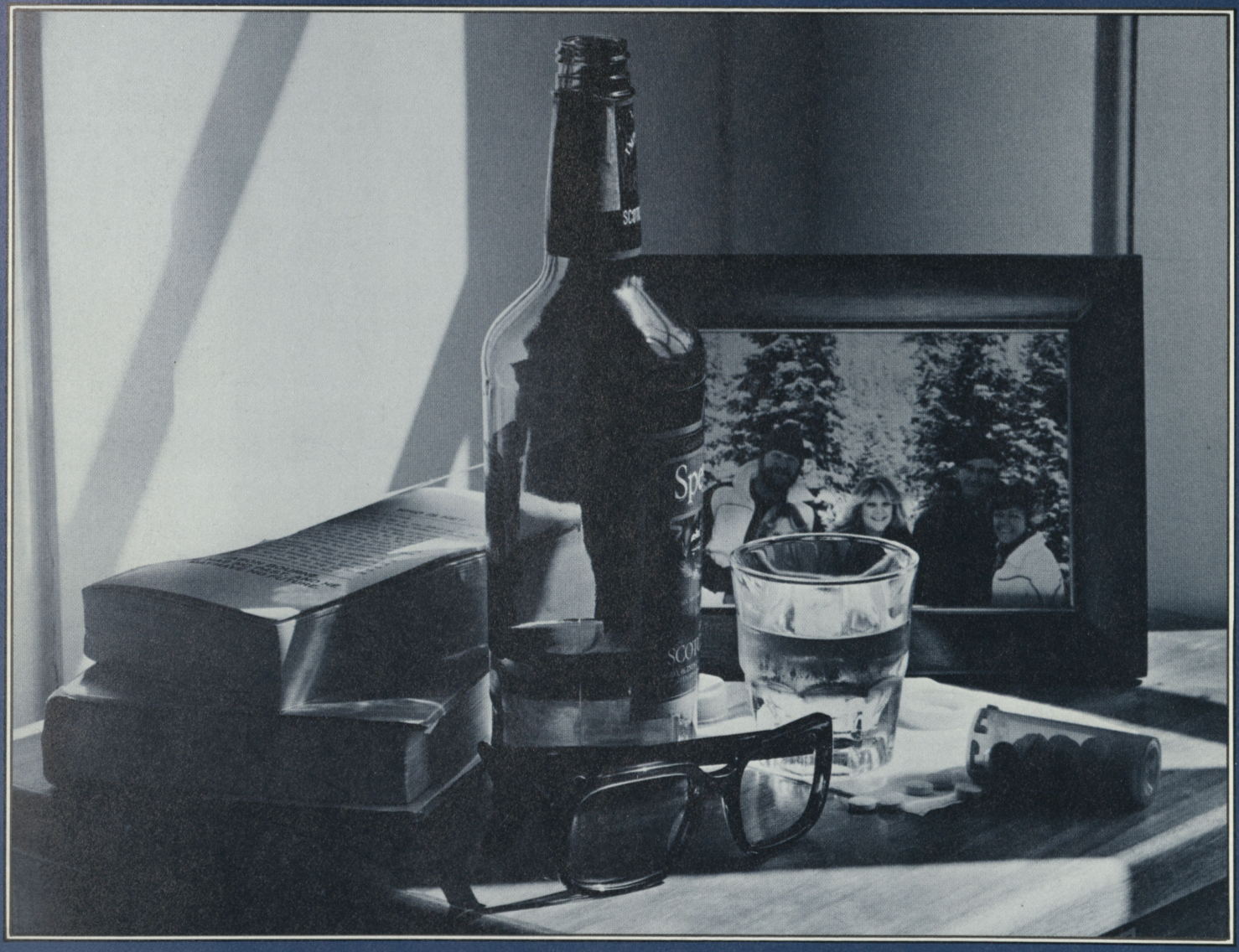
Portland Physician

September/October '82



Reaching the Impaired Physician

Project Medi-share: Helping the Medically Poor

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portland physician

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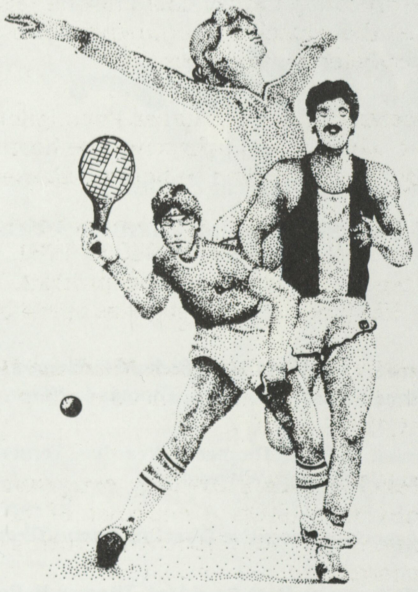

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OR COME BY AND SEE US AT JOHNS LANDING

The OMA House of Delegates will meet in Portland November 5, 6 and 7 to consider resolutions and reports. These resolutions and reports are the basis for determining OMA policy. Any OMA member may either 1)write a resolution and have it introduced by a delegate or 2)write a resolution and submit it to the MCMS board of trustees for consideration as a Society-sponsored resolution. (Resolutions not accepted by the board may be resubmitted to a delegate.) Resolutions going to the board of trustees must be at the MCMS by Monday, September 20. Resolutions going to a delegate must be at the OMA by Wednesday, October 6. This is your chance to make a change.

A credit and collections workshop for physicians is scheduled for Tuesday, September 21 from 7:30-9:00 pm at the MCMS. Transworld Systems, Inc. a Society-sponsored pre-collection service, will present the workshop and address: the importance of establishing a credit policy; essential patient information; educating patients of their financial obligations; financial arrangement options; laws regarding collection activities; and how to achieve quick turn-around time. Registration is $5. Call 222-9977.

The AMA's Fifth National Conference on the Impaired Physician will take place in Portland September 22-25 at the Marriott. Co-sponsored by the MCMS and OMA, the conference will feature national authorities on alcoholism, workshops and problem-solving discussion groups. For more information see page 29.

A federal advisory council has recommended that the US Department of Health and Human Services not grant a $20 million request to fund construction of the proposed OHSU research institute. The National Advisory Council on Health Profession Education felt the university could not assure the government it could produce the necessary $6 million in annual operating costs, according to James Durham, grants management officer with the Bureau of Health Facilities. Another factor was the State of Oregon's statutory inability to guarantee state support for the institute in case the operating money could not be raised from private donations and research grants. Durham added, however, that the council's recommendation is only advisory and the $20 million for construction has already been appropriated by Congress.

The physicians' service component of the Consumer Price Index rose 7.8 percent in the second quarter of 1982, well below the all-items index, which rose 11 percent. The hospital room component increased at an even lower rate of 6.3 percent over the quarter, according to figures released by the Bureau of Labor Statistics.

In a related development, the Department of Health and Human Services reported a 15.1 percent annual increase in public and private expenditures for health care from 1980 to 1981. Americans spent $287 billion on medical care last year, representing 9.8 percent of the gross national product. The department said health spending averaged $1,225 a person. Of that, $524, or 42.8 percent, was spent by federal, state and local governments.

Ten students from the University of Washington Medical School are attending the Impaired Physician Conference in Portland September 22-25 and need a place to stay. If you have room in your home, please call Collette Wright at the MCMS, 222-9977.

Legislation to replace the federal health planning program with a voluntary, non-regulatory system has been introduced by Senator Orrin Hatch (R-Utah), chairman of the Senate Labor and Human Resources Committee. He said the federal program has "not restrained growth in hospital costs, nor has it stimulated reduced costs in any area of health care."

The bill would encourage the states to develop their own health planning programs with minimal federal intervention, Hatch said. It would repeal the certificate-of-need program and would limit federally-supported health planning to true planning and data collection. The planning program, which the Administration recommends be phased out, will expire this year unless reauthorized by Congress. S2720 would set up a one-year program allowing $20 million for the states, which could use the money for planning or "non-regulatory experiments promoting health competition and reducing health care costs."

Metropolitan Hospitals, Inc., a non-profit multi-hospital system consisting of Emanuel, Physicians and Surgeons, Meridian Park and Gresham Community Hospitals, is in the final stages of negotiating membership in Health Network of America (HNA). HNA, an interstate health network, is an umbrella corporation recently formed by two non-profit hospital chains, SanCor of Phoenix and Lutheran Hospital Society of Southern California. The two systems own or manage 13 hospitals with 3,300 beds and have assets totalling over $638 million.

"Women Aware," a workshop sponsored by the MCMS Auxiliary and Care will take place Thursday, October 14, 9:00 am at the OMA building. Program topics include: "Understanding Depression and Grief," "Relating Effectively with Adolescents," and "Medical Marriages—the M & M Syndrome." Call Ellen Caps, 232-4294 or Jeanne Vore, 223-4620.

in summary

Providence Medical Center is offering emergency dental care on weekends, holidays and weekday evenings through an arrangement with Columbia Dental Associates. Patients needing emergency treatment or information about this service should call 222-2600.

Nearly half of all physicians believe their practices will be affected by prepaid health plans in the next ten years, according to a study conducted by Louis Harris and Associates for the Henry J. Kaiser Family Foundation. Of the 1,814 physicians surveyed, 60% expressed unfavorable attitudes toward prepaid health care, with the exception of resident physicians, 62% of whom approved of prepaid care. Physicians in the poll said the main disadvantage of HMOs was inferior physician/patient relationships. Other disadvantages included the lack of incentive for individual initiative, relatively low potential income, and less autonomy and flexibility than fee-for-service practice.

Many residents, however, may be attracted to an HMO career, states the report, which is entitled "Medical Practice in the 1980's: Physicians Look at Their Changing Profession." The most widely perceived benefits of employment in an HMO are the opportunity to establish a practice directly out of residency, hours of work, vacation time and income security, physicians told the surveyors. Politically, HMO physicians tend to be more liberal, the poll revealed.

California has enacted two bills that would shift one category of patient—the medically indigent adult or working poor—to the county systems, where the state's contribution to their care will shrink to 70 percent of its present level. In addition, Medi-Cal (Medicaid) Special Negotiator Bill Guy will be authorized to negotiate with physicians and hospitals to provide services to the poor on a pre-paid basis. At least three other states have similar pre-paid Medicaid plans, according to the federal Health Care Financing Administration.

An equally controversial provision gives Blue Cross and commercial insurance carriers the same right as Medi-Cal to enter into prospective arrangements with physicians and hospitals to treat private patients. Lower-priced group plans could require policyholders to use "preferred providers" exclusively. Dr. Hair said that the provision permits insurance companies "to end patients' free choice of their physicians and hospitals."

Portland Metro Health physicians will receive the same rate as other creditors in the liquidation of PMH assets and can expect to receive at least 60-70 percent on the dollar for services claimed from September 1–October 1, 1981. Washington County Circuit Court Judge Donald Ashmanskas made the decision after hearing arguments against the State Insurance Commission proposal to pay doctors at ½ the rate of other creditors. Judge Ashmanskas also ordered a manual recalculation of all claims after numerous processing errors were exposed during court proceedings. The Insurance Commission was directed to pay all legal expenses incurred in advancing the physicians' concerns.

In early July, OMA petitioned the court for a special hearing when it first learned that the Insurance Commission proposed to pay physicians at ½ the rate of other creditors based on the 50% physicians reimbursement policy in effect last fall when PMH went into receivership. Last month, partial payments on claims to creditors were mailed and physicians were reimbursed approximately 27.5¢ on the dollar.

OPS recently announced a new program to conduct 100 percent audits of all in-hospital bills from a selected group of OPS accounts. The audit project is supported by both employers and their associated unions and is seen as a way to bring down health insurance costs by demonstrating measurable savings in the subscriber group's hospital bills. Groups participating in the six-month audit include Nelson Trust, Boise Paper Group, Boise Non-Union Hourly, Boise LPIW and Pacific Northwest Employers Life and Health Trust.

"Medical Doctors as Expert Witnesses in the Legal System," a seminar offered by Willamette University's College of Law and the Medical/Legal Committee of the Marion-Polk County Medical Society, will take place September 17 and 18. The seminar is designed to help doctors and lawyers work together more effectively and will provide physicians with practical experience in giving expert testimony. Call the Office of External Education, Willamette Univerity, Salem, 370-6162.

