UNFINISHED
BUSINESS:
JOHN KITZHABER,
M.D. ’73, ON
BRINGING SOME
HEALTH TO OUR
HEALTH CARE
SYSTEM.
We need not be victims of the changes taking place around us. Doing so, however, requires the courage to stop clinging to the past and to start shaping the future.

JOHN KITZHABER
Health Care to Health: The Unfinished Business of the Baby Boom Generation

Former Oregon Governor John Kitzhaber, M.D. ’73, director of the Center for Evidence-Based Policy at OHSU, on transforming our health care system to a health system.

In this article, I would like to accomplish four things: impress on you the urgency of the growing crisis in our health care system, provide a context for why our current system is so dysfunctional, suggest what we need to do to fix it and discuss how you might assume a leadership role in meeting this challenge.

Are you between 43 and 61 years old? Most of us are, including me — I recently turned 60. We are the Baby Boom Generation, the 30 percent of the U.S population born between 1946 and 1964. Most of us are the children of those who weathered the Great Depression; served in the Second World War or who helped rebuild the world in its aftermath. Not only did they win the war, they built our system of higher education. They created the interstate highway system and the transmission grid. They went to the moon, cured polio, eradicated smallpox and put in place the great social programs of the 20th century: Social Security, the GI Bill, Medicare and Medicaid.

As a result, our generation has enjoyed more promise and more opportunity than any other generation in the history of our nation.

I want you to think about what our legacy is going to be — about the kind of world we are leaving to our children and grandchildren. And on our current trajectory it is not a pretty picture.

Consider the fact that last year Congress voted to raise the statutory debt ceiling to accommodate a $10 trillion national debt. Do you know how much a trillion dollars is? The number is so staggering that it is impossible to comprehend without some frame of reference: A million seconds ago was last week. A billion seconds ago, Richard Nixon resigned the presidency. A trillion seconds ago was 30,000 BC. Our national debt now exceeds $9 trillion and is escalating even as the population ages.

And while Congress is worried about Social Security, the real problem is Medicare. Social Security represents around a $5 trillion problem, but when the Baby Boom Generation fully reaches the age of 65 — starting less than two years from now in 2011 — the unfunded entitlement in Medicare is estimated to be over $67 trillion. And we are financing this huge debt by selling securities to China and to other countries still willing to purchase them, not only threatening the fiscal stability of the American government and giving enormous leverage to some of our major international competitors (who at some point may simply refuse to continue underwriting U.S. deficit...
spending), but also casting a dark cloud of debt over our children’s future.

If we fail to address this — if we fail to act boldly — this will be our legacy. We have been the major beneficiaries of the investments and sacrifices of the greatest generation and now it is our turn to give back, to ensure that we leave our children not a legacy of debt and degradation but a world of promise and opportunity and hope. How we meet this challenge will be the defining issue of our time. It is the unfinished business of the Baby Boom Generation and it is inescapably intertwined with the future of the U.S. health care system.

To resolve this crisis, two things are necessary. First, we need a shared vision, a set of agreed-upon objectives which capture the desired purpose of the U.S. health care system. Second, we need an accurate diagnosis of the underlying problem in our current system.

Let’s start by reminding ourselves that the purpose of our health care system should be to help produce healthy citizens, not simply to keep people well. Health care is a means to an end, not an end in itself. It has no intrinsic value beyond its relationship with health, except as an economic commodity. Shifting the focus of our system from health care to health, however, involves a huge shift in paradigm — especially for providers and consumers. It will also require a fundamental change in our priorities; in our patterns of investment; and in the structure of our current system.

To understand the magnitude of this challenge, we need only look at those factors which have the greatest influence on a person’s lifetime health status. As you know, fully 40 percent involve individual behavior and lifestyle choices; another 30 percent is accounted for by genetics; 15 percent are social factors (educational level, where you live, the stability of your family; whether you have a home, a good job, etc.). Only 10 percent has anything to do with involvement with the U.S. medical system. In other words, 90 percent of what keeps people healthy has nothing to do with health care. What this tells us is that we do not have a health care system, we have a sick care system; one that does not do a very good job of keeping people well.

And here’s why. As Neal Halfon, Helen DuPlessis and Moira Inkelas point out in their Health Affairs article “Transforming the U.S. Child Health System: “Because the scaffolding for physical, cognitive and socio-emotional health is built in the early years of life, early investments in prevention and health prevention can greatly improve long term health, behavior, economic and civic outcomes.

We know that lifestyle contributes as much as 90 percent to the development of diabetes and 80 percent to the development of heart disease. We also know that the lifestyle patterns and behaviors that lead to obesity, diabetes and heart disease are locked in during the early years of a child’s life. Likewise we know that there are certain social and medical risk factors to which children are exposed in their early years which have an almost linear correlation with school failure, social dependency and involvement in the criminal justice system. And the longer we wait to address these unhealthy patterns, behaviors and risk factors, the harder it is to deflect the children back toward a healthy life trajectory.

And that is one of the fundamental truths that we must confront if we hope to shift our paradigm — and the focus of our political debate — from health care to health. It is relatively inexpensive and very effective to make a small course adjustment in the early childhood period to create a healthy life trajectory. By ignoring the early childhood investments necessary to do so, however, we harvest serious, expensive and tragic social and medical consequences later on.

Now I doubt if many people would disagree with these three basic system objectives: improving population health, reducing per capita costs and improving the patients’ experiences. But the fact is that they cannot be achieved by operating within the context and the constraints of our current system because both its financing component and its delivery component are structurally flawed.

The financing component was not built around a broad and equitable commitment to access, but rather around the concept of categorical eligibility. And these categories were established through three unrelated acts of Congress. The first was the decision in 1954 to allow employers to deduct from their taxable income the cost of their contribution to their employees’ health insurance coverage — which amounts to a publicly financed tax benefit for employer-sponsored health insurance coverage. The other two acts were the creation of Medicare and Medicaid.

Today, Medicare accounts for about 9 percent of all federal income taxes, a number which is expected to rise to 19 percent by 2015 and 32 percent by 2025. It is the cost of this program as the Baby Boom Generation reaches the age of 65 which threatens the fiscal stability of our nation.

All three of these programs made sense at the time they were enacted, and all grant a public subsidy not to all citizens, but only to certain categories of citizens. The problem is that the economic and demographic environment in which they exist has changed dramatically over the past 50 years while the programs themselves have not. Maintaining this outdated structure increasingly depends on the relentless and unsustainable consumption of resources which rightly belong to future generations.

Because this system was built around categorical eligibility rather than around a broad commitment to access, a growing “coverage gap” has developed between its public and private arms. And into this gap fall those who do not fit into a category. As a consequence, the U.S. has avoided answering perhaps the most fundamental of questions — one that has been answered in some form or another by all other industrial nations in the world. And the question is simply this: Who has the responsibility to pay for the health care needs of the growing portion of our population which cannot afford to do so themselves? And because we have not explicitly answered this question as a matter of public policy we have, by default, left the economic market to answer the question for us. It should come as no great surprise that no business goes out and competes for people who will not pay them.

So cost-shifting results, which makes no sense as either a business plan or as a social policy. In effect, we have adopted a de facto policy: We won’t pay to manage your hypertension in the community, but we will pay to treat your stroke

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Night of Ice & Fire

The late Silvio John Vukov, M.D., ’38, and Dean Emeritus John Kendall, M.D., Res ’62, met at a reception in the 1980s — only to discover they’d crossed paths 40 years before in the middle of a tragedy.

The night of January 2, 1949, brought an ice storm to Seattle. There was already half an inch of ice coating everything at Boeing Field as John Kendall, a college student at Yale, boarded a converted WW II C-47, better known today as the DC-3, for his flight back to Connecticut.

Kendall had been home for Christmas vacation, and he was flying back to school on one of the two planes owned by the fledgling Seattle Air Charter line. “There were 25 of us from the Northwest on scholarship at Yale that year,” Kendall remembers, “and none of us could afford to fly home on a commercial airline. The train took six days round trip, so that wasn’t practical. Back in those days there were lots of little start-up charter airlines being run by WW II vets, so we all got together and booked a charter for 150 bucks per person. It was a lot of money in those days, but it was the same as the train and less than commercial.”

Kendall watched out the plane’s window as a United aircraft ahead of their flight was de-iced. That was the last he would see of them. He drove home to Renton and went to sleep.

The engines grew loud as the take-off run began. The burning piece of wreckage that had fallen on them probably saved his life by rossing him from unconsciousness. He reached up, threw off the wreckage and slapped out the fire on his scalp. At that point he hadn’t yet realized both his arms were broken. Eleven Yale students and the three-person crew were dead or dying.

The hanger they had slammed into was the hanger that housed the Boeing Field firefighting equipment, and the crash had jammed the door shut. All but the tail of the plane would burn up completely. The people in the last few rows survived, while everyone in the front part of the cabin died except for Kendall and one other student. In the row behind him, Kendall’s longtime friend and college roommate was killed. Standing in the midst of the flames, Kendall looked for a way out.

“I was lucky,” he recalls. “You had to get yourself out, there was no one coming. I could see that the back of the fuselage had broken open so I made my way out the rear of the plane. Someone, I think it may have been a United mechanic because we were close to their hanger, helped me down and away from the fire. I fell down in the mud and it was very cold.”

“Then someone wrapped a blanket around me, got me up and we stumbled over to a hanger where he laid me down with the other survivors and helped us all by trying to keep us warm and comfortable. I remember him being a great aid to everybody. After a while the ambulances came and took us away, and I didn’t know who that man was, and I didn’t see him again.”

