PORTLAND PHYSICIAN

MARCH 1975

A report from the Conference at Salishan
See page 18

13.1% INFLATION?

New Car Doesn't Need to Cost That Much

Representative Automobile Fleet Prices February 1975

	Dealer's Retail Price	P.C., Inc. Client Cost	Fleet Discount	
1975 Buick Riviera	$ 8,522.00	$ 6,934.00	$1,588.00	(18.6%)
1975 Buick Skylark	$ 5,045.00	$ 4,467.00	$ 578.00	(11.5%)
1974 B.M.W. 2002	$ 6,184.00	$ 5,875.00	$ 309.00	(5.0%)
1975 Chevrolet Nova, plus ($200 Factory Rebate)	$ 3,954.00	$ 3,585.00	$ 368.13	(9.3%)
1975 Chevrolet Suburban	$ 7,498.30	$ 6,067.44	$1,430.86	(19.1%)
1975 Datsun 710 2 Dr. Hdtp.	$ 3,996.00	$ 3,693.00	$ 303.00	(7.6%)
1975 Dodge B-200 Sportsman Wagon (plus $300 Factory Rebate)	$ 4,929.00	$ 4,386.00	$ 543.00	(11%)
1975 Ford Mustang II Ghia (plus $500 Factory Rebate)	$ 5,640.00	$5,135.57	$ 504.43	(8.9%)
1975 G.M.C. Sierra Grande, (¾ Ton Pickup)	$ 5,962.00	$4,849.00	$1,113.00	(18.7%)
1975 Jeep Wagoneer	$ 7,872.80	$ 6,664.00	$1,208.80	(15.4%)
1975 Mercury Monarch	$ 6,066.60	$ 5,391.67	$ 674.93	(11.1%)
1975 Porsche 911-S Coupe	$12,634.95	$11,976.85	$ 658.10	(5.2%)
Toyota Corolla 1600 Deluxe	$ 3,238.00	$ 3,013.00	$ 225.00	(6.9%)
1975 Volvo 164	$ 7,635.00	$ 6,930.00	$ 705.00	(9.2%)

Contact Dick Waterman

Professional Consultants, Inc.

Penthouse, Pacific Building
Portland, Oregon 97204
221-0002 or 228-6645

PORTLAND PHYSICIAN

OFFICIAL PUBLICATION ■ MULTNOMAH COUNTY MEDICAL SOCIETY

2188 SW PARK PLACE ■ PORTLAND ■ OREGON 97205 ■ (503) 222-9977

A MONTHLY PUBLICATION FOR MORE THAN 1900 OREGON PHYSICIANS

VOL. XXX NO. 3

In This Issue:

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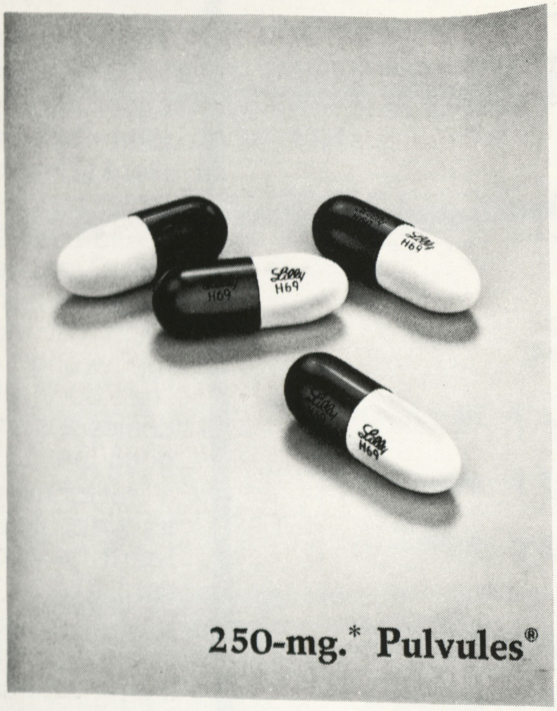
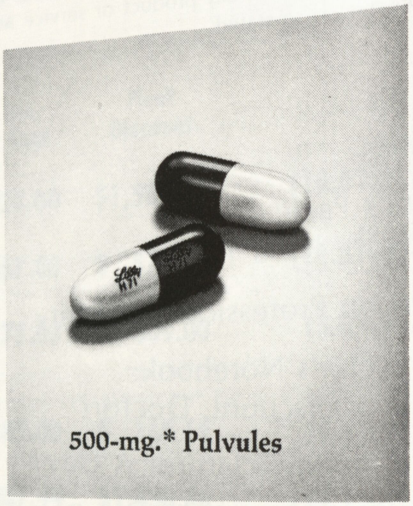
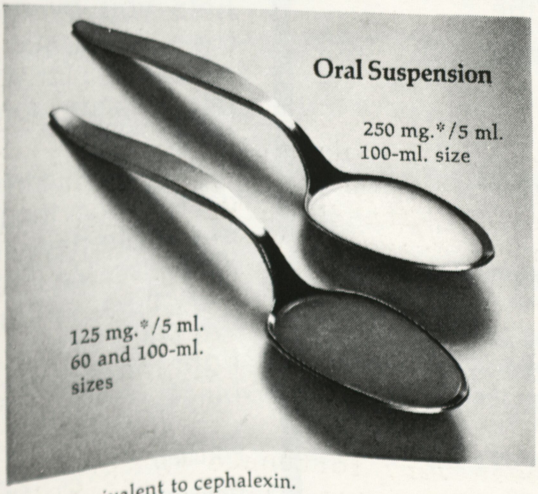
Authorized by the Board of Trustees of the Multnomah County Medical Society. Advisory Committee: Alfred J. Kreft, chairman, Phillip S. Alberts, Siegfried R. Berthelsdorf, Enrique C.M. deCastro, William P. Galen, Daniel A. Halferty, William E. Morton, Joseph B. Vander Veer, Jr., and W. Stanley Welborn.

