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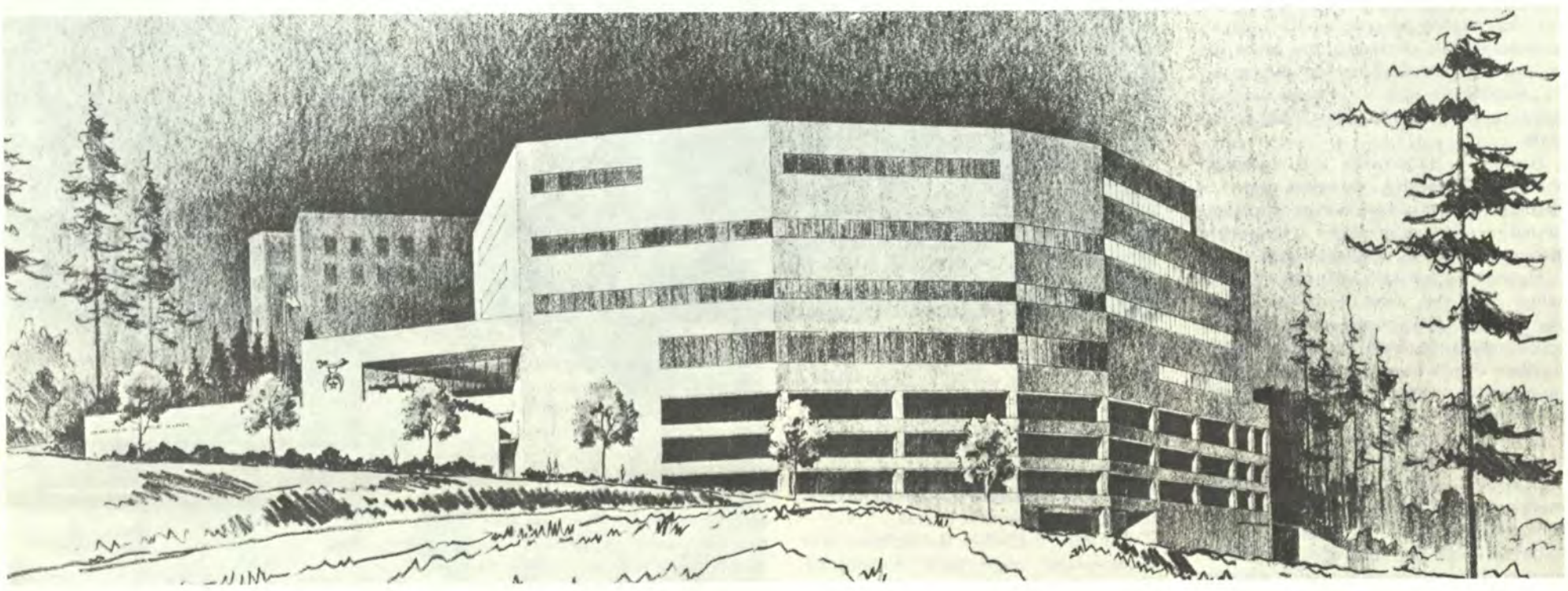
UNIVERSITY OF OREGON
HEALTH SCIENCES CENTER
NEWS

Health Sciences Center News is published by the University of Oregon Health Sciences Center to inform students, employees, faculty and friends of the institution of programs, activities and events of interest to them.

New construction to bring new life to Marquam Hill



Shriners Hospital for crippled children to rise on campus

It won't be long before those associated with the Health Sciences Center notice a buzz of new activity on campus – the construction of a new, 80,610-square-foot Shriners Hospital for crippled children.

Plans for the new building, to be built where Katherine Hall now stands, were solidified in February with the approval of the lease agreement by officials of the Shrine Board of Trustees and the Oregon State Board of Higher Education.

The 39-bed hospital, which will include at least 7,500 square feet of research space, will replace the 56-year-old Portland Shriners Hospital located at NE Sandy Boulevard and 82nd Avenue.

"We want to work very closely with the University, and that's one of the main reasons we wanted the Marquam Hill site," explained Al Holmes, chairman of the board of governors of the Portland Shriners Hospital.

HSC President Leonard Laster said, "Welcome to our new neighbors, friends and research partners! The strengthened union between the Shriners and the University will benefit children for years to come. What a fine addition to Marquam Hill!"

Phase I of the project starts soon, with the remodeling necessary to move services out of Katherine Hall before it is demolished, according to Ralph Tuomi, director

Above is the architects' drawing of the new Shriners Hospital for crippled children, to be built where Katherine Hall now stands. The first phase of the construction project will start soon.

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UOHSC hails decision to locate veterans hospital on hill

Smiles and sighs of relief at the Health Sciences Center greeted the Veterans Administration's decision to locate its new, 490-bed Portland hospital on Marquam Hill.

After years of debate, the decision was formally announced Feb. 20 by VA Administrator Max Cleland.

The facility also will include a new 120-bed nursing home, laundry and warehouse in Vancouver, Wash. Total cost of new construction, to be completed no later than 1988, will be $176.1 million.

The VA administrator's announcement reaffirmed his preference for the Marquam Hill site – location of the existing VA Hospital – over an alternate site, Emanuel Hospital in north Portland. "We are convinced that the level of care which can be provided at the Marquam Hill site is significantly greater than that provided at the Emanuel site," Mr. Cleland said.

Funding and construction of the hospital had been delayed for three years by the dispute over where the acute-care portion of the facility should be built.

The decision will allow the UOHSC and Veterans Administration Medical Center to continue a mutually beneficial relationship, said HSC President Leonard Laster.

"I couldn't be more delighted. This move will be a major step forward in the provision of high-quality health care to many veterans of this region and it will reinvigorate the 50-year-old highly productive academic partnership between the hospital and the School of Medicine," Dr. Laster said.

According to Dr. Ransom Arthur, dean of the School of Medicine, "I consider this the single most important decision for the future of the medical school in probably the last decade. The VA Hospital is absolutely essential to our educational program. Without the patients there, we just wouldn't have sufficient clinical opportunities to be able to teach our students the practice of medicine.

"Concomitantly, the Veterans Administration Hospital is a source of a good deal of important academic research. Addition-

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Center budget request seeks 'surge toward higher quality'

"We have made good use of the assistance we received in the 1979-81 budget," UOHSC President Leonard Laster told the finance committee of the Oregon State Board of Higher Education in February.

"The Health Sciences Center clearly reflects growing morale, pride, optimism and deep commitment to its missions and to its future development. Devotion and dedication to the University permeate all its segments – faculty, students, staff, patients and friends. Its academic base is strong.

"Nevertheless," the president said, "we still have 'black holes' in our academic galaxy."

It was largely as a result of a review of UOHSC needs and deficiencies, together with a presentation by University of Oregon President William Boyd and strong support from finance committee chairman Robert Ingalls, that all the State System presidents were invited to array the broad range of their institutions' needs before the Board instead of limiting their initial requests for program improvements in 1981-83 to a 2 percent increase in the base budget, as originally proposed.

With supporting data from deans and UOHSC administrators, Dr. Laster said, "The budget for 1981-83, like no previous budget, will set the tone and direction of the Health Sciences Center for many years to come. In one direction lie the hazards of dispirited coping and progressive en-

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Hospital on road to recovery from nursing shortage

This article, based on an interview with Dr. Donald Kassebaum, vice president for hospital affairs, is the first in a series of HSC News stories exploring the national issue of nursing manpower – especially as it affects the University Hospital and the health care needs of Oregon.

Nurses like Waldine Quinn, above, a registered nurse at University Hospital (south) 9C, have been working hard to keep the quality of patient care high during the nursing shortage. Gale Rankin, director of nursing service at University Hospital, said, "I really appreciate the professionalism the nurses have maintained during this period . . . We couldn't have maintained our high nursing standards without their extraordinary effort."

University Hospital appears to be on the road to recovery from the trauma of a nursing shortage that has forced the closure of 57 beds.

The vital sign is the recent settlement of labor negotiations between the State of Oregon and the Oregon Nurses Association that had been stalled since last July. The stalemate had left University Hospital without a contract.

With no salary contract, explained Dr. Donald Kassebaum, vice president for hospital affairs, University Hospital's pay scale for registered nurses has been lower than other community hospitals' – making it difficult to recruit nurses.

Compounding the problem has been an accelerated rate of resignations by nurses at University Hospital. Many of the nurses, Dr. Kassebaum said, have been working overtime to make up for the shorthanded staff.

Further, a nationwide and statewide shortage of working registered nurses – particularly critical-care nurses – has impeded recruitment of nurses at University Hospital as well as other hospitals.

However, a breakthrough came Feb. 20 when both the state Executive Department and the ONA accepted a fact finder's recommendation for a 20 percent salary increase over a two-year period for state nurses. About 600 nurses at the UOHSC are affected.

Dr. Kassebaum is optimistic yet realistic about the settlement's impact.

"The immediate results are that nursing morale is improved and resignations will be fewer," he said. "But we're still going to have a tough time for two or three more months before we can recruit enough nurses to enable us to reopen those beds."

The biggest surge of nurses onto the labor market occurs in May, he noted.

