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January/February '83

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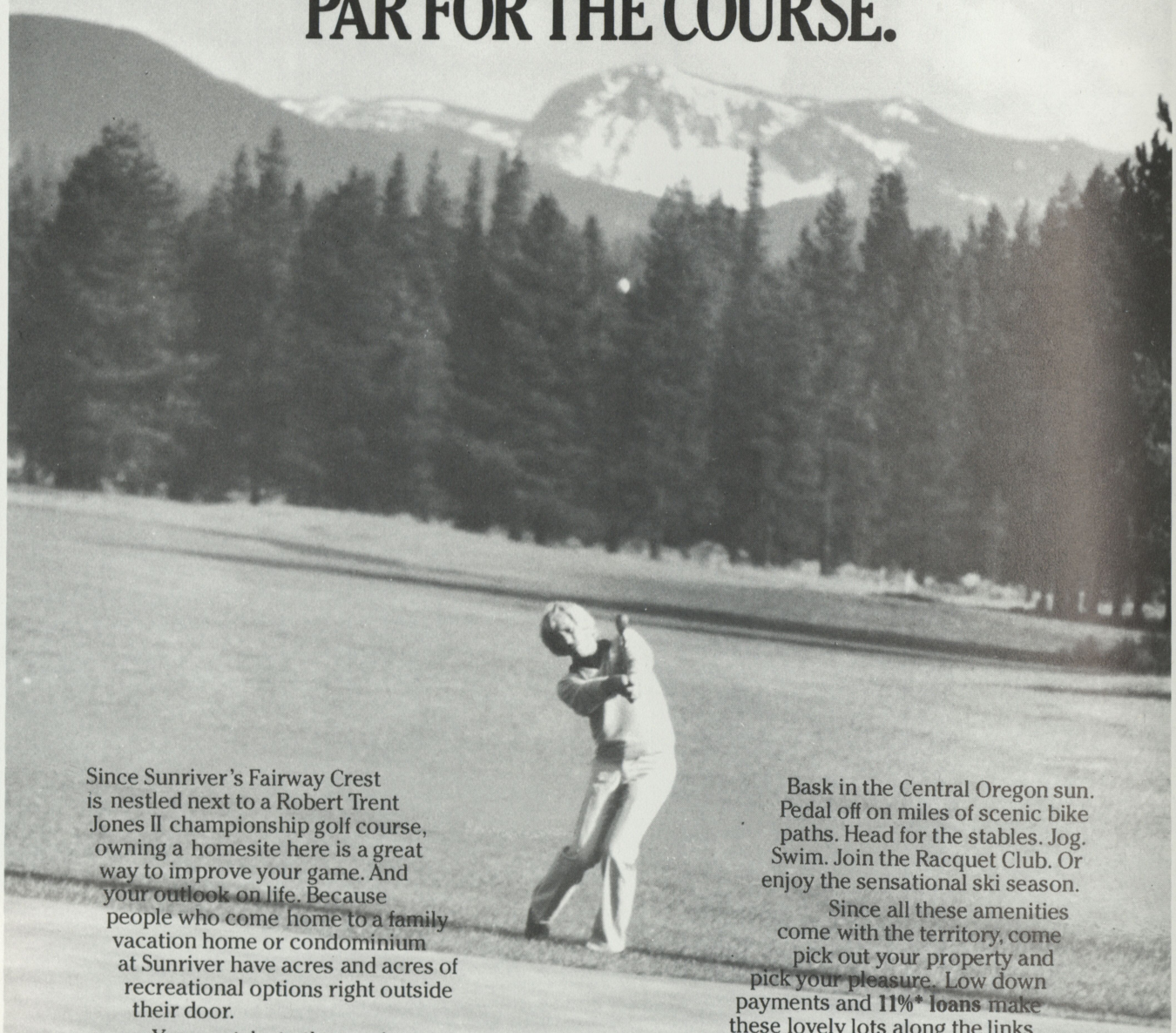

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On the cover: Dr. Barsotti, one of the 600 Project Medi-share physicians, treats Jessica Nicholson for an ear infection.

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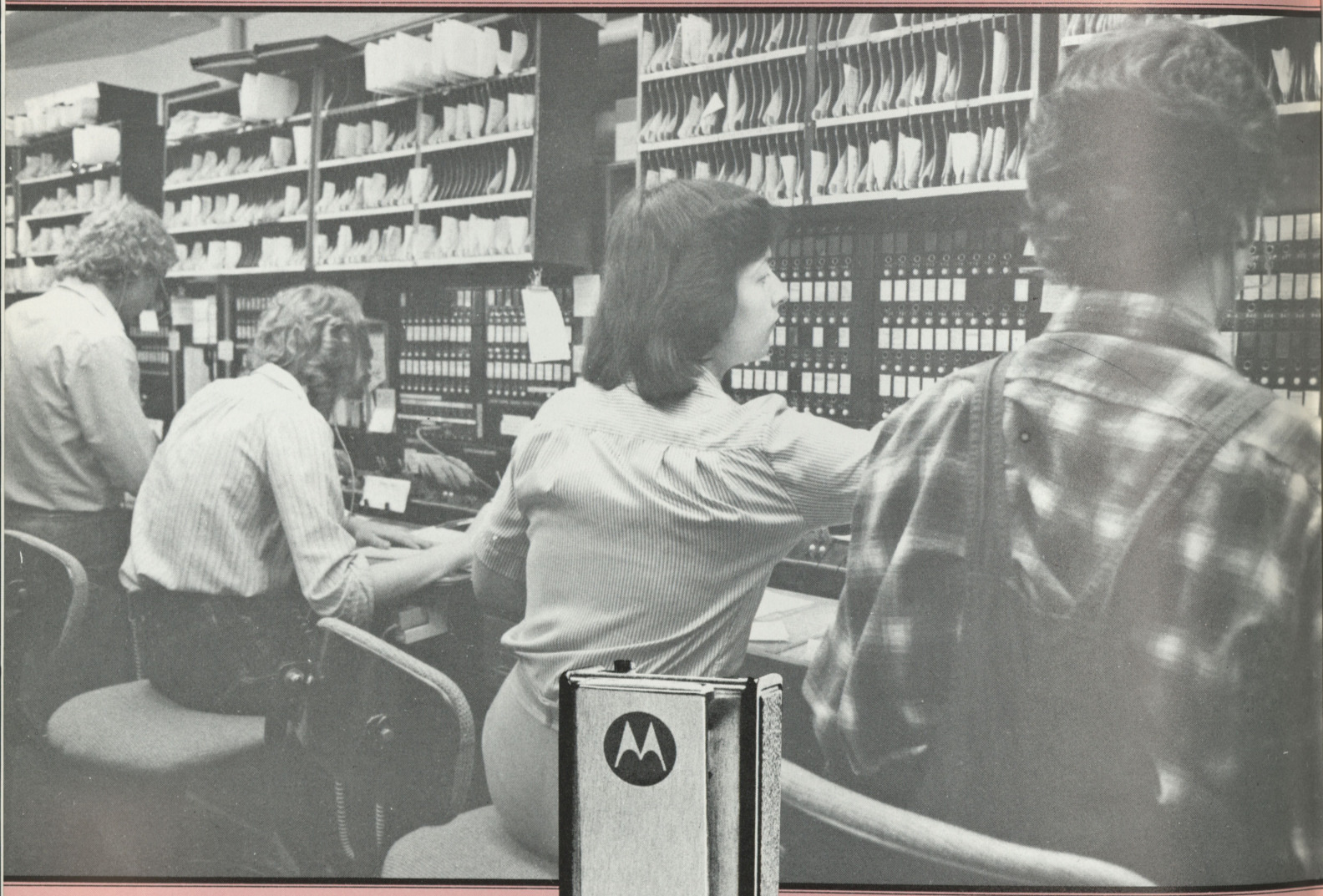

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AMA delegates debate House representation

president's page

BY John W. Tarnasky, M.D.

The AMA House of Delegates meeting, a four-day excursion into the highest order of medicine's political, economic and social intrigue, is an incredible democratic experience that works with surprising effectiveness.

To appreciate the House's effectiveness is not necessarily to agree with all it does, nor the priorities of some of its discussions and actions. Case in point: I was delighted when OMA President Genevieve Burk assigned me to reference committee "G," which dealt with reports and resolutions on: preferred provider organizations, health maintenance organizations, medical societies' involvement with peer review, block grants, AMA's marketing plan, competition among providers and protocol for emergency medical services.

These topics are important, and I was ready to hear a raging debate on each subject. Instead, the conference finished in two hours with no more than three speakers on any issue.

A bit shaken, I moved to another reference committee, where the discussion centered on how many representative groups would be allowed seats in the House of Delegates. Thirty people waited to address the issue.

The perception of what was important to the majority of members was vastly different from mine. I may not be correct, but I believe the powerful economic forces that are alive today would drive this profession to seek new answers to both old and new problems. The issue of whether ambidextrous gray-eyed doctors should be seated in the House is less important than how we address the crucial economic challenges that confront us. (The outcome was that ambidextrous gray-eyed doctors will be seated in the House—another minority gets a voice—**AND** the AMA will forge ahead with a better understanding of PPOs, marketing, etc.)

Several hundred of us were captivated by the thought-provoking comments of author and health care professional Harry Schwartz, who told a sea of nodding heads what he sees as medicine's major problems and how these problems might be addressed.

First, he noted that the incredible pressures on practicing physicians will change them from independent business people to hired hands.

"As the British Medical Association is a physicians' union, so, too, will the AMA eventually become a union," said Schwartz. Like it or not, (and I don't), I find it difficult to argue with his views.

He also said that in less than 20 years the number of doctors has doubled; there is a doctor glut. He feels medical school enrollment should be cut in half, and believes some medical schools should close. He recommended tightening medical school accreditation and the licensing of students.

The following quotes drove home the importance of his ideas:

"The more doctors, the more medical services will be delivered."

"The more doctors, the more unnecessary medical services will be delivered."

"The more doctors, the more infrequent will be the procedures performed by each."

"The more infrequent the procedures performed by doctors, the less skilled the doctors will be."

"The less skilled the doctor becomes, the more dangerous becomes the practice to the patient."

In conclusion, Schwartz said that doctors should have complete physical and mental examinations yearly to weed out the few incompetent and impaired physicians in practice. He believes that unless the profession imposes this on its members, they will face re-certification and re-licensure by others.

"We must make certain every M.D. is first class in terms of knowledge, skills and personal psyche," said Schwartz.

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230-6184

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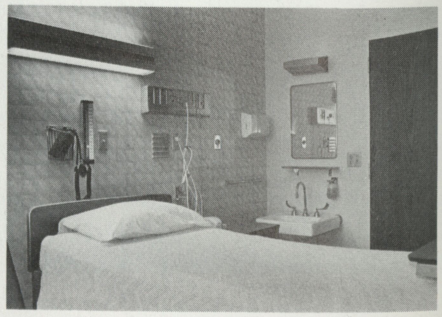

If you would like to know more about the services and facilities available at Providence Medical Center, please call Steve Fellows at 230-6280.

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in summary

Adult and Family Services has announced a five percent increase in professional fees for services provided on or after January 1, 1983. This implements the increase originally scheduled for October 1, 1982. Anesthesia services are excluded as the current rate is equal to the UCR paid by AFS.

OMA is challenging the board of naturopathic examiners proposed rules to allow naturopaths to prescribe a number of "non-poisonous" plant substances and a chiropractic effort to attain reimbursement from Adult and Family Services for procedures that may exceed their scope of practice. Among the "non-poisonous" plant substances naturopaths hope to prescribe are cocaine, belladonna extracts, digitalis, penicillin, tetracycline and vaginal diaphragms. Chiropractors seek AFS reimbursement for vasectomies, therapeutic abortions, ophthalmoscopy and several other procedures.

"Futurism—Looking into the 80s," a continuing medical education program, is scheduled for Sunday, February 6 from 8:00 am to 5:00 pm at Portland Adventist Medical Center. Registration is $55. Call 257-2500 ext. 7715.

Tuality Community Hospital is adding two floors to its nursing tower, providing room for 44 new beds, shelled space for an additional 44 beds, and a new operating room, radiology department and emergency room and laboratory. Completion is scheduled for November, 1984.

