The SCRIBE

Published by the Medical Society of Metropolitan Portland on the 1st & 3rd Fridays

NOVEMBER 7, 1997

Vol. XV, No. 20

IN BRIEF

Interest groups have the bases covered

Travel, alternative medicine and enriching your retirement years are some of the subjects on tap this month for three focused interest groups sponsored by MSMP.

The Retired Physicians Luncheon will be held Nov. 11, from noon to 1:30 p.m., at the OMA building. Guest speaker Robin Costic, of the OASIS program, will discuss enrichment pursuits ranging from learning a new skill to tutoring youngsters to read.

The Alternative Medicine Focused Interest Group will meet Nov. 12 at 7 p.m. The dinner meeting will feature a presentation by MSMP member Rene Minz, a medical and naturopathic physician.

Using the Internet for travel information will be the subject of the Outa Here Interest Group Nov. 13. This dinner meeting will also meet at 7 p.m. at the MSMP building.

For reservations, call Pat at 222-9977.

Portlanders launch campaign against handgun violence

A public education campaign sponsored by Cease Fire Inc. on the dangers of keeping handguns at home began Nov. 6.

Portlanders representing medical, public safety and child welfare organization, as well as concerned parents and families, have united in this effort to raise awareness of the threat of handguns in the home. Nationally, 10 children are killed by a handgun every day.

In the months ahead, PSAs will air on local TV stations, in Oregon newspapers and on Tri-Met buses.

For more information about Cease Fire Inc. call Elizabeth Schmidt, at (202) 429-1741.

'Social' security

Good communication between patients, doctors cited as key to avoiding lawsuits

A researcher's study linking communication and malpractice is the focus of a Dec. 5 panel discussion in Portland.

BY CLIFF COLLINS

Why do patients sue doctors? The obvious answer—poor outcomes—is only part of the story. The rest may have much to do with poor physician communication, researchers are discovering.

Not all adverse outcomes result in litigation, and threatened suits don't always involve poor outcomes. The literature on medical malpractice identifies communication between health professionals, patients and their families as one of the most influential factors in the decision to file a lawsuit.

Researchers such as Richard M. Frankel, Ph.D., from New York state say the exploration of doctor-patient communications has been hampered by lawyers' reluctance to allow their clients to talk, and by long time lapses between when suits are filed and when they are resolved. Frankel, professor of medicine at the University of Rochester and director of the Primary Care Institute of Highland Health System, said he and fellow Rochester academicians found a way: They studied patient depositions of patients who had sued.

> ***"Physician laughter was highly associated with not being sued."***
>
> **Richard Frankel, Ph.D.**

What they found was that 71 percent of the 45 patients studied specified there were "problematic relationship issues" with the physician. In a paper published in Archives of Internal Medicine, four themes emerged when Frankel and others reviewed the transcripts: Patients felt deserted; that their and their families' views were devalued; and that their doctor delivered information poorly and didn't understand them.

Frankel, a specialist in biopsychosocial studies, is scheduled to speak in Portland about his and others' research linking communication and malpractice. He is part of the expert panel slated for "Practicing Medicine in a Changing Environment: Medical Malpractice, Communication and Risk Management," a Dec. 5 symposium presented by the Foundation for Medical Excellence.

"At least until very recently, communication skills were treated as falling under the general rubric of bedside manner," Frankel said in an inter-

Turn to RELATIONSHIPS, page 12

M2FO: building awareness, taking action

After nearly six years of good works, the Metropolitan Medical Foundation seeks new members to help make a difference in the areas of community health and physician wellness.

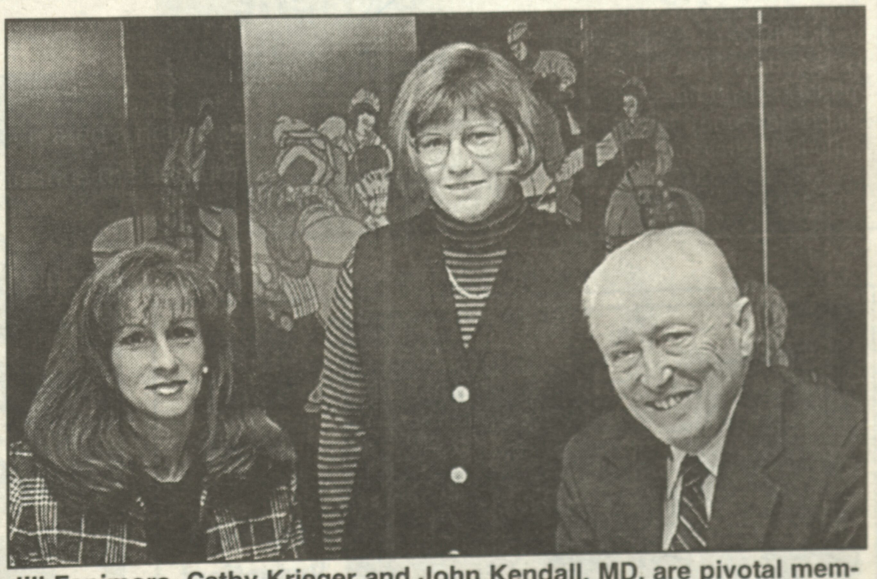
BY STEVE SINOVIC

In today's world, advances in health care are hinged on linkages between people. So is the mission of M2FO.

Though its recent progress can be measured by fundraising, its success depends on more human elements: passion, commitment and teamwork.

That's according to Jill Fenimore, president of the Metropolitan Medical Foundation of Oregon (or simply M2FO). Created six years ago by MSMP, funds to support its work come primarily from physicians and/or medical families.

Designed to be a launch pad for new ideas, the meeting house for old friends, and a place where new friends and colleagues can bring attention to health care issues, the Foundation has another purpose: "to be a credit to the profession of medicine in our region," says John Kendall, MD, one of the founding members.



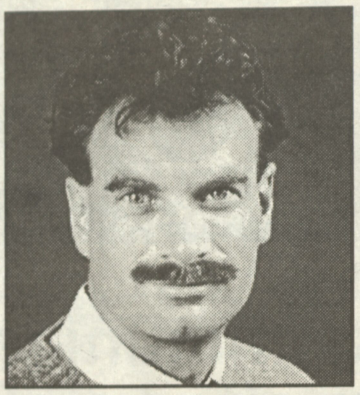
Jill Fenimore, Cathy Krieger and John Kendall, MD, are pivotal members of the M2FO volunteer team. Vern Uyetake photo

The "building blocks" for the Foundation are creating awareness and taking action, said Fenimore, president of Fenimore Associates Inc. "We're very interested in supporting worthy projects in the health sector that aren't particularly `high profile,'" said Fenimore, a second generation member of the M2FO.

"My getting involved with the (development of the) Foundation is one way of saying thank you to the medical family," said Fenimore. She initially got involved with M2FO after

Turn to M2FO, page 10

TRANSITIONS



Gary Hoffman, MD

MedPartners names Hoffman to new post

MedPartners Northwest has appointed Gary Hoffman, MD, as interim associate medical director for the Portland area. Hoffman, an OB/GYN, will continue his practice at Women's Healthcare West Hills and will assume additional leadership projects with Mullikin Medical Centers and Women's Healthcare, the local MedPartners medical groups.

