The Portland Physicians' SCRIBE

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

IN BRIEF

September 17, 1999

Vol. XVIII, No. 18

MSMP Members Forum a place to seek change

Litigation reform, writing proposed resolutions for introduction at the next OMA House of Delegates meeting, and feedback to President Mary Burry, MD, highlight the Wednesday, Sept. 29 MSMP Members Forum. The event will begin with dinner at 7 p.m. at the MSMP building.

Scott Gallant, OMA's director of government affairs, will detail OMA efforts to reverse the Oregon Supreme Court's recent action ruling the cap on non-economic damages as unconstitutional.

Looking for change? Then come prepared to offer a resolution for consideration by MSMP Board of Trustees for introduction at the next OMA Delegates meeting. (Call Rob at 944-1139 for help on the finer points of Parliamentary Procedure).

Finally, President Burry will present recent and current activities of the Society and receive your ideas for new projects, programs and activities.

Reservations: 944-1138.

Transitions file

Along with news of Barney Speight's imminent departure from the Oregon Health Plan comes news of other leave takings in the local world of health care.

The Oregon Board of Medical Examiners is searching for a medical director to replace James Hicks, MD, who is returning to private practice.

Deborah Origer, who became president of PacifiCare of Oregon in February of 1998, saw her position eliminated in the wake of administrative cuts. The for-profit HMO replaced her with a general manager who's reporting to regional top brass in Seattle.

Speight Shuttle

Departing Health Plan exec's successor will be chosen with 'particular care'

By Steve Sinovic

It was an offer too good to refuse.

Barney Speight's decision to leave the Oregon Health Plan for a newly created job at Kaiser Permanente is a decision many of his close associates understand, but still lament.

"Though we all knew when he took the job that he wouldn't be here forever, it still came as somewhat of a shock," said Kathleen Weaver, MD, medical director for the Office of Health Plan Policy & Research, the state agency that oversees the Oregon Health Plan.

"With the end of governor's second term now in sight, Barney felt there wouldn't be another opportunity such as this (the Kaiser job) to present itself over the course of the next two years."

Speight has been hired as director for public policy and government relations for Kaiser Health Plans of the Northwest, an HMO he once worked for. [A more in-depth interview with Speight will run in the next issue.] The first edition of the OHPPR newsletter did include news of his move and included this quote:

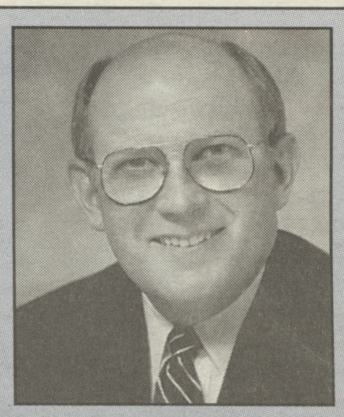
"The opportunity to work with Governor [John] Kitzhaber and his administration at OHPPR has been a remarkable experience for me," Speight said. "My new role doesn't end the professional relationships that have developed over the past few years...it merely changes them. I look forward to continued involvement in Oregon [and Northwest] health policy."

> *"My new role doesn't end the professional relationships that have developed over the past few years....it merely changes them."*
>
> **Barney Spieght outgoing OHP administrator**

During Speight's tenure with the state, OHPPR completed several program/policy evaluations, assisted in the development of the Family Health Insurance Assistance Program, worked to establish a voluntary consortium to create a managed-care performance report for Portland-area health plans, and continued development and refinement of the state's health services databases.

Bob DiPrete, executive director of the Oregon Health Council, will

Turn to SPEIGHT, page 3



Barney Speight

Health Care Merry-Go-Round

Barney Speight's new appointment marks a return to Kaiser for the outgoing OHP administrator. He served as the HMO's lobbyist in the mid-1980s.

Speight's previous health care jobs include vice president of corporate relations for Regence Blue Cross, vice president for Blue Cross Blue Shield of Oregon (overseeing corporate development and external affairs), vice president of specialty services for Good Samaritan Hospital & Medical Center, lobbyist for the OMA and working for Oregon's governor.

Insurance turmoil in Washington unlikely to head south

By Cliff Collins

Washington State's biggest health insurers have quit selling coverage to individuals, but a similar scenario is unlikely in Oregon.

That was the assessment of the Beaver State's two largest health insurers, Regence BlueCross BlueShield of Oregon and Kaiser Permanente, in the wake of the Sept. 1 announcements that Regence Blue Shield of Washington and Group Health Cooperative are declining to write new individual policies.

Oregon Blues and Kaiser executives say Oregon insurers, legislators and regulators worked together to fashion a reasonable approach to insurance reform that didn't leave carriers in the money-losing situation Washington carriers say they are in with individual plans.

"The individual market [in Washington] is broken," said Rich Nelson, Regence Blue Shield's chief executive officer in Seattle. He said the company can't participate unless the market is stabilized by changing Washington's insurance laws, which require health insurers to offer policies to anyone who applies, regardless of health status.

Similarly, Cheryl Scott, president of the only other major seller in that market, said it, too, was not writing any new individual policies, partly in reaction to Blue Shield's decision; Group Health did not want to be the only insurer left accepting all-comers, especially in light of the ending of new coverage Jan. 1, 2000, for that state's unsubsidized Basic Health Plan.

Washington officials announced in late August that new policies for the unsubsidized portion of the Basic

Turn to INSURANCE, page 2

INSURANCE

continued from page 1

Health Plan—which offers coverage to those who don't qualify for the subsidized version of the Basic Health Plan—would be frozen. Also, four of the nine carriers will drop their existing enrollees Dec. 31. Insurers anticipated a wave of new applications for individual coverage owing to those developments—and further financial losses.

Washington once had more than 50 companies peddling individual coverage. With the pullout of the three largest in less than a year, only a smattering of carriers will be available in just eight Washington counties, according to the Seattle Post-Intelligencer. By contrast, from 80 to 100 insurance plans are available for individuals in Oregon, said a Kaiser executive.

Blue Shield said it lost $30 million insuring individuals the past five years, with a projected $6.6 million for 1999—despite double-digit rate increases the last several years—after the 1993 Washington Legislature passed a series of reforms intended to broaden the number of covered residents.

