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OCTOBER 2013
VOLUME 96 • NUMBER 10

PUBLISHER

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What does it Mean for a Treatment to ‘Work?’

JOSEPH H. FRIEDMAN, MD
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IN MEDICINE WE UNDER-stand, at least on a theoretical level, that our treatments often don’t work. We like to think that they work more often than they do. We often assume that they’re working a lot better than they are. Most patients join us in this last assumption. Patients often



like to believe a treatment is working, and that often makes it work, and some patients don’t like to disappoint the doctor so they say the treatment is working even when it isn’t.

I suspect that most patients think that medications are usually intended to cure an illness. Infectious bacterial disease is the model. We treat an infectious disease until it is cured. If the infection isn’t cured, we change the medicine. But many of our treatments aren’t like that. Treating HIV, for example, isn’t like that. We treat HIV by holding it in abeyance, keeping the virus contained. Anti-hypertensives lower blood pressure. They usually work sufficiently well but when they don’t they can be adjusted until the treatment does, in fact, lower the recordings. The real payoff however, is not the blood pressure readings, it’s the reduced risk of stroke, myocardial infarction and kidney failure, all of which are much increased in people with high blood pressure. Yet, these calamities may occur anyway, despite

good blood pressure control and may even occur in people who never had high blood pressure. We treat to lower risk. When the treatment to lower one risk increases the risk of something else we have to decide which is more important.

We also have “symptomatic” treatment. In my field, movement disorders, we never cure anyone, we “manage” the condition by improving bothersome symptoms. How well a treatment works is in the eyes of the beholder. A patient may be disappointed, the doctor pleased, the family jubilant, or any combination of these. The most aggressive treatment for Parkinson’s disease, deep brain stimulation, reserved for patients with very particular problems, often results in dramatic benefits. Paradoxically, successfully treated patients believe their improvement to be far less than assessments made by family and involved physicians. We sometimes have trouble deciding therefore if our treatment is successful. Controlling pain in someone whose pain etiology is untreatable is another form of symptomatic therapy. How can we judge when pain control is “adequate”?

Treating other conditions, like depression or anxiety, also involves symptomatic therapies, but, unlike Parkinson’s disease, or chronic pain, depression

and anxiety fluctuate, even untreated, making it impossible often to be sure the treatment had anything to do with the outcome. Further complicating our judgment is the natural history of depression, which is usually time-limited and resolves on its own. If one believes in evidenced-based medicine, we find that, unlike the scenarios in infectious diseases and Parkinson’s disease, treatments for depression often don’t work much better than placebo. This is not an exaggeration to make a point. If one uses the concept of “number needed to treat,” that is, the number of people with a condition who need to be treated with a drug to make one of them “better” than if they were treated with a placebo, the usual numbers for depression are over four, meaning that four people need to be treated to make one better. Yet we don’t tell patients this. Probably because we either don’t know it ourselves, or we don’t believe it. As with infectious diseases or Parkinson’s disease, we treat with increasing doses or switch drugs, or say we treated it and ignore it.

I think we often use medications or other interventions because we believe they are likely to work. If we relied on evidence-based medicine too much we probably wouldn’t use many treatments at all. After all, the evidence we rely on arises from studies that use tightly controlled entry requirements. Our confidence in a medication to reduce the risk of stroke may be predicated

on a study of patients who never had a stroke, or only those who had a transient ischemic attack (TIA), which may be a qualitatively different type of patient from the one in the office. In Parkinson's disease studies, we typically exclude people with cognitive dysfunction, so the effects of drugs on those with such problems are known only based on anecdotal evidence or open label trials, which are notably subject to bias.

However, the concept of the "number needed to treat" has always intrigued me. It would be easy, and likely will be coming to a health insurer in your neighborhood soon, for an insurer to argue that any treatment that "works" less than 25% of the time shouldn't be paid for, which would eliminate many psychotherapeutic drugs, and probably

a lot of cancer drugs as well. Yet the other aspect has always been the large placebo effect. If you do nothing, nothing happens. If you give a sugar pill invested with a degree of confidence in improvement, the odds are much increased that benefit will occur. My guess is that when you give an active drug, not in a blinded fashion, as in a placebo-controlled study, but with the full authority of the medical establishment behind the medication's benefits, the chances of a drug working are undoubtedly much enhanced.

The number needed to treat should not be thought of in a defeatist manner, that you have to treat 3 or 4 or 5 people to make one better. Rather it should be used to maintain our humility in treating the many failures of the human body. ❖

Author

Joseph H. Friedman, MD, is Editor-in-chief of the *Rhode Island Medical Journal*, Professor and the Chief of the Division of Movement Disorders, Department of Neurology at the Alpert Medical School of Brown University, and chief of Butler Hospital's Movement Disorders Program.

Disclosures

Lectures: Teva, General Electric, UCB
Consulting: Teva, Addex Pharm, UCB, Lundbeck

Research: MJFox, NIH: EMD Serono, Teva, Acadia, Schering Plough

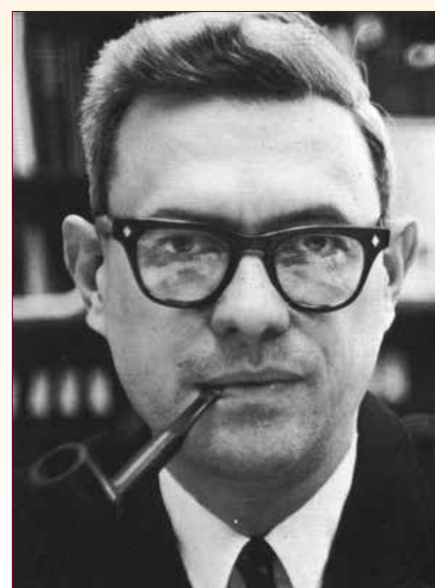
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Dr. Aronson in 2007 receiving Doctor of Medical Science (DMS) at Brown in 2007.



Stan Aronson, MD, in the early years in the 1950s at Downstate Medical Center in NYC.

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STANLEY M. ARONSON, MD
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FROM ITS EARLIEST DAYS on the plains of Africa, mankind's survival has depended upon a vigilant awareness of his vulnerability and the use of every available resource in outwitting the many predators surrounding him. And so, in the absence of manmade weaponry, man ran faster, climbed trees more rapidly and exploited his brain in devising yet other survival strategies. Still, even without aggressive endowments such as claws, man managed to survive, prosper and spread to the other continents.

How did primitive humans manage to keep at bay the world of carnivorous creatures? Certainly humanity's survival demanded a ceaseless vigilance, the inventing of primitive weapons, working conjointly with other humans and devising protective structures such as rudimentary huts and defensible caves. The salvation of the genus *Homo* ultimately depended on guile, deception and superior intelligence.

Humankind has now conquered the world, effectively protecting themselves from the many harmful predators still wandering the diminishing forests, plains and seas. Yet, in the hearts of humans, there remains a lingering fear of these many feral creatures and an



irrational need somehow to tame them.

Consider, for example, the lion: We hunt them as trophies; we capture them and then exhibit them in cages. And in our fiction we emasculate them, give them Swahili names such as Simba and imagine them as gentle humanoids with bushy manes.

The process of domesticating the entire animal kingdom has advanced so that we have now endowed many species with very human names such as Mickey, Donald, Bambi, even Dumbo (although citizens of Brooklyn have used the DUMBO acronym to signify "Down Under the Manhattan Bridge Overpass").

Are there no remaining creatures immune to taming through acculturation? Are there still creatures so vile, so nasty, so despicable that no amount of Disney-animation can diminish their malignant nature? Even the carnivorous

dinosaurs, the feral vultures and the brooding bats have had their brief, animated interludes as allegedly harmless animals. Snakes, as yet, have not found willing advocates in the world of writers.

And finally there are the cockroaches, invertebrate creatures that have defied the remorseless inroads of Darwinian extinction and have persevered through the successive Paleozoic, Mesozoic and Devonian Extinction crises. Thousands of creatures, vertebrate and invertebrate, have been rendered extinct during those many apocalyptic intervals; yet the cockroach, little changed for hundreds of million years, has quietly survived.

The heightened survival capacity of the cockroach was best exhibited by an event during the final days of World War II. On the morning of August 6, 1945, an Air Force bomber identified as Enola Gay dropped an atomic bomb on the Japanese city of Hiroshima. The effects were immediately devastating and Japanese radio reported: "Practically all things, human and animal, were literally



The first illustration of Archy the poet reincarnated as a cockroach appeared in a New York newspaper, the Tribune, in 1922, introducing the new column by humorist Don Marquis.

seared to death.” Except for the resident cockroaches.

The Atomic Bomb Casualty Commission (ABCC), established in 1948, commented frequently upon their apparent invulnerability to the intense radiation.

With such an indifference to the environmental hazards that befall other creatures, certainly there must be someone to proclaim the cockroach for its ability to survive these countless millennia. The journalist, Don Marquis (1878–1937) had written a tale, in 1927, of a cockroach named Archy, who had the astonishing ability to use a manual

typewriter (yes, Virginia, there were such contrivances) in composing poems. And Archy’s first effort read:

*expression is the need of my soul
i was once a vers libre bard
but I died and my soul went into the
body of a cockroach
it has given me a new outlook on life*

Cockroaches, it must be emphasized, are far less dangerous than insects, which carry such ailments as malaria and bubonic plague. True, the cockroach is intensely unaesthetic, but they do have some biologic singularities: For

example, they are capable of surviving without their heads for months, a unique trait share only by certain elected officials. ♦

Author

Stanley M. Aronson, MD, is Editor emeritus of the *Rhode Island Medical Journal* and dean emeritus of the Warren Alpert Medical School of Brown University.

Disclosures

The author has no financial interests to disclose.

Rhode Island Medical Journal Submissions

The Rhode Island Medical Journal is a peer-reviewed, electronic, monthly publication, owned and published by the Rhode Island Medical Society for more than a century and a half. It is indexed in PubMed within 48 hours of publication. The authors or articles must be Rhode Island-based. Editors welcome submissions in the following categories:

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Contributions report on an issue of interest to clinicians in Rhode Island. Topics include original research, treatment options, literature reviews, collaborative studies and case reports.

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Authors discuss a new laboratory technique. Maximum length: 1000 words.

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Authors submit an interesting image or series of images (up to 4), with an explanation of no more than 400 words.

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The Brown Kenya Medical Exchange Program: Part 2

JANE CARTER, MD; CHARLES SHERMAN, MD, MPH
GUEST EDITORS



PHOTOS COURTESY OF JANE CARTER, MD

Dr. Jane Carter, at left, director of the Brown Kenya Program since it began 15 years ago, was in Kenya last month working with her colleagues at the TB clinic at Lodwar Hospital, Turkana, a TB Reach project site. Dr. Carter is president of the International Union Against Tuberculosis and Lung Disease.

Karibu. Welcome to Part 2 of the *Rhode Island Medical Journal's* focus on the Brown Kenya Program, which has been in existence for more than 15 years. The September issue of the Journal carried Part 1 and if you have not yet had a chance to read it, here is the link: <http://www.rimed.org/rimedicaljournal/2013-09/2013-09.pdf>

During the last 15 years what started as a learning opportunity for a few medical trainees has developed into a comprehensive care, education, and research effort by countless Brown and Kenyan physicians. A large number of medical specialties are represented including emergency medicine, internal medicine, neurology, obstetrics and gynecology, pediatrics, psychiatry, and public health. All projects involve cross-cultural collaborations in which both groups greatly benefit.

The accomplishments have been many. From a clinical

Safety considerations No. 1 priority when planning Kenya trips

JANE CARTER, MD
BROWN KENYA PROGRAM DIRECTOR
SEPTEMBER 29, 2013

On September 21, the terrorist group Al-Shabaab launched an attack on the Westgate mall in Nairobi, Kenya. This attack resulted in the deaths of 67, a hostage situation lasting 4 days, and a resulting – and likely long lasting – sense of insecurity.

The AMPATH consortium – and the Brown Kenya Program – does not approach safety concerns lightly. Since the bombing of the US embassy in Nairobi in July 1998 when the Moi University medical students and IU faculty Dr. John Sidle were standing on the steps of the embassy to apply for their visas for their US rotation, security assessments have become an integral part of the program. Evaluation of the US State Department updates – both internally in Kenya and from public information on the US State Department website – coupled with discussions with our Kenyan partners regarding their own knowledge and assessment of local political situations factor into the program recommendations.

During the last two presidential elections, the exchange program has been closed for rotations. In 2007 this decision was prescient. Post-election violence erupted four days after the election. The mechanisms put in place by the Brown Kenya Program allowed for contact to all individuals who had been slated to leave that week to be alerted and their travel plans placed on hold. The exchange program was closed for a total of three months that year. The same decision to close the program was put in place earlier this year for the most recent presidential election; that election was peacefully carried out.

For the last year, the program has recommended limiting time in Nairobi to transit only and no travel to the coastal areas based on reviewed security analysis. As time passed, and no incidents occurred, the temptation is to become complacent. Occasionally rotators will question why the program has set forth a certain set of rules/guidelines. It is unfortunate that in our world of today, there can be no role for complacency. Security and safety for all program participants remains our highest priority. The AMPATH Executive Committee communicates by phone monthly and security assessment are ongoing – before the last incident and moving forward. We will continue to make the best recommendations possible with safety of all participants paramount.



perspective, over 100,000 persons living with HIV/AIDS are now under supervised care. Approximately 70,000 symptomatic individuals have been screened for tuberculosis. And those with diabetes are much better managed with the creative use of cell phones and portable glucose monitors. Greater access and provision of care have ensured that HIV, TB, and diabetes are no longer death sentences for those living in Western Kenya.

In this issue, there are several articles written by Brown faculty members, illustrating the profound nature of living and working in Kenya. **DR. RAMI KANTOR** provides an overview of the extensive collaborative research efforts underway between Brown and Moi University in Eldoret.

The development of specialty care can be challenging, especially when done across two universities; **DRS. BUD KAHN, JAMES MYERS, GEOFF BERG**, and **NICK CALIFANO** write about the joys and frustrations of starting such efforts in a developing country.

And finally, **DRS. JANE KAMUREN** and **DENNIS O'YIENGO** share their unique perspective of being trained at both Brown and Moi University.

The Brown Kenya Program has become an integral part of who we are as physicians and as people. We hope you will consider joining us in this most worthy of life's adventures.

Asante Sana. Thank you. ❖

Guest editors

Dr. Jane Carter, Associate Professor of Medicine at the Alpert Medical School, has been the Director of the Brown Kenya Program since its inception and is a pulmonologist affiliated with The Miriam Hospital.

Dr. Charles Sherman, Clinical Associate Professor of Medicine, the Alpert Medical School of Brown University, was the first Brown faculty member to travel to Eldoret in 1996. In 2013, Dr. Sherman was appointed as Director of Field Operations, East African Training Initiative, Ethiopian Pulmonary and Critical Care Medicine Training Program at the University of Addis Ababa in Ethiopia and Head of Global Pulmonary and Critical Care Medicine for the Brown University Global Health Initiative.

Research Components of the Brown Kenya Program: A Personal and Professional Perspective

RAMI KANTOR, MD

INTRODUCTION

Research, whether basic science, implementation, operational, clinical or other, supports and promotes clinical care.¹⁻⁴ It generates and addresses hypotheses, informs programs and provides data that can be translated to care. Research is not trivial or easy. It is time consuming, requires much planning, mandates a detail-oriented approach, involves availability of, or time and capability to create infrastructure, includes access to relevant resources and facilities and mandates complete and full dedication of experienced and motivated personnel.

The Academic Model Providing Access to Healthcare (AMPATH) in western Kenya leads with care. It has provided clinical services to >130,000 of the country's 1.6 million HIV-infected people, reducing morbidity, mortality and the very high burden of this pandemic on the country (<http://www.unaids.org>).

The Brown Kenya Program also leads with care. The medical exchange program of students, residents, post-doctoral fellows and faculty is the mainstay of the program. Both programs are intertwined with research. In this paper I discuss the conduction of research in the Brown program with the support of the AMPATH infrastructure, from a programmatic as well as from a personal perspective.

The AMPATH Research Infrastructure

<http://www.ampathkenya.org>

Brown University is part of the AMPATH consortium, led by Indiana University and consisting of multiple North American universities, in addition to Moi University and Moi Teaching and Referral Hospital. The AMPATH Research Network has dedicated much effort towards a strong and sustainable infrastructure to allow research that can support clinical care. This infrastructure includes a research administration office in Kenya that oversees and coordinates research activities; a Research and Sponsored Programs Office (RSPO) that provides grants management and other financial and human resources services; an Institutional Review Ethics Committee (IREC) to ensure that proposed research is both ethical and culturally-appropriate; and advanced laboratory capacity to support research projects.

