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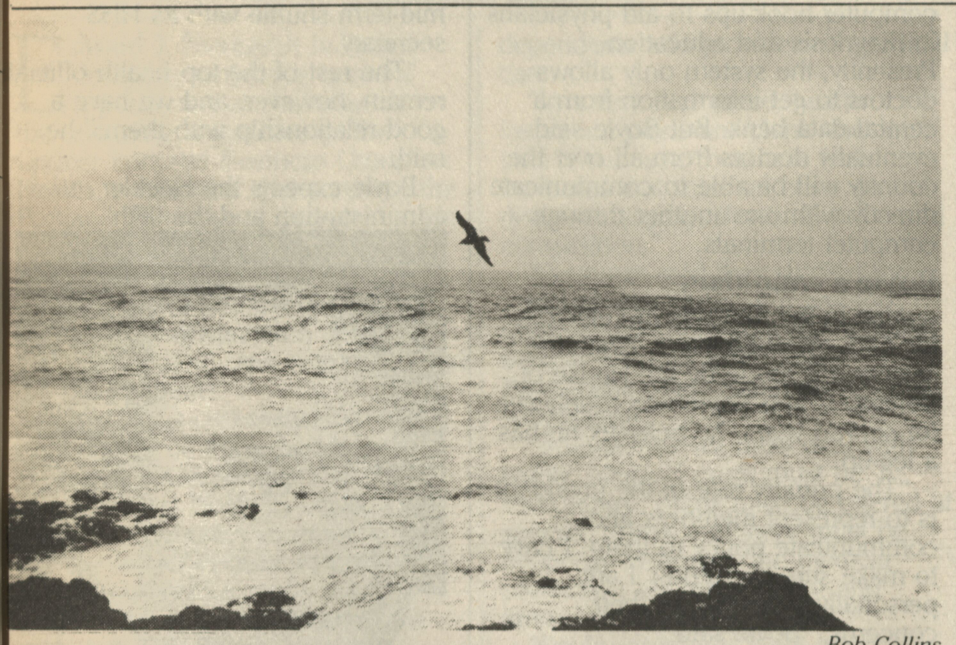


Bob Collins

Salishan speakers warn of changes in medical delivery

By Tom Gauntt

Medicine is caught up in a world of rapid, often unpredictable change, according to speakers at the Multnomah County Medical Society's 23rd Annual Winter Conference, but this revolution in progress presents some challenging opportunities to map out a new future.

While doom and gloom prevaded the speeches at the two-day conference held at Salishan, there were also several optimistic calls to action as well as some sobering insights gleaned from personal observations.

U.S. Representative Ron Wyden, State Senator John Kitzhaber, AMA Board of Trustees Chairman Joseph Boyle, nationally-known health care consultant Jeff Goldsmith and Portland physician Albert Vervloet addressed the nearly 100 attendees February 11-13.

Wyden, a second-term Congressman noted for his leadership in health care issues, warned that health in this country is becoming too costly and in the future we risk what he calls "a disasterous and unthinkable" situation — the rationing of health care.

Kitzhaber, a Roseburg physician, said there were currently forces at work in the nation that strike "at the heart" of medicine as it is practiced today.

"Organized medicine stands at a crossroads. We are caught up in the tides of change," he said. "We must recognize that change is upon us — driven by forces we cannot stop."

He called on doctors to become more involved in the political process and assume "a leadership role."

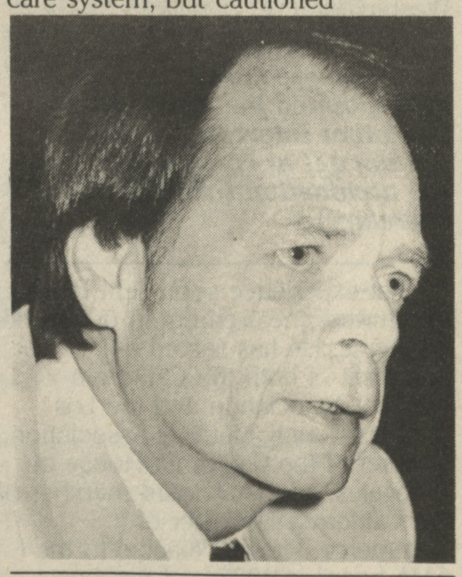
Goldsmith, a technical adviser in the health field for Ernst & Whinney accounting firm, agreed that the medical profession must take control of its own destiny.

"If you do not initiate your own (system) you will find one imposed on you by people who do not understand the health care system," he said.

Goldsmith also presented figures showing a steady decline in hospital use in the last 15 years.

"We probably have more hospitals in this country than we actually need," he said, calling the idea of large unlimited hospitals "intellectually and politically bankrupt," but noting that major revision of a hospital-based health care system was "not politically supportable" at this time.

Boyle, a candidate for AMA president-elect, joined the concerned chorus in singing out a warning about needed changes in the health care system, but cautioned



Dr. Joseph Boyle, AMA board of trustees chairman

physicians to be wary of the interventions of politicians in forming a new system.

"They could destroy the system. They could do so without even recognizing that they had set upon that course," he said.

Although concerned about medicine's future, Boyle dismissed the Chicken Littles predicting an apocalypse.

"I will submit to you that for the past 20 years economists, environmental scientists and political seers have been predicting the collapse of the private medical care system in the United States, including hospital systems, freedom of choice and fee for service," Boyle said. "Somehow we have survived

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Higgins blasts government for medically poor's plight

By Steven Arnick

Tom Higgins is the Director of the Multnomah County Department of Human Services, an agency that is suffering the effects of massive federal and state budget cutbacks and the county's decision to limit property tax growth to six percent per year. But unlike many government administrators in similar straits, Higgins does not bemoan his budget woes in terms of percentages or staff reductions. Instead, he concerns himself with people who need help — particularly the growing legion of the medically indigent who are without the financial means to secure adequate health care.

Higgins is a man who says he encourages his agency "to use our skills at manipulating the system" to try to secure care for poor people who otherwise might go without needed medical care. But he knows such skills cannot solve economically-and politically-based problems that he says are riddling health care systems locally, statewide and throughout the nation. And though he has high regard for the efforts of the local medical community to provide charity care, Higgins believes that government has not assumed its rightful share of responsibility for providing aid to the poor.

In this **SCRIBE** interview, Higgins takes aim at the problem and suggests some solutions.

SCRIBE: Are increasing numbers of people not receiving adequate care in the Portland metropolitan area?

HIGGINS: Clearly. The Blue Ribbon Committee researched that question and quantified it to point to about 95,000 people in Multnomah County who have either inadequate medical coverage or no coverage at all. The problem has been deeply exacerbated by the continued economic recession — almost depression — that we're in.

SCRIBE: Who are the medically indigent in this area?

HIGGINS: They are people who have recently become unemployed and do not have access to coverage formerly provided through their job or access to health care provided by the government.

They are people who are aged, blind, disabled and too poor to afford their own medical coverage but not so completely destitute as to meet the stringent requirements for public assistance.

They are people who are employed in relatively low-level jobs that don't pay much. They can't afford health care coverage and yet they have no health care coverage provided as part of their employment. So they fall into a sort of limbo.

SCRIBE: What is the most rapidly growing group of the medically indigent?

HIGGINS: People in their twenties and thirties, because that's where unemployment is highest.

SCRIBE: What kinds of cutbacks in services for the medically indigent have you been seeing in Multnomah County?

HIGGINS: They've come from two sources, primarily — the state and county. There have also been cutbacks from some private providers who are unable, because of their own financial difficulties, to provide medical assistance. For

Dan Carter

Tom Higgins, director of the Multnomah County Department of Human Services feels government has not assumed its rightful share of responsibility in providing health care to the poor.

example, most of the hospitals in this area long ago exceeded their Hill-Burton requirements and have not been able to provide charitable medical assistance.

The Hill-Burton program was essentially a program of hospital construction in the 1950s and 60s in

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Inside. . .

EXCLUSIVE INTERVIEW

AMA officer discusses PPOs, Heckler, FTC

By Tom Gauntt

Like many physicians, Dr. Joseph Boyle enjoys a good round of golf. But from his suite at Salishan overlooking the rainy, wind-swept course of this Oregon Coast resort, he says he is not interested in strolling across the links.

"Not this weekend," he said.

As chairman of the AMA's board of trustees and a candidate for AMA president-elect, the 58-year-old Los Angeles physician is on another course that finds him more often in the halls of power than the club house locker room.

Dr. Joseph Boyle, AMA board of trustees chairman, and Dr. J. Halisey (Spike) Kennedy, MCMS president-elect, take a break between presentations.

"For 30 years I've said golf was one of my hobbies," Boyle said. "Now I find I hardly have time to play."

While in Oregon to speak at the MCMS 23rd Annual Winter Conference, Boyle paused for a while to be interviewed by the Scribe. In the wide-ranging interview, he teed off on the phenomenon of preferred provider organizations (PPOs), drove on the dog-legs of national health politics, and made a few marks on the AMA's future scoreboard.

PPOs

"We're seeing a major revolution in people's perception of how they want to take care of themselves," Boyle said.

This change in how consumers look at things is reflected in medicine itself and, in some instances, Boyle does not like what he sees. He believes PPOs are threatening the basis of medicine in the United States.

"If I were a patient, I would wonder if the preferred provider of my choice would be the same as my employer or trust fund's choice."

A PPO is an arrangement in which a group of doctors and/or hospitals contract with an employer or other group of buyers to provide a defined array of services at a set price, usually at a discount.

"If I were a patient, I would wonder if the preferred provider of my choice would be the same as my employer's or trust fund's choice," Boyle said.

Boyle does not believe many doctors will participate in PPOs even though the pressure to do so, both from within and outside the profession, may be great.

"Most PPOs force doctors to give up the traditional freedom they enjoy in dealing directly with patients and being responsible to those patients instead of another entity," Boyle said. "Doctors are looking at PPOs cautiously. They might easily bend the system."

And while some argue that the health care system needs a little bending during tough economic times, Boyle said the relationship between doctor and patient is too important to become a political or economic trading chip.

"Independence could be forfeited and never regained," he said.

Boyle also has serious reservations about the form of PPOs and the people who put them together.

"They're entrepreneurs whose motivation, as far as I can tell, is to make money for themselves," he said. "There's a difference between "selling" and "marketing." Selling is simply selling what you have. Marketing is offering what you can sell. The people putting PPOs together don't have anything to sell. They are trying to obtain physicians' services so they can sell them."

Boyle further believes that if PPOs grow larger, they would "probably be in violation of anti-trust acts."

Technology

If one side of the medical revolution is in the business office, the other side is in the research lab. Medical technology has become so effective in recent years that its strength and power is almost overwhelming.

"We're capable of reshaping lives. We are able to maintain people in a living state far beyond the point where they know they're alive," Boyle said. "These advances create additional pressures and costs. Just how far does one go to salvage the life of a severely premature infant? The emotional and monetary costs are enormous."

This increasing ability to extend life also adds to the already well-established mystique of the doctor. The result, according to Boyle, is to further distance the physician from the patient.

"How can we use this technology without having the doctor appear to play God?" Boyle asks. "It's part of the depersonalization of care that makes it seem like we're just a set of machines taking care of people instead of people taking care of people."

Boyle is pleased that young doctors who have grown up in the world of medical miracles are not being seduced by the machine.

"Younger residents are using high tech/high touch," he said.

This crush of new doctors and technologies is having its affect on the structure and function of the AMA Boyle hopes to head. In the 1970s, Boyle pushed to include representation from interns, residents, medical students and specialty societies in the AMA House of Delegates, in recognition of the profession's youth and diversity.

In 1978, the AMA staff structure was completely reorganized. Part of this move was due to the perception of AMA members that the organization was "not doing a good job in continuing medical education." Also during this time, the AMA was feeling a membership pinch as physicians left the organization to join specialty societies.

Now the AMA has jumped into the communications revolution, organizing a nation-wide network of computer hook-ups to aid physicians in diagnosis and education. Presently, the system only allows doctors to get information from a central data bank. But Boyle said eventually doctors from all over the country will be able to communicate directly with one another through computer terminals.

Boyle's candidacy

Also in the future is the election for AMA president-elect. Since the selection is made by the House of Delegates, and Boyle was a delegate for several years, he believes he has a leg-up.

"The primary role of the president is to represent members and communicate policy to them. I have to make sure they know I am personally interested in their concerns," Boyle said.

Boyle himself became involved in organized medicine because of his personal concerns.

"I saw some issues I thought were important to the practice of medicine. Those issues have never really gone away," he said. And those issues, with others, have been what fuels Boyle as he has worked in organized medicine for over 25 years.

"It's never been part of my agenda to be elected to some position just to have it," he said.

A private practitioner of internal medicine and diseases of the chest, Boyle worked with a Los Angeles radio station to help drum up support for a clean air amendment in Congress to reduce intense smog in Southern California. The effort drew over 1 million petition signatures that were sent to Washington D.C.

". . .we were sorely disappointed that the AMA and other interested parties did not get to contribute to the nomination (of HHS secretary)."

That experience soon sent Boyle into further involvement in organized medicine. He has served as president of both the California Medical Association and the Los Angeles County Medical Association, speaker of the California House of Delegates, and is a board member of the California Chamber of Commerce. He was elected to the AMA board in 1975 and has been chairman of the board of trustees since 1981.

All that is a pretty major accomplishment for someone who modestly says of his political abilities, "I am told my taking a side in a debate makes a difference."

Secretary Heckler

But Boyle did not get a chance to work his persuasive talents on the Reagan administration earlier this year when Secretary of Health and Human Services Richard Schweiker resigned and was replaced by former Congresswoman Margaret Heckler. The administration did not consult the AMA about either action.

"We were aware that Schweiker was considering leaving, but we were sorely disappointed that the AMA and other interested parties did not get to contribute to the nomination," Boyle said. He added that Secretary Heckler lacks experience in health affairs but ha "deep and abiding interest in heal care."

The AMA must now learn to wo with a new administrator, just two years after being introduced to Schweiker. But Boyle said rotating administrators is nothing new to Washington.

"Anytime there's a change it creates a whole new process. It simply means we have to go back and do it all over again." Boyle sa pointing out that the Carter administration performed the sam mid-term shuffle with its HHS secretary.

"The rest of the top health offici remain, however, and we have a good relationship with them," he said.

Boyle expects the Heckler administration and the 98th

Boyle said recent three-way discussions between the AMA, FTC and Justice Department have yielde consensus and compromise.

