



# *Medical Society of Pierce County*

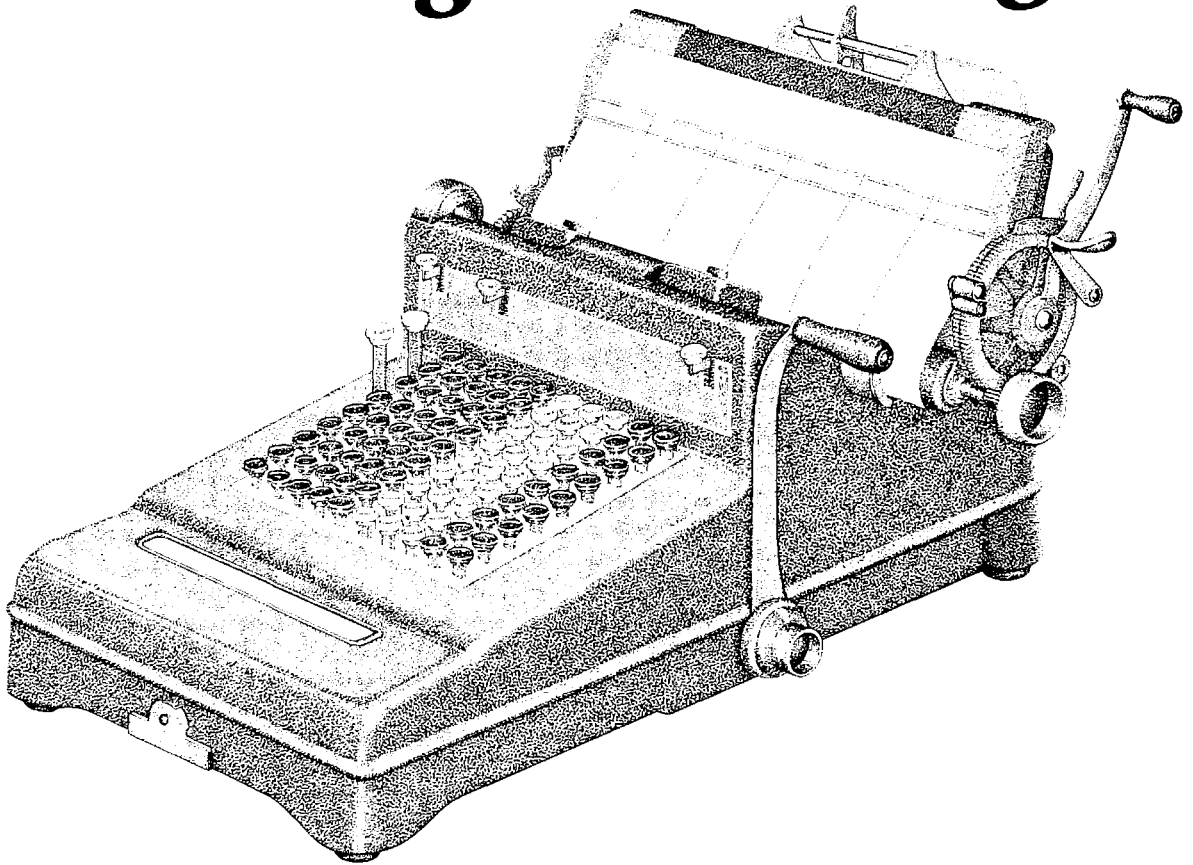
JANUARY 1982, Vol. LIV, No. 1, Tacoma, Washington



Annual Joint Meeting  
With MAMC February 9  
Details Inside . . .

## **BULLETIN**

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## COVER

Cover photo: 1981 MSPC President George A. Tanbara passes the gavel of office to 1982 President Lloyd C. Elmer.

## Staff

Editor ..... David S. Hopkins, M.D.  
Managing Editor ..... Thomas J. Curry  
Editorial Committee ..... W. Ben Blackett, M.D., Stanley W. Tuell, M.D.

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President ..... Lloyd C. Elmer, M.D.  
President-Elect ..... Robert E. Lane, M.D.  
Vice President ..... Bruce D. Buchanan, M.D.  
Secretary-Treasurer ..... Myra S. Vozenilek, M.D.  
Past President ..... George A. Tanbara, M.D.  
Executive Director ..... Thomas J. Curry

## TRUSTEES

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Guus W. Bischoff, M.D. (82)  
Juan F. Cordova, M.D. (82)  
Dale L. Hirz, M.D. (82)  
Robert F. Kapelowitz, M.D. (83)  
Gordon R. Klatt, M.D. (83)  
Gilbert J. Roller, M.D. (83)  
Nikki Crowley

Elected MSPC officers and trustees serve as delegates to the WSMA House of Delegates

## COMMITTEE CHAIRMEN

Budget and Finance ..... Myra S. Vozenilek, M.D.  
Communications ..... Jacob J. Kornberg, M.D.  
Cost of Care ..... Dumont S. Staatz, M.D.  
Credentials ..... Donald H. Mott, M.D.  
Editorial ..... David S. Hopkins, M.D.  
Emergency Medical Services Standards ..... D. Terry Kendrick, M.D.  
Ethics ..... James L. Vadheim, M.D.  
Grievance ..... George A. Tanbara, M.D.  
Health Planning ..... William T. Ritchie, M.D.  
Impaired Physician ..... William A. McPhee, M.D.  
Interprofessional ..... Herman S. Judd, M.D.  
Legislative ..... James D. Krueger, M.D.  
Library ..... Juan F. Cordova, M.D.  
Medical Education ..... Robert O. Modarelli, M.D.  
Medical-Legal ..... W. Ben Blackett, M.D.  
Medical Society-TACC Joint Health Issues ..... William B. Jackson, M.D.  
Program and Entertainment ..... Bruce D. Buchanan, M.D.  
Public Health/School Health ..... David Sparling, M.D.  
Senior Citizen ..... Edwin J. Fairbourn, M.D.  
Sports Medicine ..... Stanley A. Musler, M.D.  
Tel-Med ..... Anthony S. Lazar, M.D.  
UHI Quality Assurance ..... John M. Kanda, M.D.

# Society News Briefs

A summary of Medical Society, and local medical and health news

## 300 FREE HEALTH TIPS AT YOUR FINGER TIPS!

A campaign to increase use and general public awareness of Pierce County's unique free health information service, Tel-Med, is being launched. The promotional effort will begin late in January and will include public service announcements (filmed at the MSPC office by a crew from KSTW), bus cards, a re-designed Tel-Med brochure, physician office display cards, and other materials. The local advertising/public relations firm of Graves and Associates is contributing its services to the Tel-Med campaign.

Since its inception in 1977, Tel-Med has answered over 200,000 telephone inquiries. Each of these callers has heard a physician approved, pre-recorded message concluding with, "brought to you by the physicians of Pierce County."

Tel-Med is a joint public service project of the Pierce County Medical Society Auxiliary and Medical Society. The Tel-Med Board of Trustees is headed by President Cathy Schneider. The Auxiliary provides over 50 volunteer man hours each month for operation of the Tel-Med switchboard. In addition, two part-time employees staff the board during afternoon and evening hours.

Tel-Med hours of operation are 10:00 a.m. to 8:00 p.m., Monday thru Friday.

## STATE LEGISLATURE CONVENES

The legislature convened on Monday, January 11 and is expected to deal primarily with the state's fiscal dilemmas. On January 27 the Washington State Medical Association held a legislative workshop in Olympia for physicians participating in the "Key Contact" program aimed at establishing one-on-one working relationships between legislators and physicians. Physicians are invited to "spend a day in Olympia" staffing the legislative first-aid clinic and meeting with legislators. Please call the Medical Society office, 572-3667, for details

## PHYSICIANS INSURANCE UNDERWAY

Over 1,000 physicians have switched their professional liability insurance to Physicians Insurance. The physician-owned and directed company became a reality late in December when necessary loan guarantees and state insurance commissioner requirements were met.

Early in January it was announced that Mr. Tom Fine, account executive for the WSMA-sponsored Aetna program for the past seven years, joined Physicians Insurance as the new manager of the company's marketing department. For additional information regarding Physicians Insurance, the Seattle toll free telephone number is 1-800-732-1148.

## PHYSICIAN USE OF LIBRARY SERVICES UNDER STUDY

Use of library services provided through the joint University of Washington Health Sciences and King County Medical Society arrangement is under study by the WSMA. The 1981 House of Delegates ordered a study to determine actual use and to seek an equitable distribution of costs state-wide. A report is to be made to the House of Delegates in 1982. All MSPC members were scheduled to receive information in early January.

## SURVEY RESULTS IN FEBRUARY

Results of the annual membership opinion survey will be included in the February *Bulletin*. Over 30 percent of the membership responded to the 4th annual survey. Results were used by the Board of Trustees in its annual goal-setting retreat held on Saturday, January 30.

(continued on page 11)

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# BURN CARE UPDATE:

A Practical Approach

February 25 & 26, 1982



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COLLEGE OF MEDICAL EDUCATION  
Medical Society of Pierce County  
Pierce County Hospital Council

## ACCREDITATION:

### CREDITS: 13 HOURS

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AAFP — Accredited by the American Academy of Family Practice for 13 hours Category I (Prescribed).

ACEP — Accredited for 13 hours by the American College of Emergency Physicians.

CERP — Accredited for 13 hours continuing education recognition points (CERP) by the Washington State Nurses Association.

CEU — 13 hours continuing education units.

## REGISTRATION:

Fee: \$50 Includes lunches/Wine and Cheese Social

Paid preregistration is required before February 20, 1982. Registrations are limited by category and accepted on a paid, first-come, first-served basis.

Please address all registrations and correspondence to:

Maxine Bailey, Executive Director, College of Medical Education, Inc.  
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Lloyd C. Elmer, M.D.

## WE MUST PRESERVE OUR PROFESSIONALISM

The new year begins for some with hopes and dreams fulfilled; for others with vacant expectations and unmet realizations. But for most of us January is greeted warmly and hope springs eternal.

For the Medical Society a confident visage appears for 1982 in spite of potential pitfalls ahead. The greatest of these is the unravelling of the thread that binds us together in the practice of our science and art. As a profession and a professional organization our greatest asset is the dedication of our members. That dedication is exemplified daily in the treating of the sick, in the willingness to aid colleagues — both technically and intellectually — and in providing support and counsel when a fellow physician is in need.

However, the very factor that has been a bastion of our strength these past several years, now poses a very real threat to the harmony that has existed in this medical community. That factor is our rapidly growing membership.

The Medical Society of Pierce County has been able to expand its horizons (in both services and activities) many fold in recent years while maintaining a stable dues level. This remarkable feat, all the more so in a rapidly expanding inflationary economy, has been

accomplished because of astute management to be sure, but also because of the explosive increase in our membership.

Thus, that which has been our financial salvation now threatens us individually and collectively as an association. Bigness and growth alone are not the problems. It is the rapid increase in the number of physicians in the community in a time of economic adversity and rising unemployment that exerts potential negative forces upon us.

We must act together to fight fragmentation and to preserve collegiality. Should we fail our professionalism will be lost. We need not look too far to see what ill has been reaped by other professions which have fallen under the influence of divisiveness, unfounded criticism and selfishness. Professionalism and the ethics of our professional forebearers must be preserved as a legacy for the future.

In the coming year support one another by supporting the Medical Society. Paying your dues opens the door; the threshold lies beyond. Participate with your colleagues in an organization that will always work to make your voice heard and which welcomes your advice. By working together success will be met on all fronts.

*LCE*

# Interprofessional Committee



## PHYSICIAN ID A PROBLEM FOR PHARMACISTS

At the present time there is no way that a pharmacist in Pierce County can determine if the Drug Enforcement Agency (DEA) number on a physician's prescription is legal and in force or whether, perhaps, it has been suspended. Inquiries of the DEA, both at the state and federal levels, are met with the same answer, "we are not privileged to give out that information".

This leaves the pharmacist in a quandary if he or she has any doubts. Of course, most of the time, he knows the physician, but there have been occasions in recent years when these numbers have been rescinded for one reason or another such as retirement of the physician, inappropriate prescriptions, use or dispensation of controlled substances, etc..

Add to this the large number of new physicians in the community, something like two hundred in the last four years, and the problem of identification for the pharmacist is compounded even more. If he fills the prescription in good faith and finds later that the DEA number is not valid, it could be embarrassing although in most instances, understandable.

The problem of physician identification has been especially acute in the case of emergency room physicians. There seems to be a larger turn-over in this specialty, with physicians coming and going and being on duty at various emergency rooms on various days and at various times. Don Hebert, co-chairman of the Interprofessional Committee, representing the pharmacists, has promised to try and establish a roster of those physicians staffing the emergency rooms for his group as well as a list of the new physicians in Pierce County. Each of these physicians would have a DEA number, also.

### PHARMACY HOTLINE IS WORKING

The pharmacy "Hot Line" is working well, as was pointed out at our quarterly breakfast meeting in December. A misconception that the "Hot Line" can be used to broadcast a specific name or person as an abuser of drugs is held by many of us.

Only if the individual is known to have stolen a prescription pad or committed some criminal offense can that information be promulgated. And any physician can use the "Hot Line" to announce to all the pharmacists in Pierce County that he doesn't want any prescription filled over his name for any certain individual. This, of course, is legal. The former could be construed as libel.

### NEW GENERIC DRUGS

On December 21st a whole new group of generic drugs became available on welfare so be sure to sign your prescription in the lower left hand of the form where it says "substitution permitted." Otherwise the pharmacist will be unable to fill the prescription without sustaining a financial loss, greater than usual, on the Medicaid prescription. Remember, he is in business too, and if you want your patient to have the brand name and not the cheaper generic, warn him that he must pay for it because DSHS will not. I rather imagine he will prefer the generic. There is even a generic furosimide now which is apparently safe and effective.

Dr. Jim Krueger came up with an idea that I, at first, didn't think too much of, but when I presented it to the pharmacists the reception was enthusiastic. Jim suggests that when a physician phones the pharmacist, the pharmacist answers with his name. This lets the calling physician know who has taken the phoned prescription, just in case there is any question later of the transaction.

Don Hebert promises to spread the word to all the pharmacists asking them to cooperate in this effort. It will take a second longer on the telephone but will make a more personal combination of effort between the two professions.

By the time this summary of our most recent meeting appears in the *Bulletin* the Christmas Holidays and all the bowl games will be over. The Auxiliary-Society Annual Dinner will be history. And our next committee meeting will be — like December's — with breakfast served in the Country Squire by our faithful Patty after a drive through the dark cold morning to get there by 7:00 a.m.

And wouldn't you know it? Lloyd Elmer has asked me to chair it again!

### WORKING TOGETHER FOR THE BEST POSSIBLE PATIENT CARE

The last committee report which appeared in the September *Bulletin* inadvertently included an error. In discussing the role of the nurse practitioner in our community, Judith Sloan, FNP-CRN, was quoted by me as saying, "nurse practitioners are not needed in Pierce County except in the Indian Clinic." What Judy said was, "probably because of the influx of new physicians into Pierce County over the past few years, positions for

nurse practitioners are not as plentiful except in places like the health department."

Judy also pointed out at our meeting that family practitioners and family nurse practitioners functioning together are a dynamite combination for the delivery of primary health care. I'm not sure whether she meant dynamite or dynamic but either word would be aptly descriptive of the opportunity for good primary health care which could result from the amalgamation of these two forces.

It has been a pleasure to have Judy on our committee and she represents a much needed liaison between the practicing physician and the nurse practitioner. Similarly, we have enjoyed the addition to the committee of a podiatrist for certainly the problems arising in his practice vary little from those of us in other branches of medicine and dentistry. And, the pharmacist deals with all of us in a mutually cooperative effort to render the best care possible to our patients.

As you probably know, the Inter-professional Committee really began almost 30 years ago, functioned for a year or two and then gradually became defunct. In those days it was called by a different name, something like the Pharmacists and Doctors Committee. But your present committee, activated back in 1977, is healthy and going strong.

The committee welcomes input from the members of any of the professions represented—pharmacists, physicians, nurse practitioners and dentists. If you have a concern which you think we might consider, do not hesitate to communicate with me or any member of the committee and we will answer you, one way or another.

*Herman S. Judd, M.D.*  
Chairman



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## NEW SOCIETY OFFICERS AND TRUSTEES INSTALLED AT FESTIVE JOINT MEETING

Newly elected Medical Society officers and trustees were installed at the annual joint Medical Society-Auxiliary meeting in December. Two hundred thirty physicians and spouses attended the festive affair at Tacoma's Bicentennial Pavilion.

Outgoing MSPC President Dr. George A. Tanbara chaired the meeting. Special thanks were given to Auxiliary members who worked to promote the Speakers Bureau — Jo Roller, Linda Stilwell, Betty Virtue, Jan Thiessen, and Mary Schafferle. Physicians were urged to participate in the Speakers Bureau as it continues to take medicine's message to the community.

Auxiliary President Nikki Crowley briefly reviewed the diverse activities of the Pierce County Medical Auxiliary. In a surprise move, she presented special awards to Dr. Tom Miskovsky (for best supporting role, as Santa, at several of the Auxiliary's children's holiday parties) and Dr. Harry Lawson (for his renowned performances as a magician at the same parties).

Dr. Ben Blackett, vice chairman of Physicians Insurance, reported that the doctor-owned and directed professional liability company had qualified for its loan guarantee and had met state insurance commissioner requirements. Dr. Dave Hopkins was introduced as one of three Pierce County representatives who serve on subscriber advisory panels to the new company (other Pierce County physicians serving in that capacity are Drs. Bob Johnson and Bob Ferguson).

There was a moment of silence for Society members who passed away in 1981: Drs. William E. Avery, Charles Aylen, Charles Arnold, William C. Brown,

Gerald C. Kohl, Jack W. Lee, John W. Pelley, Frederick J. Schwind, and Don G. Willard.

Dr. Tanbara presented plaques of appreciation to outgoing trustees and officers for their service on behalf of the medical community: Drs. James P. Duffy, Robert A. O'Connell, Bruce D. Buchanan, and Robert E. Lane, completing terms as trustees in 1981; and, Drs. Vern Larson, vice president, and Myra S. Vozenilek, secretary-treasurer. Marny Weber, Auxiliary past-president, received a special gift for her service on the Medical Society Board of Trustees in 1980-81.

In his farewell remarks, Dr. Tanbara reviewed a number of issues addressed during his year as president—access to health care by the medically indigent and refugees, care provided senior citizens, emergency medical services, jail health, and other issues. He expressed his appreciation to the Auxiliary for its many efforts on behalf of medicine and urged his fellow physicians, "let's not leave the decisions up to someone else." Dr. Tanbara thanked the many members involved in board, committee and hospital medical staff activities in 1981.

Following his installation as the 89th president of the Medical Society of Pierce County, Dr. Lloyd C. Elmer thanked Dr. Tanbara for his "tireless efforts and dedication." Dr. Elmer characterized 1982 as a year of great challenge and potential for the Medical Society and community. He asked members for their continued involvement and support.

The evening concluded with music provided by the Art Doll Combo which had provided entertainment during the dinner.



*Dr. Vern Larson (left), out-going MSPC vice-president, was one of several officers and trustees recognized for their service in 1981.*



*Newly elected president-elect Dr. Bob Lane was also thanked for his work on behalf of medicine and the community in 1981.*

**1982 MSPC OFFICERS**

*President*

Lloyd C. Elmer, M.D.

*President-Elect*

Robert E. Lane, M.D.

*Vice-President*

Bruce D. Buchanan, M.D.

*Secretary-Treasurer*

Myra S. Vozenilek, M.D.

*Past President*

George A. Tanbara, M.D.

**TRUSTEES**

Richard G. Bowe, M.D. (82)

Guus W. Bischoff, M.D. (82)

Juan F. Cordova, M.D. (82)

Dale L. Hirz, M.D. (82)

Robert F. Kapelowitz, M.D. (83)

Gordon R. Klatt, M.D. (83)

Gilbert J. Roller, M.D. (83)

Nikki Crowley



*The new doctor-owned and directed PHYSICIANS INSURANCE met its loan and insurance commissioner requirements in December and would be fully operational January 1, 1982, former MSPC president Dr. Ben Blakett announced to the gathering.*



*Auxiliary President Nikki Crowley (left) huddles with President-elect Marlene Arthur (center) and another Auxilian.*



*Dr. and Mrs. (Jean) Marcel Malden were among those who danced to the music of the Arl Doll Combo following dinner.*



*Dr. and Mrs. (Sandra) Jim Griffith share a moment of conversation with another couple following dinner.*

# PERIPHERAL VASCULAR DISEASE Practical Evaluation Skills for Physicians

February 20, 1982

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6 hours

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|       |  |                             |
|-------|--|-----------------------------|
| 7:30  | Continental Breakfast  |                             |
| 8:00  | THE VASCULAR LABORATORY  | Robert A. McAlexander, M.D. |
| 8:50  | TRANSLUMINAL ANGIOPLASTY   | Charles T. Dotter, M.D.     |
| 9:40  | Break  |                             |
| 10:00 | THE PERIPHERAL VASCULAR ULCER                                      | Stevens C. Hammer, M.D.     |
| 10:50 | THE DIAGNOSIS & TREATMENT OF ACUTE THROMBOPHLEBITIS                | Brian L. Thiele, M.D.       |
| 11:40 | Lunch — Hosted by Good Samaritan Hospital Physician Education Fund |                             |
| 1:00  | DIFFERENTIAL DIAGNOSIS OF THE PAINFUL EXTREMITY                    | Needham Ward, M.D.          |
| 1:50  | THE DIAGNOSIS & MANAGEMENT OF ACUTE ARTERIAL INSUFFICIENCY         | Ramesh Sharma, M.D.         |
| 2:40  | Conclusion   |                             |
| to    |  |                             |
| 3:00  |  |                             |

Program planning committee: Theodore Apa, M.D., John Lincoln, M.D., Kenneth Gross, M.D., Shirley Hondel, Fran Meyer, R.N.

#### SPONSORED BY:

Good Samaritan Hospital  
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Pierce County Hospital Council  
Good Samaritan Hospital Continuing Medical Education Fund



#### Guest Faculty:

Brian L. Thiele, M.D.  
Chairman, Peripheral Vascular Section  
Assistant Chief Surgery Services  
Veterans Hospital, Seattle  
Assistant Professor of Surgery  
University of Washington  
Charles T. Dotter, M.D.  
Chairman, Department of Radiology  
School of Medicine  
University of Oregon

#### Local Faculty:

Stevens C. Hammer, M.D.  
General/Vascular Surgeon  
Robert A. McAlexander, M.D.  
General/Vascular Surgeon  
Ramesh Sharma, M.D.  
Cardiovascular/Thoracic Surgeon  
Needham E. Ward, M.D.  
Cardiologist

Registration fee (lunch included): \$40. Medical Society of Pierce County members: \$60, non MSPC members: \$20, all other health care personnel. Paid preregistration would be appreciated before February 18, 1982. This program is subject to cancellation if less than the minimum number of participants have registered by February 18, 1982. Please address all registrations and correspondence to:

Maxine Bailey, Executive Director  
College of Medical Education, Inc.  
Medical Society of Pierce County  
705 South 9th, #203  
Tacoma, Washington 98405  
Phone: 627-7137

## SOCIETY NEWS BRIEFS *continued*

### PHYSICAL EXAM GUIDELINES AMENDED

The Washington Interscholastic Activities Association, which governs inter-school athletic competition, has amended its physical exam guidelines. The guidelines state that only one pre-participation physical is required before a student can participate in middle school and junior high school inter-scholastic sports.

Another physical is required at the time a student begins high school sports. However, at the beginning of each year's participation, the student is required to have a physician sign a "clearance for continued athletic participation."

The old guidelines called for annual pre-participation physicals. The new WIAA guidelines, however, do not alter the procedure for the physician who provides an examination for each sports season. Only the physician can make the decision on the interval between examination and the extent of the work-up. The decision should be made on an individual basis for each student, based on past his or her past medical history.

### PEOPLE AND PLACES . . .

MSPC member Surinderjit Singh, M.D., of Tacoma, co-authored an article on "Winging of the Scapula" which was published in the October, 1981 issue of "American Family Physician."

### BURN CONFERENCE SET FOR FEBRUARY 25-26

"Burn Care Update: A Practical Approach" will be held at St. Joseph Hospital (5th floor) on February 25 and 26. The two day seminar is coordinated through the College of Medical Education and is accredited for 13 hours of continuing medical education by the AAMA, AAFP, ACEP and CERP.

Frederick A. DeClement, M.D., medical director of the Burn Center and Skin Bank at St. Agnes Hospital in Philadelphia, will be the featured speaker. The Firefighter's Burn Center at St. Joseph and the American Burn Association are sponsoring the conference for the second year.

Among the topics to be presented by Dr. DeClement and other faculty members are initial assessment and emergency care of burn injury; pain management and psychological response to burns; outpatient treatment of burns; reconstructive surgery of thermal injuries; infection; inhalation injury; acute care, monitoring and fluid management; metabolism and nutrition; skin grafting; and wound management.

A panel presentation on the team approach to burn care will conclude the seminar.

Workshops have been added this year to provide specialized information for physicians, nurses, physical and occupational therapists and other allied health personnel, and firefighters, EMTs, and paramedics.

Paid preregistration of \$50 per person, required before Feb. 20, is limited by category and will be accepted on a first come, first served basis. Registrations should be sent to the College of Medical Education, 705 S. 9th, #203, Tacoma, WA 98405. For additional information, call 627-7137.

*(continued on page 12)*

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|                       | 40% Tax Brct. | 50% Tax Brct. |
|-----------------------|---------------|---------------|
| Mortgage and Expenses | \$1,688       | \$1,688       |
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## SOCIETY NEWS BRIEFS continued

### BEWARE OF POSSIBLE LITIGATION

One unfortunate result of our local sagging economy and tightened job market may be increased litigation over civil rights complaints associated with job hiring.

Physicians have heard this before, but it is important to remember: It is unlawful to deny anyone a job on the basis of race, color, religion, sex, national origin, marital status, spouse's occupation, age, the fact of having children or not, or what child care arrangements have been made. Even if the applicant volunteers such information, the decision to hire must be based on whether the applicant can perform the job's duties.

To protect against possible discrimination suits:

1. Determine in advance the criteria to be used in selecting a job candidate. Grade all candidates equally by this criteria.
2. Keep applications for two years and document how the hiring decision was reached.
3. Don't discriminate.

The following are quotes from applicants who have interviewed in physician offices recently:

"The doctor asked me several times about my being divorced and insinuated that I would be less stable than other applicants."

"I was told they were looking for someone younger. They didn't want anybody over thirty."

"I was asked whether I was going to have children and what my husband did. When he discovered there was a possibility of a transfer, he seemed less interested, and I didn't get the job."

Any of the above statements could serve as the basis of a discrimination complaint. Remember, if a formal complaint is filed, the burden of proof falls on the employer. So be sure that questions, statements, and reasons for selecting one applicant over another are always skills-related.

The Medical Society's Placement Service exists to assist physicians and their staff in the hiring of qualified medical office personnel. Many qualified applicants are currently on the service's files. The Placement Service advertises, screens and tests applicants for your medical office position.

For assistance in filling office staffing needs, call the Placement Service, Linda Carras, manager, 572-3709.

### FREE STOMA CLINIC SET FOR MARCH 13

The free clinic on stoma care for ostomates and their families, co-sponsored by the Medical Society, has been rescheduled to Saturday, March 13. The clinic will be held at Tacoma Community College from 10:00 a.m. to 2:00 p.m. in Building 19. It is anticipated the program will include displays of stoma equipment, classes taught by enterostomal therapists instructing patients on skin care, and irrigation and ileostomy management. Dr. Jacob Kornberg is scheduled to be a guest speaker on "The Forgotten Spouse".

The clinic is being promoted throughout southwest Washington. Physicians are encouraged to make their patients who have undergone an ostomy surgery aware of the clinic. The Everett-Tacoma-Seattle Enterostomy Therapists (EST) is co-sponsoring the clinic. Additional information is available from the Medical Society office, 572-3666.



## GALLUP POLL REVEALS PATIENTS' OPINIONS AND CONCERNS

Physicians and the general public agree that cost is the main problem facing health care today, according to new studies commissioned by the American Medical Association.

Among the public, a large majority of the respondents to a Gallup Poll continue to express high degrees of satisfaction with their last visit to a physician. Nine in ten were very or fairly satisfied with the overall experience and medical care.

According to the poll, the *most dissatisfaction* was expressed about time spent waiting in an MD's office. (AMA News, November 6, 1981)

## AUXILIARY SHOWS STATE LEADERSHIP; WINS THREE OF FOUR POSSIBLE AWARDS

The Pierce County Medical Society Auxiliary cemented its reputation as a leading force in the Washington State Medical Association Auxiliary when it received three of four possible awards made at the September WSMAA State Convention. The Auxiliary received awards relating to its physical fitness program, level of AMA-ERF contributions (approximately 50% of the total contributed in the State of Washington), and handicap awareness program.

At its October meeting, the Society's Board of Trustees unanimously passed a motion of appreciation of the Auxiliary for its many efforts. Auxiliary achievements are not limited to those awards granted at the WSMAA meeting. The Medical Society's Speaker Bureau, its Public Health/School Health Committee activities and the Pierce County Tel-Med Society are among other programs and projects which benefit from Auxiliary involvement.

## HAWAIIAN TRIP CANCELLED

Thanks are expressed to members who responded to the recent survey regarding a possible Society sponsored trip to Hawaii in December, 1982. The Board of Trustees has concurred with an Executive Committee recommendation that the trip not be conducted.

One hundred seventy questionnaires were returned for a 28% response rate. Of those returned, 26% were favorable; 74% indicated no interest in the trip. Of those responding in the negative, 31% indicated their response was due to the time of year, 14% reacted negatively to the destination, 18% to the expense and 50% indicated they were just not interested.

## MCNEIL ISLAND PHYSICIAN WANTED!

A primary care physician is sought by McNeil Island; full-time position, island residence included if desired (at nominal rental). For additional information contact Mr. Dick Alright, health care administrator, McNeil Island, 588-5281, ext. 297.

## ACCESS TO MEDICAL RECORDS GUIDELINES AVAILABLE

The Medical Society office continues to receive inquiries from patients and physicians' offices regarding procedures relating to patients' access to medical records.

Patient access to medical records has been a matter of debate for several years among physicians and various segments of the public, both in the state of Washington and elsewhere. A number of legislatures have enacted

(continued on page 14)



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### SOCIETY NEWS BRIEFS Continued

statutes mandating such access; Washington is not among them.

In 1980, the WSMA House of Delegates approved a resolution directing the WSMA to "stimulate the development of physician education and consensus on patient medical record confidentiality." From that resolution, the WSMA Council on Professional Affairs investigated the legal and historical status of confidential patient records and recommended to the 1981 House that voluntary guidelines for WSMA members be adopted.

The House of Delegates responded at its 1981 Annual Meeting in September by approving the *WSMA Guidelines for Patient Access to Medical Records*. These guidelines were printed in their entirety in the November 1981 issue of the *Western Journal of Medicine*. If you do not have the Journal available and would like a copy of the *Guidelines*, please call the Medical Society office, 572-3667, and we will send you a copy.

### PHYSICIANS INTERESTED IN PRACTICE OPPORTUNITIES IN PIERCE COUNTY

**Pulmonary specialist-internist** seeks practice opportunity. Presently completing pulmonary fellowship at Utah, will be pulmonary board eligible in July, 1982. Diplomate, American Board of Internal Medicine; member, AMA, American College of Physicians, American Thoracic Society, American College of Chest Physicians. Interested in intensive care and out-patient pulmonary medicine, pulmonary function testing, respiratory therapy. Graduate, University of Wisconsin Medical School, 1976. Listing #101

**Internist** completing third year of residency seeks opportunity in internal medicine. Would prefer a group practice, but would be interested in ER work. Will be board eligible in internal medicine, June, 1982. Member, AMA, American College of Physicians, and American Society of Internal Medicine. Graduate, University of Wisconsin Medical School, 1979. Listing #102

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MANAGEMENT RESOURCES

## NEWS FROM MSPCA — JANUARY 1982

Did you survive the partying and eating of the holidays? Were you glad to send your children back to school and an organized routine? On with the New Year!

### STUDENT RECOGNITION

Student Recognition Award applications will be available at your area schools for graduating seniors of all Medical Society members. The award recognizes two students who have achieved excellence in scholarship, leadership, and service to the school and community.

Phyllis Pierce, chairman, encourages you to call her if you have questions about the program. Graduating seniors may pick up the applications at the counselor's office in their school.

### CHILDREN'S HOLIDAY PARTY

Our holiday party for the children was a smashing success. Kathleen Bitseff and her committee members — Nancy Rose, Kay North, Alice Yeh, Cindy Wilson, Jo Roller, Nikki Crowley, and Margaret Lapin — planned a myriad of activities to entertain the youngsters.

Debby McAlexander and Marilyn Bodily hosted the refreshments. Jo Roller and her singing friends started the music.

Cindy Wilson and her guitar got the children ready for the caroling after they had made Christmas cards and decorated gingerbread cookies. A special "thank you" to our Santa, Dr. Tom Miskovsky, and our magician, Dr. Harry Lawson. They really made the event.

We had a cameo appearance from "Wonder Mutt" while the children waited for Santa, courtesy of the Pierce County Humane Society. He brought us color books and brochures on the care of pets.

### AMA-ERF

Sharon Lawson and her committee produced a beautiful holiday greeting card from photography created by our own Karen Benveniste. Many thanks for all the work — the mailing and the card addressing took a lot of effort and coordination.

### OLYMPIA VISIT

Nine MSPCA board members travelled to Olympia for the State Officers visitation meeting. Those attending were: Jo Roller, Cindy Anderson, Marlene Arthur, Gloria Virak, Marny Weber, Jane Gallucci, Helen Whitney, Sharon Lawson and Nikki Crowley.

Lewis, Thurston and Pierce counties joined together for the meeting to discuss programs presented by county auxiliaries. Solo Activity Identification, Child Restraints, and Organ Donor Programs were a few of the

topics discussed. Watch for these programs in your county!

### FEBRUARY GENERAL MEETING

On Friday February 19, Debby McAlexander will host the luncheon meeting. The program is titled "Wines and their Enjoyment." Come and sample and learn about the tasting of wines with Bob James of Vinicole.

### MEMBERSHIP DUES

Dues for 1981-82 are still being accepted. For those who have not yet joined, send your check (for \$34.50) made out to the Auxiliary to Mary Whyte Lenard, Rt. 1, Box 1047, Buckley, WA 98321.

*Nikki Crowley  
Mary Whyte Lenard*

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# Membership

In accordance with the Bylaws of the Medical Society of Pierce County, Chapter Seven, Section A, MEMBERSHIP, the following physicians have applied for membership, and notice of their application is herewith presented. As outlined in the Bylaws, any member who has information of a derogatory nature concerning an applicant's moral or ethical conduct, medical qualifications or other such requisites for membership, shall assume the responsibility of conveying that information to the Credentials Committee or Board of Trustees of the society.

## FIRST NOTICE



**Barry E. London, M.D., Pediatrics.** Born in Minnesota, 6/25/46; University of Minnesota, 1972; internship, Hennepin County General Hospital, 1972-73; residency, University of Minnesota Hospitals, 1973-75; State of Washington license, 1981. Has applied for medical staff membership at Mary Bridge Children's, St. Joseph and Tacoma General hospitals. Dr. London is practicing at 2603 Bridgeport Way W., Tacoma.



**Thomas I. Kaufman, M.D., Emergency Medicine.** Born in Ohio, 12/8/51; University of Colorado, 1977; internship and residency, Valley Medical Center, Fresno, Ca., 1977-80; State of Washington license, 1981. Has applied for medical staff membership at St. Joseph Hospital. Dr. Kaufman is practicing at St. Joseph Hospital, Tacoma.



**Michael J. Regalado, M.D., Internal Medicine.** Born in Honolulu, Hawaii, 2/2/53; Stanford University Medical School, 1978; internship and residency, University of Washington Hospitals, 1978-81; State of Washington license, 1979. Has applied for medical staff membership at Allenmore, Doctors, Good Samaritan, Lakewood General, St. Joseph and Tacoma General hospitals. Dr. Regalado is practicing at 5122 Olympic Dr. N.W., Suite A-105, Gig Harbor.



**Edward J. Przasnyski, M.D., Internal Medicine.** Born in St. Louis, Mo., 5/11/47; University of Missouri, 1973; internship and residency, Madigan Army Medical Center, 1973-79; State of Washington license, 1978. Has applied for medical staff membership at Allenmore, Doctors, Good Samaritan, Lakewood General, Mary Bridge Children's, Puget Sound, St. Joseph and Tacoma General hospitals. Dr. Przasnyski is practicing at 314 So. "K" Street, Tacoma.

## SECOND NOTICE



**Robert V. Hollison, M.D., Family Practice/Internal Medicine/Emergency Medicine.** Born in Honolulu, Hawaii, 11/9/47; University of Washington, 1973; internship and residency, Madigan Army Medical Center, 1973-80; Washington State license, 1974. Has applied for medical staff membership at Allenmore, Good Samaritan, Lakewood General, Mary Bridge, St. Joseph and Tacoma General hospitals. Dr. Hollison is practicing in Tacoma.



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**Keith E. Demirjian, M.D., Family Practice.** Born in Portland, Oregon, 5/31/52; University of South Alabama, 1978; internship and residency, Moses Cone Hospital, Greensboro, N.C.; 1978-81; Washington State license, 1981. Has applied for medical staff membership at Allenmore, St. Joseph and Tacoma General hospitals. Dr. Demirjian is practicing at 1811 South "K" Street, Tacoma.



**Alan P. White, M.D., General Surgery.** Born in Winchester, VA, 6/28/48; Bowman Gray School of Medicine of Wake Forest University, Winston-Salem, N.C., 1974; internship and residency, Madigan Army Medical Center, 1974-79; Washington State license, 1981. Has applied for medical staff membership at Allenmore, Doctors, Good Samaritan, Lakewood General, Mary Bridge, Puget Sound, St. Joseph and Tacoma General hospitals. Dr. White is practicing at 314 South "K" Street, Tacoma.



**Thomas G. Griffith, M.D., Orthopedic & Hand Surgery.** Born in Fresno, CA, 10/24/46; University of Washington, 1973; internship and residency, Tripler Army Medical Center, Honolulu, Hawaii, 1973-77; Washington State license, 1981. Dr. Griffith is practicing at Madigan Army Medical Center.



**Hugh A. Larkin, Jr., M.D., General Practice.** Born in Tacoma, 9/8/49; University of Washington, 1980; internship, Swedish Hospital, 1980-81; Washington State license, 1981. Has applied for medical staff membership at Allenmore, Doctors, Good Samaritan, Lakewood General, Mary Bridge, Puget Sound, St. Joseph and Tacoma General hospitals. Dr. Larkin is practicing at 1301 N. "I" Street, Tacoma.



**Rob R. Roth, M.D., Pathology.** Born in Denver, CO, 6/16/47; University of Colorado School of Medicine, 1974; internship and residency, Madigan Army Medical Center, 1974-78; Washington State License, 1981. Has applied for medical staff membership at Doctors, Mary Bridge, St. Joseph and Tacoma General hospitals. Dr. Roth is practicing at 315 South "K" Street, Tacoma.



**Paul L. Chan, M.D., General Surgery.** Born in Canton, China, 6/25/36; School of Medicine, National Taiwan University, 1973; internship, Halifax Infirmary, Nova Scotia, Canada, 1963-64; residencies, Providence Hospital, Southfield, MI (surgical) 1965-67; St. Joseph's Hospital, Toronto, Canada (emergency medicine), 1964-65; St. Paul's Hospital, Vancouver, Canada (surgical), 1967-68; St. Paul's Hospital (pathology), 1968-69; Providence Hospital, (4th year surgical resident), 1971-72; Washington State license, 1981. Has applied for medical staff membership at Allenmore, Doctors, Good Samaritan, Lakewood General, Mary Bridge, Puget Sound, St. Joseph and Tacoma General hospitals. Dr. Chan is practicing at 5122 Olympia Drive N.W., Gig Harbor.



**John E. Goodpasture, M.D., Anesthesiology/Hyperbaric Medicine.** Born in San Antonio, Texas, 4/1/47; University of Texas Medical Branch, Galveston, 1974; residency, University of Texas, 1975-78; Washington State license, 1981. Has applied for medical staff membership at Lakewood General Hospital. Dr. Goodpasture is currently practicing at Lakewood General, Lakewood.