AMPATH's research program is organized into nine Working Groups (adult medicine, basic science, behavioral and social science, oncology, pediatrics, prevention of HIV mother-to-child transmission, public health and primary care, reproductive health, and tuberculosis) and seven Cores (operations, data management, biostatistics, clinical informatics, pharmacy, laboratory, and bioethics). Working Groups and Cores have frequent conference calls to discuss general operating procedure and specific projects. Each project, which must have both a North American and Kenyan principal investigator, is presented to and must be approved by the relevant research working group, with subsequent IREC approval. Prior to presentation or publication, abstract and papers are submitted to a publications committee, which has representatives from the various Working Groups and Cores, who review papers and provide input to authors.

A major infrastructure component of the research program is the use of an electronic medical record system throughout AMPATH.⁵ This uniform system is used in a well-organized manner, that includes specific forms filled out by clinicians throughout the network; quality controlled data entry into a carefully designed database; and a computer system that allows



Dr. Rami Kantor and his team in Kenya.

querying and efficient use of the electronic data. Such a system allows research diversity and flexibility such as patient identification for projects, provision and use of clinical data and storage of study data.

This excellent research infrastructure provides an engagement structure for efficient collaborations, maximizing capacity and expertise from all participants.

The Brown University – Kenya Program Research Scheme

<http://brownmedicine.org/kenya>

It all started with Dr. Jane Carter. Brown University was the first institution to join the Indiana University-led AMPATH consortium in 2001. Hence, tuberculosis, Dr. Carter's research focus, was the first to be incorporated into the research program. Over the years, Dr. Carter has mentored many students and faculty within the program, obtained various grants, overseen numerous research projects, collaborated with a variety of institutions and investigators and published abundant papers related to her research in Kenya (eg,⁶).

The infrastructure provided by the AMPATH consortium and Dr. Carter's vision allowed for the Brown-Kenya research program to flourish. Today, a growing number of Brown investigators and disciplines are actively involved with research in Kenya (*See Table*). Some examples include pulmonary medicine (eg, tuberculosis, household air pollution); HIV medicine (eg, HIV diversity and drug resistance); psychiatry (eg, mood disorders); nephrology (eg, genetic factors in disease); gynecology (eg, cervical cancer); pediatrics (eg, HIV and health in street kids); behavioral medicine (eg, alcohol effect on Kenyans); and biostatistics (eg, support to AMPATH's research and training a new generation of Kenyan biostatisticians).

These ongoing expansions allow involvement of students, staff and faculty in multidisciplinary areas of research, in a safe, productive and nurturing environment, supporting clinical care. This is how my personal research story in Kenya started.

HIV Drug Resistance and Patient Monitoring Research

In January of 2005, when I arrived at Brown, HIV drug resistance research was already my passion, particularly in international settings, and I wanted to continue this line of investigation. During my prior post-doctoral fellowship at Stanford I had already worked in Zimbabwe, South Africa, Thailand and India, where diverse HIV variants and resistance patterns exist, different than in the United States.⁷ A few weeks after my arrival, I learned about the Brown Kenya Program and was advised to set up a meeting

with Dr. Carter, the program's director. Our meeting went extremely well and I was very quickly introduced to the Indiana University and AMPATH leadership and to my Kenyan collaborators, and now friends, Dr. Lameck Diero, the Moi University chief of medicine, and Dr. Nathan Buziba, the AMPATH Reference Laboratory director. By April 2005 I submitted and was awarded my first Kenya grant, a Brown/Lifespan/Tufts Center for AIDS Research (CFAR) Developmental Award. This rapid turnaround, from idea to fact, opened the door of opportunity for me and would not have been possible without the amazing relationships and infrastructure that were already in place in Kenya.

In this first project, we conducted a feasibility study to investigate diversity and drug resistance in antiretroviral treatment naïve and experienced HIV-infected patients. Such research had never been done at AMPATH; circulating HIV subtypes were unknown and none of the 80,000 HIV infected patients enrolled at that time at AMPATH had ever undergone HIV drug resistance testing. We were able to enroll 120 patients and obtain blood samples using various novel analytes. We examined cheaper and simpler options for HIV viral load and resistance testing in resource limited settings. We conducted CD4 and viral load testing at the AMPATH laboratory. Further, we shipped samples of all analytes to my Brown laboratory for drug resistance testing. Study results of diversity (subtypes A, C, D and many recombinants) and low-transmitted and high-acquired drug resistance were original for the region and provided abundant data for continued research.

During this first project, an important thing happened. To examine HIV drug resistance, we first had to identify patients who were failing antiretroviral treatment. To do this, we used the World Health Organization (WHO) patient monitoring guidelines, practiced at AMPATH and in Kenya

Brown Investigators	Kenyan Investigators	Research Theme
J Carter, C Sherman, A Gardner	W Injera, N Buziba, D Menya, R Kosgei, N Kirui, L Diero, D Oyieng'o, A Siika, R Karwa, S Kimaiyo, F Ogaro	Pulmonary Medicine; Tuberculosis, Cookstove Household Air Pollution and Lung Disease
M Keller	Atwoli, E Omolo, R Songole	Psychiatry; Mood Disorders
S Winston	A Chirchir, D Ayuku	Pediatrics; Sexual Health Risks and HIV Prevalence in Street-Involved Youth
R Papas	B Gakinya, J Baliddawa	Behavioral Medicine, Alcohol research
L Brown	D Ayuku	Adolescent risk behavior research
T Montague	M Owiti	Nephrology; APOL1 as a Kidney Disease Risk Genetic Locus
S Cu-Uvin	H Mabeya, O Orangu, D Chumba, P Itsura, D Patel	Obstetrics-gynecology; Cervical Cancer in HIV-Infected Women
J Hogan	A Mwangi	Biostatistics
R Kantor	L Diero, N Buziba, S Kimaiyo	HIV Diversity, Drug Resistance and Treatment Monitoring in Adults and Children; Laboratory Assays Development

for clinical care. These guidelines are significantly different than those used in Western settings. The latter utilize HIV viral load testing every few months, whereas in resource limited settings CD4 and clinical criteria are used. Study viral load testing of enrolled patients who fit the WHO failure criteria quickly revealed that most patients actually had non-detectable HIV and thus were not failing their treatment regimens. Though it made our lives more difficult and patient enrollment much longer than anticipated, this research finding⁸ was important. With the existing AMPATH infrastructure it quickly led to clinical care change, and mandatory HIV viral load testing upon suspicion of treatment failure. Such change would avoid unnecessary switches to more advanced and costly antiretroviral therapy.

A second resistance project followed the 2007–2008 Kenya post-election violence. During this crisis multiple HIV-infected patients were displaced from their homes and had unplanned interruptions in their antiretroviral treatment. Having the collaborations and methods in place, we obtained funding to examine long-term outcomes of such treatment interruptions.⁹ Our findings, that patients with crisis-induced treatment interruptions were more likely to fail treatment compared to those with no interruption,¹⁰ are important for Kenya as well as for other resource-limited settings, where HIV prevalence is high and the likelihood for future political and other conflicts are unfortunately high as well.

In a third project we are examining treatment failure and drug resistance upon HIV second-line antiretroviral therapy, the last resort in such settings. As AMPATH, Kenya and other similar settings are programmatically preparing for third-line antiretroviral options, such data are essential. As this article is being written, results from this ongoing project, unique in Kenya, are being made available to the AMPATH leadership, and through them to the Kenya National AIDS and STI Control Program (<http://nascop.or.ke>) to plan for purchasing third-line medications and save the lives of patients who develop resistance to second-line medications.

Research projects like the three outlined above have many advantageous aspects in addition to their impact on clinical care. They allow me to mentor students and involve them in research; train, collaborate and develop friendships with Kenyan investigators; host them at Brown; incorporate Kenya into grants; increase research infrastructure; conduct resistance testing in my lab for AMPATH patients; work towards setting up a much-needed drug resistance laboratory at AMPATH; and develop multidisciplinary research collaborations at Brown (eg, Center for Statistical Sciences, Center



Dr. Rami Kantor and Kenyan medical trainee Millicent Orido, who spent six months in Dr. Kantor's lab to learn techniques in diagnosing HIV resistance mechanisms.

for Computational Molecular Biology and School of Engineering]. Every second of time spent in all these endeavors is worthwhile.

CHALLENGES

Conducting research in resource-limited settings can be different and challenging. Following is a short Swahili lesson to explain such potential differences. Anyone who has studied Swahili, whether with Wycliffe at the IU House in Eldoret or with anyone else, knows that the number 1 in Swahili is 'moja.' However, if you want to meet someone for dinner at 7 p.m., you tell them to meet you at 'moja', even though the number '7' is 'saba.' One reason for this, as Wycliffe carefully explains, is the history of time relatedness to sunrise (6 a.m.). So '7' becomes one (or 'moja') hour after 6, '8' becomes two, and so on. Google 'Swahili clock' and see for yourself.

This (perhaps confusing) example conveys the concept that details are sometimes not the same in different settings, affecting the ways things are processed, performed, executed and discussed. Issues like language, the concept of time, available resources, verbal and non-verbal communication, cultural norms and prior experience and exposures are key to essential parts of research. Typical research milestones like writing a grant, designing a protocol, executing a study, obtaining a consent form, enrolling patients, explaining an intervention or a laboratory test, quality controlling data, conducting data analyses and writing a paper collaboratively – all key for research, can be new experiences in new settings. Limited funding, long flight hours, price of phone bills and dusty shoes can all add to the burden. Addressing such challenges and learning from the experiences that this program provides offer endless opportunities.

CONCLUSIONS

Everyone who is involved with the Brown Kenya Program has their own story to tell and their own journey to travel. When people hear that I work in Kenya, their questions indicate that they're sure there is nothing there. After all, it's a developing country, with limited resources; what can possibly be accomplished there? In this article I tried to paint the picture, describe the grounds, and provide information on how far from the truth this notion is. I tried, partly through my own experience, to show what great work that answers important questions can be done through the Brown Kenya Program. I attempted to show that research helps build infrastructure and capacity to address important questions that can be translated to patient care.

This wonderful journey started with a quick meeting with Dr. Carter. It continued with the support of my superb research group including Leeann Schreier, Dr. Mia Coetzer and Dr. Austin Huang; the Brown/Lifespan/Tufts CFAR, the Brown Infectious Disease Division, and the Department of Medicine. Such an adventure is only possible due to the outstanding infrastructure that is in place through the Brown Kenya Program, which is a great testimony for the opportunities that lie ahead. ❖

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Challenges of Developing a Formal Subspecialty Pulmonary Training Program in Kenya

JAMES MYERS, MD



PHOTO: COURTESY OF DR. JIM MYERS

Dr. James Myers with a patient in Kenya.

Global medicine is now focused on non-communicable diseases such as hypertension, COPD, and diabetes. Unfortunately, there is little infrastructure in many low-income countries to properly diagnose and treat these diseases. In addition, the clinical expertise to care for patients may also be lacking. For example, in all of East Africa, there are only eight formally trained pulmonologists.

In 2009 Moi University School of Medicine (MUSOM) was awarded a grant from the National Heart Lung Blood Institute as one of 13 sites worldwide to develop a Center of Excellence (COE) in cardiopulmonary research. In parallel with that research initiative, the AMPATH consortium with Brown as the lead sought to develop clinical pulmonary training at Moi as well.

For the last 10 years, an informal pulmonary consultation service had existed. Dr. Lameck Diero, now the chair of medicine at MUSOM, had been trained

in fiberoptic bronchoscopy parallel to the development of the HIV Care program. Bronchoscopy was focused at that time on the opportunistic infections that followed on the heels of untreated HIV. With advancing HIV treatment, the incidence of these diseases fell. Dr. Diero remained interested in pulmonary medicine as the head of the chest clinic but his departmental responsibilities, coupled with the lack of trained pulmonary colleagues, has limited expansion of pulmonary services.

The first pulmonary clinical research fellow matriculated in 2009. Coincident with his research training, we developed a clinical training curriculum. Faculty consisted of the pulmonary faculty from consortium schools who were already rotating to MUSOM as part of the exchange program. A curriculum of pathophysiology and disease-specific lectures was developed. When US faculty was on site, mentored clinical time in the chest clinic, ward consultation and ICU rounds, and fiberoptic bronchoscopy were conducted in addition to the pulmonary lecture series.

With this initiative, pulmonary expertise on site has improved, although there remains much to be done. Pulmonary certification standards within Kenya have not yet been established; thus, trainees of the MUSOM pulmonary track can be considered only pulmonary-interest physicians at this point. Basic pulmonary function diagnostic testing is available, although there is not a formal pulmonary function lab established to date. Dr. David Lagat, the first COE research trainee, has submitted his manuscript from his work on isolated right heart failure and exposure to indoor air pollution in women. This research has now raised awareness of pulmonary disease and exposures at MUSOM and sparked

interest in the field of pulmonary medicine. Lessons learned from these early training experiences, such as the need for consistent rather than intermittent on-the-ground mentoring, are being used to improve and develop better training experiences.

Four years ago, Dennis Oyiengo, a Kenyan medical officer, came to Brown from Eldoret for additional training. He has since completed his internship and residency in internal medicine. He is currently a pulmonary and critical care fellow in the Brown program. Dennis is doing very well in his fellowship training. It is his hope and ours that he will return to Kenya in the future to become involved in helping to lead the pulmonary efforts at Moi.

Despite some missteps in training, over the years pulmonary care has improved at Moi. Under the direction of Dr. Jane Carter, tuberculosis management has lessened the burden of disease across all of western Kenya. As the AIDS epidemic has peaked and started to decline with the availability of better drugs, cases of pneumocystis and AIDS-related pneumonias are less prevalent. The greater availability of chest x-rays and chest CT scans has made more specific diagnoses possible.

Younger Kenyan physicians are becoming increasingly aware of their need to lead the way in program development, not just in pulmonary but in all areas of medicine. This change in focus will certainly help make control of non-communicable diseases more likely in Kenya. ♦

Author

Dr. James Myers is Clinical Associate Professor of Medicine at the Alpert Medical School of Brown University. He is one of the founders of the Brown Kenya Program and is a pulmonologist at Coastal Medical of Rhode Island.

Gastroenterology in Eldoret: Make the Journey; Share the Knowledge

NICHOLAS A. CALIFANO, MD

In 2006, my daughter Sophia, then a 4th year medical student at Brown, jumped for joy when there was a sudden opening and she was accepted to go to Kenya with Dr. Jane Carter, our program director. "I'm going to Kenya," she exclaimed, jumping up and down. "Not without me," said I. And so we went together on a life's journey into another world and culture that changed us forever. We spent a month there on that first trip and ended it on safari.

Since then I have returned several times. Our last trip was canceled because of political unrest regarding presidential elections there.

What does the Kenya Program offer in gastroenterology?

Moi University Teaching and Referral Hospital represents a huge medical facility located in Eldoret, Kenya, in the middle of the Great Rift Valley. It is a sprawling, beautifully landscaped assortment of specialty buildings connected by covered walkways surrounded by flowers and filled with the broad smiling faces of the always friendly Kenyans, patients, workers, nurses and physicians in motion.

Each specialty of medicine has its own building complex: surgery, gynecology, obstetrics, psychiatry, urology, medicine, and others. So it is easy to interact with colleagues and share in their experiences. The medical wards are a separate, large complex of beds with men and women separated into two wards of 48 beds each. This number does not reflect the number of patients as there are often two in each bed lying head to foot, side by side.

Each 48-bed ward is divided into open eight-bed rooms, three on each side, with large open windows giving ample light and ventilation. The beds now have curtains and some privacy. Three sets of eight-bed rooms are called a "Firm" and that is the teaching unit. When I first appeared at Moi, I was assigned to Ward 1, Firm 1, as an attending and consultant; which meant that I had the women's side (Ward 1) and three rooms of eight beds each (Firm 1).



PHOTOS: BROWN KENYA PROGRAM

Dr. Nicholas Califano and daughter, Sophia, at far right, and other Brown medical students upon their arrival in Kenya, where they spent a month working at the Moi Teaching and Referral Hospital.

