Hazards Activity in Progress

Rockets lie cocooned in sheets of air-cushion packaging in the back of an SUV as David Holloway and Jack Caynon pot-hole bounce over two miles of high desert dirt road. At the entrance to the Brothers, Oregon, launch site they pass a warning sign, each corner anchored by a white skull and cross-bones against a blood red square. “DANGER. Hazardous Activity in Progress. Enter at your own RISK.”

Low, heavy clouds obscure the Cascade Range, still snow-covered in late June, and contradict the event title chosen by the Oregon Rocketry Club – Summer Skies 2008. The group has secured an FAA waiver to allow their rockets to fly as high as 20,000 feet above ground level all weekend, with time-slot windows for launches to 35,000 feet – the cruising altitude of a 747. Neither missile built by Salem Health’s Chief Medical Officer or its General Counsel will likely crack the 20k ceiling this weekend, but that doesn’t dampen the men’s enthusiasm.

Caynon pulls his rig through the sagebrush and into the Summer Skies 2008 encampment – a tailgate party without the football or beer. “We tend to be rule-followers,” Holloway says. “No one would consider pulling out any alcohol until after the range closes for the day. Then we can kick back and relax.”

In the desert-cool morning, rocketeers wear sweatshirts over jeans or cargo shorts; hiking boots or stout athletic shoes complete the uniform. Picnic tables shelter under gazebo tents set up along side barbeques, lounge chairs, and Winnebagos. Instead of potato salad and watermelon, solid propellant motors and toolboxes litter the tabletops and conversation tends toward “Joules” and “Newton’s.”

Holloway unpacks his rocket from the SUV. He built the eight-foot-tall, eighteen-pound missile in his Salem garage, painted it orange and black, and named it Pistol Pete after the mascot of his alma mater,
OMA/CNA PHYSICIANS PROGRAM: A STRONG PARTNERSHIP FOR MORE THAN 35 YEARS.

The OMA/CNA Physicians Protection Program provides:

- Local underwriting specialists and claim consultants
- Local counsel with health care liability expertise and experience defending Oregon physicians
- Risk management educational opportunities and instructional materials — created for doctors by doctors

By focusing on improving patient safety and reducing financial losses, we have returned over $53 million to OMA members as part of our unique profit-sharing program. If you’re looking for dependable medical professional liability insurance benefits and coverages from an A-rated national carrier … we can show you more.²⁴

For more information on the OMA/CNA Physicians Protection Program, contact CNA at 800-341-3684.

All products and services may not be available in all states. Use of the term partnership and/or partner should not be construed to represent a legally binding partnership. CNA is a service mark registered with the United States Patent and Trademark Office. Copyright © 2008 CNA. All rights reserved.
Edward Jenner: “Vaccine Clerk to the World”
PART II

By William Purnell, Jr., M.D.

Once upon a time smallpox, the “Speckled Monster,” was a dreaded, highly contagious infectious disease with an exceedingly high rate of morbidity and mortality. It had been endemic to human populations throughout recorded history. A mere three decades ago, smallpox had the potential to freely strike anyone in the world. Following an unprecedented global public health campaign conducted in the 1960s and 1970s, the last case of naturally acquired smallpox was reported in Somalia in 1977. The World Health Organiz-
In its 2008 Report to the Nation, the Association of Fiscal Examiners estimates that $994 billion is lost in United States due to fraud. So, what is fraud, how does it happen, how is it detected and how can it be prevented? Fraud falls into three broad categories:

- **Asset Misappropriation** – this includes theft of money, other than assets such as inventory and misuse of an employer’s resources or assets.
- **Corruption** – this includes kickbacks, conflicts of interest and extortion.
- **Fraudulent Statements** – this is the intentional misrepresentation of facts (including financial statements) with the aim of having someone rely on those misrepresentations to their detriment and the fraudster’s benefit.

In almost every fraud you will find that the fraudster has an incentive or pressure that creates motive, they are presented with the opportunity to commit fraud and they have the ability to rationalize their actions. These three elements comprise the fraud triangle.

The most common types of fraud businesses encounter are fraudulent disbursements such as false billings, check tampering, false expense reimbursements, payroll fraud and cash register disbursements; and theft of incoming receipts either before they are recorded (skimming) or after they have been recorded (larceny).

Studies indicate that only 20% of frauds are prosecuted, 40% are discovered but not prosecuted, and that leaves 40% that go undetected. With the amount of dollars involved in frauds annually, management should take an active interest in establishing a culture of honesty, high integrity, and good ethical behavior. Basic, fundamental approaches to good office procedures and controls can help establish prevention methods.

While our firm performs audits of financial statements, it should be noted the objective of a financial statement is not the detection of fraud. If management has designed good internal controls, they will prevent or at least detect occurrences of fraud in the normal course of business. In fact, according to the Association of Certified Fraud Examiners, tips reveal 46% of detected frauds, internal audit detects 19%, internal controls detect 23%, 19% is detected by external audit, 3% is found by police and 20% is detected by accident (the total of these percentages exceeds 100 as many times more than one method detects fraud).

Prevention starts at the top of any organization. Establish a business culture and environment that focuses on doing the right things for the right reasons. Evaluate the risks in your business, where/when might fraud occur? Develop processes, procedures, and controls to mitigate those risks and opportunities for fraud. The controls should consider separation of duties, authorization and approval, custodial and security arrangements, review and reconciliation, physical controls, training and supervision, documentation, and cost/benefit analysis. Understanding the fraud triangle is the first step toward limiting fraud. The element of the triangle that management has the most control over is opportunity. Start there by employing strong internal controls over your financial processes and follow through with continual attention and monitoring.

Doug Parham, CPA is a partner with the firm of Boldt, Carlisle & Smith, LLC, Certified Public Accountants, which serves clients throughout the Willamette Valley and around Oregon from offices in Salem, Stayton, and Albany. He can be reached at (503) 585-7751 or at dparham@bcsllc.com. For more information please see www.bcsllc.com.
In the last two editions of Chart-Notes®, you’ve been getting information about the Project Access Program that the Foundation’s Medical Board is working to establish for uninsured residents of Marion & Polk counties. Barbara Halsey, who retired as Director of Medical Staff Services at Salem Hospital, is working on a part-time basis as Administrative Director for this program. An ad hoc Project Access Committee has been appointed to define the program and services that will be offered. Members of our ad hoc committee are: Dr. Ron Jaecks, Tom Chambers, Putnam Roberts, Barbara Halsey and me.

The primary role of the Project Access Program in our community is to codify the free medical care to uninsured patients that is already being done. Our doctors are already doing wonderful work! Once there is a Project Access system in place, all our physicians, and hospitals doing this work will get the recognition and credit for their services.

The benefit of the program to you is when someone refers an uninsured patient, you will be able to call the Project Access staff to coordinate the patient flow and referral, and not spend time doing a lot of paperwork. Keep in mind that the Project Access program will not do anything to affect the usual care of uninsured patients. If the uninsured patient is eligible for medical insurance of some type, Project Access staff will assist the patient in obtaining this insurance.

