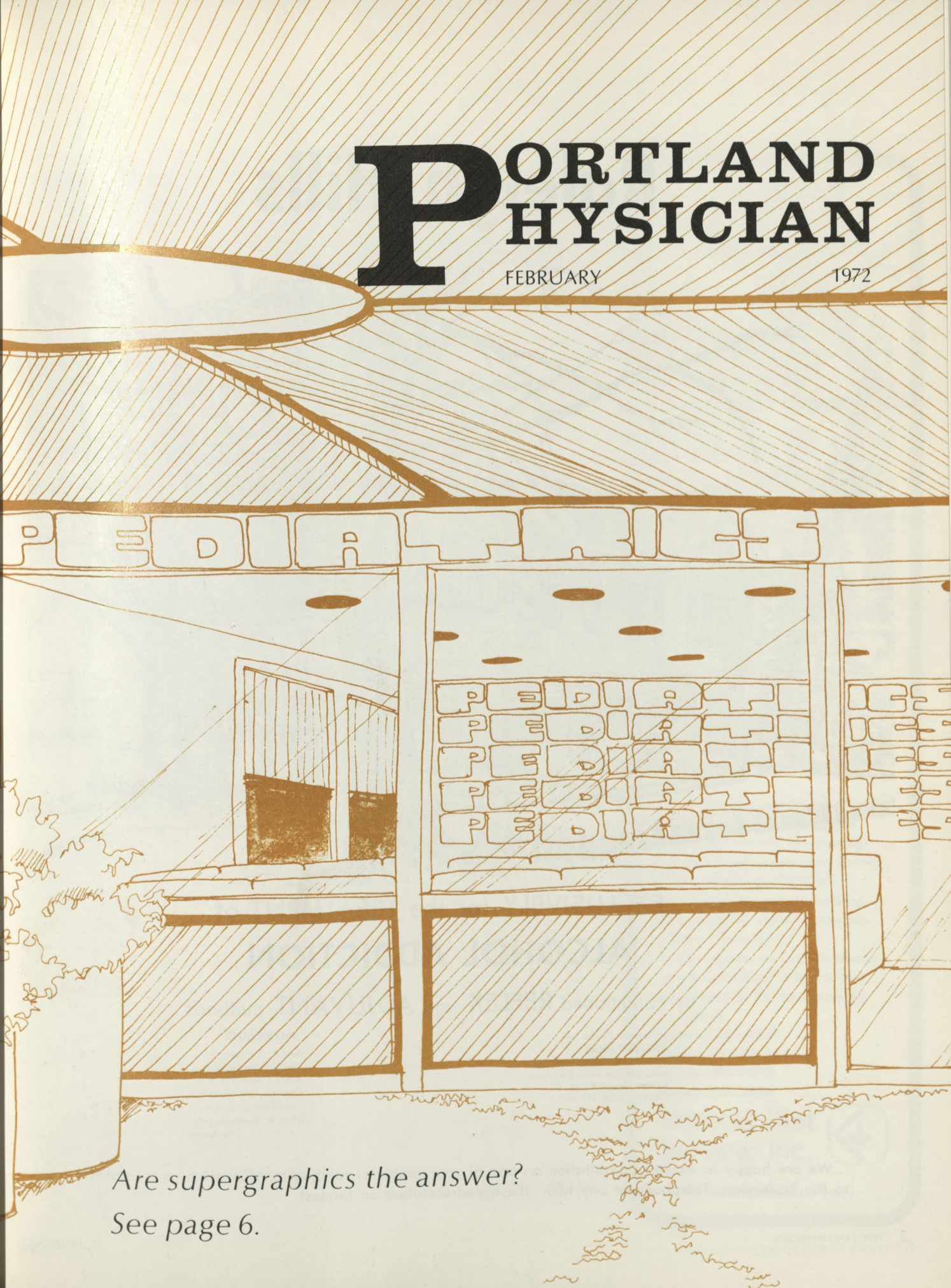
PORTLAND PHYSICIAN

FEBRUARY 1972



Are supergraphics the answer?

See page 6.

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PORTLAND PHYSICIAN

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COVER

SUPERGRAPHICS. What do they have to do with you, a physician? In interviews with several Portland doctors, we learned that supergraphics and other interior design techniques are being used to promote efficiency in the office and comfort for the patients. Perhaps some of these ideas are adaptable to your problem areas. To find out, read "For doctors with problem offices," page 6.

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Address correspondence to Miss Denise Miller, Editor, *Portland Physician*, 2188 SW Park Place, Portland, Oregon 97205. Telephone 222-3326

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Salishan report

Peer review a pain in the neck, but better than losing your head

"Why should any of you in your right minds undertake to involve yourself with this kind of program?" Gerald Besson, DHEW co-chairman of the Experimental Medical Care Review Organization's (EMCRO) steering committee, asked the more than 100 physicians and their wives who attended a Feb. 11-13 EMCRO conference at Salishan.

"It will be nothing but added work loads. You will have impossible deadlines. You'll be beset by exasperating bureaucratic obfuscations and the nagging feeling that it's not going to make any difference in the long run," he continued.

And Dr. Besson answered his own question: "But you're not completely sure that it won't make any difference, and you know that if you don't do it, somebody in Washington will – and he's no where near as right as you are."

Much of the discussion at Salishan, official and unofficial, centered around whether it was already "too late" to head off further federal intervention in the private practice of medicine.

According to Dr. Besson, "This administration in general, and the National Center for Health Services Research and Development (EMCRO's sponsor) in particular, will not ordain any answers. The administration is encouraging pluralism and volunteerism."

EMCRO aims at getting hard data on how to improve medical *quality, access* and *cost*. The Multnomah Foundation for Medical Care is one of eight groups in the nation receiving grants to develop this data.

James Schubert, president of the Medical Care Foundation of Sacramento, and Alan R. Nelson, chairman of the Utah Professional Review Council, described how their EMCRO projects are working.

Dr. Nelson emphasized that the Utah program stressed peer review as educational, not punitive. "It must be done concurrently, to monitor the errors as they happen, rather than retroactively, when the only recourse is punitive," he said.

The educational aspect of peer review was also emphasized by John W. Bussman, president of Multnomah Foundation for Medical Care. Its plans call for the selection of 250 physicians – representative by type of practice, age, education, specialty, etc. Each will be asked to enroll 100

(continued, page 9)

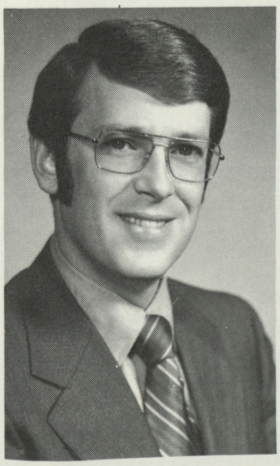
Addition, changes announced in Medical Society staff

Three executive staff changes were announced in February at the Multnomah County Medical Society.

Miss Denise Miller joined the staff as associate executive director and editor of the *Portland Physician*. She replaced Mr. J. David Lortie, who continues to serve as associate executive director of the Multnomah Foundation for Medical Care and as principal investigator of its federally-funded Experimental Medical Care Review Organization (EMCRO) project

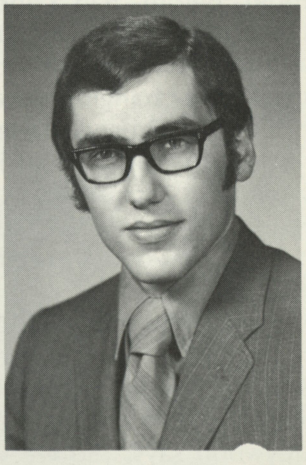
Mr. Richard (Andy) Anderson, assistant executive director for the past year and a half, was named an associate executive director. He will continue to direct the Society's Placement Service and serve as advertising manager of the *Portland Physician*. The changes were announced by Dr. Dale C. Reynolds and Executive Director Robert H. Elsner.