The laws did provide greater access to insurance, but part of the reform package—that guaranteeing universal coverage—was repealed by the 1995 Legislature, which left the state with "half a solution, but none of the commitments to universal coverage," said Blue Shield spokesman Chris Bruzzo.

Bruzzo said Washington and Kentucky are alone among states in their "liberal portability" approach to waiving pre-existing conditions—Washington does this after just a 90-day wait—and in requiring insurers to cover any applicant without a health screening. As a result, the Evergreen State's high-risk pool, subsidized by all insurers, shut down after the 1993 laws made all applications guaranteed-issue and rendered the pool unnecessary.

Blue Shield's Nelson hinted that existing individual-policy coverage would be in jeopardy if the legislative solution isn't forthcoming: "It is extremely important to me and to this company that we find a solution that will enable [us] to continue to provide coverage" to its 63,000 individual members. "It is my hope that we'll be able to re-enter a competitive market that has appropriate incentives for everyone to get health coverage."

As things stand, allowing people to wait to purchase insurance after they experience health problems is "like allowing someone to purchase fire insurance when the flames are going through the roof of their house," said Blue Shield Executive Vice President John Carlson.

"Individuals can purchase health coverage when they know they need care and drop coverage as soon as they obtain that care," Carlson said. "This cycle has caused the cost of individual coverage to rise dramatically...while carriers have continued to lose money."

Washington Insurance Commissioner Deborah Senn responded to the crisis by reopening the state high-risk pool for counties with no individual coverage available. Premiums, though, run 50 percent higher than the individual-market price, the Seattle P-I reported. Senn called for cooperation among health insurers, her office and the Legislature to try to forge a solution to the crisis. Both Blue Shield and Group Health officials expressed their willingness to help find answers.

Blue Shield's and Group Health's moves follow a late-1998 decision by Premera Blue Cross, then the largest in the individual health insurance market in Washington, to close new enrollment. Kaiser Permanente in Oregon, which sold individual coverage in Clark and Cowlitz counties, pulled out of Washington after the 1993 reform laws, anticipating the problems inherent in covering all comers without the benefit of underwriting, according to Denise Honzel, Kaiser's vice president and health plan manager.

Honzel and Ruth A. Rogers Bauman, vice president of actuarial and underwriting services for the Oregon Blues, agreed that Oregon's individual market is in better shape than its northern neighbor's.

"In Oregon, there was a more rational, incremental approach to health care reform," Honzel said. She said Oregon insurance regulators employed a moderate approach

Turn to INSURANCE, page 10

The Portland Physicians' SCRIBE

Editor:
Steven Sinovic

Account Executive:
Tracy Livermore

Production & Graphics:
Vivian Read

Published by the Medical Society of Metropolitan Portland

Mary Burry, MD	President
Colin Cave, MD	President-Elect
Martin Skinner, MD	Past President
Al Turner, DO	Secretary/ Treasurer

Trustees
Donald Girard, MD
James Hicks, MD
J. Bart McMullan, MD
Constance Powell, MD
Kim Wayson, MD

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 Portland Physicians' 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 Tracy Livermore at 503-684-0360.

Praise the Lord and pass the ammunition!

By Mary Burry, MD

During the weeks that have passed since returning home from Albania and leaving behind the refugee camps, I have found myself considering just what it was that made this type of experience so meaningful. It was not too difficult to figure out.

My experience in Albania, similar to the month my husband, Tom Hoggard, and I spent caring for Somali refugees a few years back, represented medicine in its most basic form—stripped of much of the add-ons of our current reality. In this environment there were no risk withholds, no ICD-9 codes, no pre-authorizations, no rejected claims and not surprisingly, no monetary reimbursement whatsoever!

This incredibly rewarding experience reminded us once again why we wanted to be doctors in the first place. It did nothing, however, to make the car payment, pay tuition for the kids, or provide the simple, underappreciated food, clothing and shelter necessities of life, not to mention paying the ever-increasing overhead.

These economic issues cannot be made to disappear in a cloud of idealism and warm,

Mary Burry, MD

fuzzy feelings—although there were moments when that almost seemed true. The reality is that what we do represents our bread and butter and, in turn, also creates significant impact to insurers, hospitals, businesses great and small and ultimately to individual households.

What I have experienced is that, in this country, there exists some of the finest medical care available anywhere. I watch my fellow physicians go about their work with caring and compassion, with state-of-the-art equipment and knowledge, with a strong infrastructure to support them and their patients. It once took me, while in Albania, an entire morning to do a simple paracentesis because of lack of ready access to the most basic equipment. What we take for granted here is truly not that common.

We are in this profession to help, to comfort and to heal and we need to do this with all the science, art and compassion we can muster. Simultaneously, we are in a tough business environment tossed on a sea of change, for which our medical training did not prepare us. Medical education and experience is in the mindset of the personal, the one-to-one. Governments take care of populations of citizens, insurance companies and hospitals take care of customers and stockholders, physicians take care of people...this is a fundamental difference.

How does one reconcile these conflicting aspects of what we do and participate in?

The economic issues must be addressed as such, with quality business expertise that must be learned or purchased. Our practices must be economically viable to exist, AND our patients must be truly safe when they place themselves into our hands. What we do has great value and deserves our best effort to succeed and do battle with forces that would destroy this balance.

Mary Burry, MD, a neuroradiologist, is the president of the Medical Society of Metropolitan Portland.

SPEIGHT

continued from page 1

serve as interim administrator.

"Obviously this is a significant loss to our office as we begin a period of transition, but it does leave ample time for a new person to come in and get the office on track for the next legislative session," said Weaver, who strongly urges that Speight's successor be someone "medical."

Could a doctor fill the bill?

"Certainly a physician with real hands-on understanding of the Plan and how it works would be fine, but I don't want to suggest that we'd prefer [just] a physician," said Jim Kronenberg, OMA associate executive director.

"This is primarily a policy-development position, almost a think-tank operation," said Kronenberg, talking about the key quality the job demands.

"We obviously have been pleased for a variety of reasons that Barney has had this job," added Kronenberg, lauding his "impressive intellect" and ability to "process very complicated information and come up with sound solutions."