Vukov was a general practitioner in 1949, but he’d had a long interest in emergency medicine, which wasn’t a specialty area in those days. He used what he knew on that cold night, trying to prevent shock in the survivors who were waiting for ambulances on the concrete floor of an open hanger. When the ambulances took them away, including the young man with the badly burned scalp and broken bones, that was the last he would see of them. He drove home to Renton and went to sleep.

Kendall spent several weeks at Seattle’s Virginia Mason Hospital, recovering from burns and broken bones. Eventually he developed a life-threatening, drug-resistant infection in his burned scalp.

“My life was saved yet again,” Kendall says, “by the hospital’s chief resident at that time, Dr. Donald Custis. He had read about a new experimental antibiotic and had some flown in from New York. It was topidal, so they poured it on my head and two days later the infection was cured and the skin was ready for grafts.”

Custis went on to become the surgeon general of the U.S. Navy and later the medical director of the Veterans Administration. Kendall spent the rest of 1949 at home in Seattle, recovering and taking classes at the University of Washington. Some of his friends thought it would be good therapy to set Kendall up on a blind date. So one night he met a young woman named Betty, and it seemed to go rather well.

And one night, some 40 years after the plane crash, Betty Kendall joined her husband of nearly four decades, who was then the dean of the School of Medicine, at another gathering in Seattle. This time it was a reception for local alumni of the School, and Betty Kendall found herself chatting with a recently retired general practitioner from Renton. Somehow the subject turned to emergency medicine, and the retired doctor said that he’d maintained a long interest in that branch of medicine, strengthened by the event long ago when he’d helped out at a plane crash on an icy night at Boeing Field.

Betty Kendall took his arm and said, “Dr. Vukov, do you see that man standing over there? The dean of the medical school! He’s one of the people you helped.”

“He came over to me,” John Kendall says. “It was the first time we’d seen each other since the crash, and we talked about the tragedy of that night 40 years before, and I thanked him for his help and praised his long career in medicine. He was a very fine doctor.”

And so they crossed paths once again, long removed but both mindful of that night of ice and fire half a lifetime before. Vukov, who made a gift to the School that supports the annual Silvio John Vukov, M.D., Lecture, passed away in 2003 at the age of 91. Kendall was dean of the School from 1983 to 1991, and now serves as dean emeritus.

The road to Renton no longer runs right beside Boeing Field, and Seattle Air Charter is long gone. But that cold night still burns in memory.
The End of See One, Do One, Teach One

Advances in virtual reality training will forever change the surgical tradition of "learning by random opportunity."

Throughout medical history, surgical training has essentially depended on a system that would have been familiar in the studio of a 15th century painter or the workshop of a furniture maker or millwright. Over a period of five or more years, the young physician was more or less apprenticed to a master surgeon, whom the apprentice would follow along behind in the hope that over time the master would impart everything he or she knew about surgery. At the end of that time, the young surgeon would be released out into the world as a budding master on his or her own. The process has long been codified in the phrase, "See one, do one, teach one."

The rapid changes in surgery over the past two decades, however, have begun to make that training model obsolete. Not so long ago, the apprentice had only traditional open surgery to master and was "resident" (literally living) at the hospital, able to present themselves whenever they were called. Patients spent days, even weeks, in the hospital. And the medical-legal environment was very different. Even when the model worked, it worked inconsistently — in any group of graduating chief residents, for a range of surgical procedures, one person in the group may have seen not a single example of the specific operation, another may have done five of them. But they all entered the world of surgical practice on the same day, and could theoretically be called upon, regardless of training, to perform that operation.

Today there is still open surgery to master, but now apprentices must also experience several types of minimally invasive surgery: laparoscopy, endoscopy, robotic surgery, NOTES (natural orifice transluminal endoscopic surgery) — the list grows each year. There are more types of procedures that require greater technical skill but are performed less frequently. New shift limits mean that surgical residents aren’t always around the hospital, and when they are they cover many more patients, most of whom they don’t know. And those patients spend less time admitted, and are much less willing to be used, in effect, as practice fields for apprentice surgeons. All of those factors are putting an eventual end to the tradition that OHSU assistant professor of surgery Donn Spight, M.D., calls “learning by random opportunity.”

Spight, who specializes in minimally invasive surgery, trained that way himself.

“I trained in the classic environment — the attending and the chief resident would be doing a laparoscopic operation,” he remembers, “and the attending might think of me and say, ‘Hey, call Donn to the OR,’ and upon my arrival he would say ‘We’re going to teach you to sew — right now.’ Your heart starts pounding and your sphincter tone gets high, everyone’s watching, and the attending says, ‘Step up, you have eight
minutes.' And you've never even had your hands on the instruments before! Everything you touch bleeds, the whole field is moving with the patient's respiration, and if it's a nice attending he or she is just watching — but most of the time they're huffing and puffing and asking, 'Why can't you do this?! Just do it!' and you have no clear idea of what you're doing. That's really a counterproductive way to learn.

A way to learn that Spight is helping to change. He is the director of the surgical skills program in the Department of Surgery, and with various colleagues under the direction of department chair John Hunter, M.D., is developing a virtual reality simulation training center dubbed "VirtuOHSU." Spight's program brings a formal curriculum and approach to a range of skills training that includes laparoscopy, vascular, ultrasound, endoscopy, open surgery and an ethics-in-communications module. The commitment to this new program is such that the didactic portion of the surgical residency curriculum has been expanded by several hours each week.

"I've been charged with the task of putting together a formal surgical training program outside of the OR," says Spight, who graduated from the Northwestern University School of Medicine, followed by a surgical residency at University of Cincinnati and a minimally invasive surgery fellowship at OHSU. "We use a wide range of technical simulators, from low fidelity to high fidelity, as a way to more quickly and consistently gain mastery in a nonclinical environment. The lowest fidelity would be a simple box trainer for laparoscopy, with a camera and a couple ports for the instruments. It simulates the body cavity crudely, but it's very useful for teaching the manual dexterity required. In the open surgery skills lab we use synthetic tissue, in the vascular lab we work with prosthetic tissue. Moving up the fidelity scale we have a virtual reality laparoscopic simulator, which on a screen creates an environment in which to practice procedures. We also have an endoscopy simulator which allows us to perform in a virtual environment colonoscopy, endoscopy and bronchoscopy. The highest levels of fidelity require animal or cadaveric models. These are infrequently used due primarily to cost and ethical concerns. The future of simulation is to develop tools and environments that can mimic everything cadavers can."

As the VirtuOHSU center expands, Spight hopes to include physicians from the community, nurses and allied health providers in the training mix. What does that future look like? Spight foresees the day when virtual reality simulators reach the point where digital information from an MRI or CAT scan, the details of an actual patient, can be downloaded into the simulator and reconstructed in a three-dimensional environment where the procedure can be practiced.

"Let's suppose," Spight explains, "that you were scheduled to laparoscopically remove a liver tumor. You could load the patient's CAT scan into the simulator, recreate the environment and do the procedure as many times as you need to become comfortable with the anatomy and anything you may encounter when you do the actual operation."

Beyond that, the future of simulation training may well be an entire virtual hospital, with training capabilities for everyone from EMTs to emergency medicine and ICU personnel. Imagine a virtual patient who is involved in a car crash 60 miles from our virtual hospital, triggering a training exercise in which first responders reach the patient — likely a sophisticated robotic mannequin — in the field, run through all their procedures. The patient is then transported to the ED, where physicians and nurses practice their procedures, the surgical trauma team takes part, then to the OR for a simulated abdominal exploration, perhaps, then to the ICU. Actors might play family members to bring in ethics and communication training. All in all, every member of the team receives training and experience in a controlled yet realistic environment.

"You could train and test at so many levels," Spight says, "providers, the hospital system itself, resource management — that's the holy grail of simulation, training multiple providers, specialties and disciplines at once."

That's several years down the road, but already the new model of "see one, train one, do one, teach one" raises question among some surgeons who received all their training — and their trials by fire — in the OR. Can a tactile sense of manipulating tissue really be learned on a simulator? Isn't the very real stress of performing on a living patient valuable in preparing a surgeon for the times when something goes wrong? Beyond the fact that the questions are somewhat moot because the old model of training just isn't feasible any longer (and the fact that some simulators already offer what is called haptic feedback, to train the user's sense of touch as would real tissue), Spight believes the advantages far outweigh any drawbacks.

"There are some things that will always have to be gained in the OR," he says, "and simulation can't recreate the level of stress that you can feel working on a real patient — but of course the goal for any surgeon is not to be under undue stress during a procedure! But consider that, for example, when a resident begins on the laparoscopy box trainer it may take him or her 10 to 14 minutes to tie one knot, if he or she can do it at all. And that is without the field moving as it would inside a living person. In the skills program we train to reach a standard of proficiency, which is 98 seconds. So if a procedure requires 10 knots, you can easily see where the benefits begin. As I tell my residents, using simulation we can move, with the junior residents, from teaching concepts in the OR to teaching techniques and tips. With the senior residents we can move from teaching techniques and tips to a greater cognitive understanding of the case itself. Simulation outside the OR allows us to change the teaching environment inside the OR to a much higher level of understanding."

And that higher level of understanding will serve patients and the profession more effectively than in the days of learning by random opportunity.
A medical student describes her 10-year journey to OHSU, with stops as an honors student, swimsuit model, grad student and, oh yes, Miss Oregon USA.