Keflex®
cephalexin monohydrate







*Equivalent to cephalexin.

Additional information available to the profession on request.

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In Summary

Official Publication, Multnomah County Medical Society *March, 1975*

The Society's RADIO PAGING SERVICE is moving to a new radio frequency this spring, which has been allocated by the FCC for exclusive medical and health uses. This means that all of the 400 Pageboy II receivers in use by Portland area physicians will have to be converted to receive on the new frequency. This will be accomplished by, on a scheduled basis, asking physicians to bring-in their radios to the Society's maintenance service, Electromatic Associates, where the conversion can be accomplished in a few minutes. (There aren't enough "loaners" to enable physicians to have a replacement unit while theirs is being converted.) ALL RADIO PAGING SERVICE subscribers will receive a letter this spring, asking them to bring in their radio during a certain week for conversion. During the conversion period, the RADIO PAGING SERVICE will operate on two frequencies (the old and the new), since the Society has two transmitters. Eventually, the older frequency will be vacated and all messages transmitted exclusively on the new frequency on both transmitters simultaneously.

Medical Seminars during the Society-sponsored "Adriatic Discovery" air-sea cruise this summer (July 30-August 12) have just been authorized by the American Academy of Family Physicians for 24 hours of elective credit. The seminar sessions will review medical practice and systems in Barcelona, Spain; Tunis, Tunisia; Dubrovnik, Yugoslavia, and Venice, Italy, during the 14-day air-sea cruise. Registration fee is $50 per physician, in addition to the cost of the trip. For details, contact Mrs. Diane Dillavou at Society headquarters, 222-9977.

All Oregon physicians will receive, on or around April 1st, descriptive brochures outlining the OMA-MCMS group travel programs for the 1975 AMA Clinical Convention in Hawaii. The "basic" package includes 7 nights at the Outrigger Hotel on Waikiki Beach (superior accommodations), departing by Continental Airlines DC-10 jet on Friday, November 28, returning on Friday, December 5. Pre-convention and post-convention packages are available also on Maui and Kauai, with departures on November 21 and 28, and return flight space on December 5 and 12. The OMA/MCMS, in cooperation with the AMA's travel coordinator, Group Travel Unlimited, have tied-down excellent hotels on Kauai (Coco Palms) and on Maui (Royal Lahaina or Sheraton-Maui), at rates that are below those available to the public or through regular travel agents. Many state and county medical associations, as well as the AMA, are offering group travel, and hotel space will be very tight during the 1975 Clinical Convention. Headquarters hotel will be the Sheraton-Waikiki, and its rooms are being held for AMA and state delegations. The OMA and MCMS have been very fortunate to obtain a bloc of "superior" rooms at the Outrigger, located immediately adjacent to the Sheraton-Waikiki and the Royal Hawaiian.

Nominations and applications are invited for the position of director of continuing medical education of the UOHSC School of Medicine. The candidate must have an M.D. degree and experience in designing and producing educational programs for practicing physicians. Prior administrative experience and demonstratable ability to work cooperatively with nurses, dentists and allied health professionals is desirable. The candidate must be experienced in direct patient care and cognizant of the educational needs of practicing physicians. Experience working in a medical school setting and with organized medicine is also desirable. Please send nominations or curriculum vitae to M. Roberts Grover, Jr., M.D., Associate Dean, School of Medicine.

The MCMS Board of Trustees, at its February 19th meeting, officially endorsed the Oregon/Multnomah County Medicaid Demonstration Project, and supported the Governor's budget recommendation of $1.5 million dollars to be allocated as the State's share in the proposed Medicaid plan. The project will be developed under Project Health in Multnomah County.

The Board also went on record in support of strict limitation of public access and logging activities on lands adjacent to the Bull Run Watershed. It was pointed out that no operational filtration plant exists to remove potentially unhealthy contaminants in public waters from the watershed.

Beginning March 9th Tel-Med tapes will be used by local radio station KBPS in broadcasts tailored for the blind and shut-in. At the same time the Tel-Med brochure has been reproduced in Braille (10 pages!) and is available through the Oregon Commission for the Blind.

A series of five TV specials on mental health will be broadcast starting March 31 by the Public Broadcasting Service (local Channel 10). The specials, called "The Thin Edge," are being produced by the Science Program Group at WNET-TV, New York, and financed by Bristol-Meyers Co. Topics will include depression, aggression, anxiety, guilt, and sexuality.

The State Workmen's Compensation Board has advised the OMA that it will soon adopt a rule approving usage of the AMA's new Uniform Claim Form as a BILLING form. It will not, however, be acceptable as a substitute for WCB form 127, "Physician's Initial Report of Work Injury or Occupational Disease."

A bright spot on the horizon is Oregon's 1974 firearms casualty record. 36 hunting casualties were recorded, making 1974 the lowest year on record. Nearly 400,000 hunters participated in the '74 season.

The Pacific N.W. Red Cross Blood Center tries to maintain a supply of hyper-immune plasma for seriously ill patients who cannot generate a satisfactory immune response. Since adults (age 17-65) convalescing (3-5 wks.) from Varicella or Herpes Zoster are not encountered in the normal donor population, the Blood Center is asking for help in locating and identifying potential donors. If you have patients who fit this and other blood donor requirements, please contact Mrs. Barbara Hall at 228-8561, ext. 83.

A PAS (Professional Activity Study) regional Quality Assurance Workshop will be held in Spokane on March 19 and 20, at the Ridpath Hotel. Information may be obtained from the sponsors, the Commission on Professional and Hospital Activities, 1968 Green Road, Ann Arbor, Michigan 48105.

'Establishing Yourself in Medical Practice' is the subject of a workshop sponsored by the Washington State Medical Association and the AMA to provide physicians planning to enter private practice with answers to questions such as: Where do I get the money? How do I find a good assistant? What about the paperwork? The workshop is scheduled for April 1-2 at the Quality Inn-Sherwood, Seattle. For information contact the Washington State Medical Association.

