EDITORIALS & OPINIONS

The Bulletin
AN INDEPENDENT NEWSPAPER

Heidi Wright — Publisher
Gerry O'Brien — Editor
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Here's a bill we would be glad to see die

One of our favorite things that is happening in this legislative session is something that appears to be not happening: House Bill 2888.

That's the bill introduced by State Rep. Paul Evans, D-Monmouth. It seems to be set to die.

The bill would sever the relationship between OSU-Cascades and OSU. OSU-Cascades would become its own separate entity — Central Oregon University. Employees and students would be shifted to the new school, apparently without any say in the matter. The new school would also be prohibited from offering any programs above a master's degree. OSU-Cascades had announced plans in 2020 to begin offering a doctoral program in physical therapy in the fall of 2021.

If meeting student demand for higher education is a goal for legislators and students want to go to OSU-Cascades, giving more money to support the growth of the campus is the right thing to do.

Evans believes that OSU-Cascades is growing at the expense of other institutions in the state. That includes Western Oregon University, located in the district Evans represents. And to some extent, he is likely right. The Legislature must makes decisions about where to allocate dollars for higher education. It only has so much money to spend. OSU-Cascades does benefit from its connection to OSU in no small number of ways. Is that really a problem?

While most other colleges in Oregon and across the country were struggling with enrollment even before the pandemic, OSU-Cascades was growing at a steady clip. If meeting student demand for higher education is a goal for legislators and students want to go to OSU-Cascades, giving more money to support the growth of the campus is the right thing to do. Evans should be offering ideas to improve Oregon's other institutions without the clear aim of undermining OSU-Cascades' success.

This week is a kind of do-or-die week for legislation, as Gary Warner, who reports for The Bulletin and EO Media Group, put it. If a bill has not had a work session by Friday, it's likely dead. It's not certainly dead. It's likely dead. There can be exceptions and there are workarounds, but generally no work session this week means no chance for a bill.

HB 2888 is in the House Education Committee. It has not had a work session. It is not scheduled for one.

Hooray.

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A European mink, mustela lutreola.

Should Oregon tighten rules for raising mink?

Recently it was beaver. And now it is mink. The Center for Biological Diversity has aimed to reshape how Oregon treats animals.

The group had filed a petition with the Oregon Fish and Wildlife Commission to get the state to move to ending beaver trapping and hunting on federal land. The commission rejected that last year. This year, the Center for Biological Diversity filed a petition for the commission to move to put mink on the list of prohibited species. The commission may make a decision on Friday.

Oregon has some 11 permitted mink farms with more than 400,000 mink, according to The Capital Press. Moving mink to the prohibited species list would not mean all those farms would have to close. They would, though, be subject to tighter regulation.

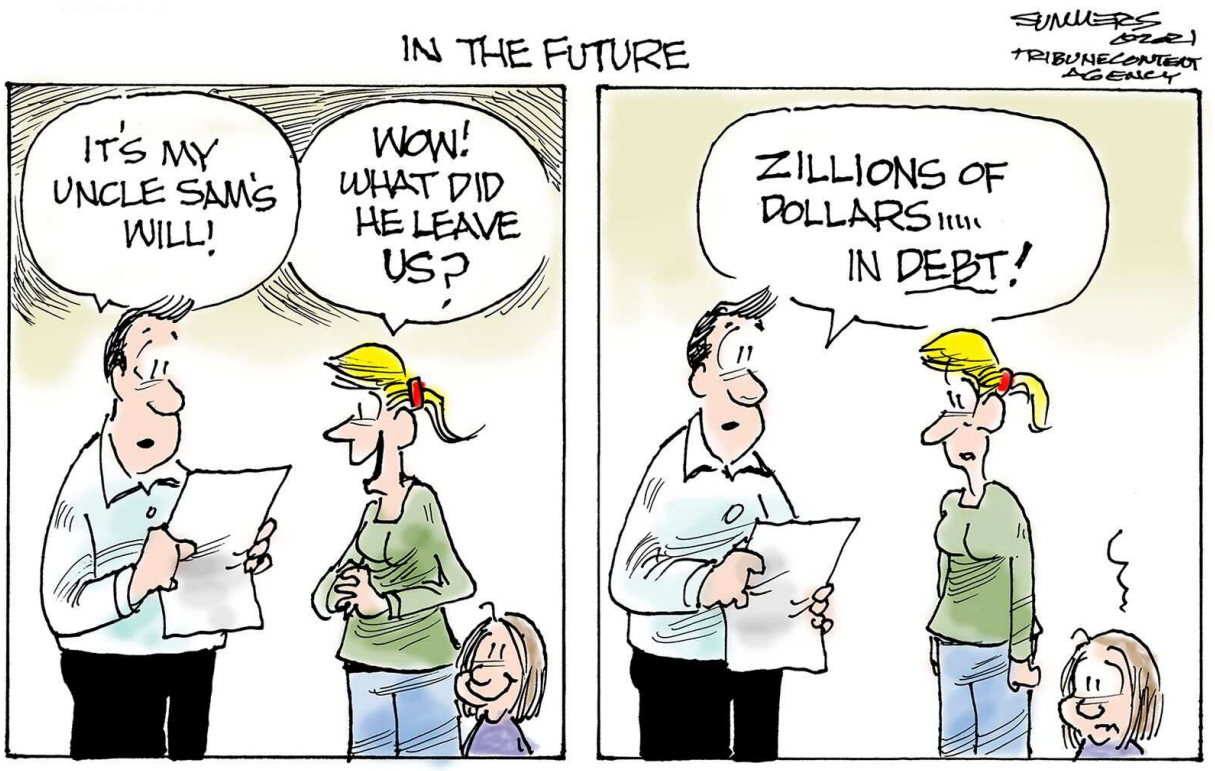
The immediate concern about mink is that there is a threat that mink can help spread COVID-19 to other animals and to humans. There have been cases of mink in this country and others catching the disease. And of course, some people do not want animals raised for their pelts or meat. A bill in the Oregon Legislature, Senate Bill 832, would actually shut down all mink farms in Oregon. That bill does not seem likely to move this session because it is not scheduled for a work session.

