Portland Physician

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metropolitan hospitals / part 3
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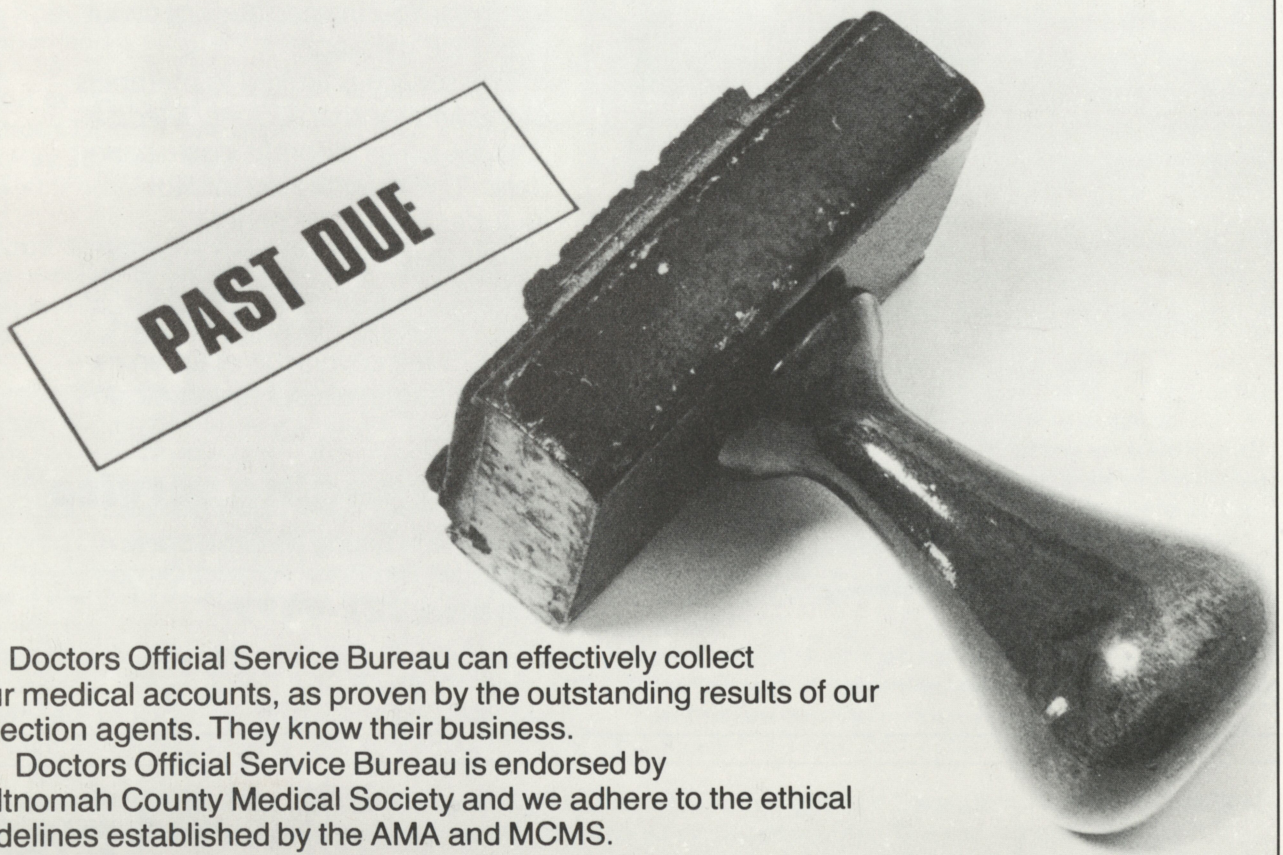
Ethical and Effective Collections



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Endorsed by Multnomah County Medical Society.

AMA Establishes New Division of Political Education The AMA Public Affairs Group adds a new division to its responsibilities: Political Education. The division is responsible for the political education activities involving physicians and their spouses, for liaison research on public attitudes toward public affairs issues. The division will be headed by William L. Watson, and the staff of AMPAC will become this division's staff.

House Calls Survey If you recently received a survey from House Calls, Inc., please complete it and return as soon as possible. The survey answers will help House Calls and the Medical Society to plan policies and services for the coming year.

Leukemia Update, 1980 Doctor Ernest Beutler, internationally known physician, will speak at Portland Adventist Medical Center on Wednesday, May 28, on Leukemia. Doctor Beutler is the Chairman, Department of Clinical Research, and Head Director of Hematology-Oncology at Scripps Clinic and Research Foundation. He also serves as the President of the American Society of Hematology. In addition to an overview of the acute and chronic leukemias will be a discussion on bone marrow transplantation. The meeting begins at 7:30 a.m. and ends at 9:45 a.m. and includes a continental breakfast. For more information, please call 257-2343.

OAFP Sets Meeting at Salishan The 33rd Annual Scientific Assembly and Congress of Delegates of the Oregon Academy of Family Physicians is set for May 29-June 1 at Salishan Lodge. Seminar speakers are coming from Washington, Michigan, California, Arkansas, New York, Alabama, Colorado and Oregon. For more information and a program, contact Mary Lundy, Executive Director, OAFP, 224-6966.

Infection in Medical Practice? Northwest Permanente, P.C., Department of Medicine, and UOHSC Division of Infectious Disease, are sponsoring their seventh annual symposium entitled "Infection in Medical Practice" on Friday, May 30, from 8:00 a.m. to 3:30 p.m., at the new downtown Portland Marriott. Registration includes lunch, $50. For information call 281-0460.

Donations Sought for Arts Inventory If you are interested in inventory reduction or disposal of reusable building supplies or office equipment, the Portland Chamber of Commerce may have the answer for you. By completing a form and donating reusable items, you will receive a tax-deductible receipt, and arrangements can be made to pick up your materials. Questions or details? Call 231-7430.

Providence Sets Series on Contemporary Issues in Medicine June Medical Grand Rounds at Providence will discuss non-scientific issues related to internal medicine. The programs will include discussions on problems in medical education, the non-medical role of the physician, contemporary physician attitudes, and the physician in a changing society. Guest speakers include Randsom Arthur, M.D., Dean, School of Medicine, UOHSC; Rabbi Emanuel Rose; Ralph Crawshaw, M.D.; and Mark O. Haggard. Each session will be held at the amphitheater, beginning at 8:00 a.m. Mark your calendars for June 4, 11, 18 and 25. For more information, contact Providence, 234-8211. The program is acceptable for one prescribed hour of credit per session by the AAFP and one hour of continuing medical education credit from the OMA.

Free Vacation in Eastern Oregon Free vacation in Eastern Oregon desert when you serve as a doctor for Camp Hancock, OMSI's camp near Fossil. Doctors' children can attend at half price, and a cabin and complete dispensary are provided for physicians and their families. Sessions are available from June through August 25. It is an exceptional opportunity. For more information, call Doctor Ed Tank, 225-7765, or 223-6528.

Eye Movement Symposium Set The Neurological Sciences Center at Good Samaritan Hospital & Medical Center is sponsoring a two-day seminar on the clinical and scientific aspects of eye movement, May 23-24. Visiting faculty from universities and medical colleges throughout the country will give lectures and presentations. John B. Selhorst, M.D., from the Department of Neurology at the Medical College of Virginia; and Davis S. Lee, M.D., from the Department of Neurology of Johns Hopkins University, will speak on cerebellar eye movements and supranuclear control of eye movements. For more information, call Margaret Newton, 229-7205.

Infant Hearing Screening Workshop The value of early detection of hearing loss will be discussed at a major morning workshop on Saturday, May 17, sponsored by Good Samaritan Hospital & Medical Center. The workshop will run from 9:00 a.m. to 11:00 a.m. in the hospital's third-floor conference rooms. Enrollment is limited, so contact the Infant Hearing Resource Center, 229-7526.

names in the news

OMA Officers Elected At the Annual Meeting of the OMA House of Delegates, Roy Skogllad, M.D., Roseburg, was elected President-elect; R. Glenn Snodgrass, M.D., Portland, Vice-president; Gene V. Bogaty, M.D., Portland, Secretary-Treasurer; Jack Blumberg, M.D., Portland, Speaker of the house; and H. Dan Moore, M.D., Albany, Vice-speaker. Serving as Delegates to the AMA are Russell Sacco, M.D., Portland; and Robert Loomis, M.D., Eugene. Alternate Delegates are Earle LeVernois, M.D., Klamath Falls; and Jack Battalia, M.D., Portland.

UOHSC Physician Appointed to FDA Committee A. Sonia Buist, associate professor of medicine and physiology at the School of Medicine, was recently appointed to the FDA Pulmonary-Allergy Drugs Advisory Committee. In addition, Doctor Buist has received a five-year Pulmonary Academic Award from the Lung Division of the National Heart, Lung and Blood Institute. Doctor Buist has also received a five-year grant from the Institute to investigate the factors which affect the aging process in the lungs.

State Public Health Officer Named Max Bader, M.D., has been appointed deputy administrator of the State Health Division and Oregon State Public Health Officer. Doctor Bader previously served the Seattle-King County Health Department as resident physician, medical epidemiologist and district health officer. He obtained his M.D. degree from the University of Washington School of Medicine and a master of public health degree in epidemiology and administration at the University of California at Berkeley. Doctor Bader replaces Edward Press, M.D., who retired in December 1978.

Urology Division Head Appointed John Barry, M.D., was recently named to head the UOHSC School of Medicine Division of Urology. Doctor Barry has served as acting head of the division since Doctor Clarence Hodges' retirement in July, 1979. Doctor Barry directs the renal transplant program, specializes in such medical problems as impotence, and has recently published a number of articles on that subject. He currently serves as the president of the Oregon Urological Society and the Western Association of Transplant Surgeons.

OPS Appoints New Assistant Legal Counsel Michael T. Mudrow has been appointed Assistant Legal Counsel for OPS-Blue Shield, responsible for contract drafting and interpretation, issuing of legal opinions on behalf of the company, and monitoring legislative developments relative to the health care field. Mudrow graduated from the University of Oregon in Business Administration and received his law degree from Lewis and Clark Law School in June 1979. Prior to joining OPS, Mudrow was an investigator for the Oregon State Board of Dental Examiners.

From the OMA . . .

- Speakers at the annual OMA Leadership Conference warned of difficulties facing the medical profession in the coming decade. R. Glenn Snodgrass, M.D., Chairman of the Public Policy Committee, and Hank Crawford, political consultant to the OMA, urged solidarity in the state's medical community and especially among OMA and component and specialty societies. Crawford further implied that membership in the OMA and OMPAC are not enough; physicians must become more personally active in the legislative process.
- Oregon's 1979 Voluntary Effort to stem the rising cost of hospital care succeeded despite soaring inflation. Don Dobson, OMA President, says that the average length of stay was down 10.02 percent from 1978, and gross revenue per stay dropped 1.4 percent.
- Adult and Family Services (Welfare) Division has filed a temporary rule extending beyond 21 the number of reimbursable hospital inpatient days for Medicaid patients with spinal cord injuries.
- The fourth edition of the AMA Drug Evaluations has been updated and expanded. The 1,522-page volume is designed for the practicing physician and offers both general and specific information on indications preferred and alternative drugs, adverse reactions and precautions, drug interactions, dosages and drug preparations. AMA Drug Evaluations may be ordered from Order Dept., OP-075, AMA, P.O. Box 821, Monroe, WI 53566. Cost is $48.

Oregon PSRO Cited Multnomah Foundation for Medical Care has been lauded by the Department of Health Education and Welfare office of PSRO, for its exemplary performance. It was one of six across the nation to receive the recognition.

legal counsel

By Gregory H. Baum

In these times of tighter credit and double-digit inflation, one's income just is not worth what is used to be. This is true for physicians as well as the general public. Unlike the majority of citizens who are employed at a fixed wage or salary and do not see the secondary effect so directly, physicians engaged in private practice are likely to suffer an actual reduction in their income as a result of the late or nonpayment of their fees. If this is not yet a serious problem, it is likely to occur with greater frequency as patients attempt to cope with their own reduced buying power and new demands on their incomes for larger minimum payments from their commercial creditors.

