MD
“Adult Spinal Deformity Complications” & “Adult Deformity and Trauma: Lessons Learned”
Eric O. Klineberg, MD, is a board-certified orthopedic spine surgeon, professor, and vice chair in the Department of Orthopedic Surgery at UTHealth Houston. He also serves as chief of orthopedic spine surgery and holds the Milton “Chip” Routt Endowed Chair of Spinal Surgery. Dr. Klineberg specializes in advanced and minimally invasive techniques for back and neck conditions. Robotic and endoscopic surgery are part of his practice when appropriate. He cares for patients with spine injuries, tumors, and infections. His expertise also includes herniated or worn discs, spinal narrowing, pinched nerves, scoliosis, arthritis, osteoporosis-related fractures, and slipped vertebrae. His procedures include spinal fusion, disc replacement, and surgeries that relieve pressure on nerves or stabilize the spine. Above all, he is dedicated to providing evidence-based, compassionate care tailored to each patient.



OHSU Faculty Speaker
Travis Philipp, MD

OHSU FACULTY SPEAKERS
Travis Philipp, MD

“Teaching and Learning in Early Practice: Applying Modern Technology to Time-tested Principles”
Dr. Philipp is an orthopaedic spine surgeon at OHSU. After his residency at OHSU, he completed his fellowship at NYU before returning to join the faculty. He takes care of a variety of spine disorders from the cervical spine to the sacrum. His other academic pursuits include teaching and academic advising. He was named the interim director of academic progress for UME at OHSU in the spring of 2025 and works regularly with medical students and administration in this role.



OHSU Faculty Speaker
Clifford Lin, MD

Clifford Lin, MD
“When Standard Alignment Targets Miss the Mark”
Dr. Lin is an orthopedic spine surgeon at Oregon Health & Science University, where he specializes in the management of complex spinal conditions including degenerative disease, trauma, deformity, and tumor. He received his medical degree from Queen’s University and completed both his orthopedic surgery residency and spine fellowship at the University of Toronto, with fellowship training at Toronto Western Hospital. Dr. Lin is the Co-Director of the OHSU Spine Center and has proudly served patients across Oregon and the broader region for over a decade.

2026

“Hip Arthroscopy: Lessons Learned Over Two Decades”

Andrea Herzka, MD, 2026

“When Pain Persists: Understanding Chronic Low Back Pain Beyond Structure”

Ryan Wexler, N.D., M.S., March 30, 2026

“Ankle Fracture Care: Evolution of Practice, Advances and Controversies”

James Meeker, M.D., March 16, 2026

“Engineering Patient-Specific Organoids for Musculoskeletal Medicine”

Gabriella Lindberg, M.D., University of Oregon, January 5, 2026

2025

“Ergonomics Update for the Orthopaedic Surgeon”

Omar Nazir, M.D., December 15, 2025

“How Can We Survive a 30-year Career?”

Ron Turker, M.D., December 1, 2025

“Advocacy and Regulation in Orthopaedic Surgery”

Kathryn Schabel, M.D., November 3, 2025

“Infrastructure for Musculoskeletal Pediatric Care Clinical Trails (IMPACCT)”

Joseph Janicki, M.D., Ann & Robert H. Lurie Children’s Hospital of Chicago & Northwestern University, October 13, 2025

“In the OR, What Happens When Plan A Fails?”

Yee-Cheen Doung, M.D., October 6, 2025

“ACL Reconstruction Options: Where Are We in 2025?”

Stephan Pro, M.D., University of Kansas, August 25, 2025

“Healthy Workplace Training”

Crystal Motherway, August 4, 2025

“AOA RLF Review”

Sarah Rogers, M.D. and Aidan Morrell, M.D., July 7, 2025

“AAOS Resident Assembly Update”

Sarah Rogers, M.D., June 9, 2025

“Firearm Injuries and the Orthopaedic Team: Treatment, and Outcomes”

Kathleen Carlson, M.S., Ph.D. and Julia Silver, M.D., May 5, 2025

“Ethics in Sports Medicine”

Jacqueline Brady, M.D., March 31, 2025

“For the Health of All People: Accelerating Possibilities for American Indians and Alaska Natives in Healthcare”

Erik Brodt, M.D., March 17, 2025

“Functional outcomes in Orthopaedic Surgery”

Dane Brodke, M.D., March 3, 2025

“Updates in Hemophilia Care”

Kristina Haley, M.D., January 6, 2025

LEO S. LUCAS OUTSTANDING ORTHOPAEDIC EDUCATOR AWARD: Presented to the faculty member most instrumental in the development of future orthopaedic surgeons.

MORRIS HUGHES AWARD: Presented to the resident who best demonstrates concern for patients and for education of the next generation of physicians.

RESEARCH AWARD: Presented to the resident recognized for a commitment to the development, execution, and publication of original research during residency.

RODNEY BEALS AWARD: Awarded yearly by faculty to the best resident based on intelligence, quality of work, work ethic, and effect on the environment.

