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The woman who could spell backwards

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My routine initial evaluation for every patient includes a reduced mental status exam. One item is a request to spell the word “earth” forwards and backwards, a slight modification of the question on the standard Mini-Mental State Examination (MMSE).

I do this because it is likely that many patients have been through the MMSE many times and recall the item asking for spelling “world” backwards. One of my patients spelled the word “earth” backwards so quickly that I was surprised. I asked her if she had a special talent for spelling words backwards and she admitted that she did. I tested her and found that she did, indeed, have this rather arcane talent. “Spell xylophone backwards,” I requested, skipping the forwards part, and she did, without hesitation. I gave her names to spell backwards, and some random lengthy words. No problem. “Do you have any other special or unusual talents?” I asked. “No.”

And, as best I’ve discovered over the next few years, she did not.

This has led me to wonder about highly focused, unusual talents that people may have that may go unrecognized, or, if present, either unexploited or unable to be exploited. Aleksandr R. Luria, the famous Soviet neuropsychologist of the 1930s, wrote a wonderful monograph, The Mind of a Mnemonist, about a Russian man with a perfect memory. He made his living impressing audiences with his unfailing ability to remember virtually everything. He was not apparently gifted in other areas, not creative, not brilliant. Luria kept detailed notes on their interactions during his laboratory visits and later would ask questions. “What color tie was I wearing at our meeting 17 years ago on March 23, 1928, and what were the headlines in the newspaper?” The man never erred. In the theater where he performed, an assistant would ask the audience to mention a number, and they would be written on a board in the order in which the audience spoke. After one or two hundred numbers they would be spoken to him once, after which he would repeat the list.

Obviously a good memory is better than a bad one. There is no field of endeavor where there is a downside to an enhanced memory. It is easy to see that certain types of memory better serve certain activities than others. Mozart’s ability to recall music obviously served his extraordinary talents. Chessmasters’ memories for whole games serve the obvious need of helping to choose a strategy or the next move. One can never know what sorts of special talents we or our family members may have if they never get the chance to exploit it. How would a poor, uneducated person in the third world know that they can repeat music that is a thousand notes long after hearing it only once, if the person never is exposed to the situation? How many people are asked to spell a word forwards and backwards? I assume it is a pretty rare request. How many readers have tested themselves spelling a word backwards?

This leads back to an important question. Why did I ask her to spell the word backwards? This is a standard test of “working memory,” which is a concept to describe the tasks involved in remembering the word and manipulating it while not forgetting it, thus “working” with it, without losing it. It is analogous to rotating a geometric shape in one’s mind to see what it looks like from different perspectives. But, interestingly, my patient seems to be no better at this than the average person who couldn’t spell xylophone backwards after several hours of trials.

I have not subjected my patient to formal neuropsychological testing to determine if there are hidden talents, perhaps even unknown to herself. The patient is herself unaware of any other special abilities, and I’ve seen none. So, what does this tell us about special talents? I think it tells us that we can’t recognize them unless the patient tells us. It tells us that the capabilities may exist in isolation, without any hint of brilliance or special talent. It tells us that testing may overlook particularly isolated but extraordinary talents, and that memory, like most human thought endeavors, can be extraordinarily focused, without generalizability. Memory, intelligence, and talent work best when united, but may exist in isolation.

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In an interview, Melinda Gates once remarked about innovations in the developing world that “when you let people participate in the design process you find that they often have ingenious ideas about what would really help them.” These words are at the heart of successful community health programs around the world aimed at bringing change to those who need it the most. But we do not need to look too far to recognize that these same principles apply to communities here at home. Early in 2014, we created Teens Empowered to Advocate for Community Health (TEACH), a partnership organization to inspire the next generation of youth to enact change in their own communities by empowering them with the basic principles of public health.

With a seed grant from the American Academy of Pediatrics Community Access to Child Health (CATCH), we sought to teach public health as an after-school curriculum with a goal of inspiring teens to be agents of change. At first, we met with many potential partners before serendipitously initiating the program at Woonsocket High School. Woonsocket proved to be a perfect place to start as a city of 40,000 people, rich with diversity and character, but still faced with many risk factors for poor health outcomes. And the high school students turned out to be motivated and engaged to initiate change from within.

Our partnership with community organizations like Riverzedge Arts was the first key to the launch of our program. Riverzedge Arts is an organization that had connections with Woonsocket High School in offering after-school courses for credit through a program called Expanded Learning Opportunities (ELO). Karen Barbosa, the ELO director of Riverzedge, and Liz Holohan, the ELO Woonsocket Coordinator, were vital to helping us to understand how to integrate our goals into a classroom curriculum. Furthermore, we brought in enthusiastic medical and public health students from Brown University to help deliver these topics into an interactive community-driven way.

Courses then took effect through an integrative approach. Nutrition is now taught in the grocery store as a scavenger hunt to build a nutritious meal. LGBT health and advocacy issues are introduced during a field trip to the local YouthPride, Inc. center. First line cardiopulmonary resuscitation and emergency medicine skills are taught at the Lifespan Medical Simulation Center. Sexual health is taught as a jeopardy game, where students team up and answer questions. Students learn reproductive anatomy by engaging in hands-on modeling activity. During the second semester, students are taught basic research skills and prompted to ask one fundamental question: what do the students perceive as public health issues in their community? And what projects can they design to bring about change?

We recognized quickly that the high school students were constantly picking up on the public health issues that the city had been facing for years. As an example, according to Rhode Island Kids Count in 2016, greater than 350 births in Woonsocket were to girls between the ages of 15 to 19. To assume that students did not understand these facts is a mistake. A student once asked why a daycare at school was not supported so that teen mothers could avoid absenteeism. Another student identified obstacles in accessing contraception education despite teens knowing they could benefit from it. Questions like these became topics of their research projects and proposals for interventions. The topics are often the most prevalent health issues in their communities, such as absenteeism, truancy, student dropout, teenage pregnancy and mental health issues. In turn, through TEACH, the students learn about the public health process and have become motivated to engage with their communities from a grassroots approach. We believe that these teens will take the next step from presenting these ideas to making real change come to life.

Now well into our third year, our organization has matured, our curriculum has been enriched and our students are still persistent with their desire to bring solutions to the problems they identify around them. We have also expanded
across state lines, where medical and nursing students at the University of Massachusetts at Worcester are bringing TEACH to Rockdale Recovery High School. Here, instead of viewing their substance use history as a problem—teens are encouraged to use their experiences as a way to educate medical providers and the public about how to approach adolescent substance use in the local community.

What began as a small group effort to bring public health knowledge to students has, in turn, taught physicians, graduate students and teachers alike that empowering teens can have a lasting and meaningful impact in a community. We believe that our model of public health education and intervention with teens can serve as a model elsewhere to engage the community to enact change. Partnerships and an interdisciplinary team were vital to our success. With help from our partnerships and passionate team members, we hope to bring these teens’ “ingenious ideas” to fruition.

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Antipsychotic Medication Use and Reduction: Unanswered Questions and Policy Implications

DANIEL HARRIS, BA; NELIA SILVA-ODOM, RN, BSN, MBA, MHA; LYNN MCNICOLL, MD

Historically, antipsychotic medications (APMs) have been used to treat mood and behavior dysregulation associated with dementia. However, their associations with early mortality and risk of adverse events for adults above the age of 65 (e.g., Parkinsonism and cerebrovascular events, respectively) prompted the Centers of Medicare & Medicaid (CMS) to introduce The National Partnership to Improve Dementia Care in 2012. The Partnership incentivizes APM reduction by publically reporting a nursing home’s prevalence of APM use and incorporating the prevalence into their quality rating, with fewer APMs indicating better quality. Notably, only residents with schizophrenia, Huntington’s or Tourette’s are excluded from the APM prevalence calculation.

During the early years of The Partnership, Rhode Island showed promise in reducing APM use among long-stay nursing home residents (24.0% in quarter-4 2011 to 16.5% in quarter-2 2014) (Figure 1). However, while the national prevalence of APM use steadily decreased, Rhode Island’s progress slowed in quarter-3 2014 and increased to 17.6% in quarter-4 2016. In response, the local CMS Medicare Quality Innovation Network-Quality Improvement Organization (QIN-QIO) implemented several educational and skill-building interventions, which, in part, are likely related to the latest reductions in APM use the state.

A recent analysis of resident-, facility- and community-level factors and APM use among Rhode Island nursing homes suggests that dementia may no longer be as strongly associated with APM use. Results showed that the prevalence of residents with dementia was negatively associated with APM use after controlling for other resident-level factors. Psychiatric diagnoses and other medications (e.g., antianxiety and antidepressants) were among the strongest factors associated with increased APM use. While additional research is necessary to elucidate these findings, the results lend insight into the success of The Partnership as well as underscore the need to reevaluate its initial aims in the context of a potentially changing nursing home population. More specifically, RI’s increased APM prevalence may, in part, be attributed to demographic shifts towards younger nursing home residents, presenting with symptoms and psychiatric diagnoses warranting further investigation.

Figure 1. National and Quarterly Rhode Island Prevalence of Antipsychotic Medication Use for Long-Stay Nursing Home Residents

Source: Data were adapted from the Centers for Medicare & Medicaid Services National Partnership to Improve Dementia Care. Notes: The Partnership began on March 29, 2012. Residents with Huntington’s, Tourette’s, or Schizophrenia were excluded.
APM use that are unassociated with dementia (e.g., bipolar disorder).

The Partnership was designed to reduce inappropriate APM use among residents with dementia. However, new empirical evidence suggests that APM use may no longer be associated with dementia at the facility level. Given these results, and CMS’ narrow exclusionary criteria, several questions emerge: Will the risk of a low quality rating motivate nursing homes to discontinue appropriate APMs? Has CMS considered the consequences of eliminating APMs in residents who have clinically justified reasons to use them? For example, under the current initiative, residents with bipolar disorder or using APMs approved for certain diagnoses (e.g., aripiprazole, an atypical antipsychotic, for depression) are at risk of medication discontinuation. Ultimately, how far can APM reduction go and remain safe and stable?

Opportunities for future research include the longitudinal study of changes in the demographic composition of nursing home residents and how those changes are associated with a nursing home’s APM use and finances. Policy-level changes may aim to refine the APM quality measure to ensure it is focused on inappropriate APM use (e.g., exclude residents less than 65 and/or with psychiatric diagnoses justifying the use of APMs).

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Jonathan Migliori pauses for a look at the journal in Croft’s Port Cellar in Vila Nova de Gaia. Port wine is produced exclusively in the Douro Valley region in northern Portugal. The double-deck Dom Luis I Bridge spans the Douro River, three miles inland from the Atlantic, connecting Porto (shown) with Vila Nova de Gaia.
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Senior Physicians: Addressing Age, Ability and Acumen

HERBERT RAKATANSKY, MD
GUEST EDITOR

Editor’s Note: This special theme section evolved from the Rhode Island Medical Society’s regional conference on Senior Physicians: Addressing Age, Ability, and Acumen held in September 2016. The symposium was arranged by the RIMS Physician Health Program and made possible by an educational grant to RIMS from the Coverys Community Healthcare Foundation.

Just a year ago the Rhode Island Medical Society (RIMS) and the Physician Health Program (PHP) convened a full-day symposium about senior physicians and their ability to continue to practice. Well over 100 people attended. Four papers in this issue reflect the variety of subjects presented.

Doctors (at any age) who are observed to be forgetful or have other manifestations of cognitive impairment should be referred for medical evaluation and cognitive testing. Mild cognitive impairment or early dementia that would mandate retirement from patient care may be documented.

Current opinion is that routine cognitive screening of all doctors over a certain age is not likely to be useful. Because of the variability of test results in a population of “high achievers” such testing is not likely to be an accurate independent predictor of whether a doctor should continue to practice. Several screening programs have ceased age-based routine cognitive testing. A detailed exploration of this subject will be presented in a paper to be published in a future issue.

Whether doctors are competent to practice is a decision made by the board of licensure and these regulatory issues are reviewed in the paper by Dr. McDonald.

The PHP recently evaluated two senior doctors.

Doctor A was referred because of poor prescribing practices. There was no other evidence of cognitive impairment such as forgetfulness, etc. though he made a “poor impression” during an initial interview with a committee. This resulted in his referral to the PHP. He was leading an active and productive life. The question of whether he was providing acceptable, quality care would not be answered by cognitive testing. The appropriate method of evaluation would be an audit of his practice to determine directly the quality of his care and this was arranged.

Doctor B was referred because many observers agreed that his clinical care was substandard. He also was noted to be forgetful. Cognitive testing did not reveal significant abnormalities. Thinking that this doctor may have had very high cognitive function previously and that the current test was part of a “downhill” process, the cognitive testing was repeated two years later and it was marginally improved!

The lesson: if the question is whether a doctor of any age, in the absence of a suspected impairing illness, is competent to practice, the best way to find out is to evaluate the quality of his patient care directly.

If an impairing illness of any type is suspected, that issue should be resolved as a part of the medical and cognitive evaluation before doing a formal practice audit. It is important to note that normal age-related changes may not impair a doctor’s ability to practice if they are recognized. Drs. Minter and Besdine review these issues in their paper.