Providence names intern and resident of the year

Richard Hunt, MD, is the Providence St. Vincent Medical Center Intern of the Year and Doug Shumaker, MD, is the Providence St. Vincent Resident of the Year. The winners were chosen by their peers.

Susan Smith, Ph.D.

Levitte joins Fanno Creek Clinic

Mark Levitte, MD, will be moving his practice to the Fanno Creek Clinic at 2400 SW Vermont St. Levitte had practiced at this location in the Hillsdale/Multnomah area for several years before relocating to Washington Square.

Smith chosen Women's Health leader

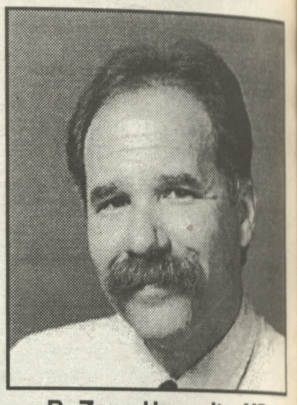
M. Susan Smith, Ph.D., was chosen as interim director for Oregon Health Sciences University's newly formed Center for Women's Health.

In addition to her work as professor of physiology and pharmacology in the School of Medicine, and director of the Oregon Regional Primate Research Center, Smith has established herself as a national leader in brain research and women's health issues.

Oregon Poison Center appoints Horowitz

B. Zane Horowitz, MD, F.A.C.M.T., has been named the new medical director of the Oregon Poison Center. He replaces Martin Smilkstein, MD, who is stepping down to spend more time with his family.

Horowitz, also an associate professor in the Department of Emergency Medicine in the OHSU School of Medicine, is board certified in both internal and emergency medicine as well as medical toxicology.



B. Zane Horowitz, MD

Casey Eye Institute recruits pediatric eye care expert

OHSU's Department of Ophthalmology at the Casey Eye Institute recently appointed David Wheeler, MD, as assistant professor of ophthalmology and adult strabismus.

Wheeler comes to OHSU from the King Khaled Eye Specialist Hospital in Riyadh, Saudi Arabia, where he practiced pediatric ophthalmology for four years. He established the world's largest pediatric intraocular lens database and has accomplished research in ocular disease, amblyopia and strabismus. ¶

We Want To Hear From You

The Scribe welcomes letters to the editor on topics that have recently appeared in the publication. Send correspondence to

Editor
The Scribe
PO Box 370
Beaverton, OR 97075
fax (503) 620-3433

The SCRIBE

Editor:
Steve Sinovic

Account Executive:
Darlene Rominger

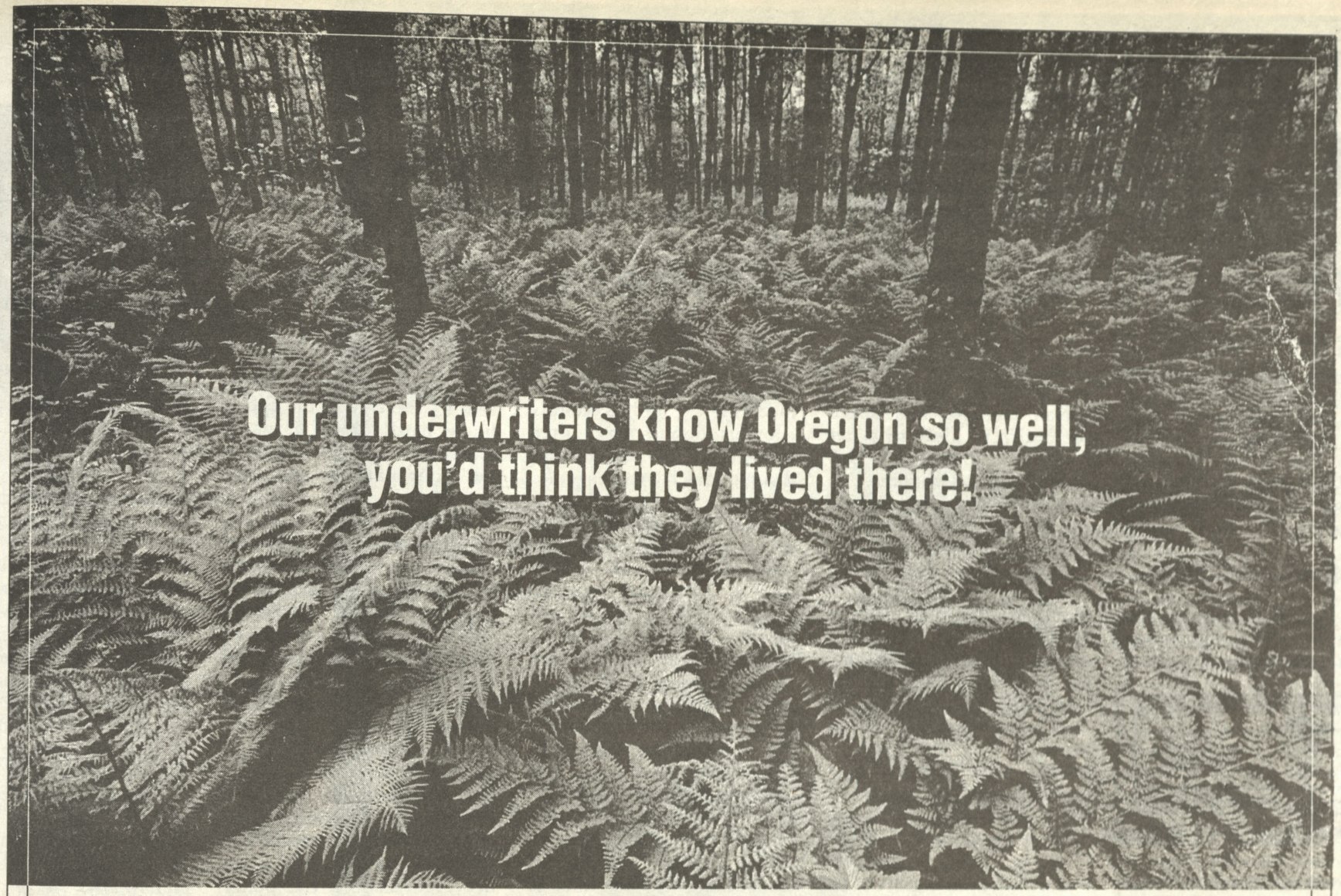
Production & Graphics:
Vivian Read

Published by the Medical Society of Metropolitan Portland

Executive Director:
Rob Delf, CAE

The Scribe (ISSN 00324930) is published twice a month at $36 a year ($2 for single issues) by the Medical Society of Metropolitan Portland 4540 S.W. Kelly Avenue, Portland, Oregon 97201. Second class postage paid at Portland, Ore. Postmaster, send address changes to: The Scribe, 4540 S.W. Kelly Avenue, Portland, Oregon. 97201.

Editorial services provided by Community Newspapers, 6975 S.W. Sandburg Road, Tigard, Oregon 97223; (503) 684-0360. For classified advertising and subscriptions, call Darlene Rominger at 503-684-0360.



Actually, they do.

The CNA Physicians Protection Program has professional liability underwriters and claim professionals living and working right here in Oregon. This means they stay on top of issues that affect Oregon's medical community. Of course, you'd expect that from a company that has provided the sponsored program for the Oregon Medical Association (OMA) for 25 years.