Option, an outpatient program for treating alcohol dependency, has opened adjacent to Dwyer Community Hospital. The program is sponsored by the Clackamas Health care consortium, composed of Dwyer and Willamette Falls hospitals and the Physicians Association of Clackamas County. Patterned after the St. Joseph's outpatient program in Vancouver, Option provides five weeks of individual and group counseling, conferences with family members and employers, and structured follow-up programs. Call 653-6668.

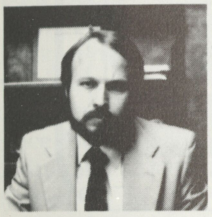
Medical Research Foundation of Oregon has established the John Raaf Institute with a $400,000 initial endowment to promote neurological research. The first grant was awarded to Dr. Edward A. Neuwelt, a neuro-surgeon at OHSU, who reportedly has succeeded in breaking the blood-brain barrier.

A free public lecture about rheumatism and arthritis is scheduled at OHSU on Thursday, January 27. Dr. Robert Bennett, chief of rheumatology at OHSU School of Medicine, will describe the two diseases and problems they pose, especially for the elderly. Sponsored by the Marquam Hill Society. Call 225-8231.

Few Portland-area CHAMPUS beneficiaries will be affected by the new National Hospital Assn. plan requiring the use of urgency care centers for primary care/triage. Contrary to initial reports, only about five percent of CHAMPUS patients are enrolled in the NHA program, an experimental prepayment option that a minority of families has chosen. NHA participants are currently being offered an open enrollment period, during which they may elect to revert to conventional CHAMPUS coverage or choose Kaiser or the Physicians Assn. of Clackamas County.

Raleigh Hills Hospitals, a chain of 26 alcohol-treatment facilities founded in Portland, has been sold to American Medical International of Beverly Hills for $87 million. The chain was sold by Advanced Health Systems of Irvine, Calif. AMI operates hospitals and health care facilities in over 500 cities worldwide. Raleigh Hills Hospitals was founded 40 years ago by Dr. John R. Montague.

"My biggest worry about in-house data processing? Computer breakdowns. But CyCare 100 arrested that fear."



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

"I knew I'd like the cost advantage and efficiency of an in-house system. But I didn't want the responsibility of taking care of hardware and the need to hire a programmer.

"CyCare 100 proved to me that an in-house system can be effortless to operate and virtually flawless as far as breakdowns are concerned," says Roger Jorgensen.

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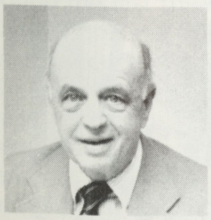

Salvatore J. Moreno, Business Manager
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Saving America's Social Security system

executive director's notebook

by Brad Davis

During an all day flight from Portland to Miami to attend the AMA Annual Meeting, I read a startling 41-page booklet, "Social Security. . .the Need for Action," by Robert A. Beck, a member of President Reagan's National Commission on Social Security Reform.

Since Medicare is a part of Social Security, and since the plan serves a vital need for so many Americans, the system should be continued.

The Problem

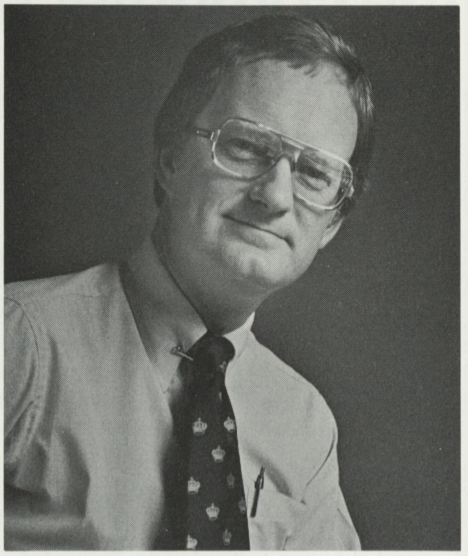
- A person retiring at age 65 who has no spouse, and who paid the maximum Social Security taxes, will receive all he paid in 2¼ years. That is the longest repayment period.
- The average wage earner, whose spouse does not work outside the home, gets back all his contributions within 17 months after retirement.
- In 1950, 16.5 workers supported each Social Security beneficiary; today, 3.2 workers support each beneficiary.
- During the last three years, average wages increased 30 percent, while Social Security benefits increased 40 percent. If benefits had held to wage increase levels, the program would have cost $11 billion less last year.
- In 1940, the life expectancy of a 65-year-old was 12.8 more years; today it is 16 years. The increased longevity added $30 billion to Social Security costs last year.
- In 1950, Social Security constituted 1 percent of all federal spending, in 1981 over 25 percent.
- Without significant changes, the Social Security fund will go bankrupt next year. This, despite the 3,700 percent increase in Social Security taxes since 1949 for the average wage earner and an increase of 6,500 percent for those paying the maximum. Income has increased only 470 percent.

Solutions

Beck offered short- and long-term solutions he believes can save an otherwise doomed program. He rejects the notion to increase taxes which, at their present rate, will average $9,000 by 1990.

He proposes:

- Limit future Social Security increases to the average wage increase for working people, rather than the inflationary consumer price index.
- Eliminate public employee "double dipping."
- Continue the retirement earnings test and not pay people who have a substantial income.
- Disallow disability benefits so high they are an incentive not to work.
- Defer cost-of-living increases for three months.
- Increase retirement age to 68 by 1990. By 2000, the average 74-year-old will have the same life expectancy a 62-year-old had in 1940.
- Mandate federal, state, municipal and non-profit employee participation, while protecting their accrued benefits.
- Expand individual savings and pension plans by increasing IRA limits, permitting tax deferral on mandatory contributions and provide favorable pension legislation and regulations.



Beck urges each of us to write our congressmen expressing our desire to restore Social Security to a solid financial base.

Reprints of this booklet can be obtained by writing:

Public Affairs Department
Prudential Insurance Co. of America
Prudential Plaza
Newark, New Jersey 07101

Speaking the computer's language

by Mark Leavitt, M.D., Ph.D.

In the past 5 years, a revolution in electronics technology has transformed the computer from a roomful of cabinets into a box the size and cost of a typewriter. Computers are being thrust into our everyday lives in countless ways. Recently, an entire issue of Medical Economics was devoted to the "budding love affair" between doctors and computers, though I suspect many physicians remain more intimidated than enamored.

For physicians who are interested in learning what the personal computing revolution is all about, this article will provide a quick guided tour. The emphasis throughout is on **personal computing**—buying a computer in a store, putting it on your desk, inserting a program (or writing one yourself) and using it immediately. Personal computers are ideally suited for many applications in physicians' offices. For applications requiring larger computers, initial experience with a personal computer can provide the right training to make the physician comfortable in selecting and using the larger machines. I believe an understanding of modern information-processing technology will soon become an essential part of medical education.

Computer Fundamentals

A computer is simply a machine which processes electronically-represented data according to a prearranged set of instructions. The machine itself is called the **hardware.** The prearranged instructions that it carries out represent **software.** This word was coined to emphasize the fact that computer software can be easily changed, in contrast to computer hardware which can only be changed with a soldering iron.

COMPUTER HARDWARE

Today's low-cost personal computers were made possible when engineers learned how to place thousands of electronic parts on tiny chips of silicon, producing the integrated circuit. The circuitry from the huge computer cabinets of the 1960s has been placed on a handful of these integrated circuits. Because integrated circuits can be mass produced without hand labor, their cost has fallen precipitously. The main processing circuit of a computer now costs about $10.

The major parts of a personal computer are shown in Figure 1. The components include a **central processing unit (CPU),** a **random access memory (RAM),** a **keyboard** and **video display.** The central processing unit fetches data from the memory, processes it, and stores it back in memory according to a prearranged set of instructions called a **program.** Data can also be entered from the keyboard or displayed on the video display by special instructions in the program.

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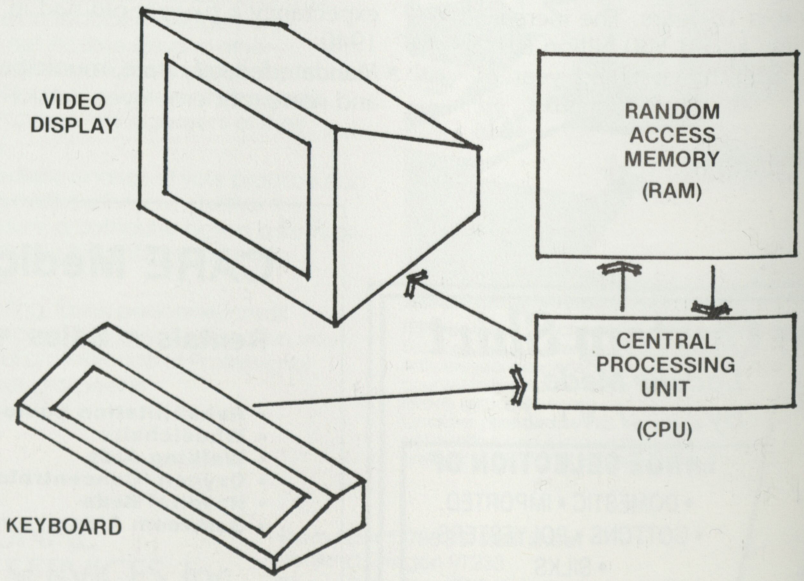

MAJOR COMPONENTS OF A PERSONAL COMPUTER
FIGURE 1

Speaking the computer's language

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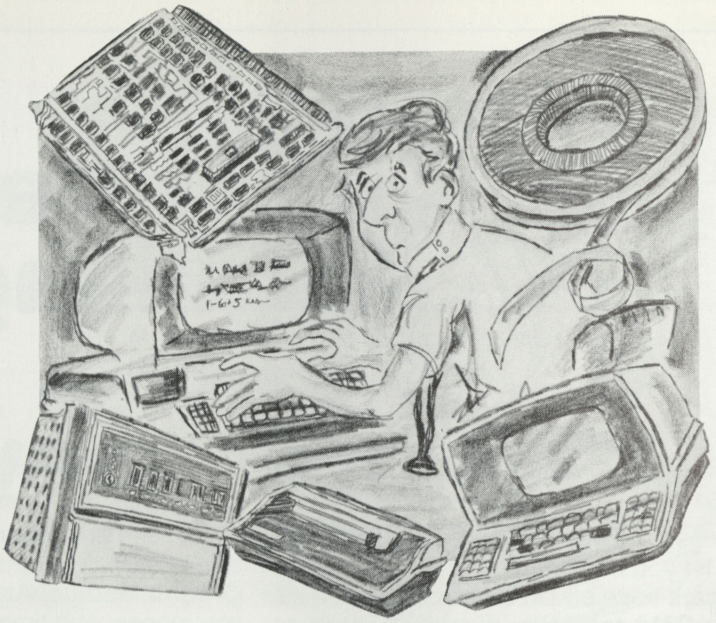

Peripherals are external devices attached to the computer to boost its memory capacity or to provide other means of getting data into and out of the machine. The most common peripherals are the **disc drive**, which supplements the computer's internal memory, and the **printer.**

The disc drive is a device that spins a thin plastic disc coated with magnetic material under a recording head. The simplest ones, about 5 inches in diameter, are called **floppy disc** drives and can store the equivalent of 25 typewritten pages of information. More expensive and precisely constructed **hard disc** drives can store over a thousand pages and access any piece of data in a fraction of a second.

Computer printers are familiar pieces of hardware to most of us. The dot-matrix variety can print very rapidly, pounding out a full page in under a minute. The result is very readable but looks obviously like computer printing. To write business letters, where a typewritten appearance is necessary, slower daisy-wheel printers are used. They produce a page in about 3 minutes.

COMPUTER SOFTWARE

Let's spend a few minutes learning software fundamentals, because software is essential to make computer hardware do useful work. The central processing unit only understands instructions in a very primitive **machine language** which is literally a string of ones and zeroes. It takes hours of tedious work by a human to write programs in this primitive language.

```
1   PRINT "ENTER PATIENT AGE, WEIGHT IN KG,
    AND SERUM CREATININE"
2   INPUT AGE,WEIGHT,CR
3   CRCL = (140 - AGE) * (WEIGHT / 72) / CR
4   PRINT "THE ESTIMATED CREATININE CLEARANCE IS:"
5   PRINT CRCL
6   GOTO 1
```

A SAMPLE PROGRAM IN BASIC
FIGURE 2

To alleviate the problem, computer scientists designed more understandable English-like programming languages, then wrote special programs called **interpreters** to translate the English-like language into machine language.