Congress to limit the amount of money paid for health care and access to that care.

"After two decades of expansionism, people are demanding more than government thinks it can afford. Government is holding its resources and I think w will continue to see more of that."

Although President Reagan's tendency is to contract rather than expand government, Boyle said th AMA will continue to push for a Department of Health separate fro the Department of Human Service

"The two (health and human services) can get intertwined, especially if run by the same administrator," Boyle said.

Knowing Reagan's less-government-is-better-governme philosophy, Boyle said the AMA w suggest a reorganization of HHS w separate undersecretaries for healt and human services. He said the move should improve both areas and place greater attention on quality of care.

"If you have an undersecretary whose primary background is welfare, he is more likely to favor over health," Boyle said. "Health care would lose out. It's essential, sooner or later, to get a single hea administrator."

The FTC

The conflict over jurisdiction between organized medicine and t Federal Trade Commission is another running battle, but Boyle said the AMA's influence has been more strongly felt in this one.

He said recent three-way discussions between the AMA, FT and Justice Department have yield consensus and compromise.

"We have insisted that medical associations have a legitimate pla in protecting patients' rights," Boyl said of the controversy over wheth organized medicine should police itself or be under the hand of a federal agency. "Now the Justice Department and the FTC agree wit us. They just want to see to it that no anti-trust action takes place."

He said he expects a proposal outlining responsibilities between

the FTC and organized medicine to go before Congress this session. And since the proposal will be backed by the AMA, FTC and Justice Department, Boyle said the legislation should pass.

Despite the controversy and changing climate in medicine today, Boyle said he would still recommend a career in the field to any of his eight children "if they were so inclined."

"Medicine to me is still exciting. We are able to do so many things," he said. "There are opportunities for many different kinds of talents — teaching, research, administration. It is very satisfying."

Local employers want competition in medicine

By Jeanne Leeson

Edward J. Nieubuurt is Hyster Company employee benefits supervisor and chairman of the operating committee of the Greater Portland Business Group on Health, a coalition sponsored by the Portland Chamber of Commerce. He works with a committee comprised of executives from 55 of Portland's largest and most influential companies, representing over 250,000 Portland-area employees and their dependents.

Also on the committee are representatives from the Multnomah County Medical Society, the Greater Portland Area Hospital Council, Kaiser-Permanente, insurance companies and public employers.

"Our committee came together because all of us find health care costs too high for businesses to handle," said Nieubuurt.

He cited his own company. For the last five years, the cost per capita of their health care plans rose at a compounded rate of 21 percent, which means a rise of 150 percent over five years, while the Consumer Price Index rose 68 percent.

He said this health issue will not disappear with a better economy because business has a lack of control. Company costs are controlled by employees, their dependents and providers of medical care.

"In a very real sense, health insurance plans are blank checks," said Nieubuurt, "business feels frustrated that medical costs do not deal with supply, demand, price and competition."

Nieubuurt said they studied the Portland area because it has too many physicians, too many hospital beds and because the Kaiser-Permanente plan continues to grow successfully.

"Somewhere we must deal with reality. Medical costs must be competitive, plans must be offered at specific prices and there must be economy instead of the medical profession asking for more and more," he said.

Nieubuurt knows there is no dramatic answer to the problem. It's not a matter of simple competition. Insurance, medicine and government are interrelated. Businesses have been forced to pay doctor and hospital bills for those unable to pay. At best, the solution will be gradual.

He also believes businesses have contributed to the problem by negotiating and implementing more generous benefit plans for their employees with little regard for cost.

"What we want are 'restrained' medical costs, something between 'reduced' and 'improved.' Businesses want to be more business-like in the purchase of health care," he said.

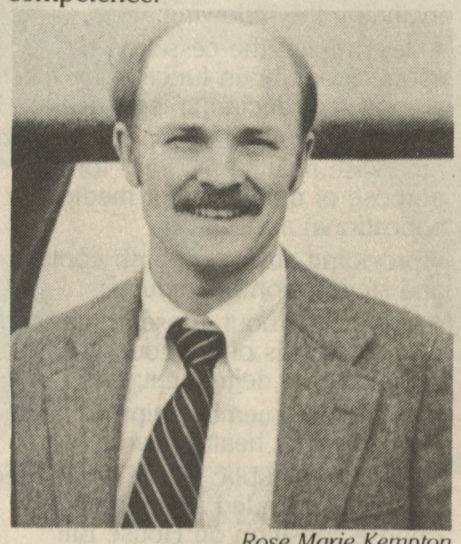
Nieubuurt doesn't just complain, he has suggestions.

First, he would like a meaningful choice of suppliers, whose prices are explicit and whose services may be purchased at agreed-upon prices.

Second, he would look for suppliers whose services include cost efficiencies such as wellness, self-care and ambulatory surgery.

"Business people are not health experts so we would look for suppliers to advise and assist us on cost efficiencies," he said.

Third, the plan needs to provide employee satisfaction, including accessibility, responsiveness, personal concern and professional competence.



Rose Marie Kempton

Ed Nieubuurt is chairman of the operating committee of the Greater Portland Business Group on Health.

"I think there is a great opportunity to build a positive response to fitness, self-care and out-patient services while trimming excesses in hospitalization, defensive medicine and income-quota practices," he said.

Fourth, Nieubuurt seeks a solution to the "cost shift" practice. He said Portland hospitals show the cost shift averages 30 percent, a cost which falls disproportionately to business as a major purchaser of health care.

"In my view, the health care industry has shown a remarkable capacity to raise its level of costs, absorb the dollars made available to pay those costs and still generate revenue shortfalls that have to be shifted," said Nieubuurt.

To tackle the problems, five task forces are at work, each focusing on a special area.

The Data Task Force investigates costs of various diagnoses, treatments and providers. They are working on a three-tiered system with regional data, data for industry groups and employer-specific data.

The Legislative Task Force will present the business perspective on health-related legislative issues, such as mandated insurance benefits and Medicare and Medicaid regulations.

The Wellness Task Force will try to determine how businesses can proceed in this new area and how to predict and measure the return achieved.

The Alternative Health Care Systems Task Force hopes to develop and promote alternatives that prove to be cost effective.

The Education and Information Task Force will coordinate the materials to be published and will arrange educational presentations for the membership.

"This is not a trendy or faddish issue that will be replaced by something more fashionable next year. Solutions are a necessity for business and they are being sought with increasing commitment and innovation," said Nieubuurt.

Already, businesses have begun to ask questions with broad implication, he said.

- How should business use the leverage available to it from coalition activities?
- Could and should business refuse to pay some of or all of the cost shift burden?
- Should business foster or support regulatory mechanisms such as rate commissions and prospective reimbursement programs?
- Should business take an active part in attempting to reduce excess hospital capacity?
- How active should business be in promoting employee health? For instance, should participation in health promotion be a requirement for employment like other performance standards?

"What we have done may sound innocent enough, but I think it will lead to significant changes in the delivery and financing of health care and the incentives that drive the system," Nieubuurt concluded.

MCMS receives OMPAC award

MCMS received the first annual Blair J. Henningsgaard, M.D. award for achieving a higher percentage increase in OMPAC membership than any other component society.

Bob Collins

OMA President Dr. Genevieve Burk presents Dr. George Caspar, immediate past-president of MCMS, with OMPAC's 1982 Blair J. Henningsgaard Award.

"I'm proud to give this award," said Dr. Daniel Billmeyer, OMPAC chairman. "Those of us involved with OMPAC thought it would be fitting to honor Dr. Henningsgaard with a memorial award because he was instrumental in starting political action for physicians locally and nationally."

continued

A gifted orator, Henningsgaard frequently testified before the state and national legislature until his death in 1980, Billmeyer said. Henningsgaard was OMA president in 1961-2 and helped form OMPAC during his presidency. He also served as AMPAC chairman in 1967-8. Although he practiced in Astoria, he was an honorary member of MCMS.

Billmeyer hopes the award will stimulate OMPAC membership. In 1982, OMPAC had 1,011 physician members — over a third of the OMA — and 60 non-physician members. MCMS got credit for 413 of those members, 405 of whom are physicians. OMPAC dues are $50 per year for regular membership, $100 for sustaining membership, and $200 for timbertopper membership.

OMA NEWS

Legislators face major health policy bills

By Genevieve S. Burk, M.D.

The issues facing organized medicine in the state legislature this session are a familiar assortment: something old, something new and something borrowed. The only missing element is something blue — and physicians may indeed be blue if many of the proposals under consideration are enacted into law.

Proposals to expand the scope of practice for alternative providers are with us each session. House Bill 2023 is an attempt to statutorily include naturopaths in many areas of traditional medical practice, including the following:

- determining the cessation of spontaneous brain function for the purposes of declaring legal death;
- diagnosing the "orthopedically and otherwise health-impaired" for the purpose of qualifying for medical or educational assistance;
- providing advice on birth control and sterilization procedures;
- treating, without consent, minors who are wards of the court, dependent or delinquent; and
- mandatory membership on county/district health boards.

The OMA Public Policy Committee has recommended a "strongly oppose" position on House Bill 2023, which has been the subject of two "Legislative Alerts" in the past month.

House Bill 2029 is the Pharmacy Board's suggested remedy to the confusion over the naturopath's right to prescribe legend drugs, particularly controlled substances. OMA strongly supports this bill, which would end the divergent interpretation of the definition of "drug" in the naturopathic statute and bring it into conformity with other medical practice statutes. This bill would effectively restrict naturopaths' access to controlled substances and restore them to their statutory definition of "drugless" practitioners.

Traffic safety issues are also resurfacing, but with renewed vigor and support from many special interest groups. 1983 might well be called "The year we finally got the drunk driver off the road" if any of several legislative proposals are successful. Although at least 30 separate bills take aim at portions of the current law which inhibit enforcement of DUI statutes, the Governor's Task Force on Drunk Driving will be introducing a comprehensive "get tough" bill that will also conform with rigorous federal requirements for additional highway safety funds.

Prospects for passage of a child passenger restraint bill are also good. As of this writing, Senate Bill 293, which was introduced by Senator Rod Monroe and co-sponsored by 16 senators and 34 representatives, has been sent to the Senate with a "do pass" recommendation. The lobbying effort for this proposal began well before the legislative session and is a product of a coalition of diverse parties, including organized medicine, traffic safety organizations, insurance company representatives, automobile manufacturers, public health departments and public officials. Governor Victor Atiyeh's wife, Dolores, offered testimony at the most recent hearing before the Senate Transportation Committee.

The third item on OMA's traffic safety agenda is reinstatement of the requirement that motorcycle riders wear protective headgear. This bill, HB2696, has been introduced by Representative Mary Alice Ford.

State Health Plan

Something new includes a variety of proposals that significantly impact the delivery and financing of medical care. Perhaps the most sweeping proposal is House Bill 2025, the State Health Plan (SHP), which was initially proposed by former Multnomah County Executive Don Clark.

This bill would reorganize medical care services into "certified health plans" that would compete with one another statewide for the health care of all Oregonians. SHP supporters claim the system could be financed by pooling all existing resources, including employer-paid insurance premiums, Medicaid funds and Medicare monies. Participation would be mandatory, and all providers hoping for reimbursement would be forced to organize into an approved health care "plan" which would have to offer a minimum benefit structure. SHP also features a number of cost-containing provisions, including beneficiary cost-sharing in the form of premium shares and optional co-payments.

A more welcome solution to the problems of patient access and provider reimbursement is House Bill 2610, which would allow credit against personal income taxes for the difference between a provider's customary charge and the amount received as medical assistance payments.

If Senate Bill 191 is passed, Oregon will also have a new "Oregon Health Council" — formerly the Statewide Health Coordinating Council — which would play an expanded role in the definition of state health policy. The State Health Planning and Development Agency would also take on additional responsibilities under this proposal, including health policy research and a concomitant advisory function to the Executive Department and legislature.

Senate Bill 191 would also raise the maximum certificate of need application fee to $6,000; exclude verbal testimony from the CN appeals procedure; authorize SHPD to establish cost containment goals and critera by administrative rule, and require hospitals to give SHPD comprehensive patient discharge data. The bill would create a structure for assessing significant fines for non-compliance with SHPDA reporting regulations, with the revenue from these fines dedicated to SHPDA's budget.

Medically needy program

The Oregon Coalition for the Medically Needy is hoping Oregon will borrow an answer for the problem of providing medical care to certain indigent populations from other states by opting to participate in the federal Title XIX Medically Needy program. The medically needy proposal, which the OMA House of Delegates supported in concept last November, has not been printed as of this writing, but has been assigned a bill number, HB 2805. This bill will be the subject of intense lobbying by numerous groups who hope to secure health care financing for those whose income falls between 100 and 133 percent of the welfare cash grant standard.

There are, of course, many other issues before the state legislature that concern organized medicine. The State Board of Medical Examiners has introduced a bill that revises many of their procedures and separates them from the State Health Division (SB 267). House Bill 2519 would remove the confidentiality provision that applies to BME proceedings.

A number of bills address the definition of "mental disease or defect," and there are a variety of suggestions to revise the Worker's Compensation program.

More than ever before, 1983 will be a year of difficult decisions for state legislators. Faced with diminishing resources and burgeoning needs, they will necessarily seek fiscal compromise. The role of organized medicine is to assure those compromises do not affect the quality of medical care.

In addition to the professional lobbying efforts on our behalf, all physicians should stand ready to participate in the legislative process as advocates for their patients, their peers and their profession.

Dr. Burk is OMA president

MCMS members run for OMA posts

Three MCMS members are running for OMA offices. Dr. Thomas R. Reardon is running unopposed for president-elect; Dr. Jack B. Blumberg is running against Dr. J. Allan Henderson of Hood River for vice-president; and Dr. George H. Caspar is running against Dr. Robert E. Inman of West Linn for secretary-treasurer.

Reardon was MCMS president in 1981, recipient of the Society's 1983 Distinguished Service Award and is chairman of the Public Policy Committee. He is currently OMA vice president, chairman of the OMA Private Practice Committee, and a member of the steering committee for the new AMA section on hospital medical staffs.

Blumberg is a former MCMS trustee and has been speaker of the OMA House of Delegates since 1979. He has served as chairman of the MCMS Public Policy and Public

Relations Committee and the OMA Private Practice Committee.

Caspar was president of the MCMS in 1982 and previously served as MCMS treasurer and second vice-president. He has chaired the Grievance Committee and is currently an OMA trustee and vice-chairman of OMPAC.