Being local allows us to be close to our insureds and to be there when we're needed. Our underwriting and claims professionals work together to provide you with prompt handling and resolution of claims-the reason you buy our services.

You get it all with the OMA endorsed CNA Physicians Protection Program: outstanding risk management; prompt local service; excellent claims handling; and profit sharing.

Let us tell you how the OMA endorsed CNA Physicians Protection Program can meet your professional liability needs.

Call us at 1-800-341-3684.

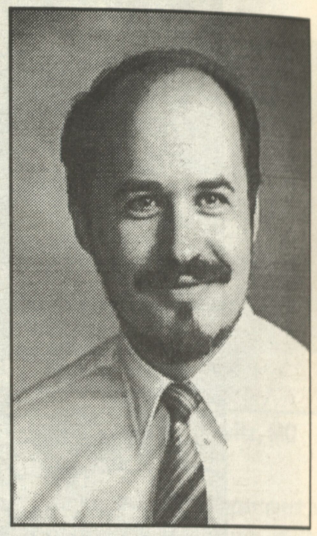
CNA HEALTHPRO

OREGON MEDICAL ASSOCIATION

This program is underwritten by Continental Casualty Companies, one of the CNA insurance companies. CNA is a registered service mark of CNA Financial Corporation.

Whom do we serve?

Relating the soul of medicine to the role of medicine



Rupert Goetz, MD

Editor's note: Considering the comments of patients on how physicians can better use "their skills and humanity" to serve them, is the focus of an interest group that is now forming. MSMP President Rupert Goetz discusses its potential value to the Society.

BY RUPERT GOETZ, MD

Over half a year ago, when I assumed the presidency of the Medical Society, I spoke of my desire to explore this question "Whom do we serve?" in the coming year. I spoke, more or less philosophically, of ideas to better hear the voices of our patients. In the meantime, I've had the opportunity to reflect and talk with many of my colleagues about these ideas.

Looking back over the last 10 years I can recall many a discussion about the "Soul of Medicine." An extremely complex topic, I realize this has over those years become very simple for me: I passionately believe that the "Soul of Medicine" is the patient. Looking back over the same last 10 years, I can also recall many discussions about the "Role of the Medical Society."

To me, there is no question that the Medical Society is an organization of physicians, for physicians.

But how might these two concepts relate? Ten years ago there was little doubt in many of our minds that we were particularly privileged to serve as physicians. On the one hand, we had the opportunity to show our compassion, skill and caring in our service to patients and to society. On the other, we assumed that a career in medicine would certainly allow us to send our children to college. How rapidly our assumptions have changed!

Today, huge administrative burdens have drawn time away from our patients, while containing costs of medical care is frequently equated with decreasing physicians' incomes. What is then more logical than to turn to the Medical Society as an opportunity to discuss and possibly influence these changes? I fear it is here that the opportunity exists for us to lose both the "Soul of Medicine" and a clear concept of the "Role of the Medical Society."

The challenges facing us today are such that this is easy. Colleagues in the last few months have answered me: "How could you say that I'm not hearing my patients when I just left the office after seeing Mrs. Smith relieved of suffering; when I will be spending all of tomorrow morning attempting to relieve that of Mr. Miller?"

As president of the Medical Society, I feel obliged to challenge back with this question: "Are you able to spend as much time now with Mrs. Smith and Mr. Miller as you would have 10 years ago?" I have little doubt that the answer will be no. In all likelihood, the care that both receive now will be of higher quality than ever before. But that quality of sitting unhurried by the side of the bed is likely hard for all of us to remember. Can this but affect both our patients and ourselves?

Similarly: "How could you suggest that the Medical Society has lost its relevance by serving physicians? Does not the Society diligently strive to provide even more services and opportunities than it did 10 years ago?" Here also, I must reflect upon at least one reality: The number of societies, both medical and otherwise, that vie for our attention has increased enormously. Specialty societies can better represent our specialty needs. Group practice organizations can better tend to our financial and organizational needs.

> ***"What I am hoping for are (comments from) those patients who still feel confident about their physicians and are still optimistic about the House of Medicine."***
>
> **Rupert Goetz, MD**
> **President, MSMP**

Where can we turn for hope and direction? I believe there is only one place, and that one place is our patients.

Included in this issue of The Scribe is a flier, which seeks to recruit patients for an interest group I would like to develop. Please consider placing this where your patients will see it. What I am not hoping to attract is angry patient X, who would like to complain about Dr. Y; there are numerous other opportunities to seek adversarial contact.

What I am hoping for are those patients who still feel confident about their physicians and are still optimistic about the House of Medicine. Hopefully, their critical analysis of how they see the Society and the profession may prove the invaluable catalyst in our struggle to reaffirm the "Soul of Medicine" and the "Role of the Medical Society."

The question before them will be this: How can the Medical Society—while serving its constituents the physicians—also serve you? I believe that we will hear much that Mrs. Smith and Mr. Miller could not previously tell us.

I am aware that posing such a question and thereby embarking on a somewhat new path is a complex and delicate undertaking. The doctor-patient relationship is an interactive one in which we routinely listen to our patients to determine history, complaints and symptoms.

Considering the comments of our patients on how we can better use our skills and humanity to serve them achieves a very important goal. It recognizes that they are recipients of our services and they place their trust in us to provide high quality, professional services.

In the coming weeks, I hope that those of you particularly interested in supporting the Society will contact me with constructive criticism, feedback and suggestions. Though I have little doubt that our patients will never lead us astray, I also have no doubt that my discussion with them will be better informed by your input. If such an interest group ultimately develops a significant role within the Society, we will have gained much. If the interest group does not prove to be viable, we will have lost nothing by trying. ¶

BUSINESS BRIEFS

Lyman departure from the Blues said imminent

Yet another top executive is on the way out at Regence BlueCross BlueShield of Oregon. Roger Lyman, who long headed HMO Oregon and its predecessor, is leaving, according to knowledgeable sources both within and outside the Blues. At press deadline, Lyman was still on the job, and no departure date was set or details available. The company had released no official announcement, and Lyman declined comment.

Lyman's tenure with BlueCross spans nearly a decade, and his associations with the company go back over 20 years. In 1976, Lyman was the principal driver in the formation of Capitol Health Care, based in Salem, a venture partly financed by BlueCross. He continued to head that company when, in 1988, Capitol became part of BlueCross' HMO Oregon (then known as Health Maintenance of Oregon, or HMOO). By 1994, the Capitol name was dropped, and Lyman assumed the title of president of HMO Oregon. With acquisitions similar to the Capitol deal, HMO Oregon eventually became the state's largest HMO.

Lyman leaves as senior vice president of health care delivery. Dayton Ault, another former Capitol executive, departed BlueCross earlier this year after serving several posts at the Blues.

Providence, Kaiser are 4-star HMOs

Kaiser Foundation Health Plan of the Northwest and Providence Health Plan of Oregon both received four stars in a recent ranking of HMOs published by U.S. News & World Report.

Only 38 of 223 health plans surveyed nationwide earned four stars for overall quality as measured in 17 areas, such as childhood immunizations, rates of mammography, prenatal care, percent of physicians who are board certified, member satisfaction and access to care.

The information came from the National Committee for Quality Assurance (NCQA), the premier accrediting agency for HMOs.