If a practice audit reveals that patient care is not acceptable, a thorough physical and cognitive evaluation should be undertaken to ascertain whether there is a treatable illness as a cause.

Thus, screening of apparently healthy older doctors is best done by directly evaluating the quality of their patient care. Doctors who practice in large groups are more easily evaluated than those who are in solo practice. Whether screening can be limited legally to older doctors is discussed in the article by attorney Chase-Lubitz.

There is, however, no age restriction on planning for retirement – in fact the earlier one thinks about this, the better. See the discussion by Donna Singer.

The symposium generated discussion about what the next step might be. The result is a task force convened by RIMS with representation including hospitals, government, cognitive scientists, FAA examiners, PHP members, lawyers, medical staffs, chief medical officers and others. It was quickly realized that the discussion must address all age groups and the effort really is a “Patient Safety Initiative.” Currently this is a work in progress.

The articles published in this special section of the Rhode Island Medical Journal offer the reader a good background in these issues and perhaps some insight into one’s own attitude and plans for retirement. And we wish you well on that journey.

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The Aging Physician

JAMES V. MCDONALD, MD, MPH

The practice of medicine, perhaps the noblest of professions, can be one of extremes. Daily in the clinical spaces where we engage in our art, matters of life, death, joy and sadness are common. As we reflect on our career, perhaps another extreme is the anxiety, excitement and expectation of the first day of medical school contrasted with the anxiety, excitement and expectation of the last day we engage in this noblest of arts.

We are all getting older and leaving our profession is a difficult and emotional topic to address. Some of us look forward to retirement, some of us can not envision retirement at all, yet all of us want to leave this profession on our own terms. No one wants to be removed from this profession due to quality of care concerns, competency issues or health issues.

Rhode Island like other states has a physician population that is getting older. Data from the Rhode Island Department of Health reveal 16% of physicians are older than 60.

Data from the 2012 AMA Masterfile report certain specialties in Rhode Island have >40% of its physicians over 60 including, Anatomic and Clinical Pathology, Endocrinology, Diabetes and Metabolism, Otolaryngology and Radiology and Diagnostic Radiology.1 The Federation of State Medical Boards reports in a 2014 census of physicians that nationally, 31% of physicians are older than 60.2

Aging is normal and quite frankly preferred. Aging has attributes that are expected and physicians are not exempt from normal aging. There are cognitive implications and declines in certain abilities such as processing speed, visuospatial orientation, language, some types of memory and executive functions.3 Normal aging is distinct from dementia and Alzheimer’s disease which is associated with a progressive functional cognitive decline and also increase in prevalence with age.4

There is another side to aging, particularly in physicians, which reflects the profound wisdom, experience and clinical judgement that come from years of practice. There is no substitute for the presence of a sage wise physician in every practice and the patient benefit and safety that flows from their accessible consultation. The practice of medicine has a well-established tradition of physicians training physicians and sharing our wisdom and knowledge benefits everyone.

Professional societies have not been silent on the issue of the aging physician and agree the time has come for this issue to be more thoroughly addressed. The American Medical Association (AMA) is exploring the possibility of competency testing for older physicians.5 “Physicians are professionally obligated to continually assess their own physical and mental health, even though there is no national standard for screening physicians who have reached a certain age. But a number of other professions that can impact public safety do have age-related cutoffs in place. Commercial airline pilots, for instance, must be regularly screened beginning at age 40 and must retire at 65.”

The American College of Surgeons (ACS) has also explored the issue of the aging physician and issued a statement in January of 2016.6 The ACS statement encourages surgeons to maintain a healthy lifestyle, recognize they are not immune to the changes of aging and also that the surgeon might not recognize their own deterioration of skills.7 The ACS took their recommendations further and recommended between the age of 65 and 70 surgeons voluntarily have physical and visual health evaluated as a baseline as well as ongoing. Additionally, ACS states: “Colleagues and staff must be able to bring forward and freely express legitimate concerns about a surgeon’s performance and apparent age-related decline to group practice, departmental and medical staff, or hospital leadership without fear of retribution.”8

It is evident that these two professional organizations recognize the gravity, complexity and emotional aspects of this issue. It is also evident no simple solution is apparent to such a complex issue. The issue of the aging physician is complex and does require engagement from several stakeholders regarding a way forward. Issues surrounding employment, regulatory responsibility, patient safety, physician autonomy, right to work are just a few that need to be explored. We have before us an opportunity to work together on this important public health, physician wellbeing and patient safety issue.

All of us are reminded we are able to practice this profession for a season of our life and our time in this season is an opportunity and a gift. This is a gift that should be treasured and yet we do need to plan for a lifetime after our season of service has concluded. It would be ideal to arrive in our golden years with both the gold and the years to enjoy them, and do so our own terms.
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Cognitive Decline in Physicians and their Patients
BRADLEY MINTER, MD; RICHARD W. BESDINE, MD

The average age of licensed practicing physicians in the United States has risen from 50 in 2010 to 52 in 2014; 26% are over 65 years of age. Given the increased demand for healthcare faces in both number and complexity of patients, it is important to consider factors that contribute to a physician’s career longevity. Often focus is on strategies to prevent burnout during a practitioner’s career. However, here we will discuss evidence-based steps that can be taken to prevent cognitive decline in aging practitioners, thus preserving the workforce.

Over time, examination of the aging nervous system undergoes predictable changes, such as in muscle tone, increased postural sway and postural hypotension, and decreased arm swing. This is an abbreviated list, but these peripheral and motor phenomena are irrelevant to clinical performance of those physicians that do primarily brain work. However, there are cognitive changes that can be seen in healthy aging. Physicians may wonder about these changes, and whether they are going to affect their ability to practice medicine. In healthy aging, varying degrees of reduced processing speed, free recall, multitasking ability and attention span can be expected. Fortunately, these changes, in the absence of actual disease states, are not expected to affect a physician’s job performance or shorten a physician’s career. Furthermore, learning strategies can be implemented that are effective in enhancing the encoding and the accessing of new and old information. Because new cognitive obstacles occur in a non-uniform manner throughout the older population, individualization of assessment and intervention is key. Intervention strategies, such as mnemonics, mental hierarchies and clusters, which are used less by elders than when they were younger, give long-lasting improvements when implemented. Distractions also interfere more in elders than the young. In practice, instructions to older patients should be given directly, and in a manner than can be easily encoded to increase adherence and outcomes.

The good news is that domains which are arguably the most important to career longevity are resilient in pure aging. Short-term memory, also known as immediate recall, persists. Long-term memory is relatively spared, with very good procedural memory – e.g., biking, knots, music – and semantic memory, meaning facts. Episodic long-term memory declines with age, making remembering location, time, and memory of events difficult. Applying learned strategies discussed above can help if these changes become problematic. Pathologic cognitive decline, feared more than death by many older adults, is a different story. But here, too, is mostly good news. In observational studies, high levels of education and continuing work that demands thinking and reasoning with learned information are protective against Alzheimer’s disease (AD) [the most common dementia worldwide]. It is very important to distinguish the cognitive changes of normal aging from the pathologic basket of dementia, which is defined as an acquired disorder producing a decline in memory and other cognitive domains sufficient to affect daily life in a previously normal adult. Diagnosis is made when progressive cognitive and functional decline are noticed, usually by family first, in a patient without any sensory deficits – such as need for a hearing aid or cataract surgery. Memory impairment plus one of four other cognitive deficits are required for diagnosis: apraxia, trouble with motor planning, aphasia, trouble with language, agnosia, a sensory processing deficit; or disturbances in executive functioning. Delirium, a distinct transient entity, must not be present and be ruled out by thorough medical evaluation. The largest proportion of those diagnosed with dementia have AD, which is notable for its gradual onset and steady progression. Although recent work has indicated that the incidence of AD has been in decline, demographic shifts in the age of our population will result in continuing increases in the number of afflicted persons. The U.S. senior population is expected to grow from 43 million in 2012 to 92 million in 2060; with that growth, the prevalence of dementia is expected to rise from 4.7 million in 2010 to 13.8 million in 2050. The costs associated with this change are projected to exceed $1 trillion by 2050.

Being the 5th or 6th leading cause of death in the United States, AD shortens life expectancy at time of diagnosis by 6.7 years in a 60-year-old, and 1.9 years in a 90-year-old. These mortality data should be a factor in clinical decision-making. Goals of care discussions should begin early and often in patients with dementia, once the patient and family understand the course of the disease.

Early diagnosis is important for social, medical and financial decision-making, but is often hindered by the insidious presentation and course of the disease. When identified early, disease burden can be mitigated by planning for the future decline while the patient still retains decision-making capacity and can participate in the process. Complaints of elders related to normal psychomotor slowing of aging can confound the challenges of screening for cognitive status in elders, but also make it more important. A patient with memory complaints of misplacing car keys, difficulty with word and name recall, and worrying about memory should...
be given reassurance and education regarding learning strategies. Family complaining a patient never remembers the correct word, loses the car keys, makes major financial mistakes, has poor insight regarding memory loss, and repetition of conversations should trigger evaluation for dementia. Occasionally, the first sign leading to a diagnosis of a pathologic cognitive impairment is failure to perform at one’s job. As a physician, development of a neurodegenerative condition such as AD would indeed be career ending. Our field has a unique system judging for competence to practice, in which we are all responsible to ensure no harm is being done to our patients and are required to report when we think harm could be done. It is important to remember that this is not driven by age but by performance.

When considering protecting the physician workforce from cognitive decline, one should consider the fixed and modifiable risk factors for AD. Fixed risk factors for AD classically include age, family history, female gender, and Down Syndrome; more recently identified risk factors are apolipoprotein E4, history of herpes simplex encephalitis, and history of depression. Modifiable risk factors include risks for stroke (e.g., hypertension, smoking, atherosclerosis, dyslipidemia, obesity, and diabetes) physical inactivity, depression and low level of education. Perhaps the best first step that protects cognition that most clinicians have already completed is decades of education and the cognitive demands of clinical practice. A recent study that followed subjects for 10 years revealed those who engage in craft activities, computer use, playing games, and social activities had significantly decreased incidence of mild cognitive impairment. One could suppose that those benefits are already reaped by practicing physicians, given the complexity of daily clinical activities. But demanding brain work should not excuse ignoring other modifiable risk factors for the development of AD, given the recently identified associations of certain behaviors with prevention of cognitive decline. Healthy diet, regular frequent exercise and minimizing stroke risk factors are a great start. A study monitoring subjects based on their level of physical activity through mid- and late life showed that moderate exercise at any frequency was associated with a lower level of physical activity through mid- and late life showed that moderate exercise at any frequency was associated with decreased incidence of mild cognitive impairment. Unfortunately, careers in medicine do not make prioritization of daily exercise easy, but we hope this association will motivate us.

A Mediterranean diet supplemented with olive oil or nuts has been shown to prevent acute myocardial infarction, stroke or death from cardiovascular events. Recent analyses from the same study has shown improved cognition. Guidelines of 2016 suggest a mix of vegetables, whole fruits, whole grains, fat-free dairy, a variety of protein, including nuts and unspecified oils. These evidence-based recommendations targeting modifiable risk factors to protect the aging brain from cognitive impairment and the development of AD are not going to protect us all, as the non-modifiable risk factors can overcome even the healthiest among us. Given the high stakes, taking these protective steps seems worthwhile. Employers often recommend their employees consider diet and exercise as a part of maintaining a healthy, stress-reduced work force. Adding preserved cognition in aging to that list may help motivate additional healthcare providers.

In summary, there are cognitive changes associated with normal aging that are not expected to affect one’s ability to practice medicine. There are learning strategies one can adopt to improve brain function during aging, and most physicians are likely to want to adopt them. Importantly, data confirm that lifestyle modification is associated with decreased incidence of developing mild cognitive impairment and subsequent AD, a diagnosis that would require retirement and end-of-life planning similar to a late stage malignancy.

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INTRODUCTION

Competency, knowledge, and experience are fundamental to quality care in the practice of medicine. Although aging physicians may show increased signs of poor competency, the medical community recognizes the high variability of the effect of age on physicians. Despite the complex correlation between aging and cognitive changes, the potential for danger to patient safety pushes the demand for improved methods of identifying declining competency in physicians. There is currently no law regulating competency assessment of the aging physician community. A host of legal considerations relevant to tangential issues exist, but there is no doctrine, no protocol, and no treatise specific to aging physicians and their ability to provide quality medical care. This article will explore the issues of age-based competency assessment (i.e. screening) in three contexts – physician as employee, physician as licensee of a state medical authority – where issues of physician competency are most likely to arise.

EMPLOYMENT CONTEXT

When a physician serves as an employee in a health facility, questions concerning his competency due to advanced age will be examined through two prisms of established employment law: age discrimination and disability discrimination.

The federal Age Discrimination and Employment Act (ADEA) and corresponding law in all fifty states prohibit the arbitrary use of age in decisions that impact the employment status of individuals. The ADEA, when passed by Congress and later amended, carves out a bona-fide qualifications exemption so certain occupations deemed to be of such importance to public safety may mandate a reasonably necessary retirement age. For example, pilots are required to retire at age 65; air traffic controllers at age 56; federal law enforcement and firefighters at age 57; and nuclear material carriers at age 57. Congress has never felt compelled to apply a mandatory retirement age to physicians.