The OMA will send out ballots and voters' pamphlets March 24, and the results will be announced at the House of Delegates April 22-24 in Eugene.

AIDS unites gays, doctors

By Allan Classen

For gay persons, finding a satisfactory physician presents a distinct dilemma. They must reveal their homosexuality to insure that certain illnesses are properly diagnosed and treated, but in so doing, they risk moral disapproval, loss of confidentiality and insensitive reactions from doctors who are uncomfortable with, or simply ill-informed about, their sexual orientation.

For these reasons, many local gays seek referral through Phoenix Rising, a support organization for homosexual men and women, which maintains a list of about 70 physicians who are willing and prepared to serve homosexual patients. Those 70 are the only ones who responded to a letter from Phoenix Rising asking if they would accept such referrals and Executive Director Jerry Weller said that number is scarcely adequate to meet the volume of requests he receives. But he contends the situation is far from hopeless. Asked if he believed physicians were opening up to the special needs of gay patients, he said, "Yes I really do. The medical community is responding to us as a group. I hadn't seen that much of it before. I'm really pleased."

The main impetus for the recent progress has been the discovery of acquired immune deficiency sydrome (AIDS), the mysterious and often fatal disorder that has struck over 800 people in the U.S. since 1981, three-fourths of them homosexual males. Dr. John Santa, director of the outpatient clinic at Good Samaritan Hospital, attended a conference on AIDS in San Francisco last fall and since then has been prodding his colleagues toward a fuller appreciation of not only this disorder but the more routine health needs unique to gays.

"This unfortunate episode with AIDS has served as a vehicle to help doctors learn about other health problems gay patients have," Dr. Santa said, explaining that physicians have to be open and sensitive in order to make their gay patients comfortable enough to reveal their sexual activities.

Physician attitudes

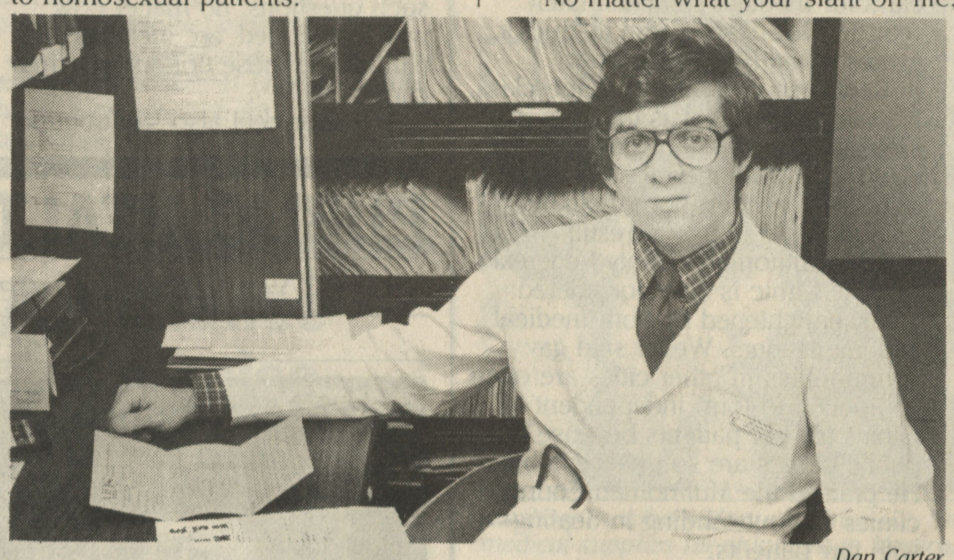
Though a 1970 study of Oregon physicians indicated that a vast majority felt their attitudes toward male homosexuals did not impair their ability to provide treatment, Santa, Weller and numerous medical studies suggest that personal prejudice toward homosexuality can indeed get in the way.

Several sources conclude that physicians who assume all their patients are heterosexual may intimidate their gay patients into hiding their sexual preference. Weller, who served on Gov. Robert Straub's Task Force on Sexual Preference, cited an example of a lesbian in Oregon who was thought to be having pregnancy complications until she explained that her lover was female.

Weller also noted that partners of homosexual patients in Intensive Care Units are refused visitation rights because hospitals generally recognize only traditional family members.

Santa includes himself when he says most doctors have a "previous bias" toward homosexual patients that undermines their ability to satisfy the patients' medical needs.

"Physicians could do a better job of getting in touch with the feelings that gay patients generate," he said, listing confusion, fear and mystification as common reactions to homosexual patients.



Dan Carter

Dr. John Santa, director of Good Samaritan's outpatient clinic, is working to increase the medical community's understanding of AIDS, an often fatal disorder prevalent among homosexual men.

"There are still an awful lot of physicians who feel uncomfortable with gay patients," said Dr. Estill Deitz, whose practice services a large share of homosexuals. He said the fact that no Portland physicians are openly gay is another indication of intolerance within the medical community, but he concurs with assessments that the local profession is becoming more concerned with the health needs of gays, partly due to the impact of AIDS.

AIDS

The growing sense of cooperation between the medical and gay communities was marked by a public seminar on AIDS February 20. Good Samaritan Hospital, Multnomah County Health Division and Phoenix Rising all helped organize the event, which was intended to educate both gays and physicians about the disorder and its impact.

Santa said many doctors still have not grasped the full significance of AIDS, adding that his own interest was limited until he attended the San Francisco conference.

"No matter what your slant on life, this is one of the most unusual diseases in the past decade," he said, describing it as a "fascinating disease," biologically and clinically, causing malignancies and unusual infections that come and go. He added that it may even hold the key to understanding the immune system.

"If we can find what their (AIDS victims') defect is, we'll understand how humans fight cancer. That's the bottom line that most physicians don't understand," he said.

The cause of AIDS is unknown, but the Center for Disease Control believes it is transmitted through infective blood or secretions. It is predominant among male homosexuals, drug abusers and persons receiving blood transfusions.

Upon returning to Portland, Santa began sharing what he had learned with other professionals and members of the gay community.

"Everyone I approached said we should get together and talk about it," he said. He was impressed that institutional barriers were ignored as physicians from various hospitals and the Oregon Health Sciences Center began sharing information freely.

The Oregon Health Division has only received two reports of AIDS, but Deitz said that figure is "way below the actual number." He attributed the discrepancy to difficulty in diagnosing the syndrome and the fact that it is not currently recognized as a reportable disease.

"I have about 10 cases I'm following at the moment," he said.

The recent warming of relations between the gay and medical communities may counteract an image of intolerance toward homosexual patients fostered by a 1977 news story. Preliminary results of a Multnomah County Medical Society survey appeared in the Oregonian under the headline, "Most doctors unwilling to treat homosexuals." It was reported that less than 20 percent of the physicians responding to a questionnaire said they would accept referrals for admitted homosexual patients.

Robert Elsner, the medical

Scribe

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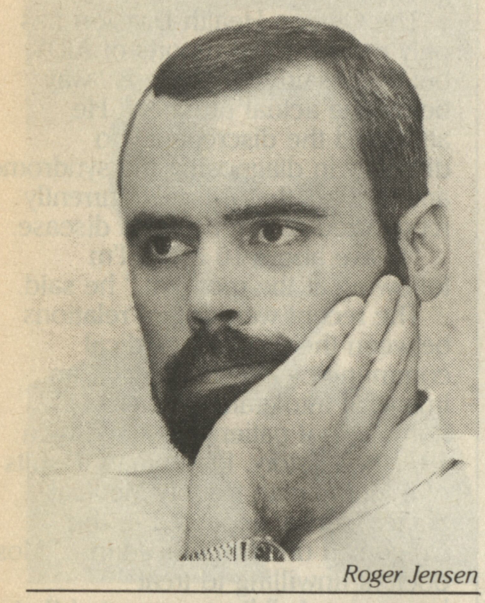
society's executive director at that time, was outraged by the article because the survey was intended to be confidential — for use in referring patients only — and because the results did not accurately reflect the percentage of doctors willing to treat gay patients. Elsner said a number of doctors had answered "no" because they thought it referred to patients who wanted to be cured of homosexuality. Those doctors either considered such treatment to be the realm of psychiatry or they did not consider homosexuality an illness.

Weller conceded that the medical society may have been unfairly slurred by the story, but Deitz



Roger Jensen

Jerry Weller, executive director of Phoenix Rising, a support group for homosexuals.

believes that, anyway you look at it, the "yes" responses were very low.

In general, public policy in Oregon has been relatively tolerant toward homosexuals. In 1971, Oregon became the second state to decriminalize sodomy, a vague statute often used against gays. In 1976, the State Board of Medical Examiners ruled that homosexuality is not a factor in granting license to practice medicine. Two years later, the Governor's Task Force released its white paper which was unswervingly sympathetic to the gay patient's point of view and called for greater awareness by medical professionals.

Relations improving

For fifteen years, the Oregon Health Sciences Center has been offering a highly-acclaimed sexuality class for medical students. Each year, Dr. Joe Trainer, the instructor, invites several gay activists to present their perspective to the class. He said the process is effective in breaking down stereotypes and that every year a number of students acknowledge their homosexual orientation to him as a result.

The Multnomah County Venereal Disease Clinic is also considered highly-enlightened by both medical and gay leaders. Weller said gay communities in other cities are often compelled to form independent VD clinics for gay patients because the public clinics are so unacceptable. He praised the Multnomah County clinics as "outstanding in dealing with gay patients."

Weller considers Portland "pretty progressive — a comparatively easy city to be gay in."

"Though the medical community may not be on the vanguard," he said "I believe a doctor will soon feel strong enough to open an all-gay practice." [f]

Medical groups ignore blood ban

By Allan Classen

The National Hemophilia Foundation's (NHF) call for a ban on blood donations from male homosexuals to prevent the spread of AIDS has drawn little acceptance locally.

The recommendations that gay men not be allowed to donate blood, and that blood collection be halted in areas where they live, has not been adopted by the Oregon Hemophilia Foundation, said Director Everett Lovrien, who is also a medical advisor to the Oregon chapter of NHF.

Though conceding there is some logic to a ban in that AIDS has been heavily concentrated in the gay male population, Dr. Lovrien said there are better ways to protect hemophilia patients and others needing blood products.

"The best way to go is to make a better product," he said, explaining that the virus or particulate that causes AIDS may be inactivated by applying heat or through other procedures.

The Oregon Hemophilia Foundation is also defying a more recent recommendation from NHF that blood products not be given new hemophilia patients until adequate safeguards are discovered. Lovrien said hepatitis B, a carcinogenic virus affecting virtually all hemophilia patients, "is a lot bigger worry than this AIDS business."

"It sounds discriminatory against homosexuals," he said of a ban on gay blood donors, "and I don't know if it would solve anything."

"You can't stigmatize an entire minority," said local gay activist Jerry Weller, adding that similar proscriptions against groups such as blacks or women would be unthinkable. He believes an individual's medical history, and not their sexual history, should determine their fitness to donate blood.

Dr. Helen Tochen of the Portland office of the American Red Cross, said her agency has not changed its donor screening procedures to accord with NHF's recommendation. Their policy is drawn from a joint statement issued in January by the American Red Cross, the American Association of Blood Banks and the Council of Community Blood Centers. It says the link between gays having AIDS who donate blood and recipients of blood products who later contract AIDS is incomplete, based on less than 10 cases of which only one involved a donor known to be an AIDS-carrying homosexual.

The statement said serious medical, ethical and legal implications are raised by the issue and concluded that:

"Direct or indirect questions about a donor's sexual preference are inappropriate. Such an invasion of privacy can be justified only if it demonstrates a clear-cut benefit. In fact, there is reason to believe that such questions, no matter how well-intentioned, are ineffective in eliminating those donors who may carry AIDS."

The statement also said routine screening of blood for AIDS was n advisable. There is no specific test for AIDS, but its presence can be detected by testing for several conditions associated with AIDS.

Dr. Gordon Doty, chairman of th MCMS Donor Committee, said his group plans to consider the issue later this month.

"The problem as I see it is identifying the 10 percent of the population that is gay," he said.

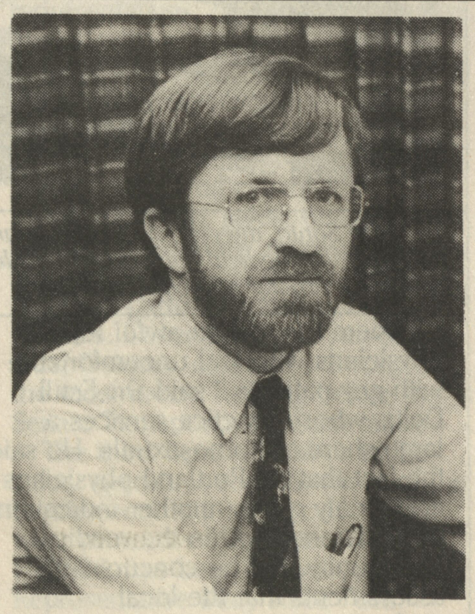
Dr. John Santa, the director of th Good Samaritan Outpatient Clinic who has shown particular interest the special medical needs of homosexuals, fears that AIDS may become a focal point of a general backlash against gay people.

"A lot of people have been waiti for something like this to happen," he said. "They take the existence o AIDS as evidence that homosexuali is improper and/or immoral." [f]

PUBLIC HEALTH LINE

"New poor" have new health problems

By Charles P. Schade, M.D.



Because of the recession, physicians are justifiably concerned that those without jobs or health insurance will be unable to obtain medical care. For certain illnesses, failure to get treatment may lead to further deterioration, additional complications or premature death.

Those who work in the public sector and volunteer clinics are seeing more patients, and the severity of their illnesses is greater. At the same time, resources for treatment are diminishing. One local volunteer clinic doubled its average patient load and found a dramatic rise in patients requiring referral or ongoing care.

Public clinics funded by Multnomah County report that their clientele is changing from "old poor" to "new poor." Calls to County Information and Referral have tripled in two years.

Hospital outpatient clinics and inpatient services are so overburdened with people unable to pay that the economic well-being of the institutions is threatened. In many non-pay situations, emergency rooms are turning away all but the most serious cases. There is substantial evidence of a large unfilled need for medical care.

But what is the actual effect of these harsh times on the health of the community? This is a far more difficult question with little data available, and I will not attempt a definitive answer in this short space. Instead, I would like to discuss the probable direct and indirect health effects of a poor economy.