Miss Miller was for seven years editor of the employee magazine at Omark Industries and has been a freelance writer and editor. She was selected as one of the "Foremost Women in Communications in the USA" in 1970, and has served as an officer and board member of the Oregon Association of Editors and Communicators. She received her degree in sociology from Portland State University in 1963.



Mr. Lortie

Miss Miller



Mr. Anderson

Are supergraphics the answer?

For doctors with problem offices

By Miss DENISE MILLER
Associate Executive Director

Doctor, is your bookkeeper grouchy?

Maybe it's the glare she's been getting. No, not from you, but from the lighting in her office.

What about your nurse? Is she less efficient than she could be? Perhaps it's those extra miles she has to walk each day because of the arrangement of your office.

And what about you? Have you been contemplating the expense of moving because your present office is too small, the noise level is distracting, the high ceilings and lighting fixtures create a nineteenth century appearance?

Moving may not be the only solution to these problems. Several doctors in the Portland area have found an answer in interior design – or redesign. Not just to pretty the place up, but to cut down on noise level, to make their patients more comfortable and their staffs more efficient.

Take, for example, the Twelfth Avenue Medical Building where Drs. Stearns, Fearl, Breese, Dahlman and Fearl practice in a two-story building about 20 years old.

They had their waiting room and restrooms redesigned. The waiting room "before" had a linoleum floor, black and grey; three couches, green and tan; some wooden chairs; lighting fixtures hanging down from the ceiling and old-style Venetian blinds.

"The only nice things in the room were two brass lamps that Mrs. Stearns had made," reports Mrs. Naomi Heywood, secretary and office manager.

Aside from the aesthetics of the room, there were other problems. Seating was one. "Strangers just don't like to sit next to one another," Mrs. Heywood says. "So we would have a patient come in and sit down on one end of the couch, another on the other end, and then have people stand rather than sit between them."

That was "before."

The "after" is quite different. So different that Delores Lennon, receptionist, reports that patients would come in the door, look around in bewilderment and leave – thinking they were in the wrong office. (They came back after circling the block a few times.)

The doctors had consulted with an interior designer, Mr. Howard Hermanson, who, by refurnishing, carpeting, changing the lighting fixtures and adding some modern screens, created a waiting room that is warm, modern and comfortable.

"Carpeting is one of the least expensive and most helpful changes, from the standpoint of noise and maintenance, that you can make," says Hermanson.

Lighting is another relatively inexpensive improvement. Fixtures hanging from the ceiling connote "old fashioned" in many minds and often give off glaring light. The building's new lights are flush with the ceiling and give a soft, evenly distributed illumination.

"Mrs. Heywood described the seating problem perfectly," Hermanson said. "Couches in your living room are one thing. Generally the people who are there are friends or acquaintances. In a doctor's waiting room, it's another story. By offering each patient an individual chair, you're respecting his privacy and thereby making him more comfortable."

The arrangement of furniture in your waiting room can ease your patients' tensions or make them more anxious.

Have you ever walked into a large, silent room where everyone was sitting around the perimeter and, as you entered, all eyes fastened upon you? Even the most confident person can feel a twinge of uneasiness in this circumstance.

But that is precisely the situation many patients encounter when they walk into a doctor's office. No longer true at the Twelfth Avenue Medical Building, however. A brightly colored screen creates an attractive entry into the room, where chairs are in small, homey groupings. Orange rugs and tan and orange chairs add to the comfortable feeling.

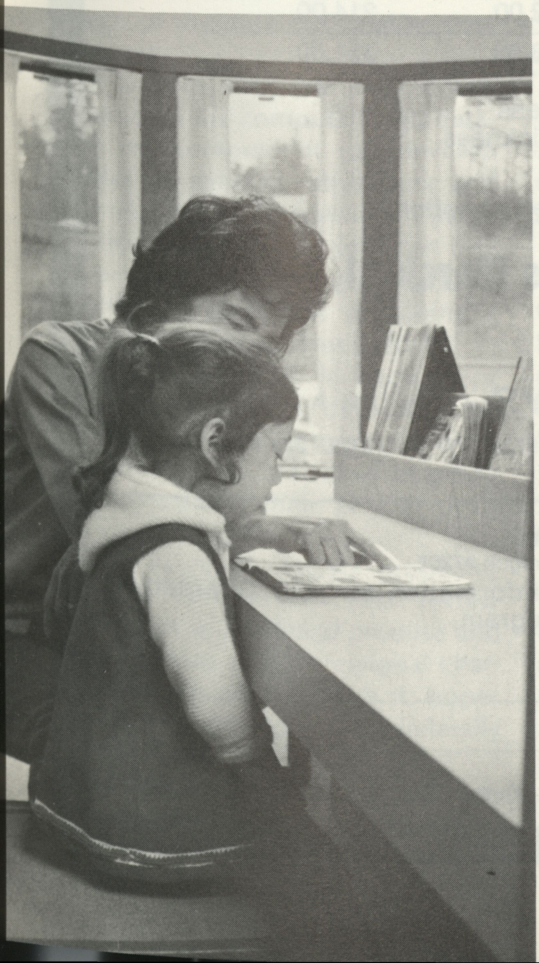
At the Children's Clinic in Sylvan they had a similar problem – one large room, more like a hall, to accommodate patients of all ages.

Here the designer has used several psychological techniques to make the waiting patients happier. Small children are naturally attracted to the sunny area at one end of the hall. A fish tank and a reading table just their size keep them there. And the adults accompanying them can comfortably monitor their activities, but without need for embarrassing "shushes" that are normal waiting room fare.

At the other end of the hall, the designer created an area for teenagers. "Quite often, teenagers don't like to be looked at, or even associate with adults or children," Hermanson says. "So, we took a relatively dark area at the far end of the waiting room, screened it off with smoked acrylic and employed supergraphics in the form of huge photos to make them feel that they, too, had a place in the room."

The Children's Clinic, where Drs. Hansen, Miller, Goodnight, Wert, May, Bussman, Hill, Nash and Campbell practice, also employs supergraphics on its walls. Large pennants, depicting scenes attractive to young persons, help make "going to the doctor" a pleasant rather than fearful experience for children.

Design gives homey feeling to waiting room at 12th Avenue Medical Building.



Tiny table just right for toddlers.

Fish fascinate youngster at Children's Clinic in Sylvan.

Teenagers can 'be alone' in screened waiting room.

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Peer review a pain in the neck (cont.)

patients, about whom he will furnish all information regarding patient-physician, hospital-patient and physician-hospital encounters.

The Foundation will also approach several insurance companies to seek their cooperation in reviewing 30,000 claims – not necessarily those of patients involved in the physicians' programs.

"Our EMCRO project is a 'total' concept," Dr. Bussman said. "It's easier to review the hospitalized patient, but physician-patient encounters are ten times as frequent as hospital-patient encounters.

"We will follow the patient through the whole process, starting with the office call, going with him to the hospital, through extended care or whatever follows, and back to the office.

"By doing this, we will be able to develop hard data about all three aspects of the problem: quality, cost and access."

To achieve this, the Multnomah Foundation will computerize its data. With the computer it can develop profiles of patients, physicians and treatment. It can determine physician practice patterns and whether one physician is doing a poor job or whether all physicians are doing a substandard job in various areas.

"And if we find individuals or groups who are not delivering the optimal quality of care, we can work with them on an individual or group basis to correct their deficiencies," Dr. Bussman said.

Dale Reynolds, MCMS president, told the conference, "Peer review started out as a political promise and has ended up as a professional challenge. If we can influence it, hopefully it will not end up as a federally funded fiasco."

Dr. Besson described the alternative to peer review: "Senator Bennett's amendment has suggested that peer review organizations be developed. First, medical organizations, but if they don't cut the mustard, then organizations which need not be medical organizations. And I see looming in the background the insurance company as an alternative suggestion. Insurance companies are interested in cost savings. Their idea of maximum quality is maximum profit."