For some physicians, increasing fees to other patients to counteract the loss of income may work to a certain point. If one has not recently reviewed the fees that are charged to ascertain whether they are indeed appropriate, such a step is definitely in order. This may be particularly difficult, however, for physicians just starting a practice who are not so well established that they have other patients to accept the increased costs. Assuming a physician cannot or will not increase his fees any further, the next step is to examine more closely his billing and collection practices to be certain that he is indeed billing the fee that he charges for his services and collecting those sums once billed. To assist in this process, this article focuses on some of the legal aspects of the billing and collection process.

It is beyond the scope of this article to analyze the ethical aspects of what may be termed medical economics, but an observation or two is appropriate to place in perspective the discussion of the legal aspects of billing and collection which follows. The Principles of Medical Ethics (Principles) adopted by the American Medical Association (AMA) and the Opinions and Reports (Opinions) of the AMA's Judicial Council interpreting those Principles contain a number of provisions which explicitly or implicitly affect a physician's fees, billing and collection practices.

Section 7 of the Principles provides that:

"In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him . . . to his patients. His fees should be commensurate with the services rendered and the patient's ability to pay . . . ."

In construing the above-referenced portion of Section 7 of the Principles, the AMA's Judicial Council has stated that while it is not in the best interests of the public or the profession to charge interest on unpaid bills or to assess a penalty for the late payment of fees, it is not ethically improper to add a service charge, equal to the actual administrative cost of rebilling, on accounts not paid within a reasonable time (Opinion 4.31). Similarly, resort to a collection agency, after due consideration is given to the patient's ability to pay and subject to the physician's control of the account, has been declared ethically permissible although an outright sale of the delinquent account is considered improper (Opinion 4.03).

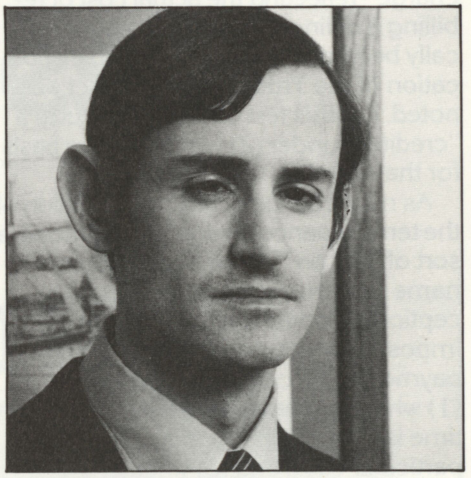
In Opinion 4.12, the AMA's Judicial Council discussed a number of inquiries it had received regarding what it termed "patient rebates." These involved discounts to patients who paid cash for services rendered or a billing charge for patients billed by mail. In essence, the Judicial Council reiterated its Opinion 4.31 to the effect that a service charge for the actual cost of rebilling would be ethically acceptable, but went on to indicate that the Federal Truth-in-Lending Act could be an additional concern. The discussion which follows is intended to take up where the ethical considerations and Opinion 4.12 leave off and should not be construed as either an endorsement of, nor an editorial on those considerations or Opinions.

Depending upon the nature of one's billing and collection procedures, a physician could be subject to any one or more of several laws regulating consumer credit. The consumer credit laws are not limited in their applicability solely to commercial lenders and banks who lend money or department stores and used car dealers who sell products. They also apply to the sale of services, including health care services. The consumer credit laws on the federal and state level are primarily of two types:

1. Disclosure laws which affect what the individual consumer must be told in advance of or concurrent with a billing; and

2. Enforcement or collection laws which dictate the manner in which the debts may be collected.

Two of the disclosure-type laws most likely to be applicable to a physician are the Federal Truth-in-Lending Act and



Fair Credit Billing Act. Whether the disclosure obligations they create are applicable is totally dependent upon the precise facts involved, but there are certain generalities which can be made about the controlling definitions.

Under both of these Acts, Truth-in-Lending and Fair Credit Billing, the term "credit" means the right granted by a "creditor" to a customer to purchase services and defer payment therefor. While by no means conclusive, it is persuasive evidence that "credit" is not involved if the physician's bill states clearly that payment in full is due at a certain time. In addition to the issue of whether the right to defer payment is involved, only "creditors" are regulated by these Acts.

A "creditor" for these purposes is defined to be a person who in the ordinary course of business regularly extends "credit" **(1)** which is payable by agreement in more than four installments; or **(2)** for which the payment of a finance charge is or may be required.

These Acts do not explain what is meant by the phrase "regularly extends credit." The courts have construed this potential exemption language very narrowly so as to effectuate what they perceive to be the intent of Congress to maximize the protection of the Acts for consumers. Therefore, unless the conditions set forth in (1) or (2) are only rarely utilized, one must consider the possibility that the Acts do apply. A physician can easily avoid the status of being a "creditor" under test (1) by not regularly agreeing to the deferred payment of his fees in more than four installments. However, some physicians may find test (2) a more difficult hurdle to overcome. As noted previously, Opinion 4.12 cau-

continued on page 6

tiously explained when a "service charge" reflecting the actual cost of rebilling a delinquent account could ethically be imposed, but the possible application of the Truth-in-Lending Act was noted. It is this test of who constitutes a "creditor" under (2) which was the basis for that warning.

As might be expected, the definition of the term "finance charge" is very broad; a sort of play on "a rose by any other name . . . ." However, an important exception is carved out for a charge if it is imposed for actual unanticipated late payment. The critical factors are, (1) whether the patient's failure to pay on time is in fact not anticipated in any particular case; and (2) whether the physician does in fact treat the account as delinquent, making a commercially reasonable effort to correct the situation. Special mailings, telephone calls, and, perhaps ultimately, referral to a collection agency, would all constitute "commercially reasonable conduct."

A physician who only imposes a service charge based upon the actual administrative cost of rebilling, and then in a commercially reasonable manner, pursues the collection of his fee together with this additional service charge, is *not* imposing a "finance charge" and is *not* a "creditor" for purposes of the Truth-in-Lending Act or Fair Credit Billing Act. However, a physician who chooses to impose additional charges which might be categorized as "finance charges" and therefore does qualify as a "creditor," is required to comply with the complicated disclosure rules mandated by the Truth-in-Lending Act. Additionally, any objections to billings raised by patients of "creditor"/physicians must be handled in accordance with the requirements of the Fair Credit Billing Act. The actual mechanics of compliance with either of these two disclosure laws would take far more space than this article permits. Anyone who believes that their actions could result in an obligation to comply with these statutes should definitely consult with their legal counsel to ascertain their precise obligations.

Assuming a physician's billing procedure is such that compliance with the disclosure type laws is not mandated, there remains the necessity to be aware of and comply with a number of laws regulating debt collection practices. Since it is likely that delinquent account collections will be handled by staff personnel, they should be carefully instructed on the procedures to be followed since the ultimate responsibility for their errors lies with the physician.

In Oregon, there are a number of types of conduct which are declared by statute to be unlawful collection practices. Certain types of conduct are the sort which one would expect to be prohibited, such as using profane or abusive language, threatening force or violence, and calling the debtor at times known to be inconvenient with the intent to harass the debtor or the debtor's family. However, there are several provisions that are not quite so obvious, including:

1. Communicating or threatening to communicate with the debtor's employer concerning the nature or existence of the debt.

2. Communicating without the debtor's permission or threatening to communicate with the debtor at his place of employment if such place is other than the debtor's residence, except that the debt collector may:

(a) Write to the debtor at his place of employment if no home address is reasonably available and if the envelope does not reveal that the communication is from a debt collector other than a provider of the goods and services from which the debt arose.

(b) Telephone at debtor's place of employment without informing any other person of the nature of the call or identifying the caller as a debt collector but only if the debt collector is unable to contact a debtor at his residence. The debt collector may not contact the debtor at his place of employment more frequently than once each business week.

3. Communicating with the debtor verbally without disclosing to the debtor within 30 seconds the name of the individual making the contact and the true purpose thereof.

4. Attempting to or threatening to enforce a right or remedy with knowledge or reason to know that the right or remedy does not exist, or threatening to take any action which the debt collector in the regular course of business does not take.

5. Collecting or attempting to collect any interest or any other charges or fees in excess of the actual debt unless such are expressly authorized by the agreement creating the debt or expressly allowed by law.

6. Threatening to assign or sell the debtor's account with the attending misrepresentation or implication that the debtor would lose any defense to the debt or be subjected to harsh, vindictive

continued on page 24

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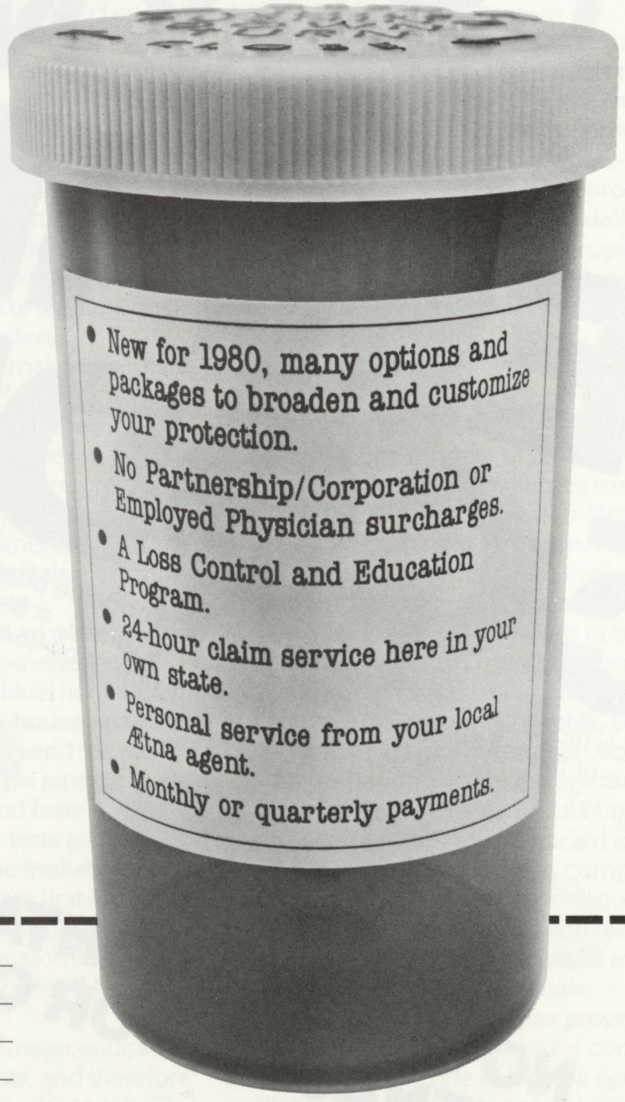

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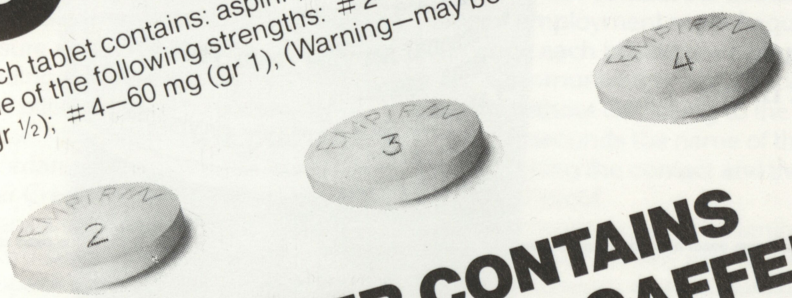

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part 3

metropolitan hospitals

Four of Portland's nonprofit hospitals are associated at a management level and they have shown that this is one way toward effective cost containment.

Metropolitan Hospitals has demonstrated that shared services does mean more and better service for patients and that hospitals can do something to combat inflation.

Each hospital retains its individual administration, identity and regional mission and at the same time enjoys the advantages of a management team and sophisticated equipment it would be hard pressed to afford on its own. In effect, the hospitals enjoy the best of all possible worlds.

The founding hospitals are 554-bed Emanuel and 160-bed Physicians and Surgeons which, in 1970, formed Metropolitan Hospitals. Metropolitan Hospitals then bought the 100-bed Gresham Community Hospital and in 1973 Metro built the 99-bed Meridian Park.

The personalities, pecularities, specialties and destinies of each of these hospitals is discussed in this issue of *Portland Physician*. This article is to show what they have in common.

Shared management has been a major boom to all participating hospitals. Metro helps member hospitals look to the future, get a handle on where they are and where they want to go through long-range planning. The planning process involves investigation of trends in demographic, economics and politics as well as health care and requires months of effort by a staff of experts.