Direct effects

Numerous studies show the poor have higher rates of many diseases. Collectively, these observations explain the shorter life expectancy in the lower socio-economic classes. Deaths from many causes, such as infectious diseases and infant mortality, appear to have declined more in response to a generally improving economy than the development of specific treatments.

In some causes of death, such a coronary artery disease, poor peopl have a high prevalence of the illnes precursors, such as hypertension and smoking. The poor also have more stress, such as divorce, recen widowhood and loss of a job. Behavioral/epidemiological studies in men as well as animal models suggest that life stress may aid the development of many chronic diseases, including cancer and hea disease, the two leading causes of death in late 20th Century America.

A primary manifestation of our economic situation is high unemployment. We can expect this stressful event to precipitate serious illnesses in susceptible individuals.

Although the epidemiological da that associate illness with socio-economic status are striking i their consistency, they are less clea on how physicians can intervene to prevent unnecessary illnesses and death, given the poor economic climate. Levin's monograph *The Hidden Health Care System,* a discussion of the effect of the socia environment on health, is not encouraging in its conclusions:

"Economic, behavioral, social, cultural and environmental sources of stress are not clearly influenced by medical care. Effective interactions therefore lie beyond medicine's capability. As a result, i social charter for service in prevention is undergoing an invisib but palpable revision. The public is turning to more relevant remedies through environmental protection, control of safety hazards, humanizing the work place, housin and employment initiatives, education and changes in life style (1)

In other words, physicians in the traditional practice of medicine ma be reduced to counting bodies as they fall.

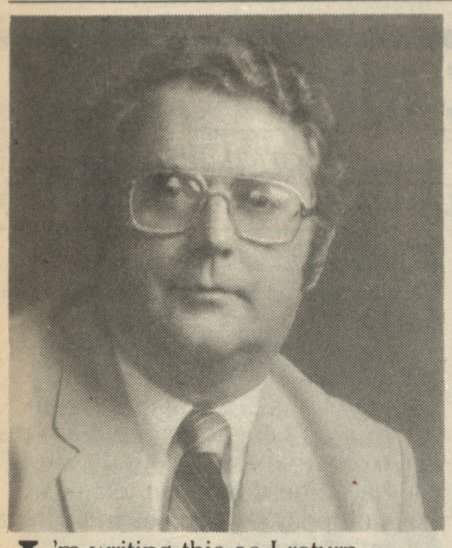
Assessing the direct effects of economic dislocation on public health will be more difficult becaus of a deliberate policy of the current federal administration, reducing the availability and timeliness of public health statistics. From delays in the production of the 1980 census reports, to slashes in the budget of the Centers for Disease Control and the National Center for Health Statistics, to the unconscionable price gouging adopted in setting th fee for the previously free *Morbidity and Mortality Weekly Report,* the Reagan administration is telling us

continued on page

PRESIDENT'S COLUMN

Soaring costs are changing the practice of medicine

By John Tarnasky, M.D.



I'm writing this as I return from the AMA Leadership Conference in Chicago. The conference concluded a frantic two-week agenda of meetings with AMA leaders, concerned Oregon physicians, health policy analysts, hospital insurance leaders and others. During this time, it has become obvious that the pressures exerted upon individual physicians and our organization are increasing at an alarming rate. Here's the "bottom line" as I see it:

However you define your role in medicine (be it a fee-for-service practitioner, HMO salaried doctor, academician, researcher, teacher, resident, intern or student), you will not pass through this period unscathed and unchanged.

The reason such dramatic change is occuring so rapidly is clear: The cost of delivering health care is perceived to be more than people want to pay for it. That's not to say people don't want top-quality health care; they just can't or don't want to pay ten cents on every dollar to get it.

As a result, those who pay for health care are becoming very creative in finding ways to purchase it at less than its total cost.

Coalitions *will* develop an economic agenda to leverage their buying power — and their actions *will* result in new health care insurance coverage, different types of medical care delivery and fewer providers.

Government, similarly strapped for money, *will* continue to urge socialized health care plans characterized by cost, not quality, and by an array of "alternative" providers. Further, government *will* continue to diminish its financial commitment to the provision, education and research of care. Government *will* continue to broker care to the lowest bidder, and *will* tighten eligibility.

And our response? We're seeing an almost frantic scramble to help hospitals and entrepreneurs devise low cost, exclusive entry, tightly-controlled PPOs. Hundreds of doctors are standing in line to join a PPO — any PPO — if it will promise (it cannot guarantee) survival. Many of you are prepared to write subscriber checks until you go bankrupt in order to assure you're not left out.

We're seeing the first steps in closed hospital staffs. Doctors are creating free standing, out-patient urgi-and surgi-centers that compete with hospitals. Churchmouse-poor educational centers are seeing their faculties accept more private-paying patients. Hospitals are offering everything from soup to nuts — whether or not related to health care — to attract paying customers.

Dr. Spence Meighan's futuristic view of hospitals and their staffs turning into armed camps to guarantee their survival is becoming increasingly real.

Perhaps there is a role for collective information and action through the medical society. While the future ultimately rests on your individual shoulders, MCMS is covering some important bases. To let you know what those bases are, and to get your input, we have dramatically expanded our communications program.

Change is inevitable. But we must assure that whatever change occurs helps increase, not diminish, the quality of care we and our patients expect.

Ambulance firms raise base rates

By Allan Classen

Two Multnomah County ambulance companies justify the recent doubling of their base rates as a strategy to recoup a higher share of Medicare patient costs, and they claim the average charge per emergency run has risen only modestly.

AA Ambulance and Buck Ambulance boosted their base rates in January from $145 and $155 to $322.50 and $310, respectively, but no longer add on charges for specific procedures such as EKG monitoring, IVs or anti-shock trousers. Medicare does not pay for these "extra" services and by folding them into the base rate, the companies hope to receive reimbursement on the total bill.

"It's an increase," Robert Phillips of Buck Ambulance said of the new rate, but added that the net effect on the bills of non-Medicare patients is slight. He could not provide data on last year's average charge per run, but said the new system is intended to raise company revenues eight percent.

But Tom Steinman of Fire District number 10 calls it "an odd coincidence" that rates have jumped just as the county's districting plan, which grants virtually exclusive service districts to the four private ambulance firms in the system, has been implemented. He faults Multnomah County Emergency Medical Services policy makers for conferring quasi-monopoly privileges to the companies without a mechanism to control rates.

He also considers it "a pretty quick increase" in light of prior assurances that the districting plan would hold down rates in the long run by reducing the number of ambulances required to serve the same area.

Officials from both companies deny any connection between the new rates and the districting plan that went into effect January 15. They say they are responding to increased costs of operation and a policy change relating to Medicare reimbursements made by the federal Health Care Financing Administration (HCFA) last March. So far, HCFA has not recognized the new base rates and continues to cover only a basic charge, as under the old system, DeWayne Clement of AA Ambulance said.

Clement conceded that the new rates sound high, but would not provide breakdowns of past and current charges.

Phillips said part of the increase is due to the new requirement of two EMT-4s in each ambulance, but that the districting plan "probably will help control rates in the long run."

The two other companies in the system, Care Ambulance and Tualatin Valley Ambulance, have not filed new rates with EMS. Care Ambulance General Manager Gary Daniels said his company probably will hold to its annual tradition of raising rates in April, but he does not know whether it will include currently-itemized charges in its new base rate.

"We don't feel it's been clarified yet," he said, explaining that different interpretations are being made at various levels within HCFA.

Phillips said about eight percent of Buck's patients last year were covered by Medicare. 1

Medical missions need supplies

By Norma Epley

Auxiliary members Margaret Price (L), Norma Epley and Pat Roduner prepare medical supplies for shipment to Medical Missions for Word Concern, a non-profit organization that supplies medical assistance to Third World countries.

When you see the difference our help makes in the lives of children in underdeveloped countries, it makes you feel better," says Pat Roduner, president-elect of the Multnomah County Medical Auxilary. "So many of the children have worms. Before-and-after pictures show how their legs, once spindly because of worms, fill out after treatment. Our medicines made the difference."

To help underdeveloped countries with medical needs, the auxiliary formed the International Health Committee in 1967. The committee collects medications, supplies and equipment and ships them to Medical Missions for World Concern in Seattle.

Medical Missions for World Concern is a non-profit,

non-denominational organization that supplies medical assistance to Third World countries. It is registered with the FDA and listed in the AMA directory of International Medical Material Collection Programs. The organization maintains medical camps in Africa and Samolia, organizes medical missions, and ships medical supplies to missions. Their volunteer medical staff sorts, packages and ships the supplies overseas.

Much more medicine is needed, and the International Health Committee is waging a campaign to increase contributions. Medicine needed most are: vitamins, especially the B complexes; eye ointments; antibiotics; parasympathic and gastrointestinal drugs; non-narcotic analgesic medications; and TB and anti-malaria drugs. Small medical instruments and diagnostic tools are also in demand.

Silver Eagle, a Portland trucking firm, provides a driver and truck to take approximately 150 boxes of supplies to Seattle three times a year. Between trips, the supplies are stored in an area provided by Providence Hospital.

"People sometimes wonder why we don't use these supplies in our own country," Roduner said "but there is a possibility of someone suing. Some of these medications have gotten close to their expiration date. They still work, but perhaps not as effectively. We just collect medicines, we don't determine anything about them because we aren't qualified to do so. The staff in Seattle decides what to ship and destroys anything that might be harmful."

Though many medical offices, clinics, pharmacies and hospitals are contributing medicine and supplies, more is needed, Roduner said. To donate items, call an IHC member in your area and she will arrange to have them picked up. The committee asks that supplies be packed in small- to medium-sized boxes with lids.

Downtown and Southwest
Mrs. Tucky Kinzel — 222-5434
Mrs. Maxine Kammer — 246-3421
Northwest
Mrs. Ethel Long — 228-5731
Mrs. Ruthanne Moore — 225-1159
Southeast
Mrs. Billy Carlson — 232-6871
Mrs. C.B. Ross — 771-6886
Mrs. Gloria Cockburn — 775-4746
Northeast
Mrs. Ruth Niece — 253-3673
Mrs. Jean Cauthorn — 253-3321
North
Mrs. Celia Wiebe — 283-6847
or call Mrs. Norma Epley, chairman — 232-9312.

Norma Epley is chairman of the International Health Committee

Renovation underway at Ronald McDonald House

Feasting on hot chili and homemade corn bread, Delores Atiyeh and Ronald McDonald joined in a Valentine's Day celebration to kick off renovation for Oregon's future Ronald McDonald House.

Scheduled to open in late 1983, the Ronald McDonald House will be Oregon's "home away from home" for families of seriously ill children being treated in Portland-area hospitals. It is located at 3440 S.W. U.S. Veterans Hospital Road, and will accommodate 20 families. Guests will have private sleeping quarters and will share the kitchen, livingroom, playroom, library and laundry facilities.

The house is a project of Children's Oncology Services of Oregon Inc., a nonprofit corporation formed by the Oregon Medical Association and OMA Auxiliary; Candelighters for Children, a parent support group; and participating McDonald owners. It will be one of over 30 Ronald McDonald Houses nationwide. The first house was built in 1973 in Philadelphia through the efforts of professional football player Fred Hill, whose own child had leukemia.

"Many families are forced to travel great distance to get medical treatment for their children," explained Rosemary Egan, president of Children's Oncology Services of Oregon. "During these periods, motel and rooming houses are poor substitutes for home. They're often expensive and lonely. Parents and siblings need a place where they can relax and, if they want, share their thoughts and concerns with families in the same situation."

Nearly a half million dollars is needed to establish a Ronald McDonald House in Portland. Abo $100,000 has already been raised through community donations and McDonalds Corporation.

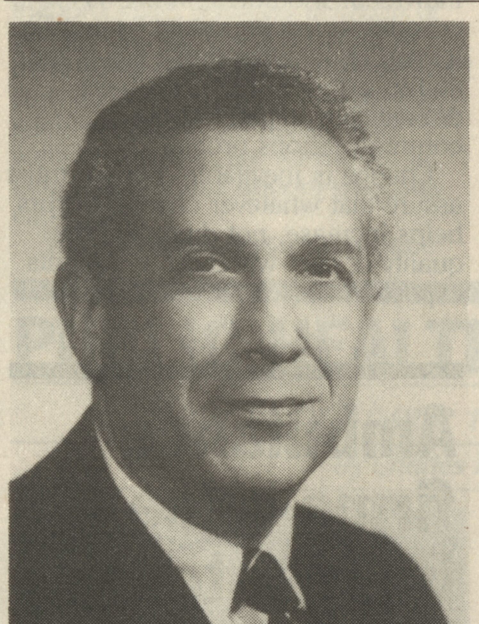
People with skills, services, goo or donations should contact: Rona McDonald House, 5210 SW Corbe Avenue, Portland, Oregon 97201.

Delores Atiyeh and Ronald McDonald helped kick off renovation of the Oregon Ronald McDonald House at a Valentine's Day celebration. The house, scheduled to open in late 1983, will provide a "home away from home" for families of seriously ill children being treated in Portland-area hospitals.

VIEW FROM THE HILL

Advisory council drafts educational strategy

By Leonard Laster, M.D.



As you are well aware, the primary mission of the Oregon Health Sciences University is to educate dentists, nurses, physicians, allied health professionals and biomedical scientists. The faculty care greatly about the content and quality of the curricula offered in the three professional schools and the associated graduate training programs and, by and large, they do a highly creditable job.

Like every other academic institution, we could do better and certainly want to keep trying. Unfortunately, the pressure of multiple and varied duties, the need for faculty to participate in national as well as local activities, the growing complexity and volume of the flow of new information in professional fields, and many other urgent factors all conspire to prevent institutions of higher learning from devoting adequate time and attention to the processes through which they educate their students. The Health Sciences University enjoys no immunity to this deficiency.

Although quick and easy solutions to the problems do not come readily to mind, one valuable first step is to emphasize for the university and its constituents the importance of a lasting and pervasive concern for its educational mission. We have, therefore, established a university Advisory Council on Educational Research and Development. This interdisciplinary group will first identify and explore the educational issues confronting this university. On the basis of these deliberations, the council will draft a proposed strategy for the university's efforts to foster its educational goals. When the institution has reviewed and adopted the strategy, we will implement as much of it as we can, given the economic constraints of the day.