Portland Adventist Hospital is presenting its 11th Annual Seminar, "Update for the Clinician," Wednesday, November 3. The seminar is targeted at physicians in family practice and internal medicine. Concurrent sessions will take place throughout the day and attendees may preregister for the lecture of their choice. Lectures will be given by 23 Portland Adventist staff physicians and special guest Dr. David J. Baylink, professor of medicine at Loma Linda University Medical Center. Call the medical education office, 257-2500.

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Project Medi-share: Helping the Medically Poor

by George Caspar, M.D.

The following remarks were delivered at a press conference July 28 to announce Project Medi-Share.

These are particularly troubling times for the many thousands of our Multnomah County citizens—neighbors, friends, previous patients—who have momentarily lost their jobs and face the future with uncertainty, if not raw fear. The food, shelter, clothing and medical care they previously paid for out of regular paychecks now comes from smaller unemployment checks or meager and dwindling savings. Their needs don't stop; but their resources are nearly non-existent.

Because of their unemployment and resultant inadequate health care coverage, they are known as the medically poor and number between 105,000 and 125,000 in Multnomah County alone. Most medically poor have some assets—perhaps a house with equity, a car or two, a few dollars squirreled away to support a son's or daughter's education. And because of these precious and few assets, these people do not meet the criteria to receive support from Medicaid or Medicare.

As our economic crisis has deepened, the plight of the medically poor has become worse, and their numbers have grown to astounding proportions. The state and county governments can no longer rely upon the successful earnings of industry and its people to pay sufficient taxes to fund even bare-boned social programs. As government's financial capacity dwindles, the need for more service grows, causing an intolerably strained condition. Private groups have extended themselves to make up this lost ground. Last year alone, Multnomah County physicians provided $17 million in unreimbursed care. That represents more than $11,000 in free services by each and every physician in this community. The amount of unreimbursable care physicians will provide this year is anybody's guess—but it will **not** be less than last year. I should note that

Photographer: Dan Carter

the hospitals of this area provided more than $30 million in unreimbursed services in 1981—in addition to the $35 million they were forced to absorb for underpayment of government-funded patients and bad debts. Additionally, numerous

"As our economic crisis has deepened, the plight of the medically poor has become worse, and their numbers have grown to astounding proportions."

government, public and private groups have met to study this problem.

The Multnomah County Medical Society's Project Medi-share is our attempt to quit talking about the needs that exist and mobilize the medical community to provide care, in an organized manner, to those who so desperately need it. In many instances the only thing these folks have is hope that they will soon return to the workforce and again become self-sufficient, taxpaying members of society. Because there but for the grace of God go we, Project Medi-share is our attempt to support volunteerism by helping those in need until they are again back on their financial feet.

As of today, we have 236 primary care physician providers—those who are family and general practitioners, obstetricians and gynecologists, internists and pediatricians—and 160 specialists who, working through the Multnomah County Medical Society, will meet and treat the medically poor.

continued on next page

president's page

continued from page 7

Here's how Project Medi-share will work:

- To qualify, an individual must meet the following criteria:
  1. Be a Multnomah County resident. Some Washington County medically poor people might be seen by our associate members in that area, but this is basically a Multnomah County program.
  2. Have a clear and present need for non-emergency medical care. True emergencies are presently being taken care of in this community.
  3. Be an individual or dependent of an individual who has been unemployed for more than 60 days. Employment benefits through employers and/or unions usually remain in effect for a time beyond termination and the economic status of these people is not so grave as it subsequently becomes.
  4. Show evidence of continuous full-time employment with a termination date after January 1, 1981. This is not intended for seasonal workers.
  5. Have no third party insurance coverage **and** be ineligible for any other medical assistance program, such as Medicaid or Medicare, Champus, Project Health or VA coverage.
- To participate, assuming the qualifications are met, all the patient needs to do is call Project Medi-share, 227-2737, and the project coordinator will determine eligibility and arrange an appointment with one of our participating physicians. If we are unable to help provide care through Project Medi-share, we will help you locate other care.

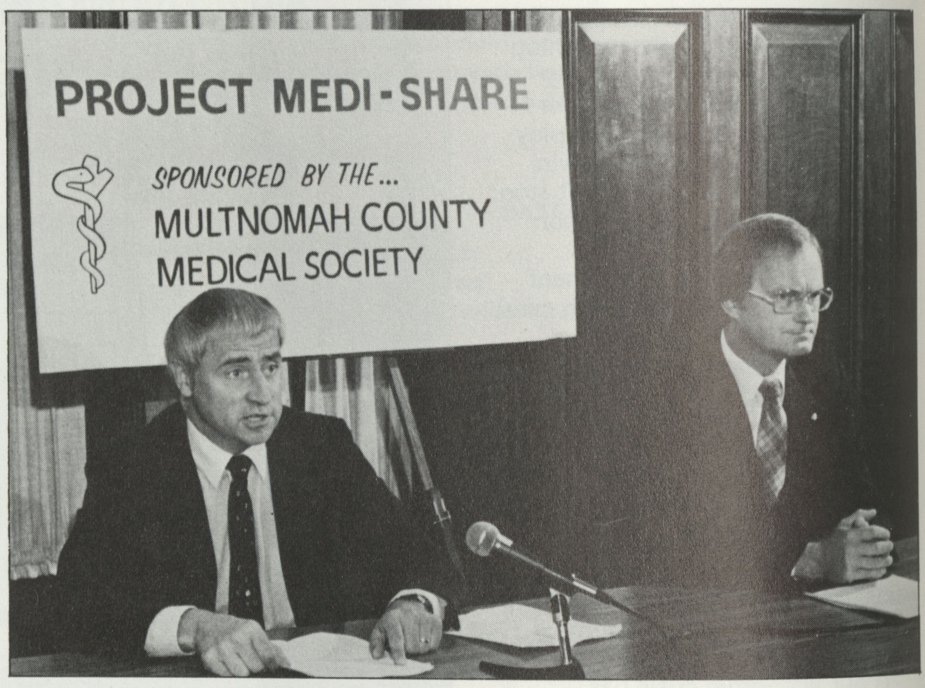
Individuals who can pay for any part of their physician's service at the time they are seen or in the future will be asked to do so. But no one will be pressured if they are financially impoverished.

We wish to emphasize that the physician is offering his or her professional services only. Out-of-pocket lab work, x-rays, medical and drug supplies and hospitalization are not included in this program. We are trying to get suppliers and other health care providers to join us in this effort. Whether that occurs has yet to be determined—but the physicians' part of the total health bill will no longer be an impediment to those needing care. We also urge those who are already receiving free or reduced-cost care from their personal doctor to stay with their doctor instead of calling Project Medi-share.

You, the press, can be helpful in informing the medically poor that Project Medi-share exists. Further, we plan to work with churches and other civic and social groups to make their medically poor members aware of this service. If private foundation monies are freed up to support some of the coordinative aspects of this program, we will attempt to communicate directly with those considered medically poor.

Why are we doing this? First, because our members have taken an oath to serve those in need irrespective of their financial capacity. Second, it would appear that unless volunteerism is exercised, government will mandate a program that will be considerably less effective than a program developed by the private sector. We also hope that our example will fan the flames of other major volunteer efforts on a variety of social and economic fronts.

This is not to say that anybody, particularly government, should be lulled into the false notion that this crisis is now abated and will be permanently taken care of by doctors.



"Why are we doing this? First, because our members have taken an oath to serve those in need irrespective of their financial capacity."

Financing care for any impoverished group is a social problem and far exceeds any one group's capacity to deal with it. We will be unrelenting in urging society, particularly government, to help us. The moment we believe our offer is being taken advantage of, or relied upon to solve a societal ill, is the day we'll walk away. This is our attempt to deal with an acute, catastrophic, short-term situation.

Project Medi-share opened for business Friday, July 30, 1982. It will last as long as a critical need exists. Taped information about the program and its eligibility requirements is available through Tel-Med by calling 248-9855.

We welcome financial support from others in the community. The Medical Society—a non-profit professional organization—is already strained in providing numerous other free services, such as Tel-Med, coordination of free care to the Southeast Asian refugees, health tips to school children, and numerous other projects.

"The moment we believe our offer is being taken advantage of, or relied upon to solve a societal ill, is the day we'll walk away."

We are in the process of organizing a separate entity that will be able to receive tax deductible contributions for the operation of Project Medi-share. If contributions are received, we will hold, and not expend, any contributions until Project Medi-share has been approved by the Internal Revenue Service as a charitable organization that may receive deductible contributions.

If prompt clearance of such an organization by the IRS is not feasible, we will attempt to work out an arrangement with a suitable organization, such as the Oregon Community Foundation, that will allow tax deductibility for contributions to the Project Medi-share program. If we have not made suitable arrangements to assure tax deductibility by year end, we will notify each donor and offer to return his or her contribution. Contributions of any size may be made to:

Project Medi-share
c/o Multnomah County
Medical Society
2188 S.W. Park Place
Portland, OR 97205

Contributions will only be used to help defray operating costs; none of the monies will be used to reimburse the physicians.

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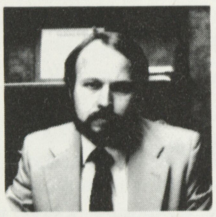

Roger Jorgensen, Business Manager
Portland Obstetric and Gynecology Clinic
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(5 physician group practice)

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Flashing: What's Under That Raincoat Anyway?

by Brad Davis

Interest groups are often so clandestine—overtly or perhaps just because that's the way they are—that they're seldom understood by the public. Sometimes they're barely understood by their own members. Two of the greatest reasons we operate undercover, or at least appear to, is because we don't think anybody is **that** interested in what we do. There's also a natural tendency to not expose our underbelly if there's a wart in the vicinity that reduces our image.

Well, people inside and outside the medical profession **are** interested in what we think and why—and I'm among those who think that we may have a few freckles, but warts? Nope!

This year has been one of opening up communication both inwardly and outwardly. As regards our own membership, we've flooded you with better news coverage in the Portland Physician, started the MCMS Memo, issued President's letters, held Town Hall meetings and gone out of our way to respond to correspondence from individual members.

But there's something going on of which we're even more proud. We've started "flashing"—exposing ourselves—to the community at large.

News Flash

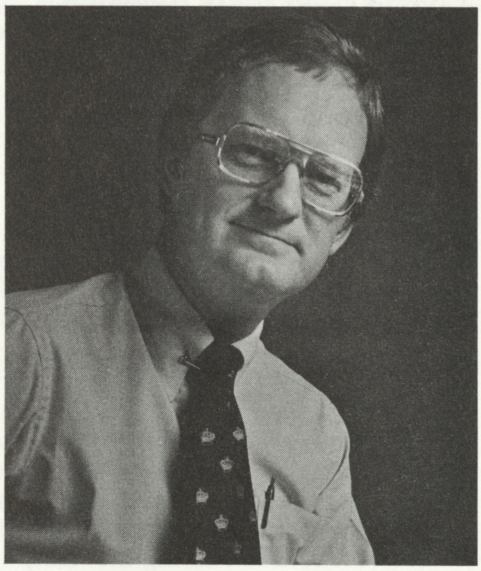
Historically, the Society has held an annual Media Night, where the working press has been presented with cocktails, canapes and conversation. (At least as much conversation as possible with a roomful of jangling glasses and too little time to discuss important subjects in depth.) We became aware that this format was not working; the press corps' heavy hitters were sending their office assistants instead of attending themselves. So, on June 29 we launched the first of thirteen evening meetings with those heavy hitters who were not showing up at other meetings.

Each evening is dedicated to one or two major news organizations in the community: KATU, the Oregonian, UPI, KYXI, etc. Interestingly, these people think they're professionals too! They want solid information; they want facts to back up views and actions; they don't want to be used. And they, like us, suffer from Xenophobia: What they don't know they distrust.

For nearly three hours MCMS doctors and staff and the newsmakers of this county have at it. We unveil ourselves, letting them know who we are, why we exist, where we get our funding and how we relate to other parts of the health care industry. We tell them what issues anger us (such as the cost shift and mandated insurance), concern us (like business-labor coalitions and New Federalism) and what we're up to (Project Medi-share and helping the Southeast Asian refugees). And they come back with questions and statements about their perspective of organized medicine which, if we had warts, would be downright unnerving.

Some of our comments are off the record. Most are for attribution. All are for building a better relationship with a very important part of this community. The consensus of these meetings? Both parties find them outstanding, substantial and worthwhile.

