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OUTLOOK

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Proliance Surgeons® Outlook, a publication from Proliance Surgeons, is an educational resource for health care professionals as well as the general public. The publication communicates education news and trends involving orthopedic, general surgery, and ear, nose and throat surgery topics and contains various health-related articles of interest. Proliance Surgeons' goal is to increase public awareness of surgical techniques and innovations and their significant roles in orthopedic, general surgery, and ear, nose and throat health care.

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Opening Remarks

by David Fitzgerald, CEO



Welcome to the fall edition of *Proliance Surgeons Outlook*. "Outlook" is a big word in today's economic environment. We have all experienced some of the roller coaster and big resets of our "outlook." But, even in that environment, Proliance Surgeons is embarking on some great initiatives.

On September 16, 2011, Proliance Surgeons hosted a Golf Invitational for Heartbeat – Serving Wounded Warriors.

Thank you to all our associates, vendors and friends who have helped make this possible through sponsorships. An article in this edition gives you more information about the event.

We are working with the ASC Association on the passage of H.R. 2108, the Ambulatory Surgical Center Quality and Access Act of 2011. We will be meeting with many of the Washington congressional delegation to explain the act and request their co-sponsorship of the bill. Its passage will help codify the benefits of ASCs and their ability to significantly impact the total cost of health care.

Proliance Surgeons is also chairing a committee that is working with the Washington ASC Association and the Washington State Healthcare Authority to restructure the payment structure for surgeries performed in an ASC for Medicaid patients. The goal of the committee is to reduce overall Medicaid costs for the state and increase access to ASCs. This type of initiative could be a model for many other states.

We are also working closely with many other organizations (physician groups, hospitals, health plans, etc.) to create a health care model that still promotes independent physician practice, yet aligns in a manner with other providers to enable the patient to receive the most effective and efficient care experience.

It is a time for change. We want that change to be thoughtful and beneficial to all parties. Health care costs can come down, but it takes everyone working together to make it happen. We commit to doing our part — that's why the efforts nationally, across the state and locally are our priorities.

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Moving into the Electronic World

by Lisa Barry, RN, M.Ed., Administrator



In January 2010, Bellevue Ear, Nose and Throat Clinic decided to be one of the pilot care centers in Proliance Surgeons to move from paper charts to an electronic health record. Bellevue ENT Clinic has multiple clinic locations, as well as several lines of business that include a retail hearing aid center and Facial Plastic Medispa. In addition, because we are a surgical group, our doctors perform surgery in both an ambulatory surgery center and the hospital setting. As the administrator overseeing the entire practice, I could appreciate the benefits of moving to an electronic system. Although I knew from my colleagues who have recently done this type of conversion that the process of converting would have its ups and downs, I was committed to seeing it through. Our goals were to improve efficiency, access, accountability and communication both internally and with referring doctors and patients. We have recently passed our one-year anniversary implementing electronic health records, and I can honestly say it was worth the effort.

The planning phase is the most important phase. To be successful, it was important for us to have an experienced project manager (PM) who understood our current work flow and could transition us to a new paradigm. Our PM would anticipate issues and give us best-practice recommendations. She also kept us on track with staff and physician training that needed to occur. In addition, we set up weekly meetings with the physicians to go over what was working and what was not. This was also an opportunity to see what training gaps we may have to address.

With the HITECH incentive dollars being available, we felt the timing of our conversion to electronic charts would allow us to qualify. Even though this was not the reason we decided to move forward with electronic records, we recognized it could benefit us.

Automating our paper processes began with e-prescribing and e-faxing prescriptions for our patients. This was helpful in getting our physicians and medical-assisting staff members familiar with the electronic world. It also allowed us to test the electronic connection we had to the pharmacies we used, which would be key for

our ongoing patient satisfaction. Once we had that well underway, we began converting our incoming faxes to electronic files. We created folders on a shared drive that multiple employees could access. This not only reduced costs by using no paper or toner, but it also increased efficiency for the staff.