The goal of the Project Access program is to provide the necessary medical services for people until they get insured.

Members of our ad hoc committee will soon be contacting you regarding your participation in this program. If you have any questions, or if you wish to volunteer to be a physician champion to spread the word about this very worthwhile program, please contact me, any member of our ad hoc committee or Dean Larsen.

**FOR SALE • HUGE PRICE REDUCTION!!!** B&B and vineyard 15 minutes from Salem. 20+ acres w/ 7 acres of grapes. Estate manor 3900SF on 3 levels w/ 5 BR - 4.5 BA. Fantastic views. Personal winery. Fish stocked pond. Walking trails. C/B Mtn West

Andy Alsok 800-637-5263


**PHYSICIAN OFFICE SPACE** Available for short or long term lease. Located in Neurosurgeon’s office on Liberty St. S. close to Salem Hospital. Space includes approximately 2000SF of private office space and additional workstation for support staff. For information call or email Judy at 503-581-5517 or judy@collada.mvipa.org
Smell the raw fear in the air! It is everywhere. What is needed now is a sense of perspective. As I write this on October 11, I hope that fear and the hemorrhaging on the world financial markets will have abated by the time you are reading this. Meanwhile, here are my answers to some very common questions and comments.

1. Despite government and central bank actions, the markets still go down. What’s driving this? There are many factors, well beyond the space limits of this article. But at its essence I would say 90% fear and 10% fundamentals. When a good company like IBM announces a very positive earnings surprise, and then gets trounced along with everything else, that is reptilian-brained fear at its worst. And both political parties are making things worse with their fear-based rhetoric.

2. When will this end? I don’t know, and frankly anyone who says they do is not being intellectually honest. But think about the medications or treatments you prescribe. Do they work instantly? No, and neither will all of the governmental and central bank interventions. They need time. We didn’t get into this mess in just one month. Don’t expect to get out of it in one week.

This is one of those situations where you just have to step back and think rationally. What would happen if every stock were worthless? For that to happen there would be no economic activity and no businesses making a profit. We wouldn’t be purchasing gas for our cars, toothpaste, groceries, medications, telephone and Internet services, clothing, movie tickets, vacations, electricity, military equipment, and much more. If that were the case, bank accounts or bonds would be worthless, too. Do you really think that Wal-Mart, Procter and Gamble, Pfizer, Microsoft, Chevron, and Google are going to go out of business? We can’t make a run on them like we can a bank.

3. Is this 1929 and the Great Depression all over again? Although we are going through extraordinary times, a number of factors make this market crash very different from those of 1929, especially the Fed’s proactivity.

- In the 1920s stock market, stock prices rose faster than earnings and market valuations were very high, making conditions more similar to the dot-com bust than the current market. Today, earnings are rising faster than stock prices and valuations are at their lowest in the last 18 years. (Source: Bloomberg Finance, LP, 09/18/08)

- Today’s problems are rooted in speculation and over-leveraging of the credit and bond markets. In 1929 the problems originated with stocks. There were no regulations on margin lending. Investors could buy stocks for pennies on the dollar.

- In the 1920s, monetary policy was tight—meaning that interest rates were high. The Fed kept them high even as the markets crashed. In contrast, during the current crisis, the Fed has been very accommodative, pumping a huge amount of money into the system. And unlike in 1929, the world’s central banks are very cooperative.

Continued on page 7
• In the 1929 situation, world governments imposed tariffs. Today, our markets are open and our corporations operate in a global economic environment. Exports are the bright spot in our economy.
• Many regulations and laws passed in the 1930s and 1940s have served us well in other bad markets including the 1987 crash. Just about everyone now agrees that they need updating and stronger enforcement. In addition, we have the FDIC for deposit insurance and state insurance guarantee associations for insurance.
• Our economy is far more diversified and less dependent upon agriculture and manufacturing.

4. When my account gets down to $____, I want out. Or, I want out now. The question is, at what point will you get back in? Where it is at right now? Or 30% higher? If you are nervous now, will you really get in at the bottom of the market when the news is even more negative? Most market recoveries start suddenly with the largest gains in the early days. You will surely miss them. If you get out now, you are locking in your losses and may never recover. With market swings of 1-7% in any given day, you could easily miss a recovery or get whipsawed by when your trades get executed.

5. How long before I get back to “even?” Short two or three excellent years in the stock market, it will take time. If you are still obsessed with getting back to where you were, remember that your account has to increase by a higher percentage than it fell. To figure the percentage gain required, simply divide the amount of the loss by your current account value.

But getting back to even or to your peak value is probably not the point. The real point is what will it take to reach your goals now? A competent advisor can help you determine your “magic number,” and help you figure out what it will take to reach it. It might be a combination of increased savings, putting your lazy dollars harder to work, tax savings strategies, working longer, or adjusting your goals.

6. Where can I move my money? There are no perfect alternatives. We are in the midst of a cycle that could last two to five years, but you may be making a decision that can affect the next 20 or 30 years. Money market accounts yielding less than 2% before inflation and taxes will not get your children through college and you to and through retirement.

7. I’m retired. I don’t want my portfolio to go down to zero. Your portfolio value is a function of its earnings and your withdrawal rate. Is the withdrawal sustainable under different assumptions? Seek advice to find out. Perhaps reducing your monthly withdrawals or postponing a major expenditure at this time is wise.

9. What should I do now?
• Get your emotions under control. Just taking a few minutes each day to reflect on your many blessings is a great way to keep some balance. Recognize where you are on the Fear and Greed chart.
• Limit your consumption of financial and political news coverage.
• Control what you can control, such as your spending and saving. As physicians, many of you have the

<table>
<thead>
<tr>
<th>% Loss Sustained</th>
<th>-10%</th>
<th>-15%</th>
<th>-25%</th>
<th>-50%</th>
<th>-75%</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Gain Required</td>
<td>+11.11%</td>
<td>+17.65%</td>
<td>+33.33%</td>
<td>+100%</td>
<td>+300%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>% Rate of Return</th>
<th>2%</th>
<th>4%</th>
<th>6%</th>
<th>8%</th>
<th>10%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Years Required</td>
<td>36</td>
<td>18</td>
<td>12</td>
<td>9</td>
<td>7.2</td>
</tr>
</tbody>
</table>

*Based on the Rule of 72. These are hypothetical, non-guaranteed returns not representing any specific investment.
On Friday, October 17, over 70 people attended this year’s Political Mixer at j.james restaurant. Physicians and their guests as well as six elected officials and three candidates for office had a chance to meet in a relaxed social atmosphere to enjoy good food, music and an evening of shared collegiality. Response on the evening has been very positive. If you were not able to attend please be watching for next year’s event. Until then, please enjoy a few photos from the evening’s festivities.
As most of you are already aware, we are critically short of physicians taking new patients. On a daily basis we receive over 30 calls from people in the community asking for our assistance to help them to find a physician. This number does not include those accessing our website referral system, nor does it account for those calling into our automated line for a primary care physician.

