LANE COUNTY MEDICAL SOCIETY | SEPTEMBER 2026

MEDICAL MATTERS

Without Borders

Dr. Tanya Bucierka's Ukrainian heritage has become a calling, taking her from emergency rooms to the front lines of a country at war.

LANE COUNTY MEDICAL SOCIETY

End-of-Year Gathering in Partnership with Cascade Health & Festival of Trees on Nov. 24th


BRONCO
KENDALL

THIS ISSUE

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LANE COUNTY MEDICAL SOCIETY | SEPTEMBER 2026

BOUNDARYLESS CARE

LCMS MISSION STATEMENT

The Lane County Medical Society is a professional organization that represents, unifies, and supports its physician members as they practice medicine. The Society promotes the interests of member physicians and advocates for the health of the community.

Lane County Medical Society FOUNDATION

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"When I realized I needed help for my substance use disorder I was anxious about sharing that information as a doctor (who should know better). My welcome into the Caduceus meeting 12 step program (for licensed health care professionals) was just what I needed as part of a program of recovery. I have been coming weekly for 15 years and care for and admire the people I've shared this journey with."

MEDICAL MATTERS

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-

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LCMS Physician Wellness Program

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New providers have been added to the PWP. Visit lcmedsociety.com/pwp to view the full list or for more details.

Standing Together for Physician Autonomy and Patient Care

BY AMANDAJO SANDERS, DO
2026 LCMS BOARD PRESIDENT, SANDERS FAMILY MEDICINE

Finding Community in Eugene

I came to Eugene after finishing my residency in Family Medicine at St. John's in Detroit, Michigan. One of the first events I attended was an LCMS meeting at the Shelton McMurphy Johnson House, where I had the opportunity to meet many members of the local physician community.

Over time, many of those colleagues became friends, trusted specialists with whom I shared patients, and the experts who would care for my own family when they needed medical attention.

It has been my honor to serve on the Lane County Medical Society Board of Trustees for the past six years and now as your President. That experience has deepened my appreciation for the importance of local leadership and physician engagement in shaping the future of our profession.

The Power of a Collective Voice

Earlier this year, our community demonstrated something easy to forget in a healthcare environment increasingly shaped by consolidation, regulation, and competing institutional priorities: physicians, patients, and community partners are stronger when they stand together.

The renewal of the Eugene Emergency Physicians contract was particularly meaningful due to the breadth of collaboration. Physicians spoke up alongside colleagues, professional organizations, nurses, political representatives, and other advocates across the country. Rather than treating the issue as an internal dispute, the community recognized that decisions about how medicine is practiced ultimately affect everyone who depends on the health care system.

That collective voice matters. Professional societies can provide a coordinated platform to advocate for policies that preserve the integrity of medical practice, ensuring that clinical decision-making remains grounded in patient welfare rather than external pressures.

Sustaining Our Collaboration

Our responsibility now is to sustain that collaboration. The fellowship built through this effort should not disappear when the immediate challenge passes. It is an important foundation for future advocacy and constructive engagement with health care institutions and policymakers.

In that spirit, I encourage each of our members to attend an event this year, stay engaged, reconnect with colleagues, and continue strengthening the network that makes this work possible.

As we look ahead, let us remember that when physicians remain engaged with one another and with the communities they serve, we are better equipped to protect both professional integrity and patient care. The strength of our profession has always come from relationships — between colleagues, across disciplines, and with our patients. It is through those relationships that we will continue to meet the challenges ahead with purpose and meaning.◆

OREGON
CANCER ALLIANCE

EDUCATING THE LOCAL PHYSICIAN COMMUNITY WITH THE LATEST ADVANCES IN THE FIELD

HOSPICE AND PALLIATIVE CARE SYMPOSIUM

September 30th, 2026
6-8pm

JENNIFER GORDON MD,
WILLAMETTE VALLEY CANCER INSTITUTE
"ADDING LIFE TO DAYS: UNDERSTANDING PALLATIVE CARE AND HOSPICE"

JULIE HUGHES MD,
PEACEHEALTH SACRED HEART PALLIATIVE CARE
"PEACEHEALTH PALLIATIVE CARE: OFFERINGS AND BENEFITS"

AUDREY GARRETT MD,
WILLAMETTE VALLEY CANCER INSTITUTE
""THE PALLIATIVE BENEFIT OF DEATH CAFES AND OTHER PALLIATIVE CARE GEMS"

LEO CYTRYNBAUM MD & JEFFREY CANTER, PA-C
FALL CREEK PAIN MANAGEMENT
"MANAGING CHRONIC PAIN"

AMBER VESTER DO, CASCADE HOSPICE
"TRANSITIONING TO HOSPICE CARE"

ADD TO CALENDAR

LOCATION
The Community at Marquis Eugene
565 Country Club Road
(Across from Willamette Valley Cancer Institute and Research Center)

Please RSVP to
oregoncanceralliance@gmail.com
(Hors d'oeuvres Provided)

Chart Notes

LCMS End-of-Year Gathering at the Festival of Trees, Tuesday, Nov. 24th

Celebrate the season with LCMS and Cascade Health at this year's Festival of Trees: Cocktails, Crafts, & Conifers night on Tuesday, November 24th, from 5:30–8 PM at the Graduate Hotel. Enjoy an evening of holiday festivities, including an early look at this year's beautifully decorated trees, seasonal craft workshops, live music, festive drinks, and delicious bites. Gather with fellow members and colleagues in an exclusive LCMS space for an evening of holiday spirit, creativity, and connection. Registration opens soon. *Spouses are welcome, and cocktail attire is encouraged.* See you there!

Become an LCMS Ally in Medicine in 2027!