And to those who still asked, "why get involved?", Dr. Besson answered, "The only strokes you will get will be the very subtle satisfaction of knowing that you have an impact on the course of events. Your input, particularly in this program, is going to be vital. If for nothing else, then to neutralize the input of some theoritician somewhere who has planned a variety of idiotic and unworkable surprises for you and me and the unsuspecting public.

"Life could be much more bucolic if you let someone else do it. But if the private sector is to maintain any measure of control over its destiny, it will have to be done by our all taking the hard road."

Dr. Ray Casterline heads national medical group

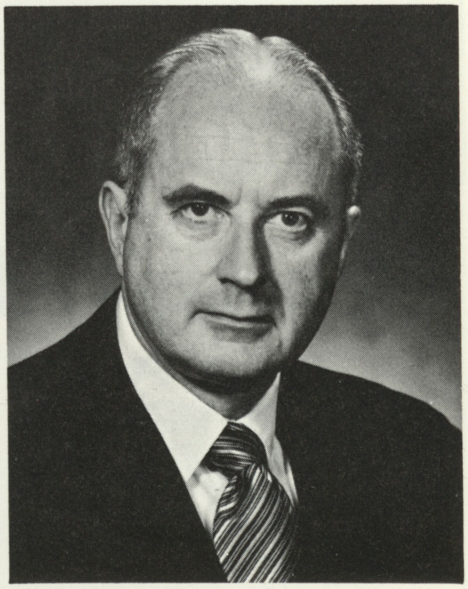
Ray L. Casterline of Medford became president of the Federation of State Medical Boards of the United States during the organization's 1972 annual meeting in February.

Dr. Casterline will preside over a membership drawn from medical licensing boards in each state, the District of Columbia, insular possessions and Canadian provinces.

He first became involved with the organization in 1964 as a member of the committee that developed the Federation Licensing Examination (FLEX) and has served as chairman of that committee for the past two years. Success of the program can be measured by its use in 7 states in 1968, 35 in 1971 and, in 1972, 43 states and at least one Canadian province are scheduled to use it in June.

For a number of years Dr. Casterline has represented the Federation as a member of the National Board of Medical Examiners. He has edited the *Federation Bulletin,* a monthly periodical featuring scientific papers and news articles related principally to medical licensing, discipline and allied subjects.

A graduate of Northwestern University Medical School, Chicago, Dr. Casterline has been a resident of Oregon for more than 25 years. Prior to his moving to Medford in 1950, he practiced medicine in Portland for a number of years. In 1959 he was appointed to the Oregon State Board of Medical Examiners and has served two terms as president of the board.



Dr. Ray Casterline

TB testing change to begin March 1

March 1 is the date slated by the Multnomah County Division of Public Health for the changeover from chest X-ray screening to Mantoux tuberculin testing for tuberculosis.

According to the Division, skin testing more closely conforms to current U.S. Public Health Service guidelines and has the strong endorsement of the Oregon Council on Tuberculosis.

With the Mantoux test, it is possible to detect infection by the organism causing tuberculosis before a person becomes ill. Treatment without hospitalization is adequate for those infected before they develop clinical TB, the Division maintains. The previous X-ray screening could not detect infection without disease and was, therefore, a less desirable and more costly method for preventing tuberculosis.

Public health officials estimate that 60,000 Multnomah County residents are infected with the tuberculosis germ. In 1972, they expect 120-135 new active cases will be reported, mostly among single, white males 45 years of age or older. Each new case infects approximately four other persons.

The Mantoux test will consist of 0.1 ml intermediate strength Purified Protein Derivative (PPD) administered intradermally. The changeover requires a change in clinic hours to facilitate reading of the test at optimum reading time. The 14 - by 17-inch X-ray will continue to be offered to those whose Mantoux test results read positive.

New clinic hours are, at the 104 S.W. 5th Ave. clinic: Monday, 9 a.m. to 5 p.m.; Tuesday, 11 a.m. to 7 p.m. and Friday, 9 a.m. to 5 p.m. At the 12240 NE. Glisan St. clinic they are Monday, 9 a.m. to 5 p.m. Tests are interpreted approximately 72 hours later, from 9 a.m. to 4 p.m.

Society volunteers needed to help staff free clinics

That clinics are "stop-gap medicine, but better than nothing," seemed to be the consensus of the members of the Committee on Medical Care to the Poor at their February 7 meeting.

The committee had voted previously to include a coupon which members of the Society could return to indicate interest in serving at the various clinics. (See coupon at below.)

"No endorsement of the clinics or their policies is implied by this action," Dr. Louis O. Machlan, committee chairman, emphasized. "We do feel, however, that many of our doctors may be interested in performing this kind of social service, but do not know how or where to contact the clinics," he continued.

By returning the coupon at right, any Society member may indicate his interest in volunteering to participate in staffing a free clinic. His name will then be given to clinics requesting physician volunteers. (If interested in serving only with a specific clinic, it should be so designated on the coupon below.)

The volunteer physician can then arrange his schedule directly with the clinic or decline to serve. Those who *do accept* a volunteer position are requested to alert the Society's staff (222-9977) so that his name will *not* be passed on to other clinics.

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VNA faces dilemma: name change in order?

By J. GORDON GROUT, M.D.

The dilemma facing the Visiting Nurse Association is a reflection of the changing nature of the services it provides. On the one hand, Visiting *Nurse* Association conveys the impression that only nursing service is provided. On the other hand, changing the name would mean abandoning that which for 70 years has stood for part-time nursing care to patients in the Portland community.

Many physicians are unaware that the VNA has a staff of physical, speech and occupational therapists in addition to the traditional nursing services. The Rehabilitation department provides these specialized services to patients in their own homes, homes for the aged, nursing homes, extended care facilities and hospitals.

Other services provided by the VNA are medical social service, home health aide and visiting aide. The latter includes personal care of a non-professional nature and is the only service not requiring specific orders from the attending physician.

Members of the Board of Directors have proposed a compromise solution for the problem of agency name. Why not call it VNA and Rehabilitation Services? suggested one member. That is where the matter rests for the time being.

It's your turn at bat

MEMCRO support urged by physician

BY ROBERT O. VOY, M.D.

On February 12th nearly 100 Multnomah County physicians met at Salishan to receive in the words of President Dale Reynolds, "a clear and concise understanding of peer review." So big deal! What difference will it all make with the ominous signs of national health insurance and federal controlled medicine a foregone conclusion?

Not necessarily so. It doesn't have to happen and I am not sure it will. The majority of doctors present were probably of the same conviction; therefore, we listened with interest to the inspirational words of Dr. Gerald Besson, co-chairman of the EMCRO Steering Committee Department of HEW, who greeted us with salutations on being the fortunate recipient of one of eight national grants for formation of experimental medical care review organization (EMCRO).

This was followed by the enthusiastic Dr. Alan R. Nelson, chairman of the Utah Professional Review Counsel, and the very proficient James J. Schubert, president of the Medical Care Foundation, Sacramento, California.

The sum total of all of this was to convince us that EMCRO might be the answer to President Nixon's recommendation for changes in health care delivery, the public's cry for availability and economies in medicine and the combined clamoring for cost control in the health industry.

National health insurance has not made great strides in spite of heavy pressure for the past three years. Our legislators are not dumb. They know that government can't meet the needs at less cost with the same or increased quality program. They know that we doctors, and only we, have the ability to deliver medical care and no other lay, corporate or government group can do it better – functionally or economically.

1972

Only doctors can control cost and at the same time deliver the highest quality of medical care possible. I say this knowing full well the claims often heard from prepaid groups and many of our Scandinavian and British friends with their socialized systems of care. The record has never proven that our system is secondary. The private enterprise system of medicine is still the best in the world. For that matter, experience has demonstrated that the public sector looks to medicine to solve many of its current problems, examples of which are medicine's involvement in education, labor movements, welfare, housing, prison reforms, auto safety and on and on.

