

Dr. David Satcher: From Alabama Farm to the Surgeon General's Office

BY MARY KORR
RIMJ MANAGING EDITOR

PROVIDENCE – Prior to delivering the annual Dr. and Mrs. Frederick W. Barnes, Jr. Lecture in Public Health at Brown University on April 18th, former U.S. Surgeon General David Satcher discussed his path to becoming a physician with the *Rhode Island Medical Journal*, and his views on medicine and health care today.

Born in March 1941 to Wilmer and Anna Satcher, Dr. Satcher's journey began on the family's rural Alabama farm when he was two years old and gravely ill with whooping cough. The town hospital was segregated and did not admit black children. His father sought the help of the only black physician in the vicinity of Anniston, Alabama, who came out to the farm to tend the toddler. His prognosis was dire.

Q. Who has inspired you the most in your life?

A. I should start with Dr. Fred Jackson, who came out to the farm on his day off when I was two years old and very sick with whooping cough and pneumonia. He told my parents I wasn't going to live out the week, but he did everything he could and showed them how to care for me. When I stopped breathing, my mother breathed for me.

I often heard that story from my mother. And the one thing I wanted to do was to meet Dr. Jackson. My parents promised me when I was six years old they would take me to meet him, but that year he died of a stroke at 54. From

then on, I told everyone I was going to be doctor like Dr. Jackson. I was as certain of that as I have been of anything in my life.

The leadership of Morehouse College and Benjamin Elijah Mays [president of Morehouse College 1940–1967] also played a major role in my development and getting into medical school. But I was first motivated by that near-death experience.

Q. What lessons have stayed with you from your boyhood days on the farm?

A. Our dad taught us to work in the field and a lot of other lessons about life that are still with me. He always said if you're not careful, the person who beats you out in the morning will beat you out in life. I still get up at 5 a.m. to exercise before work.

When it came time for me to go to Morehouse College in Atlanta, I remember standing at the bus stop with my dad. I was feeling kind of sorry for him. He never finished first grade. As the bus pulled up, he said to me: 'Son, I want you to promise me something. Where you are going you will meet people with more than you, and you will meet people with less than you. Promise me you will treat everyone with respect.' It's the best advice in life I've ever been given.

And on February 13 of this year, I acknowledged the 100th anniversary of the birth of Anna Curry, the 16th of 17 children. She was my mother. She has a



BRIEF BIO

DAVID SATCHER, MD, PhD

Graduated

Morehouse College in Atlanta (1963)

Case Western Reserve in Cleveland,
MD, PhD (1970)

Positions

President, Meharry Medical College
in Nashville (1982–1993)

Director of the CDC (1993–1998)

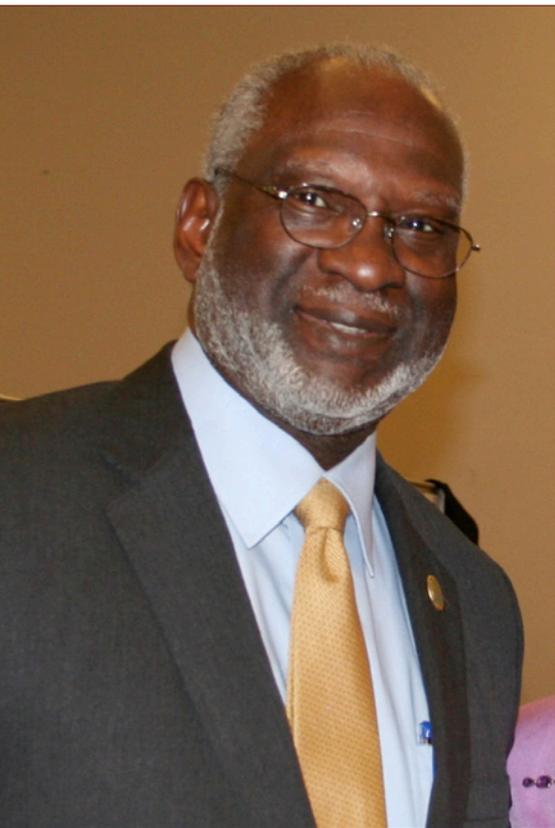
Appointed by President Clinton as
16th U.S. Surgeon General & Assistant
Secretary for Health in Dept. of Health
and Human Services (1998–2002)

President, Morehouse School of Medicine
(2004-'06)

Current

Founder & Director, The Satcher Health
Leadership Institute and Center of
Excellence on Health Disparities,
Morehouse School of Medicine

Poussaint-Satcher-Cosby Chair in Mental
Health, Morehouse School of Medicine



CORRINE GIORDANI, BROWN PUBLIC HEALTH PROGRAM

lot to do with who I am. She died on the day in 1993 it was announced I was to become director of the CDC. She lived long enough to know that.

Q. You mentioned Benjamin Elijah Mays. Can you share a recollection about him from your undergraduate days at Morehouse?

A. Dr. Mays challenged students, and Martin Luther King, Jr. [1948 Morehouse graduate] was one of them, to excel in academics and in life. Some of his words of wisdom: 'It must be borne in mind that the tragedy in life doesn't lie in not reaching your goal. The tragedy lies in having no goal to reach...It isn't a calamity to die with dreams unfulfilled, but it is a calamity not to dream...It is not a disaster to be unable to capture your ideal, but it is a disaster to have no

ideal to capture...It is not a disgrace not to reach the stars, but it is a disgrace to have no stars to reach for.'