**Frank A. Chapman, M.D., Family Practice.** Born in Chicago, Ill, 5/27/51; University of Washington, 1977; internship, San Bernardino County Medical Center, 1977-78; residency, University of Utah Dept. of Family and Community Medicine, Salt Lake City, 1978-81; Washington State license, 1979. Has applied for medical staff membership at Allenmore, Doctors, Mary Bridge, St. Joseph and Tacoma General hospitals. Dr. Chapman is currently practicing at A-314 Allenmore Medical Center, Tacoma.

## ATTENTION INVESTORS:

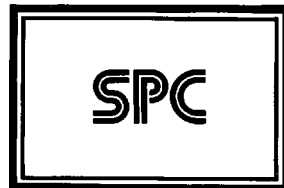
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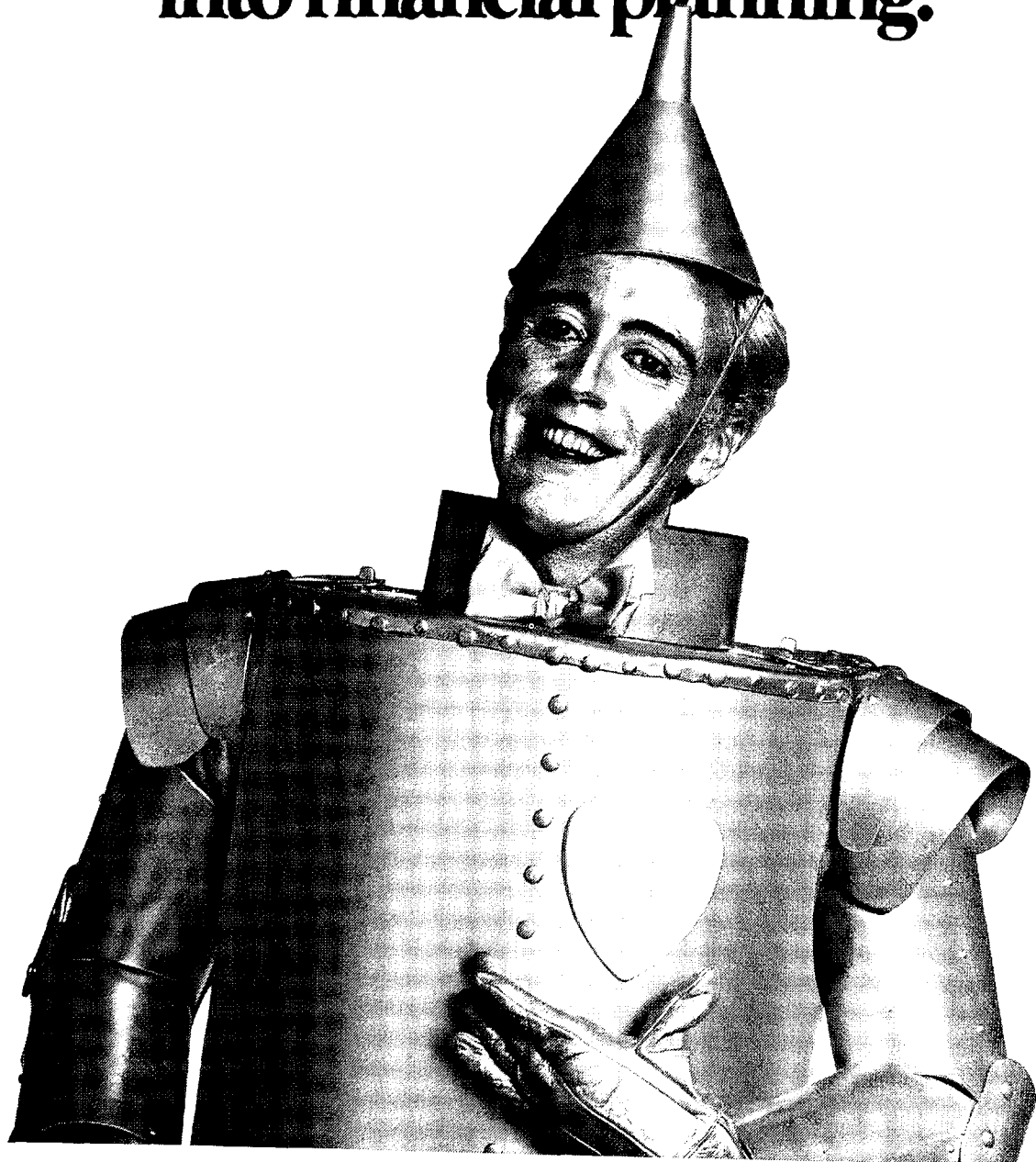
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\*Based on patient abstinence one year after treatment. Survey Source: Facts, Consolidated, Los Angeles, CA, 1980.





# Medical Society of Pierce County

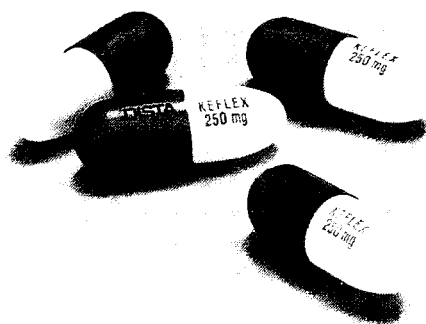
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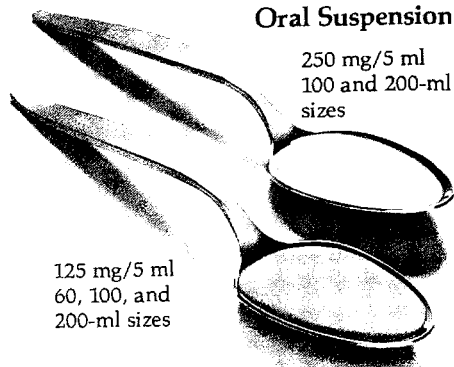
What's New — And Worthless  
See page 16  
March 9 General Membership Meeting  
Details Inside.

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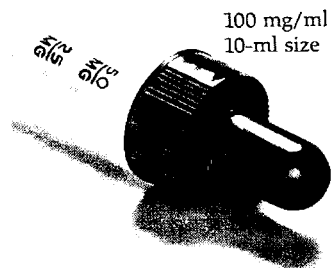


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## TRUSTEES

|                            |      |
|----------------------------|------|
| Richard G. Bowe, M.D.      | (82) |
| Guus W. Bischoff, M.D.     | (82) |
| Juan F. Cordova, M.D.      | (82) |
| Dale L. Hirz, M.D.         | (82) |
| Robert F. Kapelowitz, M.D. | (83) |
| Gordon R. Klatt, M.D.      | (83) |
| Gilbert J. Roller, M.D.    | (83) |
| Nikki Crowley              |      |

Elected MSPC officers and trustees serve as delegates to the WSMA House of Delegates

## COMMITTEE CHAIRMEN

|  |                          |
|--|--------------------------|
| Budget and Finance                       | Myra S. Vozenilek, M.D.  |
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| Medical-Legal                            | W. Ben Blackett, M.D.    |
| Medical Society-TACC Joint Health Issues | William B. Jackson, M.D. |
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| Sports Medicine                          | Stanley A. Mueller, M.D. |
| Tel-Med                                  | Anthony S. Lazar, M.D.   |
| UHI Quality Assurance                    | John M. Kanda, M.D.      |

# Society News Briefs

A summary of Medical Society, and local medical and health news

## MEMBERSHIP MEETING MARCH 9

The first of four MSPC general membership meetings scheduled for 1982 will be held on Tuesday, March 9 at the Iron Gate Inn, River Road, Puyallup. The meeting will begin with no-host cocktails at 6:15 p.m., followed by a 7:00 p.m. meal and program.

Items of business to conduct include election of a trustee to fill the vacancy created on the MSPC Board of Trustees by the resignation of Dr. Guus Bischoff (see below).

Other 1982 membership meetings are scheduled for Tuesday, May 11, Tuesday, September 14, and Tuesday, October 12. The annual Medical Society-Auxiliary joint dinner meeting and installation of officers will be held on Tuesday, December 14. The meetings will be held at locations throughout Pierce County.

## BOARD ACCEPTS RESIGNATION; DR. WALT ARTHUR APPOINTED TRUSTEE

The Board of Trustees has accepted the resignation of Trustee Guus Bischoff, M.D., due to scheduling conflicts created by his election as president-elect of the Tacoma General Hospital medical staff. Dr. Walt Arthur, a family physician from Puyallup, has accepted an appointment as trustee.

The By-laws provide that Board vacancies are filled by appointment by the Board of Trustees until the next regular meeting of the Society, at which time voting members shall elect an active or honorary member for the unexpired portion of the term. The next regularly scheduled general membership meeting will be held on Tuesday, March 9.

## COLLEGE OF MEDICAL EDUCATION ELECTS OFFICERS

At its February 1 meeting the College of Medical Education (COME) Board of Directors elected the following 1982 officers:

Dr. Ron Graf, president.  
Dr. Tom Miskovski, vice president.  
Mr. Dan Russell, president of St. Joseph Hospital, treasurer.  
Mr. Tom Curry, MSPC executive director, serves as board secretary.  
COME affairs are directed by an 11 member board, consisting of five hospital administrators appointed by the Pierce County Hospital Council and six physicians appointed by the Medical Society. Physician representatives on the COME Board, in addition to Drs. Graf and Miskovski, are Drs. Carl Gerber, David McCowen, John Kemman, and Robert Modarelli.

## PHYSICIANS HEAD EMS COUNCIL

Dr. Bob Scherz has assumed the 1982 presidency of the Pierce County Emergency Medical Services Council. The EMS Council is a county-wide voluntary organization. Its membership includes representatives from all agencies and organizations involved in providing emergency and emergency medical services in Pierce County — fire departments, ambulance companies, police departments, The Puget Sound Council of Governments, state and county government and emergency service departments, physicians, and others.

The EMS Council meets monthly and coordinates disaster planning in addition to EMS services.

Also recently elected as EMS Council president-elect was Dr. Bud Nicola, director of the Tacoma-Pierce County Health Department. Mr.

(continued on page 7)

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# EMERGENCY MEDICINE

March 5, 6, 1982

Tacoma General Medical Center Auditorium  
314 S. 'K' Street, Tacoma



## PROGRAM Friday, March 5, 1982

- 8:00 **New Cardiac Drugs**  
9:00 **New Developments in CPR**  
9:45 Break  
10:00 **Career Pressures and Burn Out**  
11:00 **The Forensic Aspects of Emergency Medicine**  
12:00 Lunch

Gregory P. Shroedl, M.D.  
James K. Fulcher, M.D.  
  
Christopher Lambert, M.D.  
Sgt. Rodney D. Englert, B.S.

### Friday, March 5

|      |   |
|------|---|
| 1:00 | CARDIAC DYSRHYTHMIAS,<br>MECHANISMS & PREDICTION OF<br>SUDDEN DEATH<br>Gail B. Strait, M.D. |
| 2:00 | CPAP by FACE MASK FOR<br>PULMONARY EDEMA<br>Barry J. Weled, M.D.                            |
| 2:40 | Break   |
| 3:00 | AVOIDING CAREER BURN OUT<br>to Christopher Lambert, M.D.                                    |
| 4:30 |   |

### Saturday, March 6

|      |   |
|------|---|
| 1 00 | TOXIC GAS EXPOSURE<br>Jerris R. Hedges, M.D.                                      |
| 2 00 | Break   |
| 2 15 | ORTHOPEDIC INJURY TO<br>THE CHILD<br>Gregory A. Popich, M.D.                      |
| 3 00 | EMERGENCY MEDICINE BOARDS—<br>to HOW TO PREPARE<br>4 30 William E. Gotthold, M.D. |

## PROGRAM Saturday, March 6, 1982

- 8:00 **Emergency Medicine and the Washington  
State Government**  
8:40 **New Product: The Sager Splint**  
9:00 **Current Diagnoses and Management of  
Acute Vascular Problems**  
9:30 **911 - Implications for the Community**  
10:00 Break  
10:15 **Radiation Illness**  
11:00 **Case Presentations: Overdose Management**  
12:00 Lunch

Jack Cvitanovic  
Baxter R. Larmon, Paramedic  
Kenton C. Bodily, M.D.  
Michael Jordan  
  
Georges C. Benjamin, M.D.  
Mark E. Jergens, M.D.

**Program Coordinator: D. Terry Kendrick, M.D.**

**ACCREDITATION: CREDITS: 14 HOURS** AMA AAFP ACEP CERP CEU

### REGISTRATION:

**Fees:** \$65 Medical Society of Pierce County Members  
\$75 Non-Medical Society of Pierce County Members  
\$55 Allied Health Personnel

Lunch is included both days.

**Paid preregistration is required before February 28, 1982. Registrations are limited.**

Please address all registrations and correspondence to:  
Maxine Bailey, Executive Director, College of Medical Education, Inc.  
705 South 9th #203, Tacoma, Washington 98405. Phone: 206-627-7137

Enclosed is my check for \_\_\_\_\_ (Make checks payable to COME)

Name \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## CHARTING OUR COURSE FOR 1982



Lloyd C. Elmer, M.D.

*"It is not the going out of port, but the coming in, that determines the success of a voyage."* Henry Ward Beecher — Proverbs from Plymouth Pulpit, 1887.

The Board of the Medical Society of Pierce County has just concluded its annual retreat which is designed to identify goals, establish plans of action and in general "charge up the batteries of its members for the year." This year the Board was augmented by the presences of three past presidents of the Medical Society of Pierce County: Dave Hopkins, Stan Tuell and Ralph Johnson, whose contributions added an extra dimension to the proceedings.

We were also fortunate to have with us for the entire day Dr. Robert Hunter, the immediate past president of the American Medical Association. It was truly a gratifying experience to have a person of his stature participating in studying the concerns and problems of Pierce County physicians. Dr. Hunter's formal remarks provided a suitable conclusion to cap a remarkable day.

Your Board used the 1982 Membership Opinion Survey as the foundation for its deliberations, and in its interpretation the Board will be guided in important decisions for 1982. A summary of the opinion survey is published elsewhere in this Bulletin. The retreat participants interpreted the survey as follows:

1. A substantial margin of members in all age categories felt maintaining high professional standards to be the number one priority of the Medical Society of Pierce County.
2. The second highest priority ranking dealt with working to assure access to quality care and supporting our members by providing them with

excellent library services, easy access to meaningful continuing medical education and other resources.

3. Political and legislative efforts to serve the public and the profession ranked high in priority.

4. The survey indicated no support for further consideration by the Medical Society of a consolidated laboratory service in Pierce County.

5. The survey did not indicate a great deal of dissatisfaction with the present answering and radio paging services available in this community. There certainly was no clear mandate for the Society to proceed in establishing its own service.

We also expanded our areas of discussion to far-reaching subjects ranging from ethics and professionalism to the role of specialty societies in organized medicine as a whole. Peer review, quality assurance and grievance and disciplinary measures required special time allocations.

The Board concluded its retreat feeling that more time and energy would be required to finalized specific actions for the Society. Small ad-hoc committees were appointed to consider four broad areas of concern. These committees will report to the Board during the next several months with concrete recommendations. During these coming months we will be conveying to the general membership the progress of these activities, and asking for greater membership participation in order to bring to fruition our goals.

As a Board we shall be reminded of Matthew's admonition, "By their fruits ye shall know them."

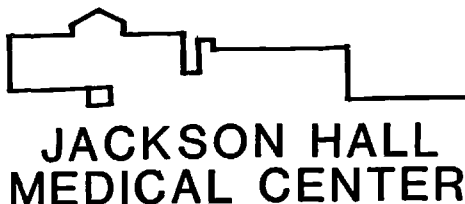
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The Army Medical Corps offers virtually unlimited opportunities to learn, teach, investigate, practice and direct. For physicians who want more in their health care career than a predictable daily routine, the Army Medical Corps has a lot to offer. There are challenging professional opportunities in patient care, preventive medicine, research, admin-

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**Captain Pat Shipley**  
**(206) 527-3548**  
**Call Collect**

**SOCIETY NEWS BRIEFS Continued**

David Vance, administrator of the Medical Society's EMS Medical Control Project, serves as Council secretary-treasurer.

**PHYSICIANS ELECTED INTO MEMBERSHIP**

Four provisional members were voted into Medical Society membership at the February Board of Trustees meeting. They are: Drs. George C. Johnston, Allen D. Mease, Maurice E. Lindell, and William F. Roes.

**PAN PACIFIC SURGICAL ASSOCIATION CONGRESS SET FOR AUSTRALIA**

Australia will be the site of the 17th Congress of the Pan Pacific Surgical Association which will be held in April of 1984. The Pan Pacific conference will be preceded by the April, 1984 American College of Surgeons meeting in Honolulu.

Details remain to be worked out, reports Stevens Dimant, M.D. Physicians requesting additional information are asked to contact Dr. Dimant at his office or home.

**WSMA OUTLINES 1982 LEGISLATIVE GOALS**

**Malpractice and the Profession**

The WSMA has undertaken a major statewide risk management program to improve the quality of medical care and thereby reduce the incidence of malpractice.

The WSMA has re-established a Task Force on Tort Reform to conduct an in-depth study during 1982 of possible changes which may be needed in tort law.

The WSMA is seeking legislative approval of two professional liability measures during the 1982 Session:

The first measure will allow the use of "Mary Carter" agreements as evidence during trials. The legislation will allow the court and jury to learn of any agreements between a plaintiff and one or more defendants regarding damages. The use of "Mary Carter" agreements as evidence will allow the court and jury to more fairly determine a proper monetary judgment in a lawsuit.

The second measure would allow the "prevailing party" in a suit for damages to recover attorneys' fees from the losing party. In order for the plaintiff to be considered the prevailing party, the plaintiff must recover more than the amount offered by the defendant to settle the lawsuit. The award of attorneys' fees may be excused by the court in the interest of justice.

**Child Auto Restraints**

The WSMA will continue to support mandatory child auto safety restraints. Statistics prove the effectiveness of child auto restraints in reducing death and serious injury to children in automobile accidents. In Tennessee, where similar legislation passed in 1978 (5 other states have subsequently enacted this legislation) there has been a 79% reduction in automobile-related deaths of children under the age of two.

**Medical Examiner System**

Many counties of the state have limited access to modern forensic medical services. The WSMA will initiate and support the establishment of a statewide medical examiner system available to any county wishing to take advantage of its services.

**Hot Water System Regulation**

Children and adults, especially the elderly, risk burns from tap water that is too hot. Hot water burns are less

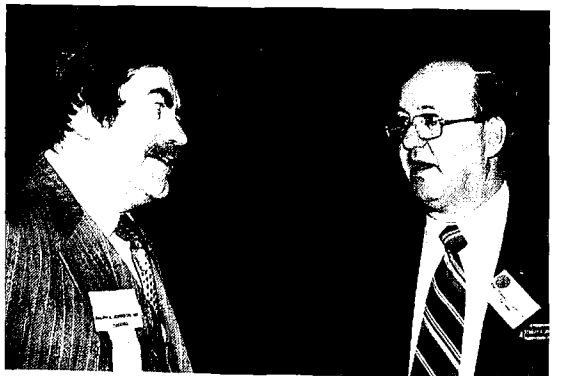
likely if the *maximum* temperature of hot water heaters is set at 120° F.

The WSMA, in cooperation with the Trial Attorneys' Association, is strongly supporting legislation requiring retailers to set newly installed hot water tanks/systems no higher than 120° unless specifically directed in writing by the home owner to do otherwise.

| Bill No. | Brief Title  | WSMA Position |
|----------|--|---------------|
| HB 31    | 3-Way Comp   | Support       |
| HB 174   | Expands Podiatry Licensure Act                                   | Oppose        |
| SB 4365  | Revises Podiatry Licensure Act                                   | Monitor       |
| HB 319   | Clarifies Natural Death Act                                      | Support       |
| SB 3111  | Extends doctor-patient privilege to nurses                       | Support       |
| SB 3121  | Deletes and repeals provisions regulating sales of prophylactics | Support       |
| SB 3332  | Expands Physical Therapy Practice                                | Oppose        |
| SB 3515/ | Amends Informed Consent Act                                      |               |
| HB 226   |  | Oppose        |
| SB 3541/ | Medication at Schools  | Support       |
| HB 189   |  |               |



*Drs. George Tanbara (left) and Roger Meyer (right) discuss a medical issue with 27th District Representative Art Wong (D) at the January WSMA Legislative Conference Reception.*



*Dr. Ralph Johnson (left), WSMA vice-president, and 28th District Representative Stan Johnson (R) converse at the reception following the Legislative Conference. An estimated 110 physicians and 100 legislators attended the reception to discuss issues of importance to medicine.*

## SOCIETY NEWS BRIEFS continued

### CONTACT YOUR LEGISLATOR!

Legislators continually emphasize the importance of direct contact with their constituents. Physicians are urged to contact their legislators regarding issues of importance to medicine and the community.

Pierce County legislators, and their Olympia telephone numbers, are listed below. Also listed are "key contact" physicians who are working as part of the 1982 legislative program. Key contact physicians assigned to each legislator are intended to serve as primary referral sources.

| Senators                                    | Olympia Phone Number | Key Physician Contact        |
|---|----------------------|------------------------------|
| 2nd District<br>R. Ted Bottiger (D)         | 753-7602             | James K. Symonds, M.D.       |
| 25th District<br>Marcus S. Gaspard (D)      | 753-7648             | Donald C. Weber, M.D.        |
| 26th District<br>Art Gallagher (R)          | 753-7650             | William B. Jackson, M.D.     |
| 27th District<br>Lorraine Wojahn (D)        | 753-7652             | MSPC officers                |
| 28th District<br>Ted Haley (R)              | 753-7654             | Richard A. Hoffmeister, M.D. |
| 29th District<br>A. L. "Slim" Rasmussen (D) | 753-7656             | George A. Tanbara, M.D.      |

### Legislative Mail Address:

Senator \_\_\_\_\_  
Legislative Building  
Olympia, WA 98504

| Representatives                       | Olympia Phone Number | Key Physician Contact                           |
|---------------------------------------|----------------------|---|
| 2nd District<br>Wayne Ehlers (D)      | 753-7824             | James K. Symonds, M.D.                          |
| Duane Kaiser (D)                      | 753-7890             | Jack J. Erickson, M.D.                          |
| 25th District<br>George Walk (D)      | 753-7806             | Thomas H. Clark, M.D./<br>Donald C. Weber, M.D. |
| Dan Grimm (D)                         | 753-7912             | Michael Haynes, M.D./<br>Donald C. Weber M.D.   |
| 26th District<br>Barbara Granlund (D) | 753-7918             | Paul Mountford, M.D.                            |

|                                      |          |   |
|--------------------------------------|----------|---|
| Dan Dawson (R)                       | 753-7974 | Larry Iverson, M.D./<br>Thomas W. Schubert,<br>M.D. |
| 27th District<br>Jim Salatino (D)    | 753-7984 | Robert G. Scherz, M.D.                              |
| Art Wang (D)                         | 753-7942 | Joseph D. Lloyd, M.D.                               |
| 28th District<br>Shirley Winsley (R) | 753-7838 | Joseph C. Nichols, M.D.                             |
| Stan Johnson (R)                     | 753-7874 | James D. Krueger, M.D.                              |
| 29th District<br>P.J. "Jim"          |          |   |
| Gallagher (D)                        | 753-7906 | George A. Tanbara, M.D.                             |
| Wendell Brown                        | 753-7936 | George A. Tanbara, M.D.                             |

### Legislative Mail Address:

Representative \_\_\_\_\_  
Legislative Building  
Olympia, WA 98504

### Olympia Telephone Numbers:

WSMA Olympia Office  
(24 hr. answering for messages) . . . (206) 352-4848  
Lobbyist Message Center  
(Capitol Building — "Ulcer Gulch") . . . . . 754-3206  
State Legislative Toll Free Message Line 1-800-562-6000  
(Quick and easy way to leave messages for your legislator urging a vote for or against or to request copies of bills.)

### Physician "Issue" Mail List:

Physicians wishing to receive WSMA mailings on specific issues should write to the WSMA Olympia office and request their name be placed on a mailing list for that issue. Those listed will receive notice of hearings, summaries of legislation and status of legislation.

### SURGICAL CLUB MEETS THIRD TUESDAYS

Members of the Tacoma Surgical Club are reminded that the organization holds its monthly meeting on the third Tuesday of each month (no such meetings are held in April, June, July and August). The Club's annual meeting will be on April 23 and 24. All members will receive a mailing in March. Herbert C. Kennedy, M.D., is the 1982 president of the Surgical Club.

### PEOPLE AND PLACES . . .

Eugene Hanson, M.D., retired MSPC member, was honored at the February 4 meeting of Tacoma's Rotary Club #8. Dr. Hanson was honored for obtaining status as a fellow in the Arthur H. Wickens Foundation. The foundation is an affiliated activity of the Rotary Club, funds of which are used for a variety of community services. Dr. Hanson, a general practitioner, was granted honorary membership status in 1972.

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MARY BRIDGE CHILDREN'S HEALTH CENTER  
10th Annual  
Day of Pediatrics  
"INFECTIOUS DISEASE UPDATE"

March 20, 1982

Tacoma General Medical Center Auditorium (Jackson Hall)  
314 South 'K' Street, Tacoma

**CATEGORY I** As an organization accredited for continuing medical education, the College of Medical Education, Inc., certifies that this offering meets the criteria for seven credit hours in Category I for the Physicians Recognition Award of the American Medical Association and for the relicensure requirements of the Board of Medical Examiners of the State of Washington.

**Credits:**  
7 hours

ALSO

Accredited by the American Academy of Family Physicians for seven credit hours—Category I (Prescribed)

PREP — Pediatric Review and Education Program

- 7:30 Registration
- MORNING SESSION**
- 8:00 Welcome *Dr. Ritchie, President, Medical Staff*  
Moderator *Dr. Scherz, Medical Director*
- 8:15 NEWER ANTIBIOTICS IN PEDIATRIC PRACTICES *John D. Nelson, M.D.*
- 9:00 IMMUNOCOMPETENCE — EVALUATION AND  
MANAGEMENT OF THE CHILD *Alan Mease, M.D.*  
WITH FREQUENT INFECTIONS *Warren Todd, M.D.*
- 10:00 BREAK
- 10:15 NEW RADIOGRAPHIC APPROACHES FOR EVALUATION *Kenneth Gross, M.D.*  
OF INFECTIOUS DISEASES
- 11:00 UPDATE ON LABORATORY TESTS FOR RAPID DIAGNOSIS *John Podgore, M.D.*  
OF INFECTIOUS DISEASES *Alan Tice, M.D.*
- 11:15 PANEL
- 12:00 LUNCH
- AFTERNOON SESSION**
- Moderator *Edward Walkley, M.D.*  
*Administrative Director, Special Care Unit*  
*Arnold Smith, M.D.*
- 1:30 NEONATAL INFECTIONS —  
RECOGNITION AND MANAGEMENT
- 2:15 AMBULATORY INFECTIOUS DISEASE MANAGEMENT *Michael Miller, M.D.*
- 3:00 BREAK
- 3:15 INFECTIOUS DISEASE MANAGEMENT *John D. Nelson, M.D.*  
OF THE HOSPITALIZED CHILD
- 4:00 PANEL  
CLOSE CONFERENCE



Program Coordinator: Robert G. Scherz, M.D.

**SPONSORED BY:**

Mary Bridge Children's Health Center  
College of Medical Education  
Medical Society of Pierce County  
Pierce County Hospital Council

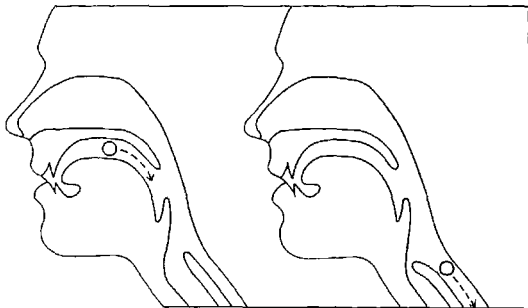
Registration fee: \$55, Medical Society of Pierce County members; \$65, non MSPC members; \$25 all other health care personnel. Paid preregistration would be appreciated before March 15, 1982. This program is subject to cancellation if less than the minimum number of participants have registered by March 15, 1982. Please address all registrations and correspondence to:

Maxine Bailey, Executive Director  
College of Medical Education, Inc.  
Medical Society of Pierce County  
705 South 9th, #203  
Tacoma, Washington 98405  
Phone: 627-7137

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Now, by means of a unique water-soluble cellulose coating, Improved Bayer® Aspirin provides

oro-pharyngo-esophageal protection for your patients. Furthermore, in a recent short term use study, perceived stomach upset was shown to be no greater than seen with placebo.<sup>1</sup>

This patented coating is *not* enteric in nature, so it is not affected by pH. And the film does not affect absorption or bioavailability. What it does is to stay intact just long enough for tablets to reach the stomach. Disintegration in the buccal cavity, pharynx and esophagus is avoided—easing swallowing and minimizing aspirin

taste, aftertaste and burning in the throat. Once tablets reach the stomach, they dissolve quickly and completely—producing the same aspirin and salicylate blood levels as regular aspirin.<sup>2</sup>

### Protective effect demonstrated in multi-center study<sup>1</sup>

In a double-blind, multi-center clinical study,<sup>1</sup> involving 907 subjects, Improved Bayer Aspirin was shown significantly superior to regular aspirin in avoiding aspirin taste, aftertaste, dissolution of tablets in the mouth and burning in the throat.

### As well tolerated as placebo

What's more, for short term use when compared to both coated and uncoated placebo tablets, Improved Bayer Aspirin showed *no significant difference in subjective complaints of stomach upset*—as shown in the chart:

Subjective evaluations—average percentage of complaints following each of three 650 mg doses of Improved Bayer Aspirin, placebo and coated placebo—given four hours apart<sup>1</sup>

| Symptom & Time of Administration* | Improved Bayer Aspirin | Placebo | Coated Placebo |
|-----------------------------------|------------------------|---------|----------------|
| <u>Burning in Throat</u>          |                        |         |                |
| 5 min.                            | 6%                     | 5%      | 5%             |
| 20 min.                           | 8%                     | 7%      | 8%             |
| 50 min.                           | 6%                     | 5%      | 5%             |
| <u>Stomach Upset</u>              |                        |         |                |
| 5 min.                            | 2%                     | 4%      | 2%             |
| 20 min.                           | 6%                     | 8%      | 5%             |
| 50 min.                           | 8%                     | 7%      | 5%             |
| <u>Nausea</u>                     |                        |         |                |
| 5 min.                            | 0%                     | 1%      | 0%             |
| 20 min.                           | 2%                     | 3%      | 2%             |
| 50 min.                           | 3%                     | 2%      | 2%             |

\* Following each of the three doses of test formulations, subjective side effects were recorded at 5, 20 and 50 minutes.

### Better patient compliance

With its low incidence of subjective complaints and high degree of acceptance, Improved Bayer Aspirin can help assure the kind of patient compliance needed for successful salicylate therapy.

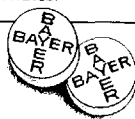
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To be sure your patients get all the benefits of Improved Bayer Aspirin, be sure to specify the name Bayer, whenever you recommend aspirin. Now, more than ever, it can make an important difference.

#### References:

1. Soller, R. W. and Baretz, D.B.: Methylcellulose Film Coating of Tablets as an Improved Delivery System for Aspirin (to be published).
2. Soller, R. W.: Bioavailability of Improved Bayer Aspirin (on file, The Bayer Company).

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New York, New York 10016



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# 1982 MEMBERSHIP OPINION SURVEY RESULTS

The 1982 Medical Society Membership Opinion Survey was conducted in late December and early January. Survey results were used by the Board of Trustees in its review of goals and priorities at its January 30 retreat.

Survey results indicate the membership, by a substantial margin and without regard to age categories, considers maintaining high professional standards and ethics as the number one priority of the Medical Society of Pierce County. Working to assure access and supporting quality medical care received the next highest rankings as Society priorities. Political and legislative efforts to serve the public and profession were indicated as high priorities. (For additional comment regarding the survey, see President's Page, page 5.)

Approximately 57% of the survey's respondents have practiced medicine in Pierce County for ten years or less. The response rate of 33.5% was consistent with the response rates of previous membership opinion surveys.

Full statistical reports of the survey follow:

Question 1: What do you think should be the major concerns of your county Medical Society?  
(Answers in the following tables are given in percentages.)

|  | Responses of members in practice: |                 |                  |                     |            |
|--|-----------------------------------|-----------------|------------------|---------------------|------------|
|  | Less Than<br>5 years              | 6 - 10<br>years | 11 - 15<br>years | 16 years<br>or more | Total      |
| <b>FIRST PRIORITY</b>  | (91)                              | (33)            | (24)             | (68)                | (216)      |
| <b>A. Maintaining high professional standards and ethics;</b> protecting patients from poor quality care or unscrupulous physicians: | 31.9%                             | 39.3%           | 29.2%            | 25.5%               | 30.3%      |
| <b>B. Working to assure access to quality medical care:</b>  | 16.3                              | 12.5            | 10.4             | 13.4                | 14.8       |
| <b>C. Political and legislative</b> efforts to serve the public and profession:  | 13.9                              | 8.9             | 6.3              | 12.1                | 11.7       |
| <b>D. Promoting community relations</b> and providing medically-related public education:  | 10.2                              | 8.9             | 8.3              | 9.4                 | 9.5        |
| <b>E. Supporting quality medical care,</b> continuing education, library services, etc.  | 14.6                              | 16.1            | 16.7             | 12.8                | 14.3       |
| <b>F. Providing services</b> that support members' professional and other practice related activities:                               | 4.8                               | 5.4             | 10.4             | 8.1                 | 6.7        |
| <b>G. Preserving goodwill and cooperation</b> among members:   | 6.0                               | 8.9             | 12.5             | 12.1                | 9.3        |
| <b>H. Other:</b>   | <u>2.4</u>                        | <u>0</u>        | <u>6.3</u>       | <u>6.7</u>          | <u>4.1</u> |
| (Base)   | (166)                             | (56)            | (48)             | (149)               | (419)      |

2. Do you feel there is a sufficient number of Medical Society general membership meetings to keep you informed of important medical issues and to provide you with an opportunity to meet with your colleagues and express your views?

|     |       |       |
|-----|-------|-------|
| Yes | 91.1% | (175) |
| No  | 8.9%  | (17)  |
|     |       | (192) |

3. What is the greatest single impediment to you attending a Medical Society general membership meeting (current meeting format/practices are indicated in parenthesis)?

|       |  |
|-------|--|
| 24.8% | The day of the week the meetings are held (Tuesdays). (31) |
| 20.8% | The time of day (6:30 p.m.). (26)                          |
| 18.4% | The format (dinner followed by the meeting). (23)          |
| 20.8% | Location (at various restaurants). (26)                    |
| 15.2% | Current programs. (19)                                     |
|       | (125)  |

4. Do you feel there is a sufficient number of hospital medical staff meetings to keep you informed of important hospital and medical staff issues and to provide you with an opportunity to express your views?  
 Yes 87.7% (185)  
 No 12.3% (26)  
 (211)

5. Do you feel, as a member of a medical staff(s), that you have sufficient impact on hospital policy affecting your patients' care?  
 Yes 60.8% (124)  
 No 39.2% (80)  
 (204)

6. The economy and other factors are adversely affecting access to quality health services for an increasing number of people.  
 6.a. Should the Medical Society participate with other agencies in a financial screening service, such as that used in health department community clinics, for patients if this would make it easier for your practice to accept additional or no fee patients?  
 Yes 41.2% (78)  
 No 58.7% (111)  
 (189)

6.b. Should the Society be involved in assisting patients who are seeking a physician?  
 Yes 96.0% (169)  
 No 4.0% (7)  
 (176)

7. In recent months members have expressed concern about local answering and paging services.

Do you use an answering service? Yes 65.2% (131)  
 No 34.8% (70)  
 (201)

Do you use a paging service? Yes 68.1% (130)  
 No 31.9% (61)  
 (191)

7.a. Which local answering and/or paging service do you currently use?  
 21.5% Doctors and Dentists Telephone Exchange (44)  
 11.7% Medical Telephone Answering Service (Answering Service Northwest) (24)  
 23.9% Answerphone (49)  
 42.9% Radio Page of Tacoma (88)  
 (205)

7.b. How would you rate the answering/paging service(s) you currently use?

| <u>Answering Service</u> | <u>Paging Service</u> |
|--------------------------|-----------------------|
| 15.5% Excellent (20)     | 14.2% Excellent (19)  |
| 29.5% Good (38)          | 38.1% Good (51)       |
| 40.3% Fair (52)          | 38.1% Fair (51)       |
| 14.7% Poor (19)          | 9.7% Poor (13)        |
| (129)                    | (134)                 |

7.c. What do you like best and least, about the service(s) you use?

| <u>Answering Service</u>                     | <u>Like Best</u>                             | <u>Like Least</u> |
|--|--|-------------------|
| 44.1% Level of service (49)                  | 23.9% Level of service (37)                  |                   |
| 9.9% Cost (11)                               | 41.9% Cost (65)                              |                   |
| 15.3% Equipment (17)                         | 8.4% Equipment (13)                          |                   |
| 20.7% Responsiveness to physician needs (23) | 21.3% Responsiveness to physician needs (33) |                   |
| 9.9% Other (11)                              | 4.5% Other (7)                               |                   |
| (111)  | (155)  |                   |

Paging Service

| <u>Like Best</u>                             | <u>Like Least</u>                            |
|--|--|
| 42.6% Level of service (43)                  | 17.6% Level of service (26)                  |
| 11.9% Cost (12)                              | 37.8% Cost (56)                              |
| 24.8% Equipment (25)                         | 20.9% Equipment (31)                         |
| 14.9% Responsiveness to physician needs (15) | 20.9% Responsiveness to physician needs (31) |
| 5.9% Other (6)                               | 2.7% Other (4)                               |
| (101)  | (148)  |

7.d. How long have you used your current service(s)?

| <u>Answering Service</u> |                         | <u>Paging Service</u> |                        |
|--------------------------|-------------------------|-----------------------|------------------------|
| 53.0%                    | Less than 5 years (79)  | 72.8%                 | Less than 5 years (99) |
| 16.1%                    | 6 - 10 years (24)       | 16.9%                 | 6 - 10 years (23)      |
| 10.1%                    | 11 - 15 years (15)      | 8.1%                  | 11 - 15 years (11)     |
| 20.8%                    | 16 years or longer (31) | 2.2%                  | 16 years or longer (3) |
|                          | (149)                   |                       | (136)                  |

7.e. When (if) you last changed to a new answering/paging service(s), was the change because of better:

| <u>Answering Service</u> |  | <u>Paging Service</u> |  |
|--------------------------|--|-----------------------|--|
| 20.4%                    | Cost (10)                                  | 16.0%                 | Cost (8)                                   |
| 28.6%                    | Level of service (14)                      | 28.0%                 | Level of service (14)                      |
| 6.1%                     | Better equipment (3)                       | 18.0%                 | Better equipment (9)                       |
| 14.3%                    | Convenience of service (7)                 | 10.0%                 | Convenience of service (5)                 |
| 18.4%                    | Perceived responsiveness to your needs (9) | 18.0%                 | Perceived responsiveness to your needs (9) |
| 12.2%                    | Other (6)                                  | 10.0%                 | Other (5)                                  |
|                          | (49)                                       |                       | (50)                                       |

7.f. It has been suggested that a physician directed and/or owned answering and/or radio paging service(s) could provide comparable or better service than what is currently available at equal or reduced expense. If it is determined that this is possible, what would be the determining factor for you to change to such a service?

| <u>Answering Service</u> |   | <u>Paging Service</u> |   |
|--------------------------|---|-----------------------|---|
| 39.7%                    | Improved service (83)                     | 38.8%                 | Improved service (71)                     |
| 36.4%                    | Reduced expense (76)                      | 35.0%                 | Reduced expense (64)                      |
| 22.5%                    | Greater responsiveness to your needs (47) | 23.0%                 | Greater responsiveness to your needs (42) |
| 1.4%                     | Other (3)                                 | 3.3%                  | Other (6)                                 |
|                          | (209)                                     |                       | (183)                                     |

7.g. Establishing a new answering and/or paging service would entail a financial commitment on the part of the participating physicians. Would you be willing to participate on that basis?

|     |       |       |
|-----|-------|-------|
| Yes | 65.1% | (99)  |
| No  | 34.9% | (53)  |
|     |       | (152) |

8. The concept of a centralized laboratory service for Pierce County performing automated lab work for physicians has been suggested as a means of reducing lab costs and improving service. Given the assumption that such a laboratory service, however organized, would have a beneficial impact on costs and service without compromising quality, do you think a centralized laboratory service is desirable?

|     |       |       |
|-----|-------|-------|
| Yes | 43.4% | (82)  |
| No  | 56.6% | (107) |
|     |       | (189) |

8.a. Do you think a centralized laboratory service is practical?

|     |       |       |
|-----|-------|-------|
| Yes | 33.1% | (58)  |
| No  | 66.9% | (117) |
|     |       | (175) |

8.b. Should the Medical Society support a study of this issue and work to promote such a service?

|     |       |       |
|-----|-------|-------|
| Yes | 40.7% | (77)  |
| No  | 59.3% | (112) |
|     |       | (189) |

9. What is your age? 46.2 years average

10. How long have you practiced medicine in Pierce County?

|       |                         |
|-------|-------------------------|
| 42.1% | Less than 5 years (91)  |
| 15.3% | 6 - 10 years (33)       |
| 11.1% | 11 - 15 years (24)      |
| 31.5% | 16 years or longer (68) |
|       | (216)                   |

RATE OF RESPONSE: 33.5%

# Correspondence

## AUTOMOBILE SAFETY: A RECENT SURVEY

To The Editor:

Through legislative initiative, professional education, and education of the public, the Medical Society of Pierce County and the WSMA in 1982 are emphasizing automobile safety for infants and children. One aspect of this year's program is the "First Ride Safe Ride" campaign, emphasizing proper automotive safety restraints for infants from the time of birth.