Please ask your administrators and office managers to call or fax our office whenever your practice is open to new patients. We will promptly add you to our referral list. On the same note, if your practice is full please call our office so that we will know to remove your practices from the list until we are notified that you are open again to new patients. As you can imagine, to do this efficiently we will almost need to be notified on a weekly basis, but by working together we will be better able to serve the people of Marion and Polk Counties.

Thank you so much for your help on this. If you have any questions or comments please do not hesitate to call our office at (503) 362-9669. We will be happy to take any updated information or help walk your representative through the steps to update and access your clinic’s information on our website.
McCain said $10 million; Obama said $7 Million. McCain said 15% tax; Obama said 45%. The estate tax is what they were discussing, of course. And while the election is now over and we have our new historic executive team, as far as the estate tax goes, the politics, posturing, positioning and promising have only just begun. What will the ultimate outcome be? No one knows. Political football season is underway and the estate tax is going to get tossed around a lot.

History of the Estate Tax

If you examine the history of the estate tax you will find some interesting facts. The first estate tax was enacted in 1797 to help construct a Navy for America. It was repealed in 1802. Its next appearance was in 1862 to help pay for the Civil War. This version was repealed in 1870 because the war had ended and, frankly, the tax didn’t raise much revenue anyway. For most of the early years, the estate tax was utilized to raise money for specific issues, mostly to pay for preparedness for war or to repay debt. Even after Roosevelt and Andrew Carnegie tried to raise the banner that the estate tax should be about the “redistribution of wealth” and to preserve opportunity and fairness, the next time Congress actually imposed the estate tax was to help pay for World War I.

Minimal Revenue

The estate tax, inheritance tax, gift tax and its many variations have come and gone many times in our economic history. Tax rates have been as high as 70%, exemptions have been raised and lowered, the gift tax has been unified and then un-unified and the rules keep changing. And when all is said and done, the estate tax still represents only about 1% of the total federal revenue receipts. The real dollars are not a small number, however. Estimates have 2009 collections at $44 Billion. And only about 5% of estates will ever be subject to the tax. The challenge for the politicians is that total repeal of the tax is just too unpopular and politically incorrect especially in a time of serious budget deficits.

Moving the Cheese

The problem for those of us, who live with these rules daily, is that the public often thinks a campaign promise or posture will actually come true. So they procrastinate with the hopes that some outside force will improve their situation so they don’t have to do anything themselves. What I understand as a seasoned estate planning attorney is only the current rules exist, and these rules are all we can use to plan with now. When and if the rules change, we’ll learn the new rules and design our plans accordingly. Everything else is conjecture and speculation and political posturing. Changes will likely take place. They always have and always will. What will change and how it will change is what we don’t know and can’t (and shouldn’t) guess.

A Voluntary Tax

What most of the “history” articles don’t discuss is that the estate tax is voluntary. We can and often do, design ways for our clients to structure their estates so that they won’t owe any estate tax whatsoever. Planning now, no matter how the law eventually changes is the smartest thing that any family can do.

What is most important to remember, however, is that good estate planning is not just about taxes; it is about planning ahead for incapacity, maximizing personal control while minimizing outside interference from the courts, and creating a legacy of values for your loved ones to inherit after you are gone. That is the true hallmark of a successful estate plan.
From July – September 2008, the Marion County Health Department, in partnership with the Chronic Disease Prevention Subcommittee of the Health Advisory Board, conducted a community needs assessment. The assessment describes the current demographics and risk behaviors of Marion County residents. It also reviews what, if any, health promotion policies are in place in communities, schools, health systems, and the workplace of Marion County.

As many health professionals know, poor diet, lack of exercise, and tobacco use are associated with the development of many chronic diseases. Research shows that policy-based initiatives are an effective strategy for large-scale behavior change. Determining the type and number of nutrition, exercise, and tobacco policies that are in place helps identify areas of strength as well as areas where policies are needed.

Ultimately, the assessment will be used to develop a plan that will support the community in developing and implementing policies that make the healthy choice the easy choice. The plan will be guided by the assessment as well as the chronic disease prevention subcommittee’s vision and mission. The main findings of the assessment are reported below.

**Vision:** All people in Marion County will live, work, play, and learn in communities that support health and optimal quality of life.

**Mission:** To advance policies, environments, and systems that promote health and prevent, reduce, and manage chronic disease.

**Demographics**

Marion County is home to over 310,000 residents. Twenty-six percent of the population is under the age of 18; 12% is 65 years of age and older, but this rises to 18% in Mt. Angel and Woodburn. Most of the residents are white, with over 20% of the population being of Hispanic decent. What’s more, over 50% of the population in Woodburn and Gervais are Hispanic. In general, the population is poorer and less educated than Oregon residents as a whole. Over 17% of Marion County residents are uninsured. The percent of students eligible for free and reduced lunches varies widely, from 35% in Silverton to 76% and 88% in Gervais and Woodburn respectively.

Residents of Marion County are more likely to be obese than residents of Oregon as a whole. This trend may continue as significantly more Marion County 8th graders are overweight (13%) than Oregon 8th graders (10%). Less than half of all 8th and 11th graders eat breakfast every day, and less than one-quarter consume 5 or more fruits and vegetables per day. Nearly 60% of 8th graders participate in daily physical education; however, this declines to 33% by 11th grade. Fifteen percent of Marion County 11th graders report smoking cigarettes in the past 30 days as compared to 20% of Marion County adults.

In 2003, Cancer surpassed heart disease as the leading cause of death in Marion County. Significantly more people die of cancer and of stroke in Marion County than in Oregon as a whole (208.4 per 100,000 vs. 198.4 per 100,000). Seven percent of Marion County residents have been diagnosed with diabetes; this is expected to grow as it is estimated that one in three first graders will develop diabetes at some point in their lifetime.

**Community Perceived Needs**

The Chronic Disease Prevention Subcommittee discussed the perceived
needs for chronic disease prevention. The top three needs identified were tobacco prevention, obesity prevention and management, and diabetes prevention and management. Barriers to addressing these needs include but are not limited to lack of access to care and chronic disease management programs, poverty, low literacy, lack of affordable healthy foods and exercise options, lack of proximity to grocery stores in rural communities as well as barriers due to language and culture.

**Tobacco Policies**

Most workplaces and all schools in Oregon are required by law to be smoke and/or tobacco-free. Additional tobacco-free policies in Marion County seem to be limited. Marion County has a Parks Ordinance that prohibits smoking on park trails, bridle paths, restrooms and in fire risk areas in all Marion County Parks. The city of Silverton has adopted a Municipal Code regarding the Regulation of Tobacco Products. Multi-housing property management companies are also developing and implementing tobacco-free policies. Guardian Management properties are tobacco-free, and Landura Management and Marion County Housing Authority are in the process of developing tobacco-free policies.