OHSU research funding tops $100 million

Oregon Health Sciences University's national reputation as a biomedical research facility is now backed up by a new number—$100 million. That's the amount of grant funding that flowed into OHSU in the last fiscal year—almost four times the funding level of just ten years ago. This is the first time the university has broken the $100 million mark.

Among the recent grant-funded discoveries and studies at OHSU are therapies against numerous disorders including drug addiction, schizophrenia, Parkinson's and Alzheimer's disease.

BUSINESS OF MEDICINE

The Rhodes Company

The Business of Medicine is sponsored by The Rhodes Company — specializing for 25 years in improving the financial health of medical professionals.

Record Roulette

The paperless office is imminent, but are computerized patient files safe after you press "Save?"

BY GREG GOTH

Every time a newspaper headline screams about a dastardly breach of computer security somewhere, inexperienced computer users tend to instinctively fret about the safety of the records they are entrusting to binary code, whether that information is personal financial data, business tax spreadsheets—or patient records. Physicians are no more immune to computer anxiety than anyone else, and the occasional story about confidential patient information leaking into the public domain does nothing to allay fears.

However, several of the nation's top authorities on health care computer security say the fear of hackers purloining patient charts is far outweighed by the lack of a strong cultural consensus that patients already have too little knowledge of, and control over, who legitimately sees their charts. Even that problem may be easier to solve than many fear, however, with Congress racing the deadline for establishing standards of data transmission under the terms of the Health Insurance Portability and Accountability Act of 1996, better known as Kennedy-Kassebaum. Those standards will need to be implemented in the marketplace by 2000.

"The first response to questions about computer security is, 'How much do you know about security at the present state?'" says Edward Fotsch, MD, president and CEO of Metis, a San Francisco-based company that designs and installs Internet and intranet networks for health care companies and organizations.

Fotsch says the traditional paper chart, kept in a file-festooned medical records room, is not exactly the proverbial Fort Knox of safety.

"In most hospitals, anybody wearing a white coat and a smile can probably get in to see records," he says.

Indeed, says Warner Slack, MD, editor-in-chief of MD Computing magazine, the greatest security device inherent in the paper chart is unintentional—the illegibility of the physician's handwriting, and the often disorganized method of entering data on the chart.

But the usefulness of scrawled notation as a secure record has just the opposite effect on its usefulness as a medical document that any subsequent physician caring for a patient can use to gather all-important background information.

Goodbye to the Age of Paper

Regardless of its properties, the point of what a paper chart is or isn't is just about moot. Its very future is like that of the horse and buggy in 1897. It is about to become a curiosity.

By the beginning of next year, the federal government, by law, will need to have devised a standard protocol for the electronic interchange of health care information and claims

Turn to RECORDS, Page 7

Transaction completed: PACC is now QualMed Oregon

Foundation Health Systems, Inc. (FHS) has completed its purchase of what used to be PACC Health Plans.

The new FHS subsidiary will merge with QualMed Oregon. The new company will have offices in Clackamas, Portland, Eugene and Medford. The name of the new company is QualMed Oregon Health Plan, Inc. an FHS company. Martin A. Preizler, previously PACC's president and CEO, becomes president and CEO of QualMed Oregon. The new company will serve approximately 180,000 members throughout Oregon and southwest Washington, and achieve annual revenues of approximately $240 million in 1997.

"We welcome PACC associates, members and health care providers to the FHS family of companies," said Malik M. Hasan, MD, chairman and chief executive officer of FHS. "This transaction enhances our ability to serve customers in the Northwest."

Preizler has stressed that members of both QualMed and the former PACC will probably not notice any changes in their plan until the two companies are well into the merger process. "What's most important now is to ensure a smooth transition for our health plan members," he said.

Although the PACC name no longer legally exists, health plan members will continue to see the PACC logo on materials and insurance ID cards through the next year.

Also announced are the senior management team members for QualMed Oregon Health Plan, Inc. "We have an excellent combination of experienced people from both PACC and QualMed Oregon to lead QMO-FHS in their respective areas of expertise," said Preizler, who selected these top-level managers to lead the new company after careful review of the defined responsibilities for the new organization.

The following individuals and positions will report to Preizler:

Vice President, Medical Affairs, Eric Wall, MD, MPH;

Vice President, Sales and Service, Fred Roberts;

Vice President, Business & Network Development, Bill Jollie;

Vice President, Legal, Ted Falk, JD, Ph.D.;

Vice President, Financial Services, Lori Mueller;

Vice President, Administrative Operations, Missy Dolan;

Director, Strategic Information, Management Rey San Antonio;

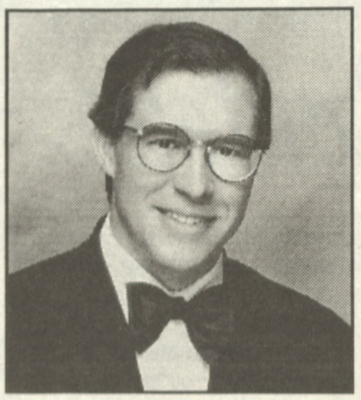
Manager, Human Resources, Chris Engelgau.

Turn to QUALMED, Page 12

In bull and bear markets, excelling at 'basics' yields above-average returns

This recent fluctuation in the market has provided the savvy investor with a rare opportunity to make some strategic purchases at a reduced cost.

BY WES RHODES



Wes Rhodes

During the week of 10/21-10/28, we were taking numerous calls from current and prospective clients concerning the economy, the status of the market, and our opinion of owning domestic stock now and in the near future. The response to the recent volatility in the stock market has prompted me to write an article that may help ebb your concerns and give you the confidence to capitalize on this buying opportunity.

Let me first start with a commentary on the state of our economy. As you are aware, I am a member of the National Association of Business Economists and participate along with other members in panel surveys throughout the year to monitor such issues as unemployment, inflation, interest rates, etc. It will come as no surprise to our clients to hear me reiterate that this recent volatility has not changed my optimism for the coming year. Here are the facts:

■ Unemployment is currently less than five percent. We should expect to see this rate continue for the balance of 1997, and remain around five percent for 1998. For all intents and purposes, there is no (chronic) unemployment. This is to say that in our healthy economy there will always be approximately five percent of the population in transition from one job to another.

■ The economy is on track to grow 3.4 percent for 1997, and is projected to grow at a sustainable rate of 2.5 percent for 1998.

■ Inflation (as measured by the CPI) is well under 2.5 percent for 1997, and is projected to be less than 2 percent for 1998. This is the lowest level since the 1950s and 1960s, and means there is little danger of rising inflation triggering a recession prior to 1999.

■ Interest rates are in check and there is very little danger of the Fed raising rates in the near future. U.S. treasuries are experiencing a great increase in demand which is helping to keep interest rates in check and making bonds more valuable.

■ Neither interest rates nor inflation are driving the movement in the market. The overriding influence in the market is corporate earnings, and looking ahead to 1998, 75 percent of domestic firms are positioned for average growth.

■ The economic fundamentals of the domestic market are still sound. Our market is very flexible when compared with some Asian markets, particularly Japan. Japan is, and has been in a recession, and they may continue to experience increased pressure on their banking system as a result of the Asian crisis.