A recent survey sampling infants discharged from the newborn nursery of Lakewood General Hospital showed only 30% leaving the hospital in appropriate safety infant seats. I felt that a review of office medical records should be carried out to determine whether safety seats were used with greater frequency at the time of the infant's first well-child examination.

The charts of the last 100 infants seen for health examinations at 2 to 3 weeks of age were retrospectively reviewed, with the following results:

|   |    |
|---|----|
| Parents stated child has and uses infant car seat ..... | 53 |
| Advised regarding need for safety car seat .....        | 27 |
| No record regarding car seat .....                      | 20 |

The findings of this chart review indicated significantly fewer infants stated to be using safety infant car seats than was expected. Higher expectations related to the previous instruction of the parents, all of whom had presumably seen exhibits of safety infant car seats at the time of delivery of their infants at local hospitals, reviewed pamphlet material displayed with these

exhibits, and in most cases, seen film strips regarding safety infant car seats. The question was raised whether economic considerations prevented more widespread use of safety infant car seats.

A further review of these 100 charts revealed the following:

|  |        |
|--|--------|
| <i>Infants covered under Title XIX</i> .....               | 30     |
| Title XIX infants using safety car seats ....              | 7 23%  |
| Title XIX infants without safety infant car seats .....    | 15 50% |
| Title XIX infants. No record regarding car seats .....     | 3 27%  |
| <i>Non-Title XIX Infants</i> .....                         | 71     |
| Non-Title XIX infants using infant safety car seats .....  | 47 67% |
| Non-Title XIX infants. No safety car seats .....           | 12 17% |
| Non-Title XIX infants. No record regarding car seats ..... | 12 17% |

The significantly less utilization of safety car seats by the economically disadvantaged may well be due to the substantial cost of car seats (\$35-\$50) but also may relate to difference in education and understanding regarding risks. Clearly improvement is needed among this population. The 67% car seat utilization by the economically more advantaged also needs improvement.

(continued on page 19)



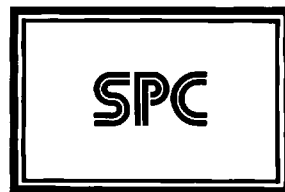
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## WHAT'S NEW — AND WORTHLESS

"Worthless" is sort of a worthless term. As I reviewed a number of "new" tests it became increasingly difficult to determine which was the most worthless. That's an unfortunate dilemma, but not very rare and it altered the initial direction of this discussion.

As commercial laboratories, in particular, do their thing, the practicing physician has become increasingly inundated with attractive claims of new tests and/or profiles that are more sensitive, more specific, more unique, more accurate — and often more expensive.

So how does one evaluate the "worth" of a new test — or an old one for that matter?

For starters, a good test for a specific disease should be positive in most folks who have that disease (sensitivity) and negative in most who don't (specificity). With that profound bit of wisdom, it follows that you should be able to make some predictions about whether a patient has or doesn't have a disease based on a positive or negative result. Obviously if you can't, the test is more or less worthless.

The "predictive value" has been discussed by Galen and Gambino<sup>1</sup> who propose this approach for evaluating test results:

|                   | # with<br>positive results | # with<br>negative results | totals         |
|-------------------|----------------------------|----------------------------|----------------|
| # with disease    | TP                         | FN                         | TP + FN        |
| # without disease | FP                         | TN                         | FP + TN        |
| TOTALS:           | Total Positives            | Total Negatives            | Total Patients |

TP = true positives  
 FP = false positives  
 TN = true negatives  
 FN = false negatives

$$\text{Predictive value of a positive result} = \frac{\text{True positives (TP)}}{\text{Total positives (TP + FP)}} \times 100$$

$$\text{Predictive value of a negative result} = \frac{\text{True negatives (TN)}}{\text{Total negatives (TN + FN)}} \times 100$$

Sensitivity = percent of true positives in patients with the disease.

Specificity = percent of true negatives in patients without the disease.

The impact of prevalence on the predictive value of a positive result is extremely important as will be emphasized in the following examples.

Consider 100 patients where 50 have "the" disease and 50 do not (prevalence is 50%). The test to identify the disease is 96% specific (all the 50 normal patients, except two false positives, will have negative results) but 50% sensitive (half of the diseased patients will test positive, but half will test false negative).

|                   | # with<br>pos. result | # with<br>neg. result | totals |                   |
|-------------------|-----------------------|-----------------------|--------|-------------------|
| # with disease    | 25                    | 25                    | 50     | sensitivity = 50% |
| # without disease | 2                     | 48                    | 50     | specificity = 96% |
| TOTALS            | 27                    | 73                    | 100    |                   |

Predictive value of a positive result =  $25/27 \times 100 = 93\%$   
 Predictive value of a negative result =  $48/73 \times 100 = 66\%$

In summary, a positive test will be accurate 93% of the time but a negative test will be wrong one third of the time, which isn't all that bad. In this example, however, the prevalence — 50% — is very high. Do we ever actually encounter that type of prevalence and what happens to the predictive value if the prevalence is much lower. Suppose we change nothing but the prevalence to a more reasonable 2%.

|                   | # with<br>pos. result | # with<br>neg. result | totals |                   |
|-------------------|-----------------------|-----------------------|--------|-------------------|
| # with disease    | 1                     | 1                     | 2      | sensitivity = 50% |
| # without disease | 4                     | 94                    | 98     | specificity = 96% |
| TOTALS            | 5                     | 95                    | 100    |                   |

Predictive value of a positive result =  $1/5 \times 100 = 20\%$   
 Predictive value of a negative result =  $94/95 \times 100 = 99\%$

It should not surprise you that in 100 patients where only two have "the" disease, a negative test is highly reliable. But would you have believed that a positive test would be wrong 80% of the time?

The moral of this story centers on *prevalence*. Perhaps you haven't realized it but prevalence is the one variable that is under *your* exquisite control and 50% prevalence is rather easy to achieve. Let me explain.

CPK-MB is one of the best laboratory tests for detecting myocardial infarction. With a high sensitivity and specificity it is an excellent tool to rule in or out a recent infarction *in the appropriate group of patients*. And that group is composed of those individuals who enter your office or the ER complaining of chest pain or other typical MI symptoms. By limiting the test to that group, you have increased the prevalence of MI and literally made the test valuable. I suppose it's obvious at this point, but the CPK-MB as a screening tool in the general population where the prevalence of MI is far below the 2% in the above example would render a positive result even less reliable than the 20% described.

The bottom line is this: most tests, new or otherwise, are "worthless" unless used under appropriate circumstances, i.e. where judicious selection of the patient increases the likelihood (prevalence) of the diagnosis under consideration. With myocardial infarction, this is relatively easy. With some diagnoses, it is more difficult. The key to predictive value and "worth" of test results is clearly tied to patient selection and how much the physician has to eliminate before ordering the test.



A quick example of what this means in real life: psychiatrists have recently been bombarded with a "new" test to diagnose endogenous depression<sup>2</sup>. Now "depression" is about as common as a head cold, but the problem is differentiating the reactive patient from the patient who has a neuroendocrine imbalance as the basis for depression (endogenous).

The approach to quantitate the neuroendocrine imbalance has been a modification of the old dexamethazone suppression test which was developed initially as a test for adrenal function to diagnose Cushing's disease. In the normal patient, dexamethazone suppresses adrenal function; in Cushing's disease it does not. The patient with endogenous depression "escapes" from the adrenal suppression sooner than the normal patient or those with other types of depression or other psychiatric disorders. The problem is that some escape and some don't.

The test has been advocated for routine use by internists, family practitioners and psychiatrists on either an inpatient or outpatient basis. In either situation the dexamethazone is administered orally at 11 p.m. With outpatients a single blood specimen is obtained the following day at 4:00 p.m.; with inpatients blood specimens are taken at 4:00 p.m. and at 11:00 p.m. Any cortisol value above 5 ug/dl is considered a positive result. Obviously the more blood specimens tested, the more likely one is to receive a positive.

The sensitivity of the procedure in the outpatient group with the prevalence adjusted to 50%, has been reported as 49% with a specificity of 97%<sup>2</sup>. The high prevalence was achieved by excluding patients for multiple medical reasons or with a history of certain drug use. The same data applied to a prevalence of 2% results in the following predictive value for a positive test:

|                      | # with<br>pos. result | # with<br>neg. result | totals |                   |
|----------------------|-----------------------|-----------------------|--------|-------------------|
| # with depression    | 1                     | 1                     | 2      | sensitivity = 49% |
| # without depression | 3                     | 95                    | 98     | specificity = 97% |
| TOTALS               | 4                     | 96                    | 100    |                   |

Predictive value of a positive result =  $1/4 \times 100 = 25\%$

I suspect that in clinical use on an outpatient basis the prevalence will be far closer to 2% than 50%. At \$27.50 for single cortisol determination the test is hardly worthless — to the laboratory — but will contribute little to the diagnosis of endogenous depression.

This discussion has emphasized the crucial importance of disease prevalence to increase the "worth" of predictive values of test results and what the physician must do to increase the validity of testing. At the opposite end of the spectrum is the scenario we have jointly created by the development and promotion of profile screening especially in hospital admission profiles and/or "health" profiles. You will recognize that such testing represents no or very little patient selection and that "positive" results have a remote value at best. The basic question is whether the low cost of the screening profile offsets the relatively high cost of following up the false positives.

I doubt it!

*Ed Wood, M.D., Ph.d.*

1. Galen, Robert S. and S. Raymond Gambino. Beyond Normality: The Predictive Value and Efficiency of Medical Diagnoses. John Wiley & Sons. New York, 1975.
2. Ritchie, James C. and Bernard J. Carroll. Melancholic Patients: A New Test to Identify Depression. Lab World, 32(9): 24-29, 1981.

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## THE AUCTION WAS A SUCCESS! THANK YOU ALL (AND TIDBITS)

### 1981-1982 FUND RAISER — THE AUCTION

The Auction Committee worked hard and diligently. The committee telephoned, sent flyers, made posters, arranged for food, developed displays and kept careful records. The outcome of their efforts was more than 130 donations.

Those whose help was so special are: Debby McAlexander, Nikki Crowley, Bev Graham, Shirley Murphy, Sharon Lawson, Norma Smith, Marlene Arthur, Mary Johnston, Jeanne Judd, Kit Larson, Verna Bergman, Donna McLees, Cathy Schneider, Cindy Anderson, Judy Robinette, Suzie Flood, Kay Kemman, Dottie Truckey, Barbara Patterson, LaVonne Campbell, Gloria Virak, Alaire Sheimo, Jo Roller, Carol Hopkins, Bob Whitney, Chuck Anderson, Vern Larson, Ken Graham, Jim Patterson, Marty Osborne, Alair Sheimo, and Gil Roller.

We are especially pleased with the generous response of our members — in the generous donations and attendance. The Finance Committee will be recom-

mending which local health charities should receive our donations.

Thank you all.

*Helen Whitney*

On Saturday, January 23rd, a very rainy night, over 100 people gathered at the Charles Wright Commons in anticipation of the auction. Members of the Auxiliary, their spouses and friends went from table to table writing their bids for items on the silent auction. "Those dahlia bulbs were up to \$8.00 now they are \$10.00." "Guess I'll bid \$11.00." "Now let's see, I'd like a quart of homemade dill pickles and then there's the wicker cat basket and the chocolates and —"

The oral auction started. Our volunteer auctioneer was Jim Konek of Fircrest, an insurance salesman with a flair for auctioneering and desire to serve his community. Some of the items were a week in July at a beach home on Merit Island, a plane ride over the Mt. St. Helen's area, a pair of live geese, a Huskie's gold and purple toilet seat, three mystery boxes, a Greek or Italian dinner for eight, and the list goes on.

The approximate amount raised from the oral and silent auctions was \$4,500—indeed a success. Our "thank you" to Helen Whitney, auction chairman, whose expertise and leadership made it all work and our "thank you" to all members who donated items.

*Mary Whyte Lenard*



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### STUDENT RECOGNITION

Applications for the Student Recognition Award will be available in principal/conference offices during February in all high schools in Pierce County. Students must be graduating seniors whose parent or parents are members of the Medical Society of Pierce County.

The award is based primarily on scholarship but also includes leadership and service to schools and the community. Students' names are not known at the time of selection. Applications must be returned by March 26. If you have any questions regarding the Student Recognition Award, please call Phyllis Pierce, 584-9240.

### PROJECT LIFE LINE NEEDS VOLUNTEER COORDINATOR

Project Life Line, a volunteer program coordinated with the county, City of Tacoma and the Tacoma-Pierce County Health Department, needs a volunteer Volunteer Coordinator to implement and maintain the program. Project Life Line has been developed out of a need recognized by professionals, community health nurses, social workers, and out-reach workers, visiting in the homes of residents.

The program's purpose is to enhance and provide reinforcement for professional visits, to provide an extra dimension of care when non-professional services are

needed by a family, and to assist individuals and families to independence when possible.

An example of the people to be served are:

1) individuals isolated from the community, such as the elderly, unwed mothers, handicapped and foreign born.

2) Individuals who need skill building, assistance in homemaking, mothering, socializing, grooming and handicrafting.

3) Individuals who need services such as help with filling out forms, transportation or escort service, and who need to feel useful and develop life goals.

The Volunteer Coordinator's responsibilities include recruitment of volunteers to make home visits, orientation and training of volunteers, receiving requests for service from professional staff, and acting as a liaison with the health department and other city and county agencies with similar needs. If you are interested or desire more information, please call June Ruth, R.N., C.H.N., health department, 593-4807.

#### MARCH GENERAL MEETING

The March General Meeting will be held on Friday, March 19 at the home of Mrs. Charles Vaught, Puyallup. Suzie Duffy, is the chairman. Our guest speaker will be Diane Schaak of Money Matters, Bellevue. She will focus on financial planning for the 1980's. This will be a luncheon meeting.

#### MARCH BOARD MEETING

The Board will meet on Monday, March 1 at 9:30 a.m. at Allenmore, Building B. Mark your calendars now.

#### WHAT SOME MEMBERS HAVE BEEN DOING

On January 12 Debby McAlexander, Helen Whitney, Marlene Arthur, and Nikki Crowley joined the Madigan medical wives to attend a stress workshop at the Ft.

Lewis Officers' Club. It was presented by Dr. Fletcher of PLU. Ladies — we expect you will now be less stressed!

On January 16, the WSMA Leadership Conference was held at the Sea-Tac Regency Hyatt. Auxiliary representatives were: Marlene Arthur, Gloria Virak, Marny Weber, Cindy Anderson, Jo Roller and Nancy Spangler. The Organ Donor Program was presented to ancillary medical personnel in order to expand the level of information to hospital emergency rooms and chaplains.

#### STATE NEWS . . .

The 1981-82 State Nominating Committee, chaired by Marny Weber, has nominated Mary Randolph (1981-1982 president) to a second term. Char Appgood, president-elect, had resigned because of health reasons. Mary's second term will be for six months because of the change in Auxiliary's business year.

*Mary Whyte Lenard*

#### Correspondence continued from page 15

All 3-week health examination patients will continue to be given the pamphlet, "Don't Risk Your Child's Life!" (Physicians for Automotive Safety, 50 Union Avenue, Irvington, New Jersey 07111). An American Academy of Pediatrics brochure regarding infant car safety will be handed by the physician to the mother of each newborn at the first hospital visit, and the mother appropriately advised regarding the use of a car seat at the time of hospital discharge. A re-survey of car seat use at the 3-week visit and a survey of car seat use at the 2-month visit will be carried out and later reported. A re-survey of car seat use at the time of hospital discharge is planned.

Sincerely,

*David Sparling, M.D.*

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# Membership

In accordance with the Bylaws of the Medical Society of Pierce County, Chapter Seven, Section A, MEMBERSHIP, the following physicians have applied for membership, and notice of their application is herewith presented. As outlined in the Bylaws, any member who has information of a derogatory nature concerning an applicant's moral or ethical conduct, medical qualifications or other such requisites for membership, shall assume the responsibility of conveying that information to the Credentials Committee or Board of Trustees of the society.

## FIRST NOTICE



**Don R. Russell, D.O., Pediatrics.** Born 10/17/45, Oskaloosa, Iowa; Des Moines College of Osteopathic Medicine & Surgery, Iowa, 1967; internship and residency, Madigan Army Medical Center, 1976-79; Washington State license, 1978. Has applied for medical staff membership at Allenmore, Doctors, Good Samaritan, Lakewood General, Mary Bridge Children's, Puget Sound, St. Joseph and Tacoma General hospitals. Dr. Russell is currently practicing at 205 15th Avenue S.W., Puyallup. **Sponsored by:** Drs. Dan Wiklund and JoHann Duenhoelter.



**Thomas I. Kaufman, M.D., Emergency Medicine.** Born in Ohio, 12/8/51; University of Colorado, 1977; internship and residency, Valley Medical Center, Fresno, Ca., 1977-80; State of Washington license, 1981. Has applied for medical staff membership at St. Joseph Hospital. Dr. Kaufman is practicing at St. Joseph Hospital, Tacoma.



**Michael J. Regalado, M.D., Internal Medicine.** Born in Honolulu, Hawaii, 2/2/53; Stanford University Medical School, 1978; internship and residency, University of Washington Hospitals, 1978-81; State of Washington license, 1979. Has applied for medical staff membership at Allenmore, Doctors, Good Samaritan, Lakewood General, St. Joseph and Tacoma General hospitals. Dr. Regalado is practicing at 5122 Olympic Dr. N.W., Suite A-105, Gig Harbor.

## SECOND NOTICE



**Barry E. London, M.D., Pediatrics.** Born in Minnesota, 6/25/46; University of Minnesota, 1972; internship, Hennepin County General Hospital, 1972-73; residency, University of Minnesota Hospitals, 1973-75; State of Washington license, 1981. Has applied for medical staff membership at Mary Bridge Children's, St. Joseph and Tacoma General hospitals. Dr. London is practicing at 2603 Bridgeport Way W., Tacoma.



**Edward J. Przasnyski, M.D., Internal Medicine.** Born in St. Louis, Mo., 5/11/47; University of Missouri, 1973; internship and residency, Madigan Army Medical Center, 1973-79; State of Washington license, 1978. Has applied for medical staff membership at Allenmore, Doctors, Good Samaritan, Lakewood General, Mary Bridge Children's, Puget Sound, St. Joseph and Tacoma General hospitals. Dr. Przasnyski is practicing at 314 So. "K" Street, Tacoma.



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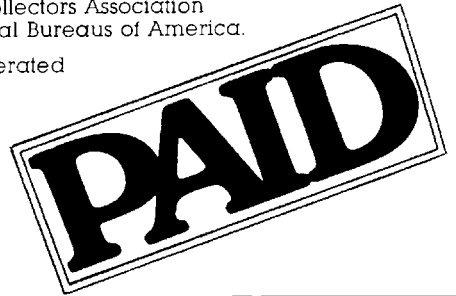
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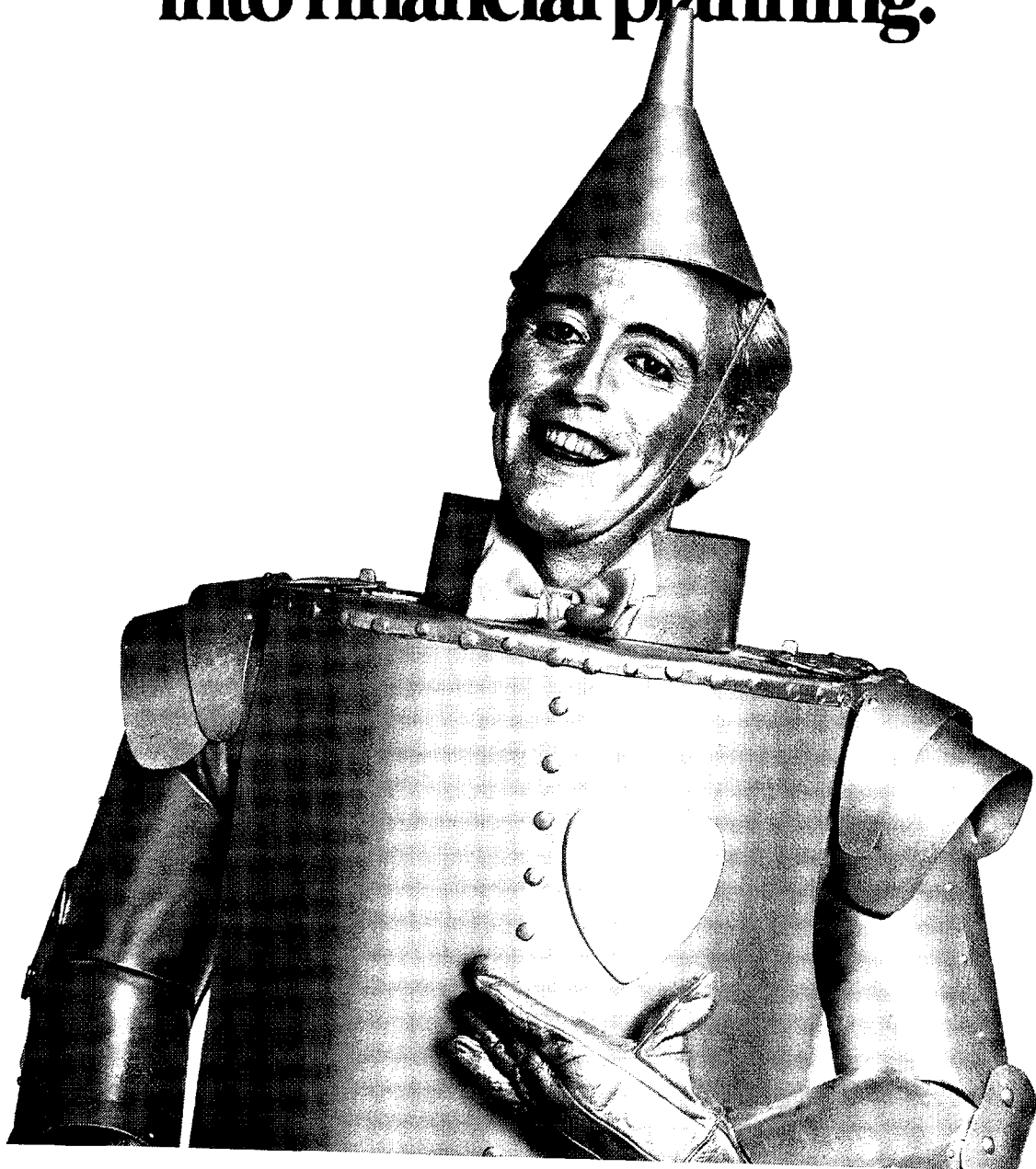
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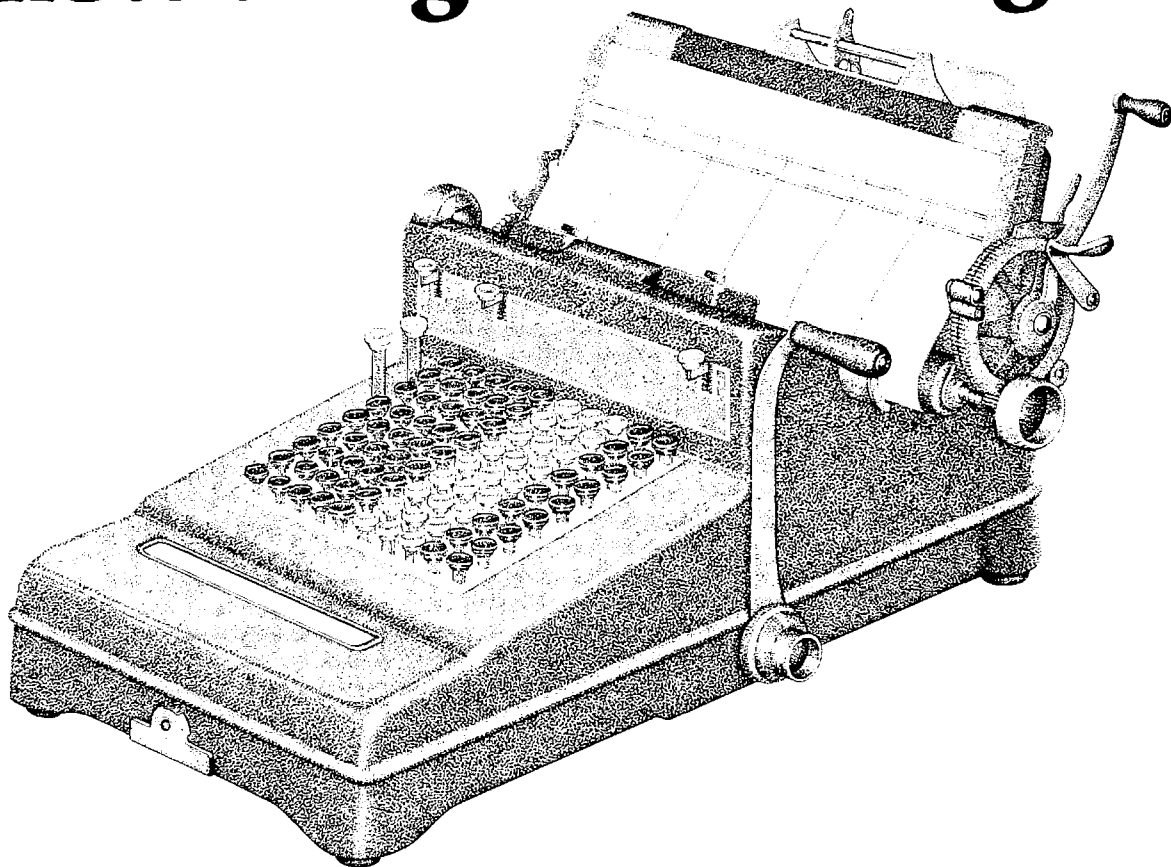
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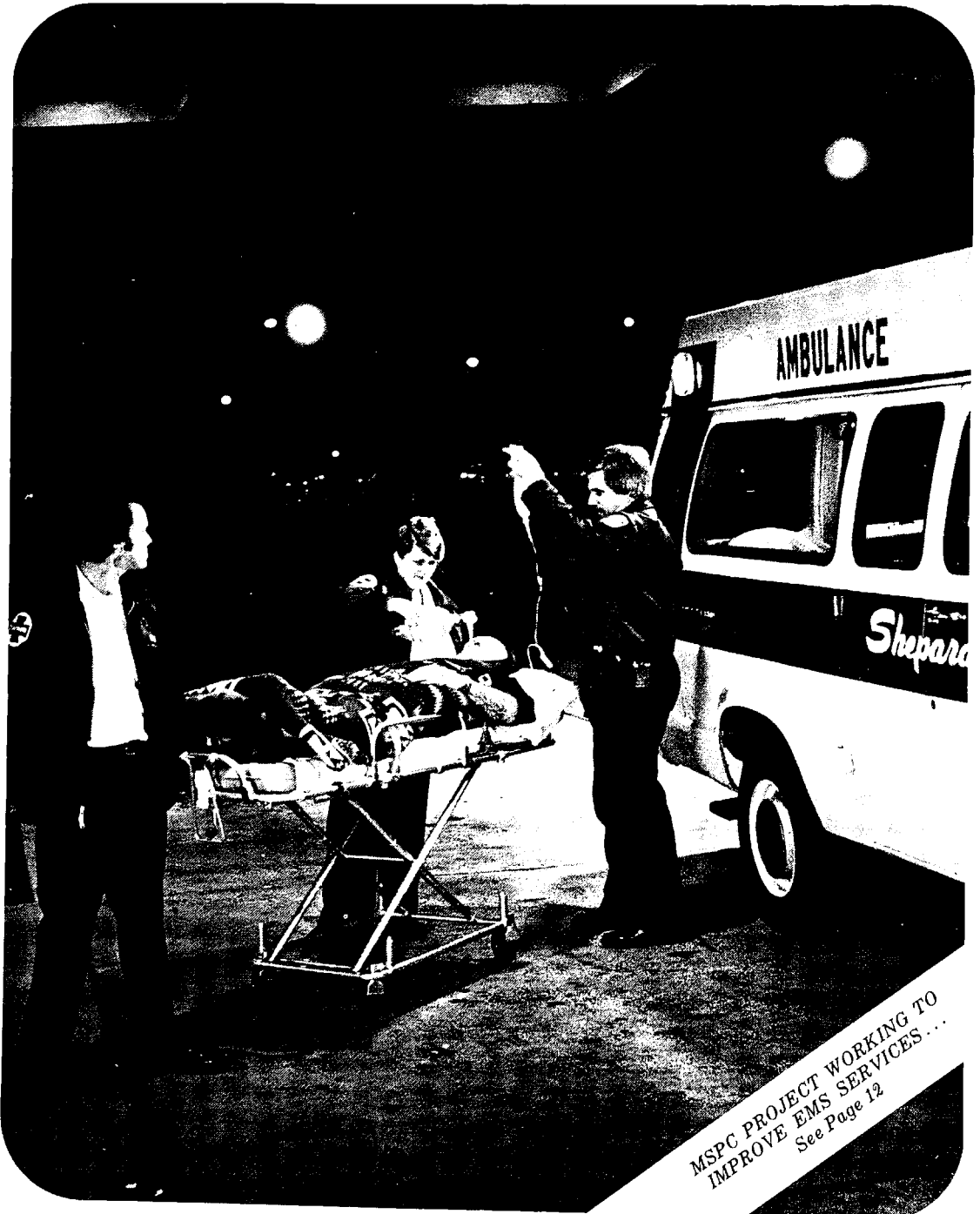
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# Medical Society of Pierce County

MARCH 1982, Vo. LIV, No. 3, Tacoma, Washington



MSPC PROJECT WORKING TO  
IMPROVE EMS SERVICES...  
See Page 12

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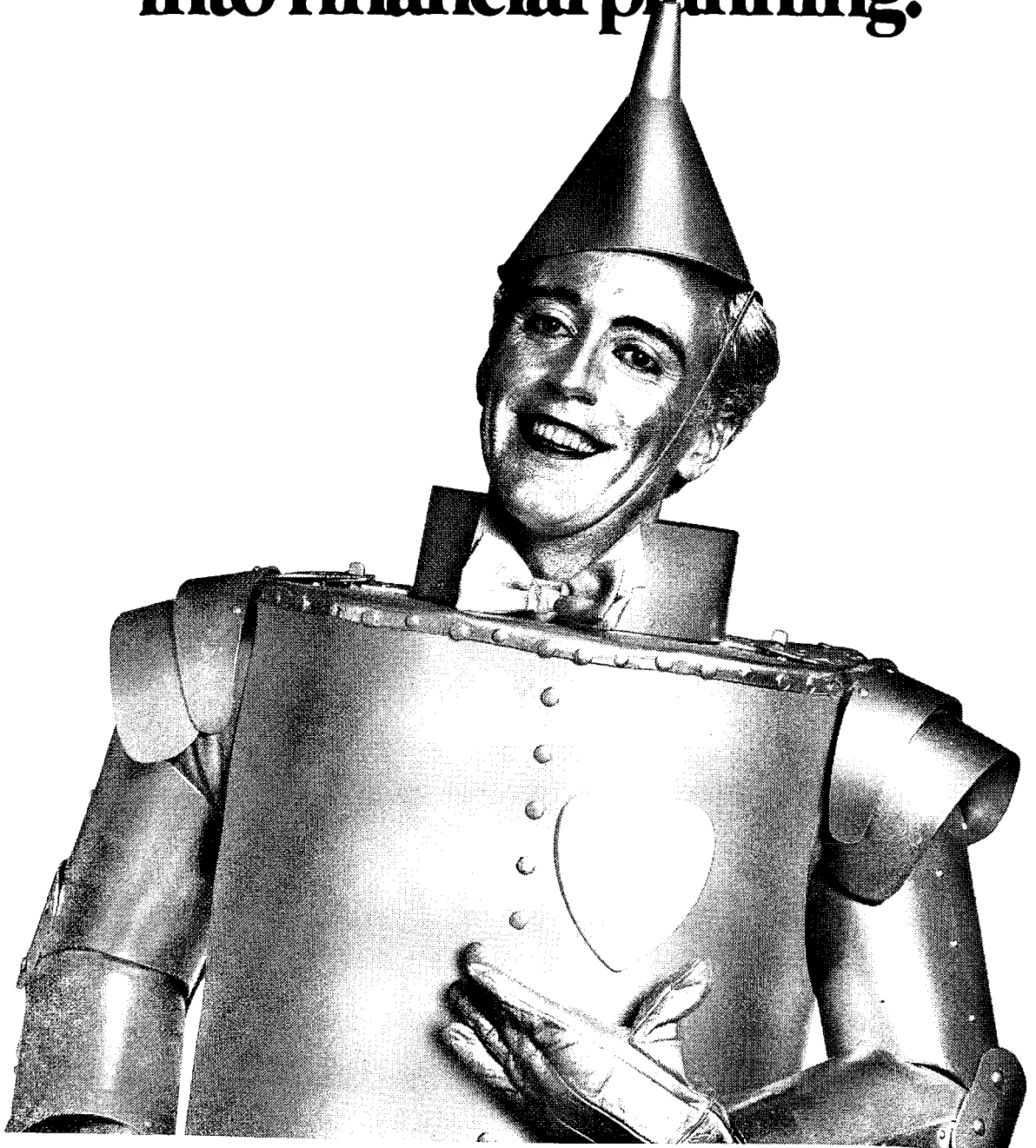
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- 5 **President's Page — Ethical Considerations of Caring for the Indigent**
- 8 **Medical-Legal Guidelines Established**
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- 12 **Improved EMS Services Goal of MSPC Project**
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## COVER

Tacoma Fire Department and Shepard Ambulance Company personnel demonstrate the unique public/private aspect of Pierce County's EMS services. For a review of the Medical Society's project to further improve EMS services see page 12. Photo courtesy of Steve Palmer, Shepard Ambulance.

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# Society News Briefs

A summary of Medical Society, and local medical and health news

## NURSING HOME VISITATION POLICY REVISED

The much discussed visitation policy of Tacoma Lutheran Nursing Home has been revised to provide for additional flexibility and deletion of the "automatic" provision as previously proposed. The revised policy was reviewed at the February meeting of the MSPC Senior Citizens Committee which expressed its agreement with the policy as modified.

## PHYSICIANS ELECTED TO MEMBERSHIP

Twenty-six provisional members were elected to membership in the Medical Society of Pierce County at the March Board of Trustees meeting. The new MSPC members are:

|                              |                      |
|------------------------------|----------------------|
| Robert V. Hollison           | Margaret Kitazawa    |
| John M. Hautala              | Gregory E. Arnette   |
| Robert W. Osborne, Jr.       | Alan P. White        |
| Thomas K. Jones              | James D. Buttorff    |
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| Charles G. Hubbell           | David B. Bork        |
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| Thomas A. Heller             | Barry E. London      |
| Peter K. Marsh               | Edward J. Przasnyski |
| Needham E. Ward              | Ray M. Nicola        |
| James E. Dunn                | Chang J. Lee         |
| David M. Brown               | John R. Harbour      |
| Michael J. Regalado          | Richard E. Waltman   |

## ASTHMA LECTURES PLANNED FOR APRIL

The American Lung Association of Washington is sponsoring two lectures for asthmatic adults and parents of asthmatic children. The lectures will be held on Monday, April 12 and Monday, April 19 at 7:00 p.m. at Allenmore Community Hospital, in the Doctors' Dining Room (lower level).

## WSMA NOMINATIONS SOUGHT

The Washington State Medical Association has contacted all county medical societies seeking local nominations for WSMA office. MSPC members serving as elected WSMA officers and trustees in 1982 are: Dr. Stan Tuell (speaker of the house); Ralph Johnson (vice president); Dave Hopkins (AMA delegate); and, Lloyd Elmer (WSMA trustee). Suggestions for possible nominees to WSMA office are encouraged. Physicians are urged to contact members of the MSPC Executive Committee or Board of Trustees, c/o the Medical Society office.

## MEDICAL DISCIPLINARY BOARD SEEKS PRO-TEM MEMBERS

The State Medical Disciplinary Board has asked for Medical Society assistance in identifying local physicians willing to serve as pro-tem disciplinary board members to help speed up investigations and hearings and to provide peers — both geographically and by specialty — of physicians who come under board scrutiny. MSPC President Lloyd C. Elmer has written local specialty society presidents seeking nominations of members willing to serve in such a capacity.

*(Continued on page 15)*

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Peripheral Vascular  
Disease and Surgery

May 10th

**George H. Krick, M.D.**  
Rheumatology

June 14th

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Lloyd C. Elmer, M.D.

## ETHICAL CONSIDERATIONS OF CARING FOR THE INDIGENT

*"Human misery must somewhere have a stop: There is no wind that always blows a storm." — Euripides*

The black clouds on the horizon foretell with each new thundercloud the economic maelstrom threatening our country. Surely, as physicians we are affected by the turbulence as it touches our practices and our personal goals and aspirations. How much more so must the impact be for families and individuals subsisting in or near poverty and for those whose jobs are threatened or have recently been terminated.

As most economic indicators continue their downward drift we find the unemployment rate over 12% in the State of Washington and higher than that in Pierce County. We have the specter of an increasing population of economically disadvantaged persons without medical insurance because of a change in state and national philosophical attitudes and stringent fiscal policies. Our local Urban Health Initiative community clinics which care for patients on a no fee or reduced fee basis are at this moment fighting for their lives.

Organized medicine in this county and state has voiced strenuous objections in the past and will continue to object to the state's concept that our legitimate fees be routinely discounted when services are provided for Medicaid patients. Our overall success, however, with the Department of Social and Health Services has been limited. The Washington State Medical Association has negotiated moderate fee increases for physicians over the past several years but the gap between reasonable,

usual and customary fees paid by DSHS and those paid by the balance of our patients is still chasmatic.

It is really no wonder that physicians may turn away from DSHS programs when compensation for services barely covers overhead expense. It is a burden difficult to bear, but bearable if we all agree to share the load.

As of February 1, 1982 of the 329 physicians on the Medical Society of Pierce County physician referral list, only 193 were accepting patients without restriction. The severity of the problem becomes more apparent when one considers that of the 193, there are only 38 primary care physicians who are accepting Medicaid or low/no fee patients. The Medical Society office handles an average of 30 referral calls a day and two-thirds of the people requesting a physician are either Medicaid or low/no fee patients.

The Judicial Council of the Washington State Medical Association has ruled that it is a violation of ethical practice to choose not to treat "a class of patients", and that Medicaid patients so qualify as a class. The good physician could never deliberately choose not to apply his skill and knowledge to help an ill or injured patient because of inability to pay. Therefore, there should be strong sentiment of approval in the medical community for the Board of Trustees' adoption of a physician referral policy\* that is fair and evenhanded and encourages all physicians to take their fair share of indigent patients.