Metro does long-range planning for the four member hospitals plus three others. Metro accepted the challenge of planning for a bank holding company when that company's president became acquainted with Metro's planning work and decided that was what his organization needed.

Metro's management team also provides Certificate of Need preparation and applications, program need analysis, statistical analysis of services and resources. Metro provides the interface with government agencies at local, state and federal levels and maintains liaison with public officials and regulators.

Cost increases have been held to a minimum at Metropolitan Hospitals. Group purchasing has saved up to half of the cost of some supplies for lab services. The hospital labs compiled lists of supplies they all purchased in 1976 and through Ron Desrosiers, the director of shared services, put the lists out for bid. Savings vary, but the effect was immediate and was recognized as quickly outside Metro. Now, Metro runs a purchasing co-op for 60 hospitals in Oregon that negotiates with local suppliers and contractors for everything from elevator maintenance to bread. Metro also does national contract negotiations for 17 hospitals for things such as capital equipment and major medical and surgical supplies.

Metropolitan Hospitals benefit from central handling of finance projects. "We have as much expertise in tax-exempt financing as any hospital in the country," said Metropolitan Hospitals President Roger Larson. Metro handles the gathering of data, preparation of applications and works with underwriters.

Other Metro services make patient care better and faster. Metro Lab, for example, makes it possible for Metro hospitals to have a more extensive lab service available to them than they might otherwise be able to to justify. A courier service transports specimens for analysis from the four Metro hospitals, plus more than 80 outside accounts.

Metro Lab purchased an automated chemistry analyzer that is efficient for batch testing. The individual hospital labs were then free to buy in-house analyzers for stat testing while they send the routine chemistries to Metro. This arrangement makes for lower cost and faster turnaround times. New tests are added as soon as they become available and Metro Lab is frequently the first in the city to have them. Metro's pathologists provide 24-hour-per-day anatomical and clinical pathology service to all four institutions.

Shared purchases of major equipment have spread capital costs, and therefore reduced them, for the four hospitals. The mobile Gamma Camera, purchased in April, 1979, is an example. This gives the three smaller hospitals the capability of brain, lung, heart, liver, bone and thyroid imaging without the capital investment of a nuclear medicine department of their own. Metro served as the organizer for formation of Mobile Scanner Systems, Inc., that will begin operation of a mobile CAT scan to serve ten area hospitals.

The Life Flight helicopter provides emergency air-ambulance service to practically every hospital within a 260-mile round-trip radius. Hundreds of flights have been made in the service's first years of existence and program personnel estimate that a high percentage of those transported for care by Life Flight might otherwise have died.

Two Metropolitan Hospitals, Gresham Community and Physicians and Surgeons, offer alcoholic treatment. The three-week inpatient program is operated through a contract with the CompCare Corporation that staffs the Care Unit. Admission to the Care Units is voluntary and most frequently comes from referrals from physicians, employers or family members. The program involves physician assessment, daily group and individual counseling, physical therapy, occupational therapy, relaxation sessions and seminars.

Physicians find Metro's library service valuable. A computer terminal is connected to the Library of Congress and researchers can request a bibliography on any topic, or reprints of articles.

Opportunities are sometimes made available to physicians through Metro's physician recruitment program, that helps place physicians where there is a need for additional private practices.

Metro relieves a vast amount of bookkeeping burden from member hospitals with centralized accounting, general ledger, payroll, accounts payable, patient billing and accounts receivable processing. Metro handles financial reporting to government agencies as well as budgeting and forecasting and Medicaid and Medicare reporting. Through computer, Metro also stores patient information and laboratory reports. And will soon relay the information to member hospitals even faster through on-site terminals.

Metropolitan Hospitals has proven itself to be a viable and attractive concept and very possibly one of the few options available in the struggle against rising costs and regulations. Metropolitan Hospitals will seek other opportunities for service to the health care community in the future.

Frank Parchman is Public Relations Director for Emanuel Hospital.

Gary Eisler is editor, photographer for Emanuel Hospital and serves the other member hospitals of Metropolitan Hospitals through the shared services system.

emanuel

On a bleak January day 68 years ago Emanuel Hospital opened its doors at an ornate, Gothic structure on 10th and Taylor in downtown Portland. The operating room was on the second floor. Surgery had to be scheduled when the Lutheran founder of the hospital, Reverend Carl Renhard, was available to carry patients down the winding staircase to their beds on the first floor.

Three deaconesses provided by a church institute in Omaha, Nebraska served as nurses for the hospital. As a teaching hospital, the nursing arts were taught to students "at the bedside."

It would have been difficult for the Reverend Renhard to realize as he toted patients on his back that one day Emanuel patients would be transported in a helicopter complete with its own portable emergency room to one of the largest and most progressive hospitals in the Northwest.

Today Emanuel Hospital is a 554-bed facility situated on a spacious 56-acre campus in northeast Portland. It serves residents from across the state of Oregon and southwest Washington.

Emanuel Hospital is a nonprofit organization providing a comprehensive range of primary, secondary and tertiary health care and health-related services.

Highly regarded orthopedic, medical, surgical, obstetrical and pediatric services are provided by the hospital. Specialized departments such as emergency care, intensive care, coronary and progressive coronary care, pediatric intensive care, neonatal intensive care, oncology, the Oregon Burn Center, the Emanuel Rehabilitation Center and the Portland Pain Center have cast Emanuel into the role of one of the region's foremost providers of health care.

The hospital also serves as one of the largest voluntary teaching hospitals in the Northwest.

Emanuel Hospital is dedicated to a "full-service philosophy," according to Walt Behn, Executive Vice President and Administrator of the hospital. This means providing the physician with a comprehensive and balanced scope of services and support in treating a patient.

"Leadership, excellence, and innovation," are key words in the philosophy of the hospital, Behn says.

Those words describe a number of programs the hospital and members of the medical staff have initiated in recent years including the Oregon Burn Center, Life Flight, the Emanuel Rehabilitation Center and the Oregon Skin Bank.

The Oregon Burn Center was established in 1974 in response to a growing need for a specialized center to provide primary burn care through a team highly trained to meet the needs of burn patients.

Physicians, nurses, burn technicians, dieticians, physical therapists, social workers, respiratory therapists, psychologists and occupational therapists are all specially trained to work with patients in the burn center.

"We recognize that a burn is one of the most traumatic injuries a person can receive," says Dr. Philip Parshley, Medical Director for the center. "The team approach and the specialized center can yield definite results which may not have been possible otherwise."

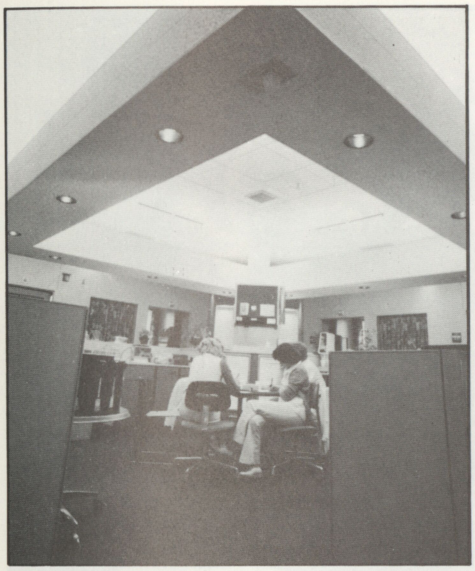
The Burn Center was almost an immediate success with patients coming from across Oregon and southern Washington. Plans were made for rapid expansion.

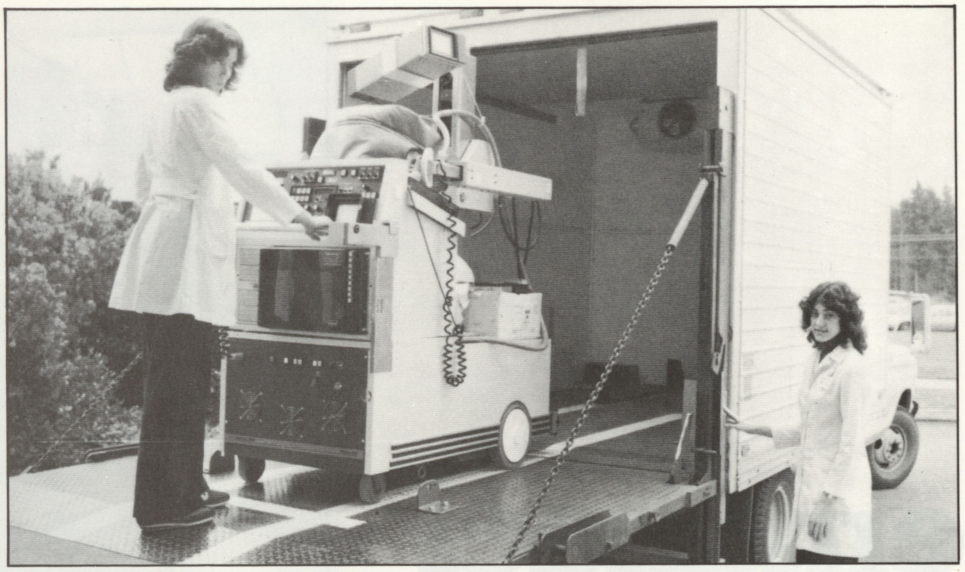
In November of 1977 the new burn center opened with four intensive care beds, eight post-acute beds, central cardiac monitoring for each room, head modules connected to all the equipment needed for a critical patient, and a treatment room used for tubbing patients, doing dressings and admitting patients.

With the team approach, all patients are treated within the unit. No patient leaves the unit for treatment with the exception of surgery.

A unique new program was started in 1979 to complement the Burn Center. This program is the Oregon Skin Bank, the only skin bank of its kind in the state. The skin is used as a temporary dressing that aids in the healing of the wound of a critically burned patient and aids in the control of infections and the lessening of pain.

Another innovative service which works closely with the Burn Center and other patient care units at Emanuel is Life Flight.





Life Flight began operation in March, 1978, as the first hospital-based patient transport system on the West Coast utilizing the helicopter. It serves not only Emanuel but is available for use by hospitals throughout the service area.

The Life Flight team consists of highly skilled and experienced nurses, communication specialists and pilots who are ready on an around-the-clock basis to respond to any medical emergency requiring safe and rapid transport of a seriously ill patient.

Within four minutes of receiving notification of an emergency, Life Flight can be airborne and on its way to any point within 139 air miles of Portland. Fixed wing craft are available for longer flights.

The helicopter, a jet-turbine powered Alouette III, is specifically designed for high altitude service. It is capable of carrying two flight nurses and two patients, in addition to the pilot.

Inside, a full-range of life-saving equipment is available. This includes cardiac monitoring and defibrillation devices, oxygen, suction, intubation and ventilation equipment, medications, emergency medicine, intravenous fluids, splints and other supplies. Additional specialized equipment is available for obstetrical, pediatric, newborn and burn patients.

A highly sophisticated communication center based at Emanuel allows the flight nurse to communicate by radio directly with physicians, emergency rooms, hospitals and rescue units. Telephone patch capability allows the physician to telephone the communications center and speak directly to the nurse in the helicopter.

Since its beginning, Life Flight has transported a wide variety of patients including those suffering from myocardial infarction, respiratory problems, burns, poisoning, accident injuries, strokes and many other causes. Additionally, high-risk obstetrical and neonatal patients have been successfully transported.

Life Flight has gone not only to other hospitals for delivery or pick-up of patients but has also transported patients from the scenes of motor vehicle accidents, logging accidents in forestry areas, airports and schools.

"The potential of Life Flight for the saving of lives and the safe, efficient transport of patients has barely begun to be tapped," says Clark Chipman, M.D., Emanuel's new Chief of Emergency Services, who is responsible for overall management of Life Flight. "As more physicians, nurses, EMTs, rescue agencies, industrial representatives and others become familiar with the life-saving benefits we have to offer, I'm sure Life Flight will become an even more vital part of the emergency services of the state. It is truly a service of the '80s."

A center which is an integral part of the hospital's "full-service" philosophy is the Emanuel Rehabilitation Center. The center is the last phase in the "from helicopter to home" concept whereby a patient could be picked up by Life Flight, receive emergency treatment and care at Emanuel and then be rehabilitated to a useful life at the center, according to Dr. Ralph Johnson, new Medical Director for the center.

The center uses the "multidisciplinary team approach" in comprehensive treatment of patients.

