SPECIAL SECTION

ADOLESCENT HEALTH

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15 Perspectives and Approaches to the Dynamic and Developmental Issues in Adolescent Health Care
PATRICIA FLANAGAN, MD
GUEST EDITOR

16 Providing Confidential Care to Adolescents in Healthcare Settings
SUSAN DUFFY, MD, MPH

19 Patient Engagement for Youth in Multiple Facets of Healthcare in Rhode Island
JOANNA BROWN, MD, MPH
JASON RAFFERTY, MD, MPH, EDM
DEBORAH GOLDING
VICTORIA ADEWALE, MSC
LAUREN CHAN
CHRISTINA PASTORELLO, MD
PATRICIA STEBBINS, MPPM, MA
JODIE NEUKIRCH, LCSW

22 Transitions to Adult Care for Rhode Island Youth with Special Healthcare Needs
SUZANNE MCLAUGHLIN, MD
CHRISTOPHER TERRY, MD
JODIE NEUKIRCH, MS, LCSW
DEBORAH GARNEAU
DEB GOLDING
JOANNA BROWN, MD

25 Here, There and Nowhere: Following Adult Survivors of Childhood Cancer
A Case Report Of Recurrent Osteosarcoma in a Young Adult
SUZANNE MCLAUGHLIN, MD, MS
CHRISTOPHER TERRY, MD
FERNANDO BARBOSA, MSW, LICSW
BRADLEY DENARDO, MD

On the cover
8 **COMMENTARY**
Shared Decision Making or Paternalism?
JOSEPH H. FRIEDMAN, MD

Fiduciary considerations in the physician-patient relationship
HERBERT RAKATANSKY, MD

9 **LETTER TO THE EDITOR**
Idiopathic Intracranial Hypertension Treatment Trial
MARK J. KUPERSMITH, MD
MICHAEL WALL, MD
MICHAEL McDERMOTT, PhD

14 **RIMJ AROUND THE WORLD**
Westerly, Rhode Island

47 **RIMS NEWS**
Are you reading RIMS Notes?
Convivium 2016
Working for You
Special Event: Demystifying the Legislature
Why You Should Join RIMS

71 **HERITAGE**
1917: Mechanical treatment of spine curvature
MARY KORR
IN THE NEWS

$19.5M GRANT 57
to bridge gaps between medical research, health care in RI

ALPERT MEDICAL SCHOOL, HOPE HOSPICE 58
expand affiliation

WOMEN & INFANTS RESEARCH 60
women trust their own instincts when choosing breast cancer surgery

LEGISLATION ON PREVENTING OVERDOSE DEATHS 62
signed into law

LEGISLATION ON FREESTANDING ERS 62
signed into law

STATE APPROVES PTSD 64
to list of conditions approved for treatment with medical marijuana

KENT PATIENT 64
receives Subcutaneous Defibrillator System (S-ICD)

PROVIDENCE VA MEDICAL CENTER 64
breaks ground on new ICU

PEOPLE/PLACES

JENNIFER HEALEY 66
named Director of Clinical Services at Southcoast Behavioral Health

KRISTIN JACOBS, MD 66
elected President of Fellows’ Research Network Committee

OBITUARY 66
Amir H. Missaghian, MD

68 TARO MINAMI, MD
honored with Teacher of the Year Award

68 STEPHANIE MARYESKI, MD
joins Newport Hospital as Director of Primary Care
CONTRIBUTIONS

28 The Refugee Community Health Worker Initiative (RCHWI) in Rhode Island: A Pilot Program
AYESHA SAYA, MD, MPH; SU AUNG, MD, MPH; PERRY GAST, MPH; CAROL LEWIS, MD

31 Student-Driven Approaches to Undergraduate Medical Research: A Peer-Led Symposium
CLAUDINE YEE, BS; ANNIE M. WU, BA; CONNIE M. WU, BS; RACHEL V. THAKORE, BS; PAUL B. GREENBERG, MD

CASE REPORTS

34 Cocaine-induced diffuse alveolar hemorrhage: A case report and review of the literature
SUBASH GHIRI, MD; JOY LIU, MS3; SAMUEL K. EVANS, MD; KEVIN M. DUSHAY, MD

37 Metastatic Prostate Cancer Presenting as Acute Appendicitis: A Case Report
PATRICK M. LEC, MD; DON C. YOO, MD; JAMES R. CARLSTEN, MD

IMAGES IN CLINICAL MEDICINE

39 Left Ventricular Free Wall Rupture
DOUG HIDLAY, MD; ROBERT WARD, MD

EMERGENCY MEDICINE RESIDENCY CPC

40 Peeping Painless Proptosis
MAUREEN LLOYD, MD; XIAO CHI ZHANG, MD, MS; SARAH JOSEPH, MD; JAY BARUCH, MD; MATTHEW SIKET, MD; WILLIAM BINDER, MD

PUBLIC HEALTH

43 Health by Numbers
Exploring the co-occurrence of bullying victimization, homophobic teasing and teen dating violence: Implications for prevention programs
DEBORAH N. PEARLMAN, PhD; HAILEE K. DUNN, MPH

46 Vital Statistics
ROSEANN GIORGIANNI, DEPUTY STATE REGISTRAR
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Shared Decision Making or Paternalism?

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I recently encountered the term, “shared decision making” (SDM) for the first time. It was in a paper that stated that a doctor needs to use SDM before instituting an antipsychotic drug with a “black box warning” to treat psychotic symptoms in people with dementia with Lewy bodies (DLB).

DLB is a variant of Parkinson’s disease (PD) in which dementia precedes motor signs, whereas PD with dementia starts with motor features, followed by dementia, which occurs in about 80% of PD patients. The rationale for SDM lies in the observation made in several distinct studies of demented elderly, that all antipsychotics are associated with an increased mortality rate, although in none of the studies is it clear what the cause of the increase is. In some of the reports the increase is clinically significant, but not in all.

What was striking in the paper was that SDM was invoked for trying the antipsychotics because they have “black box” warnings, but SDM was not invoked for trying dementia drugs, or reducing the medications that treat the PD motor symptoms, but which contribute to the psychotic symptoms. This sounds reasonable. One type of drug is associated with black box warnings while the other approaches are not. This got me to thinking about how I approach decision-making in cases of PD psychosis and found that I do the exact opposite. I can’t recall ever introducing the topic of the black box warning. These drugs have the mortality risk only over the course of several months. The problems are not immediate. It is unknown if the mortality is a result of the drugs or an associated effect, and, in my extensive experience, the benefits so far outweigh the risk that there is really no choice. But, of course, the patients and the families lack the experience to make the choice.

In treating people with PD, I use a SDM paradigm for everything but psychosis. If I introduce L-Dopa or a dopamine agonist, I discuss side effects and benefits and weigh this against the no-treatment option. I always reassure my patients that I do not subscribe to the “my way or the highway” approach to compliance with my recommendations. I always tell patients that I view my role as being similar to that of a financial advisor. I make educated recommendations, but that doesn’t mean they must be followed.

In reflecting on my approach, using SDM for medications considered benign, but not for the only drugs I use that have black box warnings, I realize that there is an element of legal risk taking, and a larger element of paternalism. If my patient dies unexpectedly, which, of course, would raise no eyebrows, because all my patients are ill, many are elderly and most are frail, there will be no statement in the chart that we discussed the increased mortality, that the drug I introduced had a “black box” warning, and that it was not FDA approved for the indication. I would also have to admit that I was biased by my extensive use of the drugs for over 30 years, and that I am quite expert in this area. In my mind, a patient can decide whether to take L-Dopa or not. It is not life saving and may be associated with long-term side effects. It improves quality of life, but who am I to judge where the proper balance lies? If a patient would prefer to be slow and stiff rather than to take a medication, because of concern for side effects or for whatever reason, that is their choice. But to choose to remain psychotic, to embrace paranoia, or to have a family choose that for a patient who cannot reasonably choose, is not a choice I offer.

I do not know how my colleagues discuss these drugs with patients. I think much depends on the relationship between them. In most cases I know my patients and their families fairly well. This is unlike the situation where psychiatrists use the same drugs on patients they have only recently met, or when the drugs are used in nursing homes. These doctors are usually involved only when the patient is in extremis. They
may be seeing the patient for the first time, and, quite reasonably, expect their recommendations to be second-guessed by the patient or family, and understand that the patient is frail, so that a bad outcome is possible, for which they might be blamed. In my situation we’ve usually been working together for years so that a large degree of trust has been built. Patients are often reluctant to take anything new, unless they are suffering. Psychosis in PD is a situation that cries out for help.

Perhaps I’m too old, too paternalistic or I’ve been doing this too long. There is sometimes a reason to not share decision making, even in the face of a “black box.”

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Disclosures on website

Letter to the Editor
Regarding the Idiopathic Intracranial Hypertension Treatment Trial
June 24, 2016

We read the article by Thakore and colleagues concerning the Idiopathic Intracranial Hypertension Treatment Trial (IIHTT)¹, published in your journal in May 2016, and were surprised at the comments. By design, both the acetazolamide and placebo groups received the same low sodium, weight reduction dietary intervention. The fact that the acetazolamide group lost more weight on average than the placebo group does not account for the positive results concerning acetazolamide on vision outcome. As we explained in the original trial report², we used mediation analysis to determine that the effect of acetazolamide was independent of its effect on weight. In other words, while acetazolamide had a significant effect on weight (acetazolamide – placebo difference of approximately 4 kg, p < 0.001), the effect of acetazolamide on the visual field PMD was independent of its effect on weight loss. This strongly suggests that the mechanism of the effect of acetazolamide on vision outcome is not through its effect on weight reduction. We note that the IIHTT findings are not inconsistent with the theory that a weight loss intervention would be an effective therapy in IIH – Indeed, there was improvement observed over time in both the acetazolamide and placebo groups on most outcome measures. The IIHTT, however, was not designed to evaluate the effect of a weight loss intervention because all subjects received such an intervention delivered by an expert obesity nutrition research center.

We sincerely hope that this clarifies, and prevents any further misperceptions about, the results of the IIHTT.

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References
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When you (or I) are patients and go to doctors, we assume that all their advice is directed to our well-being and that it will not be compromised to enhance the doctor’s welfare. But there are economic issues and time constraints that conspire to thwart this expectation.

The moral concept that doctors should always act in the best interests of their patients, even if it may be detrimental to their own interests, is rooted in antiquity. “No…physician considers his own good in what he prescribes, but the good of his patient.” [Plato c.428 BC–c.348 BC]. This obligation to always put our patients’ interests first continues as a core principle of the current AMA Code of Medical Ethics, the authoritative reference for US medical ethics.

A fiduciary has a statutory legal obligation to place the client’s interests above his own. Examples include, among others, attorneys, members of corporate boards, independent financial advisors and, recently, stockbrokers [under protest].

The concept of a legal fiduciary responsibility for doctors was introduced in a 1969 judicial opinion: “The relationship between a physician and his patient is fiduciary, which, like all such relationships, imposes a duty of full disclosure.”

However, doctors are at little risk of being charged with a breach of fiduciary duty to patients since the facts of the case almost always also involve violating a standard of professional care and the Supreme Court has disallowed the charge of violating one’s fiduciary responsibility when it is duplicative of the malpractice action. That case questioned whether a doctor who altered treatment due to financial incentives could be sued for a breach of fiduciary duty.

In one exception in 1997 in CA, Dr. Nokuzola Ntshona was convicted of Medicare fraud for prescribing unnecessary medical devices. Her sentence was “enhanced” because she profited by making her patients liable for co-payments. This constituted a breach of fiduciary duty in addition to her criminal activities and her malpractice [negligence]. She suffered very real consequences for violating her fiduciary responsibilities.

Alabama, Minnesota and Delaware courts have held that doctors do not have a fiduciary duty to their patients.

Ten other states admit the existence of a fiduciary duty but prohibit it as a cause for legal action against doctors, restricting actions to malpractice claims.

As medical care is morphing from an interpersonal interaction into an impersonal commodity, we must be aware that restrictions on care imposed by third parties such as payers, large medical “systems,” institutions, etc., may thwart the intent of doctors making medical decisions in accordance with their ethical and fiduciary responsibilities. Frustrating disincentives [prior authorizations, denials of costly treatments, exclusion from the system, etc.] may impede zealous physician advocacy for indicated medical treatment. However, hospitals and other institutions also may be considered fiduciaries and thus be required to formulate and enforce policies that protect patients. Thus doctors and institutions may be “co-fiduciaries.”

A CA court has opined: “The physician who complies without protest with the limitations imposed by a third party payor, when his medical judgment dictates otherwise, cannot avoid his ultimate responsibility for his patient’s care. He cannot point to the health care payer as the liability scapegoat when the consequences of his own determinative medical decisions go sour.”

A recent review notes that, “Fiduciary law principles have been applied to physicians only for very limited purposes” such as patient abandonment,
confidentiality, informed consent and disclosure of a financial interest in clinical research.

Additional conflicts that might be contrary to fiduciary duties [and not duplicate malpractice claims] include, but are not limited to, not advocating for indicated diagnostic and therapeutic actions when third party decisions may preclude their implementation, accepting gifts from industry, referring patients to physician-owned ancillary facilities, accepting kickbacks from non-physician-owned facilities, conditioning too great a proportion of physician income on bedside rationing, and “gag clauses” that prohibit physicians from giving patients information that might be adverse to the patient’s health plan.

So what to do?

What if all doctors and medical institutions were fiduciaries [though jurisdictional variations would make this difficult]? If this were the case, the doctor, citing his fiduciary obligation to provide medically appropriate treatment, would enhance patient advocacy. A third party that contravened such an order would risk being liable for interfering with the doctor’s fiduciary duty as well as possibly not fulfilling its own fiduciary duties.

The financial limitations of our health care system are real and constructive approaches are needed to ensure that patients receive the best possible care.

Doctors play two roles, but not simultaneously, in the maintenance of a financially healthy, efficient and high quality medical system. As administrators and members of committees, task forces, etc. we participate actively in formulating the rules and policies that are necessary to keep our medical system efficient and financially healthy. In addition to local efforts, state and national medical societies, are well suited for this effort. Transparency is critically important. Patients must be told about the rules and policies in terms they can understand. For example: patients should know if treatment for hepatitis C is restricted to those with defined complications and if referrals to specialists and institutions are limited.

But when actually caring for a patient, we zealously advocate for that patient’s health. Ethical and moral imperatives mandate this approach. A fiduciary obligation for doctors and institutions to advocate for the welfare of patients can only strengthen this advocacy. This patient-centered approach is similar to the dedicated advocacy provided by lawyers to their clients within the constraints of the legal system.

This approach will benefit us both when we are patients, as well as when we are doctors.

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Westerly, Rhode Island

Sarah Stevens enjoys reading RIMJ while relaxing at the sea shore, shown here at Misquamicut Beach. Misquamicut has a relatively short history as a state beach, having opened in 1959. After the hurricanes in 1938, 1944, and 1954 left most structures along the shore flattened, washed out to sea, or damaged to the point of being uninhabitable, Governor Dennis Roberts moved to have the state condemn the mile-long stretch of beach in Westerly that became Misquamicut State Beach.
In this and next month’s issue of the Rhode Island Medical Journal [RIMJ] we have the privilege of sharing topics in Adolescent Health with readers. Adolescence is generally a very healthy stage of life. Youth aged 10-24 years have the lowest rates of morbidity and mortality in the US and Rhode Island has the lowest teen death rate in the country. Many of the health issues faced by teens are keenly linked to the developmental dynamics of adolescence and behavioral decision making. The leading causes of death in this age group include accidents, primarily motor vehicle crashes, but also unintentional overdoses, homicide, and suicide.

It is important to note that health behaviors beginning in adolescence continue into adulthood, making this a unique time in a life-course for interventions that will have a lasting impact.

Three-quarters of adults with severe and persistent mental illness experienced their first symptoms prior to age 18. Most adult tobacco smokers began smoking as teens. The majority of young people engage in sexual activity by age 21. Rates of chlamydia and gonorrhea are highest among teens and young adults. While rates of teen pregnancy continue to fall, in 2015 we still had 509 young women under the age of 20 give birth in RI.