"Other things being equal," Dr. Kassebaum continued, "University Hospital has an edge in recruiting nurses. We are an exciting place for nurses to work, and it is fun competing intellectually with doctors in training and with very sharp faculty. We do new things, we do different things – there's never a dull moment. Moreover, many of our nurses are spouses of medical students, interns and residents.

"So I think that when we can pay them an acceptable wage, we'll probably be able to recruit most of the nurses we need."

Because of the critical shortage of registered nurses, hospital administration and the medical staff agreed in January to close temporarily a medical-surgical ward of 22 beds and to cut back on elective cardiac surgery. In February, an additional 35 beds were closed in various departments.

Dr. Kassebaum noted that the hospital has opened a day surgery center in University Hospital (south) 10A to make more economical use of the limited number of beds. The ward is serving patients who need only day care and thus is freeing up beds in other nursing units.

"The hospital is in a strong position to recover from this (nursing shortage)," Dr. Kassebaum declared.

He praised the many nurses who have worked long extra hours to pick up the slack. "The thing that has held the hospital together during the last seven or eight months has been the professionalism and the loyalty of the nurses," he said.

Dr. Kassebaum's staff worked with the state's personnel division to gather information about nursing salaries at other hospitals, and to arrive at guidelines for establishing competitive salaries.

"Nurses at teaching hospitals deserve special treatment," he said. "This is not just because if we don't provide equity of compensation we won't be able to compete for nurses on the labor market, but also because we value highly the special role nurses play in the teaching hospital.

"They are part of the teaching force and they are important components of our quality assurance program. They help guide young doctors and nurses in training. They are a 'failsafe' to ensure that high-quality patient care accompanies the learning process."

Nurses also play an important role in providing continuity of attention in special-care units at University Hospital, which has more such units than almost any other hospital in the community, Dr. Kassebaum said.

"The guts of the hospital is the nursing staff. If you don't have them, you can't take care of patients."

To recruit and retain more nurses, Dr. Kassebaum said, University Hospital is examining the feasibility of three new strategies.

First, the hospital is looking at providing a day care nursery for nurses who have children.

Second, it's studying the development of "career ladders" for nurses. This strategy, Dr. Kassebaum said, would involve programs in continuing education, broadening development of skills, promotion, and encouragement of nursing care research.

Third is the fostering of closer relations between the hospital and the School of Nursing, Dr. Kassebaum said. This would involve more nursing students working and learning in University Hospital. "We will employ faculty of the School of Nursing on the hospital's nursing service," the vice president said, "so there will be top-flight faculty teaching nursing students on our wards and promoting their choice of University Hospital as the place to make their career."

Referring to the hospital's need to bring in more nurses, Dr. Kassebaum summarized, "We cannot be complacent."

He added, "My hope is that the few nurses who are on the market now will make contact with us because they know the labor dispute is resolved and because their careers are well served by working here."

HEALTH SCIENCES CENTER
NEWS

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University of Oregon Health Sciences Center, 3181 S.W. Sam Jackson Park Road, Portland Oregon 97201

Leonard Laster, M.D., President

Mary Ann Lockwood, Executive Editor, Acting Executive Assistant to the President

Katherine Keniston, Managing Editor and Photographer

VA decision reinforces 50-year-old relationship

(continued from page 1)

ally, the hospital enables us to augment our faculty because of the fine physicians and others on the staff down there. In turn, the proximity of the medical school ensures that they will have a first-rate staff."

Dr. Arthur added, "I just can't imagine a more mutually beneficial step. New construction on the hill will really lift our spirits and enhance our morale."

"Joy" was the word that John J. Lee, administrator of the Veterans Hospital and the related facility in Vancouver, used in describing his reaction to the announcement.

"After the long struggle of three or four years, we in the VA are delighted. We're delighted that we're going to stay on Marquam Hill and be able to reinforce our affiliation with the University of Oregon Health Sciences Center," he said.

"Primarily we benefit from our affiliation in terms of our ability to recruit highly qualified people to serve as chiefs of our services. We can offer them faculty appointments and work in research. These appointments are in both the clinical and academic spheres. The affiliation enables us to get good people to come and work for us."

The relationship between the Portland VA Hospital and the UOHSC is not unique. Since the immediate post-World War II period, Dr. Laster said, a partnership has formed between the VA hospitals and the nation's medical schools that contributes significantly to patient care, education of health care professionals, and development of major biomedical research.

"Had the replacement facility been built off Marquam Hill, that action would have had the effect of removing about 30 faculty members from an already severely understaffed School of Medicine," Dr. Laster noted. "The highly effective interaction between the hospital and the medical school . . . is a commodity that cannot be purchased. It must be nurtured through the years and to have destroyed it would have been a sorry act."

Clinical Research Center stresses the human factor

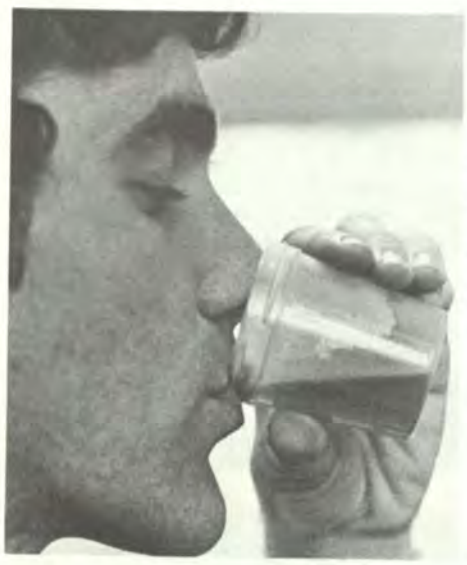
Clinical Research Centers are uniquely human in their approach to studying the diseases of man.

At the University of Oregon Health Sciences Center's Clinical Research Center – one of 83 such facilities across the nation – biomedical scientists can study man himself and not be limited to animal and tissue models alone.

The center's goal is to find answers to unsolved problems of disease.

"At some point in time, you have to apply experimental concepts to humans. You can't use the animal or laboratory model as the ultimate extrapolatory information for humans," said Dr. John Porter, professor of surgery and director of the Clinical Research Center (CRC).

The CRC recently received the largest grant ever given to a UOHSC program. The center was awarded $6.3 million for the period of 1980 to 1984 from the National Institutes of Health, which funds the national General Clinical Research Centers Program.



Clockwise from left: A normal volunteer sips salmon oil for a CRC study testing salmon as a possible element in lowering cholesterol and triglycerides; a patient with Raynaud's syndrome, which produces abnormal spasms of blood vessels in the arms and hands, dips her hands into a tub of ice water to test reaction to cold; and CRC staff nurse Sima Jatala-Brown monitors a patient during a methadone/respiration study.

Clinical Research Centers are highly specialized patient units that give medical scientists opportunities for careful study of disease. They are located in medical institutions throughout the United States.

Of the UOHSC center, Dr. Porter noted, "Its primary purpose is the evaluation of new diagnostic and/or treatment techniques in human disease. But it also functions as a laboratory for the study of human physiology and pharmacology, without any disease necessarily being present."

The CRC has important programs going in oncology, vascular disease, immunology, endocrinology, narcotic addiction, cardiology, nephrology (study of the kidney) and hypertension.

The center accepts research projects, or protocols, from any School of Medicine department. These protocols are first approved by the CRC advisory board and then by the School of Medicine Human Rights Committee.

Patients give consent to participate in the research projects, whether they are to be hospitalized in the CRC unit or seen there as outpatients. Often, participants are "normal" volunteers who serve as a point of reference from which to study a disease or treatment.

Because clinical (human) studies demand complex care and treatment, general hospital wards are not expected to cope with such specialized needs.

"With rare exception," said Dr. Porter, "the performance of human research requires the frequent and precise administration of agents, the recording of observations and the taking of patient samples."

The CRC comes well equipped for that. Located on the second floor of University Hospital's northeast wing, the center has eight beds, including a two-bed ward for patients who need close observation. Completing the unit are a conference room, patient recreation room, staff offices and a diet kitchen.

Also vital to the Clinical Research Center is its core laboratory, which provides expertise for the clinic's research over and above the standard lab services.

The laboratory, directed by Dr. Edward Keenan, has played a key role in one of the CRC's most ambitious projects. This is the devising of methods to determine which patients with breast cancer could benefit most from hormone therapy. Investigators from throughout the country have joined in the study.

That research project is but one of the 165 protocols that have been administered at the Clinical Research Center since it began in 1966. The center now has 30 active protocols, about a third of them multidisciplinary.

A major activity at the CRC is the study of various chemotherapeutic agents and methods of chemotherapy administration in the treatment of cancer patients. (See the accompanying story.)

In another big project, patients with hyperlipidemia as well as normal volunteers are being investigated in lipid metabolism studies. Conducting the research is Dr. William Connor, professor of medicine and director of the lipid research lab, who is assistant director of the Clinical Research Center.

"At some point in time you have to apply experimental concepts to humans. You can't use the animal or laboratory model as the ultimate extrapolatory information for humans."