Q. In your exemplary career in medicine and public health, you have been closely associated with two of the three outstanding American medical schools associated historically with an African-American heritage (Morehouse and Meharry). The erstwhile racial barriers in other American medical schools have diminished. Do you see a continuing role for the historically black medical schools (including Howard), in the future?

A. Meharry has been around for a long time, since 1876, and for a hundred years it educated about half the black physicians in the South. During that period, its graduates went on to practice in underserved communities, mostly in primary care. In addition to race it took on another role; its graduates worked where they were most needed, much more than other medical schools. Morehouse, founded later, also assumed this role. That has nothing to do with race. It has more to do with what the country needs.

Today, Morehouse is integrated. Our faculty and students are diverse. We were ranked No. 1 in the country last year for our social mission. It is No. 1 for medical schools when it comes to graduating under-represented minorities, to sending its graduates into underserved communities, and for its graduates going into primary care. We need more primary care, and more diversity in medicine and medical education. As long as we are leading in that area there is a critical role for us.

Q. What is your assessment of the Affordable Care Act (ACA) thus far?

A. I would have liked universal access as part of ACA. I think one of the best investments we could make as a country is that everyone has access to health care as early as possible. Not only will we save unnecessary pain and suffering, but we will save money and time.

But I think it went further than ever before in terms of access and quality. I think it incentivizes primary care, quality care, and reduces costs. The ACA said you are going to be paid for the quality. I think that's a major step forward.

And all indications are that the ACA will dramatically reduce the cost of healthcare. It takes time for prevention to work but in time we can prevent many of the chronic diseases we are paying for; 75 percent of Medicare costs go for chronic diseases that are preventable.

If we can promote prevention not only in the doctor's office but also in the community, I think we are going to see a reduction in costs.

Q. Some public health actions on the local and national level are controversial, such as Mayor Michael Bloomberg's recent efforts in New York City to try and curb the sale of large sodas. What role should the Surgeon General's office play in issues such as this to achieve a healthier populace?

A. Washington D.C. is a different town when it comes to politics. Every Surgeon General has to work with an administration, and Congress, but so far, for the most part, that has not stopped the Surgeon General from leading. The Surgeon General has to be able to have a bully pulpit. It was Surgeon General Luther Terry who called attention to

smoking as a problem in health in 1964. We have now halved the number of smokers in this country in 50 years. And Dr. C. Everett Koop and his response to HIV/AIDS in the early days is another example of the relevance of the office of the Surgeon General in this country.

When I was the Surgeon General we called attention to obesity. We are beginning to see a reversal of that trend. In Mississippi, which has the highest rate of childhood obesity, it has decreased more than 10 percent. So that means a lot of lives are going to be saved if that trend continues.

I also focused attention on mental health when I was in office. Since that time we have a parity of access to mental health services, and mental health services has been integrated into the ACA.

But within the political context, when I was in office I ran into conflict with President Clinton when it came to

needle exchange. The science said that needle exchange was effective is halting the spread of HIV. But President Clinton refused to support legislation making needle exchange legal. His reality was that Congress was not ready to lift the ban on federal funding for needle exchange programs. But the role of the scientist is to state the science. They were not listening to the available science.

When I was in office, they threatened to take all the money away from the Surgeon General's office. I didn't listen to that threat. But the offices of the Surgeon General and the CDC are not always at liberty to do what they would want to do because they are dependent on Congress for funding.

Q. What are your thoughts on the corporatization of medicine?

A. Corporatization is an issue in medicine. One of the reasons that so few of

our graduates are going into primary care is that many see medicine as a business. We have created the kind of environment where a lot of our graduates feel compelled to go into specialties where you can make the most money. And they have the burden of debt.

I like the national health service corps, but as you know it has been cut back. What I would like to see is the national service aligned with community centers where young doctors can practice with the benefit of debt forgiveness.

But I think the mission of medicine is to serve. From the beginning health care has been about serving and that's why it's called health care. I don't know any other area where the word 'care' is a part of the name. You don't say business care or law care. We are about caring for people who need us. I still think most medical students go to medical school with the idea of serving. ❖



ALAN SHAN, COURTESY OF BROWN DAILY HERALD

Dr. David Satcher was the keynote speaker during Brown's Program in Public Health's annual research day. It was also sponsored by The Alpert Medical School and co-sponsored by the Dept. of Health and the R.I. Public Health Association.

Highlights of lecture

During the Dr. and Mrs. Frederick W. Barnes, Jr. Lecture in Public Health, speaker Dr. David Satcher made the following remarks:

On smoking: "50 years ago, when the first Surgeon General's report came out on smoking and health, 60 percent of doctors were smokers. When you went to a medical meeting you could hardly see the screen for the smoke. Today, only 3 percent of doctors smoke...nevertheless, I see smoking today as a pediatric disease."

On public health: "Public health is what we do collectively as a society to ensure the conditions in which people can be healthy...The science of public health is very challenging and critical. It is the credibility of that science that translates into the Surgeon General's reports and eventual public policy."

On the future of public health: "We can't leave the emergence of public health leaders to chance alone."

On the gap between science and policy: "We are struggling with that now as it relates to gun violence. You need the science, and you need advocacy at the community level to transform science into policy. The lobbyists bring in the money. The community against gun violence has to hang in there."

