portland physician

october 80

malpractice: loss prevention?

portland physician

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volume 35, number 10

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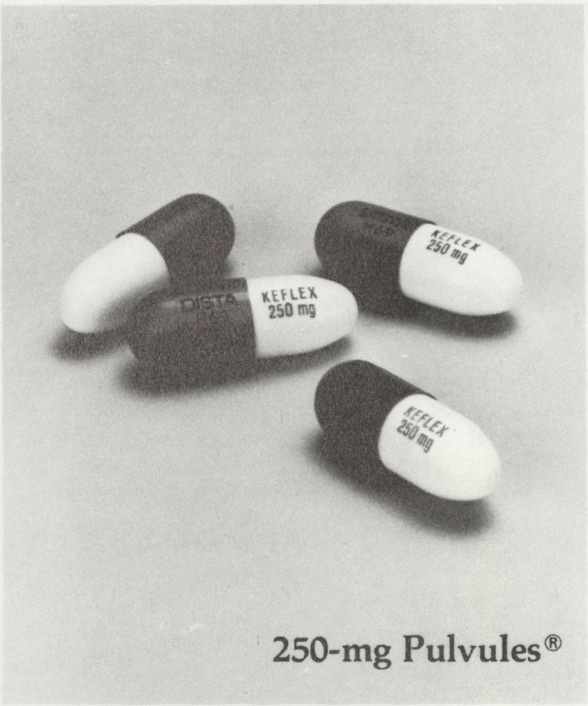

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in summary

t McPherson, MCMS staff member, who has assisted in he Photo Roster during the past few months. Beth has written In- as well as providing design and layout assistance on the Roster.

available at Multnomah County Medical Society offices. The xplain some of the reasons for increased costs in medical care to keep their personal medical costs down. For further

Professor of Cardiology and Director of Research and Training. the performance of research and supervision of the cardiology assignments. Contact Frank Kloster, M.D., Head of Cardiology,

norial Visiting Professorship in Pediatric Cardiology at rsity Hospital, Jerusalem, Israel, is this year's special guest sday, October 16, at 8:00 a.m., and present a lecture at 4:00 C University Relations, 225-8232.

film which reflects the dismay, confusion, pain and search for one of their members has committed suicide. The film will be ctober 18th. At the Mason Clinic in Seattle, it is shown once a e people to talk about their fears, stress, and views of death. The ws Eulogy as a means of getting both terminal patients and r situation. The movie will be shown at 1:00 p.m. at the Movie 0.

Volunteer nurses and non-nurses are needed to work in the Volunteer R.N. Program in Multnomah County Schools. If you can help with health screenings or serve one day a week as a school nurse, please contact Marion Waterman, R.N., 777-7436.

State Board of Medical Examiners statement regarding physician's practices of prescribing controlled drugs for themselves or their immediate families is as follows:

"When a physician becomes licensed in Oregon, and has applied for anb been granted a Drug Enforcement Administration number covering certain schedules of controlled substances, he has a **legal** right to prescribe, administer or dispense such substances to patients, himself or his family."

"However, a word of caution must be inserted at this point. Self prescribing, particularly of scheduled drugs, is not a safe or prudent practice and is discouraged by this Board. This applies particularly to instances requiring prolonged use of, or need for, such medications. Investigative files reflect a number of physicians whose judgemental errors in self prescribing have brought them to the attention of the Board."

"If a physician or a member of his family becomes ill, he should do what he tells his patients to do — "see your family doctor" — and let him do the prescribing. It may save the physician from an extremely traumatic experience before his peers, within his family or before the Board of Medical Examiners."

The Multnomah County Medical Society is once again conducting a Tri-County Salary Survey. This survey will ask for information regarding salary ranges, employee benefits, and yearly cost of living increases. Please help us give valid, accurate information by completing and returning the salary survey to the Multnomah County Medical Society Placement Service. If you have any questions, please call Tammi at 222-9977.

Changing Home Behaviors: A Program for Parents, is a four part videotape series being distributed by Good Samaritan Hospital Medical Center. The four part program discusses childhood behavior management techniques for use by parents, childcare workers and educators. For further information about rental, phone David Riker (503) 223-5335.

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in summary

Editor's Note: A special thanks to Beth Scott McPherson, MCMS staff member, who has assisted in publication of both Portland Physician and the Photo Roster during the past few months. Beth has written In-Summary and a special article in this issue, as well as providing design and layout assistance on the Roster.

Cost of Medical Care Brochures are now available at Multnomah County Medical Society offices. The brochures are helpful to you because they explain some of the reasons for increased costs in medical care and also ways in which your patient can help to keep their personal medical costs down. For further information call Cathy at 222-9977.

UOHSC is seeking an Associate Professor/Professor of Cardiology and Director of Research and Training. The full time position will include directing the performance of research and supervision of the cardiology training program as well as general clinical assignments. Contact Frank Kloster, M.D., Head of Cardiology, UOHSC. 225-8311, ext. 8750.

Don't Miss the Fifth Annual Cazden Memorial Visiting Professorship in Pediatric Cardiology at UOHSC. Dr. Simon Godfrey, Jadassah University Hospital, Jerusalem, Israel, is this year's special guest speaker. He will make grand rounds on Thursday, October 16, at 8:00 a.m., and present a lecture at 4:00 p.m. For further information, contact UOHSC University Relations, 225-8232.

Eulogy is a quietly eloquent and thoughtful film which reflects the dismay, confusion, pain and search for quiet conscience that besets a family when one of their members has committed suicide. The film will be shown by the Northwest Media Project on October 18th. At the Mason Clinic in Seattle, it is shown once a month as part of their program to encourage people to talk about their fears, stress, and views of death. The UCLA Medicine and Society Forum also shows Eulogy as a means of getting both terminal patients and recently bereaved families to talk about their situation. The movie will be shown at 1:00 p.m. at the Movie House, 1220 S.W. Taylor. Admission is $1.50.

Volunteer nurses and non-nurses are needed to work in the Volunteer R.N. Program in Multnomah County Schools. If you can help with health screenings or serve one day a week as a school nurse, please contact Marion Waterman, R.N., 777-7436.

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in summary

Names in the News

The UOHSC has announced the appointment of Don Girard, M.D. as the head of the General Medicine division as of July 1, 1980. Dr. Girard replaces Curtis Holzgang, M.D.

Stephen R. Jones, M.D. has become the first occupant of the newly created Good Samaritan Distinguished Chair of Medicine. Dr. Jones will also remain on the staff of the Health Sciences center as an Associate Professor of Medicine.

John R. Campbell, M.D., Chief of Pediatric Surgery at UOHSC was recently named President-elect for 1982, of the Oregon Chapter of the American College of Surgeons.

Robert B. Ironside, M.D., a Portland internist, has been named Medical Director of the Portland Releigh Hills Treatment Center. Dr. Ironside replaces Marvin Weinstein, M.D. who resigned to become medical director of the 15 Releigh Hills hospitals in the West and Mid-West.

multnomah county medical society

October 27 . . . . . Medical Review Committee, 6 p.m. social, 6:30 p.m. dinner
October 28 . . . . . REgional Blood Center Committee, 6 p.m. social, 6:30 p.m. dinner
October 29 . . . . . School Health Committee, 6:30 p.m. social, 7 p.m. dinner
November 6 . . . . Jail Health Committee, 6 p.m. social, 6:30 p.m. dinner
November 9 . . . . Mini-Internship Orientation Dinner, 6 p.m. social, 6:30 p.m. dinner
November 10 . . . Grievance Committee, 6 p.m. social, 6:30 p.m. dinner
November 11 . . . Mini-Internship Debriefing Dinner, 6 p.m. social, 6:30 p.m. dinner
November 12 . . . Executive Committee, 6 p.m. social, 6:45 p.m. dinner
November 13 . . . Sports Medicine Committee, 6:15 p.m. social, 6:45 p.m. dinner
November 14 . . . Legislators Night, 6 p.m. to 8 p.m. — social
November 18 . . . Orientation Dinner, 6 p.m. social, 7 p.m. dinner
November 20 . . . Tel-Med Advisory Committee, 6 p.m. social, 6:30 p.m. dinner
November 25 . . . Regional Blood Center Committee, 6 p.m. social, 6:30 p.m. dinner
November 26 . . . Committee and Commission Chairman Meeting, 6 p.m. social, 6:30 p.m. dinner
December 8 . . . . Grievance Committee, 6 p.m. social, 6:30 p.m. dinner

Remind your children (ages 6-18) that the Auxiliary card contest continues until November 15. We need an original design depicting the "Holiday Season," Entires must be submitted on white paper, using black felt tip pens **ONLY.** Each applicant is asked to include name, address, telephone and grade info. on a separate sheet of paper and mail entries, **unfolded,** to Ilene Hays, 2738 S.E. Patton Ct., Portland, OR 97201. If you clip and mail the coupon below by November 28, together with your check (tax deductible) you will accomplish the following: 1) Extending your personal group holiday greetings with you name appearing on a special insert list; 2) Providing money for the education and research funds at the medical school of your choice.

Enclosed is my AMA/ERF contribution:
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( ) $ 25
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( ) Medical Schools (all)
( ) _____ Medical School

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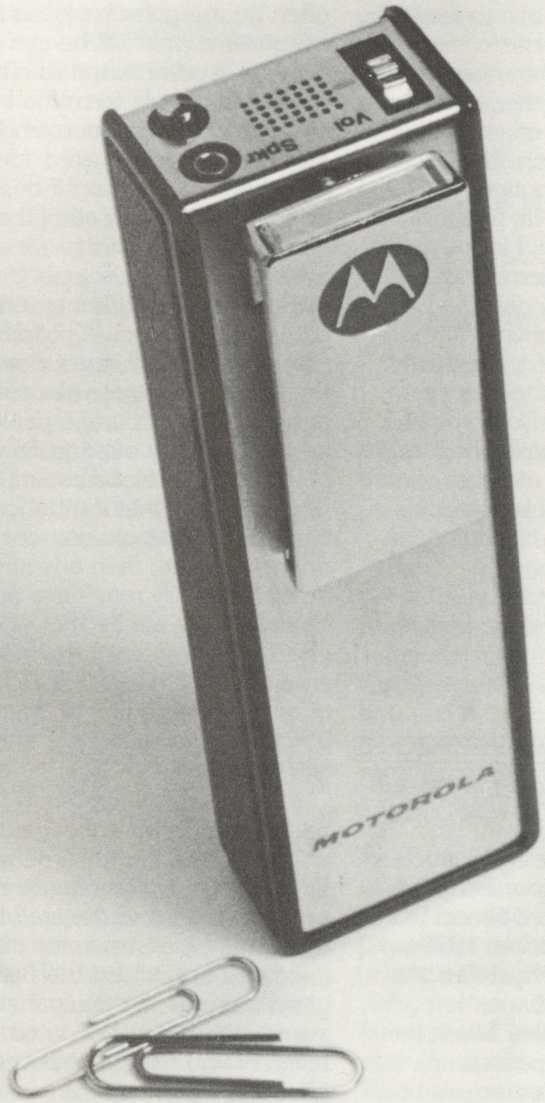

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in my opinion

praises for the answering service

The following letter was sent to Jack E. Battalia, M.D., President of the Physicians' Answering Service and is being reprinted with permission of Dr. Jewett.

Dear Dr. Battalia:

Just a short note to reconfirm and document our conversation regarding physicians' answering service of the Multnomah County Medical Society.

Prior to my move to Portland, I have utilized several answering services and have found the personnel here to be absolutely outstanding. Regardless of the hour of the day or night, regardless of the incessant demands often placed upon them, each and every operator has always been extremely courteous and efficient in the performance of his or her duties. I can only say that they are doing an excellent job and wish to recognize this by means of this letter.

Stiles T. Jewett, Jr., M.D.

physician aid for women's shelter urged

To the Editor:

I am writing to all Multnomah County physicians to urge you to consider becoming a Sustaining Member of Bradley Angle House, a shelter for battered women and their children.

As physicians, we have all seen the terrible emotional and physical damage which domestic violence reeks on its victims. Repeated assaults produce serious physical injuries. Perhaps more tragic, are the emotional wounds suffered by children who witness the physical and mental abuse of their mothers.

Since 1975, Bradley-Angle House has provided a safe, supportive environment for women and their children who seek to escape from violent living situations and mend their torn lives. Bradley-Angle House provides emergency shelter, access to legal and medical services, and counseling to enable women to begin new lives.

As physicians, we are all concerned with prevention of injury and disease, as well as treatment. It is clear to me that the Bradley-Angle House offers us all an opportunity to help prevent domestic violence in our community. Through provision of emergency shelter and counseling services to assist women in coping with the financial and emotional burdens of rearing their children without an abusive spouse, Bradley-Angle House opens to victims the option to leave the battering situation. The existence of that option is perhaps the most effective deterrent to further abuse.

Bradley-Angle House acquires a portion of its funding from United Way, but must rely on contributions from the community for most of its financial support. For this reason, I invite you to become a Sustaining Member of the Bradley-Angle House by giving a contribution. As a Sustaining Member you will receive a quarterly newsletter and learn of new efforts to reduce domestic violence in our community. While Bradley-Angle House encourages contributions of $50 or more, a donation of any size will be greatly appreciated. All contributions are tax deductible.

Thank you very much for your consideration of this request. I hope that you will help.

Laurie Moore, M.D.

blood recruitment concerns raised

To the Editor:

I have read with interest the article in your journal by Dr. Peetoom entitled "A Return to Patient Oriented Blood Donor Recruitment" in the October 1979 issue of the **Portland Physician**. As the Medical Director of Lane Memorial Blood Bank, the only other blook bank supplying the needs of patients in Oregon, I would like to comment upon the difference in recruitment philosophy to which Dr. Peetoom refers. As Dr. Peetoom has indicated, the philosophy to which the American Red Cross Blood Services subscribes is that of Community Responsibility, individual identity of patient needs and responsibilities is not acknowledged, and the community as a whole is held responsible for the needs of the patients in the community.