Initially, as various industries outside of those covered by the federal mandate were sued under the ADEA (and similar state statutes) for implementing age-based hiring and retirement policies thought to be discriminatory, courts deferred to arguments that individualized testing and monitoring were inadequate to protect against catastrophe. The courts’ test for examining the imposed retirement age was: Does the industry have a rational basis for holding that an age cut-off was an appropriate substitute for case-by-case testing? The answer typically was “yes”.

More recently, however, courts began scrutinizing actual job functions to determine if across-the-board age restrictions were superior to individualized testing. This has led to a trend in which courts have based their holdings against age-triggered hiring and retirement policies on the fact that individual testing and monitoring were available and reliable – and that such individualized testing better protects the employee from discriminatory practice.

We have yet to see a case in which a court analyzed a mandatory retirement age policy of a health care employer on the basis of employment discrimination. If we did, the court would likely reject arguments that the general protection of public health demands implementation of a pre-determined retirement age for physicians. Rather, courts are more likely to support the use of screening mechanisms, for which age may be one of several factors, that rely on testing and monitoring and take into account the particular conditions of the physician whose competency is in question.

The second prism through which to analyze age-based competency in the employment context is disability discrimination. The federal Rehabilitation Act of 1973 and Americans with Disability Act (ADA), and state disability discrimination laws, prohibit adverse employment activities based on an individual’s disability. Under the ADA, an employer may inquire about health conditions and require a medical examination only when they are “job related and consistent with business necessity.” The employer must have a reasonable belief based on objective evidence that the employee’s ability to perform essential job functions will be impaired by a medical condition, or that the employee will pose a direct threat to others as a result of that medical condition. Determining whether an employee poses a direct threat must be based on an individualized assessment of the employee’s present ability to safely perform the essential functions of his/her job.

Age itself is not a disability under the ADA. Rather, an individual is deemed to have a disability if he/she (i) has a physical or mental impairment that substantially limits one or more major life activities, (ii) has a record of such impairment, or (iii) is perceived by others of having such impairment. Given the breadth of the definition it is difficult to conceive of a situation in which a health care employer’s
initiation of an age-based competency assessment will not implicate the physical or mental impairment of the physician employee or, at a minimum, evidence that the employer perceives its physician employee suffers from such impairment. In turn, if the employer is subject to the ADA, then any request for a screening of the physician will have to meet the standards stated above (i.e., reasonable belief that essential job functions are impaired or poses direct threat to others). The employer will then be required to obtain an individual medical examination of the physician. In sum, one should not look to the disability laws for support of generally applied age-triggered screening. To the contrary, disability jurisprudence stands for the idea of case specific, individualized assessment.

MEDICAL STAFF CONTEXT

Many physicians associate with health care enterprises not through an employment relationship, but as an independent member of a facility’s medical staff – most commonly exemplified by a community physician’s credentialed position at his/her local hospital. As such, these medical staff physicians generally do not enjoy the protection of the age and disability discrimination laws discussed in the prior section because those laws apply in almost all cases only to the employment relationship. Hence, a health care institution has significant latitude to develop policies and rules that govern its relationship with its independent (i.e., non-employed) medical staff members – including the implementation of age-based competency screening. There have been cases in which physicians have argued that the controls and oversight inherent in the medical staff relationship are significant enough to create an employment relationship between hospital and physician. If successful, those arguments could cause the wholesale application of the age and disability discrimination statutes to facility medical staffs. As courts are extremely reticent to qualify medical staff members as anything other than independent contractors, the application of the discrimination laws to medical staff members is highly unlikely.

As noted, disability discrimination laws generally apply only in the employment context. However, there is one federal circuit that has held medical staff privileges to be protected from disability discrimination under Title III of the ADA. In that case, a doctor’s suspension from the medical staff was deemed to be a denial of privileges of a physical “place of public accommodation,” bringing the matter under Title III. In this particular case, the physician’s alleged disability was Attention Deficit Disorder. If this federal circuit court had been asked (or is asked in the future) to review a physician’s medical staff suspension due to a neurological impairment [perhaps resulting from advanced age], the court may very well find that the physician’s privileges are subject to the ADA and that the physician’s employer is subject to the full set of ADA standards for requesting of the physician any type of medical assessment. Barring the limited exception of possible ADA Title III application, the use of age-based screening in the review of a physician’s clinical privileges by a health care facility medical staff is generally permitted.

STATE LICENSURE CONTEXT

As the primary bodies charged with licensing and disciplining physicians, state medical licensing boards maintain the ultimate responsibility for ensuring that their physician licensees provide competent services to the public. The courts, all the way up to the U.S. Supreme Court, have repeatedly recognized the authority of state licensing bodies to regulate the practice of medicine as a means to protect the public health. In the 1889 case, Dent v. West Virginia, the Supreme Court stated:

“Few professions require more careful preparation by one who seeks to enter it than that of medicine. Reliance must be placed upon the assurance given by his license, issued by an authority competent to judge in that respect, that he possesses the requisite qualifications. Due consideration, therefore, for the protection of society may well induce the state to exclude from practice those who have no such a license, or who are found upon examination not to be fully qualified.”

In the case of age-based competency screening, if a state licensing board determined that such screening was a necessary tool to protect the public health (and ensured due process protections to those individuals’ subject to screening), courts would likely reject any challenge thereto. State licensing bodies, already established with the infrastructure to review questions of professional competency and to respond to the particular conditions of their licensees by way of practice restrictions, mandated supplementary education and oversight requirements, are undoubtedly in the best position to undertake age-based screening.

PROTECTION OF SCREENING RESULT

Age-based screening tests will by necessity involve medical information in assessing the competency of a physician’s skills. Understandably, professionals may respond with concerns regarding the confidentiality of the testing results. If the screening is conducted in the employment context, the Health Insurance Portability and Accountability Act (HIPAA) will not afford protection to medical information obtained during the test because HIPAA does not protect employment records. The confidentiality of these records will be subject to employer policy and state employee-protection law. In the medical staff context, test results from screening pursuant to a competency protocol may be deemed a product of peer review activity and protected accordingly. Most state peer review statutes protect the confidentiality and admissibility of peer review documentation. The challenge here is that the scope of peer review activities, and thus the scope of the protection, varies significantly state to state. Finally, if the screening were to take place under
the authority of a state licensing board, the results would be subject to the treatment provided them by the laws and regulations governing the activities of the board. Many states mandate the confidentiality of their investigations into professional competency, and while the final results or findings of a licensing board review are made public, the work product (including screening results) typically is not.

CONCLUSION
As the medical and legal communities develop their responses to the practical aspects of age-based competency screening, the legal framework around the issues of the aging physician will come into focus. We saw under the first section above that the general practice of age-based screening is anathema to the protections afforded employees under established employment discrimination laws. Facility medical staffs provide much greater latitude for implementing screening protocol. The result, however, of having individual health facilities develop age-based competency reviews is likely to be diverse and inconsistent screening programs applied only to limited subgroups of physicians (i.e., those who are members of a medical staff). Resting the screening process on public health concerns and requiring all physicians licensed to practice within a state removes extrinsic biases that may occur at the level of an employer or medical staff age-based screening test. Implementing an age-based screening test as a part of the licensing process at the state licensing board level also would best adhere to the courts’ emphasis on the state’s expansive authority in protecting the general welfare of its citizens.

Acknowledgment
With contributions from Wingman Cheung, wcheung@dbslawfirm.com.

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Moving Forward: Retirement Opportunities for Senior Physicians

DONNA SINGER, MS

As national and local medical organizations explore how to assess senior physicians and their competence and skill, it is important for physicians to understand that retirement can be an exciting, interesting, and significant life stage in and of itself. Many opportunities may exist – both within and outside of health care – to allow these physicians who no longer practice, to continue to live meaningful and satisfying lives. Toward that end, it may be helpful for hospitals and other health care organizations to provide lectures, seminars, and small group discussions related to retirement in order to reduce the fear that professional life may definitely be over once one leaves clinical practice.

Also while still practicing clinical medicine, some physicians may want to develop a plan as to what they will do next. Others may want to retire first and perhaps have a period of rest and relaxation for a few months before thinking about or planning how to spend the rest of their time/lives.

Each physician needs to retire in the way that works best for him or her. Yet, if observations and/or assessments indicate that one must leave clinical practice before realizing this on his or her own, the situation may be daunting.

When most people think about retirement, specific words or concepts immediately come to mind such as:

• Extended down time
• Boredom
• Lonely time
• Financial considerations
• Relaxation and fun
• Writing
• Traveling
• More family time

It is clear from the above, that there is no one attitude about retirement. Moreover, there is no one model of retirement. Jawaharlal Nehru said, “We live in a wonderful world that is full of beauty, charm, and adventure. There is no end to the adventures we can have if only we seek them with our eyes open.” These adventures for a retiring physician may involve travel or may be right at home.

In today’s world, retirement may turn out to be twenty or more years. Therefore, living with meaning, passion, and purpose will be important for well-being and longevity.

The following activities may be helpful for physicians, as they plan for the future:

Activity 1 – My Current Reality
(While still in clinical practice)
Using percentages [%], how much of my time do I currently spend in each of the following areas? [Total should add up to 100%].

• Paid work
• Leisure activities
• Family
• Friends
• Health/Self-care
• Personal growth
• Spirituality
• Financial matters
• Living environment
• Voluntary activities
• Other: ......................................................

Activity 2 – Envisioning the future
(When I am retired)
Using percentages [%] when I retire, how much of my time would I like to spend in each of these areas? [Total should add up to 100%].

• Paid work
• Leisure activities
• Family
• Friends
• Health/Self-care
• Personal growth
• Spirituality
• Financial matters
• Living environment
• Voluntary activities
• Other: ......................................................
Moving Forward: Retirement Opportunities

Many physicians have found one or more of the following options satisfying, rewarding, and/or stimulating after leaving a long career in clinical practice:

**Within health care:** Teaching medical students as a volunteer, teaching abroad, volunteering in a clinic locally, volunteering in a clinic in another country, committee work in a medical society, committee work in your hospital or organization, writing about issues or concerns in health care, lecturing, consulting, expert witness, working in a pharmaceutical company, tutoring individual medical students.

**Outside of health care:** Following an interest or passion – previous or new! Performing in a musical group (voice or instrument), learning to play an instrument, joining a chorus or choir, studying music history, taking art lessons, visiting museums, studying art history, writing articles, writing a blog, writing a novel, writing a memoir or family history, studying genealogy, travel in the United States, travel abroad, visiting specific local historical sites, travel for pure adventure, travel for learning, beginning an exercise program, learning and engaging in a new or different sport, combining travel with exercise (walking trips or bicycle trips), participating in a marathon, visiting family, family travels and vacations, caring for grandchildren, organizing family reunions, learning to cook, going to a cooking school, taking cooking classes, learning about healthy eating.

Any one of the above activities either in health care, related to health care, or completely separate from health care, could be developed into what is known as an encore career. This next career might be strictly as a volunteer, or could be a paid engagement.

Physicians may be surprised to realize how many different opportunities there are for meaningful engagement after clinical practice. Not all of the above activities are sufficient to totally satisfy one’s emotional, social, or learning desires; more than one can be engaged in at the same time. However, it’s important not to become so busy that work-life balance once again becomes a challenge.

**A Role for Hospitals and Health Care Organizations**

Hospitals and other health care organizations can play a major role in helping all senior physicians look forward to retirement regardless of their age, ability and acumen. Physicians who are suddenly advised not to practice clinically any longer or are actually told they may not practice any longer can find themselves despondent and worried. Realistic yet positive presentations by hospitals or health care organizations about this next life stage – with guest speakers, seminars, and discussion groups – can be quite helpful. Even former clinical “stars” returning to tell about their experiences since retiring can be reassuring to those who fear the loss of identity after so many years as a clinician.

The message is clear: there is meaning in life after full-time clinical practice. Those individuals who enter this life phase with a positive attitude, in spite of a variety of challenges – perhaps physical and/or cognitive challenges – will find meaning and feel energized and productive. Knowing the many possibilities available to senior physicians after clinical practice will hopefully help with this transition.
Interesting Books Related to Retirement

The Encore Career Handbook, How to Make a Living and a Difference in the Second Half of Life
Marci Alboher

80 Things to Do When You Turn 80
Mark Evan Chimsky, Editor

Live Smart after 50!
The Experts’ Guide to Life Planning for Uncertain Times
Life Planning Network Editorial Board

Legacies of the Heart, Living a Life That Matters
Meg Newhouse, PhD

Time-shifting, Creating More Time to Enjoy Your Life
Stephan Rechtschaffen, MD

70 Things to Do When You Turn 70
Ronnie Sellers, Editor

The Couple’s Retirement Puzzle, 10 Must-Have Conversations for Creating an Amazing New Life Together
Roberta K. Taylor, RNCS, MEd; Dorian Mintzer, MSW, PhD

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Respiratory viral testing in laboratories serving acute care hospitals in Rhode Island

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ABSTRACT

BACKGROUND: The rapid detection of respiratory viral infections is associated with several positive health outcomes. However, little is known about the availability of rapid respiratory viral testing in acute care hospital laboratories.