The most popular of these languages is BASIC. It is simple enough that you can probably understand the program in Figure 2 with no prior instruction in programming. It is also powerful enough to do any task in the physician's office from accounting to hemodynamic data analysis. Most personal computers come with an interpreter for the BASIC language already built in, so the machine is ready to accept a program in BASIC as soon as it is turned on.

If you have a specific and unusual task for your computer, you may want to write your own program. Most tasks, however, can be handled by standard software which is available and ready to use in your computer. This software is purchased in recorded form on a floppy disc which you insert in your disk drive. When you turn on the computer with the special disc in place, the program starts automatically. Thus it is not necessary to have any programming skills to use purchased software, and in fact the best-written software provides enough guidance right on the video display that an instruction manual is not needed.

A little patience and practice will be required, however, to become accustomed to the maddeningly literal behavior of computer programs. Every press of the keyboard is examined and interpreted, and no inferences are made. While your human secretary would have no trouble understanding your scribbled note saying "send letter to pt," most computer programs obstinately insist on correct spelling and punctuation in your commands. As computers become more powerful, inductive reasoning will be programmed in, but for now you must meet the computer halfway to enjoy its benefits.

Capabilities

To determine if personal computers can do your particular job, you must have a grasp of their data processing capacity and speed. Let's discuss capacity first.

continued on page 14

Speaking the computer's language

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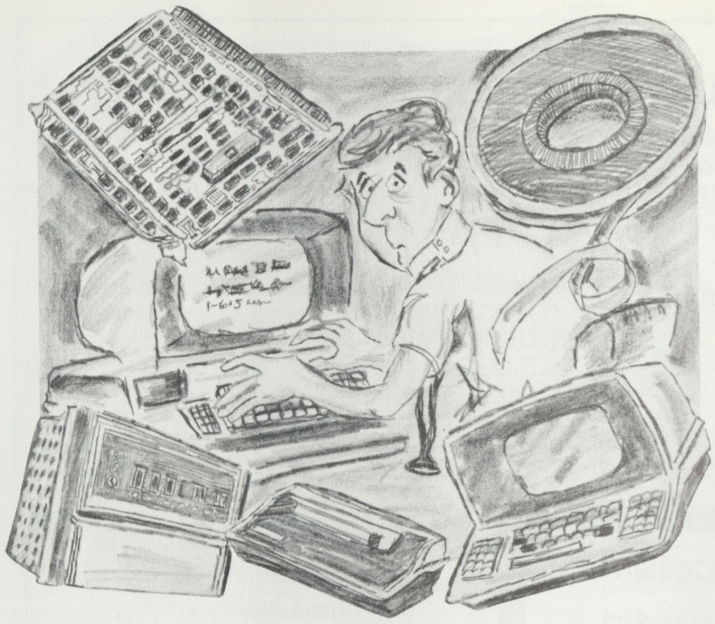

CAPACITY

Most personal computers have between 16000 (16K) and 64000 (64K) **bytes** of random-access memory, although the newest machines such as the IBM-PC can accommodate up to 256K bytes. A byte can store one character, such as the letter "a" or the number "3." The program instructions and the data must be placed in this memory. As a rule of thumb, very simple programs occupy a few thousand bytes, while complex programs reach up to 32K bytes. The remainder of random-access memory is available to store your data.

As an example, consider maintaining a mailing list of your patients on a 48K byte computer. The program instructions might be fairly simple and occupy 8K bytes, leaving 40K bytes for the actual data. It takes about 100 bytes (i.e., letters and numbers) to record a name, address, city and zip code. You could therefore expect to fit 400 such records in memory.

This storage capacity would be inadequate for many applications, so disc drives are used to supplement the random-access memory of the computer. A floppy disc drive can store over 100K bytes, while a hard disc drive can hold about 10 million bytes, providing ample capacity for any application. There are two costs incurred, however: the monetary cost of the disc drive, and the decreased speed at which data can be accessed from the disc compared to random-access memory (see discussion below). Beware of software which obtains large storage capacity by having the user insert different discs in the disc drive. A few sessions of having the computer program **you** with instructions such as "insert disc B in drive 1" will seriously dampen your enthusiasm for the marvelous machines.

SPEED

Interestingly, the speed of the computer itself is rarely a limiting factor in physicians' computer applications. The speed at which data can be stored or retrieved from the disc is often more important, and determines how quickly the computer can display information in response to a request. Floppy disc drives usually take one to five seconds to retrieve data, while the more expensive hard disc drive is about 10 times faster. The speed of the printer may also be important, as in a billing application.

Applications

The potential applications for personal computers in a physician's office are numerous. I'll begin by outlining some general applications for which software is already available, then discuss more specialized and innovative applications.

ACCOUNTING AND BILLING

By far the most common application is in managing accounts receivable. The computer's ability to store, collate, and print data on command makes it a natural tool for this task. Several software packages are available for different personal computers. There are also excellent general purpose ledger and accounts payable programs, as well as financial plotting and forecasting programs.

CORRESPONDENCE

The next most common application is in managing correspondence. **Word processing** is the use of a computer as a supercharged typewriter that can quickly revise and reproduce textual material. As an example, a word processor can instantly insert the name of a referring physician into a standard "thank you for the referral" letter and produce a copy with no typing effort from your secretary. Word processing software is available for all personal computers. The resulting performance is not quite equal to a specialized word processing machine, but if the computer is already in the office for other uses, the addition of word processing software gives you this valuable capability at very little cost.

DATA BASE MANAGEMENT

Data base management, simply stated, is the maintenance of information files using the computer. An example would be maintaining a registration list of your patients. A manual system using a rolodex file with your patients' data on cards serves only one purpose: given a patient's name, you can look up his data. Computer data base management gives you expanded capabilities for searching and displaying the data.

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Speaking the computer's language

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For example, if you were going to change your handling of Medicare accounts, you could request a list of all your patients using that form of insurance. Or better yet, just have the computer print their names on labels to help you with a mailing. If you select a data base program which integrates with your word processing program, your computer could even type a personalized letter to each of those patients automatically.

There are countless other uses for data base management in the office including: medication lists, service codes and fee schedules, management of supply inventories and patient appointment and follow-up lists.

Medical Chart Records

The pen, paper, and dictation machine are firmly entrenched as the tools of medical charting, but a physician with a pioneering spirit may find the application of computers especially rewarding in this area. Let me describe some personal experiences with computer-aided charting.

I recently established my internal medicine practice and spent some time analyzing the flow of information from the physician to the medical record, the patient, and the office staff. I decided I would be willing to type my chart entries on a computer if it could assist in accomplishing these communication tasks.

The program I developed performs the following functions: It speeds entry of chart data by entering normal findings at the press of a single key. Only the abnormal findings are actually typed in. An organized list of problems and medications is maintained from visit-to-visit, so the list does not have to be re-entered, only revised if there is a change in the patient's condition. Once the therapeutic plans have been entered, the computer takes care of printing the actual prescriptions as well as a medication list that is given to the patient. Any changes made in the medication regimen are highlighted on the list.

On the same page is a list of tests scheduled, appointments to be made with consulting physicians, and notes on medication side effects. The actual charts are printed out daily, and their legibility and consistent organization makes case review a pleasure. At the same time, the computer produces a daily list of charts reminding me to follow-up with certain patients and referring physicians. This system has drawn many favorable comments from patients, office staff, and other physicians.

MEDICAL LITERATURE ACCESS

By installing an accessory called a **modem** in a pesonal computer, it is possible to transmit and receive computer data over the telephone, allowing access to computerized information services. MEDLINE is a computerized data base for medical literature, operated by the National Library of Medicine. A copy of MEDLINE is maintained by Lockheed in California on a service called DIALOG, and they are happy to have personal computer users access their data bases by telephone at a reasonable cost of about $35 per hour.

Thus, a physician sitting at his office desk with a personal computer can perform an automated search of the world medical literature at any time he wishes! The list of references produced can be stored in the computer and accessed with your word processing program to add a bibliography to a lecture handout, for example. The AMA is currently working on its own computerized medical information service which would be accessed in the same way.

Selecting a System

The fastest way to acquire a personal computer is to walk into a computer store with checkbook in hand and children in tow. However, few salesmen have knowledge of a physician's special applications for computers, and their advice may be biased according to the products they carry. Let me arm you with a few caveats which I admit represent my own personal biases.

The importance of **software** is always underestimated by the beginner. Your satisfaction with a computer as a productivity tool depends on software which lets you enter, process, and display your data quickly and easily. You will perceive a greater difference between "good" and "bad" software than between the fanciest and most primitive hardware on the market.

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Speaking the computer's language

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I advise against selecting the computer based strictly on its speed, memory, appearance or price without strongly considering the amount of quality software available for it. Hardware design has always outpaced software design. As a result, the widest software availability is found on computers that have been popular for a year or two, rather than the newest machines.

The most popular first-generation personal computers are the Apple II® and Radio Shack TRS-80® . These have had tremendous acceptance and a large number of programs are now available for them. I personally prefer the Apple because its design provides for easier addition of peripherals and expansion to extend the computer's capabilities.

Second-generation personal computers include the Apple III® and IBM-PC® . They are unquestionably more capable than first-generation models, but are not as easy for a beginner to use, and their hardware and software are more costly. Office machine manufacturers such as Victor and Olivetti have also introduced high quality computers, but still with limited software availability. I think a beginner might do better "cutting his teeth" on the simpler machines. To those who insist on having only the latest, most advanced equipment, I would point out that in a year it too will be made obsolete by continuing rapid progress in computer technology.

Some computers are complete as purchased, but most require accessories such as the video monitor, disc drives, and other peripherals such as printers. Once you have selected your computer, the salesman can help you select the right accessories. Don't be afraid to take the equipment home and set it up yourself as it is no more complicated than setting up a stereo system. However, if you have purchased peripherals of a different brand than your computer, you will probably need some help getting them hooked up.

I urge you to experiment a little with programming rather than using only purchased software. Be reassured that you cannot damage the computer by typing something wrong at the keyboard when programming. Also, even a rudimentary understanding of programming will help you recover when your prepackaged software does not behave as expected.

RESOURCES FOR MORE INFORMATION

The world of personal computers is changing so quickly that textbooks are of limited use, and the most current information is found in monthly journals. These personal computing magazines have burgeoned in number and size at a rate rivaling the most aggressive neoplasms! Scanning the hundreds of pages of advertisements will convince you of the vigorous competition and rate of new product development in this field.

General courses in computer awareness and computer programming are offered by computer retailers, community colleges, OMSI and others. The interest I have seen at St. Vincent Hospital where my office is located has convinced me to offer an educational seminar on personal computing for physicians.

Computers have become tools for personal productivity with rapidly expanding applications in our home and business environment. Physicians who are able to harness their information-processing power will benefit greatly. The best way to learn about personal computers is to acquire one and start using it. Why wait? It's too late once your 13 year-old boy asks to use your medical practice as a tax loss for his multi-million dollar software business!

Mark Leavitt, M.D., Ph.D. is an internist at St. Vincent Hospital and Medical Center. Before entering medical school, he received a doctorate degree in electrical engineering from Stanford University and was employed by a high-technology engineering firm in California's "Silicon Valley."

Those interested in attending a tutorial seminar on personal computing for physicians may contact him at 9155 SW Barnes Rd., Suite 28, Portland, 97225.

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Project Medi-share: Reaching out to the medically poor

by Tom Gauntt

Twyla Nicholson of Gresham was concerned about her three-year-old daughter. The child was ill and—even more distressing—had a disturbing green fluid draining out of her ear.

To make matters worse, the Nicholson family had been without work, and health insurance, since June. But Mrs. Nicholson remembered an article she had clipped in July about a health care program.

"I had cut it out and held on to it in case something happened," she said. "It did."

The Nicholsons are one of more than 600 financially strapped Multnomah and Washington County families who have been helped by the Multnomah County Medical Society's Project Medi-share, a program to provide free and low-cost medical care for the medically poor.