No topics will be excluded from the Council's agenda. The substance of their conclusions will be a critical segment of their efforts, but the attentions they draw to the basic questions will be equally valuable. Obviously, there are no eternal or universal solutions to the dilemmas of education. Most likely, what we do today will be regarded as outmoded and even useless a decade from now. The important thing is to keep trying, to keep assessing and to keep caring. Fossilization is the danger. Vitality the need.

Since the issues raised will undoubtedly be relevant to the readers of this publication, I invite you to give thought to your concer and to share them with us. Some you have questioned the technical skills of today's graduates in takin patient's history or performing a physical examination. Others have wondered whether the reasoning strengths that graduates bring to diagnosis and management are optimal. Society has questioned th motivation and humaneness of so graduates.

I am not convinced that these a widespread or predominant problems. I think our graduates ar competently trained and deeply caring practitioners. Nevertheless, behooves us to assess society's criticisms and, when we detect systematic deficiencies, seek out means to make improvements. Th we may ask, "Do we need to re-evaluate admission policies, curriculum content, modes of teaching, role models we set befo the students or any of the other components of our teaching programs?" If we feel the need to make changes, how can they best accomplished?

The time seems ripe for a rigoro institutional self-evaluation, and w welcome your participation. The dean of each school will be a member of the Council, and you may address comments or questio to the most appropriate one. I will be a Council member too, and would be pleased to hear from yo especially on issues that transcend the programs of individual schools

This activity is part of our overa commitment to the excellence of t Oregon Health Sciences University Other efforts will be shared with y as they come into existence.

Dr. Laster is president of the Oreg Health Sciences Univers

Children's publication available

The Portland Children's Museum is offering an informative coloring book to Portland physicians, especially tho in pediatrics and family practice. The free publication, *A Visit to the Portland Children's Museum,* tells one child's visit to the museum a the activities available to him.

A totally volunteer effort, the bo was written by Gail Landon and Victoria Son, designed and illustrated by Jeff Fisher and produced by Boise Cascade.

Established in 1949, the Childre Museum offers exhibits, special events and a bi-monthly newspap to over 75,000 school children in tri-county area. Programs include largest elementary art program in state with over 400 courses per ye

For a free copy of *A Visit to the Portland Children's Museum,* write the museum at 3037 SW Second Avenue, Portland, 97201 or call 248-4587.

Medi-share coordinators help 50 patients a day

By Jeanne Leeson

The two Project Medi-share phones at the Multnomah County Medical Society ring incessantly, five days a week from 9 a.m. to 1 p.m. with an ever-increasing number of medically-needy people calling to request medical assistance.

Jeanette Valley, Project Medi-share coordinator, is the link between patients and physicians.

Since opening seven months ago, Project Medi-share has referred over 1,000 patients to physicians in Multnomah and Washington counties who are volunteering their services.

The program began last summer when physicians realized between 105,000 and 125,000 local residents were without adequate health care coverage. Since most health care plans are tied to employment, and since unemployment was at record peaks, the need was urgent.

So on July 31, 1982 Multnomah County Medical Society launched Project Medi-share and hired a coordinator to answer calls and refer patients to the 643 physicians participating in its program. In November, Kaiser-Permanente supplied a second coodinator to refer patients to Kaiser-Permanente physicians. The need for hospitalization brought nine hospitals into the plan in November and, around that same time, five pharmacies agreed to provide prescription drugs at a reduced cost.

While the physicians are willing to volunteer their time and expertise to tide people over difficult and traumatic times, they do not envision Project Medi-share as a permanent program, nor do they want people taking unfair advantage of their generosity.

This is why Jeanette Valley, Multnomah County Medical Society coordinator, and Diane Widmer, Kaiser-Permanente coordinator, are essential to the project's success.

They are capable, experienced registered nurses with strong communication skills and a comprehensive knowledge of community resources. They are dedicated to making the intent of Project Medi-share — to serve the medically needy — a reality.

Responsibilities

Valley and Widmer answer over 50 calls a day, determine the patient's eligibility, make referrals, maintain program records and provide suggestions to the Society's Project Medi-share Committee on ways to keep the program running smoothly.

"In all screening we try to use compassion and good sense, yet get the true picture," said Widmer.

When a person is found eligible, the two coordinators set to work to solve their problems.

Take the mother who called to say her child had been running a temperature for four days, had chills, an earache and swollen glands.

"I was able to find a doctor in their neighborhood to see the child that afternoon," said Valley. She added that she and Widmer make considerable effort to determine whether a case is indeed urgent, hoping to make it easier for participating physicians to work appointments into their schedules.

The coordinators try to find a doctor in the patient's neighborhood. This becomes complicated because certain areas of the city have many patients and keeping them in their neighborhood would overload the doctors' schedules. So the nurses determine what kind of transportation the person has available and whether or not they can make bus connections.

After the referral, the coordinators check to be certain the person kept the appointment.

"I like this job, except it makes me angry when, after detailed arrangements, someone does not keep the appointment," said Valley. She added, however, that the number of no shows is quite small.

Hospitalization and supplies

The matter of hospitalization takes infinite explanation so patients have no misunderstandings, and the coordinators use their tactful expertise here, too.

A Medi-share patient is never denied necessary hospital care because he or she cannot pay. They may enter the hospital without payment, but they are asked to make payments when they can or when they return to work.

Rose Marie Kempton photos

Diane Widmer, a Kaiser-Permanente employee, handles all referrals to Northwest Permanente physicians and Bess Kaiser Hospital.

Doctors are not expected to provide free medical supplies, medications, laboratory or x-ray materials, so the nurses help patients solve this problem.

"Sometimes we refer patients to service clubs, such as the Lions, Kiwanis or Elks, that have programs for families in need of financial assistance for vision or hearing problems," Valley said.

While the Multnomah County Medical Society looks at Project Medi-share as a way to deal with an acute, catastrophic, short-term situation, Valley and Widmer believe it may be needed longer.

Callers are increasing daily. Unemployment in Oregon is not yet decreasing. Through 51,000 brochures sent home with school children, radio announcements and newspaper publicity, more and more people are learning of the program. An increasing number of patients are also referred from Grace Peck Clinic and Project Health.

How do coordinators feel about their high-pressure jobs?

They are proud of their expertise in screening applicants, pleased to assist the medically needy and glad to help the volunteer doctors. T

Financial planning seminar aids doctors

Although physicians usually have no trouble living "the good life" while practicing, retirement is often blighted by lack of cash.

"It's not unusual in this country for people who have earned a high income to end up broke," said Collette Wright, MCMS associate executive director. "Though physicians have a higher income than any other professional, they often lack the time and knowledge to properly invest it. As a result, they're generally not as well off upon retirement as they could be."

To counteract this needless dissappointment, the MCMS has put together a comprehensive financial planning seminar for physicians and their spouses. The four-part seminar, entitled Achieving Financial Success, runs March 7, 9, 14 and 16 from 7:00 p.m. to 10:00 p.m. at the University Club downtown. It is limited to 100 people. Tuition is $150 for MCMS members, with no additional charge for spouses, and $200 for

AUXILIARY UPDATE

Auxiliary offers personal goals seminar

By Jeanne Vore

MARCH 7: A Personal Goals Seminar, designed to help participants set and achieve personal goals, is being sponsored by the Auxiliary and Care as an extension of the recent Women Aware Workshop. The eight-week seminar begins on Monday, March 7, with subsequent sessions on Wednesdays from 11:45 a.m. to 2:15 p.m. It will take place at the MCMS building, 2188 SW Park Pl. The cost for all eight sessions is $20.00. For more information, call Ellen Capps, 232-4294 or Jeanne Vore, 223-4620. To register, send a check to Barbara Kennedy, 4040 SW 53rd Pl., Portland, 97221.

APRIL 12: Open board meeting at the MCMS building.

HIKERS UPDATE: Hiking activities resume in March. If you are interested in joining, call Bea DuVall, 244-3976.

Two hundred Doctors Wife rose bushes are available at $20.00 and proceeds go to the Ronald McDonald House. Make checks payable to Ronald McDonald House and mail to Barbara Loomis, 3540 Pearl Street, Eugene, 97405. Hurry, the supply is going fast. For more information, call Pat Webster, 226-1555. T

Jeanne Vore is MCMA president.

non-members.

Eleven professionals will address such topics as: planning for your children's college needs; retirement planning; practice management; tax planning; life and disability insurance; estate planning; and Oregon economics. The instructors were selected on the basis of their expertise and ability to convey that expertise in an understandable manner, Wright said.

For information about the seminar, call 222-9977.

Doctors fare poorly in financial planning

By Ronald B. Eisen

Physicians have the highest income of any professional in America as reported by the U.S. Chamber of Commerce. And yet, less than 20 percent are financially independent upon retirement. The rest need to continue working or drastically reduce their standard of living.

In early 1982, I interviewed more than 100 Portland-area physicians for an article I later wrote on the subject of physicians as financial planners. At that time, I obtained retirement plan performance results for 53 of the physicians surveyed. The average annual rate of return on these retirement plan portfolios consisting of Keogh and Corporate Retirement Plans was approximately 7.9 percent for the previous five-year period. Of the 21 plans with experience ten years or longer, the average was about 8.25 percent.

Over the same ten-year period, the average inflation rate was 8.5 percent. The result for most of these physicians has been a reduction in the value of their retirement plans when evaluated on the basis of purchasing power.

The fact is, $10,000 invested in 1972 would need to have appreciated to over $23,000 in 1982 just to have preserved investor purchasing power over that ten-year period.

Most physicians wondered if they would have enough money to retire on, despite the fact that they universally felt they were getting a much better return than what they had gotten. Most doctors thought their return had been 13-14 percent. The real average return was just less than eight percent.

$10,000 Lump Sum Invested at 8 percent and 14 percent

Years	At 8 percent	At 14 percent	Difference
5	$14,693	$ 19,254	$ 4,561
10	21,589	37,072	15,483
15	31,721	71,379	39,770
20	46,609	137,434	90,825

Why doctors have fared poorly

The problem stems from a number of reasons:

1. Physicians indicated they didn't have the time or understanding to manage their own investments.
2. Financial planners failed to give the physicians understandable reports on the actual growth of capital. As a result, poor financial decisions compounded into significant losses before they became apparent and could be addressed.
3. The inability of physicians to compute what rate of return they need to accomplish their retirement objectives clouds the issues of what represents good, and unacceptable, results.
4. The lack of confidence in investment and brokerage advisor options and alternatives, and total absence of proper guidelines for selecting an investment advisor, caused many to avoid investing all together. Instead, they opened long-term savings programs or purchased long-term bonds that ended up guaranteeing loss of purchasing power in dynamically changing times with fluctuating interest rates.
5. The rules and laws pertaining to retirement plans are complex and confusing. Many physicians have simply transferred their hard-earned retirement nest eggs to the first salesman with a little knowledge, a smooth sales pitch, and big promises, without diligent consideration of their qualifications, references or past results.
6. Few investment executives or banks have the research, experience or real know-how to manage retirement money well.

What is financial planning?

There is no question in anyone's mind that financial planning is important. Many people, however, do not consider the significance of financial planning in terms of their present and future lifestyles and some do not fully understand what the term "financial planning" really means.

Financial planning is the assessment of all your assets, potential assets and liabilities in order to establish your financial goals and create a strategy to fulfill those goals. Professional assistance can help you properly analyze all your assets and resources and plan a strategy to preserve capital, provide risk management, take full and legal advantage of tax laws, and guard against the destructive forces of inflation. This type of strategy should incorporate your present needs with those of the future.

There's no one "formula" for successful financial planning. A strategic approach must be created for each individual, incorporating many variables. Perhaps the most important variable is you. What is your lifestyle? Do you have a spouse? Children? Other dependents? What are your assets and your problems? Your needs, your goals? Other variables, of course, are the domestic and global economies, including the effects of taxes and inflation.

The other crucial element of your financial plan is one that you alone control: time. Start planning a strategy right now, so you can have what you want when you want it. Time is money, and procrastination is a drain on your resources.

How financial planning can help

Information is a key factor in proper asset management. A professional financial planner takes the current information you provide and turns it into an accurate, timely financial strategy based upon your needs and capabilities. To do this, he needs to utilize the same principles that are used in a business enterprise.

Your financial planner should prepare a balance sheet, assist you in financial goal-setting, and then compute in terms of today's purchasing power the amount of monthly income you need to become and remain financially independent. Retirement programs, as well as investment asset growth, are projected. Using these and other figures, plus a professional assessment of all your assets, your planner can make specific written recommendations.

Immediate applications of your strategy can help reduce risk, increase cash flow, determine and provide a method for funding educational needs, increase investment returns and reduce taxes.

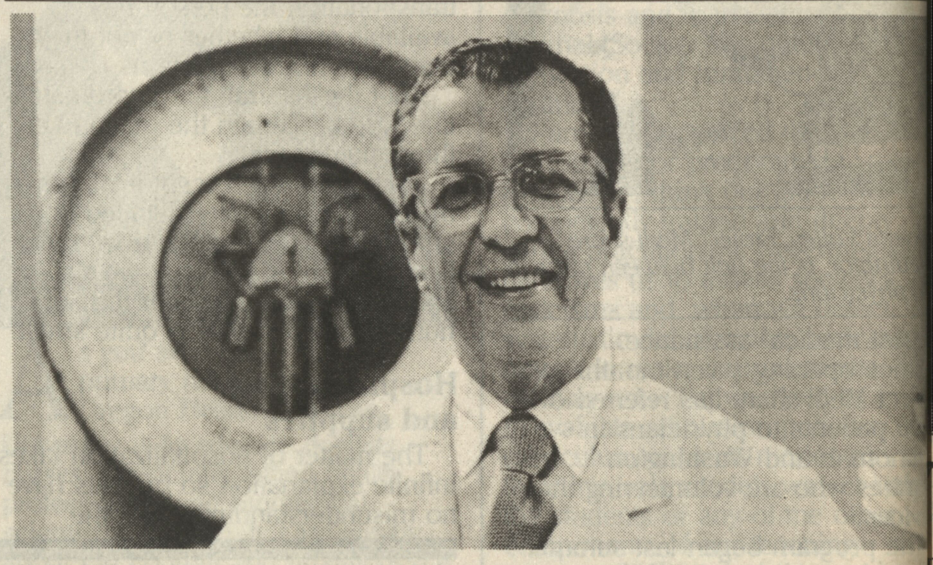
The longer-term picture provides strategies on how and when to retire or become financially independent, and the rate at which your assets need to grow. Your broker should evaluate current investment holdings and prepare a written report recommending whether to add to these holdings, hold what you ha or sell to reposition your assets i keeping with your over-all strateg written investment strategy should direct dollars into areas offering attractive values while reasonably limiting downside risk.