“The assignment for today,” Mr. Winn said, “is to write an essay about where you hope to be 10 years from now.” He was my English teacher at Grant High School in Portland, Oregon. It was 1999, my senior year. As I stared out the window, I pondered where I would be in 10 years. Where would I live, and what career would I have? I had always had a strong interest in medicine, but was it in my future?

About three weeks before, I had auditioned at a regional tryout for the Juilliard School of the Arts. Would I have a career in acting? It is hard to remember what I wrote in that essay — I’m sure it involved getting a few degrees and getting married, or at least dating a possible Mr. Right. If someone would have told me the adventures the next 10 years would bring, I’m not sure I would have believed them.

I was offered a wonderful scholarship at a college in the Midwest, but I decided to attend Portland State University. I was admitted to the Honors College. Then the question became, how to pay for college? I wanted to keep my debt low as I started on the pre-med track. It was going to be a long and expensive road ahead. Portland State offered me a scholarship of only $500. I continued modeling, which I had started at age 13, to help cover some of my college costs. I had an agent and did some commercials, runway fashion shows and photo shoots (which I still continue to do when time allows).

Modeling isn’t as glamorous as people might imagine. I worked for Jantzen swimwear as a fit model. Part of the job was trying on wet swimsuits to see how they fit and looked, and to test for opacity and coverage. Not much is worse than putting a wet swimsuit on over a dry body! But at least it helped pay for school, and it built up my own personal swimsuit collection.

On weekends I started working for a company that did children’s birthday parties. What a fun job, right? Working with adorable kids when they are happy and excited? Wrong! Imagine being inside a 30-pound Barney-the-purple-dinosaur costume where the temperature feels about 120 degrees. Next, try to do some magic tricks or make balloon animals with your three fingered gloves! Last, but certainly not least, sing the Barney song for the 15th time and get kicked in the shin for the 20th. As a college student, $75 an hour sounds like a great rate — but in the end, you realize it’s just not worth it. Be it Barney, Barbie or the Easter Bunny, it just wasn’t the job for me. I gained a deep appreciation for any sports team mascot!

Even with all my odd jobs, I wasn’t covering the cost of college. I scheduled a meeting with the director of the Honors College during the fall of my sophomore year. The previous spring the College had awarded nine scholarships covering the
majority of the tuition for those students. I wasn’t one of the recipients, but felt I should have been. In the meeting, I made my case. The director interrogated me for a good 45 minutes, and I felt as though I was testifying in front of a grand jury. At the bare minimum the man was intimidating — he could have belittled me in any of the 10 languages in which he was fluent. At the end of the meeting, a deal was made. He would give me a scholarship that covered half of my tuition for sophomore, junior and senior years of college on one condition: no more theater or fine arts classes. I wanted to scream. He went on to describe that medical school admissions committees would not look favorably on these classes and that I needed to focus on all things mathematical and scientific. With a steadfast look and a promise, I had a scholarship. But I also had a change in focus and direction. I was taking all the right classes, but now I was being held accountable to make my dream of med school a reality. I kept my promise and didn’t participate in anything outside of the pre-med world at school. In my personal life, however, I still continued to participate in professional theater, singing performance and classical ballet performance. The director noticed my diligence, by way of my transcript, and awarded me an internship in Washington, D.C. I worked at the Naval Medical Research Center, in the Combat Casualty Care Directorate, in collaboration with the National Institutes of Health. My plane left for D.C. just two weeks to the day after September 11th. I vividly remember my flight heading into Dulles Airport. There were only 12 people on board. There were fully armed SWAT teams all around downtown Washington. In order to get to my lab each day, I had to go through five military checkpoints, showing my ID as well as military identification. It was a scary time but a wonderful experience. The opportunity to conduct research on a project of my own design. The biology faculty asked me to stay and continue my research in the master’s degree program. They also offered me a teaching position in the human anatomy and physiology course, as well as a head teaching assistant position for the last year of grad school. I had never planned on earning a master’s degree before med school, but it later proved to be very beneficial. About halfway through my master’s program, a good friend of mine convinced me to enter the Miss Oregon USA contest. Actually, it was more of a dare. If nothing else, it promised to be a fun girls’ weekend in Bend with some friends. “Think of it as a paid vacation and some much needed time off from grad school,” my friend said with a wink. I won the pageant. What on earth was I going to tell my thesis advisor? “Hi there, I am now the new Miss Oregon USA 2005?” He didn’t even know I was competing. There was a lengthy article in the Portland Tribune, and an ad for Cover Girl in the Oregonian. I had to finally break the news. My advisor tried to put on a tough, “I can’t believe you did that!” attitude. But deep down, I think he liked it. It brought good publicity to his lab; different professors would inquire about it and before I knew it, a copy of the article was hanging on our lab’s chemical refrigerator. But how would this all fit in to grad school? It turned out to be excellent preparation for medical school, which involves being busier than one can truly ever imagine before being immersed in it. During my Miss Oregon year, I was a full time grad student, taking classes, teaching anatomy and cadaver lab 20 hours a week, conducting research, writing on my thesis and now making appearances as Miss O. The appearances afforded me some fabulous outreach opportunities with young people, especially women, to encourage them to pursue careers in science and medicine. As Miss Oregon, I also had the opportunity to meet Jean-Michel Cousteau, the world renowned ocean environmentalist. He was aware of my research, and reminded me, “Jessica, always remember you are first a scientist, everything else is just fun.” Good advice. So what is it like for a self-proclaimed science nerd to compete at the Miss USA pageant? Well, let me be the first to tell you, it is another world. Other than the offer of plastic surgery and Botox (no thanks!), the only advice I received was to “dumb it down” when at the pageant. Well, dumbing it down was not an option. Take me or leave me, I wasn’t going to change who I was. Luckily my roommate at the pageant was Miss Idaho, a law student. I met some wonderful people during my time in Baltimore, and was later invited back to a fundraiser for the University of Maryland Medical Center. And I met Donald Trump, the sponsor for the pageant, in truly memorable style… backstage with hot rollers in my hair and slippers on my feet. My reign as Miss Oregon came to an end and it was time to complete my master’s degree. An 80-page thesis and a four-hour defense later, I finally graduated! Then it was time to start the application process to OHSU. Luckily, I had taken almost every biology class that Portland State had to offer. I had also job-shadowed with a family practice doctor, an internal medicine doctor, and an otolaryngologist. After interviewing at other schools, I knew OHSU was where I wanted to be. The acceptance letter arrived in the mail, and I don’t think I have ever been so excited or screamed louder in my entire life! OHSU School of Medicine has been a wonderful place to grow as a future physician. I truly enjoy my position as class president and all of my wonderful classmates. I value my research opportunities in the vascular surgery department and being involved in the School of Medicine Alumni Council. Everyone at this university is so willing to reach out to students, providing a great atmosphere for learning. I don’t know of very many institutions where you can email a surgeon and be observing in their operating room the next day. The past 10 years have been truly remarkable. I have had so much fun, have done a lot of hard work, experienced some heartache, but all in all it has been great. As far as living up to my high school essay, at least I have my two degrees and I don’t think I have ever been so excited or screamed louder in my entire life! OHSU School of Medicine has been a wonderful place to grow as a future physician. I truly enjoy my position as class president and all of my wonderful classmates. I value my research opportunities in the vascular surgery department and being involved in the School of Medicine Alumni Council. Everyone at this university is so willing to reach out to students, providing a great atmosphere for learning. 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Over the past decade and more, the amount of time our medical students spend away from the Hill has grown, exposing them to the many different kinds — and the many virtues — of physician practice away from tertiary care centers and major metropolitan areas. From the beginnings of the Oregon Area Health Education Centers (AHEC) nearly 20 years ago, exposing students to non-urban practices and role models has been a priority at the School, and has been successful in opening students’ eyes and minds to the rewards and realities of practicing away from the “big city.”

In order to make that happen, physicians in those smaller communities must volunteer their time and expertise to teach the students in these rotations and clerkships. Bridges asked a few of these vital teachers and practitioners why they step forward...

Rick Wopat, M.D. Res. ’78, grew up on a farm near a town of 1,200 people in rural Wisconsin, so it wasn’t out of character for him to settle in Lebanon, southeast of Salem, population 14,400. Wopat was looking for a community in which to practice the range of family medicine for which he was trained, and set up practice here 30 years ago. For 20 of those years, Wopat has hosted medical students in his practice, showing them the practice and lifestyle advantages he was drawn to all those years ago.

“I enjoy teaching,” says Wopat, whose practice usually hosts six students per year on four- to five-week rotations. “It’s stimulating, it keeps me sharper and it challenges my thinking. From the beginning, I wanted to get students away from the Hill and away from metro Portland to see that quality medicine was practiced away from the city. It takes time and energy, but it always pays back in terms of relationships. It’s an opportunity to interest people in more rural practice.”

While modern transportation, infrastructure and especially the internet have made rural practice less isolated than in days gone by, there is still the opportunity to practice a wide range of medicine within a close-knit community. “My practice is very rewarding in its breadth and depth,” Wopat explains, “and the students are always impressed by the complexity of the patients we care for. Students like the richness of the practice environment — a good primary care provider can do 90 percent of the care in his or her community. In the end, it’s the lifestyle that either attracts or deters students from choosing small community practice. You have to be willing to see your patients every day in the grocery store. But I live on a seven-acre farm in the country and it still only takes me 10 minutes to get to work. I try to be a role model for the students, demonstrating that you can have a full life other than medicine — family, farm, community — and still be a very competent physician.”