So what does this information mean to you and your portfolio? Simply put, domestic equities have been, and continue to be, the best place to put your investment dollars for above-average returns. The economy will continue to be strong throughout 1998, with unemployment, inflation, and interest rates in check.

In addition, corporate earnings will continue to be the driving force for the direction of the market. In essence, this recent fluctuation in the market, highlighted by some substantial losses in value, has provided the savvy investor with a rare opportunity to make some strategic purchases at a reduced cost.

While we do feel like a "kid in a candy store" right now and are buying at a furious pace, prudence must always be heeded in the purchase of any stock. The fact that these recent downturns have created buying opportunities does not change our method of selection, which emphasizes a strict adherence to fundamental analysis. A reduction in the price of a company's stock only enables us to realize returns from both market disparity and long-term price appreciation.

Remember, in bull markets as well as bear markets, it is excelling at the "basics" which will yield you above-average returns. (See past Scribe articles for the discussion of fundamental analysis.)

This volatility has come at an opportune time for our company, based on our desire to position our portfolios for continued success in 1998. As previously mentioned, the success we enjoy now is a product of the quality of past investment decisions. Our current purchases are focused on a 3-5 year timeline and therefore are strategic in nature. (It is also important to note that many of

Turn to RHODES, page 10

1997 Portfolio Returns (as of Sept. 30) *

Rhodes Company Equity Income	34.1%
Rhodes Company Growth & Income	39.5%
Rhodes Company Value Growth	49.1%
Rhodes Company Aggressive Growth	76.5%

**All returns have dividends reinvested and net expenses and fees. Past performance is no indication of future results.*

"This recent volatility has not changed my optimism for the coming year."

Records

Continued from page 5

data under Kennedy-Kassebaum. It's only a matter of time before the private sector will also make such exchange the norm. Insurance companies are already paving the way for the electronic era by giving (or attempting to give) physicians disincentives, such as service charges, for filing paper claims.

The entire profession is going to have to accept the fact that electronic interchange is going to be the standard way of exchanging information, says Melvin Nutig, MD. Nutig, a Los Angeles-based orthopedic surgeon, has been a pioneer in telemedicine issues.

"There's no question about it," he says of the imminent arrival of the age of computerized records, "and the truth of the matter is, guys who have been around for a while are going to be caught in the middle. Kids growing up with it as part of their culture are not going to question it."

The efficiencies of a computerized database will be self-evident to doctors and to their patients, the experts say.

"Now, the experience of most patients is, they're in their new physician's office and their records aren't," Fotsch says.

The vagaries of having paper records forwarded are often enough to frustrate anyone. Many patients, especially those who have moved several times in recent years, or who have switched health plans and physicians as employers change insurance carriers, may not know their former physician's address, or may have, in this new era of managed care, only gone to see that physician a time or two, for minor complaints. So, even if records are available, they may be scanty and scattered among several offices.

Under the best of circumstances, the electronic era will greatly reduce the changes of misplaced and incomplete records. A request for records will be met by a few keystrokes and an almost-instantaneous e-mail transmission, easily read by the new doctor and stored on disk.

But along with that convenience will come the problem of easy access by anyone who can sit down for a few moments at the computer—if proper steps are not taken to restrict access.

The experts say that, in the vast majority of cases, existing security protocols, some remarkably simple, will suffice to restrict access to files, and to monitor those who legitimately need to see the information.

"Candidly, it's not a technical issue," Fotsch says.

"None of what we're talking about to get these up to where they should be is new technology, and is relatively economical," says Richard Kemmerer, Ph.D. He is a professor of computer science at the University of California, Santa Barbara, and served on a recent panel convened by the National Research Council that called for tighter controls on records access.

Physicians Reluctant to Log On

Kemmerer says the battle to make computer security a priority in hospitals has met with a reluctance on the part of many physicians to do such elemental things as be willing to log onto a computer each time they want to use it, or to log off after reading a patient's chart.

"There's what we heard from the doctors and what we heard from the nurses," he says. Nurses seemed to think doctors were using their lack of time as a cover for unwillingness to get with the new electronic program. But their reluctance could be hiding fear of being scrutinized for practice habits by bottom-line oriented managers, according to Kemmerer.

"What I found in talking to doctors was a concern about economics, about tracking what you're doing."

And the nervousness about having an accountant go over a spreadsheet of what a doctor has done for Patient X may mean less-effective care.

"There are things, that, as you as a practitioner look at it, you may get [a patient] out quicker in the short term, and that will look prudent," he says, "but long term may be foolish. There is a real concern about how management will use data."

However, Fotsch says, with administrators now beginning to query security experts about how to avoid unauthorized access, the fear of being second-guessed by the bean counters will probably be a casualty of the larger scope: the inevitability of computerization and the need to have some sort of method in place to monitor who has been in the system.

"People aren't sitting around dying to get into patient information, because there's no money in it," he says, "but they do want to publicly embarrass high-profile organizations. How do you stop it? The answer is, probably, you don't—but you should still have some protocols in place."

Slack says that, in his experiences, relatively simple protocols such as passwords, based on duty-related needs, and a history of who accessed each record, known as an audit trial, provide adequate protection in everyday practice.

Professor Kemmerer says hospitals and physicians who care for celebrities and other high-profile patients should probably take more precautions than those who care for the hoi polloi.

"Someone has to want what you're doing," he says. "For normal patients, the problems are not with their records. But for VIPs, that could be another story. Or there's also what we call the `nosy neighbor' phenomenon, which is a kind of semi-innocent snooping.

"Whatever you do, it has to be something that people use. We saw facilities where every doctor had the same password —well, there's no accountability in systems like that."

Security systems in which each user has a unique password would probably be vulnerable to what Kemmerer called an "intent" hacker, but would still go a long way toward establishing security protocols. And a history directory of a file, in which one could see who else has accessed a given record, would go a long way toward discouraging "nosy neighbor" co-workers who were not supposed to be in that file.

"Those auditing systems seemed to work pretty well," he says.

Within the next several years, even more individual security devices, based on factors such as fingerprints and voice recognition, will be more widespread, and more affordable.

Security Concerns

The conflict between adequate security protocols, meant to keep out data thieves, and who will have legitimate access to records, is far less easy to discern. In the health care industry's ever-increasing effort to cut costs and improve efficiency, the sharing of medical information via easily accessible databases would seem to be a no-brainer. But how much information should be allowed out of the clinical setting is the subject of debate among physicians, hospitals, patient groups, and the people who watch the bottom line.

Slack says he is working on a way to keep clinical information within the walls of the hospital, using a peer review system and a stratified reimbursement system in which claim legitimacy is checked internally.

"With all this time and effort we've dedicated to confidentiality within our walls, when our patients are discharged, we make a tape and send it to third-party payers," he ways. "I

Continued on following page

Records

Continued from page 7

think we can devise a cost-reimbursement system by which no clinical information needs to leave the hospital."

Besides, he points out, insurers who are paying physicians under a capitated contract will not pay any more than agreed upon in advance in their providers' contracts, anyway—hence, should have no need to see records.

However, many health plans' standard waivers authorize a general release of information, and Beth Givens, project director at the San Diego-based Privacy Rights Clearinghouse, says her organization has heard from patients who believe information that they believed should have been protected was used against them in a discriminatory fashion.

"I've talked to many people on the hotline who feel they have suffered serious harm because their information was released," Givens says.