LCMS is now accepting advertising reservations and event sponsorships for 2027! Reserve your spot in the LCMS Physician Directory, Medical Matters magazine, or both and connect your organization with physicians, medical practices and healthcare professionals across Lane County.

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"Cancer doesn't stop. High blood pressure doesn't treat itself. Heart attacks are still going to happen. Emergencies don't stop just because a war broke out... physicians [were] volunteering to go to the front lines, who had never even touched an ultrasound probe..." – **DR. TANYA BUCIERKA** *ON THE IMPORTANCE OF MEDICAL CARE AT THE FRONT LINES.* *SEE PAGE 14.*

RESOURCES

UPCOMING: OHSU CME Opportunities: 1st Annual Northwest Regional Hospital Medicine Conference on September 10th-11th in Hood River, Oregon. Featuring the latest clinical updates tailored for hospitalists and inpatient care providers. 14.75 AMA PRA Category 1 Credits available.

The Clinical Undergraduate Shadowing Program (CUSP) is seeking physicians to host undergraduate students interested in medicine. Email angel@lcmedsociety.com for more information.

BOUNDARYLESS CARE

When the Physician Becomes the Patient

BY AMBER VESTER, DO
MEDICAL DIRECTOR, CASCADE HEALTH HOSPICE & PALLIATIVE CARE
& EMILY KEIZER
CASCADE HEALTH MARKETING & EVENTS MANAGER

Something has felt off for weeks – persistent enough to notice, but not enough to make time to address. Concerns that would prompt investigation if raised by a patient are quickly dismissed when they come from physicians themselves. It's easy to discount fatigue, disrupted sleep, poor mood, or other vague symptoms. After all, those can logically be attributed to busy clinic days, full inboxes, waiting lists of patients, or other clinical demands. Not to mention the normal life stressors of parents, children, and spouses.

By training and a bit by self-selection, physicians become accustomed to placing the needs of others before their own. During training, physicians work long hours with very little sleep – and when "self-care" is defined as hydrating, eating, and using the restroom, there is a larger problem that needs to be addressed. Physicians are conditioned to compartmentalize and continue functioning through fatigue, grief, trauma, stress, and uncertainty. It's a perfect setup for ignoring one's own physical symptoms and mental health.

In a 2025 national survey by The Physicians Foundation, 57% of physicians reported feelings of anger, tearfulness, or anxiety during the previous year.[1] Nearly half, 46%, said they had withdrawn from family, friends, or coworkers. Yet a physician who would recognize those changes as meaningful in a patient may interpret them personally as a difficult stretch, an expected part of the work, or something that should be manageable without help.

It isn't just physicians, of course: Asking for help or admitting that a problem is more than a rough patch can be hard for anyone, but an issue that would be recognized by a primary care provider during an annual visit can't be caught if you don't have a primary care provider – a trend that the American Medical Association (AMA) notes is changing, but is still too common.[2] This can be exacerbated by living and working in a small community, where it's harder to find the anonymity that makes a physician feel comfortable disclosing personal and vulnerable emotions.

Some physicians rely on friends or colleagues to help bridge this gap, but informal conversations have limits. They may offer relief without creating space to fully examine and address a concern. The delicacy of a social relationship can make it difficult to push when it is warranted or to clearly recognize concerning behaviors or patterns. Having medical and mental health providers can be crucial in fully exploring and dealing with these issues.

To address some of these challenges, Lane County Medical Society's Physician Wellness Program (PWP) is structured differently. Through providers including Cascade Health Counseling & EAP, physicians receive six free counseling sessions each year without insurance billing or a diagnosis entered into an electronic medical record. Virtual and after-hours appointments help reduce scheduling barriers. The program creates a place where the physician does not have to assess the situation, direct the conversation, or determine the next step.

"Physicians have found our environment accepting and flexible," says Cascade Health counselor Jennifer Moorhead. They can "express emotion confidentially and be safe to explore vulnerabilities and the unpredictable events in life." In a community the size of Lane County, where "we are all coworkers and neighbors at some point," counseling provides confidentiality, safety, and an unbiased assessment of problems. Counselors with the Physician Wellness Program are sensitive to concerns such as encountering a patient in the waiting room and arrange appointments to ensure privacy.

Using available care does not require a crisis. "Preventive medicine is imperative for sustained standards of care, wellness of employees, and continued provider success," says Moorhead. That step toward prevention may begin with a symptom that keeps returning, a screening that keeps getting postponed, or the realization that the usual ways of coping are no longer working.

It may also begin with a familiar clinical question, turned inward: If a patient described the same symptom, the same degree of stress, or the same months of trying to manage alone, what would the recommendation be?◆

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2. "Pearl of the Week: Preventive Care for the Physician," American Medical Association, ama-assn.org/practice-management/ama-steps-forward-program/pearl-week-preventive-care-physician.


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Peace Health

Integrated Clinical-Social Care & Boundaries of Health Care

BY VINCENT GUILAMO-RAMOS, PHD, MSN, MSW, MPH; MARCO THIMM-KAISER, MPH; ADAM BENZEKRI, MPH; & KODY H. KINSLEY, MPP
INSTITUTE FOR POLICY SOLUTIONS, JOHNS HOPKINS UNIVERSITY; CENTER FOR LATINO ADOLESCENT AND FAMILY HEALTH, JOHNS HOPKINS UNIVERSITY

After a decade of growing momentum, the future role of health care in addressing patients' health-related social needs (HRSNs) through integrated clinical-social care is uncertain. Under the second Trump administration, health expenditures are a focus for federal budget cuts, including proposed Medicaid cuts totaling hundreds of billions. As part of cost-saving proposals, initiatives advancing integrated clinical-social care are being targeted for cuts.[1]

Recent debates about integrated clinical-social care reveal broader disagreements about how to reduce US health care expenditures, including rolling back post–Affordable Care Act coverage expansions vs structural reforms to the health care and health care financing systems (eg, single-payer system). Along these lines, opponents of integrated clinical-social care believe that addressing HRSNs in health care represents a coverage expansion that increases inefficiencies and costs,[2,3] while proponents consider it key to structurally overhauling US health care, citing evidence for reduced costs and, most importantly, improved outcomes[1] — the key metric even in cost-effectiveness analysis.[4]

In this Viewpoint, we discuss how[2] disjointed schemas for conceptualizing integrated clinical-social care produce such conflicting conclusions and clarify[3] spheres for policy and programmatic innovation where integrated clinical-social care can be advanced.