It is the philosophy of Lane Memorial Blood Bank and of other similar community banks, that donor recruitment is a multi-faceted problem and that no arbitrary philosophic approach should be relied upon to meet the needs of patients for blood and blood components. For this reason, it is felt that a combined approach to the community and to the individual is most effective.

There are fortunately very many public-spirited citizens in the community who will donate blood, often on a regular basis, so that an adequate supply will be available for patients in local hospitals. These well-motivated people form the basis of any blood donor population, and their value cannot be overestimated. Ideally, it would be encouraging if this type of donor could supply all of the needs of the community. This is not easily accomplished however, and we recognize the fact that an additional personal stimulus will provide a considerable number of donors who might otherwise not volunteer. For this purpose, we encourage personal responsibility by offering an insurance program or a "blood assurance plan" which assures that if a donor has contributed a single unit of blood during the year, then any needs which he or his family may have during that calendar year will be met at decreased cost. At the present time this decrease amounts to $15 per unit of blood out of a total charge of $40. In this way donation prior to need is encouraged and rewarded.

In addition, we approach the family and friends of patients who have utilized blood, in the same fashion that Dr. Peetoom is planning to do. They are encouraged to donate blood so that it will be available for others in need and in addition the patient is given a retroactive discount of $15 for every unit of blood donated. Thus relatives and friends of patients who have need of blood transfusions are offered the opportunity to help the patient in a material way. The blood bank benefits by the addition of needed blood and by the recruitment of new donors who, finding that the donation process is relatively simple and uneventful, often become regular donors to our program.

A third method of recruitment is a combination of the community responsibility and individual responsibility philosophies. In this method individuals belonging to an organization or working for a company form a blood donor club. Donations from members of these groups are made in the name of the club, and should any member of the group need blood, credits are drawn from the program to assist the individual member.

All of the above methods using the philosophy of individual responsibility and reward result in a decrease in the cost of donor recruitment as compared to a complete dependence upon community responsibility. We are thus able to offer a discount with no overall increase in the charge for blood as compared to blood banks who offer no discount.

This method of recruitment has proved to be highly satisfactory in Lane County for the past 20 years. At no time have we had to import blood on a regular basis from outside sources and at no time has any surgical or medical procedure been cancelled because of a lack of adequate supplies of blood. We are appreciative of the value of the "Community Responsibility" philosophy but feel that the addition of an incentive for "Individual Responsibility" is a healthy stimulus to a successful blood program.

Jacqueline D. Miller, M.D.
Medical Director
Lane Memorial Blood Bank
Eugene, Oregon

Physicians respond to HMO articles

To the Editor:

In his article, "Whatever happened to private practice?", Doctor Leonard Marcel indicates that Portland has more than twice the percentage of its population in HMOs than any other city. In a very technical sense that may be correct, but in reality, Seattle has a comparable percentage so enrolled. An HMO may not qualify as an HMO under the federal definition, but Group Health Cooperation of Puget Sound is Seattle's equivalent to Kaiser and it was *not* federally funded.

Historically, people in the Seattle area have been offered several medical care plan options by their employers. Those who have selected the HMO concept have done so voluntarily and have been given the opportunity to change plans once each year, if dissatisfied.

Presumably most people enrolled in HMOs have been satisfied with the quality of care provided, or they could easily have changed to one of the plans covering fee-for-service providers. Furthermore, a University of Washington study of care provided to persons under Group Health and Blue Cross-Blue Shield found it to be comparable for the various items included.

Quality of health services is a matter which we as physicians have an obligation to continuously address. Fundamental to defining quality is evaluation of the results of the services provided. We need to build the assessment process into our practices whatever practice organizational structure we are associated with, so that our patients will benefit.

Max Bader, M.D.

a response to "endangered" articles

To the Editor:

An article in the June 1980 *Portland Physician* by Dr. Leonard Marcel, raises the question as to whether or not the physician in private practice is an "endangered species."

My personal feeling is yes, we are endangered, and it is further my personal opinion that as individual practitioners, the area of our greatest vulnerability is the market place. Competition is increasing by leaps and bounds! A news item in a local newspaper (*Gresham Outlook*) recently stated that one prepaid closed-panel plan (Kaiser-Permanente) now has 325,000 enrollees in the Portland Metropolitan area, including Clark County, Washington. I would like to stress or underline the fact that the physicians in the Kaiser Plan are in private practice. I have been unable to verify the accuracy of the 325,000 figure, but it probably is in the vicinity of this number and represents a very sizeable percentage of the total population of this area. It is my understanding also, that this group plans to or has applied for an exemption to the requirement for "Certificate of Need" for hospital beds based on the total community beds or population, but instead that it be based on their enrollment figures.

The simple fact, put quite bluntly, is that the Kaiser Plan, through its closed panel, excellent management techniques including careful control of utilization, etc., is able to market medical care at a lower cost than the individual private practitioner has been able to accomplish. We are not as competitive in the market place.

Those of us in our own individual practices do, however, have a mechanism through which, if we really make it work, can offer high quality medical care at a competitive cost. This is the Individual Practice Association—the IPA-HMO concept which has been developed and which is being marketed in our area as the Portland Metro Health Plan or PMH.

Portland Metro Health became a reality in January 1976, and in its four and one-half years of existence has shown a moderate but healthy growth pattern with a current enrollment of just over 20,000. (The Kaiser Plan, incidentally had nearly a 30 year headstart over PMH). PMH has passed the "break-even" point and is operating in the black but still has serious problems, one in particular being that premiums are somewhat high, currently in the neighborhood of 20% higher than the major competitor. As economic conditions become tighter it is my expectation that the blue and white collar workers—the people who are the very backbone of PMH—will look closer and closer at the dollar differential in premium cost and that the selling points of wide selection of physicians and hospitals will become less alluring and that unless premium rates can be made more competitive, PMH may very will run into tougher sledding in the market place.

The increase in health care costs and the provision of health insurance as a fringe benefit has been an increasingly significant expense of doing business to industry. Business and industrial leaders are becoming concerned and are organizing throughout the country, including Portland, to study means of curbing increase in costs.

My personal feeling is that we can, by making Portland Metro Health a success, demonstrate that we can deliver high quality health care at a reasonable cost and that we can thus preserve the positive aspects of the individual private practice of medicine, as well as maintain a healthy competitive stance in the market place—and substantially reduce the threat of our being an "endangered species."

Estill N. Dietz, M.D.

look what your medical societies are doing for you . . .

The following letter was sent to Ralph Crawshaw, M.D., Chairman, OMA Welfare Advisory Committee. With

in my opinion

permission from both Doctor Crawshaw and Doctor Kraushaar, Portland Physician chose to reprint the letter because it points out what an excellent job members of OMA Committee are doing.

Dear Dr. Crawshaw:

At your request, the following is a summary of the past year's accomplishments. These are due to the cooperative and coordinated capability generated between the AFS Division of state government and the OMA Welfare Advisory Committee of which you are chairman.

As you know, about 18 months ago a list of controversial health care areas the AFS Division found difficult to address was prepared. It was my perception that the subjects required expert advice beyond the professional capabilities present in the division. This viewpoint was endorsed by the OMA; and through the able assistance of Jim Kronenberg, the concept of "mini-task forces" evolved. Not until three months ago was AFS capable of funding "out-of-pocket" expenses to members of the various task forces. It is for that reason the list is in two sections; the first being those areas which were addressed and advice given essentially "for free" by OMA, usually through the Insurance and Fee Committee chaired by Dr. Bill McHolick; the second section being those more formal task forces for which members were reimbursed "out-of-pocket" expenses.

I. Section I

A. Prior Authorization of T and A's (By your Advisory Committee)
No T and A requests have been denied. There has been a 33% decrease in the number of T and A's done in the past 12 months.

B. Restrictions on Payment for Tranquilizers
On October 20, 1978 the OMA Advisory Committee advised on guidelines and endorsed the present AFS policy. This has allowed some control of payment for tranquilizers.

C. CPT 4 and CRVS 74 — Common Medical Language
OMA the past two years has repeatedly endorsed through your committee and House of Delegates the use of this common language.

D. Acupuncture and Hypnosis
Task force under Dr. Hagmeier's chairmanship on July 20, 1979 and September 14, 1979 gave invaluable advice and guidance regarding these procedures. There has been little difficulty since.

E. Surgery for Obesity
The Advisory Committee recommended such surgical procedures, with exceptions, not be funded using public monies. This decision may come up for review if requested by surgeons in practice.

F. Itinerant Surgery and Fee Splitting
On April 18, 1980 this subject was defined and valuable advice given by the Insurance and Fee Review Committee. This has helped in the development of more realistic policy within the AFS Division.

G. Tubal Ligation At Time of Cesarean Section
On April 18, 1980 the Insurance and Fee Review Committee responded to a request by Dr. Patchin and advised that a nominal fee for this procedure was appropriate.

H. Anesthesia in Obstetrics
A joint conference of appointed members of the Oregon Society of Anesthesiologists and Oregon Society of Obstetrics and Gynecology will address this problem. No communication has been received to date.

II. Section II (Formal Mini Task Forces)

A. Visually Evoked Response (VER)
A task force under the able chairmanship of Dr. Bill Fisher met twice in March and April. The exchange between opthamologists and optomestrists was productive and resulted in mutually agreed upon criteria for this test.

B. Special Diet Task Force
This task force has met twice, and a final report advising complete revamping of the AFS Special Diet Program is being prepared.

C. Cosmetic and Reconstructive Sugery
This task force, Dr. V. Lindgren, Chairman, will have its first meeting on June 23 at OMA Headquarters.

Much indeed has been accomplished and a workable mechanism to address other present and future problems has evolved. We are about halfway through the list. On the part of both AFS Division and myself, I wish to express a profound "thank you".

Otto F. Kraushaar, M.D.
Chief Medical Advisor
Health and Social Services Section

The title of this department, In My Opinion, is intended to invite free expression of individual thought on any and all issues pertaining to Medicine. Send letters to: To the Editor, 2188 S.W. Park Place, Portland, Oregon 97205.

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OREGON MEDICAL ASSOCIATION
HEADQUARTERS

Office Practices Seminar

for Physicians' MEDICAL ASSISTANTS

8:30 a.m. to 4:00 p.m.
(Registration, 8:15 a.m. — Luncheon at 12:15 p.m.)

Sponsored by the
MULTNOMAH COUNTY MEDICAL SOCIETY
and
MULTNOMAH COUNTY ASSOCIATION OF MEDICAL ASSISTANTS

Registration fee includes lunch and materials.
$30.00 for Non-Member
$25.00 for MCAAMA member
$20.00 for students

PROGRAM HIGHLIGHTS

"MEDICAL LAW AND ETHICS"
includes medical record maintenance, patient information brochure, termination of a physician-patient relationship, and more.

"HMO – IPA"
health maintenance organizations, independent practice associations - what are they, who belongs to them, and how do they relate to your practice? These will be discussed by a panel of knowledgeable people.

SOLVING YOUR PROBLEMS WITH WELFARE & MEDICARE
Where to turn when you have a problem with the Welfare Department. Have your questions answered regarding Medicare billing and reimbursements.

SPECIAL COLLECTION AND HANDLING OF SPECIMENS
A clinical workshop regarding the basics of venipuncture, collection and handling of specimens.

LUNCHEON ENTERTAINMENT
A fashion show featuring travel wardrobe.

Continuing Education Units applied for.

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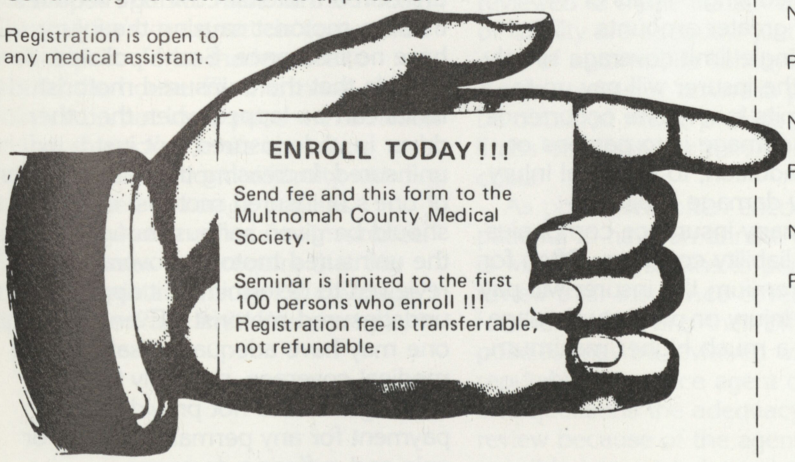

Ample time will be provided during each presentation for questions and answers.

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Portland, Oregon — November 15, 1980

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The thought of medical malpractice claims probably causes a slight shudder and a quick mental review of whether one's insurance coverage with adequate policy limits for such claims is in force. Adequacy of insurance coverages outside of professional malpractice should also be reviewed periodically. This article will briefly address automobile, fire and extended coverage and general liability insurance needs. Life, disability and health insurance are also important insurance coverages which should be reviewed, but the types of coverages and individual requirements are so diverse that consideration of these coverages cannot be undertaken in this article. Automobile coverages are essentially of three types.

A. Collision and comprehensive;
B. Personal injury and property damage liability; and
C. Uninsured motorist and personal injury protection.

Collision and comprehensive coverages apply to damages to the owner's vehicle without consideration of fault. The coverage applies if the loss were caused by an occurrence covered under the policy and subject to any deductible. For example, if the insured driver collides with a power pole in a one car accident or if a tree falls on the owner's car, the comprehensive and collision coverages would normally apply and the insurance company would pay for the cost of repairing the vehicle less any deductible. If the cost of repairs exceed the value of the vehicle, the owner is paid the current fair market value of the vehicle less any deductible and less any salvage value unless the insurance company is given the vehicle to salvage. Often considerable savings in insurance premiums may be enjoyed as the deductible is increased. The decision to increase the deductible and thus lower the premium is an economic consideration that should be given serious thought, especially in the case of older vehicles.