Kronenberg said the subject of Speight's replacement will probably come up in an upcoming meeting the governor will hold with OMA Executive Director Bob Dernedde and OMA President Rick Kincade, MD.

"The Oregon Health Plan is John Kitzhaber's baby...so you can be sure this is a position he'll fill with particular care," Kronenberg said.

We Want To Hear From You!

The Scribe welcomes letters and opinion pieces to the editor. Send them to:

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

The Rhodes Company

BUSINESS OF MEDICINE

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

America's medical boards

How well are they doing their jobs?

Editor's note: A host of challenges—political, fiscal and legal—sometimes stymie boards' efforts to protect consumers and serve their constituents. Writer Bonnie Darves provides a perspective on how boards operate around the country. Part two of this article will conclude in the next issue of The Scribe.

BY BONNIE DARVES

When the Maryland Board of Physician Quality Assurance last December decided it had gathered enough evidence supporting allegations that well-known Baltimore diet doctor Pietr Hitzig, MD, was having sex with his patients and prescribing inappropriately, it acted swiftly and decisively. The board summarily suspended Hitzig's license, even though the doctor hadn't had a hearing, because the board believed Hitzig posed a public danger and state law allows for immediate intervention in such cases.

When the State Medical Board of Ohio recently tried to act in a similarly decisive manner, to sanction a physician diagnosed with severe mental disorders, it hit a roadblock. The physician, whose license had been summarily suspended in a neighboring state, also holds an Ohio license. But because the board in the other state is forbidden by statute to release its files, the Ohio board was unable to take reciprocal action without opening its own investigation.

"You want to take action to protect the public, but sometimes you can't. Because the (other) state wasn't in a position to release the information, that impeded our ability to move as quickly as we'd like to," says Lauren Lubow, staff attorney for the Ohio board. Had the situation been reversed, Ohio could have released the information, Lubow notes. Final action in the case is still pending.

Widely varying information disclosure laws is just one of the barriers medical boards face in trying to fulfill their public-protection mission, but it's a serious one, says Ray Bumgarner, the Ohio board's executive director. "In 37 jurisdictions, boards can't release any (investigation) information at all," he says. And in some states all information gathered must be shared with the physician being investigated—which "chills the reporting of information," Bumgarner says. "We're talking about a significant problem."

If the primary mission of medical boards is to protect the public, it stands to reason that such entities should meet little in the way of resistance from the states that have given them the statutory authority to license and discipline physicians. But that's not always the case, says Dale Austin, deputy executive vice president of the Federation of State Medical Boards in Euless, Texas. The manner in which medical boards are funded, staffed, and overseen or connected to the legislative process varies from state to state. Many states, Austin says, "are dealing with diminishing resources. Boards that can be supported in full with fees can do an adequate job, but if the funds come as a percentage of the (state's) general fund, the ability to raise fees as needed can be difficult."

And if legislative approval is required to increase license fees or expand the board's purview, political tensions can serve as roadblocks to effective functioning. Former Health and Human Services Inspector General Richard Kasserow acknowledged the problem a decade ago when he said, "The problem with medical boards is that they are stuck in the backwaters of state government."

> ***"The most common disciplinary action for even the worst offenses is probation. Some states do little more than slap physicians on the wrist."***
>
> **Sidney Wolfe, MD**
> **outspoken critic of medical boards**

Andrew Watry, former executive director of the Georgia Composite Board of Medical Examiners who took the helm of the North Carolina Medical Board a year ago, knows firsthand how politics and funding problems can impact medical boards' ability to do their jobs. Two years ago, in the middle of a bitter gubernatorial campaign in which the board was being used as a pawn, Watry was asked to resign his post and six of the 13 members were replaced. "We got a young guy (then Secretary of State Lewis Massey) who wanted to be governor, and he would ask us to accelerate his constituents' applications. It was a very political process," Watry recalls. "He was more interested in making political capital than in protecting the public. The board wasn't actually under any scrutiny."

Although the Georgia board had experienced backlogs in license applications and investigations, the real issue, Watry contends, was that the board, which operated under the direct control of the secretary of state, "had no authority over either its budget or its financing."

Funding was allocated through the general fund "as the current administration saw fit," he says, which resulted in inadequate resources.

By contrast, Watry says, he has experienced little in the way of obstacles since he moved to North Carolina. "I have had great support because the board revenue is not 'siphoned off' for other purposes, as it was in Georgia."

In general, Watry believes states don't fund boards at a level commensurate with the importance of the task they perform. "In state government, what protects the residents is more important than (fixing) potholes or issuing fishing licenses," he says. "If you look at states and how medical boards are funded, it doesn't reflect the importance of that public protection function."

The Washington, D.C., Office of Professional Licensing is a case in point. The most notoriously underfunded board in the country, the D.C. entity receives, as an allocation from the district's general fund, only 11 percent of the licensing fees it collects. "And that figure has declined over the last several years," says James Granger, the board's executive director. Yet the nine-member board—which, unlike most states, has no dedicated investigator or attorney, and no control over its budget—has purview over 9,000 physicians and thousands of other allied health professionals. The upshot, says Granger, is that "the disciplinary process, by definition, is slowed down."

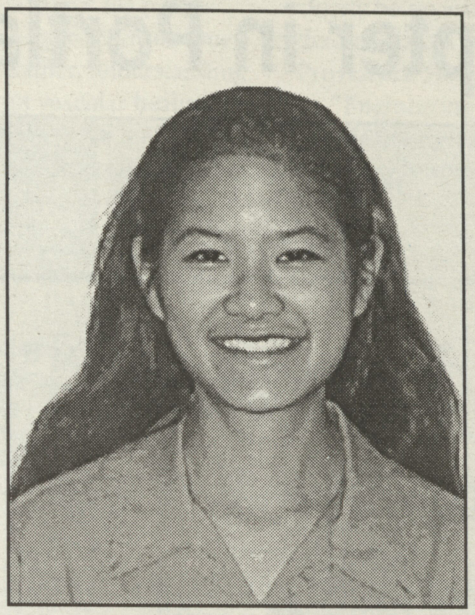
Contrast D.C. with Ohio, which has a full-time staff of 78, a biennial budget of $11 million and, by virtue of a recently enacted statute, fiscal independence from the state. The board has licensing and disciplinary oversight for 31,940 MDs, as well as the state's DOs, physician assistants and podiatrists.