Paul Neumann, M.D. ’00, who practices in Stayton, population 7,300, was just trying to be polite when he first visited the Willamette Valley town he’d never heard of: “I ran into my former partner,” Neumann remembers, “who has now retired from the practice, when I was getting ready to interview. He invited me to visit, and I didn’t want to be rude, so I said I’d stop by between my other interviews.
When I finally visited, I was so impressed with the practice and the people I came back for a formal interview and would up joining the community,” Neumann began sharing what he had discovered with OHSU medical students early on.

“I try to expose students to what it’s like to practice in a community where you’re going to see a child with a broken arm followed by a ‘90-year-old with heart failure,’ he says. “I try to show them that they can manage a variety of conditions, and to do that you don’t have to know everything, but you have to learn how to use your resources, both locally and regionally. I also want to expose the students to how much fun it is to do this.”

Neumann himself fits the data that show that the true factor of whether or not a medical student will be drawn to rural practice is whether or not that student grew up in a rural area — he grew up in tiny Cheshire on the Long Tom River in the Oregon Coast Range — but he also has lit a spark in some students with urban backgrounds.

“The most enthusiastic students are often from rural backgrounds,” he says, “but what I really enjoy is when a student from an urban background gets that light in their eyes and says ‘Hey, I could do this!’ That’s very satisfying.”

The chance to teach outside of academic medicine while being part of a small community is what appeals to rural preceptor Robert Law, M.D. ’88. Law practices in Reedsport, on the southern Oregon coast.

“We hosted one of the very first students when the School’s primary care clerkship began back in 1993,” Law says, “and we had our 100th student last year. It’s a benefit for us to have students here — we get enthusiastic young people and a connection to the School and to the cutting edge of medical thinking — and the students have a chance to see real-world medicine away from the Hill, get a rich clinical experience, and understand that you can deliver high-quality care even in a rural setting. There has been a tendency in the academic medicine world to look down their noses at rural docs, so it’s great for students to see medicine from this end of the telescope. The internet has changed everything — no rural area is isolated anymore.”

Law, who served on the regional AHEC board for six years and who, interestingly, is the only member of his data-trumping practice who grew up in a small town, wants students who visit his practice to understand what it means to be a vital part of something special.

“A lot of the people going into medicine these days,” says Law, “don’t really see how it can connect you with things. A lot of folks are drawn to being flexible and mobile, and don’t see medicine as I do — as a way to be a vital part of a community in which you have a visible identity. Small town practice is not for everybody, it’s not for people who want to compartmentalize their work for the rest of their life. As I tell the students, walking around town is like being a minor rock star... everyone knows who you are.”

Students share the rock-star status — and the long hours, the challenges and the benefits, the visits to the jail clinic and the Friday nights on the sidelines of the football games — with Law in what he thinks is not an archaic form of medical practice at all, but one that will come back to the fore in the not-too-distant future.

“I think the practice model of the family physician who handles the majority of care for his or her patients is still very viable,” Law posits, “and when the U.S. gets to redesigning its health care system will be important. It’s efficient, it’s economical, and it’s what the patients prefer. I want the students we teach to get that you don’t drop the ball nearly as often when you don’t have to hand it off so much — and that small-town medical practice is an integral part of the nation’s infrastructure.”

It’s all about the teaching for Keith Harless, M.D. ’72, who came to Bend in 1977 as the first pulmonary and critical care physician east of the Cascades. He now heads up OHSU’s regional education program in the area, working to address the continuing rural physician shortage.

“After my fellowship at the University of Utah, I was asked to stay on the faculty,” Harless says, “but I wanted to be closer to patients so I declined. But after a few years I was missing teaching, so I began having students with me in the critical care unit... since 1981.”

Today, as Director of Medical Education as well as Medical Director of the Critical Care Units for Cascade Healthcare Community, Harless leads an expanding range of student rotations in northeastern Oregon. And while, in the 30 years Harless has been there, Bend itself has become a fairly urban community, the hospital and clinics of Cascade serve a mainly rural region covering some 32,000 square miles.

“We have active rotations,” he says, “in critical care for fourth-year students, neurology for fourth-years, psychiatry for third-years and an internal medicine sub-internship for fourth-years. We’re looking at developing programs in family practice, as well as OB-GYN and surgical rotations. It’s possible that sometime down the road we’ll add a GME program in family medicine. The impetus is that OHSU would like to increase class size, and to do that education must take place off the Hill, as there isn’t enough clinical material on the Hill.”

Harless is pleased that several of his former students are now practicing in the region. “I want the student who come here to know what it is to practice outside of Portland; the challenges, benefits and opportunities that exist here.”

We’ll leave the last heartfelt words on the rewards of being a rural preceptor to Rex Parsons, M.D. ’80, who practices in Tillamook on the northern Oregon coast.

“I came to Tillamook to serve as a primary care internist,” he says, “from the office to the ICU and sometimes in the hardware store. I have been supported and nurtured by this community for 26 years. The intangible joy and fulfillment of serving one’s career in a small community cannot ever be compared to the piecemeal, salaried work in an HMO, hospitalist or other limited setting."

“So when Dutch Reinschmidt conceived the primary care rotation in the early ’90s, Walt McDonald (then the VA chief of medicine) took the dog-and-pony show on the rural roads to recruit preceptors, I am part of the generation of physicians who, when the chief asked us to jump, we did. And stayed there till he said ‘come down,’ which he has not.

“i share my daily practice, my patients, and the deeply fulfilling life I have been given with students, in the hope that they will sometimes decide to swim against the flood tide of economies, the influence of money by specialization and corporate employment, the easier, softer way of a large group — and accept the challenge of doing the right thing: bringing quality medical care to where it is needed and appreciated most.”

For more information on AHEC and the Rural Community Health Clerkship, please visit www.ohsu.edu/ahec.
“These are very well-evolved molecules.”

It is with this bit of smiling understatement that 39-year-old, India-born scientist Francis Valiyaveetil begins to describe one of nature’s most important bits of electrochemical machinery: the ion channels in cell membranes that both select for specific elements and also open and close to allow those elements to pass into the cell. The most common of these channels, present in virtually all organisms and involved in an amazing array of biological functions, are potassium ion channels.

These extraordinary tunnels through the cell membrane have a narrow passageway, called the selectivity filter, which, in the case of potassium channels, allows only potassium ions to move through. Each type of ion is a different size, so potassium fits perfectly in the selectivity filter, while larger ions are kept out. But, somehow, the filter also blocks smaller ions like sodium. It’s as though a tube the size of a basketball can also block golf balls from going through without physically closing. No one yet knows exactly how it works.

Equally perplexing is how the channels close, through a process called inactivation, to even the ions they are sized for, which must happen to prevent a continuous flow of potassium into the cell from eventually killing it.

Molecular biologist Francis Valiyaveetil, Ph.D., is working to unravel the complex mysteries of ion channels — the gates in the wall of each living cell.
The movement of these ions happens exceptionally quickly and controls a wide range of cellular functions, from nerve conduction to hormone secretion. One of the best known examples is the propagation of action potentials along the pathways that the brain uses to communicate with the rest of the body. Wiggling your fingers happens after a very long sequence of potassium and other ion channels have opened and closed almost instantly—thought turned into electrochemical messages turned into muscular contractions.

Clinically, understanding and manipulating these channels would be important in many diseases. Blocking a specific ion channel, as do the toxins in snake and scorpion venom, has been shown to alleviate the symptoms of multiple sclerosis. Cystic fibrosis is caused by a defect in a chloride ion channel. And the more that is known about all these channels, the longer this list (and the corresponding list of potential therapeutics) will become.

It is this enormous potential that drives the work of Valiyaveetil and the scientists in his lab. The importance of his research was recognized in 2007, when Valiyaveetil received a prestigious four-year Pew Scholars Award from the Pew Charitable Trusts, designed to support promising early-career researchers.

That career began in Mumbai (formerly known as Bombay), where Valiyaveetil was born. He graduated in 1990 from the University of Mumbai with a degree in chemistry then in biotechnology, Valiyaveetil went on to the respected Indian Institute of Technology. After earning a master's degree in molecular biology, Valiyaveetil left India for the University of Wisconsin where he pursued his doctorate in biophysical chemistry. It was there that his interest in the proteins that reside in cell membranes began.

Not long before Valiyaveetil received his Ph.D. in 1999, the structure of an ion channel was described for the first time by Rod MacKinnon, Ph.D., at Rockefeller University in New York. It was a major breakthrough, and Valiyaveetil decided to go right to the top, applying for a post-doctoral fellowship in MacKinnon's lab. Valiyaveetil spent the next seven years at Rockefeller working with MacKinnon. When his fellowship was complete, Valiyaveetil came west in 2006, becoming an assistant professor in OHSU's program in chemical biology in the Department of Physiology and Pharmacology.

Today, Valiyaveetil and his team are trying to do something that's never been done before: alter a potassium ion channel so that it will also allow sodium ions to pass through the membrane. This could reveal what keeps the sodium ions out in the first place.

"In the last few years," he explains, "researchers have begun to get a much better picture of what these channels look like, and knowing what they look like gives you ideas about how they might work. But what we don't really have today are experiments that test the ideas of how these channels work. In my lab we're using site-directed mutagenesis to make very small, very specific changes in the proteins, replacing one amino acid with another, which lets us disrupt specific interactions to test the functional importance of those interactions."

The process is akin to trying to understand the workings of a very complex machine by replacing one gear or pulley or piston at a time and seeing what happens.

In order to obtain the sort of precision he needs as he tweaks the ion channels, Valiyaveetil and his research team are also breaking new, if somewhat greasy, ground in the field of chemical synthesis of proteins.