METHODS: A survey was sent to 13 hospital laboratories assessing results’ turnaround time, the number of ordered tests and positive results.

RESULTS: Rapid viral panel (RVP), respiratory syncytial virus (RSV), and rapid influenza testing was available in 9 of 13, 13 of 13, and 13 of 13 hospitals, respectively. Results were available within 24 hours of specimen collection in 1 of 9 hospitals for RVP; RSV and rapid influenza results were available within 12 hours in 8 of 13 and 13 of 13 hospitals, respectively.

CONCLUSIONS: Rapid diagnosis of respiratory viral infections in RI acute care hospitals can be made for influenza and RSV. However, rapid results for other respiratory viruses are unavailable in most of RI hospitals.

KEYWORDS: viral testing, Rhode Island, respiratory viral infection

BACKGROUND

Respiratory viral infections are the most common infections in humans.1 Though they affect all ages, those at highest risk for morbidity and mortality are children, older adults and individuals with chronic medical conditions.2 Globally, the burden of respiratory infections exceeds that of any other disease etiology and is responsible for 18% of deaths in children under five years of age.3 In the United States, influenza-associated deaths are estimated to have been 12,000 in 2011-2012 and 56,000 in 2012-2013.4 Based on a recent study of nosocomial respiratory viral infections in a Rhode Island teaching hospital, the authors estimated that there are approximately 15,834 adult and 3,121 pediatric nosocomial respiratory viral infections nationally each year.5

Studies have demonstrated improved outcomes and cost benefits of rapid viral testing.6-8 For example, reduced duration of antibiotic therapy and length of stay have been documented after implementing rapid detection of respiratory viruses.7 Such testing has been associated with decreased mortality and improved antibiotic stewardship.6 Despite these findings, to our knowledge, only one study assessed availability of rapid respiratory viral testing in acute care hospitals.8 As such, the present study’s objective was to survey hospital laboratories in Rhode Island to describe the availability of respiratory viral testing, timeliness of results, and the proportion of tests that had positive results.

METHODS

The Rhode Island Department of Health, the Rhode Island State Laboratory, Healthcentric Advisors (the Centers for Medicare & Medicaid Services’ Medicare Quality Innovation Network-Quality Improvement Organization for New England), and one of the authors (LM) developed a brief survey sent to laboratory directors of 13 hospital-affiliated laboratories (all 11 non-federal acute care hospitals in Rhode Island, the Providence VA Medical Center and Eleanor Slater Hospital [state-run facility]) to assess respiratory viral testing during the calendar year 2016. The electronic survey was emailed to lab directors by one of the authors (CV), Director of the Rhode Island State Laboratory.

RESULTS

RVP, RSV, and rapid influenza testing was offered in 9 of 13, 13 of 13, and 13 of 13 hospitals, respectively (Table 1). Results were available within 24 hours of specimen collection in 1 of 9 hospitals for RVP testing; RSV and rapid influenza test results were available within 12 hours in 8 of 13 and 13 of

### Table 1. Rapid respiratory virus testing in Rhode Island acute care hospitals

<table>
<thead>
<tr>
<th>Respiratory Virus Test; Turnaround Time*</th>
<th>Off-site Processing N</th>
<th>On-site Processing N</th>
</tr>
</thead>
<tbody>
<tr>
<td>RVP</td>
<td>(N = 7)</td>
<td>(N = 2)</td>
</tr>
<tr>
<td>&lt;24 hours</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>&gt;24 hours</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>RSV</td>
<td>(N = 5)</td>
<td>(N = 7)</td>
</tr>
<tr>
<td>&lt;12 hours</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>&gt;12 hours</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Greater than 24</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Rapid Influenza</td>
<td>(N = 0)</td>
<td>(N = 13)</td>
</tr>
<tr>
<td>&lt;12 hours</td>
<td>–</td>
<td>13</td>
</tr>
<tr>
<td>&gt;12 hours</td>
<td>–</td>
<td>0</td>
</tr>
</tbody>
</table>

* Time from specimen collection to availability of results
13 hospitals, respectively. Test processing was off-site in 8 of the 9 hospitals with RVP test result availability beyond 24 hours. Test processing was off-site in all 5 hospitals with RSV test result availability beyond 24 hours. Test processing was off-site in all 5 hospitals with RSV test result availability beyond 12 hours.

Among the 13 hospitals, 6803, 521, and 15224 RVP, RSV and rapid influenza tests were ordered in 2016. In the one hospital able to provide the number of positive RVP test results, 52 of 206 (25%) were positive. In the one hospital able to provide the number of positive RSV test results, 12 of 35 (34%) were positive. Of the 8 hospitals able to provide rapid influenza test results, 1095 of 6110 (18%) were positive.

**DISCUSSION**

Clinicians in 9 of 13 Rhode Island acute care hospitals have access to RVP testing, but the availability of test results were delayed beyond 24 hours in all but 1 hospital. Clinicians at all 13 hospitals have access to RSV and rapid influenza testing. The time from specimen procurement to availability of results depends on a large part as to whether or not specimen processing is done by an individual hospital’s laboratory (i.e., on-site) or carried out at an affiliate hospital laboratory (i.e., off-site). This was particularly problematic regarding RVP testing. Not unexpectedly, 68% of the all respiratory viral testing done in our acute care hospitals involved a rapid influenza test.

The fact that most clinicians in our state treating patients that present with symptoms of a respiratory viral tract infection do not have access to rapid turnaround testing for respiratory viruses other than influenza and RSV, raises concerns regarding antibiotic stewardship and placing hospitalized patients with suspected respiratory viral infections in the same hospital room. It is possible that availability of test results for multiple respiratory viruses with a short turnaround time would assist in decision-making by the patient’s medical team regarding whether or not antimicrobial therapy should be initiated, or discontinued if such medications have already been implemented unless there is a suggestion of a bacterial superinfection. Though still clinically useful, if such test results are not available in a timely manner, there may be a greater risk of transmission to other patients or staff if isolation precautions are not implemented pending such results. Expedient diagnosis of a patient’s respiratory viral infection may alleviate some angst among patients concerned about a bacterial infection. Moreover, such testing enables clinicians to confirm a viral infection, and in doing so, justify withholding antimicrobial therapy.

Due to the nature of survey instrument, responses were self-reported with potential for reporting bias. Although our survey involved all acute care hospitals in Rhode Island, the small number of hospitals may limit generalizability to other states.

**References**


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We thank the laboratory directors and managers who kindly took the time to respond to our survey.

**Disclaimer**

The views expressed herein are those of the authors and do not necessarily reflect the views of the Brown University School of Public Health, Warren Alpert Medical School, Rhode Island Hospital, or Healthcentric Advisors.

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A rare case of amelanotic anorectal melanoma

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ABSTRACT
We report an exceedingly rare case of amelanotic anorectal melanoma misdiagnosed as hemorrhoids. A 74-year-old man presented with a week’s history of “blood on toilet tissue” without bowel complaints or history of cutaneous melanoma. Skin evaluation was normal. Rectal exam was negative for blood, but revealed an anal nodule, interpreted as a hemorrhoid. Hemoglobin was normal; bleeding persisted. After one month, colonoscopy detected a non-pigmented anal lesion. Biopsy showed melanoma.

Noncutaneous mucosal melanoma represents 0.03% of new cancer diagnoses. Anorectal melanoma accounts for 1% of melanomas and 0.4% of anal malignancies. Uncommonly, this malignancy lacks melanin pigment, complicating detection. Presenting complaints are non-specific rectal bleeding, pain, itching or incontinence, mimicking more common disorders.

Dangerous misdiagnosis occurs when benign disease, not malignancy, is suspected. Risk factors for cutaneous melanoma are less frequent. Mucosal melanoma has different genetics. Clinicians must be aware of diagnostic difficulties of anorectal melanoma, especially when amelanotic.

KEYWORDS: anorectal melanoma, GI bleeding, mucosal melanoma

INTRODUCTION
Noncutaneous mucosal melanoma, including ocular, anorectal, vaginal and nasal sites, is rare, representing 0.03% of all new cancer diagnoses based on data from the National Cancer Data Base Report on Cutaneous and Noncutaneous Melanoma. Anorectal melanoma accounts for as few as 1% of melanomas and 0.4% of anal malignancies. Uncommonly, this malignancy lacks melanin pigment, complicating detection. This tumor manifests as non-specific symptoms, including small amounts of rectal bleeding, pain, itching or incontinence, mimicking more common disorders with potential catastrophic delayed diagnosis. We describe an exceedingly rare case of amelanotic anorectal melanoma initially misdiagnosed as hemorrhoids.

CASE REPORT
A 74-year-old man presented with a one-week history of “flecks of blood on the toilet tissue” after defecation without bowel complaints, history of cutaneous melanoma or current skin complaints. Physical examination including vital signs, skin and abdominal exams, was normal. However, on rectal exam, a firm nodule was detected just inside the anal verge and interpreted as an internal hemorrhoid. [Figure 1] Rectal exam at presentation was negative for occult blood. Hemoglobin was normal, but bleeding persisted. After one month, colonoscopy was performed. A 2 cm, non-pigmented, anal lesion was biopsied, revealing melanoma on immunohistochemistry.

DISCUSSION
This rare malignancy arises from melanocytes, most commonly found in the skin, but also in ocular or mucosal sites. Mucosal and cutaneous melanomas are distinct diseases with discrete genetic features. Mucosal melanoma is characterized by a distinct pattern of chromosomal aberrations. Any mucosal site may be affected, but most arise from the vulvovaginal and head and neck mucosa; the anorectum is the 3rd most common site for mucosal melanoma, occurring nearly equally in the anal canal, rectum, or anorectum. Mucosal melanoma has been documented rarely in the mucosa of other tissues including the male urethra, gallbladder, esophagus and large and small bowel. Often discovered at an advanced stage, it is usually found in older patients with chronic disease; half present at age 70 or older. The 5-year survival rate is as low as 6%.

Risk factors for cutaneous melanoma, including light skin, exposure to ultraviolet radiation, family history of melanoma,
are not as well documented for mucosal anorectal melanoma. Cutaneous melanoma is 5 to 20 times more frequent in Caucasians whereas anorectal melanoma is only twice as common in Caucasians. In the United States, fewer than 3% of skin melanomas occur in African Americans and dark-skinned Latinos; however, these groups represent as many as 9% of individuals diagnosed with mucosal melanoma.

Additionally, recent data support an association of anorectal melanoma with HIV in men who have sex with men. A recent study reported a family history of cutaneous melanoma in 5% of individuals diagnosed with mucosal melanoma.

Anorectal melanoma is commonly asymptomatic until a late stage or manifests as non-specific, sometimes vague symptoms. The most common clinical presentation, as in our patient, is rectal bleeding. Other initial complaints may be rectal pain, sensation of rectal fullness or a mass, constipation or diarrhea, tenesmus, anal pruritis, or vague, non-specific complaints ignored by both patient and physician. Incontinence and iron deficiency are rare, but reported. Fatigue and weight loss may be reported by individuals with widespread metastatic disease.

Dangerous misdiagnosis and delayed treatment occur when benign diseases, including hemorrhoids, skin tags or small, benign polyps, are suspected rather than malignant melanoma or another malignancy. Other factors delaying diagnosis include: (1) Rarity of anorectal melanoma which is not associated with prior or contemporaneous skin malignancy so that diagnostic suspicion is low; (2) Amelanotic lesions, as in our patient, occur infrequently, although exact data does not exist; (3) Although indicated at clinical presentation, careful anorectal digital exam and anoscopy are commonly not performed; (4) Frequent atypical macroscopic appearance ranging from a firm polypoid lesion to hemorrhoid-like, pigmented or amelanotic ulceration. Misdiagnosis of anal melanoma as more common malignancies, such as carcinoma, lymphoma, or angiosarcoma, would be evaluated urgently, revealing the unsuspected anorectal melanoma in a timely manner.

Zhang et al. reported misdiagnosis at presentation in more than half of their patients, 46 of 79 (58%). In this study, the maximal diameter of tumor in the misdiagnosed group was longer than in the not-misdiagnosed group. Distant metastasis at diagnosis in the delayed diagnosis group was more common than in the not-delayed group. Of incorrect diagnoses, half were misdiagnosed as carcinoma, half as benign lesions. The danger is that benign anorectal diseases do not generally require urgent evaluation and are prone to being neglected by both patient and doctor. Pessaux and colleagues reported a mean delay in diagnosis of 6 months in this context.

Our discussion has a specific limitation. Anorectal melanoma is an extremely rare sub-type of melanoma. The majority of reports in the medical literature describe a single case report or a very small case series. Thus, some rates and percentages may be imprecise due to small sample size studies or different methodology and varied nomenclature defining tumor localization in the few large sample size database publications.

CONCLUSION

Although rare, clinicians must be aware of the diverse clinical spectrum and diagnostic difficulties associated with anorectal melanoma, especially when amelanotic. This tumor can mimic refractory hemorrhoids or other benign perianal disorders. Primary mucosal anorectal melanoma should be considered in selected patients when an anal or anorectal mass is discovered. Bowel or rectal complaints of any type in adults with a current or past history of melanoma should prompt evaluation of possible metastatic disease. Despite its rarity, anorectal melanoma should be considered when unusual or unclear anorectal lesions are detected.

