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THE SCRIBE MEDICAL FOCUS — PRACTICE MANAGEMENT — BEGINS ON PAGE 5.

Oregon's PRO Medicare bid up for grabs; local control "a colossal mess"

By Cliff Collins

Oregon's Medicare delivery is tossing about in troubled waters as the state's physicians, hospitals — and the almost-forgotten Medicare recipients — await the outcome of the Oregon Medical Professional Review Organization's efforts to win a new contract with the federal government.

OMPRO's two-year contract to review Medicare cases ended July 31 after the Health Care Financing Administration rejected a new bid during negotiating sessions at HCFA's headquarters in Baltimore, Md., July 28 - Aug. 1. Ray Mensing, vice president and general counsel for the Oregon Association of Hospitals, said HCFA officials asked OMPRO's staff to resubmit "objectives" on Aug. 4, but on Aug. 6 were advised they did not have the contract.

The Oregon contract will be reopened for bidding from other parties, possible from outside Oregon, at the end of a 10-day period beginning on the date HCFA publishes public notice for requests for proposals in *The Commerce Business Daily*, said Andrew Webber, executive director of the American Medical Professional Review Association in Washington, D.C. Webber, who said more than 50 percent of state peer review organizations were denied contract renewal, said he is confident that Oregon, Georgia and Louisiana PROs can win new contracts before the end of the 10-day period.

"We're told the only thing separating them (HCFA and OMPRO) is making a few revisions to objectives," said Webber from his Washington office. "I'm still confident Oregon can make the revisions."

OMPRO staff and physicians serving on its board of trustees have expressed concern that local control of physician peer review could be in jeopardy if OMPRO does not retain its PRO contract. OMPRO's staff would be cut back drastically if efforts to win a new contract fail. The organization provides medical case review and case management for many large corporations, but its federal contracts for Medicare and Medicaid comprise 60 percent of its business.

Peer review from California?

Robert L. Hare, M.D., immediate past chairman of the board of trustees of OMPRO, said physicians in Oregon are worried that some organization outside the state will win a bid to review Oregon physicians. "We're concerned about what happens in Oregon if (review) comes from out of state." "This will probably be the final chance," said Richard L. Banner, M.D., a member of the board, speaking of the 10-day period. "The alternative may be that (peer review) may be run from outside of Oregon, and that may not be best."

OMPRO's fear is not ungrounded. There are several instances of one state's PRO winning a contract in another state. A close-by example is Alaska, where Washington state won a new bid to continue doing review in that state, according to Thomas G. Wallner, associate regional administrator for health standards and review for HCFA's Region X office in Seattle. Idaho and Washington contracts also are up for grabs, he said. HCFA's Jerry Thompson told *The Scribe* in June that the PRO legislation requires that local physicians be used in the peer review process, and therefore the concerns expressed about loss of control were invalid. OMPRO officials, however, said current statutes do not prevent PRO "regionalization" from happening: Adding three or more local physicians to the process would be all that the law would require, OMPRO officials said at the time.

Indiana swallows Kentucky's PRO

Paul Osborne, executive director of Kentucky's Medical Peer Review Organization, said his organization, which also was denied renewal, was out-bid by "a for-profit spinoff" of Indiana's PRO. "We got underbid by 30 percent," said Osborne by phone from his Louisville office. "I'm convinced they cannot do it for what they bid." Osborne said he heard through one of the Indiana employees that that organization plans to go back and ask for more money at a later date, which Osborne described as "an old trick."

Stuart Graves, M.D., president of the board of the Kentucky PRO, said he saw the medical criteria in the Indiana bid, and "I could never get my board to go along with some of those; it might get... people hurt." Graves said his organization had received national recognition — and national contracts — for its com-

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Good Sam files application for kidney transplant program

By Diane S. Lund

Good Samaritan Hospital & Medical Center has filed a preliminary application for a kidney transplant program with the State Health Planning and Development Agency (SHPDA). "Our position is that we are actively considering beginning a kidney transplant program but really haven't yet made up our minds whether or not to proceed," said Chuck Williams, media relations coordinator at Good Samaritan.

The decision is still in the discussion stage, according to Williams.

"We're still gathering information and talking to people," Williams said. "With the new (organ) donation law, there may be more availability of kidneys. A kidney transplant program may be a way of rounding out our kidney services."

If Good Samaritan wanted to file a certificate of need application during 1986 to start the kidney transplant program, it needed to have its preliminary application in Salem by July 31, according to John Martin, manager of health facilities and regulation for SHPDA.

In its application, Good Samaritan indicated it would submit a letter of intent during October and a certificate of need application in November, Martin said.

"We may not apply, and if we do we may not stick to that timetable," Williams responded. "We're still talking to the other members of the nephrology and urology community, so we'll see what happens. This has allowed us the opportunity to apply for the certificate of need later this year if we choose to do so."

No capital expenditures were mentioned in the application, which was signed by Rebecca Bowne, division director of operations support for Good Samaritan.

"We've acknowledged receiving Good Samaritan's preliminary application," Martin said. "It was complete. All the information was there."

Bruce Blank, M.D., a urologist at Good Samaritan, said he hoped a renal transplant program could be run in cooperation with Oregon Health Sciences University.

"That's the best use of resources," Blank said. "I philosophically believe that in a community this size the patients and the community benefit if it's done in a cooperative spirit rather than... hospital competition."

Currently OHSU runs the state's only kidney transplant program. Williams acknowledged that Good Samaritan had been in contact with people from OHSU.

"We've been in touch with people at the hill for years about the possibility of beginning a transplant program down here," Williams said. "We will continue to try to work with the hill. We obviously look to them for their leadership and their expertise. At one level or another we would like to work with them."

Good Samaritan operates the state's largest dialysis program. Outside of Portland, it runs the dialysis program at the Ft. Vancouver Kidney Center in Vancouver, Wash. and the Eastern Cascades Dialysis Center in Bend. As of Aug. 8, there were 283 patients on dialysis. •

Appeals board upholds Holladay Park lithotripter site selection

By Cliff Collins

A five-person appeals board on Aug. 14 upheld the state health planning agency's May decision to allow Oregon's first lithotripter to be placed at Holladay Park Medical Center. The ruling appears to bring to an end a contentious and unusual debate that simmered for more than a year, eventually polarizing many physicians and hospitals.

The Certificate of Need Appeals Board, which was appointed by Gov. Vic Atiyeh and whose members represent both consumers and providers, reached their decision following three days of lengthy hearings. The board was asked to decide if an extracorporeal shock wave lithotripter — a German-made machine that painlessly destroys kidney stones in selected patients — would be located at Holladay Park or on the campus of Oregon Health Sciences University.

The State Health Planning and Development Agency ruled in May that the machine would be located at Holladay Park. OHSU appealed the ruling, citing that institution's track record in urology and nephrology and emphasizing the need for research on the relatively new device. The appeal came after a stalemate developed following discussions for a joint purchase agreement between several major hospitals.

Sylvia Davidson, chairwoman of the appeals board, called the appeal sessions "a tough trial." She said the board has 45 days to issue a written ruling but will complete the task sooner. Davidson said testimony from physicians played an important part in influencing the board's decision. "We will have a long and detailed (written) opinion," Davidson said. "There were very definite reasons we decided in favor of HealthLink." HealthLink owns Holladay Park and was instrumental in lining up support from area hospitals for placement at Holladay Park. Dick Grant, director of SHPDA, said the move by most Portland hospitals to jointly endorse a location for a specific technology was "somewhat unprecedented for such warring and devisive... institutions."

Cooperative effort expected

OHSU officials were disappointed with the board's ruling, but pledged their support to HealthLink in setting up the technology. "OHSU intends to fully cooperate with HealthLink in locating a lithotripter at Holladay Park," said Lee Lewis, associate director of university communications. Reading from a prepared statement, Lewis quoted University President David M. Whitter as saying, "We believe that although Holladay Park is a very acceptable site, it is not the best site for the University to accomplish its research and teaching missions."

Lewis said OHSU had appealed SHPDA's decision "because of concerns that the agency ignored criteria governing the placement of expensive equipment where it can best be utilized for patient care as well as education and research." Lewis added that it is too early to make any decision concerning further appeals. She said that decision would not be made until after the appeals board's written ruling is issued.

G. Rodney Wolford, president of HealthLink, through spokesman Michael Alesko, said he anticipates that "many hospitals will participate in the operation, financing and utilization of the machine." Wolford said the coordinated effort by hospitals to obtain a jointly-owned lithotripter has been in the making for a year, and said the move "sets a

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Over-prescribing tops list of state's disciplinary problems

By Michael Dolan

Prescribing medicine on the basis of outdated drug information or over-prescribing Schedule II drugs — a problem all over the country — has been building in Oregon for several years, according to John Ulwelling, executive secretary to the Oregon Board of Medical Examiners.