It turns out that "flashing" can be a very warming experience for everybody involved.



letters

Project Medi-share Applauded

I would like to take this opportunity to commend the members of the Multnomah County Medical Society for their actions taken with regard to project "Medi-share." I believe this is a fine example of what can be accomplished when individuals work together to assist those in need.

One of my staff, Paul Phillips, was in attendance during your Tuesday, July 27 briefing. From what Paul reports, it does appear as if you have a very broad base of support from your medical society. I truly appreciate your willingness to assist others as demonstrated by this effort.

I look forward to hearing the many positive reports that I am sure will be generated from this effort. Thank you again for your willingness to keep us informed and your willingness to help others.

Sincerely,
Victor Atiyeh
Governor

I was pleased to note in the Wednesday, July 28th newspaper about Multnomah County Medical Society's new project to provide free medical care to the indigent. On behalf of the Oregon State Health Division, I wish to commend your membership for your generosity. The giving of your time will hopefully be an incentive to others to act accordingly in this time of economic difficulty.

Sincerely,
Kristine M. Gebbie
Assistant Director, Human Resources
Administrator, Health Division

I have recently learned of an effort by your society to establish "Project Medi-share" providing health care for the poor and unemployed in Multnomah County. I wish to commend you for your sensitivity to this critical situation and your willingness to share your services, which are so badly needed.

Because my liaison assignment on the Board of Commissioners is the Department of Human Services, I am especially aware of the acute situation in our county, with unemployment soaring and federal and state monies being cut back. It is most reassuring to see your society step in with this type of project.

Our office has also been involved over the past year with several projects aimed at helping that same population: "Project Sharing," which helps coordinate donations from those able to give with those in need; project West Women's Hotel, aimed at renovating emergency shelter for women and children; a benefit for the House of Exodus, targeting youth considered below poverty level, unemployable, and bordering on juvenile delinquency.

Although my staff is limited, we too feel the need to do more from our office than enact legislation. County funds are limited, as are other governments', but with personal commitments from the public and from the private sector, it is still possible to achieve a great deal. We have seen an enormous response to our Project Sharing, so in that way I am not terribly surprised at the humane cooperation in our community.

On behalf of this office and our mutual concern for those in need, THANK YOU.

Sincerely,
Caroline Miller
Presiding Officer
Multnomah County Board of Commissioners

More Help for the Poor

Three cheers for the Multnomah County Medical Society's program for the medically poor. It is timely, efficient, humane and a reflection of what is best in the medical profession. Each of the 230 generalists and 160 specialists who have volunteered deserve a personal three cheers and public recognition.

Another response from the profession is the Concerned Physicians Committee, an ad hoc group that meets at 7:00 a.m. on Tuesdays at Dave's Delicatessen on S.W. Fourth and Yamhill in Portland. One of our aims is to reinforce the medical society's efforts by encouraging as many physicians as possible to join the cadre now at work. We plan to reach every physician in the county and state who may be unaware of the project.

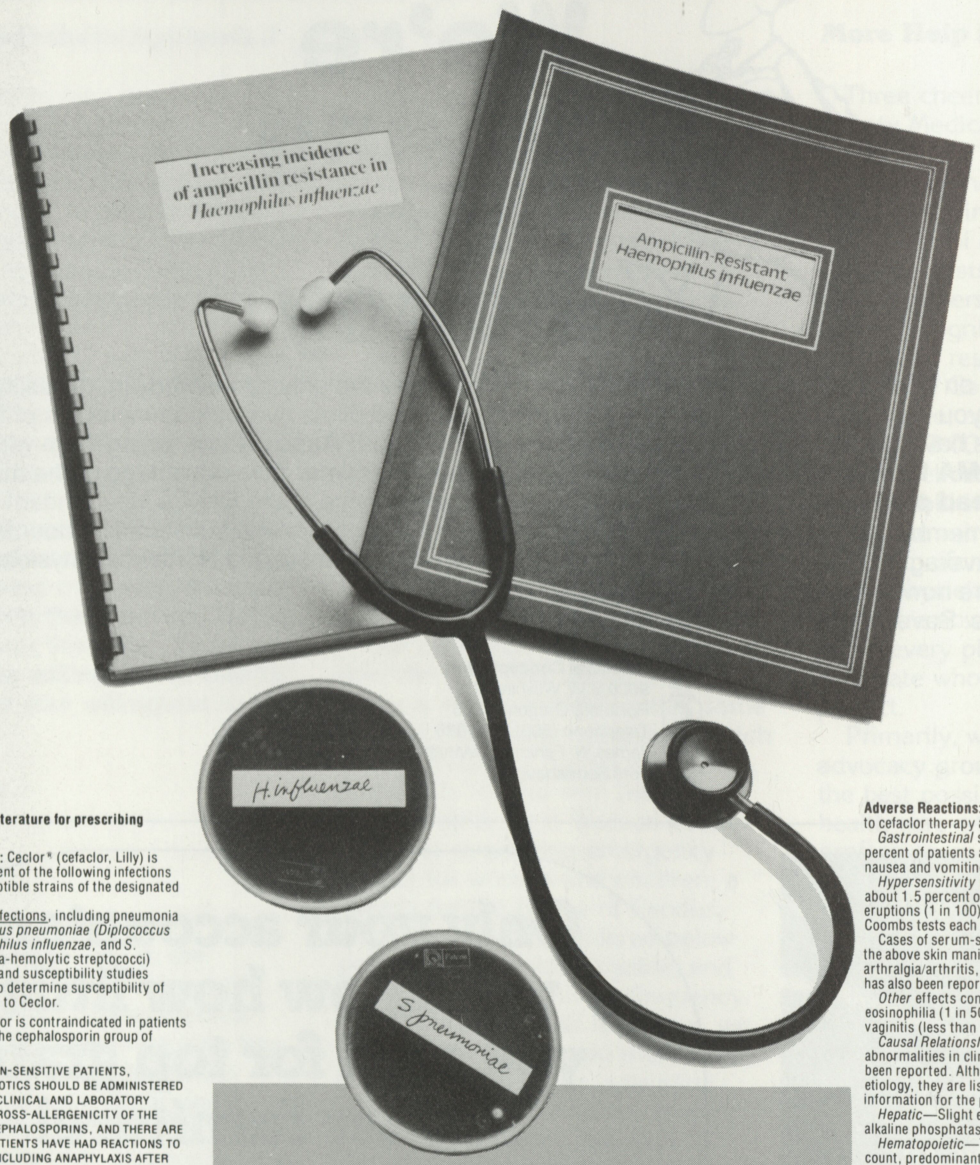
Primarily, we are a patient advocacy group planning to develop the best possible data on the present health care situation to share with the profession and public, particularly the full effect of the faltering governmental health funding.

We would appreciate case reports, confidential of course, about individual consequences of the present cutback. We also welcome any and all physicians from around the state to join us in this effort to bring the most up-to-date, complete, unbiased account of the situation to the public and to their representatives, the legislators. We are after the full story, including the long-term effects on the health of Oregon's citizens.

Sincerely yours,

C. Cassel, M.D.
W. E. Connor, M.D.
R. Crawshaw, M.D.
M. McCally, M.D.
D. Meir, M.D.
W. Sherman, M.D.

An added complication... in the treatment of bacterial bronchitis*



Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

Ceclor®
cefaclor

Pulvules®, 250 and 500 mg

Brief Summary.
Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae,* and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE).

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Usage in Pregnancy—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy—Safety of this product for use in infants less than one month of age has not been established.

Adverse Reactions: Adverse effects considered related to cefaclor therapy are uncommon and are listed below:

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients.

Cases of serum-sickness-like reactions, including the above skin manifestations, fever, and arthralgia/arthritis, have been reported. Anaphylaxis has also been reported.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200). [103080R]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae.*[8]

Note: Ceclor® (cefaclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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8. Principles and Practice of Infectious Diseases (edited by G.L. Mandell, R.G. Douglas, Jr., and J.E. Bennett), p. 487. New York: John Wiley & Sons, 1979.

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.

Lilly

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Carolina, Puerto Rico 00630

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Blues Plan Merger to Combat Rising Costs

by Lorrie Mockler

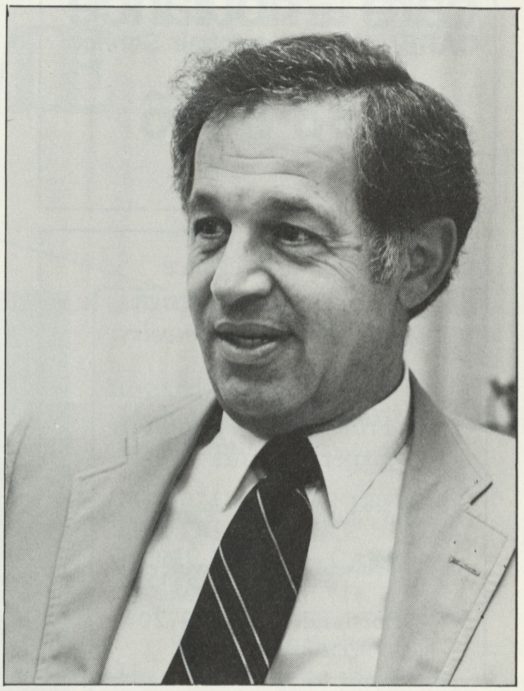
Considering the sharp rise in health care costs, utilization of services and insurance premiums during 1981, it's not surprising that Oregon's two largest health insurance companies are contemplating a merger. Blue Cross of Oregon and Oregon Physicians' Service-Blue Shield have suffered losses over the last two years due to the rapid rise in health care costs. Fiscal year 1981 proved the most damaging, with Blue Cross reporting a $4.6 million loss and OPS a $2.6 million loss. Both companies claim that though they are financially strong, a merger is seen as a way to combine administrative tasks, reduce duplication of services and save time and money.

Developing systems is an expensive task, and a lot of work is duplicated when each organization develops separate plans, explained Solomon D. Menashe, president of OPS-Blue Shield.

"We figured we could do the same administrative tasks together in less time and for less money than if each organization were to do them separately," he said.

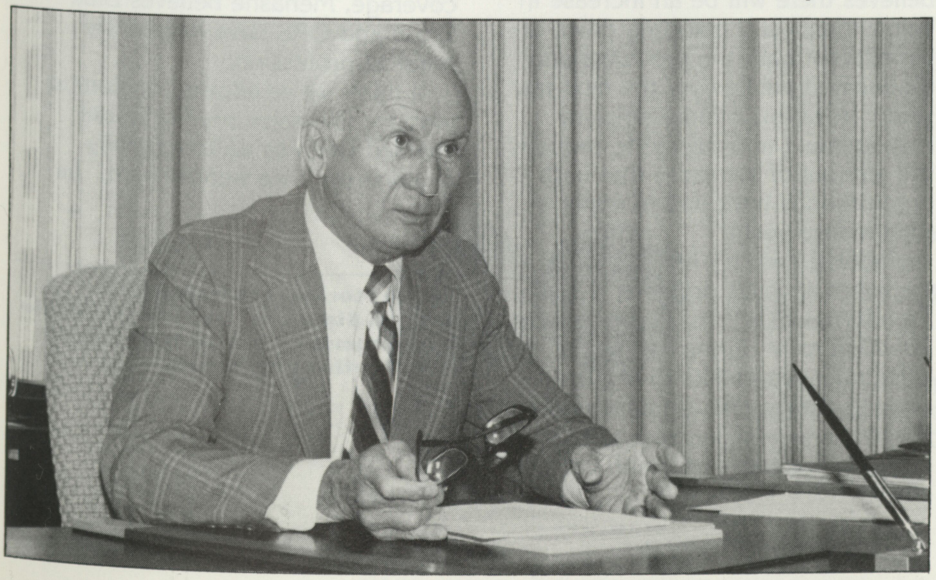
William Branson, president of Blue Cross of Oregon, sees the merger as a first step in the direction to save money on health care costs.

"Maybe we can get other organizations to cooperate in making changes too. I wonder how much duplication goes on in the health care field where money can be saved," he said.



"We figured we could do the same administrative tasks together in less time and for less money than if each organization were to do them separately."—Solomon Menashe

"People have a tendency to think of health care and health insurance as a right. Too many times a patient is told not to worry about the cost of medical care because 'the insurance will pay for it'."—William Branson



About 575,000 Oregonians subscribe to Blue Cross plans, and about 280,000 subscribe to Blue Shield plans. Branson said Blue Cross and Blue Shield operations have already merged in other states, including New York, Michigan, Ohio and Virginia.