DAILY ROUTINE

We began medical rounds daily at the very civilized hour of 9 a.m. with the Kenyan registrars and medical students, the U.S. residents and students, pharmacy and nursing students and nurses – at times a crowd! We rounded, going from bed to bed, until 11:30 a.m., when the ward doors flew open and hoards of visiting family and friends bringing food and clean bedclothes would inundate the space. That ended the serious rounding. We would go back to the IU House for lunch at noon, always an exciting gathering of stimulating people sharing world experiences. I would return to the wards in the early afternoon to discuss GI cases of particular interest, see new GI consultations from there or from other specialty

wards, or give a core lecture to Kenyan medical students on various subjects.

When they learned that a GI consultant was available and ready to work, then the requests came in. Most of what we did was based on clinical presentation and our physical examinations. We could get basic lab tests (often with delays) but most of the testing that we so depend upon here was just not available. We did have ultrasound and CT scanning and these services are improving.

However, even though this is a government hospital, all patients are charged something for their daily stay and for every test or procedure ordered (a colonoscopy or EGD cost 1,000 KS then, about \$14). This was paid to the hospital; doctors' services were gratis; they are paid by the state. These fees could be onerous for the Kenyans. If they could not pay up front then the test or procedure would be delayed and they would have a family member go back to their village to try to raise funds. And patients were kept in the hospital and not allowed to leave until fees were paid. So we had to severely limit requests for testing and rely on clinical skills.

At times we would have a morning report about an interesting GI case (we had excellent computer services so all info was right at hand). In the afternoons we could relax, study, jog, wander about the town or travel.

DAY 1 DIARY

From my own diary during my very first day of my first visit to Moi in 2006 I saw:

1. Tb meningitis
2. Bacterial meningitis
3. DVT in calf of a man failing HIV therapy
4. Renal Cell CA with IVC invasion and edema
5. AML?
6. Hepatomegaly w. huge nodular liver and no ascites
7. PCP pneumonia
8. Active pulmonary Tb
9. Malaria, Tb, and ? toxoplasmosis
10. Advanced rheumatic heart disease, multiple murmurs, huge globular heart
11. Peritonitis of pelvis
12. Cachexia, wgt. loss, anemia
13. Megaloblastic anemia, Hgb 4
14. DKA Type I diabetes
15. Tb, malaria, hypotension...



The Moi hospital in Kenya is a sprawling and interconnected complex of general and specialty wards and labs.

ESTABLISHING AN ENDOSCOPY CENTER

As a gastroenterologist I was able to help establish an active Endoscopy Center and, on subsequent trips, was able to bring over good scopes and equipment. But, as in all Third World countries, when they are not fixed, they eventually stay broken and get discarded; and there follows a frantic quest to re-equip. There is no sustainability as of yet.

We worked side-by-side with trained surgeons and GIs there and they certainly appreciated the teaching. On the mornings that we had cases booked, we would start in the "Operating Theatre" at 8 or 9 a.m., then break for tea (chai, the real thing) and continue till finished. We gave the anesthesia and used only diazepam. The Kenyan patients are very stoic and they tried to smile and never complained. We set a record there of 10 cases done in one day, very unusual as scheduling was spotty. Some patients travelled for days from very faraway villages to be seen.

Colonoscopies were rare; they don't seem to have much colon CA nor polyps and there is no screening. There is no diverticulosis but the young Kenyans do get serious sigmoid volvuli that present emergently and usually need surgery. Most cases were EGDs – there was no capability to do ERCPs. We saw lots of esophageal CA, strictures, GERD, H. Pylori gastritis and ulcers, gastric CA, varices due to the usual things but also due to Schistosomiasis and Kala-Azar (Leishmaniasis). We saw many undiagnosed diseases, a lot of toxicities (gastritis and bleeding and death) from herbal remedies, leptospirosis, aflatoxin toxicity and liver diseases, and complications of Tb and HIV – these will be seen much less now with the excellent care provided by AMPATH. We also started a GI clinic to see outpatients and prisoners; I am not sure if and how it is working now.

So our basic activities were divided on a very irregular



Pediatric patient at Moi Teaching and Referral Hospital.

basis and included consultations, rounding on the medical wards (always with lots of help and back-up), endoscopy service, and GI clinic. I also gave core and other lectures on GI subjects as requested. I did bring some Power Point slides and prior talks with me.

The Department of Gastroenterology is growing and there is some great news. Dr. Fatma Some is the chief of GI and is an excellent endoscopist and physician, and other medical and surgical colleagues contribute. We will be greatly aided there by the addition of an onsite, superbly trained (Duke) gastroenterologist and medical informatics expert, Thomas Carr, MD, who is just readying to leave. He will bring his family and will stay there; his support will be from Duke, and there are wonderful opportunities for the program to favorably explode with his onsite supervision and continuity of care.

We are working in a resource-constrained country that is developing. There is a huge ability to help upgrade their services, their endoscopy equipment, their disinfection/

sterilization of scopes, and computerizing it all and making it all sustainable. We can offer what we do here routinely and apply it there as something new. So please join us in Kenya on a mission that will help change their lives and will certainly change yours. It will be a mind-expanding experience of a lifetime. And bring along a friend, partner, or family member while you're at it. ❖

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Return to Kenya After 37 Years: Cultural and Medical Observations

GEOFFREY BERG, MD

In 1975, I spent my last three months of medical school working at a mission hospital in Kenya. It was a wonderful experience and I had always planned to go back but life got in the way. Finally, time and finances worked out so I could take part in the Brown Kenya Program in January 2012. The interval gave me the opportunity to see what had changed and what had remained the same.

The first thing that struck me was that despite a more than doubling of the population and an AIDS epidemic, modernization marched on. As an example, whereas in 1975, 90 percent of the roads were unpaved and the roofs were thatched, those ratios were reversed when I returned. And of course everyone has a cell phone.

The population explosion was evident in the towns. Eldoret was a sleepy little town in 1975 and is now a burgeoning metropolis of more than 200,000. However, progress has not come without a cost. As people acquire western amenities they also are acquiring western diseases. Over three months in 1975, I rarely saw diabetes and never saw a case of coronary artery disease. The former is becoming

prevalent and the latter is not far behind.

The AMPATH program of which Brown is a part has made miraculous progress dealing with HIV. They are expanding into chronic diseases like diabetes screening. One would hope that progress in that area is taken a step further with education programs so that Kenya can move into the future without taking on the health problems associated with western progress.

Despite my previous experience, as a practitioner of outpatient internal medicine in Providence, I experienced culture shock when thrust into the role of inpatient ward attending half a world away in Eldoret. I instantly became the presumptive leader of up to 15 house officers, students, pharmacist, nurses, etc., working within a system, language, and diseases that were all foreign to me.

Kenya has come a long way since I was first there and still has a long way to go. Good clinicians, regardless of their knowledge base in tropical medicine, can help in that journey.



Dr. Jane Carter, director of the Brown Kenya Program, was in Kenya in September and took these photos of medical workers (next page) and a new facility being built (left) at the Moi Teaching and Referral Hospital in Eldoret, which is the second largest referral facility in the country providing specialized care to patients from western Kenya and neighboring countries. The new building will increase Moi's capacity to address the challenge posed by Non-Communicable Diseases (NCDs).



JANE CARTER, MD

MAKING ROUNDS PATIENT-CENTERED

Once I got my bearings, I had to figure out how I could make a contribution to the care of patients and the education of students. For me this came when I tried to make the rounding process more patient-centered. This I tried to do in the following manner.

Rounds are conducted in English, which most patients don't speak, and they tend to emphasize teaching, since there are so many to be taught. For the most part, then, the patients are spoken about but almost never to. I made a point that each medical student has the responsibility after rounds of going back to their patient and explaining the treatment plan to the patient and give them the opportunity to have their questions answered.

Going from the classroom to the wards involves taking book learning and applying it to actual patients. This is a difficult transition in any situation but at Moi it is not really emphasized. As an example, we were rounding on a patient in renal failure with mental confusion and shortness of breath. The Kenyan attending had the students come up with a thorough list of all the problems that come with renal failure. I in turn had them look at the patient and look at the real-life manifestations that were there before them, pointing out that dialysis, cleaning the patient's blood and getting rid of extra fluid will go a long way to making the patient think and breath better.



Dr. Berg and Kenyan physicians and trainees during his visit in 2012.

ACCOUNTABILITY EXERCISE

Another area where I felt I could influence students and, in turn, be a service was in matters of accountability. Kenyan medical students are literally the brightest students in the country. That said, they have a reluctance to take responsibility and be accountable for their actions. I tried to address the issue with an experiment.

I had medical students on my team pledge to me that they would perform some task on a patient they were covering. The following day one of the students had said that he would perform a rectal exam and test for occult blood on a patient with anemia. He had not done it, so on rounds I went through an accountability exercise I had learned.

Did you make an agreement with me?

Yes.

Did you keep that agreement?

No.

What did you choose to do instead?

Not sure.

How did this affect others?

Loss of trust with me.

Don't know if the patient is bleeding.

How does this affect you?

Loss of learning opportunity.

How can you get back in accountability?

Do the stool guaiac after rounds.

After rounds I showed the student how to do a rectal exam and rather reluctantly he did it himself. Then the problems started. There were no stool cards in the side lab. There were no stool cards in the main lab. There was a suggestion that we take it to a private office who knows where and pay who knows what. Finally, the main lab suggested we try the maternity lab. With each new problem I was getting more dejected.

However, with each new problem, the student was getting more and more animated with the challenge. By the time we figured we could do it in the maternity ward, he was practically dragging me there to fulfill the mission we had started but now was clearly his. In the maternity lab we experienced a few bureaucratic hurdles before we got our answer – guaiac negative. Much more importantly, on the way to the maternity lab the student earned an "A" in accountability which showed up in his work throughout the remainder of his month on the wards.

Kenya has come a long way since I was first there and still has a long way to go. Good clinicians, regardless of their knowledge base in tropical medicine, can help in that journey. ❖

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Building a Diabetes Educational and Clinical Program in Kenya

CHARLES 'BUD' KAHN, MD

My wife and I first traveled to Eldoret in February, 2005. I was the Brown faculty member for the month, primarily responsible for teaching on a general medical ward at Moi Teaching and Referral Hospital (MTRH). Aside from these duties, I began a series of lectures in diabetes and clinical endocrinology for the residents. What struck me the most was the inadequate care of the diabetic patients, particularly on the wards. Glucose values were sent to the lab as there was no bedside glucose monitoring. A1c testing was not available at MTRH or anywhere in western Kenya. Dietitians were present on the wards. However, diabetic education was very limited. There was an outpatient diabetes clinic but it was manned by one private physician, not trained as an endocrinologist, and a few residents.

Upon my return to Brown, I began to investigate what could be done. I was able to secure the first A1c machine to be used at MTRH. In addition, I received a contribution to buy the cartridges for the A1c machine from The Miriam Hospital medical staff. To further build the diabetes program, I solicited the help of others living and working in Kenya. I was joined in this effort by Nicholas Kirui, a Kenyan medical officer; Jemima Kamano, medical director of the AMPATH Primary Care Program, and Sonak Pastakia, PharmD and a long-term faculty member from Purdue.

Through the hard work of this team, the program has grown substantially over the past several years. The emphasis remains on both inpatient and outpatient diabetic care. The primary clinic is at MTRH, but there are now three outpatient satellites in other parts of western Kenya served by AMPATH Clinics. Eli Lilly & Co. has supplied insulin and Abbott Pharmaceuticals has provided the bedside glucose monitoring, which is used for diabetics in both the hospital and in the clinics.

At Moi, a pilot project has started of lending out the home glucose monitors to insulin- and non-insulin dependent



From left are Drs. Charles 'Bud' Kahn, Nicholas Kirui, a Kenyan medical officer; Jemima Kamano, medical director of the AMPATH Primary Care Program, and Sonak Pastakia, PharmD and a long-term faculty member from Purdue.

patients and having them test twice daily. Phone calls are then made to these patients and appropriate adjustments are made in their treatment regimen. Furthermore, diabetes education has been established both at MTRH and at the satellite clinics. Several publications have been written based on the work of the program. Additional A1c machines have been secured. More satellite clinics will hopefully be added soon.

I have continued to stay involved with the program as an advisor. My wife and I have returned three more times to Eldoret. I know that the future of diabetes medicine in western Kenya is much brighter now than it was during my first visit in 2005. ❖

Author

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Two Kenyan Physicians Studying at Brown Share Perspectives

DRS. JANE KAMUREN AND DENNIS O'YIENGO



Drs. Jane Kamuren and Dennis O'Yiengo and their children.

Jane Kamuren is completing her first year of internal medicine training at the Alpert Medical School at Brown University. She trained at Moi University and was working as a medical officer in casualty at Moi Teaching and Referral Hospital before coming to Brown. Her husband, Dennis O'Yiengo, is completing his first year of pulmonary and critical care medicine fellowship at the Alpert Medical School. He also completed his residency in internal medicine at Brown. Prior to that he was a medical officer assigned to AMPATH. Jane and Dennis have a unique perspective on the medical systems in both Kenya and the United States. Here are their thoughts.

Training in the United States has been a great opportunity for us. We count ourselves fortunate to have had the privilege to train in two different healthcare systems.

Similar to many low-income countries, Kenya's medical training and healthcare system is resource constrained. A majority of Kenyans pay for their care out-of-pocket, as only a small proportion has health insurance. The Kenyan-trained physician is thus encouraged to take a detailed history and physical exam and limit investigations to those with the highest yield. Routine or daily labs are not done. A majority of the patients present late in their disease course. Often they have progressed to having classic symptoms and physical findings that allow treatment without requiring further investigations. For example, a patient presenting

with several weeks of dyspnea, an S3 gallop, crackles, and peripheral edema will be treated with diuretics for congestive heart failure without obtaining a CXR or BNP.

However, at other times, a lack of an obvious diagnosis and an inability to order further testing makes empiric treatment necessary. Differentials are often limited to reduce the cost of the work-up. With a lack of subspecialists in Kenya, we are required to be much more hands on with procedures, even as medical students.

In contrast, we find that patients in the American system usually present early in their disease course so that work-ups tend to be comprehensive. For example, a patient presenting with two hours of chest pain may have several causes that will need to be investigated. In general, work-ups are not limited by cost or social status, but by the extent to which the evaluating physician can generate differential diagnoses. This makes the probability of missing pathology very low. Ordering tests without having to consider cost was thus challenging and difficult for us. We have also found that the system here is more patient-centered, with doctors/ healthcare workers making it a priority to involve patients in decision-making. It was striking to us the emphasis placed on research and evidence-based medicine, with protocols faithfully followed to the letter.

As we have stated, we have experienced obvious differences in the healthcare systems in Kenya and the United States. Yet in the same breath there are subtle similarities. Initially it seems that resources are bountiful; however, looking keenly, one appreciates that not all tests and treatments are available for all patients. There is great disparity in healthcare access influenced by socioeconomic status in the U.S.

system. In both systems, patient compliance can be an issue. Both in Kenya and the United States, doctors are generally respected for the work they do and their value to society. Our greatest challenge yet will be going back to practice in Kenya. We will have to find a middle ground and strike a new balance between the two systems that will still be affordable and viable for the Kenyan people. ❖

Riley Mother & Baby Hospital, Eldoret

'...In this very special place no child shall cry unheard, and no mother or father shall be friendless'

— Entrance plaque



The Riley Mother & Baby Hospital in Eldoret, which opened several years ago, replaced a substandard space with no running water and where newborns were placed in hanging baskets. Over 8,000 babies a year are delivered at the hospital, which is run by Kenyan physicians and nurses. Through their efforts, the rate of transmission of HIV between mothers and babies has declined from 35 percent to less than 1 percent because of screening efforts by AMPATH and the IU School of Medicine and Moi University partnership at Riley. It also contains the first neo-natal intensive care unit (NICU) in East Africa.

Opportunities for Improving Legislative Public Health Policy in Rhode Island Through Evidence-Based Education

MOISE BOURDEAU, BA; RONALD WINTER, JD; ROBERT MARSHALL, PhD

ABSTRACT

The Rhode Island General Assembly considers nearly 3000 bills yearly – spanning the entire range of issues related to state government and legislative policy. This review analyzes the modest number of 40 “health-related” bills introduced during the 2009 session. It is often not clear to what extent these proposals consistently received analysis by both informed and independent organizations or experts regarding their “evidence-based” foundations. Only 25 of these bills received a committee hearing, and eventually become law. Hence, there may be a reasonable opportunity for expert, non-partisan organizations to provide the General Assembly with information related to proposed legislation on a routine or “as requested” basis. This study provides a systematic analysis of this degree of effort based on data regarding health-related legislation proposed during the 2009 session of the RI General Assembly.