"Physicians have been using controlled substances for the treatment of chronic benign pain when they probably should be prescribing anti-depressant drugs," he said. "We have also found a number of instances where physicians have been prescribing controlled substances to family members. We recommend against that."

Possible disciplinary action includes monitoring all prescriptions written by a physician, prohibiting prescription of Schedule II drugs, and even revoking the license. Board investigators are conducting routine pharmacy checks to uncover abuse, said Ulwelling. Investigators are looking for inappropriate prescribing of scheduled drugs, especially those containing codeine.

The board's medical consultant, Donald Dobson, M.D., has begun to review the 10-year backlog of nearly 3,200 malpractice claims to look for serious and continuing problems.

Physicians suspected of over-prescribing may be asked to volunteer to attend continuing education programs, Ulwelling explained. The programs are also available to other physicians working to stay informed of new practices. "We want physicians to learn appropriate medication practices without having to be disciplined by the board," he said.

The board, along with the Oregon Foundation for Medical Excellence, has scheduled several drug-related information programs. One program in particular, "Pain and Suffering — Clinical Strategies for Management," will be offered all day October 2 at the OMA headquarters. This program and others will be offered at additional times. The foundation has more information at 636-2234.

The board and the foundation have also joined with the Oregon Health Sciences University School of Medicine to conduct a research program to determine the characteristics of physicians most likely to engage in inappropriate prescription writing. Preliminary results may be available in six months, Ulwelling said.

Dobson divides his position into two parts: to assist the board in investigations by providing experienced medical advice and preparing case summaries, and to review malpractice claims filed with the board in order to make disciplinary recommendations to the board.

"It is imperative that medicine police its own house," explained Dobson. "The board must do it and assure the public it is being done. The board is physicians; we are only as effective as our ability to work with doctors."

So far, Dobson has found 89 physicians who have been targets of four or more malpractice suits. Most cases are filed against "high risk" physicians — obstetricians, plastic surgeons and orthopedists. The majority of claims are closed without payment, said Dobson.

"If they (physicians) have had four or more claims, they are going to hear from me," he explained. "They will get a letter of inquiry. It's just information-gathering. I don't want anyone to panic."

In fact, Dobson has already found that the physician with the most malpractice claims filed against him — 10 — has a "clean" practice, but the nature of his specialty tends to lead to claims.

Dobson has begun active review of 30 physicians with four or more malpractice claims. He has "closed the file" on 16 of them. Four physicians have been disciplined, he said. "We have arranged to modify the practices which generated the claims."

Two physicians have given up obstetrics, two have given up surgery. Two physicians entered voluntary agreements to limit their practices. "Rather than go to a formal hearing, I try to go to the physician and work out a voluntary agreement," Dobson said.

Dobson feels the vast majority of physicians are doing a good job, but one to two percent "have problems." He regularly faces tough cases in which it is difficult to determine whether or not a physician has made a mistake in judgement. But he still thinks his new post is less stressful than his former practice. "I can make decisions slowly now," he said. •

Cascade AIDS Project calls for volunteers

The growing numbers of AIDS cases in Oregon has led to a need for more volunteers at the state's largest private AIDS organization.

Brown McDonald, executive director of the Portland-based Cascade AIDS Project (CAP) said volunteers are needed for a variety of responsibilities at the non-profit community health agency.

"There are now more than 100 AIDS cases and hundreds of people with AIDS-related complex here in Oregon," McDonald said. "As that number grows, so do CAP's efforts to prevent the spread of AIDS and assist those who've already been affected."

Volunteers are needed for tasks ranging from office work to fund-raising, photography, graphics, public relations, education and data processing. At least 40 people are needed to provide emotional and practical support services to people with AIDS or their loved ones. Other volunteers are needed to staff training sessions teaching the public how to prevent the sexual transmission of AIDS. Especially welcome are people with managerial and staff development experience, McDonald said.

"The statistics keep going up much faster than the government resources available. So it's more apparent than ever that to educate the public about AIDS and help those who have AIDS, people must be willing to step forward," he said.

Anyone interested in volunteering should contact the CAP office at 223-5907. •

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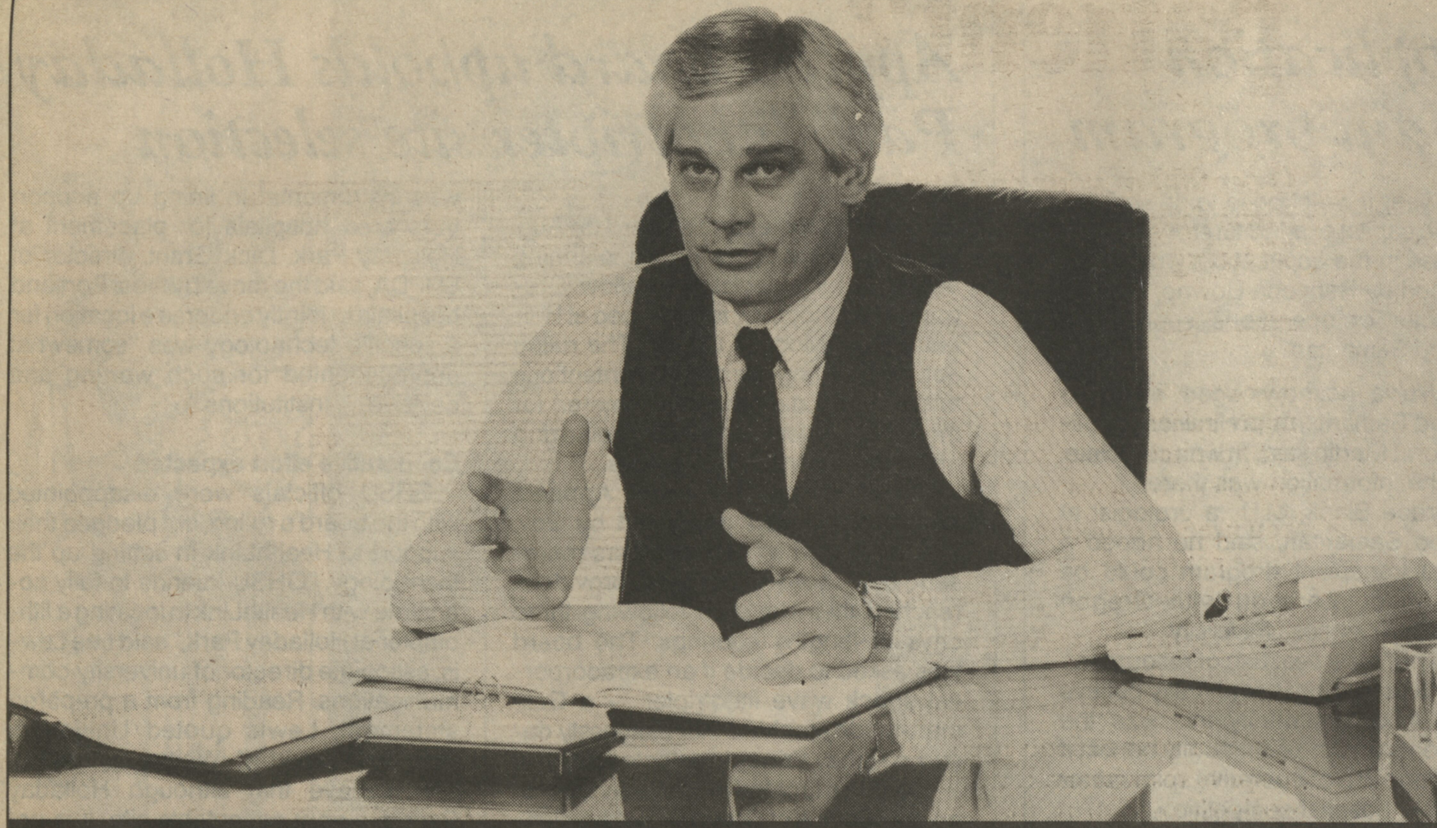

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Half of PRO Medicare contracts rejected by HCFA

continued from page 1

petence, yet was denied renewal with HCFA. "I don't think we were liked in the regional office because we challenged things," Graves said. "I still feel our primary allegiance of a PRO is to the patient."

Osborne and Graves said they believed regionalization and consolidation were very much on the minds of federal officials. Graves said the South Carolina PRO, "another one of the best, is also out of business. . . Maybe someone up there (Washington) wants the whole thing put out of business."

Graves said peer review for Medicare is "a lousy job; nobody likes what you do." He said it is difficult to convince physicians "to come in. . . and do HCFA's dirty work."

