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A recent article in the *Journal of Neuroscience* studied people between the ages of 60–80 who had intact cognition and memory; the oldest in the group are known as “superagers.” It reported that a particular location in the brain was enlarged compared to normal controls of the same age and gender. This same region had been also found to be enlarged in individuals whose careers were spent in jobs working on difficult mental tasks, that is, solving hard problems. In a newspaper article, one of the researchers took this to mean that working on solving hard problems was one key to superaging. She cited her father-in-law, who was sharp at an advanced age, a result she ascribed to his daily physical and mental efforts. She was a non-physician researcher and apparently hadn’t met many patients who exercised and thought as hard or harder than this lucky man but who didn’t do so well. Her point, stated clearly, was that simple mental exercises, things like crossword puzzles and Sudoku, weren’t adequate, that one had to think hard to avoid dementia. Not satisfied with the often-repeated homily, “no pain, no gain,” she instead cited a Marine Corps motto: “Pain is weakness leaving the body.”

I don’t know the researcher. My guess is that she believes that she thinks hard. She probably exercises a lot as well. I wonder if she’s been using the MRI scanner on the sly to check the size of her brain. This is the gluten-free diet solution for the brain. “If it’s hard to do and I do it, it must be good for everyone.” I get upset by such simplistic remarks. I am not stating that she is wrong. I am stating that she doesn’t know if she’s right, but likes the idea enough that she has convinced herself that she is. I, on the other hand, older, more jaded, find her suggestion is no better than the warnings I heard in my youth that eating chocolate produced acne. Like every other teen, my acne waxed and waned regardless of my chocolate consumption.

There are a lot of problems with scientists overstepping their knowledge to make statements that they’d like to be true. We see this weekly with epidemiological studies showing that eating something or not eating something is associated with cancer, dementia or optimism. We’ve been through many revisions of suggested eating pyramids as we learn that the latest one wasn’t so good. Why we haven’t learned that none of them are good is beyond me.

The first problem with this brain theory is that observing a correlation that makes sense and fits with a hypothesis doesn’t make it true, and the second is the lack of any data to support the recommendation. Do mathematicians, physicists and philosophers get demented less than their peers? Well, the answer is yes, but it is not their hard thinking but their
intelligence and education that conveys the benefit. Smart, educated carpenters and dishwashers do just as well. And who’s to say what hard thinking is? Did Einstein think hard or did his insights just spring into his mind via the muse of physics? Did Mozart think just as hard? Do you have to be a neuroscientist to benefit from hard thinking? Did Einstein think harder about his problems than I do when I try to figure out how to write a dataset into a readable paper? We don’t have mental calorie counts. Should we all be trying to solve differential equations? Will a less intelligent person develop a more developed brain than the one who finds these challenges less demanding? The research paper suggests that one probably needs to be very smart and to think hard.

Overlooked in this particular claim for intellectual supremacy via a bigger and better brain, are data that in diseases of the brain which cause them to shrink due to cell loss, and certainly work less well, there are often parts that actually increase in size. Brain loss is not uniform. Are these larger regions compensating? Perhaps, or more likely, the brain cells that should be there have died and are still dying but have been replaced by scar cells (gliosis). I suppose that it is indeed possible that the increased size of the identified region in the brain is related to hard thinking, but I am not so confident they have not reversed chicken and egg. For example, do artists have larger occipital cortices, the region where vision is first activated, or perhaps another part of the brain where images are processed, or yet a different part, where images produce emotions? Do we see that the region of the brain that controls finger and hand movements are increased in professional violinists? We know that atrophy in the hippocampus, one region involved in memory, is a sign of Alzheimer’s disease, so that preserved memory is associated with less dementia, even in people with the disease. Perhaps these people worked at remembering things better?

What annoys me most is not the simplicity, but the idea that scientists, since they are the only ones who can study this, tend to think that people who act like they do, that is, “think hard,” “solve difficult problems,” basically “do what I do,” are going to reap a more bountiful harvest than the rest of us.

Most basic science researchers don’t credit most clinical researchers as thinking very hard in the first place. The next study might compare basic scientists with clinical neuroscientists to see whose brain region is bigger.

In the meanwhile, keep thinking.

Reference

Author
Joseph H. Friedman, MD, is Editor-in-chief of the Rhode Island Medical Journal, Professor and the Chief of the Division of Movement Disorders, Department of Neurology at the Alpert Medical School of Brown University, chief of Butler Hospital’s Movement Disorders Program and first recipient of the Stanley Aronson Chair in Neurodegenerative Disorders.

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Your Life Made the Difference in How I Practice Medicine

ERIC J. CHOW, MD, MS, MPH

It’s been five years now since you passed. A day hasn’t gone by that I haven’t thought about our time together or that fateful day you took your own life. You were my partner in life and there’s so much I wish to tell you as so much has changed since then. After four years of residency training, I am about to graduate as a physician in internal medicine and pediatrics. I am newly engaged and I have had opportunities to travel the world since we last spoke. I feel that a lifetime of experiences and learning have taken place, especially in my medical training. As I reflect back now, I realize that I have taken care of a lot of patients between medical school and residency. Yet despite it all, your life and all its hardships still have the most lasting impacts on how I approach patient care.

I still remember that day we first learned that you had fibromyalgia. After all those years of unexplained symptoms, aching shoulders, unrelenting headaches, and chronic fatigue, we finally arrived at an answer but at what cost? After multiple doctor visits, specialists, rheumatological blood tests, trials of medications, we had finally ruled out any other explanation. At the end of the day there was no satisfactory treatment for your chronic fatigue and persistent muscle soreness and that left us in a constant search of an answer that didn’t exist. We endured long waits at the emergency rooms, eye rolls and polypharmacy that in a couple of instances with overdoses almost cost you your life. Despite our desperation to find help, we felt isolated and alone.

You were no stranger to feeling cast aside. We met so many people in the medical community along the way but no one took the time to understand your mental health struggles that began long before your physical symptoms. Disowned by your parents at an early age for being gay, you were left to figure out a way through life without the people who should have loved you unconditionally. You held out hope, answering every phone call from your parents wishing they would reconsider their decision only to be reminded that you were going to hell because of your “life choices.” Ultimately our happy times together were not enough. You had experienced loss from so many different directions that you decided suicide was the only way you would find peace from the physical and mental anguish. Had we worked with your primary care provider to provide you comprehensive care to find people who understood you as a person rather than just a medical problem, perhaps you would still be here today.

As isolated as we felt at the time, I have come to realize that our experiences were not unique to us. Now as a young physician, many patients that I care for find themselves in similar situations as we did. They struggle to understand their chronic diseases by navigating a labyrinth of medical providers that only have time to focus on their physical ailments. I saw us in a refugee couple when the wife presented with persistent unexplained headaches. They came in weekly asking for more tests, more referrals, and more treatments but in the end, we had exhausted them all. They were left frustrated and hopeless much like we were. Then there was that dear lady who developed post-op pain from abdominal surgery. Her life was turned upside down because of the crippling pain. At every appointment, she and I would have tearful moments about how she yearned to live a normal life again but she now was losing hope.

Our training teaches us to rule out the medical emergencies. Make sure it’s not a tumor or an impending bleed causing those headaches. Rule out the abdominal abscess or surgical abdomen that would explain the excruciating abdominal symptoms. But what then? Where does that leave the patient? Where did that leave us when we were searching for answers? I recall the sudden disinterest and resentment we faced after our tests came back negative. Specialists sent us back to the primary care provider. We spoke to more clinic
secretaries than doctors. On one occasion, a nurse in the emergency room said you were drug seeking. We were left with mixed emotions including anger, hopelessness and isolation, much like the patients I see today.

The day after you took your life, I made a promise that I would change the way I practiced medicine that reflected my life with you. If you didn’t receive the personalized care that you needed, I would ensure that I would. I’ll admit it wasn’t easy. Between a busy schedule and challenging patients who sometimes took advantage of my empathy, there was a constant struggle to find the right balance in actual practice. Over time, however, I managed to adopt a few changes that allowed me to better address my patients’ needs by connecting with them on a personal level. For those who had conditions I found medically frustrating, I would see these patients more often especially when symptoms worsen rather than push them away. I removed the computer and white coat from patient encounters. Instead of rushing to medical tests and treatments, I spent the time learning about the person behind the diagnosis. Who were their family members? What did they enjoy doing? What did they look forward to the most? Inevitably, these conversations provided key pieces of information that changed my approach to their care. Sometimes this meant involving more than just the patient. We would discuss who their caretakers were and what hardships they have endured. We discussed ways to reshape life to cope with the new diagnosis rather than constantly fighting against it. While my patients may never be able to return to the normal life they once lived, they at least know they don’t have to go it alone. In some of these patients I have seen remarkable changes in their lives. They have taken on new hobbies, started exercising and have made other dramatic lifestyle changes. They visit the emergency room less and no longer ask me for pain medication. Ironically, they have asked me to space their appointments now because they had made vast improvements in their life and no longer required the frequent attention.

I wish we had more time to find you that confidante – a physician whom you could turn to who saw you more than an illness – as a person. I wish they could have brought you in closer rather than push you away. While things may not have worked out better for you, realize that life with you has allowed me to improve the way others are able to live theirs. You have given them hope that they don’t have to live a life of perpetual solitude. You made a difference in my life, so I could make a difference in theirs.

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Opposing Maintenance of Certification (MOC) and the Interstate Medical Licensure Compact

To the Editor:

We have a shortage of physicians in Rhode Island and nationwide. Unregulated private examination companies are making it harder for doctors to care for patients with no evidence that their certifications improve patient care. Over 85% of physicians nationwide are against the Maintenance of Certification (MOC) program of the American Board of Medical Specialties (ABMS) that is increasingly being required to practice medicine. This program is contributing to burnout and early retirement, aggravating the shortage of physicians for a handsome profit (ABMS net assets of one billion dollars.)

We need to ensure that MOC remains “voluntary” and remains unlinked to licensure in RI. The “Patient Access Bills,” Senate Bill 0745 and House Bill 5671, codify our current licensure process, ensuring that private companies such as the ABMS and the Federation of State Medical Boards (FSMB) remain unlinked to medical licensure in Rhode Island. This will help Rhode Island compete for physicians when 7 states have passed similar laws and an additional 7 have similar legislation pending. Also the American Medical Association (AMA) has created a very strong “Right to Treat,” anti-MOC model bill that many states will be introducing next year.

Also, defeating The Interstate Medical Licensure Compact (Compact), Senate Bill 0269, will ensure that licensure in Rhode Island remains free of the ABMS-trademarked MOC. It also ensures that unelected private monopolies are not allowed to supercede RI's statutory law and prevents the imposition of undefined fees on RI. The Compact is a very complicated 17-page bill that raises many other concerns including rules of renewal, loss of due process, and MOC requirements. Of the 50 states, 17 are against it and 13 are not considering it. Many of the states that passed the bill have amended it to protect their physicians and their state. Over 260 RI physicians have signed a petition against the Compact.

Most physician do not find the MOC “voluntary” and do not think that the ABMS should have influence in any form of licensure. Even the company itself states their certification should not be linked to licensure or hospital privileges. Many physicians are planning early retirement due to increasingly burdensome requirements including the MOC program.