Creating the actual electronic patient chart took a lot of planning. We had a focus group that methodically looked at all the document types, where they were filed in the paper chart and what made sense for filing it in an electronic chart. Stakeholders were interviewed. Ultimately, the physicians drove the decisions on category naming and document filing. A clear listing was collated, and the staff followed the process without fail. As we scanned old paper charts into new electronic charts, we also decided to have a category for “pre-EMR” documents, which has been helpful in looking at historical data on a patient.

Our decision to launch EHR in phases proved to be the right thing to do. We set a timeline for each phase with the understanding we needed to keep close to the timeline. Our PM advised that we do not stay in any phase for longer than a few weeks. It is important to remember that we all handle change in different ways and learn at different speeds. Some will not want to move forward, but it is important to keep a momentum going. And although the physicians have wanted to convert to an electronic record for several years, they were concerned that the process would reduce the amount of patients they could see in a day. Another concern was introducing a computer into the exam room and how that would affect their interaction with the patient.

Phase one was launched on new patients seen in the morning clinic sessions. We entered their health history and medications. The doctors saw the patient and documented the visit.

Phase two was launched a few weeks later. Again, we documented on only new patients. In this phase, we added patients being seen in morning and afternoon sessions.

Phase three was inclusive of established patients, as well as all new patients. This phase, of course, added the task of scanning the old chart prior to the appointment.

We have opted for a record with a combination of discrete templates and free type areas within many of the templates. The system we selected gives us the flexibility to use both modalities. The physicians dedicated themselves to create custom letters that included the pertinent information pulled from the templates that would go to their referring MD community. Letters generated from an electronic record can sound robotic, and we did not want that to be the case for us. We realize these letters are the face of the practice, and they have to present well.

Our journey to embrace a completely paperless system has begun. The projects and challenges ahead of us in the near future will be

to implement a new patient portal and to install patient kiosks in our clinics. The patient portal will allow patients to connect to us through a secure manner and allow them to e-mail staff members, request appointments, request records, receive test results, view accounts and pay their bills, as well as fill out forms needed for their appointments. The convenience of this for patients is that they will have 24-hour access to the portal. They can manage many of their health care transactions when it is convenient for them, not on an 8-a.m.-to-5-p.m., Monday-through-Friday schedule. The patient kiosk in the clinic will allow patients to check themselves in for their office appointments, streamlining yet another process.

Moving to the electronic world has been a fluid process. There have been many process changes that sometimes go through several revisions as we search for the best way to accomplish a task at hand. In the ever-changing world of technology, things will continue to become more useful and more efficient. In the final analysis, the key to a successful conversion lies in the attitude and aptitude of the people you surround yourself with.

Dr. Seely, an ENT surgeon with Bellevue ENT, says, "the implementation of EHR requires a major commitment of time and effort by the entire practice. It is also a major financial investment. The return on our investment includes legible charts, as well as the immediate availability of chart notes at our two clinic locations in Bellevue and Issaquah, in the OR, at home when we are taking call and even when we are out of town for a medical meeting.

Laboratory data comes directly into our EHR via an interface, and other reports can simply be scanned into a patient's chart for physician review. We also are reclaiming space once devoted to storing charts and reducing our off-site storage needs and costs."

In addition, Dr. Seely notes, "Electronic prescribing automatically applies a powerful database to check for drug reactions/interactions, and patients greatly appreciate the improved efficiency of filling their prescriptions, since they don't have to deliver a written prescription to their pharmacy. This not only saves people time, but it also speeds up their treatment. A fully functional patient portal which will soon be implemented will reduce data entry by our staff, reducing overhead and improving patient flow. This will allow patients to input their registration, insurance information and medical history online prior to their appointment, which will directly populate into their electronic record."

Lisa Barry, RN, BSN, M.Ed., ACMPE

Lisa has been a medical group manager for 20 years. She has been practice administrator for Bellevue ENT Clinic for seven years. Lisa is a board member of Washington State Medical Group Managers Association and is an active member of the National Association of Otolaryngology Administrators.

Daniel R. Seely, MD, MPH

Dr. Seely completed his residency at the University of Washington and is board-certified by the American Academy of Otolaryngology/Head and Neck Surgery. He has been in practice since 1995 and with the Bellevue Ear, Nose and Throat Clinic since 1997.