Asked what his PRO's future looks like, Osborne said: "It's difficult to say. We have an active list of private clients, but we're still trying to do damage assessment."

"No game plan"

The overriding concern expressed by state PROs is not so much the rumors about HCFA's regionalization schemes, but about the agency's utter silence about what direction it is taking. "There is no clear central mission from HCFA about what they want to do," said AMPRA's Webber. He attributes the contradictory decisions handed down to the PROs to be a reflection of HCFA's bureaucratic disorder and lack of direction. Webber said Thomas Morford, HCFA's new chief of health standards and quality, has stated publicly he supports local review and "good representation by local physicians."

"Yet when you see the difficulty Oregon has in negotiations, you begin to suspect whether they are really supportive," Webber said, adding that the problem with bureaucracies such as HCFA's is that the leadership and the "people running the day-to-day staff may have different ideas, different agendas."

"HCFA has never said what their game plan was," charged Osborne of the Kentucky PRO. OMPRO physician Hare agreed that HCFA has been vague about their reasons for rejecting contracts. "We have made reasonable and adequate proposals — or what we thought were — without any adequate explanation of what they want from us," said Hare. "It's kind of a guessing game with them."

Hare, like his Kentucky counterparts, wondered if the financial aspects of the contract were primary to HCFA. Or was there a perceived lack of disciplinary action against physicians? No discernable pattern emerges when the acceptances and rejections are evaluated, according to Webber. Said Hare: "Guidelines for approval or non-approval have not been spelled out. We have been more vigorous (in disciplinary measures) than many that have been reviewed."

The most common charge HCFA has leveled has been a lack of disciplinary action against physicians, said Webber. "They are looking very much for punitive actions, but, quite frankly, that conflicts with our notions of peer review. You can change physician behavior without sanctions." He added it could be argued that sanctions indicate "failure of the PRO."

Review in limbo

Meanwhile in Oregon, Ray Mensing's phone is ringing off the hook. Hospitals are calling up the OAH wanting to know what they are supposed to do with OMPRO on the sidelines. Blue Cross/ Blue Shield as "fiscal intermediary" is handling some discharge review, but there is no pre-admission review being done in the state's Medicare cases, Mensing said.

"It's a colossal mess, to tell you the truth," said Mensing. "HCFA is sitting on their hands." Mensing said the original intent of the PRO legislation was to ensure that Medicare patients received appropriate care in an appropriate setting — an idea that has all but gotten tossed aside in the acrimonious disputes over contracts. "Our number-one responsibility is to the patients, as I look at it," added Hare. The second responsibility of PROs is to make sure professionals are able "to give first-rate care" without being impeded, he said.

OMPRO officials are not speaking on the record until the conclusion of the 10-day period, and HCFA officials in Seattle refused to discuss the specific reasons OMPRO was rejected. HCFA's Wallner said only that the two sides were unable "to reach agreement on review objectives called for in the RFP." Wallner said Washington state's contract was rejected because "we didn't feel their performance was adequate enough."

Packwood committee applies pressure

In June, the Senate Finance Committee ordered a General Accounting Office study of HCFA's PRO evaluation process. In a letter to the controller general, the committee, headed by Oregon Sen. Bob Packwood, wrote that members were concerned that 16 of 31 state PROs were not offered renewal. "This rate of nonrenewal indicates real problems either with some PROs or with HCFA's management of the program," the letter stated.

The letter asked that the GAO determine what criteria were used in deciding on renewal or nonrenewal: "As sponsors of the original legislation which established the PRO program, we want to be sure that it meets our expectations in assuring quality of care for Medicare beneficiaries. We are concerned that the review of PROs be based on objective, fair and verifiable measures of effective performance which meet the program's mission." •

Scribe

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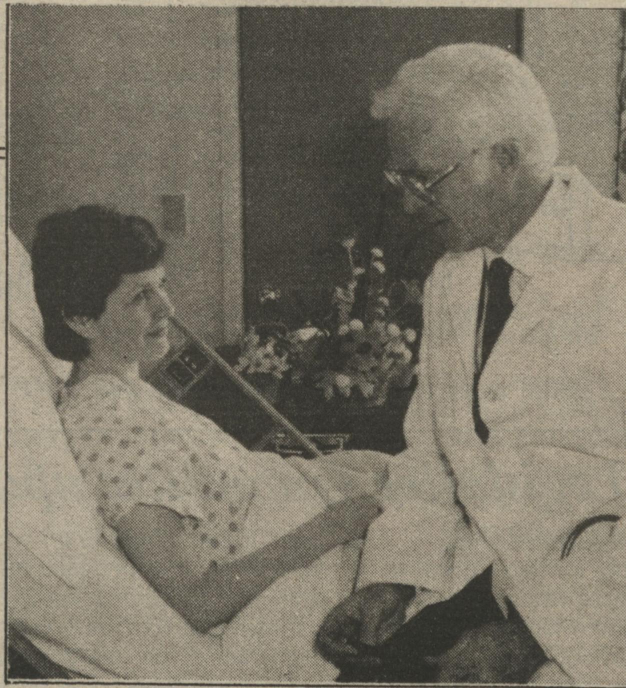

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Opinion

How many rings, how many thanks?

By Robert Delf Jr., M.P.A.
MCMS Associate Executive Director

It's Friday, around 6:10 in the evening, and I've just called the Physicians' Answering Service (I do this every day because I need answers.). I feel a little uncomfortable calling PAS, occupying a line, using valuable operator time — but I must know.

How many rings?

How professional is the service tonight?

Are our physicians and their patients receiving the best service in town — in any town in the country?

And, as I dial the last digit, I'm optimistic that today's planning has paid off. (Why, wasn't it just today that we received a letter from a group of six pediatricians complimenting the operators on their performance last weekend?).

I'm using the free 'doctor call-in' line and the last click on my old rotary phone will tell me the answer.

One ring.

Two rings.

Then three.

"Physicians' Answering Service — may I help you?"

I allow myself a smile and say, "This is Rob Delf. You answered on the fourth ring. You're doing a super job — Keep up the good work."

The operator sounds a little surprised and, perhaps, pleased. She acknowledges the praise but doesn't linger. She has more important business; she has *your* call to handle.

Next, I call a special number that will be treated like an incoming call from a patient. (This number has been created specifically for quality control.) Although I still have my reservations about using valuable operator time, I must have answers to my questions.

One ring. "Physicians' Answering Service. May I help you?"

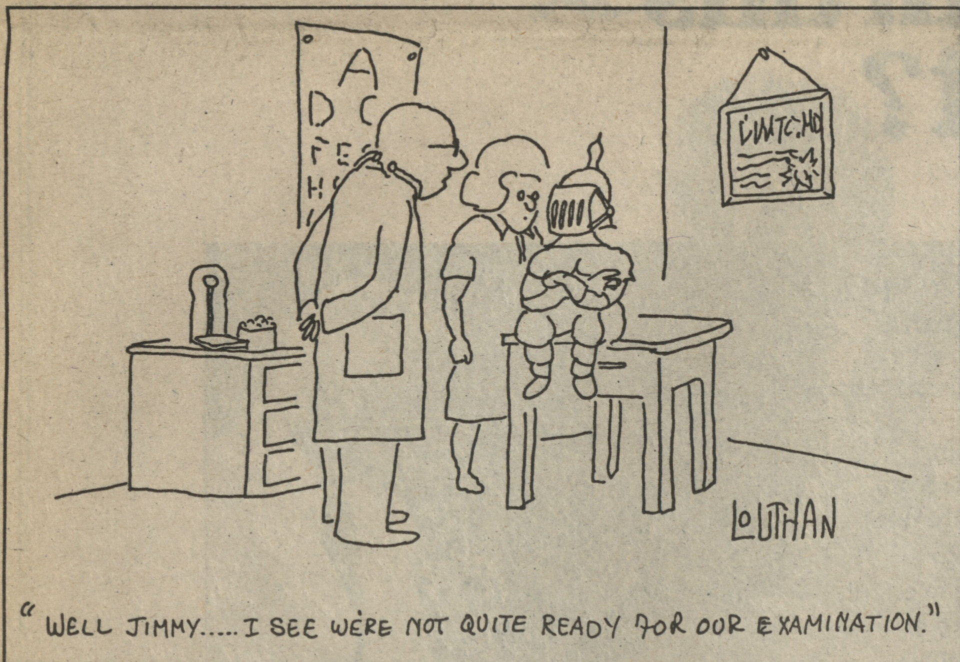
Again, I let the operator know that his performance is appreciated. And I indulge myself with the knowledge that these dedicated, caring and hard-working individuals understand that their "job" is something special, that *quality* service is the only standard we have, that when the phone rings, it's because a physician or patient has a need that requires a professional response.