KEYWORDS: Public Health, Legislative Policy, Education

INTRODUCTION

In 2007 the Rhode Island Medical Society (RIMS) offered its members a new seminar on politics and public policy.¹ The event drew many supportive comments, including the observation from some that they needed to get “way beyond billing issues” and “think about improving the future of health care” in Rhode Island and the country. A number of public policy educational programs followed and still continue today.

Similarly, the Rhode Island Public Health Association (RIPHA), the Rhode Island State Affiliate of the American Public Health Association, brings together more than 100 professionals in a unique, multi-disciplinary environment for idea exchange, study, and action. As one part of their activity, RIPHA currently publishes numerous “data briefs” each year on a wide range of policy and practice issues. These briefs are circulated to the legislature and to others throughout the state who are interested in public health.

Recently public health and law have come together to study the interaction between the two disciplines. For example, the Robert Wood Johnson Foundation set up the Public Health Law Research² group at the Temple University Law School. Much of the work in the field focuses on the

effect of completed legislation on public health practice. However, substantial interest remains on establishing an evidence-based educational role to assist the Legislature through the process of policy development. There is some discussion locally of implementing this role through an organization such as the Rhode Island Public Health Association.

Study design and dimensions

Interest in health policy can get put off, however, by the seemingly overwhelming number and complexity of issues and proposals that occur every year. The overall purpose of the project is to analyze information on the number and disposition of health-related bills in one session of the RI General Assembly. It focused on the 2009 session as the most recent and complete source of information on legislative activity available at the time.

Background and setting

The legislative process in Rhode Island involves a part-time legislature with the major responsibility for reviewing and advising the members assigned to various committees or sub-committees. With only limited permanent staff, legislators and committees often look to other various sources of information to inform policy making. Information typically arises from points of view based on the special interests of individuals, groups and organizations rather than from “evidence-based” (e.g. research and practice) findings emanating from independent and systematic evaluation. This raises the question of whether an external, non-partisan source of expertise may become instrumental for filling some of the gaps in the process of developing public health legislation. A systematic analysis of the disposition of these bills would provide valuable information for organizations interested in the magnitude of the policy-making process.

Study objectives

- (1) To identify health-related bills introduced in the 2009 session of RI General Assembly.
- (2) To determine how many of those bills were given serious consideration. Preliminary analysis indicated that unless a bill received a committee hearing, it was unlikely to become a statute.
- (3) To estimate the potential demand for evidence-based advice and information on various topics under consideration.

Rhode Island 2009 House of Representatives Health Bills

Bill No	House Committee	Hearing & Recommend Passage	House Pass	Senate Committee	Hearing & Recommend Passage	Senate Pass	Statute
H 5039	Judiciary	√	√	Judiciary	√	√	√
H 5112 C	Finance	√	√	Finance	√	√	√
H 5252	HEW	√	√	HHS	√	√	√
H 5253	HEW	√	√	Judiciary	√	√	√
H 5273 B	Corporations	√	√	HHS	√	√	√
H 5359	HEW	√	√	HHS	√	√	√
H 5393	HEW	√	√	HHS	√	√	√
H 5415 B	HEW	√	√	HHS	√	√	√
H 5449	Corporations	√	√	HHS	√	√	√
H 5453 B	Corporations	√	√	HHS	√	√	√
H 5479 B	HEW	√	√	HHS	√	√	√
H5266 A	HEW	√	√	HHS	√	√	√
H 5022	HEW	HFS	HFS	*	----	----	----
H 5132	HEW	HFS	HFS	*	----	----	----
H 5219	Judiciary	HFS	HFS	*	----	----	----
H 5287	HEW	HFS	HFS	*	----	----	----
H 5308	Corporations	HFS	HFS	*	----	----	----
H 5334	HEW	HFS	HFS	*	----	----	----
H 5397	Corporations	HFS	HFS	*	----	----	----
H 5399	Corporations	HFS	HFS	*	----	----	----
H 5413	Finance	HFS	HFS	*	----	----	----
H 5423	Judiciary	No Action	----	*	----	----	----
H 5425	Judiciary	No Action	----	*	----	----	----
H 5459	Corporations	HFS	HFS	*	----	----	----
H 5398	Corporations	No Action	----	*	----	----	----
H 5218	Environment	√	√	Environment & Agriculture	No Action	----	----

√ = Hearing and Recommended Passage

HFS = Hold for Further Study

* = Not Considered by Senate

HEW = House Health, Education and Welfare

HHS = Senate Health and Human Services

2009 Rhode Island Senate Health Bills

Bill No	Senate Committee	Hearing or Action	Senate Pass	House Committee	Hearing & Recommend Passage	House Pass	Statute
S 185	HHS	√	√	HEW	√	√	√
S 242	HHS	√	√	HEW	√	√	√
S 245	HHS	√	√	HEW	√	√	√
S 390	HHS	√	√	Corporations	√	√	√
S 539	HHS	√	√	Corporations	√	√	√
S 540	HHS	√	√	Corporations	√	√	√
S 542	HHS	√	√	Corporations	√	√	√
S 543	HHS	√	√	HEW	√	√	√
S 552	HHS	√	√	HEW	√	√	√
S 710	HHS	√	√	HEW	No Action	-----	-----
S 752	HHS	√	√	HEW	√	√	√
S 777	HHS	√	√	HEW	√	√	√
S 866	HHS	√	√	NONE	NONE	√	√
S 991	HHS	√	√	Corporations	√	√	√
S 320	Judiciary	HFS	-----	*	-----	-----	-----
S 534	HHS	HFS	-----	*	-----	-----	-----
S 547	HHS	HFS	-----	*	-----	-----	-----
S 576	HHS	HFS	-----	*	-----	-----	-----
S 707	HHS	HFS	-----	*	-----	-----	-----
S 711	HHS	HFS	-----	*	-----	-----	-----

HEW = Health Education and Welfare

HHS = Health and Human Services

√ = Hearing and Recommended Passage

HFS = Hold for Further Study Without Hearing

* = Not Considered by House

Study Steps

- (1) Consult with members of the General Assembly, staff and other offices for advice and access regarding the designation and enumeration of health-related legislation.
- (2) Identify health-related legislation introduced during the 2009 session, using legislative website.
- (3) Follow these bills through records on the legislative process, focusing on those receiving hearings and eventual passage into law.
- (4) Construct a matrix identifying each bill and tracking completed steps.
- (5) Prepare a final report of the project objectives, methods, findings and implications for public health policy and assistance with evidence-based information.
- (6) Brief members of RIPHA, the Public Health Think-Tank and/or other interested parties on the project findings.

STUDY DATA AND FINDINGS

The project team accessed the General Assembly website listing all of the legislation introduced during the 2009 legislative. Next, the team electronically “searched” all the bills for those which contained the words “health” or “public health” in the title or body of the bill. The legal expert on the project team reviewed the title and text of each selected bill to determine which bills actually addressed public health policy. The search was further refined to focus on those bills involving topics to which non-partisan, health and/or public health related expert organizations could add value. (See Tables I and II for bills and legislative steps.)

RI Legislation Bills Introduced 2009

	SENATE	HOUSE	TOTAL
Bills Submitted	1071	1463	2534
Health-Related*	14	26	40
Passed after Hearing**	13	12	25

* Includes only “key” bills with “health” or “public health” in the title and determined, after review by the project legal expert, to affect public health policy.

** Passed into law after Committee hearings in either chamber.

In a final step, the project staff reviewed the progress of each of the 40 “key” health-related bills through the legislative process, focusing on those which received committee hearings in either chamber and passed into law. Only 25 bills went through the entire process and became law. (See House and Senate Tables I and II on previous page.)

STUDY CONCLUSIONS

The project results indicate that the public health policy-making process in Rhode Island could benefit from regular access to evidence-based review and comment from an expert and non-partisan source. It suggests that members of a professional association, such as the RIPHA or RIMS, could provide this service — especially with the modest number of policies under active consideration by the Legislature (i.e.

given a Committee hearing) during the session. With limited time and other resources available to a part-time legislature, our review indicated that getting a committee hearing was the key marker indicating serious consideration being given to proposed legislation.

The results of this analysis, based on bills introduced during 2009, indicate that as few as 40 target public health policies were proposed; only 25 of those underwent a committee hearing and passed into law by the end of the session. The maximum number of requests for assistance to a non-partisan, expert organization would be approximately 25. With some assistance from staff of the legislature being available, it can be posited that all of the 25 bills would not require a call for external, non-partisan source of expertise. This clearly indicates that response by such non-partisan, expert organizations to legislative requests for expert commentary is well within the available capacity of several existing professional associations in Rhode Island.

NEXT STEPS

The Public Health Law Research program of the Robert Wood Johnson Foundation³ supports the idea of building evidence for and strengthening the use of regulatory, legal and policy solutions to improve public health. Evidence informs questions such as: How does law influence health and health behavior? Which laws have the greatest impact? RIPHA and RIMS, either independently or in association, should consider taking a more active role providing this kind of advice and consultation, as requested by the RI legislature, on an ongoing basis.

Acknowledgement

This project was supported by a Rhode Island Public Health Institute Faculty-Student Collaborative Project Grant, 2011 through funding by the Health Resources and Services Administration (HRSA).

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Financial disclosures

The authors have no financial disclosures to report.

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Rhode Island Monthly Vital Statistics Report

Provisional Occurrence Data from the Division of Vital Records

VITAL EVENTS	REPORTING PERIOD		
	APRIL 2013	12 MONTHS ENDING WITH APRIL 2013	
	Number	Number	Rates
Live Births	945	11,625	11.0*
Deaths	855	9,849	9.4*
Infant Deaths	5	81	7.0#
Neonatal Deaths	3	59	5.1#
Marriages	38	6,234	5.9*
Divorces	226	3,409	3.2*
Induced Terminations	No data available		
Spontaneous Fetal Deaths	No data available		
Under 20 weeks gestation	No data available		
20+ weeks gestation	No data available		

* Rates per 1,000 estimated population

Rates per 1,000 live births

Underlying Cause of Death Category	REPORTING PERIOD			
	OCTOBER 2012	12 MONTHS ENDING WITH OCTOBER 2012		
	Number (a)	Number (a)	Rates (b)	YPLL (c)
Diseases of the Heart	199	2,328	229.7	3,444.5
Malignant Neoplasms	170	2,189	208.6	5,637.0
Cerebrovascular Disease	38	434	42.2	684.5
Injuries (Accident/Suicide/Homicide)	50	703	65.7	9,124.5
COPD	32	493	47.3	435.0

(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 1,052,567 (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.

Lemierre's Syndrome in 15-year-old female

WILLIAM LOVERME, MD; KATHLEEN M. MCCARTEN, MD

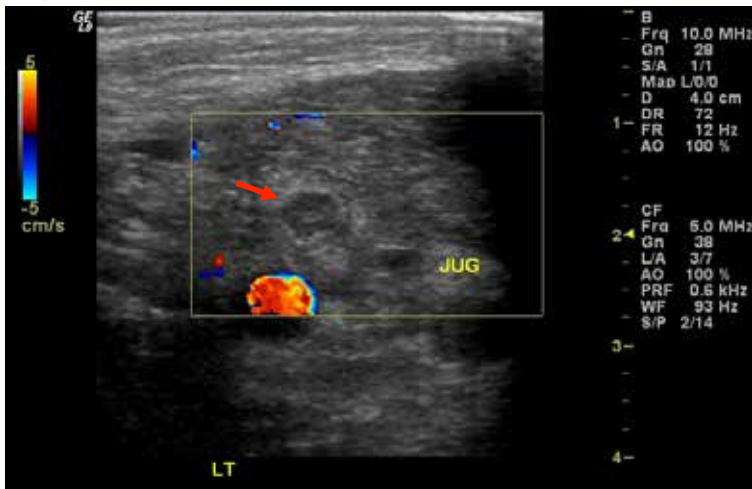
INTRODUCTION

A 15-year-old female initially presented to her primary care physician with sore throat, fever, difficulty swallowing, and neck swelling. A rapid strep test was performed and was positive. A CT of the neck was ordered and demonstrated moderate enlargement of the tonsils bilaterally, but no evidence of abscess (**Image 1**).

Image 1. CT of the neck demonstrating bilateral tonsillar enlargement, but no abscess.



Image 2. Ultrasound of the neck demonstrating left internal jugular thrombosis.

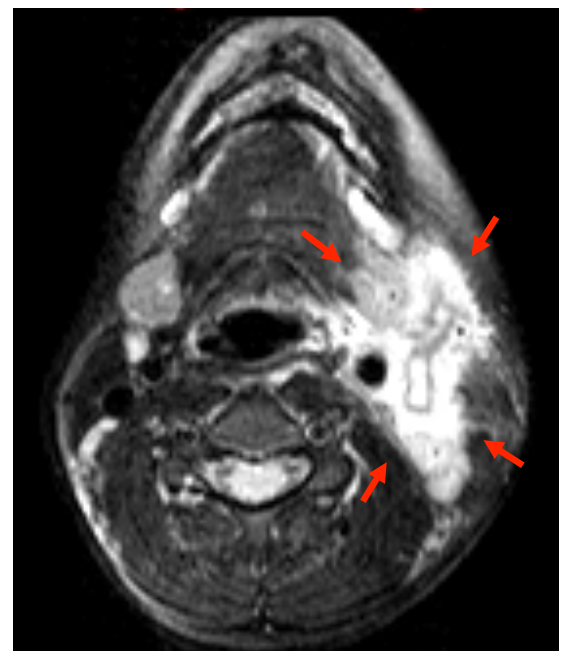


The patient was admitted to the hospital and started on clindamycin 900 mg q8h IV, with improvement. She was switched to oral clindamycin 600 mg q8h, discharged on hospital day three, and instructed to complete an 18-day course of antibiotics as an outpatient. Blood cultures obtained during the initial hospitalization were negative.

Three days following discharge, the patient returned to her primary care physician with continued sporadic fevers and increasing left neck pain. Physical exam demonstrated an asymmetrically swollen left neck. A neck ultrasound was also ordered and demonstrated left internal jugular thrombophlebitis (**Image 2**).

The patient was readmitted to the hospital. An MRI/MRA of the neck and face was ordered to further characterize the ultrasound findings and demonstrated thrombosis within the middle 3rd of the left internal jugular vein. There was severe soft tissue inflammation from the level of the left pterygoid musculature down to the level of C5/6. There was diffuse left sided cervical lymphadenopathy. The remainder of the vasculature throughout the neck was patent (**Image 3**).

Image 3. A T2 weighted image from an MRI/MRA of the neck demonstrating thrombosis of the left internal jugular vein and ipsilateral soft tissue inflammation.



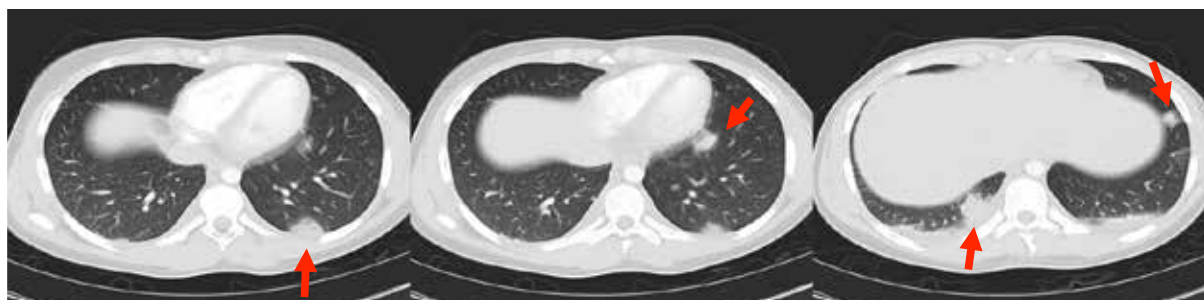


Image 4.
CTPE study
demonstrating
septic emboli at
the lung bases.

ENT, pediatric surgery and hematology/oncology teams were consulted for the left jugular vein thrombophlebitis. Medical management with Lovenox was initiated. An MRI/MRA of the head was obtained to rule out sagittal sinus thrombosis and was normal. A cardiac echo was obtained to rule out vegetation and was also normal.

One day after admission to the hospital, the patient developed sudden severe chest pain. A CT pulmonary embolus study was ordered and demonstrated multiple nodular and wedge-shaped opacities in a peripheral distribution in both lower lobes, suggestive of septic emboli (**Image 4**).