Since the program began in July, more than 600 physicians, both primary care and specialists, have gotten on the bandwagon. Eleven local hospitals and five pharmacies have also joined in the effort to make necessary health care available to the 105-125,000 Multnomah and Washington County residents who lack medical insurance due to unemployment, but are not poor enough to qualify for government assistance.

"Project Medi-share is our attempt to quit talking about the needs that exist and get the medical community to provide care, in an organized manner, to those who need it," explained Dr. George Caspar, MCMS past-president. "It's intended to deal with an acute, catastrophic, short-term situation" he said, stressing that the program is not a long-term solution.

"Financing care for any impoverished group is a societal problem —and we'll continue to urge society, particularly government, to help us," Caspar said. "The moment we feel our offer is being taken advantage of, or relied upon to solve a societal ill, is the day we'll walk away."

Although Project Medi-share has widened its scope in its five months of operation, it still holds to its goal of simply helping people through difficult economic times.

That goal became more attainable in November, when 11 hospitals joined Medi-share. Before that time, the needy could get help with relatively minor health problems, but the more serious—and expensive—problems which required hospitalization were out of the program's range. Since patients without health insurance are often asked to pay a deposit before entering a hospital, the medically poor were being left in the cold when it came to serious illnesses. The hospitals' participation assures that Project Medi-share patients requiring hospitalization will receive it, regardless of their financial resources, according to Steve Berkshire, executive director of the Northwest Oregon Council of Hospitals.

Eligibility Criteria

Jeanette Valley, Project Medi-share coordinator, said that as the economy gets worse and the program becomes better known, the phone in her MCMS office rings more and more often.

Valley said she received roughly 100 calls per week from area residents who want non-emergency medical assistance. Only about half that number, however, qualify for Medi-share. But the requirements are not strict. To be eligible, a patient must:

- be a Multnomah or Washington County resident;
- have a clear and present need for non-emergency medical care;
- show evidence of continuous full-time employment with a termination date after January 1, 1980;
- have no third party insurance and be ineligible for any other public or medical assistance program, such as Medicaid or Medicare, Champus, Project Health or veteran's coverage.

When Valley takes these calls, she obtains basic information about the patient's medical problem and, if the person qualifies, she refers him to a physician in his area as quickly as possible.

Nicholson was one of the more lucky patients in the program.

"The same day we called, we got an appointment with a doctor about three blocks away," she said.

Valley said such prompt attention is unusual, but not unheard of. She can usually get an appointment set within a few days.

Patients who can pay any part of the usual fee are asked to do so, but in most cases the office visits are free.

Pat Daugherty, office manager for a Southeast Portland clinic that has had 17 referrals from the Medi-share program, said her office has performed nearly $500 worth of service at no charge.

"It's a free service as far as we're concerned," said Daugherty, who runs the office shared by Drs. Caldwell, Henry, Hoggard and Irvine. "It's just part of being in the community."

Although the doctor's services are often free, out-of-pocket expenses, such as lab costs and x-rays, are billed to the patient. Since the five pharmacies came on board in October, Medi-share patients have been able to get the medications prescribed by participating Medi-share doctors at reduced prices.

In fact, Nicholson said the doctor who treated her family gave her some medication free from his supply of samples when she told him the

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Project Medi-share: Reaching out to the medically poor

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original prescription had run out but her daughter's infection lingered.

"We didn't have money for the medicine at that time," she said.

Still, there are special problems tied to helping people—both for the medical community as a whole and for the individuals being helped. It breaks down to pride and money.

Being out of work and in need of assistance is a new experience for many of those being helped by Project Medi-share.

"It is not a situation they want to continue," Valley said. "It's very uncomfortable."

And often the most uncomfortable part is realizing you need help and asking for it.

"My husband's pretty conscious of that," Nicholson said. "He doesn't like the idea of depending on other people. But our daughter was sick and it was the only way she was going to get better."

Valley tells of a pregnant woman whose baby was a week overdue and she had waited that long to contact a doctor.

"I don't know how she thought the baby would be born—divine providence?" Valley said.

Now that the program is further along, there are less calls like that one. Valley said that most pregnant women who call are in their first trimester. This early contact allows women to have several follow-up examinations throughout their pregnancy.

Nationally, there are only three programs similar to Project Medi-share. The others are in Salem, Seattle and Detroit, but do not include physician perinatal care. Project Medi-share has received national attention through such publications as the Wall Street Journal, New York Times and AMA News.

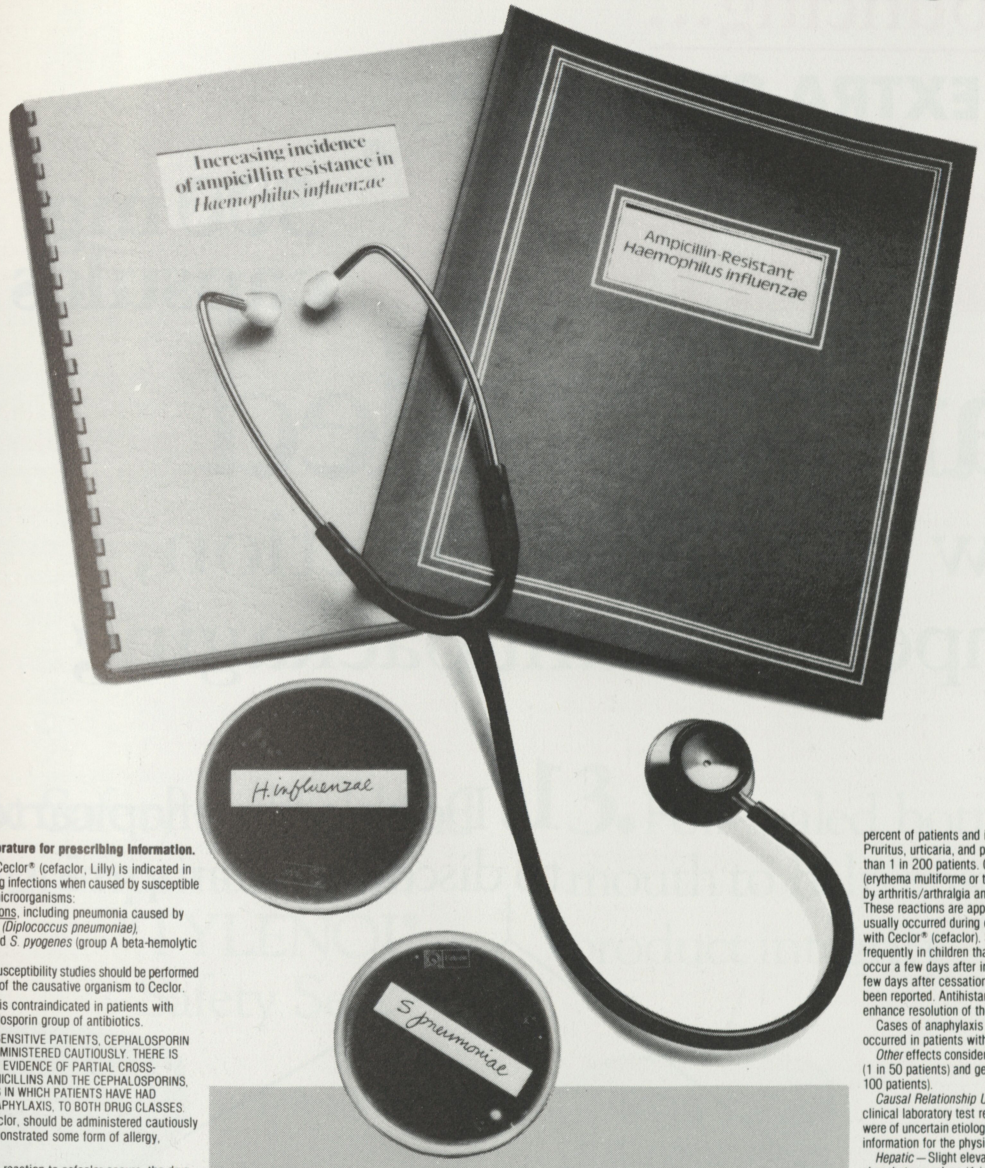
Participating Pharmacies and Hospitals

Patients can be referred to a Project Medi-share physician by calling 227-2737 from 9:00 a.m. to 1:00 p.m. Monday through Friday. A registered nurse will determine eligibility and schedule an appointment.

Patients capable of paying for any part of the services rendered will be asked to do so. Five Portland pharmacies are providing prescription drugs at a reduced price to patients referred to them by Medi-share physicians. These pharmacies are: Central Discount Drug, 538 S.W. Fourth Avenue; Woodstock Pharmacy, 4515 S.E. Woodstock; Brooklyn Rexall Pharmacy, 3370 S.E. Milwaukie; Woodlawn Pharmacy, 6728 N.E. Union; and Nob Hill Pharmacy, 2100 N.W. Glisan.

Patients will be admitted on a no-charge or reduced-charge basis at the following hospitals, when admitted by one of 600 Medi-share physicians: Bess Kaiser, Eastmoreland, Emanuel, Good Samaritan, Holladay Park, Physicians and Surgeons, Portland Adventist, Providence, University Hospital and Woodland Park.

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, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

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 Coomb 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).

As with other broad-spectrum antibiotics, colitis, including rare instances of pseudomembranous colitis, has been reported in conjunction with therapy with Ceclor.

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 (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor® (cefaclor). Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

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). [100281R]

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

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

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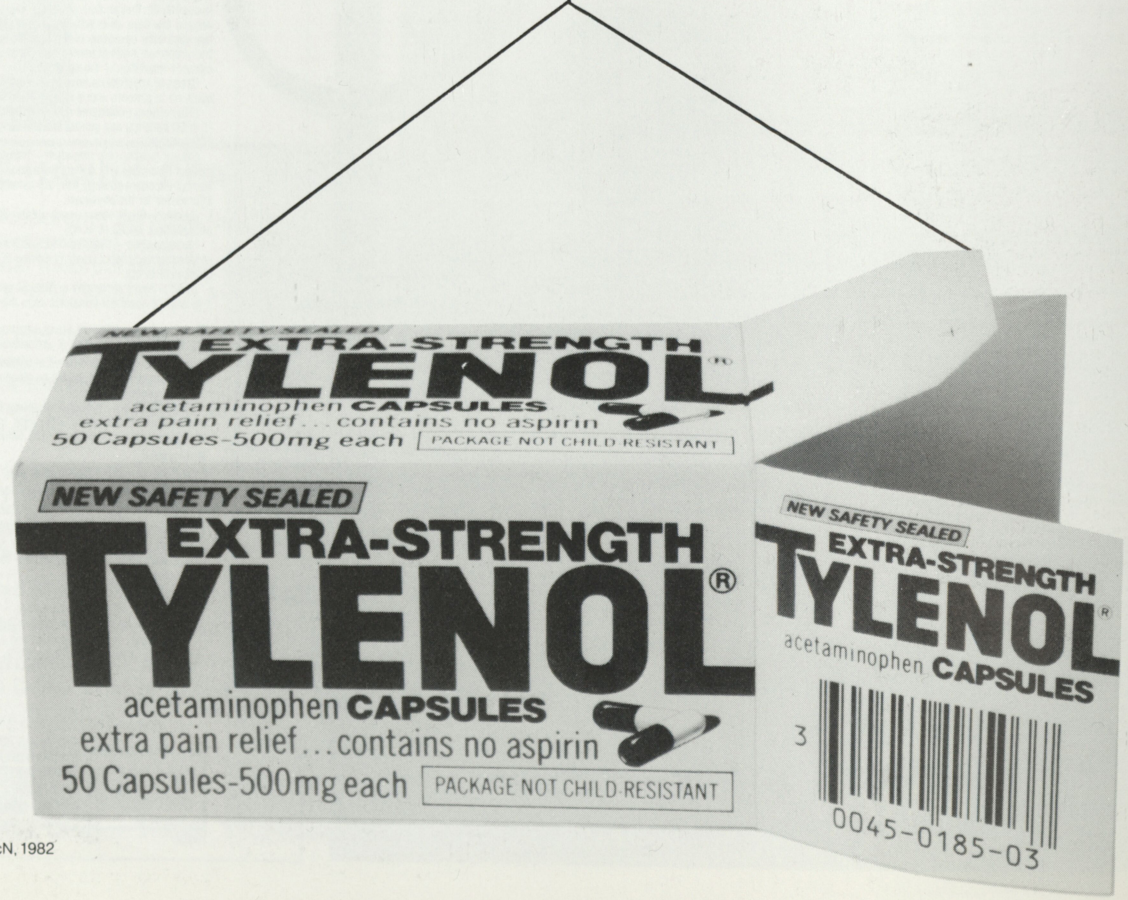