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

Indications: Edema associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. Also, mild to moderate hypertension.

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

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

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

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

Supplied: Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only).

KEEP THE HYPERTENSIVE PATIENT ON THERAPY KEEP THERAPY SIMPLE WITH

Trademark

DYAZIDE®

Each capsule contains 50 mg. of Dyrenium® (brand of triamterene) and 25 mg. of hydrochlorothiazide.

Neither inconvenient potassium supplements nor special K+rich diets needed as a rule.

Just 'Dyazide' once or twice daily for maintenance.

Two prime reasons patients drop out of hypertensive therapy are (1) the patient failed to understand directions, and (2) the regimen was overly complicated. Dosage is simple with 'Dyazide', easily understood, once or twice daily, depending on response. There's no need to complicate the regimen with potassium supplements or unwieldy potassium-rich diets.

TO KEEP BLOOD PRESSURE DOWN AND KEEP POTASSIUM LEVELS UP

SK&F Co., Carolina, P.R. 00630
Subsidiary of SmithKline Corporation

Death Takes Three

DOYLE W. CLOUSER died Monday, February 3rd, of cancer. He was 49. Dr. Clouser was born in Denver. He graduated from the University of Colorado Medical School and has practiced anesthesiology in Oregon since 1951. Dr. Clouser was a Korean War veteran and a member of the Oregon, American and International Societies of Anesthesiology.

NOBLE WILEY JONES, retired physician and surgeon, died Friday, February 7th at his home. He was 98. Dr. Jones began practicing in Portland in 1906, as this cities first internal medicine specialist. He was a co-founder of the Portland Clinic in 1921, and as the result of a study of cardiology in London in 1923-24, brought Portland its first electrocardiograph. Dr. Jones served as a clinical professor of medicine at the UOMS. He was president of the Multnomah County Medical Society in 1931.

ROY R. MATTERI, age 59, died Friday, February 21 of cancer. A lifelong resident of Portland, Dr. Matteri received his degree in immunology at UOMS. He served there as clinical instructor, clinical associate and professor. He was a past president of the Oregon Society of Allergy and of the West Coast Allergy Society. At the time of his death, Dr. Matteri was president of the Oregon chapter of the Allergy Foundation of America.

the president's page

SOFT WORDS FOR HARD TIMES

Reminiscing seems to be as much part of hard times as of war and politics. I can remember during the great depression of the 30's listening to my father and his friends discussing at length what hard times had *really been* like. That is, how it had been when they were boys. I listened attentively and particularly to one of my father's friends, Mr. McGregor. He was a lawyer, born in Scotland, trained in New York, and he has remained riveted into my memory because of a bad habit he had when making a point. He would take his pipe from his mouth, slip it into his jacket pocket, and leaning forward nail the listener with his pointed finger. Unfortunately for Mr. McGregor, the general effect was not always what he intended. For in the heat of argument, he would neglect to check if his pipe was lit and as it frequently was, he regular set himself on fire. He sticks in my mind as the protagonist of burning issues.

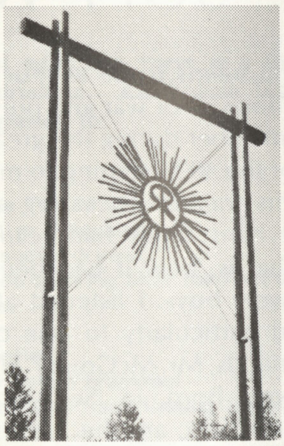
During one of these heated discussions about by-gone times and how much harder they have been, Mr. McGregor's account of the slim pickings for a lad in Glasgow ended on how you greeted your chum on the street, "Hus yur farther gat wurk?" It struck me as weak proof that his boyhood was harder than mine for I knew without asking which of my chums had fathers who were working or who had any chance of finding work. But no one asked my opinion at the time and until now I have withheld my personal belief that the hardest times are the ones you are going through now. The worst pain is the present pain.

Presuming on the office of President, I suggest the members of the Medical Society assume an attitude that these hard times are the worst that patients have experienced and relate to patients accordingly. There are a number of reactions possible, recently Dr. Morris Fishbein pointed out that during the 30's some medical societies kept a referral list of doctors who would see patients for fifty cents. Then, there was Sir William Osler who was even more direct. He made certain that no one ever left his door empty-handed. He kept a box of coins handy so that everyone who knocked at least got some silver.

But times, as hard as they may be for some, have changed. In a sense our times are harder for the harshness is less apparent, the suffering more disguised. The fifty cent examination or the hand out at the threshold no longer answer the need. Rather, I suggest some soft words, simple words, recognizing, as is possible, with the patient, his financial struggle. Simply to ask at the end of a clinical history, or while a mother bundles up her baby or, then again, as a patient prepares to leave the hospital, "How are you making it? How hard are the times for you?", may do more to meet the lonely worry of money, to give a lift in a difficult struggle, to meet a present pain, than any other help short of relief from the hard times themselves. Soft words have a way of being heard a long distance, perhaps, even into the next generation when some oldster may reminisce about the old days when doctors still give a damn.

— Ralph Crawshaw, M.D.

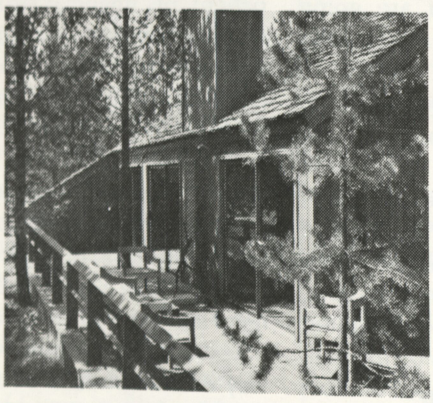
Is investing in recreational land a good idea?