Providing health care for teens requires an understanding of adolescent psycho-social, psycho-sexual, and cognitive development. Brain maturation from age 10 to age 24 is dramatic, is variable in timing and tempo, and is not always in synchrony with the dynamic physical maturation that happens throughout adolescence. The capacity of a 12-year-old to communicate his or her concerns and symptoms, to understand the ramifications of actions or behaviors, and to fully engage in healthcare decision making certainly can vary widely but is also drastically different from a 16-year-old or a 21-year-old. Helping young people navigate adolescence with the tools, knowledge and motivation to stay healthy requires building a developmental scaffolding. Partnering with parents, schools, and communities allows teens to experiment, to grow, to take risks and make good choices.

This issue of RIMJ opens with Dr. Susan Duffy’s paper on the very important and difficult topic of adolescent confidentiality. This is a topic that is central to caring for youth yet is complex. Understanding confidentiality and its limits and communicating this to youth and their families is essential to providing high quality effective health care. Dr. Joanna Brown and colleagues discuss the very important topic of youth engagement. They present three different initiatives in Rhode Island that have successfully engaged youth to participate in their own care and to help build a health care system that works for teens and young adults.

Dr. Suzanne Mclaughlin and colleagues present the proceedings of a panel discussion on transitioning youth to adult care systems that was part of a learning collaborative held by The RI Care Transformation Collaborative (CTC). The transitioning of youth from pediatric care systems to adult care systems is a transition that is often fraught with discontinuity, miscommunication and gaps in care. This is most significant for youth with special health care needs. We then present a case study of a young man whose transition was not smooth and point out multiple opportunities for systems improvement.

Next month, we will look at specific conditions and the health needs of specific populations of youth. Dr. Abigail Donaldson and her team will present an update on the care of individuals with eating disorders. Dr. Diane Der-Marderosian and colleagues write about an integrated approach to psychiatric care for children and youth with medical conditions. She describes a unique, team-based integrated care model provided both in an in-patient setting and in a partial hospital setting. Drs. Kristyn Gergelis, Jonathan Kole and Elizabeth Lowenhaupt write about the healthcare needs of incarcerated youth and Drs. Agnieszka Janicka and Michelle Forcier discuss transgender and gender non-conforming youth. Dr. Christine Barron and colleagues present their research on RI pediatricians and their training, screening, and knowledge about domestic sex trafficking of minors.

Quality health care that recognizes the dynamic developmental nature of adolescence can help youth stay safe and make good behavioral choices. It can be attuned to some of the potential pitfalls and roadblocks to healthy adolescence as well as motivations for positive health-affirming decisions. It can be a great opportunity to cultivate a strong foundation for adult health.

Reference

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Patricia Flanagan, MD, Professor and Vice Chair of Pediatrics, The Warren Alpert Medical School of Brown University, Hasbro Children’s Hospital.
Providing Confidential Care to Adolescents in Healthcare Settings

SUSAN DUFFY, MD, MPH

KEYWORDS: Adolescent Confidential Care, privacy

INTRODUCTION

An unaccompanied 15-year-old girl presents to a local emergency department (ED) with abdominal pain, but at triage does not reveal her concern that she may have a sexually transmitted infection (STI). She is seeking care in the ED instead of her primary care medical home because she believes her visit will be confidential. Upon ED arrival, the youth explains her symptoms to a nurse, who orders urine testing for pregnancy and STIs. Registration staff obtains her insurance and contact information. If she were an adult, this would be a typical ED visit for an acute complaint. Since she is a minor, the situation is complicated by the complexities of providing confidential care to an adolescent.

Based on the patient’s symptoms suggesting a possible STI, this minor has the legal right to confidential care in all 50 states. Privacy, however, even if mandated, is not always guaranteed because of the many ways confidentiality can be breached during a health care encounter. In addition, the adolescent may not be in the best position to advocate for her rights. She may be unfamiliar with the laws created by the state and the Federal governments to decrease barriers to care for specific conditions as well as the general workings of the healthcare system. Hospital staff may also be unaware of the laws, fail to inquire about confidential conditions or inform adolescents of their rights. By not recognizing that a minor is seeking confidential care, healthcare staff may unwittingly inform parents. Unless informed, minors may be unaware that their parents’ insurance company will be billed for visits and parents may receive financial statements as well as explanation of benefits (EOB) notifying them of the visit. Minors may not know that their parents may have access to confidential lab results through electronic health record (EHR) portals. Or, that healthcare providers may decide it is in the youths’ best interest to notify parents of their conditions.

PRIVACY IN ADOLESCENT MEDICAL PRACTICE

One of the tenets of adolescent medical practice is to provide confidential care and privacy to minors that align with their evolving autonomy. Medical professionals who care for adolescents practice with an appreciation for their developing cognition and limited life experiences that sometimes, but not always, limits their capacity to make fully competent decisions. Since parents are responsible by law and culture for most of the medical decisions involving minors, medical professionals routinely broker with both parents and adolescents about the allocation of medical decision-making. In many adolescent practices, minors, parents and physicians sign formal contracts, agreeing to confidentiality between adolescents and their medical providers as long as it is within the boundaries of professional practice and the law.

In most situations, parents are in the best position to help their adolescents make decisions. They typically know their children best and place the highest priority on their welfare with an appreciation for their evolving capacity for decision-making. Adolescents often welcome their parents’ input and look to them for guidance.

It is faulty to assume however, that because parents are adults they always make competent decisions for their children. Or, that minors lack the capacity to make thoughtful decisions. In fact, sometimes there is conflict between parents’ priorities and those of their adolescent children, especially in areas of reproductive health and substance abuse. Such conflict can create barriers to adolescents accessing appropriate healthcare.

POLICIES RELATED TO ADOLESCENT HEALTHCARE DECISIONS

Out of concern for adolescents and the public health, most states have adopted minor consent and privacy laws that allow certain minors to consent to confidential care in specific areas. Services supported by statute include those for family planning, pregnancy care, STI and HIV testing and treatment, substance abuse treatment, outpatient mental health care, emergency care, sexual assault evaluation and less frequently abortion. Laws differ in each state and define the limits of confidentiality and consent.

A few states have specific statutes that outline criteria for mature minor and emancipated minor status. Most states, including Rhode Island (RI), do not have laws and rely on individualized judicial decisions to make determinations.

At the federal level, protection for reproductive rights, including for adolescents, dates to 1970 when Congress added Title X of the Public Health Service Act that established federally funded programs to allow access to family planning services to everyone. The act was subsequently amended to insure that adolescents have confidential access to care in specific situations.

The Supreme Court has also ruled in favor of the consti-
tutional right to privacy of adolescents in the context of decision-making related to reproductive health and allows them autonomy in decisions to obtain contraception without parental consent.1

The Supreme Court decision in Roe v Wade in 1972 led the way for legalized abortion, including for adolescents. State statutes that followed have consistently limited access to abortion for adolescents without parental consent in all but 2 states. Federal rulings have countered state regulation and supported protection of adolescent decision-making with a “judicial bypass” where a judge determines a minor’s capacity to make the decision to have an abortion without parental consent.1,12

In 1996, Federal health care privacy regulations were issued under the Federal Health Insurance Portability and Accountability Act (HIPAA). These rules were designed to safeguard health information, and facilitate patients’ access to their health information. HIPAA rules closely align with state minor consent laws and other established laws to assure that when a minor can legally consent for care, their health information must be protected, including from their parents.3,5,13

In addition to HIPAA protections, state privacy laws also direct healthcare providers to maintain confidentiality of information. In RI, like most states, if a minor has the authority to consent for care, information cannot be released, even to parents unless the minor consents.14

There are specific federally funded healthcare programs that protect adolescent confidentiality. Title X Health Centers administered through the Department of Health and Human Services are purposed to assure access to confidential family planning services regardless of age or ability to pay. Medicaid programs are also required to support family planning services for beneficiaries. A few state public funds also support specific abortion services allowed by law.1,10

There are a variety of other state specific laws and policies that help safeguard adolescent confidentiality and direct healthcare professionals. Included are laws that address healthcare providers’ rights to care for adolescents within the boundaries of professional practice and rely on good faith information provided by a minor about their status.1,2,11

A joint statement issued by the the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the American College of Obstetricians and Gynecologists (ACOG), and the Society for Adolescent Medicine (SAM), support the principles of protecting adolescent privacy and respecting confidentiality when the adolescent has the legal right to give consent, while making reasonable efforts to encourage adolescents to involve their families in their healthcare decisions.7

**STI TESTING AND TREATMENT, CONTRACEPTION AND PREGNANCY**

In all states, youth ages 12 and older can consent to confidential care related to STIs. In RI, the law includes confidential testing and treatment of all reportable communicable diseases including HIV. There is no legal requirement to report pregnancy to a parent.10,11

In many states there are laws defining the age of consent for contraceptive and pregnancy related services. In RI there are no statutes but Federal privacy and Title X mandates allow all minors access to confidential family planning services and sets a precedent for access to adolescent confidential contraception and pregnancy care.10,11 Title X language encourages but does not require minors to involve their parents in their decisions. Medicaid programs in RI also support payment for adolescent contraception and pregnancy related services.10,11 Adolescents who consent for treatment but are not insured by Medicaid are financially responsible for services. The Affordable Care Act (ACA) mandates that private insurance cover contraceptive services with some exceptions.11

**ABORTION**

Per RI Law, abortion for a minor requires consent of one parent except for medical emergencies. There is an allowance for judicial bypass.10,11,14 Connecticut is one of two states that allow adolescents to make the autonomous decision to have an abortion.11 Many private insurers cover abortion services. A recent ruling related to the ACA however, mandates that insurers offer plans that do not offer coverage abortion services.

In RI, public insurance or programs for public employees cover abortion only in cases of life endangerment, rape or incest.15 Massachusetts Medicaid programs support specific abortion services.

**EMERGENCY CARE**

Adolescents in RI ages 16 years or older or married may consent to “routine medical or surgical care” and the health information from these visits is confidential. Since “routine emergency care” may fall outside of typical specific confidentially protected care, without safeguards in place in the EHR, this information may be vulnerable to disclosure.1,16 In general, minors are financially responsible for treatment for which they consent. In every state, laws support treatment of minors for emergency conditions without parental consent.16

**SUBSTANCE ABUSE TREATMENT**

In RI, as in many states, adolescents are allowed to seek treatment for drug or alcohol abuse without parental consent if a qualified professional agrees contacting a parent would not be helpful to the care. There is also no legal requirement to report substance abuse to parents. Parental participation is required for minors to enter a substance abuse treatment program.14,17,18

**ELECTRONIC HEALTH RECORD**

The establishment of EHRs has increased the exchange and accessibility of health information, but has also resulted in dilemmas related to the protection of adolescent confidential health information.19,20 Most commercial EHRs, including those in RI medical practices, do not have automatically instituted privacy controls for adolescent confidential information. Very few provide point of care access to medical professionals that allow them to segregate or highlight confidential information within the record.8,13,15 HIPAA and state privacy laws require
that confidential medical information of minors can only be released after their written consent. Without privacy controls, determining what constitutes confidential information requires an inspection of the record by trained personnel without guarantee that all confidential information will be identified. Some EHR vendors have customizable features that can be adapted to meet privacy standards. Patient portals, for example can be configured to allow minors of a specified age and their medical providers access to their personal health information (PHI) while parents are allowed access only by proxy. Each institution must determine how options for privacy are implemented in the EHR and inconsistency across systems may compromise confidentiality.

HEALTH INFORMATION EXCHANGE

The Health Information Exchange in RI called Current Care include policies that support the privacy of enrolled minors that aligns with HIPAA and privacy regulations. The PHI related to confidential care of minors between the ages of 10 and 18 years is released only to the minor’s authorized health care providers. The PHI of “routine emergency medical or surgical care” of minors between the ages of 16–18 years is released only to them or their authorized healthcare provider.

INSURANCE

Adolescents are typically insured as their parents’ dependents. One of the most common ways adolescent confidential information is breached is when parents receive insurer provided explanation of benefits (EOBs) or financial statements. Each insurer sets the standard for what information is included in their EOBs. Some provide detailed information related to testing and treatments while others, including EOBs from Medicaid programs, are less specific. Some states have developed regulations around EOBs to protect the confidentiality of minors insured as dependents.

Respecting the evolving autonomy and privacy of adolescents aligns with best medical practices. Healthcare professionals and their staff are obligated to know and integrate the laws and standards related to adolescent confidentiality and privacy into their practices. Medical professionals will best serve their patients by becoming educated about programs supported by the federal and state governments and other organizations to safeguard adolescent confidentiality, reduce barriers to care and promote adolescent health and wellbeing.

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Patient Engagement for Youth in Multiple Facets of Healthcare in Rhode Island

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ABSTRACT
Health reform strives to be patient-centered but often emphasizes institutional and financial well-being at the expense of patient responsiveness. Rhode Island is a pioneer, with innovative youth engagement programs in health care. The Youth Advisory Board of the Adolescent Patient-Centered Medical Home (PCMH) Initiative at Brown Family Medicine has brought together adolescents to gather feedback about participants’ preferences for their health care and bring that feedback to health care providers. The Adolescent Leadership Council (TALC) of Hasbro Children’s Hospital is comprised of adolescents with chronic medical illnesses and serves as an advisory group. The Rhode Island Department of Health’s Office of Special Needs offers Dare to Dream, a youth leadership development program, a youth advisory council and a healthy lifestyles program. These youth engagement programs allow youth to help shape the health care system to meet their needs and contribute to youth empowerment in the state.

KEYWORDS: patient engagement, Patient-Centered Medical Home, special needs, adolescent health transition, positive youth development

INTRODUCTION
Engaging youth in their health care is critical to shaping care in a way that benefits them as patients and consumers. The programs described in this article originate from a variety of sources that have shaped, and are currently shaping, health and health-related programming for adolescents and young adults. These include Positive Youth Development (PYD), the Patient-Centered Medical Home (PCMH), and efforts to enhance patient and family-centered care across the health care system.

Positive Youth Development (PYD) represents an approach to youth engagement that strives to support the “growing capacity of a young person to understand and act on the environment.” Key to this approach are inclusiveness and a focus on strength and on positivity. PYD has a rich and extensive literature, some of which focuses on community programming that helps youth build personal and social assets to enable them to make a successful transition to being competent adults.

The “Joint Principles of the Patient-Centered Medical Home” were published in 2007 by the main U.S. primary care societies; well before this time, however, medical homes were adopted in pediatrics as a way of achieving coordinated, high-quality care for children and youth with special health care needs. The PCMH model includes comprehensive, coordinated, team-based care, patient centeredness, continuity of care over time, quality, safety, enhanced access to care and payment reform. Rhode Island has demonstrated a focused commitment to PCMH, forming the Care Transformation Collaborative (CTC, formerly CSI-RI) to promote PCMH adoption in primary care, and PCMH Kids, which focuses on primary care transformation for the state’s children.

Patient engagement in medical homes can be implemented at three main levels: engagement of patients and families in their individual care, engagement of patients and families in practice improvement, and engagement of patients and families in policy, as discussed in a white paper published by the Association for Healthcare Research and Quality in 2010. Self-management support and motivational interviewing are examples of methods used at the individual level. With regard to practice improvement, techniques have been used such as patient and family advisory councils, informal suggestion books or patient “walk-throughs” to assess practice design. Regarding policy involvement, consumer representation in advisory groups on medical home projects is one example.

Substantial programmatic work has focused on engaging patients and families as advisors in health care improvement. The Institute for Patient and Family–Centered Care offers resources including conferences, tools and pamphlets such as “Families as advisors: a training guide for collaboration” and “Creating Children’s Advisory Councils.” The University of Michigan’s Adolescent Health Initiative has maintained a Teen Advisory Council and published a guidebook to help others implement such groups. Here we describe three such programs in Rhode Island.

The Youth Advisory Board of the Adolescent Patient-Centered Medical Home (PCMH) Initiative
The Youth Advisory Board (YAB) of the Rhode Island Adolescent Patient-Centered Medical Home (PCMH) Initiative, or APCMH, was designed to engage local youth in offering input about adolescent healthcare to a larger project focused on patient-centered, community-based health-care delivery.
Throughout the document, the Adolescent Leadership Council of Hasbro Children’s Hospital, or TALC, is highlighted as a key resource for promoting the PYD model in Hasbro Children’s Hospital settings. TALC provides year-long programming to help students understand their experiences, such as diagnosis, school, college, doctors, independence, relationships, and “living inside the illness box.”

