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Special report

Local physicians to launch doctor-controlled "Bestcare"

A new doctor-controlled alternative delivery system for the Greater Portland Area will be developed by members of the Multnomah County Medical Society.

The nonprofit delivery system — to be known as Bestcare — will be developed by doctors Roger Alberty, John Bussman, Harry Lee, Russell Sacco, John Tarnasky, MCMS Executive Director Brad Davis and MCMS Director of Research Robert Delf Jr. They agreed during an August 2 meeting to form Bestcare and serve on its initial board of directors. However, the society is not going to sponsor the organization.

"We've got to grab this opportunity and move—now."

Tarnasky, who is president of MCMS, said speed is essential in forming the new delivery service.

"We've got to grab this opportunity and move — now. Timing is such that doctors may not have a second chance to keep the practice of medicine in their own hands," he said.

He added that the new delivery system will be significantly different from other alternatives contemplated or in various stages of development in this area.

"The physician members of Bestcare will fund at least a significant majority, if not all, of Bestcare's required capitalization and initial operating costs," Tarnasky noted. "This will not be a delivery system owned by hospitals, insurers or business entrepreneurs. It will be owned equally by all participating physicians."

He added that the amount of individual funding by physicians is as yet unspecified.

Tarnasky said Bestcare will not be tied to any one or small combination of hospitals. "It will be areawide so all subscribing citizens may enjoy its benefits, and no doctor will be excluded by virtue of his or her staff privileges at the 'wrong' hospital," he explained.

Bestcare will be modeled after Lifeguard Inc., the highly successful physician-controlled HMO in Santa Clara County, California. That HMO/IPA was described to MCMS members recently by Dr. Robert Burnett, a founder of Lifeguard.

The three-year-old Santa Clara County organization has assets of $7.8 million, liabilities of $5.6 million and equity of $2.2 million. Doctors have received 53 percent of medical dollars earned by Lifeguard.

About $2 million was required to start Lifeguard. The cost of certification was $450,000 and

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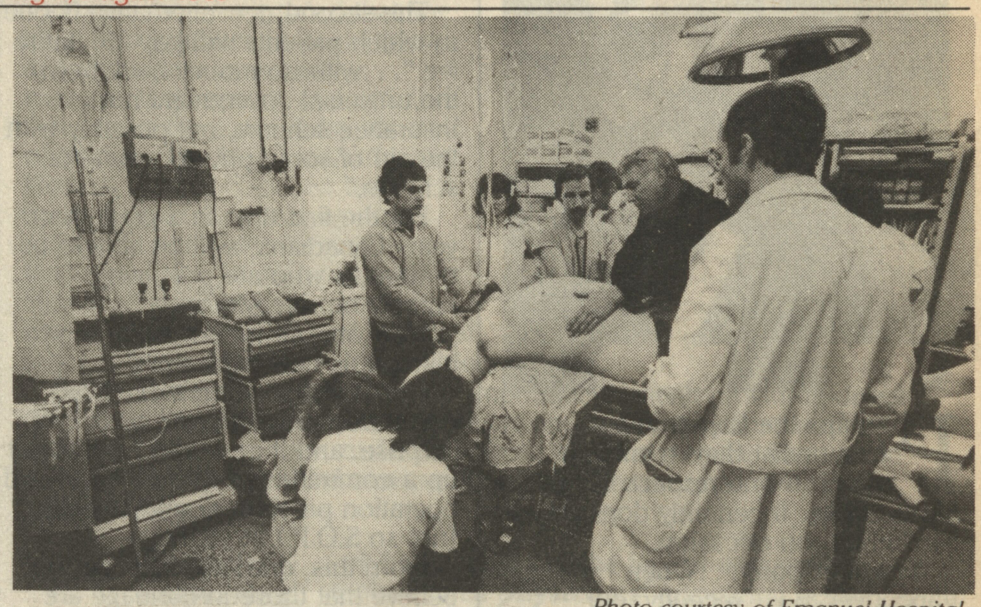

Photo courtesy of Emanuel Hospital

Emanuel Hospital Trauma Center Director Ben Bachulis works to save a motorcycle accident victim who suffered head and multiple trauma injuries interfering with essential body systems.

Legislature orders development of statewide trauma care plan

By Adrianne Page

Considerably more victims of traumatic, multisystem injury — the leading cause of death in persons under age 40 — could be successfully treated in Oregon if the medical and lay communities agree to support a statewide trauma care system, medical and public officials say.

The Oregon House of Representatives and Senate issued a clear directive on July 1, saying that Oregonians should have access to the best possible trauma care.

After a Senate vote of 26-1 and a House vote of 54-5, the House speaker and Senate president signed a joint resolution directing the State Health Division to develop a statewide emergency services and trauma system and appoint a Trauma Advisory Board to assist with the task.

The nine-member advisory board — which is to submit a statewide plan to the Health Division by July 1984 — will consist of five physicians representing the American College of Surgeons and the American College of Emergency Physicians, one hospital administrator, one class IV emergency medical technician, one emergency department nurse and one lay member.

After receiving the plan from the advisory board, the State Health Division is to make recommendations for implementing the system to the 1985 Legislative Assembly.

There is a clear need for systemized trauma care in Oregon, health officials say. For too many

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Commissioners proclaim Medi-share Day

Medical services provided by the Multnomah County Medical Society for unemployed patients were commended when the Multnomah County Board of Commissioners proclaimed July 31 Project Medi-share Day.

That day marked the first anniversary of Project Medi-share, which in the past 12 months has aided 1,700 Multnomah and Washington county residents who have lost their jobs, do not have health insurance and cannot qualify for public assistance.

More than 630 physicians, as well as 11 hospitals and 35 pharmacies, have volunteered their services to make the program work.

Project Medi-share Day was proclaimed during the Board of Commissioners regular meeting on July 28. Commissioner Caroline Miller introduced the resolution.

"We're proclaiming July 31 Project Medi-share Day to focus attention on the concern shown by Medi-share providers and to commend them for their contribution to the community's well-being," Miller said.

Representing MCMS at the ceremony, Dr. John Tarnasky said, "The Multnomah County Medical Society is proud of the way its members responded to the medically poor's plight with speed and organization. . .It is proud of the concern and commitment demonstrated by Project Medi-share physicians, pharmacies and hospitals. And it is very proud to be recognized by the Multnomah County Board of Commissioners."

Tarnasky warned, however, that the number of medically poor has grown rapidly, due to high unemployment and the defunding of government health care programs.

"Medi-share is designed for episodic health problems and doesn't claim to meet comprehensive or emergency medical needs. It is a short-term solution to a problem that society, particularly government, must resolve very soon," he said.

Other speakers during the ceremony included Kenneth Myers of the Greater Portland Area Hospital Council and Dan Wendell, who represented participating pharmacies.

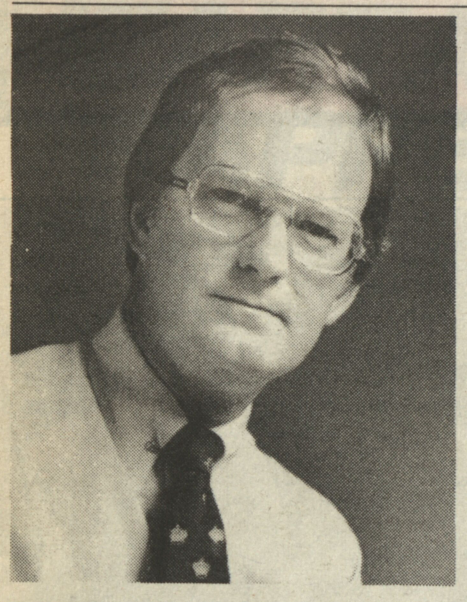
MCMS President Dr. John Tarnasky testified before the Multnomah County Commissioners in support of declaring July 31 Project Medi-share Day, marking the program's first anniversary.

Inside. . .

EXECUTIVE DIRECTOR'S NOTEBOOK

Can Canadians handle freedom?

By Brad Davis



Perhaps the Rajneeshees know what they're talking about in one respect. Maybe life is a joke. It certainly does get all twisted up, on occasion.

A case in point. . .When I was in Vancouver, B.C., recently, our business group heard a speech by W.D.S. Thomas, M.D., past president of the Canadian Medical Association, bemoaning the restrictions of a government-controlled health care system. Dr. Thomas urged those of us from the United States to zealously defend the private system of health care provided by our doctors and available to our citizens.

Shortly after he delivered those remarks, the press broke the news that the Canadian Parliament had just enacted a bill which would create two new kinds of physicians' medical care delivery systems, in addition to the present totally government-dominated National Health Services system.

Under this present Canadian "Medicare" system, all medical bills are paid by each province's medical services plan. Patients who agree to participate in the universal plan must see the physicians within this delivery system; physicians must accept government-set fees as payment in full.

The new legislation — trying to get a handle on the "skyrocketing" costs of Canadian health care (now at about 7½ percent of their Gross National Product compared to health care costs totaling 10 percent of GNP in the United States) — offers a limited return to private practice for both the doctor and patient.

Isn't that interesting? In spite of the fact that their "crisis" isn't acute by our standards, the government is attempting to return delivery and cost of care to the private marketplace because it can't cope with the current situation. Are you listening, Don Clark?

One aspect of the legislation will allow doctors to charge their patients more than the government-set fees. While I have no detail, I infer from news stories that the purpose of the change is to retard over-utilization by having the patient share in the cost of his or her care. I think this is a delightfully appealing approach, used, strangely enough, by almost every other form of insurance I can recall.

The second new alternative is one in which patients will pay the entire fee ". . .with no money back from the universal government-run insurance scheme, but possibly with the aid of some private insurance scheme."

For the first time in a great many years Canadians "will be able to go to doctors who are practicing entirely outside Medicare."

How are our friends to the north taking this new legislation?

The British Columbia Medical Association said it came as a surprise, and they would have to set up a committee of doctors (standard operation procedure) and lawyers (not so S.O.P.) to study it.

From this, one might be led to believe that those in bondage are guarded as to how they might handle their newfound freedom. Actually, it turns out that this government-controlled system may have been in effect so long that what American doctors would view as anathema, Canadian doctors now accept as comfortable. The July 12 issue of the Canadian newspaper The Globe and Mail quotes BCMA President Dr. Duncan McPherson as saying:

"This profession goes a long way back to looking after the medical needs of the people of this province. It goes back to the time before medical insurance.

"We've watched the development of a scheme we all felt satisfied with (the universal "Medicare" system) — except for some changes. What we've got now is a totally new scheme which has been sprung on us by surprise."