"Chemical synthesis of proteins has been around for 40 years, " Valiyaveetil explains, "but it's hard to get, so we're trying to make a molecule that does the same thing. Once we know the rules, we can make other channel blockers. The field is progressing very rapidly."

"One major goal of figuring it out is to understand the pharmacology of ion channels in order to eventually design therapeutics that are directed toward these channels. One of the first of these may well come in the treatment of MS, possibly within the next decade.

"It has been shown," says Valiyaveetil, "that a specific human potassium channel, K1.3, expressed in T lymphocytes, can effectively remove the symptoms of MS and other T-cell-mediated autoimmune diseases. A peptide from snake venom targets K1.3, but it's hard to get, so we're trying to make a molecule that does the same thing. Once we know the rules, we can make other channel blockers. The field is progressing very rapidly."

"One of the benefits of my lab is that we can interact with the physicians who can test the molecules we make. The clinical application that will almost certainly come first is in the treatment of MS."

It's clear that Valiyaveetil is a scientist to watch for the future — or perhaps it would be better to say "stay tuned to this channel."
There are hundreds of millions, possibly billions, of people in the world who have little or no access to an emergency medicine system. This is made even more clear when disasters strike — the 2004 Indian Ocean earthquake and tsunami, which killed some 225,000 people in several countries, is a glaring example.

When one of those battered countries, Sri Lanka, decided to attempt to put a new emergency medicine system together, among the people who helped show them how was a third-year emergency medicine resident at OHSU, Ross Bryan, M.D. Bryan spent a month in Sri Lanka, consulting with and helping to train physicians and paramedics in how to create a U.S.-style trauma care network, given far more limited resources, of course. He came home with an idea.

“For my OHSU residency project,” Bryan says, “I decided to describe and create a curriculum for a new emergency medicine fellowship focused on global health.” Bryan is today, along with Amy Marr, M.D., the first to hold the resulting Global Health Fellowship in the Department of Emergency Medicine.
The new fellowship has a central goal of enhancing the development of emergency medical care around the world — and a range of specific goals, which include training emergency medicine specialists to be proficient in assessing health systems present in developing nations and determining which interventions are most needed and can realistically be implemented; learning to coordinate short-term international expeditions as well as longer term, sustainable health care initiatives; gaining knowledge of internationally acquired infectious diseases and disaster medicine; and learning to participate in planning, development and implementation of various emergency courses that are appropriate for the level of system present in a given country. Obtaining a master's degree in public health is also part of the fellowship, to build some background in funding and other public health issues.

The two-year fellowship found a welcoming environment in the School of Medicine and OHSU — where so many different global health initiatives are under way or envisioned that a new Global Health Center has been put in place to coordinate the efforts — and an ideal director in Mohamud Daya, M.D., M.S., who has significant global health experience. He is an associate professor and the vice-chair for service and excellence in the Department of Emergency Medicine.

“The focus,” Daya says, “is to assist countries that are trying to develop the infrastructure for an effective emergency medicine system, drawing upon our department's expertise in trauma care, toxicology, simulation, graduate medical education, ultrasound, pediatric emergency medicine and more. We want to help these countries develop emergency medicine as a subspecialty, so we work sometimes with governments, sometimes with private hospital systems, sometimes with academic teaching hospitals. You have to temper each country's needs with the resources they have in order to work out an effective solution.”

Daya knows, from more than 15 years experience working in Kenya, India, Pakistan, Japan and other countries, that there is wide variability between how much and how quickly emergency medicine system development can happen in each situation — but he also knows how beneficial a little help can be. The Department of Emergency Medicine has existing relationships with two medical schools in Japan, who send both medical students and faculty to observe how we provide trauma care. A physician is coming from South Korea to spend a year here and, according to Daya, much of the Asian Peninsula is starting the move toward emulating our system. In addition, Daya and his colleagues recently consulted on the application of Pakistan's Aga Khan University to begin an emergency medicine residency program.

This isn't a one-way exchange, as Daya points out: “We can often learn as well as teach. For example, Japan is very technologically advanced, so some of their skills, particularly in ultrasound, as well as disaster planning, are ahead of ours. The global efforts that are behind this fellowship are a bidirectional, cooperative effort in which we learn, they learn, and patients and the community benefit from our shared expertise.”

Each of the initial global health fellows in this pilot program, the only one of its kind in the Northwest, have specific interests within the framework of their training. Marr is drawn to the design of global health educational programs (both abroad and on the Hill), and has done research and taught courses in all of these. Bryan, who recently returned from Japan where she worked with Daya on the residency program development in Pakistan and hopes to visit there again in the coming year, Bryan, who recently returned from Japan where he gave a lecture to a medical school faculty on how America trains emergency medicine residents, wants to continue as an ambassador and consultant.

“I plan to continue going to countries in need,” he says, “and helping however I can to improve access to emergency care, while helping enhance the education that doctors and nurses receive. And I want to practice some clinical care around the world as well.

“The School of Medicine was responsible for a lot of the global health initiatives are that happening now at OHSU, and I think the alumni will be interested in these programs. The world is getting smaller every day — all of our economies are linked, and our health is linked. If someone in Asia with the SARS virus gets on a plane, the virus can be in Portland the next day. So from a pragmatic standpoint, we need to focus on global health — and from an ethical standpoint, there are millions without access to lifesaving care and we must help do something about it. This fellowship will give people the knowledge to do that.”

School of Medicine alumni can help as well, fellowship director Daya points out: “A lot of alumni have worked abroad and have established contacts. If you meet anyone with needs in emergency medicine, well like to make a connection.”

“It's a big small world out there.

You may contact Dr. Daya at dayam@ohsu.edu.

Amy Marr, M.D.
OHSU’s Dietetics and Nutrition Program offers leading-edge training and research in these key components of health.

Diane Stadler, Ph.D., R.D., has been the director of the OHSU program since January 2008.

“This program has many years of history,” Stadler says, “and an outstanding reputation. It was originally developed as a postgraduate clinical training program to educate and provide experience to students who had a nutrition background and who wanted to become registered dietitians. Today we offer several tracks for graduate study, and we have a core group of faculty with strong research backgrounds.”

In addition to the courses and field experiences that lead to the dietetic internship certificate and eligibility to take the exam to become registered dietitians, there is an M.S. in Clinical Nutrition track, for registered dietitians who are interested in continued education and research. There is also a combined certificate/M.S. track, for incoming interns who want to earn their master's at the same time. And finally there is a Master's in Clinical Dietetics program, which enhances the clinical practice skills and knowledge of nutrition science, physiology and advanced clinical and laboratory nutrition assessment—a more clinical and less research-focused track.

Both research and practice venues for dietetics and nutrition alumni are expanding. Recent graduates are working in school districts, in community health settings, in hospitals and with health systems. There are specialists in trauma nutrition in the ICU, in oncology nutrition, in pediatric nutrition therapy. One recent grad is a metabolic dietitian, working in a genetics program to help provide care to infants with various conditions revealed by newborn genetics screening. Several of these conditions may be treatable by altering diet and nutrition.

New directions for dietetic practice are the outgrowth of expanding research in the field. At OHSU, dietetic and nutrition scientists are looking into areas as diverse as a pediatric genetic condition which prevents the metabolism of fats, gestational diabetes during pregnancy, and new techniques of nutrition physical exam, looking at chemical values and clinical signs that suggest nutrition deficiencies. Program director Stadler, who received a B.S. in Genetics and Development from Davidson College, an M.S. in nutrition science from Virginia Tech, and a Ph.D. in Human Nutrition from the University of Iowa, has studied “extreme nutrition interventions” for the treatment and prevention of disease including: nutritional rehabilitation of severely malnourished children in Zambia, Africa; dietary treatment of children with rare genetic disorders; use of extremely high-fat diets for children with severe, unresponsive seizure disorders; and comparing the health risks and benefits of very low- and high-carbohydrate diets for weight loss in obese adults. She is the principal investigator of a study that seeks to explain why low carbohydrate diets result in reduced food intake and weight loss.

“It is becoming more and more recognized,” Stadler says, “that nutrition is a component of every aspect of health care and health. We appreciate the strong collaboration that is in place between our program and the physicians and basic scientists at OHSU. We welcome contact with School of Medicine alumni, and we will continue to build on our success in dietetic and nutrition training and research.”

For more information, please visit ohsu.edu/ohsuedu/academics/som/dietetic.
Jennifer Redig is seriously busy. She is beginning her fourth year in the OHSU Department of Molecular and Medical Genetics Ph.D. program, studying in the lab of Cheryl Maslen, Ph.D. ’87 (see the 2008 issue of Bridges). She’s also one of only two Ph.D. students taking on a joint degree program — Redig is working toward a master’s degree in clinical translational research.

“My translational research project,” Redig explains, “looks at the synergism between CRELD-1, the gene which is associated with cardiac malformations known as interventricular septal defects, and vascular endothelial growth factor to see if there is a correlation between the two. My Ph.D. research is involved in characterizing the CRELD family of proteins, what they do biologically and how and why they can be a risk factor in heart defects.”

So you could reasonably expect that Redig has barely enough time beyond those two degrees for eating and sleeping. But it seems that the Montana-born, Oregon-raised Redig not only studies the heart, she also is driven to extend hers to people in need. And right now several of those people are in Romania.

“I was trying to find something I could do to reach out to people on a graduate student’s schedule! I taught English as a Second Language for a while, but it was hard to keep to a regular class schedule. Then my brother-in-law and a friend of his were traveling in Bucharest, Romania, and visited an orphanage there. They just fell in love with the kids, so they kept going back to help — they aren’t in grad school so they have time and money! They started supporting this family of four orphans who was having trouble even getting food, and we did what we could from here. Soon we became aware that the orphanage was struggling and would probably tank, so we decided we’d try to step in.”