Legislative and funding challenges aside, how are medical boards doing in disciplining doctors? The number of disciplinary actions taken by medical boards against physicians has remained essentially flat in recent years, but boards appear more willing these days to suspend or revoke

Turn to BOARDS, page 8

MSMP welcomes new members!

Patrick O'Hollaren, MD
The Urology Clinic
501 N. Graham, #420
Portland, OR 97227
Phone: 288-7303
*Urology**
OHSU 1987



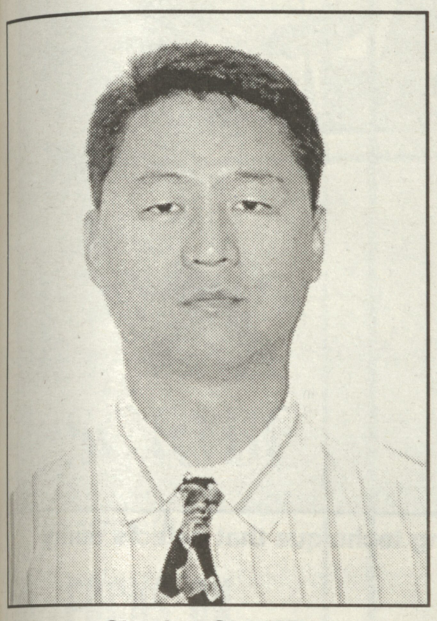
Addie Onsanit, MD

Barbara Resnick, MD
Portland Dermatology Clinic
2250 N.W. Flanders, #205
Portland, OR 97210
Phone: 223-3104
*Dermatology**
University of Rochester 1990

Walter J. Reynolds, MD
The Urology Clinic
1130 N.W. 22nd, #535
Portland, OR 97210
Phone: 274-4999
*Urology**
Jefferson Medical School 1967

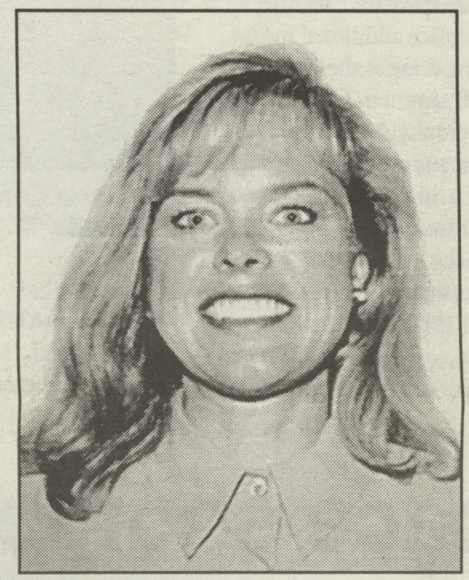
Carolyn Rhett, MD
Residency, OHSU
Emergency Medicine
University of Oklahoma 1999

Howard Sun, MD



Charles Oh, MD

Addie Onsanit, MD
Residency, OHSU
Internal Medicine
University of Virginia,
Charlottesville 1998

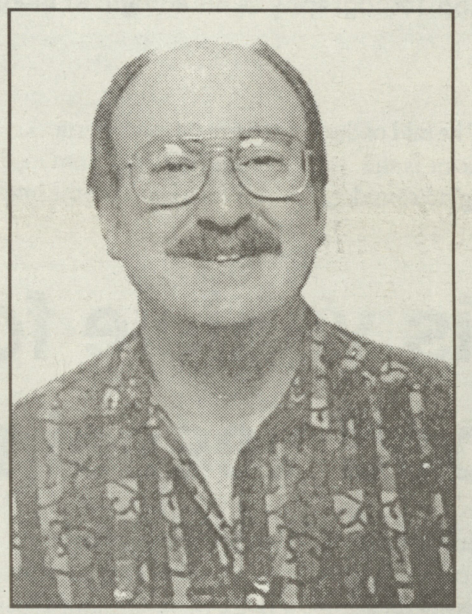


Kristen Steele, MD

Howard Sun, MD
The Oregon Clinic
507 N.E. 47th
Portland, OR 97213
Phone: 215-6079
*Radiology**
University of Illinois, 1993

Robin Yurk, MD
Foundation for Accountability
520 S.W. 6th Ave., #700
Portland, OR 97204
Phone: 223-2228
*Internal Medicine**
*Pediatrics**
Creighton University 1991

Charles Oh, MD
Fellowship, OHSU
Phone: 494-8750
Cardiology
Medical College Wisconsin, 1990



Howard Schneider, MD

Kevin Olson, MD

Kevin Olson, MD
N.W. Cancer Specialists
19250 S.W. 65th Ave., #320
Tualatin, OR 97062
Phone: 692-2032
*Internal Medicine**
*Hematology/Oncology**
OHSU 1988

Howard Schneider, MD
2560 R.C.A. Blvd., #104
Palm Beach Gardens, FL 33410
Phone: 561-694-2223
*Internal Medicine**
Rheumatology
Guadalajara, Mexico 1977

Frank Palmrose, MD
Kaiser Permanente
3500 N. Interstate Ave.
Portland, OR 97217
Phone: 331-6400
*Anesthesiology**
OHSU 1985

David Pokorny, MD
9155 S.W. Barnes Rd., #839
Portland, OR 97225
Phone: 297-8717
*Dermatology**
Creighton University 1978

Kristen Steele, MD
Oregon Pediatric Clinic
Clackamas Pediatric Clinic
5050 N.E. Hoyt St., #523
Portland, OR 97213
Phone: 233-5393
*Pediatrics**
OHSU 1996

Richard Rytting, MD
Providence Health Plan
1235 N.E. 47th Ave., #220
Portland, OR 97213
Phone: 215-7577
*Internal Medicine**
George Washington University, 1970

Cornelia Taylor, MD
Regence BlueCross BlueShield
201 High St., S.E.
Salem, OR 97309-0625
Phone: 800-643-4512
*Internal Medicine**
OHSU 1990

Mary Ellen Ulmer, MD
The Portland Clinic
15950 S.W. Millikan Way
Beaverton, OR 97006
Phone: 646-0161
*Pediatrics**
Northwestern University 1992

Andrea Zaner

Andrea Zaner, Practice Manager
Hillsboro Clinic
364 S.E. Eighth Ave., #00
Hillsboro, OR 97123
Phone: 681-4366

PET scanning: a new chapter in Portland imaging

BY STEVE SINOVIC

Chalk up another first for East Portland Imaging Center.