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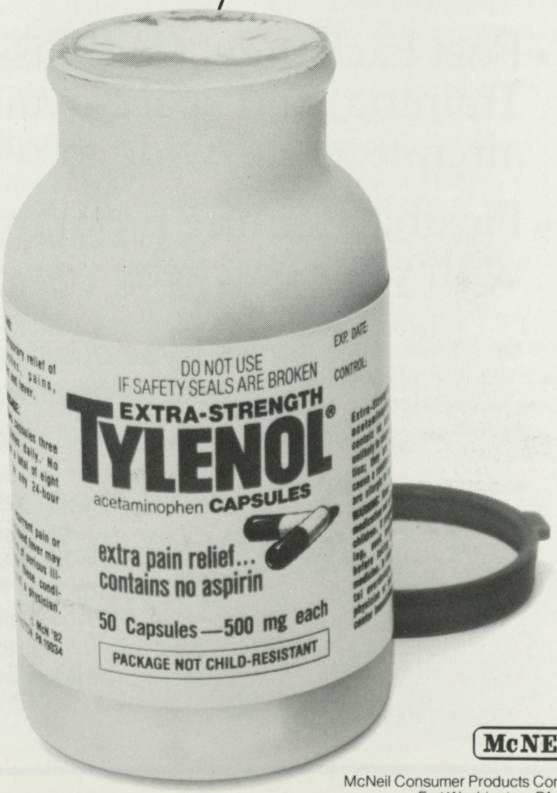

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by **David E. Bilstrom, M.D.**

"Mycin," a computer that reasons

It is 2 a.m., a tired physician is concerned about the condition of an extremely ill 8-month-old child who is obviously septic. What he urgently needs is a consultant on infectious disease to help decide the next step until culture data is available. Fortunately, the hospital has a consultant who is never fatigued or confused at having been awakened at this early hour. His name is **"MYCIN."** "MYCIN" is the progeny of a number of computer experts and physicians who have collaborated at the Stanford Medical School and the Heuristic Programming Project of Stanford University.

"MYCIN" asks the physician attending the child a variety of questions in logical order, much as his human creators would in performing a consultation. When sufficient data is available, "MYCIN" suggests an action plan. What distinguishes this approach from other attempts at computer-assisted diagnosis is the way in which the computer thinks.

One of the major distinguishing characteristics of this system is the physician's ability to interrogate the computer to find out why a question was asked and what relevance the question has to the problem at hand. This quality is called "transparency." By allowing the physician to ask questions and learn from the system's data base, the physician will be able to agree or disagree with the conclusions. If field tests indicate the conclusions are not accurate enough, or if new knowledge means the conclusions have to be changed slightly, the system can easily be modified.

Another distinguishing feature is the system's ability to incorporate the informal rules, insight and experiential knowledge of a human expert into the decision process. It functionally takes the knowledge of experts, codifies it, and makes it available to any person who chooses to use it. It is a way to propagate the experience and knowledge of an expert and disseminate it widely.

The concept is revolutionary. To understand why this is such a breakthrough, consider the types of programs printed in medical journals over the past several years. These programs lead the physician to a decision in a lock-step fashion. At the end, a conclusion is drawn without allowing the physician to interrogate the why's and wherefore's behind it. In a critical situation, this "black box" approach makes the physician uncomfortable. As a result, such programs are not widely used despite the author's raves. Moreover, if a piece of information is not available, the program can not analyze the remaining data and suggest other approaches if necessary.

Artificial intelligence

Expert systems like "MYCIN" mimic human reasoning processes. These expert systems are the outgrowth of years of work on artificial intelligence which, until recently, was regarded as intellectual curiosity in university computer departments. Early computer experts became convinced the algorithmic (black box) approach to problems was suitable only for simple questions.

The success of an expert system depends upon the breadth of its knowledge base, just as it does in human experts. An expert is questioned about the nature of his decision process and this information is then codified and entered into the computer system.

Dr. Bruce Buchanan is the director of the Hueristic Programming Project at Stanford University. Under his direction, the "MYCIN" program has spawned a variety of other programs that have applications in medical science. **"PUFF"** produces interpretations of pulmonary function test measurements from patients with lung disorders. This program is in daily use at the Pacific Medical Center in San Francisco, and physicians there have found it quite effective.

Dr. Buchanan has indicated that a physician's knowledge increases with use of the system. At first, physicians were reluctant to use the system, but did so in the interest of convenience; the conclusions were scrupulously examined. The system has been refined through this process, and physicians at Pacific Medical Center have been more and more willing to use the advice. It also has the advantage of being available at all times.

"ONCOCIN" provides an oncology protocol management system. Because of a wide variety of complex chemotherapy protocols, it is difficult to treat a patient when an unusual circumstance arises and to remember which tests should be ordered at a specific clinic visit. "ONCOCIN" helps physicians practice in accordance with established protocol.

"RX" is being developed to discover and confirm knowledge about the course and treatment of chronic diseases from a large data base of patient information recorded over several years.

Perhaps one of the more exciting applications of artificial intelligence is the **"VM"** system. In critical care situations, a patient's status is constantly changing. Functional parameters that would be acceptable shortly after entering the critical care unit might be portents of severe disfunction only 30 minutes later.

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"Mycin," a computer that reasons

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A wide varity of clinical signs must be monitored and assessed during this process. Obviously, the ability of the patient care team is stressed to the limit under these conditions. "VM" serves as a tireless aide in this process, alerting the team of impending problems and suggesting courses of action appropriate to the individual patient. Such applications are exciting and potentially valuable to augment the physician's expertise.

The National Institute of Health is quite involved in this area and has provided funding for the project at Stanford and other institutions across the United States. **"SUMEX-AIM"** is a national computer system supported by the NIH Division of Research Resources' Biotechnology Resources Program. It is dedicated to promoting artificial intelligence applications in biomedicine. "SUMEX-AIM" involves a time-share computer access system which links facilities throughout the U.S. Through these links, distant investigators communicate with each other and run programs on a time-share basis. As these systems become more available, this expertise might become accessible to practitioners in their own offices.

The tasks that artificial intelligence programs are being designed to do are tasks that require a lot of time or drudgery on the part of the professional. By giving these functions to the computer, physicians do not have to spend time worrying about certain aspects of the problem and can direct their attention to those aspects for which there is no computerized alternative. The art and science of medicine will be greatly enhanced and physicians will be more effective at dealing with the patients' emotional as well as physical needs.

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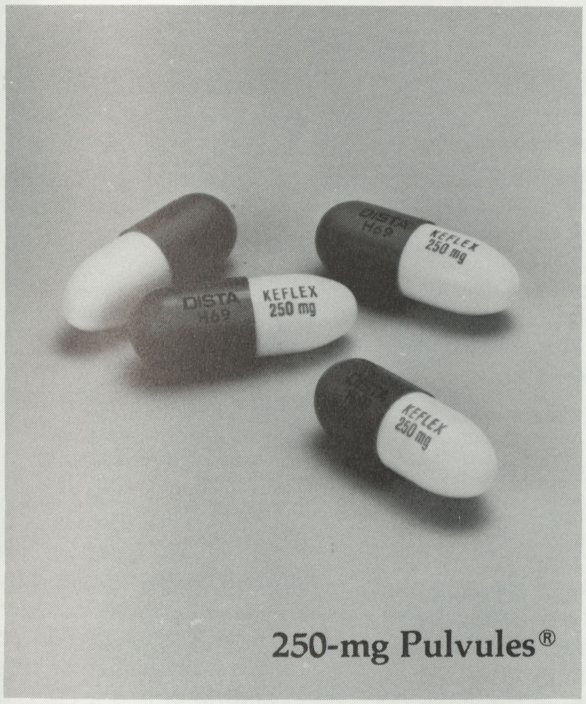

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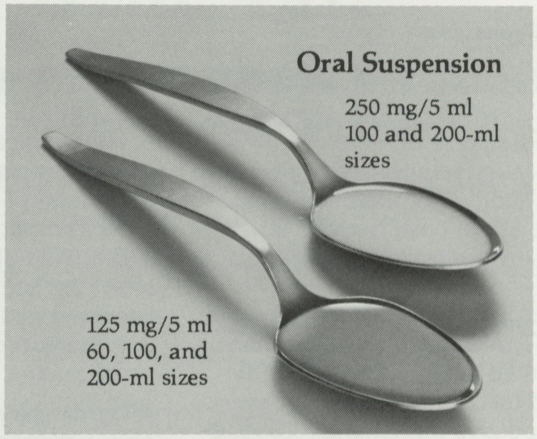

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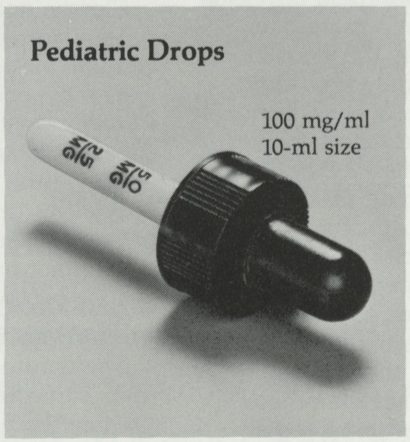

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Does your practice need a consultant?

by Jim Trounson

The basic issue of survival—survival of a medical practice; survival of the practice of medicine as we have traditionally known it—is up for very serious review.

Perhaps rightly so. There are currently 437,000 practicing physicians in the United States, with 536,000 projected for 1990—or one for every 455 prospective patients. By 1990, it is estimated, there will be a physician surplus of 60,000, and more than twice that number by the year 2000, according to a federally-sponsored Graduate Medical Education National Advisory Committee report.

In 1970, Oregon had 2,805 physicians. There were more than 5,000 by 1980—or one doctor for every 166 patients. Excluding the HMO physician and patient population, the ratio goes even lower, to one physician per 120 prospective patients. Uneven geographic and population distribution compound the problem. Not exactly news to most Oregon physicians.

While marketing the medical practice has been a popular topic for recent professional meetings, the concept is relatively new and somehow distasteful to many practitioners. Yet the fact is that while nationally the number of patient visits per year—one billion—has remained relatively constant over the last decade, the number of physicians available to provide this care has increased dramatically. The result is that physicians are seeing 20-30 percent fewer patients than they did just a few years ago, and that the average work week is now down from 60-70 hours to about 55.

The implications are clear: The private practitioner must find a way to maintain a viable practice with fewer prospective patients.

But while the implications are clear, the solution remains far from simple. It is against this background that many practitioners call in a management consultant.

Why do physicians use consultants?

Clearly, not every practice will need a management consultant, certainly not on a regular basis. Generally, according to a Medical Economics study, a consultant is called in to analyze management of money, time, space and people—specialties generally considered beyond the scope of the doctor's accountant or attorney.

When should you call in a consultant?

The common misconception is that "consultants treat sick practices." Frequently, by the time a practice is on a rapid downhill slide, there may be little a consultant can do. At best, recovery may be slow and painful. Better to call in a consultant earlier in the game.

How can you tell if you need a consultant?

The early warning flag is up when:

- The practice is looking at excessive turnover—say 50 percent, which equates to the entire staff over a two year period.
- Overhead reaches 20 percent in excess of the "average" for the specialty.
- Systems are inadequate for easy data collection filing and retrieval.
- You are not happy with your profit and loss/balance sheet/cash flow statements.
- You experience delays in routine assignments.
- Your practice growth is abnormally low.
- Too many of your patients' accounts are past due.
- Paperwork is piling up in your office.
- Patients are not being moved through your office fast enough.
- You have personnel problems.
- You are in conflict with your associate(s).

This is not to say that a consultant should be used only when the warning signs are up. Many potential problems are avoided by bringing in a consultant early.

For example, **when you are building a new facility or remodeling an existing one,** a professional space planner, particularly one specializing in medical practices, should save you far more than his fee.