LCE

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*\*The referral policy approved by the Board of Trustees at its March 2, 1982 meeting is presented on page 11.*

# CRITICAL CARE MEDICINE SYMPOSIUM

a practical review and update for physicians

April 15, 16, 1982

St. Joseph Hospital Education Center / Madigan Army Medical Center

## April 15, Thursday, St. Joseph Hospital Education Center

|       |  |                           |
|-------|--|---------------------------|
| 9:00  | SOME PHYSIOLOGIC EFFECTS OF RAISED AIRWAY PRESSURE   | John B. Downs, M.D.       |
| 9:45  | Question / Answer  |                           |
| 10:00 | OXYGEN TRANSPORT   | Terry P. Clemmer, M.D.    |
| 10:45 | Question / Answer  |                           |
| 11:00 | Break  |                           |
| 11:15 | UNUSUAL APPROACHES TO COMMON RESPIRATORY PROBLEMS  | John B. Downs, M.D.       |
| 12:00 | Question / Answer  |                           |
| 12:15 | Lunch — Box lunch provided   |                           |
| 1:00  | CHEST TRAUMA / SEPTIC SHOCK  | C. James Carrico, M.D.    |
| 2:20  | Question / Answer  |                           |
| 2:30  | Break  |                           |
| 2:45  | NEWER TREATMENT MODALITY OF ACUTE GI BLEEDING IN THE INTENSIVE CARE UNIT INCLUDING ENDOSCOPIC COAGULATION TECHNIQUES | Fred E. Silverstein, M.D. |
| 3:20  | Question / Answer  |                           |
| 3:30  | Adjourn  |                           |

## April 16, Friday, Madigan Army Medical Center

|       |   |                          |
|-------|---|--------------------------|
| 9:00  | BRAIN RESUSCITATION   | Terry P. Clemmer, M.D.   |
| 9:45  | Question / Answer   |                          |
| 10:00 | A PHYSIOLOGIC BASIS FOR WEANING FROM MECHANICAL VENTILATORS | John B. Downs, M.D.      |
| 10:45 | Question / Answer   |                          |
| 11:00 | Break   |                          |
| 11:15 | ACUTE TUBULAR NECROSIS                                      | LTC. Poong S. Shim, M.D. |
| 12:00 | Question / Answer   |                          |
| 12:15 | Lunch — No host/Officers Club                               |                          |
| 1:00  | DRUG CLEARANCE IN CRITICALLY ILL PATIENTS                   | Paul D. Schneider, M.D.  |
| 1:45  | Question / Answer   |                          |
| 2:00  | ANTIBIOTICS & INFECTION IN THE CCU                          | Peter K. Marsh, M.D.     |
| 2:45  | Question / Answer   |                          |
| 3:00  | Break   |                          |
| 3:15  | ORIGIN OF CRITICAL CARE MEDICINE                            | Terry P. Clemmer, M.D.   |
| to    |   |                          |
| 3:45  |   |                          |

Program Coordinator: Barry J. Weled, M.D.

### FACULTY:

John B. Downs, M.D.  
National Secretary,  
Critical Care Medicine Society  
Medical Director,  
Anesthesiology & Pulmonary Medicine  
Marcy Hospital  
Urbana, Illinois

Fred E. Silverstein, M.D.  
Director, Medical Affairs  
New Market Development  
Advance Technology Laboratories  
Bellevue

Terry P. Clemmer, M.D.  
Assistant Professor of Medicine  
University of Utah, School of Medicine  
Director of Critical Care Medicine  
Latter Day Saints Hospital  
Salt Lake City, Utah

Paul D. Schneider, M.D.  
Nephrologist, Tacoma

Peter K. Marsh, M.D.  
Infectious Disease Specialist  
Tacoma

C. James Carrico, M.D.  
Chief of Surgery,  
Director, Trauma Service  
Harborview Medical Center  
Professor of Medicine  
University of Washington, Seattle

LTC. Poong S. Shim, M.D.  
Chief, Nephrology Services  
Madigan Army Medical Center

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Fees: \$50 physicians (per day) or  
\$75 physicians (both days)  
\$25 critical care nurses (per day)

PAID preregistration is required before April 12, 1982.

Please address all registrations and correspondence to:  
Maxine Bailey, Executive Director, College of Medical Education, Inc.  
705 South 9th, No. 203, Tacoma, Washington 98405 (206) 627-7137

Enclosed is my check for \_\_\_\_\_  
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Name \_\_\_\_\_

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### Accreditation:

Credits: 6 or 12 hours

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AAFP — Accredited by the American Academy of Family Practice for 6 or 12 hours Category 1 (Prescribed).



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# MEDICAL - LEGAL GUIDELINES ESTABLISHED TO AID LOCAL PHYSICIANS AND LAWYERS

Guidelines to assist physicians and lawyers in matters of joint concern have been approved by the Medical Society of Pierce County and Pierce County Bar Association. The guidelines result from deliberations of the organizations' joint Medical-Legal Committee.

The benefit and need for broadest possible dissemination of the guidelines was discussed at the January Medical-Legal symposium and they are produced in this issue of the *Bulletin* for the benefit of MSPC members.

The Medical-Legal Committee was established to provide communication between physicians and lawyers on medical-legal issues, issue medical-legal opinions, and mediate disputes upon written request. The physician chairman of the committee is Dr. W. Ben Blackett. Other physicians serving on the committee are Drs. Bruce Buchanan, Dick Huish, James Kenny, and Stan Tuell.

## GUIDELINES

### A. FOR PHYSICIANS

#### 1. Availability

Patients have a legal right to court procedures and attorney representation in resolving disputes. In instances where medical information is necessary to the fair resolution of a dispute, the physician should make himself available for attorney conferences, depositions, or court testimony at reasonable times and with reasonable notice.

#### 2. Nature of Testimony

A physician's role is as an independent expert witness. While his testimony may be more helpful or harmful for one side, he should not be an advocate. He should state the truth as he sees it.

#### 3. Fees

a. A physician should charge a reasonable fee for his time which may be calculated upon a time basis or as a flat rate.

b. Stand-by charges may be made for time reserved but should not be made if the reserved time is cancelled on three full working days' notice by the attorney reserving time or if the reserved time was actually utilized for chargeable medical services.

c. A physician should furnish to the attorney upon request, his usual time basis fee or flat rate charge.

### B. FOR ATTORNEYS

#### 1. Notice to Physicians

Physicians should be given at least 30 days' notice of the need for trial testimony, 15 days' notice for deposition, and 7 or more days' notice for office conferences.

Every effort should be made to schedule testimony so as to interfere as little as possible with the physician's scheduled time.

Pierce County Local Court Rule No. 45 requires the issuance of a subpoena to physician:

"Where an expert witness will, with reasonable probability, be called as a witness at the trial of any case, the party planning to call such witness shall cause a subpoena to be issued and served upon such witness not later than thirty (30) days subsequent to the date the case is assigned for trial or, in case such a witness becomes a necessary witness in the trial of said case subsequent to the date of assignment for trial, not less than twenty (20) days prior to the trial date. A continuance may be denied should such a witness be unavailable for trial unless a subpoena has been issued and served within the time above specified. For the purpose of this Rule, service of a subpoena may be made by mail.

This Rule may be endorsed upon any subpoena issued."

#### 2. Payment of physician's fees

Physician charges for medical reports, conferences, depositions, and trial testimony arranged for by an attorney for his client are payable by the attorney to the physician within 30 days after billing for services rendered and these charges do not await final resolution of the case.

#### 3. Payment of client's medical bills

Attorneys should not advise clients to withhold payment of medical bills pending conclusion of a lawsuit. The physician's bills are not contingent upon the success of litigation and are payable when billed. If funds are simply not available, the physician should be so notified.

### C. HANDLING DISPUTES, ISSUING OPINIONS AND MEDIATION

It is hoped that the above recommendations will prevent problems, but the following mechanism is suggested for the resolution of any attorney - physician conflicts which do arise.

1. Physician submits opinion request to medical chairman. Medical chairman reviews request and sends request to legal chairman with his opinion. Legal chairman responds.

2. Lawyer submits opinion request to legal chairman. Legal chairman reviews request and sends request to



medical chairman with his opinion. Medical chairman responds.

3. If both medical and legal chairmen agree, opinion given to person requesting the same with copy to all members of the committee.

4. If medical and legal chairmen do not agree, problem submitted to members of medical-legal committee for further consideration.

5. Majority and minority opinion issued after consideration by committee.

6. If mediation demanded, then medical chairman selects two medical members of the committee and legal chairman selects two legal members of the committee and obtain an agreed date, time and place to mediate dispute. A memorandum together with affidavits and exhibits shall be presented to the chairmen by each party to the dispute and copies shall be disseminated to the members of the mediation board one month prior to the mediation date.

#### D. MEETINGS

There shall be at least one annual meeting open to all members of the committee. The date, time and place of said meeting shall be determined by the chairmen. All committee members will be given at least two weeks' notice of the meeting.

Special meetings of the committee may be had upon agreement by the chairmen with two weeks' notice to the committee members of the date, time, place, and reason for the meeting.



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# 51st Annual Tacoma Surgical Club Meeting

April 24, 1982 - 8:30 a.m. to 4:30 p.m.  
Tacoma General Medical Center Auditorium  
314 South 'K' Street, Tacoma

## SATURDAY, April 24

|       |  |   |       |   |                                     |
|-------|--|---|-------|---|-------------------------------------|
| 8:30  | WELCOME  |   | 12:00 | Lunch — Bavarian  |                                     |
| 8:35  | BRAIN ABSCESS  | Stevens Dimant, M.D.                            | 1:30  | INTRA ABDOMINAL INFECTIONS<br>Has the prognosis improved?                               | Samuel E. Wilson, M.D.,<br>F.A.C.S. |
| 8:55  | COMBINED TREATMENT OF<br>DIFFICULT BASAL CELL<br>CARCINOMAS OF THE FACE          | Sidney F. Whaley, M.D.<br>Thomas J. Irish, M.D. | 2:15  | CANCER OF THE PROSTATE  | Thomas A. Stamey, M.D.              |
| 9:20  | BENIGN TESTES TUMORS   | LTC William D. Belville, M.D.                   | 3:15  | Break   |                                     |
| 9:30  | CRYPTORCHIDISM —<br>Update & Overview  | COL Martin L. Dresner, M.D.<br>F.A.C.S.         | 3:30  | PRIMARY ADENOCARCINOMA OF<br>OF THE ESOPHAGUS   | MAJ Henry J. Zilenski, M.D.         |
| 10:00 | NEWER ANTIBIOTICS and/or<br>PROPHYLACTIC USE OF<br>ANTIBIOTICS IN SURGERY        | Alan D. Tice, M.D.                              | 3:45  | CONSERVATIVE SURGERY FOR<br>BREAST CANCER: National<br>Surgical Adjuvant Breast Project | CPT William L. Weaver, M.D.         |
| 10:30 | Break  |   | 4:00  | SUNCHROMOUS<br>GASTROINTESTINAL MALIGNANCIES  | CPT Richard M. Dearman, M.D.        |
| 10:45 | PROSTATITIS - Principles of<br>Antibiotic Diffusion & Host<br>Defense Mechanisms | Thomas A. Stamey, M.D.                          | 4:15  | PRIMARY GASTROINTESTINAL<br>LYMPHOMA  | CPT Bruce A. Snyder, M.D.           |
| 11:45 | Discussion   |   | 4:30  | Adjourn   |                                     |

## FRIDAY EVENING, APRIL 23 — TACOMA COUNTRY CLUB

|      |   |  |
|------|---|--|
| 6:30 | SOCIAL HOUR   |  |
| 7:30 | DINNER — Guest Lecture: URINARY INCONTINENCE IN THE FEMALE<br>Thomas A. Stamey, M.D.<br>Chairman, Division of Urology<br>Stanford University, School of Medicine<br>(For Surgical Club Members & Invited Guests Only) |  |

## SATURDAY EVENING, APRIL 24 — TACOMA COUNTRY CLUB

|      |   |  |
|------|---|--|
| 6:30 | SOCIAL HOUR   |  |
| 7:30 | DINNER — Guest Lecture: NAEGLERIA FOWLERI "The Key to Ancient Treasures"<br>Thomas A. Stamey, M.D.<br>(For Surgical Club Members & Invited Guests Only) |  |

Program Coordinator: Herbert C. Kennedy, M.D.  
President, Tacoma Surgical Club

### CREDITS: Category 1 — 6 hours — AMA

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PLEASE FILL OUT AND RETURN

No Fee: Compliments of the Tacoma Surgical Club.  
All who plan to attend are asked to respond.  
Please fill out and return.

Separate reservations by all wishing to attend social occasions are required before April 20, 1982.  
Membership dues include dinner for the member only.  
The dinner charge for your spouse or guest and non-members will be billed.

Please direct all correspondence, inquiries, and registrations to:  
Maxine Bailey, Executive Director  
College of Medical Education, Inc. (coordinating agency)  
705 South 9th, No. 203, Tacoma, Washington 98405  
Phone: 627-7137

- I will be attending the dinner Friday evening, April 20. Please make reservations for \_\_\_\_\_ in addition to myself.
- I will be attending the educational session on Saturday, April 20, 1982.
- I will be attending the dinner Saturday evening, April 20. Please make reservations for \_\_\_\_\_ in addition to myself.
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Approved At March Board Meeting

# PHYSICIAN REFERRAL SERVICE POLICY UPDATED

The MSPC Board of Trustees, at its March 2 meeting, approved the following revised policy for the Medical Society's Physician Referral Service. The Board's action was taken in response to a need to update the policy and to reflect the concerns of the Medical Society relative to provision of services for all segments of the community (see President's Page, page 5).

Approximately two-thirds of the average of 30 calls per day received by the service are from Medicaid or lowered or no fee patients. Approximately 7,800 inquiries were handled by the referral service in 1981. —*The Editor.*

1. Prospective patients calling the Medical Society's Physician Referral Service will be provided with the names and telephone numbers of members who have agreed to accept patients into their practice without restriction as to type of insurance or ability to pay.

2. Members of the Medical Society requesting inclusion in the referral listing will be categorized by specialty, then by geographical area.

2.A. Members will be categorized by specialty as requested by the member for his/her listing in the

"Directory For Pierce County Physicians And Surgeons."

3. Active and provisionary members may elect to be included in the listing for possible referrals.

4. Upon recommendation of the Ethics or Grievance Committees, the Medical Society of Pierce County Board of Trustees or Executive Committee may determine that a requesting physician will not be included in the referral listing.

4.A. Under certain circumstances, the Executive Director at his discretion may temporarily remove a member's name from the referral list, provided a final determination of the member's listing status is made by the Ethics or Grievance Committee within 30 days.

5. The referral list shall be continually updated and formally reviewed annually, concurrent with the annual survey of the membership for inclusion in the "Directory For Pierce County Physicians And Surgeons."

6. At no time shall a member be promoted or endorsed, or be implied as such, to a caller. The names and telephone numbers of at least three members shall be provided to each person calling the Medical Society for the referral service.

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**Radiology Search Committee**  
**Kadlec Hospital**  
**Attention: Jon Davis**  
888 Swift Boulevard  
Richland, WA 99352

**(509) 946-4611, ext. 300**

# IMPROVED EMERGENCY MEDICAL SERVICES GOAL OF MEDICAL SOCIETY PROJECT

Improved emergency medical services available to all Pierce County residents is the goal of a joint project sponsored by the Medical Society, endorsed by the Pierce County EMS Council, and funded by the Department of Social and Health Services, EMS division. This partnership of the private medical community and a local public agency is working to shape a prehospital care system consistent with appropriate medical protocols and responsive to community needs.

"Our goal is a coordinated, rational EMS system to benefit all and offering optimum access to medically sound prehospital care," says Dr. Terry Kendrick, the project director. Physicians are working with administrators, advanced life support (ALS) providers, and others to improve the EMS System.

"Pierce County does not have a county-wide systematic and efficient emergency medical services system. Services overlap and are often duplicated. There is frequently poor interface of public and private system components," observes Mr. David Vance, the project's administrator. As an example, Vance cites the fact that Pierce County has more paramedics per capita than any other county in the state while, at the same time, people

in some sections of the county must wait as long as 30 minutes for an ALS unit to respond in an emergency.

As the emphasis on EMS has increased in the last decade, so has a growing awareness of the need to combine the existing components into a functional and responsive EMS delivery system.

Medical control is the central element in the program. Physicians are crafting a framework that will define precisely the role of paramedics in providing emergency medical services, notes Kendrick, who also serves as chairman of the Medical Society's Emergency Medical Standards Committee and is the Pierce County advanced life support director with certification authority over all paramedics operating in the county. Each ALS provider has a physician medical advisor who serves on the Medical Society's EMS Committee.

Medical Society planning for the Medical Control Project began in 1980. Formal application for state funding was made by the Pierce County EMS Council in early 1981 and a one year grant was awarded effective October 1. Vance joined the Medical Society staff late in October and is assisted by a full-time secretary. He previously served as emergency medicine programs manager for the Methodist Hospital of Indiana in Indianapolis. He had earlier worked as a paramedic in Tacoma.

State funding of \$54,000 has been provided to the one year project. In the council's application for funding it was noted that well over \$200,000 worth of physician time is contributed annually to providing rudimentary medical control and improving the system locally.

"Washington State law provides that paramedics must function under physician control. No one else can do it. It's up to us," states Kendrick. Those involved in the project agree that the most important component for effective prehospital care is medical control. Effective control includes prospective control (training, examination and certification of paramedics, and formulation of protocols and standing orders), immediate control (on-line and off-line physician involvement), and retrospective control (run review, audits and tracer studies), he adds.

"Pierce County has the potential of becoming a model EMS delivery system," concludes Kendrick. "There are no other EMS projects in Washington State, and very few in the country, that have the unified support of the private sector, municipal agencies, fire service, the local EMS council, county/city government and the medical society. Each of these entities has made a commitment to the development and implementation of the best possible EMS delivery system for Pierce County."

### WHAT SERVICES CAN PARAMEDICS PERFORM?

In addition to Basic Life Support techniques such as bandaging and splinting, paramedics are capable of performing:

- \*Endo-tracheal intubation.
- \*Cardiac monitoring/dysrhythmia recognition.
- \*Medication administration.
- \*Intravenous therapy.
- \*Defibrillation.
- \*MAST application.

Paramedics performing Advanced Life Support procedures must be under the control of a physician either by direct radio or phone contact or through previously approved standing orders.

NOTE: Provision of these services should not unduly delay contact with the hospital emergency department. *It is the responsibility of those at the scene of an emergency response to contact the emergency department at the earliest possible time following initial contact with the patient(s).*

## EMS IN PIERCE COUNTY: A BRIEF HISTORY

Pierce County has a unique Emergency Medical Services network. Historically, private ambulance services have provided nearly 100 percent of all EMS patient transports. "This network has developed through cooperation between the private and public sectors and is responsible for many excellent components of the "non-system" of Emergency Medical Services within Pierce County," states Medical Control Project Administrator David Vance.

Basic Life Support (BLS) transport service was initiated in the 1920's. A combination taxi/ambulance service was developed and served the citizens of Tacoma for many years. During the 40's, 50's and 60's other BLS ambulance services developed and expanded into servicing larger portions of Pierce County.

The advent of pre-hospital medical care techniques developed in the Vietnam War and the resultant pool of former military medics led to the development of Advance Life Support (ALS) care for Pierce County. The first group of ALS technicians (paramedics) worked in a program developed by St. Joseph Hospital in the 1970's. These paramedics relied on their military experience supplemented by training provided by St. Joseph Hospital to provide comprehensive, sophisticated pre-hospital emergency medical care.

In 1974, the city of Tacoma initiated paramedic training for firefighters and civilian ambulance personnel. The training was conducted by Tacoma Community College and was funded by revenue sharing monies. This was the first formalized presentation in Pierce County of the national paramedic training curriculum developed by the Federal Department of Transportation.

### EMS AGENCIES — COMMITTEES — INDIVIDUALS

Several agencies, committees and individuals have a direct impact in the development of EMS within Pierce County. They include:

**THE PIERCE COUNTY EMS COUNCIL** — A non-profit volunteer organization whose membership is comprised of Pierce County EMS provider agencies (ambulance companies, fire services, hospitals, physicians, etc.). Organized in the mid 60's and incorporated in the mid 70's, the council acts as the main EMS advisory entity in Pierce County.

**MSPC EMERGENCY MEDICAL STANDARDS COMMITTEE** — A standing committee of the Medical Society of Pierce County. Its membership is comprised of the medical directors of hospital emergency departments, medical advisors to county paramedic services and other interested physicians. The committee is responsible for developing medical care protocols and establishing guidelines for emergency medical procedures. The chairman of the committee also serves as the county EMS/ALS medical director.

**COUNTY EMS/ALS MEDICAL DIRECTOR** — The chairman of the EMS Standards Committee serves as the County EMS/ALS medical director. The medical director is responsible for certifying county paramedics and administering EMS protocols, procedures and guidelines.

**EMS MEDICAL CONTROL PROJECT** — In 1981, the Pierce County EMS Council obtained a DSHS grant for a

one year project to develop an ongoing EMS delivery system for Pierce County. The EMS Council subcontracted with the Medical Society of Pierce County to administer the project. Funds for the project expire September 30, 1982.

**WEST REGION EMS COUNCIL** — Grant applications and funding requests to DSHS are channeled through the West Region EMS Council. The West Region EMS Council is comprised of two EMS Council representatives from Pierce, Thurston, Lewis and Grays Harbor Counties.

**DSHS, DIVISION OF EMS** — This is the state agency responsible for promulgating EMS rules/regulations, certifying paramedics and emergency medical technicians, inspecting vehicles, and developing regional EMS programs.

### MEDICAL SOCIETY EMS COMMITTEE

- Drs. D. Terry Kendrick, *Chairman*  
 — *Pierce County ALS Director*  
 — *Medical Control Project Director*  
 — *Medical Advisor, Hill Ambulance*  
 — *Medical Advisor, Peninsula Ambulance*  
 Gregory P. Schroedl  
 — *Director, Emergency Department, St. Joseph Hospital*  
 — *Chairman, EMS Council, Systems Development Committee*  
 William M. Priebe  
 Kenton C. Bodily  
 — *Chairman, Subcommittee On Trauma Regionalization*  
 Matthew S. Newman  
 James Taylor  
 — *Co-chairman, Subcommittee on ALS Protocols*  
 — *Medical Advisor, Powers Ambulance*  
 — *Director, Emergency Department, Good Samaritan Hospital*  
 Bernard I. Fouke  
 — *Medical Advisor, AA Superior Ambulance*  
 — *Director, Emergency Department, Tacoma General Hospital*  
 James G. Billingsley  
 — *Medical Advisor, Tacoma Fire Department*  
 James D. Krueger  
 — *MSPC Representative to EMS Council*  
 Roger Simms  
 Stanley Borish  
 — *Director, Emergency Department, Puget Sound Hospital*  
 Robert G. Scherz  
 — *Chairman, Pierce County EMS Council*  
 William F. Taylor  
 — *Medical Advisor, University Place and Steilacoom Fire Departments*  
 — *Director, Emergency Department, Lakewood General Hospital*  
 Mark Jergens  
 — *Medical Advisor, Shepard Ambulance*  
 — *Co-chairman, Subcommittee on ALS Protocols*  
 James F. Fulcher  
 Ray M. Nicola  
 — *Director, Tacoma-Pierce County Health Department*  
 — *Chairman-elect, Pierce County EMS Council*  
 — *Chairman, EMS Council Medical Control Committee*  
 J. Tim McNair  
 — *Chairman, Subcommittee On Paramedic Evaluation*  
 — *Director, Emergency Department, Allenmore Hospital*  
 Robert J. Stuart  
 — *Past President, Pierce County Ambulance Association*  
 — *MAMC Representative*

# MEDICAL CONTROL PROJECT ACTIVITIES PROCEED ON MANY FRONTS

The project has initiated a variety of activities. Most are being handled by subcommittees of the Society's EMS Committee. They include:

**PROTOCOLS** — Development and implementation of county-wide written and formalized treatment, triage and transfer protocols.

**TRACER STUDIES** — Systems evaluation tracer studies that will determine the effectiveness of reducing patient death and disability.

**AUDITS** — Audits of current BLS/ALS training programs to determine the appropriateness of quality, quantity and logistics of programs offered; audits of patient care through reviews of ALS services provided.

**EMS PLAN** — Development of a plan for continuation of EMS systems development, with specific emphasis on funding and identification of responsibilities for future programmatic and fiscal management.

**PARAMEDIC FILES** — Maintenance of personal files on all Pierce County paramedics, including continuing education and skill maintenance records, statistical data, test scores and related information.

**COMMUNICATIONS** — The development of a county-wide frequency allocation center to coordinate the use of the U.H.F. medical channels. Possible implementation of a county-wide 911 system.

**STATISTICAL REPORTS** — Maintenance of statistical information through EMS medical information report forms. Since January, 1982 the project has been acting as the "clearing house" between the local and state levels for the report forms.

**PARAMEDIC CERTIFICATION** — Since January, 1982 all Pierce County paramedic certification/recertification examinations are coordinated and conducted by the MSPC EMS Committee.

**TRAUMA REGIONALIZATION** — A task force is now gathering data on the utilization and capabilities of county trauma care services. Designation of trauma centers, receiving and base station hospitals is proceeding.

**INCIDENT REVIEW** — A forum has been established for the investigation of incidents involving Pierce County EMS personnel.

**PUBLIC AWARENESS** — Public information and education is being emphasized. An "EMS Awareness Show" is scheduled for May 21-23 at the Tacoma Mall.

**EMS COUNCIL REORGANIZATION** — Reorganization of the Pierce County EMS Council is underway to make it more responsive and representative of EMS requirements. An audio-visual resource materials bank is being developed through the council.

According to Project Administrator David Vance, a major project goal is development of continued funding so a permanent EMS system can be established. "The EMS system must be financed locally to insure that representation, emphasis and influence is exercised by those who live and work in the area served by the system, not by some state or federal agency."

"EMS providers will benefit from a coordinated EMS system in several ways. At the same time, it must be remembered that the ultimate result of the coordinated system is improved patient care which benefits everyone," concludes Dr. Terry Kendrick, project director.

## ALS SERVICES IN THE NURSING HOME SETTING

Considerable discussion has been generated in recent years by the provision of advanced life support (paramedic) services in the nursing home setting. The issue has been reviewed at length by several Medical Society committees, most recently at the February Senior Citizens Committee meeting at which representatives from the EMS Committee presented the issue from the EMS system viewpoint.

That discussion has been summarized in the following statement which has been approved by both committees and the Society's Board of Trustees:

1. Advanced life support services can be expected from paramedics; that is, every paramedic response will be an ALS response in accordance with their training and established EMS medical protocols.

2. Unless a written or verbal no-code order is given, it may be assumed that resuscitative efforts will be undertaken by paramedics when they arrive at the scene. If

a no-code status has been determined as appropriate it will be written in the patient's chart at the point of determination, and, if a verbal no-code order is given, it will be documented in the patient's chart in an expeditious fashion.

3. Resuscitative efforts by paramedics are undertaken under the direction of a physician at an emergency department. If the patient's (or another private) physician is at the scene he or she may direct the efforts if responsibility for the care of the patient is assumed.

4. Resuscitative efforts, once begun, can only be terminated with agreement of the physicians involved — the patient's attending physician and the emergency department physician in consultation.

As a related matter, the Senior Citizens Committee is addressing the code/no-code establishment policy for nursing homes. Membership comment is invited.

# Correspondence

## DETERMINING WEIGHTS

Following discussion at the February Public Health/School Health Committee meeting, attempts are being made to solve the annual problem of determining appropriate weights for junior high and high school wrestlers in the Tacoma Public Schools. With the excellent cooperation of Tacoma School District Athletic Director Dan Inveen, we have devised a postcard system for certifying weights by physicians. With athletes who have had appropriate physical examinations, we would hope this postcard system will be a simple process and, hopefully, a no charge situation.

Thank you for your cooperation!

Sincerely,

*Terry Torgenrud, M.D., Member,  
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## NOMINATING COMMITTEE PRESENTS 1982 - 1983 SLATE (AND IT'S PICNIC TIME)

The Nominating Committee, Marlene Arthur, Susie Duffy, Dottie Truckey, Nancy Spangler, Stephanie Tuell, and Chairman Marny Weber, presented the following slate of officers to the general membership at the February luncheon meeting:

- President-Elect ..... Gloria Virak
- 1st V-P, Programs ..... Susie Duffy
- 2nd V-P, Membership ..... Sharon Lawson
- 3rd V-P, Historian By-laws ..... Cindy Anderson
- 4th V-P, Arrangements ..... Bev Graham
- Recording Secretary ..... Martia Ohme
- Corresponding Secretary ..... Joan Sullivan
- Treasurer ..... Dottie Truckey
- Dues Treasurer ..... Mary Whyte Lenard

The slate will be presented to the general membership for voting, with nominations to be accepted from the floor, at the March general meeting.

### A FAMILY AFFAIR

Sandy Griffith, picnic chairman, announces that plans are underway for the event to be held Saturday, April 11, 12:00 noon - 4 p.m. at Titlow Lodge and Park (near the

Narrows Bridge). Members are to bring their families and their own picnic food. Grills will be available for barbecuing. The Auxiliary will provide soft drinks, and coffee. There will be games for everyone and a run for the runners. So mark your calendars and remember if it does rain — the lodge will provide ample protection from the elements.

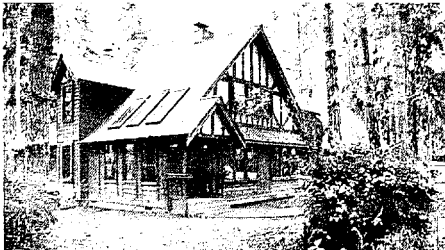
### HEALTH FAIR A SUCCESS!

A great big "thank you" to Margaret Grandquist, who organized, recruited, and planned our booth at the February 19, 20, and 21 Health Fair. Margaret wishes to thank all who helped make the project a huge success; Jo Roller, Jane Gallucci, Barbara Wong, Mary Lou Jones, Marilyn Bodily, Marny Weber, Marlene Arthur, Deva Vaught, Juna Singh, Nikki Crowley, Alberta Burrows, Cindy Anderson, Debby McAlexander, Dottie Truckey, Peggy Kornberg, Sharon Lawson, Susan Wulfestieg, Cathy Schneider, Dianna Ames, Marge Ritchie, Mary Rinker, Mary Schaeferle, and Emma Lou Lyle.

We were able to provide the public with much information about Tel-Med, The Womens' Support Shelter,

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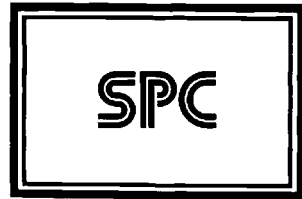
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Shape Up for Life, the Speakers Bureau and much more. A special "thanks" to Miss Idee who sat all three days in her car seat to let people know of the need for child car restraints and also for identification tags to be worn when we are out alone.

#### FEBRUARY GENERAL MEETING

The February luncheon meeting was held at the home of Dr. and Mrs. Robert McAlexander. This was a rather special event as we were treated with an opportunity to taste wines with our luncheon. Bob James, owner of Vinicole Wines (a distributor) who is fortunate to have been able to make his avocation (wines) his vocation, gave us an informative treat on medium priced California and Washington wines.

Those of us who know about nothing related to wines began to gain some knowledge of what makes a good wine. We learned about taste, sugar, acid and their relationship, and tannin. We now know what medium dry and dry means. Best of all, we now have a shopping list of wines, from those we tasted, to help us select our wines. Thank you Bob James!

Committee chairmen gave reports on their activities. The Finance Committee is diligently working on the recommendation they will present to the membership at the March meeting on the distribution of funds to agencies' health projects.

We had 213 paid members and more checks came in that day. The Nominating Committee presented the 1982-1983 slate of officers, which was approved by the Board prior to the meeting. "Thank you" to the committee which provided the luncheon — Elsie Schwin, Janice McIlroy, Ruth Meier, Alice Yeh, and Ruby Ward — and to Sally Larson and Shirley Kemman who poured the wine. "Thank you" to Debby McAlexander for providing her home.

#### STATE CONVENTION

The WSMAA State Convention will be held in Olympia April 27-29. Our Auxiliary is entitled to nine delegates. If you are interested in representing Pierce County as a delegate please contact Nikki Crowley.

#### SUNSHINE

The Medical Society has asked the Auxiliary to assume the responsibility of providing "sunshine" services to their members as well as ours. The Auxiliary will form a small committee to handle this additional responsibility.

#### ORGAN DONOR WEEK

Organ Donor Week will be state-wide the last week in April. The Auxiliary will be responsible for contacting the media to conduct the publicity.

#### STUDENT RECOGNITION

Applications, available in all high school counselors' offices, for Medical Society members' graduating seniors will close on March 27. If you have a graduating senior and wish to have him or her participate, do so now. If you have questions contact Phyllis Pierce.

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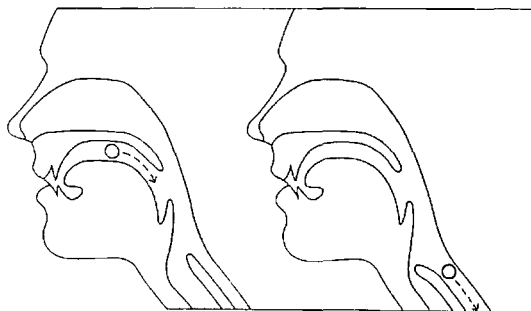
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| Symptom & Time of Administration* | Improved Bayer Aspirin | Placebo | Coated Placebo |
|-----------------------------------|------------------------|---------|----------------|
| <u>Burning in Throat</u>          |                        |         |                |
| 5 min.                            | 6%                     | 5%      | 5%             |
| 20 min.                           | 8%                     | 7%      | 8%             |
| 50 min.                           | 6%                     | 5%      | 5%             |
| <u>Stomach Upset</u>              |                        |         |                |
| 5 min.                            | 2%                     | 4%      | 2%             |
| 20 min.                           | 6%                     | 8%      | 5%             |
| 50 min.                           | 8%                     | 7%      | 5%             |
| <u>Nausea</u>                     |                        |         |                |
| 5 min.                            | 0%                     | 1%      | 0%             |
| 20 min.                           | 2%                     | 3%      | 2%             |
| 50 min.                           | 3%                     | 2%      | 2%             |

\* Following each of the three doses of test formulations, subjective side effects were recorded at 5, 20 and 50 minutes.

### Better patient compliance

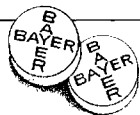
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References:  
 1. Soller, R. W. and Baretz, D.B.: Methylcellulose Film Coating of Tablets as an Improved Delivery System for Aspirin (to be published).  
 2. Soller, R. W.: Bioavailability of Improved Bayer Aspirin (on file, The Bayer Company).

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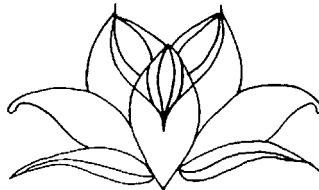
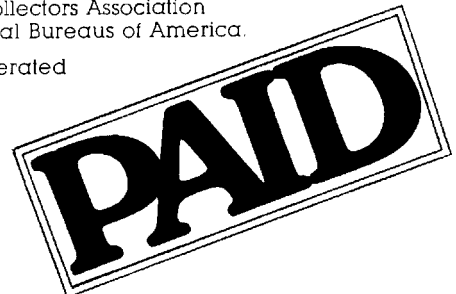
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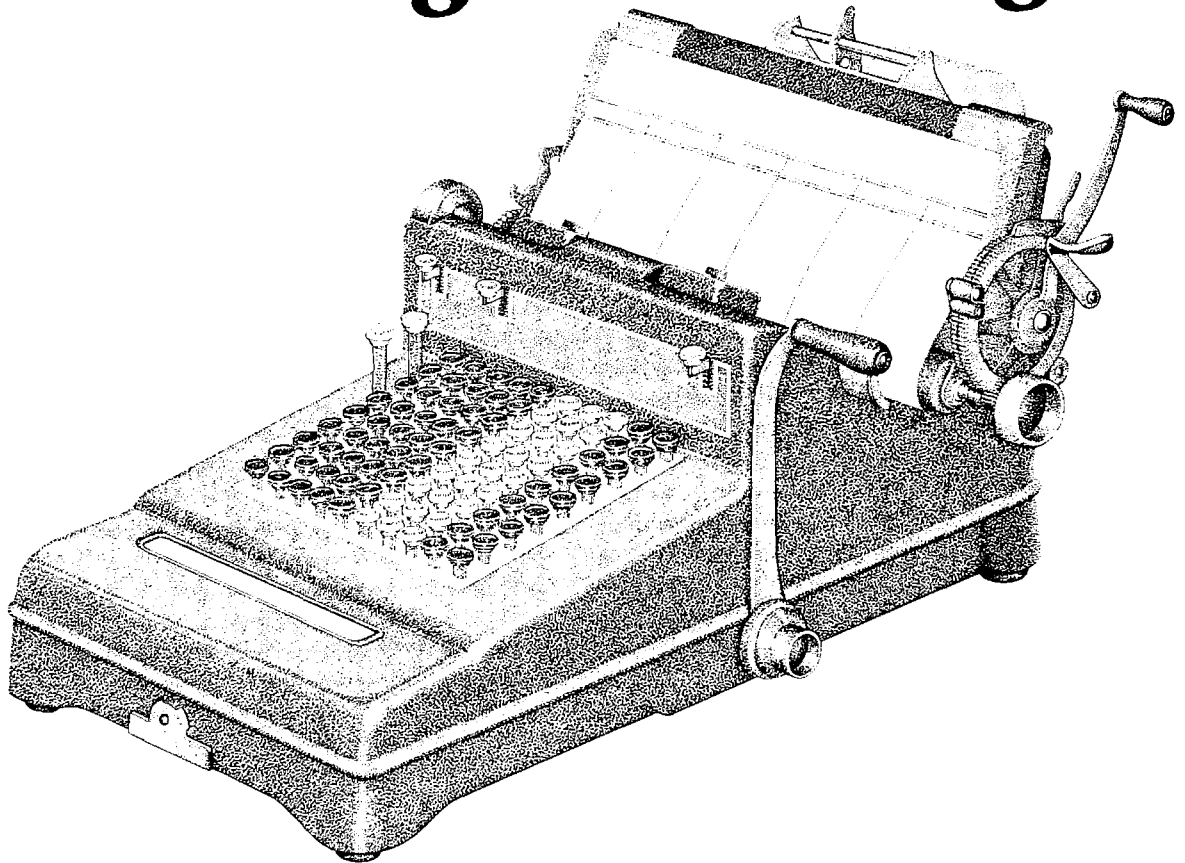
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# Medical Society of Pierce County

APRIL 1982, Vol. LIV, No. 4, Tacoma, Washington



"SPECIALISTS STEAL PATIENTS."  
"PRIMARY CARE PHYSICIANS  
PROVIDE INADEQUATE CARE" ...  
MAY 11 GENERAL MEMBERSHIP  
MEETING ... See Page 4.

## BULLETIN

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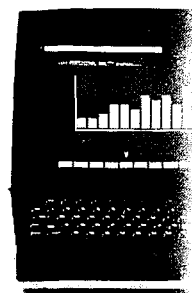
It consists of a computer terminal with telephone connection, giving you a "window" for entering data and making inquiries. Optional equipment, including a printer and a word processor with graphics, is available to augment the basic system. Software for the On-Line System has been exhaustively researched, and was approved only after thorough user-testing. The final product reflects Poorman-Douglas's long history in automated medical accounting, and incorporates refinements suggested by medical professionals.

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## COVER PHOTO

Mount Rainier from Gig Harbor

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# Society News Briefs

A summary of Medical Society, and local medical and health news

## PATIENT — PRIMARY CARE PHYSICIAN — SPECIALIST RELATIONSHIP TO BE EXPLORED AT MAY MEETING

A special panel of Drs. Ken Graham, John Nagle, John Kennedy, Bob Lane, Stu Farber, and Bruce Buchanan will review aspects of the patient — primary care physician — specialist relationship. Dr. Gil Roller will moderate.

The meeting will be held at the Fircrest Golf and Country Club on Tuesday, May 11. Mark your calendar now. See page 4 for details.

## PHYSICIANS ELECTED TO MEMBERSHIP

Six provisional members were elected to membership in the Medical Society of Pierce County at the April Board of Trustees meeting. The new MSPC members are: Drs. Matthew S. Newman, Douglas P. Jeffrey, John R. Huddleston, Don R. Russell, Thomas G. Griffith, and Rob R. Roth.

## UHI COMMITTEE CHAIRMANSHIP CHANGES

The Board of Trustees has accepted with regret the resignation of Dr. John Kanada, Due to numerous other obligations, as chairman of the UHI Quality Assurance Committee. The committee was established in 1981 to work with the UHI program administered through the health department's four community clinics in establishing and maintaining medical care consistent with that available in the private health care system in Pierce County.

The Board of Trustees has approved the appointment of Dr. Richard Robinson as new committee chairman. Other committee members are Drs. Ovidio Penalver, Kenneth Graham, George Race, Robert Lane, Johann Duenhoelter, Henry Retailliau, Howard Boyd, and Clinic Medical Director Dr. Tom Heller.

## MEMBERSHIP BENEFITS BOARD REVISED

The Board of Directors of the Medical Society's benefit subsidiary, MBI, has been increased in size in 1982. The new board consists of Drs: Doug Robson, Peter Marsh, Eileen Toth, Gregory Popich, Rod Schmidt, Dennis Waldron, Myra Vozenilek, and Dale Hirz.