My thoughts continue: Yes, there are other answering services around: some old, some new and some that rely on resources other than human beings. And yes, we've had a "challenging" six months. And yes, it's been painful and we've lost "market share." (Actually, we don't use that phrase: You are our doctors and patients — and, for a variety of very good reasons, we refuse to adopy the "profit-at-any-cost" mentality.)

Anyway, the "service" is working tonight, and, gradually, there are more good nights than bad. People in medical need will be connected with people with medical expertise. Our problems of long rings and less than perfect messages are being resolved.

And tonight, I can go to bed knowing that our only "product" — service — is being delivered.

And yet, I indulge myself with one last thought: Wouldn't it be great if our doctors told their PAS operators they were doing a good job each time their expectations were realized? •



"WELL JIMMY..... I SEE WE'RE NOT QUITE READY FOR OUR EXAMINATION."

MCMA Legislative Committee update:

By Kitty Wheeler, legislative chair

We have a loosely-formed legislative committee of 80, all of whom are committed to effecting tort reform in the 1987 State Legislature. At our June 30 meeting, Jim Kronenberg, assistant executive director of the Oregon Medical Association, gave us an overview of the statewide Citizens' Initiative for Equity in the Legal System (CIELS) coalition, which has 70 organizations as members, all pushing for tort reform. The OMA is a member of CEILS.

Tort reform affects all of us, not only in the medical world, but also in our daily lives. Cities are reeling under the high insurance rates they must underwrite, if they are fortunate enough to get coverage. Schools are reconsidering field trips due to liability. Non-profit boards of directors are increasingly coming under fire about carrying adequate liability. Clearly the issue of exhorbitant insurance rates and juries' large monetary settlements are impinging on all of us.

Become educated about the issues of tort reform and how they impact your daily lives. Network among your neighbors, friends, boards on which you sit, volunteer and professional jobs you hold about the importance of Oregon achieving tort reform in the next legislative session. Ask every candidate whom you meet between now and the November general election what his/her stand is on tort reform, and urge support. Undoubtedly, insurance rates will be regulated, but that is not enough to stem the tide of courtroom settlements.

This coming winter we will be sponsoring legislative workshops for physicians and their spouses on how to contact and inform your legislators of your opinions. We will also join the OMA auxiliary for a day at the Legislature — February 12 — where we will have an opportunity to talk with our lawmakers and convey our concern about tort reform. Together we can all make a difference!

I invite you to join our MCMA legislative committee. If you have any questions, would like more information on tort reform, and/or want to become involved, please call me at 223-0527. •

PAS Update. . .

OUR PAS CUSTOMERS have been informed of various changes in our answering service through *PAS Updates.* The following information is reprinted by customer request.

WHAT ARE ALL THE PAS PHONE NUMBERS — What does each one do, which are free, and which are charged to my account?

PHONE NUMBER	WHO SHOULD USE THIS PHONE NUMBER?	CHARGE OR NO CHARGE?	COMMENT
294-XX00	Doctor only, except for certain clinics using a '274' prefix.	no charge	Doctor should always use this number only. There is no charge for its use, and it gives the doctor priority at PAS. This number is the rounded hundreds number of your patient D.I.D. 'if no answer' number.
Whatever number has been assigned to the office by PAS. Each office is different.	Patients plus doctor's office when requesting action, except clinics using a '274' prefix.	$0.23 charge per call	Patients should always be given this 'if-no-answer' number. (Long-time patients who use your old 228-XXXX number will still be routed to PAS for about a year.) Doctors' offices should also use this number when trying to reach the doctor or telling PAS about the doctor or the doctor's location.
221-1822.	Doctors' offices when requesting information.	$0.23 charge per call	At the prompt, punch in: '46,' plus the last four digits of your D.I.D. 'if-no-answer' phone number. **If there are no messages, there is no charge for using this number.** If there are messages, the operator will give them to you and charge your account 23 cents.
221-1515	Hospital urgent calls	no charge	This is the only phone number which hospitals should use when trying to reach the doctor STAT. The call is free and is, like the doctor's personal number, dealt with on a PAS priority basis.
228-4080	Radio Paging calls	no charge	This is the number Radio Paging Service customers should use for general information and service and equipment problems.
228-4175	Anybody doing general business with PAS.	no charge	This is the same PAS business number that has been in existence for 50 years.

ARE YOU STILL HAVING TO WAIT IN LINE to get your message? Virtually every physician has a no-charge, priority call-in number *(See above)* which routes aorund all other calls. So, if you're still getting long rings, you're probably not using the right telephone number.

Except for large clinics, which have a different arrangement, the doctor's priority phone number is the rounded hundreds number of your patient's D.I.D. 'if-no-answer' phone number.

DO PATIENTS CONTINUE to complain about long ringing patterns? That should not be, since calls which ring more than five times are picked up by an announcement machine, which simply notes that our lines are busy and that we'll be with the caller momentarily.

In response to your comments, reference to 911 has been dropped, and the message has been softened both in content and by using a female voice.

If long ringing patterns are occurring, then the problem could be in your phone system. To find out, call your telephone vendor and ask if your phone has a 'stop hunt key.' If not, what is happening is while one caller is using your D.I.D. 'if-no-answer' number, the next caller is simply moved to the next phone number on your system. The result is that your phone is ringing in an empty office.

IS PAS UNIONIZED NOW? PAS employees recently voted not to unionize. If PAS had voted for a union, we would have restructured some elements to assure continuous operation in any contingency, but not changed the service in any other way.

We couldn't inform our customers of the campaign before the election and also guarantee an impartial vote. We felt it was important to hold an election which could not be contested later, and then to get back to business as quickly as possible.

THANKS TO JOHN L. STEVENSON JR., M.D. of Pediatric Associates, who took the time to praise PAS operators when it was deserved. "Just to let you know we don't only send the bad news, I'd like to tell you that after being on call for the whole weekend, your answering service did a great job with no problems," Dr. Stevenson wrote. Thank *you,* doctor. We appreciate it.

A NEW PAS ACTING DIRECTOR has been chosen: Pauline Ketchum. Pauline, who may be reached at 222-9977, has been with PAS for 18 years, serving in virtually every capacity on both old and new systems. She is particularly adept at operator training and paging, two of the key aspects of our new system. Pauline replaces Joye Richards, who has left to pursue new opportunities with another radio paging business.

A NEW MANAGEMENT TEAM has been developed. Rather than rely on floating shift supervisors, Pauline has named six full-time supervisors, each responsible for every facet of the shift they oversee. Also, three technicians are amending and adding customer data to our computers and accelerating operators' education regarding the many technical aspects of the new system. An additional training supervisor will soon be added to the team.

WHY PAY FOR NON-URGENT CALLS? More and more, physicians are deciding that there's no reason to do so. Routine billing and appointment calls can and should wait until the next business day — and through the use of an announcement machine, doctors' call volume is diminishing, and so are their PAS bills.

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Find your legal partner before the crisis, specialists urge

By Erik H. Bergman

In law as in medicine, prevention is the best cure.

As physicians find more and more legal matters impacting upon their practices, the solution is to seek and foster a solid professional relationship with an attorney knowledgeable in the medical field.

Find that attorney now to avoid a future crisis, advise Portland attorneys who specialize in a physician clientele. Prompt handling of routine legal matters means less chance of a costly mistake ahead.

No doctor would hesitate to call in a specialist should a medical case demand it. When legal issues crop up, the same advice holds true: Call a specialist. But where to look?

"Doctors assume specialization in their profession, but often overlook it in the legal profession," said Patrick J. Green, a partner in Green & Thompson, P.C. "Doctors often choose attorneys through friendships. That attorney may be a generalist." He advised that physicians seek those attorneys with tax expertise or who have experience working with medical and dental practices.

When looking for an attorney, "It's no time to let your fingers do the walking" through the phone book, said Teresa Ivey, an attorney with Tamblyn & Bush. Since attorneys can't advertise their specialties, start instead by asking your C.P.A., other doctors, your banker or the Oregon State Bar referral service.

Green advised asking other physicians and noting which names keep coming up.

An attorney-physician relationship is best when viewed as a continuum, not as crisis intervention. "Use it in a planning mode, not a crisis mode," Green said.

The relationship "is the basis for very significant decisions," said Ivey. "Work to achieve a comfort level" that allows you to check in with an attorney on a frequent basis. "If you have qualms

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PRACTICE MANAGEMENT

The Scribe Medical Focus — Part 2

Accountant advises 'vulnerable' M.D.s to form financial team

By Cliff Collins

Seeking out a professional financial planner can spell the difference in business success and failure, according to a veteran consultant to physicians and other professionals.