Automobile personal injury and property damage liability insurance covers loss to third persons caused as a result of the negligence of an insured driver. The insurer will normally provide a defense to the insured without cost. One consideration, often overlooked, is the adequacy of the limits of liability. This is especially important in the case of property damage liability coverage. Many professionals carry liability limits of at least $100,000 for each injured person, with a maximum of $300,000 for injuries to all persons in any one occurrence. For instance, if four persons were seriously injured in an automobile accident as the result of the negligence of an insured driver, the insurance company could pay a maximum of $300,000. Often these same coverages provide a property damage liability limit as low as $25,000. While the adequacy of $100,000/$300,000 personal injury liability limits may be questioned, the $25,000 property damage limit is probably inadequate given the inflationary nature of the economy and the many types of properties that could be damaged far in excess of $25,000. Many companies offer combined single limits of $300,000 or greater amounts. Combined single limit coverage simply means that the insurer will pay up to the policy limits in any one occurrence whether the damage is to persons or property. In addition, to personal injury and property damage liability coverages, many insurance companies offer excess liability coverage. Often for a nominal premium the insurer will pay for personal injury or property damage losses up to a much higher maximum, such as one to five million dollars. The premium is considerably lower than the premium on the underlying policy because the likelihood of injuries or property damage of this magnitude is remote.

Uninsured motorist and personal injury protection coverage is required by Oregon statutes. Uninsured motorist coverage provides coverage for personal injury to the driver and passengers of an insured's vehicle when the motorist who has caused the injury is uninsured. Oregon law now requires that motorists carry liability insurance or provide the Motor Vehicle Division with proof of financial responsibility up to $15,000 for the injury to any one person and $30,000, for the injury of two or more persons and $5,000 property damage. It is unfortunate but true that many motorists do not maintain even this minimum coverage. It is in this case that the uninsured motorist coverages apply. Occasionally, injured or property damage is caused by a hit and run vehicle or a "phantom" vehicle. In those instances, as well, uninsured motorist coverage applies. The uninsured motorist coverage liability limits are often inadequate. For a very nominal increase in premiums the liability limits may be substantially increased. Unfortunately, increasing these liability limits may be of no assistance if one is injured by a motorist who has inadequate limits of liability, is judgment proof and the uninsured motorist coverage requires that the motorist causing the injury have no insurance. Some policies provide that the uninsured motorist limits can be tapped when the other driver is underinsured, not just uninsured. Increasing the liability limits of one's uninsured motorist coverage should be given serious thought, and the uninsured motorist coverage reviewed to determine if it applies to underinsured motorists. Even though one may have adequate disability and medical coverage, normally these coverages would not provide any payment for any permanent injury or pain and suffering damages.

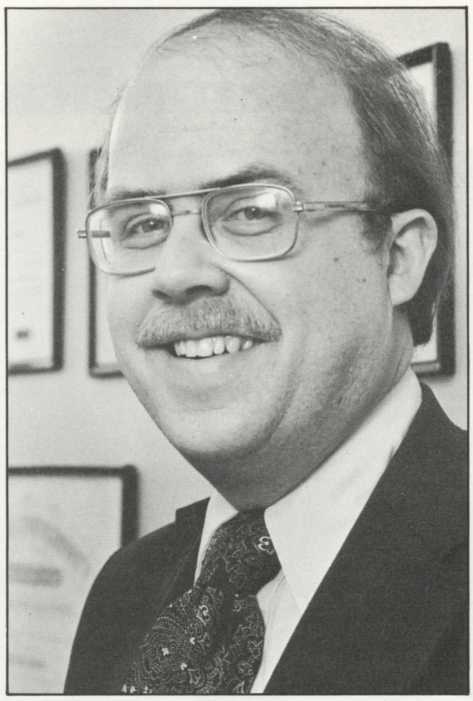
by Merrill G. Emerick

Personal injury protection coverage is also required under Oregon law. Essentially, this coverage provides that the insured operator of a motor vehicle and any passengers may receive medical reimbursement up to $5,000 and up to 70 percent of loss of income during a period of disability if the disability continues for at least 14 days following the accident. It is possible to obtain greater coverages. Naturally, the decision to increase these personal injury protection coverages would depend upon whether or not the individual insured as well as members of his or her family who might be in the automobile have adequate medical coverage or disability coverages.

Fire and extended coverages normally provide insurance subject to a deductible for the repair of damage to dwelling or office buildings caused by fire, wind or similar perils. For example, if during a wind storm a tree were to fall into one's office building causing damage to the property, a fire and extended coverage policy would normally pay for the cost of repairing the structure subject to any applicable deductible. There are two primary considerations with this type of coverage, which are often overlooked. One is that in many instances the insurance policies are written on a current fair market value basis, rather than a replacement cost basis. Thus, if a dwelling were totally destroyed by fire, the policy which provided for current fair market value would only pay the current fair market value of the house. Given today's construction costs, that probably would be inadequate to rebuild the house. Furthermore, many policies do not keep pace with inflation so that the policy limits are often inadequate. A second difficulty with fire and extended coverage policies concerns what is called "co-insurance." These clauses may require that the insured maintain insurance coverage up to a specified limit. For example, in the case of an 80 percent co-insurance clause, if coverage is afforded on a current fair market value basis, the insured is required to provide coverage for at least 80 percent of the current fair market value of the property. Failure to do so will result in a severe reduction in insurance proceeds available in the case of total or partial destruction. Fire and extended coverage policies should be carefully reviewed to be certain that the coverages are adequate and to become aware of the existence and effect of any co-insurance clause. Often, it is possible to obtain insurance with built-in cost of living or inflation provisions for increasing the policy limits and it is often possible to obtain replacement coverage at a minimal cost. Replacement value coverages would be available, not only for damage to the building but also for loss to personal property which is normally included in these policies.

General liability insurance coverages may be included in one's homeowner or business premises policy or purchased separately. Normally, these coverages provide liability insurance for personal injury or property damage caused to a person on one's premises, whether the office or home. For example, if a repairman were to slip and fall on a defective stair in one's home, the general liability coverage under the homeowner policy would normally provide coverage. It is important that these policies be reviewed to make certain that the limits of liability are adequate just as in the case of automobile liability coverages. Again, excess or umbrella policies may be obtained which provide substantial limits of liability for minimal additional costs.

As physicians often encourage their patients to have an annual check up, it is wise for physicians to periodically review their insurance coverages, both for themselves and their offices. These policies may be reviewed with a reputable insurance agent or broker. If one questions the adequacy of this review because of the agent or broker's possible interest in increased commissions, the physician should review his or her insurance coverage with an attorney.



Mr. Emerick is a member of the law firm Hermann and Smith, legal counsel for Multnomah County Medical Society. He is a member of the Oregon State Bar, and recently assisted the MCMS Judicial and Business Commission in revising and amending the Society's by-laws.

the medical malpractice climate in oregon

by Tom Cooney,
OMA Legal Counsel

I had hoped in this article to be able to announce the end of the medical malpractice problem for Oregon physicians. My thinking in this regard was based on certain simple facts. (It has been suggested by some that all thinking by this writer is simple.) The lawyers of the state of Oregon have made lawyer malpractice insurance mandatory, and this requirement is a condition to the right to practice law in this state. In connection with this requirement, the Oregon State Bar Association has created in effect a self-insurance program, for the first $100,000 of any one claim, with a maximum of $300,000 in any one year. All lawyers in the state of Oregon share equally in the cost of this program. Whether or not as a result of this mandatory insurance, or due to other factors, there has been an increase in lawyer malpractice claims, and it has been determined that lawyers are having so much fun suing one another, that it was felt that they might forget completely about doctors. Unfortunately, this has not been the case, and we are again seeing an increase in the number of claims, and an increase in the size of settlements.

The climate in Oregon is still favorable from the physician's standpoint whenever a professional liability case is tried before a jury. The doctor still has a revered position in the eyes of the community. This feeling is stronger in the smaller communities than it is in the more metropolitan areas. The win/loss record of physician cases involving professional negligence has been phenomenally in favor of the medical profession. Part of this success is the ability to recognize and settle cases which do, in fact, present a realistic exposure to the involved physician.

There have only been two jury verdicts in the state of Oregon in the $1 million range. Both verdicts were against hospitals. However, physicians had been defendants in these cases but had settled out of court before trial.

It is hoped that the OMA malpractice loss prevention program which is gaining momentum will be able to help stem the tide of claims, and also expedite the intelligent management of losses once they occur. Efforts are being made to coordinate loss prevention programs in hospitals so that all personnel will receive training on how to prevent injuries to patients, and how to promptly and intelligently handle injury claims when they do occur. This effort to educate is not only being directed to the physician staffs in the hospitals, but all support personnel. This is a massive undertaking and is being co-sponsored by the Oregon Medical Association and the Oregon Hospital Association and CNA Insurance Company. In addition, cooperation of all the professional liability insurance carriers for hospitals and physicians is being encouraged and sought. The program has tremendous potential for the prevention of injuries, and hopefully to decreased insurance costs. Whether or not it will be successful will depend a great deal upon the participation of those it seeks to reach.

Unfortunately, some of the legislation sponsored by the OMA in the 1971-75 legislature regarding professional liability has been eroded away by the Oregon appellate courts. Two fairly recent cases have given a more liberal interpretation to the statute of limitations in medical cases than was intended by the original sponsors of the legislation.

The time within which a patient may file a claim against a physician or hospital is governed by ORS 12.110(4). Since 1975, it has been the law that such claims must be filed within two years of the discovery by the patient that he has been negligently injured as a result of medical care or treatment, but under no circumstances can the claim be filed more than five years from the date of the negligent act. This limitation applies not only to adults, but to minors as well. The exception to the two and five rule is the fact that the patient may have a longer time within which to file his claim if his delay in filing the claim beyond the prescribed time is due to the fraud, deceit, or misleading representation by the physician. The patient has two years from the discovery of the fraud, deceit, or misleading representation (or in the exercise of reasonable care, when it should have been discovered). What constitutes a misleading representation has been uncertain. In the *Duncan* case decided in 286 Or. 723 (1979), the Oregon Supreme Court held for a physician who removed a patient's gallbladder and appendix in August of 1968. After the surgery, the doctor told the patient that he had removed her appendix. The patient continued to suffer pain and discomfort until 1975, when other surgeons discovered a bacterial contamination in her abdomen which was spreading from the distal end or tip of the appendix. The patient did not file her claim until February of 1976, which was beyond the prescribed time. The patient contended that there was a misleading representation by the physician when he had stated to the patient that he had removed the appendix. It was plaintiff's contention that since all of the appendix was not removed, the physician's statement was not true, and a misleading representation had been made. The case was tried and resulted in a verdict for the plaintiff, but was reversed, and judgment was entered in favor of the defendant doctor, based upon the theory that the claim had not been commenced within the prescribed time, and the mere statement by the physician shortly after the surgery that he had removed the appendix was insufficient to make out a case of misleading representation. Unfortunately, in other language in the opinion, the Court opened the door for the filing of additional claims, saying that if in fact there is a representation by the physician which in effect misleads the plaintiff, the plaintiff has additional time to file irrespective of whether it was made fraudulently by the physician, or innocently. The Court stated that it is immaterial for the purposes of extending the statute of limitations whether the physician misinformed the patient deliberately or by mistake. However, the Court said that any innocent contemporaneous representation must misrepresent something other than the careful performance or the success of the very treatment or operation whose failure is the basis of the plaintiff's claim. It can now be anticipated that in many cases plaintiffs will allege that there was a misleading representation by the physicians, and will be able to make a case that would have otherwise been barred by the statute.

In the *Repp* case, decided in April of 1980, 45 Or. App. 671, the appellate court examined the Oregon wrongful death statute insofar as it related to medical claims. In that case, the patient was examined in 1967, and a mole on the scalp was diagnosed as lupus erythematosus. Thereafter, the patient was seen in June of 1972, November of 1973, and again in March of 1975, when the patient's condition was diagnosed as malignant melanoma. The patient died on March 1, 1976. Under ORS 30.020(1), a claim for wrongful death must be brought within three years after the occurrence of the injury causing the death of the deceased person. The Court in the *Repp* case held that the injury did not occur until December of 1974, when the mole began to grow. Since the complaint was filed within three years of that time, the Court held that the plaintiff had timely filed the claim, and the case must proceed to trial. Plaintiff in that case had also made allegations of misleading representations, but the Court did not decide the case on that question.

It was hoped by limiting the time for filing a malpractice claim to two years from discovery of the negligently inflicted injury or no more than five

continued on next page

years from the date of the negligent act, the insurance industry would be able to more accurately predict future losses, and be more realistic in setting premiums. It can be seen by the above decisions it is now clearly possible for aggrieved patients to extend the time for filing their claims. New legislation will be required to restrict the time within which claims may be filed.

An even more important factor in these decisions is the realization that judge-made law has a great impact upon the lives of all of our citizens. In Oregon, our judges are elected and their decisions frequently have dramatic impact upon our lives. Awareness of the qualifications of candidates for the legislative assembly has always been carefully considered by most voters, however, the same scrutiny should be given to the qualifications of candidates for judicial positions. A change has recently been made in the Oregon appellate procedure so that now most all professional liability cases are reviewed by the Court of Appeals, whose decision is final, unless the Oregon Supreme Court in its discretion elects to grant a further appeal.

The OMA should carefully monitor the progress of the Oregon State Bar self-insurance program in order to make a careful analysis as to whether or not such a program would be desirable for the physicians in the state. The OMA had previously considered and rejected a similar proposal, primarily because a person's license to practice medicine would be contingent upon the maintenance of professional liability insurance. The Oregon State Bar plan has met with early success and seems to be on sound ground. However, as with all self-insurance type programs, a number of years must pass before the success or failure of these programs can be determined. In addition, the statute of limitations for legal malpractice is longer than for medical cases, and therefore, the long-term exposure in legal malpractice is more difficult to predict.

Where Do We Go From Here?