The team consists of physicians, psychologists, physical and occupational therapists, nurses, speech pathologists, biofeedback specialists and social workers specially trained in rehabilitation medicine and care.

Special treatment programs at the center include stroke, traumatic head injury, chronic pain, cancer and orthopedic.

A new program which has begun at the center is the Arthritis Treatment Program. It is a comprehensive outpatient and inpatient program designed for the management of the special problems of the arthritis patient. In addition to handling adult rheumatic diseases, special services and expertise are available for the care of pediatric patients with arthritis.

These programs are housed in a modern facility adjacent to the hospital complete with its own therapy pool, wide array of rehabilitation equipment and special treatment rooms.

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emanuel

Treatment at the center is a comprehensive approach addressing itself to the physical, emotional, physiological and environmental needs of the patient and his family. "For instance, discharge planning begins immediately upon admission for a patient," says Dr. Johnson. "Our social workers begin assisting the patient's family in coping with life changes resulting from illness or injury."

Occupational therapists help the patient to develop skills in the areas of self-care, homemaking, vocational and leisure activities. In addition the therapist helps the patient and family in the use of adaptive equipment. Psychologists provide counseling to help with the intellectual and emotional problems of a patient. Speech and physical therapists address the patient's physical rehabilitation. Biofeedback therapists work with the patient to improve strength, endurance and mobility for maximum functional potential. Therapists use physical exercise and agents to develop the muscle power and coordination necessary for walking and work activities.

All of these specialists interface with the rehabilitation nurse and physician to return the patient to the maximum level of physical, mental and emotional health.

Obstetrics has long been a specialty at Emanuel. The hospital operates one of the busiest open maternity services in Portland.

On August 24, 1979 the regional health system agency designated Emanuel as one of three institutions (along with Bess Kaiser and the University of Oregon Health Sciences Center) certified to provide Level III Perinatal Care. "What this means," says Peter Watson, M.D., a specialist in Maternal-Fetal Medicine and the director of the Emanuel Perinatal Care, "is that Emanuel will be providing comprehensive care for all medically complicated pregnancies including neonatal intensive care for the smallest of prematures. We will also begin a program of community outreach education and research in conjunction with the University of Oregon Health Sciences Center.

"I have no doubts that within two years we will have the finest private perinatal center in the Pacific Northwest. We have a superb facility now, and in a short period of time it will be even better."

A relatively new concept in the maternity department is the birthing room. The birthing room offers a safe alternative to home births. The room is equipped much like a room at home would be with pleasant surroundings, a comfortable armchair for the father and a cradle for the baby. It is located next to the delivery room and any emergency equipment needed is immediately available.

The labor rooms were recently relocated and remodeled, and the neonatal intensive care nursery has been renovated with the addition of new equipment.

A new sibling visitation program allowing children to see their mothers during the hospitalized period following a new baby's birth is also now in effect.

One of Emanuel's newest programs is the Oregon Children's Center. Emanuel has long been recognized as one of the two major health care centers serving children in Oregon.

The Oregon Children's Center places several highly regarded programs beneath one umbrella.

The center has a pediatric unit which has the capacity to care for 35 children. The center serves children with both medical and surgical needs and houses its own intensive care unit.

The center encourages a family-centered approach. Parents are encouraged to take an active part in the care of their children and, if they desire, spend the night. The parent can become an integral part of the care team.

Joining the parent in care of the child is a highly qualified multidisciplinary team including a social worker, Child Life worker, nurse, physician, dietician, and occupational, physicial, speech and respiratory therapists. These specialists form the center's interdisciplinary team which meets weekly to identify needs, set goals and monitor the progress of children in the center.

A unique part of the Oregon Children's Center is the Child Life Program.

The program helps children and parents understand medical procedures, provides individual and group play sessions to divert children from thoughts of pain and loneliness, and seeks to increase communication between the children, parents and staff.

This is accomplished in a wide variety of methods by the Child Life worker. A presurgery puppet show and tour of the hospital therapeutic play activities, familiarizing the child with medical procedures, individual bedside play sessions, and program planning conferences for family and staff members are directed by the Child Life worker.

Additionally the Child Life worker may accompany the child to surgery or x-ray to provide emotional support when a family member is absent.

Another innovative program directed by the Children's Center is the Child Development program.

The Child Development program is basically an outpatient program designed to serve children and adolescents with multiple problems.

The program recognizes that the life and happiness of a child are related to early recognition of his or her problems. The goal is to keep these children living and working happily in their own community and to assist the family in developing realistic expectations for a child.

When a child is referred to the program, the situation is carefully reviewed by a team consisting of a pediatric nurse practitioner, pediatrician, pediatric geneticist, occupational therapist, physical therapist, speech pathologist, social worker and psychologist. Other consultive services are made available as required.

After an evaluation and staff consultation, results of the evaluation and recommendations are discussed with the parents and reports are sent to professionals in the community involved in the child's care.

Direct therapy for the child may be continued within the program or follow-up community resources may be utilized.

The team closely monitors the child's progress and assesses changing needs.

In the future Emanual Hospital will continue to strive for excellence in providing quality health care for the people of the region. Several new programs are on the drawing board and the hospital continues with its multimillion dollar renovation program to provide one of the finest health-care facilities in the Northwest.

gresham community

Gresham Community Hospital is a community-oriented acute-care facility providing inpatient and outpatient services. The hospital is licensed for 113 beds including 64 general medical and surgical, 24 for alcoholism treatment and seven for a combination of intensive and coronary care.

Outpatient services at Gresham include a clinical laboratory, radiology, 24-hour physician staff emergency service, respiratory therapy, physical therapy, occupational therapy, EKG and EEG service. Additional depth and support for general and specialty areas of medicine are provided through service programs, coordinated by Metropolitan Hospitals.

Plans are currently being made to replace the facility with a 120-bed unit. It is estimated the project will cost between $12 and $15 million.

The replacement facility will be located on a 20-acre parcel near Mt. Hood Community College. It will feature expanded ancillary services and ambulatory care facilities that will provide day care for patients who have received minor surgery and don't plan to stay over in a room. The hospital also plans to change from multiple-bed patient care and semi-private rooms to more private rooms.

Gresham Community Hospital now has 60 active and 55 consulting staff members. Many are attracted by the long-term growth potential of the Gresham area. Estimates are that there will be 140,000 residents of the area by the turn of the century. To aid the increased physician population, part of the 20-acre hospital campus will be set aside for a physicians' office building.

The hospital offers first aid classes to the public. There are also classes in cardio-pulmonary resuscitation and chest compression. There is diabetic education available and blood pressure screening. Gresham offers clinical experience to L.P.N. and A.D.N. students as well as an R.N. refresher course. There is an experience program for physical therapy and continuing education for licensed nurses.

Gresham has one of the busiest emergency departments for its size of area hospitals. The ER was redesigned in 1977 and has a nine-patient service area and includes x-ray facilities and can accommodate minor surgeries. It handles upwards of 20,000 patients per year.

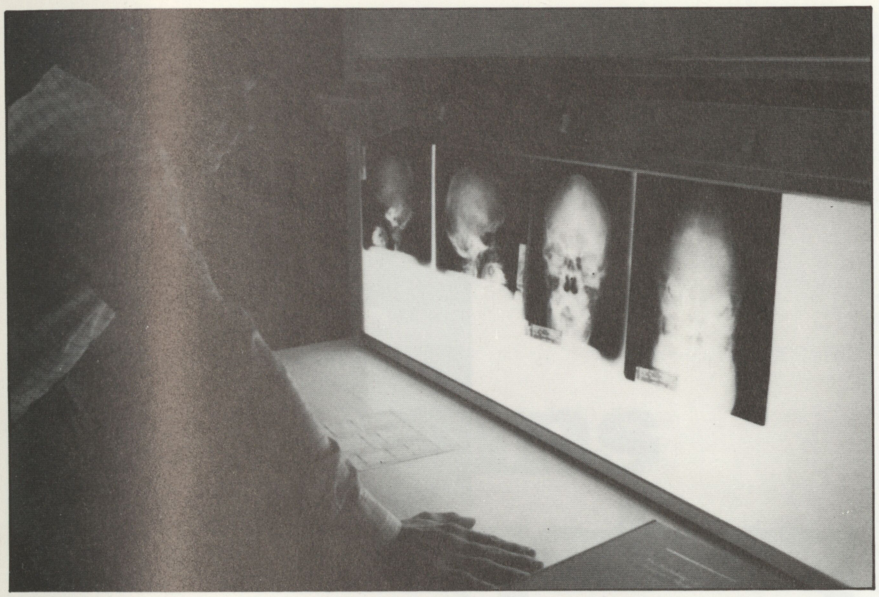
In addition to three x-ray machines, Gresham radiology department offers a full range of services including xeroradiography and will soon share in the use of a mobile CAT scanner.

The clinical laboratory at the hospital and the shared laboratory services of Metropolitan Hospitals, Inc. provide Gresham Community Hospital with 24-hour laboratory coverage. A shuttle service operates day and night between Gresham and Metropolitan Hospitals Laboratory in Portland.

The hospital provides services in surgery, postoperative recovery room, intensive/cardiac care unit, pharmacy/intravenous therapy, diagnostic radioisotope facility, blood bank, electroencephalography, electrocardiography, respiratory therapy department, physical therapy department, occupational therapy department, 24-hour emergency department, alcoholic treatment service (inpatient), chaplaincy service, radiology department, arteriography, day care surgery, discharge planning coordinator, and clinical laboratory.

CareUnit: Hospital Based Alcoholic Treatment

For the last six years, Physicians and Surgeons Hospital and Gresham Community Hospital have operated a three-week inpatient program for the treatment of alcoholism. "CareUnits are treatment programs located at community hospitals," explains Ed Leahy, CareUnit Program Coordinator at Physicians and Surgeons Hospital. "The hospital is responsible for providing a highly skilled and caring nursing staff. The CompCare Corporation provides specific staff members with special expertise."



"Alcoholism is a disease," says Cliff Benson, CareUnit Program Coordinator at Gresham Community Hospital. "The alcoholic is not a bad person getting better, but a sick person getting well." A complex, progressive illness, untreated alcoholism ends in permanent mental damage, physical incapacity or early death. "In fact, changes associated with the disease go on for a long period of time," according to Physicians and surgeons CareUnit Medical Director David D. Knowles. "All alcoholics have a degree of liver dysfunction and other side effects—irritability of the central nervous system and chronic tension secondary to the alcoholism. The physiological effects of alcoholism remain two to nine months after detoxification and a sustained sobriety."

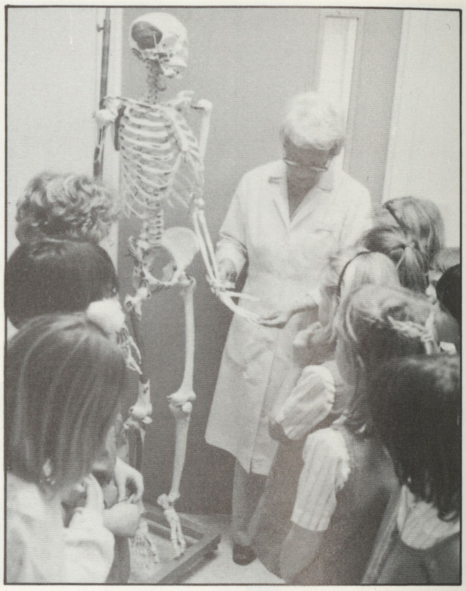
The treatment of alcoholism, like the treatment of heart disease or diabetes, requires the cooperation of the patient. Appropriate medical management, education and counseling allows successful treatment. According to Dr. Knowles, control of alcoholism is not a question of will power, but a specific treatment. "You cannot give a diabetic a syringe and a list of instructions and expect them to deal successfully with their disease without further education. Alcoholism requires the same kind of educational process, as well as treatment for the consequences of the disease."

Admission to the CareUnit program is voluntary and often referrals come to the CareUnit because of the encouragement of a family physician, employer or family member. Early intervention may prevent the alcoholic's loss of family and career. According to HEW statistics, more than two-thirds of the nine million alcoholics in the United States are employed. The average alcoholic is a man or woman, 35 to 50, and a homeowner with a family. Most alcoholics are unaware that major insurance carriers cover their treatment in a CareUnit.