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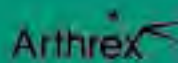
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Modern-Day Advances in Knee-Replacement Surgery

by Dr. Robin Fuchs

Knee-replacement surgery has become one of the most successful procedures in all of orthopedics. Surgical outcomes, patient satisfaction and implant survival have all improved since its inception. This operation has become widely accepted as a way to reduce pain and improve function from arthritis. The most common conditions leading to knee replacement are osteoarthritis, post-traumatic arthritis and rheumatoid arthritis. Knee-replacement surgery involves replacing the joint surface where the cartilage has been damaged with metal and plastic components.



Figure 1

In the early years of knee-replacement surgery, the operation was offered usually to an older age group whose activity level was relatively sedentary. It has now been shown that knee replacement is effective and durable in a younger, more active patient, as well as the elderly population. Ideally, the patient will be more than 50 years of age so that a successful knee replacement would last for the rest of the patient's life. Survivorship for total knee replacement ranges between 91 and 99 percent at 10 years, and between 89 and 96 percent at 15 years.

People are now living longer and remaining physically active, and knee-replacement surgery is allowing better quality of life in the later decades of life. We have all been made aware of the importance and benefits of daily physical activity as it relates to cardiovascular and mental health, and disabling arthritis of the knee can prevent participation in these activities. More and more people are making decisions to have knee-replacement surgery so they can stay active through their retirement years.

The knee joint has three separate compartments: the inside (medial) compartment, the outside (lateral) compartment and the front (patellofemoral or kneecap) compartment. Most people suffering from arthritis have involvement in more than one compartment of the knee and therefore will be best suited with a total knee replacement. During a total knee replacement, all three compartments are replaced. A small percentage of people have arthritis in only one compartment of the knee and may benefit from a partial knee replacement. During a partial knee replacement, only the affected compartment is replaced. The best way to determine how many compartments of the knee are affected is by X-ray imaging and occasionally an MRI.

John Insall was one of the founders and fathers of modern-day knee-replacement surgery. In his own words, "The most important factor in creating a successful knee replacement is surgical technique." Recent advances in medical technology have allowed the development of computer-guided navigation and custom patient-specific instruments. These new technologies are designed to improve surgical technique and allow precise alignment of the knee during surgery. Hopefully, this will lead to reduced wear and a longer-lasting knee replacement.

Computer-guided navigation involves using light-emitting diodes that are attached the leg during surgery. These devices communicate directly with a camera attached to a computer and allow the surgeon to create a digital reproduction of the entire surgery. Computer-guided navigation provides real-time 3-D imaging and guides decision-making during knee-replacement surgery. Component position, range of motion and overall alignment are viewed during every step of the procedure.



Figure 2

Patient-specific instruments can be customized to exactly match each patient's anat-

omy. This involves obtaining X-ray images and an MRI of the affected knee and scanning them into a software program that generates virtual images of the knee. Surgical cutting guides are then designed and built to exactly match the knee, mapping out specific bone cuts to accurately align the knee replacement. Customized instruments remove multiple steps from the traditional surgical technique, reducing time under anesthesia and decreasing blood loss, and they may lead to a lower infection rate.



Figure 3

Minimally invasive surgical techniques have helped transform knee-replacement surgery. Knee replacements are now being performed through a smaller incision with less muscle damage due to improved instruments and techniques. This has led to less postoperative pain, a shorter hospital stay, improved function and faster rehabilitation after knee-replacement surgery. The hospital stay is typically one to two days, and physical therapy is begun immediately after surgery. Outpatient physical therapy continues for approximately two months, although continued improvement after knee-replacement surgery is expected for six to 12 months.

Dr. Robin Fuchs completed his orthopedic surgery residency at the University of Miami – Jackson Memorial Hospital and his fellowship in knee reconstruction and sports medicine at the Insall Scott Kelly Institute for Orthopedics and Sports Medicine in New York City. He is an active researcher whose findings have been published in leading orthopedic journals. His clinical practice is at Evergreen Orthopedic Center.

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Welcome New Surgeons



Brian D. Jones, DO

We are proud to introduce Brian D. Jones, DO, who will join Southwest Seattle Orthopedics and Sports Medicine, a Proliance Surgeons Care Center.

