UOMS plans budget

The University of Oregon Medical School is preparing its biennial budget which will be presented to the 1973 Legislature for approval. A total of \$57,707,561 is being requested to cover the School's three main areas of expense; this is a revised figure suggested by the Governor.

Every two years departments at the Medical School estimate their budgetary needs for the following biennium. These figures are submitted to the Dean who reviews such requests and submits the Medical School budget to the State Board of Higher Education. The Board, in turn, makes further adjustments in the budget requests from all institutions and sends the revised budget to the Governor. Further mod-

ifications are made at this level and the Governor prepares a recommended budget to be presented to the Legislature's Ways and Means Committee. Here the final budget totals for the coming biennium are determined. The Medical School's budget request is, of course, subject to reduction at each of these review levels.

THE MEDICAL School's biennial budget for 1973-75, as it will be presented to the 1973 Legislature, is divided into three main sections: education and general services (\$16,212,556); teaching hospitals and clinics (\$35,543,925); and the Crippled Children's Division (\$5,951,080). In addition, \$299,829 is being continued on page 2

medical center

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Multnomah hospital takeover proposed

Governor Tom McCall has announced he will propose to the 1973 Legislature a gradual, six-year takeover of Multnomah Hospital by the State of Oregon. The transfer would be completed by June of 1979. The Hospital's estimated budget will range annually over the next six years from \$8,431,000 to \$19,077,394.

Governor McCall explained he felt it no longer fair for Multnomah County to carry the financial burden of the Hospital since more than 50 per cent of the clinical training for medical students is derived from the Hospital.

Multnomah County commissioners have encouraged state takeover. They have also indicated that the county can no longer support the Hospital and they may be required to close it because of the great financial strain.

The Hospital's admissions policy would be revised when the State takes over responsibility, the Governor predicted. County patients would not be adversely affected, however, as bed capacity would be raised from the current 186 to 200 beds in the first year and possibly to 275 by the end of the staged transfer.

Dr. Charles N. Holman, Dean of the Medical School, indicated the increase in bed capacity would be helpful to the Medical School. "All the beds are needed to support our educational programs," he said. "All the plans we've made for the future for increased enrollment have been predicated on having Multnomah Hospital in full operation and available to us."

County commissioners generally approved the Governor's proposal.

Because 1972 was such an eventful year, the editors of MEDICAL CENTER NEWS felt readers would be interested in an overview of the progress and achievements of programs and individuals at the University of Oregon Medical School. Accordingly, a special section has been prepared for this edition of MEDICAL CENTER NEWS, beginning on page 3, that presents some of these significant accomplishments of the last year.

-Executive Editor

New group approved

The constitution of a proposed faculty organization for the University of Oregon Medical School was approved by a narrow margin in December. Of the 202 ballots received by the elections committee, headed by Dr. Richard Jones, professor and chairman, biochemistry, 102 voted to accept the constitution as it was approved by the Dean and Executive Faculty. Ninety-nine members of the faculty voted against acceptance and one ballot was unmarked.

A major provision of the constitution, which becomes effective immediately, is for an enlarged Faculty Council to replace the Executive Faculty. The Faculty Council will be the principal advisory and legislative body of the institution. Membership will include the Dean, Associate and Assistant Deans, the Medical Director and Administrator of the hospitals and clinics, department chairmen, division heads and 21 elected faculty representatives.

Chancellor recommends merger

Consolidation of the University of Oregon Medical School, University of Oregon Dental School and University of Oregon School of Nursing under a single administrative head was recommended by Higher Education Chancellor Roy E. Lieuallen November 27.

In making the recommendation to the Oregon State Board of Higher Education, Dr. Lieuallen said that the merged institution should be given a new title, such as Oregon Medical Center or Oregon Health Center, which would not imply that it was a part of the University of Oregon.

These recommendations are being studied by a special committee of the Board, appointed by President George Layman and headed by Board Vice President John Snider. Mrs. Elizabeth Johnson, Robert Holmes, Philip Joss and John Mosser are committee members.

Dr. Lieuallen said he hopes for Board action on the consolidation in January and implementation by July, 1974.

At a meeting of the committee on December 19, one member outlined seven objectives which might be achieved through coordination. These included:

- 1. Coordination of multi-disciplinary program efforts:
- 2. Minimize duplication in curriculum, equipment, facilities, resources, people;
- 3. Coordinate budget, planning and development operations;
- Provide unity through diversity to meet societal needs;
- 5. Develop strengths through critical masses of excellence;

continued on page 2

requested for the School's renal transplant tions for this UOMS program.

"The 1973-75 budget includes funds to implement our medical training program which increased its enrollment last fall to 114 students in the entering class," explained William A. Zimmerman, associate dean for business affairs. "These funds include salaries for nine new faculty positions for the first year of the biennium and an additional nine the second year; supportive personnel will also be added." Mr. Zimmerman went on to explain, however, that federal cutbacks in the next two years are possible, in which case a portion of our state budget would be needed to support several faculty members now being paid with federal monies

"A request has been made in the educa-

The Medical School is also requesting funds for the continuation of the Community Psychiatry Training Program, which began operation last year with \$45,862 allocated by the Emergency Board. State funds requested are \$144,914 for 1973-75.

A LARGE portion of the 1973-75 budget is to support the operation of the institution's teaching hospitals and clinics. "We are asking a total of \$32,962,985 in this area which is an increase of approximately \$4 million over our current base budget," Mr. Zimmerman said. In addition, the Governor's budget includes an additional sum of \$2,580,940 which will be required to help operate Multnomah Hospital, a facility recommended for transfer to the State Board of Higher Education on July 1 of this year. The Hospital will operate at a capacity of 200 beds, receiving the remainder of its support from Multnomah County.

THE BUDGET'S third section, the Crippled being requested and \$233,700 is included-to

"Our budget still must receive the approval of the Legislature," continued Mr. Zimmerman. "Whether they will accept it at its present level depends a great deal on the state's tax resources and the needs of other programs in Oregon."

program. Funding for this latter project is made possible by a bill passed in 1969 by the Legislature which provides special appropria-

The budget also includes funds to support nine new nursing faculty positions for the first year which are needed to take care of the increased enrollment in the School of Nursing.

tional and general budget for 151/2 new classified positions for the biennium, divided equally between instruction and service," continued Mr. Zimmerman. Salaries should increase, too, as annual salary adjustments included in the Governor's budget provide for a five and onehalf per cent annual gain for faculty members and six and one-half per cent for classified employees the first year and five and one-half per cent the second. The Medical School has requested increases for interns and residents but this amount has not yet been determined.

Children's Division, also reflects increasing costs. Six additional classified positions are meet rising costs of hospital and medical care.

- 6. Specify a single point of administrative authority, unbiased and objective, to relate to the Chancellor;
- 7. Establish a central point of responsibility for planning and development where all needs can be assessed and weighed, one against the other.

Dr. Lieuallen's proposal would add a chief administrator who would be responsible for all three schools; the School of Nursing is now a part of the Medical School.

Both Dr. Louis Terkla, dean of the dental school, and Dr. Charles Holman, UOMS dean, were appointed to their positions with the understanding that a reorganization might change their status in the future, Dr. Lieuallen said.

Dr. Menashe to head CCD



Dr. Victor D. Menashe has been named director of the University of Oregon Medical School's Crippled Children's Division and assistant dean.

Professor of both pediatrics and CCD, Dr. Menashe was named associate director of the Division in 1967. He has served as acting director since Dr. Richard Sleeter's death last

Dr. Menashe is a 1953 graduate of UOMS where he also served his internship and pediatric residency. For the next two years he was chief of pediatrics at Edwards Air Force Base in California and joined the UOMS faculty as instructor in 1958.

CLIFF SMALL, administrative assistant to the Chief of Staff's Office, Portland Veterans Hospital, was elected chairman of PROPH (Public Relations Officers of Portland Hospitals) at the group's January meeting.

medical center medical center

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1972 -- in review...

1972 has been an eventful year at the University of Oregon Medical School. We thought our readers would be interested in a review of institutional and personal accomplishments—presented in this special supplement to Medical Center News.—Editor.

The first brother and sister in Oregon to receive donor kidneys from their mutual parents were patients at the University of Oregon Medical School. Last July, Dawn Shaff, 14, was given one of her mother's kidneys and on November 6 Dawn's 12-year-old brother, Wade, had one of his father's kidneys surgically implanted.

Both Shaff children suffered from familial juvenile nephronothesis, a rare renal disease which causes cysts to form on the kidneys, seriously impairing their function. The children should now live normal, healthy lives.

This past year the UOMS renal transplant team, headed by Dr. Russell Lawson, has achieved a 94 per cent success record for functioning implants from related donors and 66 per cent for nonrelated donors. The program was started in 1959 by Dr. Clarence Hodges, head of the UOMS urology division.

Dr. Lawson also developed a new procedure this last year whereby a diseased kidney can be removed from the body, repaired and then reimplanted.