**Nutrition Policies**

Community-based nutrition policies include policies that support farmers markets and community gardens. In 2002, Marion County joined with the Salem Mass Transit District in entering a license agreement with Salem Saturday Market to operate a farmers market. Although no formal policies exist, the Cities of Salem and Silverton support farmers markets by providing logistical support and/or use of public land for markets. The City of Salem also has a license agreement with Community Sun Gardens to help foster community gardens and the City of Stayton has developed an application process for use of 26 community garden plots.

There are 7 farmers markets and over 20 community gardens throughout Marion County. Of note, the Marion Polk Food Share has recently partnered with several community members to develop a 20-acre farm near the Santiam Correctional Institute. WILCO and Marion Ag Services donated pre-planting materials. Volunteers from local farms planted bean seeds. Volunteers from the correctional facility will irrigate and maintain the field. Truitt Brothers will harvest the beans, and local canneries will process and package the beans. Once processed, the beans will be distributed to Marion Polk Food Banks.

**Built Environment – Design for Health**

The built environment can be designed to support health through policy objectives stated in the County Transportation Plan, Land Use Plan, and Recreation Plan. None of the County plans specifically state health promotion as a goal. The Marion County plans include some items that could benefit health, such as allowing the clustering of activities together, incorporating a variety of housing densities, plans to prioritize the transportation needs of the underserved, and plans to support local food production. Overall, however, there is a lack of stated objectives in that support walking, cycling, and access to healthy food choices (e.g.,

---

**Financial Planning**

ability to earn more by seeing a few more patients each week.

- If you have funds available, this is a great time to buy low or contribute to your retirement plan.
- Seek competent financial advice before making moves you will regret later. This may be an excellent time to evaluate the risk profile of your portfolio now that you know how risk really bothers you.
- Stop the toxic blame game—in one way or another most of us have benefited from appreciating home and stock market prices, lines of credit and cheap mortgages.
- Don’t count the United States out. We’re not so good about the carpenter ants in the basement, but we have an impressive track record of dealing with the wolves at the door. We will get through this!
street lighting, off-street trail systems, lower speed limits, ensuring that grocery stores are available throughout the municipality).

**Self-Management Programs**

Chronic Disease Self-Management Programs provide support and resources to people living with chronic diseases. The Living Well (English) / Tomondo Control (Spanish) program is being offered on a fairly regular basis in Salem, Silverton, and Woodburn; however there are no classes in other Marion County communities.

**Schools**

Marion County is home to ten school districts: Cascade, Gervais, Jefferson, Mt. Angel, North Marion, North Santiam, Salem-Keizer, Silver Falls, St. Paul, and Woodburn. All school districts have tobacco-free policies; Cascade, Jefferson, and St. Paul have gold standard policies. All school districts have Wellness Policies in place that address nutrition and physical activity, although none of the policies contain all items suggested in the model policy developed by the Oregon Nutrition Policy Alliance. All school districts are successfully meeting the nutrition requirements set forth in House Bill 2650. They are offering fresh fruits and vegetables and are limiting calorie, fat, and sodium content of meals, snacks, and beverages. Mt. Angel and some schools in Salem-Keizer only allow foods that meet minimum nutritional standards to be used in fundraising efforts. Cascade, Mt. Angel, N. Marion, Salem-Keizer, and Silver Falls policies discourage use of food for rewards. Although all school district policies state that physical activity will be provided for students, only St. Paul and Woodburn School Districts specify the number of minutes of physical activity offered (grades K-5 = 150 minutes; grades 6-12 = 225 minutes) in their policy. None of the school Wellness policies include information on Safe Routes to School.

**Health Systems**

There are three main hospitals in Marion County: Salem Hospital, Santiam Hospital, and Silverton Hospital. Salem Hospital and Silverton Hospital have campus-wide comprehensive tobacco-free policies in place. These policies prohibit the use of tobacco anywhere on hospital premises; they also state that hospital staff must be free from tobacco odor during work hours. The policies ensure that tobacco cessation resources are...
available to staff and patients. In November 2008, Santiam Hospital will be kicking off a similar campus-wide tobacco-free policy. At this time, the Federally Qualified Health Centers, Yakima Valley Farm Workers Clinic and Northwest Human Services, do not have tobacco-free policies in place.

Worksites
The Oregon Healthy Worksites Assessment was completed for the worksite of Marion County as a whole. Overall, the assessment was mixed. There is Senior-level management support for wellness, as evidenced by the recent approval for creating a “Safety and Wellness Coordinator” position in Marion County. The Marion County health benefits package includes support for tobacco cessation, preventive screenings, and chronic disease self-management programs. Incentives are offered for employees to use alternative modes of transportation and to quit smoking. Individual health assessments were offered to all employees from 1996-2006 and will be reinstated on an annual basis in 2009.

Although there is some support for health promotion, the assessment revealed that Marion County is lacking in specific policies. For example, the County does not have a tobacco-free policy, a policy that requires healthy food choices be offered in vending machines, or one that supports flex-time for physical activity.

Next Steps
The information described above will be used to assess where and how to implement policies that will make the healthy choice the easy choice. This will ultimately help fulfill the mission that All people in Marion County will live, work, play, and learn in communities that support health and optimal quality of life.

Chronic Disease Prevention . . .


tion officially declared smallpox to be eradicated in 1980. The Speckled Monster was pronounced dead. Today smallpox is all but forgotten. But, is it truly gone?

Recapping preceding ChartNotes® articles in this series, the story of smallpox goes back to the dawn of civilization, approximately 10,000 years ago. Humans first acquired the disease from domesticated cattle when man and beast began to live and work together in close proximity. Fast-forwarding to the 18th Century, smallpox had become one of the leading causes of death worldwide. Even in the 20th Century, smallpox claimed over 300 million lives, three times the number lost to all wars of that century.

In its heyday, smallpox preyed upon individuals of all ages and in all strata of society. Children were especially vulnerable. It devastated entire civilizations. There was no cure. Until relatively recent times the etiology, epidemiology and pathophysiology of smallpox, like all infectious diseases, was not understood. For millennia, smallpox was simply a fact of life from which few escaped unscathed.

Inoculation, a procedure originating in the Far East during the Middle Ages and introduced to the West in the early 18th Century, was the first step toward eradication of the Speckled Monster. Inoculation involved scratching a small amount of pus taken from an active smallpox victim into the skin of a healthy person’s arm. Typically, a much more limited form of the disease ensued after which lifelong immunity was acquired. But inoculation, also called “variolation” or, pejoratively, “buying the pox,” was not infrequently associated with serious complications. For example, rather than inducing limited disease, as was the intent, improperly performed variolation could result in a fatal case of smallpox. Variolation sometimes started full-blown epidemics. And direct patient-to-patient inoculations often inadvertently transmitted other serious infectious diseases.