This idea of "earmarking" investment dollars for specific typ of investments that fit your needs and the subsequent monitoring o the portfolio results against your objectives, will develop the best rewards.

Ronald B. Eisen is a financial c sultant with Foster and Marsh American Express, Portland off and will be a keynote speaker at Society's financial planning semi March 7, 9, 14 and

Obstetrician offers medical reminders

By Oppie McCall, Jr., M.D.



Dr. Oppie McCall, a Portland obstetrician and gynecologist, is the first medical director of Oregon's Planned Parenthood Clinic.

From my experience as the first medical director of Oregon's Planned Parenthood Clinic, I'd like to share some pertinent points.

First, unless a patient desires a pregnancy or no longer has a sex partner, she should consult a physician before abandoning the birth control method she uses.

Second, once a woman chooses to use an oral contraception, she doesn't have to wait for her next menses to begin. If she is in the first half of her menstrual month, break open one of your office sample packets, discard the number of pills she should have taken from the fifth day and tell her to complete the remainder.

Tell her to abstain from sex or use an alternative method for the first seven pills. Thereafter she will be protected. This applies even if she had started pills on the customary fifth day. The old myth that pills do not take effect the first month is groundless.

Prescription refills

The droves of women who need their pill prescriptions refilled on weekends is mind-boggling. A few even need mid-week refills. The number is legion who ignore the pharmacist's "no refill" on the last packet and fail to have their annual examination and prescription refilled.

As curious as this is, it is even more inexplicable to see the number of physicians who obstinately refuse to allow a one-month extension and a grace period for an appointment while the woman continues her protection. We see too many unnecessary and unwanted pregnancies because "my prescription ran out" or "my doctor would not extend my prescription until I came in for an examination."

Many of us are aware of the EPT, Early Pregnancy Test kits, which quite reliable tests for kitchen chemists. The pamphlet enclosed with the kit warns that a negative result does not necessarily signify absence of a pregnancy. The test must be repeated weekly until it turns positive or the woman has normal period. This also applies office tests.

If a woman in her child-bearing years misses a period, the doctor should presume she is pregnant until proven otherwise. Too many physicians, not wanting to offend daughter or her mother, fail to ge adequate sex history or ask for a serum pregnancy test. If you do n want to offend by asking, indirect ascertain the status of the hymen the patient is young and possibly virgin, inquire about a previous pelvic examination or the use of tampons. A positive answer is evidence of an open hymen. The examination itself may be testimo of sex experience.

While it is understandable, it is inexcusable to blame mononucleosis, nerves or a chan in drinking water for missing a period. If a physician does not w to use a laboratory test, then he must continue to re-examine the patient until pregnancy is diagnos or a normal menses occurs. No woman in her child-bearing years should be given medicines or exposed to x-rays until the physic proves the patient is not pregnan

Diagnosing pregnancy

Those responsible for diagnosi a pregnancy should look for man conditions. Some are presumptiv some suspicious, some diagnosti The major symptoms are: a miss period or an abnormally short on breast soreness, nipple tingling, darkening of the areola, butterfly pigmentation on cheek bones an forehead, darkening of the vertic

abdominal line from xiphoid to pubis, changes in urinary habits, nausea and vomiting at any time of day.

Other symptoms are: appearance of or increase in a clear vaginal discharge, an acknowledged sex encounter, a velvety texture of the vaginal membranes, a bluish coloration of the cervix (Chadwick's sign) and softness of the isthmus of the uterus (Hegar's sign). If the uterus is anteflexed, a 1½ cm. soft dimple appears in the center of the fundus (Landin's sign). The fundus may be appreciably enlarged and irregular in the cornual area (Piskacek's sign), all too often mistaken for a fibroid.

Doptone identification of a fetal heart is not reliable in early weeks.

The serum pregnancy test is incontrovertible. Ultrasound will identify a gestational sac early and gives an image of the fetus and its activity.

For many reasons, the early diagnosis of a pregnancy is important to the patient. If pregnancy is not the issue, then not getting pregnant is, and we must offer a complete compendium of birth control methods. If this philosophy is not compatible with the physician's moral or religious persuasion, he should tell the patient.

Dr. McCall is an obstetrician and gynecologist in private practice.

COMPUTER TALK

Computers boost Society's profits

By Bill Larson

The computer is at work at the MCMS. As revolutionary today as Gutenberg's movable type was in the 1400s, computers perform redundant tasks with less human effort, freeing us for responsibilities requiring greater insight and personal attention.

Late last year, the Society purchased several inexpensive yet powerful Osborne computers so each department could determine the usefulness of having one without risking large sums of money. One computer, affectionately known as "Ozzie," works in the MCMS placement service, where Jo-Lynne Hamilton matches jobs with people. She provides a concrete example of how computers benefit their owners.

The quality of Hamilton's service depends on her skill and memory; its profitability on her speed. The positions she fills require combinations of experience, education, hours and salaries which, when listed, total 50 different criteria.

Imagine 100 job applicants showing up with between 20 and 50 of the necessary skills. They hope to be matched to one of the 30 available openings, which have 10 or more of the 50 requirements. The possible combinations are in the millions. Additionally, some of the people and jobs change daily.

Matching applicants' skills with job requirements takes about four hours when performed by hand. We gave Ozzie a program written to handle this activity.

"I had no experience with computer technology and was oblivious that computers could be involved in my professional life," said Hamilton.

She said she might have muttered such adages as, "you can't teach an old dog new tricks" or "if it doesn't squeak, don't grease it."

Within two weeks, Ozzie became the new employee in the placement service. Ozzie does the bookkeeping, word processing and employee/employer matches in one-eighth the time usually given these tasks. The time saved searching for appropriate applications for available positions frees Hamilton to deal with as many as 20 additional prospective employers and applicants each day.

"A part-time employee, working three days a week at $5.00 an hour ($6,192 per year), would serve only one or two of the many functions required by our department, and we would not have access to information as readily," Hamilton said.

By using the $1,800 Osborne computer and the department's software, we will save $4,492 in salaries the first year and $6,192 a year thereafter. That means only three and one-half months are needed to pay for the Osborne, which will continue to serve for many years.

Now Hamilton has Ozzie working on data supplied by MCMS members for the 1983 salary survey. The results will be available in a shorter time and with assured accuracy.

"The Osborne has opened some new windows for the placement service and the light is pouring in," said Hamilton.

Bill Larson is a management systems consultant with the Society and its service corporation.

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does not want to know about the health of the people and would prefer that we didn't either.

Nevertheless, there are reports of increasing mortality in many cities around the country. This has not occurred in Multnomah County at this point, although in 1982 we experienced more maternal deaths than in recent years. Multnomah County has not shown increases in suicide rate, violent deaths, tuberculosis, cancer or heart disease. But even if the last three disorders were increasing, they would only be detectable as a trend over a period of tens of years. Public health statisticians, too, are waiting to count the bodies.

Indirect effects

Will poor people get medical attention at a time when economic problems increase their risk of serious illness?

Studies made in the 1974-75 recession provide disquieting evidence that care will not necessarily be forthcoming. These studies indicate that use of community hospitals falls during times of high unemployment and inflation because of service cutbacks (2). One dramatic example of this occurred recently when five of six hospitals in Mobile, Alabama closed their emergency department, presumably to limit admissions of non-paying patients.

It is well known that the poor will make greater use of medical care than the non-poor, if it is available to them. Unfortunately, in a recession, their access is severely limited. The studies conducted during the 1974-75 recession show the unemployed were generally able to continue their health insurance, blunting the effect of that short recession. During the longer current recession, however, evidence suggests that many are losing coverage. In Portland, problems will be compounded by the impending demise of Project Health.

Intervention

The present recession has a doubly negative effect on health. First, it increases the risk of many diseases among disadvantaged persons. Second, it denies these people access to medical care which might ameliorate the illness.

Physicians can intervene in two ways: first, by volunteering services. Project Medi-share is a brave beginning. Second, by working through institutions with which we are affiliated to develop social support networks to protect people from the negative health effects of poverty and unemployment. We can each contribute in a large or small way to improving the overall quality of life, and therefore the health, of the community.

Dr. Schade is Multnomah County health officer.

References

(1) Levin, Lowell S., and Idler, Ellen L., *The Hidden Health Care System, Mediating Structures and Medicine,* American Enterprise Institute, Washington, D.C., 1981, page 260.

(2) National Center for Health Services Research, *Effects of the 1974-75 Recession on Health Care for the Disadvantaged,* DHEW Publication No. (PHS) 79-3248, Hyattsville, Maryland, 1980.

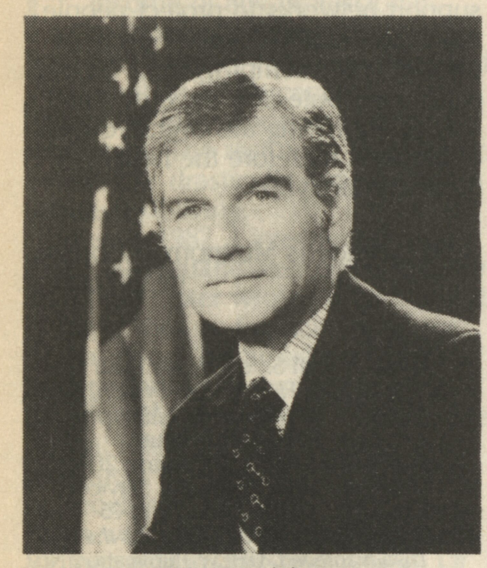
Don't forget!

March 23 is the deadline for submitting resolutions to the OMA for the April 22-24 House of Delegates in Eugene.

Portland area elected officials

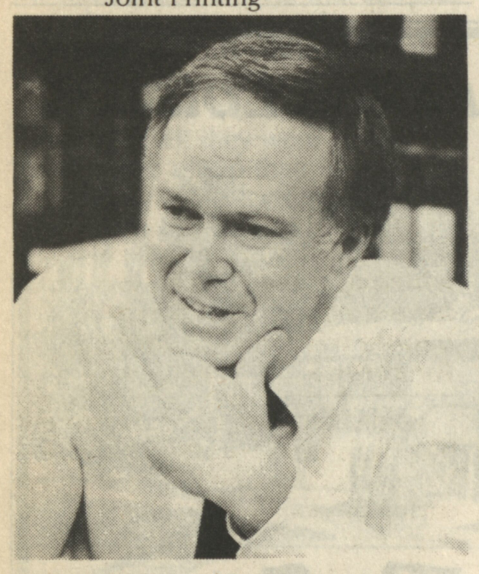
The following U.S. senators and representatives are from the Portland-metropolitan area. The MCMS urges you to contact your legislators on issues concerning the practice of medicine. To find out who represents your district, call 248-3720 in Multnomah County, 648-8856 in Washington County and 655-8551 in Clackamas County.

U.S. Senators



MARK O. HATFIELD (R) — 463 Russell Senate Office Building, Washington D.C., 20510. 221-3386 (Portland); (202) 224-3753 (D.C.).

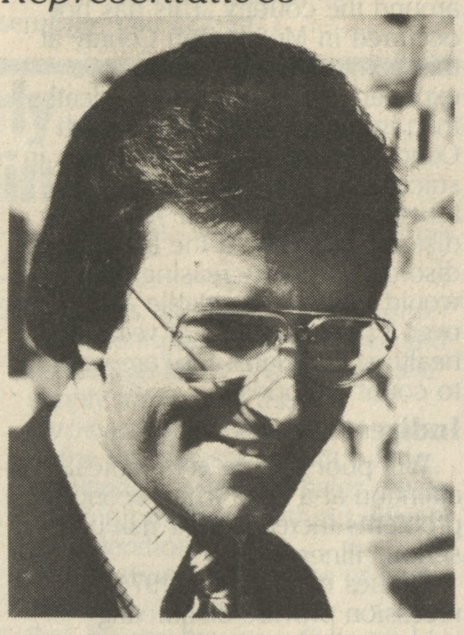
Committees
- Appropriations (chairman)
  - Energy and Water Development (chairman)
- Energy and Natural Resources
  - Energy Conservation and Supply; Public Lands and Reserved Water; Water and Power.
- Rules and Administration
- Joint Library
- Joint Printing



BOB PACKWOOD (R) — 1321 Dirksen Building, Washington, D.C., 20510. 221-3370 (Portland); (202) 224-5244 (D.C.)

Committees
- Commerce, Science and Transportation (chairman)
- Finance
  - Taxation (chairman)
- Small Business
  - Capital Formation and Retention (chairman)

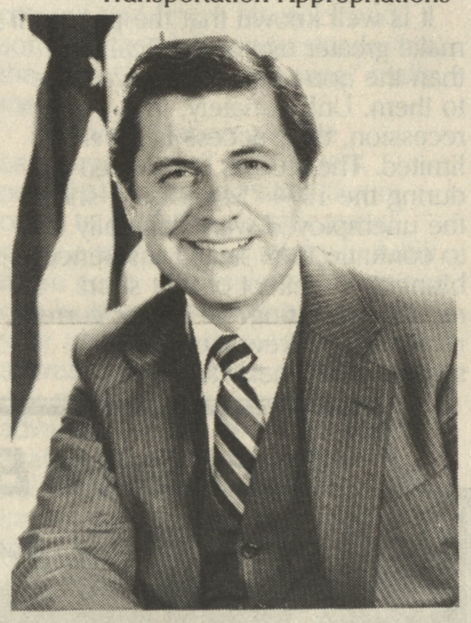
U.S. House of Representatives



LES AuCOIN (D), First District — Clatsop, Columbia, Lincoln, Polk, Tillamook, Washington, and Yamhill Counties; portions of Multnomah and Clackamas Counties. 2446 Rayburn House Office Building, Washington, D.C., 20515. 221-2901 (Portland); (202) 225-0855 (D.C.).