When you are considering a large capital purchase, either of office machinery or medically-related equipment, a professional consultant can tell you how to buy—whether lease or purchase is more favorable in your individual case, what to pay, and how long it should take to recover your investment.

If you are considering bringing in a new partner, a consultant can advise you on what his status should be: employee, full partner, shareholder? This is indeed "preventive medicine" and frequently becomes a key issue after the junior physician has been a part of the practice for a while.

If you have existing or potential income distribution problems, a competent consultant can give you an independent evaluation, and

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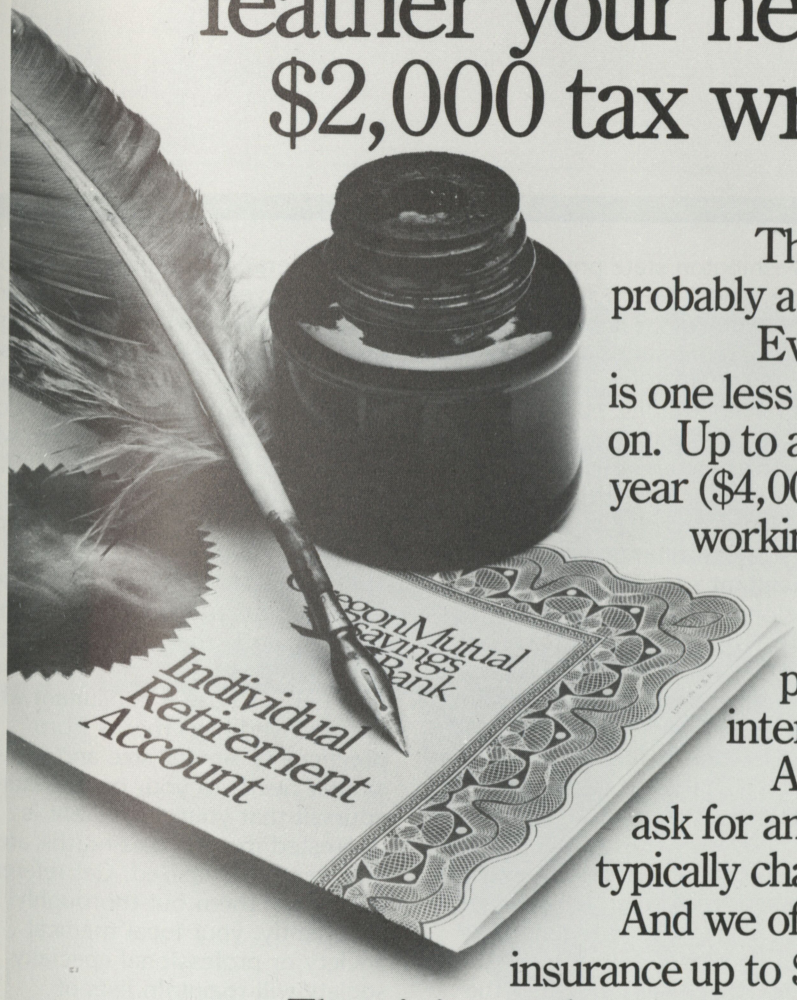

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Does your practice need a consultant?

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recommendations for meeting your objectives.

If you are setting up a pension or profit sharing plan, wondering whether your insurance is adequate, or have questions about the tax advice you have been getting, a consultant may also be needed.

What kind of a consultant should you choose?

One consultant divides professional consultants into two groups: **functional consultants** and **process consultants.**

A **functional consultant** performs a responsible practice analysis and recommends appropriate changes to solve the problems he has uncovered. This functional consultant may even recommend process consultants to implement the changes. Some functional consultants specialize in specific areas of a practice, such as training, personnel or public relations.

Many practice surveys are unsuccessful because the functional consultant's recommendations are never implemented. A **process consultant** assumes responsibility for implementing the functional consultant's recommendations. Most work on a regular, ongoing basis.

A small number of specialized process consultants performs contract management services. A contract management company takes responsibility for staffing a physician's office: for the selection, training, motivation and evaluation of employees. The contract management consultant also sees that patient services are upgraded where desirable. He may even hire, with the physician's approval, the office staff and then "lease them back" to the practice.

A Washington state practice, for example, saved itself $30,000 during its first year with a contract management firm implementing the functional consultant's recommendations to reduce receivables, cut overhead and increase production.

A further distinction should be made according to the consultant's specialty, the practice size, and other sources of consultant income.

Consultant specialty. A professional consultant normally has a general business background bolstered by years of medical practice experience. If he does not specialize, he is at least likely to have greater interest in some areas than others. Just as the physician examines a patient and then refers that patient to a specialist when necessary, a qualified management consultant will examine your practice and then tell you whether a specialist is required.

Practice size. Look for a consultant experienced with practices the size of yours. Practice size can dramatically alter the approach to a consulting situation. Larger groups generally retain a consultant for a specific problem, while smaller groups generally employ a consultant for overall evaluation.

Other sources of consultant income. A distinction must be made between a professional management consultant whose income is derived only from clients, and the consultant who offers, in addition to his or her consulting services, other services or products for sale, such as insurance or investment opportunities.

How do you select the right consultant for your practice?

Caution: Anyone can call himself a consultant. You may run into unemployed clinic managers or sales people who have taken the title. Or you may talk to the consultant who, while operating an independent business, receives some sort of "incentive payment" from vendors of the equipment or services he recommends to you. While this custom is not unusual, independent judgement may or may not be affected, adding to what one consultant calls "our uphill fight to present a professional image."

Dissatisfaction with a consultant generally results from an unclear initial understanding of the problem to be addressed by the consultant to assure a good match of his or her qualifications to the problem. Your best bet is to use a consultant who has received high marks from practices of similar size and with similar needs to your own. Assure yourself that your consultant is interested in emphasizing the area you want emphasized. Get references and check them out thoroughly. Frequently, your local medical society or professional specialty society will maintain lists of experienced consultants.

Obviously, the new consultant will be at a disadvantage, as he is likely to have few or no references for you to check. But at least you can talk with clients who have worked with him in this or another capacity.

Second, it takes consultant time and your money for the consultant to become thoroughly familiar with your practice. Therefore, you will want to be certain that he or she will continue to be available over a period of time, much as your accountant or attorney is available when needed.

Third, look for that special "chemistry" match between physician and consultant to assure a pleasant, productive relationship.

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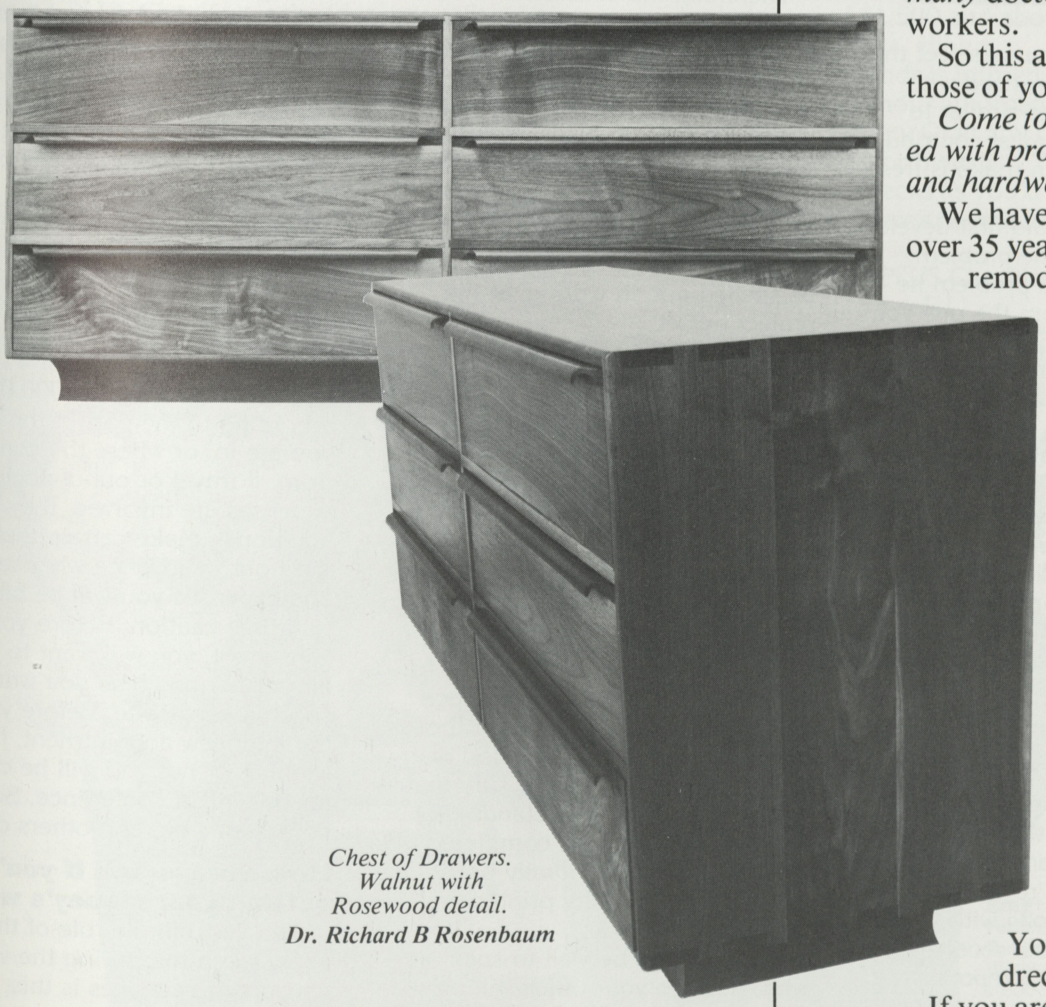

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Does your practice need a consultant?

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What should a consultant do for you?

While you will of course select the consultant most experienced with problems and practices similar to yours, perhaps the biggest contribution the consultant can make is fresh ideas.

The consultant should first develop a clear statement of the problem. Don't be surprised if a problem he defines is different from the one you recognized. As one consultant said "we first treat the problem the doctor called us about, then we get down to what's really wrong."

Further, the consultant should present alternative strategies, discussing the consequences of each and defining costs. Finally, your consultant should provide an action plan with staffing needs, time line and costs.

To get to this point, the consultant will probably meet individually with you, and with each of your partners, for an hour or so and with each of your office assistants for half an hour or so. The consultant will also observe your office at work, disrupting the daily routine as little as possible.

Before the consultant leaves your office, he will usually review his major recommendations with you. At a later time, you should receive a more complete, written report.

What should the consultant expect from you?

To achieve a workable product—your plan—there must be commitment not only on the part of the consultant but on the part of the practice. Without this commitment on the part of the physician(s), the study is not likely to be understood, supported, or acted upon.

Therefore, the consultant should expect good ongoing communication with you throughout the study, a willingness to make changes once you have been persuaded they should be made, and cooperation from your staff.

How do you negotiate a consulting contract?

Certain basic understandings must be spelled out, in writing, at the project outset.

You have already checked the consultant's references. If the firm consists of more than one consultant, your agreement should specify who will be in charge of your project, and who else will work on it.

Further, your agreement should include a statement of the scope of the study—what problem or problems will be evaluated, and to what depth. You will also need to identify the beginning and ending dates for the study, and the interim "check points" for periodic reports if the study will go on over a period of time. You will need to be sure that you have a clear understanding of exactly what form the completed plan will be delivered in: Orally only? One written copy? Twenty printed and bound copies?

It would also be well to spell out what services your office will provide, i.e., photocopy, office space, telephone, typing support—and the availability of the physicians and staff members to the consultant.

Finally, you will need to name the individual to whom the consultant will be responsible and to spell out in detail the total budget, including necessary documentation for out-of-pocket expenses.

What should a consultant charge?

To begin with, if a consultant is considerably lower priced than his colleagues, find out why. It is unlikely that you will find a good "cheap" management consultant. It is far more likely that you could find an incompetent one for a large price, which is why you have spent the time and effort to check out the consultant thoroughly.

Frequently, a consultant will develop a budget for the entire project, which is probably the most reasonable arrangement. The consultant's fee on a daily basis may range from as low as $50.00 or $100.00 an hour, to more than $1,000.00 a day, according to the part of the country you are in, or where the consultant is from. If travel or out-of-pocket expenses are involved, they will be additional. Make certain that you spell out in advance what services and expenses you will be billed for.