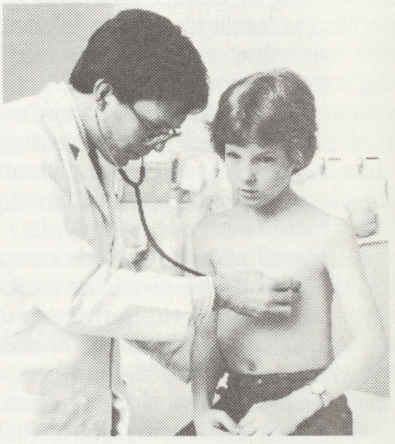
Many of you may not know of the famed Lakewood Panthers. The Panthers are a fourth-grade basketball team which the writer has coached for many years. Without a great deal of effort, we have compiled a win/loss record of 147 consecutive losses. Recently, we concluded that new and innovative ideas might be required, or losing could become a habit. A switch from man to man to a zone defense was deemed wise in view of past performances (we lost the last game of the season 64 to 12 in overtime).

Explaining a zone defense to a fourth-grade boy is difficult, to say the least. Especially when it is compared to a man to man defense. In order to dramatize the difference in the two defenses, chalk was used to draw squares on the gymnasium floor so that each boy could understand that he was to guard that box, and any player who entered the box. After weeks of practice, the final test came just last week. The Panthers started the 1980 basketball season displaying for the first time a zone defense. The gym was packed—eight or nine parents—and at the end of the first quarter, the Panthers were down 25 to 3, primarily due to our left forward following his man all over the court on defense. At the quarter, I explained to the players that they were supposed to be using a zone defense, and they were reminded of the boxes that were drawn on the gym floor. Our left forward shook his head as if to say he understood, and then said, "Coach, I know all of that, but the dumb kid I'm checking won't stay in the box."

Maybe the moral of this story is that we have been expecting all of the players in the professional liability encounter to stay in the box. New and innovative efforts may be required to control the problem of professional liability claims. The OMA's long-term plans for loss prevention is one such step. Another step will be a comprehensive risk management plan, in cooperation with hospitals and their insurance carriers to manage those injuries that do occur, notwithstanding the best efforts of those involved. In addition, a careful evaluation must be made of the qualifications of candidates for the legislature, and the qualifications of candidates seeking judicial posts. Finally, there must be an ongoing evaluation of insurance alternatives and proposals.

The early signs of another crisis in the professional liability field seem to be on the horizon. It is hoped that with the cooperative efforts of the Oregon Medical Association, the Oregon Hospital Association, all health care providers, and their insurance carriers, another crisis can be avoided.

Most people think heart disease happens only in the elderly.



It happens in children as well. Things like rheumatic heart disease and congenital heart defects. Each year, nearly one million Americans of all ages die of heart disease and stroke. And 20,000 of them die from childhood heart diseases.

The American Heart Association is fighting to reduce early death and disability from heart disease and stroke with research, professional and public education, and community service programs.

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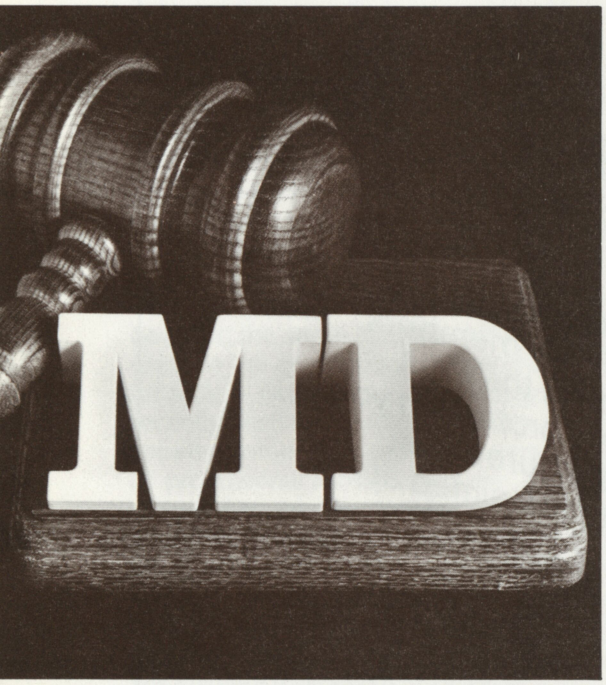


The Oregon Medical Association recently honored J. Oppie McCall, Jr., Portland obstetrician-gynecologist, for 20 years of service to the Professional Consultation Committee.

Originally the Professional Consultation Committee (PCC) provided two services; medical malpractice claims review and management of the business aspects of the OMA liability insurance program. Appointed to PCC in 1960, Dr. McCall served as chairman from 1964 ro May of 1980.

In 1976 the functions of PCC were separated and two committees were formed. The Professional Consultation Committee supervises the conduct of the OMA/CNA Physician's Protection Program, including premium structure and contract negotiation. Dr. McCall continued as chairman until his retirement from the committee in May of this year. Currently, Dr. Roy A. Payne, past president of the OMA, chairs the committee.

The Professional Liability Claims Review Committee (PLCRC) functions exclusively as the claims review mechanism. Dr. Tom L. Miller, Portland, has been chairman of PLCRC since 1976.

Throughout his long association with PCC, Dr. McCall has been recognized as an authority on medical malpractice insurance and claims review. During a recent interview Dr. McCall recalled the history of the committee and outlined its various functions.

"The review process began in 1933 after Horton Pownall, a partner in Pownall, Taylor and Hayes insurance agency*, devised the idea that doctors with claims against them would do well to have a peer review committee to listen to the doctor's side. The committee would interpret the case from a medical point of view with the doctor's lawyer present to provide input on the legal interpretation of the case," McCall remembered.

"The purpose of the program, in a nutshell, is mediation. The concept is that cases are reviewed as objectively as possible, both medically and legally. Then the two inputs are crystallized into a matter of how to handle the case," he continued. "Basically, over the intervening 47 years, the program has changed only slightly from that modest beginning."

McCall described the makeup of the committee saying, "The committee has always been multi-faceted with members coming from all branches of general medicine. The multi-faceted approach to review has been extolled over these many years. Here we have felt that specialty review committees tend to be too subjective, too sympathetic to the doctor. Consequently the defense attorney has not received an honest appraisal or interpretation of the facts."

Committee members must be long-standing in attendance for expertise is not gained with a single year appointment." McCall maintains, "Over time they become very cognizant and expert in appraising the case medically even though it may not be within their particular branch of medicine.

McCall said, "Any member of the OMA may avail himself of the claims review committee. Cases are brought before the committee in several ways. One, obviously, through an attorney communication to the defendant doctor telling him that he has a malpractice issue that needs a medical interpretation. A case review can be generated when a patient writes to the OMA stating dissatisfaction with the medical care exhibited and requests an answer regarding the caliber and quality of care given. Also, a doctor can bring a case before the committee when something has happened in an untoward fashion the doctor feels will generate disfavor in the eyes of the patient.

"The actual meeting includes committee members, consultants, defendant doctor and defense attorney as well as the insurance company claims adjuster and an insurance agency representative.

"The defendant doctor brings all records and x-rays to the committee deliberations. Protocol of the meeting is, the defendant doctor begins with a narrative account of the case.

by Justina E. Wright
OMA Loss Prevention Education Coordinator

"The committee members and consultant doctors then ask, in a round robin style, questions and interpretations of the defendant doctor. The attorney may then ask questions, not only of the defendant doctor but of the consultant and committee members as well, so he can be appraised of the legal posture of the case. At this point a decision is made as to how the case should be handled."

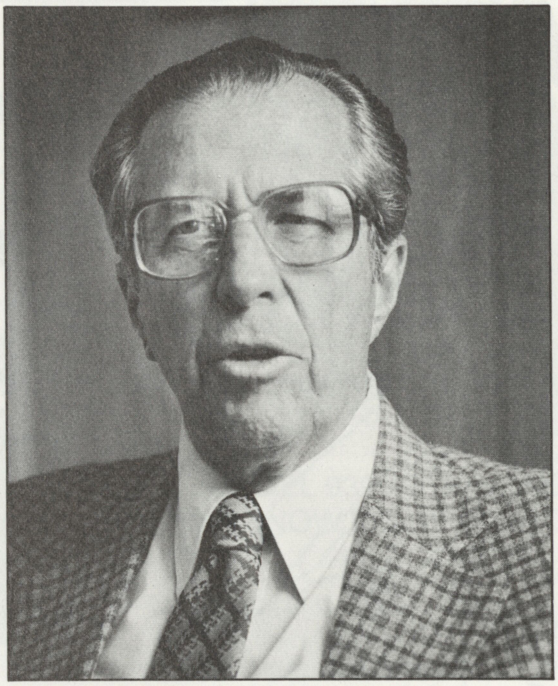
If the case is determined to be defensible McCall explains, "The claims agent, with legal backup, will approach the patient, or patient's attorney, indicating that the medical review has concluded no medical negligence or incompetence was involved.

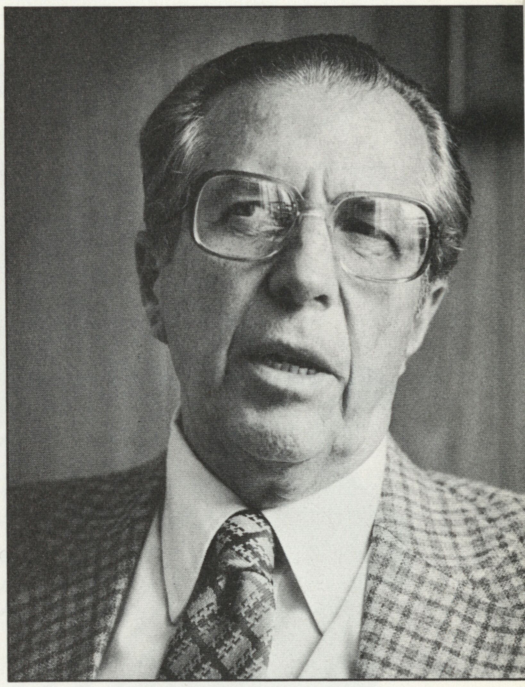
"The claims agent and his expertise carry tremendous weight, for he must show the patient that there are no grounds for further challenge of the doctor."

However, McCall added, "We win about 94% of our cases that go to court. When a case is felt to have areas of weakness, to be indefensible, it is recognized and handled as such," he said. "The claims agent then has the opportunity to agree with the patient that damage has occurred that should not have and to negotiate a financial settlement."

With most indefensible cases negotiating a settlement with the patient is preferred, McCall concluded, "For it eliminates the need for further legal action, saves the insurance company dollars and compensates the patient satisfactorily." Yet McCall stated, "If the sum of money asked for is unreasonable then there is no recourse but to go to court."

A second review of the case may be requested if the defendant doctor disagrees with the committee recomendation. McCall states, "Within the OMA claims review regulations the PCC can overrule the doctor's objections and tell the insurance company to settle the case if the appeal finds the case indefensible as well."





"I can't think of more than a handful of doctors, over the years, that have been alienated by the committee. Some have left the meeting very antagonistic yet most have called later and ceded to the fact that the committee deliberations were fair and agreed to abide by the decision.

"Over the years the relationship between the OMA, PCC and the insurance company has been amicable, whether the insurer was Metropolitan, Oregon Auto, Hawaiian or CNA. We've had the usual business fights and squabbles over premiums and contracts but it has always been a two way street with cooperation from both sides.

"No efforts are made to whitewash the case or appease the physician by saying it could happen to any of us. Negligence is labeled as such.

"The committee has always been an advocate of good patient care; he stressed. "We have felt if there has been bad management, the patient should be compensated.

"Yet the committee is not a punitive body; rather, it attempts to encourage better medical treatment. The review process is educational for committee members as well as the defendant physician."

In conclusion McCall emphasized, "The credentials of the committee have stood the wear and effects of time most admirably."

***Pownall, Taylor and Hayes has been the sole agent for OMA's Professional liability insurance for approximately 40 years.**

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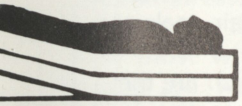

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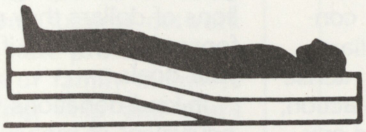

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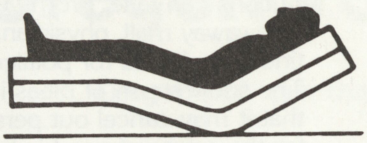

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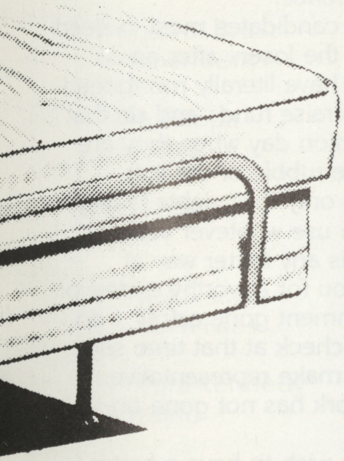

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Now is the time for all good doctors to come to the aid of their politicians

By Ralph S. Crawshaw, M.D.

As times grow hard they grow especially hard for politicians. Inflation is only part of the difficulty politicians and political parties face, for their constituents are inversely cooperative in proportion to the hardness of the times. The high cost of media time just does not interest the unemployed head of a family, and as inflation bites into everyone's income we citizens become more reluctant in freeing up a few dollars for "one of those politicians." However, without broad financial support from the electorate, our system of elected representatives government suffers at all levels, and becomes less efficient in dealing with the very problems which cause the hard times.

For physicians the financial pinch may not be as painful as for some others, but in an emotional way hard times hurt the doctor severely. With increased government regulation, the practice of medicine is increasingly constrained and the practitioner must fill out more forms and endure more investigations while at the same time watching tax dollars spent for health practices of which we do not approve. So it becomes easier than ever to dismiss political contributions as good money chasing bad. Yet, ironically, now is precisely the time for physicians to put their money where their civic values are, or should be.