Alpert Graduate Leaves Campus with MD and Medical App Start-Up

MARY KORR
RIMJ MANAGING EDITOR



PROVIDENCE – This month former U.S. Army paratrooper Timothy Jolis will graduate from the Alpert Medical School of Brown University with more than a hundred other students.

While studying at Brown, he not only earned his medical degree, but also started up a biotech company to develop and market his medical apps, Jolis Biotech, which are available for iPhone, iPad, and Android devices for 99 cents. The start-up was inspired by a hospital physician, and came to fruition with the collaboration of friends and peers at Brown and the Rhode Island School of Design (RISD).

In an interview with the *Rhode Island Medical Journal*, he spoke of his app avocation.

Q. You are graduating from Alpert Medical School in May. Where will you continue your medical training and do you have an idea of what field you will practice in?

A. I'm excited to say that after graduating I will be starting work as an emergency medicine resident physician at Albany Medical Center. I plan to continue to grow Jolis Biotech. I feel like there is a great deal more we can accomplish to facilitate evidence-based decision-making and empowering patients. As a fledgling tech start-up, we always welcome support and input from others.

Q. Medical students are pretty busy. What made you take the leap from inspiration to actuality – developing medical apps and setting up a company?

A. I like to think of creativity as an essential part of my life. I'm a prolific reader; I design my own basic oncology experiments, and I love spending time



PHOTOS: COURTESY OF TIM JOLIS

in the RISD Museum of Art. In medical school, I thought that there must be a more creative solution to disseminating all the medical knowledge that is locked up in journal articles. It seems like these articles could only be accessed through the memories of attending physicians who read them when they were originally published, or through the inevitable paywalls which pop up on the screen when a diligent medical student attempts to read them. There had to be a better way. In a conversation on this subject with the wonderful Dr. Joseph Rabatin, he suggested I make an app to manage sensitivity and specificity data. The idea stuck. With the encouragement and guidance of Dr. Kenneth Williams, I was on my way to finding better ways of getting data to doctors and patients.

Q. Who were your collaborators and what roles did they have?

A. I founded Jolis Biotech in 2012. I manage the business, invent apps, create medical content and provide "vision."

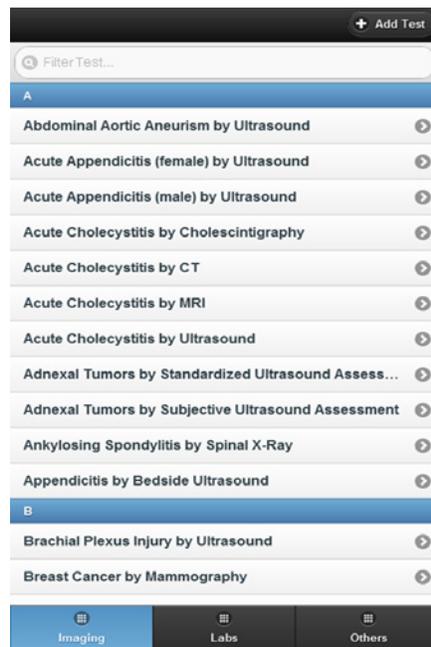
Waihong Chung is an MD/PhD student at the Alpert Medical School. His research is focused on hepatitis B and liver cancer. In his free time, he does computer programming and is a generalized very smart guy. He plans on being both a practicing physician and scientist. For Jolis Biotech, he does programming and data management. And Ivy Bradley, a graduating RISD illustration student, does interface design and illustration for Jolis Biotech.

Q. What has been your best-selling app?

A. So far, Jolis Biotech has created four apps. Some are made for patients, some for nurses, and some for physicians. My best selling app for medical people is called Sensitivity & Specificity. It's very simple. It allows you to look up the sensitivity and specificity of hundreds of tests. Every value is linked to the journal article from which it came. These data are normally difficult to find, even for the most common tests. Having them readily accessible allows physicians to make side-by-side comparisons of tests. This encourages evidence-based decision-making. It also helps prevent unnecessary testing.

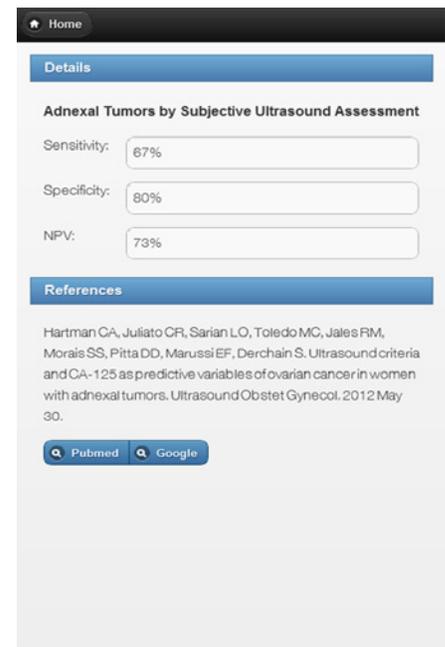
Q. When you develop/design an app, is it patented or copyright-protected? What is the process for doing this?

A. Part of dealing with Apple is realizing that they are all-powerful. If you spend \$20,000 building an app, they can decide not to allow you to list it in their store for any reason they like. While this does pose a challenge, their power reassures users that the apps they sell work. Apple's power also allows them to protect app makers from people infringing on their intellectual property. They even have a dedicated website that allows you to report intellectual property violations. That being said, some app developers take extra steps to protect themselves by filing patent applications.