DISCUSSION

Lemierre's syndrome (synonyms: Jugular vein suppurative thrombophlebitis, postanginal sepsis, necrobacillosis, and "Forgotten Disease") is a potentially lethal condition in a young and healthy patient population. The syndrome consists of pharyngitis progressing to jugular vein thrombophlebitis. Infection progresses from the oropharynx to the parapharyngeal or lateral pharyngeal space, typically in less than one week. The disease affects otherwise healthy young adults with a mean age of onset of 20 years. As such, the disease is frequently unsuspected and imaging findings often precede clinical suspicion. The disease was more common in the pre-antibiotic era, but there has been a reemergence of cases due to antibiotic resistance.

The clinical presentation of a young patient with persistent fever despite antibiotic therapy and neck pain should

raise suspicion. Occasionally, the patient will present with tonsil abscess or even purulent drainage of the involved vessel. Septic emboli to the lung is a hallmark of the disease and occurs in 80-97% of cases.

When the diagnosis is suspected in a patient older than 14 years, a CT of the neck with contrast is the imaging study of choice. For the pediatric population under 14 years of age, an ultrasound of the neck can be ordered first. Diagnosis is established with imaging demonstrating jugular vein thrombosis in the appropriate clinical setting. The classic imaging triad, as present in the case above, consists of 1) ipsilateral pharyngeal fullness, 2) pulmonary septic emboli, and 3) neck vein thrombosis (**Figure 1**).

Patients may have metastatic infection elsewhere and the clinician should be aware of empyema, septic arthritis, and/or osteomyelitis as possible complications. Intracranial complications include meningitis, abscess, and cavernous sinus thrombosis. Additional diagnostic studies should be tailored to the signs and symptoms of these manifestations.

Treatment consists of antibiotics for at least 4 weeks. The benefits of anticoagulation and surgery are uncertain, but are frequently employed. Mortality from the disease remains at 5-8%.

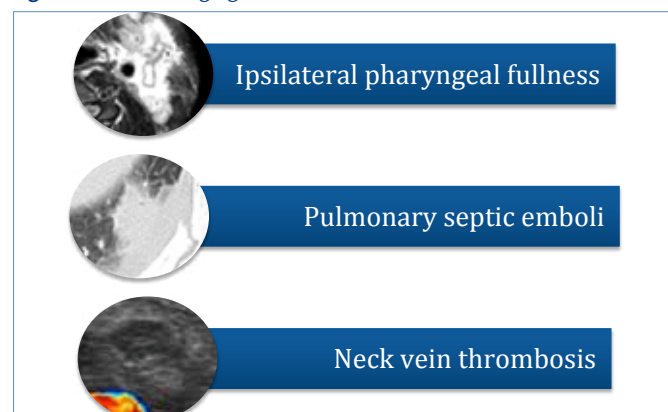
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Figure 1. Classic imaging triad of Lemierre's disease.





202nd Annual Banquet and Inauguration of Officers

September 21, 2013
Warwick Country Club



US Rep. James Langevin with RIMS officers, Vice President Russell A. Settipane, MD; Past-President Alyn L. Adrain, MD; President Elaine C. Jones, MD; Secretary Elizabeth B. Lange, MD; Treasurer Jose Polanco, MD; and President-Elect Peter Karczmar, MD



President Elaine C. Jones, MD with parents Capt. (ret) Ross and Celeste Jones



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Why You Should Join the Rhode Island Medical Society

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RIMS offers discounts for group membership, spouses, military, and those beginning their practices. Medical students can join for free.



Above: State House press conference on health care, Brown MSS at the AMA, CPT update seminar, bike helmet distribution, medical student volunteers; Upper right: Meeting of RIMS membership committee



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Password access to pay dues, access contact information for colleagues and RIMS leadership, RSVP to RIMS events, and share your thoughts with colleagues and RIMS

SPECIAL NOTICE: 2014 AMA DUES PAYMENTS

The American Medical Association (AMA) will direct bill its Rhode Island members for their 2014 dues. Beginning August 2013, AMA members will receive a separate dues statement from the AMA instead of paying AMA membership dues through the Rhode Island Medical Society (RIMS) membership invoice. This is simply an operational change so that both RIMS and AMA can concentrate on their respective member satisfaction. There remains no requirement for RIMS members to join the AMA.

Please let us know if you have questions concerning this change by emailing [Megan Turcotte](mailto:Megan.Turcotte@rimed.org) or phoning 401-331-3207.

Dr. Srecko Pogacar: From a castle in Slovenia to a clinic in RI

DR. MARA POPOVIC

(The following are excerpts from an article which first appeared in the Medical Chamber of Slovenia's magazine.)

Srecko, good day! I am pleased that after a long time I see you again in Ljubljana. We have gotten together for the purpose of the interview and to give Slovenian doctors a chance to meet their compatriot, who started in Slovenia and then continued his life and professional career in the USA.

In our conversations, you mentioned that you lived in the castle of Ljubljana.

Yes, that was the best part of my life. My father was a railroad worker and when he was transferred to Ljubljana, they assigned him an apartment in the castle of Ljubljana, with a magnificent view of the city and mountains in the background. There were many residents and there was always something, sometimes slightly mysterious, happening. In the attic of the castle we, the children of the castle, found the statue of the Emperor Franz Joseph, which in the time of the Austro-Hungarian monarchy, we learned later, stood in front of the castle.

I recall the 4th of April 1941 was a beautiful, sunny day. My mom and I sat on a bench on Wild Chestnuts Avenue on the castle hill and watched, as if in a movie, how the German stukas (planes) bombed the airport near Ljubljana. This was the start of the World War II for us Slovenians. When I was 13, the Italians occupied the castle and not long after that, we were evicted.

I assume you finished high school in Ljubljana and enrolled in the Faculty of Medicine?

Since I was a child I wanted to be a doctor. When I played with my sister, she was a nurse and I was a doctor.



From the left: Drs. Danilo Tavcar, Mara Popovic, Marija Tavcar and Srecko Pogacar at an international conference on neuropathology in Stockholm.

PHOTO COURTESY OF MARA POPOVIC

She became the head nurse in the mental hospital in Polje near Ljubljana and I became a lecturer on neurology and neuropathology at Harvard and clinical associate professor of pathology at Brown University.

After you graduated from the Medical School in Ljubljana, you specialized in neuropsychiatry?

From the beginning I wanted to become a neurologist, but I couldn't get the specialization. Therefore, I went to the Ministry of Health and talked to the minister, telling him that if I don't get the specialization in neurology, I will go to Bosnia or Serbia, where they were looking for doctors, who wanted to specialize provided that they would stay with them for three years after they finish. He was friendly and told me that

I should wait for a while. A few days later I got the message: "You have the specialization in neurology."

You also studied neuropathology in other European countries and Russia?

Yes, I studied at the National Hospital for Neurological Diseases in London. It has a neuropathological museum. This was a good opportunity to learn about rare neurological diseases. Then I studied at the Neuropathology Institute in Warsaw and finally, I spent time at the Institut Mozga (Brain Research Institute) in Moscow, which was established by the Ministry of Health in Moscow in order to investigate Lenin's brain.

The Ministry had invited Professor Oskar Vogt, founder of the Institute for Brain Research in Berlin, to found



SLOVENSKI ETNOGRAFSKI MUZEJ

Postcard from 1941 of the castle in Ljubljana, Slovenia, where Dr. Pogacar spent his early boyhood in housing assigned to his father, a railroad worker.

it. His work was on investigating the link between neurocellular changes and individual psychological characteristics. This was a sincere desire on the Ministry's part to discover the secrets of Lenin's brain – or a pretext to get the money to build the Institute. Allegedly, Dr. Vogt found an increased number of “large nerve cells” in Lenin's brain.

Harvard Professor Raymond Adams visited Dr. Vogt in 1951; he showed him the histological slides of Lenin's brain. The only thing the experienced neuropathologist Dr. Adams could detect were vascular-ischemic lesions. Apparently, Lenin had died demented.

You eventually went to the USA. How did this happen?

I was single, slightly adventurous, and curious about the world. The chairman

of the department of pathology where I was working received a letter from Dr. Mario Nicotra, the director of the Institute of Mental Health (IMH) and the Rhode Island Medical Center (RIMC). They were looking for a neuropathologist to teach neuroanatomy and neuropathology. Since I was the only neuropathologist in Slovenia, he handed me the letter. I quickly accepted the offer. On the 12th of October, 1965, the day of Christopher Columbus, I arrived at the airport in Providence.

Why you were invited to the USA?

The USA lacked neuropathologists. Besides, they paid me less than a neuropathologist trained in the USA. Also, they needed a neuropathologist for the approval of their psychiatry residency program.

I know you returned to Ljubljana with the idea to do neuropathology in Ljubljana.

After two years of working abroad, I returned with a plan to resume my work at the neurological clinic. I thought I owed something to my country. Upon arrival, there was no more neuropathology laboratory at the neurological clinic. The pathologists had appropriated the equipment and there was no technician either. I got the feeling that nobody expected that I was coming back. To be realistic, I shouldn't expect that anybody would wait for me for two years. So I returned to the USA, married and raised a family.

Did you marry an American woman?

No, I married an Armenian lady. My wife Aida and Paula, the wife of another

physician, were attending English courses together. Paula thought that I needed female company, so she asked me if I wanted to meet Aida, her attractive friend. Admittedly, I was overloaded by teaching, but female company I didn't avoid. My answer was short and without detours: "Yes." I called Aida. This had serious consequences; I married her.

Srecko, at the same time that you worked in Rhode Island, you became a lecturer in neurology and neuropathology at Harvard. Tell me how this came about?

I was part of the activities at the Massachusetts General Hospital (MGH) and Boston City Hospital, neurology departments, bringing interesting and well worked-up cases from RIMC to MGH and Boston City. Their doctors used to come as main discussers to RIMC. So did the dean of the Brown Medical

School, Dr. Stanley Aronson, an individual with the most extensive knowledge of medicine, neurology, neuropathology and the history of medicine. The most interesting cases were published. I think I was the right person at the right time to become a lecturer on neuropathology and neurology at Harvard.

At Brown University Dr. Aronson was a decisive factor; additionally my bibliography was at that time more extensive. So, I became clinical associate professor of pathology at Brown University.

How long were you head of neuropathology at RIMC?

From 1965 to 1990, when I retired from RIMC. In 1967, I had become seriously interested in psychiatry and in 1975 I passed the Board of Psychiatry and Neurology and was certified. We, my wife Aida and I, bought a building, rebuilt it

as the Pogacar Clinic and opened private practices – I, in neurology and psychiatry and Aida, in general dentistry. I was admitted to the staff of the Kent County Memorial Hospital where I was served for several years as the chief of the psychiatry department.

In 1984 we sold the Pogacar Clinic. Now I am working several days a week and limit my practice to psychiatry. My wife and I have two sons and grandchildren. My son Andre is a TV editor in New York, and my other son Peter is a pediatrician in a group practice, 15 minutes from Pogacar Clinic.

Srecko, I am very glad that we had opportunity to walk through your life.

Mara, thank you very much for the interesting questions. ❖



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Brown Celebrates 30th Anniversary of Center for Alcohol and Addiction Studies

BY DAVID ORENSTEIN
BROWN UNIVERSITY SCIENCE NEWS OFFICER



Dr. David Lewis, founding director of CAAS

PROVIDENCE — Brown University celebrated the 30th anniversary of the Center for Alcohol and Addiction Studies with a daylong colloquium on Sept. 21.

Keynote speaker **DAVID ABRAMS** came to Brown in the late 1970s as a clinical psychology intern interested in behavior therapy treatment of tobacco and alcohol addiction. Here he found a stalwart cadre of empathetic academics and clinicians who didn't see addiction as a question of immorality or bad habits. Among them were founding director **DR. DAVID LEWIS** and the CAAS current director, **PETER MONTI**. Dr. Lewis saw drug addiction this way: "Drug misuse is a complex social, economic, and physiological problem in which the actual substances play only one part."

In the '70s, Brown's medical school and community health department had just begun, and interest in addiction was scattered around Brown and area hospitals. But in 1976 **DR. STANLEY ARONSON**, Brown's inaugural dean of medicine, recruited Dr. Lewis from Harvard to develop an addiction studies program at Brown. With substantial

support from President Howard Swearer and key donors, Lewis launched CAAS in the 1982-83 school year. Monti joined the following year.

Under Dr. Lewis and Monti, who succeeded Lewis in 2000 as the Donald G. Millar Professor of Alcohol and Addiction Studies, CAAS has grown from a small office in Arnold lab with a budget of \$1,500 into a prolific center with 28 full-time faculty members, \$13.3 million in grant awards this year, and an enduring influence in research, medical and postdoctoral training, and local and national policy.

"From very small beginnings it became a national leader," said Abrams. After he left Brown in 2004, he served

as director of the Office of Behavioral and Social Sciences Research at the National Institutes of Health and now serves as a professor at Johns Hopkins University.

Teaching and training

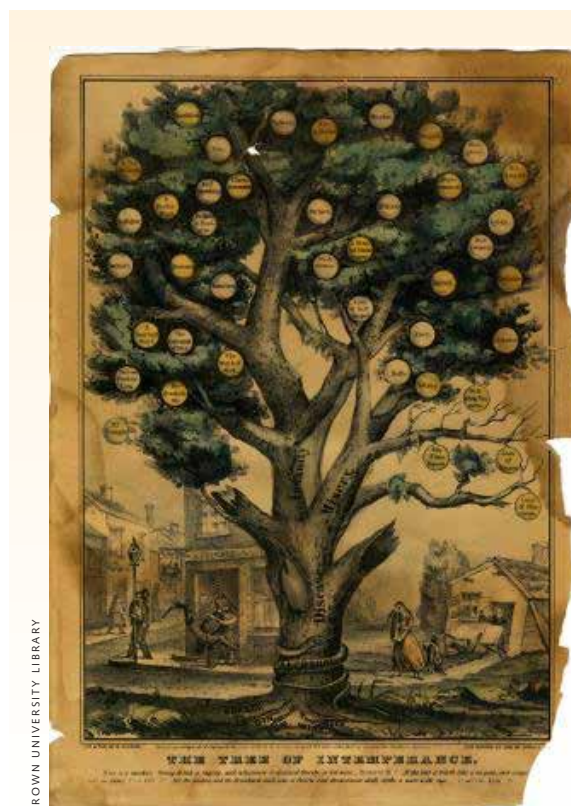
Dr. Lewis had been medical director of the Washingtonian Center for Addictions in Boston, then the nation's oldest addiction treatment center. Dr. Aronson asked Dr. Lewis to convene a committee to develop a medical curriculum on addiction. Dr. Lewis, a Brown undergraduate alumnus, invited social science and humanities professors to join.

He sought connections to the College to ensure the relevance of the center's

Hay Library collection on alcoholism and temperance

Dr. David Lewis's connections with the College also yielded a scholarly treasure: a rich and deep series of special collections at the John Hay Library on alcoholism and temperance. The collection preserves tens of thousands of items – documents, artifacts, advertisements – of both medical and sociological significance.

The Tree of Intemperance
Fruit on the "Misery" branch:
Alms House, Imprisonment,
Idiocy, Rags, Delirium Tremens,
Idleness, and A Bloated Countenance.
The tree is rooted in alcohol. (Lith. and Pub. by N. Currier, 1849)



research to students, the community, and policy development. He taught an undergraduate course titled "Addiction in the American Consciousness" and was chair of the Department of Community Health, which had a joint undergraduate concentration with sociology: "Health and Society."

CAAS also built a program in postgraduate training that would go on to become its signature achievement. The program, which continues today, has trained about 150 postdoctoral researchers in its 27-year history.

Decades of research

Faculty and trainees created influential ways of developing and evaluating various addiction treatments, which allowed them to inform federal and state policymakers about the value of

treatment. Dr. Lewis' strong clinical research foundation and passion for applying research to policy allowed him to serve many national and international committees and organizations. He became an adviser in the Clinton administration and worked with former U.S. Rep. Patrick Kennedy on legislation to ensure equal coverage by health insurers for addiction and mental illness.

From Dr. Lewis' perspective, the rapid advances in addiction genetics, neuroscience and psychology are bittersweet. "The scientific understanding of what addiction is has changed phenomenally," he said. "But the way that's been able to be applied to prevention and treatment is very discouraging still. The science has moved much faster than its application.

"We do have good treatments, we do have good results, and the public understands the need for it better than they ever did," he said. "We're moving in the right direction but much too slowly."

Over the next 30 years it will be advances in science and empirically based treatments, rather than enforcement, that will likely advance the fight against addiction, Monti said.