Completed and ready for the Medical School's incoming freshman class last fall, the new Basic Science Building stands seven stories tall and has multidiscipline laboratories, home station rooms, a lounge, lecture rooms and a variety of laboratories for student use.

The major accomplishments and highlights of the Advancement Fund for this past year include the establishment of the Edwin E. Osgood Memorial Center for Leukemia Research with Dr. James W. Linman as director and a contribution of \$30,000 from the Oregon Arthritis Foundation toward the establishment of an endowed chair in the division of rheu-

matology. The Advancement Fund has also been used as the vehicle to establish the J. Gibson Pleasants Memorial Center for Cancer Research, under the direction of Dr. Clarence Hodges, head of the division of urology.

In achieving its commitment to the Medical School for Goal '72, the Advancement Fund has made grants exceeding \$34,000 toward equipping the new Basic Science Building and Medical School Hospital. The Advancement Fund has just completed its first full year of existence with gross contributions exceeding \$300,000.

Several of the business services of the University of Oregon Medical and Dental Schools were combined last year. Now under direction of UOMS are the Dental School's student loan (payment and receipt) program and depository for cash receipts. Consolidation of the two institutions' parking programs, phone systems, grants and contracts and personnel and payroll offices has also been completed. The Dental School's accounts receivable will probably be consolidated with UOMS in the future.

Part of the new addition to the Medical School Hospital, the Medical Intensive Care Unit was named in honor of Howard P. Lewis, former instructor and chairman of the School's department of medicine for 24 years.

As of December 5, 1972, 22 neonatal/perinatal babies have been brought by helicopter to the University of Oregon Medical School via the School's Perinatal Emergency Transport System (PETS). Two expectant mothers were also flown to the UOMS during this period.

The seriously ill infants, ranging in weight from .880 kilograms to 3.31 kg. (slightly less than two pounds to almost seven pounds) have a very high survival rate—only three have died. The babies have been transported to UOMS from John Day, Prineville, Baker, Klamath Falls, Lebanon, Grants Pass, Burns, Eugene, Ontario, Roseburg, Toledo and Bend.

Transporting seriously ill infants within a 60 mile radius of Portland is a new white Chevrolet van, donated to UOMS by the Auto Dealers Association of Portland. Dubbed the "baby buggy" the vehicle was factory built to the unique specifications needed for transporting newborns.

All units within the instructional aids division, including printing, medical graphics and medical photography broadened their services over the past year. Several 16 mm sound films have been produced and new classrooms with innovative audiovisual capabilities are in use in the newly opened Basic Science Building. A small portable television production system is

now available for off-campus programs and several sets of overhead projecturals have been produced for use by students and patients.

The division is also supporting the nursing education grant in producing the self-instruction programs.



A nine-story addition to the Medical School Hospital was completed in the Spring of 1972 and includes a new surgery suite, expanded laundry, housekeeping and dietary functions plus additional equipment for the radiation therapy department.

Dr. James Linman, formerly head of special hematology at the Mayo Clinic Foundation was appointed director of the new Edwin E. Osgood Memorial Center for Leukemia Research at the University of Oregon Medical School in July. The center, which is part of the hematology division, will encompass a broad program of laboratory research, patient care and teaching.

After an extensive faculty-student self evaluation report in 1969 and 1971, and the subsequent visit of the National League for Nursing, the University of Oregon School of Nursing last December received full accreditation of its baccalaureate program and "reasonable assurance of accreditation" for its master's program from the NLN.

The modern management technique, Management by Objectives, has been implemented in some Medical School departments as well as by the Personnel Division of the Governor's Office. This system concentrates on the achievement of specific, measurable, planned results and was described to UOMS administrative officers, departmental chairmen and others by Dr. George Odiorne, Dean of the School of Business Administration, University of Utah, the nation's leading authority on MBO late in 1971.

continued on page 4

1972 -- in review...

MBO, continued

Since that time a revised system of performance appraisal, based on the MBO system, has been adopted for all classified employees and will focus greater attention on the achievement of program goals and continuous evaluation of results in carrying out agreed-upon work plans.

Dr. Frances Storrs, assistant professor of dermatology, who chairs the institution's affirmative action committee, was named to the post late in the summer. Other members of that committee include Sid Harr and Karen Ireland, medical students; William Jackson, affirmative action officer; Dr. Richard Jones, professor and chairman, biochemistry; Dr. Curtice Martin, resident in dermatology; Ken Niehans, director, public affairs; Tecla Thiman, director, physical therapy; and Ruth Wiens, associate dean, School of Nursing. Ex officio members are William Zimmerman, associate dean, and Byron Phillips, personnel director.

A proposal to allow the University of Oregon Medical School to accept private patients of faculty members in the Medical School Hospital was approved this summer by the Oregon State Board of Higher Education. The objective of the plan is to increase the number of paying patients in the Medical School Hospital in order to meet budget estimates for this portion of the operating funds. According to extensive studies conducted by a special committee chaired by Dr. Tyra Hutchens, professor and chairman of the department of clinical pathology, the admission of private patients who bring with them the ability to pay for the cost of their hospital care is the only way to increase hospital fee income.

Enrollments at the University of Oregon Medical School reached new highs of 1378 students during 1972. Fall term 397 medical students registered including 114 freshmen. In the School of Nursing there are 451 studying toward a bachelor's degree and an additional 39 in the master's program. Fifty-five students are enrolled in graduate programs in the basic sciences and in the allied health fields there are 50 in the medical technology program, 11 in dietetic internships, 35 in radiologic technology and 4 in cytotechnology. In addition, there are 52 in internship programs and 284 residents and fellows.

The UOMS Safety Committee, chaired by Dean Charles N. Holman, was formed in January, 1972. Helping to develop a safe working environment for employees, in conjunction with state employee working condition standards set by Governor Tom McCall, is Safety Officer George Johnston. Each building on the UOMS campus has a safety committee and each building manager is a member of the committee headed by the Dean.

Family practice residency expands

Newest of the University of Oregon Medical School's specialty training programs is the family practice residency. Started in July of 1971 under the direction of Dr. Laurel Case, associate professor of family practice, the program includes early emphasis on clinical experience in the School's specialty wards and clinics with increasing emphasis on comprehensive health care in the family practice clinic in the latter part of the training.

Five residents are currently enrolled in the program. Each has completed the minimum prerequisite of a one-year rotating internship, which counts as the first year of residency, and several have had additional training in other specialty programs and/or the military. Of the five physicians in training, four are in their second year and one is in his third and will finish this summer.

EIGHT SECOND-year residents will begin training in July of this year following their internships; some will also have completed military service as well. Two of them are 1972 UOMS graduates who participated in the family practice division's preceptorship program, a two-week rotation which places medical students with family physicians throughout Oregon for an inside view of a practice in family medicine. This program is now in its third year of operation.

When the eight new physicians start their training they will have the benefit of a new family practice clinic. Relocated on the first floor of Emma Jones Hall, behind Multnomah Hospital, it will replace the present clinic's temporary quarters on the fourth floor of the Outpatient Clinic and will be modeled after a family physician's office. The new area will include a biometrics room where routine diagnostic screening procedures will aid in the complete evaluation of the patient. Remodeling is scheduled to begin the end of January and should be completed by the first of April.

Patients range in age, sex, background and illness. Originally most were referred from the UOMS Outpatient Clinic but now include UOMS employees, those who come on the recommendation of friends who are patients, emergency room patients who have no family doctor and need follow-up care, and referrals from other clinics, physicians practicing in the community and other cities in Oregon and community agencies.

THIRD-YEAR residents spend about 50 per cent of their time in the family practice clinic—the other portion is used for elective study—and may see between 15 and 20 patients during a given day. The patient load is controlled, however, allowing the doctors time to accumulate background on their patients' illnesses and to keep up with their reading in



Following a weekly staff meeting members of the family practice division checked floor plans for the division's new clinic. They are, left to right, Drs. John Gilberts, Laurel Case, Robert Taubman and Robert Voy.

general. Second-year residents spend about a quarter of their time in family practice with the remaining spent on the various specialty wards and clinics.

Under the direction of Dr. Robert E. Taubman, associate professor of psychiatry, residents also receive training in behavioral science. In addition to experience in family and group therapy the physicians are trained in emergency psychiatric care and interview techniques.

The focus of training is the application of sound principles of psychological medicine in the direct, primary care of a broad spectrum of patients. In this context, residents are taught to make effective use of communication skills, to become astute observers of people in health and illness and to provide knowing, competent and compassionate care to families.

Much use is made of modern teaching devices and methods, including videotape recordings to monitor patient and physician behaviors in training the residents. The aim, states Dr. Taubman, is not to make psychiatrists out of family doctors who are desperately needed in their own spheres of competency. Rather, Dr. Taubman's program seeks to help the residents to learn to apply useful methods of integrated health care to families.