One wonders how Canadian doctors will ultimately deal with this "totally new scheme." Will they work to maximize new freedoms for patients and themselves? Or, will they fight to maintain the control government has had over them?

I know that I am painting an extremely simplified picture of what must be a complex subject. The point I'm trying to make is that we become comfortable with familiar surroundings, no matter how objectionable those surroundings are. As shown by the Birdman of Alcatraz, prison can become a man's best world.

But even as I conclude this article, that prison seemed to be closing in more tightly in Canada after the earlier hint of freedom. This time, it is a bill in which ". . .the government will take on the weighty task of controlling which doctors may practice in the cities and which are to be sent to the boondocks."

Canada — a lovely place to visit. . .

Canadian urges U.S. doctors to protect medical system

By Arlene Tiland

Though the Canadian Medical Association supported the initial concept of national health care insurance, it is opposed to the system and policies that have evolved from that concept, according to Dr. W.D.S. Thomas, past president of the CMA and a Vancouver obstetrician.

At the Northwest Medical Executives Conference in Vancouver, B.C. last month, Thomas said the CMA originally supported national health care insurance with the provisions that patients pay part of their medical bills.

"This provision has unfortunately been ignored and what was envisaged as a true insurance system to provide protection against financial ruin due to illness or injury has drifted to first dollar coverage for everyone for everything," Thomas said.

Under Canada's "Medicare" system, which covers 97 percent of the population, physicians are reimbursed by their province at a set fee schedule. Each province receives a fixed sum of money from the federal government to offset part of its costs.

Physicians can only bill the province for approved services and may not bill the patient for extra charges. Patients pay a small co-payment for the use of hospital rooms ($4 a day), emergency rooms ($4) and ambulances ($5).

The usual lack of co-payments has made patients unaware of health care costs, resulting in high utilization, Thomas said. He noted that some general practitioners are seeing 80 to 90 patients a day.

Because of over-utilization, and a dramatic reduction of federal funds in 1977, Canada's health care system is becoming seriously underfunded, Thomas said. This has resulted in reductions in hospital beds and nursing staff, waiting lists for urgent surgery and a fee schedule that fails to keep pace with inflation.

"Where we used to have three registered nurses we now have one R.N., one L.P.N. and an aide with no degree. And the line-up for ultrasounds is now three to four weeks," he said.

Physicians are growing increasingly angry over the small and infrequent increases in the fee schedule and slow payments, Thomas said. He cited the fee schedule for a number of medical procedures, including a coronary bypass — $975; prenatal care, delivery and postpartum care — $370; and a mastectomy — $330.

He said the government takes three to six months to pay in full, adding that his own accounts receivable average $25,000-30,000, without interest.

Thomas concedes there are advantages to the system. With one doctor for every 600 patients, and high utilization, the demand for physician services is high. Payment is virtually guaranteed, without collection fees, and malpractice insurance is low. Thomas said his malpractice insurance costs $500 a year.

Dr. W.D.S. Thomas told the Northwest Medical Executives Conference in Vancouver, B. C. recently that Canada's "Medicare" system has "drifted to first dollar coverage for everyone for everything."

The patient, on the other hand, receives free, unlimited medical care with no stigma attached, he added.

Still, Thomas said 70-80 percent of the people have indicated they would pay a portion of their medical bills if it would mean better care.

Thomas urged U.S. physicians to protect their right to bill patients directly, to establish the value of their services and to operate on a fee-for-service basis.

"Any insurance mechanism must provide a contractual relationship between the paying agency and the patient — not between the agency and the physician," he stressed.

Physicians' Answering Service offers new paging option

The medical society's Physicians' Answering Service is offering a new option for doctors using its paging service.

Doctors with display or tone-and-voice pagers will not be required to acknowledge pages — if they sign a waiver implementing this change. A letter will be sent to doctors which will have to be returned with a signature to effect this change.

Physicians who make the change must also notify the answering service when they are on or off the pager.

The option is not available for those with tone-only or tone-and-vibrator pagers.

Under the new non-acknowledgement system, calls will be cancelled automatically after two pages — except in emergency situations, when pages will be repeated at five-minute intervals.

"We will ask the patient to call us back after 30 minutes if the doctor has not called them," said Dorothy Price of the Physicians' Answering Service.

But in the case of calls from hospitals and doctors, "we will follow up by calling the hospital or doctor to see if the call has been returned," she said.

Those with questions about the arrangement should phone Price at 228-4175.

"Doctors have asked for this type of arrangement so they don't have to run to the telephone," said Bill Larson, who is in charge of technical services for MCMS.

Larson added that a full range of new and sophisticated pagers will be available this autumn.

He also emphasized that the service operates on a medical emergency band. Larson said the answering service's prices are "more than competitive," since a $50 flat fee is charged per doctor per month, unlike commercial answering services which charge a base rate for a specific number of calls per month, with an additional charge for calls over that number.

Loan rules change for health students

The U.S. Public Health Service has published a final rule amending existing regulations dealing with the Health Professions Student Loan program.

The rule, which took effect in June, requires borrowers to establish a repayment schedule providing for payments at least quarterly. Borrowers whose repayment is over 60 days late must set up a monthly repayment plan.

Schools participating in the program must use collection agents, include a clause in their promissory notes permitting acceleration at their option, and — if appropriate — file civil lawsuits to recover money owed. Each school will also be required to join a credit bureau and notify it of accounts overdue by more than 120 days.

PRESIDENT'S COLUMN

NOBODY does it better

By John Tarnasky, M.D.

The world is changing and times are tough — and there's no reason to believe they'll be getting better in the foreseeable future. If a professional society — **any** professional society — is to survive, it has to meet the contemporary needs of its members. Today we take for granted that we must be aggressive in peer review and participate in socially responsible programs and activities that assure the public's health and education. The Multnomah County Medical Society does just that, through such programs as the nationally prominent Project Medi-share, the MCMS-originated Mini-Internship program, school health newsletters, Tel-Med, medical service to the Salvation Army, and lots more.

But today there's another equally important element: providing direct, tangible, relevant, no-nonsense products and services to our members which save them money, make their work easier and make them more competitive. Products and services that give them an edge. We do that, too.

Here they are. . .

Physicians' answering service

● MCMS operates the largest and most sophisticated **physicians'** answering service in the country. We think you're special — and shouldn't have your medical calls commingled with those for lawyers, salesmen and repairmen. (With a flat fee charge for calls, irrespective of volume, we're also the least expensive service around.)

Radio paging

● We operate the only emergency medical band radio paging service in the area. Sure, there are lots of paging companies around which handle all sorts of clients; the question is, when it comes to priority, do doctors have any? With our radio paging service, doctors are the **only** priority. And next month, we'll be introducing a whole line of state-of-the-art pagers. Watch for details in the September/October Portland Physician.

Referrals

● MCMS members who sign up for the referral service get 80 to 100 referrals each working day.

Roster referrals

● Our Photo Roster is the most widely-used reference for physician referrals.

"High tech"

● MCMS is, to the best of my knowledge, the first medical society in the country to launch a "high tech" service to help its members with computers and peripherals, business applications software, educational seminars, national symposiums, access to medical data bases and more. (We'll give you all the news in the September Scribe).

Communication

● Our medical society provides the two best socio-economic publications of their kind in the United States: the national award-winning magazine Portland Physician and the International Association of Business Communicators' prize-winning newspaper, the Scribe.

Marketing, logos, newsletters

● MCMS now offers the sharp business-oriented professional an array of helpful marketing tools. Our staff will help design or re-design your printed material, including logos, patient brochures and newsletters. We also offer in-house typesetting, printing and mailing services.

Patient surveys

● Want to conduct patient demographics research? No problem; we've got the staff talent and computer software to conduct and analyze this entire area.

Office personnel placement

● MCMS helps find, test and hire the office employees you need. Since we deal exclusively in the employment of medical office personnel, we think our service is rather special. You will too.

There's more. . .Like the reduced price offered MCMS members who attended our Western States Conference on PPOs (the only one sponsored by a medical society in the nation). And our own investigation of a for-members-only PPO **and** IPA — one for doctors, their families and staffs, the other for a community-wide delivery system. We're also one of two medical societies in America analyzing alternative delivery system contracts; and we're presently investigating establishing a contracts negotiation arm of the society.

Oh yes, we offer our members significant discounts on long distant telephone charges (at work and home), reduced prices for certain publications, and reduced lodging, travel and admission to virtually all of California's "play lands."

Just like you, I don't want to waste my time with a medical society that doesn't deliver. That's why I'm proud of our achievements — and feel very comfortable in saying **"NOBODY** does it better."

Oregon physicians tackle pressing problems at national level

By Jeanne Leeson

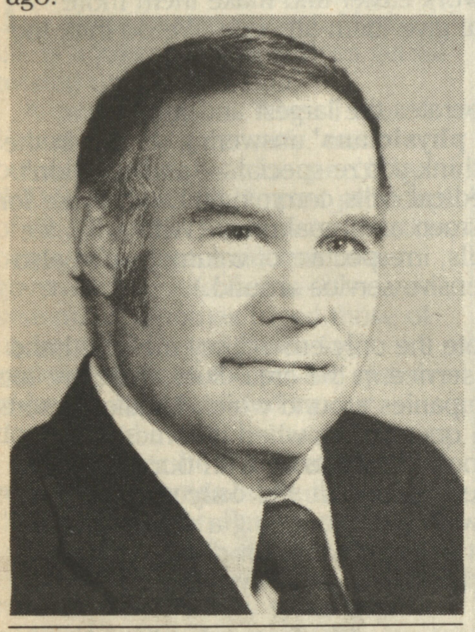
Time and travel will be the fare for three Oregon physicians chosen during the annual AMA meeting to serve on prestigious panels dealing with pressing problems.

Bob Loomis, M.D., Eugene, was appointed by the AMA Board of Trustees to his second year on the American Medical Political Action Committee (AMPAC).

Tom Reardon, M.D., Portland, was elected a delegate to the AMA House of Delegates from the new Hospital Medical Staff Section, which held its first meeting this year.

Daniel Billmeyer, M.D., Oregon City, was elected by the AMA House of Delegates to fill an unexpired term on the Council on Medical Service.

Loomis is the first Oregon doctor to serve as a member of AMPAC since the late Blair Henningsgaard contributed his expertise 11 years ago.



Robert C. Loomis, M.D., was recently reappointed to the American Medical Political Action Committee.