In addition to practicing general orthopedics, he has special interest in the surgical treatment of cervical, thoracic and lumbar spine disease. Dr. Jones has completed a spine surgery fellowship at the Oregon Health & Science University in Portland.

Dr. Jones is originally from Minnesota, where he attended Augsburg College in Minneapolis, excelling both academically and athletically. He graduated with a B.A. in chemistry and led the wrestling team with All-American efforts to three national championships. He then attended the A.T. Still University's Kirksville College of Osteopathic Medicine for his DO degree and did an internship and orthopedic surgery residency at the Michigan State University.

Brian enjoys camping, hiking, running, soccer and travel. He is also a member of Orthopedics Overseas, a philanthropic organization committed to providing medical and surgical services to underdeveloped and underserved regions around the world. He is a proud father of two young girls, 4-year-old Tallulah and 18-month-old Matilda. He and his wife, Kaliandra, are looking forward to becoming members of our community.

We are very excited to welcome Dr. Jones to our group and believe he will be an excellent addition to the Highline medical community.

Brian D. Jones, DO

Southwest Seattle Orthopedics
and Sports Medicine
16259 Sylvester Rd. S.W., Suite 501
Burien, WA 98166
(206) 243-1100



Aric Christal, MD

Dr. Aric Christal is a fellowship-trained adult reconstruction and arthroplasty surgeon specializing in complex primary and revision joint replacement.

Born and raised in Anchorage, Alaska, Dr. Christal completed his undergraduate studies at Harvard University. He earned his medical degree from the University of Washington, where he also completed his orthopedic surgical residency. Dr. Christal traveled to Charlotte, North Carolina, for a fellowship in complex adult reconstruction and joint replacement. At Ortho-Carolina, he trained under several of the nation's most renowned reconstructive surgeons. Dr. Christal has a special interest in joint preservation as well as complex joint replacement and revision.

Outside of medicine, Dr. Christal enjoys skiing, cycling, mountaineering and spending time with his wife and daughter.

Aric Christal, MD

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Doug D. Nowak, MD

Dr. Nowak offers expertise in the evaluation and treatment of sports-related injuries and general orthopedic conditions. During his fellowship, he was involved in the care of more than 60 professional and Olympic athletes, including athletes in the NFL, the NBA, the MLB and the NHL. Dr. Nowak trained with the world-leading expert in hip arthroscopy as well as leaders in the field of shoulder and knee arthroscopic surgery.

Dr. Nowak went to medical school at the University of Illinois College of Medicine, completing his residency at Columbia University Medicine Center in New York and his clinical fellowship in orthopedic sports medicine at The Steadman Clinic in Vail, Colorado.

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Proliance Surgeons *and* Heartbeat *Team Up to Honor and Help* Our Fellow Americans

by Robert M. Schwartz, Director of Public Policy

Many articles and speeches have been published about American exceptionalism. What truly sets Americans apart is their ability to help others.

American soldiers are part of an all-volunteer armed forces. They volunteer to go into harm's way at great risk. In many instances, they pay the ultimate price. Also, in many instances, they suffer serious mental and physical injuries.

A number of wonderful grassroots organizations have sprung up to assist these special warriors and their families. Proliance Surgeons identified one such program in Washington state called Heartbeat – Serving Wounded Warriors.

Heartbeat, founded by Janice Buckley, has a mission to provide emergency assistance, morale building and innovative therapeutic services for wounded warriors and their families. Heartbeat offers a variety of services but has gained statewide and national recognition for its Scuba Warriors therapeutic diving program and its Back in the Saddle equestrian program.

The scuba-diving program helps patients improve cardiovascular strength, emotional wellbeing, mobility, muscle strength and blood flow. When diving, nitrogen levels change to help with cognitive disorders.

Equine-assisted therapies assist with hippotherapy and equine-assisted psychotherapy. Horses and humans have pelvises that move in the same three-dimensional way. Hip movement is identical when walking. When a person sits on a moving horse, muscle groups for the normal human movement are strengthened. These evidence-based therapies improve muscle strength, emotional wellbeing, motor development, balance and coordination.