TALC has many demonstrated benefits. Youth with chronic illnesses are able to interact with peers who understand their experiences and can look to the mentors and staff for guidance. Physicians who refer to the program regularly report that their patients are more confident, more likely to self-advocate, and more involved in their care. TALC’s outcomes research indicates that participants become significantly less lonely, have a better attitude towards illness, and have increased transition-readiness skills after one year of participation. The youth themselves report satisfaction with the program and being better able to cope with illness. They also report increases in a variety of PYD-related measures. TALC provides one example of how the PYD model can be effectively used to help a specific adolescent population succeed as they transition to adulthood and to adult health care settings.

The RI Department of Health (RI DOH), Office of Special Needs (OSN)
The RI DOH OSN, also builds on the foundation of PYD through ongoing youth engagement focused on youth potential as a means to promote adolescent health transition. In 2008 the OSN began engaging transition-age youth through a collaborative process with state and community partners. The OSN provides a framework for youth leadership and development called the Dare to Dream Initiative, convenes a Youth Advisory Council and offers workshops for adolescents and young adults promoting health and well-being.

The Dare to Dream Leadership initiative culminates with the Dare to Dream Student Leadership Conference, held annually since 2008 at the University of Rhode Island in Kingston. The day-long event is planned and led by students, for students. Workshops are presented in a relaxed, engaging, and creative environment that encourages learning, sharing, and connections with others.

More than 900 students, teachers, support staff and volunteers of all abilities attend from across Rhode Island.

Technical assistance is provided for schools and community groups who would like to participate.

The Youth Advisory Council is comprised of adolescents and young adults who have demonstrated leadership through Dare to Dream or other statewide youth initiatives and have an interest in working with their peers to improve their school and communities. The council advises and collaborates with the OSN on activities, programs, policies,
and resources affecting the health, wellness, and transition of youth in our state. The group is open to ages 14–26 and meets September through June.

The Healthy Lifestyles Workshops offer a free, fun, and interactive evidence-based curriculum co-taught by certified youth health coaches and adult mentors. Participants learn what it takes to live a healthy, balanced life and the program concludes with creation of a personal action plan for participants. The Office of Special Needs Internship Program places transition-aged students in office-based, entry-level internships throughout the Department of Health. Intern tasks include mailings, filing, data entry, meeting preparation, outreach assistance, organizing, preparing health fair materials, presentations and providing youth input. These unpaid internships are open to students affiliated with other DOH transition programs and have resulted in a number of paid positions.

Through these initiatives, the RIDOH is creating an environment where students with diverse abilities can explore their potential, identify their unique capacities for growth and development, and feel empowered.

DISCUSSION

Due to the efforts of these varied and innovative projects and programs, Rhode Island has been an important forerunner in the movement to engage and empower youth in their health-care experiences. The programs described in this article demonstrate that there are many ways to involve youth in their own health care, to harness their input to improve the care they receive and empower them to be more active participants in the health care system. In addition, outcomes of these programs suggest that participating youth may become more activated with regard to their own care, which has the potential to improve their own health behaviors. Each youth engagement program has been tailored to the sector of health care in which it has been built and to the youth patient or consumer population the program serves. Each program has been highly attentive to outreach and recruitment, to youth-friendly design, to leadership and skills development and to supporting and building on youths’ strengths and capacity. These models of youth engagement can offer guidance to others who would like to continue to create youth-responsive health care in Rhode Island and elsewhere. Youth engagement in health care needs to be an ongoing priority, can be achieved, and can have a number of beneficial effects for the health care system and the youth themselves.

Acknowledgments

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**Transitions to Adult Care for Rhode Island Youth with Special Healthcare Needs**

**Suzanne McLaughlin, MD; Christopher Terry, MD; Jodie Neukirch, MS, LCSW; Deborah Garneau, Deb Golding, Joanna Brown, MD**

**ABSTRACT**

The transitioning of youth from pediatric to adult care systems is often fraught with discontinuity, miscommunication and gaps in care. This is most significant for youth with special health care needs. A panel discussion on transitioning youth to adult care systems that was part of a learning collaborative held by The RI Care Transformation Collaborative (CTC) is presented here, illustrated by a pertinent case of a youth with type 1 diabetes.

**KEYWORDS:** health care transition, children with special health care needs, adolescent transition

**INTRODUCTION**

**Moderator: Joanna Brown, MD MPH**

RI Adolescent Patient Centered Medical Home Initiative

I’ll briefly review the panel’s purpose. The Care Transformation Collaborative is a collection of primary care practices seeking to improve primary care in Rhode Island. The transition from pediatric to adult care is a challenge to many practices, whether transitioning from a pediatric to adult-care practice or transitioning the approach to care within a practice to become more autonomous (e.g. a family medicine or combined medicine-pediatrics practice). As more children with complex, childhood-onset conditions survive to adulthood, there is a statewide need for more health care providers who care for adults to accept these adolescent/young adult patients with special health care needs. Panel members will use the following case to illustrate best practices in transition.

**JD, a 17-year-old with type 1 diabetes presents to your office for the first time, with his mother. He has additional diagnoses of ADHD and depression, and complains of poor sleep. He takes methylphenidate and fluoxetine. He wears a Foo Fighters T-shirt and black jeans and pays more attention to his smartphone than you. His mother reports she’s always scheduled his appointments and refilled his medications. She says they argue daily about checking blood sugars. He’s had 2 recent DKA admissions. “He just says he’s sick of taking insulin.” She worries about losing her job over taking time off to care for him, and hopes it might help to go to a doctor’s office that’s “not just for little kids and babies.”**

**Suzanne McLaughlin, MD**

Medical Director, The Medicine Pediatrics Primary Care Center & the Transition Consultation Clinic, Rhode Island and Hasbro Children’s Hospitals

The case may understate the challenges. I’ve added our experiences to the scenario. JD is seen mid-morning, overbooked into a follow-up slot after a recent hospital discharge. Although I’m listed as his primary care doctor, he has not yet been seen in our office. A future physical is scheduled, but I do not have his pediatric records yet. I find 16 EMR documents from recent admissions. After a brief effort seeking responses from JD, his mother opts to answer my questions to move the visit along. I provide requested prescriptions for current medications, and ask about his most recent hemoglobin a1c, ophthalmologic exam, and endocrine care. His mother replies they were just told they need to find an adult endocrinologist to take over his care by his 18th birthday.

Does it have to be like this? No.

I have a better-case scenario: Our office was contacted at hospital discharge to book a follow-up appointment for JD. The nurse noted he was enrolled in our practice with an upcoming visit, but had not yet been seen. The needed post-discharge visit was scheduled for end-of-session, and with the visit-reminder call, his mother was asked to bring his immunization record. Prompted at morning huddle, our nurse called the pediatric office and had the record of a recent visit faxed to our office.

In meeting with JD and his mother, I note our office policy that anyone age 11 and up has time with the doctor on their own as a part of each visit. The policy preserves confidentiality, often improves the history, and offers an every-visit opportunity for an emerging-adult to develop skills in conveying their own needs and concerns when interacting with health care professionals. JD, on his own, is able to relay information regarding insulin dosing and his annoyance at how his diabetes care disrupts his school and social activities. He endorsed smoking cigarettes, but denies alcohol, illicit drugs and sex.

When his mother re-joins us, she pauses more to listen for JD’s responses. But at the conclusion of the visit, she repeats her frustration about his not monitoring blood sugars, connecting this behavior to the DKA admissions. JD is again silent. I ask: “Wow, you really stepped out of the conversation when we came to that – what happened?” JD and his mother acknowledge they fight almost daily about whether he is “responsible enough.” She says, “I wish he’d take care of it, but if he doesn’t, I have to!” He wants “to do it my way and...”
not be hassled.” I ask for a compromise: “How can we allow some level of responsibility and risk, but avoid the extremes you find scary or frustrating?” We set up a plan to trial JD being responsible to check his sugars, without nagging. They agree to review his meter together nightly, and if there is at least one check, no comments are allowed. If there are no checks, he has to check immediately, without argument. The plan stays in place until he goes a full week with at least one daily check. Neither get exactly what they want, but it’s framed as: “What could you each live with in exchange for not having the daily fights?” I acknowledge limits, “this is the small step we can take in today’s allotted time,” but plan for the next step. We book a longer physical slot for JD’s next visit, and I ask them to complete an online transition screening to give us all a better idea of how the process is going and what next-steps are needed, and give them information about a peer-based transition program for RI adolescents.

The transition process can be overwhelming to a patient and family, but also to us as physicians. There are long-standing dynamics within families, and the issues of the medical condition are superimposed on the age-appropriate adolescent struggle for independence. See Table 1 for helpful resources, which can be used to inform, engage and guide families in their efforts. I continually remind families, and myself, that transition is a process and won’t be accomplished in one over-long visit. Ultimately, transition is intended to help someone realize their potential and can be incredibly rewarding for patients and providers.

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As a hospital-based social worker, I sometimes meet with a patient as a consultant during an admission, or make an arrangement to see them at the time of a primary care or specialty visit if these are at Hasbro Chilen’s Hospital (HCH). This case is typical in that our service is often asked by a physician, family or patient to enter the picture after things are well off-track.

Chronic medical illness often co-exists with mental health issues, like depression and anxiety. I’ll focus on framing JD’s experience. He is resentful of his diabetic regimen interfering with his life. Part of his frustration is that even when he follows his insulin regimen, that doesn’t always keep his blood sugar in range. As a result, he may not fully trust his care team. Irritability, sleep disruption and poor concentration may be symptoms of uncontrolled depression. Chronic illness can be an isolating experience for adolescents and contribute to depression and anxiety. Untreated depression can interfere with his judgment and motivation. Striving for more independence is a normal adolescent behavior and brain capacity for logical reasoning and future thinking is still developing through early adulthood. All of these factors help us understand why he is upset and non-adherent.

It’s also important to consider the perspective of JD’s mother. She has spent years managing his diabetes. It is difficult for her to relinquish the role of caretaker and entrust him with self-care, but equally concerning if he does not move into this role.

Our service’s approach incorporates both the patient and parent. I try to identify past issues, without laying blame, and help the patient to develop a plan. Plans must incorporate patient suggestions, and should use a stepwise approach, allowing the patient some autonomy as an opportunity to build trust. The graduated independence, and hopefully success, will build confidence for later tasks. I encourage parents to share their concerns with their child in a non-accusatory way and to understand their developing role as

Table 1. Transition resources for practices and providers

<table>
<thead>
<tr>
<th>Resource</th>
<th>Description</th>
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<tbody>
<tr>
<td>GotTransition.org is a national clearinghouse, run by the National Alliance to Advance Adolescent Health. Their nationally recognized transition model is aligned with professional organization recommendations and includes 6 core elements of health care transition support: policy, tracking and monitoring, readiness assessment, transition planning, transfer of care and transfer completion.</td>
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<tr>
<td>- A tip sheet to start the transition process: <a href="http://www.gottransition.org/resourceGet.cfm?id=331">www.gottransition.org/resourceGet.cfm?id=331</a></td>
<td></td>
</tr>
<tr>
<td>- A validated tool providing a framework for conversation about transition: <a href="http://www.gottransition.org/resourceGet.cfm?id=126">www.gottransition.org/resourceGet.cfm?id=126</a></td>
<td></td>
</tr>
<tr>
<td>- Information regarding Billing and Coding for Transition: <a href="http://www.gottransition.org/resourceGet.cfm?id=353">www.gottransition.org/resourceGet.cfm?id=353</a></td>
<td></td>
</tr>
<tr>
<td>- The QuickGuide Transition Tool with guidance on health insurance and career goals: <a href="http://www.gottransition.org/resourceGet.cfm?id=372">www.gottransition.org/resourceGet.cfm?id=372</a></td>
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<tr>
<td>New guidelines and tools for transition for internists, from the American College of Physicians’ Pediatric to Adult Care Transition Initiative:</td>
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<tr>
<td>Local resources for transition services are listed at the bottom of the Rhode Island Department of Health’s Pediatric to Adult Healthcare Transition Guidance, along with a checklist for families and patients to plan and track progress:</td>
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<tr>
<td>RI Department of Education, Office of Student, Community and Academic Supports has 4 Regional Transition Centers:</td>
<td></td>
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<tr>
<td>- <a href="http://www.ride.ri.gov/StudentsFamilies/SpecialEducation/SpecialEducationProgramming.aspx#1239631-secondary-transition-services">http://www.ride.ri.gov/StudentsFamilies/SpecialEducation/SpecialEducationProgramming.aspx#1239631-secondary-transition-services</a></td>
<td></td>
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<tr>
<td>A community-based organization, the Rhode Island Parent Information Network (RIPIN), has a Transition Coordinator who can help families start the process.</td>
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<tr>
<td>- Phone: (401)270-0101, or on-line: <a href="http://www.RIPIN.org">www.RIPIN.org</a> or <a href="http://www.startingpointsforparents.org/content/transition-school-adult-life">http://www.startingpointsforparents.org/content/transition-school-adult-life</a>.</td>
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</table>
of professional organizations, insurers, policy makers and providers over the past decade. Despite these efforts, the 2009–2010 National Survey of Children with Special Health Care Needs (NS-CSHCN) demonstrated no significant improvement in transition preparation nationwide versus a 2005 survey. Four transition goals were measured, asking parents if their child’s doctor had discussed a shift to an adult provider, future health care needs, future insurance needs or if their child was encouraged to take increasing responsibility for their own health care needs. Fewer than half (40%) met the 4 national transition outcomes. Rhode Island performed slightly better, reaching 44% overall (a 6% increase over the state’s 2005–2006 result). A local survey identified specific areas in need of improvement: only 13% of providers had written practice policies on transition. Consistent with the national trends, 97% of providers reported that health care plans and insurers did not help in the transition process.

Rhode Island has committed to focus on transition objectives and strategies in their Title V State Action Plans for fiscal year 2016. There are many resources for providers and practices to improve transition. Table 1 highlights links to several useful options.

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Here, There and Nowhere: Following Adult Survivors of Childhood Cancer
A Case Report of Recurrent Osteosarcoma in a Young Adult

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ABSTRACT
Approximately 1 in 285 children in the United States [US] will be diagnosed with cancer before the age of 20.1 More than 80% of children diagnosed with cancer will become long-term survivors.2 As of January, 2010, there are more than 380,000 adult survivors of childhood cancer in the US.3 More than two-thirds of survivors will develop chronic conditions.4 Professional organizations have advocated for specialized risk-based care of survivors.5 Locally and nationally, lack of transition services and insurance coverage are barriers to care of these adult survivors.6 We describe one such case to illustrate these challenges and their impact.

KEYWORDS: cancer survivorship, healthcare transition, adult survivors of childhood cancer, emerging adults

CASE REPORT
A 15-year-old boy was diagnosed in November, 2005, with osteosarcoma of the right distal femur. He underwent two cycles of chemotherapy in his home country, the Dominican Republic, and travelled to Rhode Island [RI] for surgery and further treatment. He continued treatment in RI according to Pediatric Oncology Group [POG] protocol 9754, undergoing 2 cycles of chemotherapy, an amputation to mid-femur with rotationplasty of the lower extremity and 4 additional cycles of adjuvant chemotherapy completed in October, 2006. His treatment was complicated by typhlitis, febrile neutropenia and hemorrhagic cystitis. He was discharged from his final treatment with follow-up with the brace shop, orthopedics, physical therapy and hematology/oncology, and his port was removed 5/2007. He reported having no primary care physician. He was not seen in oncology follow-up from 11/2008 at the time of a negative CT scan for metastatic disease, until re-presenting in 8/2010 with more focal intense areas of uptake within the soft tissues of the right side with possible involvement of the right proximal femur in the area of internal fixation hardware, highly suspicious for recurrence of osteosarcoma.