Gary Gurnsey, president of Gurnsey & Associates, has seen too many doctors get themselves into financial straits. Many physicians go to a consultant after they get into trouble with bad investments. If planning is done ahead of time, a lot of grief — and money — can be saved.

Doctors and dentists are particularly vulnerable to bad deals for two reasons: They usually have good incomes, and they rarely have any training in business matters. One other factor contributes to the problem: Doctors often are reluctant to seek advice from other professionals, says Gurnsey.

"Many doctors want to be their own trustees for their pension funds," notes Gurnsey, who has been in insurance and investment planning for 20 years. "You just can't do that any more." Forming a financial team is an important means of protecting income and planning for retirement. Gurnsey suggests doctors add team members in stages, depending on the level of the practice.

For instance, a physician right out of medical school, just setting up a practice, should get a good accountant and an insurance agent, he advises. The next step would be to add a securities advisor and perhaps an attorney. A physician who has been in practice for from three to five years should have all four advisors; the period of five to 10 years down the road should include "a good solid relationship with a bank, and a trust officer from that bank," Gurnsey says.

Income replacement insurance is important, and even more vital is making sure the language of the policy is understood. As an example, he points out that the definition of "disability" in policies makes a big difference as to whether the doctor will ever collect. "A lot of people overlook that and just go on price," he says. "An insurance policy is a contract; you have to know what that says in order to be able to use it."

So-called tax shelters are one of the biggest trouble areas for doctors, says Raymond Maddix, an investment executive with Gurnsey. Overzealous salespeople may neglect to point out that attractive-sounding write-offs can come back to haunt investors. "Any time you see a 4-to-1 or 3-to-1 write-off, it is a tax *deferral* program," cautions Maddix. "A lot of people miss that point."

Be wary any time you see a 3-to-1 or 4-to-1 write-off, says Gurnsey, who admits that a 20 to 50 percent return on investments sounds terribly appealing. "The salesperson may lead them in the wrong direction, and they could end up with a large tax bill down the road," he explains. For that reason, impartial advice on any investment is a good idea.

Gurnsey and Maddix have seen doctors get burned after they attended free investment seminars that ended up promoting "get rich-quick write-off schemes." All seminars of that type are not deceitful, he emphasizes. The best way to discern whether the seminar is on the level is to call ahead and find out who is sponsoring it. "Find out who the people are affiliated with; they have to be affiliated with someone," says Gurnsey. "If you haven't heard of them that should raise a question."

Also, ask the sponsors how long they've been in business, he urges. Start-up companies may not be crooked, but they are more risky, Gurnsey adds. "Financial planning has gotten a negative nomenclature," he says. "There are a lot of people with no background or credentials."

Gurnsey, who counts 600 to 700 physicians and dentists among his company's clients, has consulting arrangements with several offices and maintains a library on tax changes that affect his business. He says there have been so many tax changes in the past decade that it is difficult even for specialists to stay abreast of the field — an even more compelling reason for non-specialists to seek advice.

Gurnsey laments the fact that most physicians receive no training about how to run a business, when that is one of the first tasks they face upon finishing school. Taking the initiative to get help early on can steer doctors away from the common pitfalls associated with setting up shop and making investments, he says. •

Specialized forms necessary for computerized practices

By Andrew C. Hallock, Jr.

Your computer system is a repository of unfulfilled potential without the paper that displays the end product of the micro-processor miracle. It no doubt took months of research to find the computer to suit your needs. The forms for that carefully-chosen system deserve more than a cursory glance.

Before your office became computerized, you had to order your stationery, voucher checks, payroll checks, in-

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Patient, staff considerations predominate new office design

By George S. Conomikes

Recently I finished an assignment with an outstanding group of West Coast physicians. It had taken them five years to make up their minds about a new building. One of them said to me, "I hope to hell I never have to go through this again."

He doesn't know it, but he will. And, probably, so will you.

Three out of four physicians we come into contact with are not satisfied with their physical plant — front office and back office.

And one out of every four practices is thinking of making a major facilities move: a new building, new offices, or redesigning facilities within the next year.

When new space is considered, the initial plans usually duplicate the current setup, with more space. At that point an alert physician becomes aware that the practice is in need of a restructuring involving more than the space. This is because he isn't wholly satisfied with the present system. Maybe it's the telephone-reception-appointment system; maybe it's financial and collection. Always it's the question of how productive the physicians are themselves and how well they are using their back office personnel.

So redesigning facilities usually should be preceded by redesigning the practice itself: the way patients are managed, the flow of activities — medical and financial, the utilization of personnel, and simplifying physicians' activities and tasks.

But let's assume that you have done your analysis and redesigned your practice. There is still a facility to be designed and built. What are the major pitfalls?

There are three major mistakes to be avoided in designing and building new medical offices:

- **Inadequate heating and cooling systems** — Medical offices have many areas with different sets of traffic: entry and reception room, business office, aisles, exam rooms, consultation rooms, and labs and other service areas. It requires a sophisticated system to ensure even temperature. For example, each exam room, no matter how small, must be capable of having air exchange independent of the next room or hallway.

  Therefore, have your lawyer write into any contract a guarantee of heating and cooling performance standards. If your job doesn't specify these standards, you could spend enormous amounts of money to correct a faulty system and suffer embarrassing inconvenience. Comfort is the name of the game.
- **Too much noise** — In order to maintain a quiet atmosphere, thought should be given to soundproofing or noise dampening. I've been in offices where the heating-cooling duct work was a conduit of noise from one exam room to another. Embarrassing to say the least!

  Consider these noise minimizers:

  Carpeting — in the hallways, in the exam rooms, and in the reception rooms. The new acrylic fibers allow stains to be wiped off (Wool carpeting is not as resistant). A good bet: order carpets with steel fibers woven in for antistatic purposes. A few physicians have even had their carpeting extended part way up the exam room walls to provide wainscotting.

  Drapes — Whether exam rooms have windows or not, sound absorption and a nice decorative touch are provided by floor-to-ceiling draperies.
- **Insufficient business office space** — We are seeing more and more paperwork processing, more medical records and more equipment in today's medical offices. Any two-physician practice now employs an additional staff person for these purposes that it didn't need 10 years ago. A four-physician group more likely has had to augment its front office staff by even more.

  The trend will continue, so make sure you design in an extra 100-300 feet of business space for future needs. •

George S. Conomikes is president of a medical practice consulting firm, Conomikes & Associates, based in Marina Del Ray, California.

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Computer paper

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voices and statements through an office supplier or forms printer. But the forms you normally use for manual accounting and typing may not suit computer use: Regular stationery, unless you buy an expensive ($900 to $1,500) single-sheet feeder, will have to be fed into the computer printer by hand, one sheet at a time, negating its high-speed capabilities. Manual checks, in most cases, will not work with printers, which prevents total computerization of bookkeeping. And, existing invoices, statements and checks usually will not work with your accounting software. The software comes with a built-in set of instructions for spacing and printing; it will follow those instructions whether or not they match your forms.

But the new technology that's computerized your office has also brought great advances in the quality and availability of paper. Now that you're aware of some of the problems paper can create in transition from a manual to a computerized system, here are some points to keep in mind:

- **Order quantities** — Forms printing is a high-volume business. Since most printing costs are in setting up the press to print your forms, most printers like to print as large a quantity as possible to lower the unit price. Five thousand is a common order minimum. You may want to ask your printer for a cost on a variety of quantities, instead of what you need immediately. An extra thousand invoices, purchased 'on top' of your existing order, will be cheaper than if you order them alone.
- **Turn-around time** — Ordering in time can be nearly impossible when most computer forms printers place a 45-day turn-around time on special orders such as forms compatible with a unique system, or orders below the printer's minimum. But there are printers specializing in short runs and quick turn-around. Custom orders take only a few days extra. Their prices are higher, but they may be invaluable in an emergency.
- **Software compatibility** — Software packages have strict form compatibility requirements. But most form printers are just learning to print computer forms. You will avoid wasted orders and delays if you make certain you have a printer capable of printing your software-compatible forms.
- **Relibility** — Find out what your forms supplier promises. You should expect your risk to be held to a minimum, and a guarantee that printing mistakes are the printer's problem. If you sign a contract, read it carefully to avoid surprises. For example, some printers specify ten percent under or over your exact order quantity as their standard, and you may pay for 5,500 forms when you only ordered 5,000.

  Reliability is a two-way street. If you're worried about some aspect of the job, or have had problems in the past with a form, tell the supplier. Have it written into the contract. The more specific the information, the more likely it is that the job will be delivered to your satisfaction. •

Andrew Hallock is general manager of Deluxe Computer Forms.