Proliance Surgeons decided that it was important to get behind this effort. CEO Dave Fitzgerald stated, “Our company likes to be involved in our community. Our physicians are active in many different roles and with many organizations, but we were looking for a program/cause that reflects our community and our appreciation for excellent service... Wounded Warriors fit perfectly.”

Proliance Surgeons set out to host the first annual Heartbeat – Serving Wounded Warriors Golf Invitational. The event took place at The Home Course in Dupont, Washington, with Honorary Chairs Rep. Joe Schmick and Sen. Steve Hobbs.

The golf tournament is a way to have fun and to raise much-needed funding. It has also allowed Proliance Surgeons to assist the organization to raise understanding of the needs of the warriors and their families.

Janice Buckley, the founder and chairman, was recently honored and given the Joint Base Lewis-McChord Civilian Hall of

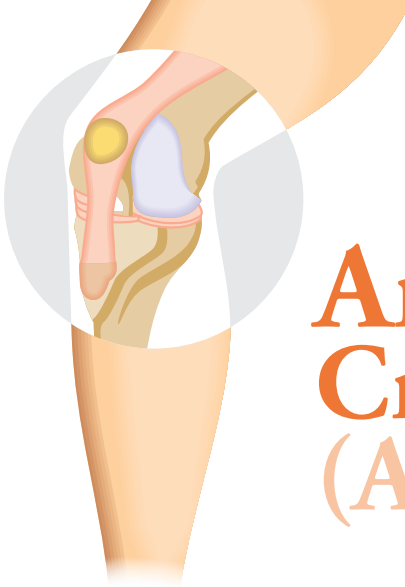
Fame Award for her efforts. In the award, it was stated, “Heartbeat helps thousands of military service members gain control of their health challenges to lead productive lives.” Heartbeat averages \$600,000 in donations each year. The program treats wounded warriors on a statewide basis. Since 2009, Heartbeat has served more than 14,000 wounded military families.

“We have served many warriors who were left on their own with no family support — homeless at a young age. That is not the way these courageous warriors should be treated,” Buckley stated.

The golf tournament raised more than \$40,000.

For more information about Heartbeat – Serving Wounded Warriors, visit its website at www.heartbeatforwarriors.org.

Robert Schwartz is public policy director for Proliance Surgeons. An attorney, he was formerly chief of staff for Sen. Joe Lieberman, when Lieberman was state Senate majority leader, and a former senior administrator at Yale New Haven Hospital.



Anterior Cruciate Ligament (ACL) Injuries



by Dr. Richard L. Angelo



Introduction/Anatomy

Anterior cruciate ligament, or ACL, injuries occur commonly among participants who engage in running, cutting and pivoting sports in particular. The exact incidence is unknown but has been estimated to be between 500,000 and 600,000 per year in the United States. Tears of the ACL usually result in significant functional disability and are often accompanied by additional damage to the protective meniscal cartilage rings and the articular, or joint, cartilage that surfaces the ends of the thigh bone (femur) and the upper leg bone (tibia). When evaluating col-

legiate athletes participating in the same sport for similar participation times (basketball, soccer, volleyball), females sustain three to eight times the number of ACL injuries as their male counterparts. The reasons for this differential are not known with certainty, but differences in strength-to-weight ratios, dynamic balance and feedback times for spatial position of the knee may play a role.

The anterior cruciate ligament (ACL) is a stout bundle of fibrous tissue that is located in the center of the knee, attaching to the top/front of the lower leg bone (tibia) and the back of the end of the thigh bone (femur) (figure 1). It serves both to limit the amount of forward shifting of the tibia relative to the femur and to help minimize excessive rotation of the knee. The ligaments of the knee and, in particular, the ACL often see significant stress in part because of the relative lack of congruity of the femur and tibia. With cutting and pivoting activities, the ACL may be injured or torn, resulting in disabling instability of the knee (figure 2). Meniscus (cartilage ring) and articular cartilage damage are often associated with ligament injuries of the knee.

Symptoms

When the anterior cruciate ligament tears, there may be an associated pop, snap or tearing sensation, and the majority of patients will experience significant swelling within 24 hours. Pain is variable and may be related to the extent of associated injuries. Depending on the magnitude of the laxity, the knee may shift, buckle or give way with walking, running or twisting activities. Stiffness is common in the weeks following injury.