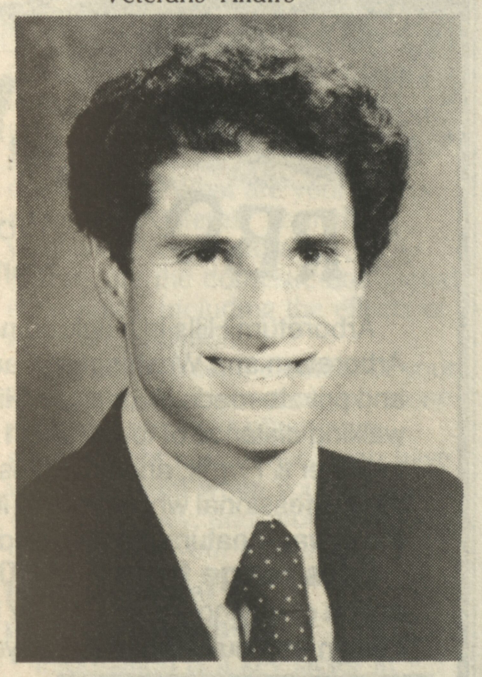
Committees
- House Appropriations

Subcommittees
- Interior Appropriations
- Transportation Appropriations



DENNY SMITH (R), Fifth District — Marion County and portions of Linn, Benton, Polk, and Clackamas Counties. 1213 Longworth House Office Building, Washington, D.C. 20515. 399-5756 (Salem); (202) 225-5711 (D.C.).

Committees
- Interior and Insular Affairs
- Veterans' Affairs



RON WYDEN (D), Third District — portions of Multnomah County. 1440 Longworth House Office Building, Washington, D.C. 20515. 231-2300 (Portland); (202) 225-4811 (D.C.).

Committees
- Energy and Commerce
- Small Business
- Select Committee on Aging

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which, as a condition of receiving federal grants and loans, hospitals were required to provide a certain amount of charity care. In the end, it's a silly requirement because it assumes that hospitals can somehow do things for free. They have to pay their bills, pay their staffs. There really isn't any such thing as a free lunch.

University Hospital has adopted policies that preclude the level of so-called free assistance it once delivered. Administrators there argue that they do not get sufficient state appropriations to continue such assistance.

Multnomah County has experienced deep cutbacks in its programs of medical assistance as a result of cutbacks in federal and state funds that provide for that, and also because of cutbacks in county revenues that have been passed on as reductions in health services.

SCRIBE: How does the situation in the county relate to conditions in the state, generally?

HIGGINS: The problem is worse around the state. There is an obvious correlation between unemployment and the number of people who aren't receiving adequate medical care. In communities where unemployment is highest, charitable and public assistance are at the lowest levels. The economy not only creates greater need, it also depletes resources available to meet that need.

SCRIBE: Is this a trend? Will it get worse?

HIGGINS: Yes. It is a trend — and it's getting worse. There is a general feeling, I think, among many policy makers that health care services for the medically poor are discretionary services.

SCRIBE: How are current national policies affecting this situation?

HIGGINS: The truth is that it's hard to figure out what current national policy is. There's a hell of a lot of talk about competition, but precious little — in fact, in the first two years, virtually nothing — has been presented to Congress. The administration's current proposals include a tax on employee health benefits that exceed a certain amount, and an optional voucher

"With respect to the government's policy for health care for the medically indigent, the kindest way I can describe it is benign neglect."

program for Medicare with a much higher deductible for Medicare recipients, along with a promise to provide catastrophic coverage.

Some parts of that plan I don't have too many qualms about. In fact, I rather like the optional voucher approach to Medicare. But if this is what's meant by competition, it's sort of unimpressive.

With respect to the government's policy for health care for the medically indigent, the kindest way I can describe it is benign neglect. They don't have a policy for the medically poor. They don't see it as a federal responsibility — which contravenes some 35 years of thought about what should be a state and local responsibility and what should be a federal responsibility.

To some extent, I think policy makers have misread the mandate. Fundamentally, I think Americans are fairly compassionate. While they want an overall reduction in government spending, I don't believe there was a mandate to target those reductions at the most vulnerable people in our society. I think most Americans are deeply offended by the lack of fairness that has governed a lot of budget reduction, believing that some sectors of our society have been disproportionately hurt by budget changes while other sectors have actually benefitted by tax changes.

I'm cautiously optimistic that a change in political attitudes is ready to take off. Nevertheless, I think we are going to have a continuing problem of high structural unemployment in this country for the next generation. And that means a widening gap of people without adequate access to health care.

SCRIBE: Are doctors and hospitals in this area trying to take up some of the slack?

HIGGINS: Yes, they are. I think it may be a different story in some parts of the country, but in Portland I've been extremely impressed with the medical community's generosity. They've made some extraordinary efforts, through Project Medi-share for example, while acknowledging

"It's important for the Scribe's audience to use their political influence to bring about a change in public policy."

publicly that voluntary efforts are a substitute for government assuming its rightful responsibilities. Government is the legitimate agent of society, and the funding of health care for the poor is a fundamental responsibility of government. The organized medical community is acknowledging that fact and, at the same time, doing their fair part. They should be commended.

SCRIBE: You've mentioned a "Grapes of Wrath" syndrome that has people leaving the state to secure medical care. What evidence is there for that?

HIGGINS: The drop in the state's population. This is the first time since the Great Depression that's happened. Oregon has seen dynamic growth, particularly in the last decade. Suddenly we've lost probably 50,000 in the last year alone. It's fairly obvious they left out of economic necessity and not because they suddenly got tired of life in Oregon.

Oregon has one of the stingiest public assistance programs in the United States. It is extremely difficult to qualify for medical assistance or cash assistance, no matter how poor you are.

For example, if you have a family — husband, wife, kids — you can't qualify for welfare or medical assistance in this state. The only way you can qualify is to divorce your spouse — and then only your spouse and children would qualify. As a single person, no matter how destitute you are, you can't qualify.

The tragedy of that is a tremendous emotional, mental and physical toll on families who are forced to migrate under such circumstances.

SCRIBE: Among people who have some political power, should providing health care publicly be a priority?

HIGGINS: I think so. I don't believe we have to take away from other basic services, but we should tax ourselves at a rate sufficient to provide basic services that include health care.

The economic argument for do that is very cogent: If we don't do

the health care that is provided is provided as a result of a hidden tax — which is, of course, the increased cost of health insurance premiums to those who are employed in order to provide health care for those who are destitute and not otherwise eligible for public assistance. It's a very expensive and inefficient tax because it means we are paying for health care for people who are at the most acute stages of illnesses in the most expensive settings. Whereas, if we tax ourselves in a straightforward manner, we could provide health care at a more preventive stage in a less expensive setting.

SCRIBE: What can readers of the Scribe do?

HIGGINS: I don't think there's any substitute for a degree of political involvement. It's a political problem, which is not to say it is a partisan problem. The system is being distorted by the failure of one piece of the system — government — to pick up and deliver its rightful responsibility. It's important for the Scribe's audience to use their political influence to bring about a change in public policy. My observation is that if they set their minds to do it, they know how.

SCRIBE: What kinds of changes would you like to see and how would they work?

HIGGINS: If you expanded the state's Medicaid program to cover the medically needy — which includes the two-parent families I mentioned earlier as well as people who are aged, blind, disabled and slightly above the poverty line but not far enough above to afford their own insurance — we'd be able to get federal assistance at about a 56 percent rate to pay for part of it.

This means we would recover some of our federal tax dollars that are otherwise spent in other states. It would also then diminish the cost-shift problem because people would have adequate health care coverage paid for by Medicaid in a straightforward manner.

"Most people, like myself, believe very strongly that the private sector is the best way to organize and deliver health care."

The idea of a regional health authority is a fairly new concept that's rapidly gaining some currency. The idea is essentially to set up, on a regional basis, a service district that would provide both public and community health care. The district presumably would have taxing authority. Its principal mission would be to plug the gap and provide health care to people who can't afford it, and to be the agent of delivering health care to other publicly-funded recipients.

I think you'd get a good deal of efficiency through such a mechanism and properly utilize the private sector to actually deliver the health care. But you would have one entitity that would have the authority and would be responsible for facilitating it.

SCRIBE: By facilitating, do you mean paying for it?

HIGGINS: Yes — essentially contracting for it. There is a variety of ways you could go about it. My guess is that the most efficient way would be to use the model we pioneered in Project Health, or some variation thereof, wherein you enroll people who are eligible and, in effect, broker their health care to a variety of organized systems delivering health care. The medical society, for example, might have its system of care; several hospitals are organizing their staffs into organized systems of care and so forth.

SCRIBE: What are the implications of increased concern for the plight of the medically indigent that have led to these kinds of suggestions?

HIGGINS: Out of this has come one positive result: a noticeable diminishment in the kind of rancor that has customarily existed between interest groups that pull and tug over health policy. I think all of us are coming to realize that we have much more in common and that we agree on many more areas of health policy than we previously imagined. We have had a tendency, in the past, to focus on areas of disagreement instead of building upon areas where there is a surprising degree of consensus.

I think many health care provider groups perceived some of us as left-wing crazies waiting for the first opportunity to strike a blow for socialized medicine. In fact, there aren't many people like that anymore. Most people, like myself, believe very strongly that the private sector is the best way to organize and deliver health care.

By the same token, many of us perceived that health care providers are basically in it for the bucks. I think we've learned that that's not really the case — that the degree of professional responsibility felt by most providers is genuine and, at times, even ennobling. [1]

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through all this and, in the process, we have provided an even greater and better form of medical care and hospital service to patients in this country, despite predictions that we would fail."

Dr. William Zieverink, director of Providence Hospital's Mental Health Services and chairman of the Oregon Coalition for the Medically Needy, told of a frosty reception he received while meeting a group at Portland's United Senior Center.

"They saw me as a doctor from a hospital and we're not well-liked," he said. "They have selected the most visible targets for high health care costs — doctors and hospitals."

Dr. William Zieverink, director of mental health services, Providence Hospital.

Zieverink said health care consumers are "frightened, angry and uninformed." He said the prevalence of this suspicion of medical professionals "casts a shadow on and gives perspective to all we've discussed this weekend."

Wyden

In his speech, Wyden displayed a little of that same suspicion, saying there is a great deal of waste in the health care system and calling for strong government guidance in forming future health care systems.

"We have to act now to make health care affordable and available to all Americans," he said. "If we don't act soon and take steps necessary to control health care costs, in a few years we'll be discussing the unthinkable — the rationing of health care."

He sees Preferred Provider Organizations as one positive move toward cost containment, a stand in opposition to most other speakers and attendees at the conference.

"PPOs are a very, very promising kind of alternative. I'm going to be taking steps in Congress to promote them," he said.

PPOs are a newly-developed method of arranging health care involving set fees and set contracts between hospitals, doctors and either employers or employee associations. Across the nation, PPOs are growing in popularity, but lack a uniform structure. Wyden wants Congress to draw-up guidelines to aid PPOs in forming.

"I'm looking at ways we can have a national policy on which to shape them," he said. "We have a climate today where people will bite the bullet for reform."

The current fee-for-service system has "a tremendous inefficiency built into it," according to Wyden.

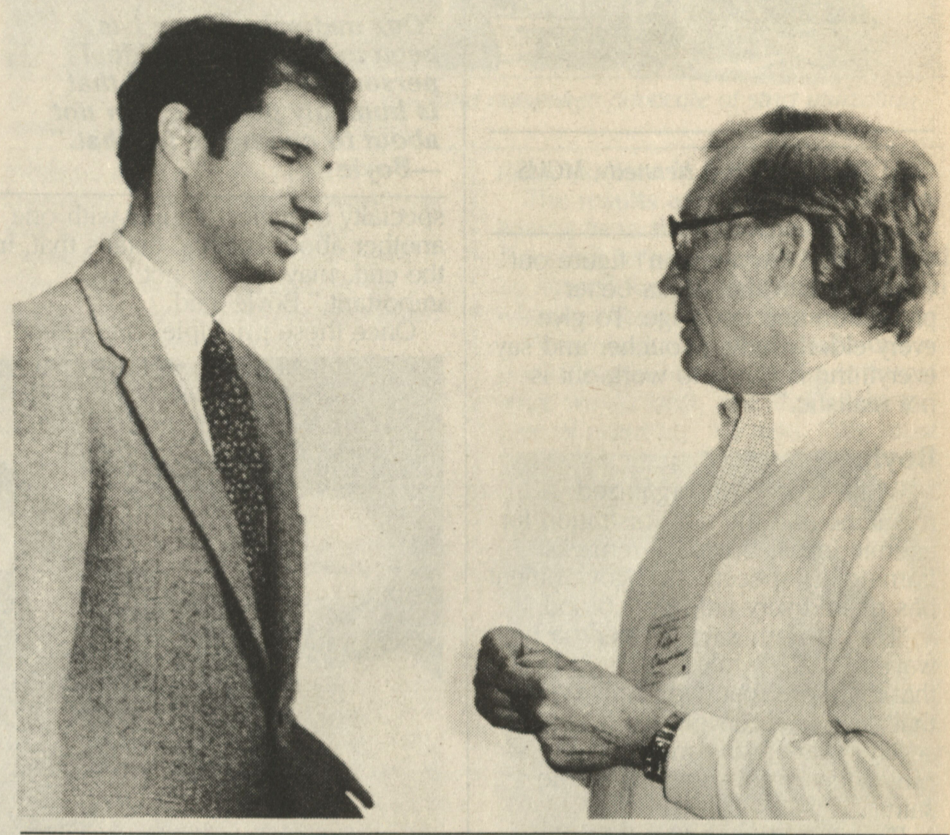
"It hurts people with a better idea," he said.

Wyden, a liberal Democrat, took the opportunity in his speech to say President Reagan's Republican administration has not added any new ideas in its proposals for changes in Medicare and Medicaid payments.

"To look at government as a bad social disease is not looking at the future," Wyden said. "We need to change the nature of the (health care) system and that needs a new wave of ideas. Unfortunately what the administration has proposed will never get that wave to shore. It will surround us with stagnant ideas that we've tried before."

The Reagan Medicare proposal would give the elderly greater catastrophic illness coverage, but greatly increase the percentage of the medical bill they pay for the first 60 days in the hospital. The proposal would also tax the Medicare benefits of three million elderly.

"The administration is going to make sick people pay for the care of even sicker people," Wyden said. "These policies are not the stuff of the new era. It has not worked in the past and it won't work now. I think they (the administration) are approaching health care in a butcher-block manner."



U.S. Representative Ron Wyden (L) and Dr. Ralph Crawshaw find time for greetings and informal discussion.

"I'm looking at ways we can have a national policy on which to shape PPOs. We have a climate today where people will bite the bullet for reform." —Wyden

Wyden also blasted administration proposals for a voucher system to increase competition in health care, saying he does not believe it is workable.