So, in February of 2007, Redig became a co-founder and the board secretary of Ana’s Children, a non-profit organization serving street kids in Romania. After much on-the-unpaying-job training, Redig helped the organization receive official 501(c)3 status in December 2007. A sister organization was founded in Romania to open up the possibility for European Union grants.

“It’s small and we’re plugging along,” says Redig, whose husband Chris is the organization’s U.S. executive director, “but we’re making it happen. The U.S. side of the organization collects money, the Romanian side is run by a social worker who coordinates the services. It’s a street program now, but we’re fixing up a donated house in Bucharest with the goal of moving kids in. It’s been mainly a big family-and-friends affair to this point, but we hope to grow the project.”

Redig has volunteered countless hours to formatting and building the mission and structure of Ana’s Children, creating the organization’s website, www.anaschildren.org, and securing funding. So what does she do with her spare time? She recently worked with an OHSU classmate to create and teach a Saturday Academy class in basic genetics.

“I give my time when I have my time,” Redig says with a laugh. “We taught a week-long class for high school students that covered basic genetics. It was good, we had them extract some DNA, run some gels — I know I would have loved it, but then I had already decided to get my Ph.D. when I was in high school!”

That’s probably the same time she discovered that a Jennifer Redig day has 25 or 26 hours in it.

For more information, please visit www.anaschildren.org.
Legendary Care

Nancy Boutin, M.D. ’83, is one of the women physicians celebrated by the National Library of Medicine.

A clinical rotation at the School brought her to radiation oncology, and Boutin was immediately drawn to the sense of “community and commitment among the patients and physicians” who specialized in the field. Her direction was set, and in the years hence, the 51-year-old Boutin has become a leader in radiation oncology. In addition to being a practicing physician, Boutin is a healthcare educator and frequent speaker on healthcare issues in her community and throughout Oregon.

“Part of the changing face of medicine,” Boutin says, “is that women are bringing traditionally female approaches to the workplace. While I consider myself a ’70s-style feminist, my way of contributing is in the traditional female mold — serving, building consensus, leading from the middle. I’ve gotten things done by nudging rather than blazing.”

Boutin has nudged her way to national recognition, serving as president of the Oregon Radiation Oncology Society, president of the Marion-Polk County Medical Society, Oregon Medical Association Trustee-at-Large, and twice chair of Salem Hospital’s Radiation Oncology Department.

“I try to balance doing the best I can for every patient and also educating them to make good and reasonable health care decisions,” Boutin emphasizes. “I believe in compassionate, honest conversations with every patient. The important thing for me is working quietly and effectively. It’s not important that I get all the credit for a cancer program. What matters is that the cancer program is out there for people.”

Thus is a quiet local legend born — following in the footsteps of more than a century of women physician alumnae of the School, and inspiring the women who now make up the majority of each graduating class.
in the hospital; we will not pay to provide all pregnant women with good prenatal care, but we will pay to resuscitate their 500-gram infants in a neonatal intensive care unit. And that should not be acceptable to any of us.

The fundamental step we must take in the financing component of our system is to explicitly determine who has the responsibility to pay for the health care needs of that growing portion of our population which is unable to do so themselves. I believe that this responsibility will inevitably fall to the public, just as it is a public responsibility to ensure that all of our children have financial access to an education; just as it is a public responsibility to finance law enforcement, fire protection and to provide for the national defense. It is a public sector responsibility to ensure that all Americans have access to some effective level of health care.

But — and this is very important — it can’t be an open-ended responsibility for the simple reason that public resources are ultimately finite. In other words, the “floor” — the level of care to which everyone will have access — is, by definition, what we are willing to pay for with public resources. One of the flaws in the current debate over universal coverage is that no one seems to want to address the pivotal question of “coverage for what?” It is here that we will need to come to terms with the reality of our fiscal limits.

So the fundamental challenge, then, is not how to find more money to pay for health care, but rather how to ensure that the shared public dollars we are already spending on health care are allocated in a way that benefits all of us, not just some of us and that we are actually getting an improvement in population health for this extraordinary and growing expenditure.

And this brings us to the second structural flaw in our health care system: the delivery component. The question is how we pay for health care; the problem is what we are buying — and how that care is organized and delivered. The inefficiencies and poor performance of the U.S. health care system are built into that system.

If we look at where most of the money is being spent we find that, in any given year, 70 to 80 percent is spent on people who have one or more chronic disease. Furthermore, the spending is concentrated on a small portion of the population. In any given year, 10 percent of the population accounts for 70 percent of health care spending.

Now we know that most chronic diseases are preventable, particularly when prevention measures are applied in early childhood. We know that chronic diseases are progressive. And we know how to intervene in order to prevent these complications. Doing so, however, requires an integrated care system — a team approach that can coordinate care and share information; it requires well-educated patients who can recognize the early warning signs of a complication leading to a quick and coordinated response.

Our system evolved around an acute care “infectious disease” model which made sense and still makes sense for acute life-threatening conditions as well as for many common non-life threatening conditions. The problem is that this acute care model has come to serve as a “one size fits all” approach to the provision of medical care in the face of a range of very different delivery challenges — not the least of which is chronic care.

In addition, only 4 percent of doctors in this country are in group practices of more than 50 physicians. Most doctors do not operate as a part of a team, which creates a problem given the fact a person with one chronic condition is being cared for on average by seven to eight different physicians who are often not in close communication with one another. Finally, the system suffers from a lack of data. Most patient information is in paper medical records stored in hospitals and in hundreds of thousands of physician offices across the country.

These factors are largely why most people with chronic conditions interact with the care system only in crisis and get the appropriate care for their condition only about 50 percent of the time. And that is exactly why so many people with chronic conditions continue to progress to ever more serious complications which require more complex and expensive treatment.

Finally, our system evolved around a set of financial incentives which reward acute care interventions and actually discourage a focus on prevention and on the kind of reorganization around care management — especially chronic care management — that is required to resolve the growing crisis. Of the 9,000 different billing codes which providers use to get paid, there is not a single billing code for a cure; for prevention; for health improvement. These are simply not billable events. Clearly, this is not a system that can achieve the three objectives listed earlier, no matter who pays for it. Addressing this challenge will require transformational change, change that cannot be accomplished by limiting ourselves to incremental tinkering within the context and constraints of the deeply flawed structure of the current system. So let me offer what I believe would have to be the key elements of a system that could achieve our objectives.

First we need a more equitable and sustainable financing structure. Categorical eligibility should be eliminated and replaced with a publicly financed floor with eligibility for a public subsidy based on financial need, not on arbitrary categories.

Second, this financing and eligibility structure must include “value-based cost sharing,” in which co-payments are used not just to shift costs to individuals but to help drive individual behavior and accountability within the context of the agreed upon system objectives. This means that there might be little or no cost sharing for those services which are extremely effective and rank higher in priority, in terms of their impact on improving population health; and higher cost-sharing for elective, discretionary services and those that are lower in priority.

Value-based cost-sharing acknowledges the reality that those with more disposable income will always be able to purchase additional services beyond those financed with public resources. It acknowledges that there will inevitably be at least two tiers based on income — but there should not be qualitative difference between them in terms of health outcomes.

Third, care within this “floor” must be organized in a way that moves beyond the “one size fits all” acute care model that underlies our current system — and in a way that recognizes the range of very different delivery challenges we face.

I believe that we must redesign our delivery system around at least those five families of conditions which currently account for the vast majority of cost in the system and the vast majority of patient encounters but which — if properly managed — could significantly reduce cost and improve health. These families of conditions include:

Because the scaffolding for physical, cognitive and socio-emotional health is built in the early years of life, early investments in prevention and health care can greatly improve long term health, behavior, economic and civic outcomes.

HALFON, DUFLESSIS, INKELAS 
HEALTH AFFAIRS, 2007

Because of the reality of fiscal limits, however, this would require the development of a defined benefit through a transparent public process in which priorities are established among health services based on their relative effectiveness in producing health for the entire covered population — very similar to the prioritization process used in the Oregon Health Plan. This “basic level of care” could serve as a floor for everyone — which is the most efficient approach from an administrative standpoint — or only for those below a certain income level, with a system of sliding scale subsidies which gradually phases out as income goes up.

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Second, this financing and eligibility structure must include “value-based cost sharing,” in which co-payments are used not just to shift costs to individuals but to help drive individual behavior and accountability within the context of the agreed upon system objectives. This means that there might be little or no cost sharing for those services which are extremely effective and rank higher in priority, in terms of their impact on improving population health; and higher cost-sharing for elective, discretionary services and those that are lower in priority.

Value-based cost-sharing acknowledges the reality that those with more disposable income will always be able to purchase additional services beyond those financed with public resources. It acknowledges that there will inevitably be at least two tiers based on income — but there should not be qualitative difference between them in terms of health outcomes.

Third, care within this “floor” must be organized in a way that moves beyond the “one size fits all” acute care model that underlies our current system — and in a way that recognizes the range of very different delivery challenges we face.