Legal partner

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about that person, I advise you find someone else with the right personal and intellectual chemistry."

Understanding how you will be charged for services is a key part of that "comfort level," Ivey advised.

Despite public perceptions, the one time you won't need your own attorney is in the case of a medical malpractice suit when your insurance company will defend you. Stay in touch with the insurance carrier for advice on cutting risks and keeping good records, Green and Ivey urged.

If faced with "the unpleasant reality of being sued, don't try to settle things with the patient," Green advised. Leave that to the insurance company's attorneys.

Accounts receivable is a major area where an attorney can help recover otherwise lost income, Ivey said. Denial of claims or slow payment by an insurance carrier "is no excuse," she stated. "You've got to explore all possibilities of other agencies paying" for a patient's care, she advised.

"Any doctor who isn't willing to think about how they're going to get paid should join the Army," she said.

Ivey was a hospital business manager before going to law school. She said this gives her the insight that "the paper trail is second in importance to the life and death side of medical care."

Her hospital experience also gave her insight into the ways doctors and hospitals can work together to solve problem areas, such as non-payment of fees by patients or insurance carriers. She advised that physicians and their attorneys work with hospitals to identify slow-paying insurance companies, to practice the right procedures for faster payment, and even team up with the hospital to sue and set a precedent for the future if the situation warrants.

Ivey said an attorney can help a doctor work out an arrangement of mutual respect between a doctor and an insurance company based on "detente, not confrontation."

Most medical practice legal matters will fall into a routine pattern and may be scheduled well in advance. For corporations, Green recommended an annual joint meeting with the lawyer and C.P.A. before the end of the fiscal year. "You'll usually save more money on taxes than you will spend on the meeting." For solo practices, he suggested a meeting at least every other year for a review of office and personnel matters. "For as little as an hour of an attorney's time, it could save you thousands of dollars."

Of course there are crises, anything from a lawsuit to a divorce to embezzlement by an employee, which demand immediate legal action. Green said in the past dozen years he has seen six embezzlement cases in which bookkeepers skimmed cash or altered records or checks. "These could have been prevented if the doctor paid attention," he said.

How to find the right attorney partner:

Attorneys Green and Ivey offer the following five pieces of advice for physicians seeking a legal partner, and what to expect:

- Be a smart shopper. Shop around for the legal specialist who meets your needs.
- Ask about fee schedules up front. Will you be charged a flat fee, by the hour, or a combination of both?
- Some lawyers will charge for every phone call. Others charge only if the call demands research on their part. If the lawyer's "meter is running," you may hesitate to make necessary phone calls or appointments.
- Expect an itemized bill.
- Stay in touch. Periodic communication is crucial. •

Physicians typically are in the habit of educating themselves on legal and money matters, Ivey noted. That works — to a point. Skimping on legal advice, however, is a false economy. "They should buy a half-hour of an attorney's time to double-check" any investments, Ivey said.

Green agreed. "We've seen so many clients burned by bad investments." Sadly, many seek legal help on investments or tax shelters only when the Internal Revenue Service demands an accounting.

Hot legal issues doctors will face in the years ahead include employment law and tax law changes, the relationships between insurers and health care providers, and the legal relationships between the new health care organizations and physicians, said Green and Ivey.

"The benefits of incorporation are shrinking rapidly," Ivey said. Yet now more than ever physicians need legal help when reading over contracts for joining HMOs or PPOs.

What Green called "tremendous changes in employment laws" have set new rules for the firing of employees. "The most significant issue today is the death of employment at will," he said. "You can't fire people willy-nilly. You must have cause and must document it and sometimes justify it to a third party such as a court." •

Feds extend employee group coverage insurance

By Mike Dolan

In an effort to plug gaps in the existing health care coverage system, the federal government is now requiring medium and large employers to continue group coverage past the time it normally would have ended.

Employers must now extend coverage for as long as 36 months for dependents who lose group coverage because of death, divorce or because they are no longer dependent children. Coverage is extended for up to 18 months for employees who leave a job for reasons other than gross misconduct.

Some of the provisions in the Consolidated Omnibus Budget Reconciliation Act, commonly known as "COBRA," may already apply to some health plans. The act was signed into law by President Reagan April 7.

The law applies to employers with 20 or more employees. Compliance with the new legislation is the responsibility of the employer, not the insurance carrier. Most provisions go into effect for groups on 'plan years' beginning July 1, 1986.

Part of the significance of the legislation is that the federal government is mandating the benefits in an employee health plan, traditionally an area regulated by state insurance commissions, according to Eric Busch, associate general counsel to Blue Cross/Blue Shield.

"Congress is concerned with maintaining the health coverage of the population in general and wants to provide health coverage to as many people as possible," he said.

Other provisions of the law apply to working people over the age of 69 and to non-service connected disability care for veterans.

The "working aged" rules which previously applied only to people between the ages of 65 and 69 have now been extended to everyone over the age of 65. And the law specifies that policies cannot exclude care received in a Veterans' Administration facility if care was received for a disability not connected to military service.

Blue Cross/Blue Shield has already issued an employer alert about the new law. Busch said most carriers can answer questions about COBRA.

More questions will be answered as federal regulations are issued, he said. Not entirely clear is the relationship of state insurance continuance regulations and the federal law. Oregon has since 1982 required a maximum of six months continuance in certain situations. •

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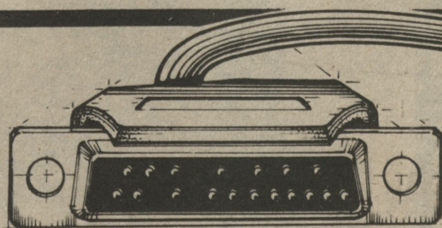

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CPAs find most physicians lacking proper financial perspective

By Erik H. Bergman

Anyone can make money, says the old adage. The hard part is holding onto it.

"That's where we come in," said James B. Jeddeloh, C.P.A., a partner in the accounting firm of Perkins, Jeddeloh & Acheson, P.C.

Helping physicians make money and hold onto it is the proper role of any accountant, according to Jeddeloh and his partner, Cheryl G. Perkins. The two, who handle most of their firm's physician clients, shared with *The Scribe* their ideas about how doctors can best work with accountants to gain control of their business and personal finances.

Despite a growing trend for physicians to be well informed about money matters, gaps still exist. Disability insurance, personal goals and tax shelter investments are three areas in which physicians tend to fall short in their financial planning, according to Jeddeloh and Perkins.

"Disability insurance coverage is generally lacking," Jeddeloh said. "Everyone has life insurance in case of death, but you're far more likely to be disabled." Doctors should plan on being able to go six months with no income in case of accidental disability, he advised.

Physicians also commonly put their personal finances second to those of their practice, although both demand equal attention, Jeddeloh noted. Estate planning, pension planning and personal budgeting are three areas where a C.P.A. can help on the home front.

As for tax shelters, "people sometimes spend more time choosing a new suit than they do checking out a $50,000 investment," Jeddeloh said. "Be skeptical" of sales pitches, he urged, and avoid committing a lot of money into any tax shelter until the details of the new federal tax laws are made known.

Because accountants do not sell insurance, investments or tax shelters, they are ready to "become the facilitators for investigating these things," said Jeddeloh.

Jeddeloh and Perkins said that their best physician clients were those who were "willing to listen and act in an organized and planned fashion."

"We've had physicians come to us whose spending had been out of control," Perkins noted. These clients "responded very well" to a carefully structured budget to control their expenses. Sometimes that means foregoing "some of the niceties of life" to achieve a long-term goal, Jeddeloh added.

Part of an accountant's job is to discover items that clients are not addressing and make them aware of the opportunities and risks. A major area that is often overlooked is estate planning. Many clients "haven't updated their wills in years," said Jeddeloh. Although an attorney is the correct person to draw up a will, an accountant is in the best position to calculate assets and to project estate taxes on their worth.

Such an estate assessment can make a big difference when writing the terms of a will, Jeddeloh noted. Often people forget to include the worth of their life insurance policy in their estate — a costly mistake if a $1 million insurance payoff is lumped into an estate, thus raising the taxes due on it.

When looking for a C.P.A., bring in the last three years' tax forms, retirement plan data, net worth forms and, perhaps most important, "goals as to where you want to be," Jeddeloh said.

Perkins said her firm offers "a no-cost, face-to-face interview" to determine if the client and the company can work together. "We feel it's a personal service business and if you can't communicate (with your C.P.A.) you'd better keep looking." Part of that communication is keeping in touch with clients throughout the year "so there aren't any surprises at year's end."

For example, when the tax laws regarding the use of autos for business travel were changed, Perkins sent out auto mileage logs to all her clients "and made sure they understood" the changes.