Two Conceptualizations of Integrated Clinical-Social Care

Integrated clinical-social care builds on strong evidence showing that social and contextual influences, or the social determinants of health, significantly shape health outcomes and inequities.5 Thus, integrated clinical-social care seeks to achieve improved individual and population health outcomes by addressing patients' HRSNs.

While HRSN interventions are heterogeneous and the evidence for their effectiveness remains mixed, a growing body of research has identified efficacious HRSN interventions.[6] However, there are no agreed-upon models by which HRSNs should be addressed in health care, leaving integrated clinical-social care with ambiguous connotations and ample room for diverging conceptualizations of its implementation.

Two schemas for conceptualizing integrated clinical-social care are noteworthy. The first conceptualizes social care interventions as add-ons to existing clinical health care models. Under this conceptualization, the health care system delivers or coordinates certain social welfare services that are historically not under the purview of health care (eg, housing or transportation assistance). The traditional health care delivery model (ie, clinic- or hospital-based service provision; a focus on diagnosis and treatment; and siloed primary, secondary, and specialty care) and traditional health care financing model (fee-for-service) largely remain constant. Here, integrated clinical-social care is akin to an expansion of health care's specialty care referral system to encompass selected social care services.

The second schema conceptualizes integrated clinical-social care as the structural alignment of clinical and social welfare systems and involves investing in infrastructure to improve service coordination across the continuum of patients' clinical and social needs. These initiatives[1] require collaboration between health care and social welfare organizations serving a defined (usually geographically) community or population, other important stakeholders (such as health departments, health care payers [eg, Medicare, Medicaid, and private insurers], and community representatives) and possibly independent third parties responsible for service coordination. Under this conceptualization, the traditional health care delivery model is restructured to increase continuity with social welfare services (eg, prevention and health promotion focus, community-based care, broadened definition of the health care workforce[7]), and new financing models allow for better cost control (eg, fixed-cost contracts or grants). Here, the focus of integration is strengthening links between health care and social welfare systems.

The lack of a uniform conceptualization of integrated clinical-social care makes a constructive discourse about its merits difficult. To guide future discourse, we next define integrated clinical-social care as aligning clinical health care and social welfare systems.

1. "Effect of Medicaid Cuts on the Medical Care Ecosystem," Michael H. Katz, JAMA, 2025, jama.com.
2. "Is Everything Health Care? The Overblown Social Determinants...," Claire Pope, Manhattan Institute, manhattan.institute/article/the-overblown-social-determinants-of-health.
3. "The Boundaries of Health: Debating ROI of Programs and Policies that...," Institute for Policy Solutions, Johns Hopkins University School of Nursing, May 22, 2025, youtube.com.
4. "Health Systems and Social Services—A Bridge Too Far?" Sherry Glied and Thomas D'Aunno, JAMA Health Forum, 2023, jama.com.
5. "Conceptualizing the Mechanisms of Social Determinants of Health...," Marco Thimm-Kaiser, Adam Benzekri and Vincent Guilamo-Ramos, Milbank Quarterly, 2023, milbank.org.
6. "Guide to Evidence for Health-Related Social Needs Interventions: 2022 Update," The Commonwealth Fund, September 2022, commonwealthfund.org.
7. Ending Unequal Treatment: Strategies to Achieve Equitable Health Care and Optimal Health for All, National Academies of Sciences..., National Academies Press, 2024, nap.edu.
8. "Recommendations from the Task Force on Community Preventive Services to Decrease Asthma Morbidity Through Home-Based, Multi-Trigger, Multicomponent Interventions," Task Force on Community Preventive Services, American Journal of Preventive Medicine, 2011, ajpm.org.

Three Spheres for Integrated Care Innovation

The discourse about integrated clinical-social care warrants recognizing that US health care is in dire need for reform given poor outcomes, growing inequities, and ballooning costs. Proponents of integrated clinical-social care argue that, if implemented correctly, it advances health care transformation. However, more common ground is needed regarding what the health care system, the social welfare system, and the bridging infrastructure between them should be expected to deliver within an integrated clinical-social care paradigm.

Health Care System

The health care system's core task is to deliver clinical care services. However, key aspects of traditional health care delivery models are ripe for innovation in integrated clinical-social care. These areas, also highlighted in the 2024 National Academies' Ending Unequal Treatment report,[7] include a focus on holistic prevention and health promotion (vs medicalized diagnosis and treatment); prioritization of primary care (vs specialty care); and locationally flexible community-based care, including community health centers, mobile health clinics, and home-based care (vs one-size-fits-all, brick-and-mortar clinical settings).

Integrated care also emphasizes multidisciplinary care teams, including nurse-led community-based care, social workers, community health workers, and behavioral health specialists (vs physician-centered, hierarchical care), as well as cultural responsiveness and workforce representativeness. The health care system's multidisciplinary workforce is also optimally positioned to coordinate interventions with strong efficacy for alleviating HRSNs that are proximally linked to health outcomes, such as home-based asthma trigger remediation interventions for children.[8]

Traditional fee-for-service reimbursement models in health care are associated with incentives for overuse of services and with elevated costs. A similar risk exists when HRSN services are reimbursed through the fee-for-service model. Alternative financing models, such as fixed-rate contracts or grants aimed at building systems coordination infrastructure, may be better suited for cost containment.