I see hundreds of patients on a regular basis, as do my colleagues. Our patients’ care is our utmost priority, including staying up to date in medicine. Continuing Medical Education, required for licensure, keeps physicians on the cutting edge of science. The MOC fills doctors’ time with busy work for private “vendors” and steals time from patient care, at a very high cost to both doctors and society.

Please urge your representatives and senators to vote “YES” for Patient Access bills: Senate Bill S0745 and House Bill H5671 and to vote “NO” on the Interstate Medical Licensure Compact bill – Senate Bill S0269.

David Kahn, MD
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BONNEVILLE SALT FLATS, NEVADA

Dr. Kenneth S. Korr checks the June issue of RIMJ on the Bonneville Salt Flats in Wendover, Nevada, west of the Great Salt Lake in Utah. It is the largest of many salt flats stretching over 30,000 acres. Visitors to the rest area can venture out onto the salty soil, the remnants of an ancient lake. It is home to a famous speedway as well.

LARAMIE, WYOMING

RIMJ Managing Editor Mary Korr reviews the Journal at a rest stop on the Lincoln Highway, I-80, in Laramie, Wyoming, the Gateway to the Rockies. The monument to President Lincoln is almost 50-feet high. In 1913 the Lincoln Highway Association was formed to promote car travel across the United States, and according to the sign, the great American road trip was born.

Wherever your travels take you, be sure to check the latest edition of RIMJ on your mobile device and send us a photo: mkorr@rimed.org.
CABO DO ROCA, PORTUGAL
At right, Michael E. Migliori, MD, RIMS Public Laws Committee Chair, and Ophthalmologist-in-Chief at Rhode Island Hospital, accessed the journal at Cabo da Roca, the westernmost point of mainland Europe.

CÓRDOBA, SPAIN
Mike Migliori visits the monument to Maimonides, the 12th-century rabbi, physician, and an acclaimed polymath in both the Jewish and Islamic worlds. Maimonides was born in Córdoba, and he pioneered the delivery of medical care with respect and multicultural sensitivity.

TANGIER, MOROCCO
Marianne Migliori, RIMJ graphic designer, was able to access the May issue (but not read it) on camel-back near Achakkar Beach on the Atlantic coast of Morocco.

Wherever your travels take you, be sure to check the latest edition of RIMJ on your mobile device and send us a photo: mkorr@rimed.org.
ABSTRACT
Chronic obstructive pulmonary disease (COPD) is associated with significant morbidity, decreased quality of life, and burdensome hospital admissions. Therefore, patients with COPD interact with clinicians in a number of healthcare settings. A coalition of healthcare practitioners in Rhode Island, in partnership with the local Quality Improvement Organization, designed and implemented a standardized, COPD education program for use across multiple healthcare settings. More than 60 organizations participated, producing 140 Master Trainers, who trained 634 staff members at their facilities from October 2015 through June 2016. Master Trainers were satisfied with the training, and we observed significant increases in knowledge scores post-training among all participants, which remained significant when stratified by setting. These results demonstrate that implementation of a community-based program to disseminate patient-centered, standardized COPD education in multiple healthcare settings is feasible. We hope this program will ultimately improve patient outcomes and serve as the foundation for expanding standardized education for other chronic conditions.

KEYWORDS: chronic obstructive pulmonary disease, patient education, self-management, quality of health care

INTRODUCTION
Chronic obstructive pulmonary disease (COPD) is a condition associated with significant morbidity, decreased health-related quality of life, and burdensome hospital admissions. An estimated 700,000 COPD hospitalizations occur each year in the United States, and about 20% of patients are readmitted to the hospital within 30 days. In 2015, 23.9% of Rhode Island’s Medicare beneficiaries with COPD were readmitted within 30 days.

Self-management, a patient’s ability to oversee their own chronic conditions, can improve health outcomes, contribute to a better patient experience, and potentially lower costs. COPD patients who have received self-management education have improved quality of life, improved adherence to medications, and lower rates of hospitalization and readmissions. Although prior work supports self-management education in COPD, use of standardized educational materials across different healthcare settings, such as a hospital and skilled nursing facility (e.g., cross-setting education), has not been studied. COPD patients seek medical care in multiple different settings, and if these settings provide self-management education using different tools and approaches, patients could receive conflicting advice and information.

METHODS
Settings and Participants
As the New England QIN-QIO, Healthcentric Advisors partners with providers to establish community coalitions. These coalitions address barriers to safe patient transitions and work to reduce unnecessary hospital readmissions. The Greater Providence Community Coalition is one such initiative, which includes a wide range of healthcare settings and providers, including leadership and staff from more than 50 healthcare organizations. The Coalition is based in Providence County, an area with seven hospitals, 57 skilled nursing facilities, and 18 home health agencies, serving nearly 75,000 of Rhode Island’s 200,000 Medicare beneficiaries.

Program Development
In early 2015, Coalition members discussed the challenges of teaching patients with COPD how to self-manage their condition, identifying a lack of standardized training materials as a key barrier. The Coalition and Healthcentric Advisors collaborated to develop and implement a cross-setting COPD education program, building on an existing CMS-sponsored initiative [Lung Talks]. The program goals were to engage patients and families in disease self-management; reduce hospital admissions for COPD patients; and improve the care of COPD patients by using consistent messaging across healthcare settings through standardized education.

Workgroups planned program content and delivery methods. Clinicians and quality improvement specialists performed a literature review, reviewed existing educational resources, and developed training materials, including a manual, PowerPoint presentations, and a brief. The program was tested in a one-month pilot in 2015, and then fully implemented from October 2015 through June 2016. Master Trainers were satisfied with the training, and we observed significant increases in knowledge scores post-training among all participants, which remained significant when stratified by setting. These results demonstrate that implementation of a community-based program to disseminate patient-centered, standardized COPD education in multiple healthcare settings is feasible. We hope this program will ultimately improve patient outcomes and serve as the foundation for expanding standardized education for other chronic conditions.
resources, and then developed and adopted tools and materials, based on their knowledge of what would work best in the local community, engaging patients throughout the process.

Tools adopted for the program included the COPD Zone Tool and Action Plan and the Lung Talk booklets and videos. The COPD Zone Tool and Action Plan is a tracking system designed to allow patients to monitor and record their symptoms. It includes education about problem symptoms that require escalation and a section to document personalized action plans. This resource was translated into Spanish and Portuguese. Lung Talk booklets and videos\(^1\) and additional content from the American Lung Association were adapted to structure and standardize the education delivered to patients.

**Program Delivery**

We invited all Coalition members to a three-hour Master Trainer session taught by two clinical pharmacists and a nurse practitioner. Project staff also reached out to other healthcare organizations in the community to increase participation. Participants were instructed on the purpose of the program, basic pathophysiology and management of COPD, use of program materials, and how to deliver an effective training session at their own organizations. Demonstration inhalers were also used to stress proper inhaler administration. Core program components are in Table 1.

Participants who attended the Master Trainer session were tasked with training targeted front-line staff at their own organizations. We provided the curriculum and materials for the front-line staff training during Master Trainer sessions. Resources to implement training at individual facilities included: training manuals; pre- and post-tests with answer keys; the Lung Talk series; COPD Zone Tool and Action Plans; slides on COPD treatment; instructions and tools for data collection; and demonstration inhalers. We also provided standardized educational resources for staff to use when working with patients. Participating organizations committed to submitting data monthly.

We administered the Lung Talk series’ 20-item COPD knowledge test to Master Trainer participants and front-line staff. This test was administered before and after a training session to assess participants’ baseline COPD knowledge and any change in that knowledge after a training session. Based on early feedback from Master Trainers, we reduced the knowledge test to 10 items for administration at individual facilities.

**Study Design and Data Analysis**

To assess effectiveness and feasibility of the program, we tracked the number of participants who completed the Master Trainer sessions and the percentage of targeted staff they trained at their organizations. We compared the average aggregate Master Trainer pre- and post-test scores and the trained staff’s pre- and post-test scores. We asked each organization to track the number of patients who received the COPD tools and education each month. We administered course evaluations after each Master Trainer session. Finally, we solicited any barriers to training staff at their organizations and to teaching patients with the provided tools and resources.

Data were collected from October 2015 to June 2016. Descriptive statistics were used to describe Master Trainer and trained staff characteristics. Pairwise t-tests were performed to test for significance in the difference between pre and post-tests, overall and by setting. Test averages were used to account for the change in number of items on the pre- and post-tests during implementation. Statistical Analysis Software (SAS) Version 9.3 was used for all analyses.

**RESULTS**

**Master Trainers**

Healthcentric Advisors hosted five train-the-trainer sessions in two phases, from October 2015 to May 2016, producing 140 Master Trainers from 61 organizations. Almost 40% \((n=53)\) of Master Trainers were from nursing homes, 15.0% \((n=21)\) were from hospitals, 14.3% \((n=20)\) were from home health agencies, and 10.7% \((n=15)\) were from physician offices. Master Trainers’ average pre-test score was 74.3% and their average post-test score was 86.9%, representing a mean absolute increase of 12.6 percentage points \((p\text{-value}<0.001)\). Session evaluations completed by Master Trainers were positive; for each of the six learning objectives, more than 95% of Master Trainers indicated that the session met the stated goal. All were either satisfied or very satisfied with the presentations and collaborative learning that occurred, and all participants agreed the session was a valuable use of their time. Additional feedback solicited after Phase 1 demonstrated that the training manual was sufficient for conducting staff trainings, and Master Trainers...
reported that the Lung Talk book and video materials were well received by their staff. They also noted that the demonstration inhalers were a valuable adjunct for teaching.

Trained Staff
Master Trainers targeted a combined 981 staff at their respective organizations to receive the COPD training. Through June 2016, 634 (64.6%) of the targeted staff completed training in 77 total sessions. Figure 1 shows reach of the program through the cumulative rate of training completion among targeted staff by month.

Among the staff members trained by Master Trainers, 37.4% (n=237) were from home health agencies, 36.1% (n=229) were from nursing homes, and 11.4% (n=72) were from hospitals. The remaining were from physician offices, behavioral health, payers, and medical equipment providers. More than 45% (n=292) of trained staff were registered nurses, 18.8% (n=119) were certified nursing assistants or medical technicians, and 16.6% (n=105) were rehabilitation professionals. The remaining were licensed practical nurses, physicians, nurse practitioners, respiratory therapists, or other support staff.

Approximately 92% (n=549) of trained staff completed pre- and post-learning tests. The pre-test average among trained staff was 67.0% and the post-test average was 83.0%, representing a mean absolute increase of 16.0 percentage points (p-value<0.001). When stratified by setting, all mean score increases remained significant (Figure 2). Average baseline scores by setting ranged from 59.8% (nursing home) to 82.5% (behavioral health).

DISCUSSION
Our results demonstrate the feasibility of a standardized, community-based approach to COPD patient education and self-management strategies. The process and curriculum were applicable to and practical for a wide range of healthcare venues.