A CRC project that has captured national attention is a study of asthmatic attacks occurring in industrial workers. The study, conducted by Dr. Emil Bardana, associate professor of medicine and head of allergy, indicated that fumes from heat-activated price labels were the cause of asthma suffered by many meat-wrappers. As a result, the meat-wrappers' union suggested a national study to re-evaluate wrapping methods.

Among other subjects the Clinical Research Center is looking into are the following:

– The possible effects of methadone on the respiratory control of pregnant methadone addicts.

– Raynaud's syndrome, which produces abnormal spasms of blood vessels in the arms and hands.

– The cause of impotence frequently seen in patients with renal failure.

– A preparation of immune serum globulin that can be given intravenously without producing side effects. The study involves patients with A gammaglobulinemia, an immune deficiency state.

– Regulatory mechanisms in parathyroid hormone synthesis and secretion in kidney transplant patients.

– Effects of aspirin on renal function. There is evidence that aspirin can be harmful to patients with kidney disease; normal volunteers are being evaluated for any aspirin-induced effects on the kidney.

– Ways to determine which patients with pituitary tumors should undergo radiation therapy and which should undergo surgery.

– The effect of a high-carbohydrate/low-fat diet on the lipids of juvenile diabetics. Both inpatients and outpatients are

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Clinical study offers hope for osteogenic sarcoma victims

Julie was 15 years old when doctors discovered she had osteogenic sarcoma, a lethal cancer of the bone.

There was at least a little hope for Julie. At 16 she was referred to the UOHSC's Clinical Research Center, which was investigating a new mode of chemotherapy for the disease.

"At this time, five years later, she is without evidence of disease," said Dr. Alan Awrich, fellow in surgical oncology and an investigator in the chemotherapeutic study. "That's not to say she is cured, but at this time she doesn't have any cancer as far as we can tell. She's engaged to be married and is generally enjoying life."

Dr. Awrich believes that a key to Julie's "remarkable" recovery is the use of high-dose methotrexate.

The chemotherapeutic drug is given in extremely high doses – 10 to 18 grams at a time – to osteogenic sarcoma patients who are participating in the protocol at the Clinical Research Center. Twenty-one-year-old Julie continues to take part in the study.

"Methotrexate does have the potential in some instances to prolong life of some (osteogenic sarcoma) patients who otherwise have a uniformly fatal disease," said Dr. Awrich.

In Julie's case and in others, the high-dose methotrexate has been used in conjunction with surgical treatment. She has had four operations on her lungs to remove the metastatic disease and has had her right leg amputated to halt the spread.

Methotrexate, Dr. Awrich explained, works by blocking a specific biochemical reaction in the body. "It prevents what is otherwise a normal enzymatic step in a cell. It inhibits an enzyme known as dihydrofolate reductase, which ultimately results in the decreased biosynthesis of DNA."

Because all cells depend on the synthesis of DNA in order to reproduce, "tumors that could not produce more DNA could not grow," Dr. Awrich said.

Methotrexate is used in treating many cancers, but unusually high doses are needed to fight osteogenic sarcoma.

Patients on the Clinical Research Center protocol come in once every three or four weeks for intravenous injections of methotrexate. A couple of hours after the injection, a patient begins receiving folinic acid, which allows the methotrexate to selectively kill the tumor cells without harming normal cells. This "folinic acid rescue" of healthy cells continues for several days.

Meanwhile, the patient is given plenty of fluids to flush the methotrexate out of the body. The patient is discharged when the drug is down to a safe level.

Each dose of methotrexate is superlethal, and this underscores the importance of the CRC's special capabilities in management and monitoring, pointed out Dr. William Fletcher, head of the division of surgical oncology and chief investigator for the study.

Said Dr. Awrich, "Methotrexate has been one of the several improvements in the therapy of what was previously a uniformly fatal problem."

A primary bone cancer, osteogenic sarcoma strikes mainly teen-agers, young adults and elderly persons.

"Ten years ago with this particular type of tumor, regardless of the type of treatment, 80 percent would develop metastatic tumor in the lungs within one-and-a-half to two years," said Dr. Awrich. "Most would be dead within a year after that."

The standard treatment for osteogenic sarcoma has been surgical removal of the tumor, which often has meant amputation. "Surgery has advanced to the point where we're now able to do a limb salvage operation," in which the diseased segment of the bone is excised and replaced with a specially designed prosthesis, Dr. Awrich said.

If high-dose methotrexate is proven successful in the Clinical Research Center's protocol, he noted, it too may become a standard therapy for victims of osteogenic sarcoma.

And, although none of the approximately 15 other patients in the study have responded as well as Julie, at least the methotrexate can buy time for them until another treatment comes along.

"If you can stay alive for one day," said Dr. Awrich, "there is hope that you can stay alive for two."

Three noted speakers coming for medical alum event

Three distinguished medical experts have been selected as Sommer Memorial Lecturers for the 65th annual scientific meeting of the School of Medicine Alumni Association April 16-18.

They are Drs. William Montagna, director of the Oregon Regional Primate Research Center; Jerome DeCosse, chairman of the department of surgery, Sloan-Kettering Institute for Cancer Research; and David A. Pyke, a diabetologist at King's College Hospital, London.

More than 400 graduates are expected to return to the UOHSC campus for the session, according to Dr. Richard Hodgson, '56, alumni president and senior clinical instructor in otolaryngology at the UOHSC. He extended a special invitation to all students, faculty and residents to attend the program.

Scientific sessions will be held in the library auditorium at no charge. Another feature of the annual alumni meeting will be the reading of a paper submitted by a Portland-area resident.

Internationally known for his work in the physiology of the skin, Dr. William Montagna, one of the Sommer Memorial Lecturers, has been director of the Oregon Regional Primate Research Center since 1963. He also is professor of dermatology and professor and head of the division of experimental biology at the UOHSC.

Dr. Montagna received his Ph.D. in zoology from Cornell University and went on to teach at Cornell, New York Downstate Medical School and Brown University. During his tenure at Brown, he initiated the annual Symposium on the Biology of Skin, now in its 29th year.

With principal research interests in the biology of skin, the reproductive system and primatology, Dr. Montagna has authored and edited more than 30 books. He lectures extensively in the United States and abroad, and has received many awards and honors for his achievements.

Dr. Jerome DeCosse has been chairman of the department of surgery at the Sloan-Kettering Institute for Cancer Research and director of the American Board of Surgery since 1978.

He was graduated from the University of Minnesota Medical School and later received his Ph.D. in zoology from State University of New York, Upstate Medical Center. He first taught at State University of New York, then Case Western Reserve University School of Medicine.

In 1971, Dr. DeCosse was named chairman of the division of surgery at Medical College of Wisconsin, where he served until 1978. At that time, he moved to New York to become professor of surgery at Cornell University Medical College, a position he still holds.

Dr. DeCosse has had many articles published, often about cancer.

Dr. David A. Pyke of King's College Hospital, London, is noted for his research on the etiology (cause) of diabetes. The British are world leaders in work in the synthesis and biochemistry of insulin.

Educated at Cambridge University and the University College Hospital Medical School, London, Dr. Pyke was appointed to the staff of King's College Hospital in 1959 and has been in charge of the diabetic clinic there since 1971.

He served as an officer of the Association of Physicians of Great Britain from 1968 to 1973 and has been a registrar with the Royal College of Physicians, London, since 1975. He was Claude Bernard Lecturer at the European Association for the Study of Diabetes in 1979.

Dr. Pyke has written or co-authored numerous scientific papers and four books.

Alumni speakers who will address the annual meeting are Drs. Marc Bayer, associate director of emergency services at the UOHSC; William Fletcher, head of the division of surgical oncology; Frederick Fraunfelder, '60, chairman of the department of ophthalmology; James Gilbaugh, '63; Stephen Miller, head of the division of plastic surgery; Samuel Newcom, head of the section of medical oncology; George Porter, '57, chairman of the department of medicine; and William Riker, chairman of the department of pharmacology.

Class reunions planned in conjunction with the event include 1930, 1935, 1940, 1945, 1950, 1955, 1960 and 1965.

Dr. Robert H. Gray, '55, is chairman of this year's program. He is alumni vice president and clinical assistant professor of medicine at the UOHSC.

President points out critical needs

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trapment in a web of mediocrity; in the other, the opportunity for a surge toward higher quality and a sense of new adventure."

Noting that the 1979-81 budget for the Health Sciences Center was generous and that its passage was attributable to strong support from other institutional presidents, the Chancellor and the Board, the Executive Department and the legislature, Dr. Laster went on to say that it was an important first step, but in itself primarily "a salvage measure."

The emphasis has changed from survival to quality, he said, but even now "the conditions in the several schools reflect such prolonged neglect and previously inadequate budgetary allocations that this University ranks quantitatively far below the average of its peers in regard to human and material resources."

The president urged Board members to give "serious and urgent consideration" to the initiation of a 10-year program to bring the support of each of the University's three schools and their associated academic infrastructure up toward "at least average values."

Additional faculty, clerical and material resources for new faculty, funds to permit vigorous pursuit of academic excellence, resources to permit optimum management of finances and administration, and physical facilities to house new and present faculty and students were listed as the UOHSC's critical needs.