It appears that national health insurance is at present held up, and will be for the next 2-5 years. In the interim medicine has been granted time to make its own reforms. Legislators have indicated through such recommendations as Health Maintenance Organizations and Peer Review that we might take care of our own problems.

Since there is some time left for us, I think it behooves us to pull our ranks together and try on experimental concepts. If we can benefit our ranks through these programs and at the same time preserve the individual concept of fee-for-service medical care, then we may postpone socialized medicine indefinitely. It appears we have nothing to lose in trying. The key mechanism to accomplish these goals is Peer Review. Peer Review can correct professional deficiencies, assist in more equal distribution of care and control spiraling medical costs where these controls are needed (i.e.: Hospital and Paramedical areas).

This is the challenge that has been handed us in accepting the Health Education Welfare Grant to establish the Multnomah EMCRO (MEMCRO) program. Unfortunately, the hour is indeed late and pressure is being brought to bear by such legislation as the proposed Bennett Amendment. Within this legislation is the directive that medicine should first be given the opportunity to formulate professional services review organizations (PSRO). But in the event we fail, the government is prepared to step into the gap. Clearly we must get with it. Multnomah EMCRO needs the undivided cooperation and encouragement of our Society membership.

The only opposition seems to be from the uninformed or those who ask the very questions that EMCRO will attempt to answer. Namely, will and can fee-for-services medical care be maintained? Will independent as well as small group practices survive? Will physicians be allowed administrative control? Will it deliver quality, one-standard care? What contracts or arrangements can be made to assure us of continued administrative authority if such programs indeed become a reality? Can discipline be educational rather than punitive, etc.?

If we find the answers to be categorically *no* to these questions, then we can modify or terminate the program. At present answers to these questions are simple conjecture. We must get facts through research. Let's get behind a scientific approach to our problems. We must keep medicine out of the greedy and unfriendly hands of partisan politicans and those of uninformed laymen. We *provide* and we must *control.*

Your Society and EMCRO need your support and communication. If you are interested, we still have time to provide each and every member a "clear and concise understanding of medical care review." It could be our last request for an independent, united and harmonious profession. Stopping at third base adds no more to the score than striking out. Let's not default.

Exec committee protests: loca

By ROBERT H. ELSNER

Local physicians and hospital people have expressed great concern over a recent trend in Oregon by the Medicare Claim Administration to control costs under the Medicare program. There is widespread feeling that local interpretations and directives go beyond the intent of the law, and are imposing unfair hardships on patients.

Of particular concern has been Medicare's (Aetna's) interpretation in areas of diagnostic testing, as outlined in writing to at least one local hospital. In December, the Oregon Administrator of the Medicare Claim Administration wrote a hospital business manager, in part:

> "... In the area of diagnostic testing, there is often a fine line between required testing and a preventive medicine test. An electrocardiogram taken on a 75 year old to determine the degree of surgical risk may be very good medicine. It is, nonetheless, a preventive test and not one for diagnosing the condition for which surgery is contemplated. It is at this point that good medical practice comes into direct conflict with expense covered under Medicare. In short, we just do not cover certain things, even though ordered by the physician in practicing good medicine. Specifically, covered diagnostic tests must be performed in direct relationship to the diagnosis for which the patient is being treated ..."

The Society's Executive Committee and Board of Trustees have taken exception to the rigid interpretations by Medicare, as have representatives of the Portland Council of Hospitals. It was agreed to convey the Society's protests to members of the Oregon Congressional Delegation, to officials of the Medicare Claim Administration and to the news media.

Physicians can assist in protesting the increasingly bureaucratic attitude of Medicare by individually writing their Congressman and Senators, and also protesting to Mr. A. G. Lindstrand, administrator of the Medicare Claim Administration, Yeon Building, Portland.

One result of Medicare's tough-line attitude has been for at least one hospital to ask each patient having an EKG to pay for the physician's component of that service, unless there is a direct relationship of this test to the diagnosis.

Isn't it interesting how aspects of the Medicare law are interpreted and applied differently in Oregon than in some other states? And isn't it also interesting how the original law is changed and bent by bureaucratic decree?

* * *

A potentially more serious, and possibly related, situation resulted last month in a Philadelphia court decision which could make physi-

nterpretation goes beyond law

cians liable for some of their patients' hospital bills. A municipal court judge held a physician responsible for hospital costs incurred by a patient that Blue Cross refused to pay.

Needless to say, this first-of-its-kind case could have broad implications for the medical profession, if the decision is not overturned in appeals to higher courts.

Blue Cross had refused to pay most of the bill because its contract does not cover hospitalization for diagnostic purposes. It maintained that the patient should have been handled as an outpatient, concluding that the inpatient charges (room and board) were "unnecessary." When the patient refused to pay the bill, the hospital instituted collection procedures, and the case went to small claims court.

Some local physician-subscribers to the Society's Radio Paging Service will soon be using a new, smaller, lighter and more sensitive radio unit. Known as "Pageboy II," the newly-introduced radios are going to gradually replace the large "Pageboy" receivers over a period of approximately the next two to three years.

Transition to the new units will be determined by the age of the older units, which will be "retired" and traded-in for new units. So, in effect, those physicians who were early subscribers when the Society began offering the service in 1966 and 1967 will be among the first to receive the new units.

As in the past, the Society obtains the radios on a lease-purchase arrangement from Motorola, carrying the contract over a five-year period. A trade-in on the older units which have been paid-off will probably enable the Society to offer the new radios at the same, or only slightly higher, cost than the existing Pageboys.

While we anticipate demand for the new radios to exceed supply, it is important to emphasize that only the older radios will be phased-out initially. Then, as other radios are paid-off and traded-in, additional "Pageboy II" units will replace them.

It is felt that priority of conversion to the newer units rightfully belongs to those physicians who have subscribed from the early days of the Society's Radio Paging Service.

We'll be happy to answer any questions regarding the new radio units, or the Radio Paging Service in general.

In Summary

Official Publication, Multnomah County Medical Society February 1972

SUMMARY. ACCORDING TO FUNK & WAGNALLS, "summary" means (1) giving the substance or sum; greatly condensed; concise. (2) performed without ceremony or delay; instant. It seemed a perfect description for this insert in the magazine, which is intended to give you up-to-the-minute-before-publication information in a condensed form.

THE AMA WILL POLL ITS MEMBERS next month (March). Questionnaires will be mailed shortly after March 15, containing seven questions to determine the membership's opinions on AMA policies and activities and on national issues facing the profession.

GOVERNOR RONALD REAGAN, an honorary MCMS member, recently signed into law a bill extending chiropractic coverage under workmen's compensation. The law permits an employee to receive chiropractic service, with or without the employer's approval, if he is dissatisfied with his medical treatment.

AND SPEAKING OF CHIROPRACTORS, the American Chiropractic Assn. has launched a national publicity campaign which capitalizes on the drug abuse theme. "Don't be a pill popper," say the ads and posters. "Protect your health with spinal care." The goal of the campaign was made clear in the instructions on the use of the kit sent to state chiropractic groups--"An anti-drug approach is more beneficial and meaningful to the chiropractic than any other profession, because doctors of chiropractic do not prescribe drugs."

EDWARD PRESS, OREGON STATE PUBLIC HEALTH officer, is the new chairman of AMA's Council on Environmental and Public Health. Dr. Press was also recently elected president of the Conference of State and Provincial Health Authorities of North America and of the American Association of Public Health Physicians.

MEMBERS ELECTED PRESIDENTS of various organizations. Stephen W. Maks was elected president of the board of trustees of the Leukemia Association of Oregon. James MacD. Watson was elected, for a second term, president of the Epilepsy League of Oregon. Arch W. Diack is president of the board of directors of Goodwill Industries. Dr. Diack has been on the Goodwill board for 14 years.