In Coalition discussions, we learned that clinician training on how to educate patients about COPD self-management strategies is inconsistent. This lack of uniformity, along with use of conflicting educational materials and tools, may limit patients’ ability to learn self-management techniques, even if they desire to do so.15 Coalition members’ common goal to address this gap drove support and interest in the program. Successful adoption and rollout was also likely due to collaboration facilitated by a neutral convener (the QIN-QIO). Fragmented healthcare systems and competing interests can prohibit shared strategies and approaches; a neutral platform allowed potential competitors to develop a uniform approach. Finally, payer and pharmaceutical company involvement further strengthened the work through encouraging participation and by offsetting costs of training materials. Inhalers are essential in controlling COPD exacerbations, yet a majority of patients use inhalers incorrectly.16-18 Therefore, obtaining demonstration inhalers at no cost facilitated teaching participants how to demonstrate use to patients.

We compared program expenses to anticipated costs to better evaluate feasibility. Time spent on program development and training was the largest expense. Using mean hourly wage information19 and the distribution of participating staff, we determined that each Master Trainer session cost $553.38 for the staff running the training and $110.22 for each participant, resulting in $18,276.90 combined for five sessions. Master Trainers then spent 77 hours leading training sessions at their organizations, at a cost of $2,828.92. Staff at the organizations spent 634 hours attending these sessions, at a cost of $22,982.03. Combined, the 1,176 hours represent an estimated $44,087.85 in personnel time. Minimal costs were expended on materials ($1,062). Therefore, program expenses totaled $45,149.85, reflecting a per-trainee cost of $58.33. Avoiding four COPD readmissions would more than pay for the cost of this intervention, based on an average cost of $12,133 for a 30-day Medicare COPD readmission.20

Our work has several limitations. First, as a pilot in one area of the state, generalizability to other

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*The difference between each setting’s pre-test and post-test scores was statistically significant at the p<0.0001 level, except for Behavioral Health (p=0.0046).
regions may be limited. Second, we did not assess the quality of the training delivered by Master Trainers to targeted staff at their facilities, which could have impacted knowledge scores and satisfaction. Finally, the impact on patients is not quantified. During this pilot project we learned about data collection challenges faced; availability of resources and time were the two common barriers shared by Coalition members. These results demonstrate that implementation of a community-based program to disseminate high quality, patient-centered, standardized COPD education in multiple settings is feasible. Next steps include identifying a reliable way for organizations to collect patient-level data and to measure program impact on patient self-management skills, knowledge, and clinical outcomes. We hope that ultimately this program will improve patient outcomes, decrease avoidable utilization of medical services, and serve as the foundation for standardized, patient-centered education for more chronic conditions.

Acknowledgments
We thank all of the Coalition members and Healthcentric Advisors’ Care Transitions team members for their contributions to program development and implementation.

Disclaimer
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Conflict of Interest
The authors declare that they have no conflict of interest.

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National Institutes of Health Funding in Rhode Island

GEORGE MAO, MD; BHARAT RAM RATNAM, MD

ABSTRACT

OBJECTIVES: We present an overview of the National Institutes of Health (NIH) funding in Rhode Island through analysis of 935 NIH grants received during the fiscal years of 2012 to 2016.

RESULTS: NIH funded over 2,600 grants from 2012 to 2016, of which approximately 900 were new grant awards, and the remainder were annual grant renewals. The most funded type of research in Rhode Island is mental health and substance abuse, followed by infectious disease, neurology, and public health. Research funding of cardiovascular diseases, on a per capita basis, are on par with the rest of the nation, while cancer research funding is less than one half the national average. The largest NIH institutional funding source is the National Institute of General Medical Sciences (NIGMS), followed by National Institute of Mental Health (NIMH) and National Institute on Alcohol Abuse and Alcoholism (NIAAA). While research grants (R01s) remain the predominant source of NIH funding, investigators in Rhode Island have secured additional funding through program project (P) grants with the aim of bolstering research resources and collaboration throughout the state.

KEYWORDS: NIH funding, research funding, NIH grants, Rhode Island research, RI research

INTRODUCTION

The National Institutes of Health (NIH), established in 1930, is a vast network comprising 21 individual institutes encompassing the myriad disciplines within biomedical research, as well as 6 multidisciplinary centers that operate across all of the institutes. In addition to conducting research on its own campus in Bethesda, MD, the NIH also serves as the largest funding mechanism for federally supported biomedical research in the United States. The NIH budget was $32 billion in 2016. Other biomedical federal agencies include the following with respective FY16 Budgets: Centers for Disease Control (CDC) [$11.7 billion], the Food and Drug Administration (FDA) [$5.1 billion], the Agency for Healthcare Research and Quality (AHRQ) [$0.428 billion]. The Department of Defense (DOD), furthermore, awards medical research grants through the Congressionally Directed Medical Research Programs (CDMRP) initiative and in 2016 spent over $0.836 billion nationwide on medical research.1,2 On average, over 80% of the NIH budget is awarded annually to support investigators at over 2,500 universities, medical schools, hospitals, biotechnology companies, and other research organizations. The main vehicle of NIH research funding is the research grant, referred to as “R” series of grants, with R01 grants being the most common. Using this mechanism, the various institutes of the NIH disbursed $17.8 billion (55.6% of total budget) in 2016 to researchers across the nation. The NIH also spent $5.4 billion supporting training, fellowship, and career-development grants (“T”, “F” & “K” grants) as well as project grants, which are thematic research programs that integrate a group of investigators across multiple institutions (“P” grants). The $23 billion in total external research funding is in contrast to $3.58 billion that the NIH spent for its own intramural research activities in the 2016 fiscal year.3

NIH FOOTPRINT IN RHODE ISLAND

The NIH is a significant source of biomedical research funding in the state of Rhode Island. Last year, RI received $150 million in NIH funding, and $707 million combined over the past five years.3 In contrast, non-NIH agencies supplied $112 million over the same time period. Since 2008, Rhode Island has received additional NIH support as it is one of the targets of NIH’s institutional development awards (IDeA), which promote translational research activity and collaboration in states that have had historically low NIH grant success rates. These IDeA grants are primarily designed to foster research career development, research collaboration, and fund Centers of Biomedical Research Excellence (COBREs) and IDeA Networks of Biomedical Research Excellence (INBRE) initiatives. COBREs are NIH-designated multi-disciplinary research units within institutions that provide material support to projects sharing a central theme (ie, cancer, skeletal repair, etc). Currently there are nine active IDeA-funded COBREs in Rhode Island, located at Rhode Island Hospital, the Providence VA Medical Center, Women and Infants Hospital, the University of Rhode Island and Brown University.4 The INBRE grants are aimed at strengthening research manpower, through funding of faculty, post-doctoral fellowship, graduate and undergraduate research positions. Currently one INBRE initiative is active in the state, based at the
University of Rhode Island. Furthermore, Rhode Island was recently awarded a five-year $19.5 million grant from the National Institutes of General Medical Sciences (NIGMS) to establish the Rhode Island Advance Clinical and Translational Research center (Advance-CTR), which serves as a funding source for translational research project as well as providing research services for junior investigators.7,8

**Figure 1a.** Total discretionary budget authority during FY 2016 of US federal agencies that award grants towards biomedical research. CDMRP is the Department of Defense’s biomedical granting agency.

**Figure 1b.** Breakdown of the sources of federal funding for biomedical research in Rhode Island from 2012 to 2016. Information from AHRQ and CDMRP are from obtained from respective agencies’ grants databases.4,5

**Figure 1c.** Breakdown of the national NIH budget in 2016.

**METHODOLOGY**

We took a snapshot of all NIH grants awarded to Rhode Island recipients between January 1, 2012 and December 31, 2016, from the NIH RePORTER database. As a measure of productivity, we quantified all of the publications in 2016 that were the result of research projects funded by the NIH. We primarily analyzed R and P series of grants for specific areas of biomedical research being funded by the NIH. To minimize overlap and double counting, we utilized NIH study sections, which are panels of researchers with shared expertise in one designated field, as the basis for categorization. For studies where multiple fields are involved, we used the funding agency as the primary category. For example, in a project involving diabetes and heart disease that is funded by the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), we considered diabetes as the primary category. Furthermore, for studies evaluating diseases within a specific subpopulation with a particular medical condition (i.e., heart disease in diabetics), the primary category was classified as the specific disease being studied rather than the medical condition. The NIH also forms ad-hoc panels (designated as special emphasis panels) to review grants in areas which are not routinely studied. In these cases, we utilized the primary funding agency and project terms field as the basis for categorization. A detailed breakdown by grant type is listed in **Figure 3a**.

**RESULTS**

R series of grants comprised the majority of NIH funding, with over $456 million awarded, funding over 1,600 grants in Rhode Island from 2012 to 2016, accounting for 64% of total NIH grant funding in the state. The next most common funded type of grants are P grants, which are larger in scope than R grants, and funds the COBRE and INBRE programs initiated by the NIH ongoing since 2008. From 2012 to 2016, the NIH dispersed $130 million to 74 P grants, accounting for 18.2% of grant funding. In terms of funding by institutes, the National Institute of General Medical Sciences (NIGMS) has been the largest source of funding to RI within the NIH, spending over $114 million over the past 5 years, covering 195 grants. Three-quarters of NIGMS grants have been related to COBRE and INBRE research efforts, to which $77 million was dedicated. Following NIGMS by order of funding are: the National Institutes of Mental Health (NIMH) at $86 million, National Institutes on Alcohol Abuse and Alcoholism (NIAAA) at $63 million, and the NIDA (National Institute on Drug Abuse) at $56 million. Full detailed list of institutes by funding amount and number of grants is in **Figure 3b**.

By subject matter, behavioral sciences, which for the purposes of this report, includes mental health, addiction, and substance abuse, is the most funded category, receiving $122 million over the past 5 years. The next most funded category is infectious disease and immunology, receiving $63
RESEARCH PRODUCTIVITY IN RHODE ISLAND

NIH-funded projects in Rhode Island produced 896 publications in 2016. 299 publications were in the field of behavioral sciences (including substance use and addiction), followed by infectious disease at 160 publications, pediatrics (69), and neurology and neurosciences (52). The ranking of research subject matter in terms of funding is roughly similar to that of research funding, with the number one and two slots occupied by behavioral sciences/mental health and infectious disease, respectively.

DISCUSSION

From 2012 to 2016, RI has received over $811 million from federal agencies, and $707 million from the NIH alone, covering 935 grants (excluding annual renewals). Annual NIH grant funding dropped from a high of $178 million in 2009 to a nadir of $131 million in 2014 and 2015, although funding has now climbed back up to $150 million in 2016 (Figure 5). The high amount of funding in 2009 and 2010 mirrored trends across the nation, and was the result of additional federal dollars from the American Recovery and Reinvestment Act.
Act (ARRA) stimulus funding. Over the past 5 years, RI has on average received $140 million annually from NIH grants, which is consistent with years prior to 2009. Mental health, substance use, and addiction continue to be the target focus of research activity in the state, which is also reflected by the sources of funding: NIMH, NIAAA, and NIDA, (which are the #2, 3, and 4 by research funding) as well as by the number of publications produced by NIH-supported research projects. This is in contrast to the rest of the United States, where the National Cancer Institute (NCI) is the leading source of funding, followed by the National Institute of Allergy and Infectious Disease (NIAID), and the National Heart, Lung, and Blood Institute (NHLBI). These institutes rank (13, 8, and 7, respectively) as sources of research funding in RI. Furthermore, per capita in terms of population, Rhode Island’s funding from NCI is less than one-half the national average, whereas funding from NHLBI and NIAID are roughly comparable to the rest of the nation.