As the resident spends increasingly more time in the family practice clinic he becomes the "family doctor" for a number of patients. They make appointments through the clinic's receptionist and see "their" doctor for any ailments as they would a physician in private practice. Patients are now seen by appointment only but walk-ins will be encouraged as soon as the clinic moves to its new facility. "We want to provide a model of an efficient practice and how it is run," explained Dr. Case. "We feel our program adds vital training beyond the year of internship, largely because of the time spent and experience gained in our clinic."

Dr. Robert O. Voy, clinical instructor in family practice and a 1964 graduate of UOMS, supervises the clinic. He explained that over 90 per cent of a family's medical problems can be treated by the family doctor and that continuous care for the patient is vitally im-

portant. "The trend is now going away from solo practice and a group of family practitioners, trained in the same way, can provide this continuous care," he said.

TWO OF the program's three original residents completed their training last November and are now in private practice. Both had previous training in other residencies but felt that family medicine was the area for them. Dr. Robert Hakala graduated from medical school in 1967 at a time when "the feeling toward general practitioners was at an all-time low and the emphasis was on specialization." Though he had always wanted to go into family practice he met with discouragement from his peers and after spending two years in the military he enrolled in a urology residency. "It was a very good program," he explained, "but I missed family medicine. Dr. Case was just getting his program off the ground at about that time and I wanted the additional training." Dr. Hakala is now in practice with two other physicians in northeast Portland.

Dr. Roy Hall practiced family medicine in the military after his internship. He also had a year of general surgery though he intended all along to go into general practice "where patients would be followed over a long period of time. I like to get to know my patients," he said. Dr. Hall is now practicing in Salem.

AN INTEGRAL part of the clinic activities is a project under the direction of Dr. John Gilberts, assistant professor and assistant director of the family practice division. By determining the best treatment for each of a variety of diseases he hopes to evaluate the quality of medical care delivery in the family practice clinic. With the assistance of specialists and other family practitioners, Dr. Gilberts hopes to establish criteria for each specific disease though he will concentrate on only six from now until July.



The Jamison family of Portland gets a complete check-up in the family practice clinic from Dr. Ernest Talley, resident. The family, from left to right, includes Raymond, Donald and Dorothea.

Diagnosis, symptoms, physical findings and laboratory tests related to current patient problems and expected outcomes, plus the time involved in the clinic for treatment, are recorded and can be fed into a computer. Ultimately Dr. Gilberts hopes to develop the optimum approach for a family physician to each disease and determine how this approach can best be applied in the minimum amount of time. "First of all we want quality care for the patients," he said. "Ours is really a project to organize and evaluate what we do in the division. We want to be able to assure our patients they are getting top-level care."

THOUGH THE idea of family practice residencies is new and the UOMS program is still in its infancy, Dr. Case now plans to have a

total of 24 residents in training each year, eight at each of the three levels. In 1977 the division hopes to train 32 each year and expand to 54 residents by 1982. Traditional internships are expected to be abolished by 1974 and this extra year will count as the first year of training in the three-year program. "Two of the original 29 students who participated in the preceptorship pilot program in the spring of 1969 are now in the military but have already written for application to our program in July of 1974," explained Dr. Case. "With our new clinic and an increasing number of residents the comprehensive health care we are striving to provide for our patients should be a reality."

-Jo Stage-

Results from 1971 survey released

Results from a 1971 survey of U.S. medical school faculty members conducted by the Association of American Medical Colleges has yielded some interesting results.

Since 1961, full-time medical faculties have more than doubled—from 11,200 to 25,600. Fifty-one per cent of the faculty were in public medical schools, 49 per cent in private schools. Twenty-three per cent were professors, 23 per cent associate professors, 34 per cent assistant professors, 14 per cent instructors and six per cent below the rank of instructor.

Medical school faculties were predominately men—86 per cent. Most women were in the areas of allied health and behavioral sciences. Men accounted for a significantly higher percentage of the total faculty in developing med-

ical schools, and at the rank of professor and associate professor. There was a relatively low percentage of women in the higher academic ranks.

Fifty-nine per cent of the faculty held M.D. degrees, five per cent had both the M.D. and the Ph.D. and 25 per cent held the Ph.D.; 10 per cent held neither degree.

Faculty members are busy; more than 84 per cent reported that they performed more than one function. The average faculty member had 2.4 areas of activity (such as teaching, service, administration, research, etc.).

Eighty-two per cent had been employed by only one medical school during the preceding 10 years, and 71 per cent said that they'd entered medical school employment from a training program.

Results of the 1972 survey that UOMS faculty members recently completed are now being analyzed at the AAMC headquarters in Washington, D.C.

Advancement fund board member dies in January

Aubrey R. Watzek, University of Oregon Medical School Advancement Fund Board of Directors member, died on January 1. An Oregon resident since 1912 he was noted for his leadership in philanthropic and civic affairs.



A lumberman for many years, Mr. Watzek was a graduate of Yale University and Harvard Law School. He served twice on the Oregon State Board of Higher Education and was trustee and regent of Reed College.

Mr. Watzek, a past director of the Doernbecher Hospital Guild, was named an honorary member of the UOMS Alumni Association in 1968.

The betatron: an advance in radiation therapy

Flanked by Marquam Hill on one side and a three-foot thick concrete wall on the other, is a room in the new wing of the Medical School Hospital containing one of the most advanced radiation therapy machines in the country.

It is the 25 million volt Betatron, the only one in medical use in the Pacific Northwest.

Used industrially to examine large castings for imperfections, the Betatron is a high-energy, high-intensity machine that provides deep penetration with high control of radiation. This has certain technical advantages for specific types of medical application not possible with the cobalt and Van de Graaf machines more commonly used for radiation therapy.

In the Betatron, electrons are generated into a porcelain donut then accelerated to an energy as high as 25 million volts by a powerful electromagnetic field; the cobalt and Van de Graaf machines have a capacity of one to two million volts. The high energy of the Betatron enables industrial users to X ray thick castings of dense materials, such as iron, to detect flaws. In medical use, the high energy of the X rays provides efficient treatment for deep-seated tumors where thick upper layers must be penetrated.

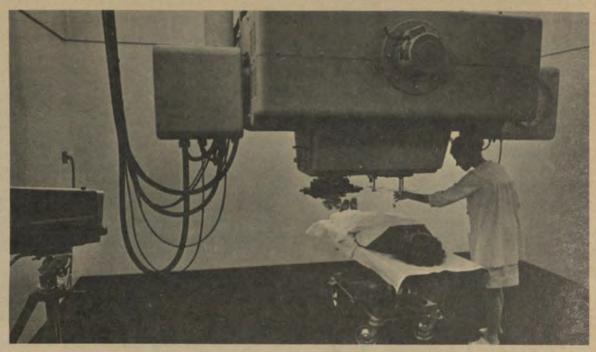
Complementing the high-energy aspect, the Betatron's blocking system—a combination of lead blocks used to define the area receiving radiation-serves to provide maximum protection to intervening and surrounding tissues.

For X ray therapy, used in treating deep tumors, the electron orbit within the donut is aimed at a target to produce an X ray beam which provides the necessary depth of penetration while the blocking system protects surrounding tissue. However, when the electrons are orbited in the opposite direction within the donut, they do not strike a target but are guided through a magnetic "peeler" and emerge through a thin beryllium window. These electrons are used for electron therapy, to treat superficial tumors without affecting underlying tissues.

Electron therapy, a relatively new development in the treatment of tumors, is possible only with the high energy capability exemplified by the Betatron. It is especially vital in the treatment of superficial cancers, allowing maximum treatment with a minimum degree of side effects due to the high energy and the lack of penetration resulting from the use of the electron beam.

Purchase of the \$200,000 Betatron was made possible by a bequest to the UOMS for cancer research. The new machine greatly increases the potential for further developments in radiation therapy, which is used for treatment of 50 to 60 per cent of all tumors.

-Kathy Mayo-



Radiation Therapy Technician Rebecca Miller adjusts Betatron for X-ray therapy. The machine's 25 megavolt energy capability opens up new areas for possible application of this form of treatment. Monitor at left transmits to operator's console, outside treatment room.

The fungus among us

variety of serious diseases. Although it is literally found everywhere around us, in our food and in the air, it does not cause illness in all people. Dr. Emil Bardana, assistant professor of immunology and allergy at the University of Oregon Medical School, calls it an "opportunistic fungus, one that attacks people whose defenses are already compromised by another medical problem."

Transplant patients, diabetics, people with burns or those on immunosuppressive therapy for medical disease, to name a few, can fall prey to the invasive form of Aspergillus. It can invade any or all parts of their bodies and can often lead to death. (The first cardiac transplant patient in the United States died because of Aspergillus infection.) People who have had cavitary tuberculosis are often victims of another form of the disease; a "fungal ball" of Aspergillus filaments grows within cavities in the lungs left by the tuberculosis. Aspergillus can also be the cause of allergic asthma in some people. The varieties of disease caused by this fungus have been difficult to diagnose and treat.

enters the body, the body produces antibodies to fight and overcome it. Dr. Bardana and his staff, working under a grant from the National Tuberculosis and Respiratory Disease Association, have been concentrating on measuring antibodies which fight the Aspergillus fungus in the body. The research team has measured these specific antibodies in people known to be infected with Aspergillus, patients with a variety of unrelated lung diseases, and healthy individuals.