At the CareUnit a closely structured three-week program begins with the physician's medical assessment of the patient. Daily sessions of group and individual counseling allow the patient to understand the nature of alcoholism. Physical therapy, occupational therapy, relaxation sessions and seminars help the alcoholic learn to set new goals and apply a variety of problem-solving techniques. Family seminars each week bring the alcoholic's family together to discuss the impact of alcoholism on their family life.

The CareUnit programs at the Metropolitan system hospitals represent an aggressive response to a major national health threat. The U.S. Department of Health, Education and Welfare has named alcoholism the country's most neglected disease. As a community resource, the CareUnit cooperates with Alcoholics Anonymous, Al Anon, local businesses, industry and colleges in order to provide the care, counseling and education required for early detection and control of alcoholism. Representatives from the CareUnit may be contacted at Gresham Community Hospital (667-1122) and at Physicians and Surgeons Hospital (224-6500).

By Donna G. Kroo,
Community Relations



meridian park

Meridian Park Hospital, located off Interstate 5 in Tualatin, opened in 1973 as the first general care hospital to serve a rapidly-growing southwest suburban area of Portland.

Fully accredited by the Joint Commission on Accreditation of Hospitals (JCAH), the 99-bed facility was designed to provide high-quality medical and hospital care to this highly-developed industrial and residential area without a costly duplication of equipment and facilities.

The design concepts incorporate flexibility for meeting current as well as future needs, primary care nursing by an all-registered-nurse staff, a problem-oriented system of medical record keeping, and a wide range of emergency and outpatient services available 24 hours daily. There are no obstetric or pediatric departments.

Meridian Park was the first Oregon hospital to attain a Certificate of Need under the 1971 Oregon legislation which requires such before construction. The not-for-profit hospital was built without use of Hill Burton funds, and is governed by a separate board of directors and the board of Metropolitan Hospitals, Inc.

The hospital received its name because of the strategic, geographic location on the Willamette Meridian. The 48-acre campus includes the hospital, a separate engineering plant, and adjacent administrative and medical office complex. A licensed helicopter landing pad is situated near the emergency room entrance to the hospital.

Patients are housed in a three-story, twin nursing tower. The nursing stations are centered in each pod, providing direct visual contact and easy access to each of the 17 rooms on each unit. The individual patient rooms have a private bath, telephone, television, and a window lending a panoramic view of the rural countryside.

A six-bed coronary-intensive care unit is adjacent to an eight-bed special care unit. One-day surgical patients are admitted to a short-stay unit. There are four operating room suites equipped with the Swedish Kifa table system for patient handling.

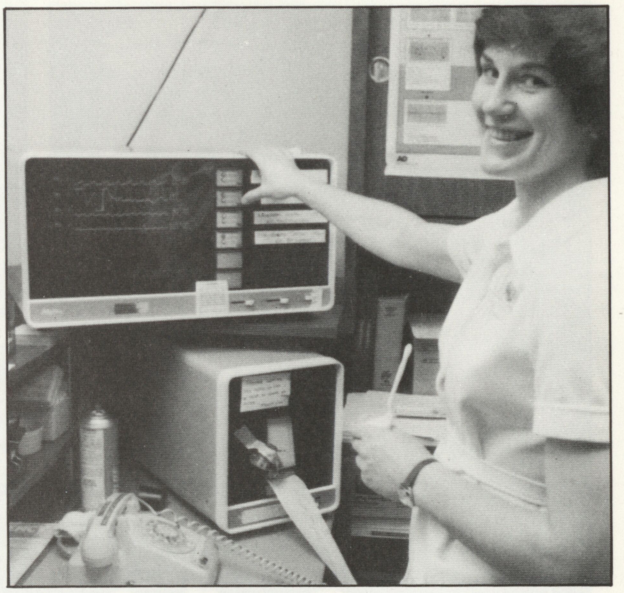
Patient education programs include ongoing diabetic and cardiac care classes. A new closed circuit television system relays health-related information and broadcasts educational information for staff in-service programs. A staff enterostomal therapist counsels all ostomy referrals.

The Meridian Park Hospital community relations program has been enhanced by the 160-member hospital auxiliary. In addition to operating the hospital gift shop, the auxiliary is involved in numerous programs of community service and health education. An in-service volunteer program draws participants from the many communities which surround the hospital, and community clergy serve in a volunteer chaplaincy program to augment the services of a part-time staff chaplain. The Meridian Park Medical Foundation recently was established to support the hospital's development and philanthropic gift giving.

Future expansion of Meridian Park Hospital was a consideration during the planning and construction. By adding three floors to the nursing towers, bed occupancy could be doubled. All clinical areas were designed for expansion by incorporating enough space initially to accommodate a potential 199 beds.

The Meridian Park Hospital medical staff numbers 270, and functions under its own bylaws. Continuing education programs are offered at Meridian as well as the other Metro hospitals on an interhospital basis. Meridian's weekly primary care educational conferences are certified by the American Academy of Family Physicians.

physicians and surgeons



Almost from the moment you entered Physicians and Surgeons Hospital in northwest Portland you sense the place has a different "feel" to it.

Patients and staff alike share a sense of place—a feeling of belonging to this very unthreatening environment.

While many of Portland's biggest hospitals have gone heavily into bigness, specialization, and expansion, Physicians and Surgeons has concentrated on developing a general, family-practice identity. They call it "a community hospital in an urban setting." They have a few long suits—such as their ophthalmological department, alcoholic rehabilitation program and their supporting role in occupational medicine.

There is a very low turnover rate among Physicians and Surgeons employees. Stories abound of nurses and staff who have been there 15 years and more. One girl started out working in the kitchen when she was in school. Years later she wound up working in the payroll department.

The long-term employees add to the family feel. Everyone on staff knows each other well and works together well. And many of them know the patients well, too. Some patients have come to Physicians and Surgeons many times over the years, and some staffers have seen patients' children grow up.

The comfortable, family feel of the hospital extends into many aspects of hospital administration and special programs and services.

Concern for the patient's well-being is probably best exemplified by the patient education program, that is unique to the metropolitan area.

"The idea is to get the patient involved in his own health care," said patient educator Regina Mork. "They must feel that it's up to them to get well—not just the doctors and nurses."

Ms. Mork is a professional educator whose job is to follow through with the patients, assisting the doctors and nurses education effort. "To some extent, every hospital has patient training by nurses and doctors discussing health problems with the patient," she said. What's different in the Physicians and Surgeons program is a professional educator who uses formalized audiovisual aids and a follow-up program.

Diabetics, for example, learn to stop craving sweets, heart patients must learn to exercise and the chronically tense learn to relax.

The hospital uses professionally prepared filmstrips, cassettes and take-home literature. The program has written objectives and goals the patient is expected to accomplish toward his own well-being.

"The patient is an integral part of his health care team," she said. "They have a lot of responsibility as far as their health care goes. They are responsible for the behavioral changes that must take place for them to get well."

To take some of the confusion out of a trip to the hospital, Physicians and Surgeons has developed a Patient Service Representative system.

The Patient Service Representative handles a patient's paperwork from beginning to end the way the patient's doctor handles the patient's medical problem from beginning to end.

When the patient shows up for admitting, the Patient Service Representative is waiting to admit the patient. The rep advises the patient on how to handle insurance claims, tells about billing and other administrative procedures.

When it's time to be discharged, the Patient Service Rep is on hand to handle all the necessary forms. The rep bills the insurance company for the patient and manages the account until it's complete.

"People seldom deal with insurance paperwork," said Neal Milburn, hospital administrator. "That's the role this person plays—to ease the problem of paperwork faced by the patient."

The hospital has also instituted procedures to cut down the growing tide of paperwork—and that ultimately helps keep health care costs down for patients.

"Except for added staff because of new technology and inflation, the greatest cause of increased hospital costs is paperwork," according to Milburn. "Paperwork required by the government has tripled in the past five years."

In response, Milburn has tailored admissions paperwork to the type of patient visit: short visits get short paperwork, longer visits are more thorough.

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By Barbara Robertson, Administrator

kaiser sunnyside

Kaiser Sunnyside Medical Center, 10180 S.E. Sunnyside Road, Clackamas, is a 131-bed JCAH-accredited, charitable, nonprofit community hospital. It is one of two Portland-area Kaiser Foundation Hospitals associated with the Kaiser-Permanente Medical Care Program.

Located in a wooded, pastoral setting in North Clackamas County, the Medical Center was opened in September, 1975. Currently, approximately 110 beds are in use. Patients are primarily members of the Kaiser-Permanente prepaid group practice Health Maintenance Organization (HMO), but the hospital treats many other community residents as well.

Inpatient services usual to an acute hospital are offered, except for obstetrical inpatient care, which is referred to Bess Kaiser Medical Center. A few highly specialized services, such as open-heart surgery or extensive burn treatment, are referred to other community hospitals. Kaiser Sunnyside has a cardiac catheterizations department which performs this service for the 230,000 Health Plan members in the Portland/Vancouver and Salem metropolitan areas. In 1979, 194 catheterizations were performed at Kaiser Sunnyside; some of these patients were subsequently referred to other community hospitals for open-heart surgery. This is consistent with the policy of using the most effective and efficient means of providing quality care for specialized medical and surgical procedures.

The average length of stay for all patients in the hospital during 1979 was 5.6 days. Occupancy averaged 86.6 percent of the staffed beds.

Kaiser Sunnyside is staffed primarily with physicians of Northwest Permanente, P.C., a 227-physician multi-specialty group that provides most of the medical services required by the Health Plan membes. Most medical specialties are represented in this physicians' group.

The Emergency Department is undergoing a $1.7 million expansion that will more than double its capacity. Completion is expected in January, 1981. A department of six full-time physicians specializing in emergency care provides 24-hour emergency services with consultations provided by other Northwest Permanente physicians representing the major medical specialties, some of whom are in the hospital 24 hours a day, seven days a week. The Emergency Room and its adjacent After-Hours Clinic saw 50,175 patients in 1979, persons from the community as well as Health Plan members.

A 30-physician outpatient facility, adjacent to the nursing wing, offers specialty services while a separate 22-physician outpatient facility next door to the hospital offers primary care services. When these medical offices are closed, extensive emergency and after-hours clinic services are provided at the hospital location. Patients are triaged for appropriate care and seen by either an Emergency Room physician, internists, surgeon, or pediatrician. Other specialists are available on-call, and 24-hour medical advice is also available by telephone to Health Plan members.

One of the most innovative features of Kaiser Sunnyside is its unique 7/70 Nursing System, instituted when the hospital opened. Instead of the traditional hours, each nurse works 10 hours a day for seven days, and then has the next seven days off. Kaiser Sunnyside is one of the few hospitals in the Pacific Northwest using this staffing system, which has been enthusiastically accepted. Nurses who work in the system utilize the shift overlap which occurs during the busiest periods of the day and allows more time for reports, exchange of information, and in-service programs. The hospital nursing department is developed around the primary nursing care model—a model into which nurses are educated during most four-year nursing preparatory programs. Primary nursing, together with the 7/70 staffing system, provides both job satisfaction and allows for continuity of patient care. Patients have been very complimentary about the system since they will usually see the same nurses each day during their complete hospital stay. The staffing system allows a certain flexibility in the usual hospital routine, and this, too, is seen as an advantage.

Physicians at Kaiser Sunnyside have been innovative in their approach to surgery. A study conducted on outpatient surgeries at Bess Kaiser Hospital from 1966 through 1974, under the auspices of the Health Care Financing Administration of the Dept. of HEW, showed that many surgeries can be done on an outpatient basis with the same high standards of quality applicable to inpatient surgical procedures. Results also showed significant cost savings (the Bess Kaiser study showed a savings of $192 per patient). More than 40 percent of Kaiser Sunnyside surgical patients now have their operations performed in the hospital operating room, but spend less than 24 hours in the facility.

Patient education is an integral part of patient care activities in the facility. Patients participate in developing their own care plans, in a setting designed to seek and answer questions that patients may be hesitant to ask in similar environments. Health information that will contribute to the remediation of their present problems is coupled with health promotion information that will assist them in seeking wellness during their personal and professional lives.

A number of specialized health education programs are also offered on a group basis, both at the hospital and at several of the satellite outpatient facilities. Such programs include pre-surgery orientation, classes on arthritis, diabetes, alcoholism, weight loss, smoking cessation, parenting, child guidance, lip reading, and body mechanics.

Nursing and ancillary personnel participate in many in-service education programs presented by the Staff Development Department. Physicians and physician extenders participate in programs conducted by the Department of Medical Education, which offers a variety of symposia and other educational opportunities which have been certified by the Oregon Medical Association for Continuing Medical Education credits.