Part of the confusion concerning physicians' fiscal-civic responsibility stems from a variety of forms contributions can take. From tax forms to throwaway mail, physicians are continually solicited for political dollars. The snow storm of pleas is so intense that it may cancel out personal action, for the apparent need is beyond any individual's practical ability to fulfill. However, this confusion need not paralyze a physician in the act of reaching for his checkbook, for there is a heirarchy of political giving which, if understood and made part of a personal plan, should help make sense of political giving.

First, in the heirarchy are some general political agencies which act above political parties, yet solicit funds in the name of "good government." *Common Cause* and *The League of Women Voters* attempt to be supra-action groups and may appeal to you to help them reinforce the political process as such.

Up until the recent past, the primary focus of political giving has been to the party. The national Republican and Democratic parties always welcome direct contributions. Lately, however, direct contributions to a political party have fallen into abeyance. The present voter is not as likely to see himself as a party member, but rather as someone who registers as a party member in order to vote in a primary. Political parties need direct support in dealing with the strategy of national politics, an appeal unfortunately seldom interests the individual while remaining a real need.

Then there is direct support of candidates. This is a way of voting more than once, for dollars given to the campaign of a worthy candidate will multiply the effect of your opinion by directly influencing the outcome of the election as your opinion dictates. Just a few dollars donated early on in a campaign work wonders in heartening a candidate to face his ordeal. Incidentally, running for office is an ordeal, if not for the weight the politicians gain while on the creamed chicken and mashed potatoes circuit, certainly an ordeal from the assault of neighborhood dogs which every door-to-door canvas brings growling to a candidate's heels.

There is also support through specific political action groups such as the Oregon Medical Political Action Committee (OMPAC). This money will have a more direct influence on government policy related to the sponsoring organization. Through organizations like the National Education Association, the American Medical Political Action Committee and the Attorney's Congressional Campaign Trust spend millions of dollars they can use more to forward their goals if their goals are your goals.

In-kind donations which are the equivalent of money in service, is another form of political benefaction. Artists often donate their services or works of art which are sold, with the proceeds going to a party or candidate. Locally a disco party, or a direct donation of services which are salable can do a great deal to help a candidate of your choice by offering publicity in the process of raining money. A coffee hour for your candidate may even make the difference.

Perhaps the candidates most in need of support are the losers after an election. Many have literally mortgaged their homes to raise funds and on that bitter post election day when they are sitting amid the rubble of the lost campaign with only their debts facing them, they can use whatever you can spare. If there is any better way of saying thank you for a worthy endeavor in good government gone astray, I do not know it. A check at that time says the attempt to make representative government work has not gone unnoticed.

So, if you do wish to have a better government, it is wise to participate as you can, directly running for office, which few can do; directly getting out and working for a candidate which more can do; and lastly, sending in dollars to the candidate or organization which is striving to carry out what you believe is a better way of solving our overbearing political problems. To make it easy for you to select how you can help out the parties and candidates in our next election the Multnomah County Medical Society and Oregon Medical Association have lists of name and addresses available of local and statewide candidates. Send along your contribution before you turn the page.

CARE

CARE is a special committee of the Oregon Medical Association Auxiliary that helps doctors' families who are hurting from mental or emotional stress. Our support network criscrosses the state providing help for those wives or family members who are wanting help and don't know where to turn. We are not a counseling service. We are a confidential resource to help the caller in finding counseling assistance. CARE members are listed here with their phone numbers and their location in the state. If you need help, please call us.

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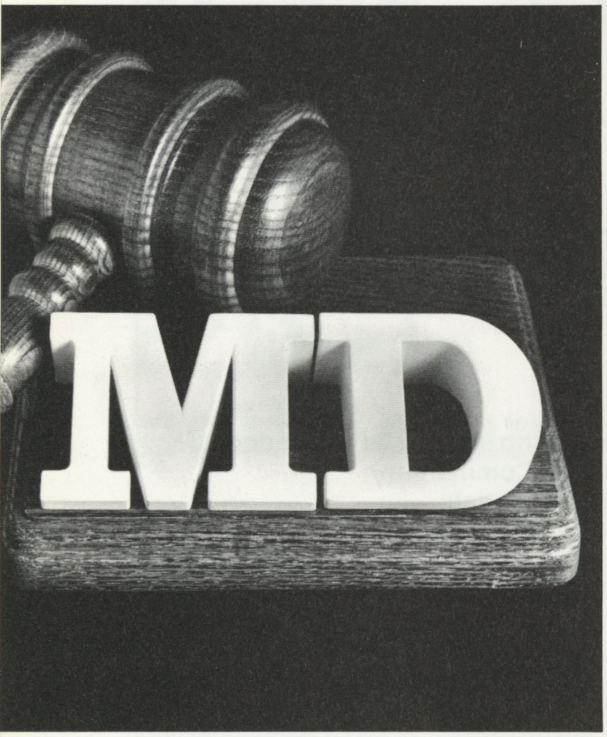
o.m.a. task force targets loss prevention



by Genevieve S. Burk, M.D.

In the fall of 1975, OMA President Roy. A Payne mandated the Malpractice Loss Prevention Task Force to investigate areas of loss in medical practice and hospital procedures. The task force was to identify and recommend areas of activity where professional liability losses could be avoided and prevented.

The task force report to the April 1978 House of Delegates outlined the areas of initial concern. Included in the report was a recommendation to increase the emphasis on education of physicians and hospital personnel regarding the changing medical-legal aspects of medical practice.

Following the assessment of various educational methods, the task force asked the April 1979 House of Delegates to authorize the development and implementation of a loss prevention education program. The House of Delegates accepted the proposal unanimously. CNA Insurance Company agreed to provide approximately $50,000 annually to underwrite the cost of the education program.

The overall objective of the Loss Prevention Education Program is to "reduce human and economic costs of medical malpractice by assisting the physician and support personnel in identifying and eliminating the principal causes of malpractice."

Today the task force sponsors a Loss Prevention Road Show for presentation to component medical societies. The sixty-minute program provides an overview of medical malpractice law in Oregon and identifies the various components of medical malpractice. Presentations are made by Tom Cooney, OMA legal counsel, and Tom L. Miller, M.D., chairman of the OMA Professional Liability Claims Review Committee.

Additionally, an AMA videotape is used to illustrate an individual case of malpractice from the initial patient-physician contact to filing of the lawsuit and the subsequent depositions.

A medical-legal handbook is provided to each road show participant. The handbook defines Oregon medical malpractice law, medical-legal terminology and outlines areas of medical and behavioral errors in malpractice claims.

Currently, a task force subcommittee is designing a Loss Prevention Workshop. The workshop will assist the physician in understanding and identifying the principal causes of malpractice claims. The management and prevention of claims through individual and collective action will be addressed as well. The proposed plan will hopefully reach approximately 2,000 Oregon physicians through 40 local workshops. Task force member Dr. Robert Daugherty of Lebanon is coordinating the development of the workshop.

The first issue of Malpractice Alert, the loss prevention newsletter, was received by OMA members in August. Focusing on the malpractice situation in Oregon, the newsletter offers case review, statistics and "tips" on loss prevention.

Through the examination of Oregon's closed claims, data is being collected to identify the vulnerable areas in the practice of medicine. The information defines the "Oregon experience" in malpractice claims and is used to develop educational tools for the road show, workshops and newsletter.

In cooperation with the Oregon Association of Hospitals, the task force is promoting the development of risk management programs within hospitals. The task force members believe that effective liability loss control in hospitals must be inspired and motivated by physicians.

Representatives of professional liability carriers in Oregon are meeting with a task force subcommittee to explore better methods of handling claims involving several carriers. Improved communication between carriers regarding claims would prove invaluable to all aspects of loss prevention.

The creation of a full scale statewide loss prevention program is a tremendous project. The task force is appreciative of the cooperation of OMA members to date.

Over the next few years we hope to contact the allied health professionals as well as physicians. All those who have contact with patients may have impact on prevention of claims—from the doctor's receptionist to the hospital custodian!

communication now easy for i.c.u. patients

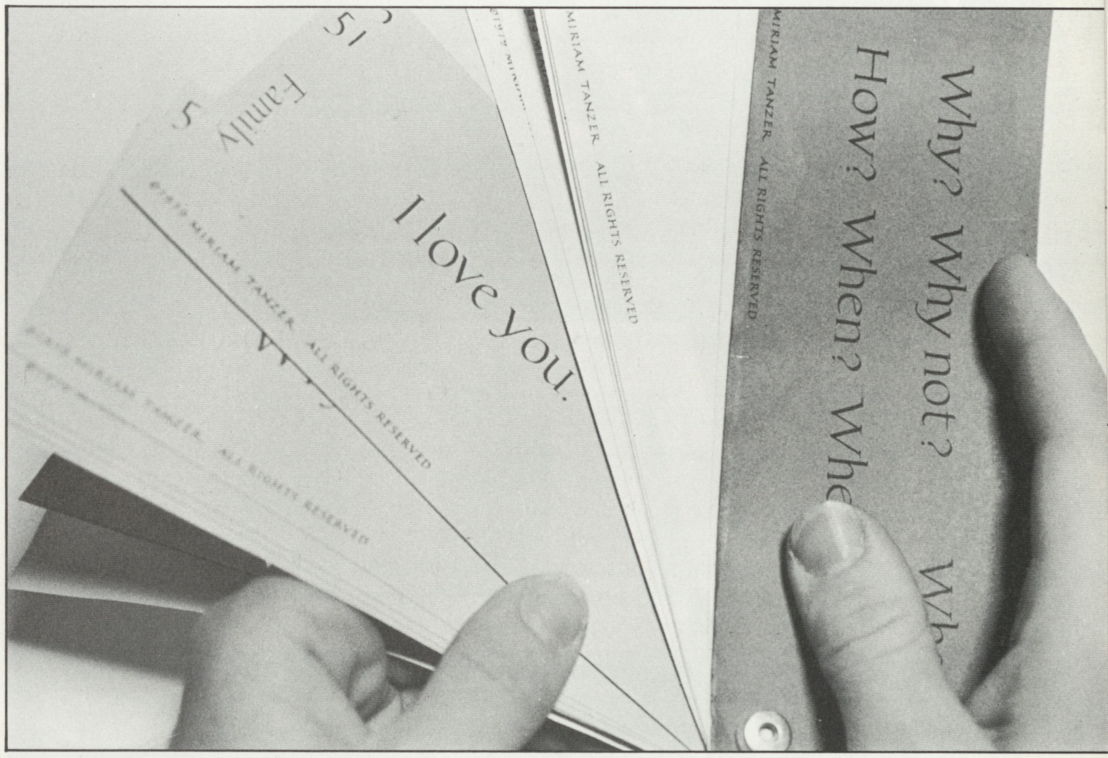
For the past 20 years, Miriam Tanzer has worked in the intensive care units of Portland's major hospitals. Those years have been filled with dedication, hard work, love and understanding, and many, many moments of frustration. As one Portland area physician so aptly states, "ICU can be so depressing because often you can't begin to communicate with your patient." Miriam Tanzer expressed that same thought many times over the years and it was only recently that she found one excellend solution, PACS.

Patient Aid Communicating Systems (PACS) are sets of cards, bound by a bracket at one end, which express feelings and thoughts, pose questions and make statements that a patient may not be able to verbally or manually convey. Some of the questions posed in the PACS include: "What day is this?" . . . "What time is it?" . . . "Where are my glasses?" . . . "Who are you?" . . . "What is that?" . . . Requests made are: "I want to see my minister;" . . . "Please call my family;" . . . "Take this tube out;" . . . "Please leave me alone for awhile." Statements made in the PACS include: "I do not like you;" . . . "heavens to Betsy;" . . . "thank you;" . . . "I'm thirsty." These are all ideas which PACS help a patient express to the doctor, nurse, aide, family and friends, when he or she is unable to speak or be understood.

Often ICU patients can't use language boards or even write. They have difficulty putting words together and they may lose their ability to spell. While they may not be able to make coherent sentences because the language requirements are too complex, they can often select the correct sentence if it is already available. When speaking, they may not be able to separate their words or know where to end their sentences, but they can still read.

PACS make it easy for patients to communicate and be involved in the world going on about them. Because the patient can now "talk", he can find out the day, time, diagnosis, course of treatment and other facts which can ease the confusion which may result from a sensory overload, the illness or disease, and a lack of familiarity of surroundings. The patient now becomes a participant in his own recovery and can tell the health professionals how he feels.

Emanuel Hospital, the University of Oregon Health Sciences Center and St. Vincent Hospital & Medical Center are currently using the PACS and



according to one hospital official, "They're the best 'technological' advance made in years. They are easy to read with or without your glasses, the print is large, patients rapidly learn which cards they use the most and can thumb to them quickly, and they help improve the atmosphere and attitudes of both the staff and patients. It's easier when we can all understand each other."

Representatives of PACS are currently negotiating with the insurance industry and the federal government for coverage under Medicare and Medicaid, as well as inclusion in future business and industry labor contracts.

PACS are also being developed for nursing home patients and stroke victims, and Ms. Tanzer is working with the courts and other governmental jurisdictions who deal regularly with foreign speaking peoples. She is creating PACS which ask and/or answer typical questions in two languages. She is now in the process of patenting her inventions and has also begun marketing on a national basis.

Stop by the ICU in your hospital soon. Take a moment to look over the PACS. Do they make communication successful? Are there other questions which should be posed? Do they allow your patients to express their anger, frustration, love and trust? If you have any ideas or want to share your opinions, Ms. Tanzer is interested in hearing from you. You may get in touch with PACS by writing 919 SW Taylor, Suite 501, Portland, OR 97205.

It looks like Oregon has another innovater, and Medicine has made another giant step forward in providing top quality, personalized care to its patients.

controlling malpractice

by Norman W. Frink, M.D.

The threat of malpractice litigation has now become a part of our professional life. It is there, every day, all day and every place. It never goes away. The years of 1974, 1975 and 1976 were the crisis years during which our insurance costs increased at an incredible rate. There had been warning signs for several years before but they were unrecognized, and we were thus unprepared when the deluge hit us. Our immediate reaction was one of outrage; but we were also bewildered and frightened. Loudly voiced cries of anger and frustration resulted with considerable bombastic blaming of others for all of the resulting unpleasantness.