She also stressed the importance of consulting with an accountant when plans are made to contract with an HMO, PPO or other organization, because such a contract may alter profits or cash flow.

As part of reviewing a client's finances, Perkins looks into the medical office's accounting system. Updating to microcomputers "is definately a trend," she states.

Perhaps no area of finances is more emotional than that of taxes. With major changes looming in tax laws, accountants are bracing for what Jeddeloh called "a second tax season" this October. Although many investors now "are in holding patterns," he said that the proposed laws will "be good for the country" and will "get people back to investments that make economic sense."

"Doctors are caught in a profit squeeze like everyone else. They have to be more efficient," Jeddeloh said. "They must come to grips with that." ■

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AFS cuts reimbursement 9%; indigent access problem 'dangerous'

y Cliff Collins

Reimbursement for medical provid-rs to the state's indigent population will e reduced nine percent effective Sept. 5. These across-the-board cuts — hich total $875,000 from the state's eneral funds — are to be implemented y Oregon's Adult and Family Services ivision after the Legislature's Emer-ency Board directed the agency to educe its $1 million deficit.

Hersch Crawford, acting director of FS, said the Emergency Board last ay directed his agency to "come up with $1 million out of provider reimburse-ment" and report to the board in July. AFS established a task force of provid-ers, such as physicians, pharmacists, dentists, ambulance company repre-sentatives and others to meet and "determine how best to implement these cuts," according to Crawford.

Since this diverse group of practition-ers could not agree on any one option for implementing the reductions, "the option that seemed best" was to impose across-the-board cuts of nine percent for all areas other than obstetrics. An additional three percent cut was im-posed for the pharmacy area, he said.

One thing the providers did agree on, as did AFS officials, was that access for clients could become a problem if pro-viders are slapped with another reduc-tion. The task force members have stated clearly that "reimbursement is already at an unacceptably low level," Crawford said; he added that no existing clients "would be thrown out," but no new patients would be added in the wake of more cuts.

AFS is concerned that providers already have seen reimbursement re-duced to the point that it "covers just overhead" expenses, and any further cut would amount to "an out-of-pocket loss," said Keith Putnam of AFS. Putnam termed the situation "dangerous" if ac-cess becomes a problem, pointing out that pharmacists have taken a 30 or 35 percent reduction per prescription in addition to other cuts, and hospitals are being reimbursed at 50 percent of usual and customary charges for outpatient procedures.

Chris Stevenson, vice president for health economics at the Oregon Asso-ciation of Hospitals, said the Emergency Board "was told in no uncertain terms" that another $1 million reduction would cause access problems. Those prob-lems could be thrown back on AFS if advocates for the poor charge that wel-fare clients are not receiving adequate care, he added.

Crawford said the provider task force plans to meet one more time before AFS presents its final plans to the September Emergency Board, but said there ap-pears to be no alternative to the nine percent plan set to begin Sept. 15.

Karen Whitaker, director of public affairs for the Oregon Medical Associa-tion, said the OMA shares AFS' concern about client access to care. Because they already have sustained cuts and have had fees frozen — and because of problems in getting payment — many physicians and pharmacists will "call it quits and throw up their hands," Whit-aker said.

Provider reimbursement had been slated to begin Aug. 1, but was deferred after the Emergency Board received a number of letters from concerned phy-sicians, according to the Oregon Medi-cal Association. Whitaker said provider pressure on Emergency Board mem-bers is the only measure preventing implementation Sept. 15. She said the extension "may inspire them to make more contact" with legislators to urge that no more cuts be made. •

Earlier AFS deficit reduction maneuvers:

AFS has met with mixed suc-cess in other recent efforts to erase its huge deficits. On the plus side, agency officials told *The Scribe* last spring that it had reduced ex-penses for its medical assistance clients by nearly 50 percent since AFS had adopted its physician care organization agreement in the tri-county area in January 1985.

However, AFS' plans to contract with Oregon hospitals for services to the agency's clients have been shelved. Chris Stevenson of the Oregon Association of Hospitals said AFS encountered stiff resis-tance from hospitals over the plan, which "met with a resounding thud" because it "pitted hospital against hospital."

"The whole idea got so much flak from the hospitals," added Stevenson, who said the plan's fate was sealed when the Health Care Financing Administration made an official inquiry about the pro-posal.

AFS had asked for hospitals to bid a minimum of five percent less than current DRG payment rates. Stevenson said AFS was hopeful that several hospitals would bid, but none did publicly. "Some were secretly saying they were con-tracting and publicly saying they weren't," he related. "AFS put it on the back burner because of HCFA's inquiry and static (from the hospitals)." •

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Lithotripter decision

continued from page 1

precedent" for cooperation between hospitals and physicians. Wolford said he hopes OHSU "will participate in this."

Debate put urologists into factions

The bitter debate about siting Oregon's initial lithotripter set more than one precedent. It marked perhaps the first time one of the state's most cohesive medical specialists — its urologists —had splintered into factions. No less significantly, the appeals sessions were the setting for a rather unusual event: vocal, vigorous testimony by a group of physicians concerning a new medical service.

Ivan L. Sandoz, M.D., president of the Oregon Urological Society, admitted the lithotripter debate has been "very devisive." Sandoz said the state's urologists have "always enjoyed a strong fellowship," that the bitter infighting common in such states as California has never been present in Oregon. But downtown-area urologists gradually coalesced over the issue to the point that 33 of 36 local urologists favored Holladay Park, he said.

One of OHSU's arguments for placing the machine there was the institution's contention that the majority of the state's urologists from outside the metropolitan area wanted OHSU to have the lithotripter. That argument was based on a poll taken more than a year ago by the urological society of its members, said Russell N. Sacco, M.D., a Portland urologist who testified at the appeals hearing. Sacco said the poll was issued before anyone had filed certificates of need, and merely asked: If there were a lithotripter where would you, as a urologist, like to see it located?

Physicians in southern and eastern Oregon are familiar with OHSU because they might "refer their more difficult cases there," and were therefore unfamiliar with other locations, Sacco said. He added that "as the issues were brought out, there became less interest in having it at the medical school." Less than 50 percent of the membership responded to the poll, according to Sandoz.

Grant said the surveys cited by both sides did not weigh heavily in SHPDA's original decision. "The assertions made about who's for what (among urologists) were so inconclusive that we didn't give much regard to this," Grant said.

On Aug. 12, when urologists and other doctors testified, the all-day session lasted until 10:30 p.m., Grant noted. He said 12 to 15 doctors, mostly urologists and some nephrologists, were present; eight testified. "There were strong statements made on both sides," he said, adding that some out-of-town physicians testified in favor of OHSU.

Access versus research

Throughout the testimonies — and since the first filings for certificates of need — the two topics most associated with the lithotripter siting have revolved around two concepts: access and research. The term "access" initially was thought of in terms of physical accessibility, such as proximity to freeways and convenience of parking, according to Grant. But as issues were discussed in greater depth, the concept of access swelled to become paramount.

"As we talked and talked some more, we realized (Holladay Park) was the best site," said Sandoz. "It was not a compromise: It was a consensus decision." Sandoz said the downtown urologists "have nothing but the highest regard for the urologists on the Hill," but said private urologists are afraid of "losing control" of their patients if they refer to the university.

"There is no real animosity between the two," he said. "It's just that most doctors don't feel they can move a patient in and out and treat them, just because of the way the system works." Added Sacco: "It was not that the school was not an acceptable site, but that we wanted the best site for the needs of everybody." Among the reasons Holladay Park was better involved "perceptions" that a private hospital would be more accessible than a "government-run" hospital, Sacco indicated.

The other chief component of the debate, research, was used as part of OHSU's defense. John W. Kendall, M.D., dean of the medical school, said the university has been the "site of medical innovation," and the faculty had "hoped new ideas would come to fruition if that machine were here." He said Eugene F. Fuchs, M.D., had performed many successful percutaneous lithotripsy procedures and had done research on the need for a lithotripter in Oregon, southwest Washington and southern Idaho. Based on his studies, and others, it has become an accepted notion that approximately 475 kidney stone patients annually could benefit from the device.

Will not be a 'stone center'

HealthLink officials and several physicians who testified responded that having the machine at a facility other than OHSU would not preclude research being done with lithotripsy. "The university has identified research as an issue," said John Collins, strategic planning director for HealthLink. "We, as the coordinator of a cooperative venture, have no less of a commitment to research than anybody else." Collins said urologists will use a lithotripter as a treatment tool.

"We don't envision this as a stone center, but as a piece of therapeutic equipment," emphasized Collins. He said any physician who referred to the Holladay Park facility has the option of doing the procedure and retains control of the patient. He said that after studying the lithotripter topic for two years, his general assumption is: most physicians more than an hour's drive away will not come in but will refer for the procedure.