"I would hope that the emphasis is placed more on treatment and away from the supply side of the equation. We've had so many years of failure with respect to this War on Drugs." ❖

CAAS Areas of Research: Teen Addiction, Alcohol/HIV

Many CAAS researchers have made their mark in other areas of research. David Abrams and Peter Monti, both psychologists, studied how people respond to contextual cues that might make them relapse to smoking or drinking, for example, and worked to help patients develop coping skills.

Monti and center colleagues have written a book on a coping skills model of addictive behavior, currently undergoing its third revision. Monti has also worked to advance and expand the technique of the motivational interview (MI), a psychosocial intervention that helps patients understand their behavior and how it could change. He has also extended the MI to adolescents.

"When our four children were teenagers there was an epidemic of alcohol-related deaths



Peter Monti, CAAS director

in East Greenwich," Monti said. "After the third funeral the kids went to, they said, 'Dad, this is something you know a whole lot about. How can we help?'"

Work on teen addiction continues in the center. One of the center's major current grants is "iSay," a five-year project led by Kristina Jackson, to survey middle school students around Rhode Island in hope of determining what motivates some kids

to experiment with drinking while others don't.

CAAS has several other major projects. One is the Alcohol Research Center on HIV (ARCH), in which researchers led by scientific director Christopher Kahler are studying the physiological and psychological interplay of alcohol, sex risk, the virus, and antiretroviral medications; and SAFER, a study now in its

17th year of testing psychological interventions in community hospital emergency rooms to affect the combination of alcohol and risky sexual behavior. Monti leads those two projects and is co-PI with Damaris Rohsenow of the famed postdoctoral training program.

Another long-lived project, in its 18th year, is the Addiction Technology and Transfer Center of New England, headed by Daniel Squires. The ATTC provides distance learning and continuing education programs, sustains regional organizations to support the recovery community, and works with Rhode Island College to support its Bachelor of Science degree in Chemical Dependency and Addiction Studies. ATTC is a model for the dissemination component of the ARCH, Monti said.

In recent years the Center has accelerated its studies to identify genetic factors that might predispose people to addiction, or that might help predict who would be more or less responsive to different treatments. ❖

Lifespan Surgeon First in Region to Perform Single-Site Robotic Gynecologic Surgery

Advanced technology offers new surgical option for hysterectomy

PROVIDENCE – **W. SCOTT WALKER, MD**, an obstetrician and gynecologist with Ob/Gyn Associates, which recently partnered with Lifespan and the Women's Medicine Collaborative, has become the first surgeon in Rhode Island and Massachusetts to perform a robotic hysterectomy that uses only a small, single abdominal incision.

Walker has performed more than 300 traditional three to five incision OB/GYN robotic procedures, including ovarian cystectomy and surgery for endometriosis, making him one of the region's most skilled and experienced robotic surgeons. Last month, he became the only surgeon in the region to operate using an innovative new approach to hysterectomy, one of the most common surgeries in the United States.

Known as a single-site hysterectomy, this delicate and complex surgery, which involves the removal of a woman's uterus, is performed using a tiny incision approximately one inch long in a woman's bellybutton. Because the incision is hidden by the navel, the procedure is virtually scar-free.

Walker is one of only a handful of surgeons across the country who received training to perform single-site



W. Scott Walker, MD

robotic surgeries using the daVinci Surgical System.

"We've been performing hysterectomies using robotic technology for over three years, but the single-site procedure takes it to the next level, offering women a state-of-the-art surgical option that is safe and less invasive, and now does it with a better cosmetic result," said Walker.

"I am honored to be the first physician in our region to perform this procedure and excited to offer my patients

the most advanced, minimally invasive surgical options," he added.

Increasing numbers of hysterectomies have been performed laparoscopically or using multiple incision robotic technology, and some even continue to be done through one large incision in an open surgery, despite recommendations by national organizations that open abdominal hysterectomy should only be performed as a last resort. Single-site hysterectomy offers all the benefits of robotic surgery, including a shorter recovery time, low blood loss, minimal pain, a shorter hospital stay and high patient satisfaction.

However, having just a single incision means less scarring both externally and internally, minimizing the risk of surgical complications. The surgery can be performed in about one hour and patients typically stay in the hospital less than 24 hours. Women are generally able to resume most normal activities within several days.

Currently, this single-incision approach to hysterectomy has only been approved by the FDA to treat non-cancerous conditions requiring a hysterectomy and removal of the ovaries and fallopian tubes. ♦

CharterCARE signs asset purchase agreement with Prospect Medical Holdings

Prospect to provide a total of \$95M to CharterCARE over next four years

PROVIDENCE – CharterCARE Health Partners (CharterCARE), the corporate parent of **ROGER WILLIAMS MEDICAL CENTER, ST. JOSEPH HEALTH SERVICES OF RI** and **ELMHURST EXTENDED CARE**, has entered into an agreement with Prospect Medical Holdings (Prospect) that will create an innovative joint venture. The transaction is expected to be complete by the early part of next year, subject to regulatory and Church approval.

Prospect has agreed to provide a total of \$95 million to CharterCARE over the next four years. Forty-five million will be provided upon regulatory approval and will be used for debt reduction and short-term working capital. An

additional \$50 million will be provided over the next four-year period to provide capital for physician network development, facility improvement and technology acquisition.

Both CharterCARE and Prospect will be equally represented on the organization's governing board. After the closing, Prospect will serve as the manager of the hospital joint venture under a management contract.

The asset purchase agreement will now be submitted for review simultaneously by the Rhode Island Department of Health and the Rhode Island Attorney General, under the provisions of the State's Hospital Conversion Act. ♦

Landmark acquisition moves ahead

WOONSOCKET – The Health Services Council of the Department of Health recommended the approval of a request by for-profit Prime Healthcare Services of California to acquire the Landmark Medical Center, which has been in receivership since 2008. The vote was 12-0 with two abstentions.

The “change of effective control” application will now go to Dr. Michael Fine, director of health, for review. A second process, a review of the acquisition under the state’s Hospital Conversion Act, reviewing Landmark change from non-profit to for-profit operation, also needs approval by Dr. Fine and Attorney General Peter Kilmartin for the acquisition to be completed. ❖

Miriam opens Kidney Stone Center

PROVIDENCE – The new Kidney Stone Center has officially opened its doors at The Miriam Hospital, bringing together a team of nephrologists, urologists and dietitians under one roof in a collaborative effort to evaluate, diagnose and treat patients suffering from kidney stones. It is the only center of its kind in Rhode Island.

According to urologist **GYAN PAREEK, MD, FACS**, director of the Center, “Our team-based approach to kidney stone treatment will streamline and ease treatment for patients, who will now be evaluated by a urologist, nephrologist and dietitian in a single visit,” he said. “Our goal is to not only treat existing kidney stones, but to also prevent new stones from forming. Because most kidney stones are diet-related, tailored nutrition and dietary management are critical to providing the best treatment and follow-up care.”

Dr. Pareek is joined by assistant director **JOHN O'BELL, MD**, a nephrologist at Miriam, and **MARY FLYNN, PHD, RD., LDN**, the hospital's chief research dietitian. ❖

RIH Opens Center for Wound Care and Hyperbaric Medicine



LIFESPAN

Vascular surgeon Edward Marcaccio, MD is co-medical advisor for Rhode Island Hospital's new wound care center in East Providence.

EAST PROVIDENCE – Rhode Island Hospital has opened the Center for Wound Care and Hyperbaric Medicine for the treatment of slow-healing and non-healing wounds. Located at 950 Warren Avenue Suite 103 in East Providence, the center will be open from 8 am to 6 pm Monday–Friday.

The wound care center will offer the newest and largest hyperbaric chamber in Rhode Island and will employ state-of-the-art wound healing technologies, including negative pressure, techniques to control edema, hyperbaric oxygen, skin substitutes, debridement of infected and chronic wounds, and advanced therapies including revascularization and tissue transfer, as well as patient and family education. The center's multidisciplinary team will provide limb preservation and limb salvage treatments to patients with acute and chronic wounds resulting from a wide variety of conditions, including diabetes, arterial and venous insufficiency, radiation and surgery or injury.

“These slow- and non-healing wounds are often very painful and even debilitating. By providing our patients with a comprehensive approach to wound care, we strive to relieve the pain and discomfort, heal the wound and get our patients back to normal life and activity as soon as possible,” said **EDWARD MARCACCIO, MD**, co-medical advisor and a vascular surgeon at Rhode Island Hospital.



Kerri Kern, RN, BSN, shown with patient by the hyperbaric chamber, is the clinical manager for the new center.

The Wound Care center will be staffed with board-certified surgeons, plastic surgeons, vascular surgeons and podiatrists. It will offer hyperbaric oxygen therapy as part of its overall wound care program. This therapy involves exposing the body to 100 percent oxygen at high pressure. Exposing a wound to 100 percent oxygen can speed up the healing process and can be used for a variety of wounds, including delayed radiation injuries, soft tissue infections, thermal burns, some skin grafts and flaps, crush injuries and diabetes-related wounds. ❖

Kent introduces Advanced Valvular Heart Disease Clinic

WARWICK – Kent Hospital's Division of Cardiology recently announced a new Advanced Valvular Heart Disease Clinic, to be directed by **ALICE Y. KIM, MD, FACC**, a new member of the Brigham and Women's Cardiovascular Associates at Kent.

Dr. Kim is a board certified physician who specializes in consultative and noninvasive cardiology including cardiovascular medicine; transthoracic, transesophageal and stress echocardiography; nuclear cardiology; and vascular interpretation. Dr. Kim is also an attending physician in the departments of cardiology at both Memorial Hospital

of Rhode Island and Brigham and Women's Hospital.

"The addition of a new clinic is a huge gain for the patients of the community who have valvular heart disease and are in need of high quality care, which includes access to the best in medical technology, clinical trials and complex treatment plans," said Chester Hedgepeth, MD, PhD, executive chief of cardiology at Kent Hospital.



KENT HOSPITAL

Dr. Alice Kim will serve as director of the new clinic.

The clinic will offer services such as:

- Comprehensive evaluation, diagnosis, and treatment planning for patients who may be candidates for advanced valve intervention
- Access to expertise with interventional cardiologists and cardiac surgeons at the advanced valvular and structural heart disease clinic at Brigham and Women's Hospital
- Appropriate multi-modality imaging including echocardiography, cardiac catheterization, and computer tomography
- Access to national research protocols for advanced valve disease



KENT HOSPITAL

Jeffrey D. Manning, MD, will direct the sports medicine program.

Kent Hospital announces new Sports Medicine Program

WARWICK – Kent Hospital recently announced the addition of Affinity Sports Medicine, an affiliate of Kent Hospital, which will be directed by **JEFFREY D. MANNING, MD**, and will offer specialized treatment and prevention of injuries and illness for all ages and abilities.

Dr. Manning is a board certified family physician with a certificate of added qualification in sports medicine. He specializes in primary care sports medicine, focusing on treating illness as well as injury.

He is a faculty member at the Alpert Medical School at Brown University and the University of Massachusetts. Prior to medical school, Dr. Manning was a high school science teacher and coached football and lacrosse.

"You do not have to be an athlete to benefit from sports medicine services," says Dr. Manning. "For an individual who wishes to become active and begin an exercise program or someone who has musculoskeletal problems, sports medicine can be extremely beneficial. I am looking forward to bringing my sports medicine training and expertise to the local community."

The program will offer clinical services such as:

- Concussion treatment
- Management of acute injuries (such as ankle sprains, muscle strains, shoulder and knee injuries, fractures)
- Management of overuse injuries (such as tendonitis and stress fractures)
- Splinting and casting
- Braces
- Throwing programs
- Customized physical therapy programs
- Coordination of care with primary care physicians, athletic trainers, physical therapists and surgeons (as needed)
- "Return to play" decisions following illness
- Counseling regarding nutrition and supplements
- Onsite X-ray and musculoskeletal ultrasound
- Access to MRI and CT scans

URI's Rothman hits NIH jackpot with another \$10M

Grant will increase capacity for vaccine research

PROVIDENCE – A University of Rhode Island biomedical researcher, Research Professor **ALAN ROTHMAN** at URI's Institute for Immunology and Informatics, who was awarded a \$11.4 million grant last month for his research on dengue fever, has been awarded another grant of nearly \$10 million to expand research efforts on vaccines and immunotherapeutics at the Providence campus.

The National Institutes of Health's Institutional Development Award (IDeA) Center of Biomedical Research Excellence, which builds research capacity in states that historically have had low levels of NIH funding, awarded the grant to support basic, clinical and translational research, faculty development, and infrastructure improvements.

Rothman said the grant will enable the Institute to build capacity for basic immunology research on global health issues, with an orientation toward the development of vaccines and therapeutics. "There are common themes in infectious disease, so what we learn about malaria and dengue also applies to infectious diseases that affect Rhode Islanders. We are conducting basic research on important public health problems, which will set the stage for determining the next steps for preventing and treating these diseases," he said.

According to Rothman, a major aim of the five-year grant is to "build a cadre of junior investigators toward independence" by providing them with funding for new research projects. One of the junior investigators supported by the grant is **CAREY MEDIN**, an immunologist at the Institute, who will work on innate immune responses to dengue virus. In addition, the Institute has used grant funds to recruit **BARBARA PAYNE**, an immunologist with 10 years of experience working in Kenya on HIV exposure in developing fetuses, to the Institute. At least one more faculty member will be hired with the new funding.

The grant will also support the development of new partnerships and pilot projects, particularly a collaboration with **JONATHAN KURTIS**, **JENNIFER FRIEDMAN** and colleagues at the Center for International Health Research at Lifespan in Providence, where the grant will support Ian Michelow, a junior researcher who is working to develop vaccines against malaria.

Institute Director and URI Research Professor **ANNIE DE GROOT** is also enthusiastic about the new grant. "Dr. Rothman is a visionary scientist who is committed to training the next generation of vaccine developers," said De Groot. "I am grateful to URI for supporting his move to Providence, and I am pleased that the iVAX suite of vaccine design tools will be put to use for basic research; that is exactly what we had in mind when we established the Institute just a few years ago. I look forward to working with the



PHOTOS BY JOE GIBLIN

new faculty members on their vaccine research programs."

A resident of Framingham, Massachusetts, Rothman came to URI in 2011 from the University of Massachusetts Medical School in Worcester, where he was awarded an \$11 million grant from the National Institutes of Health in 2008 for additional studies of the dengue virus. ♦



URI Research Professor Alan Rothman (left) briefs Rhode Island's Congressional delegation, from left, Sen. Sheldon Whitehouse, Sen. Jack Reed, Rep. David Cicilline, and Rep. Jim Langevin, about his research on dengue fever in August. Rothman was awarded a research grant of \$11.4 million from the National Institutes of Health in August and another \$10 million this month.

Searchable Website Links Researchers, Sites

PROVIDENCE — Academic and medical institutions from around Rhode Island recently unveiled CoresRI.org, a Web directory of publicly shared core science facilities and services that officials said could accelerate research collaboration for the benefit of the entire state.

CoresRI.org readily serves up detailed information on more than 500 lab instruments and services available in more than 30 core facilities and laboratories at 12 institutions. Site visitors — scientists, engineers or physicians — can search by institution, facility, general application or

as the start of a new era of inter-institutional support and cooperation to grow our research activities and to bring new grants and contracts to our state.”

Scientists, engineers and physicians do not need to work at any of the inaugural partner institutions — Brown University, Lifespan, Care New England, the University of Rhode Island, the Providence V.A. Medical Center, the Rhode Island School of Design, Providence College, Bryant University, Community College of Rhode Island, Rhode Island College, Salve Regina University and Roger Williams University — to use the site or arrange access to facilities listed there. A state environmental researcher, for example, could use CoresRI to find the spectrometer needed to test for an unusual chemical in a water sample, or a physician at an independent hospital could seek space in an ultracold freezer for a tissue specimen.

Benefits

Hawrot said the site’s partners anticipate many benefits from the new site beyond the most obvious one of facilitating researchers’ access to needed equipment. CoresRI.org can make state researchers more competitive in applying for grants, he said, because they’ll be able to show that they have access to relevant instruments even if they aren’t at their home institution. The site also can help inspire new research collaborations as researchers discover what each other can do.

Another benefit, Hawrot said, will be in recruiting researchers to the state because they can see the full spectrum of available resources within the state’s small geography.