Dr. Bardana says, "We have found that nearly everyone has antibodies to the fungus, employee is on the state payroll.

Aspergillus is a fungus which can cause a or that most, if not all, persons have been naturally immunized to it. In people with the fungal ball form of the disease, the level of antibodies was found to be significantly higher than in healthy people." Physicians can use this newly discovered difference as one more diagnostic tool to identify this form of the disease.

> Results of the tests have helped the researchers to recognize the true universality of Aspergillus fungus, and have raised additional questions. If it is everywhere, and it seems to be because all people have antibodies to itthen, what about asthmatic people who have been receiving house dust injections to immunize their allergies to house dust? Commercial house dust material has been found to contain Aspergillus. How does this affect their asthma? How does it affect their antibody level in Dr. Bardana's research? Further studies are now in progress to determine differences in antibody levels in persons before, during and after house dust therapy.

Dr. Bardana and his team have solved some riddles, they hope to find the answers to the house dust questions, and they firmly expect When a foreign substance like Aspergillus that new questions needing answers will continue to arise, plague and intrigue them.

-Carolyn Prendergast-

UOMS EMPLOYEES may enroll for courses in any institution in the State System of Higher Education for \$5 per credit hour. Further information is available from the personnel office which will provide a letter verifying the

Endoscopy--a diagnostic aid

Endo comes from the Greek root endon, meaning within, and that's what endoscopy is all about—looking within. Now a common procedure at the University of Oregon Medical School, endoscopy allows physicians, by means of a flexible tube, to directly observe the hollow organs of the body—the esophagus, stomach, duodenum and colon.

The whole idea of endoscopy evolved around the turn of the century when the sigmoidoscope gained popularity. A short, rigid instrument, it allows the physician to view about 10 inches of the large intestine. While these scopes are still widely used today, particularly for diagnosing cancer of the colon, 75 per cent of which lies in view of these 10 inches, the newer instruments of endoscopy are roughly four feet in length and very pliable.

It wasn't until the mid-1940's that gastroscopy (viewing the stomach) was practiced at UOMS. Dr. George Long, now clinical professor of medicine, was one of the first to adopt the procedure at the School. An updated instrument, the Schindler, which carried the image along prisms and mirrors, was then in use and though still a far cry from today's scopes, it had a semi-flexible tip which made insertion not only safer and easier but more tolerable for the patient.

In 1966 the UOMS purchased an even more advanced semi-flexible scope which, at the time, was called "The Cadillac" because it contained a channel for gastric suction or biopsy, an attachment not found on previous scopes. "Now it's like an Edsel," explained Dr. Ronald Katon, fellow in medicine and a member of the UOMS endoscopy team.

TODAY THE ultimate in endoscopy is fiberoptics, a new approach which UOMS physicians began using about four years ago. The highly flexible rubber-clad tube, containing thousands of solid glass fiber-like filaments "cemented" together, is not only easy to insert but permits almost total viewing of the upper gastrointestinal (GI) tract (esophagus, stomach and intestines). Light reflects down the tube through a "bundle" of fibers and the life-size image is sent up another. Probably the most advanced feature of this scope, however, is the rotating tip, the last two or three inches of which may be maneuvered by a handle to allow maximum viewing within the organ.

Dr. Clifford Melnyk, director of the UOMS endoscopy service, speaks of the procedure enthusiastically. "Endoscopy is particularly favorable because we get a better diagnosis and we get it much faster. And it is especially recommended for patients who are not strong enough for exploratory surgery. We are actually able to see ulcers and lesions, many of which would be too small to record on X ray. When we know exactly what the problem is we are better able to determine the best treatment. The task is simplified for surgeons, too, because the diseased area is pinpointed.

"We feel the procedure is very helpful for patients with negative X-ray studies, for those



Comparing scopes from three different periods in the evolution of endoscopy are, left to right, Dr. Ronald Katon (scope with semiflexible tip), Dr. Clifford Melnyk (modern instrument used today) and Dr. John Benson (one of the original rigid scopes).



Duodenal ulcer as seen by scope.

with gastrointestinal bleeding and for patients whose X rays show abnormalities and for whom a tissue biopsy is recommended." Biopsies may be taken during the procedure—a fine wire ending with two tiny cup-like pinchers slides down the tube and out close to the tip. The small piece of tissue is taken and the wire retracted.

TODAY'S SCOPES also allow the physician to see into the opening of the bile and pancreatic ducts (which join the small intestine about six inches beyond the stomach). "Many patients come to us complaining of abdominal pain and many of them are jaundiced," said Dr. John Benson, head of the UOMS division of gastroenterology. "With the scope we can introduce X-ray contrast agent into the biliary and pancreatic ducts to identify stones, tumors, strictures and other pathological conditions and then make a specific diagnosis. Dr.

Marcia Bilbao, professor of radiology (diagnosis) assists us in this work." About 80 per cent of the procedures are for ailments of the upper GI tract.

Currently at UOMS endoscopy is used at the Medical School Hospital, Multnomah and at the Veterans Hospital where Dr. Frederic Smith heads the gastroenterology section. He and Dr. Katon completed a study last summer of 100 consecutive patients with acute massive upper GI tract bleeding. In 92 per cent the source of the hemorrhaging was identified. Generally less than 30 per cent are diagnosed following an emergency upper GI series because X rays can easily miss shallow or multiple areas of disease. "This is not to say that X rays are not helpful," explained Dr. Katon, "but we are actually able to see the bleeding, even from areas with less advanced disease."

A large number of patients come for emergency treatment which can be quickly provided as the endoscopy procedure often takes under 10 minutes—never more than 30. Treatment can begin immediately. For those patients who are hospitalized and cannot leave their rooms a portable unit is brought to their bedside; the procedure remains the same. And during any of the examinations a teaching attachment may be added for viewing by students, visiting physicians, etc. During this time a camera can also be mounted to the eyepiece and can photograph any part of the procedure.

DESPITE THE advances since the first days of endoscopy the modern day scopes are not perfect. "There are still areas in the duodenal bulb (the enlarged area where the small intestine joins the stomach) which we can't see even with the rotating tip," said Dr. Melnyk. "In the future there will no doubt be adaptations to the present scope including an even more flexible tip which will allow viewing both directly ahead and laterally. Perhaps a color video projection system can be arranged to allow a whole group to view a procedure, and we may even be using Polaroid film in our detachable camera so we can include a photo with the report on the patient's chart."

The possibilities for adaptation are many but no matter what they include it's almost certain that endoscopy will be in increasing use in the future as a quick and accurate means of diagnosis.

-Jo Stage-

Mrs. Drum retires

Hilda Drum retired as professor of radiologic technology at the end of December. At the Medical School for nearly 32 years, Mrs. Drum taught radiologic technology students for much of that time. Friends and former students gathered for a reception in her honor early in January.



Problem-oriented hospital record tried at UOMS

	PROBLEM LIST	Maria			
		Name Birthdate			
Onset	ACTIVE PROBLEMS		Date Narorded	Relevant Past or Inactive Problems	
1/7/	ERYTHRODERMA 2" TO # 2		6/2.72		
/72	-LHMPWADEWSPAFTY-		6/2/72		+
/72	7. TO # 2		2/6//-		
12/22	HYPENURICEMIA -		4/0/13		-
/5/12	BLEPHARITIS, STAPHYLECCICAL		6/5/72		
14/72	LEET PLEURAL EFFUSION	<i></i>	4/0/rz	-	
19/72	HENERRHABIE LYSTIFIS		0/9/70		
					1
	172	THE PLEASE OF THE PLANE OF THE	THE PHENER MASIC CUSTITIS	172 LIMPHADANOPATHY LYMPHADANOPATHY LYMPHADANA INAPHOLYTIC 6/1/22 172 FEYER 4/10/22 1/72 HYPENDRICENIA 4/10/22 1/8/72 BEEPHARITIS, STAPHYLECCICAL 6/1/22 1/8/72 LEET PLEURAL EFFUSION 4/10/72	The standard of the standard

The University of Oregon Medical School appears to be the first institution of its kind to adopt, in all of its services throughout its various teaching hospitals (including the Veterans Hospital), a uniform problem-oriented hospital record. The problem-oriented format permits anyone to identify all of a patient's problems by looking at the front sheet of the record. Previously, one had to search through X-ray and lab reports, progress notes from physicians and nurses, temperature charts and the like, in order to find data about the patient's condition. These "raw data" are still attached to the back of the record for occasional in-depth reference but they are summarized by problem number and title in the progress notes.