Before the consolidation can be finalized, it must be approved by the state insurance commissioner. If there are no delays with this process, Menashe hopes the merger will be completed by January, 1983. Even so, he expects it may take two to three years to get the organizations operating as one.

continued on next page

Blues Plan Merger to Combat Rising Costs

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According to OPS spokesperson Jan Van Dyke, specifics of the merger are still under discussion, but the boards have agreed on a name: Blue Cross and Blue Shield of Oregon.

Blue Shield will move into the Blue Cross Building at 100 S.W. Market Street, which is undergoing major expansion. Neither company expects any immediate changes in personnel. Blue Cross employs about 650 people and Blue Shield employs almost 400. Should the merger require staff reduction, normal attrition will probably suffice, Branson said.

Preliminary discussions indicate there will be a 25-member board of directors comprised of members from the two existing boards, with Branson as chairman and Menashe as president of the new corporation. The combined corporation would have assets of $123 million.

Menashe does not foresee any significant changes that would affect physicians, though he hopes the merger will make insurance transactions easier and less expensive for hospitals, physicians and providers.

As far as insurance coverage and premiums are concerned, Menashe believes there will be an increase in co-payments and a scaling down of benefits for both the providers and the insured public over the next few years. However, a more efficient management is expected to reduce the amount of increases that both organizations have had to apply in the last two years.

"We will even try not to apply increases, if that's possible," he said. Premiums of OPS insureds rose 20–40 percent during 1981.

Branson would like to see the merged companies use educational programs to help increase the public's awareness of health care costs.

"People have a tendency to think of health care and health insurance as a right. Too many times a patient is told not to worry about the cost of medical care because 'the insurance will pay for it'. Therefore, the patient doesn't clearly know or understand what costs are," he explained.

Branson and Menashe agree that over-utilization of services is a primary factor in today's high cost of health care. An overabundance of physicians has been partially responsible for over-utilization of services in the Portland community, claimed Menashe.

"There's also more services than we need in the state. More beds than we need, more equipment than we need . . . the hospitals have to pay for these services and the money to pay these costs has to come from somebody," he said.

To help ease the over-utilization burden, Branson suggested that patients wait for an office call whenever possible, rather than using the emergency room. Offering more hospital services on an out-patient basis would also provide some relief, he said.

According to Menashe, the objective of the merged companies will continue to be what it was in the past: to provide the broadest and best coverage possible for a medium price. By providing such wide coverage, Menashe believes Blue Cross and OPS have helped the medical profession.

"I think we've allowed doctors to practice extensive medicine and enabled them to do things they couldn't do if we weren't here," he said.

Lorrie Mockler graduated from Oregon State University in journalism and community health and interned with Portland Physician.

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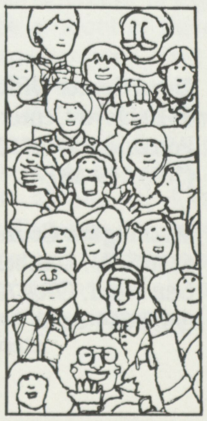

The Price of Federal Assistance

by S. Spence Meighan, M.D.

I once served as a medical consultant to a Health Maintenance Organization (HMO) of the Individual Practice Association (IPA) type. During that time, I was confronted by a great variety of medical and socio-economic issues—and with not a small number of people. Nowadays, it is fashionable to describe a task of this nature as "challenging." Certainly the job was rarely dull.

The federal government has devoted a considerable amount of energy and substantial amounts of money to assist in the development of HMOs. But, whenever the federal government gets involved—even with the best intentions—it always seems to contribute a significant number of problems through its system of regulatory controls. There is, for example, a regulation which requires that pre-existing illness, a medical condition or disability of any degree, cannot be reasons for denying enrollment in the Plan.

Under this regulation, women may sign up for the Plan and give birth the very next week. The Plan must accept financial responsibility for their hospital stay and the obstetrician's services. A man with a hernia can join the Plan and immediately undergo surgery, for which the Plan must accept financial responsibility. The Plan's financial resources were severely tested by such occurances. The IPA's intrinsic design makes it very difficult to control over-utilization of services by members and over-servicing by physicians: it is hard to develop and administer fiscal controls.

In an attempt to contain costs, the Plan instituted a system which required that before a Plan member could be admitted to the hospital for elective surgery, the participating surgeon must give the Plan some basic information about the patient's illness and details concerning the type of surgery being contemplated. This system was quite effective in reducing the incidence of "iffy" surgery. Certainly, it required that discussion take place before the procedure was carried out so the Plan would not be left in the difficult position of determining whether to accept financial responsibility for a procedure after it was performed.

One day, I noted that a patient with chronic ulcerative colitis was to be admitted to "Memorial" Hospital. The proposed admission date was fourteen days hence. I reviewed the clinical information, indicated that the surgery was appropriate and that the Plan should accept financial responsibility. The claims assistant brought the patient's file into my office shortly afterwards and said, "I should have checked this out before giving you the file, but there is a problem here—the patient is not a member of the Plan." It was clear that a call to the surgeon, Dr. Jack Ellis, was my next step.

When I got through he said, "Oh yes, I know he's not a member now . . . but he has applied. He will be a member on the 8th of the month. That's why I didn't schedule his surgery until the 10th."

"I understand," I said rather glumly, because the Plan was having financial difficulties and, although I really like the IPA model, it is very difficult to make it work financially.

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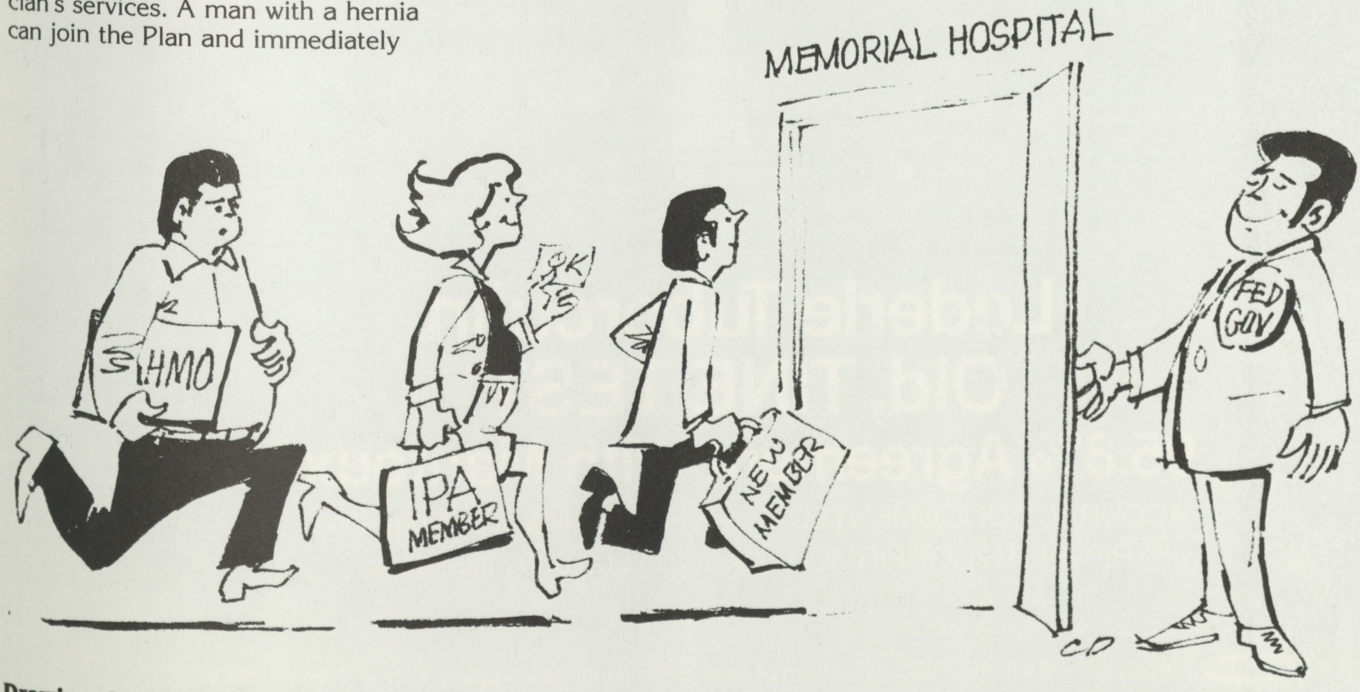

Drawings by Clive Davies

The Price of Federal Assistance

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Research of the files showed that Dr. Ellis was correct. A new company had accepted our Plan as one of the options for their employees, the patient had applied, and by law the Plan would be financially responsible for this surgery.

It seemed to me that the Plan was being cheated. But by whom? Surgery was the correct treatment for the patient's disease; the patient was availing himself of an opportunity to have his hospital and medical bills taken care of; the federal bureaucracy in its customary bungling fashion was trying to guarantee access to health services. There was no single "bad actor" in this cast of characters.

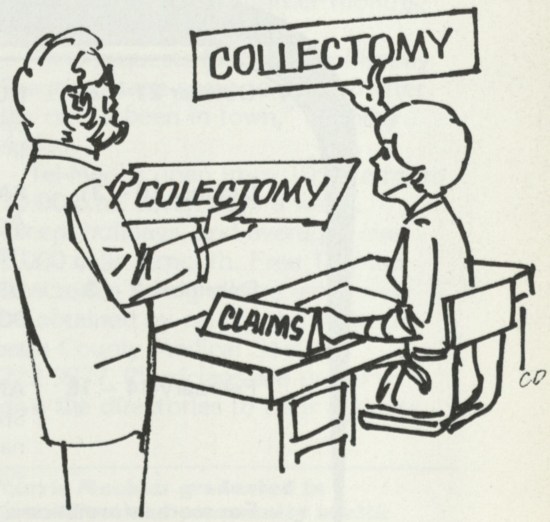
My thoughts were disturbed by the claims assistant who asked me, "What surgical procedure is planned?"

"A colectomy," I replied.

"Hmm," said the assistant, "how do you spell that?"

I began, "C-O-L-E-C-T-O," but she interrupted . . .

"I think it would be more appropriate if there were two Ls.



Dr. Meighan is an internist in private practice and president of Spence Meighan Associates, a consulting firm on hospital and medical staff affairs in Portland. He is chairman of American Society of Internal Medicine's Meetings Committee.

Call Tel-Med... For the Health of it

by Lorrie Mockler

When Multnomah County residents want information on cancer, arthritis, first aid or skin disorders, Tel-Med is there to help. Tel-Med is a free health and medical tape library sponsored by the Multnomah County Medical Society and OPS Insurance. Anyone can use the library by calling 248-9855 and requesting the tape they'd like to hear. Over 240 tapes provide information on specific illnesses as well as general health topics such as ski conditioning, family planning and smoking. Scripts are written by Society members and reviewed by the Tel-Med committee for clarity and accuracy.

Tel-Med is the brainchild of the San Bernardino Medical Society, which manufactures the recording equipment and cassette tapes. Multnomah County Medical Society installed the system in 1966, making it one of the first Societies in the nation to offer this service. Since then, Tel-Med has spread to all corners of the country.

A single telephone operator handles all ten Tel-Med lines, answering over 200 calls a day.

"I've always tried to hire physically handicapped people to run the program," said Dorothy Price, Tel-Med manager. Three blind people and one physically disabled person have been employed as operators in the past.

Paulette Stokes, who has operated Tel-Med for the past three years, is legally blind but can see lights. When a call comes in, a red light flashes, enabling her to answer the appropriate line.

Paulette Stokes, Tel-Med operator

In order to keep track of the 247 tapes, Paulette worked with the Volunteer Braille Service and the Oregon Commission for the Blind to set up a system in which each tape is labeled in braille. This system is so effective that it takes her less than five seconds to find the correct tape.

The Hit List

According to Paulette and Dorothy, the most requested tapes are those dealing with sex.

"Tape number 174 on masturbation is the most popular one," Paulette said. "Actually, all the sex tapes are frequently requested by people of all ages, even children—though I don't think they know what they're getting when they call in with some of their requests."

Some tapes are popular throughout the year, such as those on cancer, while others vary with the season. Tapes on bee stings and poison oak are requested more frequently during the summer months, Paulette said.