Frankly, it's our opinion that Sunriver property may be one of the better investment opportunities available today.

Especially when you consider the fact that while the demand for land is increasing, the supply is becoming more and more limited. And that, while the values of gold, stocks and other commodities have fluctuated over the years, value of the average land parcel has consistently increased.

Of course, Sunriver is anything but average. It's one of America's most spectacular resort communities. 5,500 acres of enjoyment. It's a place for fishing along 8½ miles of the Deschutes River, pedaling over 18 miles of paved bicycle paths, golfing on a public 18-hole championship course, playing tennis on any one of 8 courts, horseback riding, hiking in the adjoining Deschutes National Forest, swimming in an Olympic-sized pool, enjoying a gourmet meal in the elegant Sunriver Lodge dining room, shopping at the Country Mall, and many more activities.



Sunriver could be your family vacation retreat, a year-around home, or an important part of your retirement plans.

We invite you to see our selection of condominiums, private homes, lots and homesites for sale... and everything else Sunriver has to offer.

And we think you'll agree Sunriver is one opportunity you won't want to miss.

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Please have a copy of **Land Investment U.S.A.** delivered to me without obligation.

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Obtain the HUD property report from developer and read it before signing anything. HUD neither approves the merits of the offering nor the value, if any, of the property.

Mail the coupon today, and we'll see that you receive your copy of **Land Investment U.S.A.** This informative and authoritative book is a perfect guide for anyone considering property investments. Authors Leland and Lee Cooley cite Sunriver as an example of the ideal leisure property opportunity.

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Professional Liability~A Peek at the Oregon Picture

Insuring professional liability has become a very expensive business because the incidence of legal actions against physicians for alleged negligence has increased dramatically. Moreover, actual awards for professional negligence ranging into the hundreds of thousands or even millions of dollars have become all too common across the country.

In 1971 the OMA and CNA/insurance signed a 5-year contract to provide qualifying members with professional and business liability protection. The fifth year of that contract has begun.

The Fundamental Objectives of the OMA Professional Liability program:

* To minimize the causes of claims
* To resist unfounded claims
* To promptly and fairly resolve legitimate claims
* To provide doctors with financial protection
* To enhance the image of the medical profession
* To stabilize rates for members of the Program
* To seek legislative relief
* To educate the public in the ultimate cost of excessive awards

10 Major points of the OMA/CNA Professional Liability Program:

1. Custom-made insurance to meet the needs of OMA members.

2. Insurability - The OMA's Professional Consultation Committee and CNA have established eligivility standards that will qualify a majority of applicants and members.

3. Rate Stability - By making every possible effort to reverse the cause and effect of litigation. Oregon rate schedules are based on claims experience in Oregon ONLY.

4. Cancellation protection - During the 5-year contract period CNA will not cancel or refuse to renew any coverage provided under the Program without the consent of the Professional Liability Committee.

5. Reserve Premium Fund - During the Program's first three years, an additional amount equal to 25% of the basic premium was collected and set aside to earn investment income. This Reserve Premium Fund is an additional check in the effort to stabilize rates.

6. Profit Sharing - CNA has guaranteed to return excess underwriting profits on a formula basis, as a credit against future premiums.

7. Investment Sharing Income - All participating members will share in investment income from the premiums collected for the first $100,000 of coverage.

8. Claims Handling - A local claim administrator has been assigned by CNA to work closely with the OMA's Professional Consultation Committee. A physician should look upon an untoward result, an inquisitive letter from a patient's attorney, or any incident which might possibly develop a claim as reason to contact his insurance carrier as soon as it is brought to his attention.

9. Financila reports of the operation of the entire Program will be provided by CNA.

10. Claims Settlement - The basic philosophy of the Program is to resist unjustified claims and to make prompt reparation of justified claims. All claims will be reviewed by the professional Consultation Committee and CNA. A vital function

(continued on page 12)

of the Committee is to give expert appraisal of the medical facts to determine the best course of action. When it is necessary to retain an attorney, the Committee will assist in providing expert witnesses to aid in the defense. When a case is not defensible, the Committee will aid CNA in effecting prompt settlement to avoid costly litigation and adverse publicity which would be detrimental to the image of the profession.

Despite the efforts of this Program physicians in Oregon are facing rates which are two to three times as much as premiums for the same coverage only a year ago. Without some form of relief in Oregon premiums will continue to increase. Moreover there is no assurance that our present carrier or other insurers will be willing to write professional liability insurance in the state without some substantive evidence that claims will stabilize. Based on the experience of several other states this unfortunate possibility whould be considered to be very real in Oregon.

Based on the disturbing situation that now exists and the potential crisis that could well confront the state, the OMA has designed a bill to partially ease the problem, and introduced it for consideration by the Oregon State Legislature. The omnibus bill, HB 2647, relates to medical licensure and medical negligence, and is intended to attack the problem from three standpoints: 1) by limiting awards in cases of proven negligence to "true economic loss" to the injured party or his family; 2) by either limiting or more clearly defining certain legal doctrine commonly involved in professional liability cases; and 3) by providing the State Board of Medical Licensure and the medical profession as a whole with more effective tools with which to discover and control physicians who are or may become prone to suits because of their own actions.

The Oregon Medical Association cites the following major objectivew which it feels could be accomplished through the passage of HB 2647:

1. Assure that the medical profession in Oregon will remain insurable and that any professional liability program in the state can be maintained on an actuarialy sound basis.

2. Maintain a climate assuring reasonable protection and fair compensation for the patient injured through medical negligence.