The change is seen by Dr. James Metcalfe, chairman of the UOMS problem-oriented record committee and professor of medicine, as a breakthrough in medical education. "Historians will write that in the 1970's patients' charts became understandable for the first time," he said.

THE NEED for such a change in record-keeping has been evident for some time, especially in teaching facilities where many persons refer to patients' records. Residents, interns, nurses, medical and nursing students, research workers, record librarians, and social workers must all consult the records. The problem-oriented format makes communication and understanding among all members of the health care team much easier to accomplish. From the teaching standpoint, the system

The top page of the problem-oriented hospital record lists all of a patient's problems, by number, the date they were recognized and the date the problem disappeared.

works well because an instructor can tell by looking at the front sheet of the record how a student has defined a patient's problems. Previously, the patient's problems would not be listed together anywhere in the chart.

According to Dr. Metcalfe, the POR system gives a "table of contents" to data about all the problems by providing a Problem List on the front of the chart. This is a cardboard sheet on which all the patient's problems (both active and inactive) are listed and numbered, each problem followed by the date on which that problem was first recognized. By looking at the notes in the chart for that date (which are numbered and titled to correspond with the Problem List), one can find the basis for defining that problem. If one wanted to review the information about one of a patient's several problems, he would look on the Problem List for the title and number of that problem and see when the problem was first recognized. If, for example, "Nausea" were listed as problem number 3 and it was first recorded on 12-6-72, one would turn to the progress note for that date and find "Problem number 3-Nausea," and the original information pertaining to that problem would be summarized there. Further information about the prob-

lem as it accumulated would be recorded under succeeding dates, but always labeled "Problem number 3—Nausea." In this way one can easily follow the progression of a problem.

According to Dr. Metcalfe, most medical schools in the country are switching to similar POR programs. At present the UOMS hospitals are the only ones in the Portland area which have adopted the new system. Good Samaritan Hospital, in Northwest Portland, however, is now in the process of changing to a problem-oriented record format.

INITIAL INTEREST in the problem-oriented record followed publication of several articles by Dr. Lawrence Weed while he was on the faculty at Case Western Reserve Medical School in Cleveland, Ohio. In 1968-69 his articles attracted national attention and following his appointment at the University of Vermont the concept spread.

Several UOMS students became interested in the new approach and invited Dr. Weed for a two-day seminar at UOMS in 1968. Later, in 1969, the School's psychiatry department changed its records to a similar system. In April of 1971, Dr. J. David Bristow, newly appointed head of the UOMS department of medicine, selected a committee to redesign the hospitals' patient record forms.

After reviewing forms from other hospitals, the committee, with the aid of the clinical department heads, devised, revised and adopted the present forms which have several carefully structured pages and are computer-compatible. They are now in a year of experimental trial following a preliminary three-month pilot period.

At UOMS the opposition to adoption of the problem-oriented format has been minimal. The POR committee has not enforced use of the system but instead has recommended it highly. Periodically the group reviews charts at random, recording the results to see if improvements have been made and if the system is working.

According to Dr. Metcalfe, the POR system is the best the committee has encountered and is definitely a step in the right direction to clarifying and simplifying the tasks of recording, analyzing and recalling data about hospitalized patients.

Dr. Bristow honored

New fellow of the American College of Cardiology is Dr. J. David Bristow, professor and chairman of the UOMS department of medicine. He is one of 94 physicians from the United States and Canada recently admitted to the College's highest membership classification,



an honor based on years of practice and specialty certification. The AAC is a national medical society for specialists in cardiovascular diseases.

ACTH studied by team at medical school

Endocrinology has been revolutionized by the principle of radioimmunoassay. Started at the Bronx Veterans Hospital in New York about 10 years ago, this principle allows scientists, by using antibodies obtained from rabbits or guinea pigs, to measure biochemical substances in human blood.

Diagnosis of many endocrine disorders of the body can now be made earlier and more accurately. Pancreatic tumors which cause low blood sugar, pituitary tumors and disorders of underactive glands are among those detectable. The University of Oregon Medical School's clinical pathology laboratories measure several hormones by this technique including insulin and those controlling growth.

One particular area of interest is ACTH (adrenocorticotropic hormone), a hormone secreted by the pituitary gland. Under the direction of Dr. John W. Kendall, Jr., head of the UOMS division of diabetes and metabolism and associate chief of staff for research at the Portland Veterans Hospital, and Dr. David M. Cook, UOMS assistant professor of medicine (endocrinology), a team of researchers is measuring ACTH levels in the blood to enable earlier and accurate diagnosis of disorders of the pituitary and adrenal glands.

The only location in the Northwest where

ACTH is being measured, the UOMS and Veterans Hospital labs get samples from all over the world. "Tumors are not common in the adrenal and pituitary glands," Dr. Kendall explained, "so there is no real need for a large number of labs to measure ACTH levels. Ours is one of the few to measure these levels regu-

Dr. Kendall and his team can also distinguish between pituitary and adrenal disorders. ACTH, after leaving the pituitary gland, located in the center of the brain and weighing about one gram, goes to the adrenal glands which rest on top of the kidneys and together weigh about five grams. These glands are then stimulated to produce cortisol which, in a continuous cycle, returns to the pituitary gland. A higher-than-normal level of ACTH could indicate a pituitary tumor which would have caused over-production of the hormone. A low level might suggest a tumorous adrenal gland for here cortisol would be produced in high quantities. The pituitary gland, sensing this abnormally high level, markedly decreases the output of ACTH.

Research is also an ongoing part of Dr. Kendall's work with ACTH. The scientists already know the brain activates the pituitary gland which, in turn, secretes the ACTH. What they want to know is WHY the pituitary over-secretes ACTH and HOW the brain regulates the pituitary hormones. An understanding of this basic function of the brain would provide new means of treatment for disorders of the endocrine glands under control of the pituitary and could lead to therapy advancements in areas such as reproduction and mental dis--Jo Stage-

gy Group) tests some of the new drugs. At this time, there is one phase I, plus two phase II and seven phase III and adjuvant investigations being carried out at the UOMS.

The UOMS is the major center in the area permitted to use new drugs not yet approved, and it draws patients from Oregon, southern Washington, Idaho and northern California. (Out-of-state patients pay full cost for their care.) The patients in the chemotherapy clinic have quadrupled in the past year; where 20 to 30 patients were seen a week a year ago, 80 to 100 are now seen.

Dr. William Fletcher, professor of surgery, attributes the increase to several factors. There are no similar facilities in the area; treatments are now available that were not available before; certain new drugs have proved very effective for some types of cancer; pressures from the public have changed-people know more about cancer now and want to get the new treatments if they need them. The UOMS also serves as a resource for patients' doctors, and as a teaching center for nurses and residents, since many unusual types of cancer are treated. The UOMS serves as a controlled research environment to carry out studies, seeing how each cancer can best be treated.

IN THEIR work, UOMS investigators have confirmed the steroid receptor theory recently advanced by a University of Chicago endocrinologist. It claims that doctors can now tell women with breast cancer whether or not removal of their adrenals and/or ovaries will prolong disease-free intervals. Such surgery has been shown to benefit the 25 per cent of breast cancer patients who have hormone receptors which are related to further cancer growth. Knowing which patients the surgery will help saves the other patients needless surgery, when drugs or radiation therapy could be more beneficial.

Dr. Fletcher believes that cancer chemotherapy could become even more important in the future, as combinations of cancer drugs to stem the cancer cell's reproduction in different ways are used to fight one of the most dreaded of modern man's maladies.

-Diane Ledgerwood -

Cancer chemotherapy advances

Cancer can be treated. There are three ways of doing it: surgery, radiation therapy and chemotherapy. The newest, chemotherapy, is the treatment of cancer with drugs that selectively seek out and destroy cancer cells. It was not until the early 1960's, with the coming of modern cancer drugs, that chemotherapy became a recognized method of treatment. At first, chemotherapy at the University of Oregon Medical School, and other medical centers in the country, was limited to patients whom other treatments had not helped. Drugs were then experimental, but with time and testing, many have been approved and are now being used in community hospitals as well as medical centers.

The battlefield of cancer is at the cellular level. In cell-to-cell competition, cancer replaces the normal, orderly growth of cells with its own uncontrolled growth. It grows through normal tissue and replaces it, or around organs and interferes with their functions, or deprives the cells of their supply of nutrients. Drugs which harm the cancer but not the organism must be very toxic to the cancer to retard its growth, and yet not destroy too many of the normal cells around it.

Anti-cancer drugs now in use do have side effects to the person taking them, ranging from temporary loss of hair to cardiac complica-

SOME 40,000 drugs are screened each year in the world for anti-cancer activity. Before they can be used in humans, they are tested in animals with tumors which respond similarly to those in man. Drugs which affect cancers in animals adversely or show other beneficial effects are then tested for safety, best ways of administration and dosage level.