Commission staff have reviewed the Center for Biological Diversity's request and recommend that it be denied. It believes there are already adequate protections in place. We have only briefly summarized the issue here, but what do you think the state should do? Let us know. Letters to the editor can be up to 250 words and emailed to letters@bendbulletin.com.

Editorials reflect the views of The Bulletin's editorial board, Publisher Heidi Wright, Editor Gerry O'Brien and Editorial Page Editor Richard Coe. They are written by Richard Coe.

Editor's note

The policy of this page is to allow people to have their say in letters and guest columns but we don't want people to attack other people personally — just their ideas. We recently ran a guest column that took aim at a frequent guest columnist, Rich Belzer, for his lack of credentials. We have never asked Belzer to provide us with a broader explanation of his background and so that was our fault. Belzer's tagline has typically read: Rich Belzer lives in Bend. There is more to Belzer than that. Belzer served as director of federal marketing for a NYSE-listed computer company and was subsequently a senior executive with two Nasdaq-listed high-tech companies. He moved to Bend to join Columbia Aircraft where he became vice president of worldwide sales. We wanted to set the record straight.



Surgical smoke can prove hazardous

BY BRENDA LARKIN

GUEST COLUMN

As a long-time operating room clinical nurse specialist, I work tirelessly for my patients and in support of frontline caregivers. Patients entrust their lives into our hands as members of the team providing them with safe surgical care. Unfortunately, however, my life is also on the line as I inhale the harmful surgical smoke prevalent in operating rooms across Oregon.

Larkin

Surgical smoke is generated in the operating room when electrosurgical pencils and lasers are used to cut or cauterize tissue. In other words, it is the smoke produced from burning human flesh.

Like cigarette smoke, surgical smoke can be seen and smelled. The average impact of this smoke to the surgical team is equivalent to inhaling the smoke of 27-30 unfiltered cigarettes during each day spent in the operating room. Secondhand smoke exposure at this level is not acceptable in our restaurants or bars. Surely, we shouldn't accept it in any of Oregon's healthcare settings.

In addition to causing respiratory illness, asthma and allergy-like symptoms, surgical smoke can contain live viruses such as human papilloma virus. In fact, there are documented cases of HPV transmission from patients to providers via surgical smoke inhalation.

Surgical smoke can also cause cancer cells to metastasize in the incision site of patients undergoing the surgical removal of a cancer. For babies born by cesarean-section, their first breath outside the womb may be one filled with surgical smoke.

Toxic surgical smoke, which contains over 150 hazardous chemicals as well as, carcinogenic and mutagenic cells, can be safely evacuated from the operating room with the use of a simple hand-held device. No expensive construction or HVAC changes are needed. In fact, all operating rooms already are equipped with suction equipment that can be used to evacuate surgical smoke, and costs for the filters are minimal.

For electrosurgical pencils, cost differences between traditional pencils and those with attached evacuators can be as little as a few dollars per pencil.

For decades, several health and safety agencies have recognized the hazards of surgical smoke and recommended surgical smoke evacuation, but there are no state or national enforceable requirements for such evacuation. Even though some Oregon surgical facilities evacuate smoke voluntarily during some procedures, few facilities evacuate consistently during every procedure.

Nurses have little control over whether we are assigned to a smoking or nonsmoking operating room. We are forced to argue for the use of life-saving smoke evacuation equipment at a time when we should all be focused on the surgery at hand.