Q. When you use your apps during your clinical rotations does it confuse the older physicians or are they pretty savvy about using information technology?

A. I've found that the more experienced physicians are actually very receptive to these new tools. They've been adapting to changing fields their entire lives. Also, most of them are fellow tinkerers, with a lot of lab experience, who get as excited as I do about the process of experimentation and invention.



Q. Other than your own apps, how many medical apps do you have on your own phone/tablet? What's your favorite as a medical student?

A. Other than my own apps, I have five other medical apps. I think my favorite is the one built by the U.S. Preventive Services Task Force called AHRQ ePSS. It allows you to stay current with ever changing recommendations for disease prevention. I also enjoy Diagnosaurus, which helps you build differentials. ❖

U.S. Emergency Care Costs May Be 2X Previous Estimates

Analysis published by Drs. Lee, Zink

BY DAVID ORENSTEIN
BROWN UNIVERSITY SCIENCE NEWS OFFICER

PROVIDENCE – Alternately praised in the aftermath of horrible tragedies as a heroic service and lamented in policy debates as an expensive safety net for people without primary care, emergency medicine is often a hot topic. Despite that importance, an analysis published online April 26 in the *Annals of Emergency Medicine* finds that national expenditures on emergency care are likely significantly higher than previously thought.

“The ER has become increasingly important as a place where people go for acute unscheduled care, however there has been little rigorous analysis of its cost structure,” said paper lead author Dr. Michael Lee, assistant professor of emergency medicine in the Warren Alpert Medical School and a physician at Rhode Island Hospital and The Miriam Hospital.

Dr. Lee, who had a prior career in economics and finance before training in emergency medicine, co-wrote the analysis with Dr. Brian Zink, professor and chair of the Department of Emergency Medicine at the Alpert Medical School, and Dr. Jeremiah Schuur, assistant professor at Harvard Medical School and director of quality and patient safety for the Department of Emergency Medicine at the Brigham and Women’s Hospital.

The challenge of properly accounting for the costs of emergency care, Dr. Lee said, becomes crucial as health care financing moves from a fee-for-service model to bundled payments for patient populations or episodes of care.

Clarifying costs

The analysis first examines current estimates of aggregate spending on emergency department (ED) care. The Agency for Healthcare Research and Quality’s Medical Expenditure Panel Survey (MEPS) estimates \$48.3 billion of spending on



Dr. Michael Lee

emergency care in 2010, or 1.9 percent of the nation’s total health care expenditures of \$2.6 trillion.

But Dr. Lee and his co-authors point out, based on data from other studies, that MEPS undercounts the number of ED visits and the number of ED patients who are admitted to hospitals. Adjusting for those discrepancies using data from a variety of other published sources, the authors estimate that ED costs are between 4.9 percent to 5.8 percent of total health care spending.

The authors went beyond national data sets, including the National Emergency Department Sample, to review ED spending data from a different source: a major national private insurer. The data included charges from doctors and hospitals for imaging, testing, and other procedures. But again there were accounting differences between admitted and discharged patients and a need to account fully for spending from Medicare and Medicaid. The authors’ estimate based on this data is ED spending that is 6.2 to 10 percent of

total health care spending.

Much of the debate in the academic literature around the expense of ED care has to do with whether the bulk of costs are fixed (e.g., expensive equipment and continuous staffing) or marginal (e.g., flexible staff time, expendable supplies). According to Dr. Lee, the cost structure of the ED remains poorly understood and is significantly more complex than what is modeled in existing studies.

As with assessments of total costs, the authors report, the studies vary widely even after adjusting for inflation. Across four major studies over the last three decades, the average cost per patient of an ED visit in 2010 dollars ranged from only \$134 to more than \$1,000, Dr. Lee and colleagues found. Meanwhile, the marginal cost of an ED visit (factoring out the fixed costs), ranged from \$150 to \$638.

Alternative accounting

The authors instead argue for an accounting based approach to ED costs using a methodology known as “Time-Driven

PHOTO BY FRANK MULLIN/BROWN UNIVERSITY

Activity Based Costing (ABC),” which has been applied to health care by Robert Kaplan and Michael Porter, professors at the Harvard Business School.

The method maps all clinical, administrative, and diagnostic steps in a patient encounter and assigns costs to each activity, explicitly accounting for the time spent on each task.

ABC accounting might provide a more realistic and transparent measure of ED costs, Dr. Lee said, because the emphasis on time is particularly relevant for

emergency medicine.

The authors acknowledge that an outcome of their analysis reporting higher overall costs for emergency care, may invite further criticism that the expense of emergency care represents unnecessary, inefficient care.

“However, we offer a more sanguine interpretation — the high share of spending affirms the importance of emergency medicine within the health care system,” they wrote. “With 130 million visits, 28 percent of all acute care visits, and

accounting for nearly half of all admissions, emergency medicine should be expected to represent a large share of health care spending.”

And Dr. Lee cautions, based on other studies, that efforts by private and government payers to divert ER care may not lead to large aggregate savings.