The first imaging practice in the metro area to offer MRI capability, it also was the first outpatient facility to have a CAT scanner. A new chapter for East Portland Imaging begins with the arrival of a PET scanner in November.

> *"It's a very science-oriented, service-type atmosphere we produce."*
>
> **Gerald Warnock, MD**
> **East Portland Imaging Center**

While PET (as in Positron Emission Tomography) scanning is not new technology, it has only been available in the region at a few academic centers. This was due in part to the need of a cyclotron for the radioactive isotope construction and perhaps more so because insurance companies were unwilling to reimburse for the procedure. Now, Medicare recognizes PET as a diagnostic tool for cancer staging.

Oncologists statewide have been contacting the Center wanting additional information and start dates, said Gerald Warnock, MD, the Center's director. "They're excited by the prospects," said Warnock, referring to the preciseness of outcomes such scanning brings. He estimated the PET scanner should be in place around the first of November. The equipment represents a considerable investment for the facility: about $2 million plus remodeling costs to accommodate the scanner.

PET scanning has shown a high degree of accuracy for determining the presence or spread of many malignant tumors. Physicians also use PET images to diagnose and manage patient treament plans for cardiac disease. PET scanning's value in brain surgery characterized its early history, said Warnock.

High activity of glucose during a scan shows the way to tumors, said Warnock.

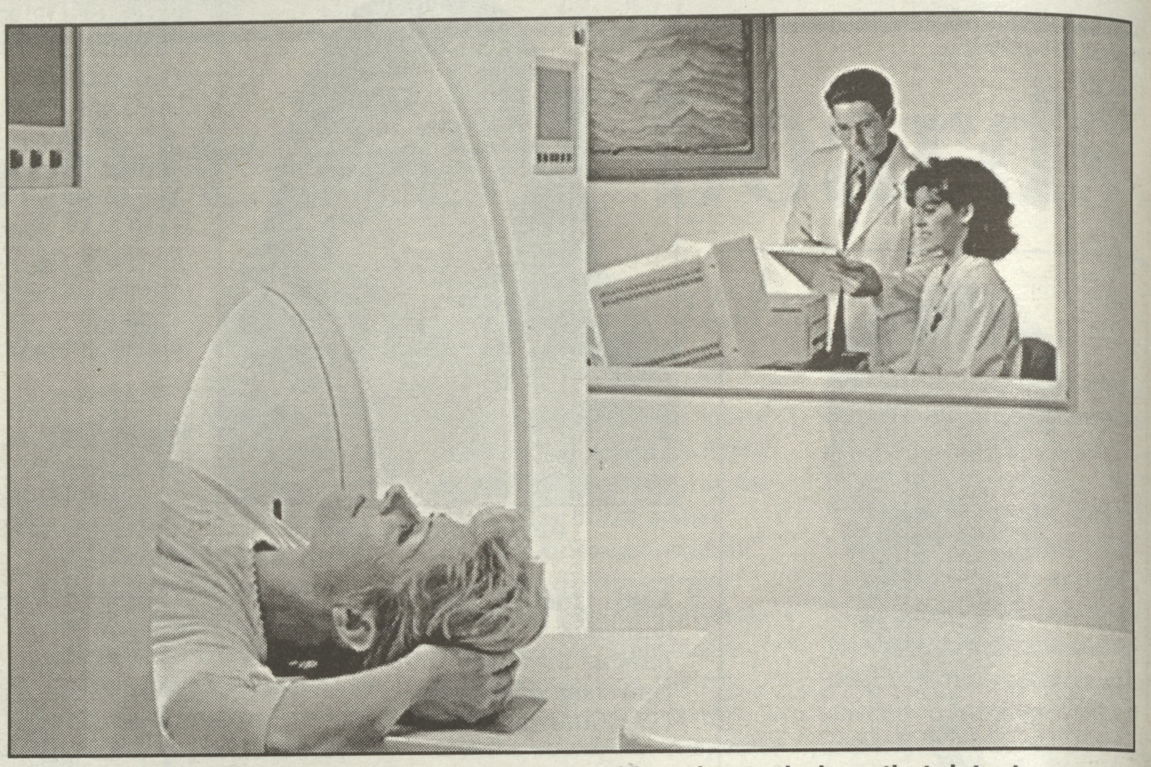
"Thoroughness" seems to be the watchword when it comes to the new equipment. "It's not fast," said Warnock. The average scan takes about two hours.

Ultimately, "Success (in this business) is based on the quality of interpretation," said Warnock. "It's a very science-oriented, service-type atmosphere we produce," he added, referring to the 350 patients Center staff serves each day.

Arrival of the PET scanner doesn't replace additional means of imaging done at the Center. Four MRI scanners, CT, radiology, mammography, nuclear medicine and Dexacans are on the premises. The 94-member staff includes seven full-time radiologists.

Warnock, who graduated from the University of Oregon Medical School in 1958, said he still enjoys coming to work every day. "It's the kind of work that transgresses all phases of medicine," he said of the imaging field. "Medicine is still much too fascinating" to consider retirement, said Warnock.

And life away from medicine? Well, right after the interview he was heading for Outer Mongolia to hunt mountain sheep in the Altai Mountains.



Positron Emission Tomography is an advanced imaging technique that detects many diseases.

Space shuttle is vehicle for Portland physician's blood vessel research

Kenton Gregory, MD, holds one of the artificial blood vessels (housed inside a cartridge) that went into space on NASA's July 20 shuttle mission.

Space injuries have broad implications for astronauts living on a new space station or for the manned Mars expedition. But a Providence St. Vincent Medical Center physician is trying to change all that—while at the same time shedding light on heart disease.