In order to stem these complications, many procedural variations emerged early in the 18th Century. Some, such as those developed by Robert Sutton of Suffolk, England, were empirically based and proved beneficial. They included patient isolation (ideally at home, but all too often in cold, crowded and unsanitary “inoculation stables”), intradermal rather than deep soft tissue inoculation and forgoing dressings so as to promote healing of lesions in the open air.

Other protocols, rooted in ancient Humoralism, were detrimental. They exacerbated the discomforts and risks of variolation by the addition of bleeding, purgatives and dietary restrictions. A description of one young English boy’s preparation for variolation in 1760 is illustrative:

“He was a fine, ruddy boy, and, at eight years of age was, with many others, put under a preparatory process for inoculation with the smallpox. This preparation lasted six weeks. He was bled to ascertain whether his blood was fine; was purged repeatedly, till he became emaciated and feeble; he was kept on a low diet … and dosed with a diet drink to sweeten his blood.”

Three years earlier, in 1757, another young English country lad, Edward Jenner, was subjected to a similar variolation procedure. Frightful memories of that experience almost certainly drove Jenner’s desire,
as a practicing physician in Berkeley, Gloucestershire, to scientifically validate a potentially more benign but then controversial procedure.

Jenner wanted to test the veracity of folk tales that milkmaids who had been infected with cowpox were immune to smallpox. His hypothesis was “that the Cow-pox protects the human constitution from the infection of the Small-pox.” If true, “vaccination,” or inoculation using safer cowpox pus could replace “variolation,” or inoculation using riskier smallpox pus. (In Jenner’s honor, the great French bacteriologist Louis Pasteur later extended the definition of “vaccination” to include inoculation against any infectious disease.)

After the failure of his first milkmaid vaccination trials during the Berkeley smallpox epidemic of 1778, Jenner postulated that the ability of cowpox exposure to confer immunity to smallpox depended upon the stage of the cowpox infection. Jenner theorized that, for reasons he did not understand, infected matter from cowpox pustules produced immunity only when collected at the height of the disease process. Milkmaids could, therefore, fail to develop immunity to smallpox if exposed to cowpox pus obtained either too early or too late in the course of the disease.

Following a long hiatus, cowpox returned to the Berkeley countryside in the spring of 1796. In early May 1796, a 19-year-old milkmaid by the name of Sarah Nelmes contracted cowpox from a Gloucester cow called Blossom. Before milking Blossom, Sarah had pricked her finger on a thorn. Blossom happened to have large cowpox pustules on her udder at the time. (Blossom’s hide is now displayed at St. George’s Hospital, London, where Jenner trained under the great surgeon John Hunter; Blossom’s horns can be seen at the Jenner Museum, Berkeley).

Sara developed cowpox pustules on her hand and, after presenting to Jenner for consultation, agreed to participate in a new clinical trial. Jenner then received consent from the parents of a young boy named James Phipps to vaccinate him on May 14, 1796. Phipps had neither contracted smallpox or cowpox before nor had he been variolated. Jenner used pus from the hand of Sara Nelmes at the height of her clinical illness for the procedure. Jenner wrote in his notebook:

“To more accurately observe the progress of the infection I selected a healthy boy, about eight years old. The matter was taken from a sore on the hand of a dairymaid, who was infected by her master’s cows, and it was inserted, on the 14th of May, 1796 into the arm of the boy by two incisions, each about half an inch long.”

Continued on page 17
“On the seventh day he (James Phipps) complained of uneasiness in the axilla, and on the ninth day he became a little chilly, lost his appetite, and had a slight headache. During the whole of this day he was uncomfortable, and spent the night with some degree of restlessness, but on the following day was perfectly well.” James developed characteristic cowpox pustules at the vaccination site followed in turn by scabs that eventually fell off.

The Speckled Monster also returned to Berkeley in the spring of 1796, after a period of quiescence. This gave Jenner the opportunity he needed to determine whether James Phipps, newly vaccinated with cowpox, was now truly resistant to smallpox. On July 1, 1796 Jenner obtained pus from a patient with a severe case of smallpox. He then variolated James. The smallpox did not “take.” There was no reaction. Young Phipps was immune!

Jenner summarized the sequence of events in a letter to a friend, Edward Gardner, on July 19, 1796, eighteen days after attempting to variolate James Phipps with smallpox:

“A boy of the name of Phipps was inoculated in the arm from the pustule on the hand of a young woman who was infected by her master’s cows. Having never seen the disease but in its casual way before, that is when communicated from the cow to the hand of the milker, I was astonished at the close resemblance of the pustules in some of their stages to the smallpox pustules. But now, listen to the most delightful part of my story. The boy has since been inoculated for the smallpox which, as I ventured to predict, produced no effect. I shall now pursue my experiments with redoubled ardor.”

Jenner did just that, and with continued success. Over the next two years, Jenner conducted research in Berkeley using his improved collection technique in trials that were

Continued on page 18
more scientifically controlled. He even included his eighteen-month-old son, Robert F. Jenner, in one of the trials. Jenner submitted his findings to the Royal Society, London, in a series of three reports. The first paper, offered in 1797, was entitled “An inquiry into the causes and effects of the Variolae Vaccinae, a disease discovered in some of the western counties of England, particularly Gloucestershire, and known by the name of the Cow Pox.” Two addenda followed, in 1798 and 1799.

The Royal Society was at first cautious in its response to Jenner’s findings. It ultimately accepted a revised report of twenty-three vaccination cases. Jenner’s initial work met with active opposition from various members of society including doctors, clergymen and the press. Some claimed that vaccination was actually more dangerous than variolation. Others predicted that vaccination would dehumanize or “bovinize” people. Rumors circulated of a vaccinated bellowing “ox-faced boy” and of a hairy girl who “coughed like a cow.”

Ah, Jenner, je ne puis rien refuser a Jenner.”
(“Ah, Jenner, I can refuse him nothing”)  
NAPOLeON BONAPARTE  
(1769-1821)  
Response to Jenner’s petition for release of Napoleonic War prisoners, 1804

The tide of public opinion turned in favor of vaccination as physicians in England and throughout the world began validating Jenner’s work. In 1803 the Jennerian Institution was founded in London to promote vaccination as a means of eradicating smallpox. Large-scale vaccinations were begun in Europe (notwithstanding the ongoing Napoleonic Wars), Australia and the Americas.

The Cow Pock or the Wonderful Effects of the New Inoculation!  
Etching and aquatint by James Gillray (1757-1815)  
Published by Hannah Humphrey, London, June 12, 1802

Napoleon Bonaparte, who disliked physicians but greatly admired Jenner for his discovery, ordered his army to be vaccinated. After experiments by Dr. Benjamin Waterhouse in Boston confirmed Jenner’s findings, President Thomas Jefferson vaccinated his family and sent army doctors to the newly purchased Louisiana Territory to vaccinate Native Americans, who were especially vulnerable to smallpox. By 1840 variolation had been banned in England. In 1853 vaccination was made compulsory.