While hospital associations in Kentucky and Colorado have supported similar legislation in their states, the Oregon hospital association has opposed the legislation here for three years. They argue that voluntary compliance is sufficient.

However, we on the front lines know that voluntary compliance is insufficient because operating room staff in Oregon continue to work in hazardous, smoke-filled operating rooms — even in the middle of a deadly, viral pandemic.

This is why the Oregon Legislature must pass HB 2622 this year and make Oregon a surgical smoke-free state. HB 2622 would require hospitals and outpatient surgery facilities to create and implement policies to evacuate surgical smoke. The bill allows maximum flexibility for surgical teams and facilities to select and use the equipment of their choice.

Oregon must become surgical smoke-free. My health depends on it.

Brenda Larkin is a board member for the Association for periOperative Registered Nurses and an operating room clinical nurse specialist in Bend.

Letters policy

We welcome your letters. Letters should be limited to one issue, contain no more than 250 words and include the writer's signature, phone number and address for verification. We edit letters for brevity, grammar, taste and legal reasons. We reject poetry, personal attacks, form letters, letters submitted elsewhere and those appropriate for other sections of The Bulletin. Writers are limited to one letter or guest column every 30 days.

Guest columns

Your submissions should be between 550 and 650 words; they must be signed; and they must include the writer's phone number and address for verification. We edit submissions for brevity, grammar, taste and legal reasons. We reject those submitted elsewhere. Locally submitted columns alternate with national columnists and commentaries. Writers are limited to one letter or guest column every 30 days.

How to submit

Please address your submission to either My Nickel's Worth or Guest Column and mail, fax or email it to The Bulletin. Email submissions are preferred.

Email: letters@bendbulletin.com

Write: My Nickel's Worth/Guest Column
P.O. Box 6020
Bend, OR 97708

Fax: 541-385-5804

How to make sure people still get tested

BY JESSICA COHEN AND JOSEPH ALLEN
Special to The Washington Post

Public health officials are rightly concerned about the rapid decline in coronavirus testing. Maintaining adequate testing — including among asymptomatic people — will be key to navigating to the end of the pandemic and rebuilding confidence that going to work, to school, to a Broadway show or on international travel is safe. The vaccine rollout is going well, but not everyone will be vaccinated, and we are still many months away from vaccine approval for children. Testing will remain a pillar of our overall public health strategy.

But getting people to take those tests will become increasingly difficult. Health officials too often resort to fear or shame to encourage people to do things, but repeating tired refrains such as, "COVID-19 is a threat!" and, "Get tested!" won't cut it. Instead, we need fresh approaches informed by behavioral economics.

People are responding exactly as we would expect as infection rates decline and vaccinations accelerate. Let's say a person with a cough is deciding whether to get a coronavirus test. We could characterize this choice as weighing expected costs against expected benefits. The expected costs include out-of-pocket costs, travel time and waiting time, as well as concerns about discomfort or about the potential need to quarantine if the results are positive. Expected benefits include getting treatment sooner if the test is positive and preventing loved ones from getting sick.

But here is where declining COVID-19 rates come in: The less likely people are to test positive and accrue benefits from testing, the less likely they will be willing to take on the costs. This is a particularly important problem for many essential and low-income workers, who, because of lack of paid sick leave, are further disincentivized to get tested.

To increase testing, we need to dramatically reduce the costs to testing — for example, offer free, rapid tests that are comfortable, easy to use and available at home. Increasing the benefits to testing is harder, but we can emphasize the benefits in public health messaging of keeping one's community, schools and local economy open. However, we should not rely exclusively on feelings of altruism.

Of course, our decision-making isn't always so rational and carefully considered. One thing we know from behavioral economics, a field that integrates economics and psychology, is that small "nudges" can have outsize effects on behavior. Nudges are small changes in how choices are framed. The classic example comes from defaults. People tend to stick with whatever option they start with. Simply making organ donation and retirement savings opt-out instead of opt-in often leads to huge increases in take-up. Asymptomatic testing programs might find that take-up is substantially higher if the default is to participate. Bundling free, at-home rapid tests with reservations for sporting and entertainment events and distributing them to parents at all well-child visits are other small nudges that could reinforce participation.

On the other side is "sludge." Sludge is the idea that minor costs or inconveniences — such as paperwork and waiting in line — can dramatically discourage participation. Our primary mode of testing — lab-based polymerase chain reaction testing — while important and valuable, is full of sludge.

At-home rapid tests can potentially remove this sludge. Let's meet people where they are: At their home, with plenty of nudges and as little sludge as possible.

Jessica Cohen and Joseph Allen are associate professors at the Harvard T.H. Chan School of Public Health.