"So much of a physician's professional life is controlled by government regulations, we have to work diligently to know very well the people elected to office," Loomis said.

His committee is composed of nine physicians and one auxiliary member who are scattered throughout the United States.

This committee reviews all candidates for the U.S. House of Representatives and Senate each year.

"In the last election 84 percent of the winners were politicans we supported," said Loomis.

"We are a bipartisan committee, we are only interested in the candidate's views on medical issues."

Members of the committee search for viable candidates — ones who will listen to AMPAC members and have the ability to win. They carefully question candidates about the free enterprise system as it affects doctors, about cost reimbursement including the Tax Equity and Fiscal Responsibility Act (TEFRA) and about their concept of the way Medicare operates.

If a candidate passes the committee's standards, the committee has the privilege of contributing $5,000 per candidate, per race. This means if a strong candidate wins the primary, he could be given another $5,000 for the general election.

The budget for these funds comes from individual doctors who are members of AMPAC. When a member donates $100, $50 goes to the national fund and $50 is kept at the state level.

Another AMPAC duty is running political education seminars.

"No matter how much money we have to give, it is important for us to become involved locally. We need to know how to campaign, how to set up a phone bank, how to canvass, how to get people involved," said Loomis.

Correspondence and phone calls take a great deal of his time. He attends five AMPAC weekend meetings each year and two meetings with the House of Delegates. Scores of trips are taken to attend other state meetings.

Loomis believes in what AMPAC does and feels its work is basic to achieving a better understanding with politicians.

Medical Staff Section

Tom Reardon is ecstatic about the success of the first meeting of the new Hospital Medical Staff Section. Representatives from 657 hospitals, with 570 of the members voting delegates, attended the Chicago AMA meeting. The group represented 7,000 hospitals in the United States.

Reardon is one of seven members on the Governing Council which will meet twice before the next meeting of the Hospital Medical Staff Section.

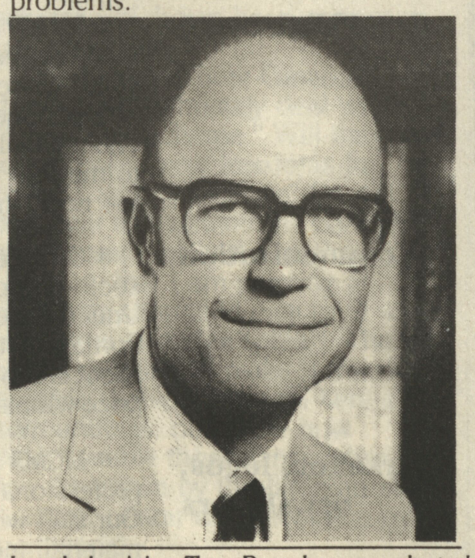
"This section is part of a new thrust to have a national forum where issues germane to hospital medical staffs can be studied and discussed," said Reardon.

He added that the hottest issue is hospital organization.

The section recommended that the term "medical staff" be retained instead of being replaced by "organized staff," a change proposed by the Joint Commission of Hospitals for use in the JCAH manual. Section members believed that the quality of hospital service is the responsibility of physicians.

Most of the 647 who attended the AMA meeting had not been deeply involved in county, state or national issues.

He is pleased so many expressed interest and believes the group will be most helpful in solving common problems.



Local physician Tom Reardon was elected AMA House delegate from the Medical Staff Section.

Council on Medical Service

Dan Billmeyer will fill the unexpired term on the Council on Medical Service left open when John Dawson, M.D., of Seattle was elected to the Board of Trustees.

Billmeyer's name was placed on the ballot after Loomis nominated him from the floor, a move that "shocked" the entire delegation.

"It is almost unheard of to nominate someone from the floor," Billmeyer explained. "The other candidates had spent a lot of time and money campaigning."

Billmeyer said the mind-boggling problem for the council is to find answers to physicians' reimbursement problems.

"The government and the insurance companies are adulterating the term 'reasonable' when we speak of our 'usual, customary or reasonable' (UCR) fees," he said.

Since 1966 the UCR-based payment method has been used widely, partly because the method was mandated by Medicare law.

However, lately two trends have surfaced, 1) the gap between the "reasonable charge" allowed by payers and the physicians' actual charge has widened, and 2) pressures are increasing on physicians to accept the payers' version of the reasonable charge.

The Council on Medical Service recently sent Report D to all county and state medical societies, asking members to discuss the matter of physicians' reimbursement by means of indemnity versus UCR with their constituents and then send any additional views to the council no later than Aug. 31.

"When we have all reports in, our group will develop recommendations for the AMA on schedules of costs," said Billmeyer.

Dr. Daniel Billmeyer, who practices in Oregon City, was chosen to fill a position on the AMA's Council on Medical Service.

President says Vantage slow, but still alive and well

By Tom Gauntt

The Portland area health care rumor tom-tom recently pounded out a dirge for Vantage Health Services, the city's first preferred provider organization (PPO). But, paraphrasing Mark Twain, VHS President Charles McGreevy said reports of the organization's death are greatly exaggerated.

"That's not true. Under no circumstances are we in financial trouble," he said. "We haven't sold out and we don't plan to. We're not moving as fast as we would like, but we're still alive and well."

McGreevy, head of the company that started up in late 1982 as a health care alternative that "must succeed," according to company statements at the time, believes the rumor-mongers mistook slow movement for rigor mortis.

"We knew early on it was going to be an evolutionary process and that we were going to learn a little each day," he said. "We've learned to develop an attitude of patience. We continue to be dependent on the provider community and it's a calculated risk, but we're going to make it work."

Vantage, begun with mild fanfare, has suffered from an apparent lack of popularity with the physicians and dentists it wished to recruit. Original plans called for 200-250 physicians and 25 to 35 dentists being involved. So far, total recruitment has not come near that 200-plus total.

Vantage has signed up 26 dentists and 31 physicians, according to McGreevy, with most of the medical specialty areas beginning to fill up. He said another 40 to 50 doctors are considering joining Vantage.

"What we thought we needed was 90 to 120 physicians for the first phase of the network," McGreevy said, adding that the size of medical stable Vantage will need depends somewhat on where the eventual client population is concentrated.

McGreevy blames some entrenched attitudes in some sectors of the medical community for the recalcitrance of doctors.

"Some of the most difficult nuts to crack are members of the medical and dental professions," he said. "When it comes to change, some of them aren't interested."

Donald Young, a Northwest Portland urologist, signed up with Vantage fairly early in the process, but has since dropped out — the only one to do so, according to McGreevy.

"I initially joined and nothing happened. There was no benefit to it," Young said. "They said it was moving, but I saw no evidence of it. I asked for my deposit back; you can't go around giving $500 to every guy wanting to start one up. I could go and buy some horse race tickets or something with it."

But Young said he would probably join the organization if it indeed gets underway.

Like other PPOs, Vantage seeks to create an organization of health care professionals who would provide care to groups of patients at discount prices. Hailed as an innovation in some quarters, PPOs are condemned in others as too experimental and detrimental to the fee-for-service system.

The organizations also get under the skins of hospitals, where a large amount of health care money goes. With PPOs trying to cut their expenses to gain clients, hospitals are pressured in turn. Since these institutions are already facing adaptation to changes in the Medicare reimbursement procedures an additional complication is not welcome.

McGreevy realizes that additional pressure could further hinder recruitment by sullying the relationship between physician and hospital, but believes a change in the health care delivery system is inevitable.

"Every hospital within the VHS market area is positioning for change," he wrote in early 1983, outlining Vantage strategies. "That independent posturing should be viewed by physicians (medical staff) in terms of its potential. We are prepared to reach hospital administrators and their boards of trustees with evidence that a new day had dawned and that new day is now."

But in Portland this summer, like the summer itself, this "new day" is slow in coming. Vantage, however, has a plan to get the dawning back on schedule.

"We're putting together a steering committee of business, labor, providers — all the affected groups — to come up with something," McGreevy said. "It should be a stimulant to physicians who are marginal, trying to decide whether or not they should join."

Lessons can be learned from Israeli strike

By Arnold Rustin, M.D.

Headlines proclaim: "Israeli doctors go on strike—Health services crippled." Newscasters report: "Three thousand of Israel's physicians have been on a hunger strike for the past two weeks in protest of the government's policies. Many are admitted to hospitals in collapse."

What does it all mean? What can we learn from it?

Israel has about 8,500 physicians and a population of 4,000,000. Directly or indirectly, all physicians are employed by the government and serve in the socialized medicine system. None is in private practice exclusively.

The Labor Federation, (Histadrut), has a health plan, (Kupat Holim Clalit), which employs 5,500 physicians and gives total health care to 91 percent of the population. This plan is similar to that of Portland's Kaiser-Permanente Plan or the Health Insurance Plan (HIP) of New York City. The remaining 3,000 physicians work in government or private hospitals, like the Hadassah Hospital of Jerusalem and are paid on the same scale as the Kupat Holim physicians.

Today, in Israel, a senior surgeon earns less than a first-year resident in Portland or New York City. An average physician in Israel works longer hours and earns far less money per hour than an average Israeli bus driver, plumber, or tour guide. Indeed, one of the main points of contention is that the hourly wage of doctors is below the hourly wage of the average Israeli worker. Most physicians are paid by the government and their salaries range from $550 a month for a resident to $1,200 a month for a department chief in a first class hospital.

The opportunities for private practice are few and only a department chief can admit private patients to a hospital. Most Israelis work a 36-hour week while physicians work a 45-hour week. Physicians are called to active military service more frequently than any other occupational group.

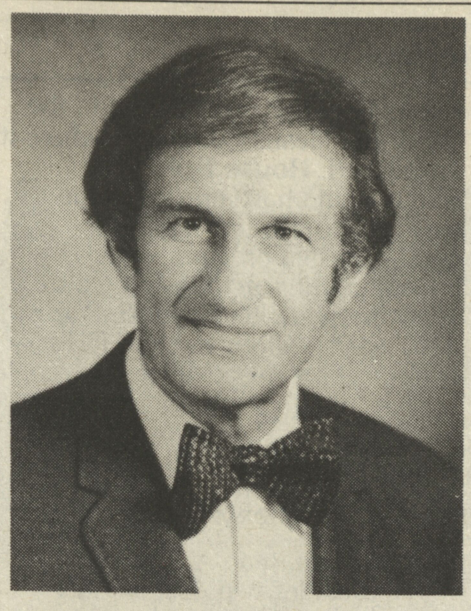
Because of these disparities, the Israel Medical Association, which represents most of the 8,500 physicians, endeavored to discuss and resolve the problems with the government beginning in December 1981. The talks dragged on for 15 months and the doctors felt the government was not proceeding in good faith, was intransigent and unreasonable.