A final caution: Before you hire a consultant, you will want to interview him or her much as you would a prospective employee. Before you make the interview appointment, find out whether or not you will be charged for this initial conference. Some consultants do, and others don't.

How can you tell if you're getting your money's worth?

The very simple rule of thumb to apply when measuring the value of a consultant's services is this: A consultant should save you more than he or she costs. If you have conscientiously implemented the consultant's recommendations, you should see results.

Jim Trounson is president of Medical Management Inc., a Boise, Idaho contract management and consulting company which is a division of Brim & Associates, Portland, Oregon.

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February is children's dental health month

by **Susan M. Sanzi-Schaedel**

February is National Children's Dental Health Month and the theme for the ADA-sponsored event is "Smile America." Children's Dental Health Month provides an opportunity to focus energies on informing patients and the community on the nature of oral diseases, the best means available to prevent them, and the need for regular dental care.

In spite of the increased number of people covered by some form of dental insurance[1], the National Center for Vital Statistics figures show that only 50 percent of the American population has visited a dentist within the last year, while 75 percent have seen their physician. Because of this, physicians are being asked to help provide preventive dental information and therapies.

As a result of the May 1980 referendum to repeal fluoridation of the Bull Run Water Supply, Multnomah County will not receive the decay-preventive benefits of community water fluoridation anytime in the near future. In the absence of fluoridation, dietary supplements of fluoride are the most effective means of preventing tooth decay. Physicians are urged to make sure parents living outside the fluoridated Wolf Creek Hwy Water District know the importance of daily supplementation, and are provided with prescriptions. The ADA[4] and American Academy of Pediatrics[5] have both accepted the following dosage schedule:

Birth-2 years old—.25 mg/F daily
2-3 years old—.50 mg/F daily
3-12/14 year old—1 mg/F daily

The Multnomah County Community Health Services Division has been sponsoring a school-based fluoride mouthrinse program in public and private schools within the county since 1974. A 0.2 percent neutral sodium fluoride rinse is swished over the teeth for 60 seconds, once a week in the classroom. The program is voluntary and requires parent permission. Research from the National Institute of Dental Research National caries Program has shown a 20-50 percent reduction in caries when used weekly during the school year[6]. More recent studies have shown that even in fluoridated communities there can be an additional 34 prcent reduction by using a fluoride mouthrinse[7].

Presently there are over eight million children on this program nationwide. Multnomah County has over 43,000 children participating. Your support is needed to maintain this excellent participation. You can help in the following ways:

1 Encourage students, teachers and principals who are your patients to participate in the fluoride mouthrinse program.
2. Encourage parents to sign their children up for the program in their school office and let them know that there is no charge.

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February is children's dental health month

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3. Remind parents that the rinse is topical, and should be used even if the child is taking fluoride drops or tablets. Also inform them that the rinse does not take the place of the fluoride treatment provided in the dentist's office.

If you or your patients would like further information on the fluoride mouthrinse program, call Multnomah County Dental Health Services at 248-3711.

For patients in schools that don't have this program, there are three commercial fluoride mouthrinses available without a prescription that have been accepted by the ADA Council on Dental Therapeutics as effective in preventing cavities: Fluorigard Anti-Cavity Dental Rinse, Pacemaker Fluorinse, and Stancare Anti-Cavity Fluoride Rinse[8].

Toothpastes with fluoride are also recommended, though they are not as effective or inexpensive as the rinse or fluoridation. The following commercially available toothpastes have been accepted by the ADA Council on Dental Therapeutics: Aim, mint and regular flavor; Aqua-fresh; Colgate with MFP and gel with MFP; Crest, mint, regular and gel formulas; and Macleans fluoride toothpaste.

The other regimens recommended for the prevention of tooth decay and periodontal disease are the daily removal of plaque by brushing and flossing, fewer sweets and regular dental care.

As you are seeing patients during Children's Dental Health Month and beyond, take a moment to make sure you have taken a role to keep America smiling.

Susan M. Sanzi-Schaedel is director of the School/Community Dental Health Programs for the Multnomah County Community Health Services Division.

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Local physicians study AIDS

by **John Santa, M.D.**

In 1979 and 1980 physicians in New York City and San Francisco independently noted Kaposi's sarcoma and pneumocystis pneumonia in several previously healthy young homosexual men.

Communication between these physicians and subsequent reporting of these cases to the Center for Disease Control led to documentation of an ongoing epidemic of opportunistic infections and unusual malignancies among gay men and intravenous drug abusers. Cases were eventually described from several cities and other population groups, including a case of Kaposi's sarcoma in Portland.

Initial patients were identified because of the appearance of Kaposi's sarcoma or pneumocystis pneumonia. Kaposi's sarcoma is a rare hemangiosarcoma previously seen only in the elderly or in equatorial regions of Africa. Pneumocystis pneumonia is a protozoan infection seen primarily in newborns or in severely immunocompromised patients. Subsequent patients were decribed with other opportunistic infections. Study of these patients demonstrated a severe immunodeficiency state manifested primarily by an inability to perform certain T cell (thymus derived) functions.

Since this initial group has been described, it is clear that a spectrum of clinical manifestations exists with acquired immunodeficiency the common denominator. This spectrum of disease has been termed the **Acquired Immunodeficiency Syndrome (AIDS).**

Defining the Syndrome

Exact definition of the syndrome is not yet agreed on, but includes patients who are from high-risk groups and have opportunistic infections, Kaposi's sarcoma and other unusual malignancies. These high-risk groups include gay males, intravenous drug abusers, Haitians and hemophiliacs. The syndrome may also include patients with a preceding disorder consisting of diffuse lymphadenopathy and fever of unknown origin. The latter symptoms may be the ones most commonly seen by clinicians in community practice.

There is no single laboratory test that confirms the diagnosis, though study of T cell subpopulations shows suggestive findings of an immune defect. Cases are most frequently reported from New York City, San Francisco, Los Angeles and Miami, though scattered cases exist throughout the U.S.

Study by the CDC suggests that this clustering of cases in a few cities is a real phenomenon and not a reporting artifact. Clustering of cases and unique risk groups suggest that an infectious agent may be involved.

Morbidity and mortality among patients with Kaposi's sarcoma and pneumocystis pneumonia is staggering. Eighty-five percent of the cases diagnosed prior to 1981 are dead. Overall mortality for the 700 cases described thus far is 40 percent. The number of reported cases is increasing and there are recent reports of cases among children.

In contrast to toxic shock syndrome, it is unlikely that an easy solution (i.e. staph toxin via tampon) will be found for AIDS. Researchers initially suspected inhalants such as amyl nitrite. Subsequent study suggests these agents are not playing a major role. Life style factors among the gay population appear to be a factor, though their overall importance is still unknown. Infections common in the gay population, especially cytomegalovirus, are associated with the syndrome if not actually causing it.

Controlling the problem

What is the significance of the AIDS syndrome? On a national level, this syndrome appears to be a major epidemic of a life-threatening illness, potentially affecting hundreds of previously healthy people. It also appears to offer an opportunity to observe, study and attempt to alter a biological phenomenon causing immune suppression and malignancy. The CDC, with the cooperation of physicians in many cities, has launched a major effort to describe and hopefully solve this problem.

In Oregon, the syndrome appears to be relatively rare, though AIDS just became a reportable disease last November. One case of Kaposi's sarcoma has been seen. There have been no known cases in Oregon of pneumocystis pneumonia. Several cases of diffuse lymphadenopathy in gay males have been seen by a variety of physicians in Portland. Some of these patients were visitors from other cities, some Portland residents. Dr. David Regan initiated studies of the immune defect in these patients.

As in other cities, the size of Portland's gay community is unknown but estimated at 8-10 percent of the male population. A number of businesses catering to the gay community flourishes in Portland, and a variety of health care providers meets the medical needs of these people. Literature circulating within the community indicates a need and interest in current information on a variety of health care topics, including AIDS. Communication between physicians and gay patients has traditionally been hampered by fear and stereotype. Appearance of the AIDS syndrome makes it imperative that physicians and their gay patients attempt to educate each other, decrease the barriers between them, and make decisions about impacting issues that may affect the patient's health.

A conference on the AIDS syndrome is scheduled for February 26 at Good Samaritan's Nursing Education Building, room 110. Physicians from the Atlanta CDC, the University of California at San Francisco and the Portland area will discuss this syndrome and current thinking regarding detection and management. A public session will take place in the afternoon. Physicians interested in helping with this conference or improving community education on this problem should contact John Santa at 229-7074. For details about the conference, call 229-7400. Many health care providers will be receiving information by mail.

Dr. Santa is an internist in private practice and director of primary care at Good Samaritan.

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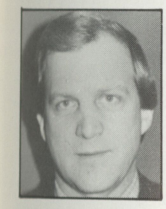

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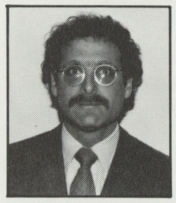

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4710 SW 60th Pl 292-3794
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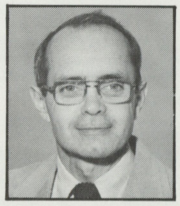

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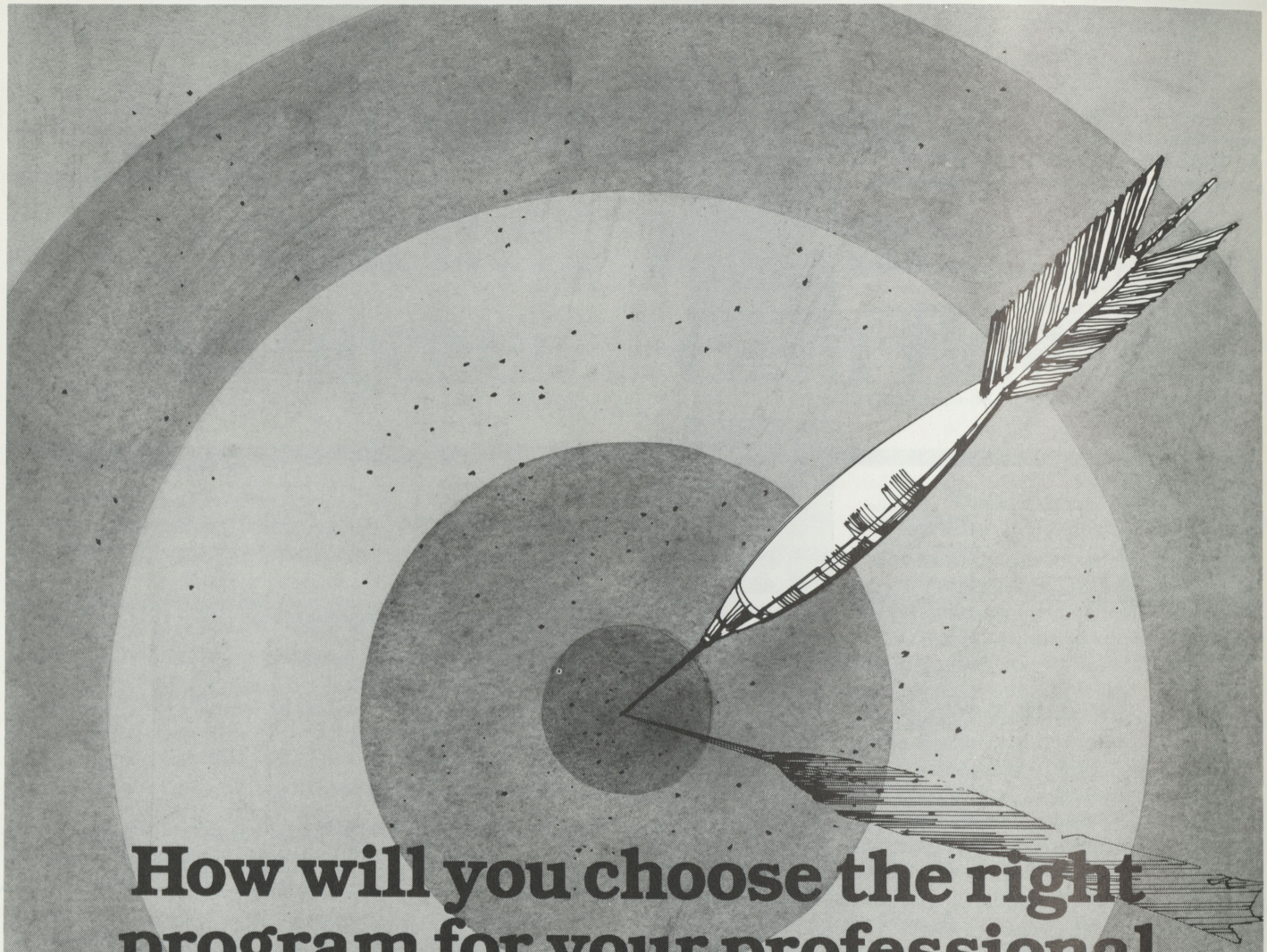

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Dr. Michael Brodeur has been installed as 1983 Medical Staff president at St. Vincent Hospital. Other officers are: **Dr. Robert Simmons,** president-elect, and **Drs. Anthony Peck, John Bergstrom and James Wood,** all members-at-large.