But, experts say, an insurance company does have a legitimate right to have access to information for which a patient wants coverage, and Neil Day, president of the Boston-based Medical Information Bureau, says a breach of confidentiality is something insurers try to avoid at all costs. Physicians in insurance underwriting departments, Day says, have a vested interest in ensuring that records stay confidential.

"If the newspapers were filled with horror stories of insurance company employees publicly discussing health records, doctors in Los Angeles would likely refuse to send information to that company," Day says. "So the physicians in underwriting departments, who are often part of the company's management team, have a great interest in keeping medical records confidential."

The MIB, which sends coded information via computer to its 680 member companies, has been computerized since the early 1970s. Day says security measures adopted in transmitting the coded reports have thus far prevented any security breaches.

"Don't be user-friendly," Day advised those setting up databases over which information may be sent. The MIB system uses a communications break, in which the MIB computers will receive a request from an insurance company, then disconnect the phone line before calling the insurer's mainframe back on another line.

In addition, he says, all information reported by the MIB to member companies must stay within those companies' walls. They may not report that information further. But not all databanks adhere to strict rules of confidentiality, and thus legislation is often the route privacy advocates take to ensure the public's rights.

In the California legislature this year, State Sens. Herschel Rosenthal (D-Los Angeles) and Steve Peace (D-El Cajon) introduced legislation, SB-379, intended to ensure that patients are not compelled to sign what Michael Shapiro, the Senate Insurance Committee's staff director, calls "overly broad waivers," but the bill will not be enacted upon this year. It is scheduled for action in the 1998 legislative session.

Shapiro says the bill, which would also make the penalties for misuse of medical records far stiffer than they are presently (the limit for punitive damages would rise from $3,000 to $300,000), was put on two-year status to allow the Senate's privacy task force to complete its research into the topic, as well as to capitalize from work done on the federal level, in the establishment of privacy standards in the course of implementing the Kennedy-Kassebaum protocols.

Peace's chief of staff, Robin Larson, says the Kennedy-Kassebaum protocols would be a major help in forming the state's computer privacy standards—if they are strict enough.

"You've got to look at the beef," Larson says. "What do they say? I've seen a lot of things that are not much more than lip service."

Larson says the task force heard one entire day of hearings on medical records privacy, and says there is a "dire need" for a strong electronic records privacy law.

"People are afraid that if news is shared, they won't want to tell their doctors anything," she says. Especially sensitive are areas regarding psychiatric and psychological care, she says.

"The more sensitive the issue, the more private people think it should be," she says. Larson says another problem area is the proliferation of the broad "blanket waivers" several managed care organizations issue their enrollees.

Despite likely opposition from the industry, she says she expects to see some sort of omnibus privacy legislation enacted after the task force submits its findings in March 1998.

Janlori Goldman, deputy director of the Center for Democracy and Technology, a Washington, DC-based privacy watchdog group, says Health and Human Services Secretary Donna Shalala is scheduled to issue her privacy standard recommendations by the end of this month. Advisory recommendations issued so far, Goldman says, are "minimally adequate," and will need significant tightening in the legislative process.

The Kennedy-Kassebaum standards give lawmakers a deadline for enacting definitive legislation; the lack of such a deadline has caused legislation designed to preserve privacy, such as Sen. Patrick Leahy's (D-Vermont) 1995 initiative, SB-1360, to languish in the past.

Leahy has introduced privacy legislation again in this session, and Goldman says it has picked up the support of key patient advocacy and physicians' groups, as well as the American Civil Liberties Union. She says its fate may be far different than its predecessor's.

"The real difference between SB-1360 and this current bill is, there is a legislative mandate from Kennedy-Kassebaum," Goldman says. "Congress has to act. They can't put it off. And there are certain critical members that are committed to it."

Goldman is optimistic, therefore, that some sort of consensus can be built fairly quickly about computerized privacy standards.

But Goldman says the road to consensus may be easier to build than it appears to those who are expecting a prolonged debate. Should legislative efforts fail, she says, Shalala can issue regulations governing privacy standards. And industry groups, she says, would rather have some say in establishing legislative standards than see regulations in which they have no input enforced.

But even the best-intentioned legislation could also have the unintended effect of slowing down the electronic system, negating much of the efficiency for which it has been designed. Requiring a release form every time a physician needs to send a record would require a large amount of time that physicians and their staffs simply don't have.

"That adds a tremendous burden," Nutig says.

MD Computing's Slack says he thinks concerted cooperative action by physicians can do much to assure adequate privacy for patients without benefit of legislation.

"They can certainly assure the patients about what they're doing with the data," he says. "I hope doctors will rise up and insist on good clinical computing and being in charge of confidentiality."

Reprinted with permission of the Los Angeles County Medical Association, publishers of the LACMA Physician magazine.

Doernbecher program treats aftereffects of childhood cancer

Sometimes the very treatment that saves lives can create physicial or psychological problems later. That's the focus of a new program at Doernbecher Children's Hospital.

Having cancer is the worst thing that could happen to a kid. Those carefree days of childhood can be quickly replaced with endless doctor visits, scary needles and sometimes painful treatments.

The good news is that these treatments frequently pay off. Nowadays, more than 60 percent of kids who have cancer are long-term survivors. But sometimes survival comes with a price. Sometimes the very treatment that saves lives can create physical or psychosocial problems later. That's the focus of a new program at Doernbecher Children's Hospital.

Sometimes as a result of their treatment, kids with cancer can get another form of cancer, develop hormonal abnormalities, have cardiac problems or have emotional problems coping with their approaching adulthood.

"The bottom line is that the cure is always worth the treatment. Medical science today has made tremendous strides in saving the lives of children with cancer," said Gary Jones, MD, associate professor in the division of pediatric hematology/oncology at Doernbecher Children's Hospital. "But clearly a cure is not enough. Without taking an in-depth look at problems following a successful cancer treatment, many childhood survivors will be faced with an uncertain and disconcerting future."

Jones is the head of the Childhood Cancer Survivors Program at Doernbecher, where he and his multi-disciplinary team of health professionals have been working in four critical areas.

The program examines, for example, whether radiation therapy and some chemotherapy drugs can inhibit normal cell or tissue growth, create cardiac problems, cause reproductive problems, or reduce the ability to learn or reason cognitively.

Other problems are not physical but instead can be psychological or social. Some studies have shown that many childhood cancer survivors face significant job discrimination and less access to health insurance as a result of their childhood illness. Federal and state disability laws have significantly decreased that type of discrimination.

"What we've also found is that many young adults are relatively unaware of the details of their childhood cancer and treatment," said Jones. "Their parents were the primary caregivers, and as these young people near adulthood and become responsible for themselves and their own health, they need to be fully aware of their former illness and any possible long-term ramifications."

The program also conducts valuable research about ways to treat children's cancer with fewer long-term side effects. The research and clinical work with patients will be shared with other health care professionals so that the medical profession as a whole can learn more about late effects of childhood cancer.

Patients eligible for Doernbecher's Childhood Cancer Survivors Program can be any age as long as their malignant disease was diagnosed before age 19. They must have been in remission and not under active treatment for at least two years; they also must be predicted to have a less than 10 percent chance of relapse.

"Our ultimate goal is to help these people, as well as future children with cancer, provide themselves with the best possible outcome, which is a normal, productive and satisfying life," said Jones.