"I am convinced it cannot be

Dr. J. Halisey (Spike) Kennedy, MCMS president-elect.

done. Most lawyers can't figure out which health plan offers better protection and coverage. To give every elderly lady a voucher and say everything is going to work out is not realistic."

Boyle

While Wyden hit organized medicine and the administration for anemic ideas, Boyle, in remarks framing his speech, said government has offered very little new blood.

"He (Wyden) says we need a new wave of ideas while ignoring the fact that there are many innovative ideas that have been developed in the last several years and none of them originated in government," Boyle said.

Boyle told the audience that the AMA has one of these innovative ideas now percolating and, when complete, it will form the basis for a new national health policy based on a broad consensus.

The AMA project, still in its infancy but making promising progress, according to Boyle, involves gathering together representatives of the AMA, the American Hospital Association, virtually every specialty medical society, state medical associations, the U.S. Chamber of Commerce, the Business Roundtable, labor, consumers and the insurance industry.

The plan is to have these representatives "sit down at one table and see if we can, over a period of time, develop a set of principles that will allow us to develop a programmed policy for action in the future," according to Boyle.

"It is an enormous project with a very far-reaching scope. It is our intention to evaluate the entire health care delivery system and the structure upon which it rests," he said.

Boyle believes there is a window in the calendar to allow this kind of careful study and evaluation. But in order to keep the discussions free of political bickering, Boyle said these initial talks will restrict themselves to principles only.

"If you start talking about policy, automatically you are going to have representatives of labor, the Chamber of Commerce, medicine and hospitals, state associations and specialty societies arguing with one another about specific details that, in the end, may or may not be important," Boyle said.

"Our major incentive has been to provide individual personal care, the best that is humanly possible. I'm not about to apologize for that." —Boyle

Once these principles are agreed upon — and signed off by the representatives' parent bodies — the policy recommendations can be made. A health care proposal with such broad-based support would have a much easier time in Congress than a plan from any of the separate groups.

One of the principles Boyle holds in highest esteem is that of individual personal care for the patient. He sees that principle as the cornerstone of health care in this country.

"Our major incentive has been to provide individual personal care, the best that is humanly possible," he said. "I am not about to apologize (for that.)"

And the PPOs Wyden sees as so promising are anathema to Boyle. He calls PPOs "a very seductive notion," but one that physicians should be very careful about entering.

"There are a variety of modes that have been put together, some of which do preserve freedom of choice for both patient and physician, some of which do preserve the fee-for-service system of reimbursement, some of which appear, at least, to preserve the right of individual physicians to deal directly with their own patients," Boyle said. "But there are many, many forms that have been put together."

The PPOs organized by hospitals often are structured completely in favor of the hospital. Other PPOs are formed by private entrepreneurs who act as a "dating service" between employers and providers and whose motivation, according to Boyle, "is only to make money for themselves."

He told of a PPO organizational meeting in California where a PPO promoter "quite blatantly addressing a medical staff said the question is no longer whether you will be concerned about traditional medical values, the question is will you get your share?"

"If our profession is reduced to that kind of option," Boyle said, "I am very disappointed."

If the prospect of PPOs ascending worries Boyle, AMA negotiations with the Federal Trade Commission and the U.S. Department of Justice have encouraged him.

For years, the AMA and the federal government have been battling over what role the FTC should play in regulating the medical profession. Organized medicine has insisted on a role for medical associations in reviewing fees and physician conduct, and overseeing the quality of care received by patients.

The FTC has held that these practices, particularly fee review, violate anti-trust laws. Now, Boyle says, after a year of open media warfare, the three groups have settled into agreement.

"A year ago, I would have said it was a pipe-dream to suggest the Justice Department would agree in any of those areas," he said. "Bu assure you today that the answe each of those questions was 'yes We are proceeding further in ou discussions with Justice to see i can develop legislative changes will allow us to continue in the we believe a conscientious profession should accept and willingly pursue."

Wyden, who opposed the AM its recent battles with the FTC, nonetheless welcomed the compromise even though it will undoubtedly be seen as a victor organized medicine.

"I hope this is the year we ca this done so we can go on to m fruitful things," Wyden said.

"It is my objective to awaken you to the reality that change is coming. . .and will occur with or without the participation of organized medicine." —Kitzhaber

Kitzhaber

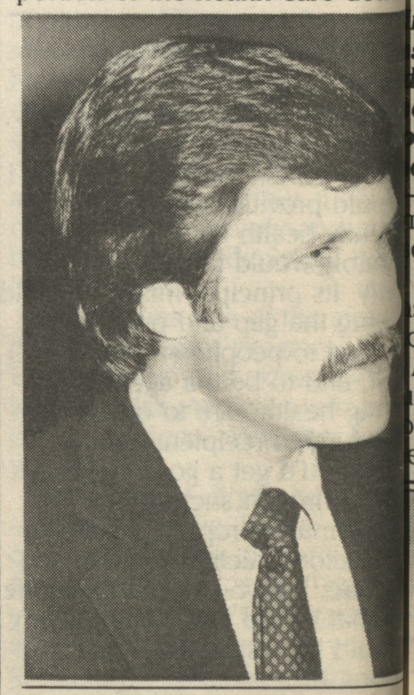
For Kitzhaber, one of the mos fruitful things physicians can do become more involved in the political process since that is th arena where the fate of their profession will be shaped.

"It is my objective to awaken to the reality that change is com — whether you like it or not — that change will occur with or without the participation of organized medicine," Kitzhaber "We're really on the edge of something very revolutionary."

This revolution, in Kitzhaber's view, is imminent because he s the collapse of third party payer inevitable. He has mixed feeling about the onset of PPOs — the system many are promoting to replace insurers.

"There is a clear incentive to down costs (in a PPO) since sa are realized as profits," Kitzhabe said. But at the same time, Kitz has some of the same feelings the basis of medicine in this co as Boyle does.

"Economic competition in th health care market place and prospective reimbursement strik the heart of traditional fee-for-se practice," he said. "There are m competitors in the field vying fo portion of the health care dolla



Dr. John Kitzhaber, state senator f Roseburg.

has traditionally gone to the pri practitioner. Yet, I do not belie the threat to private practitioner comes from the alternative hea care provider.

"The real threat comes from organized medicine itself becau our failure to involve ourselves actively and constructively in th politics of change," Kitzhaber s "For too long we have refused recognize the inevitability of ch for too long we have resisted change, for too long we have remained aloof from the politic

Physicians and their families had the option of attending a short seminar on personal computers and their applications in the home and office.

process."

He acknowledged that the AMA and local medical organizations have always employed lobbyists, but said they often worked on isolated issues.

"They (legislators) hear from the medically indigent and labor unions, but they don't hear from their doctors," he said.

Goldsmith

Goldsmith said communications with the medical profession leave much to be desired. "There is an abysmal state of communication between physicians and hospitals," he said.

"In seeking to protect their institutions, many (hospital) administrators have placed their hospitals in competition with their medical staffs," Goldsmith said. "Medical staffers are understandably anxious about some changes that could damage their practices, but think nothing of what some of their colleagues do that may damage the hospital."

"Each party in that relationship has not taken the time to understand the economic pressures bearing on the other side," he said.

Goldsmith told the audience that hospital use has declined since 1966. He presented figures showing a 25 percent reduction in hospital stays among people between the ages of 15 and 44. While older Americans continue to be heavy users of hospitals, the introduction of hospice care for the terminally ill has taken a chunk out of hospitals' income.

"In seeking to protect their institutions, many administrators have placed their hospitals in competition with their medical staffs." —Goldsmith

At the same time, the large number of elderly in the nation's hospitals leaves the institutions at the mercy of the federal Medicare system. Changes in that system's payment schedules have forced hospitals in recent years to lay off employees and even reduce services to other poor and elderly patients, according to Goldsmith.

If these conditions continue at their present rate, Goldsmith sees hospitals in this country becoming depressing health care ghettos.

"They (the changes) will leave the hospital with a much sicklier and expensive patient population while, at the same time, all the insurers will be asking for discounts," he said.

Goldsmith said county medical associations can play an important role in improving the communications between physicians and hospitals and believes that if both sides understand the other, there will be less possibility of those outside the health care community capitalizing on the divisiveness.

"When they realize the competition in health care, they will begin to play one off the other," he said. "Rather than helping members circle their wagons, medical societies should help their members work with hospitals."

Jeff Goldsmith, health care consultant and technical advisor to Ernst and Whinney accounting firm.

Vervloet

Dr. Albert Vervloet, who practices in Northwest Portland, agreed with Goldsmith on the issues of competition and an overabundance of hospital beds.

Vervloet, who was with Northwest Permanente for seven years, told MCMS members that the giant HMO is the largest competitor they face. The reason for Kaiser's strength, he said, is its avoidance of long hospital stays for its members.

"Kaiser can serve the entire Portland area with two more hospitals," Vervloet said, explaining that Kaiser now has 250,000 members and less than 400 beds. "The other five hospitals can be bulldozed into the Willamette River."

Since the Kaiser system emphasizes outpatient care and avoids costly hospital care wherever possible, its rates are much lower than third-party payers such as Oregon Blue Cross.

"Everything you've heard (at the conference) is of no importance," Vervloet said. "The main thing that has to happen for the fee-for-service system to survive is the lowering of premiums."

"Kaiser can serve the entire Portland area with two more hospitals," Vervloet said, explaining that Kaiser now has 250,000 members and less than 400 beds.

Otherwise, according to Vervloet, "the fee-for-service system is on the road to bankruptcy" due to "enormous waste" built into the system.

The attendees digested this feast on the health care famine in a series of group discussions. While no definite direction was set, the overall mood, as reflected in Zieverink's audience survey, was one of pessimism, tinged with hope.

The survey, which elicited an 80 percent response, found that only five of the 40 respondents strongly recommended a career in medicine. Four others recommended careers in anything but medicine.

Zieverink found 40 percent of the physicians surveyed believe their incomes will decrease in the future and that 75 percent feel there are too many doctors in their specialty.

The results and the discussions arising from the speeches led Zieverink to several conclusions, and he shared them with the audience in what bordered on an admonition.

"If we only pay attention to our pocketbooks, we are going to forget what we do best, and that's taking care of patients," he said. "We must remember that whenever someone other than a physician talks about the health care delivery system, they're talking about the cost, not the quality of care."

"We separate medicine and politics at our own peril," Zieverink said. "We have to get into those smoke-filled rooms."

Dr. Albert Vervloet, a Portland internist and outspoken advocate of strict utilization control to decrease health care costs.

Dr. John Tarnasky, MCMS president

photos by Bob Collins

***Editors Note:* Speeches from the conference will be printed in the March/April issue of Portland Physician.**

◦MCMS Announces◦

Super Seminar Series

Tues., March 29 through Sat., April 2, 1983

	Tuesday March 29	Wednesday March 30	Thursday March 31	Saturday April 2
10:00	EITHER Fundamental Computer Skills OR Wordstar Supercalc & Telephone Access of Information	EITHER Fundamental Computer Skills OR Wordstar Supercalc & Telephone Access of Information	EITHER Fundamental Computer Skills OR Wordstar Supercalc & Telephone Access of Information	Doctors are invited to see demonstrations of computers, software & peripherals currently available through local reps
1:00				
2:00	"Basic" Programming Language Primer	D Base II Programming Information Storage & Retrieval	Comparison of Computer Attributes	
5:30				
6:00	Comparison of Computer Attributes	Comparison of Computer Attributes	Doctors Computer Club Meeting	
9:00				

Outline of Classes

Fundamental Computer Skills
- Anatomy of a Computer System
- What is "Memory"?
- Computer Speed, Benefit, Cost Tradeoffs
- Communicating with Other Computers
- A Survey of Peripheral Equipment
- A Survey of Local Vendors

"Basic" Programming Language Primer
- What can be done with "Basic"?
- Generic "Basic" Instructions
- Writing, Reading and Running a Program
- Saving Information
- Automated Algebra
- Variations by Manufacturers

Comparison of Computer Attributes
- Discussion of Attribute vs. Manufacturers
- Aspects to be considered include:
  Price, CPU, RAM, ROM, Storage Media, Communications Displays, Graphics, Expansion, Service, Operating Systems, Available Software.

Wordstar, Supercalc & Telephone Access of Information
- Word Processing Attributes
- Text Size, Storage and Retrieval
- Form Generation
- Merging Files With Forms

D Base II Programming for Information Storage & Retrieval
- Organizing Information for Easy Access
- How Much Information Can I Store?
- Sorting, Locating and Merging Information
- Selective Access to Stored Data
- Automating the Process
- Printing Results In a Meaningful Way
- Hands-on Demonstrations of Three Applications
  Summarizing Survey Information — Locating Employees for Employers — "The Needle in the Haystack" or "I Know It's Here Somewhere"

Computer Club Meeting
- Doctors are invited to attend the first plenary session of the Doctors Computer Interest Group. Bring you own machine and show what you've done. Talk with associates who already own machines. Find answers to questions about their use at home and at work. Share your experience . . .

Demonstration Day
- A variety of local vendors will be on hand all day Saturday, April 1 to exhibit and discuss their products. Stop in and see first hand the equipment revolutionizing our professions.

Fees are $45.00 each for 1 or 2 classes, $35.00 each for 3 or 4 classes, $150.00 for 5 classes. No charge for vendor day attendance.

Before sending payment, please call Cherrill at 222-9977 to register — enrollment is limited to 25 per class.

MAR. 29 TUES.	MAR. 30 WED.	MAR. 31 THUR.	
☐ am	☐ am	☐ am	**Fundamental Computer Skills** 10 AM - 1 PM Tues. or Wed. or Thurs.
☐ am	☐ am	☐ am	**Wordstar, Supercalc & Telephone Access of Information** 10 AM - 1 PM Tues. or Wed. or Thurs.
☐ pm	**TUES. ONLY**		**"Basic" Programming Language Primer** 2 PM - 5:30 PM
☐ pm	**WED. ONLY**		**"D Base II" — Programming for Information storage and Retrieval.** 2 PM - 5:30 PM
☐ eve	☐ eve	☐ pm	**Comparison of Attributes** 6 - 9 PM Tues. or Wed. or 2 - 5:30 PM Thurs.

☐ I plan to attend the Computer Interest Group meeting on Thursday evening, March 31 at 7:00 p.m.

☐ I plan to attend on Vendor Display Day, Friday, April 1st at approximately a.m. / p.m.

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by Oscar W. Thomsen MD, PhD

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