Bridging Infrastructure

Successful initiatives for clinical-social care integration[1] primarily rely on aligning rather than duplicating existing systems. In this framework, the health care system serves clinical needs and only directly addresses HRSNs if they proximally relate to health, and the social welfare system serves broader social needs, including those shaping health outcomes (ie, HRSNs). The key feature of this setup is care coordination infrastructure development, ensuring continuity of services across a holistic set of HRSNs, a burden that currently falls on patients navigating fragmented services.

In existing clinical-social care initiatives,[1] this bridging function frequently falls to third parties not directly involved in delivering clinical or social services, such as health departments or contractually designated bridge organizations that evaluate patients' HRSNs and provide service referrals and navigation.

Social Welfare System

Care coordination across the continuum of patients' HRSNs requires strong social services that complement health care. However, the US has historically underinvested in its social safety net relative to comparable high-income countries, which achieve better population health outcomes with lower health care spending.[8]

This underinvestment has contributed to pronounced social inequities and unaddressed social welfare needs in the US population, which manifest in unnecessarily elevated chronic disease burden, complex care needs, and high health care costs.[9] Inadequate funding and prioritization of the social welfare system poses a challenge for clinical-social care initiatives that rely on systems alignment, because their success relies in part on the social welfare system's capacity to mitigate patients' HRSNs and communities' exposure to harmful social determinants of health such that the health care systems' direct service delivery in these domains can remain limited.

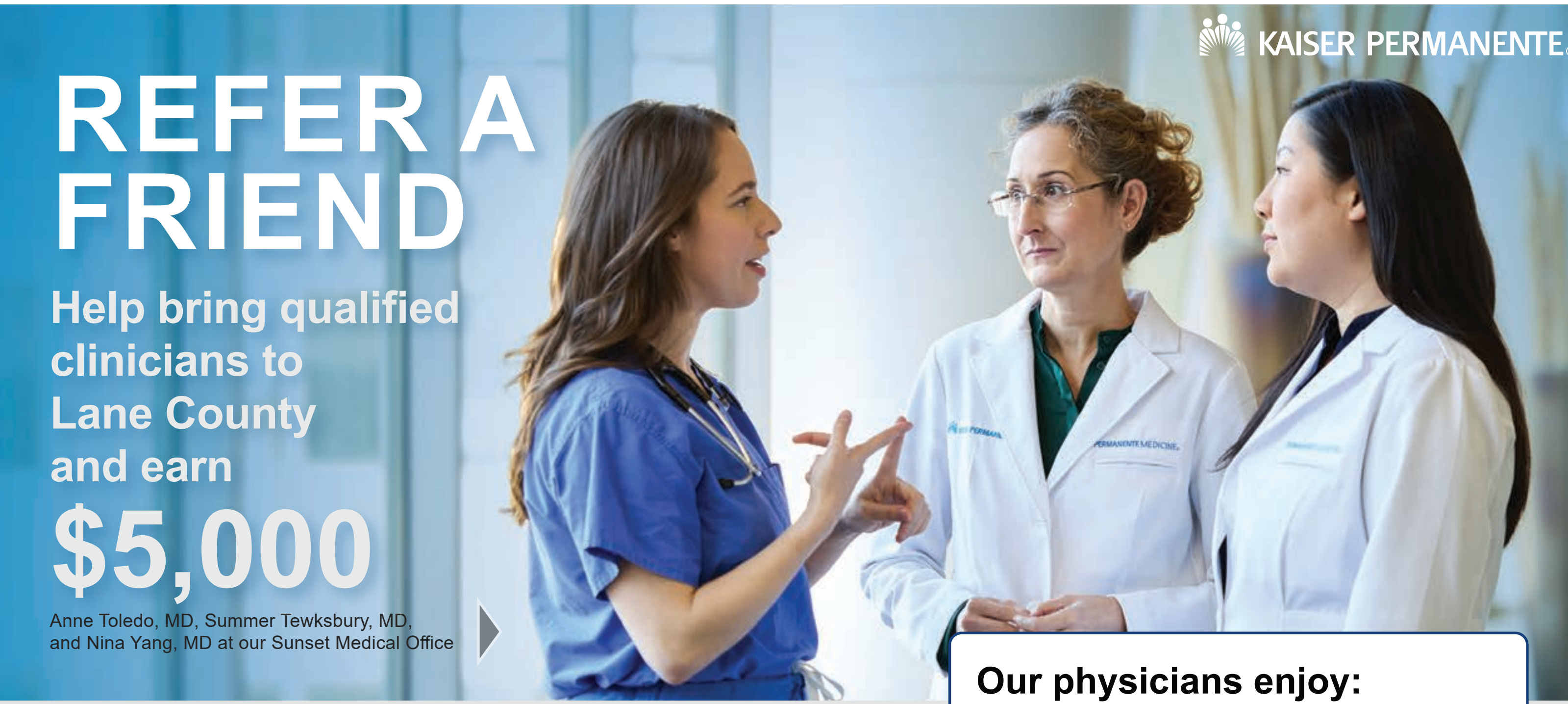
Investments that strengthen the underdeveloped social welfare system in the US are necessary for synergy in integrated clinical-social care frameworks, benefitting both social and health outcomes. Health care organizations and actors should advocate for such investments.[10]

Conclusions

There is agreement that increasing health care expenditures are a significant burden on the national budget, but there is disagreement over remedies to reduce costs while improving outcomes. We argue that a constructive debate over the role of integrated clinical-social care within health care reforms requires a shared vision for its implementation. We advance this debate by delineating the boundaries of what the health care system, social welfare system, and bridging infrastructure between them can deliver in an integrated clinical-social care paradigm.◆

This article was sourced from the JAMA Network website at jamanetwork.com/journals/jama-health-forum/fullarticle/2839490.