Editor's note: Physicians wanting more information about the program may call Jones at 494-0905 or the Clinic at 494-6505.

M2FO

Continued from page 1

the death of her father, James Fenimore, founder of the insurance company that bears his name and a charter member of the foundation. His commitment to the larger community was at the forefront of his business and personal philosophy, said Fenimore and she carries on proudly in the family tradition.

Now that the Foundation has accomplished several important projects, the group, which Fenimore says is "rich in people resources," could profit from additional members' ideas and insights, especially in the area of special events and fundraising. In addition to Fenimore and Kendall, the board includes Cathy Krieger, a physician's spouse and Wes Rhodes, a columnist for The Scribe.

"We're very interested in supporting projects in the health sector that aren't particularly 'high profile'."

— Jill Fenimore, President, M2FO

To date, M2FO's principal contribution has been in the sector of childhood immunization, a project against tobacco, and "supporting physician well-being in these troubled times," said Kendall. A donation to the Foundation for Medical Excellence helped achieve the latter goal.

Striking a responsive chord with board members, who are all parents, made the donation to Oregon Preschool Immunization Consortium (OPIC) especially meaningful, said Fenimore.

Indeed, immunizations are the most cost-effective way to protect children against 10 serious diseases, says OPIC and every dollar invested in vaccinations saves $10-$14 in direct health costs.

Fenimore's main goal over the next few months is to recruit and support volunteer leaders.

"This is a great vehicle to reach out and make a difference in people's lives," she says of M2FO.

For more information about M2FO's upcoming meetings, call Pat at 222-9977. ¶

Rhodes

Continued from page 6

the technologies we are interested in have a timeline of 20-plus years).

We expect our aggressive approach to become more so, particularly as it relates to emerging technologies. Our value approach will become more oriented to undiscovered strengths that may not look as attractive on the surface, but whose fundamentals place these companies as emerging prospects. Finally, our growth and income approaches will roll back a little and become more cautious as gains on the big board slow down. For each of our 1998 portfolio strategies, we are looking at the following industries and technologies:

- Energy—alternative energy sources, organic energy, energy efficiency technology, fuel cells, hydrogen energy sources, fission, and fusion.
- Environment—CFC replacement, industrial ecology, recycling, fossil fuels, and Green environmental methods.
- Farming and Food—genetically grown foods, aquaculture, precision farming.
- Information Technology—computer hardware, computer software, communications, information services.
- Manufacturing and Robots.
- Materials—ceramic engines, super ceramic technology.
- Medicine—computerized self-care, holistic health care, gene therapy, computerized vision implants.
- Space—new materials from space, private space ventures, moon base, man/Mars mission.
- Transportation—hybrid vehicles, electric cars, intelligent transportation systems, automated highway systems.

Within each of these industries there will be current and future market leaders. Furthermore, there will be numerous companies out of favor with the market, yet financially sound and strategically positioned. Focus on these companies for your purchases.

If you have any additional questions or comments about the market or our opinions, feel free to contact me at 226-4668. I would be more than happy to meet with you and discuss your concerns. ¶

CLASSIFIEDS

PRACTICE OPPORTUNITIES

PHYSICIANS, PRIMARY CARE — Primary care clinic on outskirts of Portland is seeking a general internist, or physician with comparable skills, to provide ambulatory care to low income multi-cultural clientele. Prefer applicants experienced in primary care, with enthusiasm for preventive care, cross cultural medicine and ability to speak Spanish, 20 hours per week, inpatient duties optional. Competitive salary, bonus for inpatient call. Excellent benefits. Easy commute from many wonderful Portland neighborhoods or choose rural living close to Oregon's outdoor recreational areas. Contact: Patsy Kullberg, M.D. (503) 248-3674, Multnomah County Health Department, 426 S.W. Stark, 8th floor, Portland, OR 97204. Fax CV to Yolanda Reyes: (503) 248-3676. Equal opportunity employer.

ONCOLOGY — The Portland Clinic Physicians and Surgeons seeking full time oncologist for established practice. Competitive benefits and salary leading to partnership. Send CV to: Human Resources Department, The Portland Clinic, 800 SW 13th Avenue, Portland, OR 97205.

INTERNAL MEDICINE AND FAMILY PRACTICE – Established Multi-Specialty Clinic seeking BC/BE IM and FP. Competitive salary leading to partnership, paid CME, weekend rotation call. Send CV with three references to: Human Resource Dept., The Portland Clinic, 800 SW 13th Ave., Portland, OR 97205.

FT/PT OCCUPATIONAL MEDI-CINE PHYSICIAN — Preplace-ment, Surveillance, Physical Exams as well as Injury Care. Send CV to: Applicant PO Box 15349, Portland, OR 97232.

OPENINGS — for internal medicine and pediatrics. Dynamic independent group practice in southwest Portland - full and part time ok, flexible hours partnership opportunity - send CV to Gregg Coodley, MD, Fanno Creek Clinic, 2400 SW Vermont Street, Portland, OR 97219 or call 452-0915.

INTERNAL MEDICINE — Northwest Primary Care Group P.C. is seeking a FT BC/BE Internist to assume a retiring physicians practice. Competitive salary and benefits offered, leading to partnership. Send CV to: David McAnulty MD, Northwest Primary Care Group P.C., PO Box 22075, Milwaukie, OR 97269.

OFFICE SPACE

BEAUTIFUL PROFESSIONAL OFFCIES FOR LEASE — 1) 3,000 sq. ft. w/parking - N.E. 122nd area. 2) 1,900 (+) sq. ft. w/parking - N.W. 23rd Ave. 3) 1000 to 2100 sq. ft. w/parking - Milwaukie, S.E. MCLaughlin. All well maintained, leases negotiable, please call 503-252-1600 before 8 p.m.

25TH & LOVEJOY MEDICAL BLDG. — 2525 NW Lovejoy St., Portland - OB & GYN Office Space for Lease, 1325 sq. ft. ideally suited, excellent condition, full service, no charge parking for tenants and patients. Professional Group Ltd., Broker Managing Agent. 223-6059.

SYLVAN — 1200 square feet. Private office/exit, 2 exam rooms, reception, bathroom, nurses' area, storage, kitchen. Scherzer Real Estate 292-7150.

SPACE AVAILABLE IN BEAUTIFUL DOWNTOWN PILATES STUDIO! — Ideal for Treatment room, Body work or Consulting. Shared waiting area. Parking available $275 per month. 227-1470.

1106 SQ. FT. OFFICE SPACE — or sublease in Hillsboro. Well maintained with 3 exam rooms, lab, office. Located 4 blocks from Tuality Hospital. Call administrator at 288-7303.

VACATION RENTALS

MAUI-OCEAN FRONT — very private beautiful 2 BR, 2 Bath, 40 ft. from soothing surf. All extras - 180 deg. - view. Longest beach on Maui. Central location. Week Days 644-9919.

MAUI — Spacious oceanfront condo. 2 BR, 2 bath, fully equipped kitchen, LR, lanai, lush tropical grounds, pool, B-Q. Quiet beach. (503) 245-5769 eves. & weekends.