3. Negate or modify the factors of civil law which contribute to excessive professional liability claims and awards.

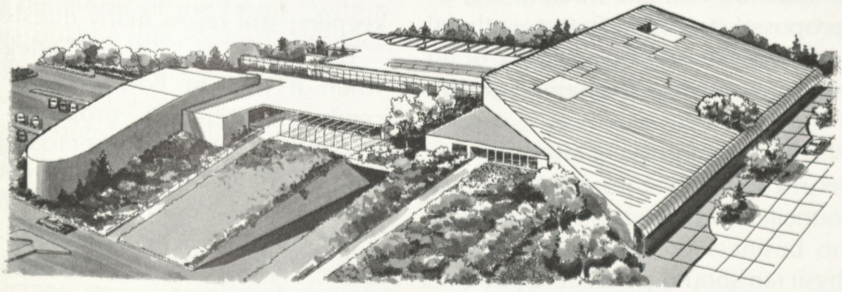
4. Reduce the penalizing effect which huge professional liability awards have on the economics of the society as a whole, as reflected by the increased financial hardship placed on the individual physician and ultimately his patients.

5. Develop an early warning system to permit the medical profession, through its professional organizations and the State Board of Medical Examiners, to more quickly and effectively intervene when the individual physician begins to encounter difficulty.

It is important that the membership, the public and the Legislature understand that this bill is not an attempt to "get doctors off the hook". Rather it is the only remaining alternative to stabilize and hopefully ease the malpractice situation which now confronts us.

YOUR HELP IS NECESSARY. For more information about HB 2647 contact the Oregon Medical Association, 2164 S.W. Park Place, Portland, 97205 (226-1555) or Mr. Rainey or Mr. McCowan, OMA/CNA Physicians Protection Program, Pownall, Taylor & Hays, 1215 S.W. Broadway Portland, 97205 (228-1131)

THE TOWN CENTER: A BUSINESS LOCATION THAT WON'T SPOIL THE COUNTRYSIDE.



We're building an unusual new business location, right in the middle of the future.

It's called the Town Center at Tanasbourne. But it won't be just another shopping mall. It will be a community center for the flourishing residential areas of eastern Washington County.

And it will grow nicely out of its own surroundings, with sensitive landscaping and tasteful design.

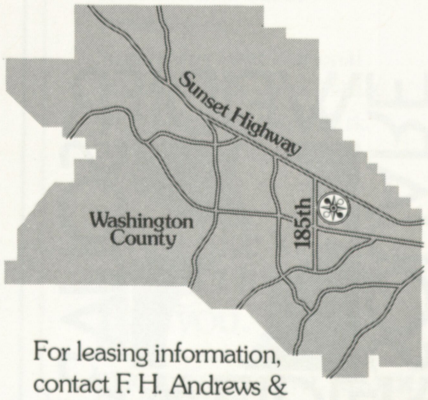
Which means the Town Center will be an exceptional location for shops, for stores, and for business and professional offices.

the town center

Think of it as a business opportunity with trees.

You can see it all taking shape right now, just off the Sunset Highway at 185th.

And to make you feel at home, the people behind the Town Center are the people of Standard Insurance, headquartered right here in town.



For leasing information, contact F. H. Andrews & Associates, Inc., Realtors, 1511 Standard Plaza, 222-1924.

1975

By Robert H. Elsner

Executive Director's Notebook

How About a Discount, Doctor?

Several inquiries have been received lately from physicians or their office managers, asking if it's ethical to offer discounts for payments made in cash or if medical bills are paid in full within a prescribed period of time.

This subject has been considered by the Society's Judicial & Business Commission, which is responsible for reviewing ethical policies in this community. It is their – and the AMA's – attitude that a discount on medical bills paid within a prescribed period of time is improper. The Society's Board of Trustees, some months ago, concurred with a recommendation of the Judicial & Business Commission that the Society "reject a proposed statement that it is ethical for a physician to offer a discount on bills paid within a prescribed period of time."

In researching the matter, the Society contacted the AMA Judicial Council, and their response was that "no business practice adopted by a physician should penalize a patient's financial condition. Financial inducements should not be permitted to interfere with the physician-patient relationship. Cash discounts are beneath the dignity of the profession."

The question arose, locally, when a physician requested an opinion on the ethics of his proposal to offer a 5% discount on bills paid within 30 days of receipt. The Judicial & Business Commission, in rejecting the concept, also raised questions over the practical applications of such a proposal, when insurance payments – which may be delayed for some weeks – are involved.

One obstetrician recently asked if it would be ethical to allow a substantial discount to patients to pay in full prior to delivery. They were advised that such would not be ethical, based on the above position. In addition, there is the question of requiring or requesting payment before a service is rendered, which also poses certain ethical problems.

* * *

The subject of penalties, interest or other charges on past-due medical bills is one that many physicians (and medical office managers and bookkeepers) still raises many questions.

The AMA House of Delegates, when it met in Portland last December, *rejected* a proposal that would have made it proper to impose interest charges on overdue medical bills. The AMA did re-affirm its long-standing policy which stated in part that "... the practice of medicine is a profession and not a business, (and) the practices adopted by businesses are not necessarily suitable to medicine," and which also states that "it is not in the best interest of the public or the profession to charge interest on an unpaid bill or note for professional services not paid within a prescribed period of time, nor is it proper to charge a patient a flat collection fee if it becomes necessary to refer the account to an agency for collection." The Oregon Medical As-

sociation has also upheld this basic concept.

The attitude of the Multnomah County Medical Society is that *it is unethical* to charge interest or a penalty on past due accounts, and this has been re-affirmed several times by the Board of Trustees – most recently in 1974.

The AMA did state at its 1974 Clinical Convention in Portland that "it is not improper, however, for a physician to add a *service charge,* equal to the actual administrative cost of rebilling, on accounts not paid *within a reasonable time.* Patients must be notified in advance of the existence of this practice."

While the Multnomah County Medical Society has not yet commented on this latest AMA position, the general attitude has been that it is a reasonable approach. Questions to Society headquarters have asked for a definition of the terms "within a reasonable time" and "service charge equal to the actual administrative cost of rebilling."