Clinical trials are then begun on the drugs in three phases. Phase I studies establish the dosage and assure that future trial of the drug is indicated and safe. Phase II consists of a more intensive search for anti-cancer effects with many types of cancers, and establishes whether the drug is effective enough to justify further use. Phase III is limited to drugs with beneficial effects. Controlled chemical studies are done with larger numbers of patients. If a drug passes these tests, it is then approved for more general use.

THE UOMS (along with the other 24 medical centers which make up the Central Oncolo-

Hospital and clinic manager appointed

David Witter, newly appointed business manager for the hospitals and clinics, has come to the UOMS from Portland State University, where he was in the business office for five years, serving part of that time as assistant business manager. He is now working as liaison for bud-



get and fiscal problems in the hospitals and clinics and will help in the implementation of a financial management system.

Some reflections on emergency care

Reprinted with permission of PORTLAND PHYSI-CIAN, December, 1972.

The weather in Portland was clear as the plane touched down at the airport. I was returning from the meeting of the American College of Emergency Physicians in San Francisco, and was looking forward to being greeted by my wife and children.

The meeting had been impressive. There were more than 1500 physicians attending from all parts of the United States. The organization itself had grown immensely in the few years since it had been founded, evidence of the growing interest in emergency services across the land. I was struck that there seemed to be two age groups of physicians primarily represented. There was a younger group of physicians, recently out of their training who were doing emergency room work, and there was an older group of doctors who were at about retirement age and who were trying to work into a less strenuous situation from a busy practice.

These two groups, I thought, seemed to reflect the training needs in the area of emergency room care as it presently exists. The older practitioner often had general medical experience that was very valuable in dealing with the increasing numbers of general medical problems, which are being seen in emergency rooms, the type of problems that would have been seen in the past in a general practitioner's office. But this older physician badly needed the training in acute resuscitative care and use of sophisticated equipment currently available for treatment of true emergencies.

The younger physicians, on the other hand, were well schooled in much of this sophisticated care but lacked practical experience to deal with the everyday problems. Thus, I thought, the training needs were rather diverse and might not easily be solved by any one method.

As the plane came to a stop at the loading gate and I arose and was putting on my coat, the pilot's voice came over the intercom, "Will Dr. Vander Veer please report to the agent at the boarding area." There was perhaps some delay, I thought, and my family would not be there to pick me up. However, as I emerged from the long, carpeted tube leading out into the airport, a man with a searching look on his face came up and told me that my wife and children had been involved in a collision enroute to the airport: I was to go immediately to the City of Roses Hospital. He took me down to the Airport Police office where I called a cab and set out for the hospital.

The way to the hospital seemed interminable. My family must be seriously hurt, I thought, since we always wore seat belts and since in a minor accident there would not have been injuries enough to put them in the hospital, or, if they had needed treatment they would probably have gone to Multnomah Hospital where I work.

As I sat in the cab and heard the consecutive clicks of the meter, the whole field of emergency medical services tumbled out before me in my thoughts. What happened at the scene of the accident?

From my own work I was well aware of the grim statistics across the country, namely that as late as 1970 half of the ambulance services were run by morticians. But we in Portland had an excellent system and fine ambulances with certified technicians. But what about the hospital where they were taken? Would a small hospital emergency room, with perhaps no physician on duty, be able to handle a major car accident, or, would lives be lost because of inability to deal quickly with major problems of trauma?

I thought of the survey that we had recently made of Oregon hospitals to see if there was a need for emergency physicians. We had contacted 31 hospitals of intermediate size and all of them felt that a full-time emergency physician would be very helpful and could be supported by their emergency department. Hospitals all over the state were experiencing increasing use of their emergency facilities and the need for physicians far exceeded the available supply.

In Portland itself many of the emergency rooms of the smaller hospitals were using residents who were moonlighting to serve the need after daytime hours. This was only a partial solution, I thought. I surely hoped a competent resident was on duty this morning at City of Roses.

I arrived at the hospital and immediately went to the emergency department. I was surprised to see several of my surgical colleagues there, men who had come over from the University when they had been contacted about the accident by the resident in the emergency room who was, indeed, one of our own best residents.

I saw the children first. Elizabeth Ann was awake and had her head bandaged and was complaining of her stomach. She had a bandlike bruise where the seat belt had been and her belly was quite tender. She was crying quietly and did not fully understand what was going on, confusing, scurrying activity hard to unravel for a seven-year-old. Joey was unconscious and he, too, had a seat belt mark on his lower belly. His arms were extended and his hands turned inward in the posturing I had seen so many times but never in my own child.

I moved to the next room and saw my wife, who had a badly bruised eye and a cut knee; she, too, had a seat belt bruise on her abdomen. She told me what she remembered of the accident, a head-on collision, in which my car—a new and sporty Toyota—had gone out of control and across into the opposite lane.

"I'm worried about Joey," she said. "He was so limp and blue when they took him out." He had been removed from the car by

Dr. Ron Markham, who had been passing the scene of the accident and had arrived almost immediately. He had resuscitated the boy with mouth-to-mouth breathing and cardiac massage. "He would be dead if Dr. Markham hadn't stopped," she said.

I returned to the other room where Joey was having some trouble with his airway. An oral airway had been inserted and did not seem adequate. We put in a nasotracheal airway and his breathing became much easier. Then we moved the children to Multnomah Hospital by ambulance, a heart-rending sight with them both on the same stretcher.

Elizabeth needed a laparotomy where a small bowel laceration was repaired, after which Joey had a laparotomy at which a large hematoma of the mesentery of the colon was found. It was discouraging to see these injuries and to realize that seat belts were not a panacea, but comforting to know that without them they probably both would not have survived. Phyllis, who was wearing a shoulder harness and lap belt, did not require laparotomy but she did need suturing of her eyelid and knee where they had struck the steering mechanism.

My wife was discharged two days later. On the fourth day after the accident we were returning home from visiting the kids in the evening when we came upon another bad collision very near where our accident had occurred. A Volkswagen carrying four teenagers had been struck broadside by another car. All the young people were severely injured, with the driver unconscious.

We had great difficulty getting the victims out because the car had been knocked off the road and the driver's door was against the bank with the other door so badly smashed by the accident that we could not open it. We had to pull the car back on the road to get the driver out. When we did he was barely breathing and had a profuse nose bleed.

We needed suction and intubation equipment badly; mouth-to-mouth resuscitation seemed so futile in the cool, dark night. At last an ambulance arrived and a physician stopped who had an endotracheal tube. We intubated the boy but we had no adapters so still had to give mouth-to-tube breathing on the way to the hospital.

He died later in the hospital, never regaining consciousness. The others in the car fared better but still were badly injured. The girl in the front seat required resection of part of her liver and another had a fractured pelvis.

As we left Emanuel Hospital and drove home that night, I thought about this great killer of our youth—trauma—that has become captain of the men of death in those under age 40. In our country 300 people die and 32,000 persons require hospitalization each day because of accidents. I saw that war must be waged on all fronts: from design of safer cars, through perfection of emergency transportation services, to improvement of emergency room care. Each step was vital and necessary if lives were to be saved.

As I write this now it is almost three weeks later. My wife and daughter are home, their wounds healing well, their sleep beginning to be troubled less by startling dreams. My son is still in the Intensive Care Unit, with a tracheostomy and getting tube feedings, but he seems to fully understand and is responsive, though he cannot yet move his arms or legs at will.

I am hopeful for the future and grateful for the care we have received. Among the many notes of sympathy, one especially stands out. It was from the mother of one of the girls in the Volkswagen wreck where we had stopped. "All that you had been through prior to that night should have been enough for any man or woman to endure and then to come upon the accident."

She wondered how I could do it. But I felt that I could not do otherwise—because another doctor had done so for my own family.

—Dr. Joseph B. Vander Veer, Jr., director of Emergency Services and assistant professor of surgery

Editor's note: Joey was released from the hospital December 23 and is progressing steadily at home. Elizabeth is back in school.

J. Gibson Pleasants research center established

A first annual grant of \$15,000 has been received by the University of Oregon Medical School Advancement Fund to establish the J. Gibson Pleasants Memorial Cancer Research Center for the study of prostatic cancer.

Prostatic cancer is the most common cancer in men over 50, and second only to lung cancer as the highest cause of death from malignancy in males. An anonymous donor has funded the Center in memory of Mr. Pleasants who lived in Oregon following his retirement as Vice-President of Research and Development for Procter and Gamble Company. He died of the disease early last year.

Dr. Clarence Hodges, chairman of the Medical School's urology department, said the Pleasants Memorial Center on the School's campus will focus on prostatic tumor prevention and early detection, and the development of a specific immuno-therapy.

DR. JAMES W. ANDRUES has recently been appointed head of audiology services at Portland Center for Hearing and Speech. Prior to joining the Center staff, he served as clinical audiologist at the National Technical Institute for the Deaf in Rochester, New York. He received a Ph.D. from the University of Washington in 1970 and later earned a certificate of clinical competence in audiology from the American Speech and Hearing Association.