RICHARD J. HOPKINS AND MICHAEL T. H. BRODEUR have been named to head the medical staffs at their hospitals. Dr. Hopkins, an orthopedic surgeon who interned at Emanuel and returned there to complete his specialty training, was installed as president of the Emanuel medical staff. He had previously served four years as chief of the hospital's orthopedic service.

Dr. Brodeur was installed as chief of the medical staff for City of Roses Hospital. A specialist in cardiology, he received his medical degree from McGill University. His internship,residency and senior assistant residency in Internal Medicine were at the Royal Victoria hospital in Montreal. He is an assistant clinical professor in medicine at the University of Oregon Medical School.

THE AMA SUBMITTED A DETAILED STATEMENT in February to the Senate Finance Committee. It presented the Association's views on nearly 30 health proposals included in 1971 Social Security Amendments. The AMA Newsletter says that provisions of greatest significance to the medical profession are those dealing with "health maintenance organizations," peer review, limitations of fees and catastrophic insurance.

The AMA strongly recommended that the "professional standards review organization" (PRSO) amendment not be enacted because further experimentation with a variety of peer review mechanisms is necessary. "PRSO would lock peer review into one single, untested, nationwide program with unpredictable consequences," the AMA cautioned. The AMA said such a massive program would be extremely costly and would duplicate many existing peer review resources.

Mr. James D. Knebel of the National Association of Blue Shield Plans asked in his testimony that carriers be given a greater role in utilization review on the basis that peer review can only be effective on a large scale when it is supported by claims review. He stated that much of the information required of the PRSO, as envisioned in the Bennett Amendment, could be more effectively gathered by the carriers.

The American Association of Foundations for Medical Care, through F. William Dowda, firmly supported and endorsed the Bennett Amendment to establish PRSO's. Dr. Dowda told of the successes of foundations in reducing costs and improving the educational processes of medicine.

Mr. Richard M. Loughery appeared on behalf of the American Hospital Association. He favored strong utilization review programs and urged support for the H.R. 1 provision authorizing experiments and demonstration projects in area-wide peer review.

THOROUGH TESTING OF THE CAPABILITY of Government contract practices to achieve savings should be made through controlled demonstrations before any attempt is made to initiate nationwide coverage for Medicare beneficiaries under this type of practice arrangement, the AMA urged. Under one proposal now before Congress, Medicare beneficiaries could elect to receive their services through contract practice. The government would pay up to 95% of the estimated costs of similar services provided by existing health delivery systems.

The AMA raised objections to an amendment under which government would increase its financial support under Medicaid only when services are provided in a government contract practice (HMO) or community center. Such an approach, it said, would tend to destroy a patient's choice of medical care and might lead states to require that medical care under Medicaid be furnished only in favored settings so they could capitalize on additional federal funding.

THE GOVERNMENT WILL MAKE CAPITATION PAYMENTS for 3,500 Medicaid patients who are expected to enroll in a prepaid group practice health program in Baltimore. This marks the first time that it has contracted to provide capitation payments for Medicaid patients. Under the experiment, monthly payments ranging from $14-24 per person will be made for the enrollees. In addition, the Public Health Service has awarded a one-year, $600,000 contract for the plan to cover a second group of enrollees having incomes too large to be eligible for Medicaid benefits, but too small to afford private health insurance.

'NOSE JOB, ANYONE?' is the title of an interesting bit in the EMKO Newsletter: "At some time in the future, man's reproduction may be influenced by modification of his sense of smell, providing a new method of birth control. This is one of the possibilities being investigated at the first major institute devoted exclusively to the senses of taste and smell--the Monell Chemical Senses Center and the University of Pennsylvania. Through tests at the center, researchers are discovering that the sense of smell is vital for reproduction in many animal species. It is possible that smell will be discovered to be a critical factor in human reproduction.

WANTS TO HELP. Placement Director Andy Anderson asked us to pass on this information about a young man who wants work as a physician's assistant: William Sievertsen, 22 years of age, has had 2½ years' experience as a medical corpsman in the Army, 1 year of technician training in the Army, is a certified O.R. technician and is currently working as a surgical technician. If interested, write him at 10807 S.E. Fuller Road, Milwaukie, Oregon

IT MAKES HIM MAD. George Robins told Mr. John Tuttle of KGW-TV that yes, he accepted Welfare patients, but it made him mad to get 45% of his usual and customary fee, while the cab driver who transported the patient got 100%. The occasion was a

taped interview with seven east-side physicians regarding their practices in treating the poor. Mr. Tuttle filmed the interviews at Salishan for airing on the March 20 "Northwest Notebook" show. Also "starring" in the program will be William A. Fisher, Willis J. Irvine, Louis O. Machlan, Dale C. Reynolds, William M. Ross and Augustus M. Tanaka.

A WOMAN OF ACCOMPLISHMENT AWARD for 1971 went to Mrs. G. Prentiss Lee for health education. "Being the first Oregon woman ever to be elected president of the Woman's Auxiliary to the American Medical Association provides a framework in which to picture the contributions of Mrs. G. Prentiss Lee," the Journal article said.

CALENDAR OF EVENTS: This will be a regular feature of "In Summary," so we would like to encourage you to send us information to include in it.

March 2......"Pots - Prints - Presents" show at the MCMS headquarters, 10 a.m. - 8 p.m. Presented by Woman's Auxiliary, Gallery West and Contemporary Crafts. Admission $1.00.

March 4.....OMA Board of Trustees meeting, 9 a.m. - 4 p.m., Burton Town House, Corvallis.

Any Wednesday...Methadone Clinic open for physicians' perusal, 2-6 p.m., 309 S.W. Henry; Drs. Blachly and David.

March 13.....Filing deadline date for April 13 - 15 meeting of the Board of Medical Examiners.

March 16.....Press dinner, MCMS headquarters.

March 29.....Board of Trustees meeting, MCMS headquarters.

April 3.....MCMS Quarterly Meeting, Sheraton Hotel, Congresswoman Edith Green speaking.

April 14-16.....OMA mid-year meeting, Country Squire.

May 3-5.....Oregon Academy of Family Physicians' silver anniversary meeting, Sunriver.

May 5-7....."Seminars for improvement in interpersonal relationships," Physicians Institute meeting, Inn of the Seventh Mountain.

AND A CONCLUDING THOUGHT. Emanuel Progress magazine recently carried this quotation from the brittle pages of old records: "1937: The constant agitation for state medicine and hospital service has been acute." As the article comments, "Some things never change."

Letters of interest

Nasty questions will save time

Dear Dave:

The January comment by Dr. Bea Rose stirred a dormant germ in my cerebrum. Why not have a monthly column in the magazine in which a single field of practice is held in open season to receive and answer the questions of the other fields? Burning questions could be handled such as: Why don't the Ob-Gyn's take care of the above the navel complaints of their lovely young patients? Why do the radiologists charge for a Monday reading of a fracture casted Saturday afternoon? Why do closed panel physicians feel the time and mileage of their patients doesn't make up for any saving in office fees? The questions could be solicited by scheduling each specialty or whatever for a given month, (all questioners anonymous; it would be a shame to lose a referral or two). The answerer could be the most facile of his group and would be allowed to use his name.

The results might be interesting. Less time to make rounds; we wouldn't have to listen to orthopedists complaining to dermatologists about urologists anymore. More readers; everybody likes someone else to be asked nasty questions. Lower dues; maybe we could copyright it and sell it to one of the throwaways. Someone might even get around to answering Dr. Rose's question.

Sincerely,
John H. Springer, M. D.

Ed. note: Dr. Springer has volunteered Pediatricians to be the first specialty to field your questions. However, if you would enjoy asking nasty questions of any other field, feel free. We'll have an informal contest, and whichever specialty wins the nasty-questions-contest will appear in the next issue of the Physician.