Diagnosis

The history of the events surrounding the injury provide important clues as to the probability of an ACL tear. Cutting from a planted foot, hyperextension (excessive straightening) or direct impact to the knee are common mechanisms of injury. Physical examination of the knee usually reveals excessive forward displacement of the tibia relative to the femur. Using a special maneuver, a rotational shifting of the knee may also be able to be detected on examination. X-rays are usually unremarkable. A magnetic resonance imaging study (MRI) is very accurate in determining whether an ACL injury and associated injuries have occurred.

Treatment

Not everyone with a damaged ACL needs to undergo surgery. If the resulting laxity is not excessive, and the patient is not involved in cutting, pivoting or aggressive stopping maneuvers, function may be satisfactory for the patient who is willing to modify his or her lifestyle. Occasional brace wear may be necessary. The majority of patients who are involved in cutting and twisting activities, e.g., with sports, work or avocational activities, will find their disability unacceptable.

Anterior Cruciate Ligament Reconstruction

In most cases, it is not possible to surgically “repair” a torn anterior cruciate ligament. The blood supply and healing potential are relatively poor. A new ligament must be created. Using arthroscopically assisted methods, tunnels are drilled into the tibia and femur so as to exit into the knee joint at the appropriate locations (the exact sites where the normal ACL attaches) (figures 3 and 4). The graft is then fixed in the tunnels using a variety of metallic, absorbable or plastic devices, including pins, screws or sheaths.

Graft Choices

Hamstring

The smaller two (of four) hamstring tendons on the inside of the knee can be harvested through a 1-inch incision. These strips of tendon are then doubled over to make a four-bundled graft. There tends to be somewhat less pain using this



graft. For very loose knees, those with multiple ligament damage or those with chronic laxity, a different graft is often preferred.

Patellar Tendon

The middle one-third of the patellar tendon and attached wedges of bone from the kneecap and the upper tibia are harvested from the front of the knee. The bone plugs are then fixed into the previously drilled tunnels (figure 5). This graft is often preferred for very lax knees and for reconstructions in young, athletically aggressive male patients. There is a somewhat greater tendency for pain in the front of the knee, although it is very rarely disabling.

Quadriceps Tendon

This graft source is from the tendon above the kneecap and is similar to but less commonly used than the patellar tendon.

Allograft

Allograft tissues are harvested in a sterile manner from an individual who is recently deceased. A certified tissue bank then stores the various "grafts" until they are needed. Various tendons are available for use as a substitute ACL. There tends to be less pain when using allografts, largely because the harvesting of tissue from the patient's own knee is avoided. Allografts tend to take somewhat longer to incorporate and mature after implantation. For lower-demand patients not wishing to sacrifice any of their own normal tissues, allografts may be an attractive option.


Double-Bundle Technique

Surgeons are unable to duplicate the complexity of the native ACL, which has a broad attachment and fibers that spiral. Many ACLs also have two separate functional bundles. This special configuration permits a portion of the ACL to be relatively tight throughout a full knee range-of-motion. With traditional reconstructive techniques, only a single graft bundle is implanted during the surgery. Through research and study, double-bundle techniques are evolving wherein both functional bundles of the ACL are reconstructed using two separate and distinct tunnels in the tibia and femur. Studies have suggested that more normal rotational stability may result.

Recovery

Anterior cruciate ligament reconstruction is performed on an outpatient basis. Partial weight-bearing is performed for the first one to two weeks following surgery. A protective brace is employed for three to four weeks. Range of motion exercises are begun the day after surgery. Physical therapy to assist in restoring motion and regaining strength begins at one week following surgery. Exercise cycling starts at one month and jogging at two and a half to three months. Gentle cutting and pivoting sports are permitted at five months but graduate in intensity up to eight to nine months.

Dr. Richard L. Angelo is an orthopedic surgeon at Evergreen Orthopedic Surgery Center. He is certified by the American Board of Orthopedic Surgery and holds a Sports Medicine Certificate of Added Qualification (CAQ). He is specialty fellowship-trained with more than 25 years of experience in helping patients return to a healthy, active lifestyle by providing them with unsurpassed orthopedic and musculoskeletal care.