These questions will be discussed by the Society's Judicial & Business Commission on March 11. In the meantime, staff is advising physicians – after conferring with a number of physicians and clinics, that a "reasonable time" should be at least 60-90 days, before a service charge is imposed. The service charge should be, as stated in the policy, "equal to the actual administrative cost of rebilling," which could vary from office to office and clinic to clinic, depending upon their own billing and bookkeeping systems and overhead costs. A general guideline has been in the 50¢ to $1.50 range, per month, although in some unusual situations the cost might be higher. As mentioned, this bill will be discussed by the Judicial and Business Commission this month, and referred to the Board of Trustees at its February 19th meeting.

One office asked if the service charge could vary with the size of the bill, and staff's response – pending further clarification from the Judicial and Business Commission – was that it should not vary, unless it could be shown that it somehow cost more to produce a "past due" bill for one balance than it did for a lesser balance. Staff's interpretation was that to have a sliding scale on rebilling service charges is similar to applying penalties or interest and does not coincide with the AMA's definition of a charge "equal to the actual administrative cost of rebilling."

* * *

Quote of the month: "I am becoming increasingly intolerant of those who would improve the quality of my life at the expense of my standard of living. And vice versa." –

– John W. Alltucker, President, Associated Oregon Industries (in AOI News Digest, February, 1975).

* * *

A limited number of copies of the new "Statement of Principles" regarding physician-lawyer relationships, and "Guidelines" for their application in Multnomah County are available from Society headquarters @ 50¢ per copy, plus postage. One copy was sent last month to every member of the MCMS and Multnomah Bar Association, at no charge. The booklet was prepared by the organizations' Joint Medical-Legal Committee.

You too can be PHYSICIAN for a DAY

The Official Legislative Physician is on call in the Capital for emergencies, and to treat the ills of legislators and their staffs. The Physician for the Day is introduced to both Assemblies and is free to attend any Committee meeting. What else will he do? Perhaps have coffee with his Representative, discuss his interests with the House Minority Leader, and have his check ok'd by the State Treasurer. Such was the day for Dr. Roy Payne, as official Legislative Physician. Any Oregon physician may participate in the Physician for a Day program. Contact the OMA, 226-1555.

Roy M. Payne, M.D. during his day at the Legislature with (clockwise, beginning above) State Treasurer Jim Redden, Senator Dick Groener, Representative Dick Magruder and House Minority Leader Roger Martin.

Taking a look at Those Cracks

A Report from the 15th Annual Officers, Trustees & Commissioners Conference

Controversy is the forerunner of change, it may even bring understanding. The controversy generated at the 15th Annual Salishan Conference may not have produced direct change, but it illuminated the picture for all concerned. Of the four panels which originally presented skim-the-surface views of cracks in Portland's health care, two were invited to return for closer inspection.

"The Need Chasm" panel included Corinne Murch, Medical Service Specialist, and Ray E. Moore, M.D., Medical Consultant, both from Multnomah County Public Welfare Dept., and James B. Landis, Medical Director, Oregon State Public Welfare Division.

On the Cover – Two of the featured speakers at this years conference. Joe D. Miller (inset), Deputy Executive Vice President, AMA and Rex E. Kenyon, M.D. of Oklahoma City, an honorary member of MCMS and a member of the AMA Council on Legislation and the AMPAC Board of Directors.

The panel on "State & County Approaches" included Donald E. Clark, Chairman, Multnomah County Board of Commissioners, Vera Katz, Oregon House of Representatives and Roy A. Payne, M.D., Chairman of the OMA's Public Policy Committee.

The following are excerpts from each panels presentation.

"It's quite obvious that the public servants at the head table are talking a different language than the people who are sitting here. There's one distinction that should be made, the distinction between health care and medical care. To anybody who practices medicine, there is a distinct difference on who can review or peer review either and on what they cost. The physician has been hung as the provider of health care – something he has little responsibility for. If he took that responsibility, he would have little control. That distinction between health care and medical care, must be made sooner or later.

—Max Parrott, M.D.
Marc

THE NEED CHASM

Murch
Moore
Landis

Persons in Oregon who qualify for monetary Welfare assistance also qualify for medical assistance. In Multnomah County 44,400 people qualify for that assistance; only 15,400 use the program.

The poor who don't qualify for medical assistance are the medically indigent or medically needy. Oregon has a law which would provide medical assistance for persons in this category, but the legislature has never approved funding. An estimated 178,000 would be eligible for such a program, with usage predicted by 46,200 persons.

The Welfare program is plagued with problems in supplying medical care. First among these is inadequate reimbursement of physician fees. The highest reimbursement is computed at 60% of the 75 percentile, or about 50% of usual & customary. The lowest reimbursement is about 23% of usual & customary. Inadequacies exist in other payments also: Welfare can pay $24 to a nurse who makes a home visit to a patient, but only $5.50 were a physician to make the same house call.

The second problem is the complex billing procedure. The forms are cumbersome, the coding arbitrary. (A five-digit coding system will be implemented July 1 to alleviate some of this problem.) 45% of the billings submitted to Welfare are either incorrect or incomplete, and physicians complain that when claim forms are rejected, they are returned with no markings as to what is wrong.

Problem number three is the shortage of nursing home beds. Beds are scarce, forcing some patients to remain in more expensive hospital beds. Reimbursement rates for nursing homes average 30% of cost of care. Beds do exist, but only when money is available. There is no way to force beds into being Welfare beds.

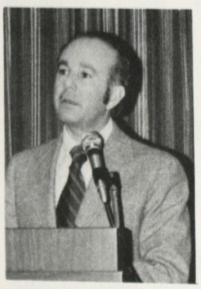
Another problem is access. Specialty care is available only through referral, emergency care only through the hospital emergency room. Welfare clients want a physician they can call their family doctor, someone to provide on-going care.

Medical reports must be marked CONFIDENTIAL if the physician wishes them to be treated that way. And while it is not a required part of the form, the Welfare department would appreciate knowing when a course of treatment, therapy, or an appliance could reverse the diagnosis.