I believe that we must redesign our delivery system around at least those five families of conditions which currently account for the vast majority of cost in the system and the vast majority of patient encounters but which — if properly managed — could significantly reduce cost and improve health. These families of conditions include:
This payment would cover:

- Pregnancy, Childbirth and Early Childhood Care
- Acute Fatal Conditions (e.g. acute MI, major trauma)
- Chronic Fatal Conditions (e.g. diabetes, CHF, asthma)
- Acute episodic non-fatal conditions (e.g. cystitis, minor URI)
- End of Life Care

Fourth, revenue must flow to risk-bearing entities organized at the regional or local level, each of which would bear economic risk and assume responsibility for the health of a defined population. This entity could be:

- A hospital or health system with an affiliated physician group
- A large primary care group practice in partnership with payers
- A powerful, visionary health plan
- A "Health Development Organization"
- An entirely new entity

This concept is perhaps the most radical — yet in my mind the most essential — component of a new system if we hope to change our focus from health care to health. Organizing the delivery of care at the local and regional level recognizes the reality of local and regional differences and it provides a "single point of contact" for each individual within the defined population. And it serves as an "integrator" — to ensure that the necessary investments are made to establish trajectories for health — focused on prevention, health promotion, and improving the conditions of children's lives. These investments include not only medical investments but the wide array of social and civic programs and services which are currently under-funded and uncoordinated.

Finally, payment for the basic level of care in the floor would take three forms. The initial form would be a monthly/annual risk adjusted "subscription" payment to cover the cost of maintaining the relationship with each individual and fulfilling the integrator function I just described. This payment would cover:

- Patient education
- Maintaining an electronic medical record
- Individual case management

- Coordinating care and services
- Office visits, home visits
- 24/7 consultation

The next form would be a bundled payment — also risk adjusted — to cover the cost of managing complex conditions, especially those requiring hospitalization.

The final form would be an annual performance bonus payment for high quality care (i.e. improving the health of the population, reducing complications, hospitalizations, etc.).

Traditional fee-for-service reimbursement would continue to flourish in the secondary insurance market for those services not covered in the floor.

Obviously what I have just described does not even remotely resemble what we have today. And moving to such a system poses a huge challenge because of the sheer number of economic stakeholders deeply invested in the status quo. When any proposal to change the system is introduced within the legislative process, each stakeholder does a quick bit of mental calculus and often concludes that moving from the current system to the proposed system would disadvantage them economically. Thus, each of these stakeholders becomes a political advocate for or against a proposed vision for a new health care system, based on how they think it will impact them economically in the short term.

These competing economic interests have thus been able to effectively block any serious consideration of a solution to a problem that poses a clear and present danger to our nation. The point is that it is not only politically impossible, it is also economically impossible to move from our current health care system to a new one overnight. It is going to take some time and will therefore require a transition period. The problem is that, because of the significant trapped equity in the way our current system is organized and financed, the economic burden will go up for many stakeholders during the transition period. And these stakeholders, all of whom have a significant influence over the political process, are able individually and/or collectively to block anything that will adversely affect their short term economic interests. Furthermore, our political process tends to invest in crisis rather than prevention.

In order to successfully put together the politics of health care reform, we must be able to transcend the transactional stakeholder politics which anchor us to the past by shifting the focus of the debate from where we want to end up to how we are actually going to get there.

The challenge here is to make the politics of the transition period explicit by acknowledging and legitimizing the economic interests involved; by shifting the focus of the debate away from the narrow question of how a given stakeholder may be adversely impacted in the short term, to the much more productive question of how the economic impact on all stakeholders can be mitigated during the transition state.

But without first agreeing on the future state, there is no political pathway by which to get there. As the Roman Senator Seneca said, "No wind is the right wind if you don't know what port you're sailing for."

Unfortunately, there is no evidence that this shared vision will emerge from our current political leadership — or from any of the economic interests so deeply invested in the status quo. But I believe that it can, and indeed it must, emerge from us. Meeting this challenge requires three steps. The first involves laying the foundation for reform. We need to agree upon a set of clear system objectives, an accurate diagnosis of the problem, and a description of the key design elements necessary to achieve objectives. Unfortunately, this key step has been bypassed by the mainstream debate over health care in America today.

The second step involves managing the transition. Doing so requires not just regulation, but intentionally engaging the economic market, particularly entrepreneurial capitalism, to create an enterprise that becomes ever more profitable by promoting wellness, prevention and reducing avoidable acute care.

The third step involves creating test sites — for example, a hospital with an affiliated physician group that decides it wants to transform itself along the lines of the key design elements we have been discussing. Because of the deep structural flaws in the current system, this effort will inevitably run into a variety of statutory, regulatory and structural barriers that will prevent it from moving to scale. Exposing these barriers, however, creates an important tension between the current system and the new model, thus providing a clear avenue through which to seek specific legislative relief.

We need not be victims of the changes taking place around us. Doing so, however, requires the courage to stop clinging to the past and to start shaping the future. The challenges we must overcome in doing so may be less tangible than the menace of WW II. But they are just as deadly, in part because they are less tangible, less obvious, than a Pearl Harbor. Yet the challenges we face today, if we can successfully meet them, will have every bit as much impact on the lives of our children as did the winning of WW II on my generation.

That is our challenge today. To plant the seeds of tomorrow; to change the parameters and the context of this debate by acting, by leading, by personally engaging in this struggle — not as captives of the past; not as victims of the status quo, but as the proud architects of a new future.
Message from the Dean

Dear friends:

The focus of much of my attention — and that of the entire nation — has been the continuing news about the global economic crisis and its far-reaching consequences. As is true for many academic institutions throughout the country, OHSU is moving aggressively to adapt to this new economic reality. Throughout this tumultuous time, as we make decisions, our emphasis at OHSU will always be to steadfastly protect the excellence of our missions. With this approach, we will emerge from this global crisis a stronger, more focused institution.

While these times are indeed trying, they have brought out the best in our students, faculty and staff. I am impressed by how everyone within the OHSU School of Medicine — and within the larger OHSU community — continually demonstrates the strength of their commitment to the service of others. I am also humbled by the comments we receive daily from patients, community advocates and others about the importance of OHSU to Oregon.

Each day, I am reminded of our alumni when I arrive at the campus. Lining the walls on the second floor of Mackenzie Hall are photos of every medical school graduating class dating back to our first in 1887. Walking past these photos, there are always new details to uncover: the style of photos, the clothes, even the expressions of students as they are photographed. Not surprisingly, the early class photos are almost exclusively men whereas the more recent photos are at least half women. Looking at these photos, it’s hard not to wonder what the daily lives of physicians were like in the early 1900s. I also wonder what the lives of our newest graduates will be like decades from now, given the pace at which medicine is likely to change.

Displaying these photos may seem like a small way to honor our students and alumni, but it takes on great significance over time. To see a child excited to find a photo of her mother in the corridor, to see one of our alumni seeking out his own photo from years prior — these are moving events. The photos are evidence of the depth and breadth of the legacy of School of Medicine alumni and a symbol of our constant evolution, strength and stability through even more challenging times than these.

We inaugurated another event this year that I hope will create a similar legacy. The Office of the Dean hosted a reception to honor faculty members who were promoted from one faculty rank to the next during the prior year.

Some of the faculty members at this new Promotion & Tenure Reception spoke out about what had helped them attain this success in their academic careers. Without exception, they attributed it to the guidance and mentorship of those who had come before them. Their words were a strong reminder of how each of us, especially those of us now in the latter phases of our careers, has an important role to play in shaping the future by participating in education.

A permanent outcome of the Promotion & Tenure Reception is that an officially framed “honor roll” of all faculty members promoted that year will be hung in the same corridor in Mackenzie Hall. This year the names of 58 faculty members were added. I imagine a time, many years from now, when the great-grandchild of one of these faculty members will proudly point at a name and say, “That’s my great grandmother.”

Big or small, all gestures that honor the foundation of our success — our people — are important. This past year, the OHSU Cancer Institute received a $100 million gift from Nike founder Phil Knight. The magnitude of this incredibly generous gift was a testament to the exceptional talent and vision of the people at OHSU, those who came before us, and those who will follow us.

Philanthropy is an important way to honor an institution, and I am perpetually grateful for the generosity of our alumni and other donors. I also want to acknowledge other important ways our alumni contribute to our legacy. Every single time one of you speaks positively about your School of Medicine experience, you are honoring this institution and contributing to our culture of excellence. You are also helping colleagues, family, friends and neighbors better understand our school and our educational mission. Every time one of you talks to a new student, or a young person considering a career in medicine, you honor your educational experience here. Every time you care for a patient, you honor our faculty and our accomplishments.

And it has been a terrific year in terms of accomplishments. Our students and faculty created the OHSU Global Health Center, which was recently awarded a prestigious NIH Fogarty Framework Grant. The OGI School of Science & Engineering became the Department of Science & Engineering in the School of Medicine. This transition makes OHSU one of the few medical schools in the country with a biomedical engineering emphasis.

OHSU researchers were responsible for the start-up of four new biomedical companies, and the School is among the top NIH funded medical schools in the country. We honored 34 faculty members for excellence in teaching this year, and our faculty members continue to be recognized and to serve their constituents in numerous ways locally, nationally and internationally.

Other accomplishments are not as easy to quantify, but equally impressive. For example, our first-year medical students held a memorial service for the families of donors to the OHSU Body Donation Program. This year, it was attended by over 100 family members and 125 students and faculty members. The program included tributes in the form of songs, poems, photographs of the donors’ lives, musical performances and stories. It is a moving ceremony and a heartfelt way to honor the generous contribution of the donors to the education of future physicians.

During this ceremony, I was struck anew by the maturity and commitment to service exhibited by our students. One of them announced that after these first few months in medical school, she had no doubt that the future of medicine was very bright, given the caliber of her fellow students.