Rhode Island ranks 25th among states in terms of total overall NIH funding. Over ten percent of NIH funding has been dedicated to INBRE and COBRE centers, which are multidisciplinary research centers designated by the NIH to support research in specific topics and to develop the biomedical research workforce. As of 2016, there are nine active COBREs, and the areas of interest explored by these COBRE centers include cancer biology, stem cell development, tissue repair, perinatal biology, immunotherapy, and CNS biology, as detailed in Figure 2. In addition, in 2016, the NIGMS has provided an additional $19.6 million to fund a clinical and translational research center (Advance-CTR) dedicated to serve as a funding source and a provider of research services to junior investigators.

Despite the additional funding from the NIGMS, the overall NIH funding to Rhode Island declined during the federal budget sequestration crises of 2014 and 2015. During the past year, NIH funding has recovered, although current total funding to Rhode Island remains at comparable levels to what they were a decade ago, or if adjusting for inflation, has declined by about 10%. The stagnation in NIH funding is a nationwide issue, given that overall NIH appropriations have been relatively constant over the past decade, and when adjusted for inflation, has declined by around 12%. The recent establishment of the RI-CCTS, allowing for more local decision-making over the use of NIH resources, should in theory, stretch each NIH dollar through more efficient allocation of funds as a result of local geographical oversight.

CONCLUSION

While Rhode Island ranks 25th in the nation in terms of NIH biomedical research funding, much of that funding is not evenly distributed across disciplines. While fields such as mental health, behavioral sciences and addiction medicine receive special research attention, other fields, most notably cancer, still lag behind the rest of the nation in terms of per capita funding. A significant percentage of research dollars has been geared to improve research efficiency, shore up and develop new research capabilities in Rhode Island, however, the actual impact of the research investment will not be immediately apparent in the short term. Given that cardiovascular diseases and cancer remains the number one and number two top causes of mortality in Rhode Island, these two domains should become the focus of future funding.
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Junk science for sale
Sham journals proliferating online
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ABSTRACT
A new danger threatens the integrity of scholarly publishing: predatory journals. Internet-only, “open-access” publishing is a valid way for researchers to reach the public without a paywall separating them. But, of thousands of open-access scientific journals today, as many as twenty-five percent are believed to be fake, existing only to make money by charging authors high processing fees.

In sham journals, peer review is cursory or absent: as many as eighty to ninety percent of submitted manuscripts are accepted, many within days, without any editorial comment. Predatory journalism can be remarkably good at mimicking reputable publishers. Sham journals use names and logos that closely resemble those of legitimate journals, intentionally confusing site visitors.

Untrustworthy publications have not received the widespread, damning publicity they deserve. If junk science is not confronted and eliminated, it will continue to tarnish and undermine ethical, open-access scholarly publishing.

KEYWORDS: open-access publishing, predatory journalism, misrepresentation, junk science

Are you and your patients unwittingly reading junk science or making personal or professional health decisions based on shoddy, substandard research? Have you been duped into publishing research in a phony, only for-profit journal? If so, you are not alone.

The vast majority who read scholarly literature do not know that hundreds of thousands of legitimate-appearing articles are published by unscrupulous journals with minimal scientific validity.1,2 Unsuspecting readers may be unable to distinguish between credible research and junk science. Thus, they may make personal medical decisions based on promising sounding research, such as “An Advance in Therapy for Lung Cancer,” that was actually published by a predatory journal, motivated only by the high publication fees paid by authors. Also, as health professionals, we use search engines such as PubMed or Google Scholar to research investigative studies and clinical topics in patient care. As a result, we may reference and use seemingly relevant material published in these sham journals.

Most academic physicians are familiar with the almost daily bombardment of spam emails from questionable journals to submit a manuscript, join an editorial board, or present at a bogus scientific conference. Some small fraction then go on to submit manuscripts. Desktop publishing now allows anyone to create a “virtual journal,” masquerading as a legitimate business.3

Ethical, established journals, such as the New England Journal of Medicine, accept less than ten percent of all submissions which have undergone rigorous pre-acceptance feedback and review by peers—a crucial staple of scholarship. In sham journals, peer review is cursory or absent: as many as eighty to ninety percent of submitted manuscripts are accepted, many within days, without any editorial comment (See Table). Editorial boards tend to be fabricated or composed of American, Canadian, or British academics who have been solicited and then duped to be members of editorial

Table. Common characteristics of predatory journals1,4-7

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<th>Characteristic</th>
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<td>Active pursuit of prospective authors by frequent spam email invitations, such as to join editorial boards or a “Call for Submissions” to submit manuscripts, on research topics that may be outside an author’s expertise</td>
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<tr>
<td>Unrealistic promises of rapid peer review and publication</td>
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<tr>
<td>Absent peer review or minimal, useless feedback</td>
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<tr>
<td>Attempt to confuse prospective authors by creating journal and publisher names or logos very similar to legitimate, established ones</td>
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<tr>
<td>Provide no academic information such as institutional affiliation of editors or editorial board members</td>
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<tr>
<td>False claim to be indexed, or are not indexed in legitimate electronic databases, such as PubMed</td>
</tr>
<tr>
<td>Contact information does not include verifiable data, including addresses of editor, editorial board; contact is Internet-only without telephone or fax listed</td>
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<tr>
<td>Peer-review process is not described clearly</td>
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<tr>
<td>Review of published papers reveals shoddy, substandard manuscripts</td>
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<tr>
<td>Journal is not indexed in the Directory of Open Access Journals (DOAJ, <a href="http://www.doaj.org">www.doaj.org</a>)</td>
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<td>Journal publisher is not a member of the Open Access Scholarly Publishers’ Association (OASPA, <a href="http://www.oaspa.org">www.oaspa.org</a>) or the Committee on Publication Ethics (COPE)</td>
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<tr>
<td>Impact Factor claims are fictitious; may use fabricated impact factors, using non-existent ratings such as “Universal Impact Factor” or “Global Impact Factor”</td>
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<td>Unsuccessful search for the journal online</td>
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Predatory publishing has exploded in recent years. Between 2005 and 2010, the number of dishonest, online-only journals had increased from 18 to more than 900, many sporting deceptive names that mimic legitimate journals. A later investigation identified as many as 8,000 predatory journals that published 420,000 articles in 2014.

Medicine is not the only victim. A broad spectrum of shady, predatory publishers exists in fields as diverse as metallurgy, quantum mechanics, molecular biology, engineering, political science, and ornithology. Medicine is unique, however. It is the only science that is read by the lay public to inform personal health choices.

Internet-only, “open-access” publishing is a valid way for researchers to reach the public without a paywall standing between them. But, of the thousands of open-access scientific journals online, as many as 25% are believed to be fake, existing only to make money for their publishers by charging authors high processing fees. There are two broad types of predatory journals. The first is an easily recognized shoddy sham, replete with grammatical errors and nonsense. This type is primarily designed for inexperienced authors in underdeveloped countries for whom any publication is important for maintaining their position or helping with promotion.

The second, more pernicious type of phony journal may be difficult to detect because it mimics reputable publications. An example, well-documented by John Bohannon, a respected journalist at Science, is the bogus American Journal of Polymer Science, a sound-alike and look-alike publication that intentionally mimics the respected Journal of Polymer Science, published by Wiley since 1946.

Why are authors and readers fooled? To quote a famous cartoon, “On the Internet, nobody knows you’re a dog.” Predatory journalism can be remarkably good at mimicking reputable publishers. Sham journals use names and logos that closely resemble those of legitimate journals, intentionally confusing site visitors. Some bogus journals have professional-, legitimate-looking websites, despite their dubious origins. Many will adopt names with “American” in the title. But their only connection to the United States is a rented mailbox somewhere. The vast majority of sham publishers and authors are from underdeveloped nations without rigorous academic enterprises. Yet many submissions are from authors in respected American medical institutions. Experienced scholars have been fooled into submitting manuscripts and joining editorial boards.

One large study comparing potential predatory and legitimate journals found that one-third of predatory journals promoted bogus, non-existent impact metrics, one measure of an individual journal’s quality. This investigation reported that as many as half of phony journals had names similar to other existing journals.

In a 2013 exposé, Bohannon used a fake name to submit a fabricated manuscript “so hopelessly flawed as to be meaningless” to 300 suspicious open-access publishers. More than half accepted the article, failing to respond even to blatant, glaring mistakes.

How do experienced academics get hooked? We speculate that one explanation may be that many of us have experienced the problem of our own borderline acceptable manuscript rejected two or three times by reputable journals, the last submission rejected in a few days without being sent for external peer review. The manuscript may be a case report with low publication priority, or a hypothesis-driven paper with study design problems without a robust sample size or marginal clinical outcomes. One of the authors, commonly a junior author, finds a seemingly satisfactory candidate publication; the manuscript is submitted. A few days later, without peer review, the manuscript is accepted along with a hefty authors’ publication charge.

Now, a new scam bedevils the universe of scholarly publication: hijacked journals. A hijacked journal differs from a predatory one. A hijacked journal appropriates an inactive or careless website or uses a fake website that mimics the look, title and International Standard Serial Numbers (ISSNs) of a reputable journal. The distinction is that a predatory journal establishes a new brand.

Hijacked journals may be more likely to receive manuscripts from authors, because they mimic known publications, frequently appropriating the impact factor that ethical journals have earned from Thomson Reuters, the industry standard. Both predatory and hijacked journals commonly claim to have impact factors, but they usually have phony metrics such as the non-existent Universal Impact Factor or Global Impact Factor. Efforts by predatory publishers to enter the Thompson Reuters Impact factor database, through ploys such as purchasing journals already indexed in PubMed, must be thwarted.

Bohannon used the following example to illustrate construction of a fake website: build a convincing version of a website at a similar address – http://www.sciencemag.org/ rather than www.sciencemag.org – then drive Web visitors to the phony site. Hijacking the official domain is a devious twist because unsuspecting visitors still will log on to the hijacked journal site. Because the co-opted site retains the official Web domain of the legitimate publication, it is difficult to tell that it is fake. This new ploy of journal hijacking can flourish when journals are careless in maintaining website administration and security features. In the current system, publishers must pay periodically to re-register their journals’ legitimate Web domains. Failure to re-register allows a waiting hacker to snatch a domain to create a fake journal site. As Bohannon states, there is no simple way to identify a journal that has lost control of its own Web domain.

Why does junk science thrive? For the unsuspecting, sham journals can present an easy path to success. Pressure to publish is another major reason for novice researchers and doctoral students in developing countries who are the major
patients of predatory journals.\textsuperscript{8} Employers and scholars in government and business organizations as well as university research institutions frequently use publishing as a standard of productivity. An unknown percentage of submitting authors, some American, are complicit, knowingly choosing a dubious journal to advance their careers.

Reputable algorithmic search engines, including Google Scholar, Scopus, and Thomson Reuters, despite active detection and deletion efforts, index some sham journals in their efforts to be comprehensive. As a result, these databases unwittingly preserve pseudoscience to be accessed later by unwary readers.