Dear Sir:

Dr. Oppie McCall in the December 1971 issue of the Portland Physician has written an excellent resume of the technique of interval or post abortal sterilization by colpotomy.

I agree wholeheartedly with his thoughts relative to the subject of sterilization, but I feel that the comments relative to the laparoscopic sterilization need to be discussed further.

A *trained* laparoscopist can perform most laparoscopic procedures including tubal sterilization with the aid of one assistant, not necessarily another physician as in all operative procedures, a scrub nurse, a circulating nurse, and a qualified anesthetist are required.

Special equipment is needed, but the cost of this equipment is not beyond the reach of most hospital budgets and the multiple uses of the equipment would amortize the expense quite rapidly. A diagnostic laparoscope and second puncture instruments are quite adequate. The operating laparoscope is an unnecessary luxury.

Dr. McCall speaks of the necessity of procuring a surgical specimen to demonstrate interruption of tubal continuity. I do not believe this is necessary. However, the use of the specially designed Cohen-Eder biopsy forceps will enable the Gynecologist to procure a segment of tube if he feels he must have one.

Another advantage of the laparoscopic approach is the panoramic view of the pelvis afforded by the instrument. This view is similar to that seen at laparotomy, but is superior in its detail because of the magnification of the lens.

Laparoscopy enables the Gynecologist to see the internal genitalia in their entirety without the need for laparotomy and the indication of sterilization enables him to perform this valuable diagnostic procedure.

For the Gynecologist who is trained in this procedure, sterilization by laparoscopy is as good a procedure as vaginal sterilization and offers the patient additional advantages she cannot receive from the latter.

Sincerely,
Phillip S. Alberts, M.D.
ALBERTS CLINIC

Board approves 1972 budget

The 1972 budget for the Multnomah County Medical Society was approved by the Board of Trustees at its January meeting. Estimated expenditures are $156,484, up from $147,370 actual expense in 1971. Income for 1972 is estimated at $161,350, compared to actual income of $153,478 in 1971.

Membership dues will account for the major portion of the income, with $90,000 expected in 1972. Services to members will generate the remainder. The printing and stenographic service is expected to contribute $30,000; the Portland Physician, $7,200; meal service, $9,000; Radio Paging, $9,000 and Placement Service, $7,500.

Salaries and benefits, at $71,225, and office management, at $75,767, were the largest areas of expenditure. The Woman's Auxiliary, with a contribution of $2,175 (up from $1,460 in 1971) and commission-committee expense of $4,700 accounted for a portion of the increased expense.

Fifteen Portlanders licensed to practice

Fifteen Portland physicians were licensed by the Board of Medical Examiners at its January meeting, according to Raymond M. Reichle, secretary.

Doctors newly licensed to practice in Oregon are Janice Mae Wood Anderson, Eugene Blank, Gary John Delorit, Eugene Fredrick Fuchs, Mary Patricia Garlinger, Beatrice Thomas Bloom Gilbert, Jon Michael Hanifin, Robert Fleming Harris, Jr., David Charles Holman, John Halisey Kennedy, Harold Robert McCartor, Carter Noland, Richard Alan Schaefer, Mark Lewis Teitelbaum and Robert Hendrick Turner.

Editor's note:

There've been some changes made

If only to show that you have a new editor for the *Portland Physician,* we've made some changes in this issue of the magazine and would like to make some more – with your help.

Probably the most obvious change was in the cover. Perhaps you'll miss those beautiful scenic photos of Oregon that had become a standard feature of the magazine. We can't argue with their beauty, but we do believe that with our limited space, we should when possible, tie the cover to some feature inside the magazine.

A second change is the colored newsletter insert in the center of the book. This is intended to add space for last minute information, for a calendar of events (*and this is one area where we need your input)* and to summarize short articles of general interest. Best part about it, Mike Grantz prints it at the Society's headquarters and saves us a lot of money!

In the beginning we asked for your help. The easiest way you can do this is by alerting the editor (222-3326) to events that should be covered in the magazine.

A second, harder, way is by contributing articles, letters and ideas to the *Portland Physician.* It's not a technical magazine, but with all the ferment in the medical profession at present, we believe that there is a wealth of other material out there – hopefully in your minds – that would make interesting reading for your fellow physicians.

Controversy corner

Doctor says HMO an alternative

By J. DAVID LORTIE
Associate Executive Director
Multnomah Foundation

One of the best explanations of the HMO concept was given in West Linn in October before a meeting of the Clackamas County Medical Society. Talking to the Clackamas physicians, whose Physicians Association of Clackamas County plan is very close to a HMO, was Walter J. McClure, Ph.D, one of the major contributors to the HMO concept in health care delivery.

Because Health Maintenance Organizations are something more than mere talk now in Portland, it seems appropriate to extensively quote from Dr. McClure's speech. A single copy of the speech is available to read at MCMS headquarters.

"The health care crisis is not really one problem but two. There is a financing problem; that is, getting dollars to people who need the dollars to buy care. And there is a delivery problem; that is, we have to be concerned about the system that delivers the services that the dollars are supposed to buy.

"It's the financing that happens to be getting the most press. And the press is not really covering the fact that here is all this Democratic and Republican agreement, that the thing that we need to do on our delivery system is going to look a lot like what we're calling Health Maintenance Organizations. In fact, there seems to be a realization that if you don't have some fundamental reform in your delivery system that all these promises of new dollars are just rhetoric. If you don't do something to your delivery system to increase its productivity and capacity, then you can put all the new dollars in you want and all you'll get is inflation.

"A true solution has to deal both with delivery and financing. It cannot deal with just financing alone. And that's what the HMO strategy is. It's really a delivery reform.

"It seemed to us that the government had two choices. It could continue its piece meal planning regulatory investment strategy. Or you could really try something fundamentally new. You could try to offer the health care system a new structure which would allow it to be more self-regulating so that the government could actually withdraw from the day to day operation of the health care system. And that's what the HMO strategy is about. It tries to introduce new structures and new incentives so that the health care industry can be self-regulating.

"What's the trouble then (with the current health care system)? It's structural and the structural elements really boil down to two that are deficient. They are the fragmented organization and backwards incentives.

"The fragmented organization. The units that deliver care are too small, too specialized, and too separated to be as efficient or effective as they could be. We have separate primary doctors, separate specialists, separate hospitals, separate insurers, separate nursing homes, everything is separate.

"Now let's go on to the other thing, misdirected incentives. I think the simplest way to see this is that the physician is actually rewarded for sickness not for health. In putting this more specifically, a physician is paid for services and he's rewarded for services – more services and more expensive services. The real problem is it removes a cost consciousness from the health care system. It sort of takes the lid off. And this taking the lid off gets aggravated by some other incentives in our system.

"Let's take the third party insurance problem. Third party insurance really removes the financial contingencies from both the provider and the consumer. It really insulates them from the financial consequences of their behavior.

"Let's talk about how the HMO model tries to deal with these problems of organization and incentive. Here it comes – definition of HMO. Three elements. The first is integrated comprehensive units of care. The second is prepayment. The third is pluralism and competition.

"Integrated comprehensive units of care. This is what we call Health Maintenance Organization. They contain all the major elements to provide health care for a whole persons. And at a minimum we mean physician care and in-patient care. And eventually we certainly hope that all the rest of the units will gradually be brought under each HMO's organization unit – dental care, nursing home care and so forth.

"What does this get you. First thing it does – in cost you have the possibility for economies of scale. Now I don't think these are necessarily great in physician practice, but they are great in hospital care. You can separate your functions of medical practice and management. You can substitute allied health manpower when you have these larger units much easier. You can computerize and you really integrated physicians' positions within the hospital.

"What does this do for you in terms of quality? The most obvious thing, it's got one-stop access for the consumer. He knows where the front door is now. He goes there and there's a primary physician to guide him through this system. It makes physician consultation amongst their colleagues much easier. You can have continuous medical records and continuity so that one provider knows what the next one is doing for a pjpcular patient. All these are aspects of good quality medicine.