"And requests for the 'Am I Really Pregnant' tape seem to pop up after the navy's been in town," Dorothy added.

Tel-Med is open from 10:00 a.m. to 10:00 p.m. seven days a week, except holidays, and averages over 6,000 calls a month. Free Tel-Med directories listing all the tapes may be obtained by calling the Multnomah County Medical Society, 222-9977. Physicians are urged to give the directories to their patients.

Lorrie Mockler graduated in journalism and community health from Oregon State University and interned with the Portland Physician.

Reaching the Impaired Physician

by David W. Moore, M.D.

Bill W., age 45, is a hard working, high achieving, tireless surgeon at the peak of his career. He has excellent training and impeccable surgical skills. He typically works 70 to 80 hours a week, operates at three hospitals, has a large referral practice and is in an enviable financial position.

Bill drives an expensive car, plays golf and goes fishing. He and his wife of 21 years have three teenage girls. His life has been good, his reputation with patients and peers excellent, and his performance flawless.

"I don't see how Bill stands the pace and pressures of his practice," his friends say. He is seen at medical society functions, staff meetings, the country club and is at each of his hospitals twice a day, including weekends. A close friend covers his practice on the rare week or weekend he is out of town.

About 18 months ago, some small and seemingly unimportant flaws began to appear in Bill's performance. He avoided scheduling surgery on Mondays, his hospital visits diminished and he stopped attending hospital meetings. Nurses noted that he had become brusque, critical and inattentive. His office workers reported that he was often unavailable, late to work, early to leave. His hospital charts became chronically incomplete. Bill had two serious traffic accidents and began taking numerous four day weekends "to relax and recharge myself," he would state. Nevertheless, he quit fishing and playing golf.

Last March, Bill moved out of his house, separating himself from his family. His wife sued for divorce. He now lives with a 26-year-old divorced model, and is never seen socially, even by old and close friends. The rumor at his hospital is that Bill has "burned out" from the stress of 15 years' intensive surgical practice.

"Given some time and rest he'll rebound, you'll see," says an old associate. "He's tough and resilient."

Bill's close friend and psychiatrist bolsters this idea.

"Bill is a high energy over-achiever who is exhausted and depressed," he says. "Some minor sedatives, some extra rest and diversion and Bill will emerge as an effective surgeon again."

Bill's sister says, "I know Bill's problems stem from over-work, stress and fatigue. His wife pushed him too much. All she ever cared about was money, clothes and being 'the doctor's wife.' He's better off without the stress she gave him."

Bill's minister says "Bill cares too much about his patients and has worked too hard. If he can get his life reorganized, return to church and prayer, God will set him right."

All of these well-wishers are right—in a sense. Bill has over-worked, over-achieved and finally buckled. His social, spiritual, profes-

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Reaching the Impaired Physician

continued from page 25

sional and personal lives have all gone sour. But each of these well-wishers has failed to make the proper diagnosis. Bill is and has been an impaired physician. He is an alcoholic.

A New Perception

This story, with major and minor variations, has been heard nationwide over the last few years. At last, the medical profession recognizes that its members, too, are only human. They have the same potential for drug and alcohol addiction, mental disease, compulsions and obsessions as their patients.

Until about five years ago, Bill's case would have been handled by one or two disciplinary bodies. At the first level, a hospital governing body would assemble grievances and proven acts of poor judgment, then curtail or suspend staff privileges. If this did not work, the matter was handled by the state licensure board. The board would investigate complaints, hold hearings, then put the errant physician on probation, limit his practice or suspend or revoke his license.

A brutal flaw in this process has now emerged. The impaired physician, his life already in complete disarray, was finally exposed and his last two friends were denied him, namely his practice and income, and his salvation—his bottle. Suicide was often the tragic result. Dr. Ralph Crawshaw, in his landmark article "AN EPIDEMIC OF SUICIDE IN OREGON PHYSICIANS," (JAMA, May '80), reveals that of 40 physicians placed on probation during a 13 month period, ten attempted suicide and eight died.

These stark, horrible statistics were unacceptable to most of the medical profession. Faced with this mounting problem, a new look at procedure, identification and treatment was imperative.

Much progress has been made in the knowledge, physiology, pathogenesis, pathology, identification and treatment of drug and alcohol addiction in the last ten years. The public perception is and has been that alcoholism and drug addiction are a result of psychiatric illness, weak will, poor motivation or craziness.

New data show that these are both diseases with strong genetic predilection, at times predictable. Intensive therapy, with structured post-treatment follow-up and supervision, will arrest this disease 90 percent of the time. This form of therapy leans heavily on Alcoholics Anonymous principles, with professional and family support. Properly applied, today's therapy yields spectacular results.

Fortunately, the disease of alcoholism is the **only** fatal disease that is potentially curable, once the diagnosis is made and appropriate treatment carried out. The real problem in treating alcoholism is the denial process, since the victim is unable to make and/or accept his diagnosis.

The Denial Process

Denial is manifested in myriad ways. The patient assures his physician that "I can quit any time I want to" and means it. His family, peers and associates assure an investigator that "he drinks more than he should but his pressures are greater."

Common rationalizations are:

He only does it to relax from tension.
It never interferes with his work or driving.
He can't sleep without relaxing.
He's Irish, and you know how the Irish are!
His brothers drink twice as much and they're not alcoholics.
Some people can hold their liquor, some can't—he can!
The list goes on and on.

The basic definition of alcoholism is inappropriate, illogical, uncontrolled abuse of alcohol. This results in significant organ damage, neurologic impairment, social alienation, family disruption, and financial, legal, ethical and professional problems.

Most state or county medical societies have established a group to help the impaired physician. The goals of these groups are two-fold: 1) Protect the public from inadequate or inappropriate diagnosis and treatment by an impaired physician. 2) Identify, verify and confront the ailing and impaired physician, urging treatment if necessary after he accepts the reality of his problem. Help initiate and supervise the post-treatment period until quality, dependable sobriety is accomplished.

Disciplinary action by hospital staff and medical licensure boards can be avoided. Confrontation is usually carried out in teams of two physicians, both strangers if possible, one of whom is a recovering alcoholic or drug addict. Their approach is informal, non-judgmental, non-coercive. Several sessions are sometimes necessary to overcome the denial process. Great patience is required.

The findings, opinions and advice of the confronter/managers are private, and closed to disciplinary or legal investigators.

The Hot Line

In Oregon, the impaired physicians organization can be reached through a "hot line" (503) 220-0125. Anyone suspecting that a physician may have a problem with alcohol or drug abuse is urged to call. Their identity and remarks are kept confidential.

Indicators of alcohol or drug impairment are:

1. Frequent absences or tardiness from work, often on Mondays.
2. Inattention to detail and record keeping.
3. Sloppy dress, poor grooming and hygiene.
4. Alienation of old friends and family.
5. Marital, social and professional disruptions.
6. Marked change in behavior (hostile, critical, defensive, arrogant, demanding, angry).
7. Avoidance of recreation, vacations, meetings, hobbies and fraternal groups.
8. Auto accidents, driving under the influence of alcohol convictions.
9. Socially embarrassing incidents associated with alcohol.

If any combination of these positive observations makes you think your employer, colleague, physician or friend has an alcohol problem, seek prompt help. Reporting your suspicions to a group of well-meaning, educated and caring professionals is safe, protected and effective. Your action could save a career, if not a life.

Dr. Moore is an obstetrician in private practice, a member of the OMA Physicians' Committee and medical director at Gresham Hospital Alcohol Treatment Center.

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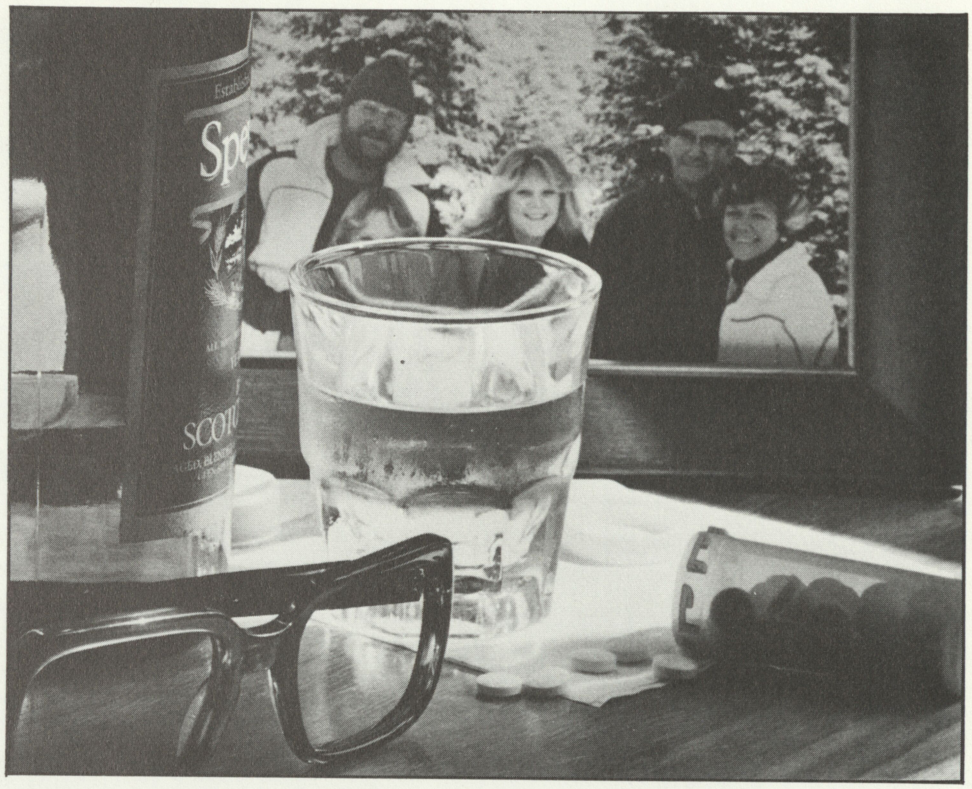
Portland Hosts Impaired Physician Conference



Physician impairment and its effect on patients, families and colleagues is the subject of the American Medical Association's Fifth National Conference on the Impaired Physician, slated for September 22–25 at the Portland Marriott. The conference is co-sponsored by the Oregon Medical Association and the Multnomah County Medical Society, with Dr. Ralph Crawshaw as chairman.

In an effort to foster the recognition and prompt treatment of impaired physicians, experts in the field will share their experiences and discuss individual and collective responsibilities for caring for disabled doctors.

Highlights of the four-day meeting are:

- Wednesday evening, September 22, George D. Lundberg, M.D., editor of the **Journal of the American Medical Association**, will talk about "Physician Health in a Changing Society."
- Thursday morning, Martin R. Lipp, M.D., a San Francisco psychiatrist and author, will present "Evolution of the Physician." S. Spence Meighan, M.D., a Portland internist, will deliver a presentation entitled the "Changing Face of Medicine: New Contexts for Impairment in the Future."

Concurrent discussion groups, revolving around family, legal, educational and treatment issues, are scheduled for the morning and afternoon sessions on Thursday and Friday, and will be led by physicians and other professionals knowledgeable in the fields of chemical and mental impairment.