“Diverting nonemergency care may simply shift costs onto primary care offices and clinics which may not have the infrastructure to accommodate a large volume of unscheduled care,” Dr. Lee said. ❖

Linakis, DeSpirito receive \$3.2M grant to study teen alcohol use

Hasbro Children's Hospital is one of 16 study sites

PROVIDENCE – Hasbro Children’s Hospital emergency medicine physician James Linakis, MD, PhD, was recently awarded a five-year, \$3.2 million grant from the National Institute on Alcohol Abuse and Alcoholism (NIAAA) at the National Institutes of Health (NIH) to validate a more efficient test to screen teenagers for future alcohol abuse and other risk behaviors. Dr. Linakis will be joined on the multi-site study by co-principal investigator Anthony Spirito, PhD.

The project, titled “Teen Alcohol Screening in the Pediatric Emergency Care Applied Research Network (PECARN),” will utilize 16 children’s hospital sites to determine if the NIAAA two-question screen is an efficient and valid alcohol screening instrument among U.S. pediatric emergency department patients compared to the previously utilized more lengthy questionnaires.

“We know that the younger an individual starts to drink, the higher their risk for developing alcohol related issues later in life. We need to find the best way to catch this early,” said Dr. Linakis.

Over the past few years, the NIAAA has focused on the importance of screening adolescents for alcohol problems, but the only screening tools have been relatively lengthy. A basic, two-question screening questionnaire was created that the NIAAA hopes will be predictive of both current and future alcohol problems in adolescents. It asks:

- 1.) Do you drink alcohol? How much?
- 2.) Do you have friends who drink alcohol?

“This two-question screening is based on established literature, but it has never been validated. The NIAAA is asking for PECARN hospital sites to test the two-question screener, so we can make sure that the screening system works,” said Dr. Linakis.

Adolescents ages 12 to 17, who are being treated in the emergency room, will be randomly selected to take part in the questionnaire. They will be asked these questions, along with a series of others to compare them with longer questionnaires. The goal is to screen 5,000 teens over three-and-a-half years.



Dr. James Linakis is an associate professor of emergency medicine and pediatrics at The Alpert Medical School and associate director of pediatric emergency medicine at Hasbro Children’s Hospital.



Anthony Spirito, PhD, co-investigator, is professor of psychiatry and human behavior at The Warren Alpert Medical School.

Researchers will then contact 1,000 of those teens and screen them again.

“We want to see if the shorter survey can just as effectively predict risky behaviors, both current and future,” said Dr. Linakis. “When we follow up we will also be able to see if the questionnaire predicted drug abuse or risky behaviors, not just alcohol use.”

After the study is complete, Dr. Linakis’ team and the NIH hope to use this data to help develop an intervention for adolescents who drink alcohol and display other unsafe behaviors.

“The study, the data it finds, and the future intervention program will be extremely helpful for anyone who takes care of kids in a primary care setting,” he said. ❖

Health Insurance Commissioner Koller leaving post

Accepts post as head of health policy foundation

PROVIDENCE – Gov. Lincoln Chafee announced on April 18 that Health Insurance Commissioner Christopher F. Koller will be stepping down to become president of the Milbank Memorial Fund, a national health policy foundation based in New York City. Koller will leave his post following the current rate factor review process, expected to be concluded at the end of June 2013.

“This is a tremendous opportunity for Commissioner Koller, and I want to sincerely thank him for his service to our state in this critically important area over the past decade,” Gov. Chafee said. “We appreciate his hard work and leadership – both locally and nationally – in implementing systemic reforms to improve health insurance in Rhode Island. I am committed to identifying a successor who will continue the excellent work of the Office and the Executive Committee for Health Care Reform.”

Koller was appointed as the country's first and only Health Insurance Commissioner in January of 2005. In this role, he has developed a comprehensive commercial health insurance rate review process, established and enforced expectations of commercial insurer efforts to reduce the underlying costs of medical care, established the nationally recognized Chronic Care Sustainability Initiative focused on improving primary care, and led the initial state applications for the Insurance Exchange planning grants. ❖

RI Foundation awards Taylor Innovation Fellowship to ‘defeat Hep C’

Will receive up to \$300,000 over the next three years



LIFESPAN

PROVIDENCE – Lynn E. Taylor, MD, an HIV and viral hepatitis specialist, primary care physician and director of the HIV/Viral Hepatitis Coinfection Program at The Miriam Hospital, is one of two recipients of the 2013 Rhode Island Innovation Fellowship, an annual program in its second year designed to stimulate solutions by Rhode Islanders to Rhode Island challenges. She is the first physician to be selected.

The Fellowship provides two individuals with up to \$300,000 over three years to develop, test, and implement innovative ideas that have the potential to dramatically improve any area of life in Rhode Island.

Dr. Taylor's project, Rhode Island Defeats Hep C, aims to make Rhode Island the first state to eradicate the Hepatitis C virus infection (HCV). She calls HCV a “time bomb in Rhode Island” and says the epidemic will peak in the state over the next two decades unless dramatic action is taken. With the medical community now on the verge of a radical, “game-changing” shift in HCV therapy, Dr. Taylor says the cure rate can potentially be 100 percent.

She proposed a comprehensive plan that includes several steps: awareness, rapid testing, linkage to care, building infrastructure for a sustainable model and evaluation.

“At no other time in history have we had such opportunity to eradicate this harmful, costly epidemic,” she said.