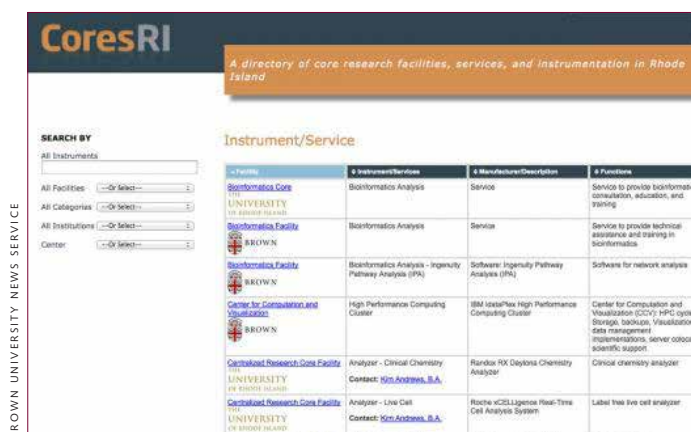
CoresRI could also aid long-term economic development by helping scientists at a startup companies accomplish research and development tasks, said **PAM SWIATEK**, director of research operations in Brown’s Division of Biology and Medicine.

DR. JAMES PADBURY, a pediatrician and researcher at Women & Infants Hospital and professor of pediatrics in the Warren Alpert Medical School, said CoresRI.org will also help the state’s researchers make the most of the resources they share.

“Additional benefits beyond knowledge of and access to this equipment are coordination of shared equipment grants among investigators, avoidance of duplication on equipment purchases, and conservation of valuable resources to sustain these core labs at each of our institutions,” Dr. Padbury said. “In these days of tight federal and foundation budgets, collaboration across core laboratories in equipment use and sustainability will help us to use our precious resources most efficiently.”

Swiatek said the partners have a process for keeping the site up-to-date, a step that Snyder said will be key to the site’s success.

“CoresRI.org will be a ‘living’ site that will be updated regularly, allowing any scientist or trainee to easily find the equipment or specialty services they need to succeed in their work,” Snyder said.



A new website, CoresRI.org, lists hundreds of shared research instruments and services at 12 academic and medical institutions around the state. The resource is open to any scientist looking to arrange access to needed facilities for research purposes.

any keyword to find electron microscopes, high-throughput gene sequencers, nuclear magnetic resonance spectrometers, bioinformatics services and many other resources.

The site helps fulfill and expand on the promise of shared core facilities, which are designed to make expensive scientific resources, such as high-end equipment and expert staff, available to a broad scientific community.

“Research is very technology-driven and so access to instrumentation is really critical,” said **EDWARD HAWROT**, the Alva O. Way University Professor of Medical Science at Brown and associate dean for the Program in Biology in the University’s Division of Biology and Medicine. “Having a searchable database is a big advantage.”

DR. PETER SNYDER, senior vice president and chief research officer for the Lifespan health system and a professor of neurology in the Alpert Medical School, said CoresRI.org provides an important new tool to promote scientific productivity and cooperation.

“This collective cataloguing of all core facilities, spanning all of the major research institutions across the State of Rhode Island, will allow any of our investigators — no matter where they are located or where their salary is drawn from — equal access to critical resources to support scientific research,” Snyder said. “This is an entirely unprecedented first step for all of our partner institutions, and I see this

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MEDICAL SOCIETY**

OCTOBER

Seasonal influenza update – Live Webcast

Oct. 3rd by 8:20 am

amms.oshean.org/content/DOH/PHGR-10-3-2013

Speaker **Nicole E. Alexander-Scott, MD, MPH**

Assistant Professor of Pediatrics and Medicine, Warren Alpert Medical School of Brown University; Medical Director, Division of Infectious Disease and Epidemiology
Rhode Island Department of Health

Target Audience Primary care providers (physicians and mid-level practitioners) and public health staff, especially health care planners and policy makers

Educational Objectives At the conclusion of this activity, attendees should be able to:

- Describe the current forecast for the 2013–14 influenza season
- Describe Rhode Island's surveillance and prevention goals for the 2013-2014 influenza season
- Describe specific recommendations of the Advisory Committee on Immunization Practices for the use of 2013-2014 seasonal influenza vaccines.

**Pediatric Global Health Conference – Focus on Haiti:
Building Local Capacities through Sustainable Partnerships**

Saturday, Oct. 12, 2013 (*all day*)

Alpert Medical School of Brown University
222 Richmond Street

This regional CME event for physicians, clinicians, nurses, allied professionals, residents and students is hosted by the Brown

University Global Health Initiative and Hasbro Children's Hospital. The conference will include a keynote address, lectures, panel discussions, and breakout sessions centered on significant pediatric global health issues including: building and sustaining international partnerships, millennium development goals, and the art of medicine in developing countries, with many of the breakout sessions focused specifically on Haiti.

Hasbro Children's Hospital is part of the St. Damien Collaborative to Improve Pediatrics in Haiti (SCIPH) a new consortium of six US-based Children's Hospitals dedicated to building capacity for pediatric care in Haiti at St. Damien Hospital for sick children. St. Damien is the premier pediatric hospital in Haiti, providing services free of charge, and is funded through donations from benefactors all over the world, primarily in Europe and the United States.

The conference will culminate in an evening benefit that will support both The Haitian Project and St. Damien Pediatric Hospital. [Conference Brochure](#)

Keynote speakers

Dr. Linda Arnold, current chairperson of the American Academy of Pediatrics Section on International Child Health, and Associate Professor of Pediatrics (Emergency Medicine) at Yale University, CT.

Dr. Jean Hugues Henrys, Dean of the University of Notre Dame d'Haiti, Faculty of Medicine and Health Sciences, Port-au-Prince, Haiti.

Contact Global Health Initiative: 401-863-1499

**Bridging Neurology & Psychiatry:
Movement Disorders**

Saturday, October 12, 2013

The Joseph B. Martin Conference Center
at Harvard Medical School
Boston, Massachusetts

This full day course is aimed at reviewing the interface between neurology and psychiatry to enhance the clinician's ability to recognize and classify movement disorders

in psychiatric patients and psychiatric problems in movement disorder patients. Behavior problems are the major determinants of quality of life in Parkinson's disease yet they are often not recognized. Similarly, movement disorders caused by antipsychotics frequently go unrecognized.

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



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

Click to download the [Course Program](#).

Register Online: <http://www.worldwide-medicalexchange.org/content/movement-disorder-course>



RI Healthcare Showcase

Tuesday, Oct. 15, 11:30 am to 7 pm

Registration: Attendance is limited.

The Warren Alpert Medical School, 222 Richmond St.

Registration/lunch: 12:30 to 1:30 pm

Keynote John L. Brooks III

President & CEO, Joslin Diabetes Center (Room 170)

1:45–2:45 pm *Panel discussion:* Our Aging Population & Aging Brains: Medical Home and Social Design Challenges for the 21st Century – Peter J. Snyder, PhD. Sr. Vice President and Chief Research Officer, Lifespan; Professor of Neurology, Alpert Medical School

2:45–3:45 pm *Panel discussion:* Future of Genomics in Medicine – Barrett W. Bready, MD, President & CEO, Nabsys, Inc.

4–5 pm *Panel discussion:* Medical Nutrition: Treatment of Disease and Conditions Using Nutritional Strategies – Stephen Lane, Co-Founder, Chairman & Chief Venture Officer, Ximedita

5–7 pm *Poster session and reception*

and the Boston University Multidisciplinary Research Center. An expert on the epidemiology and pathophysiology of osteoarthritis, Dr. Felson has led numerous large cohort studies in osteoarthritis, with the goal of elucidating risk factors for the disease, as well as its natural history.

Meeting Chairs

J.J. Trey Crisco, PhD; Amy L. Ladd, MD;

Arnold-Peter C. Weiss, MD

NOVEMBER

Current Trends in the Treatment of the Adult Orthopedic Patient for the Primary Care Provider

Saturday, Nov. 16, 7:15 am–4:15 pm

Omni Providence Hotel, Providence

Program Description This CME activity is designed to enhance the primary care provider's familiarity with common orthopedic conditions.



Rhode Island Medical Women's Association Meeting

Monday, Oct. 21, 2013

Registration: 6–6:30 pm

Presentation and Dinner: 7 pm

Chapel Grille, 3000 Chapel View Blvd., Cranston

Topic Professional Development

Speaker Terrie Fox Wetle, MS, PhD

Dean, Brown School of Public Health

Cost: Students, residents: \$30; RIMWA members: \$40; non-members/guests: \$40; To register contact Jane Coutu, 401-528-3288

1st International Carpometacarpal Workshop (ICMCW)

October 25–26, 2013

Hotel Viking, Newport, RI

Keynote Lectures

Matt Tocheri PhD, Smithsonian National Museum of Natural History, Washington, DC

Dr. Tocheri is a paleoanthropologist whose research interests focus on the evolutionary history and functional morphology of the human and great ape family, the Hominidae. His work on the wrist of *Homo floresiensis*, the so-called 'hobbits' of human evolution, received worldwide attention after it was published in 2007 in the journal *Science*.

David Felson MD, MPH, Boston University, Boston MA

Dr. Felson is a Professor of Medicine and Public Health, and Principal Investigator of the NIH-funded Boston University Multipurpose Arthritis and Musculoskeletal Diseases Center

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Recognition

Home & Hospice Care Honors Dr. Hamolsky with Human Dignity Award

Pioneer figure in the Rhode Island medical community



From left, Vince Mor, PhD; Rabbi Leslie Gutterman, Sandy Hamolsky, RN; Milton W. Hamolsky, MD, Recipient of the 2013 Human Dignity Award, Joseph Chazan, MD, and Diana Franchitto, President & CEO of HHCRI.

PROVIDENCE – Home & Hospice Care of Rhode Island (HHCRI) honored **MILTON W. HAMOLSKY, MD**, with its annual Human Dignity Award presented at an annual breakfast held September 24.

Dr. Hamolsky, a member of the HHCRI board of directors, is considered a pioneer within the Rhode Island medical profession. He was the first full-time physician-in-chief at Rhode Island Hospital and a major catalyst for the creation of a medical school at Brown University. Today, HHCRI is the major teaching affiliate for hospice and palliative medicine of The Warren Alpert Medical School of Brown University.

"It is with great joy and gratitude that we honor Dr. Hamolsky today with our 2013 Human Dignity Award," said Diana Franchitto, president & CEO of HHCRI. "I am thrilled to recognize someone who is so important and special to the medical community here in Rhode Island. He is a champion for the values we share at Home

& Hospice Care of Rhode Island, and we are indebted to him for his work in this community and across the profession."

The Human Dignity Award is presented annually to an individual who has made significant contributions to enhancing human dignity and meaning at the end of life. Started in 2011, the award was created in memory of Martin Temkin, a former HHCRI board member, long-time benefactor, and staunch hospice advocate.

"It is beyond fitting to honor Dr. Hamolsky today for his commitment to the dignity of the patient," said Joseph Chazan, MD, who helped present the award. "Above all, Dr. Hamolsky recognizes and respects the sanctity of the patient/doctor relationship and the need for humanism and compassion in the treatment of patients, especially those in hospice care."

A 1943 graduate from Harvard Medical School who finished first in his class, Dr. Hamolsky began his career at Beth

Israel Hospital in Boston as chief medical resident. From there he left to serve in the Army, before earning a Commonwealth Fellowship that allowed for a year of research in France, where he developed the T3 uptake test, which is still used to evaluate human thyroid function.

Dr. Hamolsky began working in Rhode Island in 1963 when he was offered the position of physician-in-chief for the Department of Medicine at Rhode Island Hospital. As part of the offer, he also took on a professor's role with the Brown University's six-year Biomedical Sciences program, which he was instrumental in transforming into the Brown University medical school.

In addition to helping attract some of the brightest medical minds to build subspecialties of internal medicine at Rhode Island Hospital, Dr. Hamolsky also served as: senior consultant to Miriam Hospital and the Veterans Administration Hospital; physician-in-chief at Women and Infants Hospital; chairman of the Rhode Island Heart Association; president of the Rhode Island Diabetes Association; and, Governor of the American College of Physicians. In 1987, Dr. Hamolsky retired from his work at Rhode Island Hospital, only to take on the role of chief administrative officer for the state's Board of Medical Licensure & Discipline, a position he held until the end of 2001.

Dr. Hamolsky thanked the members of HHCRI for their dedication to caring for people in their last stages of life. "Hospice is one of the best groups of human beings I have ever been associated with. They are the most compassionate, committed, dedicated people I know," he said. "This is the gold standard."

The awards breakfast was held at the Providence Marriott and included comments from Vince Mor, PhD, who sits on the HHCRI board of directors and reflected on why the award was created, as well as, Rabbi Leslie Gutterman, who recounted Dr. Hamolsky's many remarkable accomplishments and contributions to the Rhode Island medical community. ❖



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Appointments

Thomas F. Tracy, Jr., MD, named Chief Medical Officer at Miriam Currently pediatric surgeon-in-chief at Hasbro Children's Hospital



Thomas F. Tracy, Jr., MD

PROVIDENCE – **THOMAS F. TRACY, JR., MD**, has been named chief medical officer and senior vice president of medical affairs at The Miriam Hospital. He succeeds William Corwin, MD, who was recently appointed to a key leadership position on the implementation team for Lifespan's new IT infrastructure, known as Epic.

In this new position, Dr. Tracy will serve as the liaison between the medical staff and administration at the hospital, and will oversee medical affairs, graduate medical education, clinical management programs, and physician quality improvement and peer review.

Along with his new role at The Miriam, Dr. Tracy is currently the pediatric surgeon-in-chief at Hasbro Children's Hospital and vice chairman of the Department of Surgery at the Warren Alpert Medical School of Brown University.

A graduate of Colgate University, Dr. Tracy received a master's degree from Albany Medical College and his medical degree from the Sackler School of Medicine's New York State Program at Tel Aviv University. He completed his internship and general surgery at

the Medical College of Virginia and his pediatric surgery residency at the College of Physicians and Surgeons at Columbia-Presbyterian Medical Center.

He began his surgical career at Cardinal Glennon Children's Hospital in St. Louis and held several academic appointments at St. Louis University, eventually progressing to full professor of surgery and pediatrics. In 1997, Dr. Tracy came to Hasbro Children's Hospital as its inaugural pediatric surgeon-in-chief and has been a vital part of the hospital for more than 16 years.

Signature programs in pediatric surgery were developed under his leadership, such as fetal surgery, pediatric surgical critical care and innovative family center care approaches in transplantation, trauma, and pediatric pain management. He has participated in outreach and extensions of surgical services throughout the Lifespan health system and the Brown community and provided enhancement of academic surgical support and expertise for those institutions.

A native of Albany, New York, Dr. Tracy previously served as a director of the American Board of Surgery, chairman of the Pediatric Surgical Board of the American Board of Surgery, president of the Association of Pediatric Surgery Training Program Directors, and president of the New England Surgical Society, among others.

The author of more than 130 scientific publications, Dr. Tracy also serves on numerous editorial boards and has been elected to several leading national and international organizations, including Alpha Omega Alpha, the American Surgical Association, the Southern Surgical, the Halsted Surgical Society and the Society of University Surgeons.

His clinical interests include pediatric hepatobiliary disease, cloacal malformations and acquired and congenital airway malformations. ❖

BU Appoints Two RWMC Physicians to Dean Positions

BOSTON – **DR. STEVEN SEPE** and **DR. N. JOSEPH ESPAT** have been named Assistant Deans of Clinical Affairs at Roger Williams' teaching affiliate Boston University School of Medicine (BUSM).

Dr. Sepe has served as a professor of medicine at BUSM since 2012. He joined Roger Williams in 2011 as chairman of the Department of Medicine, where he oversees clinical affairs, quality, and program development. Dr. Sepe is a cum laude graduate of BUSM, where he also received his PhD in immunopathology. A cofounder of Coastal Medical, Inc., he has held a number of leadership positions in a variety of health care settings.



Steven Sepe, MD, PhD



N. Joseph Espat, MD

Dr. Espat has been a professor of surgery at BUSM since 2007. He joined Roger Williams in 2007 as chief of surgical oncology and has since been named chairman of surgery and director of the Cancer Center. Dr. Espat completed a surgical oncology/hepatobiliary fellowship at the Memorial Sloan-Kettering Cancer Center in New York. He has authored more than 250 articles, chapters and abstracts and is on the editorial board of four journals ❖

Appointments

Kent announces clinical leadership promotions

Drs. Boudjouk and Gates named to new roles

WARWICK – Kent Hospital recently announced **JASON BOUDJOUK, MD**, of Lincoln, has been elected chief of medicine at Kent Hospital and **JONATHAN GATES, MD**, of South Kingstown, has been elected director of patient safety and high reliability at Kent Hospital.



Jason Boudjouk, MD, has been named chief of medicine at Kent.