9. "American Health Care Paradox—High Spending on Health Care and Poor Health," Elizabeth H. Bradley, H. Sipsma and L. A. Taylor, QJM, 2017, academic.oup.com/qjmed.
10. "The Role of Physicians in Addressing Social Determinants of Health," Nason Maani and Sandro Galea, JAMA, 2020, jama.com.



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MEMBER PROFILE

Without Borders

Dr. Tanya Bucierka shares how her Ukrainian roots shaped service, from fighting for independent medicine to training physicians in a country at war.

BY VANESSA SALVIA
FOR LANE COUNTY MEDICAL SOCIETY

Dr. Tanya Bucierka was eight years old when she decided she wanted to be a doctor. Her sister had just been born, and she remembers going along to a pediatrician's appointment and thinking the doctor had the coolest job in the world.

"I'm going to be a doctor," she told herself.

Today, Bucierka is a partner at Eugene Emergency Physicians. She is also Ukrainian-American, and that connection has shaped a second important chapter of her career.

Bucierka, who grew up in Rochester, New York, first pictured herself as a pediatrician. Then her father died unexpectedly as she was preparing to apply to medical school, and she took time off. A high school friend was working as a scribe, so Bucierka became one too, shadowing an emergency physician for eight- to 12-hour shifts and documenting everything the doctor did. She liked the fast pace and that no two days were the same. She also liked the flexibility of the schedule.

"I kept an open mind in medical school," she says, "but I always came back to emergency medicine."

Dr. Tanya Bucierka, her husband, Franky Valenzuela, charge nurse at Cottage Grove ED, and their dog, Coco, enjoying one of their favorite spots, Sarver Winery.

Photos provided by Angel Montes

A Ukrainian Childhood

For most Americans, Ukraine wasn't a country they thought much about before the Russian invasion made headlines, but Bucierka's connection to Ukraine started the day she was born. Both sets of her grandparents immigrated from Ukraine, and she grew up inside Rochester's tight-knit community of roughly 30,000 Ukrainians.

Her grandparents helped raise her, and Ukrainian was her first language. As a kid, she did Ukrainian dancing on Mondays, youth group on Tuesdays, Ukrainian school on Saturdays, church on Sundays, and summers either at Ukrainian camp or flying to Ukraine to visit family.

"I always joked, and I really believe it, that my childhood was like 'My Big Fat Greek Wedding' except it was 'My Big Fat Ukrainian Wedding,'" she says.

So when the war broke out in February 2022, there was no real decision to make. "It wasn't, 'Am I going or not going?'" she says. "What organization is already on the ground there, and who can I go with, and how can I be helpful?"

She had joined Eugene Emergency Physicians only months earlier and hadn't yet made partner, so it seemed risky to ask for weeks off at a time, but her colleagues understood, and her shifts got covered. Since April 2022, she has returned to Ukraine roughly ten times.

Finding a Home in Eugene

After medical school at Lincoln Memorial University in Tennessee and a residency in Rochester, where she served as chief resident her third year, her younger sister, Sonya, became a nurse and moved to Portland. Bucierka wanted to live nearby, so she started looking at jobs in the Portland area. A former co-resident, Dr. Nate Garton, was already at Eugene Emergency Physicians and urged her to interview. She's now been with the group for almost five years.

Part of what drew her in was EEP's structure as an independent, physician-led group at a time when those are increasingly rare. "We are our own business owners," she said. "We make the schedule. We cover each other's shifts. Our lives are invested here."

> "Cancer doesn't stop. High blood pressure doesn't treat itself. Heart attacks are still going to happen. Emergencies don't stop just because a war broke out... physicians [were] volunteering to go to the front lines, who had never even touched an ultrasound probe..."

That investment was tested recently when the group faced the possibility of being replaced. Bucierka focused on public outreach and advocacy while colleagues Dr. Jeremy Brown and Dr. Julie Seo took the fight to a legislative hearing in Salem. She connected with Portland ophthalmologist and physician advocate Dr. Will Flanary, aka Dr. Glaucomflecken, to organize a fundraiser that supported the American Academy of Emergency Medicine's advocacy fund.

Ultimately, the group stayed. "We couldn't have done it without everybody's support," she said. She and colleague Dr. Dan McGee later traveled to Washington, D.C., for AAEM's summit on Capitol Hill, which focused on ending the corporate practice of medicine nationally, and she says EEP has since fielded questions from other independent groups facing similar threats.

Training the Front Line

On her first trip to Ukraine, Bucierka and a friend rented a car and ran one-day clinics in the western part of the country, where school gymnasiums had been converted into shelters for displaced families. People arrived with nothing but passports and prescriptions they could no longer refill.

"Cancer doesn't stop," she says. "High blood pressure doesn't treat itself. Heart attacks are still going to happen. Emergencies don't stop just because a war broke out."

Many of the patients were Russian speakers from the east, who didn't know where to go and were afraid to speak Russian where the language of "the enemy" was frowned upon. It was during that first trip that Bucierka connected with MedGlobal, a Chicago-based non-governmental organization, or NGO, and began training physicians in point-of-care ultrasound, known as POCUS. "These were physicians volunteering to go to the front lines, who had never even touched an ultrasound probe, spanning across every medical specialty," she says.