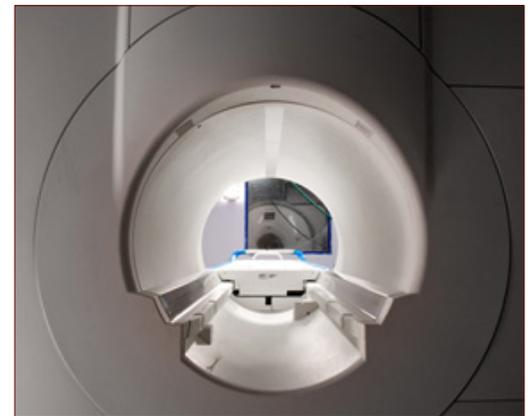
Dr. Lynae Brayboy, a fellow in obstetrics and gynecology, who proposed a smartphone app with sexual health information for girls, was a finalist for the awards. ❖

Rhode Island Hospital adds MRI unit to ER

PROVIDENCE – Rhode Island Hospital is expanding its emergency department services with the addition of a magnetic resonance imaging (MRI) unit. In doing this, Rhode Island Hospital becomes one of just a few hospitals in the country, and the first in New England, to make MRI available in the emergency department.

Prior to the launch of this unit, emergency department patients requiring an MRI had to be taken through the hospital to the Grosvenor building, often requiring travel through high-volume patient areas.

“The emergency department at Rhode Island Hospital is essentially a hospital within a hospital,” said John Cronan, MD, chief of the department of diagnostic imaging at Rhode Island Hospital. “Any diagnostic imaging test that a patient needs while in our emergency department – X-ray, ultrasound, CT scan, MRI – it can all be done right there in the ER. We are among the first in the country to bring this sophisticated technology to the emergency room patient.” ❖



LIFESPAN

Atty. Gen. Kilmartin OKs Westerly Hospital sale to Lawrence + Memorial Corp.

PROVIDENCE – R.I. Attorney General Peter F. Kilmartin announced April 17th that he has approved, with conditions, the proposed sale of Westerly Hospital and affiliated entities to Lawrence + Memorial Corporation (L+M), pursuant to the expedited review process of the Hospital Conversions Act.

The closing date of the \$69.1 million sale will happen before June 1. On June 1, the hospital will close its maternity services. The hospital has been in receivership since December 2011.

“This is the first time we have reviewed a hospital conversion under the expedited review process, reducing the number of days for review from 120 to 90. All parties recognize the critically important role Westerly Hospital plays in providing quality healthcare to the residents of the area and as an important economic engine for the region,” said Kilmartin.

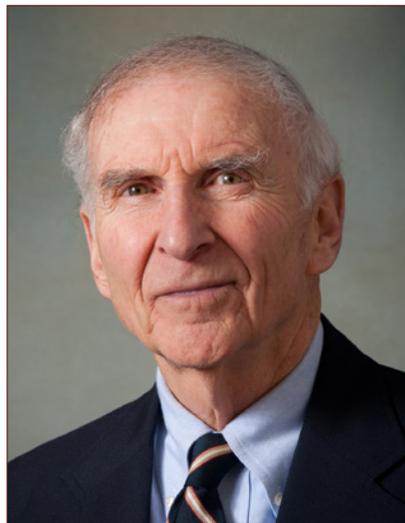
“There are currently three hospital conversions before this office in various stages. The Office is always mindful, in our role as a regulator, to the balance need to protect the interests of the community, the employees and the state with the economic realities of the rapidly-changing and highly competitive healthcare marketplace,” added Kilmartin. ❖

Grape Street Orthopedic joins Southcoast Physicians Group

NEW BEDFORD, MASS. – Grape Street Orthopedic has joined Southcoast Physicians Group. The orthopedic practice includes Harry Von Ertfelda, MD, and Gilbert L. Shapiro, MD, FACS. It will now be recognized as Southcoast Physicians Group Orthopedics. ❖



Harry Von Ertfelda, MD



Gilbert L. Shapiro, MD

OB/GYN Associates Joins Lifespan's Women's Medicine Collaborative

PROVIDENCE – Lifespan's Women's Medicine Collaborative has announced a new partnership with OB/GYN Associates, Inc., one of the state's largest obstetrics and gynecology practices with locations throughout Rhode Island and Massachusetts. The partnership is expected to be finalized in August.

“This affiliation with Lifespan's Women's Medicine Collaborative will give our patients more options, while not diminishing our presence at Women & Infants' Hospital, especially as our patients will continue to deliver their babies at Women & Infants Hospital,” said John Bert, MD, of OB/GYN Associates. ❖

Hillside, S. County family practices join Coastal

PROVIDENCE – Hillside Family and Community Medicine in Pawtucket and South County Family Medicine, Narragansett signed agreements in April to join Coastal Medical.

The Coastal Hillside Family Medicine physicians are Christopher Campanile, MD; Hana Hagos, MD; Barbara Jablow, MD; Christine Kennedy, MD; Cristina Mitchell, MD; Kenneth Sperber, MD, and Carla Garcia-Benoit, NP.

Coastal Narragansett Family Medicine is a four-physician practice comprised of Catherine DeGood, DO; Dariusz Koszrzewa, MD; Eileen Gonzalez, MD, and Michael Gonzalez, MD.

Coastal Medical is Rhode Island's first Medicare Shared Savings ACO. It provides predominantly primary care, along with some specialty services, to 130,000 patients in 20 medical offices across Rhode Island. Coastal also owns state-wide laboratories, an imaging center and a medical billing company. ❖

Study examines public health implications of lack of methadone treatment in prisons

PROVIDENCE – Methadone treatment for opioid dependence remains widely unavailable behind bars in the United States, and many inmates are forced to discontinue this evidence-based therapy, which lessens painful withdrawal symptoms. Now a new study by researchers from the Center for Prisoner Health and Human Rights, a collaboration of The Miriam Hospital and Brown University, offers some insight on the consequences of these mandatory withdrawal policies.