Kenton Gregory, MD, director of the Oregon Medical Laser Center at Providence St. Vincent, is on a mission to find new ways to heal injured blood vessels. For the past three years, Gregory has been growing artificial blood vessels in his lab, using a natural tissue protein called elastin. Biomaterials made of elastin can be fashioned into any shape or size and have biological and mechanical properties that may make them ideal for repairing or replacing vessels and arteries.

With the help of collaborators at Tissue Engineering Services Inc., in Germantown, Maryland, Gregory recently sent into space several of his lab-grown artificial blood vessels to study whether they would heal in microgravity. The five-day mission with Gregory's experiment departed from Kennedy Space Center last July 20.

"We are so pleased to have been selected for this mission," says Gregory. "It's exciting to be part of something that could have such a significant impact on space exploration."

Gregory's artificial blood vessels traveled through space equipped with special bioreactors and perfusion pumps that replicate the blood flow in the body to maintain and grow cells.

When the mission ended, Gregory removed the vessels from the bioreactor and started microscopic studies to see if the cells have healed or are in the process of healing. He'll then compare this information to the same experiments being conducted in the lab, where artificial blood vessels usually take between two to six days to heal.

"We don't think the vessels going into space will heal," says Gregory. "For a wound to heal, the cells must migrate towards one another. Cells use gravity as their cue, but without gravity, the filaments that cause movement won't migrate correctly.

"If hypothesis is proven, it will pave the way for new

Turn to RESEARCH, page 7

RESEARCH
continued from page 6

research into ways that we may be able to stimulate healing in space." Experiment results don't have implications for people spending long periods of time in space. Rather, understanding more about vascular healing "benefits everyone," says Gregory, whose expertise is closely being watched by cardiac specialists at the Providence Heart Institute.

"Engineering tissues to help people live healthier lives is very satisfying," says Gregory. "This is truly the future of medicine and surgery."

The Oregon Medical Laser Center is the only facility of its kind in the Northwest and one of the few laboratories in the world working on tissue engineering. The OMLC is a collaborative effort between Providence, OHSU and the Oregon Graduate Institute of Science & Technology.

BOARDS

continued from page 4

medical licenses. The most recent data from the Federation of State Medical Boards shows that while punitive actions, overall, declined slightly between 1996 and 1997, from 3,821 to 3,728, the number of physicians who lost their licenses increased two percent over that period.

Sidney Wolfe, MD, an outspoken critic of medical boards and how they function, isn't happy with the numbers. Wolfe, director of health research at Public Citizen, a Washington, D.C., watchdog organization founded in 1971 by Ralph Nader, maintains that boards are too lax in disciplining doctors and that many doctors who pose a threat to the public are allowed to continue practicing.

"The most common disciplinary action for even the worst offenses is probation. Some states do little more than slap physicians on the wrist, leaving most questionable doctors free to practice with few if any restrictions," Wolfe writes in a statement accompanying the recent release of Public Citizen's 1998 edition of "16,638 Questionable Doctors." The highly controversial volume lists names of doctors disciplined, the nature of the offense and disciplinary action taken, and, in some cases, additional updates regarding license status.

Wolfe's critics take issue not with the accuracy of the data published in "Questionable Doctors"—which comes from the state medical boards, the Department of Health and Human Services and the Food and Drug Administration—but with Public Citizen's annual relative rankings of medical boards. Using a formula of disciplinary actions per 1,000 non-federal doctors, Wolfe defines "worst states" as those with the lowest rate of serious disciplinary actions, and equates higher disciplinary rates with better public-protection performance. In the most recent analysis, Alaska, with 15.4 actions per 1,000 physicians, tops the list of "best states." Tennessee, with 0.85 actions per 1,000 doctors, earned Public Citizen's "worst state" ranking. Oregon tallied in at 3.36 actions per 1,000.

J. Michael Compton, executive director of the Maryland Board of Physician Quality Assurance, claims Wolfe's methodology is faulty. "His statistics are wrong. He plagiarizes from the AMA," whose list, Compton says, is based only on mailing addresses, not residence or license status. "It doesn't compute. According to Sidney, the best state (is one that) takes more actions, but where do you want to go for care—Biloxi or Baltimore?" Compton, and the NFSMB's Austin, maintain that it's more instructive to look at a single board over a period of years, to determine how it's doing.

Whether Wolfe's methodology is faulty or not, he is convinced that medical boards don't go far enough in protecting the public. Performance of state boards is "dangerously uneven," he says, and boards in general have a "dismal record" of prosecuting such serious offenses as physician sexual misconduct. In a study published in the June 17, 1998, issue of JAMA, Wolfe and co-author Christine Dehlendorf claim that about 40 percent of U.S. physicians disciplined before 1995 for sexual offenses involving their own patients, were still practicing in 1997. "The number of disciplinary actions taken against doctors is extraordinarily low compared to estimates by physicians themselves of the real number of sex-related offenses they commit. Many guilty doctors are escaping any sanction at all," the authors wrote.

At the very least, Public Citizen recommends that the national Practitioner Data Bank be opened to the public, and that the names of physicians whose prescribing licenses have been restricted or revoked be publicized in mainstream media such as local newspapers.

Part two of this article concludes in the next issue of The Scribe.

CPR training one of many priorities for M2FO

By Steve Sinovic

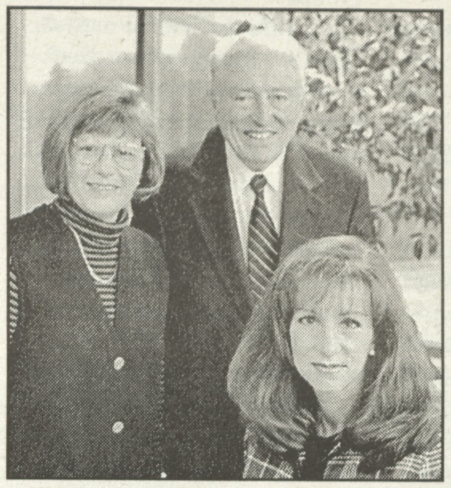
Childhood immunization. Violence prevention. Smoking cessation. And now, mass CPR training.

The Metropolitan Medical Foundation of Oregon (M2FO), affiliated with MSMP, is living up to its word to help support health education and delivery to the community.