"Distribution, I think we have our hands on a realistic solution with the inner cities and the rural areas, because the organization can hold the practice and positions can be mobile within the organization. This seems to us a way to create mobility of physicians into difficult-to-serve areas, without trapping a physician there.

"Now let's talk about the second element, prepayment. The enrollee in HMO has his choice to decide if he's going to enroll with an HMO or stay in the traditional system or he has his choice of several HMO's eventually I hope. And he pays them a fixed sum a month, for all the care, regardless of the amount.

"What does this get you? Well, in cost it really turns everything around. In the old traditional system, fee-for-service, each service represents income. But in an HMO you get income through enrollment, and each service represents a cost. So what you now have in an HMO is a tremendous incentive to treat early, to prevent as much illness as practical, to treat the patient in the most economical site. And remember all the sites are now in the organization. We've tried to vertically integrate a health care system together under one organizational roof. So we have a cost consciousness and we have created structure where that cost consciousness can be effective. And the system is motivated to not only do good medicine because if you don't do good medicine your patients are going to get seriously ill and it's going to cost you money. But they're motivated to do it in the most economical way. This is a new element introduced into the health care system, a cost consciousness.

"There is another way of looking at this and that is prepayment really frees the system's income for being tied to services. What the HMO gives you is an opportunity – it says, here is so many dollars for each member for each month; you spread these dollars, you the professionals, spread these dollars over this system in the most effective way to keep these patients well. You're not tied to particular kinds of income and services. We're going to give you so much money, you run a health care system.

"Another thing that happens by this prepayment incentive is that the savings can be passed from one unit to the other. You've eliminated the third party insurance mechanism.

(continued, page 31)

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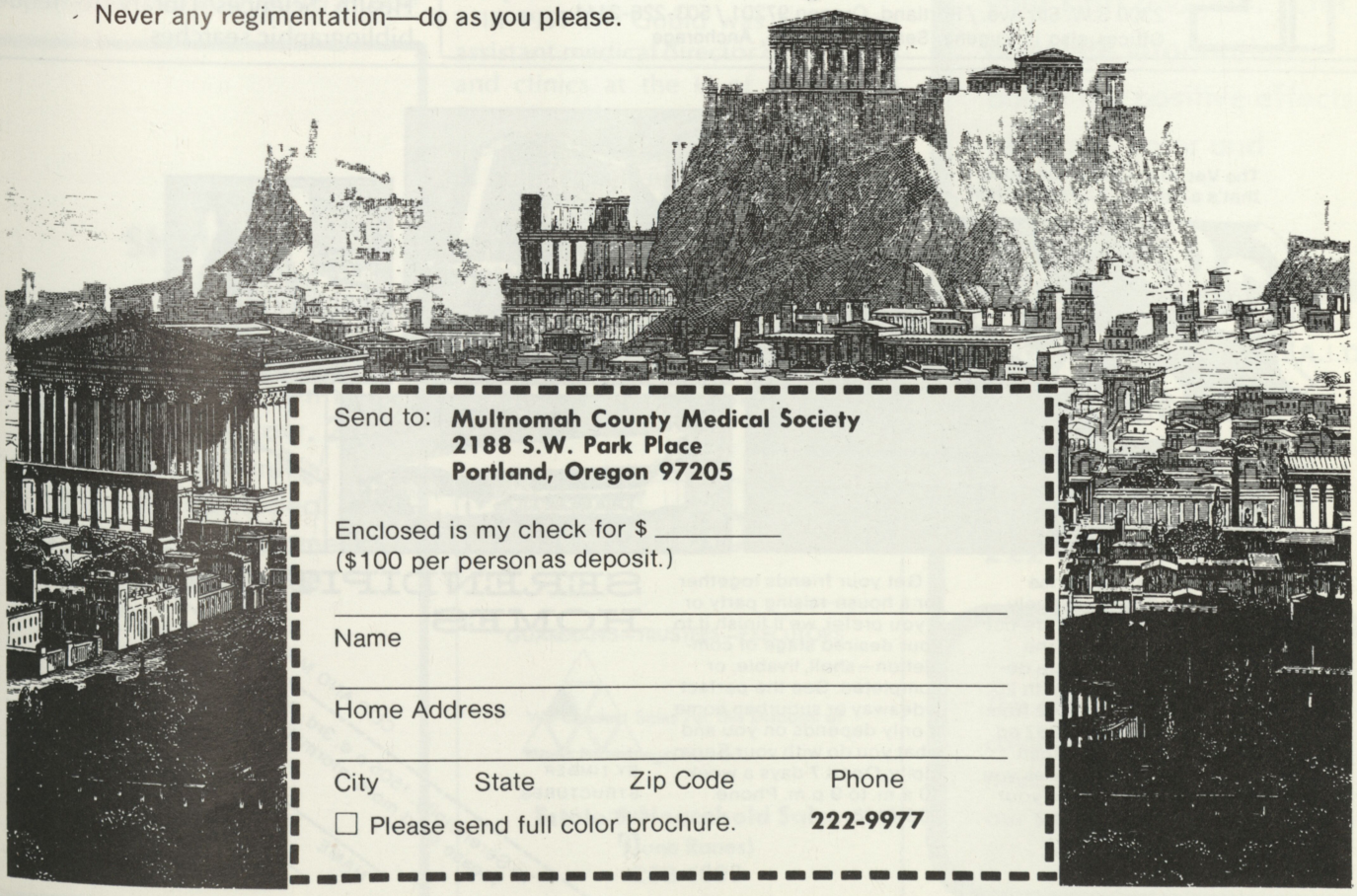

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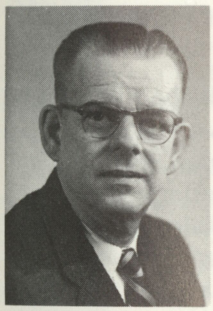
MEDLINE has local telephone

The MEDLARS Center at the Pacific Northwest Regional Health Sciences Library now has local telephone access to MEDLINE, the on-line system for retrieval of citations to the biomedical literature which is being established at the National Library of Medicine.

The MEDLINE data base is approximately 130,000 citations from 239 of the most important biomedical journals indexed for MEDLARS from January, 1969 to date. The base is being expanded to over 300,000 citations in about 1,000 journals. This should be accomplished within a month or two.

Now that there is access by means of local telephone (206) 543-5530) the Center wishes to encourage users of the Pacific Northwest Regional Health Sciences Library to request bibliographic searches.

Two Society members die



Dr. Starr

Dr. Gould

Two long-time members of the Society died in February. Paul H. Starr, 63, an anesthesiologist, died February 7 and Jarvis Gould, 57, administrator of Multnomah County Hospital, February 13.

Dr. Starr graduated from the University of Oregon Medical School in 1935 and interned at Emanuel Hospital. From 1936 to 1949 he was a general practicioner in Clatskanie and in 1949, returned to Portland to specialize in anesthesiology. He held a residency at Emanuel from 1949 to 1951 and had been on the staff there since.

A member of the American Society of Anesthesiologists, the American Medical Association, the Oregon Medical Association and the Oregon State Society of Anesthesiologists, Dr. Starr had been a member of the Multnomah County Medical Society since 1952.

Dr. Gould graduated from the University of Oregon Medical School in 1941. From 1942 to 1945 he served with the U.S. Army Medical Corps in Europe. He later became chief of medical service at the U.S. Veterans Hospital in Portland.

In 1951 Dr. Gould was appointed assistant medical director of hospitals and clinics at the U of O Medical School and assistant professor of medicine. He was made administrator of Multnomah Hospital in 1955.

Dr. Gould had been a member of the Society since 1942 and also held memberships in the American College of Hospital Administrators, the Oregon Medical Association, the American College of Physicians and the Portland Academy of Medicine.