Systematic identification of potential junk publishers is challenging. Recognition of their existence among physicians and the public is not widespread. The reality of thousands of deceptive journals makes vetting difficult and time consuming. A current standard of credible journals is the Directory of Open Access Journals (www.doaj.org), which keeps a changing list of legitimate open-access publishers. Still, lines can be blurred, as not all journals are clearly identified as junk. Thus, the designations above may be subjective for some entries.\textsuperscript{4} Two long-term, widely publicized lists have been developed by John Beale, an academic librarian at the University of Colorado; publishers of single phony journals [http://scholarlyoa.com/individual-journals] and publishers of multiple journals [http://scholarlyoa.com/publishers].\textsuperscript{5} However, Beale’s lists have been removed and were unavailable when we attempted to access the sites on April 14, 2017, reportedly due to legal threats from publishers.\textsuperscript{14}

To stamp out fake science, we must publicize vetted, authoritative lists separating ethical journals from sleazy ones. Reputable search engines must be vigilant by removing phony journal sites when discovered. However, piecemeal removal of individual journals is woefully inadequate, given the enormous reach and drive of these publishers.\textsuperscript{15} A vigorous, coordinated international effort from all stakeholders is needed to disseminate validated criteria separating ethical, credible science from worthless, dangerous, irresponsible publications.\textsuperscript{4,11}

All physicians, including trainees and medical students, have a responsibility to self-police their own work. The best strategy to avoid submitting or publishing in a phony journal is self-assessment. Use the “smell” test to determine whether your target journal is fake. Be self-critical about the deficiencies in content, study design, and other methodological flaws in your own manuscript. Read and assess articles in the journal before submitting your work.\textsuperscript{16}

Untrustworthy publications have not received the widespread, damning publicity they deserve. If junk science is not confronted and eliminated, it will continue to tarnish and undermine ethical, open-access scholarly publishing.
Practical Considerations for Prescribing Benzodiazepines and Opioids

JAMES. V. MCDONALD, MD, MPH; VICTORIA AYERS, ASCJ; JACKIE PAQUIN

INTRODUCTION

The Food and Drug Administration is responsible for evaluating and approving the medications we prescribe. The FDA reviews post-market experience and monitors adverse drug reactions or unexpected effects. One of the strictest warnings the FDA can apply to a medication is a Boxed warning or Black Box warning. “Drugs that have special problems, particularly ones that may lead to death or serious injury, may have this warning information displayed within a box in the prescribing information. This is often referred to as a “boxed” or “black box” warning. Drugs that have such boxed warnings are not permitted to have reminder ads.”

In August of 2016, the FDA issued a Black Box warning regarding co-prescribing of benzodiazepines and opioids: Important Information for Patients

This black box warning requires the prescriber to thoughtfully consider the warning and interpret the concomitant risks and benefits. It is important to discuss these risks and benefits with the patient when establishing a treatment plan.

DATA ON CO-PRESCRIBING OF BENZODIAZEPINES AND OPIOIDS

Figure 1 illustrates annual doses of benzodiazepines, opioids and respective combinations of benzodiazepines and opioids. In 2015, there were over 17 million doses of benzodiazepines prescribed to patients already taking an opioid; in 2016, this rose to almost 22 million doses. Conversely, in 2015, almost 21 million doses of opioids were given to patients who were taking a benzodiazepine; in 2016, this number increased to almost 26 million doses.

Figure 2 illustrates are active licensees by discipline for physicians, advanced practice registered nurses, dentists and physician assistants, followed by the number of that group who have at least one patient in 2016 who was prescribed a benzodiazepine and an opioid in the same 30-day period. It is evident that about 50% of all prescribers have at least one patient who has been prescribed a benzodiazepine and an opioid in 2016.
Stop Starting: Prescribers have a duty to warn patients about the potential for adverse outcomes due to the combination of a benzodiazepine and an opioid. Prescribers should additionally warn patients about the added risk when patients co-ingest alcohol. The black box warning specifically requires education regarding potential adverse events: “unusual dizziness or lightheadedness, extreme sleepiness, slowed or difficult breathing, coma, and death.”

Prescribers are already required when prescribing an opioid to educate patients.4 If prescribers must start a benzodiazepine, this should be done with a short course planned (no more than 2–4 weeks). There should be a clear expectation regarding anticipated clinical benefit and a plan for stopping if side effects.

Taper, titrate and do not escalate: Patients who are already on a benzodiazepine and an opioid are at increased risk.5 Prescribers should review with the patient the risks and benefits of the current therapy and decide if tapering of either or both medications is appropriate. Consideration should be given to a functional assessment of each patient and optimizing functional outcome based on treatment goals. Achieving a pain free status may not be possible. A thoughtful consideration of alternatives to medication should be considered as well.

Tapering benzodiazepines can be done via several different methods and there are resources available for review to consider.5,7,8,9,10 There are also several resources for tapering opioids that prescribers may find useful.11,12 The CDC pocket guide is one such resource. Deciding whether to taper the benzodiazepine or opioid first is a decision that may be made with the patient, considering risks, benefits and treatment goals.

If medications cannot be tapered, the dose(s) should be carefully titrated to the minimum effective dose. Consideration needs to be given to the ability to function and to perform activities of daily living.

Tolerance is an issue with each of these medications. Prescribers are reminded not to escalate a patient’s dose without a clear treatment goal. Patients should be carefully evaluated prior to dose increases and risks and benefits reviewed.

Monitor Closely: Existing regulations detail minimum requirement for patients on opioids.13 Patients who are also prescribed a benzodiazepine are at higher risk. Prescribers must monitor the patient at appropriate intervals. The frequency of visits needs to be customized to the patient and their comorbidities. Patients with coexisting diseases and past history need to be seen more frequently.
SUMMARY

• The FDA has issued a black box warning regarding the combination of benzodiazepines and opioids
• Patients who take benzodiazepines and opioids can experience tolerance, dependence and addiction
• Patients who are co-prescribed benzodiazepines and opioids are at higher risk of overdose
• Prescribers have a duty to warn patients about the risk of these medications
• Stop Starting new patients on the combination of benzodiazepines and opioids
• Taper, titrate and do not escalate dosages of benzodiazepines and opioids in patients being co-prescribed these medications
• Monitor closely all patients on long term (>4 weeks) patients on opioids and benzodiazepines

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Spontaneous Rupture of the Spleen due to Infectious Mononucleosis

ALMAZ DESSIE, MD; WILLIAM BINDER, MD

From the Case Records of the Alpert Medical School of Brown University Residency in Emergency Medicine

HISTORY OF PRESENT ILLNESS (HPI)

DR. ALMAZ DESSIE: A 17-year-old boy presented to the emergency department after developing abdominal pain and having a syncopal episode while at home. The patient had not been feeling well for about 5–6 days prior to this event and had complained of fatigue, sore throat, and decreased appetite. He was a high school soccer player and had participated in practice during the week but complained of feeling run down. During the evening prior to presentation, the patient played in a soccer game and was jostled on a corner kick. Shortly afterward he felt increasingly weak, and upon completion of the game he went home. He was unable to sleep and got up to go to the bathroom but had a syncopal episode and fell, striking his head. He complained of abdominal pain to his parents and was brought to the emergency department. Past medical history was significant for mild asthma for which the patient occasionally used albuterol.

Upon arrival, the patient was pale, but alert. His initial vital signs were: Temperature 98.3°F, pulse 90 beats per minute, blood pressure 129/60 mm Hg, respiratory rate of 16 and his oxygen saturation was 100% on room air.

His head exam revealed a small hematoma and an abrasion to the occiput. He had no midline cervical tenderness, his lungs were clear, and heart sounds were normal. His abdominal exam was significant for diffuse tenderness and guarding in the upper quadrants. He had strong femoral and radial pulses bilaterally, and his neurologic exam was normal. Laboratory studies were sent and the patient had a white blood cell count of 15.6, with 59% segmented neutrophils (segs) and 10% atypical lymphocytes. His hemoglobin was 11.1, and his AST and ALT were mildly elevated (72 and 69, respectively).

Because the injury occurred during a sports activity, as well as the fall and head contusion, the decision at triage was to consider this a level C trauma, which is defined at our hospital by both anatomic findings consistent with a significant mechanism (for instance, abdominal pain after blunt injury in a patient involved in a rollover MVA).

DR. WHIT FISHER: Given that this was considered a trauma, what resources were mobilized and was a Focused Assessment with Sonography in Trauma (FAST) performed?

DR. DESSIE: Our trauma team of physicians and nurses quickly came to the bedside and performed a primary and secondary survey of the patient, and intravenous access was rapidly obtained. A FAST was performed, and free fluid was noted, with blood pooled around the bladder. The FAST was first used as a quick, bedside screening tool to detect hemoperitoneum in adult trauma patients. The goal of the FAST is to detect free fluid in the abdomen, pelvis, thorax, or pericardium in patients with acute blunt abdominal/chest trauma. The FAST has a sensitivity of 69–100% and specificity of 83–100% to detect free intra-abdominal fluid in adults. Studies have shown the use of FAST decreases time to operative care, CT scan use, hospital length of stay, and hospital costs in adult patients. One study found that combining FAST results with an AST or ALT >100 IU/L gives a positive predictive value of 94% and negative predictive value of 96% for identifying hemoperitoneum in pediatric blunt trauma patients. Unfortunately, sensitivity is lower for the detection of solid organ injury without hemoperitoneum, which is commonly seen in children. Newer studies are assessing clinical prediction rules that use the FAST in conjunction with laboratory studies or specific historical and physical exam findings to assess the risk for intra-abdominal injury in pediatric trauma. One study found that combining FAST results with an AST or ALT >100 IU/L gives a positive predictive value of 94% and negative predictive value of 96%. Overall, sensitivity of FAST seems to be lower in children than in adults, but specificity is comparable.

Given the relative uncertainty about how to use FAST in children, most EM providers use a positive FAST exam in an unstable, injured child as they would in an adult – this is an indication for emergent laparotomy. The role of a FAST in a hemodynamically stable pediatric trauma patient is still unclear. A negative FAST doesn’t definitively rule out abdominal injury, and a positive FAST does not tell you the actual location and extent of injury, so a CT is often still necessary. Since the majority of splenic and hepatic injuries in children are managed conservatively, patient status, especially vital signs, remain paramount regardless of FAST results.
DR. DAVID CURLEY: The FAST exam was positive for blood. What further diagnostic tests were run?

DR. DESSIE: Because of the diffuse appearance of the blood, as well as the hemodynamic stability of this patient, we were able to obtain a CT scan of his abdomen and pelvis. The CT revealed a large splenic laceration with active extravasation of intravascular contrast medium and a large volume of hemoperitoneum, as well as splenomegaly. This corresponds to either a grade 3, or a grade 4 splenic laceration. The splenic injury grading system, published by the American Association for the Surgery of Trauma (AAST), corresponds to the extent of the injury noted on a CT scan. A grade I injury is subcapsular with a tear < 1 cm, while a grade V injury describes a shattered spleen with a hilar laceration leading to significant devascularization. [5] The AAST CT grading system, while not always accurate in comparison to an injury identified in the operating room, is important in the initial evaluation of a splenic injury and needs to be considered alongside hemodynamic stability. Treatment for blunt splenic trauma in pediatric patients has changed over recent years. Nonoperative management of hemodynamically stable patients with splenic injury is now the gold standard in pediatric centers, regardless of grade of laceration. [6] While adults with grade 4 and grade 5 splenic lacerations can fail nonoperative management and may require surgical intervention, children have very low rates of complications after non-operative management, even with high-grade lacerations. [7,8] Splenic artery embolization may be used as an alternative to surgical exploration and has been successful in some high-grade splenic injuries in certain cohorts. [9] Studies have shown that greater than 90% of children with isolated splenic injuries require no surgical intervention, less than 5% require transfusion, and only about 1% will need splenectomy. [6]

DR. SUSAN DUFFY: What steps were taken to resuscitate the patient? Additionally, what do you think was the cause of the splenomegaly and was this concern pursued?