A busy Volunteer Department, headed by a full-time director, contributed over 13,000 hours of service in 1979. In addition to performing duties which add to staff and patient comfort, they make many other contributions. For instance, one of the volunteers noted that some pediatric patients had fears about hospitals and were reluctant to communicate. She addressed these questions in a coloring book which is now used to assist the children in their adjustment, and is available in Kaiser Foundation Hospitals in Oregon, Ohio, and California.

Trauma

Do we need a regional trauma center?

I recall several years ago a conversation with Dr. Chet Ward, who was at that time one of the White House physicians to President Gerald Ford. He was stopping in Portland in advance of a Presidential visit, arranging back-up services for the President. "You've got an interesting city here," he said. "In most other cities of this size in the United States, there would be only one place to take the President if he was injured. In Portland, there appear to be several places of equal capability where he could be taken." What he said was true, and he had done his homework.

In effect, we at that time had several "trauma centers" in the metropolitan area; hospitals which had the capability to care for an injured patient with multiple system injuries. But despite his observation, my own observation over the past decade in Portland is that we could improve the care of the trauma victim by establishing a regional trauma center. During the past several years, I have had the opportunity to visit many of the trauma centers in this country, including those in Dallas, Miami, Baltimore, Maryland and Seattle. With better organization, we in Portland, could deliver better care.

Early in April there was a meeting at Holladay Park Hospital; well-attended by hospital administrators, trauma surgeons and nursing personnel. It came in response to information that Dr. David Boyd, national EMS Director for HEW, had threatened to withhold further Federal funds from the State of Oregon unless a regional trauma center was designated. As you might expect, much heated discussion occurred, and the Northwest Oregon Council of Hospitals took some positive steps toward studying the problem and moving forward, albeit on their own schedule, not Dr. Boyd's. Mr. Pete Fleissner, Oregon Administrator of Hospitals, seemed to have done his homework and indicated that probably withholding such funds would not be possible. The emphasis during the meeting was on the care of the patient, and I believe rightly so.

Do we need a regional trauma center? I believe we do, for several reasons, the two most pressing relating to patient care, today and in the future.

First, we need a regional trauma center to insure the best possible immediate care for the injured patient. To me, this means connecting that patient with the appropriate resources and particularly with the most skilled medical and surgical personnel available. In Portland, Oregon, this means designating a place where such victims can be taken, which has 24-hour coverage for the operating room and support services, and which is staffed by experienced trauma surgeons who are interested and committed to delivering timely care. To me, that is the crux of the matter. Studies in recent years have supported the belief that experienced surgeons who do something regularly and in volume, maintain their skills. This is true for open heart surgery and it is true for trauma. The occasional operator loses skills and does not have results as good as the experienced surgeon who operates frequently. And, in a city like Portland — not a high trauma city

— spreading the critically injured patients around simply dilutes the experience and, I believe, promotes mediocrity instead of excellence. Although we would like to think that anyone who has been through a surgical residency can be a trauma surgeon, it takes more than that. It takes continual use of skills and updating of knowledge; just like it does in any other area of surgery. The cancer surgeon who never operates for cancer quickly loses his skills. The second reason relates to patient care in the future. There is an important function for the surgical community to train residents who will be tomorrow's surgeons, and these individuals need training in trauma, just as in all aspects of surgery. This is another important reasons why such care must be centralized. I do not mean that residents should be doing all of the cases, any more than I mean all cases of trauma should of necessity, go to the regional trauma center. The regional trauma center should receive only the high-risk trauma victims; those with multiple system injury who are at risk for complications. This trauma service should be staffed with the best trauma surgeons in the city on rotation and should be used for training all the surgical residents in the city. It must be a closely-staffed and supervised service, where residents gain experience and where results are looked at closely in conjunction with an ongoing educational program, perhaps even tied to research.

What's important in a regional trauma center. I think there are several crucial factors, and I will speak to the realities of Portland, as well as to theoretical aspects from visits to other trauma centers.

First, the facilities must be adequate. This means that there must be easy access to the facility from major highways and from the air, with a helipad situated close to the resuscitation area. Operating room facilities must be staffed to function immediately and crucial back-up services such as radiology (including angiography), CT scanning and a blood bank must be able to be activated quickly.

Second, there must be a commitment for staffing the Center. Not only does this involve the administration of the hospital to provide operating room staff around the clock, as well as the other ancillary services, but perhaps most crucial, it demands a rapid, adequate response to staff persons in surgery, committed to the care of the trauma victim. Obviously, in-house residents and the emergency physician on duty should be skilled in the initial resuscitation, but increasingly I believe that 24 hour, on site availability of a broadly-based and skilled general surgeon is crucial. He becomes the key man in the operative management of the trauma victim, even though other subspecialties are called into play as well. If these factors are combined with a fee for service system, then I believe the system would work quite well.

Third, there must be a source of patients. Portland is in the throes of setting up a central access, central dispatch and medical advice system for pre-hospital care, and a regional trauma center would fit into this well. The key issue is designing protocols which can effectively sort

out the multiple-injured, high-risk trauma victim so that that person can receive the special care the system in trauma can provide. It does not mean that every ruptured spllen or straight-forward orthopedic case would be skimmed off to the regional trauma center. Our major hospitals are perfectly capable of taking care of those kinds of injuries, and should continue to do so.

Fourth, there must be agreement on the part of the hospitals in the region to observe the guidelines for referral of patients to the trauma center. This should probably be done with the understanding that patients transferred from an emergency department to the trauma center should be able to be returned to the original hospital once the crisis has passed. This would of course be dependent upon the wishes of the patient and the patient's family, but it seems to me it would be better to develop the best care and have the patient survive and then be transferred, than to deliver mediocre care which might risk life or limb.

Finally, the regional trauma center must provide a strong, ongoing educational system, which I believe should have four facets. First, there should be a mandatory review of all complex trauma cases. Second, a recurring interdisciplinary trauma conference should occur perhaps twice a month involving not only case reviews but new advances in the field of trauma, and should be open to all in the community who would like to attend. Third, the regional trauma center should be responsible for extending training in a circuit course manner to community hospitals in the region to help them upgrade their response to trauma and to keep channels of communication and referral open. Fourth, a research opportunity should be utilized insofar as possible to gain the maximum experience, not only for training of residents but for improvement of patient care for the future.

It appears that prior to the April meeting at Holliday Park Hospital, state EMS personnel had narrowed down the choices for a regional trauma center to the University of Oregon Hospitals and to Emanuel Hospital. These choices seem reasonable to me, in that each could, with commitment and effort, be the location of the regional trauma center, but each has advantages and disadvantages of its own.

The university has strengths in that it is traditionally devoted to teaching and research, and has the crucial role in the training of the vast majority of surgical residents in this region. It has weaknesses in that the major surgical expertise in care of trauma victims is not at the University, but out in the community hospitals at the present time. There would also have to be a major change in politics regarding fee-for-service payments for private attending physicians off the hill if such trauma system were to be set up and successful. Finally, the geographic location of the University works against it being a regional trauma center, not only because of its isolated situation off the freeway and away from the site of occurrence of most trauma in Portland. It is, moreover, occasionally inaccessible in the winter.

Emanuel Hospital is situated in what perhaps is the highest density for trauma in the metropolitan area, and has experienced surgeons on its staff — although far from a monopoly of surgeons trained and interested in trauma in this region. It's helipad is situated close to the resuscitation facilities (very much like the one in Maryland) and its Life-Flight helicopter system could be useful in transferring trauma victims in from outside the urban area. Its residency program, however, is quite shaky, although the model presently used for rotating residents from the University through the Oregon Burn Center at Emanuel could be applied to trauma as well, if Emanuel were to become the regional trauma center. So both the University and Emanuel could be possible sites, but each would have to coordinate closely with the other. I believe that to designate two centers would be redundant, inefficient and not really improve the system. So in response to the title question, I believe we do need a regional trauma center and should direct our efforts toward setting one up. Care of the trauma victim can indeed be improved, and although I do not disagree with "studying the problem", I doubt that we will learn much more than most experienced trauma surgeons already know. Good care is delivered by committed, experienced people who are trained and equipped to provide such care, who keep up with current developments and who see the requisite volumes of cases to keep sharp. In Portland, in my opinion, this means centralizing trauma care, and the way to make that equitable is to have an open medical staffing pattern on a fee for service basis.

Dr. Vander Veer is Chairman of the Multnomah County Medical Society Emergency Medical Services Committee, and of the Committee on Trauma for the Oregon State Chapter of the American College of Surgeons. He is a general and vascular surgeon in private practice, who is editor of the Oregon Trauma Newsletter.

NOTICE

FOR ALL MEMBERS OF MCMS

The 1980-81 edition of the Portland Physician Photo Roster is in production and will be ready for delivery in September. The deadline for corrections, additions or changes in the data carried in the 1979-80 Roster and/or the Roster Update which was in your January issue of Portland Physician is June 6, 1980. Because of production schedules, that is a firm and inflexible deadline. Your changes and corrections must be on hand June 6. Furthermore, if you would like to replace your Roster photograph (some of which appear to be graduation pictures taken decades ago) please submit a recent black and white head and shoulder portrait (2 × 3 glossy) and a check for $7 payable to Multnomah County Medical Society to cover the cost of replacing the photo.

Data and photographs should be mailed to:
Peggy Cloyd, Multnomah County Medical Society
2188 S.W. Park Place, Portland, Oregon 97205

P.S. Correction forms will be mailed by May 15. If you don't receive yours, call Peggy Cloyd, 222-9977.

or abusive collection tactics.

Of particular import to the foregoing discussion about the imposition of a "service charge" for the actual administrative cost of rebilling, is the limitation contained in item 5 above, that such a service charge could not be collected unless it was expressly authorized by the agreement creating the debt. This can be overcome and, if a physician intends to impose such a charge, must be overcome by the inclusion of appropriate language in the initial written fee agreement with the patient.

For the most part, physicians will not be subject to the limitations contained in the Federal Fair Debt Collection Practices Act since its application is limited solely to persons who are collecting debts owed to another. If a physician's employees are seeking to collect a debt on his behalf, they are not considered "debt collectors" for the purposes of the federal law. Nevertheless, a violation of the Oregon law by a physician's employees may result in litigation by the person injured as a result of the use of the unlawful practice to enjoin that practice or to recover actual damages or $200, whichever is greater. Additionally, the court or the jury could award punitive damages and reasonable attorney fees and costs.

If it is determined that the physician's staff is incapable of collecting on the debt, but all other factors suggest that it is a debt which should be pursued, the physician may wish to consider referring the matter to a collection service or agency. Besides the ethical aspects contained in Opinion 4.03 which caution against utilization of the services of a collection agency whose tactics and methods of collection might be unfair or abusive, a physician could also be exposed to some liability if accounts were regularly referred to an agency which the physician knew utilized unlawful tactics. It is clearly in the best interests of the physician and the public that accounts be referred to organizations such as the Doctors Official Service Bureau, Inc. or other such entity which is familiar with the limitations imposed by law and the special constraints imposed on the collection of accounts owed to physicians.

Gregory H. Baum is a member of the firm, Hermann and Smith, legal counsel for MCMS. He received his B.S. in civil engineering from Cornell University and his J.D. from Lewis and Clark College.

Physicians and Surgeons

For example, emergency room visits, in which all patient treatment is handled in the ER and the patient will be gone in one to four hours, receive the most simplified admissions handling.

If there is an unforeseen problem that requires further treatment, the patient can go on to other care and the paperwork simply shifts to another mode: the Short Stay Mode.

Short Stay patients are in the hospital from three to 48 hours. Because these patients are placed in a hospital room, more paperwork is required. There is an expanded medical chart, but it is simplified—pertinent data is condensed as much as possible.

If there is a problem in treatment that requires a longer stay, the patient simply stays in his room and the paperwork is shifted to the Inpatient Mode.

Inpatients receive the most thorough and detailed paperwork. Milburn estimates that there is a ten-fold increase in the cost of paperwork from emergency room to inpatient modes.