Standing committe

Members and chairmen for Multnomah County Medical Society's six standing committees were approved by the Board of Trustees at their January meeting.

Ernest H. Price will chair the Grievance Committee, with Wilbur L. E. Larson as vice chairman. Members are Thomas E. Bachhuber, Daniel L. Dennis, Robert L. Kalez, Joseph W. Nadal, Thomas R. Reardon, Russell T. Stodd, Robert T. Capps, Harvey D. Klevit, William R. Olson, William M. Ross, John W. Tarnasky and Gary Gambill, student.

Donald P. Dobson, Raymond M. Reichle, Guy A. Parvaresh and Harry E. Sprang are special advisors to the Grievance Committee.

James B. Hampton was named chairman of the Program Committee. Serving with him are Jack Copperman, Martin A. Howard, S. F. Rabiner,

chairmen, members appointed

Edmund W. Campbell, Peter DeWitt, Huldrick Kammer, Arthur L. Rogers and Charles Varga.

The Committee on Regional Blood Center will be headed by Gordon L. Doty. Esmond Braun, Robert D. Goldman, James G. Hatheway, Williams W. Hicks, Jr., LeRoy F. Lamoreaux, E. Colton Meek, Richard C. Rogers, Reuben Straus, Gene V. Bogaty, Richard A. Gingrich, Martha L. Hamilton, Lawrence R. Heiselt, David S. Johnson, C. H. Manlove, Suzanne M. Paulsen, Harold E. Shuey and Edward M. Schneider are committee members. William C. Scott is special advisor.

W. Rich Warrington will chair the Oregon Physicians' Service Review Committee. Working with him will be Robert E. Fischer, Virgil L. Hamlin, Jr., Lewis W. Jordan, J. Wayne Loomis, William R. McAllister, Thomas L. Miller, David P. Paull, Nathan Shlim, J. Edward Field, Fredrick L. Goodwin, James D. Hearn, Toshiaki Kuge, James V. Meyer, Jr., Joseph C. Mitchell, John Raaf, Joel L. Seres and Daniel Lowe, student.

The School Health Committee will have Peter H. R. Roberts as chairman. Timothy J. Campbell, Allan K. Chappell, Morton G. Eleff, Robert A. Mendelson, Robert H. Post, Clifford O. Stranburg, John Wobig, Robert F. Balen, Richard E. Cavalli, John M. Deeney, Walter A. Goss, Robert A. McFarlane, Richard W. Olmsted, William Snook, J. Houghton Todd, Herbert Woodcock and Karen Ireland, student, are members.

Alfred J. Kreft will chair the Portland Physician Advisory Committee. Working with him will be Siegfried R. Berthelsdorf, William M. Ross, Phillip S. Alberts, W. James Kuhl, John H. Stalnaker and W. Stanley Welborn.

Controversy corner (continued)

"More than that, it really connects supply to need. An HMO has no incentive to overbuild hospital beds. That's an unnecessary expense which comes out of their income. They don't like that, and so they don't build excess hospital beds.

"Let's talk about quality. What does prepayment do for you in quality? Well, we've already mentioned that there is an emphasis on good primary care. There is an emphasis on everything being done to prevent that late-stage illness from occurring, because it's expensive. In other words, we're putting a real cost benefit-type of thinking into medical care.

"Let's talk about the third element – pluralism and competition. We want competition between HMO's and the traditional system. We do not envision monopolistic organizations. We do not invision a monolithic HMO industry that displaces our traditional fee-for-service industry. We think that traditional fee-for-service medicine offers advantages which some patients will like and prefer to HMO. We want these two elements to compete side by side and let the market determine. So the government is really going to make an effort to get the HMO industry started, to remove the legal, the financial and the ignorance barriers to HMO care. And once it's got the industry underway, it's going to let the market determine who wins.

"In quality, we think it's extremely important, the dissatisfied consumer can leave. If an HMO gets a reputation for poor quality, it's just not going to be able to attract consumers.

"In distribution we think competition has historically proven the best way to get the product distributed.

"Let me talk about two side advantages. I've already mentioned that the industry would be more self-regulating and I think this means less government involvement in the day-to-day operations of health care. We won't have bureaucrats deciding who can get into an extended care facility any more.

"The second thing is, I think it's going to create, eventually, a constituency for community health. Consider an HMO that's serving a ghetto area; and the kids are coming in with rat bites or they're coming in with lead poisoning from eating paint. Now here is the HMO with a financial stake in this thing, because those kids are going to require treatment. It's going to be a lot cheaper for the HMO to go down and shake up the Public Health people, than it is for them to treat those rat bites and that lead poisoning.

"In summary, the HMO is not a panacea. I think it's a step in the right direction. We know that these advantages have worked in the slowly growing HMO's.

Fats added to diet

A new, weight reduction program has been formally introduced by Weight Watchers of Oregon, Inc.

People who join Weight Watchers here will now be able to eat, in moderation, such foods as spaghetti, macaroni, potatoes and cereals, according to Jeannine Cowles, area director for Oregon.

Changes in the Weight Watchers program have occurred because the organization's research and information indicate that fats should be added on a daily basis to provide better nutrient stimulus for the body and its physiological needs.

The new weight reduction program includes a leveling plan that gives members added incentive and stimulus when they are 10 pounds from their goal weight, and a maintenance plan that teaches members how to keep the weight off once they are at goal weight.

Classes have been meeting weekly since last spring at Adventist Hospital and Good Samaritan, and recently began at Emanuel and Providence. Others will be opening soon.

Psychiatrists' numbers grow

Psychiatrists in private practice currently number almost 10,200, or just 6% of all physicians in private practice. However, the number of psychiatrists has grown rapidly in recent years, showing an increment of 36% between 1964 and 1970; the entire physician population shows only a 9% increment over the same time period.

Psychiatrists handle only 2% of the patient visits made annually to private practitioners. This discrepancy is due primarily to the traditionally longer visit allowed psychiatric patients.

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***Indications:** Edema associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome, late pregnancy; also steroid-induced and idiopathic edema, and edema resistant to other diuretic therapy. 'Dyazide' is also indicated in the treatment of mild to moderate hypertension.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., certain elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—they can both cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

Supplied: Bottles of 100 capsules.

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Vasectomies show increase

According to the National Disease and Therapeutic Index (N.D.T.I.), there has recently been a dramatic increase in the number of vasectomies performed in the United States.

An N.D.T.I. report, which reflects only private medical practice, says some 700,000 male sterilizations were performed in 1970; this compared to 200,000 in 1969. Additionally, indications are that the trend has yet to level.

A check of data for the first six months of 1971 showed these procedures running ahead of 1970. The report emphasized that these totals do not include an assumedly significant number of vasectomies obtained in specialized clinics, of which there are currently 125 operational in the United States.

Virtually all vasectomies reported to the N.D.T.I. were by GP/DOs, surgeons and urologists, with close to half of these physicians indicating that the patient was referred to them by another doctor. On a per man basis, urologists reported the greatest number of vasectomy procedures.

Other salient characteristics gleaned from the N.D.T.I. include the following:

Locational readings show over 90% of vasectomies performed in the physician's office.

Patient age distributions indicated three-fourths of the total were performed on males between the ages of 20 to 39, with the balance of patients being over 40 years of age.

In comparison to the N.D.T.I. aggregate statistics for all diagnosis visits, the western region of the U.S. is well above average for vasectomies.

The report noted that female sterilizations are also on the increase with 200,000 ligations estimated in 1970.

Congresswoman to speak April 3

Congresswoman Edith Green will be the featured speaker at the April 3 quarterly membership meeting of the Multnomah County Medical Society at the Sheraton Motor Inn.

The quarterly meeting scheduled for February 22 was postponed because Congresswoman Green, who was to have been the speaker, had to return to Washington for a key meeting between representatives of the National Governor's Conference and Senate-House conferees to discuss the higher education bill now pending before Congress.