DR. DESSIE: Given the vascular blush on the CT, the pediatric surgery service was notified. The patient received 2 liters of normal saline and remained hemodynamically stable. He was provided morphine for pain control and ondansetron for nausea. The decision was made to monitor the patient closely and manage him non-operatively, and he was admitted to the ICU for serial exams and repeat CBCs. The concern about the splenomegaly was well founded. Given his 5–6 day history of a sore throat and fatigue, as well as his transaminitis, we sent a monospot and EBV titers. Both of these were positive.

DR. WILLIAM BINDER: While trauma is the most common etiology of splenic injury, neoplastic disease and infectious causes are well established causes of atraumatic splenic rupture in 30% and 27% of spontaneous splenic injuries, respectively. [10] Infectious causes of spontaneous splenic rupture include babesiosis, Bartonella henselae, cytomegalovirus, HIV, malaria, and Epstein-Barr virus [EBV], among other causes. [11] Our patient had infectious mononucleosis [IM] due to EBV.

Epstein-Barr virus [EBV] is a common viral infection and over 95% of adults worldwide have been infected with EBV. [12] While in developing countries, IM primarily occurs in early childhood, in the US the highest incidence of disease occurs between 15–24 years. [12]

Over time the proliferation of mononuclear cells and atypical lymphocytes collect within the splenic lymphoid tissue resulting in splenic enlargement and capsular thinning. Splenomegaly can be clinically apparent in up to 50% of patients with an acute EBV, but splenic injury or rupture is a rare complication, occurring in less than 0.5% of those infected. [13,14,15] Capsular hematoma or rupture can occur either spontaneously or from mild trauma, as was noted in our patient. Splenic injury from EBV infection usually occurs between 1–4 weeks after the onset of infection, but has appeared as late as 7 weeks after diagnosis. [13, 16]
DR. JANE PREOTLE: Are there sequelae from splenic injury and what was the outcome with this patient?

DR. DESSIE: There are a number of complications associated with a splenic injury. As our patient was managed nonoperatively, one concern is delayed splenic rupture and continued bleeding. While studies at the turn of the 21st century showed about a 5% rate of re-bleeding after 4 days, a more recent prospective study found significant re-bleeding to occur in less than 1% of patients 24 hours after an injury managed nonoperatively.\(^\text{[17, 18]}\) Additional rare outcomes include the development of splenic pseudocysts and pseudoaneurysms, but the majority of these are clinically insignificant and pseudoaneurysms under 10 mm will likely resolve over time.\(^\text{[8,19,20]}\)

Our patient did well. He remained on strict bed rest for 3 days and required pain control. His hemoglobin and hematocrit dropped to 8.9/26.6 in his first 12 hours, but stabilized and he was discharged on hospital day 5. He was followed with periodic monthly ultrasound studies, which demonstrated eventual resolution of the perisplenic collection. He remained out of sports over the following 6 months, but has returned to full activity and has played high school soccer and lacrosse.

References


Authors

Almaz Dessie, MD, Fellow, Pediatric Emergency Medicine, Alpert Medical School, Brown University.

William Binder, MD, Associate Professor of Emergency Medicine, Alpert Medical School, Brown University.
Rhode Island Monthly Vital Statistics Report
Provisional Occurrence Data from the Division of Vital Records

<table>
<thead>
<tr>
<th>VITAL EVENTS</th>
<th>REPORTING PERIOD</th>
<th>12 MONTHS ENDING WITH OCTOBER 2016</th>
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<tr>
<td></td>
<td>JANUARY 2017</td>
<td>Number</td>
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<tr>
<td>Live Births</td>
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<tr>
<td>Deaths</td>
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<td>Infant Deaths</td>
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<td>Neonatal Deaths</td>
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<tr>
<td>Spontaneous Fetal Deaths</td>
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<td>Under 20 weeks gestation</td>
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<tr>
<td>20+ weeks gestation</td>
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<td>72</td>
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* Rates per 1,000 estimated population
# Rates per 1,000 live births

<table>
<thead>
<tr>
<th>Underlying Cause of Death Category</th>
<th>REPORTING PERIOD</th>
<th>12 MONTHS ENDING WITH JULY 2016</th>
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<tr>
<td></td>
<td>JULY 2016</td>
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<tr>
<td>Diseases of the Heart</td>
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<td>Malignant Neoplasms</td>
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<td>Cerebrovascular Disease</td>
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<td>Injuries (Accident/Suicide/Homicide)</td>
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<tr>
<td>COPD</td>
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<td>18</td>
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</table>

(a) Cause of death statistics were derived from the underlying cause of death reported by physicians on death certificates.
(b) Rates per 100,000 estimated population of 1,056,298 (www.census.gov)
(c) Years of Potential Life Lost (YPLL).

NOTE: Totals represent vital events, which occurred in Rhode Island for the reporting periods listed above. Monthly provisional totals should be analyzed with caution because the numbers may be small and subject to seasonal variation.
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Contact Sarah if you’ve missed an issue, sstevens@rimed.org.
Working for You: RIMS advocacy activities

June 1, Thursday
Legislative hearings

June 2, Friday
Conference call with CMS regarding Social Security Number Removal Initiative (SSNRI).

June 5, Monday
Meeting with Blue Cross:
Sarah J. Fessler, MD, President ;
Bradley Collins, MD, President-elect
RIMS Council meeting:
Sarah J. Fessler, MD, President

June 6, Tuesday
RIMS Physician Health Committee:
Herbert Rakatansky, MD, Chair
Legislative hearings
RIMS Foundation Strategic Planning

June 7, Wednesday
Legislative hearings
Senator Kettle fundraiser

June 8, Thursday
Legislative Hearings
SIM Steering Committee:
Peter A. Hollmann, MD
Majority Leader Shekarchi fundraiser

June 9–14, Friday–Wednesday
AMA House of Delegates Meeting,
Chicago: Peter Hollmann, MD;
Alyn Adrain, MD; Sarah Fessler, MD;
RIMS staff

June 14, Wednesday
Board of Medical Licensure and Discipline Task Force
Meeting of the Governor’s Opioid Overdose Prevention Task Force:
Sarah J. Fessler, MD, President;
Gary Bubly, MD, Past President

Meeting with RI Quality Institute regarding credentialing
Legislative hearings

June 15, Thursday
Legislative hearings

June 16, Friday
Governor’s Health Care Workforce Transformation Summit

June 20, Tuesday
MACRA Symposium:
New England Tech, East Greenwich Vice President Peter Hollmann, MD, Moderator
Co-sponsored by RIMS, Hospital Association of RI, and Healthcentric Advisors
Legislative hearings

June 21, Wednesday
RI Department of Health’s Primary Care Physician Advisory Committee
Legislative hearings

June 22, Thursday
Out of Network Billing Webinar:
RI Chapter American College of Emergency Physicians, RI Chapter American College of Radiology;
RI Society of Anesthesiologists, College of American Pathology, RI Chapter
Legislative hearings

June 23, Friday
Residents’ Orientation: RIMS Staff

June 27 Tuesday
Legislative hearings

June 28, Wednesday
Legislative hearings

June 29, Thursday
RIMS Foundation Strategic Planning

OFFICE SPACE AVAILABLE
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Inquiries to Newell Warde, nwarde@rimed.org

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401-331-3207
The Rhode Island Medical Society continues to drive forward into the future with the implementation of various new programs. As such, RIMS is expanded its Affinity Program to allow for more of our colleagues in healthcare and related business to work with our membership. RIMS thanks these participants for their support of our membership. Contact Marc Bialek for more information: 401-331-3207 or mbialek@rimed.org

Neighborhood Health Plan of Rhode Island is a non-profit HMO founded in 1993 in partnership with Rhode Island’s Community Health Centers. Serving over 185,000 members, Neighborhood has doubled in membership, revenue and staff since November 2013. In January 2014, Neighborhood extended its service, benefits and value through the HealthSource RI health insurance exchange, serving 49% the RI exchange market. Neighborhood has been rated by National Committee for Quality Assurance (NCQA) as one of the Top 10 Medicaid health plans in America, every year since ratings began twelve years ago.

RIPCPC is an independent practice association (IPA) of primary care physicians located throughout the state of Rhode Island. The IPA, originally formed in 1994, represent 150 physicians from Family Practice, Internal Medicine and Pediatrics. RIPCPC also has an affiliation with over 200 specialty-care member physicians. Our PCP’s act as primary care providers for over 340,000 patients throughout the state of Rhode Island. The IPA was formed to provide a venue for the smaller independent practices to work together with the ultimate goal of improving quality of care for our patients.
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Contact Marc Bialek, Director of Membership

The Rhode Island Medical Society’s annual CME event was held on April 22 at the Warwick Country Club. This year’s focus was on Building Practitioner Resilience in Challenging Times.

A Rhode Island Academy of Physician Assistants (RIAPA) town hall meeting was held April 11 at Kent Hospital on PA practice in the state. Representatives from the state and national PA organizations and the Rhode Island Department of Health and the Rhode Island Medical Society participated in a series of meetings and updates on recertification and looking at the future of PA practice in the state.

A RIMS Mix and Mingle event was held at the Chapel Grille restaurant in Cranston on April 11.

RIMS Leadership: Treasurer José Polanco, MD; Secretary Christine Brousseau, MD; President-Elect Bradley J. Collins, MD; President Sarah J. Fessler, MD; Vice President Peter A. Hollman, MD; and (seated) Immediate Past President Russell A. Settipane, MD.
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Lifespan Recovery Center for patients with opioid addiction opens

PROVIDENCE – The Lifespan Recovery Center, a program of Rhode Island Hospital, officially opened at 200 Corliss St. on June 19 to provide comprehensive outpatient treatment for those seeking to overcome opioid addiction.

“This new clinic will provide a single touchpoint to some of our most vulnerable community members — those struggling with addiction,” said Rhode Island Hospital President MARGARET M. VAN BREE, MHA, DRPH. “We are proud to offer this comprehensive center of care to members of our community who are battling to get their lives back on course.”

Van Bree, Lifespan President and CEO Timothy J. Babineau, MD; Lifespan Senior Vice President of Psychiatry and Behavior Health Richard J. Goldberg, MD, MS, and Lifespan board member and chairman of the board’s Behavioral Health Committee Steven Pare were joined by Sen. Jack Reed, Rep. James Langevin, Gov. Gina Raimondo and R.I. state senator Josh Miller, among others.