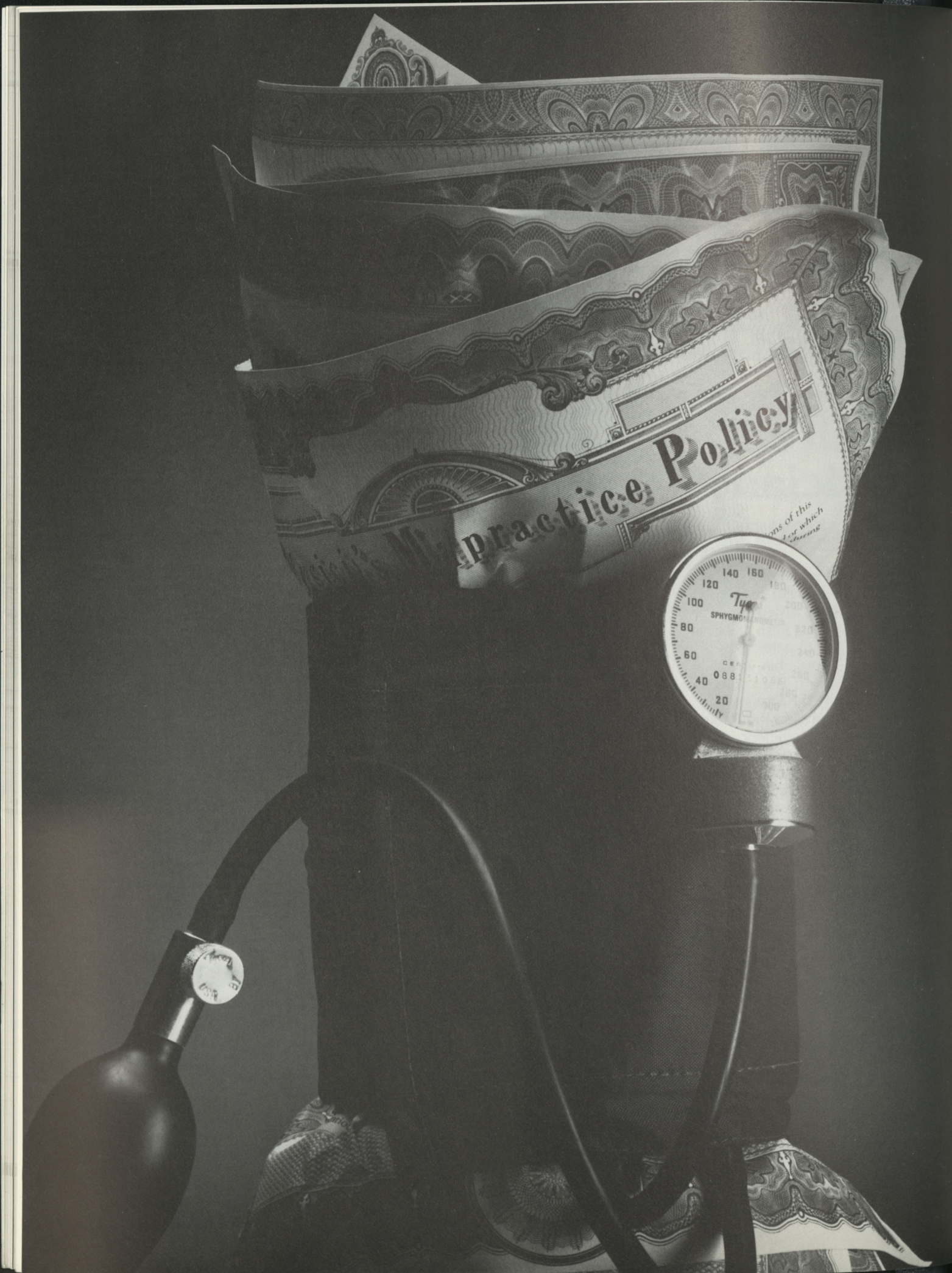
A Media Mart, featuring films on physician impairment, will also take place Thursday and Friday. "Our Brothers' Keeper," an Operation Cork film starring Laurence Luckenbill, is one of the films scheduled.

- Thursday's luncheon speaker is Rogers J. Smith, M.D., a forensic psychiatrist practicing in Portland and a member of the AMA Council on Scientific Affairs.

Focus groups will meet on Thursday and Friday evenings for free-form discussion on: The concerns of state licensing boards; various state and county medical society programs for impaired physicians; International Doctors in Alcoholics Anonymous; families of impaired physicians; and impairment among other professions.

- Friday morning, a panel discussion on "The Physician's Family: Is It Different?" will be moderated by Thomas E. Bittker, M.D., a psychiatrist and chairman of the Arizona Medical Association Physician's Health Committee. A panel on "The Educational System: How Does It Impact on Impairment?" will be moderated by Ralph Crawshaw, M.D. a Portland psychiatrist.
- Saturday morning, Douglas A. Sargent, M.D., J.D., a psychiatrist from Grosse Point Farms, Michigan, will present a progress report on the joint AMA/American Psychiatric Assocation Physician Mortality Project. Dr. Sargent is chairman of the AMA Panel on Physician Mortality.

The conference adjourns at 12:30 p.m. Saturday, September 25. For a program and registration form, call the Multnomah County Medical Society, 222-9977 or the Oregon Medical Association, 226-1555.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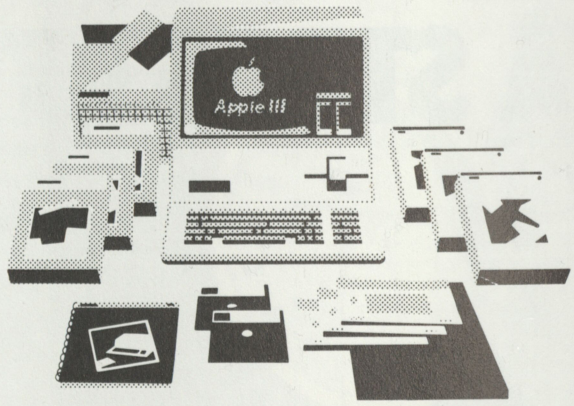

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The OMA Physicians' Committee: Its Evolution and Progress

by Kent E. Neff, M.D.

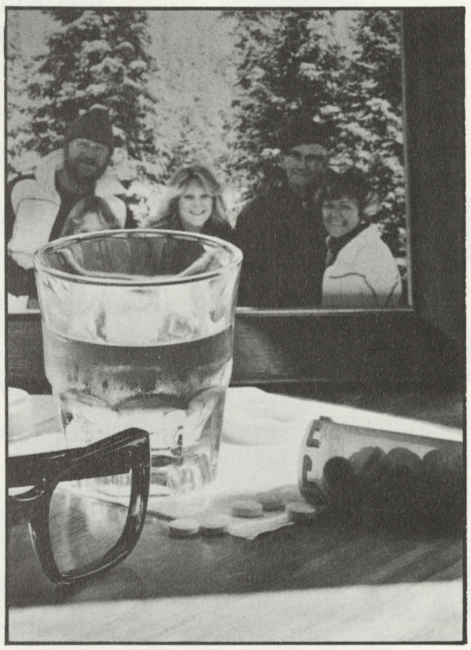
In March 1981, the OMA House of Delegates approved the establishment of a formal committee to deal with physician illness and impairment. In so doing, Oregon became one of the last states to develop a formal medical society program to help these physicians.

Historically, however, Oregon has provided considerable leadership in this area. Almost a decade ago, Dr. Rogers Smith was instrumental in increasing national awareness of the problem through his involvement with the AMA Council on Mental Health. Friends of Medicine, founded in the early 1970s by Drs. Ralph Crawshaw and Harry Sprang, informally offered support and treatment to colleagues in difficulty. It was one of the first organizations in the country specifically concerned with this problem.

The last decade has seen a virtual explosion of medical society programs to help the troubled physician. These programs differ greatly in their modus operandi, but they share a common purpose: To identify the troubled and/or impaired doctor as early as possible and encourage him or her to seek treatment.

The programs have been successful because they provide an alternative to punitive involvement by the Board of Medical Examiners. Most of us are hesitant to report a colleague if we know he will be punished. Medical society committees offer a nonpunitive, voluntary alternative with emphasis on treatment and rehabilitation. Troubled physicians are identifed much earlier through a voluntary, physician-run system.

In the summer of 1980, representatives from the Friends of Medicine, the Board of Medical Examiners and the OMA met under the auspices of the OMA to establish a more comprehensive and formal state mechanism for dealing with the troubled and/or impaired doctor. Over the next ten months, they developed the program's objectives, structure and guidelines, which were formally approved by the House of Delegates.



Program Objectives

The purpose of the OMA Physicians' Program is four-fold:[1]

1. To establish a formal statewide program for identifying, contacting and assisting troubled physicians. This program is noncoercive and rehabilitative in nature. It is open to all Oregon doctors and medical students, regardless of OMA membership, and is designed to address a broad scope of problems, including mental, emotional and/or physical concerns, alcohol or drug dependency and aging.
2. To educate Oregon doctors and other relevant parties about the program and problems of troubled physicians.
3. To establish effective liaison with other state organizations working with these doctors.
4. To make recommendations to the OMA House of Delegates about the management of problems related to distressed or impaired physicians, and to evaluate and make recommendations regarding the effectiveness of state law governing medical licensure and practice as it relates to doctors whose abilities have been compromised.

[1]OMA Joint Committee on the Distressed Physician, 1981.

Program Elements

The first formal committee was established by Dr. Roy Skoglund, then president of the OMA. Like the present committee it consisted of OMA members with skills, experience, and interest in this area. Committee members came from various parts of the state, represented various specialties and included recovering alcoholic physicians. Since the committee was responsible for dealing with troubled as well as impaired colleagues, the word "impaired" was avoided in the committee's title, which officially is the OMA Physicians' Committee.

The essential elements of the program are:

Confidentiality: In order to develop enough trust and confidence for the program to work, full confidentiality must be maintained. The impaired physician is assured anonymity. While some statistical data is collected to evaluate the program's effectiveness, it is recorded in a manner that makes identification, or even conjecture, impossible.

Non coercive, nonpunitive approach: This is not a coercive program. The committee has no connection with the Board of Medical Examiners and does not have the authority or intent to punish any doctor. Troubled physicians meet with intervenors and accept treatment or recommendations on a voluntary basis. However, the caring and concern of colleagues is enormously influential in helping the physician understand his problem. In fact, one of the main reasons for establishing a physician-run program is to capitalize on the effectiveness of peer intervention.

Open to all physicians: The committee is comprised solely of doctors. Its services are available to **all** Oregon physicians, residents and students regardless of membership in organized medicine. The only exceptions are physicians who belong to the Oregon Osteopathic Association, since the OOA prefers to deal with its own members.

continued on page 35

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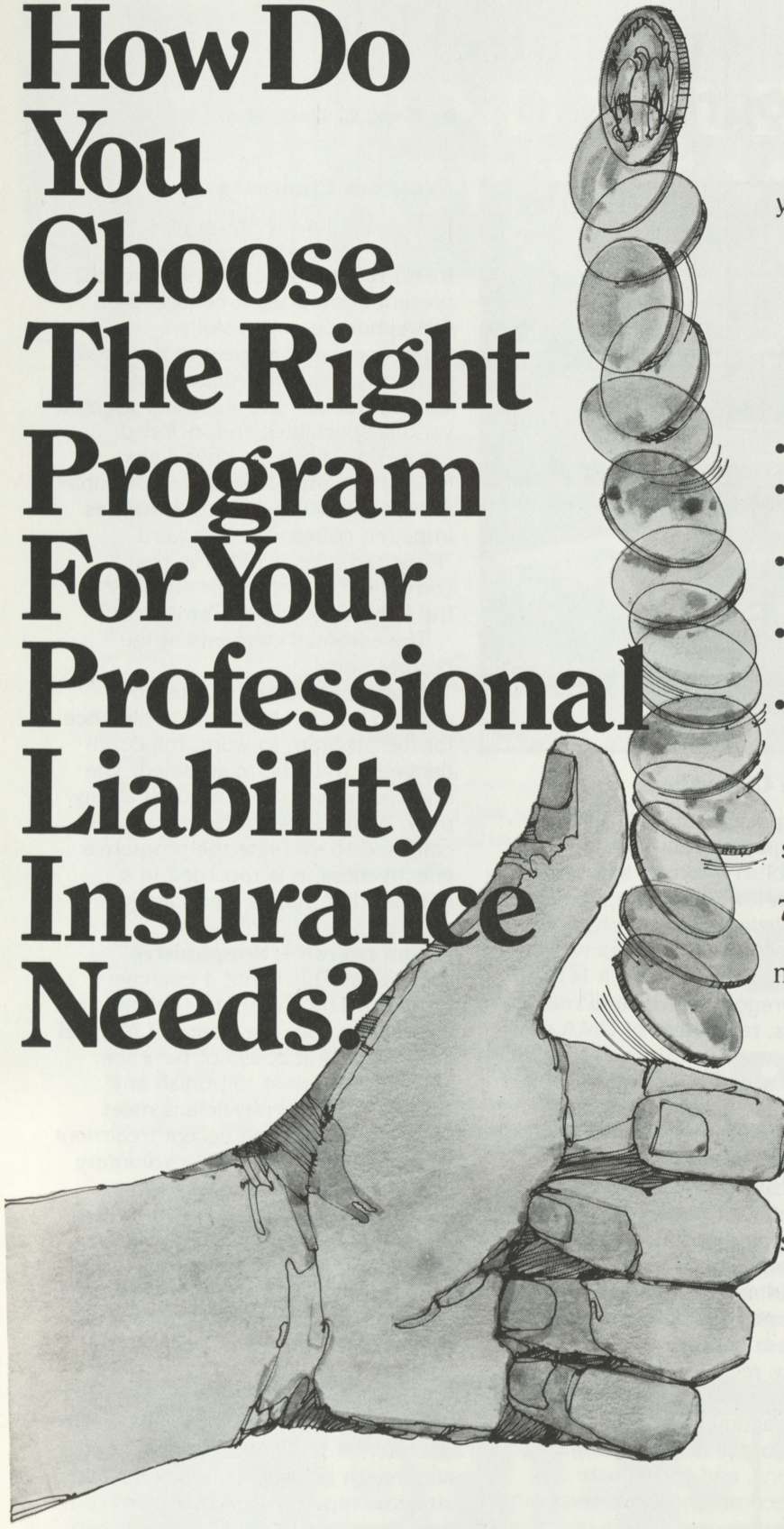

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The OMA Physicians' Committee: Its Evolution and Progress

continued from page 33

Interaction with other organizations: The committee is not intended to supplant local medical society programs or hospital programs organized for the same purpose. If a local program exists, the case is handled by that group. The OMA Physicians' Committee serves as an umbrella organization for the entire state. It deals with troubled physicians in areas where help is not available, lends support to local committees and helps county medical societies and hospitals start new programs. Liaison with these groups is an important function.