Dr. Hirz is president of the corporation in 1982. Dr. Vozenilek serves as secretary-treasurer and Dr. Toth has agreed to serve as vice president for the year. The Board held its organizational meeting in March.

## CONGRESSIONAL ADVISORY GROUP MEETS WITH CONGRESSMAN DICKS

The Medical Society's Congressional Advisory Committee met in March with Congressman Norm Dicks. Issues discussed included the new federalism and its impact on Medicaid and Medicare, hospital cost shifting, the status of Pierce County's community clinics, the health

*(Continued on page 16)*

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# Medical Society of Pierce County

## GENERAL MEMBERSHIP MEETING NOTICE

—THE PROGRAM—

### The Patient — Primary Care Physician — Specialist Relationship

**CONSIDER:** "Specialists steal patients"

"Primary care physicians provide inadequate care"

"Specialists do not keep primary care physicians informed"

"Primary care physicians 'use' specialists on nights and weekends"

*What are the ethical implications of the relationship between patients, primary care physicians and specialists? A panel discussion will explore these and related issues.*

**PANELISTS:** Drs. Ken Graham, John Kennedy, Robert Lane, Bruce Buchanan, Stu Farber, Jack Nagle.

**MODERATOR:** Dr. Gil Roller

**DATE:** Tuesday, May 11, 1982

**TIME:** 6:15 P.M. - Social Hour  
7:00 P.M. - Dinner  
8:00 P.M. - Program

**PLACE:** Fircrest Golf Club  
6520 Regents Blvd., Fircrest  
(Take Fircrest exit off of Hiway 16. Proceed on Regents Blvd. to the club which will be on your left.)

**COST:** Dinner, \$10.50 per person.  
Salad bar, chicken and baron of beef buffet.  
(price includes tax & gratuity)

Register now. Mail with a check for the appropriate amount, to the Medical Society office. Or, call the office, **572-3667**, to confirm your attendance. Make check payable to Medical Society of Pierce County.

#### REGISTRATION:

Yes, I have set aside the evening of May 11 to meet with my colleagues.

\_\_\_\_ Please reserve \_\_\_\_\_ dinner(s) for me at \$10.50 each (price includes tax & gratuity).  
Enclosed is my check for \$ \_\_\_\_\_

\_\_\_\_ I regret I am unable to attend the dinner portion of the meeting. I will attend the program only at 8:00 P.M.

DR: \_\_\_\_\_ Telephone No. \_\_\_\_\_

RETURN TO THE MEDICAL SOCIETY BY NO LATER THAN ~~FRIDAY, MAY 7.~~

## TASK FORCE REPORT AIMS TO ASSIST COMMUNITY HEALTH NEEDS



Lloyd C. Elmer, M.D.

*"Action springs not from thought but from a readiness for responsibility." — Dietrich Bonhoeffer.*

Members of the Medical Society of Pierce County can always take pride in that their organization is often in the lead in terms of important and fresh new ideas and programs relating to medical care in the community. If Washington State is a bellweather state for the nation, then the Medical Society of Pierce County must be a bellweather organization for the WSMA. This has been demonstrated once again with the development of the Health Needs Task Force which was approved in mid-1982 by the Medical Society's Board of Trustees.

The concept was to place the Medical Society in a pivotal role in the establishment of an organization that would review the health needs of the community, study existing health services available within the county, and foster and encourage methods of cooperation among health agencies and within the Medical Society. Furthermore, the Task Force would issue a report including appropriate recommendations to participating agencies and the Medical Society.

Physician input was obtained by questionnaire at the October, 1981 general membership meeting. Subsequently, a similar survey was sent to local health agencies. The Task Force members met individually with 22 agency representatives to discuss agency needs, community health needs, and the impact of the economy and government policies on funding.

There was general agreement by physicians and the agencies that the greatest health needs in Pierce County are: 1) access to general medical care — including care for the indigent, senior citizens and preventive services for all; 2) mental health services; 3) services for the handicapped; and, 4) services for those with chronic disorders. It was felt that underlying these specific needs was the *absolute necessity* for continued and greater emphasis on health education.

The specific recommendations to help agencies weather cutbacks in funding, survive the current econ-

omic conditions, and still provide community health needs were reviewed and approved at the April Board of Trustees meeting. The recommendations are as follows:

1) Establishment of a Medical Society sponsored Pierce County health agencies group to meet on a regular basis and to be convened through the Public Health/School Health Committee. The group would, among other things, facilitate communications between and cooperation among agencies where possible and appropriate;

2) Formalize an on-going Medical Society liaison with health agencies on an organization-to-organization basis;

3) Promotion of formal Medical Society physician advisor relationships with the agencies;

4) Expansion of the Medical Society's referral service to address the special needs of agencies' clients;

5) Make available to agencies, within the limits of its resources, Medical Society of Pierce County communications vehicles — such as the *Bulletin* — for the purpose of informing physicians of the goals and needs of the various agencies;

6) Increase the Medical Society's involvement in health education activities — to the extent practical given its resources.

Organized medicine has been the target for well deserved criticism in the past because it too often found itself *reacting* to issues and events rather than helping to shape them. By adopting a proactive role such as in the Health Needs Task Force, and with proper leadership, medicine can accomplish its ethical goals. It can direct the currents and cross currents of the profession and at the same time be the premier patient advocate. Survival of our profession as a highly ethical one rests not with our own introspective analysis of our worth but rather with the public's perception of our motives, deeds and overall value.

The Pierce County Health Needs Task Force may very well become a model to be emulated by other counties and states. It is a project of which we can all be proud.

LCE

## Measles Update

# PHYSICIANS' CONTINUED SUPPORT OF REPORTING AND CONTROL ESSENTIAL TO ERADICATION OF INDIGENOUS MEASLES

Measles is a highly infectious disease. Clinically, it presents with a fever of 101 degrees, or greater, a cough, coryza and conjunctivitis preceding the rash, which persists three or more days. Measles is usually a mild disease, but it can be severe. Complications include otitis media, pneumonia, encephalitis, (1 per 1,000 reported cases) and subacute sclerosing panencephalitis. The mortality rate is 1 per 1,000 reported cases with greater incidence in infants and adults than in children and adolescents.

Out breaks have been predictable, occurring at two to three-year intervals. Between 1950 and 1959, the annual average numbers of reported cases were 500,000 and 495 deaths in the United States. These figures changed dramatically after the licensure of live measles vaccine in 1963. In the first 48 weeks of 1981 a total of 2,961 cases were reported in the United States. This represents a 78% decrease from the 13,255 cases reported for the same period in 1980.

As the number of measles cases continues to decrease, the goal of eliminating indigenous measles by October 1, 1982 becomes an achievable reality. Our present status is the result of mobilizing the national resources of health care professionals and all levels of government. This effort must continue uninterrupted if the goal is to be reached. We must be cautioned against complacency generated by the reports of a "measles free" 1981.

In 1979, Pierce County physicians reported 360 cases of measles. The state reported a total of 1,170 cases, the *highest* incidence of measles among school age children in the nation. During one period in that outbreak, Pierce County reported a number greater than the total for the rest of the nation. This, no doubt, accounts for the outstanding support for measles control by Pierce County physicians.

Besides physician reporting, other factors of importance in measles control in Pierce County include:

1. Ninety-four Pierce County physicians participate in a program with the health department to provide vaccine to patients for a minimum administration fee.

Doses distributed:

|           |              |
|-----------|--------------|
| 1977..... | 22,809 doses |
| 1978..... | 42,886 doses |
| 1979..... | 72,851 doses |

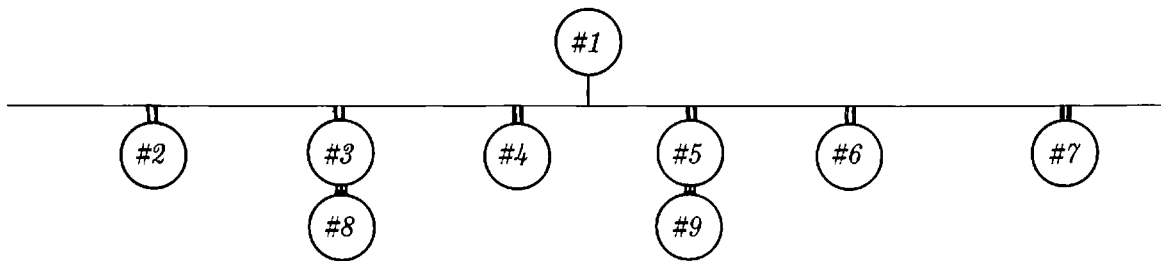
|           |              |
|-----------|--------------|
| 1980..... | 64,709 doses |
| 1981..... | 61,365 doses |

2. The passing of Washington State's mandatory immunization law in 1979.
3. Pierce County hospital and physician support for the "in-hospital" immunization education of mothers of newborns through the distribution of "ABC Baby Packs."
4. Immunization assessment in day care and cooperative nursery schools by public health nursing staff.
5. Immunizations given in 20 health department Well Child Clinics located throughout Pierce County.
6. Immediate follow-up of all reports of rash illness meeting the basic measles criteria. This includes: Search for susceptible contacts and immunization within 72 hours of exposure, ISG for household contacts under 12 months, exclusion of susceptibles from the school setting and obtaining acute and convalescent titers on all suspected cases, *all of which is dependent upon prompt physician reporting.*

Though measles free in 1981, in 1982 Pierce County has confirmed two cases of measles and has two more in the confirmation process. Interestingly, Washington State has now documented eight measles cases associated with a Southern California serviceman who departed from Sea-Tac last December 23; six of the cases reported being at the terminal on the same evening. Washington State Immunization Program personnel were notified by California authorities that the serviceman was a diagnosed case. (See chart below).

Note — Five of the cases had been vaccinated, one before the age of 12 months. In another case there was a question about proper vaccine handling and storage. We also know that 5% of the vaccinees will not seroconvert in response to the vaccine and suspicious cases should not be ruled out on the basis of a satisfactory history of vaccination.

*Evelyn Peterson, R.N.,*  
Health Department



|    | County/Location | Ex. Source          | Age | Onset Date<br>Rash | Measles<br>Titer<br>Rise | MX<br>MD | Vaccine<br>History |
|----|-----------------|---------------------|-----|--------------------|--------------------------|----------|--------------------|
| #1 | California      | 2 Yr. old<br>Mexico | 27  | 12/23/81           | ?                        |          | ?                  |
| #2 | Kitsap          | BOQ<br>Bangor, WA   | 30  | 1/1/82             | +                        |          | ?                  |
| #3 | Pierce          | Sea-Tac             | 12  | 1/5/82             | +                        | X        | <12 Months         |
| #4 | Snohomish       | Sea-Tac             | 37  | 1/6/82             | +                        |          | ?                  |
| #5 | Snohomish       | Sea-Tac             | 9   | 1/6/82             | +                        | X        | Yes                |
| #6 | King            | Sea-Tac             | 30  | 1/11/82            | ?                        |          | ?                  |
| #7 | Pierce          | Case #3             | 11  | 1/19/82            | +                        | X        | Yes                |
| #8 | Snohomish       | Case #5             | 7   | 1/26/82            | ?                        | X        | Yes                |
| #9 | Sea-Tac         | Sea-Tac             | 13  | 1/6/82             | +                        |          | Yes                |



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## COMPREHENSIVE TRAUMA PLAN NEEDED IN PIERCE COUNTY



K. Bodily, M.D.

Trauma remains a major health and social problem in the United States. In 1980 alone, it accounted for over 164,000 deaths. However, it was not until 1966 when the National Academy of Science (NAS) published its now classic "White Paper", *Accidental Death and Disability — Neglected Disease of Modern Society*, that attention was focused on this problem. The NAS paper outlined the basic building blocks and a blueprint for the improvement of trauma care. These are still being implemented today.

As an outgrowth of this paper, "The Emergency Medical Services System Act of 1973" PL 93-154 was passed by Congress and subsequently amended in 1976. As its title implies, PL 93-154 was intended to provide assistance and encouragement for the development of comprehensive, area-wide EMS systems. In 1979, funding at the national level was not renewed and states were required to pick up the cost of systems development, a stage we are at today. In Washington State Substitute Senate Bill 2305, later amended to RCW 18.73, provides funding for continuation of EMS systems development.

Inherent in EMS system development is improved care for trauma patients. As succinctly put by Dr. Donald D. Trunkey, professor of surgery, University of California, San Francisco, "The goal of the trauma system is to get the right patient to the right hospital at the right time." The advent of advanced life support (ALS) vans and advanced life support providers, field to hospital communications and field protocols have done much to achieve or improve the time factor. The patient and hospital factors, however, have for the most part remained elusive. Two states, Illinois and Maryland, are notable exceptions and their statewide systems are considered models.

Their systems are built around two types of categorization. The first — *Patient or Field Categorization* — is placement of trauma patients at the scene of injury into one of three categories depending on the severity of the injuries. The second — *Hospital Categorization* — is assessment of capabilities of hospitals to care for the trauma patient and the designation of trauma centers according to these capabilities.

### THE IMPACT ON PATIENT CARE

Before pursuing further categorization of hospital trauma facilities, it is important to recognize the impact trauma centers have on the quality of patient care. For instance, Illinois has documented a 15.4% decrease in deaths from highway accidents when compared to its pre-trauma plan implementation. Trunkey more recently evaluated 100 consecutive trauma deaths in two California counties, one with and one without hospital categorization and trauma center designation. In the deaths from the county without trauma categorization, one-third of the non-neurologic deaths were considered clearly preventable; that is, patients received acceptable prehospital care and subsequently died in the hospital

without receiving definitive treatment for ruptured spleens, livers, bowel perforations, etc. An additional 11 deaths were felt to be essentially preventable. In the county with trauma center designation, there were no clearly preventable deaths and only one potentially preventable death. Other studies have shown similar findings. Clearly, trauma center designation does make a difference.

The American College of Surgeons has published guidelines for the optimal care of trauma patients. Appendices concerning specific types of trauma have also been developed. In essence, these guidelines stress the capabilities and, more importantly, the commitment of facilities to the performance of specialized trauma care. Facilities meeting the criteria may then be categorized into three levels depending on their commitment, personnel and physical resources.

Differences in the requirements for Level I and Level II facilities are minimal. The major difference is the professional and paraprofessional training programs in trauma care and an active trauma research program in Level I facilities. This requirement technically limits this designation to hospitals in a university system. It is recommended that the Level I facility treat approximately 1,000 critically injured patients per year to maintain proficiency. Level II facilities have similar requirements including the need for 24 hour in-house surgery and anesthesia coverage. The later requirement may be waived if there is a commitment for these personnel to be physically available at the time the patient enters the emergency department. Level II facilities are expected to treat between 350 and 450 critically injured patients annually. Level III facilities might be expected to encompass the remainder of facilities treating trauma patients. However, such is not the case as certain minimum requirements must be met including an active surgical specialty call roster and a commitment of those individuals to provide quality and timely trauma care.

### THE IMPACT ON FACILITIES

Concern is often expressed during the development of local categorization and regionalization plans that lesser level facilities will be adversely affected to the benefit of higher level facilities as a result of diversion of patients. In practice *this concern has not been borne out*. Most trauma patients are not critically injured and do not need sophisticated care from Level I or II facilities. In fact, it is estimated that no more than 5-10% of trauma patients require categorization and these are the multi-system injured hemodynamically unstable patients.

A study of trauma patterns in Pierce County has indicated that on the average approximately one patient per day currently fits this injury pattern. It has also been stated that Level III trauma centers are capable of stabilizing the patient, diagnosing the majority of injuries and treating almost all locomotor injuries and the majority of

visceral injuries. Clearly, little impact will be felt in terms of the volume of patients seen in any facility, and outcomes (as noted previously) of the critically injured patient should be significantly enhanced as a result of a comprehensive trauma plan.

**CURRENT STATUS IN PIERCE COUNTY**

What then is the status of trauma categorization, regionalization and trauma center designation in Pierce County? In short, at present there is none. There is no field categorization to identify the right patient. There is no hospital categorization, regionalization or trauma center designation to identify the right hospital for that patient. The right time is generally "as quickly as possible" and is the only one of the three "R's" in which improvement has been made. The ALS vans and ALS providers in this county have made a major impact on the pre-hospital care of trauma patients, yet it provides little benefit if that patient is delivered to a facility not optimally prepared for trauma care.

Pierce County needs categorization and regionalization of trauma care. Steps toward categorization and regionalization are being taken by the Medical Society of Pierce County EMS Committee. Ultimate approval of the criteria to be used in the hospital categorization process, in addition to the designation of trauma centers in Pierce County, will be made through the Medical Society. Support of health care providers and individual Society members will be required for such a program to be effective. Consider yourself as a critically injured patient — what would you want?

*Kenton C. Bodily, M.D.*  
 Member, MSPC EMS Committee  
 Chairman, Subcommittee on  
 Trauma Regionalization

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|                    |   |   |
|--------------------|---|---|
| 10:45              | Welcome — Opening Remarks                           | Chris C. Reynolds, M.D.<br>Puget Sound Hospital |
| 11:00              | <b>DIAGNOSIS IN SELF DEFENSE</b>                    | Marc A. Schuckit, M.D.                          |
| 12:00              | Lunch — Courtesy of Puget Sound Hospital            |   |
| 1:00               | <b>RECOGNITION: CONFRONTATION &amp; REFERRAL</b>    | Marc A. Schuckit, M.D.                          |
| 3:00               | Break   |   |
| 3:15               | <b>LABORATORY FINDINGS IN THE ALCOHOLIC</b>         | Robert F. Kapelowitz, M.D.                      |
| 3:45<br>to<br>4:15 | <b>RESOLUTION THROUGH LOCAL TREATMENT RESOURCES</b> | Bud Atkins, M.A.<br>Jackie Brolsma, M.N.        |

---

Program Planning Committee: Chris C. Reynolds, M.D., Jackie Brolsma, M.N., Bud Atkins, M.A.

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Please address all registrations, inquiries and correspondence to:  
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## A RADIOLOGIST'S POINT OF VIEW

Marc J. Homer, M.D.

After the clinician indicates the examination he wants on the x-ray requisition, there are four choices he has regarding what to do about the section of the form reserved for clinical information. This space will either (1) remain blank, (2) contain incorrect clinical information, (3) contain correct clinical information totally irrelevant to the examination being requested, or (4) contain information that is appropriate to the examination ordered.

Having spent the last eight years as a radiologist in three different medical centers, seven community hospitals, and four private offices, it is apparent to me that the options chosen do not relate to the setting of either academia or private practice. It is a function of the individual rather than a function of the institution. Some physicians view the x-ray requisition as an order to the radiologist to perform a particular imaging procedure, and the radiologist's role is to perform the examination merely because the clinician orders it. Justification for the examination is extraneous. Other physicians view the x-ray requisition as a consultation form. The examination ordered by the clinician is, in his judgement, the most appropriate to provide the diagnostic information he needs. If the radiologist believes that the examination requested is inappropriate, these clinicians expect the radiologist to consult with them rather than to proceed as ordered.

Two incidents come to mind. One of our recently graduated residents, now in private practice, returned for a visit and related a story that upset him considerably. He had read a chest roentgenogram that showed the heart to be much larger than it was on a previous examination. Since he recognized certain roentgenographic signs that suggested that the enlargement was more likely caused by pericardial fluid than chamber dilation, he ended his descriptive report by recommending that echocardiography would be the simplest way to differentiate between pericardial fluid and chamber enlargement. The next day an irate cardiologist came to the radiology department. While thrusting the typed report into the radiologist's hands, the cardiologist proclaimed that the radiologist's role was to read the chest roentgenogram, not to tell the cardiologist what to order.

The second incident happened to me. A mammogram that was just performed on a woman showed a large 5-cm cancer in one breast. The clinical history said "routine screening." I promptly telephoned the referring clinician

to tell her that her patient had a breast cancer, and added that I was bit surprised that the cancer was not palpable. I said that since the lesion was nonpalpable, a preoperative percutaneous localization should be performed to guide the surgeon to the area. She replied that of course she had felt the mass but she did not want to bias my impression by telling me that it was present.

It is sad that such misguided clinicians exist. It is sad that these two incidents are not unique.

Most diagnostic radiology teaching programs try to train their residents to act as consultants. This is not an optional aspect of performing radiologic studies, but rather is considered to be an integral part of performing them well. The residents are taught that if the radiologist believes that another modality is more advisable, or if the examination is contraindicated for any number of reasons, then it is within the radiologist's right, in fact it is his responsibility, not to proceed with the examination but rather to discuss the particular case with the referring physician.

The recent explosion of diagnostic modalities has been unbelievable. It is the rare clinician who can keep up with all aspects of the new imaging modalities, their indications and their contraindications. This is the responsibility of the radiologist. In fact, so much new technology must be taught that many radiologists believe that the three-year residency program should be expanded to four years.

Someday, someone (not me) will analyze a statistically significant group of patients and write an article concluding that there is an astounding waste of time and money as a direct result of noncommunication between the radiologists and the referring clinician. I wonder how many patients have had their hospital stay lengthened because a gallium scan could not be performed after a barium enema was given. I wonder how many computed tomographic scans and ultrasound examinations had to be delayed because other contrast studies, either not indicated or less indicated, were done first.

Just the other day I read an apical lordotic chest roentgenogram and cervical spine films with both oblique views. These were ordered because a patient had a hard supraclavicular mass. The history on the requisition stated "rule out cervical rib." Had the clinician bothered to speak to a radiologist or to look at a chest roentgenogram taken one day earlier, he would have seen the large left cervical rib projecting into the supraclavicular fossa. Examples such as this are legion.

The x-ray requisition should be viewed as a request for a consultation rather than an order. Radiologists need all the clinical history available in order to reach sound

*(Continued on page 17)*

From the Department of Radiology, Tufts-New England Medical Center, Boston.

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# Membership

In accordance with the Bylaws of the Medical Society of Pierce County, Chapter Seven, Section A, MEMBERSHIP, the following physicians have applied for membership, and notice of their application is herewith presented. As outlined in the Bylaws, any member who has information of a derogatory nature concerning an applicant's moral or ethical conduct, medical qualifications or other such requisites for membership, shall assume the responsibility of conveying that information to the Credentials Committee or Board of Trustees of the society.

## FIRST NOTICE



**Hugh K. Lancaster, M.D., Pathology.** Born in Myrtle Point, Ore., 10/3/43; University of Wisconsin, 1971; internship, Sacred Heart Medical Center, Spokane, WA, 1971-72; residency, Sacred Heart Medical Center, 1974-78 (pathology); Washington State license, 1975. Has applied for medical staff membership at Allenmore and St. Joseph hospitals. Dr. Lancaster is practicing at 1718 South I Street, Tacoma. **Sponsors:** Juan F. Cordova, M.D., and Richard T. Vimont, M.D.



**James V. Taylor, M.D., Emergency Medicine.** Born in Cential Butte, Saskatchewan, Canada, 4/17/29; University of B.C., Canada, 1954; internship, St. Paul's Hospital, 1954-55; residency, Vancouver General Hospital, 1956-59; University of Washington (fellow, cardiology) 1963-64; Washington State license, 1961. Has applied for medical staff membership at Good

Samaritan Hospital. Dr. Taylor is practicing at Good Samaritan Hospital, Puyallup. **Sponsors:** Donald C. Weber, M.D. and Leonard S. Allott, M.D.



**Stephen S. Tobias, M.D., General Practice.** Born in New York, NY, 8/29/46; Baylor College of Medicine, 1974; internship, Maryland General Hospital, Baltimore, 1974-75; Washington State license, 1976. Has applied for medical staff membership at Allenmore, Lakewood General and Tacoma General hospitals. Dr. Tobias is practicing at 7424 Bridgeport Way, Tacoma. **Sponsors:** Gerhart A. Drucker, M.D. and Matthew White, M.D.

## SECOND NOTICE



**Mohammad A. Saeed, M.D., Physical and Rehabilitative Medicine.** Born in India, 10/1/45; Dow Medical College, Karachi, Pakistan, 1970; internship, Deaconess Hospital, Detroit, Michigan, 1973-74; residency, University of Washington Hospitals, Seattle, WA., 1974-77; State of Washington license, 1981. Has applied for medical staff membership at Allenmore, Lakewood General, Puget Sound, St. Joseph, and Tacoma General hospitals. Dr. Saeed is practicing at 1624 South I Street, Suite 305, Tacoma. **Sponsors:** Drs. Surinderjit Singh and Richard Hoffmeister.



**Daniel T. Hayden, M.D., Family Practice.** Born in Great Falls, Montana, 10/2/18; University of Washington, 1959; internship, United States Public Health Service, Seattle, 1959-60; State of Washington license, 1981. Has applied for medical staff membership at Doctors, Good Samaritan, Mary Bridge, St. Joseph and Tacoma General hospitals. Dr. Hayden is practicing at 301 South 320th Street, Federal Way. **Sponsors:** Drs. Ward C. Miles and John Ligon.



**Mark Jergens, M.D., Emergency Medicine.** Born in Dayton, Ohio, 8/25/47; University of Cincinnati College of Medicine, 1973; internship, UCLA, 1973-74; residency, UCLA, 1974-78; State of Washington license, 1981. Has applied for medical staff membership at Allenmore and St. Joseph hospitals. Dr. Jergens is practicing at St. Joseph Hospital, Tacoma. **Sponsors:** Drs. James Fulcher and James Billingsley.



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# Correspondence

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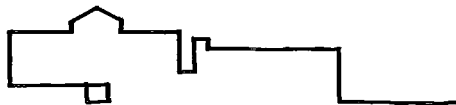
As many of you know, the American Association of Medical Assistants (AAMA) is an educational organization which enables its members to increase their effectiveness to the physicians and patients they serve. Next year our local chapter of AAMA will celebrate its 10th anniversary. For several of those years I have served as one of three physician advisors. Many of you have members of this organization working for you in your offices already and we certainly appreciate your support.

Over the past decade the Pierce County AAMA Chapter has grown in its ability to reach its educational goals, but support and endorsement from the local medical community is the essential part of the success of this organization. Monthly programs, special workshops and seminars can only serve those who attend. It is in this capacity that we, as physicians, can offer assistance.

If we encourage our employees to participate in the activities of AAMA the benefits will be ours. Each of us can readily appreciate the value of a good medical assistant and the medical assistant whose knowledge and skills keep pace with responsibility will gain enormous personal satisfaction, fellowship, and a chance to share and solve common medical office problems.

Professional growth of our medical assistants is an ongoing process which is why membership in AAMA becomes so important. Please encourage your office staff to join this organization and become active in its affairs. We need you on our team.

Sincerely yours,  
*James R. Stilwell, M.D.*



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The Christian Counseling Service accepts clients regardless of race, ethnic origin, economic status, creed or religion (approximately one third of CCS's clients have no church affiliation).

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For "How to Refer" literature and additional information, call the Christian Counseling Service in Tacoma at 272-2279, or have your patients call the same number to arrange an intake interview.

Very truly yours,  
*David C. Cross*  
*Christian Counseling Service*

## INCREASED PHYSICIAN AWARENESS IN REPORTING TRANSFUSION RELATED HEPATITIS NEEDED

The reported incidence of hepatitis related to transfusion of blood products for 1981 in Pierce County is one in five thousand units of donated blood at the Tacoma-Pierce County Blood Bank. The Blood Bank protocol is to remove all donors involved in cases of transfusion associated hepatitis from the donor pool. The greatest problem with purging in the donor pool has been the poor reporting of transfusion associated hepatitis.

All reporting of cases of hepatitis is properly to the county health department. This is usually (I am told, 90 percent) by friends or family members concerned about their own welfare related to contact with the patient. Perhaps there is a need for increased physician awareness in reporting, not only for transfusion related hepatitis but also other so-called reportable diseases.

The Blood Bank would appreciate diligent application of the reporting mechanism in order to deter hepatitis carriers from being donors. In spite of current testing modalities and interrogation of prospective donors, we must expect that hepatitis is still the largest epidemiological problem in transfusion practice.

Respectfully submitted,  
*M. J. Wicks, M.D.*  
*Medical Director*

## WSMAA CONVENTION, 1982-1983 OFFICERS ELECTED, AND IT'S FINALLY SPRING!

### STATE CONVENTION

The WSMAA State Convention is to be held in Olympia April 27-29. If you are planning to attend please let Nikki Crowley know. Rides can be shared and additional delegates or alternate delegates may be needed. Speakers at the convention will include, Ralph Palmen, author of *Professionals At Their Best*, who will talk about increasing "Your People Power." Nancy Evans, wife of former Governor Dan Evans, will "Look at Yesterday," and Lynn Spormans will talk about "The Outer You." Our own Jo Roller will speak on leadership.

### COMBINED BOARD MEETING

New (1982-1983) and past (1981-1982) board members will meet on Tuesday, May 11, at 10:30 a.m. at the Tacoma Golf and Country Club. A no-host luncheon will follow the meeting. All 1981-82 board members are reminded that their annual reports are due on that day (three copies, please). If you are unable to attend please mail your report to Nikki Crowley by May 11.

### MAY LUNCHEON MEETING — "VOGUES AND VITTLES"

The May luncheon meeting, Friday, May 21, 11:30 a.m., will be held at the Tacoma Golf and Country Club. The special program, "Vogues and Vittles", will feature historical fashions of Washington State, presented by the State Capital Museum of Olympia. Guests are welcome.

### MARCH GENERAL LUNCHEON MEETING

The March 19th luncheon meeting was held at the home of Dr. and Mrs. Charles Vaught (Deva) in Puyallup. The luncheon committee — Joanne Iverson (chairman), Mary Rinker, Cheri Romig, Barry Mott and Alberta Burrows — get a big "thank you" for an excellent feast... high in calories, but good. Committee members gave reports on the various activities as our year begins to come to an end.

The Finance Committee made the following recommendations for charitable contributions: Greater Lakes Mental Health Geriatric Center, \$300 for permanent equipment for day care; Rape Relief, \$500 for brochure printing; Womens Support Shelter, \$500 for the purchase of a large appliance, such as a refrigerator or stove; Mary Bridge Hospital, \$600 for the purchase of sleeping futons for mothers of hospitalized children; and Good Samaritan Hospital Rehab Center, \$360 for recreational therapy materials.

The Auxiliary will purchase for educational purposes a video recorder to be used to show such programs as Handicapped Awareness, and other tapes available from the state and national auxiliaries. The report of the

Finance Committee, presented by Chairman Juley Hoffmeister, was accepted by the general membership.

The program, Financial Planning for the Eighties, was presented by our guest speaker Diane V. Schaak, financial planner and owner of Comprehensive Financial Planning of Bellevue. She sparked a lot of interest and questions about financial planning — so much that several of the members expressed interest in a workshop on the subject. (see below). Members brought a dessert to the meeting to be purchased by the members and to assist with the funding of the Student Recognition Program.

### FINANCIAL PLANNING WORKSHOP FOR MEMBERS AND GUESTS

Diane V. Schaak, financial planner, will present a one day workshop for Auxiliary members and guests on Friday, April 30, 9:00 a.m.-3:00 p.m. at St. Joseph Hospital. Call Debby McAlexander for information and a reservation. The cost is \$40.00. Reservations will only be made at the time you have paid, no money will be accepted at the time of the workshop. Reservations are limited to 50 persons.

This is the time of year that we pay our taxes and are in a state of shock (or are just recovering from the shock) and wish we knew what to do to reduce the amount of taxes paid without reducing our income — financial planning could answer that problem. Diane's workshop will be intense, covering a lot of material. The content will include: Paying yourself first; developing personal credit; know when to borrow; creating alternate savings plans; planning and overall budgeting; life insurance, term vs. whole life; medical, dental, disability, homeowners and auto insurance; investing, savings bonds, mutual funds, real estate, tax shelters and commodities; estate planning, wills, trust funds, effects of joint ownership, and gifts to minors. There will be time for questions and answers.

### SLATE PRESENTED TO THE MEMBERS

The following slate was presented by Marny Weber, chairman of the Nominating Committee. The slate was elected by the members at the March general meeting:

#### 1982-1983 OFFICERS

|                              |                   |
|------------------------------|-------------------|
| President-Elect              | Gloria Virak      |
| 1st V.P., Programs           | Susie Duffy       |
| 2nd V.P., Membership         | Sharon Lawson     |
| 3rd V.P., Historian, By-laws | Cindy Anderson    |
| 4th V.P., Arrangements       | Bev Graham        |
| Recording Secretary          | Martia Ohme       |
| Corresponding Secretary      | Joan Sullivan     |
| Treasurer                    | Dottie Truckey    |
| Dues Treasurer               | Mary Whyte Lenard |

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## SOCIETY NEWS BRIEFS Continued

status of Asian refugees and federal funding for refugee services, and the cost of care.

Congressman Dicks stressed his support for continued funding of the community clinics (Eastside, Family, Summer, and Lakewood). Subsequent to the meeting, a legislative assistant from the congressman's office met with MSPC Executive Director Tom Curry and UHI Project Administrator Florence Reeves to review specific clinic funding issues.

## PARKINSON SUPPORT GROUP TO HOLD WORKSHOP

The Parkinson Support Group of Tacoma will hold a workshop on Saturday, May 15, 1982 from 10:00 a.m. to 3:00 p.m. at the Parkland United Methodist Church, 12183 "A" Street.

The purpose of the workshop is to bring to the general public and to friends and relatives of Parkinson patients information and support in dealing with this disorder. Information will be given by Parkinson patients and by several local physicians active in the treatment of Parkinsonism.

Topics for the Workshop include:

1. *Exercise* — What kind and how much?
2. *Speech* — Communication, a frustration.
3. *Diet and medication* — What and when?
4. *Support* — for the patient and others involved.

A \$1.00 donation is requested, and a light lunch is planned at noon. Physicians, patients, relatives and the general public are invited. For more information, call Bill Detering at 537-5312.

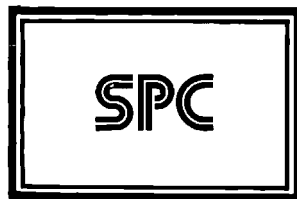
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**RADIOLOGISTS' POINT OF VIEW Continued**

interpretations of roentgenographic findings that may be non-specific or subtle. Interpretation of a roentgenogram without knowledge of the appropriate clinical information can be likened to evaluation of a patient's symptoms without knowledge of the physical findings.

In both instances, the physician's skills are not being used optimally. New imaging modalities, as well as the rapidly expanding field of interventional procedures, have transformed radiology into a specialty different than it was a decade ago. Close communication between the clinician and radiologist is even more necessary today to ensure optimal patient care.

*Article reprinted courtesy of Marc J. Homer, MD, and the Journal of the American Medical Association, 12/4/81, vol. 246, no. 22.*

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*(More on page 18)*

# 3

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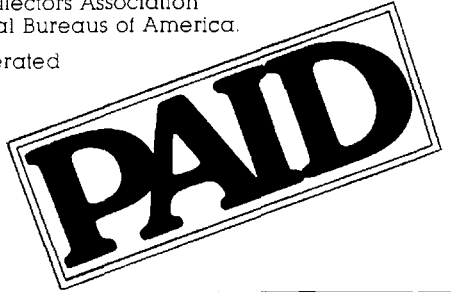
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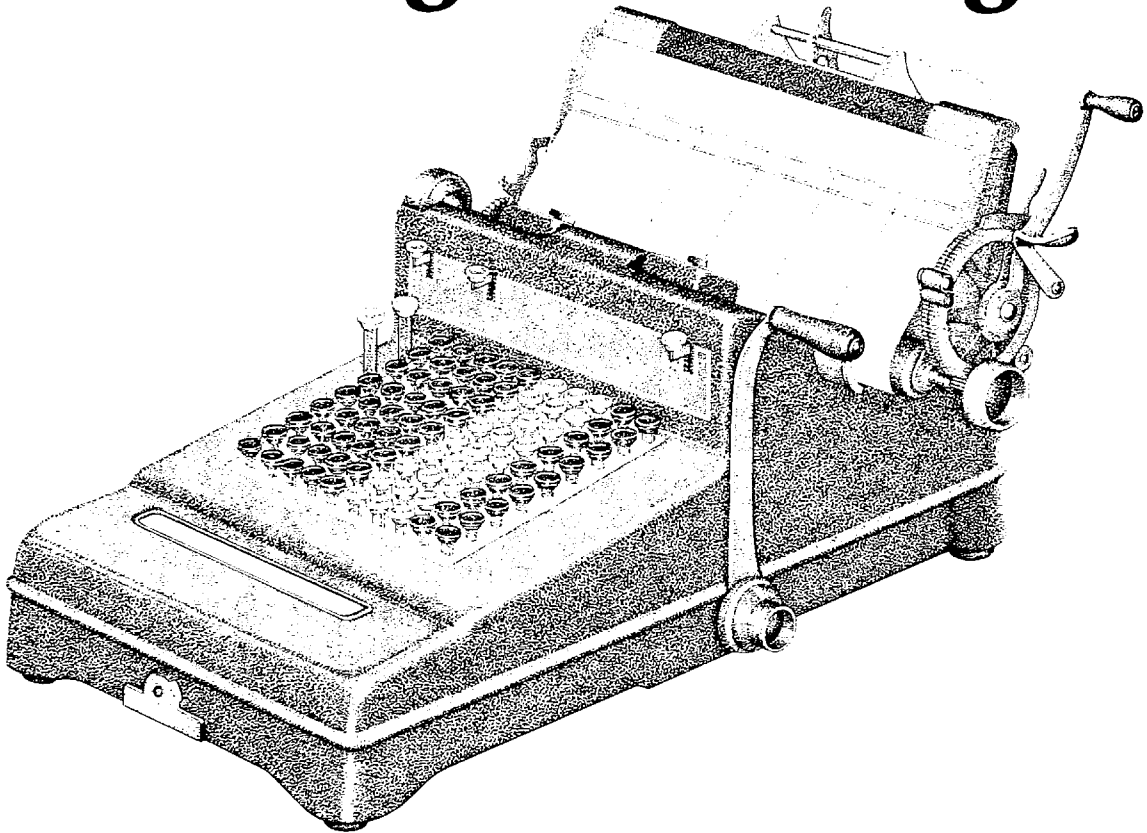
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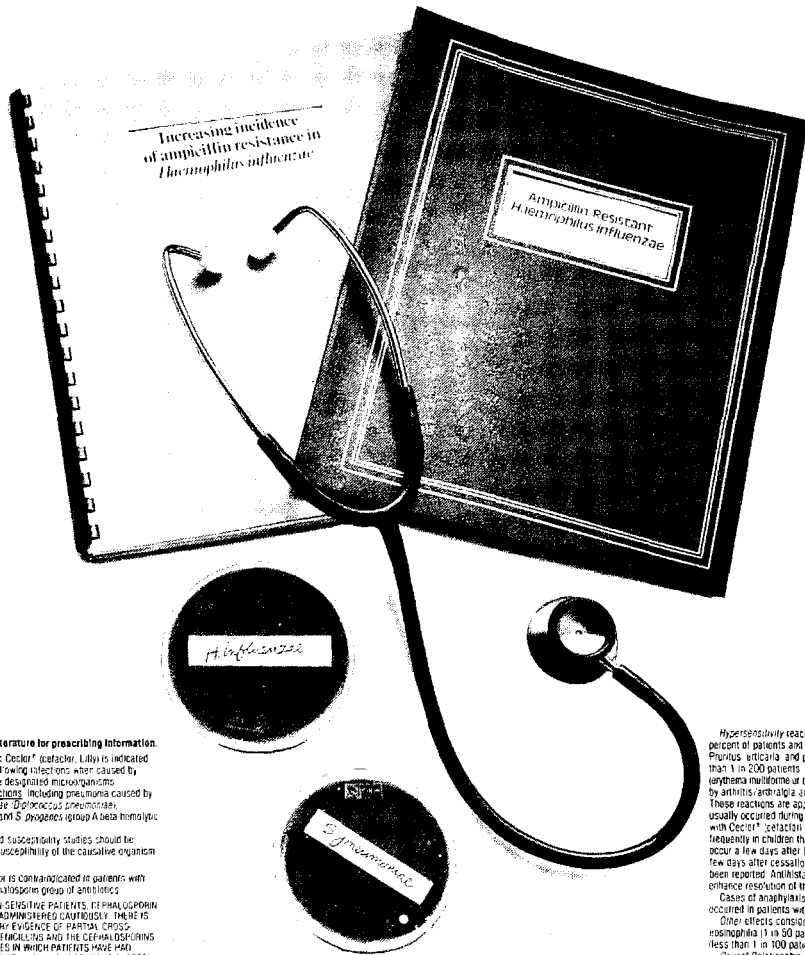
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# An added complication... in the treatment of bacterial bronchitis\*



**Brief Summary:**  
Consult the package literature for prescribing information, indications and usage. Ceclor® (cefadroxil) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms.