Edward Jenner continued vaccination research throughout the remainder of his life. He also maintained his cherished medical practice in Berkeley, offering free weekly vaccinations for the needy of his community. Jenner suffered a stroke in 1823, dying at the age of 73. Despite repeated setbacks and the initial derision of his peers, Jenner received numerous accolades from a grateful world in his latter years. Now considered to be the father of modern Immunology, Jenner was always modest about

“Future nations will know by history only that the loathsome smallpox has existed and by you has been extirpated.”

THOMAS JEFFERSON  
(1743-1826)  
From a letter to Edward Jenner, 1806

Continued on page 19
As many of you are aware, MVIPA and Marion-Polk County Medical Society entered into a number of agreements at the beginning of this year, most notably teaming together to assist in recruiting physicians to our area and for the Medical Society to manage Physicians Choice Foundation, MVIPA’s newly formed charitable organization. Since that time we have been quietly working together to launch a number of programs and initiatives related to these agreements.

In physician recruiting we have defined our purpose to assist clinics as well as individual practitioners in their efforts to recruit physicians as well as mid-level providers to practice in Marion and Polk Counties. Obviously a main focus is primary care, but we are not ignoring other areas where access to care is a major problem. Toward this end we have hired Linda Safina-Massey to work full time on all things related to physician recruitment and to assist me in those efforts. So, what have we done so far?

We have hired Ken Graven, M.D. to serve as Medical Director for a rebuilt, revamped, and improved Clinical Residency Rotation program. Previously the program was exclusive to the internist program at Legacy Hospital in Portland. Although small in the number of residents who rotated through each year, it proved highly effective by retaining a large percentage of those residents to practice in our area. The new program will reestablish the Legacy connection, but will also expand to other specialties through OHSU and possibly Providence. Once the program is fully developed, we are looking at the potential of expanding it to medical schools outside the state.

Marketing materials have been developed that carry a common theme around what a great place the Willamette Valley is to live and work. These materials are available at no charge to local physicians to use in their own recruiting efforts as we have used them at physician job fairs this year in Dallas/Fort Worth, Albuquerque, Los Angeles, and Chicago. In addition, we have developed an 8-minute DVD that provides a visual tour of our area and virtual plethora of things Oregon in general and the Willamette Valley in particular have to offer. This DVD was developed so that clinics can have their own message seamlessly inserted if desired, but stands well on its own if not. Copies can be obtained from the Medical Society at our cost of $10 each.

To-date we have been able to help facilitate the hiring of two physicians, hosted a visit by a physician and his spouse interested in our area and are working on another. We continue our search for eighteen physicians at several clinics who have notified us of their needs. We have partnered with the Salem Hospital recruiting effort when it has been advantageous to all concerned and continue to look for ways where our individual efforts can compliment each other for the good of our communities.

Physicians Choice Foundation has two primary programs: Salem Area Community Health Information Exchange (SACHIE) and Marion-Polk Obstetrics Mentoring Services (MOMS).

The impetus of the MOMS program emerged as a response to the growing methamphetamine epidemic in the Marion and Polk County areas. Early on in the administration of the Marion Polk Communities Health Plan, it became clear that a number of eligible pregnant women were not accessing prenatal care. Through further exploration, it was discovered that many of these women had alcohol or drug (often meth) addictions and many had previously lost parental custody of their children due to issues resulting from these addictions. Some of these women did not access health care and social services because they...
were unaware of how to do so. But still others were purposely attempting to “fly under the radar.” If these women’s minds if their pregnancy wasn’t detected “by the system,” they stood a better chance of keeping their baby. Therefore, the two things (treatment and prenatal care) that would actually increase the likelihood of having a successful pregnancy and transitioning into custodial parenting were being purposely avoided.

To-date the program has had a phenomenal 100% success rate with over 80 clean births. The ultimate success of the program goes beyond a baby born with alcohol or drug related problems. Ultimate success is also dependent on the mother not falling back on old habits after the birth. The recidivism rate for addicted mothers is very high if follow-up care is not available. However, if the mother can be kept in the program for 15 months post partum the recidivism rate falls dramatically. Currently these mothers are covered under OHP for three months post-partum. We are actively pursuing grant monies to fund the additional thirteen months of the program and expand the number of women who can enroll. In the meantime, the program continues to serve a small population with the support of the MVIPA.

Collecting, managing, and sharing critical patient information across a wide health care community represents a tremendous opportunity to improve access to quality and affordable health care. Salem Area Community Health Information Exchange (SACHIE) not only will enhance access to quality and affordable health care but also will leverage the estimated $8 million investment made on Electronic Medical Records Systems by health care providers in the greater Salem area. However, prior to launching SACHIE, a number of critical steps must be taken. These steps will ensure SACHIE is:

- **Integrated** – SACHIE must be able to accommodate the widest range of EMR systems already in use in the community.
- **Inclusive** – SACHIE must be developed in coordination with the individuals and organizations who ultimately will be responsible for utilizing the system.
- **Systematic** – The launch of SACHIE must be coordinated in such a manner as to attract participants while optimizing the quality and cost improvements inherent in the system.
- **Flexible** – SACHIE must be able to address the anticipated needs of the community as well as respond to future needs that have yet to be conceived.
- **Safe** – The collection and storage of the data must be safe from external threats, as well as respect the ethical privacy requirements of the health care providers.
- **Sustainable** – There must be reliable and consistent revenue streams associated with SACHIE in order to ensure the operation and management of the system is uninterrupted.

The SACHIE program is in the second of three phases. Phase I was research and development of a framework for program development. This was accomplished over the last three years through a steering committee organized by MVIPA and much research by Dr. Greg Frasier and other MVIPA staff. Phase II is the codification of plans, in other words developing policies and procedures, a viable business plan that includes sustainability options, and a thorough implementation timeline. We are seeking grant monies to fund this critical stage in the process and take the program into phase three eligible for federal funds. Phase III is the implementation and adoption of the program beginning with the purchase of hardware and software followed by a phased roll-out and continuing full utilization with sustainable funding streams.

It has been a busy year of ramping up to what promises to be a very productive year in 2009.
The Duchess of York, formerly Miss Sarah Ferguson, is the second daughter of the late Major Ronald Ferguson and his former wife, the late Mrs. Hector Barrantes. The Duchess of York married The Prince Andrew, second son of Her Majesty The Queen and The Duke of Edinburgh, at Westminster Abbey on the 23rd of July 1986, at which time His Royal Highness was created The Duke of York, Earl of Inverness and Baron Killyleagh.

The Duke and Duchess of York have two daughters, Princess Beatrice Elizabeth Mary of York (age 20) and Princess Eugenie Victoria Helena of York (age 18).