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A Medical Mission of Hope

by Beth MacLean, RN



The medical mission team.

It was a nudge, one with such clarity that I returned home with a passion. It was 2010, and my first trip to Africa; my first to this little community that we had been supporting for the past few years. Africa can stun you in an instant. It can throw disease, famine and poverty at you at the same time. In the next moment, it surprises you with its people and its beauty. It all happens in a way that touches your soul and begs you to keep coming back. I knew I needed to go, even though I wasn't sure what my purpose would be. It was a relational trip — meeting, greeting, observing, and I was changed by it.

In 2006, my husband and I helped start a nonprofit called Dwankhozi Hope with the goal of supporting a school in rural Zambia, a country in Southern Africa. We were inspired by the capabilities, commitment and dedication of the parents and the community leaders to provide a better life for their children. We were also moved by the tremendous needs of this community. Although they had the intrinsic values and required skills to start a school for their children, they did not have the necessary resources to sustain, much less grow, the institution. Learning was nearly impossible with only nine volunteer teachers and 500 students, no supplies or even a school building. Many of the children were orphaned and suffered from various illnesses endemic to the region, but the school offered an opportunity and hope for a better life.

The idea of a medical trip was borne from my first visit to the school. As a registered nurse, I instinctively looked to the medical needs of the community. Although the students appeared healthy, I knew they each faced such a huge disease burden — malaria, schistosomiasis, malnutrition and HIV/AIDS, to name a few. Knowing that health and education are intimately intertwined, it planted the seed for a return trip to conduct our first-ever medical clinic.

It didn't take long to put together a team. It was during a donor party that Sandy Rowe, RN (nurse manager at Evergreen Orthopedic Surgery Center), felt that familiar nudge. Before the idea of a medical trip was mentioned, she approached me with the desire to do something to use her skills to help this community. Her husband, Jerry, was happy to join the team as well, to help in any way he could. When I approached Dr. JR Robbins (Proliance Surgeons) with the idea of making the trek all the way to Africa, there was little hesitation.

Before long, we had a team of eight volunteers — JR Robbins, MD; Sandy Rowe, RN; Mat Kummerfeldt, PA; Beth MacLean, RN; Missy Lein, RN; Kate Ballbach; Jerry Rowe; and Janice Hoshizaki. After considerable planning and preparation, our team headed to rural Zambia to conduct our first three-day medical clinic at Dwankhozi Community School. The goal was to initiate a medical file and get a baseline assessment for each student. We also conducted education classes in hand-washing and hygiene.

With the team's feet on ground, we were able to experience it all upon our arrival. We were greeted so warmly by our Zambian family, the Masalas. It is because of this family that our visit was even possible. This family of 12 grew up in rural Zambia and, through education, was able to find hope for a future. However, they are the minority — most families like theirs don't reach a basic level of education, if at all, and are left living in the village of their ancestors.

This was my first time leading a team, my second trip to Zambia and our first medical endeavor — so, needless to say, our team spent a lot of time figuring things out as we went. Even if we COULD have expectations, we knew we had to leave everything at the door. Things would NOT be like we planned, and they weren't — 8 a.m. turned into 11 a.m., one-hour meetings turned to three, printers didn't work, otoscopes failed, paperwork wasn't complete. The list went on. But our Zambian brother, Moses, always had the same refrain: "No problem." And in truth, there never really was a problem — every situation had a solution.



JR performs a medical exam.

The clinic proved to be a success, although inadequate in some ways. The school's attendance jumped to 602 pupils in the last four years. Our team was able to see a total of 353 students and 13 adults (teachers and PTA members). The health assessment consisted of three stations — initiating the patient record to include demographics, photo, height, weight and vision; a nursing assessment to include vitals and basic health history — specifically, whether they have had a history of malaria and if they sleep under a bed net; and a medical exam — focusing on head, chest, abdomen and extremities.