Strike begins

Finally, in desperation, they called a general strike of physicians on March 2, 1983, and 100 percent of the physicians joined the strike. They agreed, however, to leave 30 percent of their fellows at hospitals and clinics that emergency cases could be attended. Additionally, anyone could go to a doctor's home for treatment for a $15 fee. To the doctors' credit, there has been no report of death as a result of the strike.

Public reaction to the strike ranged from acquiescence to annoyance to outrage.

The physicians demanded a 100 percent increase in pay, diminuation of their work hours to 36 hours a week, and increased privileges for private practice. Finance Minister Yoram Aridor would consent only to an overall 22 percent wage increase — the same increase that had been negotiated with the Histadrut Labor Federation in October 1982 for all workers. He was willing to use a sliding scale so that the poorest-paid practitioners would receive the largest percentage increase. Thus, a



Dr. Arnold Rustin has utilized extensive contacts with the Israeli medical community to develop a story explaining the recent doctors' strike in that country.

resident's salary would go from $550 to $737 a month and a department head's salary would go from $1,200 to $1,296 a month. The doctors did not acquiesce to the proposal.

Aridor held that a special concession to doctors would cause a collapse of the national wage structure and would create a flood of similar wage demands. Many felt that his position was partially dictated by political considerations. Health Minister Eliezer Shostak was largely in support of the doctors' demands and bitter arguments took place in the Israeli Cabinet. However, no accord was reached and the doctors were frustrated by a feeling that government officials would not sit down to meaningful negotiations.

"Belgian Plan"

After 77 days on strike, the doctors' position looked desperate. The government refused to reach any agreement and threatened to issue back-to-work orders. Failure to comply with such a direct order could result in imprisonment. Thus, on May 22, the "Belgian Plan" was instituted. Acting with military precision, 7,800 physicians simply "disappeared" — were transported to places unknown by their strike committee — and could not be served back-to-work orders.

It was named the "Belgian Plan" due to previous responses by doctors in Belgium, who reacted to repressive government measures by going on a holiday to France.

The exodus in Israel was organized by a company the doctors had hired to conduct strike activities. Physicians were bused to hotels and desert campsites.

Again, 30 percent of the doctors remained on duty.

Nevertheless, the effects of the "Belgian Plan" were dramatic. The government relented and the doctors returned.

But again there was poor cooperation and now Health Minister Shostak was less supportive. Once more negotiations stalled and the practitioners felt they were being ignored. In an effort to force the government to attend bargaining sessions and to bring attention to their plight, 3,000 physicians went on a hunger strike beginning June 19. Many doctors collapsed and were hospitalized. Finally, Prime Minister Menachim Begin appeared at the negotiation table for the first time and agreed to binding arbitration. With that promise, the doctors returned to their posts on June 27 — 117 days after the formal strike began.

The principles agreed to choose an arbitration team composed of one member from the Israel Medical Association, one member from the government and one neutral member acceptable to both sides. This team is to review the evidence and formulate an agreement by Aug. 22. This accord will be binding on both parties.

This is the first physician strike since the State of Israel was founded in 1948. The Israel Medical Association hired a consulting firm to coordinate all activities, a lawyer to handle the legal matters and a public relations firm to direct public attention to the issues and conflicts.

What are the lessons for us? As I see it:

1. Physicians in the United States have an excellent system of compensation and it would behoove us to protect it.

2. Employment of physicians by one or more large corporate entities impedes the free practice of medicine and restricts a physician's ability to earn a fair income.

3. By acting in concert, and by employing professionals to coordinate their activities, physicians can make government consider a change in its policies.

The author, Arnold Rustin, M.D., has been in the private practice of urology in Portland for the past 29 years. This article is based on his personal interviews with Israeli doctors and government officials, United States doctors who have worked in Israel, his readings and personal observations in Israel. The statements made have been checked for accuracy by a member of the negotiating team in Israel.

MCMS plans train trip to football game

An exciting one-day train excursion to a Seattle Seahawks football game has been planned by the Multnomah County Medical Society.

The program will give members, spouses and friends a chance to travel from Portland to Seattle via Amtrak and attend a game at the Kingdome on Sunday, Oct. 23, at a total cost of just $49 per person.

The Seahawks will be playing against the Pittsburgh Steelers.

The train will depart from Union Station at 8 a.m. on Oct. 23, and return to Portland at 9:20 p.m. Game time is 1 p.m.

The deadline for sign-up is Sept. 15, but a limited number of tickets are available so reserve your place soon.

.....

Please include the following people on the Seahawks Football train tour.

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Amount $_____

Please make checks payable to **Sportsworld Tours,** then mail with **full payment** to: MCMS, Attn: Pam, 2188 S.W. Park Place, Portland, OR. 97205.

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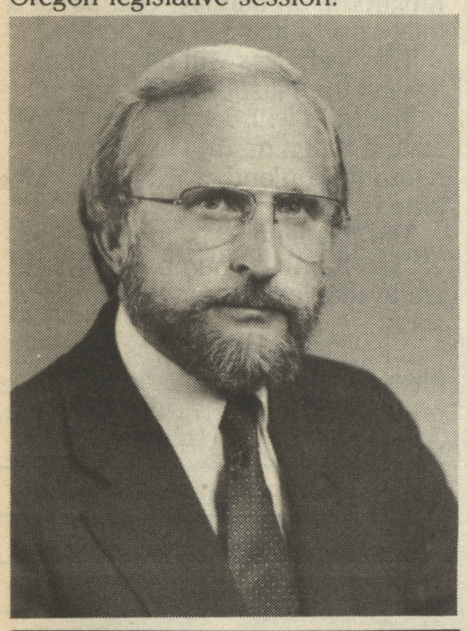
OMA NEWS

Recent legislative session benefits health care

By Roy W. Skoglund, M.D.

A streamlined and independent Board of Medical Examiners, a "right to die" act that might serve as a national model, good Samaritan protection for volunteer athletic team physicians, mandatory child auto restraints, a new system of Medicaid reimbursement and the toughest drunk driving laws in the nation — all of these can be counted among the achievements of the 1983 Oregon legislative session.



Dr. Roy W. Skoglund views the recent session of Oregon's Legislative Assembly as a successful one for health care providers.

From the perspective of organized medicine, the 62nd biennial Legislative Assembly is also notable for what it did **not** do. It did not grant any expanded scopes of practice to non-physician medical care providers; and it did not mandate additional health insurance coverage for any particular provider or service. And in spite of much interim session talk of a new State Health Plan for Oregon citizens based on a national health insurance model, it did not modify the basic delivery system for medicine in this state.

In the inevitable "letdown" period that follows the legislature's adjournment, it is natural to attempt an evaluation of how well our own interests fared. In spite of the general public's dissatisfaction with the legislature's inaction on important taxation and revenue measures, physicians in Oregon can feel generally comfortable with actions (or inactions) that affect the way they practice medicine.

Nearly a year ago, the OMA Public Relations Committee decided to seek a sense of direction from our members regarding priorities in the upcoming legislative session. Although the results of this survey have been widely disseminated, I thought it would be a useful exercise to compare the actual legislative outcome with the expressed concerns of the members.

The survey was mailed to a random sample of OMA members in September 1982. Tabulation of the returns was terminated on Nov. 1, with a 29.3 per cent response rate, or 112 surveys. The top five priorites stated by respondents were as follows:

1. Opposition to a universal health insurance plan for Oregon:

Originally conceived by former Multnomah County Executive Don Clark, this proposal emerged as **House Bill 2025,** introduced by the House Interim Committee on Human Resources. The bill received only two hearings and was still in its original assigned committee upon adjournment.

2. Opposition to expanding scopes of practice of non-M.D. health care providers:

The earliest bid for expanded scope of practice this session came from naturopaths, who asked the Interim House Human Resources Committee to introduce **House Bill 2023.** This proposal would have granted naturopaths a number of additional practice privileges, including the dissemination of birth control and sterilization information, emergency treatment of minors without consent under certain circumstances and diagnosis of orthopedic disability. On the Senate side, the naturopathic association requested introduction of **Senate Bill 636,** which would have allowed naturopaths to refer patients to hospitals for diagnostic procedures and obligated the hospital to share its records with the referring naturopath. After consuming a substantial amount of OMA lobbying time, neither of these bills made it out of committee.

Ophthalmologists have come to expect the traditional optometric bid for prescriptive privileges and OMA focused its attention early in the session on **House Bill 2608,** which would have granted optometrists the right to use drugs for diagnostic and therapeutic purposes. This bill received little action and was tabled in April. In the last week of the session, however, optometric advocates attempted to amend House-approved **House Bill 2359** to include the provisions of HB 2608. The new version was passed by the Senate, failed to achieve House concurrence, and died in conference committee as the session ended.

3. Adequate funding for OHSU education and services:

Not only did OHSU receive an additional $9.7 million bond appropriation for patient services equipment, several other bills which affect the fiscal well-being of the university had favorable outcomes. **House Bill 2481,** which would have required OHSU to dedicate one-half of their graduate positions to osteopathic training, reached the House floor but was referred to the Ways and Means Committee where it languished. **House Bill 2882,** which would have created some expensive modifications to the family practice program, was amended to create a task force to study the issue; and **Senate Bill 426,** which will enhance OHSU's ability to perform contractual services, was successful.

4. Higher physician reimbursement for services to welfare recipients:

In addition to an AFS budget which includes two cost-of-living raises for providers, the legislature passed three other bills that relate to reimbursement for Medicaid clients. Many patients who lack the ability to pay for medical services will now be eligible for Medicaid benefits under **House Bill 2805,** which creates a medically needy program, and **House Bill 2483,** which extends welfare eligibility to two-parent unemployed families. **House Bill 3013,** while not expanding eligibility, will allow for contractual arrangements with provider groups for Medicaid clients.

5. Prevent remote hospitals from going broke during hard times:

Two bills were passed this session that will help hospitals resolve their fiscal difficulties. **House Bill 2335,** originally introduced as a measure to allow OHSU to participate in group leasing plans, was amended to empower Hospital Facility Authorities to issue revenue obligations payable from the revenues derived not only by the authority, but also from repayment of loans. **Senate Bill 788,** introduced late in the session at the request of the Oregon Association of Hospitals, also expands a hospital's ability to raise revenue, in addition to granting a health district the authority to invest in stocks and bonds. The bill further grants a health district the flexibility to adopt a corporate structure that is most effective in carrying out its purposes and allows district hospitals to acquire and operate additional health services.