References


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Multimodality imaging in the diagnosis of a large accessory papillary muscle

AMR EL MELIGY, MD; SOMWAIL RASLA, MD; AARON WHEELER, MD; ROY SOUAI, MD; THOMAS NOONAN, MD, FACCRHODE ISLAND MEDICAL JOURNAL | SEPTEMBER 2017

ABSTRACT
An accessory papillary muscle is an uncommon congenital anomaly usually found incidentally on routine cardiac imaging. While frequently asymptomatic, it is occasionally associated with mitral regurgitation, left ventricular dynamic outflow obstruction and hypertrophic cardiomyopathy and it is important to differentiate it from other pathological processes including papillary fibroelastoma, left ventricle thrombus, hemangioma, a single papillary muscle with a parachute mitral valve and a left ventricle false tendon.

The clinical implication of these findings varies according to the degree of left ventricular outflow obstruction, location and pathology. We report a case that underscores the importance of multimodality imaging in the diagnosis and differentiation of an accessory papillary muscle from other intracardiac masses.

KEYWORDS: Accessory papillary muscle, cardiac mass, imaging

CASE REPORT
A 66-year-old woman with a history of diabetes mellitus, hypertension and obesity was referred to the cardiology outpatient clinic by her primary care physician following an abnormal stress test. She was incidentally found to have an abnormal electrocardiogram, prompting an exercise tolerance test (ETT) where she exercised for six minutes and reached 88% of the maximum predicted heart rate with borderline ST depressions in the inferolateral leads. She denied any history of coronary artery disease or stroke. She exercises twice weekly. Medication regimen included: simvastatin, lisinopril, and metformin. At the time of her outpatient visit blood pressure was 120/60mmHg, pulse of 80, body mass index of 30.20 kg/m², and oxygen saturation of 98% on room air. She had unremarkable physical exam, including cardiac exam. An electrocardiogram revealed sinus rhythm with a non-specific intraventricular conduction delay, and laboratory tests showed normal complete blood count, basic metabolic panel, thyroid stimulating hormone and liver function. Due to the abnormal ETT, she had a transthoracic echocardiogram (TTE) ordered which showed normal left ventricular size and systolic function with no regional wall motion abnormalities. An echodense mass was found with independent mobility in the mid to upper septum measuring 1.5 x 1.1 cm without significant left ventricular outflow tract (LVOT) gradient, concerning for fibroelastoma. The decision was made to proceed with a cardiovascular magnetic resonance (CMR) and transesophageal echocardiogram (TEE) for further evaluation of the underlying mass.

A CMR with gadavist gadolinium-based contrast showed an indeterminate 1.5 x 1.2cm left ventricular mass with elongated morphology which demonstrated similar signal characteristics to the adjacent papillary muscles; however, the motion was different on cine images requiring a TEE for better differentiation and to exclude fibroelastoma. (Figure 1). The TEE demonstrated a contractile echodense mass attached to the interventricular septum on the left ventricular side with no LVOT gradient crossing the left ventricular chamber, unlikely to be a fibroelastoma and likely representing a large accessory papillary muscle (Figure 2).

The patient then underwent a nuclear stress test, showing normal myocardial wall thickening with a left ventricular ejection fraction of 60% and no signs of underlying ischemia.

INTRODUCTION
Papillary muscles (PMS) vary in number, shape, thickness and location, with three PMS located in the right ventricle and two located in the left. Variations in PM distribution are related to incomplete delamination of trabecular ridge in the ventricles and are classified on the numbers of heads (I-III) and type of insertion (A-C). Usually an incidental discovery on echocardiogram imaging, it may occasionally be associated with mitral regurgitation or obstruction of the left ventricular outflow tract. An increase in number or mass of papillary muscles may be seen in patients with hypertrophic cardiomyopathy (HCM) and is considered a variant of HCM. Recognition of this congenital anomaly is fundamental in distinguishing it from other intracardiac pathologies like papillary fibroelastoma, left ventricular thrombus, a single papillary muscle with a parachute mitral valve and a left ventricle false tendon that may warrant a different treatment approach. Here, we present a clinical scenario whereby we diagnose a large accessory papillary muscle using its characteristic radiographic findings in accordance with various imaging modalities.
Figure 1. A cardiovascular magnetic resonance with Gadavist Gadolinium-based contrast images
A. Cine steady-state free precession (SSFP) sequence, 3 chamber views showing an accessory papillary muscle (APM) in systole
B. Cine SSFP sequence, short axis view showing an APM during systole.

DISCUSSION
An accessory papillary muscle is an uncommon congenital anomaly, usually found incidentally in asymptomatic patients. However, it can cause mitral valve regurgitation and left ventricular outflow tract obstruction. It is often misinterpreted for a papillary fibroelastoma, left ventricular thrombus, hemangioma, left ventricular false tendon or a single papillary muscle with parachute mitral valve (PMV). A single papillary muscle with PMV is a rare congenital anomaly of the mitral valve apparatus where the chordae tendinea converge to the centrally placed single papillary muscle instead. It is usually associated with aortic stenosis (32%), atrial septal defect (54%) and hypoplastic heart (19%) and when isolated accounts for less than 1% of PMV.6

However, left ventricular false tendons are cords that do not attach to the leaflets of the atrioventricular valves and instead connects papillary muscles to each other or to the ventricular wall, interventricular septum, or merely pass between two points on the wall itself. It has been suggested that they might be implicated as a source of idiopathic left ventricular tachycardia.6 In contrast, a papillary fibroelastoma is usually a small (usually <9 mm), well delineated, pedunculated, non-contractile mass with a characteristic shimmer or vibration at the tumor-blood interface on TEE, ascribed to the finger-like projections of the tumor.7 On CMR, it appears as a hypointense or intermediate signal in T1-weighted sequences, intermediate signal in T2-weighted sequences and hypointense in the cine-MR steady-state free precession (SSFP) sequences and is not usually enhanced after the administration of contrast.8 While an accessory papillary muscle will obviously have signal characteristics identical to a normal papillary muscle on CMR, a left ventricle thrombus may include an accompanying regional wall motion abnormality, especially with an apically located thrombus, along with a distinct thrombus margin with jagged edges and movement separate from the underlying endocardium with a higher echodensity reading compared to the myocardium itself.9

In this case, an accessory papillary muscle resembled a large fibroelastoma on transthoracic imaging given its independent motion from the other papillary muscles. However, it demonstrated similar characteristic signals to the papillary muscles on cine images of CMR and on TEE. The mass appeared as an echodense mass attached to the interventricular septum with similar morphology to the papillary muscle and without signs of left ventricular obstruction.1

While echocardiogram is usually the initial imaging modality, cross sectional imaging with CT or CMR can provide a detailed anatomical picture and is also helpful in the assessment of associated anomalies.1 A CMR is useful in the evaluation of any physiological consequences of these abnormalities, especially in the context of emerging studies suggesting a hypertrophic cardiomyopathy variant for those who have isolated papillary muscle hypertrophy.10
**CONCLUSION**

This case illustrates the role of multimodality imaging in the diagnosis of different intracardiac masses and providing insight into future management. There is very scarce data in the literature about long term outcomes in patients with asymptomatic variants of these abnormalities, and future studies are needed to better prognosticate and determine the best course of treatment for these underlying medical conditions.¹¹

**References**


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**Figure 2. Transesophageal Echocardiogram images.**

**A.** Mid-esophageal long axis view (ME-LAX) showing an accessory papillary muscle (APM) in systole.

**B.** ME-LAX view showing an APM during diastole.

**C.** ME-two chamber view showing an APM during systole.

**D.** ME -two chamber view showing an APM during diastole.


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Suicide deaths among Rhode Island adults aged 25 years and older: An epidemiologic and spatial analysis

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In 2014, suicide deaths in the United States reached their highest levels in nearly 30 years, capturing much media attention. The age-adjusted adult suicide rate increased 24%, from 10.5 per 100,000 people in 1999 to 13.0 per 100,000 people in 2014.1 The increase was greatest between 2006 and 2014 (about 2% per year),1 and particularly pronounced middle-aged non-Hispanic whites without a college degree.2-4 Between 1999 and 2014, the suicide rate for men aged 45 to 64 increased by 43% from 20.8 to 29.7.1 Suicide rates for females were highest for those aged 45–64 increasing by 63% from 1999 to 2014 (1999: 6.0 per 100,000; 2014: 9.8 per 100,000 people).1

The severe economic recession in the U.S. from 2007 to 2009, that continued well into 2014 in states like Rhode Island,5 may have contributed to the growth in suicide deaths due to high unemployment rates.2-4 Other contributing factors included untreated depression, and the rise in opioid and alcohol abuse. Researchers Anne Case and Angus Deaton have called the rise in suicide rates “deaths of despair” among less educated non-Hispanic white Americans.2-3 Suicide remains one of the 10 leading causes of death for US adults. By contrast, advances in early detection and treatment for heart disease, cancer, and stroke have substantially reduced deaths from these diseases.6 In this article, we describe the characteristics and spatial patterning of suicide deaths among Rhode Island adults aged 25 and older.

METHODS
Information on suicide deaths were obtained from the 2004 to 2014 Rhode Island Violent Death Reporting System (RIVDRS) using data abstractor-assigned manners of death. RIVDRS collects data from death certificates, medical examiner records, and law enforcement reports. Descriptive statistical analyses were conducted using SAS version 9.4 (SAS Institute, Inc. Cary, NY). Geographic Information System (GIS) mapping was performed using ArcGIS Desktop version 10.2 (Redlands, Environmental Systems Research Institute, CA) to identify spatial clusters of suicide deaths.

RESULTS
From 2004 through 2014, 1,065 Rhode Island adults aged 25 and older died of suicide. Adults who died by suicide were more likely to be 35–64 years old, male, and non-Hispanic white. Suburban regions had higher proportions of suicide deaths compared to other areas of the state. Most adult suicide deaths occurred at a house/apartment. Firearm, poisoning, hanging, strangulation, or suffocation were the most common methods of suicide (85.9%) (Table 1).

Toxicology data showed 33% of cases tested positive for alcohol, 28% for antidepressants, and 18% for opiates. In 566 (53%) cases, the decedent had a current mental health problem. About 77% of adults with a current mental health problem had a diagnosis of depression/dysthymia, with anxiety disorder (16%), and bipolar disorder (14%). Nearly 46% of adults who died by suicide were in mental health treatment. The most common precipitating events were intimate partner problems, a recent crisis, and physical health problems. Over one-third of adult suicide decedents left a suicide note (Table 2).

Four Rhode Island towns with the lowest average annual rates of suicide were Cumberland (6.9), Barrington (7.5), Johnston (9.0), and North Kingstown (9.9). Five towns with the highest suicide rates were Warren (20.9), Glocester (23.7), Richmond (23.8), Hopkinton (26.6), and New Shoreham (31.8) (Figure 1). The national rate is 13 deaths per 100,000 population.

DISCUSSION
We investigated the epidemiology of suicides at the city/town level as reported in the 2004–2014 Rhode Island Violent Death Reporting System (RIVDRS). On average, 97 Rhode Island adults commit suicide annually. Adults who committed suicide were more likely to be middle aged, male, white, living in suburban areas, and having mental health problems. They also were more likely to have intimate partner problems, have experienced a recent crisis, and left a suicide note. Our findings confirm previous research documenting midlife increases in suicides among white non-Hispanic men aged 45–54.2 Additional analyses found that veterans accounted for 18% of all suicide deaths among Rhode Island adults.