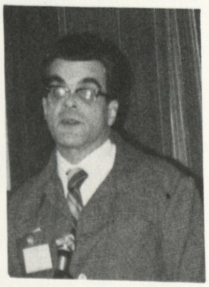
The panel reminded physicians that they are dealing with a bureaucracy. Changes and corrections can be made in the system, but only if specific incidents are documented. Complaints must be backed with hard data.

On the opposite side of the coin, Dr. Landis reviewed the results of a random survey in which 75% of the welfare sample said they had a regular doctor. 63% of the sample said they had seen their doctor within the last year.

STATE & COUNTY APPROACHES



Clark
Katz
Payne



Multnomah county, with the initiation of Project Health, moved from the business of providing health care for the poor to the position of coordinator or broker of health services for the poor. Beginning in 1970 the county began asking questions such as: How many people in Multnomah County are medically indigent? How are their health needs being served? How many public dollars are being spent to meet those needs? and Are we meeting specific needs? Their findings? That all the money for all the necessary reforms was available and currently being spent. It was a matter of allocating resources. $500-$600 per person, per year was available in Multnomah county. Monies from all sectors, state, federal and county, were pooled, and Multnomah County began buying the poor into mainstream health care. They deal, or will eventually deal with PMHI, Kaiser, Cascade, OPS, and Blue Cross, as well as individual physician on a fee-for-service basis. They also plan to deal with UOMS, on HMO basis for a group of excludables. The county has found that mainstream health care is cheaper & more efficient.

The state's position on health care has been complicated by cuts in the federal budget. President Ford's 1976 budget proposed cuts totaling $17-billion. More than half of those cuts will involve health and income funds for the poor and elderly. The implication is that individual states will pick up the slack. Oregon, however, has not accepted that burden.

Similarily, current programs in Oregon do not fill the existing gap. Only 37% of the families living below the poverty level in Oregon are on welfare. When the medically needy are included, 18% of Oregon's population cannot provide its own health care, yet each year a portion of the state monies allotted for health care and public assistance revert back to the general budget. The state does not allot any money for county health services and few areas choose to use their revenue sharing funds in this way.

According to Representative Katz manpower utilization on the rural level must be re-examined and reorganized to include nurse practitioners and medical assistants, centrally located hospitals and efficient emergency transportation. She feels that since taxpayers subsidize medical education to the tune of $10 thousand per year, per student, some commitment must be made by those students to practice in rural areas. Ms. Katz stated repeatedly that the money to fund comprehensive health services is there, "It's just a matter of priorities. The legislature must make health care a priority."

Dr. Roy Payne pointed out that all of these solutions must continue what the physician does best – care for his patients. Cost and access must be approached through alternate and competitive delivery systems, with adequate funding. Access and quality should be approached through education, of both the physician and the patient.

In working to meed these cracks or gaps in health care, organized medicine has worked to support the doctor-patient relationship. It has acted to identify and evaluate problems through its membership and associations, its auxiliary, and in cooperation with other private and public agencies. All the responses of organized medicine have been and will continue to be found within the framework of the doctor-patient relationship.

Marc

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Revised effective March 15, 1975

TAPE NO. **ADOLESCENTS**

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133 Advice for **Parents** of Teenagers
50 Teen Years: The Age of **Rebellion**

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310 How Important are **Baby** Teeth?
314 We Know What Causes **Bad Breath**. Do You?
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* These tapes were prepared by the dentists of the Multnomah County Dental Society.

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1975

24 Apply for Society Membership

The following physicians and students have applied for membership in the Multnomah County Medical Society. In accordance with the Society's bylaws, this constitutes first publication. Applicants will be eligible for membership only upon completion of all other law requirements.

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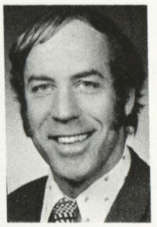

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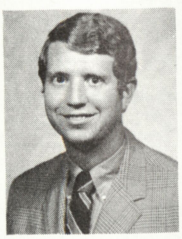

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97207
10895 NW Damascus 644-5308
97229

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Beaverton 97005

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7037 SW Garden Home Rd 246-2041
97223

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3722 SW Condor
97201

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Beaverton 97005 646-6779

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97201 225-8311
3717 SW Corbett #8 227-6016
97201

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97201 225-8311
5815 SW Tucker 644-1043
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1001 SW Wood #2 228-2779
97201

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FOX, Robert H.
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97201 225-8311
3425 SW Vets Hosp Rd
97201 227-4002

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1975

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6265 SE Stark 236-0812
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HALL, Michael L. Vickie
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Not all health maintenance organizations are receiving instant public support, contrary to predictions of social planners and politicians who believe HMOs represent the "only way to fly" so far as health care is concerned. One example is "Healthcare," set up in downtown Brooklyn in January, 1974, by Connecticut General Life Insurance Co. It looked for at least 10,000 subscribers, according to the New York Times, but has only attracted 500. Connecticut General has decided to end the program on March 31 of this year.

President Ford's proposal to slash almost $1 billion out of federal spending for health programs and to shift the burden to local and state governments was called "irresponsible" by officials of the Coalition for Health Funding, an organization of 45 national health groups.

Health spending in the U.S. rose above $100 billion for the first time in fiscal year 1974. The total of $104.2 billion was 10.6% higher than the 1973 total. Public spending for health was $41.3 billion, a 15.3% increase. Private spending, up 7.7%, totaled 62.9 billion. Despite the increases, spending for health was the same proportion of the gross national product--7.7%--as in fiscal year 1973.

January was the third successive month in which the percentage change in physicians' fees has increased over the previous month. But since August, 1971, physicians' fees have risen 22.6%, while the all-items category of the CPI has risen 27.7% and the all-services category 24.6%.

Hospitals are now the largest employer in the United States, with approximately 2.67 million persons employed in the nation's 7,061 hospitals. By contrast, in 1946, 830,000 people were employed in the nation's then 6,125 hospitals.