The patient was admitted for a CT-guided biopsy of the right thigh mass, which confirmed recurrent osteosarcoma. He underwent a right hip disarticulation. With no evidence for metastatic disease at that time, no adjuvant chemotherapy was pursued. However, subsequent 5/2012 surveillance chest CT demonstrated pulmonary nodules consistent with metastatic disease. The patient was treated with neoadjuvant chemotherapy consisting of methotrexate, doxorubicin and cisplatin, with subsequent decreased size of nodules and then underwent a right thoracotomy with wedge resection of metastatic nodules in the right middle and lower lobes in 7/2012. This was followed with an individualized adjuvant chemotherapy protocol, including methotrexate, doxorubicin, carboplatin, cyclophosphamide, etoposide and zole
dronic acid completed in 12/2012. He next presented to the survivorship clinic in 8/2014, reporting cough and intermittent chest pain, after a period of lost-to-follow-up. A chest
CT and bone scan did not show new disease and his echocardiogram was normal. He was again advised to establish primary care. He presented to primary care in 9/2014, and returned for a health maintenance visits 12/2014 and 1/2016. At his most recent well adult visit it was noted that he had not had interim care with the survivorship program, and was encouraged to follow-up. He presented for survivorship follow-up 1/2016, and had negative surveillance imaging and a normal echocardiogram.

discussion
Our patient experienced multiple secondary effects of chemotherapy, including hearing loss, learning disabilities and infertility. In addition, he experienced recurrence of his osteosarcoma. Adherence to routine monitoring and care coordination might have mitigated some of these conditions and allowed for earlier detection. Importantly, adherence to recommended off-therapy tumor surveillance imaging may have detected this patient’s tumor recurrence earlier. Early detection followed by early treatment of relapsed disease may have also decreased this patient’s risk for pulmonary metastatic disease, for which he required a substantial amount of additional chemotherapy. In the past 35 years, the 5-year survival rate for localized osteosarcoma improved from 40-76% for children <15 years, and from 56-66% in adolescents ages 15–19 years.7

Our patient sought care primarily to evaluate acute conditions, and engaged in primary preventive and survivor-related follow-up only when prompted by other providers. Among the more than 10,000 adult survivors in the Childhood Cancer Survivor Study (CCSS), more than 62% reported one or more chronic conditions.8 However, although 87% reported general medical contact and 71% a general physical exam within the prior 2 years, only 19% had a visit at a cancer center.9 Thus, the majority of adult survivors of childhood cancer are getting care from providers who are not oncologists. Encouraging routine care and developing and maintaining an awareness of secondary effects and screening recommendations are important steps for primary care providers. Yet, in a survey of internists, only 12% stated that they felt at least “somewhat familiar” with available guidelines.10 The Children’s Oncology Group’s Long-Term Follow-Up Guidelines for Survivors of Childhood, Adolescent, and Young Adult Cancers summarizes secondary effects of treatments, surveillance recommendations, and provides sample treatment summaries. http://www.survivorshipguidelines.org/11

Our patient identified cost of care and lack of insurance as significant barriers. Uninsured survivors in the CCSS cohort had lower utilization of both survivor-focused and general preventive health care than privately or publicly insured survivors.12 Fewer than 14% and 10% of survivors, respectively, have ever been enrolled in the supplemental security income (SSI) or social security disability insurance (SSDI) federal disability programs providing income and insurance support for disabled adults.13 The 2010 Patient Protection and Affordable Care Act (ACA) established provisions intended to increase access to affordable health insurance, including requiring employer-sponsored health insurance plans to cover enrolled members’ children up to age 26 and limiting exclusions for pre-existing conditions. During the first two full years following the passage of the ACA, young adults (YA) ages 19–25 per capita health care spending grew at a rate nearly double that for the non-YA adult population.14 However, in a 2011–12 survey of survivors, only 27% reported familiarity with the ACA.15 And most recently, a comparison of adult childhood cancer survivors to adults without cancer found fewer CCS were insured (76% vs 81%), and were more likely to report delaying medical care (25% vs 13%) and to report needing but not getting medical care in the previous 12 months [20% vs 10%].16 A regional review of all of the academic pediatric oncology programs in New England found that funding for resource intense programs and transitioning care to adult clinical services were common challenges.17

Hasbro Children’s Hospital’s Comprehensive Health Assessment and Management for Pediatric Cancer Survivors (CHAMPS) Program is a local resource that includes monitoring for late-effects, as well as social work support that can assist patients seeking coverage and resources: http://www.hasbrochildrenshospital.org/programs.html.

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The Refugee Community Health Worker Initiative (RCHWI) in Rhode Island: A Pilot Program

AYEshaSayA, MD, MPH; Su auNg, MD, MPH; PeRRy GaSt, MPH; CaRoL LewIS, MD

ABSTRACT

BACKGROUND: Refugee resettlement in the United States will reach record numbers in 2016. Approximately 200 refugees arrive in Rhode Island annually and require culturally and linguistically appropriate health care.

METHODS: Eight community health care workers (CHWs) were hired for the Refugee Community Health-care Worker Initiative (RCHWI) program. CHWs completed 30 hours of paid training. Health topic presentations were preceded by an initial knowledge assessment and an attitudes survey regarding the training. A final knowledge assessment and attitudes survey were administered after the presentations.

DISCUSSION: The initial and final responses were compared. Scores improved from the pre- to post-presentations in both knowledge assessments and attitudes surveys. The results support the program’s effectiveness in training. This pilot collaborative effort emphasizes the potential benefits to further enhance the medical community for newly arrived refugees.

KEYWORDS: refugee, community health worker, training

INTRODUCTION

Refugees flee their homes to escape political, religious or ethnic persecution, as well as war and famine. In the last three fiscal years, the U.S. State Department resettled close to 70,000 refugees across the country. Approximately 200 refugees arrive in Rhode Island each year, and nearly half are children. During fiscal year 2015, 47% of Rhode Island refugee arrivals were children under the age of 18, three out of four originating from one of four countries: The Democratic Republic of the Congo (DRC), Colombia, Iraq, or Somalia.

The United Nations High Commissioner for Refugees (UNHCR) reports that 2016 is likely to exceed all previous records for global forced displacement. There are over 55,000,000 refugees, asylum-seekers and internally displaced people worldwide. Trends suggest that this number will increase above 60,000,000 for the first time.¹ In response to the Syrian refugee crisis, the United States has agreed to resettle another 15,000 refugees in 2016, bringing the total projected to 85,000.² Currently, there are two volunteer refugee resettlement agencies in Rhode Island, Dorcas International Institute of RI [DIIRI] and the Diocese of Providence. Approximately 85% of the state’s refugees resettle through DIIRI.

In recent years, DIIRI has received an increasing number of refugees with complex medical and/or psychological histories. The US health care system is complicated and confusing; cultural differences in medical care make this even more challenging for refugees. Newly arrived refugee children and their families need culturally and linguistically appropriate support to navigate the health care system, along with health education directed to their specific health issues.

The mission of the Refugee Health Program (RHP) at Hasbro Children’s Hospital (HCH) is to close the gap in health care delivery for newly arrived refugees. The program, founded in 2007, emphasizes easy access, coordination of services, continuity and culturally appropriate services. A team of Brown University Alpert Medical School faculty pediatricians, pediatric residents and medical students provides initial medical evaluation as well as ongoing primary care. A psychologist provides integrated mental and behavioral health care. Pediatric dental residents from St Joseph’s Dental Center provide oral health screenings at initial evaluation and ensure ongoing oral health education and follow-up. There is also support for adjudication of lawful permanent resident status with a physician authorized by the U.S. Citizenship and Immigration Services [also known as civil surgeons] on site who is certified to sign the medical portion of their Lawful Permanent Resident [Green Card] application. We work closely with medical interpreters serving refugees for linguistic and cultural interpretation. However, despite our large team of providers, more help is needed to enhance the delivery of care for this population.

Prior to the development of the HCH Refugee Health Program, a chart review 2003–2006 by Watts et al found that only half of recently arrived refugee children were up-to-date on all vaccines 15 months after arrival to the US – the standard is within 12 months of their first appointment.³ The most common medical conditions for arriving refugee children continue to include elevated lead, infectious diseases [hepatitis B; Latent Tuberculosis Infection; and parasitic infections including giardia, schistosomiasis and strongyloides], oral health problems, nutritional deficiencies in iron, folate and vitamin D as well as mental health concerns such as depression, anxiety and PTSD. In addition to the
disproportionate health burden and difficulty accessing care, community-based support is lacking.

With support from the Rhode Island Foundation, The Refugee Community Health Worker Initiative (RCHWI) pilot program came into existence through collaboration between DIIRI, HCH RHP, Rhode Island Department of Health (RIDOH), Alpert Medical School of Brown University, and leaders of the local refugee communities.

The goal of the RCHWI Program is to develop and train a cadre of former refugees to serve as health liaisons for more recently arrived refugee families in order to improve outcomes. The use of community health workers (CHWs) has been shown to improve health outcomes in varied settings. Additional, when CHWs come from the community they serve, there is greater accessibility and utilization of services.

**METHODS**

The Refugee CHWs were recruited through an application process executed by DIIRI. The CHWs are all refugees or former refugees. Inclusion criteria were English proficiency and preferably prior involvement in the health sector. Exclusion criteria included inability to commit sufficient time for the program. Moreover, the RCHW pilot program was focused on serving refugees from three of the most common countries of origin for refugees in RI: Iraq, the Democratic Republic of the Congo (DRC) and Somalia. Therefore, applicants not from these three countries were also excluded.

Once chosen, the CHW attended 30 hours of paid training over the course of six weeks. The first 10 hours focused on the role of a CHW, motivational interviewing, mental health, trauma, and self-care. Another 13 hours were adapted for refugees from a Community Health Worker training curriculum previously created through partnership with RIDOH and the former Community Health Worker Association of RI. Topics covered in these adapted sessions included: introduction to community health work, knowing your community/community assessment and resources, health literacy, effective communication, motivational interviewing, health information and the internet, health education for behavior change, culturally and linguistically appropriate services, and health care in America. Five hours were focused on the pediatric health education topics of nutrition, lead, infectious diseases, care of the well and sick child, and adolescent and women’s health. The remaining two hours were spent with DIIRI’s medical caseworker reviewing the checklist of tasks to be completed with refugee families as part of the pilot RCHWI program. The aim of this checklist was to reinforce the role of the CHW as a teacher and to encourage sustainability of the acquired skills by the newly arrived refugee families.

At the submission of this report, CHWs had been matched with newly arrived refugee families. The relationship will last for approximately 6 months after a family arrives to Rhode Island with a total of 25 expected hours of contact time. The CHWs are compensated for their time. The six-month timeline and number of hours will be studied for feasibility in accomplishing the stated tasks and goals of the RCHWI.

As a part of the RCHWI evaluation, a participant knowledge assessment was conducted before and after the health curriculum portion of the training. A survey on perception of ability discussing curriculum topics was also administered. The knowledge assessment consisted of 36 questions, the format of which included true/false questions, multiple-choice questions, and fill-in-the-blank questions. The attitudes survey consisted of 11 statements, and response options were ordered according to a Likert scale, with 1 signifying “strongly disagree,” 3 signifying “neutral,” and 5 signifying “strongly agree.” In scoring the questionnaires, three questions were eliminated: two fill-in-the-blank questions and one multiple-choice question.

The project was approved for Quality Improvement (QI) by the Rhode Island Hospital Institutional Review Board.

**RESULTS**

For the RCHWI Pilot study, sixteen individuals applied, and eight were chosen. The demographics of the CHWs are shown in Table 1. There were five males and three females. The primary languages spoken included Arabic, Somali and Swahili. Within the four Swahili speakers, three also speak Kinyarwanda, one speaks Kirundi and one speaks French. All participants have been in the US less than three years. They come from a variety of educational backgrounds. All eight CHWs completed the 30 hours of training.

In the initial knowledge assessment, the mean accuracy score was 61.5%, ranging from 12–85%, excluding the questionnaire that was not completed. Of note, the participant with a score of 12% on the initial assessment only partially completed the questionnaire. One questionnaire was not answered at all and thus was omitted. In the final assessment, all eight participants finished the questionnaire. The mean score was 81.1%, ranging from 66.7% to 87.9%. The initial attitudes survey was completed by six of eight participants, and the average response was 4.01 on a Likert scale. All eight participants completed the final attitudes survey and the average response was 4.33 on the Likert scale. A Likert score of 4 signifies “agree.”
DISCUSSION

The benefit of having a Community Health Worker (CHW) has been documented for initiatives in resource poor settings, and more recently in the domestic setting. In some states, such as Minnesota, the role of the CHW has been formalized such that Medicaid plans reimburse for these services. This is not currently the case in Rhode Island. The incorporation of a CHW into the care team of a refugee family is beneficial for all stakeholders. A CHW can help newly arrived refugee families acquire skills critical for operating the U.S. health care system. Examples include assisting with public transportation, helping with calls to the doctor’s office, and encouraging medication adherence. For physicians and other medical providers, the presence of a CHW allows the provider flexibility to focus on acute medical concerns while the CHW can further discuss general health topics in a culturally appropriate way within and outside of the office. For the CHW, working as a health liaison provides employment and the fulfillment of serving one’s community. Lastly, having a CHW designated to serve newly arrived refugees has been shown to improve health outcomes and be cost effective for the health system at large.

The RCHWI pilot project has completed the selection and training of the CHWs. They are now matched with newly arrived refugee families to put the program into action. The teaching process was successful in engaging CHWs and generating meaningful conversations on cultural differences regarding controversial issues such as discipline, teenage sexuality, and HIV/AIDS. The participation and scores on the knowledge questionnaires improved from before to after the teaching sessions. The questionnaires were anonymous and were not released to instructors until after the completion of the teaching sessions. The questionnaires were anonymous and were not released to instructors until after the completion of the teaching sessions.

This is the initial phase of what the partnership hopes will be the development of a larger RCHWI program. Ultimately, the collaboration will work to expand the RCHWI to more families and also address the needs of adult refugee patients with chronic diseases. The group will also obtain data on medical outcomes to evaluate success and review the cost-effectiveness of the RCHWI as it operates in Rhode Island. Sustainable financing is needed to ensure lasting benefits to refugee families.

CONCLUSION

This pilot study of the Refugee Community Health Worker Initiative highlights the successful partnership of DIIIR, HCH, RIDOH, and the Rhode Island Foundation in successfully engaging the refugee and former refugee communities and transferring applicable health knowledge to CHWs. This pilot collaborative effort emphasizes the potential benefits of this program to further enhance the medical community for newly arrived refugees.

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Student-Driven Approaches to Undergraduate Medical Research: A Peer-Led Symposium

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ABSTRACT

Exposure to research early in medical school facilitates the development of physician-scientists and competent clinicians. In the last decade, institutions have established programs and policies to address the physician-scientist shortage. However, student-led initiatives to promote medical student engagement in research remain unexplored. This paper presents the design and results of the third iteration of a symposium in which senior medical students provided guidance and advice to preclinical students interested in research. It also reviews the lessons learned from three years of conducting the symposium.

KEYWORDS: undergraduate medical education, research, peer-assisted learning

INTRODUCTION

Medical school is a crucial entry point into academic medicine and research. Since the identification of the physician-scientist shortage, institutions have sought to increase student involvement in research through initiatives such as physician-scientist training programs and MD/PhD tracks, which offer consistent research opportunities throughout medical training and prepare students for dual roles in biomedical research and clinical practice. However, peer-assisted learning (PAL), which has been used across many facets of medical education including academic tutoring, clinical exam skills, and evidence-based clinical practice, has not been formally explored in the context of research despite recommendations to promote student-led research education. The timing of student exposure to research is also critical: most students who participate in research begin their projects in the first two years of medical school. Hence, it is important to provide mentorship and guidance for research early in preclinical education. Finally, student participation in research-related activities develops skills in written and oral communication, teamwork, and problem-solving, which are transferable to clinical practice regardless of future research involvement.

We sought to promote early research exposure at our institution by evaluating the needs of preclinical students and establishing an annual student-led symposium featuring senior medical students who provided guidance and advice to students interested in research. In this paper, we present the design and results of the third iteration of this symposium and review lessons learned from three years of conducting the symposium.

METHODS

With the support of experienced faculty advisors, we planned each symposium with four primary considerations: choosing topics, selecting fourth-year student panelists with research experience, structuring question and answer (Q/A) sessions, and incorporating post-course feedback. For the second and third symposia, we used a needs assessment – with attention to the perceived, expressed, and relative needs of students at our institution – to define goals within each of the four areas. We surveyed all preclinical students with open-ended questions soliciting topics of interest, used feedback from the prior year’s post-symposium survey, and quantified the amount of prior research experience among students to facilitate the selection of diverse student panelists.