We decended upon our respective state legislatures demanding relief. Many legislatures responded with a variety of measurer felt to represent "tort reforms," often of questionable legality. These were primarily attempts to shore up the compensation payment system. In essence we were circling the wagons for self-protection. As time passed one appeals court after another has declared much of the new legislation invalid.

The crisis atmosphere does seem to have subsided. Insurance premiums have generally stabilized and the fears that insurance might become unavailable have not materialized. But the high costs of malpractice litigation remain with us, as evidenced by our premium rates. Worse, there are gathering signs that portend another upheavel may be on its way.

Physicians tend to react to this subject with strong emotions. Each claim is taken as a personal affront, and indictment of professional integrity. We seem to be almost incapable of admitting to even the possibility of any fault or liability. Our usual reflex is to flail out at "unscrupulous lawyers, ungrateful patients, incompetent juries, exorbitant awards or settlements, restrictive laws and untrustworthy insurance companies." This of course begs the issue and accomplishes

nothing. This attitude, while it is not a universal one, does color our thinking and leads us to deviate from our usual scientific methods. We end up directing our efforts at treating the symptoms of malpractice instead of searching for the causes and attempting to correct them. In malpractice as in disease, it is only when causes are identified and understood that we can hope to develop cures or methods of prevention.

We live in an era of great expectations and litigious consumerism. Our patients are learning what the big words mean and are starting to ask questions, sometimes embarrassing ones. As physicians we have not been accustomed to being held accountable for our professional acts. Certainly we have not been accustomed to having our authority questioned. This is now occuring. Our pedestals seem to be crumbling and we don't like it. In fact we resent it.

As a group we are unfamiliar with our Anglo-American judicial system, its history, its purposes and how it works. We look upon it with a degree of disdain and distrust. In truth most of us know little about medical-legal issues and possibly less about the intricacies of insurance and the arts of claims management. Our education and training does not prepare us to understand or to cope with the rapidly enlarging interface of law and medicine. Because of this we are handicapped in dealing with it.

There are six separate but closely related components implicated in malpractice litigation. They are: the physician, the patient, the hospital, the law, the lawyer and the insurance company. In the usual course of events these components come into conflict. To a varying degree each becomes an adversary of one or more of the others. This inevitable leads to continuing and increasing discord which contributes to delay, discourages equitable solutions, and increases costs. To a considerable degree it is self defeating.

Medicine must be viewed not only as a profession but also as a business and above all as a social institution. As such it must react to changing societal patterns since the underlying causes of the malpractice situation derive from the problems of society itself. These problems are the complex ones of social, legal, economic and professional factors. While we may be able to exert an influence upon some of the factors we must adapt to those we cannot change or control.

Staring at us is the blunt fact that virtually all malpractice claims start with an angry or frustrated patient and an unexpected or perceived poor result. A great many physicians do not seem to appreciate the significance of this. Herein lies the keys to successful claims prevention.

To better control its own burgeoning liability losses the business world has developed a management technique that works. It accepts the irrefutable fact that all human activities carry risk and devotes itself to managing those risks. Not illogically it is called Risk Management. Its principles, in their simplist form, are to identify risks, correct or reduce those risks to the greatest extent possible and to protect those risks not preventable with appropriate insurance.

Risk management procedures can be applied to medical care and they appear to offer the best hope now available for controlling malpractice losses. They combine aggressive and realistic claims management with the implementation of effective claims prevention programs. These two functions are laced together with continuing medical-legal education for the physicians, administrators, nurses, and others engaged in providing medical care. The six involved components might thus be brought together for the first time into a more cooperative harmony, each making direct or indirect contributions toward common goals.

The goals are simply stated: to reduce and contain malpractice and other liability losses, to provide the highest possible quality of medical care in all of its aspects and to preserve and protect the rights of everyone involved with equity and justice.

There is a new boy on our street. He has a strange sounding name. He uses funny words, words like exposure, loss prevention and risk control. May we ask him to join us? His name is Risk Management.

by Beth McPherson

patient-centered medicine

The concept that the complaints patients present to their doctors frequently stem not only from physical disorders but also from emotional needs and problems, is the basis for a series of Michael Balint seminars, which will be held in Portland starting in October.

Michael Balint (1896-1970), an Hungarian born analyst, made many important contributions to psychoanalysis in his publications about primary object relationships and their implications for the therapeutic alliance and technique. He was strongly influenced by his teacher, Ferenczi, and was devoted to the development of shorter forms of psychotherapy based on psychoanalytic principals and knowledge. The concept of "Focal Psycho Therapy" and the treatment method connected with it, are Balint's creation. They are the basis for the ongoing research at the Tavistock Clinic in London, the Sigmund Freud Institute in Frankfurt, Germany and the Balint Institute in Hamburg, and have also influenced the development of short term psychotherapy methods in this country.

"The most frequently used drug in practice is the doctor himself. No pharmacology of this drug exists yet. No guidance whatsoever is given as to the dosage in which the doctor should prescribe himself, in what form, how frequently, what his curative and maintenance doses should be, and so on ..."

Balint became best known for his investigative collaboration with small groups of general practitioners. Part of his motivation in this field may have originated from his experience as a boy in Budapest, where he accompanied his physician father on house calls. He was determined to use psychoanalytic understanding in observing the doctor-patient encounter and in studying the dynamics of the ensuing relationship. His longterm affiliation and study with his practicing colleagues resulted in the book, "The Doctor, His Patient, and the Illness," in which he created the metaphor "the drug doctor." The book has found wide recognition, especially in Europe, and has been praised by Loch, one of the foremost German analysts, as an "epochal work."

Balint began work with general practitioners in London in the thirties. At the Tavistock Clinic, he initiated what is now known as the Michael Balint Seminars for physicians, which are without question, the most widely used form of continuous medical education in Europe at the present time.

Balint's basic assumption was that medical school training, is by necessity, "illness oriented." The setting itself, with the hierarchy of supervisors and emphasis on scientific, didactic learning, does not allow for the development of the doctor-patient relationship which the physician later encounters in his own office.

His concern was to help the physicians with their orientation process from "illness centered" medicine which was learned at medical school to the "patient centered" medicine which must be practiced in the office. While using psychoanalytic thinking about human motivation and interaction for conceptualizations, the doctor must emphasize respect for the setting in which individual physicians work. Balint explicitly stated that he did not want to make amateur psychiatrists or psychotherapists of his colleagues. His definition of setting included the theoretical framework within which the physician made his observations and collected data, as well as the physicians' personal attitudes and convictions as they shape his personal ways of dealing with patients.

In this context, the symptoms that a patient presents to the physician are seen as an initial offering. It is the physicians responsibility to receive this offering, recognizing the emotional component involved. Not to do so, by maintaining an "illness centered attitude", frequently leads to dissatisfaction and frustration for both the doctor and the patient.

In the investigative setting of a small group, factors are explored as they become apparent from patient presentation and the resulting group response. The analyst conducting the session bring his psychoanalytic mode of observation and understanding to bear on the presented data. In this way, he helps the group to extend and transform their understanding of the ongoing process. Learning is not primarily didactic but mainly experimental.

Balint developed a method for helping the practicing physician improve his diagnostic skills, and his ability to recognize and respond to the emotional needs of patients. The American Psychiatric Association and the Oregon Psychoanalytic Foundation are co-sponsoring the initiation of Balint Seminars in Portland. Physicians meet in a selected group on a weekly basis and present to each other encounters with patients from their daily practice. The group members then respond with questions and reactions to the case material. In the resulting dialogue, wider aspects of the patient's emotional needs and the physician's response pattern are examined. Based on a better understanding and deeper insight of this ongoing process, the physician will learn to respond in a more specific, therapeutic way.

Due to the nature of the seminar, groups will be limited to ten physicians, with weekly meetings lasting ninety minutes each. The cost is $15.00 per session, and has been certified for thirty hours of LCCME Category I CME credits. For application or further information, call Hans F. Fink, M.D., 223-0550.

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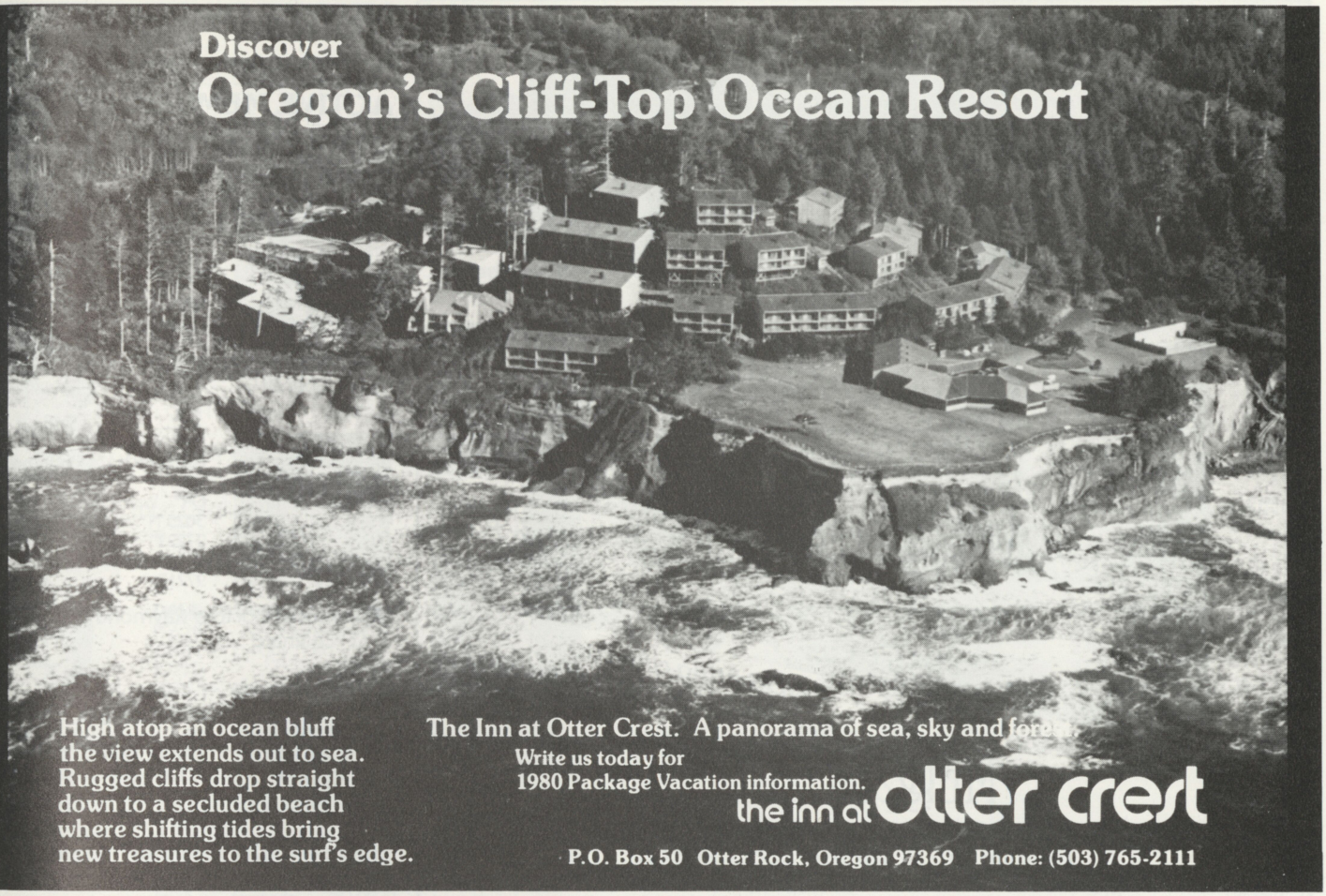

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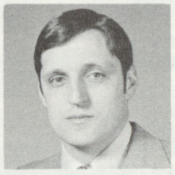

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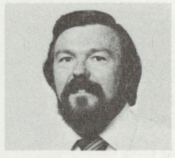

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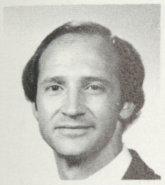

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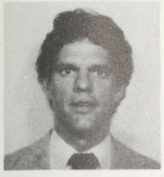

CORNWELL, John M.
FP* Oregon '72
11705 NE Glisan 256-2821
97220
3417 SW Front 222-3098
97201

Sponsors: Doctors Cecilia B. Singh and Velma J. Horenstein

DALE, D. Duane Nancy
P*-CHP Washington '75
2222 NW Lovejoy #361
97210 229-7942
2015 SW Anthony Dr 649-5175
Aloha 97005

Sponsors: Doctors Penelope Garrison and Herbert M. Woodcock

DURIS, Gerald F. Rosemary
FP* U of Washington '73
5635 NE Alameda 282-0979
97213
6414 NE Alameda 281-5627
97213

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ERDE, Karen M.
FP SUNY, Stonybrook '76
Gresham Comm Hospital
Gresham 97030
667-1122, X-323
3109 NE 21st 249-6910
97212

Doctor is transferring from Affiliate to Active membership.