Other "black holes" the president described are the following:

– A library – both facilities and collection – slipping well into inferiority;

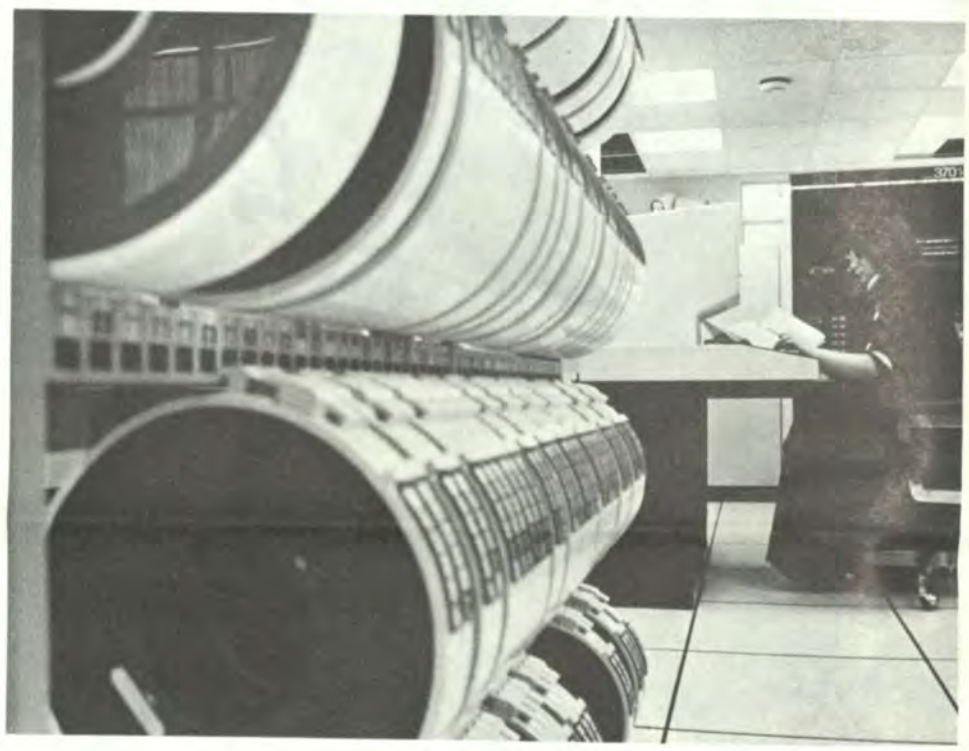
– A maintenance program in the physical plant which is crisis oriented rather than preventive;

– Inherited past problems, such as chronic underfunding of heating costs and of services and supplies;

– The absence of an office to foster and oversee the academic affairs of faculty and students;

– A paucity of resources to facilitate acquisition of support from the private sector.

The finance committee reviewed the most urgent needs of the State System institutions and revised its earlier guideline to permit each one to propose program improvements that will amount to a 5 percent increase in base budget. These proposals will be reviewed at the March 28 meeting of the Board, at which time a final decision will be made on the percentage increase that will be recommended to the Executive Department.



University Hospital's new IBM computer is humming along smoothly as the Hospital Information Systems Division converts the systems from the old computer to the new one. Located in the Campus Services Building, the computer will, among other things, increase the efficiency of information reporting and decrease patients' waiting time. Work has begun on the installation of about 60 terminals throughout the hospital and clinics which will be in direct communication with the computer. Shown at a terminal in the computer center is operator Donna Palmer.

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Spanish interpreter's work translates into caring

"Estoy aqui para ayudarlo."

For many patients at University Hospital and Clinics, those words – Spanish for "I am here to help you" – are warm and comforting.

The person who speaks them often is Antonio Esteban, the hospital's first full-time Spanish-language interpreter.

Mr. Esteban's job is to be "the ears and mouth" for the many Spanish-speaking people who pass through the care of University Hospital. Often, he is the reassuring hand as well.

Although University Hospital's Spanish language needs are well taken care of, volunteer interpreters still are needed for other foreign languages.

"I like the human side of it and the fact that I am doing something good for people, something that helps improve their lives," said Mr. Esteban (Es-TAY-bahn) in his melodic accent. "That's very rewarding, definitely."

About 5 percent of University Hospital's patients are Hispanic, and some speak little or no English.

Before Mr. Esteban settled into his job in January at the University Hospital (north) admitting desk, the hospital had relied on a list of volunteers to interpret for Hispanic patients. This "potluck" approach proved less than ideal. Frequently the volunteers were off work or busy when needed or couldn't negotiate the subtleties of the speakers' Spanish.

"This way, we feel we can provide better care to those who have a language barrier," said Barbara Glidewell, University Hospital's patient advocate, who speaks Spanish herself.

She added, "One of the important services Antonio will provide is translating of forms, patients' letters and patient instruction sheets. This will show that we care."

A native of Spain, Mr. Esteban, 32, visited or lived in a number of South American countries before becoming a U.S. citizen several years ago. "I guess I got a good feel for different accents and inflections of Spanish, being in so many places where they speak Spanish differently," he said.

He got a good feel for English, too, by studying it for 12 years in Lima, Peru.

Serving as an interpreter and translator for a pharmaceutical company also prepared him well for his hospital job. He picked up some medical terms there, but, he added with a smile, "I still have to find the Spanish word for 'outpatient.' "

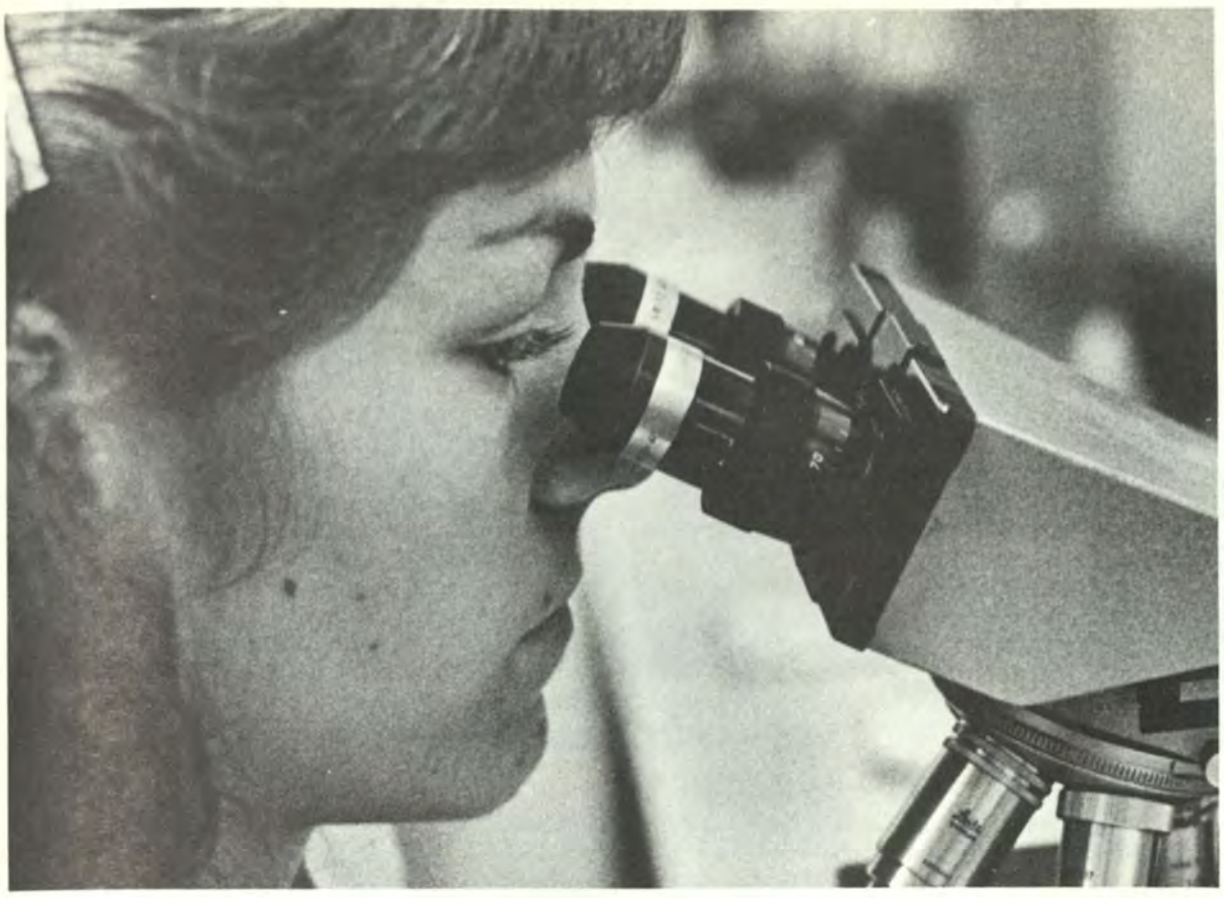
In the short time he's been in his new position, Mr. Esteban has had experiences as varied as the accents he's encountered.

One day he was able to ease the isolation of a poor Mexican from Portland who could speak no English. After helping the man through his doctor's appointment here, Mr. Esteban took time to show him around the hospital and even helped him get a bus pass.