Physicians and Surgeons plans to continue offering quality primary and secondary care facilities while maintaining that elusive quality that makes patients, physicians and staff feel comfortable and safe there.

calendar

May 1, 8, 15, 22, 29
1980 Internal Medicine Review Sessions for 1980 Certifying Exam in Internal Medicine, sponsored by Providence Medical Center. May 1—Gastroenterology, Bruce Borthistle, M.D.; May 8—Liver Disease, Emmette Keeffe, M.D.; May 15—Immunology, Robert Bennett, M.D.; May 22—Allergy, Emil Bardana, M.D.; May 29—Dermatology, Douglas Key, M.D. Amphitheater, Providence Hall, 6:00 p.m. Coffee and light dessert available.

May 14
Hematology/Oncology Symposium, "Hematology Update: Diagnosis and Treatment of Red Cell Diseases," sponsored by Providence Medical Center. The Benson Hotel, 8:00 a.m.-4:00 p.m.

May 15
Woodland Park Hospital Annual Family Practice Symposium, 7:30 a.m. to 4:30 p.m. Details? Woodland Park Hospital, 234-5353.

May 16-18
Second Annual National Symposium on Sexuality and Disability, sponsored by University of California, San Francisco, Continuing Education Health Sciences. Claremont Resort Hotel, Oakland, CA. Details? UC, San Francisco, CEHS, 1308 Third Avenue, San Francisco, CA 94143 or call (415) 666-2894.

May 21
Providence Medical Center Grand Rounds, "Obesity Surgery," Randall D. Gore, M.D. and Bennett E. Uhlig, M.D. 8:00 a.m., Amphitheater, Providence Hall.

May 28
Providence Medical Center Grand Rounds, "Research at Providence," Carl H. Lawyer, M.D., Gordon L. Maurice, M.D., David H. Regan, M.D. and Mark O. Loveless, M.D.

June 4, 11, 18, 25
Contemporary Issues in Medicine, sponsored by the Providence Medical Center, June Medical Grand Rounds. June 4—Ransom Arthur, M.D., Dean, School of Medicine, UOHSC, "Problems in Medical Education Today"; June 11—Rabbi Emanuel Rose, Temple Beth Israel, "The Non-Medical Role of the Physician"; June 18—Ralph Crawshaw, M.D., "Caution, Conservatism and Paranoia—Contemporary Physician Attitudes?"; June 25—Mark O. Haggard, Professor of Political Science, PSU, "The Physician in a Changing Society." This program is acceptable for one prescribed hour of credit for each session by the AAFP and one hour of continuing medical education credit by the OMA. All conferences will be held at the Amphitheater in Providence Hall beginning promptly at 8:00 a.m. Details? Providence Medical Center, 234-8211, David N. Gilbert, M.D.

June 5-6
Legal and Ethical Aspects of Treatment for the Critically and Terminally Ill Patient, sponsored by the American Society of Law and Medicine, at the Radisson South Hotel, Minneapolis, Minnesota. Details? A. Edward Doudera, (617) 262-4490 or write 520 Commonwealth Avenue, Suite 211, Boston, MA 02215.

June 13-15
AMA Regional Education Meeting, San Francisco, Hyatt on Union Square. Courses include: Pulmonary Function and Blood Gasses, Male and Female Sexual Dysfunction, Practice Management, Infectious Disease and Antibiotics, Cardia Arhythmias, Controversy in the Management of Gallstones, Diabetes and its Sequelae, Prevention of Occupational Injury and Disease, Allergy and Immunology Update, Mass Media-Speaker Training, Office Dermatology, Cutaneous Surgery, Gynecologic Endocrinology, Refresher Course of Clinical Neurology, and Controversy in Treatment of Atherosclerosis. Details? AMA Department of Meeting Services, 535 N. Dearborn St., Chicago, IL 60610 or call (312) 751-6503.

June 16-17
National Journal—The Weekly on Politics and Government sponsoring their Fifth Annual National Leadership Conference on Health Policy at the Hyatt Regency Hotel, Washington, D.C. Details? Barbara Norris, 202/857-1400 or write National Journal, 1730 M St., N.W., Washington, D.C. 20036.

June 17-20
American College of Physicians Review Course, Thunderbird at Jantzen Beach. Details? Division of CME, UOHSC, 3181 S.W. Sam Jackson Park Road, Portland, 97201 or call 225-8700.

June 17-July 23
Center for Public Health Studies, PSU sponsoring two summer session courses: Hospital Epidemiology and Occupational Health, three credits each. Details? Katherine H. Chavigny, P.O. Box 751, Portland, OR 97207 or 229-3473 or 229-3821.

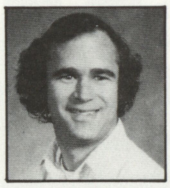
June 22-25
Child Welfare League of America sponsors Northwest Regional Conference, "Children and Families—Emerging Perspectives," Hotel Saskatchewan, Regina, Saskatchewan, Canada. Details? P.O. Box 875, Regina, Sask., Canada S4P 3B1.

June 22-27
Developing a Hospice Care Team, sponsored by Oregon Comprehensive Cancer Program and conducted by Hospice of Marin Team Members. Lewis and Clark College, $475 tuition including room, board and printed material. Details? OCCP, Gaines Hall, 3181 S.W. Sam Jackson Park Road, Portland.

June 25-27
Symposium on Sports Medicine, in conjunction with U.S. Olympic Trials, University of Oregon, Eugene. Details? Division of CME, UOHSC, 3181 S.W. Sam Jackson Park Road, Portland, 97201 or call 225-8700.

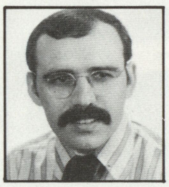
new members

ACTIVE MEMBERSHIP



PRISLIN, Michael D. Jill
FP Georgetown '76
3181 SW Sam Jackson Pk Rd
97201 225-8573
9232 SW 44th 246-7567
97219

Sponsors: Doctors Laurel G. Case and William Fisher



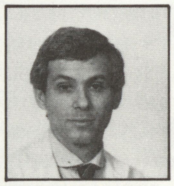
FELDMAN, Peter M. Donna
S* Louvain '71
5055 N Greeley 285-9321
97217
12035 SW Lanewood
97225 641-1937

Sponsors: Doctors John D. Johnson and Paul Trautman

ASSOCIATE MEMBERSHIP

FISHER, Peter B.
I-NEPH (Fellow) · State U, NY '76
3181 SW Sam Jackson Pk Rd
97201 225-8490
1803 NE Ainsworth 288-9787
97211

Sponsors: Doctors Thomas A. Golper and Marsha Wolfson



LAWRENCE, Stuart A.
Lorene
PD Colorado '72
6475 SW Borland Rd 638-9626
Tualatin 97062
1620 SW Englewood Ct
Lake Oswego 97034 246-0748

Sponsors: Doctors Clarice Nordlum and James A. Enden

AFFILIATE MEMBERSHIP

HALFERTY, Daniel A.
OR Oregon '45
901 SW King Ave #516
97205 227-5286

Sponsors: Doctors John F. Abele and F. A. Short

KNOPF, Gregory M. Bonnie
FP Oregon '76
7656 SE Division 774-8827
97206
Rt 3 Box 392A 665-8509
Troutdale 97060

Sponsors: Doctors William M. Ross and David R. Blessing

POTTER, Bryce E. C. Jane
OTO*&MFS Washington '75
833 SW 11th #1020 242-6284
97205
17421 SW Blue Heron Rd
Lake Oswego 97034

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SCALONE, Howard A.
Josephine
ANES* Phil Coll Osteo Med '58
2900 SE Steele 234-0411
97202

Sponsors: Doctors Robert E. Butler and Burnham Brooke

SMITH, Mary Anne DeWitt
Frederic
P Cornell '59
2035 SW 58th 292-4359
97221
5110 SW Hewett Blvd
97221 292-8420

Dr. Smith is transferring from Junior to Active membership.

Historical Society Opens Research Center The Oregon Historical Society has an extensive research library which contains large and expanding collections of manuscripts, maps, historic photos, microfilms, old movie film, television news and documentary film, oral history interviews, and many kinds of rich, colorful and useful ephmera, including posters, architectural drawings, broadsides, sketches, promotional brochures and pamphlets. If you are working on a project, article or paper where historical information might help, contact Louis Flannery, Chief Librarian, 222-1741.

Portland Metro Health Moves Portland Metro Health offices have moved offices in West Slope. New address is: 8840 S.W. Canyon Rd., Portland 97225. Phone numbers are still the same.

Health Confab Set for May 29 The Portland Chamber of Commerce is sponsoring a one-day meeting, Business Conference on Health Costs, to be held at the Portland Center Red Lion Inn. Guest speakers include Walter McClure, Ph.D., and Gerald Gleeson. The question to be answered is, "What role does the business community have in health care cost containment?" A panel discussion will also take place, with Charles Jennings of Healthworks, Inc., Henry Swigert of ESCO Corp., Sam Naito of Norcrest China Company, and Nellie Fox of the AFL-CIO. For further information, contact Kelly Wellington, 228-9411.

MCMS President Makes National Press The inaugural address made by MCMS President Guy Parvaresh, M.D., was recently published in the national publication "Medical World News." Doctor Parvaresh's comments dealt with the role of medical societies as an intermediary between consumers/patients and physicians. If you are interested in a copy of these comments, contact MCMS at 222-9977.

Spring Mini-Internship The Spring Mini-Internship was just completed by seven lay people and one physician. Robert Dernedde, Executive Director, OMA; Suzanne Gilkey, OPS-Blue Shield; Eugene Douthit, Principal, Washington-Monroe High School; Bill Weber, Tektronix; Genevieve Jernstedt, lay representative to the Board of Medical Examiners; Frank Campion, AMA; Doctor James Walker, Lane County Medical Society; and Mickey Duke, Executive Director, Lane County Medical Society, all participated. MCMS physicians who served as sponsors included doctors Thomas Reardon, James Baldwin, James Baker, Gary Rothenberger, John Tarnasky, James W. Asaph, Richard Rogers, Bennett Uhlig, Douglas Walta, Merritt Linn, Ernest Price and Michael Hovett. The Mini-Internship program runs for two days, three times a year, and is coordinated by William Zieverink, M.D., and Ralph S. Crawshaw, M.D.

Component Health Planning The local HSA, Northwest Oregon Health Systems (NOHS), has a futures committee which has the responsibility of looking into the activities of NOHS and will shortly be making recommendations to the agency's Board of Directors. MCMS Component Health Planning Committee is watching this action as well as NOHS's Appropriateness Review of institutional health "services" as directed by the federal government. The criterion used in evaluating appropriateness has been developed by HEW. The first service set for review is radiation therapy.

Orientation for New Members The next orientation meeting for new members is set for late summer. During the past year orientation has taken on a new look. New members are greeted by members of the Executive Committee and staff, and spend several hours over dinner learning about MCMS business and professional services, community relations and approved ethical practices.

Emergency Medical Services/Disaster Medical Care These two committees recently met jointly and as a result have recommended to the Executive Committee that their duties and responsibilities be combined into one joint committee. Other actions included an informational exchange regarding the designation of a regional trauma center in the Portland area. An ad hoc committee of the Northwest Oregon Council of Hospitals (NOCH) has been created to determine appropriate criteria and standards for trauma care, oversee inventory and validation process. The State EMS office has reported that it will **not** designate a trauma center. The committee has volunteered assistance to the Ad Hoc Committee in the form of auditing records to determine retrospective study of trauma care in this community. The volunteers are doctors Ben Bachulis, Daniel Lowe, David Noall, Fernando Leon and Joseph Vander Veer.

Tel-Med Advisory Since adding the Tel-Med Tape listing to the Portland area Yellow Pages, callership has risen from approximately 7,000 per month to over 12,000 in April. The Committee is currently working on scripts for bladder and kidney infections, depression, diarrhea, poison oak and myasthenia gravis.

in summary

Public Relations & Public Policy Commission PR & PP is getting ready for Media Night, scheduled for June 4. The Commission is also looking into a good health/preventive medicine program for large employers. They recently revised the medical costs brochure, which will be available to members by mid-June.

School Health During the past year, members of the School Health Committee have been writing a monthly newsletter for primary school teachers in Portland School District. Called **good health,** the newsletter provides health tips, information on the Speakers' Bureau and Tel-Med, suggested television programs, and local health presentations. Subjects covered in the past year include nutrition, safety tips for skateboarding, how the heart works, colds and influenza, alcohol and drugs.