As chairman of the OMA Legislative Committee, I am, of course, very pleased that our member's most pressing concerns were addressed and favorably resolved during the past session. The credit for accomplishing these aims belongs to an assortment of groups and individuals. I am particularly gratified by the unprecedented participation of individual physicians who were willing to write letters, make telephone calls and testify before legislative committees. Both members and staff of our state and local medical associations and societies deserve special thanks for contributing to one of the most successful legislative sessions in recent memory.

Dr. Skoglund is chairman of the OMA Legislative Committee.

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Administration, Congress face problems of unemployed

By Tom Gauntt

The paycheck stops and, often, so does employer-paid health insurance. That is the dilemma facing millions of the nation's unemployed — not poor enough for state welfare systems, but too poor to pay for health plans as individuals.

Organized medicine, the Reagan Administration and Congress are all offering solutions, but so far no proposal has made the leap from idea to law.

The proposals range from making federal block grants available to states, to largely volunteer programs, to costly new entitlement programs. Although presently the block grant plan seems the most likely to get a congressional nod, a September of political wrangling seems an inevitable part of its future.

Passage of a block grant system would not necessarily eliminate the volunteerism push initiated by the Reagan administration and the American Medical Association, but it would mean that $1.8 billion pared out of the Medicare budget would be plowed into providing health care to the unemployed through the states.

Under the block grant proposal, approved by the Senate Finance Committee in July, the federal money would be parceled out to the states which would administer the funds and determine eligibility requirements.

The House of Representatives has approved a much more costly program, calling for $4 billion over the next three years. But the House bill contains no funding provisions and President Reagan has said he would veto any bill attempting to solve the problem without paying for it in the same legislation.

Sen. Robert Dole (R-Kansas), chairman of the Finance Committee, told reporters in Washington he believes the House should work out the funding differences in a conference committee.

"I understand the president will sign this if we can pay for it," said Dole, considered an insider in the Reagan White House.

One of the problems in solving the dilemma is that the nation's leaders have very different perceptions of the issue. While some view it as a dangerous situation, others see it as an inevitable side effect of the two-year-long recession. The first group wants immediate, strong action on what they see as a social health crisis while the second is wary of committing huge amounts of public funds to a problem that may take care of itself if unemployment dips to more tolerable levels.

All this is played out at a time when Reagan has focused political attention on the role of government in peoples' lives and amid universal pleas for tax relief and a reduction in government spending.

Administration's plan

While Reagan is concerned about the loss of health insurance, his budget director, David Stockman, told Dole's committee in April the administration does not see it as "a pervasive problem."

At that time, Stockman laid out the administration's plan for the jobless which increases jobless workers' access to coverage without helping them pay for it.

The package, most of it now dormant in Congress, would fund a small program aimed at helping the long-term unemployed by taxing employer-paid health benefits, now exempt, above a capped figure.

Stockman said setting the cap at $160 per month for families would produce $500 million in revenue.

Other parts of the administration package would:

- Encourage more volunteer efforts such as the Multnomah County Medical Society's Project Medi-Share.
- Require employers and insurers to permit laid-off workers to continue in the company health plan for up to 12 months at individual rather than the cheaper group rates.
- Require insurers to allow the laid-off worker to convert his regular coverage to a special catastrophic plan which could carry as much as a $1,500 deductible and be fairly inexpensive.
- Require employers to allow workers to pick up family coverage when they had previously selected only individual coverage. This could be used to make up for the loss of a laid-off spouse's benefits.
- Amend the Social Security Act to permit states to spend federal block grant funds for health insurance for the unemployed. This proposal has been picked up and is the basis of the other Congressional bills.

Congressmen with interests and backgrounds in health care, such as Oregon's Ron Wyden, do not believe that giving people with little or no income the opportunity to pay for what they were getting free, when they had an income, is the best way to handle things.

"The fact is, there are 160,000 people out of work in Oregon," he said. "The vast majority of them have little or no health care insurance. Physicians have been yeoman-like in their volunteer programs, but the gap between the supply and the demand is just getting bigger and bigger."

AMA

Dr. Joseph Boyle, chairman of the AMA Board of Trustees, told Congress that 79 percent of physicians surveyed said they had treated patients who had lost their employer-paid health insurance. More than 70 percent of these doctors provided the care either free or at reduced fees and 10 percent donated their services to community programs for the unemployed.

While President Reagan has publicly lauded the efforts of organized medicine in assisting the unemployed, even the AMA does not believe its volunteer programs are a match for the growing nationwide problem.

Boyle told Congress a temporary federal program was necessary to supplement private sector efforts, but that while government monies would be used, they should be administered by private hands.

He suggested that health insurance be made available through a pooling arrangement in each state and that eligibility be restricted to those currently receiving unemployment compensation. Limiting the services to the essentials — prenatal care, maternity, emergency outpatient services and the like — would help keep the cost down.

Wyden, however, does not think the White House or the AMA proposal goes far enough to actually solve the problem.

"It is still primarily volunteer programs and things which are just not feasible in the real world," Wyden said.

But Oregon Sen. Bob Packwood claims it is those seeking to use more federal funds who are being unrealistic.

"If the insurance companies will be realistic about taking care of those temporarily depressed and financially embarrassed, we can make it," according to Etta Fielek, Packwood's press secretary. "The general feeling is that we are coming out of it (the recession)."

And since Packwood sees things getting brighter, he believes there is no reason to commit scant federal funds to what could be a passing problem.

Picnic unites "graduates" of Neonatal Intensive Care Center

By Jeanne Leeson

The picnic included every accouterment any festive outing could have — pony rides, balloons, hot dogs, hamburgers, pop, potato salad, races and games. But it had an added dimension which could be found only at this picnic.

Proud, happy parents brought their "graduates" of the Neonatal Intensive Care Center at Doernbecher Memorial Hospital for Children, part of the Oregon Health Sciences University. These children, but for the expertise of devoted nurses and skilled physicians, would not be alive today.

Each attending parent once had a tiny, fragile baby — premature or ill — who could today enjoy all, or nearly all, the activities of a normal child.

Approximately 500 people — 76 "graduates" of the center, their families and center staffers — joyously gathered on the rolling hills of Sellwood Park, greeted friends, compared successes and enjoyed each other because they shared appreciative understanding.

The families had suffered the same fears and known the same heartaches as they had waited to find whether their childrens' lives could be saved.

Success stories abounded.

Connie Gill Richter, herself a patient at the center 19 years ago, attended the picnic with her son, Ryan, now 3, who spent three weeks in the center until specialists could unravel the problems caused by scores of allergies and asthma which threatened his life.

The youngest "graduate" to attend, Jeremy Keim, now 13 weeks, spent the first three weeks of his life fighting meningitis.

Memories

Bill and Sharon Forster came the longest distance, from Enterprise, to see their friends who had children in the center when they did, but even more important, to see again the nurses who helped save their children, and to reiterate their appreciation that the twins are alive, well, sturdy and healthy.

The Forster twins, Alta and Kate, were born Jan. 19, 1978. The weather was horrendous, no pilot dared take them to Portland. Bill drove the usual six-hour drive in five hours, sometimes hitting 90 miles an hour on snow-covered roads.

When they arrived, the doctor stopped labor for a few hours, and later the twins were delivered by C-section.

One twin, Alta, spent six weeks in the center; the other twin, Kate, spent five months; but one would never suspect their struggle to live, for at the picnic they ran races and played games.

Christina Ober, a sturdy 7-year-old, weighed 1 pound 14 ounces at birth. Her mother said everyone believed there was zero chance she would survive until she came into the skillful hands at the Neonatal Intensive Care Center.

"You can bet I love those nurses and I've kept in close contact with them," said her mother, Jody Ober.

Dr. Paula Irvin, a pediatrician, attended the picnic with her daughter, Katie.

"When Ken and I knew Katie had to have special care to survive, it was good to know we had supportive, competent nurses in whose care we could leave her," said Dr. Irvin.

The remaining three of the well-known Potter quintuplets born in 1981 to Jim and Vivian Potter of Portland, also attended the picnic.

Prizes were given for every event, but perhaps the prize most representative of the feeling of those who attended was the prize awarded Jessica Hazelett, 2, who won the smiling contest.

Sharing

The conversations included talk of miracles, of accomplishments, of happinesses.

While children played, parents gave encouragement to each other, compared notes, talked of their children's futures, and offered courage to parents starting the long ordeal they have completed. Each family brought photos of their babies from the time of hospitalization and a recent picture. These will be placed in a large scrapbook, to be kept at the Neonatal Intensive Care Center to encourage other parents of premature and critically ill newborns who are going through the worrisome vigil these parents experienced.

Sue Brusch and Barbara Whitford, both long-time nurses at the center, organized the picnic. They plan to make it an annual event.

Jeanne Leeson

Twins Alta and Kate Forster played games and ran races at a picnic for "graduates" of Doernbecher Hospital's Neonatal Intensive Care Center. Their father Bill loves to watch them frolic, remembering their fragile hold on life as infants.

AFS launches experiment with contracting health care

By Tom Gauntt

An experiment that could change the way public health care in Oregon works will begin in the next few months.

House Bill 3013 passed with strong majorities in both the House of Representatives and the Senate in mid-July. The bill, signed by Gov. Vic Atiyeh, allows the Adult and Family Services Division to contract out health care for its clients to groups of physicians.

The pilot project will be started in Marion and Clackamas counties late this summer, serving the 10,000 AFS clients in those two areas. If, over the next two years, the program works as hoped, it could spread to the rest of the state.

"If it does work, it can change the state's entire structure of health care for the indigent," said Portland Rep. Vera Katz, one of the bill's primary sponsors.

Although Katz and others who helped shepherd the legislation through what proved to be a listless session of lawmaking in Salem believe the experiment will bear fruit, there is still some trouble in the orchard.

The plan is for the program to save some of the $207 million the State spends annually for families eligible for AFS help. But even James Hutchison of AFS has some doubts about how it will work out.

"These projects have saved some states money, but in others it hasn't saved any," he said. Hutchison could not estimate how much could be saved in Oregon.

Katz is enthusiastic, but concedes that the ball is now in the court of the state administration.

"It's only going to work if the AFS can put some contracts together that people want to bid on," she said. "The key is creating enough incentive. If the amount of reimbursement is not enough, no one will bid. It's (as) if you gave a party and nobody came."