Jonathan Gates, MD, has been named director of patient safety and high reliability at Kent.

Dr. Boudjouk previously served as Kent's assistant chief of medicine and has worked at Kent Hospital since 2006. Dr. Gates previously served as chief of medicine at Kent, as well as lead researcher on Kent's Emergency Department redesign. Dr. Gates has worked at Kent since 2003.

The chief of medicine is responsible for the privileging, oversight and training of medical staff while facilitating departmental efforts at quality and service integration.

The director of patient safety and high reliability is focused on Kent's system level process improvement, education, and safety culture with the goal of achieving excellent outcomes centered on patient health and experience.

Dr. Boudjouk has been in private practice focusing on internal medicine since 2006 and also served as a hospitalist at Kent Hospital from 2006–2007. Dr. Gates also currently serves as the assistant program director of the University of New England College of Osteopathic Medicine's affiliated internal medicine residency at Kent Hospital and chair of the Kent Hospital Institutional Review Board, overseeing clinical research. He was awarded the inaugural Kent Hospital's physician of the year for 2009-2010. ❖



Michael P. Betler, DO

Dr. Betler joins Westerly Hospital's surgery department

WESTERLY – **MICHAEL P. BETLER, DO**, has joined Westerly Hospital's Department of Surgery.

Dr. Betler received his medical degree from Lake Erie College of Osteopathic Medicine, Erie, PA, and completed his residency at Wyckoff Heights Medical Center in Brooklyn, NY. His special interests include laparoscopic repair of hernias, laparoscopic colon resection, general excision of lesions, biopsies of masses, and general surgical emergencies. ❖

Five urogynecologists achieve subspecialty certification

PROVIDENCE – Five physicians with the Division of Urogynecology and Reconstructive Pelvic Surgery at Women & Infants Hospital of Rhode Island (a Care New England hospital) and The Warren Alpert Medical School of Brown University have achieved certification in Female Pelvic Medicine and Reconstructive Surgery (FPMRS) by the American Board of Obstetrics and Gynecology (ABOG).

Achieving this subspecialty certification are **CASSANDRA L. CARBERRY, MD, FACOG**, of Pawtucket; **B. STAR HAMPTON, MD, FACOG**, of Providence; **DEBORAH L. MYERS, MD, FACOG**, of North Kingstown, division director; **Charles Rardin, MD, FACOG**, of Providence, director of Minimally Invasive Surgery at Care New England; and **VIVIAN SUNG, MD, MPH, FACOG**, of Providence. ❖

Newport expands women's health services

NEWPORT – Newport Hospital has added two physicians who specialize in obstetrics and gynecologic medicine. **LINDSEY BRUCE, MD**, and **LINDSAY GOODMAN, MD**, recently joined Randall Rosenthal, MD, Triste Coulombe, MD, and Judi Rosenthal, MD, to provide comprehensive OB/GYN care.

Drs. Bruce and Goodman are both graduates of the Ross University School of Medicine in Dominica and completed their OB/GYN residencies at Yale New Haven Health at Bridgeport Hospital in Bridgeport, Conn. Dr. Bruce

received her undergraduate degree from Southern Methodist University in Dallas, Texas, while Dr. Goodman received hers from Baylor University in Waco, Texas. ❖




Lindsay Goodman, MD



Lindsey Bruce, MD

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The Vocabulary of Gender

STANLEY M. ARONSON, MD

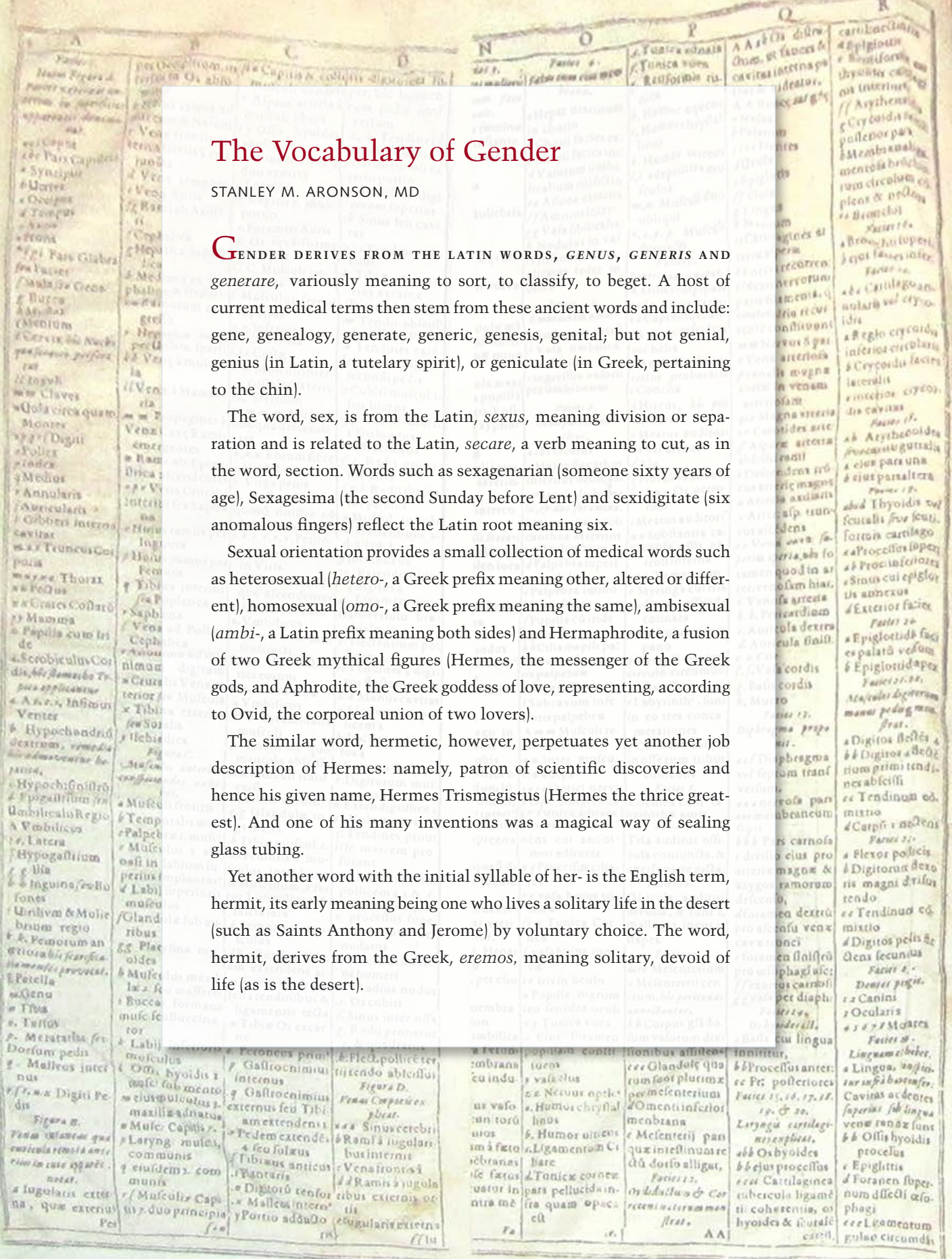
GENDER DERIVES FROM THE LATIN WORDS, *GENUS*, *GENERIS* AND *generare*, variously meaning to sort, to classify, to beget. A host of current medical terms then stem from these ancient words and include: gene, genealogy, generate, generic, genesis, genital; but not genial, genius (in Latin, a tutelary spirit), or geniculate (in Greek, pertaining to the chin).

The word, sex, is from the Latin, *sexus*, meaning division or separation and is related to the Latin, *secare*, a verb meaning to cut, as in the word, section. Words such as sexagenarian (someone sixty years of age), Sexagesima (the second Sunday before Lent) and sexidigitate (six anomalous fingers) reflect the Latin root meaning six.

Sexual orientation provides a small collection of medical words such as heterosexual (*hetero-*, a Greek prefix meaning other, altered or different), homosexual (*omo-*, a Greek prefix meaning the same), ambisexual (*ambi-*, a Latin prefix meaning both sides) and Hermaphrodite, a fusion of two Greek mythical figures (Hermes, the messenger of the Greek gods, and Aphrodite, the Greek goddess of love, representing, according to Ovid, the corporeal union of two lovers).

The similar word, hermetic, however, perpetuates yet another job description of Hermes: namely, patron of scientific discoveries and hence his given name, Hermes Trismegistus (Hermes the thrice greatest). And one of his many inventions was a magical way of sealing glass tubing.

Yet another word with the initial syllable of her- is the English term, hermit, its early meaning being one who lives a solitary life in the desert (such as Saints Anthony and Jerome) by voluntary choice. The word, hermit, derives from the Greek, *eremos*, meaning solitary, devoid of life (as is the desert).





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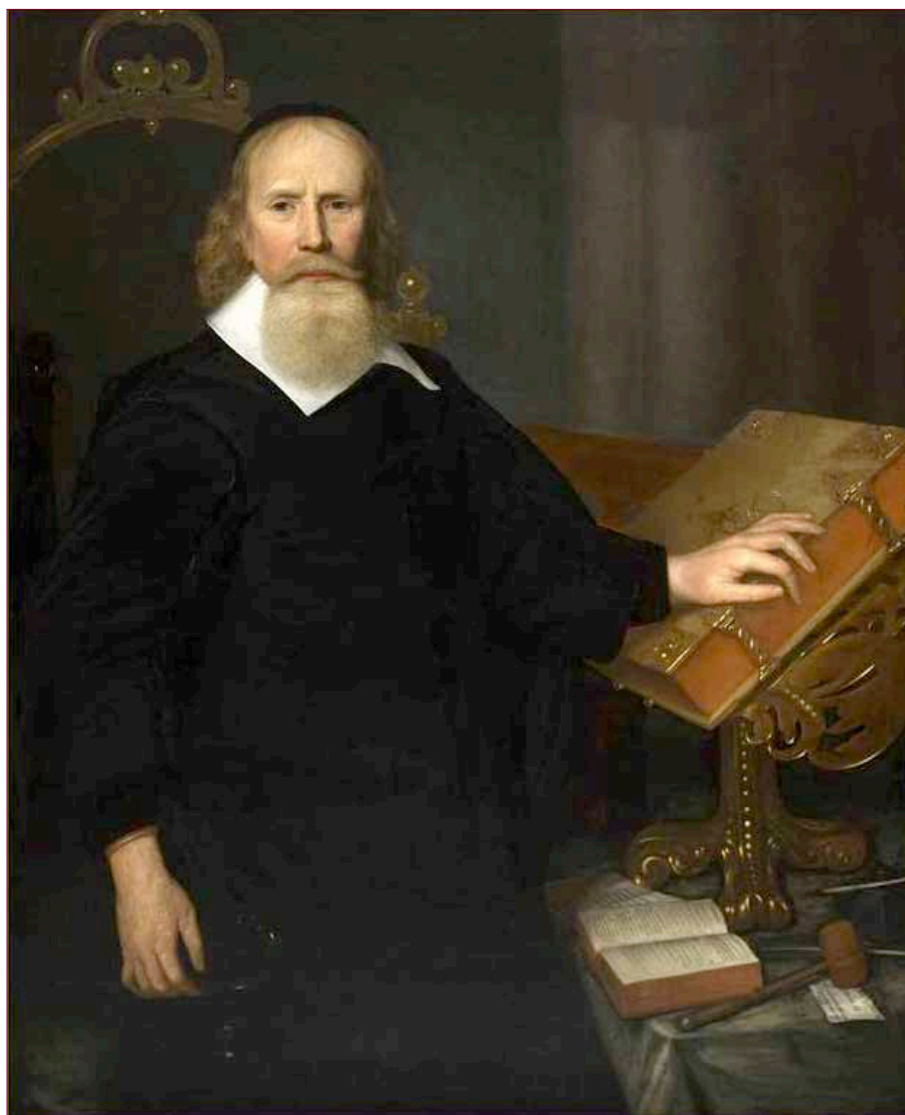
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350 Years Ago: Dr. John Clarke's 'livlie experiment'

Physician, patriot, philanthropist's legacies live on

MARY KORR

RIMJ MANAGING EDITOR



Portrait believed to be that of Dr. John Clarke and painted by Guiliam de Ville, from the Redwood Library & Athenaeum Painting Collection.

Prior to George Washington, Thomas Jefferson and James Madison, **DR. JOHN CLARKE**, the first physician of the Rhode Island colony, advanced the idea of the separation of church and state. This year the state is celebrating the 350th anniversary of its Colonial

Charter, secured by Dr. Clarke in 1663 from King Charles II of England. The charter's principles, most noteworthy the provision codifying religious freedom, were subsequently inculcated into the United States Constitution and the Bill of Rights.

An iconic passage is inscribed in stone on the façade of the Statehouse:

...That it is much on their hearts (if they may be permitted), to hold forth a livlie experiment that a most flourishing civil state may stand and best be maintained... with full libertie in religious concernements...

A search of the *Rhode Island Medical Journal* archives, as well as other historical accounts, offers glimpses of the man. Rhode Island historian Thomas Bicknell, who wrote a monograph on Dr. Clarke in 1915, described the young physician upon his arrival in Boston in 1637 as "thoroughly inoculated with the spirit of Democracy of the Baptists of Holland. He is in his twenty-eighth year, a strong, stalwart fellow, over six feet in height, magnetic, enthusiastic, having a judicial mind, a calm temper, and a bold and resolute will."

Bicknell related the conditions Dr. Clarke faced in Puritan Boston:

"The town is stirred as never before or since, in a contest for the emancipation of the soul of man from the chains of a spiritual bondage. A freeman himself, he (Dr. Clarke) at once casts in his lot with advocates and disciples of a liberal Democracy, and at once is chosen their new leader and proposes the formation of a new state in a new land."

Dr. Clarke was soon exiled from Massachusetts and arrived with a small band of settlers on Aquidneck Island in 1638. William P. Sheffield, a Rhode Island senator, described the area as "Canonocus's city" in a talk before the American Medical Association in 1889. "Here they lived in caves until they could provide better shelters," he said.

The land was purchased from

Canonicus, chief of the Narragansett tribe, and Pocasset (Portsmouth) was founded. Dr. Clarke would co-found Newport the following year. Sheffield noted that Dr. Clarke was “their preacher as well as their physician.”

Mention of Dr. Clarke again surfaces in the May 1931 *Rhode Island Medical Journal*, which published the remarks on early medicine and surgery in Newport delivered by **WILLIAM S. SHER-**

MAN, MD, to the Naval Hospital and the Newport County Medical Society. He recounted that Dr. Clarke studied medicine at the University of Leyden in Holland where “he attained high repute for ability and scholarship in languages, including Latin, Greek and Hebrew, law, medicine and theology.”

Dr. Sherman noted that it was due to Dr. Clarke’s work, after a dozen years in England, that the Royal Charter of 1663 was signed and remained the colony’s form of government for 180 years.



R.I. STATE ARCHIVES

Among the items on display at the Rhode Island State House Charter Room are the remnant sections of the wax and resin seal of King Charles II that was originally appended to the charter, and the charter box.

At the same time that it established the colony of Rhode Island and Providence Plantations, it also squelched a land-grab by neighboring Connecticut.

Dr. Sherman mentioned in his talk that the Newport Medical Society erected a tablet at the city’s Historical Society in 1885, which stated:

*To John Clarke, Physician,
1609–1676
Founder of Newport,
And of the Civil Polity
of Rhode Island.*

Dr. Sherman also remarked that one of the first acts under the Royal Charter “is of more than passing interest as it is believed to be the first medical degree conferred in any of the colonies, March 1st, 1664 in Newport.”

The decree read:

Wheras the Court have taken notice of the good endeavors of Captayne John Cranston of Newport, both in phissicke, and chirurgery, to the great comfort of such as had occation to improve his skill and practice... The Court doe therefore unanimously enacte and declare that the said Captayne John Cranston is lycenced and commistioned to adminester phissicke, and practice chirurgery throughout this whole Collony... by the Authority of the Generall Assembly of this Collony.

Dr. Clarke returned to Newport after securing the charter and remained a physician and a Baptist minister until his death in 1676. He was married three times; his first and second wives and one child preceded him in death.

His will created a trust “for the relief of the poor and the bringing up of children unto learning from time to time forever.” The John Clarke Trust remains the oldest charitable trust in the country and is administered by the Bank of America. ❖



NATALIA KENT

The Royal Charter, granted By King Charles II on July 8, 1663, is on display in the new Charter Room at the Rhode Island State House, where a charter museum opened this year to celebrate the document’s 350th anniversary.