NORTH OREGON COAST VACATION RENTALS — Gear-hart, Seaside, Cannon Beach, Arch Cape. Ideal for families of all sizes! Northwind Property Management. Discounted fall and winter rates. (800) 488 3301 or (503) 738-5532 Visit us at http://www.-clatsop.com/propmgt

OCEANFRONT HOME — Luxury oceanfront home located 3 miles south of Salisham. Fully equipped, sleeps 8. Spectacular panoramic view. $190/night. Midweek & winter discounts available. Call (503) 246-0563.

SUNRIVER — Perfect ski cabin. Sleeps 4 - 6, 1 1/2 baths. $78.00/nite. Call Jean for brochure, 292-5429.

SALMONBERRY RIVER-LODGE — Gorgeous brand new 3 - 4 bedroom 4 1/2 bath lodge on 55 acre private river-front estate near coast. All amenities, caretaker 226-3607; 294-0455.

THE WHALE HOUSE — Oceanfront, 1 mile south of Depoe Bay. Sleeps 10. Fully equipped, fireplace, deck. Secluded beach. $125/night. (503) 721-0177, (503) 241-1913.

GEARHART OCEANVIEW — Fabulous 2 bedroom, 2 bath condo, heated pool, fireplace, golf, no pets/smoking, holiday availability, $95 - $125/night. Brochure (503) 239-7457.

INVESTMENT PROPERTY

BEAUTIFUL MANZANITA — Oceanview, golf course, property. One tenth deeded interest to new 2700 sq. ft. immaculate vacation home. Join some great, organized partners. $49,500 (503) 656-7561.

HOMES FOR SALE

SOUTHWEST PORTLAND

NO MORE HIGHWAY TRAFFIC! Move in this West Hills day ranch with possible two living quarters. Only minutes from OHSU and Good Samaritan $214,900. For Appt. call Aulikki 244-6400 Waters Realty 244-1346. Owner is Lic. Realtor.

FINANCIAL SERVICES

DOCTOR'S MONEY SOURCE, INC. — is here to help you, the professional with practice acquisition funding, equipment financing or leasing, leasehold improvements, construction financing (SBA), working capital, unsecured line of credit, practice start-up financing, and debt consolidation funding. Call (503) 350-1768, FAX (503) 350-1769.

EQUIPMENT FOR SALE

STANDBY POWER GENERATORS Be ready for the next power outage! Permanent installation, automatic power transfer. Natural gas, propane or diesel powered. Residential or business. Sales/Installation. Call Jerry, Winski Associates, 626-4717.

The SCRIBE Classifieds – $1 per word

Twenty word minimum — any item, any category

Your Name: _____

Address: _____

City, State, Zip _____

Phone( ) _____

Please print clearly. Put each letter and punctuation mark (periods, commas, semi-colons and spaces between words) in its own box. 32 letters and spaces per line maximum

Fax to 620-3433 or call Darlene Rominger at 684-0360

Relationships–

Continued from page 1

view from his Rochester office. The watershed event that demonstrated a new consciousness about the issue was the Journal of the American Medical Association's addition in January 1996 of a new section called "The Patient Physician Relationship," he said.

Most doctors had little training in the subject. Frankel cited a survey showing that two-thirds of physicians polled said they had been inadequately trained to communicate with patients. Significantly, 99 percent recognized that communication with patients is important.

Research has noted that only a fraction of patients sue. In a 1995 study of all hospitals in New York state, chart reviews showed that one percent of patients had "negligent outcomes," and thus the potential for suing. But only two-tenths of that one percent ever did. Several studies have found that a leading reason why a few sue and others don't has to do with the relationship established between doctor and patient.

One study found that in situations where doctors displayed "low empathy skills" and also made a mistake, patients were "eager" to sue, Frankel said. "Even when no mistake was made and there was low empathy," the patient was more likely to file suit. It has been assumed that nurses were a frequent catalyst to encourage the patient to consider litigation; but Frankel and his colleagues found instead that data showed consulting physicians as playing an important role in influencing the patient to sue the original doctor.

The most common relationship complaint arising from the depositions was the feeling of being deserted by the doctor. This involved not being able to reach the doctor, or having a replacement doctor, such as a resident, perform follow-up visits. "If residents are likely to provide a significant portion of service, it would be valuable to ... let patients know explicitly whom they will see," Frankel and his colleagues wrote. "(If) a patient is experiencing postoperative problems, it is provocative to tell the patient" that residents are "filling in" for the original physician, who is "too busy" to see every patient.

The next-most-frequent complaint of litigants was that their and their families' views didn't count for anything with the physician. When patients perceive that the doctor rejected their opinions or observations — and the patients' opinion turned out to be correct—"their initial anger can evolve into a desire to seek retribution," the researchers wrote.

In another study, researchers reviewed audiotapes of 125 primary care doctors and specialists and their encounters with patients. Half the doctors had been sued at least once, the other half had never been sued. Those studying the tapes had no knowledge ahead of time of which group was which. "We were able to say two out of three times if the person had been sued, by observing communication skills," Frankel said.

> ***"We were able to say two out of three times if the person had been sued by observing communication skills."***
>
> **— Richard Frankel, Ph.D.**

For primary care, time spent was a crucial factor: On average, doctors spend 16.1 minutes with the patient in an office visit. Doctors sued spent an average of 15 minutes, and those physicians never sued spent an average of 18 minutes. Patients who felt rushed, uncared for, not listened to were the most likely to sue. Doctors who had not been sued displayed none of these characteristics.

Besides time spent, important other components were for the doctor to show compassion and allow the patient the opportunity to ask questions. Unsued physicians "attended to the psychological and social concerns of the patient," Frankel said. They displayed "active listening skills" and were "social," he added. "Physician laughter was highly associated with not being sued."

QualMed—

Continued from page 5

PACC was founded in 1938 as one of the first physician-sponsored, not-for-profit health care contractors in the United States. Because of the company's not-for-profit status, the purchase price, subject to certain adjustments, will be used to endow the Northwest Health Foundation, a permanent charitable organization established by PACC to receive the proceeds of the sale. The foundation is chaired by former U.S. Senator Mark O. Hatfield and its board includes several prominent Oregonians.

FHS is the nation's fourth-largest publicly traded managed health care company. The company's HMO, insured PPO and government contracts subsidiaries provide health benefits to nearly five million individuals in 17 states through group, individual, Medicare risk, Medicaid and CHAMPUS programs. FHS subsidiaries also offer managed health care products related to workers' compensation, PPO networks, behavioral health, dental, vision and prescription drugs, and offer managed health care product coordination for multi-region employers and administrative services for medical groups and self-funded benefits programs. The company's principal offices are in Woodland Hills and Rancho Cordova, Calif. and Pueblo, Colo.

Editorial contributions sought

The Scribe encourages contributions from readers on issues affecting physicians and their practices, and the regional health care industry. Letters should be sent to Steve Sinovic, Editor, The Scribe, 6975 SW Sandburg Road, Tigard OR 97223. (Fax: (503) 620-3433). Letters should be signed, and should include the contributor's address and telephone number (Addresses and phone numbers are required for verification purposes only and will not be published.)

Articles or opinion columns on topics of interest to the physician and practice management communities — as well as suggestions for future articles — are also welcome. For more information on submitting an article, call Steve Sinovic at (503) 684-0360 during regular business hours, or leave a detailed message on the Scribe voice mail line, (503) 306-3999.