Under the cost containment plan, groups of physicians would bid to serve AFS clients and be responsible for their care. Currently, AFS clients seek out their own doctors who are reimbursed on a fee-for-service basis.

OMA

Although fee-for-service has long been a rallying cry for organized medicine, the Oregon Medical Association has supported the project.

Katz said that the change in the position of the powerful organized medicine lobby was important to the bill's becoming law.

"They've finally come into the 20th century," said the Northwest Portland representative who has had her share of run-ins with doctors' groups over the years.

Oregon Medical Association President Hugh Johnston, M.D., said, "The OMA tried to work with the system as best we can. The law is broad enough to cover various ways of doing it. We worked with Representative Katz in modifying the language. We did not lobby for the law but we did not object to it. We are not overjoyed with some aspects but we can't object to an experimental pilot project."

An OMA resolution on the subject urged that "quality and continuity of care be consistent with current standards" and that at least two pilot projects be implemented and assessed.

The resolution also stated that all physicians in the pilot project areas should have an opportunity to engage in negotiations for participation.

OMA President-elect Tom Reardon, M.D., said that negotiations were much preferred over bids, and Johnston said the final result was that there will at least be "dialogue between AFS and prospective bidders."

Reardon and Johnston both warned that few physicians would want to participate in the program if reimbursement is too low.

"We worked with Representative Katz to come up with a cost-effective method of delivering quality health care," said Reardon. "However, AFS has already been cut to the bare minimum. They are paying about 50 percent of our usual and customary fees now. I am concerned that they want to put us at risk for that 50 percent figure.

"If we are at risk and reimbursement is low, physicians might not see AFS clients," he warned. "We don't want that kind of situation."

Doctors may benefit

However, Katz and Hutchison agree that the project, although inimical to what many physicians have been preaching for decades, may turn out to be very profitable for doctors in the long run.

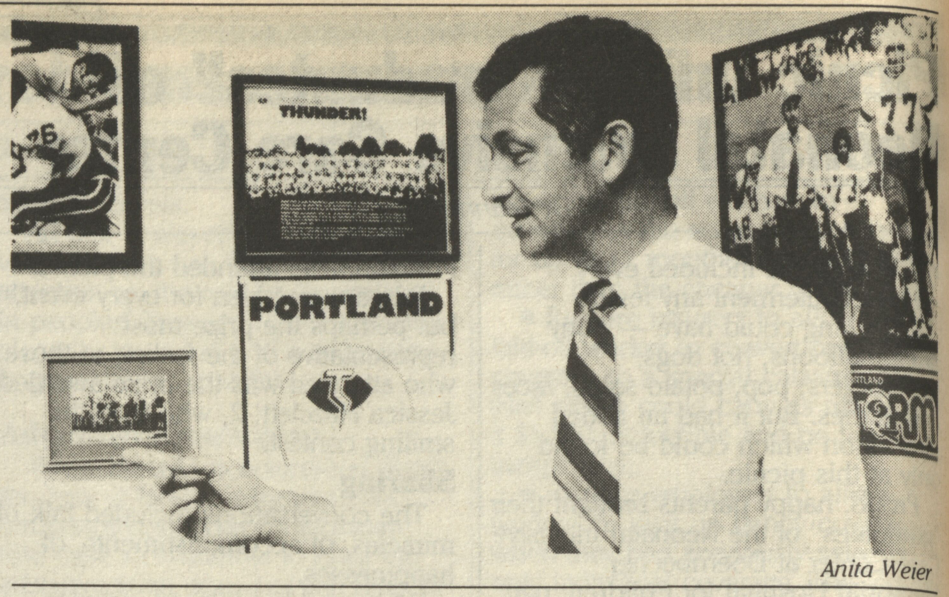
"They may be better off financially under this system than the status quo," Katz said.

Hutchison added that the program will put the care of patients back into the hands of health care professionals.

"We're returning the management of health care to the doctors," he said. "Currently individual physicians are not actually responsible for their (AFS) patients. If it's like programs elsewhere, the quality of care will go up because there will be somebody managing their health care. We'll see less emergency room use for non-emergency purposes."

The experiment, derived from those of other states, is being tried out in Marion and Clackamas counties because of the urban-rural mix of the populations. Multnomah County would be too intense and Eastern Oregon would not be intense enough.

In fact, the OMA is concerned over how the system would work in less populated areas where there are fewer doctors.



Anita Weier

Dr. Robert Voy shows pictures of athletes he has assisted over the years.

Local doctor Olympics-bound

Tualatin general practitioner Dr. Robert Voy has been chosen a member of the medical staff for the 1984 Winter Olympics in February in Yugoslavia.

Selection for this honor, however, meant resignation from another prestigious post.

Voy, 49, has served since 1979 as chairman of the Oregon Republican Party. But due to the time and travel requirements of the Olympic position, he resigned the political post effective July 16. He will continue his medical practice.

"I will have to do some traveling for the Olympic Committee in helping prepare the winter term, and I just felt that — 1984 being an election year — I could not do a good job for the party (as well)," Voy explained.

Portland attorney Diarmuid O'Scannlain replaced Voy as party chairman.

Garden Home resident Voy has treated athletes at the U.S. Olympic Training Center in Colorado Springs since 1981. He also served as a staff physician at the National Sports Festival in Colorado Springs in June. The festival is an elimination contest for the Pan-Am and World Games and the 1984 Summer and Winter Olympics, he said.

Devoted to sports since he "played basketball and football on the bench in high school," Voy hopes to ultimately establish — with Portland Trail Blazer team physician Dr. Robert Cook and former Blazer Geoff Petri — a sports medicine facility in the Portland area.

An avid tennis player and "part-time exerciser," Voy is undertaking his Olympic task as a voluntary position with no salary, though expenses will be paid.

Voy — who has "always been in politics" — ran unsuccessfully for the State Assembly in 1974 and served as Oregon chairman for Ronald Reagan's presidential campaign in 1976.

The doctor was re-elected party chairman twice, and said he is proudest of "bringing party unity and putting the party in the black."

"There is now an excellent staff and an ongoing program, though I don't take credit for that. And we have four statewide candidates elected," he said.

Kid Works needs donated medical gear

Nurses' and doctors' uniforms, stethoscopes, crutches, needleless syringes, old X-rays and any other equipment unique to the medical profession is needed by Kid Works Inc., a nonprofit organization which uses participatory exhibits to give children a realistic picture of the world and alleviate their fears.

The newly formed organization will provide an Exhibit Center with participatory exhibits, informal and group activities, and public services; and an outreach program which will be taken to schools and other places to provide participatory activities and circulate educational materials.

Kid Works Inc. will give a "Coming Out Party" from 4 to 6 p.m. Sunday, Aug. 21, at either Wallace Park or the Friendly House Community Center. The formation of displays is still taking place and those with items which may be usable should contact Gail Landon at 224-0996.

Gifts to the organization are tax-deductible.

Lobbyists review Oregon's legislative session

By Allan Classen

The recently concluded session of Oregon's Legislative Assembly produced no shake-up in the health care field, and lobbyists for several health organizations believe they gained more than they lost in 1983.

Barney Speight, director of government relations for the Oregon Association of Hospitals (OAH), described it as "a generally successful session for all of health care."

He said measures approved were "moderate in tone" though he foresees major changes just around the corner. He predicted that 1985, the year of the next full legislative session, will be "a year of health policy review."

Scott Gallant, who represents the Oregon Medical Association (OMA), agreed with Speight's appraisal. He surmised that the legislators were so bogged down by budgetary wrangling that they had "less free time" to pursue health issues vigorously.

"Generally, the legislature decided to utilize the interim to try to gather the facts and decide what, if anything, should be done," he said.

Noting a "tremendous interest" in the rise in health care costs, he said lawmakers initiated a number of interim studies to monitor cost trends with an eye toward more fundamental reforms in 1985.

Hank Crawford, an independent lobbyist who represented Blue Cross-Blue Shield of Oregon, freely admitted that the state's revenue squeeze was a boon to health insurers. He was pleased with the rejection of a raft of bills mandating specific coverages in health policies, and believes lawmakers shied away from mandatory benefits primarily due to their high cost.

He rated the session as "a pretty productive one for health insurers," referring also to the defeat of efforts by physical and occupational therapists, naturopaths and chiropractors to expand their spheres and qualify for insurance reimbursements. While licensed acupuncturists gained the right to be reimbursed for their services, Crawford does not expect it will have much impact on insurers.

Although there was minimal action to expand recognition to various groups of health practitioners, Jim Markee, lobbyist of the Oregon Association of Chiropractic Physicians, found reason for optimism.

"Nothing passed that would hurt the chiropractic profession," he said. "I'm not as pleased as I might have been but overall I'd have to say it wasn't too bad."

Although failing to obtain equal footing with medical doctors regarding insurance reimbursement, a proposal Oregon chiropractors have raised in three previous sessions, Markee said they scored a victory by amending the worker's compensation law to allow them to collect more than the minimum office visit fee if they perform a manipulation. Previously, it was assumed that manipulation was a part of a routine office visit, he said.

"I think there is a broader recognition of what chiropractors do," he explained. "We don't just manipulate the spine."

Speight said the OAH was successful in convincing the legislature that an alternative inpatient reimbursement system was desirable for the 1983-85 biennium — specifically, moving from cost-based reimbursement to a flat price per discharge, determined by hospital peer grouping. He said the setting of flat fees for certain types of disorders provides a predictable level of payment and "puts us in synch" with changes in the federal Medicare program effective Oct. 1.

"There are changes going on in the private sector that look to new forms of payment," he said, mentioning DRGs, PPOs, IPAs and HMOs. "We merely recognize that it's a changing world and we want to have a part in shaping the changes."

House Bill 3013, Rep. Vera Katz's measure to foster alternative health plans for Medicaid patients in four Oregon cities, was also supported by the OMA, after some amendments were made to "tone down the rhetoric" and tune some more practical parts of the bill, Gallant said.

Blue Cross-Blue Shield and OAH helped pass measures to encourage outpatient treatment of alcohol and drug abuse and mental illness. Crawford said the state cut benefits for inpatient treatment while expanding benefits for outpatient services. Speight said hospitals will no longer have to demonstrate a need before they expand outpatient programs in these areas, a change he thinks will allow hospitals to compete more effectively with other institutions that are not subject to the certificate of need process.

OAH also worked to defeat a bill that would have given the patient access to the findings of peer review committees. Speight said patients have other means of documenting legal claims, and that eliminating the confidentiality of peer review would render it ineffective as a tool to improve the quality of medical care.