Another day found him chatting with a highly educated aristocrat from Cuba who was pleased to find someone on the staff who spoke his native tongue.

Antonio Esteban calls on a Spanish-speaking patient in University Hospital's obstetrics ward. A freelance architect, Mr. Esteban will use his skills in graphic design to create signs and teaching aids in Spanish for the hospital.

Although University Hospital's Spanish language needs are well taken care of, said Ms. Glidewell, volunteer interpreters still are needed for other foreign languages – especially Russian and Far Eastern languages. Anyone interested may contact her at 225-8504.



Medical technologists at work are (clockwise from large photo at upper left) LeAnne Carrigg, hematology; Terry Kenny, supervisor, chemistry; Jim Day, serology; Phyllis Popenuk (filing), urinalysis; Shirley Jensen, chemistry, with an instrument that processes 18 tests on one blood sample; supervisor Bill Roarke and Julie Hatch, microbiology; and Flor Irlandez, chemistry.

HSC medical technologists are put to the test every day

Most University Hospital patients come and go without ever seeing some of the professionals who are most vital to their treatment. But, then, medical technologists are used to working behind the scenes.

In the Clinical Laboratories Building and in other labs around campus, medical technologists bend to the task of processing 2.2 million tests a year for the hospital and clinics. Some of the labs are busy 24 hours a day.

The 110 med techs do everything from testing blood, urine and spinal fluid to isolating microorganisms and operating brain scan equipment.

"It would not be possible to offer the wide variety and complexity of tests we offer here without a very well trained group of medical technologists," said Dr. Victor Marquardt, professor of clinical pathology and assistant director of clinical lab services. "There's just no way we could take advantage of as many of the advances that have been made in medicine in the last few years, particularly advances in laboratory medicine, without medical technologists."

While all lab work is important, some is especially vital. Surgical patients depend on medical technologists to do compatibility testing for the blood and blood products they're to receive, for example, and blood gas testing helps monitor the health of babies in the Neonatal Intensive Care Center.

The med techs work in the clinical pathology department's divisions of chemistry, toxicology, hematology, hemostasis/thrombosis, serology/immunology, urinalysis, nuclear medicine, blood bank, microbiology (virology, mycology and parasitology), Neonatal Intensive Care Center blood gas lab, and emergency laboratory service.

In such a large operation, most of the medical technologists have to specialize. "We're offering about 600 different tests here and many of them are very, very complicated," said Dr. Marquardt. "It wouldn't be possible for any single technologist to be able to do them all."

Medical technologists are required to have a baccalaureate degree plus 12 months of intensive education and training.

Besides skill in analyzing patients' specimens, medical technologists also have to be proficient in operating equipment as more and more lab work is done by instruments. A good part of their job is quality control, keeping the instruments running smoothly in accordance with stringent standards.

"It's getting to the point now where we almost need a degree in electronics to run some of these things," Barbara McGarry, med tech in the chemistry lab, said with a chuckle.

Ms. McGarry said she enjoys learning firsthand about medical care. "I feel that a lot of people don't know enough about their own bodies and how they work," she continued. "Every time I learn something up here, I'm learning something about myself."

Admitting that medical technologists labor away from the spotlight, she said, "The satisfaction comes from the people you work with and the fact that you're always learning something new."

Something new for the Clinical Laboratories Building is the $900,000 computer sitting on the building's roof and waiting to begin operation soon. The computer will cut down on med techs' paperwork and speed up reporting of lab results to the hospital and clinics.

Said Dr. Marquardt, "This will free them to spend more time doing the kind of thing they've been trained to do."

Shriners Hospital will launch research program

(continued from page 1)

of facilities management at the UOHSC. These services include the x-ray film storage area, fiscal services, mechanical shops and utilities, all of which will be relocated in University Hospital (north).

This phase may begin as soon as late April, Mr. Tuomi said. Phase I alterations are to cost about $700,000; all costs of the entire project will be paid by Shriners Hospitals.

Later this summer, Phase II will begin, which includes the demolition of Katherine Hall and construction of the new, approximately $8.5 million hospital. The structure will include four stories of hospital facilities, with ample parking underneath.

Mr. Tuomi said the new hospital will cover about 2½ times the ground space of Katherine Hall. It will be the first building people see as they come to the hill.

A "sky bridge" will connect the Shriners Hospital to University Hospital (north), symbolizing the sharing of medical expertise that will occur between the Shriners Hospital and the UOHSC.

Such a relationship will reflect the trend Shriners are initiating to locate their hospitals near major medical centers.

Mr. Holmes stressed the new hospital's proposed research program, although it has not yet been specified. The current Shriners Hospital has done little basic research, he added.

"It's very important that we start a research program immediately," said Mr. Holmes. "The Shriners now want to develop research so we can find the reasons for some of the deformities and crippling diseases children have, and maybe overcome them."

Representatives from the Health Sciences Center and Shriners Hospitals will conduct a search for a director of research who will propose research projects and coordinate the program. Shriners Hospitals will fund the research director and the program costs, and Shriners will have final approval.

The interaction between the Health Sciences Center and the Shriners Hospital will be vital because "children with orthopedic problems often have others as well," said Webb Harrington, member of the board of trustees of Shriners Hospitals.

But this interaction is nothing new. Most HSC residents in orthopedic surgery spend an average of one-third of their training time at the Portland Shriners Hospital. Faculty from anesthesiology, child psychiatry, orthopedics and other areas also spend time at the children's hospital.

"We can develop research programs that will be mutually beneficial," said Dr. Robert Neerhout, chairman of pediatrics in the School of Medicine, about the strengthened HSC-Shriners link. He added, "We already take care of some Shriners patients, but the new hospital will make this tie more efficient."

Since it opened in 1924, more than 20,000 youngsters up to age 15 have been treated free at the Portland Shriners Hospital, and some 400 children are admitted yearly for surgery.

The Portland hospital is one of 19 such orthopedic hospitals and three burn treatment institutes funded by the Shriners. The only other Shriners Hospital in the Pacific Northwest is in Spokane, Wash.

Keeping costs down, quality up is committee's goal

While some are loudly blaming physicians for high hospital bills, many of those physicians are working quietly to keep costs down.

At the same time, they are striving to keep quality of care up.

Such is the two-pronged task of the Utilization and Professional Standards Review Committee (utilization review committee for short) at University Hospital.

Composed of physicians and other hospital professionals, the all-volunteer committee takes on its challenge with audits and peer review.

"We advocate quality care done with the most efficiency," summed up Dr. Marion Krippaehne, professor of medicine and chairman of the utilization review committee.

Monitoring quality and cost effectiveness and making recommendations are the committee's assignments. The group's work is just part of University Hospital's quality-control process, which involves the whole staff.

The utilization review committee's efforts have reaped benefits such as shorter average length of hospital stay, transfer of care for some conditions from the inpatient to the outpatient setting, and better documentation of medical care, according to Dr. Krippaehne.

(Average length of stay for University Hospital patients has dropped from 8.9 days to 6.9 in the last seven years. At current hospital rates, this reduces costs for the average hospitalization by $760.)

The utilization review committee takes the PSRO's work a step further. It looks at quality assurance and cost containment for all hospital patients, not just federally sponsored ones.

The committee works closely with the Multnomah Foundation for Medical Care, the federally funded Professional Standards Review Organization (PSRO) for Multnomah County.

Born of a 1972 amendment to the Social Security Act, PSRO's were established across the country to make sure that all federally sponsored patients get high-quality medical care in hospitals, and that the government receives full value for its hospital-care dollars. (Federally sponsored patients are those under the Medicare, Medicaid or Maternal and Child Health programs.)

The directives called for development and implementation of peer review mechanisms to monitor quantity and quality of inpatient care. Special emphasis was placed on keeping hospital stays down to a reasonable length.

The nonprofit Multnomah Foundation for Medical Care was selected as the federally financed but doctor-run PSRO for this area. It is responsible for reviewing 13 hospitals in Multnomah County, including University Hospital.

University Hospital's utilization review committee, also the offspring of federal mandate as well as requirements of the Joint Commission on Accreditation of Hospitals, cooperates with the local PSRO in quality assurance studies and monitoring of hospital care.

The committee takes the PSRO's work a step further. It looks at quality assurance and cost containment for all hospital patients, not just federally sponsored ones.

Reviewing patients' charts at a nursing station in University Hospital (south) are Dr. Marion Krippaehne, left, chairman of the utilization review committee, and Linda Walker, nurse oncologist. "We've gotten wonderful cooperation from the staff of this institution," Dr. Krippaehne said. "I really think that once they've understood what we're trying to do, they've been, each and every one, more than happy to do the studies and take the time." Dr. Krippaehne also serves on a committee of the Multnomah Foundation for Medical Care, the local PSRO.

Also, it reaches beyond the inpatient environment into the outpatient setting.

Referring to the PSRO and agencies like the Joint Commission on Accreditation of Hospitals, Dr. Krippaehne said, "They've made specific requirements of institutions like ours nationwide. Our committee's job is to comply with the standards they've set up."