Co-medical directors are DR. TAHIR TELLIOLGU, division director of the Substance Abuse Treatment Program at Rhode Island Hospital and DR. STEPHEN L. CHABOT, a psychiatrist and medical director of Gateway Healthcare.

The outpatient center, which initially will serve 250 patients currently under the care of the medical directors, has a capacity for 650 patients. It combines medication-assisted treatments, such as Buprenorphine [Suboxone®], and in certain cases, Naltrexone [Vivitrol®], with psychotherapies and the supports needed to succeed in recovery.

Individualized recovery plans may include:

- Medication-assisted treatment
- Individual and group therapy
- Case management/care coordination/recovery coaches
- Peer support
- Family education and support

The Center is positioned to provide continuity of care by coordinating and leveraging the resources of its partner facilities, including inpatient and outpatient medical, mental and behavioral health services; ongoing coordination with primary care services; and liaison activity with emergency departments at Lifespan hospitals.

“In a small state like Rhode Island, the opioid crisis hits close to home because it seems everybody knows a family that has had their lives upended by addiction,” said U.S. Senator Sheldon Whitehouse, who authored the Comprehensive Addiction and Recovery Act, sweeping legislation to combat opioid addiction that was signed into law last year.

“It was clear to me from walking the halls of the new Lifespan Recovery Center that the medical and addiction professionals here will be an asset for those on the long, noble road to recovery. I’m keeping up the fight to get more federal resources to stem this public health crisis, and I am proud of the work being done in Rhode Island to treat and prevent addiction.”

In 2016, according to the Department of Health, 336 individuals died of accidental drug-related overdose in Rhode Island.
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Bess Marcus, PhD, appointed next dean of Brown’s School of Public Health

PROVIDENCE – The next dean of the Brown University School of Public Health will be BESS MARCUS, PhD, a leading scholar in health behavior changes and the first senior associate dean for public health at the University of California San Diego School of Medicine.

Marcus will begin her tenure as dean effective November 1, 2017, succeeding Terrie Fox Wetle, who became the school’s inaugural dean in 2013.

Brown University President Christina Paxson announced her appointment in a June 14 email to the Brown community. Marcus brings to the deanship a commitment to rigorous research, innovative education and engagement with the greater community, which is critical for advancing the School of Public Health’s mission, Paxson said.

A clinical health psychologist and expert in health promotion, Marcus served as a professor of community health and psychiatry and human behavior at Brown before leaving for UCSD in 2011. After serving as chair of the Department of Family Medicine and Public Health at the UCSD School of Medicine for six years and the school’s senior associate dean for public health – a position in which she founded and directed the UCSD Institute for Public Health – for three, she said she is excited to return to Brown and build on the momentum the School of Public Health has generated since it was founded in 2013.

“I’m excited and honored by the opportunity to return to Brown to lead the School of Public Health at such a critical time, given all of the local, national and global health challenges facing us, from obesity to climate change to so much more,” Marcus said. “One of the factors that’s so exciting is the richness of the University itself – addressing important, complex issues related to population health is a central part of Brown’s mission.”

In her role as dean, Marcus will provide strategic direction, leadership and administrative oversight for all aspects of the School of Public Health, promoting its mission of academic excellence in education, research and civic engagement. Reporting directly to the University’s provost, she will oversee the school’s four academic departments, research centers, doctoral and master’s programs and its undergraduate concentration.

After Wetle announced her intent to step down as dean following the 2016-17 academic year, Paxson led a search committee of Brown faculty members and public health students to identify her successor. The committee held open forums on campus, consulted with the school’s advisory board members and engaged with senior leaders from Brown and key off-campus partners, including the Rhode Island Department of Health.

Marcus stood out as a leader who can build on the School of Public Health’s core strengths while launching new initiatives that elevate its work in public health, Provost Richard M. Locke said.

“Bess has an impressive record of supporting student and faculty research and outreach aimed at sharply reducing death and disability associated with chronic and infectious diseases and increasing life expectancy,” Locke said. “This mix of high-quality work and engagement is exactly what Brown is known for, making Bess a great fit for the School of Public Health.”

Background

Marcus has published more than 250 papers on the role of exercise in health and how to motivate people to maintain healthy behaviors such as physical activity and smoking cessation. She first arrived at Brown as a postdoctoral scholar in 1988 after earning her master’s degree and PhD in clinical psychology at Auburn University. After five years as an assistant professor, she became an associate professor of psychiatry and human behavior in 1995 and then a full professor in 2000. In 2004, she became director of the Centers for Behavioral and Preventive Medicine at the Miriam Hospital, an affiliated hospital partner for Brown.

In 2007, Marcus joined the faculty of Brown’s Department of Community Health and remained on the faculty when the department became the School of Public Health in 2013.

When the opportunity arose in 2011 for Marcus to become chair of the Department of Family Medicine and Public Health at the University of California San Diego, she remained an adjunct professor at Brown to facilitate ongoing collaborations with Brown researchers. UCSD appointed Marcus as the School of Medicine’s inaugural senior associate dean in 2014.

In that role, she created the Institute for Public Health, promoted public health research and education activities across campus and supervised the medical school’s public health degree offerings. She oversaw the establishment of a bachelor of science in public health, the first undergraduate degree offered by the School of Medicine, a doctoral degree program in biostatistics and a master of public health program that will launch soon.

Throughout her career, Marcus has supervised, mentored and advised scores of students and taught hundreds more. She has served as principal investigator or co-investigator on a wide range of National Institutes of Health grants on physical activity behavior. She has regularly participated in panels for the American Heart Association, American College of Sports Medicine, Centers for Disease Control and Prevention, and National Institutes of Health, which have created recommendations and guidelines on the quantity and intensity of physical activity necessary for health benefits. Marcus served on the executive committee for the Development of a National Strategic Plan for Physical Activity and on the board of directors for the National Physical Activity Plan Alliance.

In addition to her master’s and doctoral degrees from Auburn, Marcus holds a bachelor of arts in psychology from Washington University in St. Louis.
OHIC Commissioner Kathleen Hittner, MD, announces retirement

Raimondo Appoints Dr. Marie L. Ganim to post

PROVIDENCE – Health Insurance Commissioner **DR. KATHLEEN HITTNER** recently announced plans to retire from her position effective this month. In her place, Governor Gina M. Raimondo will appoint **DR. MARIE L. GANIM**. The Governor has submitted her name to the Rhode Island State Senate for advice and consent.

“We’ve made great strides over the past few years in ensuring Rhode Islanders have access to quality, affordable health care,” Raimondo said. “Ninety-six percent of all Rhode Islanders now have health insurance, and our state is home to one the lowest uninsured rates in the country. I am confident that Dr. Ganim possesses the expertise and strong professional background needed to keep us moving in the right direction.”

Dr. Marie L. Ganim is currently the Deputy Chief of Staff and Policy Director for the Rhode Island State Senate. She previously served as the Senate’s Director of Health and Human Services Policy. Prior to working for the Senate, she spent time as Policy Director for former U.S. Congressman Robert A. Weygand and as a Health Policy Specialist in the Rhode Island House of Representatives. Dr. Ganim holds an undergraduate degree in political science from Providence College, a master’s degree in public administration from Syracuse University and a PhD in public and international affairs with a specialty in health policy from Northeastern University. She lives in Lincoln.

Current Health Insurance Commissioner Dr. Kathleen Hittner has served the state for four years, since her appointment in June 2013. Over her tenure, Rhode Island has maintained some of the lowest rate increases in the country, despite national uncertainty about health care. Under Dr. Hittner’s leadership, the office has saved Rhode Island consumers hundreds of thousands of dollars through its rate review process, focused on care transformation and promoted collaboration among providers and insurance carriers.

“I am grateful to Dr. Hittner for her years of service to Rhode Islanders, and wish her the best of luck in this next chapter in her life,” Raimondo said. ❖

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Recognition

Fatima Hospital graduates medical technology students

NORTH PROVIDENCE – On June 8, seven students graduated from the School of Medical Technology at Our Lady of Fatima Hospital, completing an intensive year-long clinical laboratory internship program. All have new jobs to start their careers with two of the students accepting positions Fatima Hospital.

The graduates are: Dakota Donth, Alannah Duffy, Elysha Grant, Lauren Hartnett, Megan Tessier, Abigail Tubman, and Randy Vinas.

The school is a member of the Board of Rhode Island Schools of Allied Health, a consortium of two university and one college Medical Laboratory Science programs – the University of Rhode Island, Salve Regina University and Rhode Island College. Our Lady of Fatima Hospital’s school is one of two schools of Medical Technology remaining in this state. The purpose of this consortium is to integrate individual teaching programs into a coordinated didactic experience through the School of Medical Technology.

Medical Laboratory Scientists play a critical role in the detection, diagnosis and treatment of patients. This is accomplished through extensive examination and analysis of various body fluids, cells, and direct stains from patient specimens. They look for microorganisms, analyze chemical content of body fluids, match blood for patient transfusions, perform cell count, look for abnormal cells, and test for drug levels in the blood to find out how a patient may be responding to different treatments and/or antibiotics.

South County Hospital rated among top in nation for Quality and Patient Experience

This year, five of the graduating students came from the University of Rhode Island, one from Salve Regina University, and one from Rhode Island College. Our Lady of Fatima’s School of Medical Technology is part of the Department of Pathology and is under the direction of Mirela Stancu, MD, as medical advisor and Theresa Tellier-Castellone MPH, MLS (ASCP) as the program director.

The program is accredited by the National Accrediting Agency for Clinical Laboratory Sciences and is recognized by the Rhode Island Department of Education and the Rhode Island Department of Health as an accredited clinical program under specifications provided in the “RI Clinical Laboratory Science Practice Act.”

Wakefield – South County Hospital in Wakefield, RI, a 100-bed, independent hospital, is one of only 19 hospitals in the country to receive the highest score of 5-Stars in two areas used to measure healthcare excellence – Overall Hospital Quality and Patient Care.

The Centers for Medicare and Medicaid Services (CMS) developed the Star Rating System to simplify complex criteria that measure healthcare quality so that healthcare consumers can make informed decisions when choosing providers. The ratings are assigned to over 4,000 hospitals across the country.

“Our staff is focused on delivering the best patient care possible. We strive to ensure that our healthcare system performs up to our own high expectations,” said Lou Giancola, South County Health president and CEO. “When the data reinforces the success and feedback we get from our patients, it reassures us that we are providing quality care, centered on the patient. It also inspires us to work harder to improve outcomes and the patient experience.”

South County Hospital is the only hospital in the Northeast to earn a 5-Star rating in the two categories.
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**Obituaries**

**DR. JANE KIFF** of Sandwich, MA, passed away May 25, 2017.

Dr. Kiff received her medical degree from the University of Missouri in May 1992, then did her residency at Stanford, followed by a fellowship at Children’s Hospital of Philadelphia. Her medical specialty was pediatric critical care. She often cared for the sickest of the sick children in her hospital. Friends described her as a dedicated, compassionate physician.

She began her practice in Madison, WI, then moved to Hasbro Children’s Hospital. In recent years, she worked for Albany Medical Center, Albany, NY, and joined Cape Cod Hospital of Hyannis Mass in January of this year. Her co-workers and friends always gave her glowing recommendations.