The team used portable ultrasound probes known as Butterfly, which can easily plug into a cell phone or tablet and can be used to rapidly evaluate a patient for critical injuries such as a collapsed lung, fluid around the heart or in the abdomen, blood clots in legs, and many other diagnoses.

On the front lines, that assessment determines how urgently the patient needs surgery, whether they can be transported farther from the front line for care or whether they need stabilization at a field hospital first.

"If you're trained very well, POCUS takes a minute or two," she says. "Those are very critical for decision-making."

One of Bucierka's mentors and now one of her best friends, Dr. Nahreen Ahmed, led the first couple of trips. Bucierka then took over Ahmed's role.

"We'd have classrooms full of doctors, but not just surgeons and ER doctors," she says. "It was pediatricians. It was ENT surgeons. It was trauma surgeons. It was people who had never touched an ultrasound before."

Bucierka would run through a two- or three-day training course at least twice during a trip, taking it to different locations and hospitals. And the group is able to donate point-of-care ultrasounds as well as iPads, so the doctors can continue their work, share findings, and consult with the team in the U.S.

The trips themselves are grueling before they even begin. Since commercial planes aren't flying into Ukraine, just getting there takes two to three days. Flights are routed into London or Germany, then she connects by flight into Krakow, Poland, stays overnight there, and spends several more hours awaiting transportation to cross the border into Ukraine.

From there, trains to destinations like the capital city of Kyiv can be delayed for hours if an air raid siren sounds. She returned most recently the first week of August, when she delivered medical supplies. She and colleagues are now working with Ukrainian medical schools to build point-of-care ultrasound into the standard curriculum.

A Wedding in Lviv

In September 2024, Bucierka and her husband, Franky Valenzuela, married in Saints Peter and Paul Garrison Church in Lviv. Built in the early 1600s, the church is now the Center of Military Chaplaincy, which provides care and support for military personnel. Martial law prevents Ukrainian men between 18 and 60 from leaving the country, and Bucierka wasn't willing to hold a wedding without her Ukrainian relatives present.

"Instead of asking our Ukrainian family to try to come to us, we brought the wedding to them," she says. The church hosts funerals most days of the week, but the ceremony drew coverage from a Ukrainian news channel as a rare, hopeful story in a country still at war.

Why She Keeps Going Back

People often ask Bucierka how she can keep returning to a country at war, but to her, it feels like going home. What keeps her committed, she says, is watching the next generation of Ukrainian doctors come through the training programs she is helping to build, some of whom have gone on to residencies in the United States.◆

The First Kiss: Point of Care Ultrasound

BY ESTEFANIA MONTAÑEZ RAMOS, MD
SAMUEL H. WISE FELLOW IN GENERAL INTERNAL MEDICINE, POINT OF CARE ULTRASOUND FELLOW
& MICHELLE BEAM MD, MPH
INTERNAL MEDICINE, ASSISTANT PROFESSOR, DIVISION OF GENERAL INTERNAL MEDICINE AND GERIATRICS, OREGON HEALTH & SCIENCE UNIVERSITY

> "My POCUS 'first kiss' showed me its potential to create infrastructure for equitable care by democratizing diagnosis and compressing the wait for timely, high-quality care. Six years later, I see its potential to help clinicians collaborate across practice settings and across rural and urban geographies."

I once heard that we all have our Point-of-Care Ultrasound (POCUS) "first kiss" stories — the first time we witnessed POCUS change clinical management. In the Fall of 2020, in a hotel room off Route 66 on the border of Diné Bikéyah (Navajo Nation), I had mine.

Between the third and fourth years of medical school, I worked in a COVID alternative care site. In these field hospitals — repurposed hotels and high school gyms — I documented patient vitals and symptoms and escalated concerns to local physicians.

An elderly Navajo-speaking man reported worsening right-sided, pleuritic chest pain despite stable oxygenation. The staffing physician — who was visiting from an academic institution on the East Coast — scanned with their personal handheld POCUS device, while I held the tablet. Placing the small machine on his chest, we quickly acquired and saved images of a complex pleural effusion. POCUS allowed us to expedite his transfer to a higher level of care and to share our findings at the bedside with the patient and later with his family. This was particularly impactful at a time when misinformation and mistrust heightened tensions in patient-provider relationships.

As a scholar in the University of New Mexico's Rural and Urban Underserved Program, I learned that geography is destiny, especially in critical healthcare situations. Long travel times and the availability of specialists, technicians, and equipment all factor into timely care. What surprised me then, and continues to ground my work now as an OHSU Internal Medicine POCUS fellow, is that ultrasound surpasses chest radiographs in detecting and characterizing pleural effusions and performs similarly to CT scans.[1] A traditional exam might have identified dullness to percussion, but POCUS revealed loculations at the bedside, which changed our management.

In internal medicine residency at OHSU-Hillsboro, I was eager to use handheld ultrasound, evaluating for abdominal free fluid in hospitalized patients with decompensated cirrhosis and reassuring clinic patients with interval lung ultrasound following pneumonia.

The availability of these tools affirmed OHSU-Hillsboro's mission to bring exceptional patient-centered care to local and rural communities. It also highlighted an essential gap in the mentorship needed to train, advance, practice, and retain these skills. Only 38.84% of rural counties have access to POCUS compared to 88.56% of metropolitan counties.[2] This gap does not exist because rural physicians are less skilled. As powerful a tool as POCUS is, POCUS skills and practice deteriorate substantially without a robust community of practice.[3]

1. "Ultrasound in the Diagnosis and Management of Pleural Effusions," Soni NJ, Franco R, Velez MI, Schnobrich D, Dancel R, Restrepo MI, Mayo PH, Journal of Hospital Medicine, 2015. pubmed.ncbi.nlm.nih.gov/26218493.
2. "Analysis of Rural Disparities in Ultrasound Access," Peterman NJ, Yeo E, Kaptur B, Smith EJ, Christensen A, Huang E, Rasheed M, Cureus, 2022. pubmed.ncbi.nlm.nih.gov/35774712.
3. "The Aims and Effectiveness of Communities of Practice in Healthcare: A Systematic Review," Noar AP, Jeffery HE, Subbiah Ponniah H, Jaffer U, PLOS ONE, 2023. journals.plos.org/plosone/doi/10.1371/journal.pone.0292343.