Dr. Michael Baird, director of medical services at University Hospital, commented that PSRO's and utilization review committees play a vital role.

"One thing they certainly have done is to focus the attention of physicians, hospital personnel, boards of trustees and administration upon the issues of cost and care.

"In other words, it's kind of a consciousness-raising effort, and it is being raised in terms of the public interest. Quality assurance and cost containment *are* public issues. PSRO's and utilization review committees have done it with a goal of rendering more efficient medical care without sacrificing quality."

University Hospital's utilization review committee meets monthly to review cases suspected of overutilizing hospital time, to look at medical audits, and to review quality control activities of other hospital committees. Medical audits are studies done by all hospital departments and divisions to ensure that patient care is up to standard.

"We sometimes make recommendations to departments and divisions for designing an audit or a focused review of a certain problem or problems," said Dr. Krippaehne.

In cooperation with the local PSRO, "We used to do elaborate, lengthy audits which took a horrendous amount of time. But lately," she said in explaining focused review, "we've been looking at one or two critical criteria (such as amount of time a procedure takes) to make an ongoing review for a month or so, to determine whether we have a problem.

"If such a focused review indicates there is a problem, the areas involved generally undergo an educational exercise and then reaudit to see whether or not it was effective." An educational exercise usually is a discussion among faculty and house staff about how a pinpointed problem can be corrected.

What's an example of a success story from the utilization review committee?

"In ambulatory medicine," Dr. Krippaehne said, "it seemed that there was a delay in reporting laboratory results back. So we set up a one-criterion focused audit stating that the lab results should, in all practicality, be reported in the chart within 72 hours.

"We monitored the charts for a month and found that indeed there was a delay in a certain percentage. The result was a conference between the ambulatory clinic staff and the lab personnel.

"Two things happened. Ambulatory medicine was found to be excessively ordering some laboratory studies, and as a result cut down unnecessary requests. The other was that the lab took steps to be more efficient in their reporting, and a higher percentage of results was reported within the optimum period of time."

By cutting down the number of lab studies, Dr. Krippaehne noted, this effort cut costs (but not quality of treatment).

In another instance, the utilization review committee recommended that some nurses do an audit to find whether outpatients were understanding the procedure for their anticoagulation therapy. The patients were asked to fill out a questionnaire on their return to the clinic. Some deficiencies were discovered in the patients' understanding, and the nurses took educational steps to improve the results.

Topics for focused review spring from computer data of University Hospital and the local PSRO, from committee minutes, from financial accounts – anything that suggests things are less than efficient.

By upgrading the patients' compliance, Dr. Krippaehne pointed out, this effort upgraded quality of care.

Topics for focused review spring from computer data of University Hospital and the local PSRO, from committee minutes, from financial accounts – anything that suggests things are less than efficient, said Dr. Krippaehne. Support personnel from the hospital help supply the information.

Physicians from the 13-member utilization review committee act as "physician advisers" for audits and focused reviews in various departments. Sometimes they serve alongside a nurse-coordinator from the PSRO, who monitors patient records and quality of medical care.

Once a problem is uncovered, Dr. Krippaehne said, it may be worked out by a consultation between the physician adviser and the physician involved. "Sometimes it's solved by purchasing more efficient equipment," she continued. "Sometimes it's a matter of beefing up staffing. Much of the time it is a question of just an educational process, particularly among the young house staff."

She emphasized, "I think everyone must be responsible for the efficient use of costly hospital time."

Occasionally, focused reviews at University Hospital are done at the PSRO's urging as part of a larger study. For example, the local PSRO recently asked all hospitals in Multnomah County to focus on skull x-rays ordered in their emergency rooms on patients who had head trauma. The PSRO used the results to evaluate the relative efficiency of the procedure throughout the community, then set up non-mandatory guidelines that hospitals might find useful.

Nationally, the concept of the Professional Standards Review Organization is highly controversial.

Some physicians have greeted PSRO's with groans about red tape and questions about the ultimate value to quality of patient care.

"Some physicians feel there is interference by the federal government in their right to practice medicine as they see fit, but that has not caused any significant interference with operation of the PSRO program in this hospital," said Dr. William M. Clark, professor of pediatrics and director of graduate medical education, who serves on the utilization review committee and the Multnomah Foundation for Medical Care (PSRO) board of directors.

"The program requires that some medical staff serve on a committee and spend time reviewing cases and that all departments perform medical care evaluation studies.

"But those are activities that are *good* for the hospital, and they're also activities that are required by the Joint Commission on Accreditation of Hospitals. They certainly serve an educational and training function for not only the physicians involved but the physicians to whom the results are reported."

The activities also are valuable to residents in stressing the need to work up their patients efficiently and to plan ahead for discharge, Dr. Clark said.

Serving on University Hospital's utilization review committee with Drs. Krippaehne and Clark are Dr. Stanley Jacob, associate professor of surgery; Dr. John Isom, professor of pediatrics; Dr. Robert Bigley, professor of medicine and medical genetics; Dr. John Jendrzejewski, assistant professor of medicine; Dr. Douglas Robb, assistant clinical director of the psychiatric crisis unit; Leslie Hunter, director, social service; Ardys Hokeness, assistant director of nursing service, University Hospital (south); Sally Mount, director, medical records; and Gloria Bryant, PSRO. Bernie Andreotti of medical records is secretary. Nola Becket, nursing service, and Christy Doyle, patient accounts, are regular guests at the committee meetings.

Dr. John Barry new chief of urology division

Dr. John M. Barry was named head of the division of urology at the Health Sciences Center in February.

Dr. Barry had served as acting head since July, after Dr. Clarence Hodges retired from the position.

An associate professor of surgery in the division of urology since 1977, Dr. Barry has directed the renal transplant program since 1976.

He has been at the UOHSC since 1969, starting as a general surgical resident and completing his urology residency in 1973. That year he was named assistant professor of surgery in the division of urology and also chief of the urology section at the Veterans Administration Medical Center.

He has had more than 50 published works in the field of urology, including his special interests of impotence and kidney transplantation.

Dental know-how uncovers clues to identification mysteries

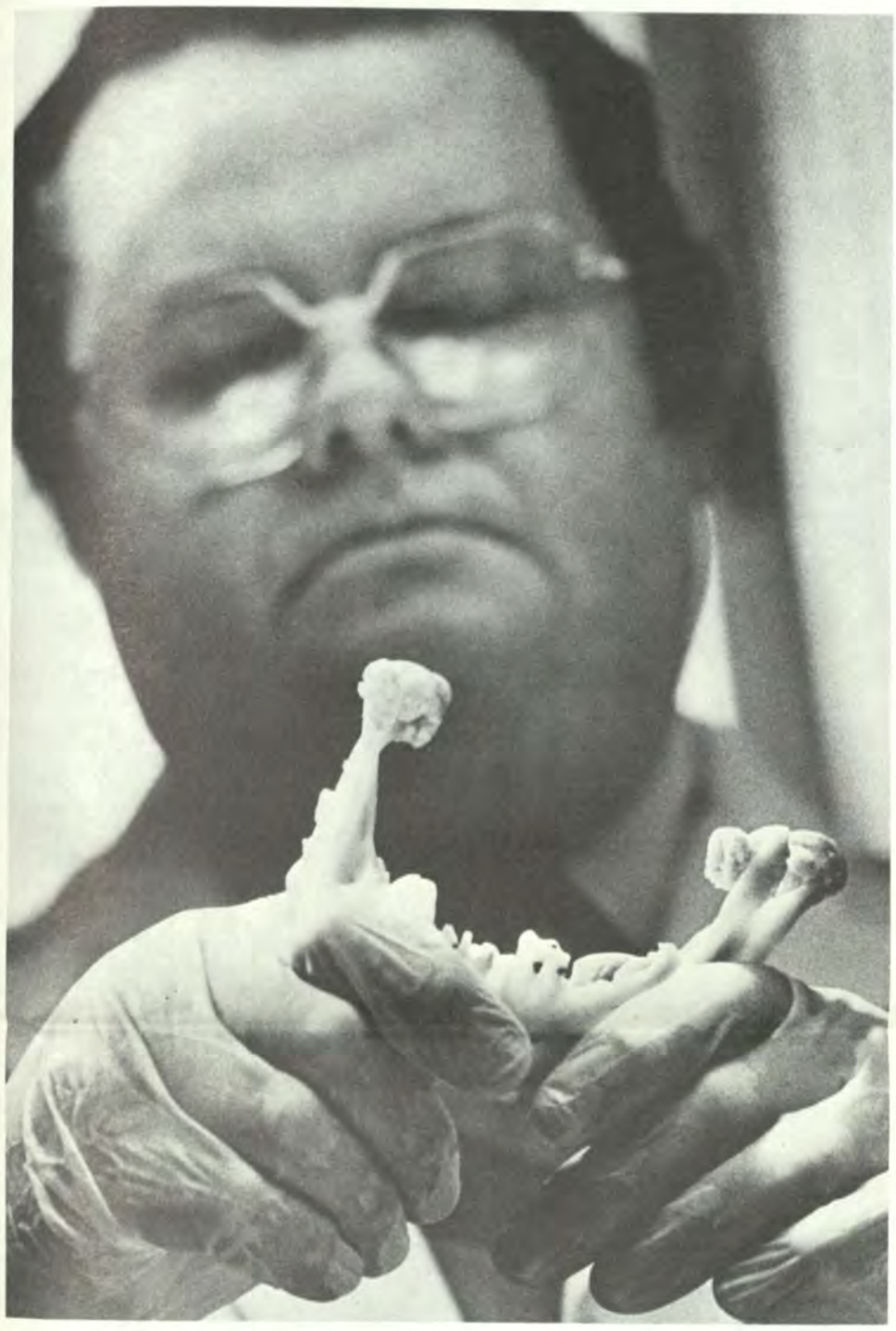
One January day in 1975, a mysterious human skull arrived at the School of Dentistry's department of oral pathology.