She leaves behind her mother Virginia Kiff of Attleboro, her brother Bill Kiff and his wife Ann of Granbury, TX; her beloved dog Callie, along with numerous cousins and other family members.

In lieu of flowers, donations in her memory may be made to the Providence Animal Rescue League, 34 Elbow St, Providence RI, 02903 or Hasbro Children’s Hospital, PO Box H, Providence RI, 02901.

**DR. JOHN CHAMPLIN LATHROP**, 89, of Laurelmead died Monday, May 22, 2017 at home surrounded by his family. He was the husband of the late Irene McKenzie Lathrop.

Dr. Lathrop was a graduate of the University of Rhode Island and the Albany Medical College. He was in private practice for 40 years with offices in Providence, Barrington and South County before retiring. He was a physician in the US Army at Camp Leroy Johnston in Louisiana.

He is survived by his daughters, Joan Elizabeth Lathrop of Seymour, CT, Diane Lathrop of Middletown, RI, Mary Lathrop Truslow of Loveland, CO and Catherine Lathrop Strahan of Sudbury, MA. He leaves 6 grandchildren, 3 great grandchildren and 7 nieces and nephews.

Donations in his memory may be made to Westerly Land Trust, PO Box 601, Westerly, RI 02891.

**AZHAR Q. MUSTAFA, MD**, 73, of Barrington, a Fall River surgeon, husband of Penny J. (Lucier) Mustafa, passed away June 9, 2017. Dr. Mustafa, his wife and son, Ameer, also operated A & P Orchids, Swansea.

Besides his wife of 33 years, he leaves his former wife, Mary Mustafa, of Needham; three sons, Shamael Mustafa and his wife Aber of California, Shaheer Mustafa and his wife Yolanda of Needham and Ameer Mustafa of Barrington. He also was the grandfather of Adeem and Imaad Mustafa, Rahsaa and Akeem Mustafa-Coentro and the late Abdul Rahman Mustafa; the brother of Zahida Imran of Texas, Tahira Chaudhry of East Providence and the late Athar Mustafa and also leaves nieces, nephews and cousins.

To anyone who had the benefit of knowing him, he held himself and others to the highest standard, was brilliantly gifted and a true original. His loving family will miss his warm presence, enthusiasm and passion for living in the moment. Donations in his memory may be made to the Dr. Azhar Mustafa Memorial Scholarship Fund, Bristol Community College, 777 Elsbree St., Fall River MA 02720.

**DONYA ANN POWERS, MD**, of Providence, RI, passed away May 19. She was a graduate of The Warren Alpert Medical School in 1983, and spent her entire professional career serving the needs of patients in the greater Providence region through her family-medicine practice.

She held a number of hospital appointments, including terms as chair of family practice and medical staff president at Sturdy Memorial Hospital in Attleboro, MA. She also served as a part-time medical director for Hospice of CVNA in Attleboro, MA.

Dr. Powers was a clinical associate professor of family medicine at Brown, where she received a number of teaching awards from the university and its family medicine residency. She served on the AAFP’s Commission on Science, helping to develop official clinical recommendations and guidelines, as well as planning national continuing medical-education programs for family physicians.

She was a member of the AAFP’s National Research Network, and presented original clinical research at the World Family Medicine meetings in many countries. She also served as a volunteer with the AAFP Foundation’s “Physicians with Heart” program, traveling to Tajikistan (2007), Kyrgyzstan (2008, 2011), and the Republic of Georgia (2009) to deliver humanitarian aid to local hospitals and lead educational sessions for local family physicians.

Friends and family members recall her love of travel, photography, cooking, and ballroom dancing. She also was an avid reader of both mystery and science fiction stories.

Donations in her memory may be made to the American Academy of Family Physicians (AAFP) Foundation, 11400 Tomahawk Creek Parkway, Suite 440, Leawood, KS 66211-2672.
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As recommended by many Rhode Island physicians, Blue Cross now extends protection to Self-employed, unemployed, retired, or other persons employed in establishments having five or less employees. Opportunity for this new individual enrollment is open to October 18th only.

This new, widespread Blue Cross service, bringing the important protection of prepaid hospital service to the vast majority of Rhode Island citizens, will undoubtedly have your active support through recommendation to all eligible people within your sphere of professional and social contacts.

Farmers, fishermen, domestic employees, professional people, small businessmen—are among those who may now join. The age limit is 65 years and the usual Blue Cross health statement is required. The waiting period for maternity cases will remain at 9 months.

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Editorial

The State Board of Health

The members of the State Board of Health must not forget that as public officials they are subject to criticism which does not necessarily apply to them personally and that commendation of their official acts is not meant as a compliment to the individuals even though their official action is influenced or effected by the energy or activity of a few men. There should be no Star Chamber proceedings, no official action which is not duly spread upon in records, and no feeling that they are being persecuted if their actions are questioned or criticized.

It is known to everybody that there has been clashes of interest in the board, that the elements of discord still exist, that the good which has been accomplished during the past two years is minimized by a lack of unity and it is believed by many that this unsatisfactory condition of affairs is largely due to the activity of one or more members. The editorials of the Providence Medical Journal have contained both praise and criticism of the State Board of Health.

It is currently believed that a small clique is responsible for much, if not all, of the dissension, and should be held responsible for the discredit which has attached to the Board. If we are in error, and the Board as a whole assumes responsibility for all of its actions, we believe that the Board has been guilty or cognizant of things which do not redound to its credit.

The methods used in the Legislature to unseat Dr. Swarts as a member of the Board were unfair, unjust, and disgraceful and were both parts of a long continued and persistent campaign to discredit his valuable services. The failure to reelect him as secretary was the culmination of personal attacks and was made possible, we are informed, only by the absence of one member and the introduction of the technicality regarding proxies. The charge that other duties interfered with his secretarial work is absurd. The new incumbent at the time this is written had not resigned his position as health officer of a neighboring city and the state is deprived of valuable services of the man recognized as an expert of national reputation, and this recognition of Dr. Swarts’ ability does not deny the worth of the present and current holder of the office, but it is yet to be proven.

The establishment of the pathological library was an innovation and its worth was at first questionable. The Board is entitled to great credit for its action in creating and establishing this department, which is now the greatest value to the physicians and to the state, but once having placed at its head a pathologist of reputation, it should not interfere with its management.

We have no fault to find that those who have had an opportunity to feed a little at the public crib, but in our opinion the methods by which the recent appointments to the pathological staff were unworthy of the Board and would not look well in print.

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When diets call for the wholesome nourishment and uniform cream content of Grade A homogenized milk, suggest A. B. Munroe Dairy. Strictly sanitary production and close laboratory control result in a product that backs up your good judgment.

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Meetings

Medical Review Society
June 28, 1917

Regional anesthesia

After a brief discussion of the history of local anesthesia and a discussion of the action of cocaine and its various substitutes, the paper described the method of nerve blocking as applied to various parts of the body and the operations that may be performed under this type of anesthesia. Special stress was laid upon the method of paravertebral injections for the production of anesthesia of the regions supplied by the spinal nerves, and a description of the technique of Dr. EO Jones of Washington was presented. Novocaine was advocated as the anesthetic of choice because its action is less toxic than that of cocaine. The method of producing anesthesia of the perineum by nerve blocking was also described in detail.

Skin grafting

BY ARTHUR M. SHIPLEY, MD
(INTERNATIONAL CLINICS, JUNE 1917)

Shipley describes the excellent results he has obtained in the treatment of chronic leg ulcers by the use of skin grafts, as described by John Davis in the Journal AMA of September 19, 1914. He recommends this method for the following reasons: first, the ease and the simplicity of the procedure; second, its uniform success if the proper precautions are taken in the preparation of the surfaces of the application of the grafts; third, the robust surface that is formed by the grafts; fourth, the fact that the operation can be done without a general anesthetic; fifth, the very rapid and remarkable filling up of the base of the ulcer to the level of the surrounding tissues.

Rhode Island Medical Society

Organization of dispensary services of the Second Naval District

DN Carpenter, Medical Inspector, United States Navy:

“I have been asked to speak to you today on the organization and work of the medical department of the Second Naval District. This is a subject that should interest the members of the Rhode Island Medical Society, whose coast is entirely included within this district, extending from Chatham, Mass., to New London, Conn.

At Block Island, it is contemplated to use a private house that has been offered to the government, and this will be equipped as a small hospital. As Block Island is 26 miles at sea, there will be some days during the winter when it will be difficult or impossible to send patients to the Naval Hospital, and therefore, this dispensary must be able to care for its own emergency cases.

So far I have only spoken on the organization of the medical department on shore. There is also the organization for dispensary service afloat; but as yet there has been no need to send medical officers to the smaller boats used for patrols.”

‘Red Cross Tag Day’

On June 22, 1917 the Retail Merchants’ Division of the Providence Chamber of Commerce assembled 7,000 collection boxes tagged for the American Red Cross Tag Day. With the assistance of the Boy Scouts, the donation boxes were distributed to retail outlets throughout the city. In short order, almost $10,000 was raised. The City of Providence’s total donations from myriad groups raised approximately $600,000 for the Red Cross.
Hospitals

The St. Joseph’s Hospital Staff Association to the number of about 40 men participated in the annual outing at the Warwick Club. Field sports and a baseball game were enjoyed.

Dr. HP Jordan, assistant superintendent of the Providence City Hospital, has recently left for training at Fort Benjamin Harrison, Indiana, with the Medical Reserve Corps. Dr. Henry J. Connor will assume the position of assistant superintendent beginning July 1.

State Hospital for the Insane

In the 1860s, Rhode Island purchased more than 400 acres to use for a state farm. Later on the general hospital, a prison, and a mental institution, the State Hospital for the Insane, were built in the Howard complex and opened in 1870. Dr. Arthur H. Harrington served as superintendent in the first half of the 20th century.

Dr. Joseph F. Hawkins has been appointed oculist to the state institutions.
AN EXPERIMENT IN MEDICAL NOMENCLATURE INTRODUCING THE TERM:

“cell examination for uterine cancer”

The exfoliative cytological examination is called by some doctors the *cytologic cervical test*—by others the “Pap” *smear test*. In urging all women to have this test annually, we are calling it the *cell examination for uterine cancer*.

Here are our reasons:

*Cytologic cervical test* is a term which seems complicated to many women.

“Pap” *smear test* is simple, but women we have talked to find the word “smear” unpleasant and disturbing; and it may add to their anxieties about pelvic examinations.

Public relations advisors say that broadcasters and editors will dislike “smear”—and TV, radio and the press will be essential to the success of this educational project.

We have considered other terms but have at last agreed on *cell examination for uterine cancer* as the term which simply and accurately describes the keystone of this vitally important program.

This test can help save thousands of women each year. In many parts of the country it is becoming widely accepted as a part of a routine checkup. As fast as county medical societies approve, our local Units will urge women to go to their physicians annually for a *cell examination for uterine cancer*. 
Images from the Past

Two patients and hospital workers are shown in a Providence infirmary during the Victorian era.

Vintage postcard shows main drive into Butler Hospital in the early 1900s.

Nurses marching during the Armistice Day Parade in downtown Providence in 1923.

Photos of Cranston State Hospital and its dining hall with house pipe organ were taken in 1926 and 1930.