To that end, M2FO recently donated $1,000 to help underwrite CPR Sunday, a program to provide free mass public training in cardiopulmonary resuscitation. The event, which will be held at Memorial Coliseum Sept. 26, aims to train people to help those dying unnecessarily each day from sudden cardiac arrest. The event is being sponsored by the local chapters of the the American Red Cross and Heart Association.

"It fits perfectly within our health education mission to (offer) support," said Jill Fenimore, M2FO board president. "It's a very worthwhile cause."

According to the event co-sponsors, the average cardiac arrest survival rate in the U.S. is just five percent. Raising the survival rate to 20 percent could save 50,000 lives each year, they estimate.



M2FO board members Cathy Kreiger, John Kendall, MD, and Jill Fenimore meet regularly to identify strategies that enhance community health.

Victims of these emergencies stand a much better chance of survival if a sequence of action called the chain of survival is initiated. This chain links the victim to the health care system, but it depends on actions by lay people. Simply stated, the chain of survival consists of early access to emergency medical services, early CPR, early defibrillation and early advanced care.

Since mass CPR training programs were first initiated in Seattle, there has been a great increase in both the survival of out-of-hospital cardiac arrests and the percent of lay people trained in CPR. Seattle boasts that their survival rate increased from two to 24 percent.

"With M2FO serving as the charitable-giving vehicle in this area for physicians, supporting these events is an extension of the spirit of medicine in the community," said Rob Delf, MSMP executive director.

Delf said 150 physicians have contributed regularly to M2FO. "It's not large as foundations go, but its donations are important to those who get the funds," said Delf. In addition to CPR Sunday, M2FO funds childhood immunizations, a gun and violence prevention program called "Cops, Docs and DAs," and smoking cessation education.

Joining Fenimore on the M2FO board are Wes Rhodes, Cathy Kreiger, Colin Cave, MD and John Kendall, MD.

For more information about CPR Sunday, call 233-0100.

INSURANCE
continued from page 2

that took into account the needs of both insurers and the public. As a result, the market has been more stable, and more people are covered.

Both executives said the major difference in the two Northwest states has been in Washington's guaranteed-issue requirement. "In Oregon, we can still deny coverage," Bauman said, with those denied coverage having a safety valve through the high-risk insurance pool, which all health insurers must contribute to and which spreads risk in a more equitable fashion.

Although Group Health, which is affiliated with Kaiser, stated in its decision that, collectively, "the individual market is inherently a higher risk and more expensive population" to cover, Bauman and Honzel said that is not necessarily the case in Oregon. Instead, they explained that the individual market is more variable and unpredictable to underwrite than are large groups.

"In the individual market, there is a lot more turnover," with people coming in and out, either from group coverage or as new applicants, observed Bauman. Thus, when underwriters assess new rates based on that population's past year's experience, the same population won't be covered by the time the next year's rates take effect.

But the past year's experience was a poor one for Blue Cross' individual market in terms of large claims, she said, and individual members received nearly a 22 percent hike in premiums beginning Aug. 1. Kaiser's new rates take effect Jan. 1, and it is now assessing what those premiums will be, according to Honzel.

Overall, individual coverage comprises a small percentage of the big carriers' business. In the first half of 1999, Blue Cross counted 66,000 individual subscribers out of its total 1.1 million members. Kaiser covers 27,000 individual subscribers, which constitutes about six percent of the HMO's total members.

Health insurers in Oregon, either for-profit or nonprofits such as Blue Cross and Kaiser, are not required by state law to offer individual health coverage, said Blue Cross spokesman Ken Strobeck.

CLASSIFIEDS

PRACTICE OPPORTUNITIES

PACIFIC NORTHWEST
Locum Tenens
Perm/Part Time
Physician Owned
and Operated
Malpractice Included

1-800-DOCS-R-US
1-800-362-7787
(OREGON)

MULLIKIN MEDICAL CENTER OF OREGON, P.C. — is currently interviewing BC/BE Family Practitioners and Internists. Our primary care clinics are located in Portland, Beaverton, Canby and Oregon City. For more information, please contact: RaeLynn Dieter, Physician Resources Manager @ Voice-(503) 872-2121 Fax CV to (503) 872-2116 Email to RaeLynn. Dieter@mdmnetwork.com Mail to - 123 NE Third Avenue, Suite 500, Portland, OR 97232

INTERNIST OR FAMILY PHYSICIAN — Part or full time permanent to join well established independent Washington County practice. Fax CV to (503) 359-0320.

PHYSICIANS WANTED — If you have an existing practice we are looking for you! Downtown Portland office with free on-site parking and friendly staff. For information contact Dr. Rodriguez or Penny at (503) 226-6966 or send vitae to 2220 SW First Ave., Portland, Oregon 97201

NORTHWEST PRIMARY CARE GROUP — BC/BE Internist needed for well established Internal Medicine office. We offer competitive salary, benefits and four day work week with call. Please send CV to David McAnulty MD, 3033 SE Monroe Street, Milwaukie, OR 97222.

OCCUPATIONAL MEDICINE! — Providence Health System is seeking BC/BE Internal Medicine, Occupational Medicine or Family Practice Physicians who are interested in Full-Time Occ. Med., no call, no weekends or evenings. Working with injured workers, consultive services, etc. Excellent salary and benefits. If this sounds like what you are looking for to balance medicine and quality of life, please send your CV to Mary Beth Cruz, Director of Physician Recruitment, 5050 NE Hoyt, Suite 315, Portland, OR 97213, (503) 215-6389 or fax (503) 215-6561 or e-mail mcruz@providence.org

---

FAMILY PRACTICE — Oregon Wine Country! Providence Health System is seeking BE/BC Family Practice physician with or without OB to join small groups in Sherwood and Newberg. Close enough to the Rose City for Arts and Culture, far enough away to see the Stars and enjoy a smaller and more quaint community. Competitive compensation, excellent benefits and call. Wonderful practice environment surrounded by the beauty of Oregon's Award winning Wineries and vineyards! Interested candidates please send CV to MaryBeth Cruz, Director of Physician Recruitment, 5050 NE Hoyt, Suite 315, Portland, OR 97213, (503) 215-6389 or fax (503) 215-6561 or e-mail mcruz@providence.org

---

IMMEDIATE OPPORTUNITY — For Psychiatrist to join OP-IP practice with three (3) solo practitioners near Providence Portland Medical Center. Contact: Ron Spangler, MD (503) 239-8078

IMMEDIATE PRACTICE OPPORTUNITY — Portland-area internal medicine clinic has an established practice in immediate need of an internal medicine or family practice physician, full-time. Emphasis is on primary care. Competitive compensation and benefits plus strong association with local hospitals. Arrangements to be negotiated. Send current C.V. to fax (503) 257-5672. For more information, call (503) 257-5678.