The needs assessment helped guide the evolution of the symposia. At the first symposium, the student panelists gave advice on pre-determined topics and answered questions directly from the audience. In response to feedback from attendees, the second symposium tailored topics to student preferences, incorporated live online question and answer (Q/A) sessions, and included a post-symposium survey. The third symposium built on these improvements and incorporated three additional modifications based on survey results: (1) discussion of obstacles to successful research in addition to general advice; (2) selection of panelists based on student interests; and (3) post-symposium follow-up through additional peer contacts.

The third symposium incorporated our lessons learned to date. We designed the symposium based on results from a survey of all preclinical students regarding past research experience, current research interests, and suggestions for potential symposium topics. We selected the four major topics of the symposium according to student preferences, with emphasis placed on the relative needs of students with little research experience. For each topic, we advised panelists to discuss overcoming any obstacles (“pitfalls”) they faced in addition to providing general advice (“pearls”). In contrast to previous symposia, we selected our peer panelists by surveying all fourth-year medical students about their research
experience, publication history, and research interests. We chose four panelists that reflected the stated project interests noted in the pre-symposium student surveys and provided diverse perspectives in research and publication. We addressed audience questions following discussion of each main topic using an online voting system (Mentimeter, Stockholm, Sweden). The allotted time for the symposium was one hour. Following the symposium, we electronically surveyed all attendees for feedback and gave them access to a database containing fourth-year student projects and contact information.

RESULTS
The pre-symposium survey was completed by 35% (92/264) of preclinical students. Respondents’ past research experience included poster (53%; 49/92) and oral (26%; 24/92) conference presentations, co-authorship on a publication (42%; 39/92), and first-authorship on a publication (16%; 15/92). The most requested topics were selecting a mentor (79%; 73/92), choosing a project (59%; 54/92), project management (50%; 46/92), and time management (41%; 38/92) [Figure 1].

Nineteen percent (50/264) of first- and second-year students attended the symposium. We selected four fourth-year student panelists with previous publications in peer-reviewed journals and interests in emergency medicine, internal medicine, obstetrics and gynecology, and ophthalmology. They discussed “pearls” and “pitfalls” regarding the four main topics. Questions raised during the Q/A section ranged from research basics (“Who needs to submit an IRB? What is an IRB?”) to logistics (“how do you ask about the potential productivity of a project without sounding demanding? If you get a project outside of our institution, how do you maintain the project and mentorship during the school year?”) to advice on the value of research (“How important is doing research in the specialty that you ultimately choose? Is social science research less valued than clinical/bench research for residency applications?”).

Forty-four percent (22/50) of attendees completed the post-symposium survey. Respondents found Q/A sessions most helpful [45%; 10/22], followed by “pearls” [36%; 8/22] and “pitfalls” [32%; 7/22]. Students commented that they wanted longer Q/A sessions. Others requested more personal discussion from panelists about the process of beginning research and their individual experiences. On a scale from one to ten, students rated the symposium a mean of 7 in terms of helpfulness in addressing their questions about research.

DISCUSSION
Our annual symposia aimed to provide an early entry point into research for preclinical medical students using an interactive PAL model. Based on our needs assessment, we found that half of preclinical students had previous experience presenting posters [53%; 49/92], however, requested topics of discussion largely included basics such as selecting mentors [79%; 73/92] and choosing projects [59%; 54/92] rather than advanced research topics such as writing manuscripts [15%; 14/92]. Thus we selected symposium topics based on students’ expressed interests with focus on guiding those with little to no research experience.

Overall, students found the third symposium effective in introducing the logistics and skills of beginning research. They rated Q/A sessions to be the most helpful, a theme strongly supported by feedback gathered from the prior symposia. Students requested more time for panelists to speak in-depth about their personal experiences, suggesting that students highly value learning from peers. We can maximize the PAL model by continuing to allocate more time to Q/A and soliciting specific questions for panelists before each symposium. Similarly, developing separate symposia for students based on past research experience as a follow-up series to the initial symposium would address the concerns of a broader array of students. For example, a symposium for students with little research experience could discuss the IRB process in greater depth while a symposium for advanced students may focus on writing and publishing manuscripts.

Limitations of the symposia include time constraints precluding in-depth discussion of all topics, tailoring the presentation to a general rather than a specific group of students [e.g., based on prior experience], and conflicting advice from panelists. In addition, the feedback expressed in surveys may not have been representative of all of students’ concerns given our low response rate. With each year’s iteration of the symposium, we have addressed some of these limitations by ensuring better adherence to the predetermined schedule and adding a
pre-symposium rehearsal to allow panelists to streamline their presentations. As we build upon the annual series, we will facilitate continuity by maintaining communication between each year’s symposium leaders. We will also examine trends in research involvement and attitudes toward research at our institution to assess the long-term efficacy of our symposia.

To increase student involvement in research, numerous institutions have trained clinical faculty, incorporated research experiences into the medical curriculum, and ensured the availability of mentors. To our knowledge, this is the first student-led initiative that proposes to meet this objective by taking advantage of readily available institutional resources. Our rationale is that programs are irrelevant unless they inform students—the primary stakeholders—about how to use resources already available at their institution. The student-led symposia address barriers to entering research by providing preclinical students early guidance on research at our home institution and beyond. Our PAL model is also easily reproducible at other medical schools aiming to expand their research curricula.

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Cocaine-induced diffuse alveolar hemorrhage: 
A case report and review of the literature

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ABSTRACT
Cocaine is one of the most commonly abused drugs in the United States. Ingestion of cocaine may result in a wide array of disease processes due to its stimulant properties, contaminants, or to downstream effects, such as myocardial infarction, stroke, or cardiac arrest. Pulmonary complaints are common in patients seeking treatment for cocaine-associated medical problems and include acute eosinophilic pneumonia, pneumothorax, pneumomediastium, diffuse alveolar hemorrhage (DAH), pulmonary hypertension and granulomatosis. We present a case of DAH due to cocaine abuse and rapid resolution with mechanical ventilation and supportive care.

KEYWORDS: diffuse alveolar hemorrhage, respiratory failure, cocaine, crack

INTRODUCTION
Cocaine is one of the most commonly abused drugs in the United States with about 1.5 million active users. Toxic effects depend on the quantity of cocaine ingested, the route and frequency of administration [e.g., smoked versus inhaled], contaminants in the drug [e.g., levamisole], and the size of inhaled particles, among others. Pulmonary complaints are common in patients seeking treatment for cocaine-associated medical problems. Its toxic effects include acute eosinophilic pneumonia, pneumothorax, pneumomediastium, diffuse alveolar hemorrhage [DAH], pulmonary hypertension and granulomatosis associated with contaminants.

DAH due to cocaine use is an important cause of cocaine related morbidity. In an autopsy review of 52 patients with toxicological confirmation of cocaine use, some degree of alveolar hemorrhage was observed in 71% of cases. However, the literature regarding DAH and cocaine use is sparse, perhaps due to variability in cocaine consumption, the presence of multiple co-morbidities, and differences in the natural history of cocaine associated lung disease. We present a case of diffuse alveolar hemorrhage due to cocaine abuse and rapid resolution with mechanical ventilation and supportive care.

CASE PRESENTATION
A 31-year-old man with a history of substance abuse presented to the Emergency Department (ED) after being found unconscious in a bathroom in a bar. His family reported that he intermittently used intranasal cocaine. EMS reported agonal respirations at 4 breaths/min, blood pressure of 104/68 mm Hg, pulse of 82/min, oxygen saturation 87% on room air and a fluctuating mental status. Supplemental oxygen was provided, and empiric administration of IV naloxone had no appreciable effect on the respiratory status. He developed small amounts of epistaxis and hemoptysis in the ED. His family reported that he took no medications. Initial labs, including a complete blood count with differential and tests of coagulation were normal. A urine toxicology screen was positive for cocaine and tetrahydrocannabinol [THC]. Chest radiography was normal. After an initial improvement, his respiratory status began to rapidly worsen. A CT angiogram of the chest demonstrated diffuse, bilateral, upper and lower lung zone airspace disease (Figure 1). The patient’s oxygen levels began to rapidly decrease, necessitating invasive mechanical ventilation. He was transferred to our institution for hypoxic respiratory failure and diffuse parenchymal lung disease (DPLD). He was admitted to the Medical Intensive Care Unit [MICU].

The following disorders were considered: massive aspiration, ANCA-positive vasculitis, non-cardiogenic and cardiogenic pulmonary edema, and DAH. His nares were noted to have minimal dried blood, but there was no evidence of
bleeding in the visualized posterior oropharynx. Electrocardiogram revealed no evidence of myocardial ischemia. The troponin-I level was less than 0.15ng/ml [normal < 0.15ng/ml], and the B-type natriuretic peptide was 12.7 pg/ml [normal 0.0–33.3 pg/ml]. The procalcitonin level was markedly elevated at 10.95 ng/ml [normal 0.00–0.05 ng/ml]. He was treated with a lung protective strategy [tidal volume of 6cc/kg of ideal body weight, plateau pressure < 30 cm H2O]. He required high levels of ventilatory support, with a fraction of inspired oxygen (FiO2) of 100%, and positive end-expiratory pressure [PEEP] of 12 cm H2O. There were scant bloody secretions aspirated from the endotracheal tube. Oxygen saturation decreased to 84% despite an FiO2 of 100%, and improved transiently in response to two recruitment maneuvers, in which 30cm H2O of PEEP was applied for 30 seconds. Broad spectrum antibiotic therapy with IV vancomycin and piperacillin-tazobactam was initiated. A repeat chest x-ray demonstrated an appropriately positioned endotracheal tube, bilateral diffuse hazy parenchymal opacities, air bronchograms, and evidence of pneumopericardium and pneumomediastinum [Figure 2]. He developed palpable subcutaneous emphysema in the neck and upper chest wall believed to be due to barotrauma from high transpulmonary pressures. Extracorporeal membrane oxygenation [ECMO] was considered. Over the next 12 hours the patient’s oxygenation stabilized and both the FiO2 and PEEP were decreased. Fiberoptic bronchoscopy revealed no visible evidence of mucosal damage and no active bleeding. Serial bronchoalveolar lavage [BAL] of the right middle lobe demonstrated increasingly blood-tinged fluid [Figure 3]. The BAL fluid cytology was positive for hemosiderin-laden macrophages, and negative for microorganisms. These findings supported a diagnosis of DAH. During the next 24 hours, the patient’s oxygenation improved significantly and he tolerated further decreases in his PEEP and FiO2. His sputum became clear. Repeat chest x-ray showed near complete resolution of the bilateral opacities [Figure 4]. He was rapidly weaned from mechanical ventilation and extubated on the third day of his MICU stay. At this time, labs including a CBC, metabolic panel, creatinine and LFTs were normal. On further questioning, the patient admitted use of marijuana and intranasal cocaine; he denied using other drugs. Microbiologic studies of the BAL fluid remained negative for bacteria, viruses, fungi, Pneumocystis jirovecii, and acid-fast bacilli. The patient was transferred to the medical floor on hospital day four to continue his recovery and to receive substance abuse counseling. He was discharged home on hospital day seven with no further complications.

**DISCUSSION**

Cocaine, especially in the form of crack (smoked free-base cocaine), is a highly addictive substance that blocks the reuptake of biogenic amines at synaptic junctions. It is a sympatheticomimetic agent that stimulates alpha
[preferentially] and beta receptors. It is well absorbed into the body via mucosal surfaces and in the lungs across the alveolar membrane.

Hemoptysis and shortness of breath are common symptoms of diffuse alveolar hemorrhage due to cocaine. The exact pathogenesis of cocaine-induced DAH is unclear. Current theories include vasoconstriction-mediated hypoxic alveolar epithelial or capillary endothelial cell damage, and direct cytotoxic effects of substances co-ingested with cocaine. 7

In the case presented above, numerous other possible causes of pulmonary hemorrhage were considered and excluded, leaving cocaine-induced DAH as the most likely cause of the patient’s presentation. The rapid improvement without immunosuppressive therapy argued against a vasculitic process. Interestingly, the procalcitonin level was markedly elevated, which in the appropriate context suggests the presence of a bacterial pneumonia. However antibiotic therapy was stopped after three days, by which time the patient had rapidly improved and the infectious workup failed to reveal a pathogen. The ECG was without ischemic signs, and cardiac enzymes were normal, arguing against cardiogenic pulmonary edema and resultant hemorrhage. Aspiration pneumonitis would not likely have resulted in such a widely and symmetrically distributed disease process. Although the patient’s urine was also positive for tetrahydrocannabinol, and synthetic cannabinoids have been reported to cause DPLD, the patient gave no history of using this type of drug. Barotrauma developed due to high transpulmonary pressures likely from high levels of PEEP applied to the patient’s noncompliant lungs. While crack cocaine abuse with subsequent valsala maneuvers can precipitate barotrauma, this patient’s development of pneumomediastinum and pneumopericardium later in the course of mechanical ventilation suggested an iatrogenic cause, likely from the effort to maintain alveolar recruitment and adequate oxygenation. In the setting of cocaine ingestion, hemoptysis, hypoxic respiratory failure, diffuse airspace opacities on radiography, and rapid resolution in a short period with supportive care, cocaine-induced DAH was the most likely diagnosis.

Diffuse alveolar hemorrhage from cocaine can be a life-threatening condition making early identification and treatment crucial.

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Metastatic Prostate Cancer Presenting as Acute Appendicitis: A Case Report

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KEYWORDS: prostate cancer, appendiceal metastasis, nuclear medicine

PRESENTATION/HISTORY
A 71-year-old man with a history of prostate cancer, without any recent evidence of gross metastatic disease, presented with right-sided abdominal pain, nausea, and vomiting. An abdominal computed tomography (CT) was performed (Figure 1) and findings were consistent with acute appendicitis on imaging. Appendectomy was performed, and pathology unexpectedly demonstrated metastatic prostate cancer to the appendix with secondary acute appendicitis (Figure 2 and Figure 3).

Initial diagnosis of the patient’s prostate cancer was made by biopsy in 2001 (T1c NX MX), Gleason grade 4+4 with tertiary Gleason 5 pattern. Radical retropubic prostatectomy was performed and the patient was restaged to T3b N0 M0, with ten out of ten negative lymph nodes. Post-operatively the patient was deemed to have biochemical failure with a Prostate Specific Antigen (PSA) nadir of 0.95 ng/mL, despite salvage external beam radiation and androgen deprivation therapy. In 2004, a restaging PET scan showed no evidence of metastatic disease and a nuclear medicine ProstaScint study only showed mild increased uptake within a retroperitoneal...
lymph node. PSA remained stable until 2013, when it reached a peak of 5.8 ng/mL. A bone scan and CT of the abdomen and pelvis showed no evidence of gross metastatic disease. This patient did not demonstrate evidence of gross metastatic disease at the time of this presentation. The first definite evidence of metastatic disease was discovered from the appendectomy after histologic examination was performed.

**DISCUSSION**

New cases of prostate cancer in the United States exceed 220,000 annually, making it the most common cancer - and second greatest cause of cancer-related mortality – in men.\(^3\) Although increased screening and surveillance have led to earlier detection of the disease, prostate cancer commonly metastasizes, with particular affinity for lymph nodes, bone, lung and liver.\(^2\) Primary metastatic disease to the gut, and particularly appendix, however, remain exceedingly rare, with only a few cases of the latter reported in the literature.\(^3,4\)

The overall incidence of appendiceal tumors, however, is higher than one might expect. One retrospective review of nearly eight thousand appendectomy specimens found an incidental tumor occurrence approaching 0.9%.\(^5\) The series revealed less than one third of tumors were secondary to metastatic spread, and none were from a prostatic source.