It had been found recently in Mt. Hood National Forest near a weathered parachute that had hung in a tree in the area for several years.

Could this, wondered the state medical examiner's office, be the remains of the celebrated hijacker "D.B. Cooper"?

As it turned out, of course, it was not. But Dr. Charles C. Thompson, associate professor of oral pathology, remembers that as one of the more unusual forensic odontological cases to come his way.

Forensic odontology refers generally to identification of a deceased person by dental means for legal purposes. It also can involve analysis of bite marks for legal evidence.



Dr. Charles Thompson examines a mandible (lower jawbone) for clues to identification.

Dr. Thompson and his colleagues in the department are called upon several times a year to help the state medical examiner's office, and sometimes other agencies, identify victims of accidents and foul play. Often, he pointed out, time and the severity of injury have left only the teeth as clues.

"Tooth enamel is the hardest calcified tissue in the body," Dr. Thompson said.

"And, of course, you have the restorations. But that's a problem because today, with fluoride, we have had some cases where there were no restorations at all and we had to go on the position and configuration of the eruption pattern of the third molars as well as other teeth."

"Our group is not involved in this because of morbid curiosity, but because we feel it is a professional obligation. In some of these cases you just have to have the dental knowledge to establish identification."

Identification usually depends on having x-rays and other dental records of the deceased so that there is some basis for comparison.

Although he gets kidded about being "the Quincy of the dental school," Dr. Thompson takes his often unsavory work in forensic odontology very seriously.

He and fellow department members are in the Oregon Society of Forensic Odontology and, he said, "Our group is not involved in this because of morbid curiosity, but because we feel it is a professional obligation. In some of these cases you just have to have the dental knowledge to establish identification."

The know-how of Dr. Thompson and his HSC colleagues helped confirm the identity of a murder victim whose skull was discovered in a pond in Bend last spring. The skull contained few teeth, but the dentists were able to make positive identification of the middle-aged woman by referring to x-rays obtained by a Central Oregon dentist.

"I thought it was going to be an impossibility with what we had to work with, but the dental records matched perfectly. We had four specific points that were identical," said Dr. Thompson. "What had looked to be a very difficult identification turned out to be very easy."

Not all cases that cross his desk are so simple. One of his file drawers contains folders labeled "Jane Doe" or "John Doe," sad testimony to the futility of some identification efforts.

"In such cases we will do whatever documentation we can, and sometimes information will turn up later," he said. "There are many cases that you're just stuck on."

When the state medical examiner's office calls on Dr. Thompson for help, usually the material is delivered right to his department. "We chart the case ourselves and make our own postmortem record. Then we take all the antemortem records and convert those to our charting system, if necessary. We'll draw in the restorations and go through and compare the points of similarity on the charts. We compare the x-ray films as well," he said.

The search for clues may be as painstaking as removing a filling to find out what kind of cement was used beneath the metal.

Even without the help of dental records and x-rays, Dr. Thompson said, there are clues that the forensic odontologist's trained eye can detect.

For instance, there are certain racial characteristics such as shape of incisors. Wear and tear on the teeth as well as morphology may give evidence of age. Carpenters and dressmakers often have notched teeth from holding nails or pins in their mouths, and stains on the teeth may suggest that the victim was a tobacco user.

"Sometimes socioeconomic status can be estimated (by amount and type of dental work), but this is becoming less reliable in days of preventive dentistry," Dr. Thompson noted.

School of Dentistry students do get exposure to forensic odontology. Senior students can take a special selective course, and juniors sample the subject in their comprehensive oral pathology class.

The staff emphasizes to students the importance of keeping good dental records. When it comes to the enigmas of forensic odontology, Dr. Thompson explained, "That's a major contribution right there."

HSC professor's perinatal ideas reach Danish Parliament

DR. MARY ANN CURRY
associate professor, School of Nursing

It never occurred to Dr. Mary Ann Curry, associate professor of graduate studies in the UOHSC School of Nursing, that she'd be such a hit in Scandinavia.

But her lecture tour there Jan. 13-20 on parent-infant attachment and nursing research made quite an impact.

Not only was she interviewed for a TV documentary and a leading women's magazine, but some of her ideas are being taken to the Danish Parliament. And she has been invited back to both Denmark and Sweden.

Why all the stir? The main reason was the seminar in Copenhagen that she presented with Dr. Marshall Klaus of Case Western Reserve University, co-author of the book "Maternal-Infant Bonding" and a pioneer in the field of parent-infant attachment.

Throughout the seminar Drs. Curry and Klaus emphasized a humanistic outlook on childbirth. They stressed that mothers and families should have more choices in perinatal matters, from the place of birth to the position of birth.

"It was very reassuring to me that the data I presented was research-based," Dr. Curry said. "So if action is taken, there is scientific rationale for Dr. Klaus' and my statements."

The Danish Parliament has a lot of say in what goes on inside hospitals and clinics because of the country's system of socialized medicine.

With its low infant-mortality rate, Dr. Curry said, Denmark long has been regarded as a model for perinatal care. However, many Danes are concerned that the movement toward technology in perinatal care may bring risks to both the safety of the mother and the psychosocial well-being of the family.

This concern prompted the Danish government to invite Drs. Curry and Klaus to present a seminar on parent-child attachment to obstetricians, pediatricians, neonatologists, midwives (who do most of the normal deliveries in Denmark), other health care providers and lay people.

"I am very pleased that they wanted a nurse to present the views of nursing and nursing research as well as to have Dr. Klaus come," said Dr. Curry.

Always citing research to back up her remarks, Dr. Curry offered up ideas for the Danes to grapple with. The concepts – all based on facilitating attachment between mother and infant – sparked lively discussion.

Among her comments were the following:

– The routine use of fetal monitoring may have a negative effect in confining the mother to bed and reducing personal contact between nurse and patient.

– Research increasingly shows that if a mother is allowed to assume the birthing position that seems most natural and comfortable to her, the labor is shorter and thus there is less possibility of fetal distress.

– "Rooming in" with her infant may give a new mother a chance to get to know her baby sooner, but the benefits should be weighed against the detriments of sleep deprivation.

– For cesarean births, mothers should have the option of receiving a local anesthetic so they can watch the delivery.

– Although many hospitals strictly limit visits from the new baby's siblings, there is no data to show that these visits increase the chance of infection.

– Parents should be together when there is bad news about the birth. "Our belief is that parents should be told as soon as possible that something is wrong," added Dr. Curry. "We often underestimate parents' ability to cope."

– Parents have a need for nurturing throughout the childbearing process. "One of the best ways to facilitate attachment is by supporting the family," said Dr. Curry.

Recognizing the value of postpartum nurturing for the family, Dr. Curry said, the Danes give mothers a 12-week paid maternity leave. The Swedes do even better – they allow nine months.

"So many of our young families in this country, with the high cost of delivery, have to go back to work in four or five weeks. In Sweden, the fathers can take a maternity leave and they can actually split the nine months with their wives," noted Dr. Curry.