Participating in the American College of Physicians (ACP) Point-of-Care Ultrasound Virtual Mentorship Program and ACP Foundational Skills course showed me how we can make POCUS training accessible for clinicians in primary care, rural, and community settings to extend their diagnostic reach.

At the 2026 American Institute of Ultrasound in Medicine (AIUM) General Medicine and Advanced POCUS Course, hosted by OHSU, I met clinicians practicing in underserved communities across Oregon asking excellent, patient-centered questions: Can POCUS help me expedite DVT diagnosis in clinic? Does this patient need higher-level care now?

My POCUS "first kiss" showed me its potential to create infrastructure for equitable care by democratizing diagnosis and compressing the wait for timely, high-quality care. Six years later, I see its potential to help clinicians collaborate across practice settings and across rural and urban geographies.

Throughout my POCUS fellowship, colleagues and clinical engagement have sustained my growth and enthusiasm for incorporating POCUS into practice. I'm hopeful about how primary and acute care are changing to better meet patient and clinician needs through the use of POCUS, but equipment alone will not carry us there. A future where clinicians in all corners of Oregon integrate POCUS into daily practice depends on building that community deliberately, together.

That is the work the OHSU POCUS Group has taken up, and I am asking you to join us at our next training. Whether you scan every day or have never held a probe, bring your questions, your images, and the cases that keep you up at night. Every physician who shows up widens the reach of this tool and strengthens our collective ability to provide the care our patients deserve. I hope to be in community with you in the years to come.◆

Interested in learning more? Scan the QR code or email Dr. Montañez Ramos at montanee@ohsu.edu.

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BOUNDARYLESS CARE

Bringing Physician Voices to the Capitol

BY NICK JONES, MD
CLEAR HEALTH DIRECT PRIMARY CARE

As Lane County's trustee to the Oregon Medical Association, I appreciate the opportunity to help ensure the healthcare challenges facing our community are represented at the state level. At our most recent board meeting, we heard from House majority leader Ben Bowman and discussed topics ranging from SB 951 and corporate practice of medicine protections to healthcare affordability, access, and system reform proposals.

One thing is clear: policymakers and the OMA want physician input as they work through increasingly complex healthcare issues affecting patients and practices across Oregon.

Two policy areas I will be following closely include:

- Passing legislation similar to Iowa's recent law preventing insurers from denying specialist referrals solely because a patient's PCP is out of network. Certain Medicare Advantage HMO's are creating unnecessary administrative burdens requiring long-established patients to obtain new referrals from in-network PCPs.
- Clarifying that OHP patients may voluntarily participate in concierge and direct primary care (DPC) practices. As OHP funding pressures grow, pilot programs could help evaluate whether prospective PMPM support from CCOs, combined with optional patient contributions, can improve access and sustainability for patients and participating retainer practices alike.

I also encourage anyone interested in advocacy to consider participating in OMA Day at the Capitol on March 16th, 2027.

The OMA organizes small group meetings with legislators representing where you live or practice and provides concise policy summaries covering current healthcare legislation and advocacy priorities related to expanding access to care, reducing administrative burdens, improving reimbursement, and supporting patients across Oregon. It is a valuable opportunity to meet legislators, start conversations, and help inform policymakers about the realities and complexities physicians and patients face in healthcare today.

The OMA is also meeting with physicians and practices across the state to better understand operational and financial challenges and identify areas where advocacy, resources, and collaboration may be helpful.◆

SAVE THE DATE!

Join OMA, Oregon ACP, OAFP, and OPS on March 16 for Day at the Capitol!

OREGON MEDICAL ASSOCIATION | ACP American College of Physicians Leading Internal Medicine, Improving Lives Oregon Chapter | OAFP | OREGON PEDIATRIC SOCIETY A Chapter of the American Academy of Pediatrics

2027 DAY AT THE CAPITOL

March 16, 2027
Salem

You are invited to join the OMA Day at the Capitol in partnership with the American College of Physicians Oregon Chapter, the Oregon Academy of Family Physicians, and the Oregon Pediatrics Society. Physicians, PAs, students, and clinic staff are invited to meet in Salem on March 16, 2027, to hear from legislative leaders and learn how to effectively deliver messages to policymakers. Attendees will meet in groups with legislators to discuss key issues facing the Oregon medical community. Together, we show up for the issues that matter most to Oregon's medical community — and the patients who depend on them.

DAY AT THE CAPITOL IS SUPPORTED BY THE FOLLOWING ORGANIZATIONS:

American College of Surgeons Oregon Chapter | Dalton Advocacy Inc. | Lane County Medical Society
Marion-Polk County Medical Society | Oregon Academy of Ophthalmologists
Oregon Association of Orthopedic Surgeons | Oregon Psychiatric Physicians Association
Oregon Society of Medical Oncologists | Oregon Society of Physician Associates
Osteopathic Physicians and Surgeons of Oregon | Southern Oregon Alliance of Physicians and Providers
Southern Oregon Medical Society

For more information, contact Courtni Dresser (courtni@theoma.org), OMA Vice President of Government Relations.