This unusual case highlights the challenges of radiologically assessing prostate CA metastasis in low-volume disease, particularly following prostatectomy. Bone scan and CT scans, though routinely ordered in the setting of biochemical recurrence, have a low yield in patients with PSA <10ng/mL. Magnetic resonance imaging (MRI) is showing promise for the evaluation of nodal prostate metastasis, particularly when used in conjunction with lymphotropic superparamagnetic nanoparticles such as monocrystalline iron oxide. These particles traverse the vascular and interstitial spaces and are transported by the lymphatics to lymph nodes, where, after being engulfed by macrophages, exert their influence on the imaging properties of MRI. Asymmetric or irregular accumulation of these nanoparticles, secondary to tumor infiltration, are therefore visualized on imaging.\(^6,8\) Prospective studies comparing MRI with nanoparticles against a histopathologic gold standard have demonstrated patient-level sensitivities and specificities ranging from 55–100% and 85.5–95.7%, respectively, significantly higher than MRI alone.\(^6,8\)

Advancements in nuclear medicine techniques offer additional tools for evaluating nodal as well as distant prostate cancer metastases, both in the context of pre-operative planning and in biochemical relapse. Pre- and retrospective studies show varying degrees of efficacy for\(^11\) C-Choline positron emission tomography (PET)/CT for detecting lymph node metastases, with sensitivities and specificities ranging from 69–80% and 78–96%, respectively.\(^9,10\) A recent prospective study suggests that\(^11\) F-Choline PET/CT is superior to\(^11\) C-Choline for lymph node and bone metastases as well as local recurrence, but is still inferior to surgical lymph node dissection.\(^11,12\) More importantly, a prospective study evaluating\(^11\) C-Choline PET/CT-guided salvage lymph node dissection in the setting of biochemical recurrence suggests that this technique may offer significant progression-free and cancer specific survival.\(^13\)

**References**


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Left Ventricular Free Wall Rupture
DOUG HIDLAY, MD; ROBERT WARD, MD

A 37-year-old male lost consciousness while riding in the car with a friend. EMS arrived on the scene and found him unresponsive but were able to arouse him en route to the ER. The patient complained of “ripping” chest and back pain that started just minutes after arrival to the hospital and quickly went into pulseless electrical activity (PEA) cardiac arrest. He was stabilized and CTA was performed, showing evidence of left ventricular free wall rupture causing hemo-pericardium and tamponade physiology. He was rushed to the operating room where free wall rupture was confirmed and successfully repaired.

Left ventricular free wall rupture is an uncommon complication in the first week following a lateral wall myocardial infarction, occurring in anywhere from 2.2% to 10% of heart attacks in various series.1 Acute rupture is nearly always fatal if the patient isn’t already in an acute care setting with access to immediate intervention, as such most epidemiological data is derived from autopsy series.

Reference

Authors
Doug Hidlay, MD, is a second-year radiology resident, Department of Diagnostic Imaging, Warren Alpert Medical School of Brown University, Providence, RI.

Robert Ward, MD, is an attending radiologist, Department of Diagnostic Imaging, Warren Alpert Medical School of Brown University, Providence, RI.
Peeping Painless Proptosis

MAUREEN LLOYD, MD; XIAO CHI ZHANG, MD, MS; SARAH JOSEPH, MD; JAY BARUCH, MD; MATTHEW SIKET, MD; WILLIAM BINDER, MD

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

KEYWORDS: proptosis, retrobulbar hematoma, trauma, orbital tumor, emergency department, ophthalmology

DR. XIAO CHI ZHANG: A 92-year-old woman with dementia was brought to the emergency department (ED) from a nursing home for headache and "left eye bulge" after falling backward, striking her head on the ground. While the review of systems was limited due to the patient’s baseline dementia, she only reported occipital headache, left knee pain and denied any eye pain, changes in her vision and stated: “my right eye is my bad eye.” Her past medical history was significant for bilateral glaucoma, right orbital reconstruction due to childhood trauma, and coronary artery disease. Current medications included aspirin/extended-release dipyridamole (Aggrenox®), timolol, and latanoprost eye drops.

On arrival to the ED, the patient’s blood pressure was 154/66 mm Hg, pulse rate 63 beats/min, respiratory rate 20 breaths/min, temperature 36.5°C (97.7°F), and SaO2 96% on room air. She was in no acute distress without any obvious signs of external trauma. She was alert and oriented to her name, perseverated on her headache, and had reproducible left knee discomfort with active range of motion. Her external ocular exam was significant for a left proptotic eye, with a 3mm pupil that was reactive to light and a normal appearing right eye with a surgical, 3mm pupil; there were no signs of irritation or hyphema on either eye [Figure 1].

Her left extraocular motion (EOM) was intact, but her right eye movement was restricted on superior temporal, inferior temporal, superior nasal, and inferior nasal motions. She was able to see fingers through her left proptotic eye, but unable to perceive light on her right eye. The patient denied diplopia and there was no appreciable afferent pupillary defect. The remainder of her physical exam and trauma evaluation was negative for any major deformities, contusions, ecchymosis, hematomas, lacerations or step-offs.

Initial blood work was unremarkable for acute metabolic or hematologic abnormalities. Imaging revealed a normal chest x-ray. A computed tomography (CT) scan of the brain, face, and neck revealed a soft-tissue mass within the left orbital space without any obvious evidence of acute infarct, hemorrhage, mass or mass effect in the brain or facial fractures [Figure 2]. The differential diagnosis for this mass included a retrobulbar hematoma, given the patient’s history of trauma while on an antiplatelet agent.

DR. NADINE HIMMELFARB: What were your immediate concerns when you recognized the proptosis in the setting of head trauma?

DR. SARAH JOSEPH: One of the most concerning pathologies when confronted with a proptotic eye after head trauma is retrobulbar hematoma, especially in the setting of anti-platelet medication use. Retrobulbar hematoma is considered a true ophthalmologic emergency and a vision threatening condition as it can rapidly lead to orbital compartment syndrome (OCS), where the optic nerve experiences rapidly...
elevated intraorbital pressure, resulting in nerve ischemia and permanent blindness.¹

**DR. MICHELLE LIPPMANN:** What are some of the common clinical findings associated with retrobulbar hematoma? What are some of the other potentially traumatic vision threatening pathologies that warrant an emergent ophthalmology consult?

**DR. ZHANG:** Patients with OCS often present with decreased vision, severe eye pain and proptosis. Additional concerning findings include diplopia, periorbital swelling, afferent pupillary defect (APD), diffuse subconjunctival hemorrhage, chemosis, tight eyelids and decreased retropulsion as physical evidences of increased intraorbital pressure (IOP).² Fundoscopic exam may also reveal vascular and optic disc edema and the absence of spontaneous venous pulsation (SVP). While our patient did have a proptotic eye and a retrobulbar mass, she did not endorse any new ocular complaints and or new vision deficits, making her case a clinical conundrum.

Other vision-threatening conditions that require emergent ophthalmologist consultation include caustic eye exposures (ocular chemical burns) or direct ocular trauma (i.e. open globe ruptures) that require EM clinicians to either initiate immediate ocular irrigation or placing a protective barrier. Neither ophthalmology emergencies would present as painless proptosis without external irritation.

**DR. JESSICA SMITH:** How do you explain the poor vision (count-fingers only) of the left eye and respective absence of afferent pupillary defect (APD)?

**DR. MAUREEN LLOYD:** Great catch! We reviewed the patient’s records and she has always had better vision on her left eye than her right eye; at the ED bedside, the right eye had no light perception. Even after the head trauma, the left eye was still the better seeing-eye. As a result, she did not develop an APD because the left eye still offered more afferent input than the right eye.

**DR. WILLIAM BINDER:** If this patient had a retrobulbar hematoma, what would be the ultimate therapy?

**DR. JOSEPH:** In the setting of progressive vision loss and concern for OCS, clinicians should consider performing an emergent lateral canthotomy.³ EM clinicians should consider performing this vision saving procedure by identifying the lateral canthus and incising the canthus at full thickness to sever the lateral canthal tendon in order to release the ocular pressure. After lateral canthotomy, efforts should be made to decrease IOP, including head-of-bed elevation, analgesia, antiemetics, and coagulopathy corrections. Visual acuity and intraocular pressure should also be assessed every 15 minutes after the procedure until the patient demonstrates objective and subjective improvements.⁴ Complications may include eyelid droop, ptosis, or infection, the former of which can be cosmetically addressed by an oculoplastic surgeon after OCS has been appropriately addressed.⁴ It is imperative that patients with high suspicion of an open globe should not receive any examination or therapeutic procedures, such as IOP measurement or lateral canthotomy. In such cases an eye shield should be placed over the eye until the patient is emergently evaluated by an ophthalmologist.
**DR. MARK GREVE:** The patient appeared to have proptosis from a retrobulbar mass, but did not have severe eye pain or vision loss. Was a lateral canthotomy performed?

**DR. ZHANG:** While this patient had every risk factor for a retrobulbar hematoma and a concerning CT imaging, we were hesitant to perform this procedure as the patient did not have any orbital fractures, compromised visual acuity or EOM on the proptotic eye. We consulted ophthalmology for the unusual presentation of retrobulbar hematoma and painless proptosis.

**DR. ROBERT TUBBS:** What did the ophthalmologist find?

**DR. LLOYD:** I was the consulting ophthalmologist. Because we had low suspicion for ruptured globe injuries, I was able to measure the intraocular pressure (IOP) on both eyes and noted a lower IOP on the left proptotic eye than the right normal appearing eye (15 vs. 30 mm Hg). While pupillary dilatation in the setting of significant head trauma can interfere with subsequent pupillary exams to discern potential mass effect, the CT in this case did not reveal intracranial hemorrhage and we were able to dilate this patient for funduscopic exam. A fully dilated slit lamp exam only revealed dilated tortuous conjunctival vessels in the left proptotic eye, with normal appearing cornea, anterior chamber, iris, lens and vitreous on both eyes without any fluorescein uptake. The fundus exam, including disc, macula, and vessels of both eyes was also normal.

Due to the reassuring ocular exam, we agreed to hold off on performing a lateral canthotomy in the absence of impending vision loss and instead observed the patient for any further worsening or changes in vision.

**DR. BINDER:** Did the patient worsen?

**DR. ZHANG:** Two hours after the patient’s arrival, the ED providers noted a gradual resolution of the patient’s proptosis. The initial CT finding was concerning for a retrobulbar hematoma in the setting of head trauma, however, this read was reevaluated and the Hounsfield units were considered to be less consistent with blood, and more consistent with a “lobulated hyperdense soft tissue mass within the left orbit suspicious for tumor.” The tumor had apparently been displaced by the trauma, and over time reverted back to its previous position. The finding was discussed with the patient’s family and a joint decision was made to withhold any surgical intervention due to the patient’s age and goals of care. The patient was ultimately discharged back to the nursing home with outpatient ophthalmology follow-up for diagnosis with a new, left orbital tumor. The patient continued to experience intermittent painless proptosis at the nursing home after discharge, but never complained of any visual disturbances.

**References**


**Authors**

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Exploring the co-occurrence of bullying victimization, homophobic teasing and teen dating violence: Implications for prevention programs

DEBORAH N. PEARLMAN, PhD; HAILEE K. DUNN, MPH

No longer viewed as a normal part of growing up, bullying is now recognized as a serious public health problem in the United States. At one time bullying was studied independently from other forms of interpersonal violence. Studies examining the nature of bullying have found that bullying perpetration often reflects social biases and prejudices targeting teens not conforming to perceived “in group” social/cultural norms, as one way to demonstrate superiority over other students. In addition, research now suggests that bullying behavior is expressed as a function of teens’ changing social contexts and diversifies as teens get older. As adolescents move through puberty, exploring their sexuality, shifting from same-gender to mixed-gender peer groups and begin dating, there is substantial overlap in bullying, sexual harassment and teen dating violence within the context of peer relationships. Girls are more frequently targets of indirect bullying, such as rumors and gossip stemming from relationship issues like dating, break-ups, and jealousy, as well as unwanted sexual attention or harassment. Boys, on the other hand, are more frequently victims of physical forms of bullying and homophobic messages.

This study examined overlapping forms of peer and dating abuse from a gendered perspective. The co-occurrence of bullying, homophobic teasing, and dating violence through a gendered lens highlights the need to better recognize and address the shared risk and protective factors for these interrelated behaviors.

METHODS

Data were from the 2015 Rhode Island High School Youth Risk Behavior Survey (YRBS). The YRBS is conducted using a two-stage random sample design by schools and classrooms to produce a statewide representative sample of students. There were 3462 completed surveys for a 68% overall response rate in 2015 (unweighted sample). Participants who answered “yes” to one or more of the following questions were considered to have experienced peer and dating abuse.

Table 1. Characteristics of high school students experiencing peer and dating abuse in the past 12 months1,2

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Experienced 1 form of abuse</th>
<th>Experienced 2 or more forms of abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Percent</td>
</tr>
<tr>
<td>Gender</td>
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<tr>
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<td>Hispanic/Latino or non-Hispanic Black or other non-Hispanic racial group</td>
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<tr>
<td>Grade</td>
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<td>1738</td>
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<tr>
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<td>1397</td>
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</tr>
<tr>
<td>11th grade</td>
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<tr>
<td>Number of lifetime sexual partners</td>
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<td>In physical fights on school property 1 or more times past 12 months</td>
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<tr>
<td>Yes</td>
<td>1153</td>
<td>42.6</td>
</tr>
<tr>
<td>Total sample</td>
<td>6390</td>
<td>15.4</td>
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</tbody>
</table>

1 Peer and dating abuse in the past 12 months includes bullying, homophobic teasing, and/or teen dating violence.
2 Weighted n and percentages.
abuse during the 12 months before the survey: (1) bullied on school property; (2) electronically bullied through e-mail, chat rooms, instant messaging, websites, or texting; (3) victim of teasing or name calling because someone thought you were gay, lesbian, or bisexual; (4) someone you were dating or going out with physically hurt you on purpose, such as being hit, slammed into something, or injured with an object or weapon; (5) someone you were dating or going out with forced you to do sexual things that you did not want to do, such as kissing, touching, or being physically forced to have sexual intercourse.

Multivariate logistic regression models (total sample and stratified by gender) were conducted using SAS 9.4 software to examine the association between study variables (Table 1) and overlapping forms of peer and dating abuse (Table 2). Statistical significance for regression coefficients was tested using the Wald chi-square statistic (p<.05).

**RESULTS**

Of the students who reported peer and dating abuse victimization in the past 12 months (27.7%), 15.4% experienced one form of victimization. Almost half (12.3%) reported being the victim of two or more forms of violence. Bullying was the most prevalent form of abuse (97.1%), followed by homophobic teasing (52.7%) and teen dating violence (40.9%). Table 1 contains additional descriptive analyses.

Regardless of gender, teens who identified as a sexual minority, possessed a physical or emotional disability, and got into school fights were more likely to experience one or more forms of violence victimization. Having one or more lifetime sexual partners was associated with peer victimization for girls, but not for boys (Table 2).

**DISCUSSION**

This brief advances public health knowledge in three important ways. We found that 12% of high school students had experienced two or more forms of violence victimization involving school and electronically bullying, homophobic name-calling and/or teen dating violence. This represents 5,107 students in grades 9–12, who were the target of interpersonal violence; a finding that has never before been examined in a large representative sample of Rhode Island public high school students. Our findings support prior research on the overlap of bullying, homophobic teasing and teen dating violence.5,6

There is now considerable evidence that bullying victimization can have pernicious effects on adolescent’s health.9,10 The links between bullying and other forms of peer and dating abuse suggest that the negative health consequences associated with bulling victimization, such as low self-esteem, problems at school, and depression, will be compounded for youth who are victims of overlapping forms of interpersonal violence. It is important that family physicians provide a supportive environment in which adolescents feel comfortable disclosing issues of dating violence and other co-occurring forms of peer perpetrated abuse.11 Results of our study and other research12 suggest that poly-aggression perpetration and victimization should be a primary focus of clinical, community-and school-based bullying and dating violence prevention programs.

Our study found that sexual minority youth, sexually active girls, and adolescents possessing an emotional or physical disability were more likely to experience at least one form of peer victimization. These findings are consistent with previous research suggesting that youth who do not conform to normative expectations regarding sexuality, gender, and physical appearance are more likely to be rejected by
their peers.\(^1\) This study provides some preliminary support for implementing prevention programs that target the underlying patriarchal and heteronormative social norms that may facilitate co-occurring forms of peer aggression.

Previously identified limitations of YRBS apply to this study.\(^13\) Qualitative research is needed to determine the context within which adolescent dating violence occurs, often concurrently with bullying and gender-based harassment.