Emphasis on rehabilitation: If a single word could describe the program, it would be "rehabilitation." The sick or troubled doctor generally has a good prognosis, even in situations that might seem "advanced" to the outsider. The most common diagnosis is alcoholism and/or chemical dependency. Studies in various parts of the country show that most physicians can successfully return to practice. This has certainly been the case in Oregon.

Improved Medical Care: It is not the committee's function to monitor the quality of medical care rendered by Oregon doctors. However, by identifying impaired and troubled physicians earlier, the program should improve the quality of medical care statewide.

Physician intervenors: In order to be effective, the committe must remain small. But its members cannot do all the work. Help is needed from interested physicians, especially for intervention. Intervention is handled by a group of doctors, including recovering alcoholic physicians, who are trained and supervised by committee members. Physicians interested in helping should contact the OMA.

Hot Line: A 24-hour confidential hot line is maintained at the OMA headquarters. The number is 220-0125. Incoming calls are strictly confidential.

How the System Works:

1. Anyone can refer a doctor to the committee by contacting a committee member or calling the hot line.
2. When a call comes in, the committee chairman is notified. If the referral comes through the hot line, a committee member contacts the caller and gathers as much factual information as possible. If the caller wishes, his or her identity is kept confidential.
3. The case is assigned to a committee member who evaluates the information to verify that a problem exists.
4. If a problem exists, the committee appoints an intervention team, usually comprised of two doctors. If alcoholism or chemical dependency is suspected, at least one of the intervenors is a recovering alcoholic physician.
5. The intervenors meet confidentially with the troubled physician, explain the program and discuss the problem. They offer appropriate help and suggest treatment options. Subsequent meetings or interventions may be arranged as needed. In many cases, the first intervention is only the beginning of an ongoing, supportive relationship between the committee and the troubled doctor.

The Recovering Alcoholic Physician

For all practical purposes, it does not matter whether a doctor is addicted to alcohol, sedatives, or opiates. Multiple addictions are so common among troubled physicians that treatment programs deal with all drugs in much the same manner. Principles for maintaining sobriety are also the same. Because of this, physicians who have had a previous history of alcohol and/or drug abuse are referred to as recovering alcoholic physicians.

The recovering alcoholic physician plays a critical and unique role. This physician has special credibility because he has been there. The troubled doctor gets reassurance from his insight and self-revelation. He also sees a physician who had a similar problem and overcame it. Recovering alcoholic physicians have made enormous personal sacrifices on behalf of troubled colleagues. Fortunately, these interventions also reinforce their own sobriety. Our program could not survive without them and we need more such physicians, particularly in remote areas.

Caduceus Club

The Caduceus Club, the Portland Alcoholics Anonymous for physicians, is largely responsible for the committee's success. This group meets weekly and is a major source of support for addicted physicians before, during and after treatment. It deserves considerable credit.

The Troubled Physician

The experience in Oregon has been consistent with the experience in other states. The major points can be summarized as follows:

1. Alcohol and chemical dependency are by far the most common problems confronted by physicians' rehabilitation programs.
2. Physicians come to our attention late. The average doctor has been abusing alcohol or drugs for many years, at enormous personal cost.
3. Physicians usually do not seek help voluntarily, particularly if the problem involves alcohol or other drugs.
4. Concerned colleagues carry enormous clout in dealing with the troubled doctor. If the problem involves alcohol or other drugs, an alcoholic physician is particularly effective.
5. The troubled physician is frequently concerned about someone finding out he has a problem. Usually the opposite is true: Everybody knows. An enormous collusion of well-meaning friends and associates tries, often for years, to "cover up." Only when someone is concerned enough to identify the doctor can the steps to successful intervention begin.
6. The prognosis for a troubled physician is quite good if he gets appropriate treatment.[2]

[2]Talbott, G. Douglas, M.D., et al, The MAG Disabled Doctors' Program: A Two-Year Review," Jrnl. of the Med. Assn. of Georgia, Oct. 1977, pg. 777–781.

continued on page 37

The OMA Physicians' Committee: Its Evolution and Progress

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How To Help

This is a complicated question that each physician must work out individually. Following are some general guidelines.

1. To do nothing is to do a disservice. Perpetuating the veil of secrecy only delays treatment and potentially worsens the prognosis. The majority of physicians who have been successfully treated say they wish an intervention had come sooner.
2. Evaluate your concerns to see if they are valid and if **you** think there is, indeed, a problem. It is better to settle the issue promptly rather than view a physician as troubled when he is not. Talking confidentially to trusted colleagues gives them an opportunity to express their concerns, which are often the same as yours. This may help you decide what to do.
3. If you feel comfortable doing it, talk with the physician yourself. Consider taking an interested colleague with you. Explain your concern and disclose the nature of the problem as you see it. Avoid being accusative or judgmental. Use **factual** material to illustrate the problem. Concentrate on defining reality as objectively as possible. You may be surprised by the results. Even if the physician disagrees, he should be able to sense your genuine concern. Your talk may smooth the way for further intervention.
4. If you prefer not to intervene or you are uncertain what to do, call a member of the Physicians' Committee or the hot line. It is often better to have an outside physician intervene. Remember, all reports are confidential. The earlier we treat the troubled physician, the better his chance for recovery.

OMA Physicians' Committee
1982 and 83

Kent Neff (chairman)	Portland
Phil Snedecor (vice chairman)	Portland
Daniel Billmeyer	Oregon City
Dick Brust	Independence
David Fredstrom	Bend
Donald McGeary	Medford
David Moore	Portland
George Robins	Portland
Joel Shilling	Portland

Dr. Neff is in private practice and health care consulting in Portland and was formerly director of psychiatry at St. Vincent Hospital and Medical Center.

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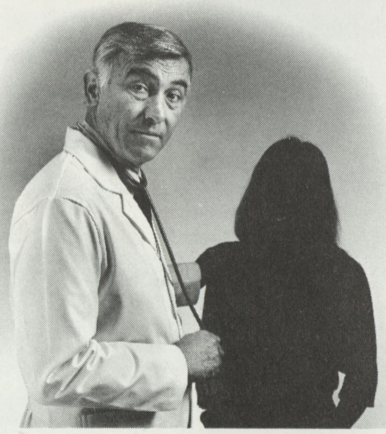

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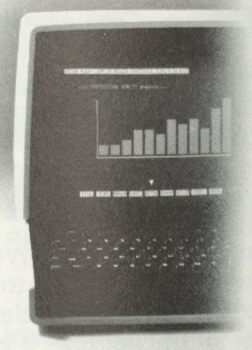

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Why I Support the New VA Hospital, Where it is

guest editorial

by **Joseph B. Vander Veer, Jr., M.D.**

I had just returned from visiting an 84-year-old veteran with advanced vascular disease who has a below-the-knee amputation with a prosthesis on one side. He is now having gangrene of his toes and we are trying to save his other foot. After talking with the resident and reviewing the films, I discussed the case with him, gave him my recommendations and prepared to leave the campus.

Outside, men and women from a local veterans group were busy festooning a booth and wheelchairs so some of the veterans might participate in the Rose Parade later that week. I reflected on the whole issue of the Veterans Hospital which has undergone heated discussion over the past several years and tried to formulate **my** reasons for favoring the new VA Hospital in its present location.

I have been active at Portland's VA Hospital since my residency, and usually staff there about three months out of the year. Hence, I have a great opportunity to see the place in action, although I do have a full-time private practice. I will not deny the inefficiencies of the VA system and I believe the private hospital sector has a more efficient opperation in terms of pure dollars. But there are two factors that counterbalance a purely efficient approach.

Educational Facility

The first is the teaching function of the VA Hospital system. In my own field of surgery, the need for individual patient responsibility is especially apparent. To gain sufficient experience and maturity, the resident surgeon needs to have patients that he or she personally manages, albeit with close staff supervision. One simply does not get the same quality of training experience in a private hospital, acting as assistant to the primary surgeon. This problem has become more acute in the past few years as medical reimbursement providers have looked closely at who actually is doing surgery.

With University Hospital limiting its number of indigent patients, there are fewer and fewer patients for whom residents can take primary responsibility under supervision. The VA system is perhaps the last great source of these patients, and if adequate staffing and supervision exists, I believe such patients can receive good care while resident surgeons receive good training.

I recall being struck by the difference between cardiac surgical programs when I visited John Kirklin's program in Birmingham, Alabama. At the time, I was contemplating pursuing cardiac surgery with Albert Starr here in Portland. I went to the operating room with Kirklin's resident and was surprised to see the first-year general surgery resident across the table from Kirklin assisting him, while his own chief resident stood to his left, "so he can see the operation from my perspective," Kirklin explained.

When I later spoke with Kirklin, I asked him whether a resident had ever performed a triple valve replacement. His reply, "I believe a resident has no business performing a triple valve replacement," told me much about the program. I knew of Kirklin's fine reputation, and that the results of his program were no different than our own, but I also knew that the maturity and experience of the residents who emerged from each program was different. So the type of program and the type of patient makes a difference in residency training.

Camaraderie

The second reason I favor the new VA Hospital where it is relates to an argument against the VA Hospital itself, namely that veterans should be mainstreamed into Portland's private hospitals. This, too, would be a measure for fiscal efficiency, but would seriously curtail the care of these men. Over the years I have been profoundly impressed by the care given in the Veterans Hospital—not only the care rendered by the staff but by veterans to one another. Watching a neck cancer patient or an amputee interact with other men in the social milieu of the VA makes me realize that there is a camaraderie and spirit at the hospital that provides a family for these men.

It is hard to put a dollar sign on that sort of support, but it is very real. Particularly in surgery, where we see patients subjected to severe stresses, and where we perform deforming operations to save life or limb, one becomes aware of the crucial importance of the caring environment.

I think of that great story by Franz Kafka, "The Metamorphosis" which speaks so truly to the issue. He describes the grotesque tale of traveling salesman Gregor Samsa who one morning was transformed into a gigantic beetle. Gregor lived at home with his mother, father and sister, and although his outward appearance had changed dramatically, he had all his same feelings and reactions. The story is a chronicle of the withdrawal of love from him because he had become unattractive. Eventually, he gets put away by his family. How often we see the same phenomenon in medicine, particularly when people get very old, have cancer or require mutilating surgery.

So to me, the inefficiencies of the VA system are outweighed considerably by the benefits derived in resident training and in the camaraderie and caring it offers. That is enough to stay with the system, and I favor putting it in a location next to the Medical School because of the ease with which faculty, students and residents can commute. The primary faculty for the VA is the faculty for the school, and the staffing would suffer if the hospital were built elsewhere, even at the Emanuel site. My only concern is parking, since this is already a real problem on the hill. When they've got **that** licked, they'll have really done something!

Dr. Vander Veer is a surgeon in private practice and a member of the Portland Physician advisory committee.