According to their research, recently published online by the *Journal of Substance Abuse Treatment*, nearly half of the opioid-dependent individuals who participated in the study say concerns with forced methadone withdrawal discouraged them from seeking methadone therapy in the community after their release.

“Inmates are aware of these correctional methadone withdrawal policies and know they’ll be forced to undergo this painful process again if they are re-arrested. It’s not surprising that many reported that if they were incarcerated and forced into withdrawal, they would rather withdraw from heroin than from methadone, because it is over in days rather than weeks or longer,” said senior author Josiah D. Rich, MD, MPH, director of the Center for Prisoner Health and Human Rights, which is based at The Miriam Hospital, and professor of medicine and epidemiology at The Alpert Medical School.

He points out that methadone is one of the only medications



LIFESPAN

that is routinely stopped upon incarceration. “Given that opioid dependence causes major health and social issues, these correctional policies have serious implications,” he said.

Additionally, methadone therapy has been shown to reduce the risk of criminal activity, relapse, infectious disease transmission (including HIV and hepatitis) and overdose death.

In the study, Dr. Rich and colleagues surveyed 205 people in drug treatment in two states – Rhode Island and Massachusetts – that routinely enforce methadone withdrawal in correctional facilities. They found nearly half of all participants reported concern regarding forced methadone withdrawal during incarceration.

“We should examine the impact of incarceration itself, and what happens behind bars, on public health and public safety outcomes, and tailor our policies appropriately,” Dr. Rich said. ❖

W&I physician awarded \$1.6M grant

PROVIDENCE – Kristen A. Matteson, MD, MPH, of the Department of Obstetrics and Gynecology at Women & Infants Hospital and assistant professor of obstetrics and gynecology at The Warren Alpert Medical School of Brown University, has earned a \$1.6 million grant from the Eunice Kennedy Shriver National Institute of Child Health and Human Development of the National Institutes of Health to study the effectiveness of two treatments options for heavy menstrual bleeding.

“Heavy menstrual bleeding is one of the most common gynecologic problems women encounter,” explained Dr. Matteson. “It is such an important problem to study because heavy menstrual bleeding has a negative impact



WOMEN & INFANTS HOSPITAL

on a woman’s quality of life, often leading women to utilize expensive medical resources.”

There are two commonly prescribed non-surgical treatments for heavy menstrual bleeding – combined oral contraceptives and the levonorgestrel intrauterine system (the use of an intrauterine device (IUD) with progestogen). However, studies comparing these treatments are extremely limited.

The primary goal of the study is to determine the relative effectiveness of both treatment options in improving the quality of life in women with heavy menstrual bleeding. The study will also compare rates of treatment failure (defined as stopping the treatment and/or request for surgery).

Enrollment in the study will begin in the fall. ❖

Traumatic brain injury in patients with nonepileptic seizures ups risk for psychiatric disorders

PROVIDENCE – A new study by a Rhode Island Hospital researcher has found that traumatic brain injury (TBI) can significantly increase the odds of having major depression, personality impulsivity and post-traumatic stress disorder (PTSD) in patients with psychogenic nonepileptic seizures (PNES). The paper, by W. Curt LaFrance Jr., MD, MPH, director of neuropsychiatry and behavioral neurology, was published in the April edition of the journal *Epilepsia*.

“Some patients who sustain a TBI develop seizures,” Dr. LaFrance said. “Very often, these seizures are believed to be epileptic in nature, and the patient, therefore, is treated for epilepsy. Later the seizures are found to be PNES. This study demonstrates the prevalence of co-morbid mild TBI and PNES, which could suggest that

some patients are being inappropriately treated for epilepsy with antiepileptic drugs, while not being treated for their actual illness: nonepileptic seizures.”

The study underscores the importance of identifying and addressing the impact of TBI in patients with seizure disorders to ensure appropriate and effective treatment.

“Another significant finding from the study was that if a patient had both PNES and TBI, the combination resulted in 2.75 odds increase of having PTSD, and triple the odds increase of having a history of trauma/abuse,” Dr. LaFrance said. “This finding illustrates the importance of the ‘double hit’ of emotional and physical traumatic experiences that may occur with abuse and/or a head injury commonly found in the PNES population. This study shows that TBI and PNES are significantly associated with a cluster of diagnoses including depression and PTSD, personality, and/or trauma/abuse history, all of which could have an impact on functioning.”

Mild TBI appears to be a significant risk factor in patients with PNES, and is associated with increased psychiatric co-morbidity, symptom severity, poor functioning and increased disability. ❖



BROWN

Research links chemoresponse assays, improved ovarian cancer survival rates

PROVIDENCE – A team of researchers has released results from an eight-year study that shows improved survival rates for women diagnosed with ovarian cancer who undergo cancer tumor testing to determine the best treatment.

Part of the team was Richard G. Moore, MD, director of the Center for Biomarkers and Emerging Technologies and a gynecologic oncologist with the Program in Women’s Oncology at Women & Infants Hospital of Rhode Island.

“Essentially, we have demonstrated that by using a tissue sample from the patient’s tumor and a chemoresponse assay, we are able to determine which treatment may or may not work for her,” Dr. Moore explains of the study, which was presented at a recent meeting of the Society of Gynecologic Oncology and in the journal *Cure*.