FARRIS, Clyde A. Rebecca
OR* Stanford '73
10000 SE Main #402 252-3456
97216
2524 Hillcrest Ct 635-5459
West Linn 97068

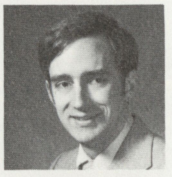
Sponsors: Doctors John A. Neufeld and Robert E. Manley

GILES, Donald E.
S (G&V) Loma Linda '74
10000 SE Main #408 256-1575
97216 (228-4346)
12033 SE 116th CT
Clackamas 97015

Sponsors: Doctors Richard A. Gingrich and Robert M. Harsany

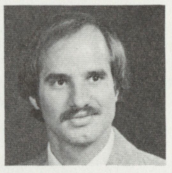
GIRAUDIER, Maurice E.
Patricia
DR* U of Saskatchewan '67
800 SW 13th 221-0161
97205
14025 SW 164th
Tigard 97223

Sponsors: Doctors Gilbert M. Cordova and James L. Mack



GLEASON, Daniel L. Wendy
PD Washington '77
5415 SW Westgate Dr
97221 297-3371
4335 SW Cullen Blvd. 244-6547
97221

Sponsors: Doctors J. Arthur May and Edward M. Richman



HARVEY, Thomas P. Janice
FP Baylor '77
5010 NE 33rd 282-4541
97221
2823 NE 47th 284-2896
97213

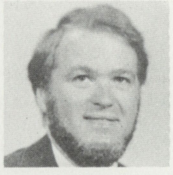
Sponsors: Doctors R.M. Reichle and E.A. Kazmierski

HAYS, Marcia L.
P Calif, Davis '73
2250 NW Flanders #310
97210 226-3338
908 SW Gaines #28 227-6807
97201

Sponsors: Doctors George Saslow and Joseph B. Trainer

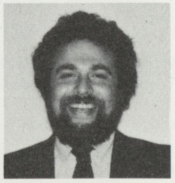
HUBER, Stanley J. Terry
OPH* Oregon '65
4424 NE Glisan 232-4846
97213
6 Essex Ct
Lake Oswego 97034

Sponsors: Doctors Gary. B Rothenberger and Gordon Summers



JULIEN, Robert M. Judith
ANES California, Irvine '77
3181 SW Sam Jackson Pk Rd
97201 225-7641
760 SW Timberline Dr
Lake Oswego 97034 635-5336

Sponsors: Doctors Gerald Edelstein and Carol A. Hirschmann



KAPLAN, Paul D. Mary
OTO Tufts '75
800 SW 13th Avenue 221-0161
97205
979 Devon Lane
Lake Oswego 97034

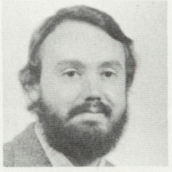
Sponsors: Doctors George E. Chamberlain and Gilbert M. Cordova

KHONSARI, Siavosh Houri
S*(C-T*) Dublin '62
3181 SW Sam Jackson Pk Rd
97201 225-7820
3640 SW 44th 297-5010
97221

Sponsors: Doctors Albert Starr and Bradley J. Harlan

KLUBERT, David M. Barbara
FP Ohio '77
5825 N Greeley 285-6607
97217
2601 SW Custer 246-0356
97219

Doctor Klubert is transferring from Affiliate to Active status



LIEDEL, John W.
PD* Ohio St. '74
2222 NW Lovejoy 229-7220
97210
4118 SW View Point Terr
97201 241-8268

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LOEB, Felix F., Jr. Loretta
P*-PYA Harvard '55
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97201
1908 SW Terrace Dr 242-0976
97201

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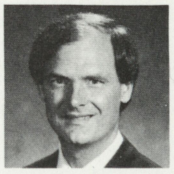
LOEB, Loretta R. Felix
P*-PYA* U of Pittsburgh '57
1908 SW Terrace Dr 242-2565
97201
1908 SW Terrace Dr 242-0476
97201

Sponsors: Doctors Siegfried R. Berthelsdorf and Lawrence Duckler



LORENCE, Thomas A. Ginger
I* Oregon '76
4511 SE Hawthorne 233-5219
97215
4502 SE 17th Ct 666-4338
Gresham 97030

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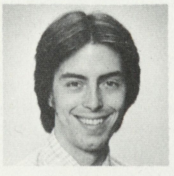

LOVELESS, Mark O. Karen
ID Northwestern U '75
700 NE 47th 234-8211
97213
4305 SE Ash 233-9735
97215

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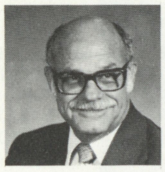

MINARD, Eugene W.
P-Prev.Med.* Stanford '79
336 NE 20th 238-6260
97232
5142 SW Slavin Rd #79
97201 227-2995

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PEDERSEN, Donal H. Janet
C*-I* Oregon '69
507 NE 47th 238-7220
97213

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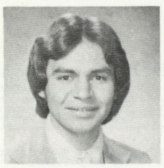
ROBERTSON, Wanda L. James
FP U Autonoma, Mexico '77
2020 SE 182nd 777-9576
97233
2407-A NE Rene (Unlisted)
Gresham 97030

Sponsors: Doctors Herbert R. Gray and Howard I. Osborne



TORRES, Samuel E. Ellen
ANES Loma Linda '76
3434 SE Powell 234-8000
PO Box 42126
97242

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YOUNG, John V., Jr. Susan
S(GE-V) U. of Mass. '74
3620 NE 122nd 257-8891
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7000 SW Vermont Ct. #1111
97223 244-3798

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OR* St. Louis '72
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Lake Oswego 97034
930 SW West Point (228-1678)
Lake Oswego 97034 635-4996

Doctor Tongue is transferring from Active to Associate status

YASUI, Homer Miyuki
S* Hahnemann '49
3300 SE Dwyer Dr 659-3232
Milwaukie 97222
227 SE 52nd 234-4714
97215

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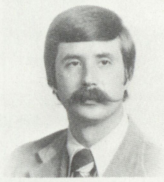
BENSMILLER, Diane E.
I Oregon '77
366 SE 8th
Hillsboro 97123

Sponsors: Doctors Huldrick Kammer and Martha G. Regan

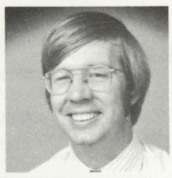


COCHRAN, Thomas P. Patricia
OR Jefferson '74
111 C Avenue 635-3788
Lake Oswego 97034
149 Iron Mt Blvd
Lake Oswego 97034

Sponsors: Doctors John R. Tongue and Steven R. Crawford

FRABACK, Ronald C.
RHU* Oregon '69
9155 SW Barnes Rd 297-3384
97225
711 SW48th Dr 223-2486
97221

Sponsors: Doctors Robert M. Bennett and Kip L. Kemple



HOLDEN, William E. Donna
I*-PUD Cincinati '68
3181 SW Sam Jackson Pk Rd
97201 225-7680
2735 SW Rutland Terr
97201 223-9149

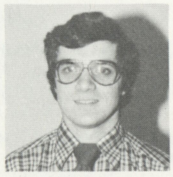
Sponsors: Doctors Miles J. Edwards and Alan F. Barker

KIM, Carol Larry Hough
I Northwestern '77
366 SE 8th
Hillsboro 97123
20440 SW Rosa Rd 642-3551
Aloha 97007

Sponsors: Doctors Huldrick Kammer and Robert M. Palmer

ROBIE, George F., Jr. Diane
OBG-PD Texas, Galveston '74
3181 SW Sam Jackson Pk Rd
97201 225-8311

Sponsors: Doctors Leon Speroff and E. Paul Kirk



SANTA, John S. Anne
I* Tufts '76
2210 NW Lovejoy 229-7074
97210
9850 SW Denney Rd 646-2179
Beaverton 97005

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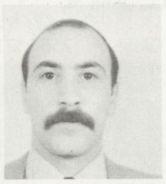
STUDENT AFFILIATE

BARRON, Lauren R.
Jeffrey M. Reynolds, M.D.
EM(Resident) Miami '79
3181 SW Sam Jackson Pk Rd
97201 225-7500
5963 SW Terwilliger Blvd
97201 246-3547

Sponsors: Doctors Craig Stevenson and karen Ireland



MAHL, Charles F. Louanne
OPH(Resident) Chicago '77
1200 NW 23rd 229-7022
97201
12185 SW Calico-Apt. B
Beaverton 97005 646-4346

Sponsors: Doctors Michael L. Klein and Richard G. Chenoweth

MARKHAM, Michael J. Tamara
NS(Resident) Oregon '73
3181 SW Sam Jackson Pk Rd
97201 225-7736
7137 SW 32nd
97219 245-5792

Sponsors: Doctors Anthony E. Gallo, Jr. and H.D. Paxton

RICHTERICH, Gregory C. Lia
Intern Oregon '80
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9760 SW Lancaster Rd
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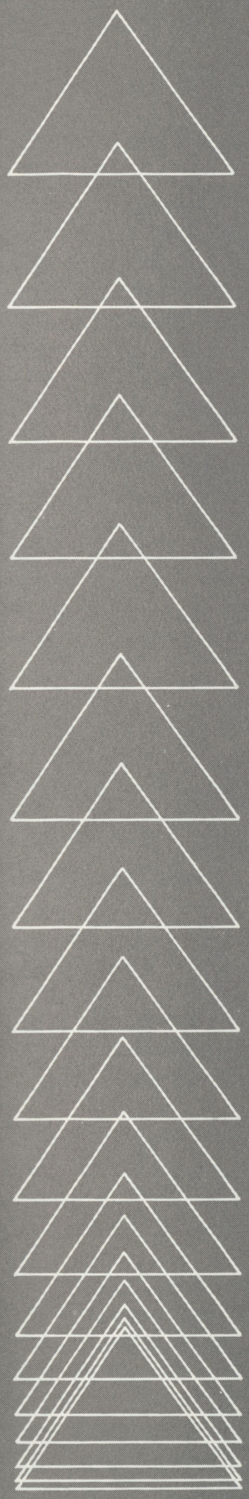

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in summary

From Your Oregon Medical Association:

The OMA/CNA Professional Liability Program announced premium rate reductions of approximately 17% last week. CNA Insurance will again cut basic $100,000/300,000 liability rates by 10% in all classes effective on or after January 1, 1981. Also, $706,000 in experience dividends and several program improvements were included: 1) 505 reduction in premiums for physicians entering their first year of practice following completion of residency program; 2) A $60,000 contribution to the OMA Malpractice/Loss Prevention program in 1981, up 20% from the 1980 contribution; 3) Improved communication with program policy holders and expanded marketing activities; 4) A study to determine the adequacy of current specialty placements in rate classes; 5) Overall re-evaluation of program content, including master contract provisions, profit sharing formula, underwriting guidelines, claims handling and coverage of other physician office-employed professionals.

Adult and Family Services Division (Welfare) has amended its proposed rules regarding new prior authorization requirements announced for October 1. The new requirements will be directed at less than 800 procedures which will be designated as "elective" in a revised procedure guide. Office visits will not be affected. Don Dobson, M.D., OMA President, testified on behalf of the OMA in opposition of the creation of a "second class" health care package for the state's poor. He announced that the OMA will continue to alert the public whenever the state attempts to ration medical services. He told the press he felt the profession would honor its traditional standard of providing essential care irrespective of the patient's ability to pay. His appeal follows:

"An honored tradition and elemental strength of our profession is that all persons, regardless of their ability to pay, should receive our services based on their need. Today, however, government at all levels plays an ever greater role in our professional lives. Regrettably, we are no different than many other segments of contemporary American society; and nearly fifty years of government promises to provide for the medical needs of the old, the weak and the poor have created expectations on the part of many of our patients we simply cannot meet.

"Government's failure deliver, its meddling and tinkering have seriously eroded the traditional patient-physician relationship and have made it impossible to treat our patients in ignorance of their economic situation. The politicians will not provide the funds to make good their promises, for it is easier to point to us as the villains of the piece. Now we are faced with the dual dilemmas of not enough money to fund the promise and a classic case of government meddling in medical practice. It is tempting to simply avoid the frustration of those patients who are dependent on government funding of their medical care.

"We must resist the temptation. Nor can we succumb to this latest encroachment into our professional lives. We must continue to exercise our best medical judgement for every patient and to provide care to those who truly need it. Despite the economic and political barriers we may encounter, we must be our patients' advocates and demand for them that is not being delivered."

OMA's 106th Annual Scientific Sessions, October 30-31, 1980 will be held at the Portland Hilton Hotel in conjunction with the 70th **Summer Memorial Lecture Series.** Distinguished speakers include **Felix A. Conte, M.D.,** Associate Professor of Pediatrics, University of California, San Francisco; **John A. Laragh, M.D.,** Director, Hypertension of Cardiovascular Center, and Chief, Division of Cardiology, Department of Medicine, The New York Hospital-Cornell Medical Center, New York City; and **Alexander Jeffrey Walt, M.D.,** Chief of Surgery, Detroit General Hospital and Harper-Grave Hospitals, and Professor and Chairman, Department of Surgery, Wayne State University School of Medicine, Detroit. **James H. Sammons, Executive Vice-President of the AMA** will keynote opening night ceremonies of the House of Delegates, October 31, in Portland at OMA headquarters. Specialty section meetings in **Family Practice, Radiology** and **Urology** will also be presented. Programs will be mailed at the end of the month.

Pro Rate Shares of $117,479 in Dividends Will Be Mailed Later This Month to members who participate in the OMA group Workers' Compensation Insurance Program. State Accident Insurance Fund, underwriter of the group plan, has declared a $99,735 dividend to participants in the program during the 1978-79 fiscal year and another $17,744 of unused premium for the 1975-76 program year which will also be distributed to participants on a **pro rata** basis.

in summary

October 8, 1980
Providence Medical Center Grand Rounds, "Clinicopathological Conference," John P. Hammerstad, M.D., UOHSC. 8:00 a.m., Amphitheater, Providence Hall. 234-8211.

October 9, 1980
St. Vincent Medical/Surgical Grand Rounds, "Tumor Markers," James Booth, M.D., South Dining Room, 8:00 a.m. 297-4411, ext. 2010 or 2220.

October 11 & 12, 1980
"The Healing Brain II," sponsored by University of California, San Francisco, Continuing Education, Sheraton-Palace Hotel. Recent advances in brain and behavioral sciences that reveal critical links between interpersonal interactions and physiological responses, social support networks and immunity and nutrition and brain development and function. $95/11 hours CME. (415) 666-2894.

October 15, 1980
Providence Medical Center Grand Rounds, "Chlamydia," Mark Loveless, M.D., 8:00 a.m., Amphitheater, Providence Hall. 234-8211.

October 15, 1980
St. Vincent Medical Grand Rounds, "Cardiology Update: After Load Reduction," Barry Greenburg, M.D., UOHSC. South Dining Room, 8:00 a.m. 297-4411, ext. 2010 or 2220.