The University of Oregon Medical School's six-bed dialysis unit provides facilities for patients awaiting kidney transplants, those acutely ill and individuals who have just received donor organs. Checking on ten-year-old Tracie, left to right, are Drs. Yeshawant Talwalkar and James Musgrave, both instructors in pediatrics and Kurt Martyn, senior medical student from the Medical College of Wisconsin taking an elective course at UOMS.

Kidney center opens

A centralized in-service kidney center, designed to broaden the efficiency and quality of kidney patient care, went into operation recently at the University of Oregon Medical School. All facilities for the kidney transplant, dialysis and renal outpatient programs on the School's campus are currently consolidated on the fifth floor of the new wing of the Medical School Hospital.

The center provides 10 beds for pre- and post-operative care of patients undergoing kidney transplant surgery. A six-bed dialysis unit will be used for persons awaiting kidney transplants, and for those being dialyzed during acute illness and early rehabilitation. Four additional beds are reserved for nephrology patients receiving non-surgical care.

Staff for the center consists of a merged group of doctors, nurses and technologists from the dialysis unit formerly located in Multnomah Hospital and the kidney transplant team at the Medical School Hospital. The consolidation, according to Dr. Russell Lawson, associate professor of urology and head of the kidney transplant team, will permit maximum benefit of the legislative funds allocated for the kidney treatment program, without involving any cost increases. He said, "It is simply a relocation of physical facilities for the benefit of patients and staff." Dr. Lawson added that patient morale should be improved; a patient on dialysis awaiting a transplant will be able

to see and relate to the outpatient coming in for check-ups after a successful surgery.

The first renal transplant at the UOMS, and the tenth done in the world, was performed in 1959 by Dr. Clarence Hodges, head of the urology division. During the following years new techniques and more effective anti-rejection drugs paved the way for urologists to accept an increasing number of patients for transplants with a comfortable degree of certainty in their successful outcome. To date, the transplant team at the Medical School has done 125 transplants on 102 patients, 14 of whom have had more than one kidney implanted.

For the entire series of transplants done since 1959 the UOMS rate of successful functioning grafts is 85 percent for patients receiving kidneys from related donors and 57 percent for implanted cadaver kidneys. (A cadaver kidney is used when there is no compatible related donor.) These statistics represent not patient survival rates but renal transplant functional survivals of at least one year, when the major likelihood of rejection has passed. If a graft is rejected the patient is put back on dialysis to wait for another suitable kidney. Currently 34 patients are being maintained in hospitals or by the Kidney Association of Oregon's home dialysis program while waiting for their transplants.

-Thelma Wilson-

North unit meets inpatient needs

Since the north unit of the Child Development & Rehabilitation Center opened a little more than a year ago, many Crippled Children's Division patients and their families have been served in a new way. CCD has traditionally cared for crippled children as outpatients, but in cases where bedfast patients or patients whose parents live far away need to use the multidiscipline CCD services in Portland, a small hospital facility is needed. And the sixbed north unit fills that need; there were 91 admissions last year.

Thirty-four families were also helped in the family inpatient units, in the same building but on the floor below. There are apartments with viewing windows so a child and his family can be observed in many of their daily activities. The family can then be advised on how to manage their child better.

All the disciplines of CCD are available to the child (or his family) in this unit. Children eligible for these services have multiple disabilities, with complexities which their communities cannot manage.

Faculty / legislature relationship defined

A statement clarifying the relationship of faculty and staff of the Medical and Nursing Schools to the State Legislature has been released by UOMS Dean Dr. Charles N. Holman.

"Relationship to the Legislature is defined in the statutes and the administrative rules of the State Board of Higher Education (ORS 351.110 and AR 42.140 and AR 42.150).

"These documents do not prevent any staff member from appearing at the Legislature or conferring with legislators. It is only when they represent the Department of Higher Education that it is necessary to obtain written approval of the Chancellor.

"Faculty members particularly are cautioned that their position on the faculty may give the mistaken appearance of officially representing the Department, even when they do not. In such cases, faculty members are requested to state specifically that they do not represent the Department of Higher Education.

"To comply with the letter and intent of ORS 351.110, written authorization of the Chancellor is required prior to a staff member giving any testimony before the Legislature or a legislative committee on matters relating directly to the Department of Higher Education or its institutions. The only exception to this requirement is when the staff member testifies pursuant to a specific invitation from the Legislature or a legislative committee, or at the invitation of the Chancellor's office."

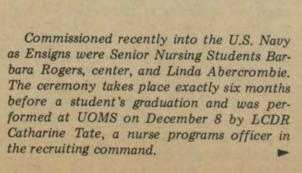
PHOTOS



A The highlight of the day at Doernbecher Hospital was a visit by Disneyland's Chip 'n' Dale and Goofy on December 11. The characters sang, danced and distributed presents to the patients.



▲ The UOMS security division's four motorized carts are now equipped with two signs each, hand-lettered by Phil Jacob of the physical plant. Serving as a reminder to motorists, the signs carry six different slogans.







▶ Dr. Robert Koler, head of the division of medical genetics and recently retired chairman of the Veterans Hospital's research and education committee, received a commendation from the committee for his efforts, which produced the results of "new professional staff members attracted to the Hospital, new research facilities. . .added to the station and a strengthened relationship in research activities . .established between the Hospital and the University of Oregon Medical School."





≺ Kingsley Lewis, a Winston Churchill Fellow for 1972 and a state registered public health nurse from Kent, England, visited the Child Development and Rehabilitation Center in December as part of a three-month tour of the U.S. During his visit he has been observing services for the mentally retarded, especially children, and programs for preschoolers and in behavior modification.

Mr. Lewis also holds the title of Queen's Nurse, an honor bestowed after completion of the Queen's Institute of District Nursing exam.

A Taking part in a new State Board of Higher Education program, Board members, left to right, John D. Mosser, Robert D. Holmes and Mrs. Elizabeth H. Johnson visited the Medical School recently to better acquaint themselves with the institution's programs and facilities. Dr. Curtis Holzgang, right, assistant professor of medicine and director of education, medicine outpatient professional services, led a tour through the UOMS medicine intensive care unit

The Crippled Children's Division second annual flower show, featured single blooms, bouquets and original arrangements. First place ribbons went to: Dr. L. Paul Rasmussen, Gertrude Lister, Dorothy Macfarlane and Beb Van Veen.



▲ Prior to the opening of the new legislative session Representative Roger E. Martin, center to right, Senator Kenneth A. Jernstedt and Representative Michael C. Ragsdale met with Medical School officials Joseph J. Adams, assistant dean, left, and Dean Charles N. Holman for an update on the institution's activities.





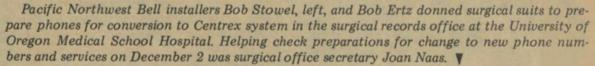
▲ Temporarily slowed down by bad weather, construction on the new 787-space parking structure has resumed. About 10 per cent of the 320 lintees (pre-cast flooring) have been laid, over which will be poured three to five inches of cement formed for drainage.



▲ Multnomah Hospital's surgery intensive care unit won first place for their Christmas wall display in the Hospital's cafeteria. The 15 entries were judged on creativity, attractiveness and originality.



→ The faculty wives' bazaar was held on December 14 and offered a variety of greens, baked goods and hand-made items for sale. Proceeds will go to the Medical School though the exact use has not yet been determined.





A Russian dance called Troika, depicting teams of three horses, is one of many folk dances performed by a group from UOMS which meets every Wednesday evening. The group, led by Junior Nursing Student Lyn Metz, welcomes new participants.



More on higher education board members

The Oregon State Board of Higher Education is the subject of a four-part series in Medical Center News. Continuing, this month we introduce three more of the nine-member lay board. Board members are appointed by the Governor to four-year terms and the Board meets bimonthly.—Editor



Mrs. Johnson, John Snider, George Corey

The only woman on the Oregon State Board Higher Education is articulate Elizabeth Hill Johnson of Redmond.

Mrs. Johnson chairs the committee on academic affairs and serves as an alternate on the public service committee as well.

A Phi Beta Kappa graduate of Miami University (Oxford, Ohio), Mrs. Johnson took graduate studies in English literature at Wellesley where she received her master's degree. She immediately went into teaching at the high school level.

For three years, during World War II, Mrs. Johnson served with the WAVES and in August 1945 was named director of the WAVES for the Thirteenth Naval District.

Active in Redmond and Deschutes County affairs, Mrs. Johnson has also served as vice president and member of the executive committee of the Association of Governing Boards of Colleges and Universities, a member of the presidential search committee of the University of Oregon, a member of the board of directors of the Oregon Medical Education Foundation, and is co-founder and vice president of the S. S. Johnson Foundation.

CHAIRMAN OF the Board of Higher Education's committee on buildings is Portland attorney, Philip A. Joss. Mr. Joss also serves as an alternate on the academic affairs committee.