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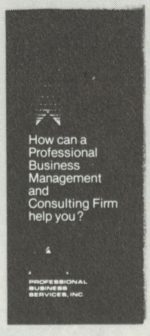

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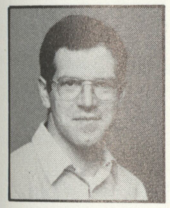

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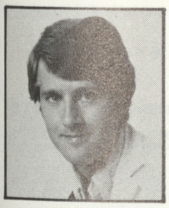

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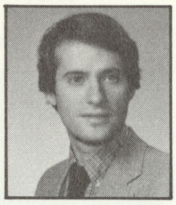

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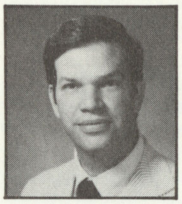

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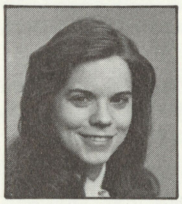

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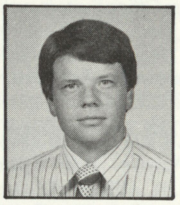

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NAMES IN THE NEWS

Dr. Alexander Schleuning II has been elected a director of the American Board of Otolaryngology. Dr. Schleuning is chairman of the otolaryngology department at the OHSU School of Medicine and is on the board of directors of the Portland Center for Hearing and Speech.

Dr. Frederick Kingery, clinical professor of dermatology at the OHSU School of Medicine, has been elected president of the American Board of Dermatology.

Dr. Gary Rothenberger has been elected president of the Providence Medical Foundation. Dr. Rothenberger is the first president of the philanthropic corporation, which was established last year to provide an organized method for giving to the charitable, educational and scientific activities of Providence Medical Center.

Dr. Lester L. Bergeron has been elected president of the Tuality Community Hospital medical staff. Other officers are: **Dr. Russell E. Hutchinson**, vice president-president elect and **Dr. Laurence M. Hornick**, secretary-treasurer.

Dr. William Brady, head of the Oregon Board of Medical Examiners, and **Dr. Christina West**, a Portland ophthalmologist, have been elected to the Oregon Lions Eye Bank board of directors.

Peter Van Deusen has been named administrator of Holladay Park Hospital. Van Deusen was previously administrator of Rolling Plains Memorial Hospital in Sweetwater, Texas.

Gary McCormack has been appointed administrator of Willamette Falls Community Hospital. McCormack was previously associate administrator at Good Samaritan Hospital in Corvallis.

John Anderson has been elected to his seventh year as chairman of the Oregon Lions Eye Bank board of directors. Anderson has also served as chairman of the Oregon Lions Sight and Hearing Foundation, which funds the eye bank at Good Samaritan Hospital.

CALENDAR

September 15 Acute Coronary Update I; St. Vincent Hospital; 297-4411.

September 16 Ts, Bs and IGEs; Raymond Brady, MD; 8:00 am; University Hospital South; Dr. Emily Tufts, 225-8500.

September 17-18 Medical Doctors as Expert Witnesses in the Legal System; Willamette University College of Law; Salem; co-sponsored by the Medical/Legal Committee of Marion-Polk County Medical Society; (503) 370-6162.

September 21 Credit & Collections Workshop for Physicians; 7:30 pm; MCMS; 222-9977.

September 22 Management of the Menopause; Robert Dyson, MD; 8:00 am; Amphitheater, Providence Hall; 234-8211.

September 22 Board of Trustees; 6:00 pm; MCMS; 222-9977.

September 22-23 Third Annual Conference on Refugee Health Care; Cosmopolitan Hotel; Portland; sponsored by the Oregon State Health Division; contact Roberta Harrison, 229-6392.

September 22-23 Fifth National Conference on the Impaired Physician; Marriott Hotel; sponsored by the AMA, OMA and MCMS: 226-1555, 222-9977.

September 23 Brain Tumors in Children; Edward Neuwelt, MD; 8:00 am; University Hospital South; Dr. Emily Tufts, 225-8500.

September 23-25 American Heart Association Annual Session; 8:30 am; Carol Mack, 226-2575.

September 24 Koch Centennial Tuberculosis Conference; Cosmopolitan Hotel, Portland; sponsored by the Oregon Lung Assoc.; pre-registration; Joe Weller, 224-5145.

September 24 The Pathophysiology & Treatment of CHF; Vincent DeQuattro, MD, Professor of Medicine, USC; Education Center, Portland Adventist; 12:30 pm; Melanie Graham, 239-6166.

in summary

September 25 Multiple Sclerosis Workshop; Child Development Rehabilitation Center, OHSU; pre-registration; Roy L. Swank, MD, 225-8370.

September 29 M & M Conference; St. Vincent; 297-4411.

September 29 Bills to Make You Ill—The Use of & Abuse of Lab Testing; Richard Belsey, MD; 8:00 am; Amphitheater, Providence Hall; 234-8211.

September 30 Iron Deficiency: New Thoughts on an Old Problem; Robert Neerhout, MD; 8:00 am; University Hospital South; Dr. Emily Tufts, 225-8500.

October 1 Lung Symposium; 8:00 am; Auditorium, Providence Hall; 234-8211.

October 2 Scientific Session; Caduceus; Town Hall, 3425 North Montana Avenue, Portland; papers by Northwest Permanente, P.C. physicians; 249-8371.

October 2 Tax Planning & Sheltering Seminar; 9:00 am; Holiday Inn, Wilsonville; sponsored by Clackamas Community College; 657-8400 ext. 233.

October 6 Treatment of Metabolic Bone Disease; Eric Orwoll, MD; 8:00 am; Amphitheater, Providence Hall; 234-8211.

October 6 Scleroderma & Eosinophilic Fascilitis; Gary Sultany, MD; St. Vincent; 297-4411.

October 7 DNA Methods for Diagnosing Thalassemia; Robert Koler, MD; 8:00 am; University Hospital South; Dr. Emily Tufts, 225-8500.

October 13 Cardiac Cath Conference; St. Vincent; 297-4411.

October 14 Women Aware, 9:00 am; OMA building; sponsored by the MCMS Auxiliary and Care; Ellen Caps, 232-4294 or Jeanne Vore, 223-4620.

October 15 New Concepts in Diagnostic Radiology for the Non-Radiologist; OMA Building, Portland; sponsored by the Division of Continuing Medical Education, OHSU; Pat Iverson 225-8700.

October 15-16 Evoked Response Workshop; Good Samaritan Hospital, Nursing Education Building; pre-registration; 229-7265.

October 20 The Low Back From an Orthopedist's Point of View; Freeman Fitch, MD; 8:00 am; Amphitheater, Providence Hall; 234-8211.

October 20 M & M Conference; St. Vincent; 297-4411.

October 21 Recent Advances in the Treatment of Congestive Heart Failure; Gerald Marks, MD; 8:00 am; University Hospital South; Dr. Emily Tufts, 225-8500.

October 21-23 Sixth Annual Pacific Northwest Review of Obstetrics & Gynecology; Red Lion Motor Inn at Jantzen Beach, Portland; sponsored by the Division of Continuing Medical Education, OHSU; Pat Iverson 225-8700.

October 22 Assault of a Child: A Question of Justice; 2:30 pm; Willamette Center Auditorium; sponsored by the Multnomah County Child Abuse Coalition; Carolyn Piper, 248-4005 or 232-1781.

October 27 Update on Inflammatory Bowel Disease; Keith Wrigley, MD; St. Vincent; 297-4411.

October 28 An Inquiry into the Nature of Nausea and Vomiting; Robert Campbell, MD; 8:00 am; University Hospital South; Dr. Emily Tufts, 225-8500.

October 29-31 The Salishan Conference: Recent Advances in Cardiology; Salishan Lodge; sponsored by the Division of Continuing Medical Education; Pat Iverson 225-8700.

November 3 Septic Shock; Curtis R. Holzgang, MD; St. Vincent; 297-4411.

November 3 Post-Operative Jaundice; Gilbert Lipshutz, MD; 8:00 am; Amphitheater, Providence Hall; 234-8211.

November 3 11th Annual Seminar: Update for the Clinician; Portland Adventist Hospital; pre-registration; 257-2500.

November 4 Peripheral and Central Neurologic Problems Associated with Apnea; John Yount, MD; 8:00 am; University Hospital South; Dr. Emily Tufts, 225-8500.

November 5-6 Disorders of Sleep; Good Samaritan; pre-registration; Susan Nanson, 229-7348.

November 5-7 OMA House of Delegates; OMA; 226-1555.

November 6-7 MCMS Auxiliary Book Fairs; B. Dalton Booksellers, Portland; Jeanne Vore, 223-4620.

November 10 Stump the Staff; 8:00 am; Amphitheater, Providence Hall; 234-8211.

November 10 Current Approach to Treatment of Hyperlipidemia; Scott M. Grundy, MD; St. Vincent; 297-4411.

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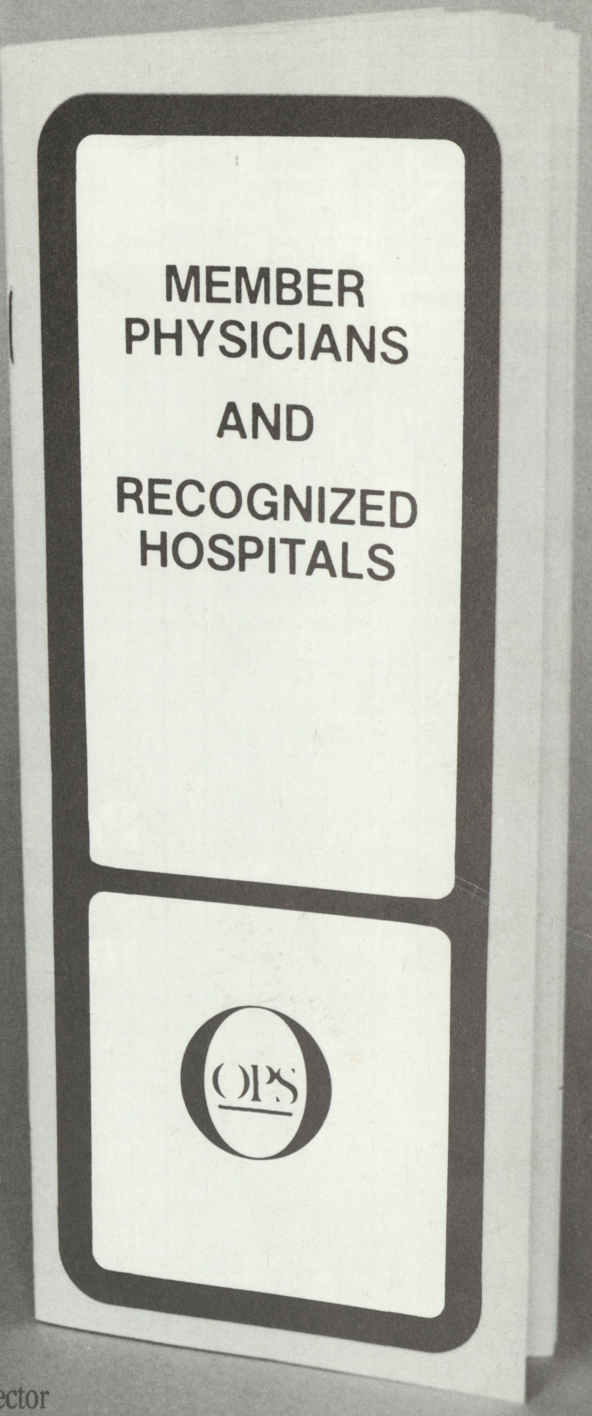
THE BOOK



2,726* Oregon physicians consider it to be a best seller!

The book lists 2,726 OPS member physicians.

Being an OPS member physician means more than having your name in a book though. It means you have a say in what we do.

You have a say through our board of trustees—half of them are fellow physicians.

You have a say through the Physician Medical Advisory Committee who sets medical policy.

You have a say through the OPS Review Committees established throughout the state and meeting on a regular basis. These committees provide input to the Medical Advisory Committee as well as dealing with individual situations among local physicians.

You have a say in what we do through our medical director with whom you can communicate *directly*.

You have a say in what we do. Because we do provide you with the means to express your views, concerns and complaints, the result is fair and equitable treatment for all member physicians.

92% of the eligible physicians in Oregon are OPS member physicians; 100% of our member physicians are in the book.

*OPS member physicians as of 5/31/81

OPS INSURANCE
HEALTH · DENTAL · VISION

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