**Lower respiratory infections:** including pneumonia caused by *Streptococcus pneumoniae*, *Streptococcus pneumoniae*, *Haemophilus influenzae*, and *S. pyogenes* (group A beta hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

**Contraindications:** Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

**Warnings:** IN PENICILLIN-SENSITIVE PATIENTS, OTHER CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGICITY BETWEEN THE PENICILLINS AND THE CEPHALOSPORINS AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS INCLUDING ANAPHYLAXIS TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

**Precautions:** If an allergic reaction to ceclor occurs, the drug should be discontinued and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies on mice, leukocyte counts were depressed when ampicillin tests are performed on the minor side or in Coombs testing of the worms whose mothers have received cephalosporin antibiotics before parturition. It should be recognized that a positive Coombs test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been reported with Benedict's and Fehling's solutions and also with Clinistix® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, MSP, Lilly).

**Usage in Pregnancy:** Although its teratogenic or embryonic effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in fetuses given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefit of the drug in pregnant women should be weighed against possible risk to the fetus.

**Usage in Children:** Safety of this product for use in children less than one month of age has not been established.

**Adverse Reactions:** Adverse effects considered related to Ceclor therapy are common and are listed below. Gastrointestinal symptoms occur in about 25 percent of patients and include diarrhea (1 in 10), and nausea and vomiting (1 in 10).

An wide other broad spectrum antibiotics, ceclor, including rare instances of *Pseudomonas* spp., has been reported in conjunction with therapy with Ceclor.

Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis\*—are sensitive to treatment with Ceclor.<sup>1-6</sup>

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.<sup>7</sup>

**Hypersensitivity reactions** have been reported in about 1-5 percent of patients and include morbilliform eruptions (1 in 100), pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis, arthralgia, and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Seizures. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

**Causal Relationship (Uncertain)**—Transitory abnormalities in clinical laboratory tests: results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

**Regain**—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

**Hematopoietic**—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

**Renal**—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

\*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin allergic patients.

Ceclor is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

**References:**

1. Antimicrob Agents Chemother, 6:91, 1975.
2. Antimicrob Agents Chemother, 11:470, 1977.
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4. Antimicrob Agents Chemother, 12:490, 1977.
5. Current Chemotherapy, edited by W. Siegenbauer and G. Luthy, H. 1800, Washington, D.C. American Society for Microbiology, 1978.
6. Antimicrob Agents Chemother, 13:961, 1978.
7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases, edited by G.L. Mandel, H.D. Douglas, Jr., and J.E. Bennett, p. 487. New York: John Wiley & Sons, 1979.

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# *Medical Society of Pierce County*

MAY 1982, Vol LIV, No. 5, Tacoma, Washington



## **BULLETIN**

# How Poorman-Douglas can help you cure an occluded cash flow.

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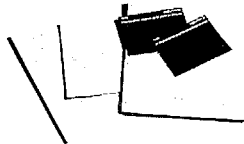
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## COVER

Tacoma's Old City Hall. Photo courtesy of the late Dr. Fred Schwind.

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# Society News Briefs

A summary of Medical Society, and local medical and health news

## MEDICAL SOCIETY REFERRAL SERVICE STUDIED

The Executive Committee reviewed the status of the Society's Referral Service at its April meeting. Over a four week period all calls to the Medical Society office seeking an appointment with a physician were tabulated with the following results:

1. Average daily number of calls: 23
2. Percentage of calls from patients with insurance or ability to pay full fee: 48%
3. Percentage of calls from patients on Medicaid: 20%
4. Percentage of calls from patients on Medicare: 4%
5. Percentage of calls from patients without insurance and seeking lowered or no fee care: 22%
6. Percentage of calls referred to health department clinics: 9%

## COUNTY EXECUTIVE FORMS EMS TASK FORCE

County Executive Booth Gardner has established an emergency medical services task force at the urging of the Medical Society and EMS Council to evaluate means of improving the local EMS system, with specific emphasis on funding and identification of responsibilities for future EMS system management.

Task force members are: Chairman Donald Cohen, professor of medical law at UPS Law School; Ned Shera, president of Schwarz and Shera; Shirley Payne, City of Tacoma planning staff; Carol Paas, Weyerhaeuser Company; Lewis Noel, Sumner mayor; Wesley Janke, retired fire commissioner; Glen Graves, president of Graves & Associates; Sandi Stevens, director of research and development, Pacific Lutheran University; and Grace Brooks, director, YWCA. Task force staff assistance will be provided by the Medical Society and David Vance, administrator of the Society's Medical Control Project.

The task force held its initial meeting on May 12. September is the target date for completion of the task force's work.

## EMS MEDICAL CONTROL UPDATE

The Medical Society EMS Committee, Medical Control Project, and the Pierce County EMS Council have taken a number of steps recently to further medical control and establish policy relative to EMS services. The Society's committee has established revised cardiac protocols and cardiac standing orders for paramedics in the field. Draft environmental and trauma protocols and standing orders are being reviewed.

Policy concerning the relationship between Advanced Life Support (ALS) units and private physicians has been established and approved by the Society and EMS Council. Implemented May 1, the policy is reproduced on page 6.

## NEW HOUSE OF DELEGATES TO MEET IN OCTOBER

The State Medical Association's policy making House of Delegates will hold its annual meeting in Yakima on October 7-10. The deadline for submission of resolutions for inclusion in the delegates' handbook is early July. MSPC members interested in submitting resolutions are urged to contact MSPC officers and trustees (officers and trustees serve as official delegates to the annual meeting).

*(Continued on page 13)*

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### UNORGANIZED MEDICINE - The Alternative

*"Every man owes part of his time and money to the business or industry in which he is engaged. No man has the moral right to withhold his support from an organization that is striving to improve conditions within his sphere." — Theodore Roosevelt*

The AMA as a professional organization functions on numerous important levels. Over 15% of its budget is spent on medical education. Membership information draws nearly 40% and 17% is spent on speaking for the profession. Socio-economic policy and medical practice requires nearly 8%, and the list goes on. But to me, the most important function of the AMA is its role as a potent and respected voice in the nation's capital, speaking out for individual physicians from Topeka, Kansas, to Tacoma, Washington.

Now more than ever we need the American Medical Association. In an era of deregulation, medicine finds itself precariously placed as the possible exception to the rule. It is faced with the paradox of a conservative government that advocates a new federalism and less government interference while at the same time proposing legislation that would further encumber the medical profession with more government rules, regulations and control. In fact, knowledgeable individuals have speculated that the 1980's may be the decade of vastly increased government control of medicine.

The many commendable aspects of the administration's so-called "pro-competition bill" carry with them

the stark reality of increasing government interference. If Medicaid should become federalized, one more large sector of the population will come under Washington's umbrella. Many other major issues — such as cost containment, PSRO, and health planning legislation, to name a few — face the medical profession and are being addressed by Congress and the administration.

Who speaks at the national level for you and me? Who can muster the attention and demand the respect of senators and bureaucrats? Who has its finger on the pulse of America's physicians and has the mechanisms to relay that data to the national media and government hierarchy?

The answer to all of the above, of course, is the AMA, and *we* are the AMA.

It is incredible that 50% of America's physicians are willing to sit back and let the other half be the participants. How can so many physicians casually accept all of the benefits, direct and indirect, that the AMA provides, and silently allow the rest to pay the freight?

The time has come for every physician to examine his own conscience and decide whether he is willing to accept the responsibility to his profession, his colleagues, and ultimately to himself, or whether he shall forfeit his duty and privilege to become a member of the American Medical Association.

— LCE

# POLICY ESTABLISHED TO DEFINE RELATIONSHIP BETWEEN ALS UNITS AND PRIVATE PHYSICIANS

Following several months of deliberation, the Medical Society's EMS Committee recommended a policy statement addressing the situations which often develop when Advanced Life Support (ALS) units respond to calls for assistance for patients under the concurrent care of private physicians. The recommended policy was approved by the Medical Society's Board of Trustees and the Pierce County EMS Council at their respective April meetings. Member comment on the policy is invited.

The policy is:

**PURPOSE:** To provide maximum benefit for patients under the care of a private physician.

The patient will have the benefit of knowledge of his or her personal physician concerning the physical conditions present and previous history of findings; the patient will also have the benefit of the base hospital physician in case the private physician can't be immediately contacted or should the patient's condition deteriorate.

**PROCEDURE:**

1. The Advanced Life Support (ALS) unit will be provided by the dispatching agency with the name and the telephone number of the physician. The physician will remain available for report by the ALS unit. If the private physician wishes the report may be deferred to the base hospital.

2. In the event the private ALS unit cannot immediately contact the physician by telephone, the base hospital will receive the patient report and provide directions. Assuming the private physician is not present or in direct voice contact with the ALS team, and should there be some unexpected serious development while enroute to the hospital, the ALS team will contact their base hospital by radio for instructions, advising the base hospital and then complying with the instructions of the base hospital physician. The private physician must be notified of any change in the patient receiving facility.

3. When the patient's private physician is present and has identified himself upon arrival of the ALS team, the ALS team will comply with the private physician's instructions and the base hospital will be contacted for reporting and estimated time of arrival to the hospital. If orders are given which are inconsistent with established protocol, clearance must be obtained through the base hospital physician.

In general, the physician who has the most expertise in the management of the emergency should exercise control. The physician at the scene may: (1) Request to talk directly to the base hospital physician to offer advice and assistance; (2) Offer assistance with another pair of eyes, hands or suggestions, but let the ALS team remain under base hospital physician control; or (3) The physician may take total responsibility for the patient with the concurrence of the base hospital physician.

4. In those patients who are critically or seriously ill, either at the initiation of the transport or during transport, and who are scheduled to be a direct admission to the hospital, it is expected that one of the following criteria will be met:

(a) The private physician will be waiting at the

receiving facility for ongoing care of the patient.  
(b) The patient will go directly to the hospital emergency department for immediate care and stabilization until the patient's private physician is contacted.

If the receiving hospital has no emergency department and none of the above criteria are met, it is considered to be in the patient's best interest to be transported to the nearest approved emergency department appropriate for the patient's condition.

A paramedic identification card outlining options of involvement for physicians who may be present at the scene of an Advanced Life Support (ALS) response has been approved by the EMS Council and Medical Society. The card is intended to clarify responsibilities and options physicians at the scene may wish to consider. The card was implemented May 1.

## THANK YOU FOR YOUR OFFER OF ASSISTANCE

This ADVANCED LIFE SUPPORT team is operating under Washington law and policy established jointly by the Medical Society of Pierce County and the Pierce County EMS Council. The ALS team is functioning under the command of the base hospital physician. If you wish to assist please see other side for options.

ADVANCED LIFE SUPPORT MEDICAL DIRECTOR  
Pierce County

In general, the physician who has the most expertise in the management of the emergency should take control. This is usually the base hospital physician. You may: (1) Request to talk directly to the base hospital physician to offer your advice and assistance; (2) Offer your assistance with another pair of eyes, hands, or suggestions, but let the ALS team remain under base hospital physician control; or (3) If you have an area of special expertise for the patient's problem you may take total responsibility, if delegated by the base hospital physician, and accompany the patient to the hospital.



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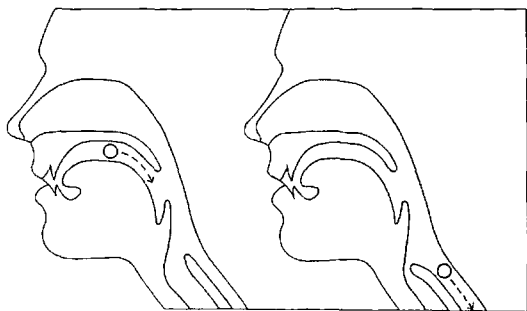
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taste, aftertaste and burning in the throat. Once tablets reach the stomach, they dissolve quickly and completely—producing the same aspirin and salicylate blood levels as regular aspirin.<sup>2</sup>

## Protective effect demonstrated in multi-center study<sup>1</sup>

In a double-blind, multi-center clinical study,<sup>1</sup> involving 907 subjects, Improved Bayer Aspirin was shown significantly superior to regular aspirin in avoiding aspirin taste, aftertaste, dissolution of tablets in the mouth and burning in the throat.

## As well tolerated as placebo

What's more, for short term use when compared to both coated and uncoated placebo tablets, Improved Bayer Aspirin showed *no significant difference in subjective complaints of stomach upset*—as shown in the chart:

Subjective evaluations—average percentage of complaints following each of three 650 mg doses of Improved Bayer Aspirin, placebo and coated placebo—given four hours apart<sup>1</sup>

| Symptom & Time of Administration* | Improved Bayer Aspirin | Placebo | Coated Placebo |
|-----------------------------------|------------------------|---------|----------------|
| <u>Burning in Throat</u>          |                        |         |                |
| 5 min.                            | 6%                     | 5%      | 5%             |
| 20 min.                           | 8%                     | 7%      | 8%             |
| 50 min.                           | 6%                     | 5%      | 5%             |
| <u>Stomach Upset</u>              |                        |         |                |
| 5 min.                            | 2%                     | 4%      | 2%             |
| 20 min.                           | 6%                     | 8%      | 5%             |
| 50 min.                           | 8%                     | 7%      | 5%             |
| <u>Nausea</u>                     |                        |         |                |
| 5 min.                            | 0%                     | 1%      | 0%             |
| 20 min.                           | 2%                     | 3%      | 2%             |
| 50 min.                           | 3%                     | 2%      | 2%             |

\* Following each of the three doses of test formulations, subjective side effects were recorded at 5, 20 and 50 minutes.

## Better patient compliance

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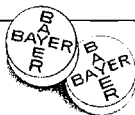
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### References:

1. Soller, R. W. and Baretz, D. B.: Methylcellulose Film Coating of Tablets as an Improved Delivery System for Aspirin (to be published).
2. Soller, R. W.: Bioavailability of Improved Bayer Aspirin (on file, The Bayer Company).

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## Interprofessional Committee



*Herman S. Judd, M.D.*

# ADVERTISING, GENERICS, AND INTEGRITY HIGHLIGHT COMMITTEE MEETING

A recent newspaper advertisement for a cream to relieve arthritis was called to the attention of your Interprofessional Committee. It was placed by one of the drug chains and was touted to be one of the most effective arthritis relief products currently available.

One of our physician colleagues called it to my attention and I was surprised to see that the product was also effective in "bursitis, back pain, headaches or tennis elbow!" He felt that we should at least discourage our patients from patronizing that pharmacy because of such advertising. I contracted the pharmacist and he personally visited the complaining physician and reassured him that every effort to prevent such advertising would be made. He also had assurances from his superiors this would be done.

The committee agreed with the physician, complimented the pharmacist on the action he had taken and, at the same time, pointed out that in the larger drug store chains, at least, advertising is the responsibility of a separate department and the pharmacist is rarely consulted. This apparently will be done with more effectiveness in the future.

Did you know that DSHS audits pharmacies? Actually, this is usually done only when there seems to be a problem with that pharmacy. But DSHS can audit your records, too. For this reason, it is a very good idea, when a pharmacist calls for authority to refill a prescription, to make a note on the patient's record of the medicine refilled and the date. Otherwise there can be a discrepancy between the pharmacist's records and ours which could take some explaining. (I hope that your office staff clears refills with you unless it is a chronically used item like digoxin or orinase.) It was also pointed out by a physician who had been audited that the auditors spent three days going over three years records trying to find one error or omission. They did, too, a urinalysis that wasn't charted!

Incidentally, a prescription on your blank signed with your name, then added to under the name of your nurse is not valid and may be refused at the pharmacy. Only a licensed nurse practitioner can write such a prescription and then never for a controlled substance (without you

countersigning it and using your DEA number).

Physicians should not resent the pharmacist seeking some form of identification from us when we call in a prescription. Most of the time we recognize each other's voices but there are a lot of new doctors in Pierce County and some new pharmacists. It only takes a moment to give your DEA number or your phone number or address as a means of identification. There have been occasions when a pharmacist has received a call for a medication, particularly a controlled substance, where the caller was not a physician. The pharmacist has to be sure.

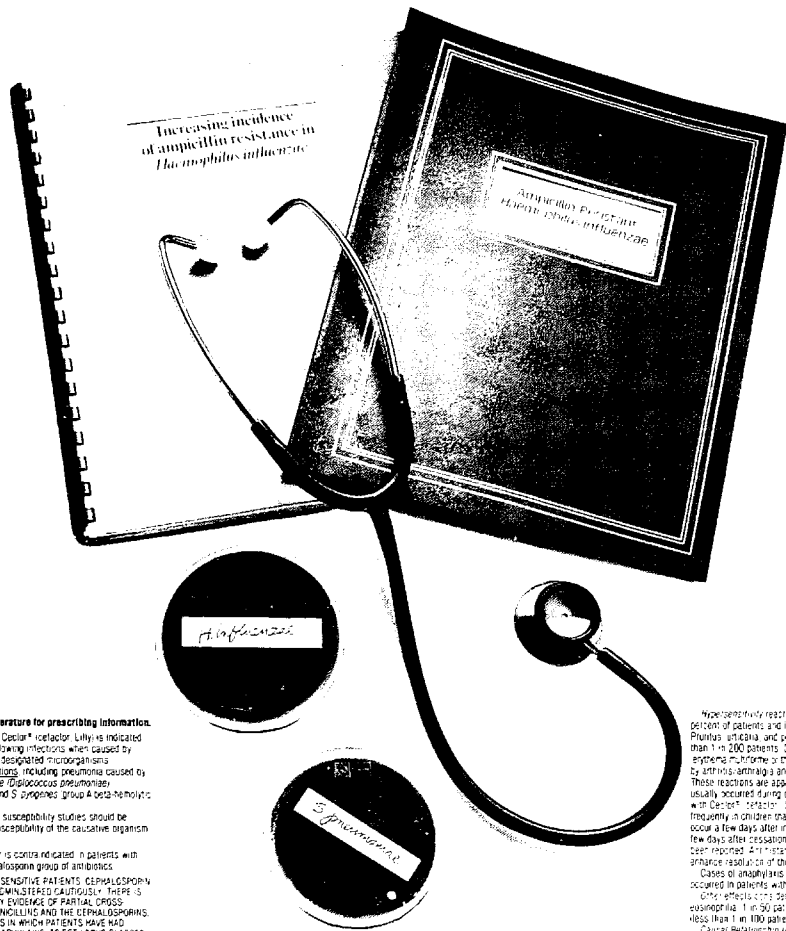
The question of generic drugs came up at our last committee meeting. DSHS demands it and some governmental agencies request it. It is true that the generic drug is usually less expensive, but is it just as effective? That has been our worry for a long time. The patent on a new drug lasts for 17 years. The time that that drug is under investigation is counted in the 17 years so if it is studied for 12 years before marketing, the patent lasts another five years. Whether the generic is of equal bioavailability is being tested more and more these days and reliable firms are engaged in their manufacture. When it comes right down to it, trust your pharmacist. He usually knows if the generic is equal to the name brand. Ask him; he'll help you.

Pharmacists now have, as part of their curriculum, a required year in Pharmacokinetics. Serum levels of various drugs are being measured, not only in hospitals but in outside laboratories and the pharmacists are cognizant of these levels. There is even a calculator available that is pre-programmed so that you can insert the age and weight of the patient and certain other factors and come up with the desirable blood level of a drug you intend to use.

As will be seen by the above, a lively discussion was held at the March meeting of your Interprofessional Committee. You know, when it all boils down to the bottom line, it spells "INTEGRITY". It is up to all of us, in the interest of good patient care, to demand as well as provide integrity.

*Herman S. Judd, M.D.*  
Chairman

# An added complication... in the treatment of bacterial bronchitis\*



## Brief Summary

Consult the package literature for prescribing information.

**Indications and Usage:** Ceclor<sup>®</sup> (cefalor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae* and *S. pneumoniae* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

**Contraindications:** Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

**Warnings:** IN PENICILLIN SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS INCLUDING ANAPHYLAXIS TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

**Precautions:** If an allergic reaction to Ceclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of non-susceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive Coombs tests have been reported during treatment with the cephalosporin antibiotics in neonatologic studies or in transfusion cross-matching procedures when ampicillin tests are performed on the same side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition; it should be recognized that a positive Coombs test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinistest tablets but not with Test-Tape<sup>®</sup> Glucose Epizymatic Test Strip, USP, Lilly.

**Usage in Pregnancy:** Although the teratogenic or anti-fertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in fetuses given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

**Usage in Lactation:** Safety of this product for use in infants less than one month of age has not been established.

**Adverse Reactions:** Adverse effects considered related to cefalor therapy are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2-5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 50).

As with other broad-spectrum antibiotics, colitis, including rare instances of pseudomembranous colitis, has been reported in conjunction with therapy with Ceclor.

## Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis\*—are sensitive to treatment with Ceclor.<sup>1-6</sup>

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.<sup>7</sup>

# Ceclor<sup>®</sup>

## cefalor

Pulvules<sup>®</sup>, 250 and 500 mg

Ampicillin-resistant reactions have been reported in about 1-5 percent of patients and include mucocutaneous eruptions, 1 in 100; Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients. Cases of serum sickness-like reactions, erythema multiforme or the above serum hypersensitivity reactions, exfoliative dermatitis and frequently fever have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor<sup>®</sup> tablets. Such reactions have been reported most frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. The serious reactions have been reported. All reactions are not considered to be anaphylaxis resolution of the syndrome.

Cases of anaphylaxis have been reported, part of which have occurred in patients with a history of penicillin allergy.

Other effects considered to be due to therapy include eosinophilia, 1 in 50 patients and genital chondritis or vaginitis (less than 1 in 100 patients).

Genital chondritis or chondritis—rarely, but definitely in 2-3% laboratory test results have been reported. Although they were of uncertain origin, they are listed below to serve as alerting information for the physician.

Reaction—SGPT elevations in SGPT, SGPT (or alkaline phosphatase) values 1 in 40.

Neutropenia—Transient leukopenia with a low neutrophil percentage, leukopenia occurring in infants and young children (1 in 40).

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1. *Antimicrob Agents Chemother*, 1975, 1:1075.  
2. *Antimicrob Agents Chemother*, 1975, 1:1077.  
3. *Antimicrob Agents Chemother*, 1975, 1:1079.  
4. *Antimicrob Agents Chemother*, 1975, 1:1081.  
5. *Current Chemotherapy*, edited by W. Siegelbald and H. Luder, 1975, Washington, DC: American Society for Microbiology, 1975.  
6. *Antimicrob Agents Chemother*, 1975, 1:1083.  
7. Data on file, Lilly and Company.

8. *Pharmacology and Therapeutics*, 1975, 1:1075.  
9. *Current Chemotherapy*, edited by W. Siegelbald and H. Luder, 1975, Washington, DC: American Society for Microbiology, 1975.

10. *Antimicrob Agents Chemother*, 1975, 1:1077.

11. *Antimicrob Agents Chemother*, 1975, 1:1079.

12. *Antimicrob Agents Chemother*, 1975, 1:1081.



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## GAMES STATISTICIANS PLAY



Ed Wood, M.D., Ph.D.

The search for the perfect test is a little like looking for the fountain of youth—there isn't any such animal. Yet the implications of a false negative or false positive result keep us looking just the same. In the absence of that 100% accuracy we may attempt with various statistical maneuvers to squeeze more conclusions from the data than are justified. A sterling example appeared not long ago in the quest for a laboratory approach to alcoholism.

It has been known for some time that gamma glutamyl transpeptidase (GGT) is often elevated in early liver damage secondary to an increased alcohol intake. For a time GGT enjoyed considerable popularity as "the" test to identify the silent alcoholic. As is usual, it wasn't too long until multiple other causes for an elevated GGT were recognized and it was appreciated that the sensitivity (number of true positives) for alcoholism wasn't absolute. Next it was noted that the mean corpuscular volume (MCV) of red blood cells was also often increased in the alcoholic. Ergo, when a patient has both an elevated GGT and an increased MCV, the diagnosis is practically made—well, maybe—

Investigators at the National Institute on Alcohol Abuse and Alcoholism by utilizing the GGT and MCV were able to correctly identify only 36% of the alcoholics in their study group.<sup>1</sup> (Frankly, I think the GGT alone is better than that—as a matter of fact, the MCV alone is better than that.<sup>2</sup>)

Partially as a consequence of those results, however, these investigators "devised" a 24 test profile—that's right, twenty-four—and reached into their statistical grab bag for a method to massage the data. Their choice was something called quadratic discriminant analysis which defined loosely—very loosely—measures the inter-relationships of the various test results to each other. In other words, minor abnormalities of individual tests might be meaningless but the composite abnormalities are like winning at Bingo. Well, after smoothing out the data with a few other tricks, the computers correctly identified 98% of the alcoholics (sensitivity) and 100% of the non-alcoholics (specificity). Wow! With data like that you don't even have to see the patient. And if you believe it, do I have a deal for you on the Tacoma Narrows Bridge.

If you consider that a little much, the statisticians suggest a more conservative approach with the same profile called the "leaving-one-out" method which results in a sensitivity of 94% and a specificity of 95%. Or, if you

prefer to use only the best ten tests of the profile, you can still achieve an 86% sensitivity.

There really is a moral to all of this. There is more to the interpretation of test results than sensitivity and specificity—and particularly statistics.

As for alcoholics, the GGT is still a pretty good test, particularly for the patient who acknowledges a concern about his intake and wants some kind of an assessment. Any elevation of the GGT is sufficient reason to delete the cocktail hour. For the silent alcoholic, if you really want the diagnosis, schedule one fasting test (as an outpatient) at 6 a.m. and repeat it non-fasting at 3 p.m.—a blood alcohol.

### A "QUICK" PEARL

A not infrequent diagnostic challenge is gram negative bacterial meningitis. A little known but very rapid and highly sensitive and specific test has been available for a number of years. It is the *Limulus* Amoebocyte Lysate (LAL) assay.<sup>3</sup> The test utilizes an extract from the amoebocytes of the horseshoe crab (*Limulus*) which reacts with the endotoxins of gram negative bacteria producing a firm gel. In the assay, equal volumes of CSF and the extract are mixed gently and incubated for one hour. The production of a clot is a positive test (sensitivity = 99.1%; specificity = 99.6%; cost: around \$10.00).

The test is equally useful, although speed is obviously less essential, to detect gram negative bacteriuria and gram negative infections in a variety of other body fluids (ascitic, joint, vitreous, etc.). The test is not as useful, unfortunately, for blood where both false positives and false negatives occur. And remember, it has no role for gram positives.

One clinker. Not a single laboratory in Tacoma offers the test even though it is available in kit form and is relatively simple to perform. Maybe if you asked—?

Ed Wood, M.D., Ph.D.

1) Eckardt, M. J., Ryback, R. S., Rawlings, R. R., and B. I. Graubard. Biochemical Diagnosis of Alcoholism. A Test of the Discriminating Capabilities of Gamma Glutamyl Transpeptidase and Mean Corpuscular Volume. *JAMA*, 246 (23):2707-2710, 1981.

2) Wu, A., Chanarin, I. and A. J. Levi. Macrocytosis of Chronic Alcoholism. *Lancet*, I, 829-831, 1974.

3) Nachum, R. and M. Neely. Clinical Diagnostic Usefulness of the *Limulus* Amoebocyte Lysate Assay. *Lab. Med.*, 13 (2):112-117, 1982.

## SOCIETY NEWS BRIEFS *Continued*

### SUMMER TEMPORARY ASSISTANCE AVAILABLE

The Medical Society's Placement Service has a roster of qualified office personnel ready for your temporary staffing needs. For help in covering vacation and other staffing needs call Linda Carras, Placement Service manager, 572-3709.

### PHYSICIANS ELECTED TO MEMBERSHIP

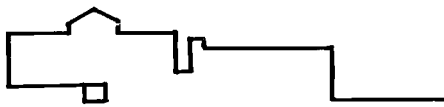
Three provisional members were elected to membership in the Medical Society of Pierce County at the May Board of Trustees meeting. The new MSPC members are: Drs. Paul L. Chan, John E. Goodpasture, and Keith E. Demirjian.

### PHYSICIANS INTERESTED . . .

**General Practitioner** seeks practice opportunity in clinical setting. Recently completed post-graduate training at University of California, Davis. Internship included rotations in emergency medicine, ward medicine, pediatrics, surgery, OB/Gyn. Residency in obstetrics and gynecology completed in November, 1981. Diplomate, National Board of Medical Examiners. Listing #501.

**Physician seeks emergency medicine** opportunity. Board eligible, internal medicine; advanced cardiac life support instructor; graduate, University of Rochester, 1978. Available, November, 1982. Listing #502.

Postdoctoral fellow seeking a position in **allergy and/or rheumatology**. Certified by American Board of Internal Medicine; has completed training in rheumatology and will take rheumatology boards in November 1982. Board eligible in pediatric and adult allergy and immunology, June, 1983. Available July 1983. Listing #503.



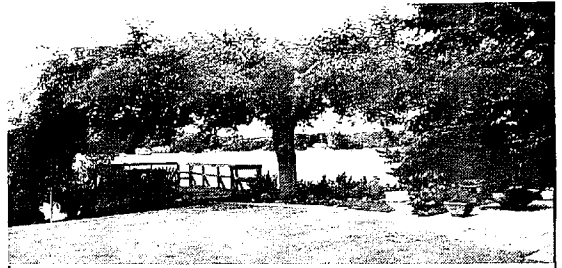
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# Membership

In accordance with the Bylaws of the Medical Society of Pierce County, Chapter Seven, Section A, MEMBERSHIP, the following physicians have applied for membership, and notice of their application is herewith presented. As outlined in the Bylaws, any member who has information of a derogatory nature concerning an applicant's moral or ethical conduct, medical qualifications or other such requisites for membership, shall assume the responsibility of conveying that information to the Credentials Committee or Board of Trustees of the society.

## FIRST NOTICE



**John E. Kooiker, M.D., Psychiatry.** Born in Minneapolis, Minnesota, 7/20/20; State University of Iowa, Iowa City, Ia., 1945; internship, U.S. Naval Hospital, Great Lakes, Illinois, 1945-46; residency, Menninger Foundation School of Psychiatry, Topeka, Kansas, 1949-52; State of Washington license, 1982. Dr. Kooiker is practicing at Western State Hospital, Tacoma. **Sponsors:** Drs. E. M. Wood and Singa Krishnamoorti.



**James V. Taylor, M.D., Emergency Medicine.** Born in Cential Butte, Saskatchewan, Canada, 4/17/29; University of B.C., Canada, 1954; internship, St. Paul's Hospital, 1954-55; residency, Vancouver General Hospital, 1956-59; University of Washington (fellow, cardiology) 1963-64; Washington State license, 1961. Has applied for medical staff membership at Good Samaritan Hospital. Dr. Taylor is practicing at Good Samaritan Hospital, Puyallup. **Sponsors:** Donald C. Weber, M.D. and Leonard S. Allott, M.D.

## SECOND NOTICE



**Hugh K. Lancaster, M.D., Pathology.** Born in Myrtle Point, Ore., 10/3/43; University of Wisconsin, 1971; internship, Sacred Heart Medical Center, Spokane, WA, 1971-72; residency, Sacred Heart Medical Center, 1974-78 (pathology); Washington State license, 1975. Has applied for medical staff membership at Allenmore and St. Joseph hospitals. Dr. Lancaster is practicing at 1718 South I Street, Tacoma. **Sponsors:** Juan F. Cordova, M.D., and Richard T. Vimont, M.D.



**Stephen S. Tobias, M.D., General Practice.** Born in New York, NY, 8/29/46; Baylor College of Medicine, 1974; internship, Maryland General Hospital, Baltimore, 1974-75; Washington State license, 1976. Has applied for medical staff membership at Allenmore, Lakewood General and Tacoma General hospitals. Dr. Tobias is practicing at 7424 Bridgeport Way, Tacoma. **Sponsors:** Gerhart A. Drucker, M.D. and Matthew White, M.D.



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# TURN ACCOUNTS RECEIVABLE INTO CASH IN THE BANK

*The current economy makes it more important than ever that medical offices establish clearly written credit policies and effectively manage accounts receivables. The following article, written by Frank Rossiter, president and general manager of Puget Sound Collections (PSC) of Tacoma, offers several suggestions on improving office collection techniques. PSC is endorsed by the Medical Society of Pierce County. — The Editor.*

The scene, a typical Northwest home. Wife and husband are reviewing the monthly bills.

SHE: The fuel company says they'll stop delivery if we don't pay them.

HE: Those dirty guys. Send them a check.

SHE: The phone company says they'll disconnect us if we aren't current by next week.

HE: Rotten monopoly. You'd better pay them.

SHE: Here's that bill from Dr. Softy again.

HE: Good old Dr. Softy; what a nice guy. Maybe we can pay him next month. What's the next bill?

And so the story goes. The image as a benevolent benefactor may be a doctor's worst enemy when it comes to getting paid. Yet by using sound credit management, many medical practices have substantially reduced the amount of money they have tied up in overdue accounts.

There are five simple guidelines that can keep you from becoming another Dr. Softy: (1) a clearly written credit policy; (2) a thorough initial interview; (3) consistent billing procedures; (4) systematic follow-up; and, (5) a professional collection agency.

### THE CREDIT POLICY

First and foremost, you must establish a clearly written credit policy. Include billing dates, payment due dates, payment arrangements, cash or advance payment needs, policies toward charity, policy on medical insurance, use of credit bureaus, normal follow-up activities, finance charges, and when to call in a professional collection agency. Establish your policy, then follow it.

### STARTING OFF ON THE RIGHT FOOT

The initial patient interview lays the foundation for good credit performance. Your patient information form should provide as much information as possible about the person, including full name and nickname, both home and work mailing addresses, home and work phone numbers, occupation and employment information, nearest relative and address, medical insurance information, Medicare and Medicaid data, and, of course, Social Security number. The form should be checked immediately for completeness and accuracy.

It is very important that your staff completely explain the credit policy to the patient. You will find it very helpful if a point is made of marking down the exact method of payment agreed upon. The patient should then acknowledge that he/she understands and agrees to the arrangement.

This is the best time to brief the patient on your way of handling health insurance claims. Make it clear that although you are happy to help with the paperwork, the final responsibility for payment still rests with the patient.

Don't neglect to get a credit report on the patient. Often your collection agency will offer this as a free service. For example, at Puget Sound Collections we have available the resources of the Retailers' Commercial Agency.

### THE NUMBER ONE CAUSE OF SLOW PAYMENT

Bill on time and be consistent. Haphazard billings are the major cause of delayed payments and slow collections. If you itemize your statements, you will probably produce a greater number of timely payments than you will by simply billing a total amount due.

### Rx FOR LATE PAYMENT — TAKE ACTION IMMEDIATELY

Nothing shows you mean business better than quick action when terms are not met. Be nice, but be business-like. A successful collection effort means: (1) getting the money; and, (2) keeping the good-will. Insist on a specific date and specific amount to be paid. Then send a note to the patient confirming the understanding.

### WHEN TO CALL IN THE HEAVY ARTILLERY

When a patient constantly ignores calls and letters, breaks promises, and is indifferent about paying the bill, it is time to turn the account over to a professional collection agency. Give them as much information about the account as possible, including the patient's credit information form and all itemized statements. Be sure to keep the agency informed of any subsequent information that might assist them in collecting your account.

By managing these few fundamentals, strained patient relationships can be kept to a minimum and, most importantly, your bank balance will begin to look a lot better.

*Frank Rossiter,  
Puget Sound Collections*

\*PSC is endorsed by the Medical Society of Pierce County. For information on how PSC can serve you, call the Society, 572-3667, or PSC, 383-5011.

## A MESSAGE FROM OUR PRESIDENT AND LATE SPRING POTPOURRI

### FROM NIKKI . . .

One of our goals for 1981-1982 was to try to reach out to all Medical Society members and spouses to make them feel as though they are part of a big family. "Needed and Appreciated" were the themes we followed in setting up the year's programming. During our program development discussions we heard the same theme (too much rush and not enough time to stop and smell the roses), we ate lunch, had the business meeting and raced home, only to discover that we hadn't allowed time to visit with our friends.

We hope that you know that you are needed and appreciated by the Pierce County Medical Auxiliary and will continue to be. It has been an exciting year. We were extremely successful in our fund raising efforts we're still number one in AMA-ERF fund raising.

Thank you to all of you for your unceasing support. I made some more new friends and hope that each of you did the same. "People don't care how much you know until they know how much you care."

*Nikki Crowley*

### RAINY WINDY DAY - PICNIC

Forty brave souls came out for the picnic at Titlow

Park on April 17. Despite the rather awful weather the children had a good time and ignored the weather as they went on a treasure hunt and were rewarded with chocolate treasures, played in the mud at the lagoon, played football, handball, and "swang" on the swings. Two clowns assisted with the childrens' entertainment. Our thanks go to chairman Sandy Griffith and her committee members, Susie Wiese, Jena Singh, and Mary Martin.

### FROM MARLENE ARTHUR . . .

There will be a summer Board meeting to begin planning for the coming year, particular attention will be paid to planning for newcomers and membership.

### STATE CONVENTION DELEGATES

The following members represented Pierce County at the state convention: Marlene Arthur (for Nikki Crowley), Gloria Virak, Dottie Truckey, Shirley Kemman, Debby McAlexander, Susie Duffy, Bev Graham, Joan Sullivan, and Sally Larson. The alternates were Kit Larson, Cathy Schneider, and Sharron Gilbert. See the June Auxiliary Page for the convention outcome.