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Into Access
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Scientific innovation changes outcomes only when it reaches patients. Through dedicated physician leadership and participation in clinical trials, WVCI helps bring promising therapies and evolving standards of care to the communities we serve.
OregonCancer.com
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Dr. Jeff Sharman
Dr. Bo Wang
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Future of Cancer Care is Being Shaped by Clinical Trials

At Willamette Valley Cancer Institute and Research Center, physicians are helping shape the next generation of cancer treatment while expanding access to innovative therapies for Lane County patients.

For patients facing a cancer diagnosis, geography has traditionally played an outsized role in determining treatment options. The newest therapies, often years away from becoming standard of care, have historically been available only at major academic medical centers in large cities. At Willamette Valley Cancer Institute and Research Center (WVCI), national research collaborations and physician leadership in clinical trials are helping close that gap for patients across Lane County.

Every cancer therapy considered standard of care today was once an investigational treatment studied through clinical research. From targeted therapies and immunotherapies to novel treatment combinations, clinical trials help physicians identify better approaches, improve outcomes, and expand treatment options for future patients. Increasingly, they are also providing patients in our community access to promising therapies closer to home.

Expanding Access

For Dr. Charles Anderson, a gynecologic oncologist and Director of the Gynecologic Oncology Research Program at WVCI, expanding access to clinical trials is both a professional commitment and a driving force behind his research involvement. Through leadership roles in national cooperative group studies and clinical trial development, Dr. Anderson helps connect Lane County patients with emerging treatment strategies while contributing to the research that will inform future standards of care.

"For gynecologic cancers especially, where treatment options can be limited, trials open doors to therapies that are actively reshaping how we treat ovarian, endometrial, and cervical cancers," Anderson explains.

Precision Medicine Brings New Possibilities

Clinical trials provide access to emerging therapies that continue to evolve as researchers answer longstanding questions and uncover new ones. With each phase of research, physicians gain a better understanding of which approaches lead to the best outcomes and which patients are most likely to benefit. Lung cancer research provides a compelling example of how those discoveries are shaping modern cancer care.

"The wide adoption of comprehensive molecular testing for non-small cell lung cancer has enabled us to rapidly and more frequently identify targetable driver alterations, allowing us to offer patients more effective and often better tolerated therapies," says Dr. Bo Wang, a medical oncologist at WVCI and executive member of the Lung Cancer Research Committee of Sarah Cannon Research Institute.

Dr. Wang's research focuses on bringing those advances to patients in the community setting. Recent studies have explored therapies targeting specific mutations, including KRAS-mutant lung cancers, while other studies are investigating antibody-based treatments designed to harness the body's immune system in new ways. Together, these approaches reflect a broader shift toward increasingly personalized treatment strategies that may reduce — and in some cases eliminate — the need for traditional chemotherapy while improving long-term outcomes for many patients.

Progress Through Research

The impact of clinical research is perhaps most evident when viewed over time. Few areas of cancer medicine have changed as dramatically as chronic lymphocytic leukemia (CLL), where years of research have transformed treatment options and outcomes for patients.

"Fifteen years ago, treatment options for leukemia and lymphoma were far more limited, and outcomes less predictable. Since then, we've seen remarkable progress. From targeted therapies to CAR T-cell approaches and precision medicine strategies, these approaches allow us to tailor care more than ever before," says Dr. Jeff Sharman, Director of Research for Sarah Cannon Research Institute at WVCI and Medical Director of Hematology Research at The US Oncology Network.

WVCI has played a role in that evolution. In 2009, a patient treated at WVCI became the first person in the world with CLL to receive what would later become ibrutinib, a BTK inhibitor that helped redefine treatment for the disease. Today, research continues to focus on more precise therapies, thoughtful treatment combinations, and expanding access to innovation for patients regardless of where they live.

Whether advancing new therapies in gynecologic cancers, refining precision medicine approaches in lung cancer, or driving breakthroughs in blood cancers, WVCI physicians are helping shape future standards of care through active leadership in clinical research. For Lane County patients, participation in clinical trials offers access to emerging therapies while helping answer the questions that will guide the next generation of cancer treatment.◆

Announcements

LCMS Events

Visit the LCMS website to sign up for future events or email us at info@lcmedsociety.com for any inquiries.

Join us for the last LCMS main event of the year in partnership with Cascade Health's Festival of Trees. Enjoy a unique experience of this event at The Graduate Hotel on Tuesday, Nov. 24, with an exclusive LCMS section. The evening will include live music, beverages, and bites, tree previews, holiday crafting, and much more! Cocktail attire is highly encouraged.

Community

Remaining Native: Indigenous Movie Night Presented by Dr. Don Dexter Gallery/Eugene Dental Sleep Center on Wednesday, Sept. 9, 2026, at the Hult Center for the Performing Arts. Free and open to the community, with an artist talk, film screening, and virtual Q&A. Email dondextergallery@gmail.com for more info.

Dr. Kristin Collier will be hosted by Dr. Brick Lantz in Eugene on Sunday, January 17th, 2027, for a free evening presentation, "Is Conscience Freedom Threatened in Medicine? Dr. Kristin Collier Experienced Death Threats at Her University." For more details, please contact bricklantz@comcast.net.

Lane County Caduceus meets every Wednesday from 7:30-8:30 PM for licensed healthcare professionals seeking peer support during addiction recovery.

Join the Healthcare for All Lane County Chapter to advocate for affordable, simplified healthcare for all Oregonians. Meetings are the first Tuesday of each month at 7 PM at First United Methodist Church, 1376 Olive St., Eugene, OR, and via Zoom.

NOTES

New LCMS Member Benefit: Need a space for meetings, team sessions, or workshops? Enjoy a 15% discount at The District Coworking! Email us for details.

The Clinical Undergraduate Shadowing Program (CUSP) is seeking physicians to host undergraduate students interested in medicine. Email us for more information.

MEDICAL MATTERS

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