About 75 percent of procedures can be done on an outpatient basis, with the remainder admitted to the hospital, said Sandoz. Dornier has the only FDA-approved lithotripter currently, with 75 operational in the U.S. and 100 worldwide, according to HealthLink's Alesko. The closest is in Seattle. HealthLink's goal is to have a machine running by year's end. The Dornier model costs about $2 million.

'Tempest in a teapot'

Sacco and other physicians said whatever hard feelings may have surfaced during the lithotripter debate probably will pass away following the board's decision. OHSU's Kendall emphasized "the long-standing close relationship with the urologists on the Hill and community urologists," and predicted that just because the two "came to a head" during the controversy, does not signify any permanent change.

The most ironic aspect of the lithotripter debate is that its specific points of contention could prove embarrassingly ephemeral. Sandoz believes the dispute will prove to be "a tempest in a teapot" as more advanced — and much less expensive — lithotripters become available in two or three years. Then, after more companies are approved and the price falls below certificate of need limitations, other hospitals may add machines, making everyone forget who was first.

What may not be forgotten easily is the long delay in obtaining the technology for the community — a delay that could have been avoided, according to Michael Goldwyn, executive director of Northwest Oregon Health Systems. "Both sides are equally to blame for not agreeing," Goldwyn charged. "Because hospitals and physicians have chosen to fight it out, they have disadvantaged citizens of the community." Regulators would have given the machine to "anyone in a second" had there been any kind of consensus, he said.

"An argument about where it should be is slicing hairs," said Goldwyn. "The real story is, they have an obligation to serve the community." •

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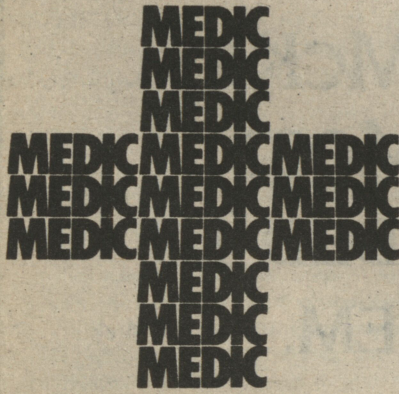

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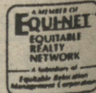

Calendar

AUGUST

20 **MCMS Board of Trustees meeting** (tentative).

20 Lecture: "Selected Aspects of Cardiac Arrhythmias." Rodney Crislip, M.D.; Providence Medical Center, Amphitheater, Providence Hall, 8:00 a.m.

23 Cystic Fibrosis Trapshoot Benefit; Portland Gun Club, 10:00 a.m. For more information contact Terry Mowdy at 231-4015.

27 Lecture: "Psychiatric Emergencies." William Zieverink, M.D.; Providence Medical Center, Amphitheater, Providence Hall, 8:00 a.m.

SEPTEMBER

1 Labor Day. Office closed.

3 Medical Grand Rounds Conference: "Newer Thoughts Concerning Pathogenesis of Type 1 Diabetes." Guest speaker Jerry P. Palmer, M.D. Providence Medical Center, 8:00 a.m.

5-6 Continuing Medical Education: The Annual Ashland Conference. OHSU; Ashland Hills Inn, Ashland, Oregon.

7 **MCMS Mini Internship Program Dinner.**

8 **MCMS Auxiliary Health Education Committee meeting** — 9:30 a.m. - 12:30 p.m. New members welcome. Call Sharon Naemura, 252-7906.

9 **MCMS Auxiliary Board of Directors breakfast meeting and new member orientation.** 7:15 a.m.; program 10:00 a.m.

9 **MCMS Mini Internship Program dinner.**

10 **MCMS Executive Committee meeting.**

10 Medical Grand Rounds Conference: "Diagnosis and Management of Dysmenorrhea." Guest Speaker M. Yusoff Dawood, M.D. Providence Medical Center, 8:00 a.m.

13 Medical Staff Leadership Conference: California Medical Association, Sacramento. Guest speaker Assemblyman Phil Isenberg. For more information call 415-863-5522, ext. 347.

16 **MCMS Grievance Committee meeting.**

17 **MCMS Board of Trustees meeting.**

17 Medical Grand Rounds Conference: "Current Concepts of Ischemic Necrosis." Guest speakers Elizabeth Tindall, M.D., and Christopher Hikes, M.D. Providence Medical Center, 8:00 a.m.

23 **MCMS Auxiliary General Membership meeting:** Len Tritsch, health education specialist, Oregon Department of Education, and the MCMA Seaside Health Promotion Conference Team. Providence Hospital; business: 9:15 a.m., program: 10:00 a.m.

23 Psychiatry Grand Rounds: "Psychiatric Issues in Head Trauma." William Hoffman, M.D.; St. Vincent Hospital Medical Office Building, Room 62, 7:30 a.m.

24 Medical Grand Rounds Conference: "The Cardiomyopathies." Guest speaker Steven E. Reinhart, M.D. Providence Medical Center, 8:00 a.m.

OCTOBER

1 Medical Grand Rounds Conference: "Thrombolytic Therapy." Guest speaker Sol Sherry, M.D. Providence Medical Center, 8:00 a.m.

8 Medical Grand Rounds Conference: "The Current Role of MRI in Clinical Medicine." Guest speaker Christopher J. Morgan, M.D. Providence Medical Center, 8:00 a.m.

8 **MCMS Executive Committee meeting** (half-day meeting).

10-11 Bioethics Conference: "The Malpractice Dilemma." Keynote speaker Ron Wyden. Good Samaritan Hospital Neurological Sciences Center, Northwestern School of Law and Lewis and Clark College. For further information contact Gary Meyers at 244-1181, or Susan Nanson at 229-7348.

10-12 Continuing Medical Education: The Salishan Conference: Cardiology. OHSU. Salishan Lodge, Gleneden Beach, Oregon.

13 **MCMS Auxiliary Health Education Committee meeting** — 9:30 a.m. - 12:00 p.m.

14 **MCMS Auxiliary Women Aware V Conference.** Nancy Wilgenbush, pres., Marylhurst College, keynote speaker. Topic: "Success and Personal Power." Afternoon session: Karen Karelius, dean of students, Marylhurst College. Topic: "Fathers and Daughters." OMA; 9:00 a.m. - 2:30 p.m. For further information call Pat Webster at 226-1555 or Barbara Kennedy at 292-0459.

15 **MCMS Board of Trustees meeting and Delegates Caucus.**

15 Medical Grand Rounds Conference: "Neuroendocrine Models of Brain Transplantation." Guest speaker Earl Zimmerman, M.D. Providence Medical Center, 8:00 a.m.

23-24 Continuing Medical Education: Pacific Northwest Review of Obstetrics and Gynecology. Red Lion Motor Inn/Jantzen Beach, Portland, Oregon.

23-24 Continuing Medical Education: Pediatric Advanced Life Transplant Support. Red Lion Motor Inn/Portland Center, Portland, Oregon.

28 Psychiatry Grand Rounds: "Psychiatric Issues in Cardiac Transplant Surgery." Robert Maricle, M.D.; St. Vincent Hospital Medical Office Building, Room 62, 7:30 a.m.

29 Medical Grand Rounds Conference: "Irritable Bowel Syndrome: Update 1986." Guest speaker Norton Greenberger, M.D. Providence Medical Center, 8:00 a.m.

NOVEMBER

5 Medical Grand Rounds Conference: "CPC." Speaker Mark O. Loveless, M.D.; Providence Medical Center, 8:00 a.m.

7-9 OMA Interim House of Delegates meeting.

8 Continuing Medical Education: "Resistant Staphylococci: Concern of the '80s." OHSU Library Auditorium/Dr. Bryant.

8 Medical Staff Leadership Conference: California Medical Association, Palm Springs. Guest speaker State Senator Robert B. Presley. For further information call 415-863-5522 ext. 347.

10 **MCMS Auxiliary Health Education Committee meeting** — 9:30 a.m. - 12:00 p.m.

11 Veterans Day. Office closed.

12 **MCMS Executive Committee meeting.**

12 Medical Grand Rounds Conference: "Rheumatoid and Osteoarthritis — Differential Diagnosis." Guest speaker Ronald Kaye, M.D. Providence Medical Center, 8:00 a.m.

19 **MCMS Board of Trustees meeting.**

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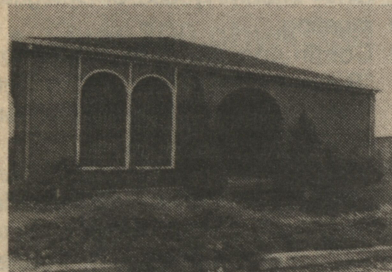

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