YEAR	LEO S. LUCAS	MORRIS HUGHES	RESEARCH AWARD	RODNEY BEALS AWARD
2007	Tom Ellis	Rob Tatsumi	Joseph Schenck	
2008	Dennis Crawford	Stephan Pro	Kate Deisseroth	
2009	Darin Friess	Stephan Pro	Khalid Shirzad	
2010	Amer Mirza	Gary Kegel Gregory Byrd	Patrick Denard	
2011	James Hayden	Jayme Hiratzka	Jayme Hiratzka Matthew Harrison	
2012	Jesse A. McCarron	Luke Rust	Dawson Brown Matthew McElvany	
2013	James Hayden	Laura Matsen Ko Jacqueline Munch	Adam Baker	
2014	Adam Mirarchi	Rich Myers	Trevor Mclver	
2015	Kathryn Schabel	Dustin Larson	Alexander DeHaan	
2016	Paul Duwelius	Jacob Adams	Thomas Kowalik	
2017	Jacqueline Brady	Ryland Kagan	Michael Rose	
2018	Darin Friess	Dayton Opel	Derek Smith	Elizabeth Lieberman
2019	Kenneth Gundle	Elizabeth Lieberman	Shanjean Lee	Taylor Lara
2020	Yee-Cheen Doung	Taylor Lara	Duncan Ramsey	Loren Black
2021	Kenneth Gundle	Trevor Barronian	Sean Sterrenberg	Natalie Zusman
2022	Zachary Working	Natalie Zusman	Natalie Zusman Erik Woelber	Jamil Kendall
2023	Paul Duwelius	Connor Pihl	Jamil Kendall	Sarah Lindsay
2024	Darin Friess	Frank Rodgers	Danielle Peterson	Kate Hutchison
2025	James Hayden	Catherine Hutchison	Mackenzie Kelly	Mackenzie Kelly

OHSU Department of Orthopaedics and Rehabilitation

We are building on a tradition of excellence and innovation among faculty leaders and staff. Your personal gift is a vital part of this legacy and will help us advance the future of Orthopaedics in Oregon.

Please make your gift to the Department of Orthopaedics and Rehabilitation by donating to one or more of the fund areas below. Each provides crucial and strategic resources for our educational, training, and research missions.

Jung Yoo, MD Endowment for the Advancement of Education and Leadership in Orthopaedics

A recently created permanent endowed fund supporting teaching and education.

John and Susan Hayhurst Endowed Professorship and Distinguished Scholar

Prestigious holders to OHSU's first-ever endowed faculty position in Orthopaedics are provided with additional resources to propel innovation and advancements in the field, and may be appointed as either a Professor or Distinguished Scholar.

Rodney K. Beals, MD Endowment for Faculty Excellence in Orthopaedics & Rehabilitation

Supports mission-focused work of exceptional faculty members, honoring Dr. Beals' legacy in the exploration of new horizons in the field of Orthopaedics.

Lawrence Noall, MD Fund for Excellence in Orthopaedic Resident Education

Supports resident education and training.

Orthopaedic Research Endowment

Supports basic science research in the field of Orthopaedics.

OHSU Department of Orthopaedics & Rehabilitation Support Fund

Advances the education, training and research missions of the department. It provides crucial bridge funding for innovative projects.

Please contact us if you wish to discuss these and other giving opportunities, or if you plan to include the OHSU Department of Orthopaedics and Rehabilitation in your estate plans.

Ways to Give

Outright gifts and pledges: You can make an outright gift of cash or certain other assets with the option of making your gift as a pledge over a period of up to five years.

Planned or deferred gifts: A gift made through your will or trust, retirement account or life insurance, is a great way to support OHSU Orthopaedics. OHSU Foundation can also assist with gifts of real estate, stocks, and other assets.

www.ohsufoundation.org

OHSU Foundation
1121 SW Salmon St., Suite 100
Portland, OR 97205

<https://www.ohsu.edu/ortho/giving-opportunities>

For further inquiries, please contact Tim Coffey, Senior Director of Development, OHSU Foundation
Phone: (503) 901-6100, Email: coffeyt@ohsu.edu

Special Thanks

The editorial board would like to [extend our thanks and gratitude](#) to several individuals who are instrumental not only for orthopaedic surgery residency training in the state of Oregon, but in the preparation of this edition of the Oregon Journal of Orthopaedics. Thank you to Robin Sasaoka (Education Manager) and Tatianna Jefferson (Administrative Coordinator) for their daily efforts in planning, coordinating, and executing the programs and education necessary for the orthopaedic surgery residency program at OHSU. To Rebecca Smith, Research Manager for the OHSU Department of Orthopaedic Surgery and Rehabilitation, thank you for your ongoing efforts in developing and expanding our research capabilities across subspecialties.

We would also like to thank our medical student editors and contributors for their vital assistance in this year's Journal. The organization, creativity, and diligence displayed by these students will make them valuable assets as future orthopaedic surgery residents.



David Chen



Michelle Hernandez



McKenzie Hopfer



Jonathan Ivankovic



Kaleb Roach



Shrey Sharma



Steven Shelofsky

This journal would not be possible without the guidance and assistance from Lia Mitermique, graphic designer (Avive Design) for design and layout of the journal. Thank you for all of your help!