The spatial analysis of suicide deaths identified five high-risk suicide clusters. The clusters were located in semirural towns where 93.1 to 97.5% of the residents are non-Hispanic White.7 Whether these suicides were in response to the marked increase in unemployment and housing foreclosures spurred by the Great Recession of 2007–2009 is unknown.
Table 1. Characteristics of adult (25 years and older) suicide deaths, Rhode Island 2004–2014 (N=1,065)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age group</strong> (mean: 49.6 years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25-34 years</td>
<td>159</td>
<td>14.9</td>
</tr>
<tr>
<td>35-44 years</td>
<td>232</td>
<td>21.8</td>
</tr>
<tr>
<td>45-54 years</td>
<td>322</td>
<td>30.2</td>
</tr>
<tr>
<td>55-64 years</td>
<td>212</td>
<td>19.9</td>
</tr>
<tr>
<td>65 years and older</td>
<td>140</td>
<td>13.2</td>
</tr>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>818</td>
<td>76.8</td>
</tr>
<tr>
<td>Female</td>
<td>247</td>
<td>23.2</td>
</tr>
<tr>
<td><strong>Race/Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Hispanic White</td>
<td>970</td>
<td>91.8</td>
</tr>
<tr>
<td>Non-Hispanic Black</td>
<td>33</td>
<td>3.1</td>
</tr>
<tr>
<td>Hispanic</td>
<td>37</td>
<td>3.5</td>
</tr>
<tr>
<td>Other</td>
<td>17</td>
<td>1.6</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
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</tr>
<tr>
<td>Never Married/Single, not otherwise specified</td>
<td>373</td>
<td>35.2</td>
</tr>
<tr>
<td>Married/Civil Union/Domestic Partnership</td>
<td>370</td>
<td>34.9</td>
</tr>
<tr>
<td>Divorced/Married, but separated</td>
<td>253</td>
<td>23.9</td>
</tr>
<tr>
<td>Widowed</td>
<td>65</td>
<td>6.1</td>
</tr>
<tr>
<td><strong>City/Town of Residence</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban core cities¹</td>
<td>242</td>
<td>22.8</td>
</tr>
<tr>
<td>Suburban regions</td>
<td>545</td>
<td>51.4</td>
</tr>
<tr>
<td>Non-metro/rural areas</td>
<td>215</td>
<td>20.3</td>
</tr>
<tr>
<td>Out of state</td>
<td>58</td>
<td>5.5</td>
</tr>
<tr>
<td><strong>Injury Location</strong></td>
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<tr>
<td>House, apartment</td>
<td>762</td>
<td>72.9</td>
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<tr>
<td>Natural area (e.g., field, river, beaches, woods)</td>
<td>87</td>
<td>8.3</td>
</tr>
<tr>
<td>Motor vehicle (excluding school &amp; public buses)</td>
<td>32</td>
<td>3.1</td>
</tr>
<tr>
<td>Hotel/Motel</td>
<td>27</td>
<td>2.6</td>
</tr>
<tr>
<td>Parking lot/Public parking garage</td>
<td>22</td>
<td>2.1</td>
</tr>
<tr>
<td>Street, sidewalk, alley</td>
<td>19</td>
<td>1.8</td>
</tr>
<tr>
<td>Jail, prison, detention facility</td>
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<td>1.6</td>
</tr>
<tr>
<td>Park, playground, public use area</td>
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<td>1.1</td>
</tr>
<tr>
<td>Other</td>
<td>68</td>
<td>6.5</td>
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<tr>
<td><strong>Injured at Victim Home</strong></td>
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<td></td>
</tr>
<tr>
<td>Yes</td>
<td>725</td>
<td>69.3</td>
</tr>
<tr>
<td>No</td>
<td>321</td>
<td>30.7</td>
</tr>
<tr>
<td><strong>Weapon Type</strong></td>
<td></td>
<td></td>
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<tr>
<td>Firearm</td>
<td>264</td>
<td>24.8</td>
</tr>
<tr>
<td>Hanging, strangulation, suffocation</td>
<td>399</td>
<td>37.5</td>
</tr>
<tr>
<td>Poisoning</td>
<td>251</td>
<td>23.6</td>
</tr>
<tr>
<td>Fall</td>
<td>67</td>
<td>6.3</td>
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<tr>
<td>Drowning</td>
<td>23</td>
<td>2.2</td>
</tr>
<tr>
<td>Other</td>
<td>59</td>
<td>5.6</td>
</tr>
</tbody>
</table>


¹ Urban core-cities: Central Falls, Pawtucket, Providence and Woonsocket.

Table 2. Toxicology tests and circumstances of adult (25 years and older) suicide deaths, Rhode Island 2004–2014 (N=1065)

<table>
<thead>
<tr>
<th>Toxicology Test and Circumstance</th>
<th>n</th>
<th>%</th>
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</thead>
<tbody>
<tr>
<td>Tested</td>
<td>1042</td>
<td>97.8</td>
</tr>
<tr>
<td><strong>Toxicology test positive</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any toxicology</td>
<td>685</td>
<td>65.7</td>
</tr>
<tr>
<td>Any illicit substance</td>
<td>547</td>
<td>52.5</td>
</tr>
<tr>
<td>Alcohol</td>
<td>345</td>
<td>33.1</td>
</tr>
<tr>
<td>BAC≥0.08 g/dl</td>
<td>271</td>
<td></td>
</tr>
<tr>
<td>Antidepressants</td>
<td>294</td>
<td>28.4</td>
</tr>
<tr>
<td>Opiates</td>
<td>185</td>
<td>17.8</td>
</tr>
<tr>
<td>Marijuana</td>
<td>95</td>
<td>9.1</td>
</tr>
<tr>
<td>Cocaine</td>
<td>95</td>
<td>9.1</td>
</tr>
<tr>
<td><strong>Mental health/substance abuse circumstance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current depressed mood</td>
<td>520</td>
<td>49.0</td>
</tr>
<tr>
<td>Current diagnosed mental health problem</td>
<td>566</td>
<td>53.4</td>
</tr>
<tr>
<td>Depression/dysthymia</td>
<td>436</td>
<td></td>
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<tr>
<td>Anxiety disorder</td>
<td>93</td>
<td></td>
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<tr>
<td>Bipolar disorder</td>
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<tr>
<td>Post-traumatic stress disorder (PTSD)</td>
<td>29</td>
<td></td>
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<tr>
<td>Schizophrenia</td>
<td>29</td>
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<tr>
<td>Attention deficit or hyperactivity disorder</td>
<td>13</td>
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<tr>
<td>Other</td>
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<tr>
<td><strong>Interpersonal circumstance</strong></td>
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<tr>
<td>Intimate partner problem</td>
<td>307</td>
<td>28.9</td>
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<td>Family relationship</td>
<td>82</td>
<td>7.7</td>
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<tr>
<td>Other death of family member/friend past 5 years</td>
<td>81</td>
<td>7.6</td>
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<tr>
<td>Other relationship problem (non-intimate)</td>
<td>67</td>
<td>6.3</td>
</tr>
<tr>
<td>An argument or conflict led to the victim’s death</td>
<td>44</td>
<td>4.2</td>
</tr>
<tr>
<td><strong>Life stressor circumstance</strong></td>
<td></td>
<td></td>
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<tr>
<td>Crisis in past or impending two weeks</td>
<td>228</td>
<td>21.5</td>
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<tr>
<td>Physical health problems</td>
<td>217</td>
<td>20.5</td>
</tr>
<tr>
<td>Job problems</td>
<td>168</td>
<td>15.8</td>
</tr>
<tr>
<td>Financial problems</td>
<td>154</td>
<td>14.5</td>
</tr>
<tr>
<td>Recent criminal legal problem</td>
<td>80</td>
<td>7.5</td>
</tr>
<tr>
<td>Civil legal (non-criminal) problems</td>
<td>57</td>
<td>5.4</td>
</tr>
<tr>
<td>Eviction or loss of home</td>
<td>44</td>
<td>4.2</td>
</tr>
<tr>
<td><strong>Suicide event circumstance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Left a suicide note</td>
<td>372</td>
<td>35.1</td>
</tr>
<tr>
<td>Disclosed intent to commit suicide</td>
<td>272</td>
<td>25.6</td>
</tr>
<tr>
<td>History of suicide attempt(s)</td>
<td>269</td>
<td>25.4</td>
</tr>
</tbody>
</table>


a Subcategories do not sum to 100% because test results of victims can be positive for alcohol or multi-drugs.

b Percentages might exceed 100% because multiple circumstances might have been coded.

c One victim can have two or three current mental health diagnoses.
Figure 1. Average annual suicide rate (1/100,000) among adults aged 25 and older by Rhode Island cities and towns of residence, 2004–2014.

Some, but not all studies have suggested strong associations between economic downturns and suicide mortality. To our knowledge this is the first study to investigate the characteristics and spatial patterning of suicide deaths among Rhode Island adults aged 25 and older. This study allows for a better understanding of where to target resources and prevention efforts in Rhode Island to reduce the burden of suicide in areas of greatest risk.

There are at least two limitations of our study. This study used data from death certificates, medical examiner records, and law enforcement reports, which can have data errors. Although we combined 11 years of RIVDRS data, findings on suicide deaths should be interpreted with caution. Rhode Island is a small state (population ~ 1 million) with substantial year-to-year fluctuations in suicide rates.

Despite these limitations, RIVDRS data are extremely useful for ongoing surveillance of suicide deaths in subpopulations. GIS mapping can be exceptionally useful to identify significant spatial clusters of high suicide risk.

No single intervention will prevent all suicides. Clinical care protocols to establish follow-up to ensure patient safety have shown promise, especially among high risk adults with serious mental illnesses or who have attempted suicide. The protocols include working with primary care and emergency department healthcare professionals to (1) assess suicide risk and protective factors, (2) ensure patient safety and reduce access to lethal means, and (3) develop and implement treatment plans that include continuity of care.

Acknowledgments
This brief was funded by a Centers for Disease Control and Prevention (CDC) grant (SU17CE002615) awarded to the Rhode Island Department of Health. We would like to thank our data parties: the Center for Vital Records, and the Center for the Office of State Medical Examiners at RIDOH, the Rhode Island State Police and local law enforcement agencies, and the State Crime Laboratory, which provided data in a timely manner and are the backbone of RIVDRS. We thank data abstractors Karen Foss and Shannon Young who spent hours compiling the RIVDRS data and constructing sound narratives to make RIVDRS one of the best.

References

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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 MARCH 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MARCH 2017</td>
<td>Number</td>
</tr>
<tr>
<td>Live Births</td>
<td></td>
<td>929</td>
</tr>
<tr>
<td>Deaths</td>
<td></td>
<td>958</td>
</tr>
<tr>
<td>Infant Deaths</td>
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</tr>
<tr>
<td>Neonatal Deaths</td>
<td></td>
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</tr>
<tr>
<td>Marriages</td>
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<td>310</td>
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<tr>
<td>Divorces</td>
<td></td>
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<tr>
<td>Induced Terminations</td>
<td></td>
<td>184</td>
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<tr>
<td>Spontaneous Fetal Deaths</td>
<td></td>
<td>83</td>
</tr>
<tr>
<td>Under 20 weeks gestation</td>
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<td>76</td>
</tr>
<tr>
<td>20+ weeks gestation</td>
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<td>7</td>
</tr>
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</table>

* 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 SEPTEMBER 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SEPTEMBER 2016</td>
<td>Number (a)</td>
</tr>
<tr>
<td>Diseases of the Heart</td>
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<tr>
<td>Malignant Neoplasms</td>
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<tr>
<td>Cerebrovascular Disease</td>
<td></td>
<td>26</td>
</tr>
<tr>
<td>Injuries (Accident/Suicide/Homicide)</td>
<td></td>
<td>72</td>
</tr>
<tr>
<td>COPD</td>
<td></td>
<td>27</td>
</tr>
</tbody>
</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

August 1, Tuesday
RIMS Physician Health Committee: Herbert Rakatansky, MD, Chair

August 1–4, Tuesday–Friday
AMA Advocacy Resource Center
State Advocacy Roundtable: RIMS’ Steven R. DeToy, Presenter

August 7, Monday
Alpert Medical School New Student Orientation: RIMS Staff
National Council of State Legislators Annual Meeting, Boston, MA: RIMS’ Steve DeToy referent on provider directory issue.

August 9, Wednesday
Board of Medical Licensure and Discipline
Meeting of the Governor’s Opioid Overdose Prevention Task Force: Sarah J. Fessler, MD, President; Gary Bubly, MD, Past President; RIMS Staff

August 16, Wednesday
RI Health Center Association meeting regarding Student Loan Repayment Program
RIMS Foundation Strategic Planning

August 18, Friday
RI Health Center Association Event
Meeting with Anchor Medical Associates, Department of Health, and RI Parents Information Network regarding RIMS’ Diabetes Prevention Program grant

August 25, Friday
OHIC Quality Measure Alignment Work Group: Peter Hollmann, MD, Vice President, RIMS Staff
Conference call with Anchor Medical Associates, Department of Health, and RI Parents Information Network regarding RIMS’ Diabetes Prevention Program grant

August 28, Monday
Meeting with Blue Cross Blue Shield of RI: Sarah J. Fessler, MD, President; Bradley Collins, MD, President-elect, and RIMS staff

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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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Membership in The Rhode Island Medical Society (RIMS) makes you a part of a dynamic network of physicians, residents, students, physician assistants, and healthcare professionals who represent, like you, the best of the profession.

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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Brentwood By The Bay Assisted Living
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Saint Antoine Community
 a caring community serving the physical, social, emotional, and spiritual needs of older adults and their families.

Saint Elizabeth Community
 a non-profit, non-sectarian, charitable organization that provides a full spectrum of quality care to older adults and people with physical disabilities.

The Branches of North Attleboro
 new assisted living and memory care community scheduled to open in Fall 2017 EEOA certification pending

Thundermist Health Center
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University Orthopedics
 a regional referral center for patients with back and neck pain, joint pain, sports medicine problems, shoulder pain, hand problems, hip and knee pain, and foot and ankle injury.

Visiting Nurse of Hope Health
 an independent non-profit, community-based home health care provider providing high-quality care to residents of Rhode Island and Massachusetts.

WASHINGTON TRUST

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Multidisciplinary approach may help vets with pulmonary hypertension and coexisting conditions

PROVIDENCE – A paper published August 22 in the print version of *Pulmonary Circulation* by a Providence VA Medical Center researcher suggests that a multidisciplinary approach may improve outcomes for Veterans with pulmonary hypertension and coexisting cardiopulmonary conditions.

“A multispecialty approach to a suspected case of pulmonary hypertension is recommended, but there are few data available on the adherence to guidelines or outcomes in such patients,” said DR. MATTHEW JANKOWICH, a researcher at Providence VAMC and the Alpert Medical School of Brown University, and lead author of the paper.