OFFICE SPACE

FOR LEASE - Medical/professional office space, 503 sq. ft.; 660 sq. ft.; 2,183 sq. ft. Downtown Gresham. Within one block walking distance to MAX. 501 Building Gresham. Dr. Stephen Choong, 661-6765.

FOR LEASE/MEDICAL OFFICE BUILDING - 1,800 sq. ft. building, 12715 NE Halsey St., Portland. Contact Ron Smith at (503) 284-8888.

MEDICAL OFFICE FOR LEASE - at Mountainview Professional Plaza, Near Mt. Hood Med. Center and I-84 access. Call G. Wayman (503) 652-2260 or vm 493-6787. Oregon Realty Co.

VACATION RENTALS

SUNRIVER RETREAT HOME — Casual elegance, serene setting, spacious and bright, large hot tub, dramatic stone fireplace, luxurious amenities, all new, accommodates 8-10, no smoking/pets. (503) 524-1102.

FAX Your Classifieds 24-Hours A Day

620-3433

We make it easy!

Oregon: Family Physician Faculty Clinician Teacher at OHSU Gabriel Park Family Health Center.

Duties and responsibilities will include direct patient care including obstetrics and impatient service and supervision of an interdisciplinary primary care team. He/she will practice eight half-days per week with direct patient care. Teaching may include medical students, nurse practitioner students, physician assistant students, as well as family practice residents and other university learners. The faculty member will be expected to participate in continuing education, professional and faculty development and scholarship as directed by the Department of Family Medicine. Qualifications include completion of professional training to receive either the MD or DO degree as well as graduate medical education in an ACGME accredited Family Practice residency. Board certified or board eligibility required.

Send resume with three references to Laurie Charon, Mail Code FP, 3181 SW Sam Jackson Pk. Rd., Portland, Oregon 97201, AA/EO employer

The SCRIBE Classifieds – $1 per word

Twenty word minimum — any item, any category

Your Name: _____

Address: _____

City, State, Zip _____

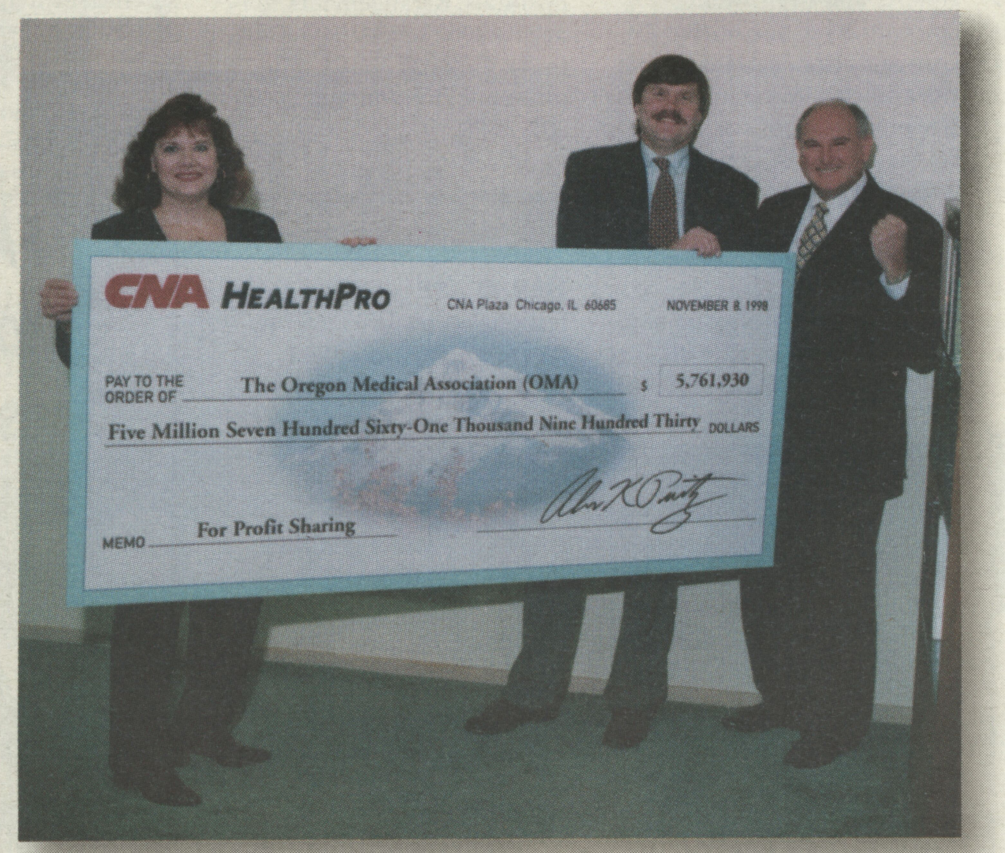
Phone( ) _____

Category _____

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 (503) 620-3433 or call Tracy at (503) 670-2885

How Much Has Your Carrier Returned?



Shirley Wells Meigs, Assistant Vice President of CNA HealthPro, Oregon Branch, hands the CNA HealthPro 1998 Profit Sharing check to Andy Antoniskis, M.D., Chairman of the Professional Consultation Committee, and Tom Hoggard, MD, President of the OMA.

1998 Profit Sharing
$5,700,000

1997 Profit Sharing
$5,400,000

Since its inception, more than $40,000,000 has been returned to our policyholders.
Checks were mailed to policyholders in November.

For More Information regarding CNA HealthPro Call 1-800-341-3684 or 503-526-6867.

CNA HEALTHPRO