Gallant took satisfaction in the passage of two other OMA-backed proposals — mandatory restraints for auto passengers under the age of five and the tightening of drunk driving laws. He said the bills were important because "one of the roles of OMA is to encourage the health and safety of the public" and he believes these laws can significantly reduce unnecessary deaths, injuries and lifelong disabilities.

OMA and OAH were part of the Coalition for the Medically Needy's effort to expand programs for low income people. The legislature approved $7.1 million (to be matched by $7.7 million from the federal government) for pregnancy and prenatal programs and extending benefits to two-parent families.

"It's always nice to get a little more funding," Gallant said.

Bestcare

Continued from page 1

additional funds were needed to cover the time when there were salaries but no income.

Sacco noted that though Bestcare will be modeled after Lifeguard, variations will reflect the differences between the two communities.

He added that as soon as Bestcare is incorporated it will begin negotiations with Burnett, who with a team of local experts will take the fledgling company through the federal qualification process. Burnett is chairman of the 28,000-member California Medical Association as well as outgoing president of Lifeguard.

A major difference between Bestcare and other alternative systems will be that a prerequisite to joining Bestcare is membership in at least one of this area's four medical societies — Multnomah, Washington, Clackamas or Clark.

"Physicians can create all the representative organizations they want," Sacco said, "but if there's not some common bond that holds all our activities together, we will be a mob instead of organized medicine."

Bestcare incorporation is expected to occur within a week. Soon thereafter, one or more of the initial board members will request meetings with the various hospital medical staffs to explain the philosophy behind the new enterprise.

"There's an incredible amount of highly sophisticated and detailed work which will have to go into Bestcare," said Tarnasky. "But the people putting this together are accustomed to working a fast track. Given that, and their personal integrity and dedication to the survival of private practice, I believe we'll see the fruits of their labor very quickly."

Doctor-controlled health system can succeed

By Russell N. Sacco, M.D.

The fee-for-service practice of medicine is becoming a beleaguered profession while ADSs, HMOs, PPOs, and IPAs — at one and the same time — promise security and threaten ruin. Every day there seems to be another public or private medical care delivery plan devised by entrepreneurial businessmen or health care professionals, physicians and/or hospitals. All press physicians to "hurry up and sign now while you can," portending doom for the dilatory doctor soon to be isolated from patients and colleagues.

There is a rational basis for concern. Competition for patients has increased. Some of our colleagues are too busy, but many are not busy enough. It doesn't take genius to understand why many well trained, competent physicians who have been adequately employed in the past no longer complain about being overworked. They lack the volume of patients needed to fulfill their professional potential.

The supersaturation of Multnomah County and the rest of Oregon with physicians is a major cause of the problem. There are fewer than 300 potential patients for each practitioner in Portland. Not long ago there were twice as many.

The percentage of patients seeking care from independent, fee-for-service practitioners has decreased steadily with the growth of pre-paid medical care plans. I believe the growth has occurred primarily because the pre-paid plans offer care at a set price significantly less than those charged by fee-for-service physicians. Quality of care, whether or not it can be measured precisely or objectively, is only a minor factor.

The patient pool available to individually practicing doctors has been eroded by the entrance of private and government hospitals and non-physicians into the business of outpatient care.

All physicians, salaried and non-salaried, are threatened by government plans designed to divide physicians into actively competitive camps. The winners would receive the right to treat more persons for less pay using fewer resources; the losers would receive early retirement without pay.

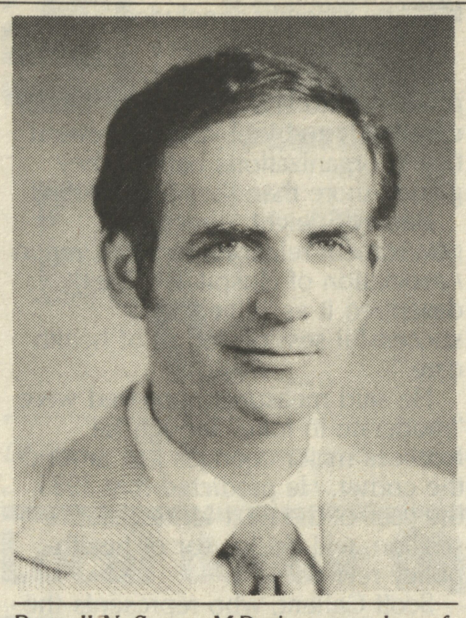
It's almost enough to precipitate ill-considered, panicky action — almost enough, but not enough.

If physicians work together, if they are willing to alter their practice patterns a little, if they compare themselves to their colleagues in order to improve their "cost-benefit" efficiency, if they do not isolate themselves in mutually exclusive, parochial enclaves — they can preserve both fee-for-service and salaried independent practice.

Lifeguard Inc.

Bestcare, the alternative delivery system being formed by MCMS members John Tarnasky, Roger Alberty, John Bussman, Harry Lee and myself, and staff members Brad Davis and Robert Delf, is modeled after the physician-controlled countywide HMO/IPA Lifeguard Inc., which operates in Santa Clara County, Calif. As an ad hoc committee appointed by MCMS President Tarnasky to study Lifeguard, we researched this matter thoroughly prior to our decision.

The number of physicians practicing there is comparable to the number in Portland. Santa Clara has a Veteran's Administration hospital. There is a medical school hospital. The Kaiser health plan there has enrolled about 25 percent of the inhabitants as members.



Russell N. Sacco, M.D., is a member of a committee appointed by MCMS President John Tarnasky to study the workings of a physician-controlled countywide HMO/IPA.

The principles on which the program was founded include dedication to fee-for-service reimbursement without capitation, open enrollment for physicians, reasonable restrictions on fee schedules, complete risk-taking by member physicians, and STRICT utilization controls for reducing hospital services. The Santa Clara program is alive today because it has reduced hospital days to less than 300 per year per thousand beneficiaries, a number similar to the Kaiser plan.

It is prospering because it has marketed its plan to groups whose members are younger and healthier than those persons who tend to purchase indemnity health insurance policies. Although it gets a substantial number of its members as transfers from the Kaiser plan, it is not a threat to group practice. Salaried and fee-for-service physicians coexist.

Lifeguard Inc. is thriving because the medical community there is self disciplined; no physician member has been expelled. The physician participants have decreased their hospital utilization.

I believe that a similar program may benefit physicians here. But, I can hear you saying it now, "Just another hair-brained scheme created for another bureaucracy! Another Portland Metro Health. It won't work. It can't work."

It is working elsewhere. The Santa Clara physicians' organization is financially successful; it is making a profit. It can work here. If Oregon physicians conclude that a similar program is necessary here, they can equal anyone's success.

However, if a reduction in utilization and costs is effected, the present quality of care will change. Quality may be improved for some and decreased for others.

Affordable care

The independent, fee-for-service practice of medicine is endangered by market forces. Too many people believe that they cannot afford health insurance programs which offer complete choice of physician and access to every modern technology. If patients are unable to pay for the highest quality of care available, then physicians must face reality. Affordable care is better than no care. Physicians can improve their efficiency, reduce the cost of care, and maintain the highest standards possible.

Union reaches agreement with Emanuel, Good Sam

After strenuous bargaining, negotiators for the Service Employees International Union and Good Samaritan Hospital have forged a new contract covering wage increases for the next two years as well as a compromise on mandatory union membership.

The agreement, approved by union members July 27, "is couched in language that safeguards union security as well as the hospital employees' freedom of choice as to union membership," stated a Good Samaritan press statement.

Earlier, the same union and Emanuel Hospital reached a wage agreement calling for a 2 percent raise in salary retroactive to July 1. Emanuel's 357 union members, who include nurses and patients aides and laundry workers, voted to accept the new contract July 25.

"Naturally, we're very pleased to have avoided a strike," said Emanuel spokesman Bob Foreman, who added that the issues resolved were "strictly economic."

Negotiations were somewhat more complex at Good Samaritan, where meetings between union and hospital officials and federal mediator Paul Stuckenschneider, reached a temporary stalemate July 22.

"We're not far apart on the economic issues," Good Samaritan spokesman Jeff Selberg said at the time.

"In fact, when I heard about the Emanuel settlement I was rather surprised — the salary and benefit increases we've agreed to are generous compared to theirs."

No exact percentage figures for the final agreement were available at press time — but increases for laundry workers ranged from 14 to 61 cents per hour, and raises for nurses and patients aides ranged from 5 to 14 cents per hour, retroactive to July 1. Additional increases will occur in January 1984 and January 1985.

Union spokesman Harold Knutson said the key issue was whether hospital employees should be required to join the union. Service Employees negotiators wanted a membership requirement for all employees covered by the contract included in the agreement.

At a special bargaining session July 26, negotiators worked out a compromise on the issue, allowing yearly "window periods" when members can withdraw from the union. New employees will be free to join or not, as they desire.

Good Samaritan's 450 union members voted — by a 3½ to 1 margin — to accept the pact on the evening of July 27. Their strike deadline had been set for the next morning.

Locum tenens service pondered

The Multnomah County Medical Society was recently asked to consider establishing a mechanism to provide physicians to temporarily take the place of others.

Persons suggesting that a *locum tenens* service be provided said significant numbers of physicians would like additional work for short or extended time periods, while others would like to take varying amounts of time off and need people to cover their practices.

The society would like to determine whether there is sufficient need for such a service. If you would use this service and believe MCMS should provide it, call Pam at 222-9977.

Revised handicapped care rule issued by federal government

By Anita Weier

The U.S. Department of Health and Social Services has proposed a modified rule regarding the protection of handicapped infants from discriminatory denial of food or medical treatment solely due to their handicaps.

The department's first ruling on the subject, issued in March, was opposed by medical organizations who believed it to be government interference with hospitals, doctors and patients and their families.

The ruling required that hospitals receiving federal funds post notices in delivery wards, maternity wards, pediatric wards and nurseries warning that failure to feed or care for handicapped infants is illegal. The ruling also set up a toll-free hot line for the reporting of violations to the department.

The American Academy of Pediatrics took the issue to court, where a federal judge found the ruling arbitrary and capricious because it was effective without a comment period, according to Virginia Apodaca of HHS. The department has appealed the decision, but also issued the revised rule July 5, starting the clock running on a 60-day comment period. Copies of the proposed ruling can be obtained from the regional office of the U.S. Department of Health and Social Services, 2901 Third Ave., Seattle, Wash. 98121.

Apodaca, regional director of the Office of Civil Rights for HHS, can provide information about the ruling or the comment procedure. Her phone number is (206) 442-0473.