Judicial & Business Commission During the fall and winter, the Judicial & Business Commission worked with MCMS Legal Counsel to revise our current by-laws. Recommended changes will be published in the July-August issue of **Portland Physician**, and a vote will be taken at the September 1980 meeting of the Board of Trustees set for Wednesday, September 17.

multnomah county medical society calendar

May 21	Board of Trustees Meeting, 6 p.m. social, 6:45 p.m. dinner
May 22	Regional Blood Center Committee, 6 p.m. social, 6:30 p.m. dinner
May 25	American Cancer Society — Oregon Historical Tour 12 p.m. & 3 p.m.
May 28	Public Health Committee, 12:15 p.m. lunch
June 4	Media Night, OMA, 6:15 p.m. social, 7:15 p.m. dinner
June 9	Grievance Committee, 6 p.m. social, 6:45 p.m. dinner

classifieds

OFFICE SPACE

SUBLEASE 600 INEXPENSIVE, NEWLY DECORATED SQ. FT. in NW Portland. Some furnishings available. Call 221-1784 or 244-0268.

MEDICAL OFFICE SPACE FOR LEASE. 800-1700 square feet. New Medical-Dental Building, S.E. 139th and Stark. For information call: 252-5565 or 254-5535.

AVAILABLE NOW! Doctor's office suite in well-established northeast medical-dental building within 10 minutes of three hospitals. 900 sq. ft., a/c. Heat and cold water furnished. $490/month, renewable two-year lease. Byron Shields, 256-4292 or 228-6495.

MEDICAL OFFICE SPACE NEAR PROVIDENCE MEDICAL CENTER. Physicians interested in office space near Providence Medical Center can call the Medical Staff Office at 234-8211, ext. 217 for information.

LAKE GROVE AREA. Office space available in new brick/cedar bldg. Parking, excellent access. Available late 1980. 635-7773.

NE OR NW OFFICES

NE 28th & Everett. 2800 sq. ft., X-ray, lab & surgery. Beautiful decor. Up to 4 physicians.

NE 2nd & Holladay. Custom design your suite in this beautiful new office building next to HPH. Close to Lloyd Center and Downtown. Up to 6,000 sq. ft. Practice can be adapted to individual or large group.

NW 19th & Johnson. Good Sam or P & S a short walk from this recently remodeled quality location with suites from 700 sq. ft. to 1700 sq. ft. Best rates in town.

Great parking & public transportation to all of these locations. Call 222-7000, Hale Associates Realty, LTD.

MEDICAL SPACE NEAR PORTLAND ADVENTIST MEDICAL CENTER. Two 1,000 sq. ft. suites in new office complex, Plaza 125 at 127th & Stark. Ample parking, on bus route, security system. Professionally designed for medical practice. Call Mr. Lundy at 257-2592.

NEWBERG, OREGON-OFFICE SUITE for OB/GYN-1250 sq feet adjacent to Community Hospital. Private Office plus 3 exams rooms. Available May, 1980. Contact Dr. Tom Gail M.D., 1314 E. Sherman, Newberg, Oregon 97132. Phone 538-2145.

ARGAY CLINIC 3620 NE 122nd Ave. Approx. 1000 sq/ft, custom designed, ground level. 3 exam rms, consultation rm, attractive receptionist's office, lounge w/stove & refrigerator. Excellent location near freeways and hospitals. ULTRA REASONABLE. Donald Ogard, 254-0573, 243-9106.

NOW LEASING Gresham Office Space. 500 sq/ft and up. Located across from Gresham Community Hospital. Will finish interior as desired. New, 3-level brick building. Call Gresham Professional Group. 254-2594 or 636-6149.

BUY YOUR OWN OFFICE SPACE in a beautiful new quality office building next to Holladay Park Hospital. Terrific location & parking. Owners will share attractive terms, tax benefits and management. Call Bill Hale or Carl Long, 222-7000, Hale Associates Realty, LTD.

NEW EASTSIDE OFFICE SPACE AND PERSONNEL to share with two dermatologists. 255-9626.

MARSHALL STREET DOCTORS BLDG. 1104 & 1750 sq/ft available Aug. 1, adj. space can be combined. Faces lovely garden courtyard. $9 per sq/ft, services and utl. incl. Call 227-4911.

MEDICAL CLINIC AVAILABLE. 2400 sq. ft. in southeast Portland. Brick exterior, six exam rooms, x-ray and lab. Two offices, parking, 284-5276, 287-5207.

VACATION

MONTEREY/CARMEL LUXURY CONDO 2 brm, 2 bth. 244-9937/246-0006.

RIVER TRIPS. Oregon River Experiences: Specialists in small group "row your own" raft trips. Salmon, Rogue, Owyhee, Deschutes. Free brochure, 1935 Hayes, Eugene, 97405. 342-3293.

SUN VALLEY HOUSE. 3 bdrm, 2 baths, lg. deck, sleeps 8. In Elkhorn, fully furnished. From $750/wk up winter rate. 244-0244.

SUNRIVER HOUSE. Sleeps 6. $50 day-$300 wk, close to Mall. 256-1717 or 252-4864.

BLACK BUTTE RANCH. Superbly furnished, 3 bdrm, 2 bth home. Views, Jacuzzi, JennAire, Microwave and more. Booking now for Summer. $75/nite. 243-1173/day, 638-5056/nite.

SUNRIVER HOME. 2 bdrm, 2 bunkrms, 2 bth, 288-1848.

BLACK BUTTE GOLF COURSE CONDO 3 bedroom, 2 baths, fully equipped. $75.00 per night plus cleaning. Weekly rates. Phone: 665-3994 or 595-6928.

HOUSE SITTER AVAILABLE. Excellent references. 222-3326 or 223-3684.

SEASIDE HOME on beachfront. Sleeps 8. Rent: Week—$425, Weekend—$135. 628-2509.

SUNRIVER HOME, sleeps 8, additional space for 4 unheated, $60 nite, 246-7507.

SUNRIVER — Beautiful 3 bdrm home; view of Mt. Bachelor; fully furnished, sleeps 8; $65/nite. 287-0655 or 238-0992.

JOHN ADAIR WHITEWATER RAFTING. Professional Guides. Fine Food. Great Fun. 1425 SE Flavel, Portland. 236-5148.

KAUAI, POIPU SHORES. 2bdrm/2bth condo, fully equipped. On a tall surf-splashed bluff at the end of beautiful Poipu Beach. Pool. $90/nite. (503) 292-2363 or (503) 222-4441.

BRIGHTWOOD MOUNTAIN HOUSE. Luxurious weekend ski and summer vacation home for rent. Two bedroom, two bath, two fireplaces. $50 per night. Sleeps 8. Call Jim Buell at 222-6406 or 635-6495.

SUNRIVER RANCH CABIN. 3 bdrm, 2 bth, fam rm, frplc, JennAire, complt furnished. Near pool and tennis ct. $420/wk, summer rates. 224-3336.

SALISHAN CONDO. 2 bdrm, 2 bth, elegant. Frplc, kit. $70/nite. 2 adj. units ideal for 4-couple mini-vacation. 223-0125.

REAL ESTATE

PARRETT MT. VIEW PROPERTY. Magnificent 4600 sq. ft. dalite ranch on 10 parklike acres. 5-6 bdrms, 3½ bth, den, sew. rm., 3 fplc; 20x40 inground pool, bath house; lge metal barn for sheep & horses. Too much to list. A MUST SEE! $295,000. For an appointment call Marie Breed 357-7545 eve, or 640-4751. E.G. STASSENS, INC., REALTORS.

ESTATE SITE. 73 gently sloping spectacular view acres north of McMinnville, city water, electricity, telephone, roads, year round stream, approved lake site, suitable for grapes and nuts. Private road thru property. Absentee owner will carry contract. Call Robert McNulty, Tamarack Realty. 224-8214.

FOR SALE: HOUSE TO REMODEL FOR OFFICE in East Vancouver near St. Joseph Hospital plus 1/2 adjacent lot for parking. Please call for details? Marie or John Morasch, DDS. (206) 693-2551 or (206) 834-5976.

WORK WANTED

BOOKKEEPING, BILLING, COLLECTIONS. Office Procedures Consultant, References. Sandra Standley, 1220 S.W. Morrison, #515, Portland, OR 97205. Ph: 223-3023.

ACCOUNTING FOR PROFESSIONALS. Reduce overhead and increase internal control. Monthly summaries, payroll reports, etc. Let my 15 years' experience minimize your accounting dollars. Call Lonna Chenoweth, 223-9439.

U.C. DAVIS MASTER'S-PREPARED FAMILY NURSE PRACTITIONER looking for position in internal medicine or family practice office. Two years independent experience. CV available, write 2188 S.W. Park Place, Portland, 97205, 222-3326.

PEDIATRICIAN AVAILABLE AUG. 1980. Will consider part/full time, locum tenens, etc. M.F. Rogers, M.D., LBJ Med Center, Pago Pago, American Samoa 96799

BOARD ELIGIBLE INTERNIST SEEKING LOCUM TENENS in Internal Medicine or Family Practice, July and/or August 1980. References and CV available on request. Harold Frolich, M.D., (B)280-3200, (H)282-6336.

PRACTICE OPPORTUNITY

PEDIATRICIAN LEAVING FOR ONE YEAR. Sub-specialty training. Looking for potential associate to take over practice. Minimal investment required. Call 357-4886.

OPENING FAM PRAC GRP HILLSBORO early 81. Salary $1,500 mo. starting. Contact Dr. Schludermann, 660 E. Baseline, Hillsboro 97123.

WANTED: A LOCUM FOR PART OF JUNE AND JULY to work in the Family Practice at Rockcreek. Please contact Dr. Euan Horniman. (H) 241-9777, (O) 645-4332.

EQUIPMENT

WANTED: USED MEDICAL EQUIPMENT, less than 10 yrs. old, to outfit for exam rooms. Please call 665-5105, Dr. Ernie Talley.

OLIVETTI POSTING MACHINE. Assume Lease. Terms negotiable, optional purchase. 222-9401.

WANTED: PORTABLE X-RAY MACHINE. Prefer Proflex. Also need 8x10 cassettes. John Metcalf, DVM, 635-2156.

STAND-UP CONTINENTAL SCALE for physician's office, mint condition, $130. Underwood 288 Adding machine, $50. 227-2832.

1975 MODEL MINOLTA ELECTROGRAPHIC 101 OFFICE COPIER. Good condition. $750. Call 224-6966.

WANTED: BOOKS AND JOURNALS DEALING WITH PSYCHOANALYTIC SUBJECTS. Oregon Psychoanalytic Foundation, 297-4858.

RENTAL

FOR RENT: Furnished 4 bdrm, 3 bth, waterfront home on Lake Oswego. Dr. going on 1 yr. sabbatical beginning July 1, 1980. Desires reliable tenant. 635-3267.

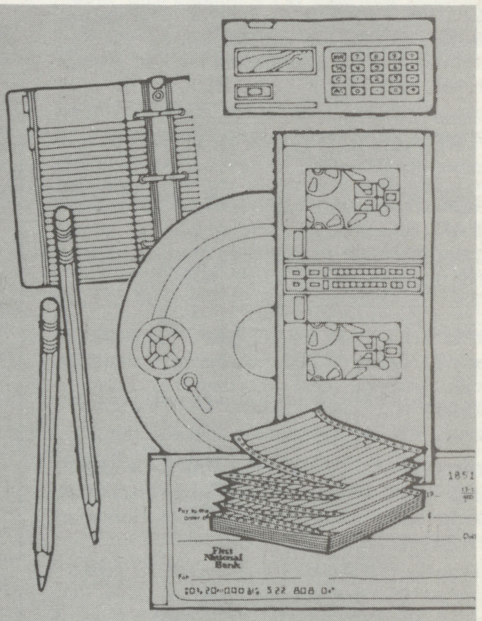
MISCELLANEOUS

OFFERING BOOKS, PRINTS, & ITEMS RELATED TO WAR YEARS 1939-1945. Located in Books & Prints, 12680 SW Farmington, Beaverton.

Insurance Claims — Are they costing you too much to process?

Consider the alternative of a properly designed and properly utilized office charge slip form to save you time and money.

- **It can reduce physician involvement in purely clerical work.**
- **It serves your own internal accounting system needs and is compatible with all other bookkeeping systems.**
- **It meets the needs of the patient and his insurance company.**
- **It often eliminates the expense of an outside billing service or the investment in computer facilities.**




Insurance Claims:

Save Time

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