October 22, 1980
"Drugs and the Heart," sponsored by the Providence Medical Center, 8:00 a.m. to 4:00 p.m., Oregon Medical Association, 5210 S.W. Corbett, Portland. Faculty comes from University of California Medical School at Davis and San Francisco and UOHSC. Registration fees: $35/physician, $15/non-physician. 5/5 hours CME. 234-8211, ext. 532.

October 22-25, 1980
National Council Family Relations Annual Meeting, Hilton Hotel, Portland. "The Quality of Family Life: Integrating Theory. Research and Application." Experts from Cornell, University of Uppsala, Sweden, UOHSC, OSU and others will conduct the Family Life Department, Oregon State University, Corvallis 97331 or call 754-4765.

October 23-25, 1980
Fourth Annual Pacific Northwest Review of Obstetrics and Gynecology, sponsored by UOHSC Division of Continuing Medical Education, Marriott Hotel, Portland. 225-8700.

October 24-26, 1980
"In Pursuit of Wellness," sponsored by University of California, San Francisco, Continuing Education, Sheraton Palace Hotel. An in-depth look at the state of our knowledge about what health is once we get beyond the idea that health is merely the absence of disease. $40/12 hours CME. (415) 666-3904.

October 29, 1980
Providence Medical Grand Rounds, "Office Management of Fungal Skin Diseases," Keith H. Swenson, M.D. 8:00 a.m., Amphitheater, Providence Hall. 234-8211.

October 29, 1980
St. Vincent Medical Grand Rounds, "Non-Hodgkin's Lymphoma," Samuel Newcom, M.D., UOHSC. South Dining Room, 8:00 a.m. 297-4411, ext. 2010 or 2220.

November 4, 1980
"Immunology for the Practicing Physician," sponsored by Portland Adventist Medical Center, 8:50 a.m. to 5:00 p.m. $40 registration. This symposium is designed to update the practicing physician in radical advances in immunology should affect the daily care of patients. 239-6166.

November 5, 1980
Providence Medical Grand Rounds, Abraham Braude, M.D., Professor of Medicine, Head, Division of Infectious Diseases, University Hospital, San Diego, California. 8:00 a.m., Auditorium, Providence Hall. 234-8211.

November 5, 1980
St. Vincent Medical Grand Rounds, "Antiarrhythmic Update," John McAnulty, M.D., UOHSC. South Dining Room, 8:00 a.m., 297-4411, ext. 2010 or 2220.

November 7, 1980
"Pediatrics in Practice: The Adolescent," sponsored by the Kaiser Department of Medical Education. 8:00 a.m. to 4:30 p.m., Town Hall, 3425 N. Montana Avenue. $30/physicians. 281-0460.

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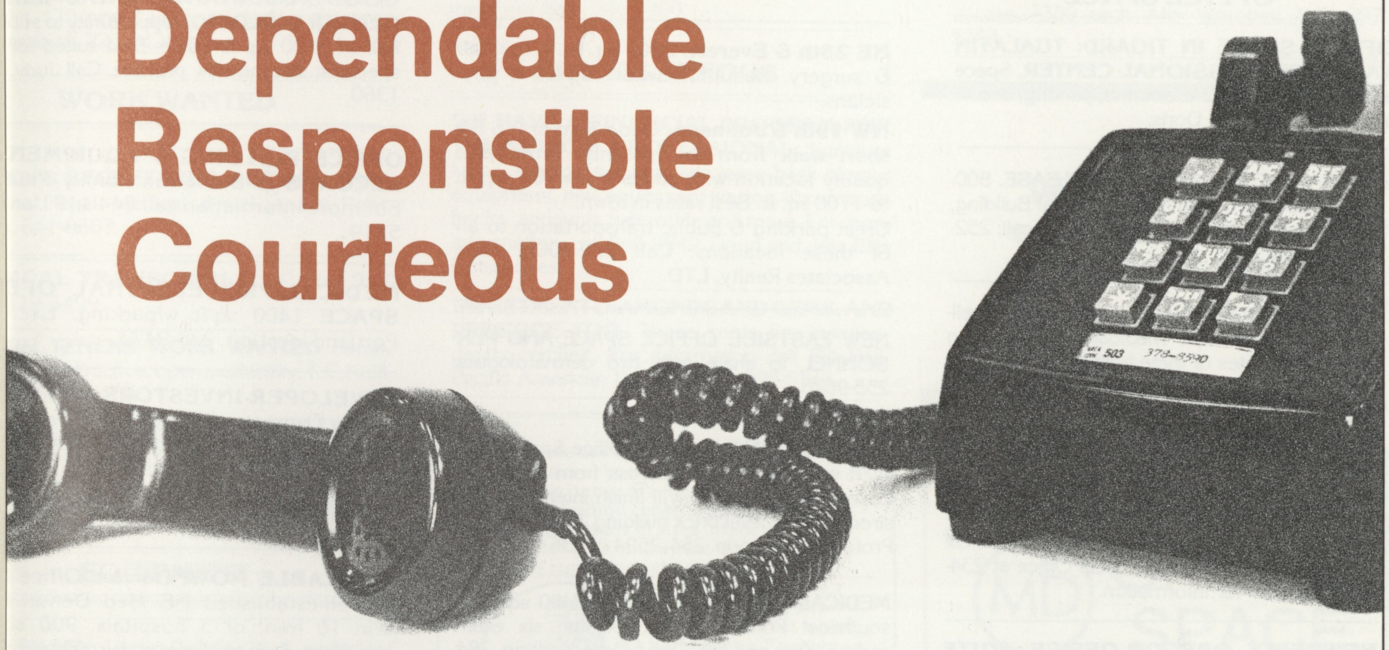

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in summary

October 8, 1980
Providence Medical Center Grand Rounds, "Clinicopathological Conference," John P. Hammerstad, M.D., UOHSC. 8:00 a.m., Amphitheater, Providence Hall. 234-8211.

October 9, 1980
St. Vincent Medical/Surgical Grand Rounds, "Tumor Markers," James Booth, M.D., South Dining Room, 8:00 a.m. 297-4411, ext. 2010 or 2220.

October 11 & 12, 1980
"The Healing Brain II," sponsored by University of California, San Francisco, Continuing Education, Sheraton-Palace Hotel. Recent advances in brain and behavioral sciences that reveal critical links between interpersonal interactions and physiological responses, social support networks and immunity and nutrition and brain development and function. $95/11 hours CME. (415) 666-2894.

October 15, 1980
Providence Medical Center Grand Rounds, "Chlamydia," Mark Loveless, M.D., 8:00 a.m., Amphitheater, Providence Hall. 234-8211.

October 15, 1980
St. Vincent Medical Grand Rounds, "Cardiology Update: After Load Reduction," Barry Greenburg, M.D., UOHSC. South Dining Room, 8:00 a.m. 297-4411, ext. 2010 or 2220.

October 22, 1980
"Drugs and the Heart," sponsored by the Providence Medical Center, 8:00 a.m. to 4:00 p.m., Oregon Medica Association, 5210 S.W. Corbett, Portland. Faculty comes from University of California Medical School at Davis and San Francisco and UOHSC. Registration fees: $35/physician, $15/non-physician. 5/5 hours CME. 234-8211, ext. 532.

October 22-25, 1980
National Council Family Relations Annual Meeting, Hilton Hotel, Portland. "The Quality of Family Life: Integrating Theory. Research and Application." Experts from Cornell, University of Uppsala, Sweden, UOHSC, OSU and others will conduct the Family Life Department, Oregon State University, Corvallis 97331 or call 754-4765.

October 23-25, 1980
Fourth Annual Pacific Northwest Review of Obstetrics and Gynecology, sponsored by UOHSC Division of Continuing Medical Education, Marriott Hotel, Portland. 225-8700.

October 24-26, 1980
"In Pursuit of Wellness," sponsored by University of California, San Francisco, Continuing Education, Sheraton Palace Hotel. An in-depth look at the state of our knowledge about what health is once we get beyond the idea that health is merely the absence of disease. $40/12 hours CME. (415) 666-3904.

October 29, 1980
Providence Medical Grand Rounds, "Office Management of Fungal Skin Diseases," Keith H. Swenson, M.D. 8:00 a.m., Amphitheater, Providence Hall. 234-8211.

October 29, 1980
St. Vincent Medical Grand Rounds, "Non-Hodgkin's Lymphoma," Samuel Newcom, M.D., UOHSC. South Dining Room, 8:00 a.m. 297-4411, ext. 2010 or 2220.

November 4, 1980
"Immunology for the Practicing Physician," sponsored by Portland Adventist Medical Center, 8:50 a.m. to 5:00 p.m. $40 registration. This symposium is designed to update the practicing physician in radical advances in immunology should affect the daily care of patients. 239-6166.

November 5, 1980
Providence Medical Grand Rounds, Abraham Braude, M.D., Professor of Medicine, Head, Division of Infectious Diseases, University Hospital, San Diego, California. 8:00 a.m., Auditorium, Providence Hall. 234-8211.

November 5, 1980
St. Vincent Medical Grand Rounds, "Antiarrhythmic Update," John McAnulty, M.D., UOHSC. South Dining Room, 8:00 a.m., 297-4411, ext. 2010 or 2220.

November 7, 1980
"Pediatrics in Practice: The Adolescent," sponsored by the Kaiser Department of Medical Education. 8:00 a.m. to 4:30 p.m., Town Hall, 3425 N. Montana Avenue. $30/physicians. 281-0460.

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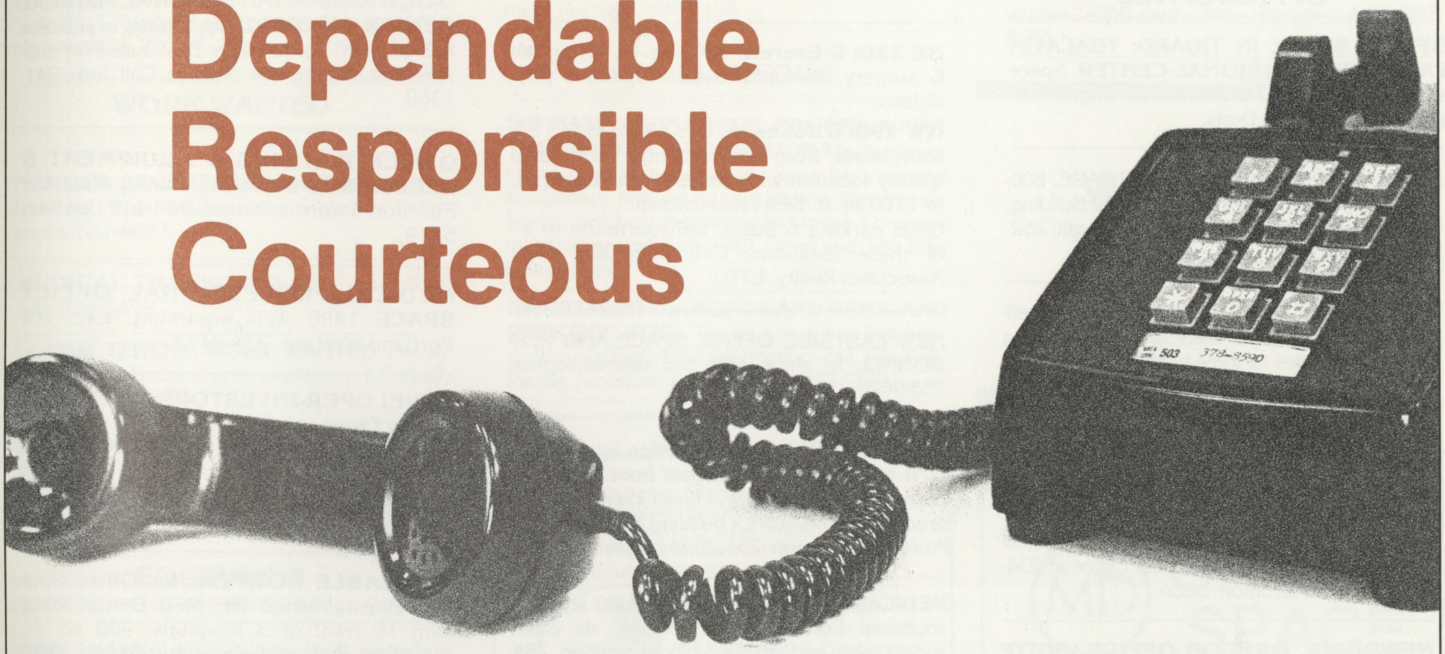

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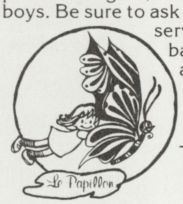

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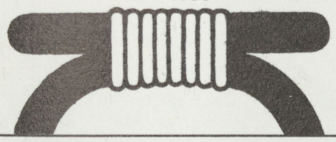

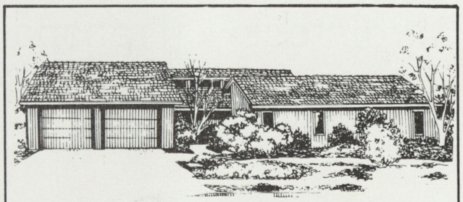

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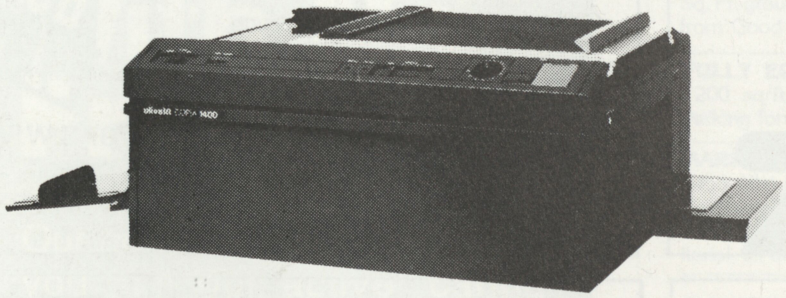

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