We were so impressed with the students as they made their way through our makeshift clinic. Imagine: most of these children had never ever seen a doctor, and those that had were in a medical crisis. So to ask them to go to a clinic run by strangers not knowing what to expect without their parents takes a huge dose of courage. Totally unlike my own children's experience with doctors — where it is mostly preventive, regular and bathed with parental assurances. Many of the kids had lips quivering, pulses racing, palms sweating — and yet, with the exception of a few of the very young kids, none of them cried or complained.

Our results were remarkable. We all had the knowledge that malaria is endemic to the region, but seeing it firsthand was truly unbelievable. Malaria is the constant foe, but resilience is the constant refrain. Ninety-two percent of the children and 100 percent of the adults we examined have had a history of malaria. Some who denied a history still manifested lingering symptoms of malaria, such as enlarged spleens. Few used bed nets, and their reasoning varied: lack of resources or access; old ones riddled with holes; irritation to their skin because of a misunderstanding of proper usage; feeling hot or claustrophobic; or using the net, yet still getting malaria, which caused them to doubt its efficacy.

We got a sense that the parents were fatigued — the recurrence rate, the lack of resources, and the incomplete or inappropriate treatment was exhausting. One mother brought her child to us from a local clinic to see if we could do anything as well. Another pregnant mom had just been discharged from a clinic in the area with her young child only to make the 20-plus-kilometer trek home. A father lost both of his children (in their early '20s) to the disease in the same week we were there. It is so commonplace that people have become complacent to the seriousness of the matter.

Though we gathered important data, it was easy to notice the inadequacies. No medications. A simple wellness check. But just like they gave us the gift of their resilience, we gave them the gift of being known. Known as individuals with names — not just a sea of blue uniforms — with a pulse in the exact same place as our own. And making them known as a community to the nearest health clinics — advocating for them through our visits and donations of supplies.

When Sandy Rowe was asked to describe her experience using one word, her answer was “enormity.” The enormity of the preparation alone — passports and visa applications, Zambian applications for medical licensure, travel clinics, shots, preventive medications, procuring supplies and equipment. The enormity of defining our goal as a medical team, recognizing that we would not be able to provide treatment without knowing what we would be facing; therefore, we determined it would be a visit of assessment. The enormity of the need — so many of these students live in a world that is void of the common everyday process that we take for granted, like electricity, running water, routine bathing, dental care, clean clothes to wear, shoes, transportation, basic preventive health care. This is a list that can go on. The enormity of the responsibility —



Beth provides medical care.

for many of these students, we would be their first experience with any form of health care. Could we be effective without being frightening? Would they trust us? The enormity of the passion — the teachers and volunteers of the school spent hours as facilitators, interpreters, clerks, photographers, tour guides, setup and cleanup assistants, and all around whatever needed to be done so that their students could get this care. The enormity of what is left to be done — with the focus being on health assessment, the team gathered information and data that will be vital to ongoing health care organizations already in the region.

When you allow yourself to get up close and personal like we did, you realize how much we are the same. We all want to see ourselves after our picture is taken. We all instinctively take off our shoes to get weighed. We all want the same thing for our kids. We all were made and loved by the same God.

We live with enormous privilege in all aspects of our life. It is our sense of empowerment that leads us to believe we can accomplish the impossible. The challenge is to not take our privilege for granted and to use it in a way that serves others. It has been a privilege for me to be invited into this Zambian community, a privilege to work with this amazing team that made the trek all the way to Africa and a privilege to share my experience with you all.

We are so grateful for the support of all our family, friends and co-workers in this endeavor. We received countless supplies from numerous donors to enable us to accomplish our mission. We could not have done it without your interest, prayers and support.

For more information about Dwankhozi Hope, please visit our website, www.dwankhozi-hope.org.

Beth MacLean, RN, is a registered nurse at Evergreen Orthopedic Surgery Center and has been an employee of Proliance for eight years.

Sandy Rowe, RN, is the nurse manager for Evergreen Orthopedic Surgery Center.

JR Robbins, MD, has practiced in Redmond, Washington, for 31 years. He specializes in arthroscopic surgery of the knee and shoulder and has been involved in coverage of sports events at both college and high school levels. His medical and orthopedic training was at the University of Oregon Medical School, and he did a fellowship in knee reconstructive surgery in Cincinnati.

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