Findings from this study expand the empirical knowledge base on overlapping forms of peer and dating abuse by simultaneously examining bullying, homophobic name-calling and teen dating violence using a statewide representative sample of public high school students.

Mixed methods studies will augment our findings by examining individual and contextual predictors of the co-occurrence of bullying, homophobic teasing and dating violence in early and late adolescence.

References


Acknowledgments

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Authors

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Rhode Island Monthly Vital Statistics Report
Provisional Occurrence Data from the Division of Vital Records

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<th>VITAL EVENTS</th>
<th>REPORTING PERIOD</th>
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<tr>
<td>Live Births</td>
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<tr>
<td>Deaths</td>
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<td>Spontaneous Fetal Deaths</td>
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<table>
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* Rates per 1,000 estimated population
# Rates per 1,000 live births

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<th>Underlying Cause of Death Category</th>
<th>REPORTING PERIOD</th>
<th>12 MONTHS ENDING WITH AUGUST 2015</th>
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<td>AUGUST 2015</td>
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<tr>
<td></td>
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<tr>
<td>Diseases of the Heart</td>
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<td>Malignant Neoplasms</td>
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<td>Cerebrovascular Disease</td>
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<td>Injuries (Accident/Suicide/Homicide)</td>
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<td>840</td>
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<tr>
<td>COPD</td>
<td>26</td>
<td>549</td>
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</tbody>
</table>

| Rates (b)                      | 229.2            |                                   |
| YPLL (c)                       | 3,599.0          |                                   |
|                                | 214.3            |                                   |
|                                | 42.2             |                                   |
|                                | 79.5             |                                   |
|                                | 52.0             |                                   |
|                                | 595.0            |                                   |

(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 1,056,298 (www.census.gov)
(c) Years of Potential Life Lost (YPLL).

NOTE: Totals represent vital events, which occurred in Rhode Island for the reporting periods listed above. Monthly provisional totals should be analyzed with caution because the numbers may be small and subject to seasonal variation.
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**RIMS NOTES: News You Can Use**

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- Clear.
- Concise.
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- Respectful of Your Time.

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THIRD ANNUAL RIMS MEMBERS

CONVIVIUM

SAVE THE DATE

SEPTEMBER 23
The new tradition continues. Members and guests are invited to schmooze, graze, and relax with colleagues while enjoying live music and watching the sun set over Narragansett Bay.

205TH ANNUAL MEETING
Inauguration of Officers and award presentations:
Dr. Charles L. Hill Award
Dr. Herbert Rakatansky Award
Dr. John Clarke Award

EAT, DRINK, BE CHUMMY
Nosh and mingle waterside at the Squantum Association. Entertainment by Alpert Medical School's own Chords of Bilroth. 6:30pm

WATCH FOR YOUR INVITATION LATER THIS SUMMER!
Working for You: RIMS advocacy activities

July 4, Monday
Closed in observance of Independence Day

July 5, Tuesday
RIMS Physician Health Committee: Herbert Rakatansky, MD, Chair

July 6, Wednesday
Lifespan Fellow Orientation: Presentation by Herbert Rakatansky, MD, and Kathleen Boyd, MSW, LICSW, Physician Health Program; new member recruitment, Diane R. Siedlecki, MD, Co-chair, Membership Committee

July 7, Thursday
Inter-Agency Food and Nutrition Policy Advisory Council

July 11, Monday
Special joint meeting of Board of Directors and Committee on Membership

July 12, Tuesday
Governor’s bill signing of opioid-related legislation
Conference call: AMA, RIMS, Department of Health, and Department of Behavioral Health, Developmental Disabilities and Hospitals, regarding AMA grant to develop a toolbox of support, resources, and referrals for treatment of chronic pain patients.
Health Services Council

July 13, Wednesday
Board of Medical Licensure and Discipline
Kids Count meeting with Brown University, RI Quality Institute, and state agencies, to develop more robust data on pediatric BMI
Meeting of Governor’s Opioid Taskforce, including representatives from the Centers for Disease Control

July 14, Thursday
SIMS Steering Committee
RIMS Committee on Continuing Medical Education: Patrick J. Sweeney, MD, PhD, Chair

July 15, Friday
Diabetes Prevention Program
Stakeholders Network: Newell Warde

July 18, Monday
Executive Committee Conference Call, AMA Advocacy Resource Center, Steven DeToy

July 19, Tuesday
Health Services Council
AMA Advocacy Resource Center conference call regarding TRICARE and telemedicine
Provider Advisory Committee to HHS Secretary Elizabeth Roberts, hosted by RIMS

July 20, Wednesday
Primary Care Physicians Advisory Committee, Department of Health
SIM Population Health Planning Group
Health Advocacy and Equities Commission, Department of Health
RI Free Clinic Event, Barbara Wolfe, PhD, new Dean of Nursing, University of Rhode Island

July 20–23, Wednesday–Saturday
American Association of Medical Society Executives, Annual Conference, Baltimore, MD

July 21, Thursday
RI Quality Institute Medicare Incentive Payment System Webinar

July 22, Friday
Meeting with Tufts Health Plan: Russell Settipane, MD, President; Sarah Fessler, MD, President-elect; RIMS staff

July 25, Monday
RIMS Finance Committee: Jose Polanco, MD, Chair

July 28, Thursday
Conference call American Cancer Society regarding “80% By 2018” Colorectal Screening Advocacy Campaign
Conference call: AMA, RIMS, Department of Health, and Department of Behavioral Health, Developmental Disabilities and Hospitals, regarding AMA grant to develop a toolbox of support, resources, and referrals for treatment of chronic pain patients.
RIMS Special Event

Demystifying The Legislature

Join us in this opportunity to meet and mingle with your local legislators at regional receptions.

Newport County Residents
Monday, September 26, 5:30–8:30pm
Pasta Beach, 7 Memorial Boulevard, Newport

Kent and Washington County Residents
Wednesday, October 5, 5:30–8:30pm
Meritage Restaurant, 5454 Post Road, East Greenwich

Providence and Bristol County Residents
Monday, October 24, 5:30–8:30pm
Mile and a Quarter, 334 South Water Street, Providence

For RIMS Members and Their Guests
Light fare provided
$30 per person per event
Limited space availability, RSVP by September 15
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THE RHODE ISLAND MEDICAL SOCIETY HOSTS
DATA BREACH AND YOUR PRACTICE:
NEW REGULATIONS AND THEIR IMPLICATIONS

WEDNESDAY, AUGUST 31, 2016
RHODE ISLAND MEDICAL SOCIETY
405 PROMENADE STREET, SUITE A
PROVIDENCE, RI 02908

AGENDA

7:30 am — 8:00 am: Continental Breakfast

8:00 am — 9:00 am: Expert Panel Presentations

I) 2016 regulations and some of the latest breaches
   Jeffrey F. Chase-Lubitz, Esq., Donoghue Barrett & Singal, PC

II) A case study and compliance audit for a medical practice
    Chris Sheehan, Compliance Agent, Shred-it

III) Insurance options for your practice
     David White, Partner, Butler & Messier Insurance
     Robert Anderson, Jr., President, RIMS Insurance Brokerage
     Corporation

9:00 am — 9:30 am: Question & Answer

This Event is Free to the Members of the RI Medical Society and their staff. Please visit www.rimed.org for further registration information.

Senior Physicians: Addressing Age, Ability and Acumen
... exploring challenges and opportunities for senior physicians as well as implications for healthcare systems, regulatory agencies, and medical practices

Friday, September 30, 2016
8:00 am to 4:00 pm
Crowne Plaza, Warwick, RI

This conference is made possible through an educational grant from the Coverys Community Healthcare Foundation. Program agenda and registration details may be found here or at www.rimed.org

RIMS Special Event
 Puzzle Challenge
Mingle with your colleagues over a bite to eat at the Mile and a Quarter, then walk to Escape Rhode Island where your team will try to escape a mysterious room by solving a series of puzzles.

MILE AND A QUARTER
334 South Water Street, Providence

ESCAPE RHODE ISLAND
385 South Main Street, 2nd Floor, Providence

THURSDAY, SEPTEMBER 8, 2016
5:00–6:30 pm  Mingle at Mile and a Quarter
6:50–8:30 pm  Teams participate in one of three games
The Study 21% success rate, record time 34:22
The Gallery 15% success rate, record time 39:10
Ex Machina 12% success rate, record time 45:29

FOR RIMS MEMBERS AND THEIR GUESTS
$60 per person
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Care New England was founded in 1996 and is the parent organization of Butler, Kent, Memorial and Women & Infants hospitals, the VNA of Care New England, The Providence Center, CNE Wellness Center and Integra, a certified Accountable Care Organization. Care New England includes 970 licensed beds and 216 infant bassinets. Through Butler, Memorial and Women & Infants, Care New England has a teaching and research affiliation with The Warren Alpert Medical School of Brown University. Kent is a teaching affiliate of the University of New England College of Osteopathic Medicine.

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Doctor’s Choice provides no cost Medicare consultations. Doctor’s Choice was founded by Dr. John Luo, a graduate of the Alpert Medical School at Brown University to provide patient education and guidance when it comes to choosing a Medicare Supplemental, Advantage, or Part D prescription plan. Doctor’s Choice works with individuals in RI, MA, as well as CT and helps compare across a wide variety of Medicare plans including Blue Cross, United Health, Humana, and Harvard Pilgrim.

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

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

The Rhode Island Medical Society continues to drive forward into the future with the implementation of various new programs. As such, RIMS is expanded its Affinity Program to allow for more of our colleagues in healthcare and related business to work with our membership. RIMS thanks these participants for their support of our membership.

Contact Megan Turcotte for more information: 401-331-3207 or mturcotte@rimed.org
RIMS gratefully acknowledges the practices who participate in our discounted Group Membership Program.
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$19.5M Grant to Bridge Gaps Between Medical Research, Health Care in RI

With a new five-year federal grant, the Rhode Island Center for Clinical Translational Science will strengthen connections between scientific discovery and health around the state.

PROVIDENCE – Rhode Island’s scientists can deliver the benefits of discoveries more quickly to health care providers and those clinicians can pose more pertinent questions to scientists when they work together closely with broad, deep and cohesive services and support from their academic medical institutions. That’s the vision the Rhode Island Center for Clinical Translational Science (RI-CCTS) will implement with a new $19.5 million, five-year grant from the National Institute of General Medical Sciences.

The grant will allow RI-CCTS to create the educational and technical infrastructure needed to spur Rhode Island researchers to design, conduct and analyze more medical studies, including treatment trials, that build on basic research. The center — based at Brown University in full partnership with the University of Rhode Island and the Care New England, Lifespan and Veterans Affairs hospitals – will also expand the access that medical and public health researchers have to population health data by working with the Rhode Island Quality Institute.

To achieve those aims, RI-CCTS will create a robust foundation of services and supports and fund dozens of pilot projects and training grants to catalyze new clinical research, said DR. JAMES PADBURY, principal investigator and program director of the new center.

“This is an infrastructure grant,” said Padbury, the William and Mary Oh-William and Elsa Zopfi Professor of Pediatrics for Perinatal Research at Brown’s AlpertMedicalSchool and pediatrician-in-chief at Care New England’s Women & Infants Hospital. “We aren’t being awarded resources to target a specific disease but to build the infrastructure to target a wide range of opportunities.

“Nonetheless, with these resources we will be able to support the kinds of advances that have already been taking place in our own research community – for example, new therapies for asthma and muscular dystrophy; technology for cardiac regenerative medicine; methods for pain management; national trials on hormone therapy for menopause; the development of vaccines for malaria; the measurement of the effect of home-delivered meals on loneliness in the elderly; and the identification of the link between the mechanisms underlying preeclampsia and Alzheimer’s disease.”

The funding comes from the Institutional Development Award program at the National Institutes of Health, which has supported many local Center of Biomedical Research Excellence (COBRE) grants dedicated to conducting research in areas ranging from behavioral neuroscience to perinatal medicine, cancer and skeletal health. As those centers around the state have emerged over the last decade, local professors and physicians also began to lay the groundwork to earn a grant that would amplify the ability to pursue clinical research.
“There has been a group of faculty across our various institutions who have worked together on this for quite a while,” said RI-CTTS program coordinator Ed Hawrot, Brown’s Alva O. Way University Professor of Medical Science and associate dean of biology. “This has been a great collaboration.”

The structure of RI-CTTS will be built upon seven cores and programs and will create at least 10 jobs, said Helen Leffers, administrative director of the new center. For example, the administrative core will hire four new staff members for functions including communications and finance. As researchers earn funding for pilot projects, they may create additional jobs for the 1–2 year duration of their projects.

• Administrative Core: Led by Padbury, Hawrot and Leffers, the center’s administrative core will be housed at 233 Richmond Street and will manage, coordinate and supervise RI-CTTS operations.

• Pilot Projects Program: Led by medical professors and Providence VA Medical Center physicians Dr. Sharon Rounds and Dr. Michelle Lally, the core will provide 20 seed grants to multidisciplinary teams of junior researchers and mentors to do new clinical research. At least one project each year will be a clinical trial.

• Biomedical Informatics Core: Led by Brown medical professors Neil Sarkar and Elizabeth Chen, this core will provide expertise, training and technological resources to allow for “big data” analyses of medical and genomic data. Sarkar said the grant will accelerate the ability of the Brown Center for Biomedical Informatics to establish a multi-institutional framework for using electronic health data from Lifespan, Care New England and RI to enable novel biomedical research opportunities and to support enhanced patient care. This would be among the first such statewide integrations of biomedical, clinical and health data spanning research laboratory, healthcare system and state government sources in the U.S., Sarkar said.

• Clinical Research Design, Epidemiology and Biostatistics Core: Led by Brown School of Public Health biostatistics professor Chris Schmid and Lifespan Biostatistics Core Director Jason Machan, this core will create a central “storefront” of statewide resources and services, mentoring and training, and tools and methods development for conducting well-designed clinical research.

• Professional Development Core: Led by Ira Wilson, chair of health services, policy and practices in the Brown University School of Public Health, the core will provide Mentored Research Awards to three scholars each year. It will also create training programs and develop a statewide mentoring network for clinical and translational research.

• Clinical Research Resources and Facilities: Led by Rhode Island Hospital Clinical Research Center Medical Director Dr. Bharat Ramratnam, this core will unify the many successful clinical research enterprises among partner institutions (encompassing 700 researchers) into a general Clinical Research Center to share best project management and other practices and to gain cost efficiency in setting up and conducting clinical research.

• Tracking and Evaluation Core: Led by University of Rhode Island pharmacy professor Cynthia Willey and Hasbro Children’s Hospital pediatric immunologist Dr. Anthony Hayward, this core will ensure that the center’s work is aligned with program goals and community needs and uses resources wisely. The core will also track the center’s output and monitor progress and practices to achieve continuous process improvement in the center’s work.

Alpert Medical School, Hope Hospice & Palliative Care Expand Affiliation

Providence – The Warren Alpert Medical School of Brown University and Hope Hospice & Palliative Care Rhode Island have renewed and expanded their affiliation for five more years, the institutions announced Tuesday, July 12. Dr. Jack A. Elias, dean of medicine and biological sciences at Brown, said the renewal between Rhode Island’s medical school and its largest not-for-profit hospice and palliative care organization emphasizes the importance of training new and future physicians in compassionate care for those who are seriously ill. Brown and Hope Hospice first affiliated in 2012, formalizing a longstanding collaboration under which scores of students and residents receive training every year.

“Comforting and guiding patients and their loved ones at the end of life is an essential responsibility of medical practice,” Elias said.

“We are honored this renewal allows us to continue to train the next generation of physicians to understand the role and importance of caring for those who are seriously ill,” said Edward W. Martin, MD, MPH, FAAHPM, Chief Medical Officer, Hope Hospice & Palliative Care Rhode Island and clinical associate professor, Warren Alpert Medical School of Brown University.

Hope Hospice President and CEO Diana Franchitto praised the new accord and the partnership it represents. “We are honored this renewal allows us to continue to train the next generation of physicians to understand the role and importance of caring for those who are seriously ill.”