The study evaluated the clinical characteristics, outcomes and prognoses of Veteran patients with suspected pulmonary hypertension who are receiving care from the Pulmonary Hypertension Clinic at the Providence VAMC. It revealed a high prevalence of coexisting cardiopulmonary conditions in these patients. The patients underwent evaluation according to established guidelines for pulmonary hypertension and, although the patients showed a high rate of hospitalizations and mortality, supportive care for these patients improved following a comprehensive, multidisciplinary evaluation. The paper is available online at: http://journals.sagepub.com/doi/pdf/10.1177/2045893217726063.

“The results are encouraging, but further research is needed to determine if the approach can improve outcomes in the larger Veteran population with pulmonary hypertension,” said Dr. Gaurav Choudhary, the senior author for the paper and chief of the Research and Development Service at the Providence VAMC.

RI first state to require coverage of fertility preservation for at-risk patients

PROVIDENCE – Rhode Island has become the first state to pass a law explicitly requiring coverage for fertility preservation prior to gonadotoxic medical therapy, treatment that could directly or indirectly cause infertility.

Clinicians from the Fertility Center and Program in Women’s Oncology/Breast Health Center at Women & Infants Hospital initiated the legislative process, co-wrote the bill, and along with patients testified on behalf of its passage at hearings at both the Rhode Island House of Representatives and Senate.

This law explicitly mandates fertility preservation coverage prior to medical treatment that could render a patient infertile, setting a new precedent nationwide.

More than 100,000 new cancer diagnoses in the United States are in patients under the age of 45. Advances in cancer therapies, particularly chemotherapies, have led to dramatic improvements in patient survival, and thus a growing population of cancer survivors who wish to start a family.

According to EDEN CARDozo, MD, a reproductive endocrinologist with Women & Infants’ Fertility Center, “Unfortunately, in nearly 90 percent of cases, these treatments result in infertility, which has been shown to have negative physical and psychological consequences. There are options currently available to preserve the fertility of these patients, but the unfortunate reality is that without insurance coverage, most patients can’t afford to see a reproductive specialist for these services.”

RUBEN ALVERO, MD, director of the Division of Reproductive Endocrinology and Infertility at Women & Infants and the Warren Alpert Medical School, credits Dr. Cardozo with developing the idea for the legislation. This physician team, along with government affairs and legal teams, shepherded the legislative process for fertility preservation coverage in Rhode Island.

Legislation aimed at providing fertility preservation coverage was passed in Connecticut in June, which revises the definition of infertility to include “medically necessary” treatments. The Rhode Island law provides a separate definition, which explicitly mandates fertility preservation coverage prior to gonadotoxic therapies.
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State reduces health care premium increases requested for 2018

CRANSTON – Health insurance premium rates for 2018 have been approved by Rhode Island’s Office of the Health Insurance Commissioner (OHIC).

Overall, these 2018 premiums will be $16.7 million dollars lower than what the insurers asked OHIC to approve.

OHIC’s decisions include some reductions in insurers’ cost estimates and contributions to reserves and profit. Across the US, health insurers are seeking double-digit rate increases for 2018 plans.

The main drivers of Rhode Island premiums for 2018 are:

• Double digit annual increases for prescription drug costs, which range from 9.7% to 13.7% across insurers.
• Higher hospital outpatient use than in recent years.
• The reinstatement of a federal health insurance tax, which adds up to 2% to most premiums.

“Fortunately, the outlook is better in Rhode Island relative to health insurance premium increases in other states, and we have been able to reduce the 2018 rate increases by $16.7 million. However, health insurance costs are already very high for many Rhode Islanders, and we understand that annual increases are a burden for individuals and companies in our state,” said state health insurance commissioner MARIE GANIM. “It is our job at the Office of the Health Insurance Commissioner to continue to work to transform the health care system to get costs under control.”

The tables above reflect the average premium increase to consumers, before reflecting changes in age. Final rates will differ based on a subscriber’s age and the benefits he or she chooses. In the large group market, the expected premium increases are averages—employers will see higher and lower rates depending on demographic changes in their workforce and their own company’s rates of medical care utilization.

Brown to lead center for creating bioluminescent neuroscience tools with NSF $9.2M grant

PROVIDENCE – With up to $9.2 million in funding over five years from the National Science Foundation, Brown University will lead a national center dedicated to developing and disseminating new tools based on giving nervous system cells the ability to make and respond to light. Neuroscientists could use the tools to uniquely manipulate and observe the circuitry of the brain in a variety of model organisms.

The new “NeuroNex Technology Hub” is a collaboration of labs at Brown, Central Michigan University and the Scintillon Institute. The team’s charge is to invent, improve upon and combine several unique bioengineering technologies to create new research capabilities. They will then make their advances rapidly, easily and freely available to the global scientific community.

“Through NeuroNex, we want to enable all scientists to take advantage of the best tools,” said principal investigator Christopher Moore, a professor of neuroscience at Brown and associate director of the Brown Institute for Brain Science (BIBS). “There is a real problem in science of certain inequities in access. The idea is to systemically address that.”

The center’s other leaders are DIANE LIPSCOMBE, a Brown professor of neuroscience and BIBS director, UTE HOCHGESCHWENDER, a professor at CMU, and Scintillon researcher NATHAN SHANER. JUSTINE ALLEN, a graduate of
Brown’s doctoral program in neuroscience, will serve as the center’s administrative director.

In addition to creating the new tools for the scientific community, the team intends to turn its research, which combines elements of biology, chemistry, physics and engineering, into a curriculum to engage and educate high school students.

Enlightened brains

The research has its roots in bioluminescence, the natural ability of cells to make light, as fireflies and many aquatic animals do. Moore, Lipscombe, Hochgeschwender and Shaner have already been working together to engineer bioluminescence into a variety of cells, including neurons, in a project supported in its early stages by the W. M. Keck Foundation. Their work includes making light production contingent on an influx of calcium, a typical means that neurons employ to trigger each other into action. They’ve also created a brighter form of bioluminescence with proteins they call LumiCaMPsins. In the new project, they will continue to work to create even brighter calcium-modulated bioluminescence in neurons.

Beyond programming cells to regulate their own activity, the team also hopes to develop ways to make cells stimulate each other with light. Such “inter-luminescence” would allow scientists to program and observe calcium-modulated dynamics in whole circuits, Moore said.

Moreover, the group also plans to create new imaging tools. Using a variety of fluorescent molecules, including some that Shaner helped to pioneer, scientists today can make cells glow in response to experimental events, Moore said, but that requires shining a stimulating light on them that can damage tissue and adds a source of noise as that incoming light scatters. Bioluminescence allows cells to glow on cue without that external stimulation, reducing the possibility of damage and reducing a source of scatter. Implanted imaging devices could also be lighter and use less power if they don’t have to produce stimulating light.

Moore said one of the reasons the collaborators are excited to share what they are finding is that there is much more room for innovation with the technology than they can fill on their own.

“In our own experience as a cloud of labs working on this stuff, the list of things we want to create to make the world better is getting bigger and bigger,” Moore said. “We want to enable the whole field to let them all go after it.”

Enlightening minds

As they develop new tools and techniques, the team will employ several means to disseminate them, Moore said. They will produce a website with downloadable experimental protocols, genetic sequences and other documentation and will send “emissaries” to teach other research groups. They will annual hold workshops for visiting scientists to come together, generate and discuss ideas, form new collaborations and learn how to use the new technologies.

“Bring all your students and all your postdocs, and inspire them to take a few of these research questions,” Allen said. “Take those home and let this grow.”

Moore noted that the collaborators have a strong ethic of such openness. He serves on the board of OpenEphys, an open-source initiative to promote sharing of electrophysiology tools started by two former graduate students in his lab. Lipscombe, Hochgeschwender and Shaner have also openly shared tools and technologies with the research community before, he said.

In addition to teaching other scientists, Moore said, the collaboration will also teach students at several different levels. They plan to hold a weeklong “intensive practicum” course for undergraduate students every spring at the Marine Biological Laboratory in Woods Hole, Mass., to which they encourage applications from students underrepresented in science, technology, engineering and mathematics. They will also create and teach courses in local Providence high schools that already work with the Brown Brain Bee. And finally, Moore said they hope to create an online version of the curriculum for other schools nationwide.
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Independent Living *An ideal retirement living experience*
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Assisted Living *The right choice for people who need extra help with daily activities*
- Qualified staff assists with taking medication, dressing, bathing, etc.
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- Activities and events for various levels of acuity

Alzheimer’s & Dementia Care *Person-centered care for people at various stages*
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- A care philosophy defined by more than the symptoms of Alzheimer’s & dementia
- An experienced staff who help residents thrive

Rehabilitation & Skilled Nursing *For short-term surgical recovery or long-term rehabilitation*
- Around-the-clock, licensed nursing care
- Providing clinical resources in a comfortable setting that feels like home
- A mission and focus to helping residents get well and then get home as quickly as possible

Personalized Living *For people who just need a little help with things*
- One-on-one non-medical services for home care needs
- Additional personal needs for those in assisted living or home such as escorts to doctor appointments and more

Home Health *For qualified people in need of therapy or rehabilitation — all in the comfort of home*
- Get Medicare-certified assistance from experienced professionals
- Many healthcare services such as wound care and stroke therapy

Therapy *Specialized programming personalized to encourage recovery*
- An emphasis on education, fitness and rehabilitation that helps seniors retain or enhance their independence
- Most insurances accepted

Hospice *Promoting comfort by addressing the full range of needs of patients and families*
- Primary focus of quality of life
- Specially trained staff help families and patients cope with overwhelming feelings accompanying end-of-life care

The Rhode Island Network

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Brookdale Cumberland
Brookdale Smithfield
Brookdale Greenwich Bay
Brookdale Pocasset Bay

Brookdale Sakonnet Bay
Brookdale East Bay
Brookdale West Bay
Brookdale South Bay

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WASHINGTON, D.C. – On August 3 the Senate confirmed the nomination of Dr. Elinore McCance-Katz for Assistant Secretary for Mental Health and Substance Use.

Dr. McCance-Katz, a member of the Rhode Island Medical Society, is currently the Chief Medical Officer for the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals. She is also a professor of psychiatry and human behavior and professor of behavioral and social sciences at the Alpert Medical School of Brown University. She previously held the position of Chief Medical Officer at the Substance Abuse and Mental Health Services Administration (SAMHSA).

She will be the first to hold the position of assistant secretary for mental health and substance use, a position created by the 2016 Helping Families in Mental Health Crisis Act.

The American Psychiatric Association and the National Alliance on Mental Illness endorsed Dr. McCance-Katz, a psychiatrist, for the new position.

In addition, The American Society of Addiction Medicine (ASAM) applauds the Senate for approving Dr. McCance-Katz’s nomination and congratulates Dr. McCance-Katz on her new role.

“Dr. McCance-Katz brings exceptional clinical expertise and leadership experience to this important role, and ASAM looks forward to working with her and supporting her success as our nation’s first Assistant Secretary for Mental Health and Substance Use,” said ASAM President Dr. Kelly Clark.

“Dr. McCance-Katz boasts significant expertise in psychiatry and addiction medicine, gained over decades of practice as a clinician, teacher, and researcher. She has demonstrated her capability as an effective executive and civil servant as the head of a major state substance use disorder agency and the first Chief Medical Officer of the Substance Abuse and Mental Health Services Administration [SAMHSA]. Additionally, Dr. Katz’s background in providing medication-assisted treatment will be especially valuable to this Administration as it seeks to combat the current epidemic of opioid addiction and overdose deaths. She is uniquely qualified to help inform the Administration’s efforts to expand access to effective treatment for opioid addiction and ASAM looks forward to working with the Administration toward this mutual goal.”

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Appointments

Diane Lipscombe, director of the Brown Institute for Brain Science, elected next president of Society for Neuroscience

PROVIDENCE – The Society for Neuroscience, the world’s largest organization for the study of the brain and nervous system with nearly 38,000 members from 90 countries, has chosen Brown University neuroscience professor DIANE LIPSCOMBE, PhD, as its president, a title she will assume in November 2018 at the close of the annual meeting in Washington, DC.

Lipscombe will first serve for a year as president-elect starting this November and after one year as president, she will serve as past president, completing a three-year course of society leadership on the society’s executive committee.

“I am incredibly honored to serve the Society for Neuroscience, a dynamic organization that advances research, communicates the value and importance of neuroscience, trains and educates future scientists and advocates for sustained funding and support for science,” Lipscombe said. “I look forward to engaging in global advocacy for neuroscience research and to ensuring that we support our next generation of neuroscientists.”

As Lipscombe leads the society, she will continue to direct the Brown Institute for Brain Science, where she took the helm in 2015, and maintain her teaching and research at Brown.

Drs. Hines, Gogne join Women & Infants’ Department Of Medicine

PROVIDENCE – Two new providers have joined the Department of Obstetrics and Gynecology at Women & Infants Hospital.

AUTUMN HINES, DO, of Warwick, has joined the Center for Women’s Gastrointestinal Health. A graduate of the University of Virginia, Dr. Hines attended medical school at the Lincoln Memorial University–DeBusk College of Osteopathic Medicine in Tennessee. After completing her medical degree, she completed both her internal medicine residency and gastroenterology fellowship at Kent Hospital. Dr. Hines has a special interest in women’s gastrointestinal health and wellness, management of inflammatory bowel disease, colorectal cancer screening and prevention, and disorders of the liver.