In 2006 the Duchess founded Hartmoor, a lifestyle and media company based in New York that is devoted to promoting wellness and supporting motherhood. The company earmarks a portion of its profits for charity through the Sarah Ferguson Foundation. It is the Duchess's vision to pursue successful business ventures that will in turn have a positive social impact.

In 2007 the Duchess established the Sarah Ferguson Foundation in New York to fund programs that promote education and wellness (including efforts to curb obesity among children) worldwide. In 1993 the Duchess founded Children in Crisis, based in London, and she remains active in its mission to provide aid to forgotten children around the world. The Duchess recently toured CiC projects in Liberia, Sierra Leone, Chile, Poland, Albania, and Russia.

In Britain the Duchess is a long-standing patron to a number of British charities, including the Teenage Cancer Trust, Tommy's - The Baby Charity; The African Caribbean Leukemia Trust; The Motor Neurone Disease Association; The Chemical Dependency Centre; and Carr-Gomm. She also supports The Daisychain Foundation; Springboard for Children.

In addition, the Duchess of York has served as U. S. spokesperson for Weight Watchers International, Inc. since 1997.

The Duchess of York will be the featured patron for the 2009 Medical Foundation of Marion & Polk Counties fundraiser benefiting MedAssist and Project Access. The event will be held at the Historic Elsinore Theater in Salem the evening of Friday, April 3rd, 2009. Early bird tickets will be available for Medical Society members beginning in November and available to the general public in December. Sponsorship opportunities are available now that include a photo opportunity with the Duchess, admittance to a private mixer prior to her presentation, and preferred seating at the presentation.

Don't miss this opportunity to share an evening with the Duchess, friends and family while supporting a very worthwhile cause.
Oklahoma State. Compared to Pete, Caynon's replica of the Army's “free flight artillery rocket,” Little John, looks like a bruiser. Its eight-inch diameter airframe, twice Pete's four, Little John can fly four to eight times higher than the smaller rocket. Of course, its greater weight demands more thrust and Caynon's Level 3 certification clears him to buy beefier motors.

As the day warms, Central Oregon’s signature scents of sage and pumice fill the air and fleece gives way to t-shirts, sunglasses, and ball caps or floppy Tilley hats. With so much explosive material around, one might expect the aroma of black powder or cordite, but the rockets use the same sophisticated solid propellant as the Space Shuttle, pre-packaged into the motors. “If I could smell rocket fuel at launch,” Caynon says, “I'd be standing way too close.”

Holloway shoulders Pistol Pete for the short hike to the launch line. While model rockets don't require the scaffolding of a Gemini lift-off, they do need a stabilizing apparatus. At the line, a row of 10-foot-tall launch rods top two-foot tall tubular quad pod bases. Caynon helps thread the rod through launch lugs on Pete's airframe and Holloway checks the igniter hook up and launch control cord. After verifying angle and azimuth, they radio the range officer that they have completed pre-flight.

Standing by, Holloway doesn't worry about pushing the button that will send Pistol Pete into flight. He worries he may have missed some step in the wiring and his rocket will sit stubbornly on the pad like an obstinate child. He worries that he'll lose sight of it somewhere in the wide sky and be forced to track its locator signal across acres of scrubby desert. He worries that Pete will suffer a cato, rocket talk for “catastrophe,” that will leave it a twisted mass of fiberglass, aviation-grade aluminum, wire, and fabric.

Holloway already knows about pre-launch jitters. “Like a lot of guys at 10, 11, 12, I built these little model rockets. But then you get older and go on to other things. When I came to Salem and Jack told me grown-ups actually fly them, too, I couldn’t believe it.”

“These little model rockets” grossly understates reality. Roll back the calendar to July 1968, exactly one year before Neil Armstrong teed up a golf ball on the moon. That month, the Tulsa Tribune featured a very young David Holloway above the fold. The headline reads, “Boy May Make It To Space If His Sister Feeds the Animals” and a grainy photo shows three pre-teen boys with Beaver Cleaver haircuts bent over a tidy workbench.

Holloway figured manned-flight beyond the Solar System would require suspended animation and went to work sorting it all out. The future physiology major designed a series of cryogenic grasshopper...
experiments to test the roles of freezing method, insect orientation within the payload bay, launch, recovery, and thaw method necessary to produce maximum survival rate. By the time the Tulsa feature writer had come up with the photo caption, Future Astronauts? Holloway had already launched dozens, if not hundreds, of “bugged-flights.”

Even as a youngster, he understood clearly what it would take to become an astronaut. Jerry Gentry, his mother’s cousin and a test pilot in the Lifting Body program, sent him NASA information unavailable to most civilians at the time. Holloway had also spent his earliest years on Air Force bases during his father’s enlistment, steeped in a culture of flight, a culture of calculated risk, a can-do culture exemplified by Chuck Yeager and his own cousin Jerry.

Holloway might have gone the route of service academy appointment and astronaut training if his mechanical tinkering hadn’t caused him to insert his right hand into the business end of a boat winch far from the nearest hospital. Somewhere between the fan belt and the flywheel he discovered the vulnerability of his own flesh and bone, sacrificing a finger to the lesson. His parents put the amputated index finger on ice for the long drive to the nearest trauma-equipped hospital in hopes of reattachment, even though successful digital replantation still rated case study reports in the late 60s.

Somehow, through the fog of pain and fear that must have permeated the emergency room, OR, and rehabbing his index finger, a little corner of Holloway’s brain kept cataloguing the experiences, thinking, “how cool.” While his injury might not have excluded him from the Air Force, his attention had been diverted from outer space travel to the inner space world of medicine.

Holloway’s career includes direct patient care, practice building, clinic administration, creation of what might be the country’s first Chief Quality Officer position, and now his duties at Salem Health. As much as he enjoys his reconnection with the world of rocketry, Holloway doesn’t for a minute regret his decision to forego space for medical school. He does say, however, that if Virgin Galactic dropped their ticket price

Continued on page 24
from $200,000 to something more attainable, he'd sign up in a heartbeat to put himself in their payload bay.

When Caynon learned about Holloway's interests, he gave his new colleague a relatively inexpensive rocket kit. Now, a couple of years later, Holloway finds himself building increasingly sophisticated rockets. He says a cato for Pistol Pete wouldn't represent a huge financial loss; he estimates he only spent about $500 in parts and materials. A quick tally of the power tools, jigs, router bits and gizmos on and around his tidy workbench, however, suggests this isn't a shoe-string hobby, nor one devoted only to the rocket range. "I love everything from the planning and drafting to fabrication and flying," he says. "There's always something new to learn or to do better, with a wide spectrum from the challenge of exactly replicating an existing rocket to building the biggest brute you can."

"And it's still less expensive than golf," Holloway's wife, Lisa, says. She doesn't seem to mind sharing the garage with sheets of fiberglass, aviation-grade plywood, and an ATF-approved storage magazine. Besides, except during launch weekends, she knows exactly where to find her husband. If he's not at the hospital, he'll probably be tinkering at the workbench and checking items off a precise to-do list posted next to the color-coded collection of drill bits.