Among the specific terms of the agreement, Hope Hospice & Palliative Care can now begin using Brown’s logo. The medical school will approve clerkship directors, elective directors and key faculty.
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Women & Infants Research: Women Trust Their Own Instincts When Choosing Breast Cancer Surgery

PROVIDENCE – A research team led by Breast Health Fellow REBECCA M. KWAIT, MD, at The Breast Health Center at Women & Infants Hospital of Rhode Island, recently presented research indicating that when faced with a decision on the type of surgery to have to remove breast cancer, more women trust their own judgment over the input of their surgeon and even their partner.

The manuscript – which is scheduled for publication this fall in the *Annals of Surgical Oncology* and was presented at the New England Association of Gynecologic Oncologists annual meeting – is entitled “Influential Forces in Breast Cancer Surgical Decision-Making and Impact on Body Image and Sexual Function.” In addition to Dr. Kwait, the research team included: SARAH PESEK, MD; MICHAELA ONSTAD, MD; DAVID EDMONSON, MD; MELISSA A. CLARK, PhD; CHRISTINA RAKER, ScD; ASHLEY STUCKEY, MD; and JENNIFER GASS, MD, co-director of The Breast Health Center and surgeon-in-chief at Women & Infants.

“We think about the great advances in screening and treatment for breast cancer, leading to prolonged survival rates as high as 98 percent, survivorship outcomes have become an increasingly important consideration among patients. Women must consider quality of life and intimacy after surgery, these become influencing factors when they make decisions about their care,” Dr. Kwait explains.

The proportion of early stage breast cancer patients choosing mastectomy with reconstruction surgery over lumpectomy has been steadily increasing, prompting the team to wonder what factors are driving the decisions. In addition, while there is substantial research available showing the relationship between surgery and a woman’s self-confidence and sexual pleasure, there was nothing identifying who or what influences her surgery-related decisions.

“We know that women feel especially vulnerable when they receive a breast cancer diagnosis and turn to their support system, including their partner,” Dr. Kwait says. “We also know that the greater the support she receives from her partner leads to greater relationship satisfaction and less sexual difficulty in the long run.

“However, the partner’s role in treatment decision-making remained nuanced. No studies to date, that we were aware of, had evaluated the influence of a partner in surgical decision-making.”

Close to 400 women returned surveys as part of the study. Of those, 67.9 percent had lumpectomy; 8.6 percent had a mastectomy; and 23.5 percent had a mastectomy with breast reconstruction. More than 77 percent of participants were in a relationship, and almost 75 percent of those women reported that their partner attended their surgical consultation.

To the researchers’ surprise, the majority of women having a mastectomy identified themselves as the most important influence on their surgical decision (56.6 percent of those having mastectomy with reconstruction, 46.3 percent having a mastectomy, and 42.7 percent having a lumpectomy). Those women who chose a lumpectomy identified their surgeon as the most influential (44.2 percent having lumpectomy versus 39 percent having a mastectomy and 23.2 percent having a mastectomy with reconstruction).

“Only 7.5 percent of patients identified their partner as the greatest influence on their surgical choice,” Dr. Kwait notes. “Yet, within this subgroup, patients who chose a mastectomy with reconstruction valued their partner’s opinion more than those who chose a mastectomy alone or a lumpectomy.”

Post-surgical satisfaction

The researchers also asked about the patients’ satisfaction with their breast appearance and the breast’s role in intimacy both before and after cancer surgery. All levels of satisfaction dropped dramatically after surgery, with a significantly greater decrease in breast intimacy for women having a mastectomy with reconstruction.

“Nearly half of the patients – or 48.6 percent – who chose a mastectomy with reconstruction devalued the breast in intimacy post-operatively,” Dr. Kwait says. “Comparatively, only 20.4 percent of patients who chose lumpectomy experienced this change.

The reason, she says, is simple.

“The breast relates to attraction, intimacy and sexuality. A woman must define a new normal for herself and her breasts in survivorship.”

This correlates with their finding that despite most patients making their own surgical choices, the type of surgery they have significantly impacts their romantic relationships. The majority of women surveyed reported that after surgery they were less comfortable undressed in front of their partner and experiencing less pleasure from caresses during intimacy. This was particularly true for patients who were eligible for a lumpectomy but instead opted for a mastectomy with reconstruction.

“Our findings highlighted a need for clinicians to mention specific things as part of the informed surgical consent discussions they have with their patients,” Dr. Kwait notes.
Patients deserve a healthcare experience they can trust. Keep private information private with Shred-it. **We protect what matters.**

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Legislation Aimed at Preventing Overdose Deaths Signed into Law

New requirements for health care providers, hospitals, insurers

PROVIDENCE – On July 12, Gov. Gina M. Raimondo, joined by Senate President M. Teresa Paiva Weed, Senate Health and Human Services Committee Chairman Joshua Miller, Representative David A. Bennett, legislators, advocates and individuals in recovery, signed a broad, aggressive suite of legislation aimed at preventing drug overdose deaths.

Among other measures, the bills will set opioid prescribing parameters for health care providers, require hospitals to connect overdose victims with treatment and recovery resources, and require insurers to cover life-saving overdose medication.

The bill signing, which took place at a recovery house administered by Bridgemark Addiction Recovery Services, follows the passage of several bills, summarized here:

- Requires all insurers to cover naloxone and related devices, including in cases where the medication is intended for patients other than the insured.
- Allows the PDMP to be electronically connected to electronic medical records systems.
- Adds Schedule V prescriptions to the PDMP.
- Requires DOH to look for federal funding opportunities to improve the PDMP, such as by adding additional analytical functions and incorporating data from similar programs in other states.
- Authorizes BHDDH to develop a process to certify recovery housing facilities for residential substance use disorder treatment.
- Allows patients to synchronize certain drug refills for chronic conditions by requesting a limited supply (less than 30 days), with pro-rata cost sharing applied by the insurer.
- Allows licensed chemical dependency professionals with the proper training to use treatment known as auricular acu-detox.

Legislation Regulating Freestanding Emergency Rooms Signed into Law

PROVIDENCE – Governor Gina Raimondo has signed legislation that makes freestanding emergency care facilities subject to the same regulatory requirements as other health care facilities.

The law (2016-H 7500A, 2016-S 2696aa) defines freestanding emergency care facilities within state law, and makes them subject to the certificate of need process as well as emergency medical transportation regulations, just like all other medical facilities.

Under existing state law, proposals to build or expand other types of health care facilities are required to undergo a public process to get a certificate of need, which involves assessing the need for the proposal and ensuring that it wouldn’t be harmful to existing hospitals and medical facilities by offering unnecessarily duplicative services. But since freestanding emergency rooms are not currently addressed in the law, an emergency room is able to apply for a license from the Department of Health without a certificate of need, and has only to demonstrate that it is financially sound and capable of providing the services it proposes.
Staying competitive in today’s changing healthcare environment can be a challenge. It may require investing in new technologies, expanding services, even merging with another practice.

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Webster Bank is the affinity banking partner for the members of RHODE ISLAND MEDICAL SOCIETY.
State Approves PTSD to List of Conditions Approved for Treatment with Medical Marijuana

PROVIDENCE – Recently passed legislation and signed into law adds post-traumatic stress disorder to the list of conditions that may be treated with medical marijuana.


According to a report from the Veterans Administration, nearly 30 percent of veterans who served in the Iraq and Afghanistan wars suffer from PTSD. Some scientists have suggested that marijuana may help PTSD symptoms, which can include anxiety, flashbacks and depression. In a recent study, patients who smoked cannabis saw an average 75 percent reduction in PTSD symptoms.

The law also accelerates the issuance of an approved medical marijuana use application if the patient is eligible for hospice care. It requires the Department of Health to issue a registry identification card to the qualifying patient and primary caregivers named in the patient’s application within 72 hours of receipt of the completed application.

According to the Department of Health, more than 10,000 people in Rhode Island carry medical marijuana cards to treat an approved list of conditions, including cancer, glaucoma, AIDS, hepatitis C, Crohn’s disease and Alzheimer’s, among others.

First Patient at Kent Receives Subcutaneous Defibrillator System (S-ICD)

WARWICK – Kent Hospital announced recently the successful implantation of its first subcutaneous defibrillator (S-ICD) system for the treatment of patients at risk for sudden cardiac arrest (SCA).

The procedure was performed by BRUCE A. KOPLAN, MD, MPH, director of the Cardiac Arrhythmia Service for Care New England. Dr. Koplan, part of Brigham and Women’s Cardiovascular Associates at Care New England, is also the first physician in New England to implant the same device in a patient previously at Brigham and Women’s Hospital in Boston.

Said Dr. Koplan, “As clinical technology continues to advance it allows us to provide our patients with excellent options that are best suited to their specific needs while also improving upon safety and long-term results. The first implant of this lifesaving device here continues to show Kent and Care New England’s ongoing commitment to providing the best possible cardiac care closer to home.”

The U.S. Food and Drug Administration (FDA) granted regulatory approval for the latest S-ICD system in March 2015.

A groundbreaking for a new intensive care unit at the Providence VA Medical Center was held July 22. In attendance were U.S. Sen. Jack Reed; U.S. Sen. Sheldon Whitehouse; U.S. Rep. James Langevin; Providence VA Medical Center Director Dr. Susan A. Mackenzie; and Retired Gen. Rick Baccus, Rhode Island Office of Veterans Affairs.

The new 10,000 square foot ICU, which is expected to be completed July 2017, will provide state-of-the-art equipment, a location adjacent to the surgical suite, and additional space for patients and staff. The facility will incorporate nine inpatient care units, modern nurse stations, modern consultation rooms and adequate family space.
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Jennifer Healey named Director of Clinical Services at Southcoast Behavioral Health

DARTMOUTH, MASS – JENNIFER HEALEY, LMHC, MFT, of Rumford, RI, has joined the staff at Southcoast Behavioral Health as the Director of Clinical Services.

Healey earned her Bachelor of Arts and her Master of Science in Counseling and Human Relations from Villanova University. She also holds a Master of Science in Marriage and Family Therapy from the University of Rhode Island.

Prior to joining Southcoast Behavioral Health, Healey was the Associate Director of Outpatient and New Business Development for Continuum Behavioral Health in Cranston, RI. Healey has extensive experience in substance abuse programs, Dialectical Behavior Therapy (DBT) skills sessions with adults, couples and families and knowledge of Partial Hospitalization Programs.

Healey holds membership in the American Mental Health Counselors Association, the American Association of Marriage and Family Therapy, and is the Human Rights Chairperson of ARC of Blackstone Valley. She currently maintains an outpatient psychotherapy practice in Middletown, RI.

Dr. Kristin Jacobs elected President of Fellows’ Research Network Committee

PROVIDENCE – KRISTIN JACOBS, MD, a fellow in the Department of Urogynecology and Reconstructive Pelvic Surgery at Women & Infants Hospital, has been elected to serve as president of the Steering Committee for the Fellow’s Pelvic Research Network® of the Society of Gynecologic Surgeons (SGS).

The Society of Gynecologic Surgeons (SGS) sponsored the creation of the first fellows multi-center research network, the Fellows’ Pelvic Research Network (FPRN), to promote research training and expose fellows to multi-center studies. The idea for this research network was suggested by a fellow in 2007. SGS considers the FPRN® an important initiative within the context of its mission statement to promote education and research in gynecologic surgery.

The purpose of the FPRN® is to enable fellows to work together cooperatively and conduct multi-center research projects. The FPRN® and its research projects are operating under the mentorship and supervision of a Senior Advisory Board which includes established researchers in gynecology from across the country.

As president of the Steering Committee, Dr. Jacobs is responsible for overseeing the administrative logistics of national, multi-site research being conducted within the FPRN® by gynecology fellows from more than 20 participating medical centers in the U.S.

A graduate of North Central College in Illinois, Dr. Jacobs earned her medical degree at Rush Medical College in Chicago and completed a residency in obstetrics and gynecology at Loyola University Medical Center. Her current research focuses on painful bladder syndrome, female urinary microbiom, and patients’ knowledge and preferences regarding hysterectomy procedures.

Obituary

AMIR H. MISSAGHIAN, MD, 83 of West Falmouth, MA, formerly of Cumberland, RI, died on July 7, 2016 at Cape Cod Hospital following a brief illness.

He was the beloved husband of Lisa Missaghian. Dr. and Mrs. Missaghian were married for 58 years.

Born in Tehran, he resided in Cumberland, RI for 34 years before retiring to Falmouth, MA.

Dr. Missaghian was board certified in Pediatrics and Allergy & Immunology. He received his undergraduate degree at Wurzburg University and received his medical degree from Ludwig Maximillian University in Munich, Germany.

Among the places he worked and trained include: Milwaukee County Hospital, Roger Williams Hospital, St. Mary’s Hospital in Brooklyn, Denver General Hospital, The National Asthma Research Hospital in Denver, the U.S. Army Hospital in Augsburg, Germany and the University of Texas Medical Branch.

In 1969, he returned to RI and started his private allergy practice which he had for 34 years. He was also a past president of the RI Allergy Society and volunteered his time at RI Hospital’s Allergy Clinic.

Dr. Missaghian was an avid reader and sports fan. He loved playing golf and enjoyed doing crossword puzzles. He will be missed for his kindness, generosity, sincerity and sense of humor.

He leaves behind his wife Lisa, daughter Angelic and son-in-law Kevin, his son Richard and fiancé Amy, his grandchildren Olivia and Elena, his sisters Farah, Shahin and Shahan, nieces and nephews, and many dear friends and neighbors.

In lieu of flowers, donations can be made to the American Parkinson Disease Association, 135 Parkinson Avenue, Staten Island, NY 10305 or the American Cancer Society P.O. Box 22478, Oklahoma City, OK 73123.
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Stephanie Maryeski, MD, Joins Newport Hospital as Director of Primary Care

NEWPORT – Newport Hospital announced that STEPHANIE MARYESKI, MD, has joined the Newport Hospital medical staff as Director of Primary Care. She began seeing patients on July 21. Maryeski received her medical degree from Brown University and completed her internship and residency training at the Walter Reed Army Medical Center in Washington, D.C., now the Walter Reed National Military Medical Center in Bethesda, Maryland. Following her residency, she served as Chief of Internal Medicine and Chief of the Warrior Transition Unit at Keller Army Community Hospital at the United States Military Academy at West Point, New York, and served 12 years in the military, including a 2010 deployment to Iraq. Board-certified in internal medicine, Maryeski is a member of the American College of Physicians.

Memorial’s Taro Minami, MD, Honored with a Teacher of the Year Award

PAWTUCKET – TARO MINAMI, MD, FACP, FCCP, director of simulation and ultrasound training and fellowship site director for pulmonary and critical care medicine in the Division of Pulmonary, Critical Care and Sleep Medicine at Memorial Hospital, and assistant professor of medicine (clinical) at the Warren Alpert Medical School of Brown University, was recently recognized with a Teacher of the Year Award.

The award was given by the Division of Pulmonary, Critical Care and Sleep Medicine at Alpert Medical School. Dr. Minami was selected by the pulmonary and critical care fellows and received this recognition at the Brown Chest Conference on June 17.
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1917: Mechanical treatment of spine curvature

MARY KORR
RIMJ MANAGING EDITOR


The article was accompanied by lantern slides of one of his patients, a 13-year-old boy. ([Figures 2 and 3](#)) Dr. Peckham described the “mechanical” treatment of correcting the condition and noted that “if a child with a spinal curvature was laid face down over a convex surface, the spine became immediately lengthened and the deformity quite markedly diminished just by the position alone. If to this is added rotating pulls, as in **Figure 2**, the spine may be made straight temporarily…”

With the body in different degrees of flexion, rotary pulls were made to obtain as much correction as possible while keeping the patient comfortable. **Figure 3 A** shows the spine with patient standing, **B** shows the spine after 5 minutes in arranging the patient as shown in **Figure 2**, **C** shows the spine in January, while **D** shows the spine three months later.

Dr. Peckham reported the steady progress of the patient over a six-month period, with a follow-up recommendation that gymnastic exercises be initiated until the “musculature will hold the body and head in the erect position.”

**Figure 2.** Showing patient in position, face down over a convex frame. Rotary pulls are also in evidence.

**Figure 3.**

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*Figures 2 and 3*
Other apparatus to treat spinal conditions

Use of the Sayre head sling for the correction of scoliosis.


A patient stretched on a frame to treat rheumatoid spondylitis.