*Mary Whyte Lenard*

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**NEXT GENERAL MEMBERSHIP MEETING**

**Tuesday, September 14, 1982**

**program to be announced**

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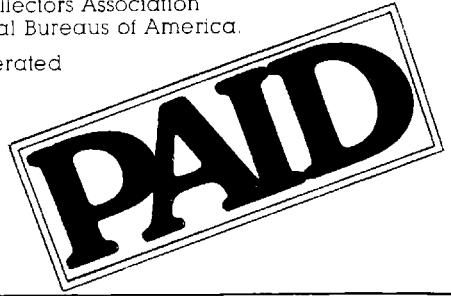
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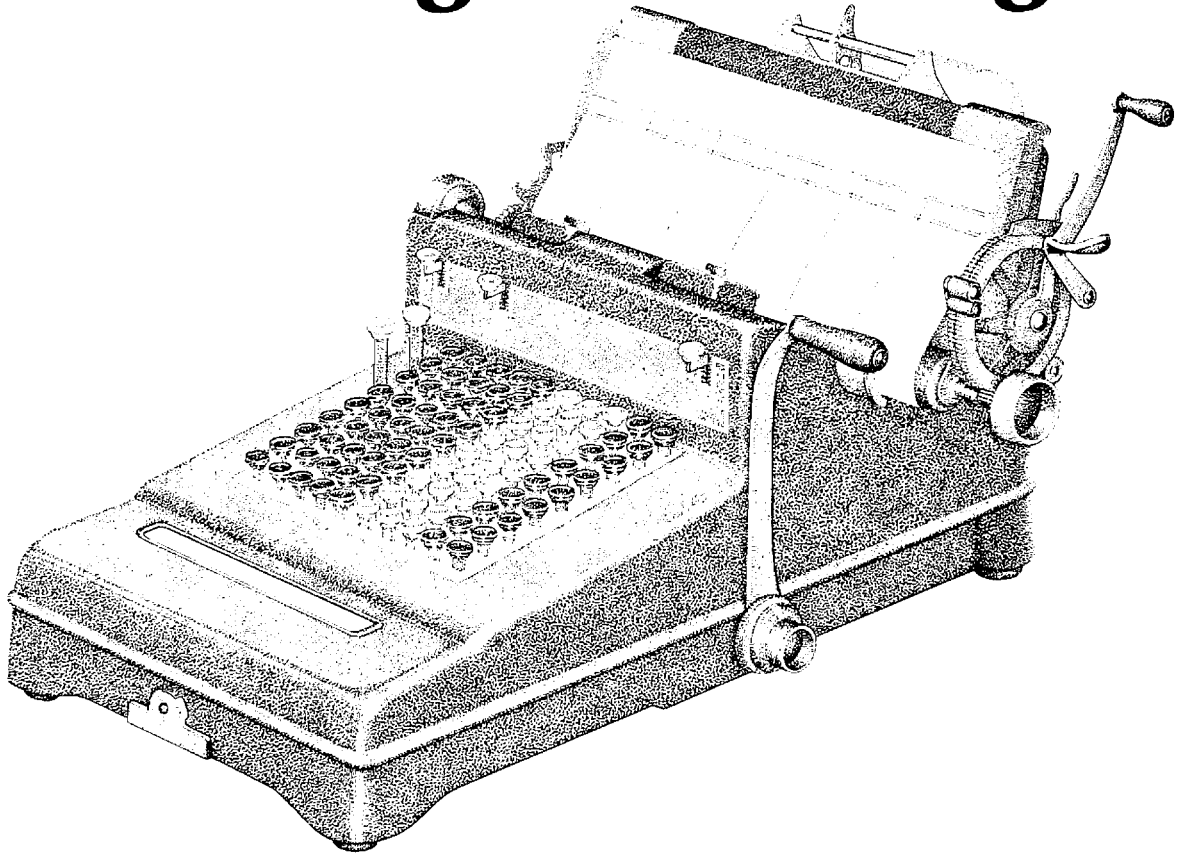


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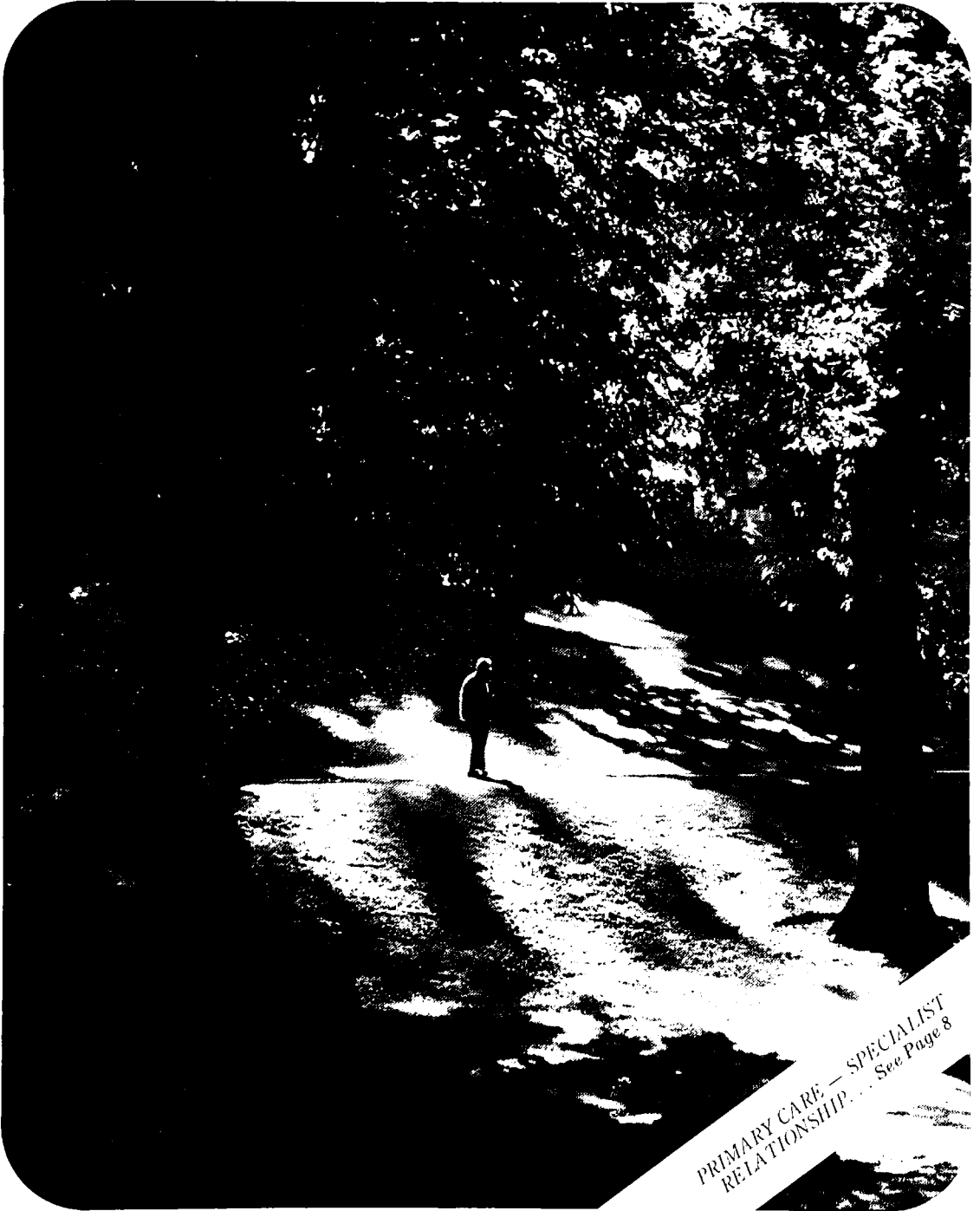
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# Medical Society of Pierce County

JUNE 1982, Vol. LIV, No. 5, Tacoma, Washington



PRIMARY CARE — SPECIALIST  
RELATIONSHIP. . . See Page 8

## BULLETIN

# How much of your medical practice are you giving away?

Even the most competent and dedicated office staff can have a tough time controlling accounts receivable. That's where Poorman-Douglas can help. Our On-Line Medical Accounting System provides the tools your staff needs to improve collections and strengthen the business side of your practice.

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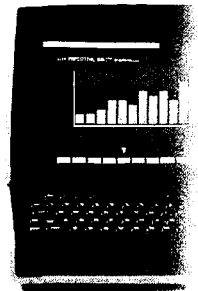
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## COVER PHOTO

Courtesy of Glen McBride, M.D.

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# Society News Briefs

A summary of Medical Society, and local medical and health news

## BOARD MEETS WITH HOSPITAL MEDICAL STAFF PRESIDENTS

Hospital medical staff presidents joined the Board of Trustees at its June 1 meeting to review a variety of issues of concern to physicians practicing in Pierce County. Issues addressed included:

*Hospital Trauma Center.* Criteria for trauma center categorization and the designation of a trauma center in Pierce County were discussed at length. There was general agreement as to the benefits to patient care and the community which would result from a trauma center designation. The Board deferred final action on the EMS committee's recommended criteria for trauma center categorization and the issue of trauma center designation until its October meeting in order to seek maximum individual physician and local specialty society input.

*Ethics/Standards of Practice.* Plans to strengthen the Society's activities in the area of ethics and standards of practice, a highly desired goal as outlined by the members in the last membership opinion survey, were reviewed. Medical staff presidents expressed support for a coordinated effort. (see below).

*Credentialing.* Medical staff presidents suggested the Society should work with hospital staffs to establish more uniform wording and criteria for privileging. There was agreement that the existing joint credentials committee is working well.

The following physicians represented medical staffs: Drs. John Kennedy (St. Joseph), John May (Doctor's), Bob Ferguson (Allenmore), George Gilman (Puget Sound), Larry Larson (Mary Bridge), Robert Eggen (Lakewood), and J. Symonds (Good Samaritan). Dr. Ben Blackett, president of the Tacoma General medical staff, was unable to attend due to a scheduling conflict and has been invited to a future Board meeting.

## STRENGTHENED ETHICS/STANDARDS OF PRACTICE EFFORTS APPROVED

A program to strengthen the Medical Society's efforts to maintain high professional standards and ethics in Pierce County and to protect patients from poor quality or unscrupulous physicians was approved at the June Board of Trustees meeting. Recommendations from the Board's ethics working group—Drs. George Tanbara, Bruce Buchanan, Gil Roller and Jim Early—included establishing formal liaison with hospital medical staffs, educating physicians regarding ethical questions, expanding the Ethics Committee composition and revising its statement of purpose.

Following consultation with MSPC and WSMA legal counsel, and the discussion spanning three Board meetings, the Board voted unanimously to accept the group's recommendations. The adopted statement of purpose for the Society's new Ethics/Standards of Practice Committee is:

### Statement of Purpose:

*Ethics/Standards of Practice Committee:* The Ethics/Standards of Practice Committee is established by the Medical Society of Pierce County to:

- 1) Define local ethical standards of medical practice;
- 2) Educate physicians on ethical issues;

(Continued on page 6)

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### LIBRARY SERVICE FACES THORNY ISSUES



Lloyd C. Elmer, M.D.

Practicing medicine in Pierce County approaches the ideal in most respects. In addition to being privileged to practice in a community where such a high level of medical care is provided, we physicians may avail ourselves of a sterling resource in the excellent Pierce County Medical Library. Our library is unique in its organization and in its joint financial underwriting by all of the hospitals in the community and the Medical Society of Pierce County. Its extensive listings of journals and textbooks is overwhelming. Our library enjoys a neighborly friendship with other regional libraries such as those at Madigan Army Medical Center, the Veterans Administration Hospital, the Washington State Library, and the King County Medical Society Library/Health Sciences Library at the University of Washington.

In addition, the Pierce County Medical Library works in conjunction with smaller satellite libraries housed in the various hospitals in the county. This allows close cooperation and assures local physicians of prompt service even if the main library doesn't shelf the needed material. This spirit of friendly cooperation spills over at every level from our capable and well regarded librarian, Marion Von Bruck, to the couriers who deliver the journals with a friendly smile.

The library is an extensively used service. During the first four months of 1982 there were over 900 physician visits and more than 1,200 telephone calls to the library. There were over 1,600 computer reference searches and nearly 700 manual reference searches. Further statistical documentation of the high utilization of the library could continue, but hardly seems necessary. One visit to this quietly humming beehive of activity tells all.

The library's main problems center around two issues, money and space. The time has come to take a long-range look at the library's role and its level of service in the 1980's. The strong inflationary pressures that have influenced the economy as a whole are fully manifest in the library's services. Rapid increases in the cost of postage and journals puts ever increasing and often unpredictable demands on the library's budget. Increasing Medical Society membership and the proportionate increase in required library service places extra demands on staff time and ultimately may require

increased personnel expense. Also, fees charged to our library by other libraries are increasing. It now costs our library \$5.00 for every reprint or borrowed book from the University's Health Sciences Library, for example.

The library suffers from overcrowding and each month adds to this problem. The hardworking Library Committee, chaired by Juan Cordova, is wrestling with decisions affecting which older journals and texts should be kept and for how long. The committee must also evaluate current literature and text material and recommend deletions and additions.

Some of the thorny questions and issues provide several possible alternatives, none of which are fully palatable. Consider that one-sixth of the entire Medical Society of Pierce County budget is destined for the library. Should the Society continue to underwrite the library with ever increasing levels of financial support or should we conclude that if more financial demands are made the difference must be made up by greatly increased user fees? Can the level of service be maintained, or by necessity will the librarians be unable to meet each and every request for journals and reprints and literature searches? Can the library continue to function where it is currently housed for the next decade, or is expansion feasible or even possible? If a larger plant is determined to be vitally necessary and expansion at the present location is not possible, should the library be moved? If so, should the library be free standing or housed under the roof of another hospital or within the confines of the Medical Society office?

Thoughtful responses to these questions must be forthcoming and the Library Committee and the Medical Society of Pierce County Board of Trustees values input from the membership in order to make the most reasonable and proper decisions on these vital issues. We all derive benefit from the library whether or not we are direct users. Our College of Continuing Medical Education could not provide the fine level of courses and programs without the Medical Library.

In the final analysis our patients are the ultimate beneficiaries of this legacy so wisely established by physicians of vision years ago.

— LCE

**SOCIETY NEWS BRIEFS Continued**

- 3) Review and make determinations where possible regarding allegations of unethical behavior;
- 4) Make recommendations to the Board of Trustees regarding the membership status of physicians against whom allegations of unethical behavior are substantiated;
- 5) Forward to the State Medical Disciplinary Board and/or other state or medical association body as appropriate committee findings and recommendations.

The committee is chaired by a physician appointed by the MSPC president. The committee consists of hospital medical staff presidents or their designees, and additional members appointed by the chairman of

the committee and approved by the Board of Trustees. The committee meets at least quarterly. Dr. Gil Roller, trustee, has been appointed chairman of the revised committee.

**PHYSICIANS ELECTED TO MEMBERSHIP**

The following applicants were elected to membership in the Medical Society of Pierce County at the June Board of Trustees meeting: Drs. Daniel T. Hayden, Mark Jergens, Charles Weatherby, and Donald E. Maurer.

**BOARD OF TRUSTEES ENDORSES CONTINUED SUPPORT OF MEDICAL CONTROL PROJECT**

Following a review of the status of the EMS Medical Control Project at its May meeting, trustees voted unanimously to support continuation of the project in 1983. Current state funding runs out on September 30.

The project's contractual obligations include development of treatment, triage and transfer protocols; systems evaluation tracer studies; review of basic life support and advanced life support training programs; development of run reviews to analyze patient care; and, development of an ongoing plan for the coordinated implementation of a county-wide emergency medical services delivery system. As reported in the May *Bulletin*, County Executive Booth Gardner has established, at the request of the Society, a community task force to pursue improved EMS.

A special presentation of the status of the EMS project and emergency medical services locally was made late in May to representatives of all Pierce County hospitals. Hospital administrators have been invited to comment on the project and other activities aimed at improving EMS locally.

**NOTARY SERVICES AVAILABLE**

Free Notary Public Services are available to the members of the Medical Society through the Society's Membership Benefits office. The MBI office is located adjacent to the Society at 705 So. 9th (corner of 9th and G), Suite 202.

**TEMPORARY ASSISTANCE AVAILABLE**

The Medical Society's Placement Service has a roster of qualified office personnel ready for your temporary staffing needs. For help in covering vacation and other staffing needs call Linda Carras, Placement Service manager, 572-3709.



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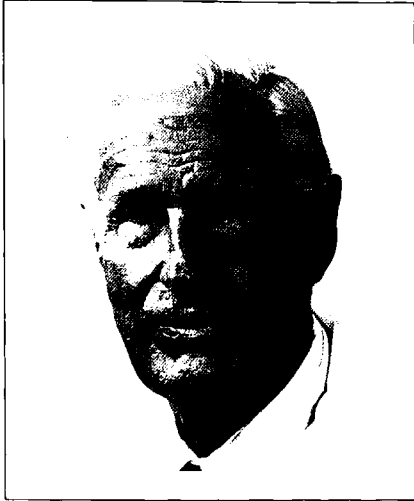
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**Friday, September 24, 1982**

**Schedule:**

10:00 a.m. "Hemobilia — Salient  
Features and Causes"

12:15 p.m. \*Complimentary  
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1:00 p.m. "Disease and Artistic  
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## General Membership Meeting

# SOCIETY MEMBERS GATHER TO DISCUSS PRIMARY CARE-SPECIALIST RELATIONSHIP

The opportunity to discuss openly the concerns felt by physicians about the primary care-specialist relationship drew over 150 members of the Medical Society to the May 11 general membership meeting. Following dinner at the Fircrest Country Club, a panel of six physicians — Drs. Ken Graham, Stu Farber, and Bob Lane (representing generalists) and Bruce Buchanan, John Kennedy, and Jack Nagle (representing specialists)—presented their views of the issue and responded to questions from the floor. The program was moderated by Dr. Gil Roller.

Spokesmen from both sides of the panel led off the discussion with a brief statement of their views of the primary care-specialist relationship. The presentation is summarized below:

*Dr. Roller:* We are here to discuss the ethical implications of the relationship between the patient, primary care physician and the specialist. This meeting is an outgrowth of our January Board of Trustees retreat where we reviewed the strengths and the weaknesses of our Medical Society and came up with some goals for this year.

We discovered we had more strengths than weaknesses. You all know this. We have a good strong Society, we get along well, we have strong inter-personal relationships. I think we have an excellent standard of medical care in this community and, most of all, we still have an open medical staff situation.

We did feel we had one weakness and that was really no program for self-regulation. We are not unique.

In last winter's membership survey, by a substantial margin, the membership said that the maintenance of high professional standards in this community was a top

priority for the Society. As a result, we came up with an ethics working group composed of myself, and Drs. Buchanan, Tanbara and Early. One of our recommendations was to have a meeting like tonight's. Our first speaker is Dr. Ken Graham.

*Dr. Graham:* Most of us in primary care feel that relationships with our consultants are quite good and, perhaps, much better than those in other communities. The chief concern, I think, is one that is continually stressed by our Academy of Family Physicians, *continuity of care*. The one area of our practice that causes maybe the greatest frustration is the feeling that suddenly we are not involved in the "team" effort to treat our patients. Even though many times we have requested the consultant to manage the patient through the acute phase of his illness, we are still expected, or we feel we are expected by the patient and his family, to be current with his care and his progress.



*As part of the May 11 program, Dr. Roy Virak, director of Tacoma Family Medicine, received a check for \$10,000 from the Medical Society representing a contribution from Allenmore Community Hospital to the TFM program. The contribution will be used to establish a procedures room for TFM residents.*



*Prior to the panel discussion, Dr. Jack Nagle (right) received a plaque from President Lloyd Elmer in appreciation of his service as a member of the Board of Trustees. Dr. Elmer noted in his presentation that the Society had been seeking an appropriate opportunity to present the plaque to Dr. Nagle since he concluded his term on the Board—in 1974.*

Most of us will then continue to visit the patient, hoping or planning at least, that perhaps after he's over his acute illness, we will become his primary physician again and actively take over his care. We visit the patient and I would say most of the time make no charges unless actively involved in writing orders.

This problem can only be resolved through improved communications with the attending physicians and better defining the reimbursement policies of third party carriers. The Pierce County Medical Bureau is



*Dr. Gil Roller moderated the panel discussion on the relationship between specialists and generalists. Panelists at the head table were (from left to right) Drs. John Kennedy, Ken Graham, Bob Lane, Gil Roller, Bruce Buchanan, Stu Farber, and Jack Nagle.*

investigating the impact of multiple physician charges in the hospitals.

Interspecialty referral is another area that needs to be addressed. Most consultants are sensitive to this and do call the primary physician before making a further referral if indicated. Dr. Al Thompson, a WSMA past president, said it best when he stated that primary care physicians are the patients' health care managers. This is one of the principles stressed most frequently in cost containment programs.

*Dr. Kennedy:* What makes medicine so interesting and so challenging is that it is both an art and a science. Some of us practice one style of medicine, some another style and, to me, that is the art of medicine. All of us should practice the science of medicine as it is currently known.

Why are we here? We are here because we don't all agree on patient management. We don't all agree on how this care should be delivered, by whom and in what setting. This is flavored by personalities and background. Specialty consultation needs to be integrated into the overall patient care program. How this is done varies widely in this and other communities. The consultant should hear from the referring physician and this should include pertinent information, what is specifically desired by the referring physician. Following this consultation, the consultant should notify the referring physician of his findings and of his recommendations.

Three subsequent decisions need to be made — Who is the captain of the ship? What is to be done, who else is to be called? What are the complications that might be expected from this or that treatment?

Over the long haul, when is a specialist no longer needed? What follow-up is appropriate (and by whom) and what can we expect in the long-term care of the patient? Regardless of whether you're an internist, a generalist, a surgeon, a psychiatrist or an obstetrician, one thing is required — communication. That's the only thing required — the ability to communicate with others and to discuss the welfare of the patient.

*Dr. Lane:* I think this is a very valuable discussion and I hope we can continue with similar programs. My position is somewhat of a hybrid because, now and then, I still do a consultation.

Today, patients often come in and want the "whole works." They can have a parade of specialists and the patient may initially love it until it becomes so confusing

that nobody really knows what is going on. This is one of the gross errors we have right now; where there are so many specialists seeing a patient that nobody really knows what's going on.

I have reviewed charts of patients who have gone through special care, had an extensive workup and come out and what the devil was wrong with them was completely missed. We've got to improve this situation. The essence of it is that we've got to have a lot more respect for each other and for every patient. If we have respect for each other, it will work out fine.

*Dr. Farber:* If people would communicate with each other there would probably be almost no problem. Everyone should be aware of the true intellectual difference that family practice tries to bring to medicine, one physician who can provide continuity of care. It can also see beyond each particular specialty and really does provide an aspect to medical care that can be of great value to the patient and to the other physicians providing care.

I don't think a patient, if I have that patient's trust and I refer that patient, is *my* patient. He is a person who has come to me for medical care and who has placed his trust in me. That patient is not mine, not the specialist's, not anybody's. In the end, that patient is responsible for his care. I would hope that every physician would interact with the patients in a manner that would respond to their individual wishes and demands.

*Dr. Roller:* Let's have our panelists respond to questions from the floor.

**Question: A specialist sees a patient in consultation. The patient goes home and two weeks later has the same problem again, calls the specialist and is admitted to the hospital. The generalist comes into the hospital and doesn't know the patient is there. Should the specialist keep the generalist informed on the status of the original referral?**

*Specialist:* Absolutely. The primary care physician is the captain of the ship. The response should be to immediately call the primary care physician. Again, communications — personally and in writing — is the number one aspect of the consultant-primary physician relationship.

**Question: A surgeon or a surgical subspecialist sees the generalist's patient on referral, and determines that a surgical procedure is necessary and you call and ask to be present at surgery but he really doesn't feel it is necessary. How do you handle that?**

*Generalist:* It depends. If an assistant is truly not needed, I don't see any particular reason to be there. If that patient has medical problems that go beyond just that surgical procedure, then I would expect to be involved in the care of those problems and to charge accordingly.

**Question: What is the most effective approach to a consultant who never sends written reports or phones and then commonly, or occasionally, initiates treatment on a second unreferred member of the family?**

*Specialist:* In our office we try very hard to require a physician referral for patients we see. We try to qualify the levels of our patient care and the extent of our follow-up on the basis of what kinds of disease process the



Over 150 members attended the meeting, preceded by a baron of beef and chicken buffet at the Fircrest Country Club.

patient has and how extensive it is. I think sometimes we feel that a patient is perhaps sicker than the primary care physician might feel and that the patient is really more deserving of our seeing him on a regular basis, limited to his disease.

If it is a patient who is very sick and we are unaware of the patient having a primary care physician, we would see him without hesitancy. If there is a primary care physician, we would ask that family member to please have that physician ask us to see the patient. Sometimes we see patients at the request of the family member and don't realize there is a primary care physician because we are told that there is not. That is a very difficult situation because we don't find out until we get nailed in the hall retrospectively by the physician who has been caring for that patient. I know that there are exceptions.

**Question: Any suggestions regarding the physician who generally requests consultation for in-hospital care the hour before he leaves for the weekend or a vacation?**

*Generalist:* When you're starting out that's kind of nice (laughter). After awhile, when you've got a few bucks in your pocket and you've got a lot of plans and the kids are grown up, then you say, "gee, that's kind of a nasty thing to do." It forms a pattern that's just certain people and isn't hard to handle. They'll find some other young guy who wants to do it. Everybody wants to get away Friday night now; I think a little bit too much. It's amazing how busy we are during the week and how important everybody is, then Saturday and Sunday comes and one guy can only do so much.

**Question: If a patient is referred to you from a family physician and you do such a great job that the patient doesn't want to return to the family physician, how do you handle that?**

*Specialist:* That places us in a real dilemma. I must say, and I'm only speaking for myself now, that if I felt that this were very important in terms of the patient's overall care, I would carry out whatever procedure, study or whatever care that I thought that patient might have. Some of you may not like this, but this is how I look at it.

**Question: What do you do about the patient sent for an office consultation who is unaccompanied by any medical records and then the specialist calls and the family doctor is out of town?**

*Generalist:* It is obviously very rude. We try, when we refer a patient, to give as much information as we can over the phone. Several of the doctors I refer to give me the courtesy of calling back and enlarging on the case and I really appreciate that, even if it's in the middle of the afternoon. This opens up this communication thing we were talking about a little bit more than a letter. If I'm out of town I guess I've fumbled the ball if I haven't given them that much information, but our office is always open when I'm away and I rely on my nurses to give that information.

**Question: With increasing subspecialization in the community, what is the role of the general internist and pediatrician in receiving referrals from family physicians?**

*Generalist:* There is still a strong place for most of us in family medicine. The general internist has the wealth of overall knowledge about many things. If we've got a diagnostic problem that is generalized, it is very helpful to rely on some of the strong general internists in this community. In addition, they may give a little better insight into how much ought to be spent for the patient's care in view of the patient's age — is all that testing really necessary? If this patient is going to a nursing home, does he really need a CAT scan when the overall results are apparent to all? As far as the pediatrician is concerned, I think we still appreciate the pediatrician as much as we ever had in family medicine and there has been no real change that I can see here. We still rely very heavily on our pediatric associates for consultation.



Dr. Ken Graham, Family Physician, and a past president of the Medical Society, was one of the generalists on the panel.

**Question: One sees all too often what appears to be a somewhat ritualistic work-up ordered by certain subspecialists often involving unnecessary hospitalization and testing without regard to cost for the patient or insurer and without giving the patient adequate information. How do you feel about that?**

*Generalist:* I think when you end up sending someone to a specialist you have a whole different ballgame. The specialist thinks they should find out what's wrong



because that's why you sent him there. The intellectual approach is, there are X number of things that cause this symptom and, by God, we're going to find out what it is in a short period of time. That's very costly. If there is a particular problem that you want the specialist to deal with, then I think you have to use communication, call or write him a letter. Better yet, do both, and be specific.

**Question: What should be done when the consultant acts or feels like the referring generalist isn't ordering or treating correctly?**

*Specialist:* It depends on what is wrong with the patient at the time he is seen. There are certain patients who absolutely require and demand that a specialist follow them regularly because of the extent of their disease.

There are patients who the specialist is perfectly suited for following on a regular basis and making certain they are continually fine tuned. In those settings, I feel justified in continuing to follow that patient, hopefully, keeping the primary care physician involved.

Communication is a two way street. One of the subliminal messages I'm getting here is that it's the responsibility of the specialist to keep the primary care physician informed when we do things, but I think it's the primary care physician's responsibility before things ever get started to tell us what he wants us to do and how he wants us to do it once we get involved. There are patients that need a specialist and, on the other hand, I think there is a group that is very comfortably referred back to the primary care physician. We have to negotiate this.

*Specialist:* In general, I would agree, but the one thing that concerns me is that there are certain patients that I must see as a specialist and you have the picture of the COPD patient that is standing there with his oxygen on and smoking a cigarette. That still varies with the skill and interest of the primary care physician.

**Moderator: Our current problem seems to be communications so I thought I would make a couple of suggestions that came up at this time. One was, has there been any consideration of a referral form which informs the consultant of the problem in question and the pertinent information — lab, x-rays, etc. — so that he would not be dependent on deciphering scribbles? Another comment along this line was that communication is poor if we don't know who is communicating. If there are four doctors on a case, at least three sign their names with initials or names that are totally illegible. We all just keep laughing at this problem, but it is actually a terrible discourtesy and reflects an arrogant attitude toward the other physicians. Is there any way to correct this?**

*Generalist:* We've been working on such a form for six months at Tacoma General's medical staff and it is being referred to the Medicine Committee. It is a pretty good form and we may be able to share it with other hospitals and also our primary offices.

**Question: What about the patient of the family practitioner or generalist who is off call who goes to the emergency room with an acute problem and a specialist is called and the generalist is never notified?**

*Specialist:* There is just no question that he should be notified and made cognizant of the fact that his patient is



*Dr. John Kennedy, Nephrology/Cardiology, presented an opening statement for the specialists.*

hospitalized and arrangements are being made for follow-up care.

**Question: Can the special care unit be a place where the primary physician can participate?**

*Specialist:* There is no question about that. Too often patients in special care units are referred. If the primary physician is skilled enough in the area of the patient's problem he certainly may take care of that patient without consultation. It isn't necessary for every patient in an intensive coronary care unit to have consultation.

**Question: What is the specialist's obligation to the generalist with regard to self-referrals from friends, relatives and so forth?**

*Specialist:* It is an increasingly common problem. The bigger your practice, the more of your patients there will be with family who will have something they want seen or taken care of and who will self-refer and don't have primary care physicians. Our practice is set up such that we always try to have a referral physician before we see the patient. If the patient does not have a physician and has a specific problem, say he's from out of town, we will, on occasion, see him and then try to find him a physician. I think that is a good way to handle those particular problems when they arise. It is a problem that doesn't have to be a big hassle and those patients who are going to want their cardio-vascular problem answered, or their renal problem, or what have you, that's the way they got to you in the first place. Answer it. Take care of it. Get them into the primary care community.

**Question: What do you do when you refer patients from your practice to a family practitioner and he insists on seeing the entire family or none at all?**

*Generalist:* I'd never refer them to that physician again. One of the theories that some of us have had ingrained in us in family practice is that we should take care of everybody in the world in that family and, certainly, there is lots of room for discussion on that point.

*Generalist:* I totally agree. I can't imagine how some physicians might feel that way and if that was the case, I'd do the same. I'd say thank you very much and forget it and refer to someone else.

One issue we haven't addressed at all this evening is money and the fact that there are more and more

physicians in the community and a stable number of patients and there is an undercurrent of who charges and bills for what. Maybe we're not going to address it, but it might be an interesting topic.

**Question: How does a generalist feel if a consultant says thanks for the consult but I have six others and would you mind if another consultant sees the patient?**

*Generalist:* As long as he communicated with me, I wouldn't mind at all. I might say, "well, who's the other one going to be" and he might say "Joe Blow" and I might say, "I don't like Joe Blow. I'll hold the patient till you come back or vice versa". Again, that's communication.

**Question: Would a specialist on the panel comment on the specialists' interest in continuity of care? Should the general practitioner send follow-up notes to the consultant periodically?**

*Specialist:* The type of patient that we see we generally have followed as the primary physician, not simply because of our interest and, hopefully, expertise in that area, but also because the way reimbursement measures for this type of patient are set by the government. In terms of the general practitioner sending follow-up notes to the consultant, this is at the discretion of the family practitioner and whether or not he thinks that is necessary. I think quite often, a phone call is adequate if it is felt to be important.

**Question: When does the patient get to say no more doctors and no more tests?**

*Specialist:* Anybody seeing patients in these areas (intensive and coronary care units) must have some knowledge and some ethical background to understand how to deal with them. The biggest problem is when the physician taking care of the patient is really unwilling or

does not want to take the time to discuss with the family, or perhaps the patient if he is able to discuss, what his expectations are and what kind of care the patient wants and when he wants to quit.

These are things we tend to glide over because we're busy.

*Specialist:* I hope that people would understand that as specialists we are incredibly dependent on an ongoing basis for all the kinds of things that are involved in total patient care outside of our area of expertise, and I hope that we would look individually at the people who refer to us regarding what kinds of things they would like to follow and how extensive that follow-up would be.

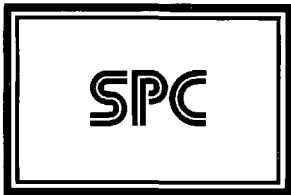
In special care settings, the primary care physician can do what nobody else can because he knows the family better than anybody else. On the other hand, I think you get to know a family very quickly in a critical care setting, and it is absolutely imperative that we have honest communication between a primary care physician and the patient when he is dealing with a very significant problem. There have been times when I have talked to the family and have found that the primary care physician has talked to the family and they have a different kind of perception about how sick the patient really is. We need to be honest and the most important thing is being honest with the patient.

Finally, it is important for primary care people who have a problem with me as a specialist seeing their patients to let me know directly rather than telling an associate.

*Moderator:* I want to thank our panelists. I think we'll look forward to doing this again, perhaps with a different battery of questions and a different panel, this Fall. Overall, I learned quite a bit tonight.

As you know, the thrust of the Medical Society this year is ethics and professionalism.

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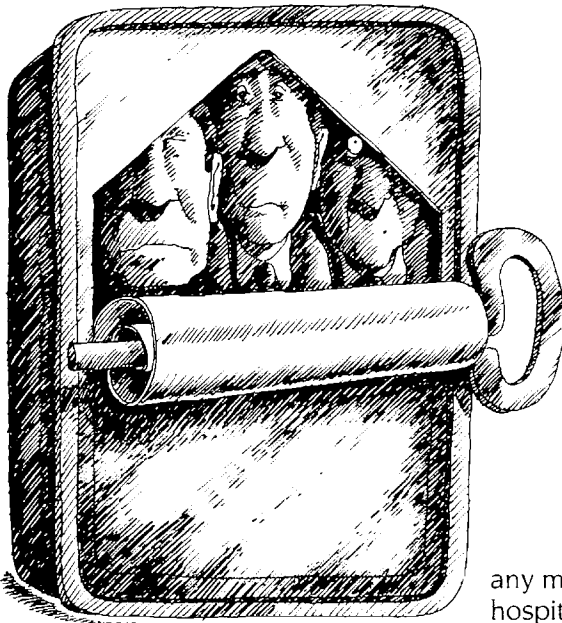
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## STUDENT RECOGNITION; 1982-1983 COMMITTEE CHAIRMEN; SUMMER BEGINS

### STUDENT RECOGNITION

The Student Recognition Committee wishes to announce the winners for 1982. They are: Marie Betteridge, daughter of Bryce and Leona Betteridge, a graduating senior from Curtis High School; and, York Baur, son of the Ernst Baus, a graduating senior from Washington High School.

The winners received a monetary award and a commemorative plaque. The committee wishes to list the following students as honorable mention: Robert Modarelli, Thomas Miskovsky, Edward Kramer, Kevin Coffinger, Nancy Hirz, Karen Stevens, Patricia Martin, Jean Kanda, Michelle Arthur, and Jill Spangler. Congratulations to all of you.

*Phyllis Pierce, Chairman*

### WSMA AUXILIARY CONVENTION REPORT

The Pierce County Medical Society Auxiliary had full representation at the 51st Annual Washington State Medical Association Auxiliary Convention held in Olympia April 27-29. There were ten delegates and one alternate attending each day from Pierce County: Marlene Arthur, Gloria Virak, Dottie Trucky, Shirley Kemman, Debbie McAlexander, Susie Duffy, Bev Graham, Sally Larson, Joan Sullivan, Kit Larson, Cathy Schneider, and Sharon Gilbert. Four of our members are

members of the State Board: Nancy Spangler, Jo Roller, Cindy Anderson, and Marny Weber.

*Marlene Arthur*

### COMBINED BOARD MEETING

The annual combined board (1981-82 and 1982-1983 board members) met Tuesday May 11 at the Tacoma Golf and Country Club. Members shared their committees' accomplishments and prepared the new chairmen for their responsibilities.

Beginning work was done for the coming new year. Nikki Crowley presented the gavel to incoming president Marlene Arthur. Nikki was given a big "thank you" for her year of service as president—a job well done. The members joined for lunch after the meeting.

### 1982-1983 COMMITTEE CHAIRMEN

AMA-ERF: Holiday Card ..... Helen Whitney  
Merchandise ..... Stephanie Tuell  
Communications: Bulletin ..... Judy Baerg  
Newsletter ..... Sharon Lukens  
County Health Projects ..... Gloria Virak  
Health Fair ..... Barbara Wong  
Community Reports ..... Julia Mueller  
Tel-Med Coordinator ..... Jessie Gillespie  
Co-Coordinator ..... Mary Schaeferle  
Womens Shelter ..... Ginny Miller  
Handicapped Awareness ..... Sharon Lukens

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- Organ Donor ..... Barry Mott
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- Long Range Planning ..... Debbie McAlexander
- Mailing ..... Shirley Kemman  
 Marilyn Bodily
- Finance ..... Shirley Murphy
- Newcomers..... Alberta Burrows  
 Mary Lou Jones (Co)  
 Sharon Gilbert (Co)
- Telephone Network ..... Donna McLees  
 Lavonne Campbell (Co)  
 Jane Nowsgroski (Co)
- Sunshine..... Marny Weber  
 Deana Dean (Co)  
 Rubye Ward (Co)
- Remembered ..... Norma Smith
- Volunteers ..... Phyllis Pierce
- Speakers Bureau..... Jo Roller
- Nominating ..... Nikki Crowley, Past President

**THANK YOU**

I wish to thank all of you who helped me gather the news for the Auxiliary Page these two years. I appreciated the timely response given to my requests for news items and your willingness to return calls. I couldn't have done the job without your help. Special thanks to Tom Curry and his staff.

*Mary Whyte Lenard*



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# Correspondence

## SOCIETY ENDORSES APPLICATION FOR CONTINUED COMMUNITY CLINIC FUNDING

*The Medical Society, by action of the Executive Committee and Board of Trustees, has strongly supported the application by the health department for continued funding of its community clinic program—the Eastside, Family, Sumner and Lakewood Clinics. The following letter was sent in May in support of the department's application—the editor*

Andrea Jordan  
Primary Care, Bureau of  
Community Health Services  
Mail Stop M/S 7-A55  
Parkland Building  
5600 Fisher Lane  
Rockville, Maryland 20857

Dear Ms. Jordan:

This letter is being written in support of the application of the Tacoma-Pierce County Health Department for Medically Underserved Area (MUA) designation for the areas served by its community clinic program and for continued funding for the program. Many physician members of the Medical Society have been involved in the implementation of the four community clinics operated by the health department and in the ongoing review of the quality of medical care provided through the clinics. Other physicians also have

been involved in the preparation and review of the MUA application data submitted to your office under separate cover earlier this week. The health department's application provides three methods for MUA determination and designation of the most appropriate statistical configuration based on existing criteria may be made at your option.

It is the position of the Medical Society that the need to provide medical services for the medically indigent in Pierce County is real and must be met. While private physicians have absorbed a significant percentage of Medicaid, lowered fee and no fee patients into their practices the need is increasing and the clinics are a vital part of the local health delivery system. It is somewhat academic for those involved (either those in need of the care or those anxious to provide it) as to which statistical configuration is used by the Bureau.

A recent Medical Society telephone survey of physicians in the Lakewood area, site of one of the four clinics, underscores the fact that the clinics are very important. The Society surveyed 92% of the primary care physicians in the area and found that 87% of the respondents are accepting patients with Medicaid coverage, 51% are accepting adjusted or lowered fee patients, and 32% are accepting patients unable to pay any fee. On the average, the physicians surveyed estimate that 14% of their practices are devoted to Medicaid beneficiaries, 6% to adjusted or lowered fee patients, and 3% to no fee patients (the no fee estimates do not include bad debt patients). Finally, 47% of those surveyed cannot accept a larger percentage of such patients. The clinics are needed to serve that portion of the population that exceeds what can be absorbed into private medical practices. The state of the economy in our area virtually guarantees that the number of medically indigent will continue to grow.

As has been stated in the past, the Medical Society strongly supports the four clinics operated by the health department. They provide good quality care and are strategically located. Their location provides a number of advantages as they are close to mass transit, centrally located for the people served, close to hospitals, laboratories, and physician specialists who treat clinic patients on a referral basis, and are conveniently located to other health resource centers and special service agencies. It is perhaps a unique feature of Pierce County that those who are medically indigent and who have a problem with access to medical services are geographically scattered throughout the county. There is no easily defined geographical "pocket" of individuals in need.

Medical Society representatives have met with Sixth District Congressman Norm Dicks, members of Congressman Dicks' staff, county and city elected officials and others to express our strong support for continued funding of the four clinics. We urge that you give the health department's application favorable consideration.

Sincerely,

Lloyd C. Elmer, M.D., President  
Medical Society of Pierce County

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# Membership

In accordance with the Bylaws of the Medical Society of Pierce County, Chapter Seven, Section A, MEMBERSHIP, the following physicians have applied for membership, and notice of their application is herewith presented. As outlined in the Bylaws, any member who has information of a derogatory nature concerning an applicant's moral or ethical conduct, medical qualifications or other such requisites for membership, shall assume the responsibility of conveying that information to the Credentials Committee or Board of Trustees of the society.

## FIRST NOTICE



**Edgar S. Steinitz, M.D., Physical Medicine and Rehabilitation.** Born in New York, NY, 2/1/52; University of Cincinnati College of Medicine, 1978; internship, University of Washington, 1979-81; Washington State license, 1979. Has applied for medical staff membership at Allenmore, Doctors, Lakewood General, Mary Bridge Children's, St. Joseph and Tacoma General hospitals. Dr. Steinitz is practicing at Allenmore Medical Center, Suite B-3003, Tacoma. **Sponsors:** Drs. Lee R. Dorey and Charles Ray.



**Robert E. Sands, M.D., Psychiatry.** Born in Seattle, WA, 5/4/46; University of Washington, 1979; internship (1972-73) and residency (1973-75), Walter Reed Army Medical Center; Fellowship in child psychiatry, Letterman Army Medical Center/Langley Porter Inst. UCSF, 1976-78; Washington State license, 1967. Has applied for medical staff membership at Allenmore, Doctors, Mary Bridge Children's, Puget Sound, St. Joseph and Tacoma General hospitals. Dr. Sands is practicing at 2607 Bridgeport Way W., Tacoma. **Sponsors:** Drs. J. Dale Howard and Barry J. Weled.



**Rufino R. Ramos, M.D., Psychiatry.** Born in Philippines, 8/19/33; Southwestern University, Philippines, 1964; residency, Fairfield Hills Hospital, Newtown, Conn., 1970-73; Washington State license, 1979. Has applied for medical staff membership at Good Samaritan, Puget Sound and St. Joseph's hospitals. Dr. Ramos is practicing at 1420 Meridian S., Suite D, Puyallup, WA. **Sponsors:** Drs. Hugo VanDooren and Dale Howard.