“This study shows that a woman with recurrent ovarian cancer could benefit from having a biopsy and chemosensitivity testing. The results from such testing will allow for the identification of chemotherapeutics that are active against the patient’s disease and those that are not resulting in decreased toxicity from ineffective treatments. Learning that personal directed therapies may improve overall survival for these patients made this the first study in two decades to show a significant increase in survival in recurrent ovarian cancer.”

The study, launched in 2004, included 283 women. Of those, 262 had successful biopsies which were tested in vitro, or in a test tube. The assay ChemoFx®, by Precision Therapeutics, tested up to 15 approved treatment regimens on the samples, identifying chemotherapy drugs and regimens to which each tumor might be sensitive. The study was non-interventional, meaning that physicians chose the treatment regimens without knowing of the assay results. The researchers then evaluated the assay’s result against actual patient outcomes.

“The assay identified at least one treatment to which the tumor would be sensitive in 52% of patients in the study,” Dr. Moore says. “Overall, median survival was 37.5 months for patients with treatment-sensitive tumors, compared to 23.9 months for intermediate and resistant tumors.”

Assay-directed therapy has long been debated among oncologists, he continues. Such debate provided the impetus for this study. ❖



WOMEN & INFANTS HOSPITAL

Bridging Neurology & Psychiatry: Movement Disorders

Saturday, October 12, 2013
The Joseph B. Martin Conference Center
at Harvard Medical School
Boston, Massachusetts

This full day course is aimed at reviewing the interface between neurology and psychiatry to enhance the clinician's ability to recognize and classify movement disorders in psychiatric patients and psychiatric problems in movement disorder patients. Behavior problems are the major determinants of quality of life in Parkinson's disease yet they are often not recognized. Similarly, movement disorders caused by antipsychotics frequently go unrecognized.

World renowned experts in movement and psychiatric disorders will review drug-induced movement disorders, psychogenic movement disorders and movement disorders associated with primary psychiatric disorders.



This course is designed for neurologists, psychiatrists, primary care physicians, nurses, psychologists, pharmacists, physician assistants, social workers, medical students and fellows.

Click to download the [Course Program](http://www.worldwide-medicalexchange.org/content/movement-disorder-course).
Register Online: <http://www.worldwide-medicalexchange.org/content/movement-disorder-course>



MAY

3rd Annual Rhode Island Stroke Conference

Keynote Speaker: **Mark J. Alberts, MD, FAHA**
May 3, 2013, 7:15am
Crowne Plaza Providence-Warwick
[Conference Agenda and Registration Information](#)

Rhode Island Medical Women's Association 2013 Annual Meeting & 32nd Anniversary Celebration

Wednesday, May 13, 2013
Providence Marriott Hotel, One Orms Street
6:30 pm Reception, 7 pm Dinner and Program
This meeting is open to medical and non-medical communities.

Public Health Grand Rounds Webcast Event (CME credit)

May 16, 2013, 8:30 am–9:30 am

Lessons Learned about Shared Decision Making: The Group Health Story

Ben Moulton, JD, MPH

Dr. Moulton is the senior legal adviser at the Foundation for Informed Medical Decision Making. He provides health law oversight and guidance to all foundation activities to support sustainable models of health care that include informed medical decision making and improved quality of medical decisions. In addition, Dr. Moulton is an adjunct professor of health law at the Boston University Law School and the Harvard School of Public Health. [Pre-register online](#)

Innovative Approaches to Medication Management

Networking Dinner and Panel Discussion
May 22, 2013, 5:30pm
Location: 235 Promenade Street, Suite 500
[Register](#)

JUNE

Scope of Pain Safe and Competent Opioid Prescribing Education

June 8, 2013, 7:30 am–1:30 pm
Warren Alpert Medical School
To register, visit www.scopeofpain.com

Collaborative Office Rounds 2012–2013 Series (CME credit)

Motivational Interviewing for Adolescent Alcohol and Marijuana Use

All are welcome to attend sessions at South County Hospital and Westerly Hospital or participate online via webcast.

Wednesday, June 12, 2013
7:30 a.m.–9:45 a.m.

Anthony Spirito, PhD, ABPP

Professor of Psychiatry & Human Behavior
Director, Division of Clinical Psychology
Warren Alpert Medical School of Brown University

Webcasted and Live

<http://med.brown.edu/cme/brouchure/COR-2013%20Sessions.pdf>

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Opportunity—Medical Director

Blue Cross & Blue Shield of Rhode Island is in need of a Medical Director to provide leadership and guidance to organization related to the administration of medical services; ensure quality of medical care, efficiency, quality, and affordability of healthcare services. Perform utilization review functions for plan; ensure organization is compliant with federal, state, and local laws, along with accreditation standards. Serve as lead on organization Credentialing and Medical Policy Committees. Enhance and maintain relationships with the provider community. To apply, please visit our careers page: <https://www.bcbsri.com/about-us/careers>

At Blue Cross & Blue Shield of Rhode Island (BCBSRI), diversity and inclusion are central to our core values and strengthen our ability to meet the challenges of today's healthcare industry. BCBSRI is an equal opportunity, affirmative action employer. We provide equal opportunities without regard to race, color, religion, gender, age, national origin, disability, veteran status, sexual orientation, gender identity or expression.