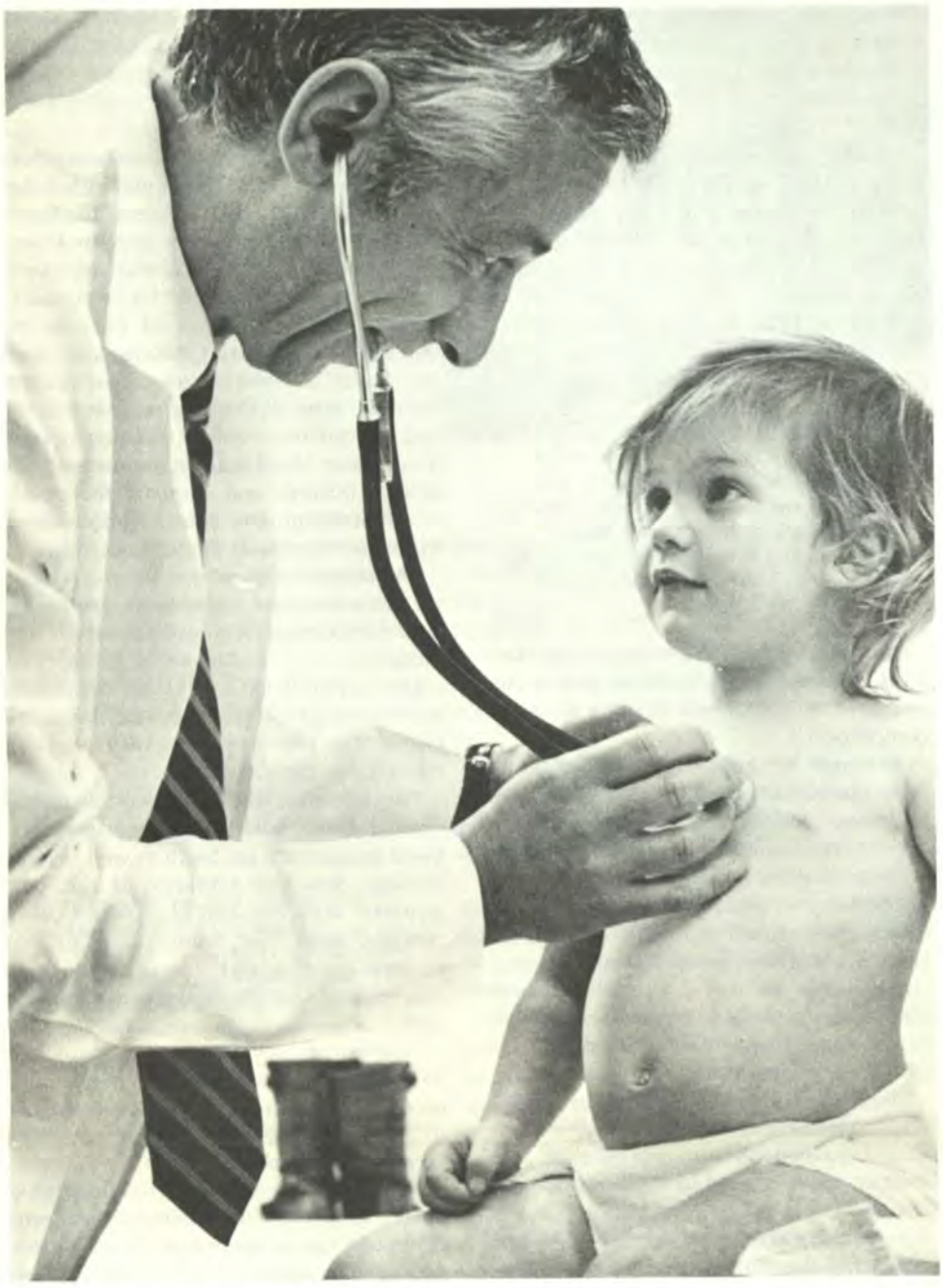
Her Scandinavia sojourn included presenting lectures on nursing research at a nursing school in Stockholm, Sweden.

25-year-old program heals thousands of young hearts

For a former "blue baby" who went through the children's heart program at the Crippled Children's Division years ago, his treatment worked well. The young man has scaled Mt. Rainier twice.

Success stories like that gave CCD cause to celebrate when it recently observed the children's heart program's 25th anniversary.

Over the years the program has served at least 7,000 Oregon children and teenagers with congenital and acquired heart defects. In fact, said Dr. Victor Menashe, CCD director and head of the heart clinic, most young Oregonians with congenital heart problems have been seen through the program.



Examining a young patient during the heart clinic at the CDRC is Dr. Victor Menashe, CCD director and head of the children's heart program. Staff members celebrated the program's 25th anniversary in December with a party.

What began 25 years ago in December 1954 as a small clinic in the old CCD building serving a few children a month has evolved into a network of three clinics – in the Child Development and Rehabilitation Center, Eugene and Medford – now serving an active roster of about 2,500 young patients.

"We're doing approximately 150 surgeries on children in the hospital each year, and close to 300 catheterizations – which is a big service," said Dr. Menashe.

The children's heart program was formed by Dr. Herbert Griswold, now a professor of medicine in the division of cardiology; the late Dr. Richard Sleeter, then director of CCD; and Dr. John Bussman, clinical professor of pediatrics.

To this day Dr. Bussman participates regularly in the clinic, held every Friday at the CDRC, calling it "the high point of my week."

The clinic was a natural outgrowth of CCD's program. Many of the youngsters seen at CCD had heart defects as well as other handicaps.

"We had been seeing some pediatric cardiac patients in the outpatient pediatric clinic," recalled Dr. Bussman, "but felt that a program under sponsorship of the Crippled Children's Division would make these services more generally available to the underprivileged child cardiac patients throughout the state.

"Dr. Griswold and I used to schedule one or two patients in an afternoon and sometimes be there from 1 to 6 p.m. with two patients, discussing them by the hour. A few visitors (fellow physicians) used to come and sit in on the sessions."

Dr. Bussman continued, "The clinic has gradually grown in volume till now we see 12 to 15 patients in an afternoon and more than that in a morning" at the CDRC.

As pediatric cardiology changed and advanced through the years, so did CCD's heart program.

The program got a boost with the arrival of Dr. Albert Starr, renowned heart surgeon, who began doing open-heart operations here in 1958. Earlier, Dr. William Conklin, then head of cardiothoracic surgery, and Dr. Stanley Bergquist had done open-heart surgery for the children's heart program.

In 1958, Dr. Griswold returned from a sabbatical in England with important new skills to share in the clinical examination of the heart.

Dr. Martin Lees, the UOHSC's first full-time board-certified pediatric cardiologist, arrived in 1963 to bolster the program.

Meanwhile, the children's heart program was making arterials into the state. A satellite clinic was formed in Eugene in 1961 and in Medford in 1967.

According to Dr. Menashe, a major new development for the heart program is echocardiography, a non-invasive technique for detecting cardiac abnormalities and observing the workings of the heart. The technique is an alternative to cardiac catheterization and is of special value in treating infants.

"What we're really pushing now is the early referral of newborn infants who are in difficulty," said Dr. Menashe, "because there is so much more that we can do for them today."

The heart program follows patients until their 21st birthday. The most common congenital problems treated are ventricular septal defects, atrial septal defects, tetralogy of Fallot ("blue baby" syndrome) and transposition of the great arteries.

"Generally our patients are referred to us by their own family doctor or pediatrician. Occasionally it's through a health clinic or a school examination," said Dr. Menashe.

"Then we see the child in the clinic and a disposition is made. Some children, of course, are going to require more definitive diagnostic work – cardiac catheterization, angiography, echocardiography. Then some are going to require surgery."

"Heart conferences" after each clinic bring together pediatricians, cardiologists and surgeons (and, at the UOHSC, students and fellows) to discuss each patient and determine treatments.

Participating regularly in the CDRC heart clinic with Drs. Menashe, Lees and Bussman are Dr. Michael Nichols, assistant professor of pediatrics, and Dr. Cecille Sunderland, associate professor of pediatrics.

The faculty members also travel to Eugene and Medford for CCD congenital heart clinics. There they work with Dr. Roland Schmidt, director of the CCD Regional Services Center in Eugene, and private pediatricians and cardiologists.

Inevitably, some of the tiny patients they see are the offspring of patients who emerged successfully from the CCD children's heart program years ago.

Clinical Research Center contributes many ways

(continued from page 3)

being followed in this study.

– Methods of increasing the fat-soluble vitamin levels of patients with A beta lipoproteinemia, a rare inherited disease characterized by inability to metabolize fat.

– Whether drugs that decrease the activities of certain brain cells will alter the involuntary movements of Huntington's disease, a severe neurological disorder.

– Use of high-dosage drugs to induce a remission in children with "minimal change nephrotic syndrome." Investigators are looking into the feasibility of giving steroids intravenously instead of orally, thereby avoiding long treatment with side effects.

"One of the purposes for establishment of the Clinical Research Center system was to attempt to move basic laboratory discoveries into general medical application as quickly as possible," pointed out Dr. Porter.

The benefits of the Clinical Research Center reach beyond the obvious ones of preventing, diagnosing and treating disease.

"The CRC has played a role in the attractiveness of this institution for new faculty members," said Dr. Porter. "It has been most important to the career development of our faculty members, as it has given them a place to perform research, an essential component of the scholarly activities demanded of a faculty member in the clinical areas."

All the while, the center encourages collaboration among researchers with a variety of interests and specialties.

The center also serves as a training ground for medical students, interns, residents, fellows, student nurses and dietetic interns.

Eight full-time and two part-time registered nurses care for the adult and pediatric patients involved in research at the Clinical Research Center. Last year there were 947 outpatient visits to the CRC.

Anne Kelleher, head nurse at the Clinical Research Center, commented, "One of the reasons nurses stay with us is because of the closeness that we develop with the patients. We get to know them, and it's as if they're part of our family."

United Way tops goal

UOHSC employees outdid themselves in the 1979 United Way campaign, topping the campuswide goal of $41,500 by pledging over $42,488.

A total of 958 employees contributed, according to Gary Stevens, assistant director of fiscal services, who spearheaded the HSC drive.

The contributions will help fund United Way's 1980 operations. In 1978, 93 cents of every dollar donated was used to help people in the Portland area through 88 agencies.

"Employees really came through this year and were interested in and supportive of United Way," said Mr. Stevens.

The HSC's 1979 campaign bettered the previous year's results by 15 percent.

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