A graduate of Yale University and Harvard Law School, Mr. Joss served as chairman of the Oregon State Civil Service Commission for 10 years; was director of the Portland Community Council for five years; is a past presi-

DECEMBER Service Anniversaries

> Marylee Gowin, psychiatry Teresa Huntington, bookstore Dr. Elaine Lis, CCD Barbara Smith, clinical pathology

Richard Baerwald, animal care Delbert Brumble, printing Frances Cetinich, anesthesiology Dr. Warren Fay, CCD Joyce McKay, TB Hospital

Anorvia Hardy, MSH nursing Jean Matsumoto, cardiology Oral Snively, physical plant

Moving Up

Chiane Binford, X-ray tech. 1 to X-ray tech. 2, radiology

Mary Bird, clerk 1 to clerk 2, personnel Diane Cole, clerk 3T to clerk 4T, patients' business office

Kenneth Cook, storeclerk to storekeeper 2, lab stores

William Dacy, animal caretaker to admin. asst., animal care

Mary Ferrioli, sec. 2T to sec. 3, CCD Mary Hargreaves, clerk 3T to sec. 2T, MSH nursing

Ana Horn, clerk 2T to clerk 3T, MSH

Theresa Hoss, sec. 1T to sec. 2T, CCD John Huff, cust. wkr. to main repairman, physical plant

Irena Humphrey, dental asst. to clerk 4T, medical correspondence

Harry Jones, laborer 1 to laborer 2, physical plant

Bruce Krohn, lab. asst. 1 to storeclerk, lab stores

Donna Marsonette, clerk 2T to clerk 3T, medical records

Patricia Meade, clerk 3T to clerk 4T, patients' business office

Frances Olson, X-ray tech. 2 to X-ray tech. 3, radiology

Stanley Parras, inst. wkr. 2 to cust. wkr. sup. 1, MSH hskpg.

Maxine Stone, laundry wkr. 1 to laundry supervisor, MSH laundry

Constance Strawn, clerk 2T to sec. 3T, social service

Constance Whiteley, clerk 2T to clerk 3T, patients' business office

Karen Wild, clerk 2T to clerk 3T, library

New Faculty Volunteer

Dr. Richard G. W. Anderson, affiliate in anatomy

Dr. John D. Brose, clinical instructor in surgery

Dr. George F. Donahower, senior clinical instructor in medicine (endocrinology)

Dr. Charles R. Hahn, clinical instructor in dermatology

Dr. John B. Hardiman, affiliate in ana-

Dr. Dennis D. Knutson, instructor in dermatology (Primate Center)

Dr. Carl E. Morgan, lecturer in medical psychology

Dr. Loren D. Pankratz, instructor in psychiatry (psychology) Dr. Rhesa Lee Penn, associate clinical

professor of pediatrics

Dr. Arlen Quan, associate clinical professor of psychiatry (VAH) Dr. David A. Ross, clinical instructor in

surgery

Dr. Henry Wilde, assistant clinical professor of medicine

IN MEMORIAM

Dr. W. Ronald Frazier, former assistant clinical professor of obstetrics/gynecology......December 29, 1972

Dr. Robert A. Wise, clinical professor of surgery......December 30, 1972





Mr. Joss

dent of the Portland Art Association; a trustee of the Boys and Girls Aid Society; and the Family Counseling Service; and a member of the Portland Committee on Foreign Rela-

Mr. Holmes

ROBERT D. HOLMES is chairman of the committee on finance for the Board of Higher Education and serves on the academic affairs committee as well.

The former Governor of Oregon served as a state senator for eight years and has been active in Clatsop county. He has served, in addition, as coordinator for Oregon Welcome, Inc., conducted the television program, "Let's Face It," for many years; is a board member of the Oregon Historical Society and the Oregon Shakespearean Festival Association. Serving as chairman for Colleges for Oregon's Future, Mr. Holmes was named Education Citizen of the Year in 1953.

Budget officer named

New to the UOMS is Budget Officer Bob Peterson. Formerly with Portland State University as assistant business manager and assistant budget officer prior to that, he was also affiliated with U.S. National Bank in the trust department.



A native of Moscow, Idaho, Mr. Peterson has lived in Portland for six years.

Campus bulletin board

The American Medical Association Council on Foods and Nutrition has announced its 1973 Joseph Goldberger Fellowships for medical students. The fellowships provide students an opportunity to gain research experience and stimulate their interest in clinical nutrition. The grant will consist of \$250 per month for three months of the year in which academic work is not scheduled.

Application by a faculty sponsor must give information concerning the research project, the student's qualifications and the necessary facilities.

There is no special application form required, although format for the application is on file in the office of public affairs, or from the Council on Foods and Nutrition/American Medical Association/535 N. Dearborn St./Chicago, Illinois 60610. Deadline for application is February 28, 1973.

The San Francisco Heart Association announces the William and Dorothy Fish Kerr Student Fellowship in Clinical Cardiology, an eight-week fellowship experience for medical students in their third and fourth years. The opportunity to gain this experience is under supervision in clinical cardiology in an accredited medical center or hospital in San Francisco. Fellowships may be initiated any eight consecutive weeks between July 1, 1973 and June 30, 1974. Stipend is \$600.

Application forms must be completed by March 1, 1973. They are available in the public affairs office (Adm. 1011) or from Rodman D. Starke, M.D./Chairman, Kerr Fellowship Review Committee/San Francisco Heart Association/259 Geary Street/San Francisco, California 94102.

The SAMA-University of Texas Medical Branch National Student Research Forum is now calling for scientific abstracts and manuscripts from medical students, residents, interns and graduate students. Several cash awards and plaques will be given in all categories.

Deadline for abstracts is February 1, 1973 and for manuscripts, March 12, 1973. For more information on the form entries should take, consult the office of public affairs files or write: SAMA-UTMB National Student Research Forum/Room 209 Libbie Moody Thompson Basic Sciences Building/The University of Texas Medical Branch/Galveston, Texas 77550.

The National Multiple Sclerosis Society sponsors a program of predoctoral fellowships for medical students who have completed one or more years of study in medical school. Fellowships are awarded for from three months to a year of full-time training in research; stipend is \$400 a month. Completed applications received before March 15, 1973 will be considered for grants to begin on or after July 1, 1973. Potential applicants may request application forms by letter, including in the letter a very brief statement as to proposed research. Direct letters to: National Multiple Sclerosis Society/Research Programs Department/257 Park Avenue South/New York, New York 10010.



NEWSMAKERS

Dr. Norton B. Young, professor of speech pathology and audiology, Crippled Children's Division and pediatrics, was honored at the recent meeting of the American Speech and Hearing Association by elevation to the status of fellow in recognition of his "outstanding professional achievement."

Dr. Emil J. Bardana, Jr., assistant professor of medicine, spoke on "Measurement of Humoral Antibodies in Aspergillosis" at the International Conference on Pulmonary Reactions to Organic Materials in November. The meeting was sponsored by the New York Academy of Sciences in New York.

Recently voted second president-elect of the United States Section of the International College of Surgeons was Dr. Jesse L. Ray, assistant clinical professor of obstetrics and gynecology. The College, a worldwide organization of surgeons and related specialists with chapters throughout the world, has a U.S. membership of over 10,000. Dr. Ray will take office in January of 1975.

Dr. Herbert L. Collier, former UOMS medical psychology intern, is author of a new book, *The Psychology of Twins*. The father of twins himself, Dr. Collier has spent a number of years gathering data on the subject and counseling parents, teachers and their children. He is currently clinical psychologist at St. Joseph's Medical Center in Phoenix, Arizona.

New president of the Portland Medical Center Hospital medical staff is Dr. Rosemary E. Brodie, assistant clinical professor of neurology.

Public Affairs Director Ken Niehans was elected national chairman of the Association of American Medical Colleges' public relations section at the group's national convention at Miami Beach in November. The Association represents 113 medical schools in the United States, Puerto Rico, Lebanon and the Philippines.

Dr. Forrest E. Rieke, assistant clinical professor of environmental medicine, was one of 20 Americans invited by the U.S. Department of State to attend an international symposium on management and disposal of radioactive wastes held in Paris the end of November.

Security Director Jim Whalen has been elected president of the Oregon Hospital Security Association, a group of 20 hospitals with common interests in administration, operation and development in hospital security.

Dr. Richard L. Dobson, formerly professor of dermatology at UOMS, has been named professor and chairman of the dermatology department, School of Medicine, State University of New York at Buffalo.

Dr. Roy E. Lieuallen, chancellor, Oregon State System of Higher Education, has been unanimously elected chairman of the Western Interstate Commission for Higher Education (WICHE). He has served on the Commission since 1962 and held the position of vice-chairman in 1971-72.

Program Planning Director William H. Prentice has been appointed by Secretary of Defense Melvin R. Laird to the National Advisory Council of the National Committee for Employer Support of the Guard and Reserve. Major General Prentice is affiliated with the Army Reserve and, in his new public service assignment, joins 200 other Americans on a special committee to bolster the total force concept of national defense.