ANUPIYA GOGNE, MD, of Cranston, has joined the Center for Women’s Behavioral Health. A graduate of Vardham Mahavir Medical College in New Delhi, India, where she also completed an internship, Dr. Gogne completed a residency at State University of New York Downstate Medical Center and a fellowship in addiction psychiatry at the New York University School of Medicine and in reproductive psychiatry at Women & Infants Hospital/Brown University. Dr. Gogne is an adult psychiatrist with training in addiction psychiatry and women’s mental health. She has a special interest in working with women presenting with both addiction and psychiatric issues, and also has experience with treatment of trauma and dialectical behavior therapy.

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A health care ministry of the Roman Catholic Diocese of Providence.
Francois Luks, MD, named Hasbro’s pediatric surgeon-in-chief, chief of pediatric surgery

PROVIDENCE – FRANCOIS LUKS, MD, has been appointed pediatric surgeon-in-chief and division chief of pediatric surgery at Hasbro Children’s Hospital. He has served as interim pediatric surgeon-in-chief and division chief of pediatric surgery since June, 2016.

“Dr. Luks has been an esteemed member of the surgical staff at Hasbro Children’s Hospital for more than 20 years and we are very pleased and fortunate to have him permanently fill these two vital roles,” said MARGARET M. VAN BREE, MHA, DRPH, president, Rhode Island Hospital and Hasbro Children’s Hospital.

Luks served as director for trauma in Hasbro Children’s pediatric intensive care unit from 1995 to 2010 and subsequently as director of trauma for the hospital. He has served on and led more than a dozen standing and ad-hoc committees at Hasbro Children’s, ranging from chairing the pediatric trauma patient care committee, to participation in those addressing broader hospital community issues, such as the medical executive committee at Rhode Island Hospital and the Hasbro Children’s Hospital advisory committee. Luks has also served as attending surgeon at Morton Hospital in Taunton and Boston’s New England Medical Center, now called Tufts Medical Center, and most recently at St. Anne’s Hospital in Fall River.

Luks succeeds Thomas F. Tracy, Jr., MD, who served as Hasbro Children’s Hospital pediatric surgeon-in-chief in addition to his role as senior vice president of medical affairs at The Miriam Hospital.

“There are few surgeons who can pay as much as Dr. Luks’ for their practice, both for adults and for children. We are indeed fortunate to have him continue to lead Hasbro Children’s in this role,” said WILLIAM G. CIOFFI, MD, FACS, surgeon-in-chief, Rhode Island Hospital and The Miriam Hospital.

Dr. Luks earned his bachelor’s degree from Rijksuniversitair Centrum Antwerpen, his medical degree from Universitaire Instelling Antwerpen, and his PhD in medical sciences from Catholic University Leuven, all in his native Belgium. He completed his residency in general surgery at Catholic Medical Center of Brooklyn and Queens, then a residency in pediatric surgery at Hospital Ste-Justine in Montreal. He spent two years on a research fellowship through Catholic University of Leuven before joining Hasbro Children’s as an attending surgeon in 1994.

Among Luks’ research interests are fetal development and fetal surgery, including twin-to-twin transfusion syndrome (TTTS), a disease affecting unborn identical twins causing one to have decreased blood volume. Under his leadership, the first center of fetal surgery in New England was established in 2000. He was the site principal investigator for the first randomized study on endoscopic fetal surgery for TTTS; the Brown Fetal Treatment Program was the only North American center participating in the study. The Program is a founding member of the North American Fetal Treatment Network (NAFTNet), of which Luks has been an executive committee member since 2007. He was elected president of the International Fetal Medicine and Surgery Society in 2014.

Luks has more than 120 peer-reviewed publications and book chapters and nearly 200 abstracts. He is associate editor of the journal Fetal Diagnosis & Therapy. He has served the Albert Medical School of Brown University for his entire 20-plus years in Providence, currently as director of the program in fetal medicine, and professor of surgery, pediatrics and obstetrics and gynecology.
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James F. Griffin, DO, of South County Anesthesia Associates, LLC, has been named a Fellow of the American Society of Anesthesiology (FASA). He is affiliated with South County Hospital Department of Anesthesiology.

South County Hospital among ‘Best Hospitals’ by US News and World Report

Wakefield – South County Hospital has been recognized as a High Performing Hospital in the U.S. News & World Report’s 2017–2018 edition of “Best Hospitals.” It was the only hospital in Rhode Island to receive the “High Performing” rating for knee replacement surgery.

To be nationally ranked in a specialty, a hospital must excel in caring for the sickest, most medically complex patients. The ratings in procedures and conditions, by contrast, focus on typical Medicare patients.

South County Hospital’s score on its knee replacement specialty is based on multiple data categories, including patient survival, readmissions, volume and other data points. Hospitals received one of three ratings - high performing, average or below average.

Hospitals that earned a high performing rating were significantly better than the national average.

Significant high scores were given to South County Hospital for survival, based on U.S. News analysis of Medicare claims; preventing readmissions; preventing prolonged hospitalizations; preventing complications after hip or knee replacement; and the number of patients receiving surgery.

Mechanics Cooperative Bank donates $125,000 to cardiovascular care at Southcoast Health’s Charlton Memorial Hospital in Fall River

Fall River – Southcoast Health recently announced that Mechanics Cooperative Bank has donated $125,000 to the Campaign for Southcoast Health – a $25 million capital fundraising campaign which is the largest in the not-for-profit healthcare system’s history. In recognition of the gift, Southcoast Health will name the patient waiting area for outpatient cardiac services at Charlton Memorial Hospital in Fall River after Mechanics Cooperative Bank.

Mechanics Cooperative Bank has contributed $425,000 to Southcoast Health since 2011.

“As a member of the Southcoast President’s Council, Joe Baptista has significantly supported Southcoast Health through his advocacy efforts and philanthropic giving,” said Keith A. Hovan, President & CEO of Southcoast Health. “As a not-for-profit healthcare system, we rely on the generosity of so many within our community to support vital programs and services. With Joe’s leadership, Mechanics Cooperative Bank has been a great partner to Southcoast Health and we look forward to working together to improve the health of the South Coast for years to come.”

The Campaign for Southcoast Health is currently raising funds to support major capital initiatives across Southcoast Health’s three acute-care hospitals – St. Luke’s, Charlton Memorial in Fall River and Tobey in Wareham. Currently, over $16 million has been raised out of a $25 million goal.

Southcoast Health’s Cardiovascular Services are nationally recognized for excellence. Healthgrades recently named Southcoast Health one of America’s 100 Best Hospitals for Cardiac Care – one of just four hospitals in Massachusetts to receive this distinction for six years in a row. Southcoast Health also received 13 additional recognitions for superior cardiovascular services, including Healthgrades’ Cardiac Care Excellence Award for the 11th straight year.
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Recognition

Hasbro Children's Hospital pediatric ICU receives second Silver Beacon Award
Pediatric intensive care unit among just 27 pediatric ICUs nationwide to earn Beacon Award from American Association of Critical Care Nurses

PROVIDENCE – The Hasbro Children’s Hospital pediatric intensive care unit (PICU) nursing staff has attained a Silver Beacon Award for Excellence from the American Association of Critical Care Nurses (AACN). The distinction recognizes the hospital’s PICU, a 2013 silver-level Beacon designee, for delivering exceptional patient care and achieving healthy work environments. Hasbro Children’s PICU is one of 16 pediatric intensive care units from across the country to receive the silver designation for 2017 and the only nursing unit in the state to hold Beacon Award designation.

“The Beacon Award for Excellence recognizes our PICU nursing staff who serve as role models for excellent patient and family care,” said Myra Edens, RN, MSN, administrative director of Hasbro Children’s Hospital. “It signifies continuous learning and a systematic approach for optimizing evidence-based patient care, outcomes and satisfaction.”

The PICU staff at Hasbro Children’s earned the silver award by meeting the following evidence-based Beacon Award for Excellence criteria:

- Leadership Structures and Systems
- Appropriate Staffing and Staff Engagement
- Effective Communication, Knowledge Management, Learning and Development
- Evidence-Based Practice and Processes
- Outcome Measurement

“It’s a thrill to be honored with this designation again,” said Lisa Paolino, RN, BSN, clinical manager of the Hasbro Children’s Hospital PICU. “This acknowledgment of our team’s effective leadership, staffing, communication, and nursing practice – along with our workplace environment and outcomes – is a significant milestone. It’s recognition of the hard work that has gone into achieving national quality standards for improved patient outcomes and a healthy work environment.”

“The Beacon Award for Excellence recognizes caregivers in stellar units whose consistent and systematic approach to evidence-based care optimizes patient outcomes,” said AACN President Christine Schulman, MS, RN, CNS, CCRN-K. “Units that receive this national recognition serve as role models to others on their journey to excellent patient and family care.”

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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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Obituaries

STEPHEN A. FANNING, III, DO, 59, of North Kingstown, died on August 4, 2017. He was the loving and ever devoted husband, father and grandfather of Susan, Timothy, Daniel and Emily, Michael, Patrick, Katharine and Kailar Fanning.

He was predeceased by his parents, Stephen A. Fanning, Jr. and Margaret Eldredge Fanning and is survived by his siblings, Margaret E. Carney and Michaela, James and Robert Fanning.

Steve graduated from College of the Holy Cross and New England College of Osteopathic Medicine. He was a dedicated physician who served patients for more than 30 years at the Apple Valley Family Treatment Center, Greenville, Rhode Island. He was a kind, loving healing man who will be missed greatly and remembered always.

Donations in his memory may be sent to the North Kingstown Food Pantry.

JOHN BEATON MONTGOMERY, MD, 82, died peacefully on August 14, 2017 after a short battle with leukemia at Hope Hospice & Palliative Care RI. He was the beloved husband of Marjorie (Cunniam) Montgomery for 56 years.

Born in Bulawayo, Zimbabwe, Jack was the eldest son of the late Dr. James and Gwendolyn (Goodwin) Montgomery. As a young man, he attended the Ruzawi School in Zimbabwe and Michaelhouse in KwaZulu-Natal Midlands, South Africa before graduating with a medical degree from Trinity College in Dublin, Ireland in 1959. He came to America in 1960 to pursue a pediatric internship and residency at Roger William Hospital in Providence. He served as a Captain in the US Army during the Vietnam era and was stationed at Fort Gordon in Augusta, GA. He returned to Providence in 1969 and opened a pediatric practice on Waterman Street where he tended to generations of infants and children before retiring in 2011. He was on the staff of Hasbro Children’s Hospital and Women & Infants Hospital.

His love of plants and in particular, flowers, brightened the neighborhood and his garden was a reflection of his patience, perseverance, and quiet endurance. Jack woke early and started most days with a cup of hot tea and the New York Times crossword puzzle. He found pleasure in nature walks, identifying bird’s songs, classical music, traveling, and attending plays at Trinity Rep. He was a voracious reader of mysteries and non-fiction and spent many happy hours at the Providence Athenaeum. He especially delighted in watching his five grandchildren enjoy their many pursuits.

Long after he retired from practice, Jack was fondly greeted by former patients, some of whom cared for him during his recent illness. The Montgomery family would like to thank all the medical professionals at the Miriam Hospital, especially Dr. Robert Sokolic, Hallworth House, Hope Nursing Home Care, and Hope Hospice & Palliative Care RI, who treated him and our family with so much care, respect and kindness.

In addition to his wife, he is survived by his children Amanda Montgomery and her husband Rick Von Kaenel of Santa Fe, NM; John Montgomery and his wife Pamela of Riverside, CT; Julie Andrews and son-in-law Todd Andrews of Providence, RI; Sarah Montgomery and her husband Kevin O’Shea of Concord, NH; his five cherished grandchildren Charlie and Jack Andrews and Kate, Emma, and Jake Montgomery; and his brother James Montgomery of Brisbane, Australia and his sister Tessa Paulay of Perth, Australia. He also leaves many loving in-laws, nieces and nephews.

A Mass of Christian Burial will be celebrated by Rev. Edward L. Pieroni at St. Donations can be made in his name to St. Raymond’s Church or The Leukemia & Lymphoma Society.

DR. JORGE HUGO STURAM, a retired pediatric allergist living in Barrington, RI, passed away peacefully on July 23, 2017 at the age of 80. He was the beloved husband of Marjorie (Cunniam) Montgomery for 56 years.

Born in Bulawayo, Zimbabwe, Jack was the eldest son of the late Dr. James and Gwendolyn (Goodwin) Montgomery. As a young man, he attended the Ruzawi School in Zimbabwe and Michaelhouse in KwaZulu-Natal Midlands, South Africa before graduating with a medical degree from Trinity College in Dublin, Ireland in 1959. He came to America in 1960 to pursue a pediatric internship and residency at Roger William Hospital in Providence. He served as a Captain in the US Army during the Vietnam era and was stationed at Fort Gordon in Augusta, GA. He returned to Providence in 1969 and opened a pediatric practice on Waterman Street where he tended to generations of infants and children before retiring in 2011. He was on the staff of Hasbro Children’s Hospital and Women & Infants Hospital.

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