Dr. James Maras has been named 1983 chief-of-staff at Dwyer Community Hospital. **Dr. Donald Fortlage** is president-elect, **Dr. Winhard Bohme** is treasurer and **Dr. John Stewart** is member-at-large.

Becky E. Belangy has joined Kaiser-Permanente as a governmental relations representative. Ms. Belangy was previously manager of Project Health and, prior to that, chief of the office of resource generation for Multnomah County.

Robert R. Mitchell has been elected chairman, and **Elizabeth N. Gray** vice-chairman of the OHSU Board of Overseers. Mitchell, president of U.S. National Bank of Oregon, is also a trustee of the OSU Foundation and a director of the Cardio-Pulmonary Research Institute. Ms. Gray serves on the boards of the Oregon Historical Society, Loaves and Fishes and the Oregon Independent College Foundation.

Belle Slesh, R.N., clinical nursing supervisor for the emergency room at Kaiser Sunnyside Medical Center, has received the Emergency Department Nurses Association's 1982 Michael Turman award. The award is presented annually to an emergency nurse in Oregon who has been voted by his/her peers as having made the greatest contribution to emergency nursing. It is given in memory of Michael Turman, a physician assistant who helped further continuing education for nurses.

Joan Waldvogel, an instructor at PCC, has been re-elected chairman of the Associated Home Health Service board of directors.

Stuart P. Bowne, M.D. has been named Kaiser Sunnyside area medical director and vice president of operations. Dr. Bowne will be responsible for medical services at the Kaiser Sunnyside Medical Center and Kaiser-Permanente Medical Offices in Southeast Portland. David M. Lawrence, M.D., Bess Kaiser area medical director and vice president of operations, will continue to oversee Bess Kaiser Medical Center and other Kaiser-Permanente medical facilities in North Portland, Beaverton and Vancouver, Washington. Dr. Bowne received his medical degree from Yale University School of Medicine, after receiving a B.A. cum laude from Middlebury College, Vermont and attending the Graduate School of Chemistry at the University of Edinburgh. He served a surgical internship and residency at the University of Rochester, N.Y.

CALENDAR

January 24	Grievance Committee; 6:00 p.m.; MCMS
January 26-28	26th Annual Scientific Sessions of Arizona Heart Association and Clinical Recognition and Management of Heart Disease—1983; Tucson, AZ; pre-registration required; American College of Physicians, P.O. Box 7777-R-0510, Philadelphia, PA 19175.
January 27	Nutrition: An Update in the Prevention and Treatment of Disease; OMA building; sponsored by the Division of Continuing Medical Education, OHSU; 225-8700.
	1983 Internal Medicine Review Session: Infectious Diseases I; David Gilbert, M.D.; 6:00 p.m.; Amphitheater, Prov. Hall; 230-6086.
January 29	Colposcopy—An Update and a Review; Duane E. Townsend, M.D., FACOG; Red Lion, Jantzen Beach; pre-registration required; sponsored by Providence Medical Center; 230-6085.
February 3	1983 Internal Medicine Review Session: Cardiology I; John McAnulty, M.D.; 6:00 p.m.; Amphitheater, Prov. Hall; 230-6086.
February 6	Advances in Medical Genetics; Red Lion, Jantzen Beach; sponsored by Tri-County Chapter of the March of Dimes Birth Defects Foundation and Oregon Children's Medical Center; for information and registration call 222-9434.
February 8	Visit Your Legislator in Salem; sponsored by MCMS Auxiliary; contact Darlene Dunhan, 248-9160.

in summary

February 9 Nutrition Alternative—A New Dimension in Health; 7:30 am; Red Lion, Lloyd Center; sponsored by Safeway Stores, Inc. and the School of Health and Physical Education, Portland State Univ.; contact Bridget Flanagan, Public Relations Mgr; 656-1461.

February 10 1983 Internal Medicine Review Session: Cardiology II; Edward Murphy, M.D.; 6:00 p.m.; Amphitheater, Prov. Hall; 230-6086.

February 11 OMA OMPAC Meeting; Salishan Lodge; 226-1555.

February 11-13 MCMS Winter Conference; Salishan Lodge; 222-9977.

February 14-18 14th Annual Family Practice Review; Red Lion, Lloyd Center; sponsored by the Division of Continuing Medical Education, OHSU; 225-8700.

February 17 1983 Internal Medicine Review: Hematology I; Peter Kane, M.D.; 6:00 p.m.; Amphitheater, Prov. Hall; 230-6086.

February 21 Washington's Birthday; Society Offices Closed.

February 21-25 Clinical Approach to Disturbances of Fluid, Electrolyte and Acid-Base Balance; Vail, CO; pre-registration required; American College of Physicians, P.O. Box 7777-R-0510, Philadelphia, PA 19175.

4th Annual Conference on Problems in Gastroenterology: A Clinical and Pathological Approach; Keystone, CO; pre-registration required; American College of Physicians, P.O. Box 7777-R-0510, Philadelphia, PA 19175.

February 24 1983 Internal Medicine Review Sessions: Hematology II; Gordon Doty, M.D.; 6:00 p.m.; Amphitheater, Prov. Hall; 230-6086.

Shape up for Life; 9:45 a.m.; OMA building; sponsored by MCMS Auxiliary; contact Becky Kalez, 222-7249.

March 3 1983 Internal Medicine Review Sessions: Hematology III; David Regan, M.D.; 6:00 p.m.; Amphitheater, Prov. Hall; 230-6086.

March 4-5 Complex and Controversial Issues in Multiple System Trauma; Red Lion, Downtown; sponsored by the Division of Continuing Medical Education, OHSU; 225-8700.

March 7-11 9th Stanford Palo-Alto Medical Research Foundation Winter Course in Infectious Diseases; Sun Valley, ID; pre-registration required; American College of Physicians, P.O. Box 7777-R-0510, Philadelphia, PA 19175.

March 10 1983 Internal Medicine Review Sessions: Pulmonary Diseases I; James Patterson, M.D.; 6:00 p.m.; Amphitheater, Prov. Hall; 230-6086.

March 10-11 Workshop in Dermatopathology; OMA building; sponsored by the Division of Continuing Medical Education, OHSU; 225-8700.

March 16 MCMS Board of Trustees; 6:00 p.m.; MCMS.

March 17 1983 Internal Medicine Review Sessions: Pulmonary Diseases II; Drs. Lawyer/Keppel; 6:00 p.m.; Amphitheater, Prov. Hall; 230-6086.

March 18-27 MCMS Hawaii Conference; Maui; contact Mary Kay at Churchill Tours; 243-3450.

March 24 1983 Internal Medicine Review Sessions: Endocrinology I; Huldrick Kammer, M.D.; 6:00 p.m.; Amphitheater, Prov. Hall; 230-6086.

March 25-26 Endourological Percutaneous Stone Extraction; 7:30 a.m.–5:00 p.m.; Long Island Jewish-Hillside Medical Center, NY; pre-registration required; Ann J. Boehme, Continuing Education Coordinator, (212) 470-2114.

March 31 1983 Internal Medicine review Sessions: Endocrinology II; Huldrick Kammer, M.D.; 6:00 p.m.; Amphitheater, Prov. Hall; 230-6086.

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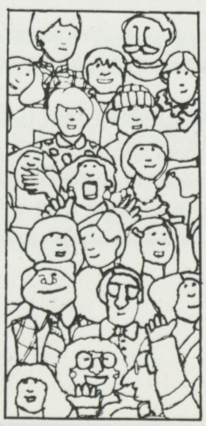

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continued from page 47

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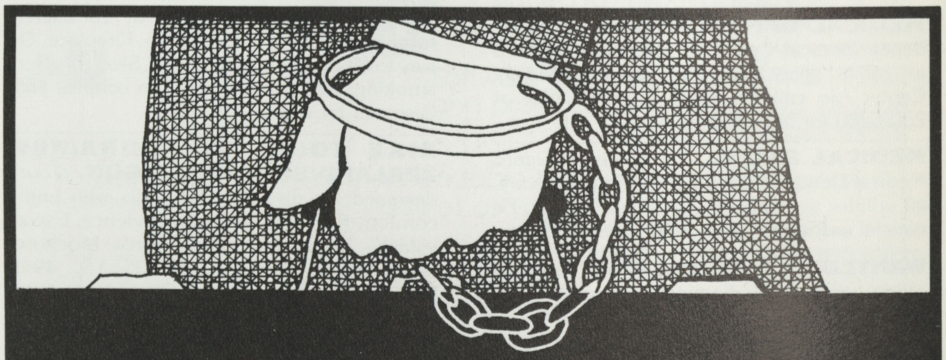

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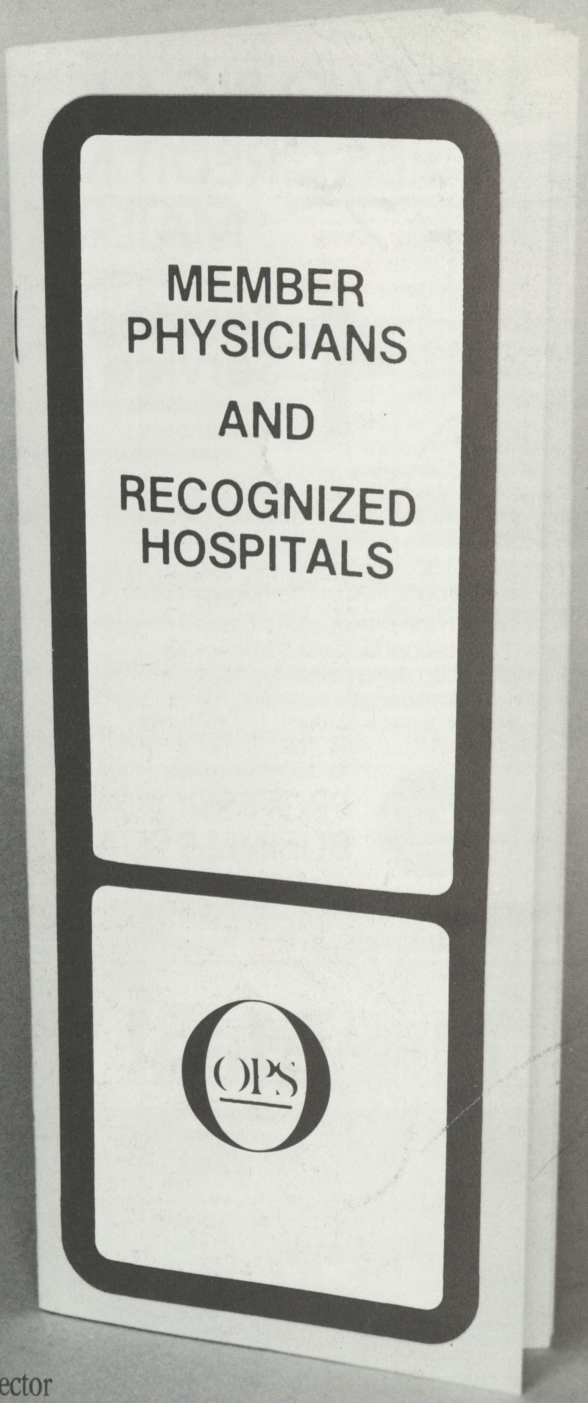

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You have a say through the Physician Medical Advisory Committee who sets medical policy.

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.

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