Comments on the ruling are to be sent to: Director, Office of Civil Rights, Department of Health and Social Services, 330 Independence Ave. S.W., Room 5400, Washington, D.C. 20201 by Sept. 6.

Under the proposed rule, hospitals receiving federal funds would be required to post a notice in a conspicuous place at nurses stations with responsibilities for delivery wards, maternity wards, pediatric wards, nurseries and intensive care nurseries.

The previous notice required that notices be posted in a conspicuous place in these wards.

The notice would have to include the toll-free telephone number at HHS to which alleged violations could be reported, as well as the phone number of the appropriate state child protective services agency.

The proposed rule also contains new language explaining the scope and intent of the regulation, which is intended to enforce the provisions of Section 504 of the Rehabilitation Act of 1973. Several court cases are cited, and the reasoning behind the rule is explained.

"Section 504 is in essence an equal treatment, non-discrimination standard. Programs or activities receiving federal financial assistance may not deny a benefit or service solely on grounds of a person's handicap," the notice states.

"Recognizing that Section 504 protects only those infants who are able to benefit from treatment. . . a violation occurs when the treatment is withheld because of the existence of a handicap and the handicap does not render the treatment medically contraindicated," the proposed rule says.

"This regulation does not interfere with medical judgment concerning which treatment is beneficial," said Surgeon General C. Everett Koop. "Section 504 does not compel medical personnel to attempt to perform impossible or futile acts or therapies. Thus, it does not require the imposition of futile treatment which temporarily prolongs the dying process of a terminally ill infant.

"It is only when non-medical considerations, such as subjective judgments that an unrelated handicap makes a person's life not worth living, are interjected in the decision-making process that concerns arise," the surgeon general said.

"A judgment not to correct an intestinal obstruction or repair the heart of a Down's Syndrome infant because the infant suffers from Down's Syndrome is not a medical judgment," the notice states.

"The basic provision of nourishment, fluids, and routine nursing care is a fundamental matter of human dignity, not an option for medical judgment," the explanatory appendix to the rule says.

One of many provisions which remain the same is a requirement that access to records and facilities of recipients (of federal funds) shall not be limited to normal business hours when, in the judgment of the responsible department official, immediate access is necessary to protect the life or health of a handicapped individual.

Also the same is a statement that the HHS secretary solicits comments on the advisability of eventually requiring that recipients providing health care services to infants perform a self-evaluation with respect to their policies and practices concerning services to handicapped infants.

MCMS offers book discount

The title may be long, but the lines of people wanting "The Social Transformation of American Medicine" are longer.

The MCMS is nearly out of the new book by Harvard sociologist Paul Starr. Regularly selling for $24.95, the book is available to MCMS members for $18.90. But they are going fast. To order, send a check to: MCMS Book, 2188 S.W. Park Place, Portland, 97205.

Trauma

Continued from page 1

years, concerns about occupancy rates, balance sheets and pride have prevented development of such a system.

Survival

"The only concern worth addressing in trauma care is the ability of the patient to survive multiple-system injuries and go on to lead a productive life," said Dr. Dan Lowe, assistant professor of surgery and head of the trauma section at the Oregon Health Sciences University.

"The trauma patient has the right to the best care immediately"

He and other trauma surgeons said that while trauma victims in Oregon can obtain the best care a hospital can provide, those victims often do not receive the best care available in a timely manner. "The trauma patient has the right to the best care immediately," said Dr. Richard Cales, medical director at Portland Adventist Medical Center.

Detailed treatment plans must be cooperatively developed and supported by both field and hospital teams to ensure survival and productive lives, the surgeons said.

Currently, the decision to transport a trauma victim to "whatever hospital" is left to the emergency medical technician at the accident scene, said David Long, manager of the Oregon Health Division Emergency Medical Services Section. The technician, often a volunteer in rural areas, may not be acquainted with the capabilities of the hospital to adequately treat the particular multisystem injuries sustained by the victim, he added.

A trauma system established with geographical centers for treatment would provide the EMTs with a pre-determined plan of response, and in some cases, would shorten the time spent at the scene, Long said.

Time critical

Critical minutes spent on the radio determining if a hospital has a neurosurgeon on staff who could treat a massive head injury, or searching for an available operatory, subtract from the "golden hour," decreasing that victim's chances for survival, said Cales and Lowe.

If traumatic shock resulting from blood loss is not reversed within an hour's time, irreversible cellular damage results, setting the stage for a systematic shutdown of the kidney, liver and lungs, Emanuel Hospital Trauma Center Director Ben Bachulis said. When the cellular integrity is destroyed, death results within 10 days to a week, he added.

Research has shown that when an effective trauma system is in place, the death rate from multiple-system injuries declines, said Cales, who served for three years as medical director of the Orange County, Calif., trauma system.

Statistical studies of the death rates in Orange County for the fiscal years 1977-78 and 1980-81 — before and after the trauma system was in place — showed that the percentage of persons who died but potentially could have been saved dropped from 34 to 15 percent, Cales said.

Medical record studies of 58 trauma-related deaths in 1977-78 showed that 20 victims, could have been saved if they had received timely care at a trauma center.

Case reviews of 60 victims who died from multiple-system injuries during 1980-81 showed that nine persons could have been saved, Cales said. Of 47 victims who were transported to a trauma center, two died. However, of the 13 victims who were transported to a non-trauma center, seven died — a percentage of 54 percent.

"It's frightening," commented Cales.

The earlier study showed that due to their involvement in dangerous activities such as skydiving, hang gliding, riding motorcycles without wearing helmets or speeding, the typical trauma patient was a 20-year-old male, said Cales.

A comparison of the trauma victims' ages in the two studies showed that the increased level of care provided in the trauma centers "literally wiped out deaths as a result of trauma in persons under age 16," said Cales. The median age of the victims rose from 22 years in the 1977-78 study to 27 years in the 1980-81 study.

"One had to be more severely injured to die," Cales explained.

All four medical officials called for a trauma system that would categorize trauma injuries according to severity and complexity, categorize Oregon's hospitals according to the three levels of care delineated by the American College of Surgeons, and divide the hospitals according to their level and geographical region.

The distance "between wide spots in the road" in rural Oregon underscores the necessity for regional centers, said Long.

Currently, a person who sustains multiple-system injuries in the Interstate 5 and 84 corridors has a better chance of survival than those trauma victims in rural areas, Long said.

According to Oregon Department of Motor Vehicle statistics compiled for the years 1974 through 1980, for every 13 motor vehicle accidents in Wallowa County, one person died. Wheeler and Lake counties recorded one death for every 16 accidents.

By comparison, during that same study period Multnomah County recorded one death out of 111 accidents; Washington County, one death for every 70 accidents; and Clackamas County, one death out of every 54 accidents.

The length of time it takes to transport a victim to a hospital in the rural areas definitely lowers the chances for survival, said Long.

Some hospitals cannot afford to maintain an operatory reserved for trauma cases only and therefore do not qualify as Level 1 centers, said Bachulis. Often the operatories in those hospitals are not self-contained — equipped to care for poly-system trauma, he said. Nor do they always have a board-certified surgeon or a chief resident in the last year of training in house, as required by the American College of Surgeons' standards.

Level 2 hospitals must also have a reserved operating room, however,

The level of trauma care would be improved through. . .cooperation

the staff may be on an on-call basis. Level 3 hospitals are required to have only an emergency physician on call. There is no requirement for a reserved operatory, said Bachulis.

While not all of Oregon's hospitals can qualify as Level 1 or 2 hospitals, the administrators and medical staffs could agree to pool their resources, instead of competing with each other for the trauma patient, said Lowe.

The level of trauma care would be significantly improved through that kind of cooperation, the surgeons said.

Holladay Park rejects AMA Grand Rounds

A Portland hospital invited to participate in the American Medical Association's Economic Grand Rounds effectiveness study will not participate in the project.

Holladay Park Administrator Peter Van Deusen said the program — intended to develop and test cost-effectiveness activities via indepth analysis of clinical cases and financial records — has been put on "permanent hold" due to a belief that the same purpose could be better achieved as staff gathers information necessary to handle Medicare requirements for diagnostic related groups (DRGs).

Medicare is changing procedures so hospitals will be reimbursed according to diagnostic groupings. For example, Medicare would pay a fixed rate for treatment of all people under 70 with pneumonia and no major complications. "If it costs less, you can make a profit. If it costs more, you eat the difference," Van Deusen explained.

Previously Medicare paid a percentage of total allowable hospital costs based on the percentage of Medicare patients' use of the hospital, he said.

Van Deusen believes the incentive resulting from the change — which will become effective when hospitals begin their varying fiscal years — will do more to encourage cost-effective decision-making than the grand round program sponsored by the AMA, the American Hospital Association and the Federation of American Hospitals.

However, an AMA spokesman said that some hospitals are using the grand rounds program to help adjust to DRGs. More than 80 hospitals nationally have volunteered to take part in the program, he said, though the original plan was to use the procedures at 75 hospitals.

A total of 225 hospitals nationwide were invited to participate. They were selected randomly following classification by geography, size, ownership, urban/rural location and teaching/non-teaching status — to ensure that a variety participated.

Institutions chosen received a thick book of procedures and a letter asking the facility to participate.

Thirty hospitals have conducted one or more grand rounds sessions and 12 have sessions on their calendars, the AMA representative said. At smaller hospitals, the whole medical staff meets to go through the process. At large facilities, one meeting may be conducted for medicine and one for surgery, or even greater specialization by department might occur.

The only remaining Oregon hospital participating in the program is the Merle West Medical Center in Klamath Falls, the spokesman said. Two Seattle-area hospitals may also take part.

Participating hospitals conduct at least one Economic Grand Rounds session, and usually continue with quarterly or twice-a-year sessions. The AMA requests general verbal or written feedback from participants.

The program is intended to increase efficiency and demonstrate that hospitals have taken the initiative on the issue of high hospital costs, according to an AMA brochure outlining the procedure.

AMA chooses Boyle, Burnett

Two men who recently spoke before the Multnomah County Medical Society have been chosen to fill important posts in the American Medical Association.

Joseph F. Boyle, M.D., who spoke during the society's winter conference at Salishan, was chosen president-elect of the AMA during its recent annual meeting in Chicago. He said he plans to deal with legislative barriers and funding processes that prevent physicians from maintaining high professional standards.

Additionally, Robert Burnett, M.D., Los Altos, Calif., who spoke to the MCMS in June about a doctor-controlled health care provider system which he heads, was elected to the Council on Medical Service.

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