Hearings began March 4th on the AMA lawsuit seeking a preliminary injunction to restrain the federal government from enforcing its utilization review regulations. The AMA filed suit against HEW on Feb. 20, charging that the UR regulations violate the Constitutional rights of both patients and physicians.

HEW Secretary Caspar W. Weinberger approved proposed regulations permitting teaching hospitals to receive Medicare reimbursement for physicians services on the basis of costs rather than charges for the services. This option is available if all physicians who render services in the hospital agree not to bill Medicare for their services.

Unified membership will be retained in California following the CMA's House of Delegates vote against making AMA membership voluntary. The CMA Council had recommended unified membership and most of the testimony supported unity.

Venereal disease rate in the U.S. leveled off last year, says Center for Disease Control. In the fiscal year that ended last June 30, syphilis cases declined 4%, and the rate remained stable for the first six months of the current fiscal year, the CDC said. The rate of increase of gonorrhea cases was 4.8% in the past fiscal year, and 3% during the first six months of the current year.

CALENDAR OF EVENTS: Send information of upcoming events to Editor, Portland Physician. All MCMS-sponsored meetings are open to any member. Call 222-99

March 17------MCMS Medical Review Committee, 6:15 p.m. Social, 7:00 p.m. Dinner, Society Headquarters
MCMS Emergency Medical Services Committee, 8:00 p.m. No Dinner, Society Headquarters

March 18------MCMS Committee on Regional Blood Center, 12:15 Luncheon, Society Headquarters

March 19------Medical Morbidity & Mortality by W. Miller, M.D., Chief Medicine Resident & W. Olson, M.D., Ch., Medical Comm., 8:00 a.m., Providence Hall, Providence Hospital
MCMS Board of Trustees & Delegates Caucus, 6:15 p.m. Social, 7:00 p.m. Dinner, Society Headquarters

March 20-21---National Conference on Medical Malpractice, Arlington, Virginia.
AMA's 28th National Conference on Rural Health, Roanoke, Virgi

March 21-30---MCMS Spring Conference, Maui, Hawaii

March 30-April 4-American College of Radiology's 52nd Annual Meeting, Hilton Hotel, Portland

April 1-------"Endocrine Treatment of Breast Cancer", G. Gordon, M.D., U. of Calif. at San Francisco, 7:30 p.m., Auditorium, Providence Hall, Providence Hospital

April 4-6-----OMA Annual Meeting, Valley River Inn, Eugene

April 11-12---AMA's Conference on the "Disabled Doctor-Challenge to the Profession", San Francisco. Contact Rogers J. Smith, M.D.,221-2

NAMES IN THE NEWS: Mrs. EVELYN CONNER, president of AA Ambulance Service in Portland, has been named Region IX Director of the Ambulance Society of America. Mrs. Conner will work with ambulance operators in the four state area to upgrade emergency medical care. LOUIS H. FRISCHE, M.D. will be one of 107 physicians named as Fellows of the American College of Radiolo when that organization meets in Portland March 30-April 4th. C. H. Hagmeier, M.D., has been nominated for a third term as Chairman of the Board of Oregon Physicians' Service. Nominated for 1975-75 OPS-Blue Shield Vice Chairman is another MCMS member WILLIAM C. SCOTT, M.D. Harry S. Irvine, M.D. is new physician-advisor from the MCMS to the Multnomah County Association of Medical Assistants, named by the Society's Executive Committee. He joins ROBERT E. FISCHER, M.D., and FRANK D. McBARRON, M.D., who continue as advisors to MCAMA. GORDON L. MAURICE, M.D. and FRANK D. McBARRON, M.D. are recipients of the Persantine Aspirin Re-Infarction Study (PARIS) to be conducted at Providence Medical Center. Their grant is the first award of its type in which the company granting the monies relinquished all control over use, research protocol, administration & publication details. ROBERT E. WAGNER has been named administrator of Dwyer Memorial Hospital in Milwaukie. He was previously assistant administrator at Overlake Memorial Hospital in Bellevue, Washington.

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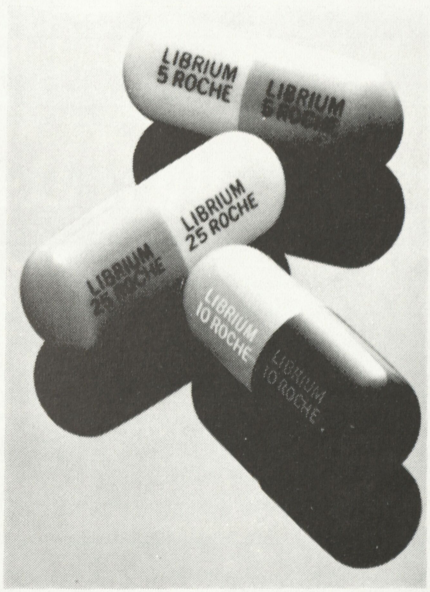
Precautions:

ORAL: In the elderly and debilitated and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six.

INJECTABLE: Keep patients under observation, preferably in bed, up to three hours after initial injection; forbid ambulatory patients to operate vehicle following injection; do not administer to patients in shock or comatose states; use reduced dosage (usually 25 to 50 mg) for the elderly or debilitated and for children age twelve or older.

ORAL AND INJECTABLE: Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating compounds such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual



precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

With the injectable form, isolated instances of hypotension, tachycardia and blurred vision have been reported; also hypotension associated with spinal anesthesia, and pain following I.M. injection.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral: Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

For Parenteral Administration: Should be individualized according to diagnosis and response. While 300 mg may be given during a 6-hour period, do not exceed this dose in any 24-hour period. To control acute conditions rapidly, the usual initial adult dose is 50 to 100 mg I.M. or I.V. Subsequent treatment, if necessary, may be given orally. (See Precautions.)

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