This sentiment, I believe, could have been expressed for any of the medical school classes since 1887, as well as for all of our graduate studies, physician assistant, and other programs. To all of you who have passed through our doors, who have been educated here, whose photos grace our walls or yearbooks, thank you for distinguishing the OHSU School of Medicine. We are honored by your service to Oregon and beyond. §
Time to Take a Bow

Honoring our 2008 Alumni Association award winners

Remember back to last June? When the weather was warm and the economy was stable? Well, here’s a chance to return to those halcyon days and an event that also produced a lot of warmth and good cheer: your Alumni Association Annual Dinner and Awards Presentation.

Past Alumni Association President Sam Connell, Ph.D. ’67, welcomed alumni and their guests. OHSU President Joe Robertson, M.D., M.B.A., Res. ’82 and SM Dean Mark Richardson, M.D., M.Sc.B., M.B.A., gave encouraging, if challenge-filled, reports on the state of the university and the medical school. And then the award recipients took their bows.

The annual paper competitions produced some tremendous work in 2008. Neurological surgery resident Jonathan Carlson, M.D., Ph.D. won the Resident Paper Competition, and Ian Amanna, Ph.D., of the Vaccine and Gene Therapy Institute, was the Post-Doc Paper of the Year winner.

The SM Dean’s Award, presented to a faculty member or an alum in recognition of exceptional service to the School, went to the one-and-only Ed Keenan, Ph.D. Keenan, the associate dean of medical education and an honorary alumnus of the School, stepped to the mike for a few words, which filled, reports on the state of the university and the medical school. And then the award recipients took their bows.

Six outstanding alumni volunteer faculty were recognized for their expertise and service, without which the School simply couldn’t provide the thorough and respected medical education for which it is known:

Donald Blanchard, M.D. ’73, was honored by the Department of Ophthalmology.

Frank DiGregorio, M.D. ’89, was honored by the Department of Pediatrics.

Melvin Kohn, M.D., M.M.S.C., M.P.H ’07, was honored by the Department of Public Health.

Mark Hampton, M.D. ’77, was honored by the Department of Family Medicine.

Kenneth Stevens Jr., M.D. Res. ’70, was honored by the Department of Radiation Medicine.

And Ronald Wolf, M.D. ’87, was honored by the Department of Surgery.

The Richard T. Jones, M.D., Ph.D. Distinguished Alumni Scientist Award was presented to Kent Erickson, Ph.D. ’75, who is professor and chair of the Department of Cell Biology and Human Anatomy at the University of California Davis School of Medicine. He is a noted researcher in the fields of cancer, stem cell biology and immunology.

“This is a great honor,” Erickson said, “and I fondly remember Dick Jones, who was one of my biochem instructors. It took me two tries to get through OHSU — I completed my first quarter, then got a notice from Uncle Sam saying ‘welcome to the U.S. Army, and you get to go to Vietnam.’ I was in a precarious state when I got back, and four people helped me make it through graduate school: Bob Bacon, Sam Connell, Bill Stotler and Dave Gunberg. Without their help, concern and mentorship I probably wouldn’t have completed my education. And I’d like to thank my colleagues and students for teaching me so much — and the British government for their confidence back in the beginning that I could develop stem cells.”

The inaugural Esther Pohl Lovejoy, M.D. Leadership Award was presented, honoring a graduate who demonstrates exceptional leadership and service to the medical profession on a national or international level. Lovejoy was the second female graduate of the School, in 1894, served during WW I with the Red Cross in Europe, and was an international leader in the development of relief services, improved sanitation and organizations for women in medicine. The award went to Terry Yamauchi, M.D. ’67, who is professor of pediatrics and the inaugural professor of the Clinton School of Public Health at the University of Arkansas for Medical Sciences.

“I was asked to speak for only five minutes,” Yamauchi joked, “and I don’t know whether that’s because I’m Japanese and my language skills are questionable, or because I’m from Little Rock, Arkansas! I probably won’t need all those minutes, because Dr. Keenan took up most of my time. I was going to thank all the people who were instrumental in my career, beginning with Miss Gamble, my third grade teacher — I think Ed mentioned her already. But I do want to thank all the great people in the Class of ’67 — I’ve never had friends like I made in those years. Thanks for this honor.”

The Charles A. Preuss, M.D. Distinguished Alumni Award was given to Ted Vigeland, M.D. ’68, a longtime Portland orthopaedic surgeon who joined the faculty of the OHSU Department of Orthopaedics and Rehabilitation in 2000 and served as its interim chairman in 2003-2004.

“I was privileged to present this award to Rod Beals in 1999,” Vigeland said, “who was a great mentor to me, and it’s an honor to be up here tonight. I want to thank my wife Julie — I lived the first year of medical school with my brother George, but the cooking was so bad I got married the next year. Julie put me through school on her lavish salary of $5000 per year as a schoolteacher. It’s been a wonderful career. When Charlie Bird called me in 2000 and asked me to come up to the Hill and teach, he asked me if titles were important to me, because he could only make me an assistant professor. I said, ‘Well, after 22 years in ortho I can still be an assistant, no problem. A couple years later our chairman left, and since I was the oldest guy there who hadn’t been chairman, they made me interim chair. I thought it didn’t quite work to be the chair and just an assistant professor, so I asked Joe Robertson if I could at least be associate... he said my résumé was a little light! Anyway, the program is amazing, and it’s a privilege to be up on the Hill.”

This evening concluded with Sam Connell recognizing incoming SM Alumni Association President James Asaph, M.D. ’62. Congratulations to all our award recipients, and we hope to see you at this year’s event on May 31, 2009. (see page 33).

The OHSU School of Medicine Alumni Association is proud to announce our 2009 Award Recipients!

CHARLES A. PREUSS, M.D.
DISTINGUISHED ALUMNI AWARD
John W. Kendall, Jr., M.D. Resident ’62
Named in honor of Charles A. Preuss, M.D., 29, who advocated for physicians to be active in their community and show support for the School of Medicine, this award was established in 1983. It honors a School of Medicine graduate who, in professional achievement and service to their community, reflects the highest ideals of the School of Medicine.

ESTHER POHL LOVEJOY, M.D.
LEADERSHIP AWARD
Sam Lin, M.D., Ph.D. ’75
New in 2008, the award was named for one of America’s outstanding early medical leaders, Esther Pohl Lovejoy, M.D., Class of 1894, who led the nation’s fight for food handling reform. It is presented in recognition of exceptional leadership and service to the medical profession on a national or international level.

RICHARD T. JONES, M.D., PH.D.
DISTINGUISHED ALUMNI SCIENTIST AWARD
Fred L. Minnear, Ph.D. ’79
This award was established in 2001 honor a graduate from the School of Medicine’s Masters or Doctor of Philosophy degree programs who displays continued research excellence, service to the scientific community, and/or contributions to basic science education. The award name was amended in 2006 in recognition of Dr. Jones’ many years of exceptional service to the School of Medicine.

VOLUNTEER FACULTY RECOGNITION AWARD
The Alumni Association provides the School’s departments and divisions with the opportunity to recognize School of Medicine graduates who provide invaluable volunteer faculty service to the School.

Nancy Boutin, M.D. ’83
Radiation Medicine

Linda Humphrey, M.D. ’83
Public Health & Preventive Medicine

James Novak, M.D. ’80
Family Medicine

These exceptional School of Medicine alumni will be honored at the Alumni Association Annual Dinner & Awards Presentation on Sunday, May 31st.
Reunions
An all-class reunion gala was the highlight of 2008 Alumni Weekend. Held May 9, 2008, at the Multnomah Athletic Club, graduates from six different decades gathered to celebrate. Comments were heard about how much fun it was to discover an old friend from a different class year or even former faculty who were there with their own class.
A good time was had by all at several alumni events this year. The Golden Circle Alumni Luncheon is an annual event for alumni who are 50 or more years out of medical school, and attendees enjoyed a presentation on Dr. Hod Lewis given by Madison Macht, M.D. ’04.

Dr. Richard Deyo, Professor of Evidence-Based Medicine in the School’s Department of Family Medicine, presented the Silvio John Vukov, M.D. Lecture at the OHSU Alumni Scientific Meeting. (see article about Dr. Vukov on page 6)

One of the highlights of the annual Sommer Memorial Lectures is the presentation by the winner of the Alumni Association’s Resident Paper Competition. The 2008 winner was Jonathan Carlson, M.D., Ph.D., a fellow in Neurological Surgery.

Greetings, fellow School of Medicine graduate!

I hope you had a wonderful holiday season and the New Year finds you in good health and enjoying family and friends.

In the last issue of Bridges, past Alumni Council President Sam Connell (Ph.D. ’67), asked you to let us know what the Alumni Association could do for you. We heard from many people who shared some great ideas, and we heard some ideas that would be terrific if we had a million-dollar budget. I’d like to ask you to keep the ideas coming and also to let us know how we are doing.

In an alumni relations program, it’s hard to measure if we are being successful. If you have a requirement of a certain amount of income or a certain number of products produced, it’s easy to see if you have met your goals. When your success or failure is based on feelings and perceptions, that job is much tougher. Once again, I’d like to ask for your input.

Please take just a few moments to answer the following questions. You can cut this out and mail the survey to the alumni office, or you can forward your answers via email to sm-alum@ohsu.edu. The questionnaire is also available at our alumni online community at www.ohsu.edu/som/alum. Your answers will help us know what progress we are making in meeting the needs of School of Medicine alumni.

Many thanks to you all for your support of the School and its Alumni Association!

James W. Asaph, M.D. ’62
President
School of Medicine Alumni Association