A big brother for Pistol Pete, twice his diameter at eight inches, has already moved from the drawing board to cardboard-model stage. A couple of plywood end plates lie on the bench next to a butane torch, each designed to hold a central lift-off motor and two outboard booster air start motors. During the winter months Holloway will construct the fiberglass version — although he promises the mock-up will fly. He also plans to bring it all full circle to his kit days of childhood and build a scale model of NASA's Nike Smoke missile.

Standing knee-deep in sagebrush, Holloway waits, hoping to see Pete perform. The range office pushes the pad #2 button and for a fraction of a second nothing seems to happen. A crack sounds and smoke, appearing beneath the nozzle, roils across the ground, spreading like pond ripples around a dropped stone. Pete hovers for an instant and then shoots upward...
Hazardous Activity in Progress . . . continued from page 24.

with the familiar *faa-shew* of lift off. Holloway holds a pair of pocket binoculars to his eyes and watches four seconds of flame push Pete toward the clouds. The fuel spent; forward momentum battles gravity for a little while longer. The onboard computer recognizes apogee, just before the orange and black starts to fall, and signals a small drogue parachute to open, slowing descent without providing so much sail surface that the whole thing drifts to Idaho. At 800 feet above launch elevation, the computer signals the main parachute to open.

Holloway maintains visual contact as the rocket settles gently to earth. The landowner who loans his property to Oregon Rocketry several times a year prohibits powered vehicles from going off-road, so a precision touchdown saves the rocketeer a long walk over rough terrain.

High desert clouds dissipate over the next few days, leaving just a few cirrus ribbons to backdrop Summer Skies rocket photos. The white-coated mountains, 75 miles to the west, snap into sharp focus. Holloway launches Pistol Pete several more times and Caynon’s Little John hits 18,000 feet. Neither suffers a cato and no one experiences any close encounters with rattle snakes, heat exhaustion, or errant fly wheels. “Rockets Magazine” records the event in written, photo, and video formats, the images available at their website. On the way back to Salem, Holloway and Caynon bounce over a couple of miles of unimproved desert road. Pistol Pete and Little John lie cocooned in sheets of air-cushion packaging material, a little scuffed, a little scraped, but ready for their next shot at the launch line.
Keizer Public Arts

Keizer Public Arts is the next step in our community’s evolution! Keizer Public Arts (KPA) is the long term vision of Keizer’s Mayor Lore Christopher that will come to fruition in three phases. Phase one is to place 7-10 outdoor sculptures, created by local artists, throughout the River Road corridor. These amazing sculptures will be placed in locations that are either city property or in front of businesses that choose to participate through sponsorship. The concept is to create an “Art Walk” that encourages citizens and visitors to get out and walk around town enjoying the art while supporting local businesses. Through the River Road Renaissance project, the city has already witnessed a beautification of our economic corridor. The art sculptures will be unveiled within the next month and will incorporate a “meet the artist” event. The fun part is the “People’s Choice Awards” that will take place next spring with local citizens voting on the art sculpture they liked best. Each sculpture is placed for one year and then rotated, with the sponsoring business having the first right of refusal to purchase the sculpture and permanently.

The second phase will be the Thomas Dove Keizur statue unveiling at the opening of the new Keizer Civic Center. In addition to this wonderful tribute to Keizer’s founder, the Arts will move inside as local artists submit their artwork to be displayed inside the new Civic Center. Old and young citizens continue to be involved in this phase through a variety of art related classes offered at the new facility.

The third phase is the introduction of theatre. Through collaborative efforts of our own local talent, Keizer and our students will benefit from the efforts of a drama teacher/coach who will work with high school students, who in turn will work with middle and elementary school children developing plays and performances for everyone’s enjoyment. The city now provides different venues for live performances of plays, drama or music through the new Civic Center and the Amphitheatre at Keizer Rapids Park.

There is an upcoming event to help build a solid foundation for KPA and to ensure its sustainability; it is our inaugural Keizer Public Arts Fundraiser Gala Event on November 8th. This will be an evening to celebrate local artists from the theatre, music and visual arts. Mayor Lore Christopher & Mr. Dick Withnell will be our guest speakers. What to expect, the cocktail reception starts at 6:30, followed by dinner and speakers, with the Swing Street Band playing throughout the evening and a silent auction. For more information on how you can support the arts or to purchase tickets please contact the Keizer Chamber of Commerce at 503-393-9111.

Public Arts add an important layer to any community, Keizer is no exception. KPA is the collaborative efforts of local businesses, artists and citizens working together to enhance the economic growth and livability of our community. It just needs our participation to support it. Just like art, support comes in all shapes and sizes. Support can be your time, talent, ideas or monetary donations. This effort has goals and commitments that will benefit all of us. This is just the beginning of something beautiful blooming in Keizer. ☺

Be a Part of MedAssist

MedAssist is offering a paid position at our new location to open in the Woodburn area. Must be bilingual; able to speak, read and write both Spanish and English fluently. Must also be computer literate. At this time we are looking for someone to work 2 days a week. Please fax résumé and contact information to (503) 561-6046.
Many of the most prestigious medical organizations in the Pacific Northwest recognize our leadership and have chosen to endorse Northwest Physicians as their preferred provider of professional liability coverage. They’ve found a company that is committed to excellence and integrity in medical care, and together we strive for a common objective: a determination to advance and protect the practice of good medicine.

As you think about the organizations you respect the most, remember that each of these organizations is made up of people. Practicing physicians, healthcare professionals; people who have done their research and recognize top-flight service, aggressive defense of local physicians, and the kind of company that supports physician initiatives in legislative tort reform discussions.

These local organizations include:
- Association of Northwest Physicians
- Columbia-Pacific IPA
- Doctors of Clackamas County
- Eastern Idaho IPA
- InterHospital Physicians Association
- Jackson County Medical Society
- Lane County Medical Society
- Lane Individual Practice Association
- Marion-Polk County Medical Society
- McMinnville Physicians Organization
- Medical Society of Metropolitan Portland
- North Idaho Health Network, Inc.
- Quality Care Associates
- Tuality Health Alliance

Don’t you think it is time you joined with your colleagues who think supporting physicians is essential?
Wealth Care Professionals for
Health Care Professionals

When you are in physical need, it is always good to
know that there's a doctor in the house. And when
you are in need of assistance in planning your
financial future, it's comforting to know that a wealth
care professional from Pioneer Trust Bank will always
be there to assist you. Stop in someday soon and let
us show you how much better banking can be.

PIONEER TRUST BANK
Main Office: 100 Commercial St. NE • P.O. Box 2305 • Salem, OR 97308 • Phone: (503) 363-3136
Medical Center Office: SE 12th and Oak • Salem, OR 97301 • Phone: (503) 399-1083
24 Hour Automated Information System: 1-888-507-8784  Member FDIC / Equal Opportunity Lender