## SECOND NOTICE



**John E. Kooiker, M.D., Psychiatry.** Born in Minneapolis, Minnesota, 7/20/20; State University of Iowa, Iowa City, Ia., 1945; internship, U.S. Naval Hospital, Great Lakes, Illinois, 1945-46; residency, Menninger Foundation School of Psychiatry, Topeka, Kansas, 1949-52; State of Washington license, 1982. Dr. Kooiker is practicing at Western State Hospital, Tacoma. **Sponsors:** Drs. E. M. Wood and Singa Krishnamoorti.

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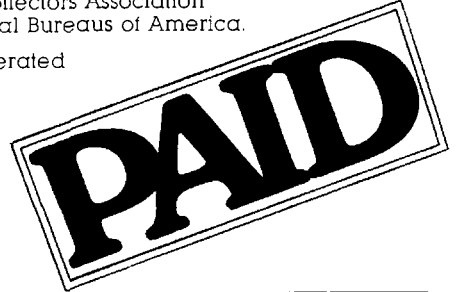
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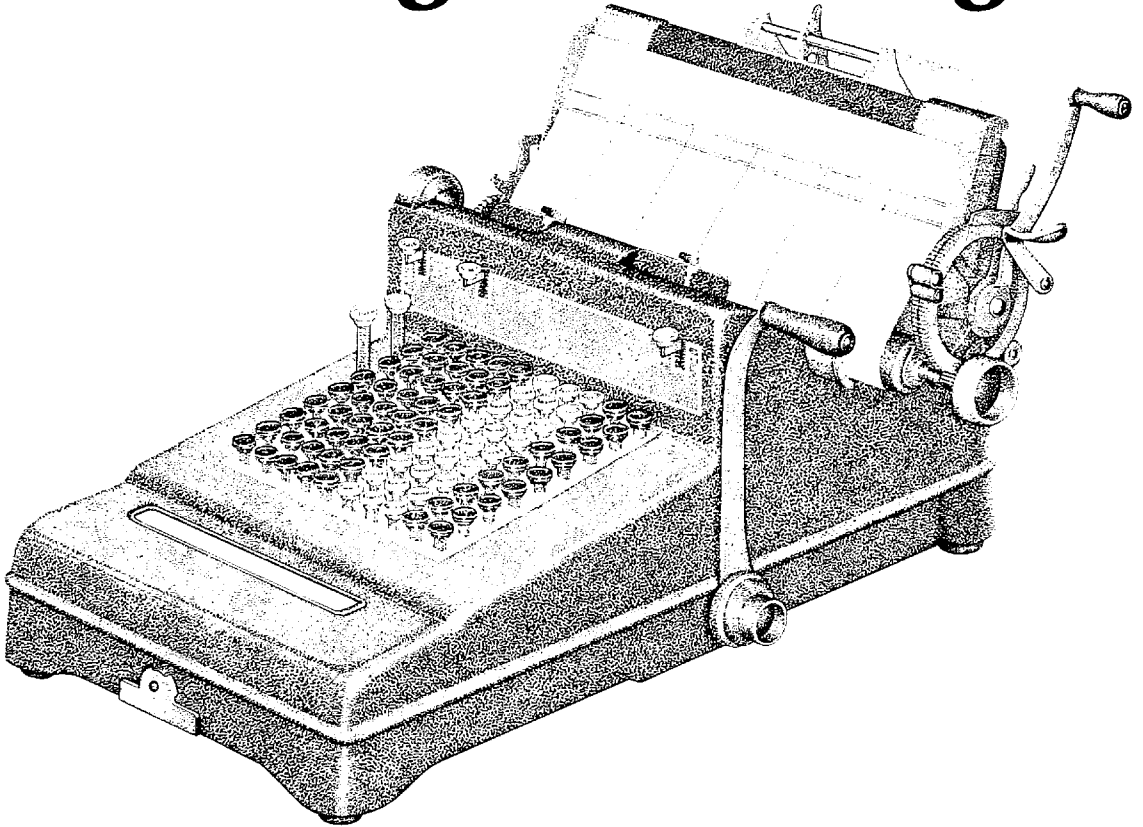
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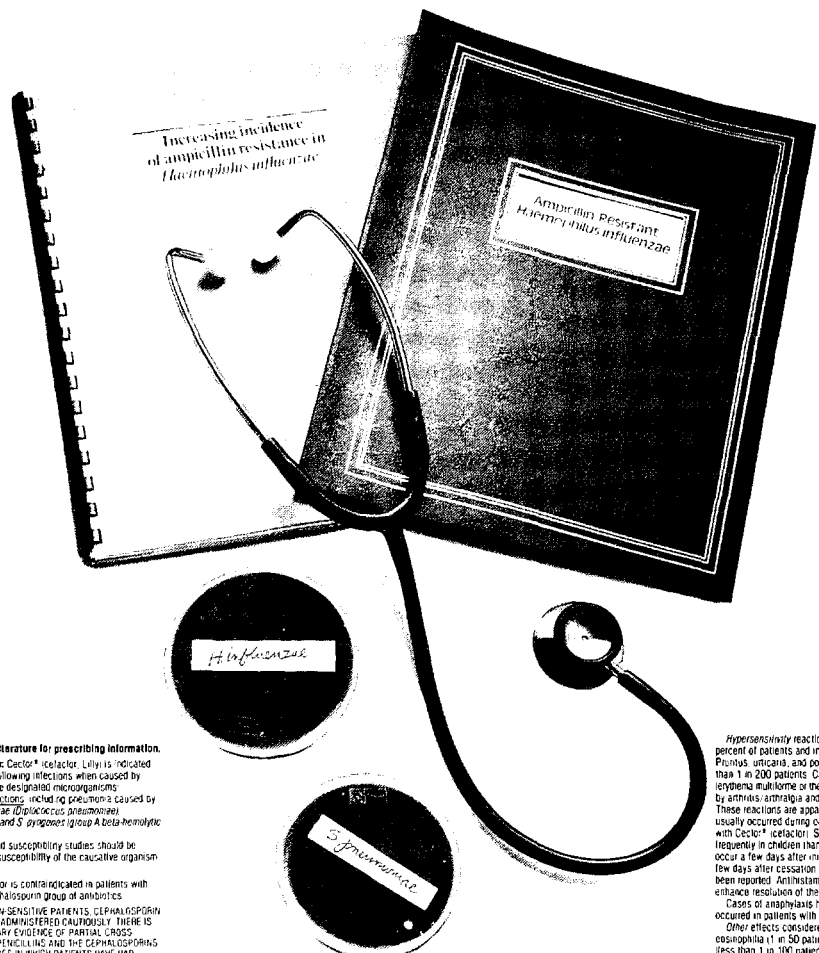
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**Precautions:** If an allergic reaction to ceclor occurs, the drug should be discontinued, and if necessary the patient should be treated with appropriate agents, e.g. epinephrine, antihistamines, or corticosteroids.

Prolonged use of ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential if superinfection occurs during therapy; appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In homologous studies or in transfusion cross matching procedures when antioglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor a false positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with ClinicalX® tablets, but not with Test-Tape® (Glucose Enzymatic Test Strip USP, Lilly).

**Usage in Pregnancy:** Although no teratogenic or aneuploidy effects were seen in reproduction studies in mice and rats receiving up to 1/2 times the maximum human dose or in fetuses given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

**Usage in Lactation:** Safety of this product for use in infants less than one month of age has not been established.

**Adverse Reactions:** Adverse effects considered related to ceclor therapy are uncommon and are listed below. Gastrointestinal symptoms occur in about 2% percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

As with other broad-spectrum antibiotics, colitis, including rare instances of pseudomembranous colitis, has been observed in conjunction with therapy with Ceclor.

Some ampicillin-resistant strains of ***Haemophilus influenzae***—a recognized complication of bacterial bronchitis\*—are sensitive to treatment with Ceclor.<sup>1-6</sup>

In clinical trials, patients with bacterial bronchitis due to susceptible strains of ***Streptococcus pneumoniae***, ***H. influenzae***, ***S. pyogenes*** (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.<sup>7</sup>

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**Hypersensitivity reactions** have been reported in about 1-5 percent of patients and include morbilliform eruptions (1 in 100), Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthralgia) and, frequently, fever have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor®. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy. Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

**Causal Relationship Uncertain**—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

**Algalic**—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

**Renal/epoietic**—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

**Renal**—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

(1002218)

\*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

**Note:** Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

**References**

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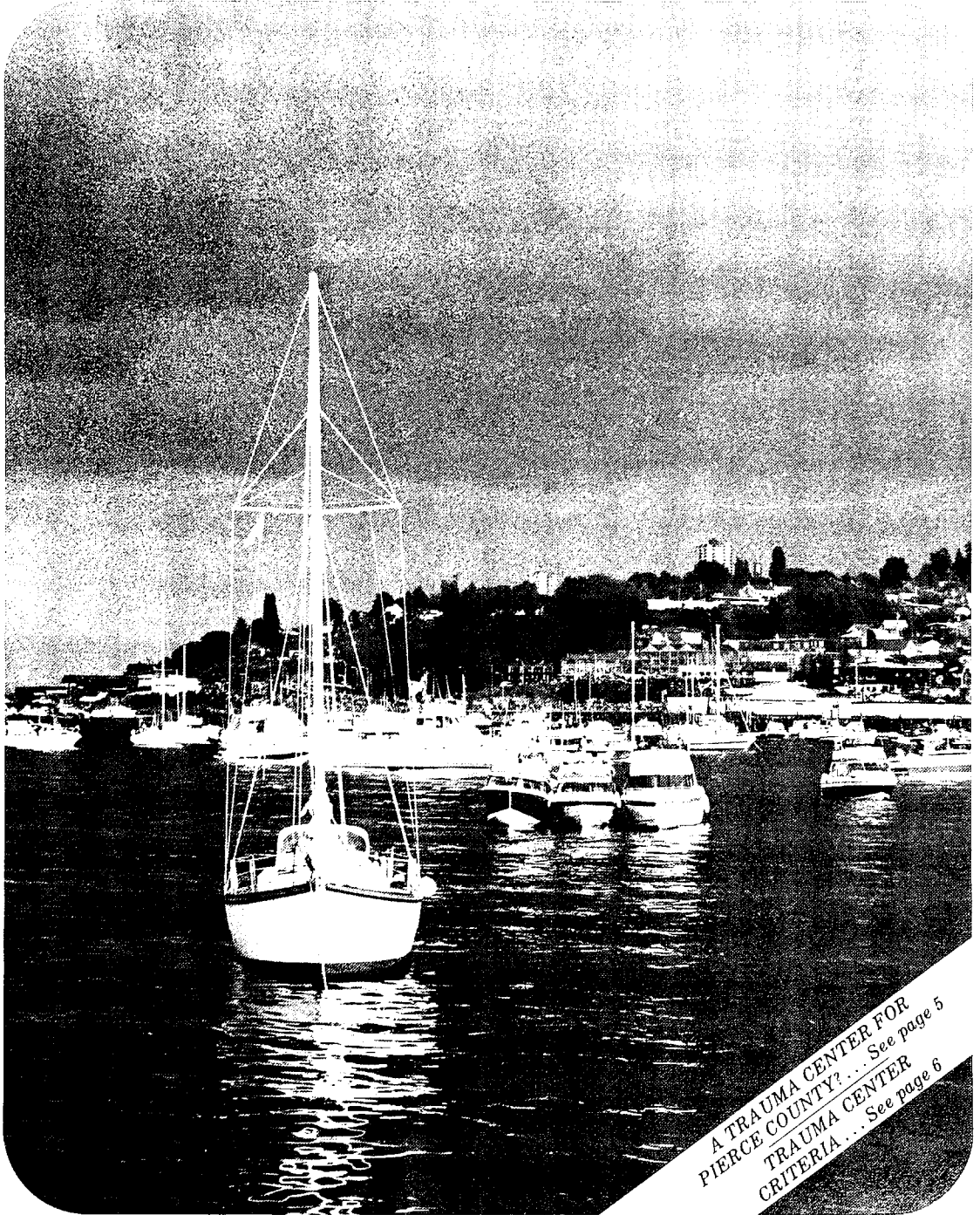
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# *Medical Society of Pierce County*

JULY 1982, Vol. LIV, No. 6, Tacoma, Washington



A TRAUMA CENTER FOR  
PIERCE COUNTY? . . . See page 5  
TRAUMA CENTER  
CRITERIA . . . See page 6

## **BULLETIN**

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## COVER PHOTO

Courtesy of Dr. Marcel Malden

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# Society News Briefs

A summary of Medical Society, and local medical and health news

## MEDICAL ECONOMY AND SURVIVAL FEATURES OF WSMA ANNUAL MEETING

The WSMA Annual Meeting, October 7-10 in Yakima, will feature programs that critically explore physicians' economic survival: What is happening in the medical economy, prepaid plans, and "will free choice of physician" survive? Several well-known and nationally recognized experts will speak on Saturday, October 9, on competitive factors, marketing new forms of practice, hospital-physician combines and the choices physicians will have regarding the way they choose to practice medicine.

Scientific programs, all offering CME credit and free to WSMA members will take place on Friday, October 8 and Saturday, October 9. Sessions in pediatrics, surgery, psychiatry, ophthalmology, emergency medicine, internal medicine and obstetrics will take place during those two days.

Physicians Insurance, the WSMA sponsored professional liability insurance carrier, will hold its first annual meeting on Thursday, October 7. The WSMA Annual Meeting is the 93rd for the state organization and will take place at the Yakima Convention Center, Towne Plaza Motel and the Holiday Inn. All facilities are in close proximity to one another.

A packet of annual meeting materials will be mailed to all WSMA members in August. A preliminary program will be included along with meeting registration forms and hotel/motel reservation cards.

## PHYSICIANS ELECTED TO MEMBERSHIP

Four provisional members were elected to membership in the Medical Society of Pierce County at the June Executive Committee meeting. The new MSPC members are: Drs. Rufino R. Ramos, Hugh K. Lancaster, Mohammad A. Saeed, and Stephen S. Tobias.

## PUBLIC HEALTH/SCHOOL HEALTH COMMITTEE TO MEET WITH SCHOOL REPRESENTATIVES

Pierce County School district superintendents, private school administrators, school nurses, special education directors, and sports/physical education directors have been invited to meet with physicians on August 26. This is an annual meeting, sponsored by the Society and its Public Health/School Health Committee.

Among the issues to be discussed are: Medical clearance for sports, implementation of the new school medication law, Child Find, health screening activities and resources, and modified physical education. MSPC members interested in attending, or who have concerns that should be brought to the attention of the group, are invited to contact the Medical Society office.

## TEMPORARY ASSISTANCE AVAILABLE

The Medical Society's Placement Service has a roster of qualified office personnel ready for your temporary staffing needs. For help in covering vacation and other staffing needs call Linda Carras, Placement Service manager, 572-3709.

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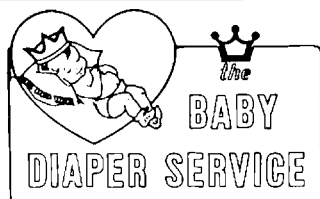
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Lloyd C. Elmer, M.D.

### A TRAUMA CENTER FOR PIERCE COUNTY?

The next several months promise to be a torrid season. Given the unpredictable proclivities of our Northwest marine climate, I am referring more to the sizzling issue of regional trauma center designation than to the somewhat anemic solar energy that lights up this part of our planet.

Already this issue is acting as a divisive force polarizing our medical community. This certainly is not in the best interest of our members, and has enormous negative impact on clinical practice and patient care. The Society's Board of Trustees addressed the trauma center issue at its June meeting and is committed to studying it to the fullest, and obtaining input from as many concerned groups, organizations and individuals as possible before reaching a decision. Designation begins with a Medical Society recommendation to the local Emergency Medical Services Council.

To date, in discussion with all hospital medical staff presidents, no voice has been raised against the concept of trauma center designation. Pierce County has long since come of age in the sophisticated delivery of the most advanced level of medical care. The scientific and statistical data would seem to bear out, as outlined in a previous guest editorial,<sup>1</sup> the benefits of such a system in terms of morbidity and especially in salvage of multi-system trauma patients.

The areas of conflict and disagreement center primarily around two issues. First, should there be one or more than one hospital designated as a regional trauma center? It very well may be that more than one hospital may meet the criteria for level II designation. Second, which hospital or hospitals should be so designated? The Society's Emergency Medical Standards Committee has modified the criteria of the American College of Surgeons for trauma center categorization and has recommended their adoption for Pierce County. These criteria (see page 6) have been studied by the Board of Trustees, but final approval will not be made until input is heard from all sides.

In coming to a decision on this most important and volatile issue, members are asked to put aside any parochial interests and to consider the pros and cons in a clear, objective light. The impact of our conclusions will directly affect, in a life and death fashion, several hundred Pierce County residents each year.

If it is to be a hot summer, let the heat burn away our prejudices and ignite a unifying spirit of cooperation for the good of all concerned.

*LCE*

<sup>1</sup> Bodily, K.C. "Comprehensive Trauma Plan Needed in Pierce County." *The BULLETIN*. LIV (4):8-9, 1982.

## CRITERIA FOR TRAUMA CENTER CATEGORIZATION PROPOSED

*The Medical Society's Emergency Medical Standards Committee has proposed criteria for hospital trauma center categorization. The criteria, drafted by the EMS Subcommittee on Trauma Regionalization chaired by Dr. Ken Bodily, were approved by the EMS Committee at its May meeting.*

*The Medical Society's Board of Trustees reviewed the proposed criteria at its June meeting and deferred final action pending individual physician and local specialty society comment. The proposed criteria are reprinted below, as is the relevant section of the minutes of the May EMS Committee meeting.*

*Individual physician and specialty society comment are encouraged. Please address your comments to MSPC President Lloyd C. Elmer, M.D., c/o Medical Society of Pierce County, 705 S. 9th, Suite 203, Tacoma, WA 98405 — The Editor.*

Minutes — EMS Committee Meeting, Thursday, May 27, 1982, Mary Bridge Hospital (Board Room), 7:00 a.m.

Present were: Drs. Kendrick (chairman), Scherz, Fulcher, Schroedl, Bodily, Fouke, Taylor (Jim), Dronen, Billingsley, Simms, Newman, Jergens, Taylor (Bill), and Nicola; Dr. Bob Lane, MSPC president-elect; Mr. Vance, Medical Control Project administrator; Mr. Curry, MSPC executive director.

Dr. Kendrick called the meeting to order at 7:00 a.m. The minutes of the April 22, 1982 meeting were approved as submitted.

### PROPOSED CRITERIA FOR HOSPITAL TRAUMA CATEGORIZATION

Dr. Bodily, chairman of the Subcommittee on Trauma Regionalization, introduced the subject. Establishment of criteria for trauma categorization is a responsibility of the Medical Society, the local EMS Council, and the state. The American College of Surgeons will adhere to local approval of criteria and designation of trauma centers if that is desired, it was stated. The proposed criteria are based largely on two sources — the American College of Surgeons' requirements for categorization (published in 1979) and requirements established by the AMA or AHA.

The proposed criteria do not address regionalization nor the actual designation of trauma centers, it was pointed out. Criteria can be modified to fit local needs.

The subcommittee's survey on trauma, conducted in January and February, was reviewed. All hospitals responded to the request for information and the issue was discussed with most administrators. Of 58 patients tracked over a two month period, two were transferred from one hospital to another due to injury status. Other

transfers were due to physician requests, patient or family requests, or the fact that no beds were available. Bed availability was a significant factor.

Dr. Bodily's article on trauma, published in the April 1982 issue of the *Bulletin*, was noted — particularly the fact that during the development of local categorization and regionalization plans concern is often expressed that lesser level facilities will be adversely affected to the benefit of higher level facilities as a result of diversion of patients. However, this concern has not been borne out in practice.

In his article Dr. Bodily wrote, "Most trauma patients are not critically injured and do not need sophisticated care from level I or II facilities. In fact, it is estimated that no more than 5-10% of trauma patients require categorization and these are the multi-system injured hemodynamically unstable patients. A study of trauma patterns in Pierce County has indicated that on the average approximately one patient per day currently fits this injury pattern."

It was pointed out that the main difference between level I and level II trauma centers is that level I incorporates a training center. Following additional discussion, a motion was made to amend Section A, 4, "Non-surgical physician specialist availability, on-call and promptly available from inside or outside the hospital," to list gastroenterology, hematology, nephrology, and psychiatry as essential for level II trauma centers. The motion was seconded and passed unanimously.

Rehabilitation services were discussed and a motion was made to amend Section B, 8, "Rehabilitation medicine," to require "acute rehabilitation medicine" as an essential, not desired, criterion for level II. The motion was seconded and passed unanimously.

Following additional discussion, a motion was made to amend the same section to include the phrase "with physician director." the motion was seconded and passed unanimously.

It was moved to adopt the Requirements for Trauma Hospital Categorization as amended and to recommend their endorsement by the Society's Board of Trustees and, if endorsed, that they be forwarded to the Pierce County EMS Council with a recommendation for adoption by the council. The motion was seconded and passed unanimously.

Hospital involvement in trauma categorization was discussed. It was the concensus of the committee that the requirements should be sent to hospitals for their review/comment and that hospitals could address the issue either individually or as a group through the hospital council's representation on the EMS Council.

If adopted, the Requirements for Trauma Hospital



Categorization will serve as a basis for Society review of any hospital application for designation as a level I, II, or III trauma center. The committee agreed that it should be left to the hospitals to determine their degree of commitment to the improvement of emergency medical services and the community, and that each institution should have the prerogative of committing its resources to meeting the requirements for trauma center designation.

The committee agreed that local trauma center designation more directly affects those instances where patients are currently being transported through (or over) Pierce County to other institutions designated as trauma centers. The adverse impact of this by-passing of Pierce County health facilities, particularly with respect to subspecialties, was pointed out and the committee agreed this is an issue that must be addressed by the Society.

## REQUIREMENTS FOR TRAUMA HOSPITAL CATEGORIZATION

KEY: E = Essential  
D = Desired

### LEVELS

I      II      III

#### A. HOSPITAL ORGANIZATION

|  |   |    |   |
|--|---|----|---|
| 1. Trauma Service  | E | E  |   |
| 2. Surgery Department/Divisions/<br>Services/Sections (each staffed<br>by qualified specialists) |   |    |   |
| Cardiothoracic Surgery   | E | E  |   |
| General Surgery  | E | E  | E |
| Neurologic Surgery   | E | E  | D |
| Obstetrics-Gynecologic Surgery   | E | E  | D |
| Ophthalmic Surgery   | E | E  | D |
| Oral Surgery-Dental  | E | E  | D |
| Othopaedic Surgery   | E | E  | E |
| Otorhinolaryngologic Surgery   | E | E  | D |
| Pediatric Surgery  | E | D  |   |
| Plastic and Maxillo-facial Surgery   | E | E  | D |
| Urologic Surgery   | E | E  | D |
| 3. Surgical Specialist Availability<br>In-hospital 24 hours a day:                               |   |    |   |
| General Surgery  | E | E' |   |
| Neurologic Surgery   | E | E' |   |
| On-call and promptly available<br>from inside or outside hospital:                               |   |    |   |
| Cardiac Surgery  | E | E  |   |
| General Surgery  |   |    | E |
| Neurologic Surgery   |   | E  | D |
| Microsurgery Capabilities  | E | D  |   |
| Gynecologic Surgery  | E | E  | E |
| Ophthalmic Surgery   | E | E  | D |
| Orthopedic Surgery   | E | E  | E |
| Otorhinolaryngologic Surgery   | E | E  | D |
| Plastic and Maxillo-facial<br>Surgery  | E | E  | D |
| Thoracic Surgery   | E | E  | D |
| Urologic Surgery   | E | E  | D |

|   |   |    |    |
|---|---|----|----|
| Pediatric Surgery   | E | D  |    |
| Hand Surgery  | E | E  |    |
| Oral Surgery-Dental   | E | E  | D  |
| 4. Non-surgical Physician Specialist<br>Availability In-hospital 24 hours<br>a day: |   |    |    |
| Anesthesiology  | E | E' | D' |
| On-call and promptly available<br>from inside or outside hospital:                  |   |    |    |
| Cardiology  | E | E  | D  |
| Gastroenterology  | E | E  | D  |
| Hematology  | E | E  | D  |
| Infectious Diseases   | E | D  | D  |
| Internal Medicine   | E | E  | E  |
| Nephrology  | E | E  | D  |
| Pulmonary Diseases  | E | E  | D  |
| Pathology   | E | E  | E  |
| Psychiatry  | E | E  | D  |
| Pediatrics  | E | E  | E  |
| Radiology   | E | E  | E  |
| Neuroradiology  | E | E' | D' |

#### B. SPECIAL FACILITIES/RESOURCES/ CAPABILITIES

|  |   |   |   |
|--|---|---|---|
| 1. Emergency Department  |   |   |   |
| a. Personnel:  |   |   |   |
| (1) Designated Medical Director  | E | E | E |
| (2) Physician(s) with special<br>competence in care of the<br>critically injured on duty in E.D.<br>24 hours a day.                                  | E | E | E |
| (3) RNs, LPNs and nurses'<br>aides in adequate numbers.  | E | E | E |
| b. Equipment for resuscitations<br>and to provide life support for<br>the critically or seriously<br>injured shall include but not be<br>limited to: |   |   |   |
| (1) Airway control and ventila-<br>tion equipment, including   |   |   |   |

|   |   |   |   |
|---|---|---|---|
| laryngoscopes and endotracheal tubes of all sizes, bag-mask resuscitator, sources of oxygen and mechanical ventilator.  | E | E | E |
| (2) Suction devices   | E | E | E |
| (3) Electrocardiograph-oscilloscope-defibrillator   | E | E | E |
| (4) Apparatus to establish central venous pressure monitoring   | E | E | E |
| (5) All standard intravenous fluid administration devices, including intravenous catheters  | E | E | E |
| (6) Sterile surgical sets for procedures standard for E.D., such as thoracostomy, cut-down, etc.  | E | E | E |
| (7) Gastric lavage equipment  | E | E | E |
| (8) Drugs and supplies necessary for emergency care   | E | E | E |
| (9) X-ray capability, 24-hour coverage by technicians   | E | E | E |
| (10) Two-way radio linking vehicles of emergency transport system with essential on-call physicians in hospital or county designated EMS communication system | E | E | E |
| (11) MAST Garment (Medical Anti-Shock Trousers)   | E | E | E |
| (12) Skeletal Tongs   | E | E | E |
| 2. Intensive Care Units (ICU) — For trauma patients, ICUs may be separate specialty units   |   |   |   |
| a. Designated Medical Director  | E | E | E |
| b. Physician on duty in ICU 24 hours a day or immediately available from in-hospital  | E | D | D |
| c. Nurse-patient minimum ratio of 1:2 on each shift   | E | E | E |
| d. Immediate access to clinical laboratory services   | E | E | E |
| e. Equipment:   |   |   |   |
| (1) Airway control and ventilation devices  | E | E | E |
| (2) Oxygen source with concentration controls   | E | E | E |
| (3) Cardiac emergency cart  | E | E | E |
| (4) Temporary transvenous pacemaker   | E | E | E |
| (5) Electrocardiograph-oscilloscope-defibrillator   | E | E | E |
| (6) Cardiac output monitoring   | E | E | D |
| (7) Electronic pressure monitoring  | E | E | D |

|   |   |   |   |
|---|---|---|---|
| (8) Mechanical ventilator-respirator  | E | E | E |
| (9) Patient weighing devices  | E | E | E |
| (10) Pulmonary function measuring devices   | E | E | E |
| (11) Temperature control devices  | E | E | E |
| (12) Pressure distribution equipment  | E | E | E |
| (13) Drugs, intravenous fluids, and supplies  | E | E | E |
| (14) Intracranial pressure monitoring devices   | E | E |   |
| 3. Postanesthetic Recovery Room (PAR) (surgical intensive care unit is acceptable)  |   |   |   |
| a. Registered nurses and other essential personnel 24 hours a day   | E | E | E |
| b. Physician (usually anesthesiologist) supervision in-hospital 24 hours a day  | E | D | D |
| c. Appropriate monitoring and resuscitation equipment   | E | E | E |
| 4. Hemodialysis capability  |   |   |   |
| a. Physician-directed dialysis center/unit staffed by nursing personnel trained in dialysis techniques and properly equipped for care of patients requiring dialysis, OR  |   |   |   |
| b. Transfer agreement with a nearby hospital dialysis center  |   |   |   |
| 5. Organized Burn Care  |   |   |   |
| a. Physician-direct Burn Center/ Unit staffed by nursing personnel trained to burn care and equipped properly for care of the extensively burned patient, OR  |   |   |   |
| b. Transfer agreement with nearby burn center or hospital with a burn unit.   |   |   |   |
| 6. Acute Spinal Cord Injury Management Capability<br>In circumstances where a designated spinal cord injury rehabilitation center exists in the region, early transfer should be considered; transfer agreements should be in effect. |   |   |   |
| 7. Radiological Special Capabilities  |   |   |   |
| a. Angiography of all types   | E | E | D |
| b. Sonography   | E | E | D |
| c. Nuclear scanning   | E | E | D |
| d. Computerized tomography — 24 hours a day availability  | E | E | D |
| 8. Acute Rehabilitation Medicine with Physician Director  | E | E |   |

**C. OPERATING SUITE SPECIAL REQUIREMENTS —**

| Equipment-instrumentation   |   |   |   |
|---|---|---|---|
| 1. Operating room adequately staffed and immediately available 24 hours a day | E | E | D |
| 2. Cardiopulmonary bypass pump-oxygenator                                     | E | E |   |
| 3. Operating microscope   | E | D |   |
| 4. Thermal control equipment  |   |   |   |
| a. for patient  | E | E | E |
| b. for blood  | E | E | E |
| 5. X-ray capability   | E | E | E |
| 6. Endoscopes, all varieties  | E | E | E |
| 7. Craniotome   | E | E | D |
| 8. Monitoring equipment   | E | E | E |

**D. CLINICAL LABORATORIES SERVICE IN HOUSE 24 HOURS A DAY**

|  |   |   |   |
|--|---|---|---|
| 1. Standard analyses of blood, urine, and other body fluids  | E | E | E |
| 2. Blood typing and cross-matching   | E | E | E |
| 3. Coagulation studies   | E | E | E |
| 4. Comprehensive blood bank or access to a community central blood bank and adequate hospital storage facilities | E | E | E |
| 5. Blood gases and pH determinations   | E | E | E |
| 6. Serum and urine osmolality  | E | E | E |
| 7. Microbiology  | E | E | E |

**E. PROGRAMS FOR QUALITY ASSURANCE**

|   |   |   |   |
|---|---|---|---|
| 1. Medical Care evaluation including:   |   |   |   |
| a. Special audit for trauma deaths  | E | E | E |
| b. Morbidity and mortality review   | E | E | E |
| c. Trauma conference, multi-disciplinary  | E | E |   |
| d. Medical nursing audit, utilization review, tissue review   | E | E | E |
| e. Medical records review   | E | E | E |
| 2. Outreach program: telephone and on-site consultations with physicians of the community and out-lying areas   | E | D |   |
| 3. Public educations: injury prevention in the home and industry and on the highways and athletic fields; standard first-aid; problems confronting public, medical profession, and hospitals regarding optimal care for the injured | E | E | D |

|  |   |
|--|---|
| 4. Qualifications of trauma care personnel | E |
|--|---|

|                                   |   |
|-----------------------------------|---|
| <b>F. TRAUMA RESEARCH PROGRAM</b> | E |
|-----------------------------------|---|

**G. TRAINING PROGRAM**

|  |   |   |
|--|---|---|
| 1. Formal programs in continuing education provided by hospital for: |   |   |
| a. Staff physicians  | E | E |
| b. Nurses  | E | E |
| c. Allied health personnel   | E | E |
| d. Community physicians  | E | E |

1. May be fulfilled by ensuring physician will be in the E.D. or O.R. at time of patient's arrival.
2. May be fulfilled by Radiologist with special interest in Neuro-radiology.



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**FOR THE RECORD . . .**

Due to a production error, three photographs of the May General Membership Meeting printed in the June *Bulletin* were incorrectly identified. The photos, with proper identification, are reprinted here. — The Editor.



*Over 150 members attended the meeting, preceded by a baron of beef and chicken buffet at the Fircrest Country Club.*



*Dr. John Kennedy, Nephrology/Cardiology, presented an opening statement for the specialists.*



*Dr. Ken Graham, Family Physician, and a past president of the Medical Society, was one of the generalists.*

## BE ALERT TO POSSIBLE DRUG INTERACTIONS

A patient of mine came into the office the other day complaining, "Doctor, I just don't feel good. I am so tired but I can't sleep. My ankles and my eye lids are swollen and I have no appetite and everything I eat makes me gassy." Physicians hate to hear symptoms such as these because we immediately have a diagnosis. But this time I was horrified to find that she was taking *nine* different kinds of medicine, most of which I had at one time or another prescribed. The important point is that I had neglected to make sure that when she started a new medication she had discontinued an old one.

It was a refreshing coincidence when, at the June meeting of your Interprofessional Committee the very next day, Dr. John Doelle, one of our members from Sumner, requested to open the meeting with a discussion of the problem of multiple medications and the potential interactions of various drugs which we prescribe. "Pharmacists express concern," said John, "when patients are on numerous prescriptions."

He continued to point out the concern when a patient's previous medications are not discontinued when new ones are added (for example, a patient who is on two different types of beta blockers), and situations where a possible drug interaction may be encountered. This seems to be especially important in the area of cardiovascular medications where numerous new medications are coming onto the market and frequently are utilized in treating angina, hypertension and congestive failure. Potential drug interactions include the potentiation of digoxin by quinidine and the potentiation of theophylline by tagamet.

It was pointed out that tagamet is a very popular medication and does have some drug reactions such as prolonging the effects of theophyllin. A recent issue of the JAMA calls attention to the dangers of using tagamet in a patient who is receiving lidocaine. Apparently, the tagamet blocks the liver metabolism of lidocaine so the lidocaine dosage can quickly become toxic, causing tremors, mental confusion and even death.

Physicians and pharmacists alike should be alert to possible medication interactions and should carefully monitor for side effects patients who are on large numbers of medications. Fortunately, both serum digoxin and serum theophyllin and lidocaine levels are available for patients who are on these medications and possibly several other medications as well. The committee agreed that care should be taken in explaining to patients the discontinuance of former medications when new medications are initiated.

We also encourage physicians to respond to questions on the part of their pharmacists. Some of the pharmacists again expressed concern when prescriptions are renewed over the phone by a member of the office staff apparently without review of the patient's chart or without checking with the physician if there is any question.

We know that we are all busy and that time is precious. But we all should remember that we can look up a medication in the PDR for its possible drug interactions. Or,



we can ask our pharmacist friends who are glad to help us. After all, it was a long time ago that we took our pharmacology in medical school and since then thousands of new drugs have emerged. For our patients' sake, let's be more careful.

Incidentally, the patient I described in the beginning of this report feels "fine" now. She is on *no* medication!

Herman S. Judd, M.D.  
Chairman



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## Medical-Legal Committee

# ADDITIONAL ASSISTANCE FOR PHYSICIANS AND LAWYERS CONSIDERED

The joint Medical-Legal Committee met in May to review possible revisions to the Medical-Legal Guidelines as well as other issues of mutual concern. A summary of the minutes of the meeting is reproduced below. Physician comment is invited.

Present were: Drs. Ben Blackett (physician chairman), Stan Tuell, Dick Huish, Bruce Buchanan, and Don Pearson; Mssrs. Jim Krueger (attorney chairman), Jim Lowry, Jim Healy and Don Kelly; Tom Curry, MSPC Executive Director.

*Committee Status:* Dr. Blackett and Mr. Krueger reviewed recent committee activities. The committee currently reviews between five and ten physician/lawyer complaints each year. Complaints generally deal with fees charged as a result of depositions or preparation for testimony, often when there is cancellation of depositions or testimony on short notice. Physician members of the committee expressed their interest in meeting more frequently. It was agreed to do so.

*Arbitration:* Mr. Krueger suggested offering a binding arbitration clause to the existing Medical-Legal Guidelines. Such a clause could be legally enforced if both parties agree to arbitration before submitting a dispute to the committee for resolution. Concern was expressed about occasional incidents where the "losing" party has

not complied with the opinion issued by the committee. The committee agreed that the addition of such a clause to the guidelines would add an additional and useful alternative for the resolution of disputes. Mr. Krueger said the attorneys would draft an arbitration clause for committee consideration.

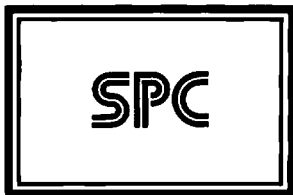
*Fees:* The committee discussed the variations in fees charged by different physicians. Mr. Curry will check with other county medical-legal committees to see what guidelines, if any, are used elsewhere.

*Physician Vs. Lawyer Complaint:* The committee reviewed a current dispute. Copies of the correspondence dealing with the matter were distributed as were copies of the draft opinion prepared by Dr. Blackett and Mr. Krueger. Following some discussion, the opinion was amended and approved.

*Medical-Legal Symposium:* The committee agreed that it would be desirable to meet more frequently in order to provide additional input into the content of the annual Medical-Legal Symposium held each January. The success of the first two conferences were noted and the committee expressed a desire to build on that success for future programs of benefit to physicians and attorneys.

As there was no further business to conduct, the meeting was adjourned.

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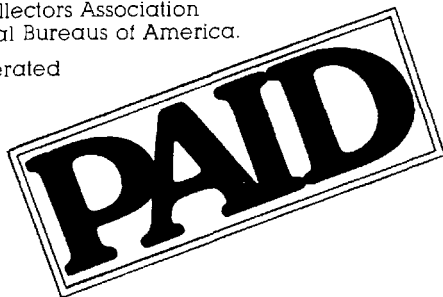
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Page 14*

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Ed Wood, M.D., Ph.D.

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In a provocative discussion, Klatt and his coworkers have examined the cost of a creatine kinase (CK) in a typical 19 test profile performed routinely in a large California hospital.<sup>1</sup> CK in association with the isozyme CK-MB is clearly one of the best laboratory tools for diagnosing myocardial infarction. As a screening admission test, however, the predictive value is very low indeed. The California workers calculated the actual total cost per CK at \$0.64 which emphasizes the financial clout of automation. When they compared the *clinical* value to cost of some 600 CKs performed daily as part of a 19 test profile, their conclusions were strikingly different.

Using the definition that a screening test is used to discover disease that would otherwise go unrecognized, they concluded that virtually none of the positive CKs were indicative of unrecognized disease. In four days of testing, they performed 2274 CKs with 16 from patients with possible myocardial infarctions. If the recognition of these 16 patients was considered the net yield from the four days of testing, each “useful” CK would have cost \$90.96! In actual practice, all 16 patients had already been clinically recognized as probable infarctions and the CK isozymes had already been ordered. In summary, the CK test as a part of the admission profile of that

hospital contributed *almost no* clinical information at a cost of approximately \$140,000 annually.

If that bothers you, take another look at the admission profiles in Tacoma hospitals. They almost all include a CK.

### A PAP PEARL

Cervical cytology preparations are of unquestioned value in the detection of cervical neoplastic disease. The associated use of the Maturation Index, however, as a measure of estrogen effect is probably over promoted. Somewhere between those two indications for a pap smear, lies a third which you may not be utilizing.

A number of investigators have reported *Actinomyces* in pap smears from women using IUDs. This organism has been implicated as an agent causing endometritis, salpingo-oophoritis and tubo-ovarian abscess. Significant infections can and do occur although the majority respond well to simple IUD removal.<sup>2</sup>

*Actinomyces* can be recognized with the conventional Papanicolaou stains although the method of choice utilizes specific fluorescein isothiocyanate labeled antisera.

All of this simply underscores the importance of communicating with the cytologist. Write “IUD” on the pap requisition form and that slide will be looked at a little harder.

Ed Wood, M.D., Ph.D.

1 Klatt, E. C., Wasel, E. S. and E. T. Wong. Creatine Kinase In A Biochemical Test Panel. The High Cost of a Seemingly Inexpensive Test. *Am. J. Clin. Path.*, 77(3):280-284, 1982.

2 Valicenti, J. F., Pappas, A. A., Graber, C. D., Williamson, H. O., and N. F. Willis. Detection and Prevalence of IUD-Associated *Actinomyces* Colonization and Related Morbidity. *JAMA*, 247(8): 1149-1152, 1982.

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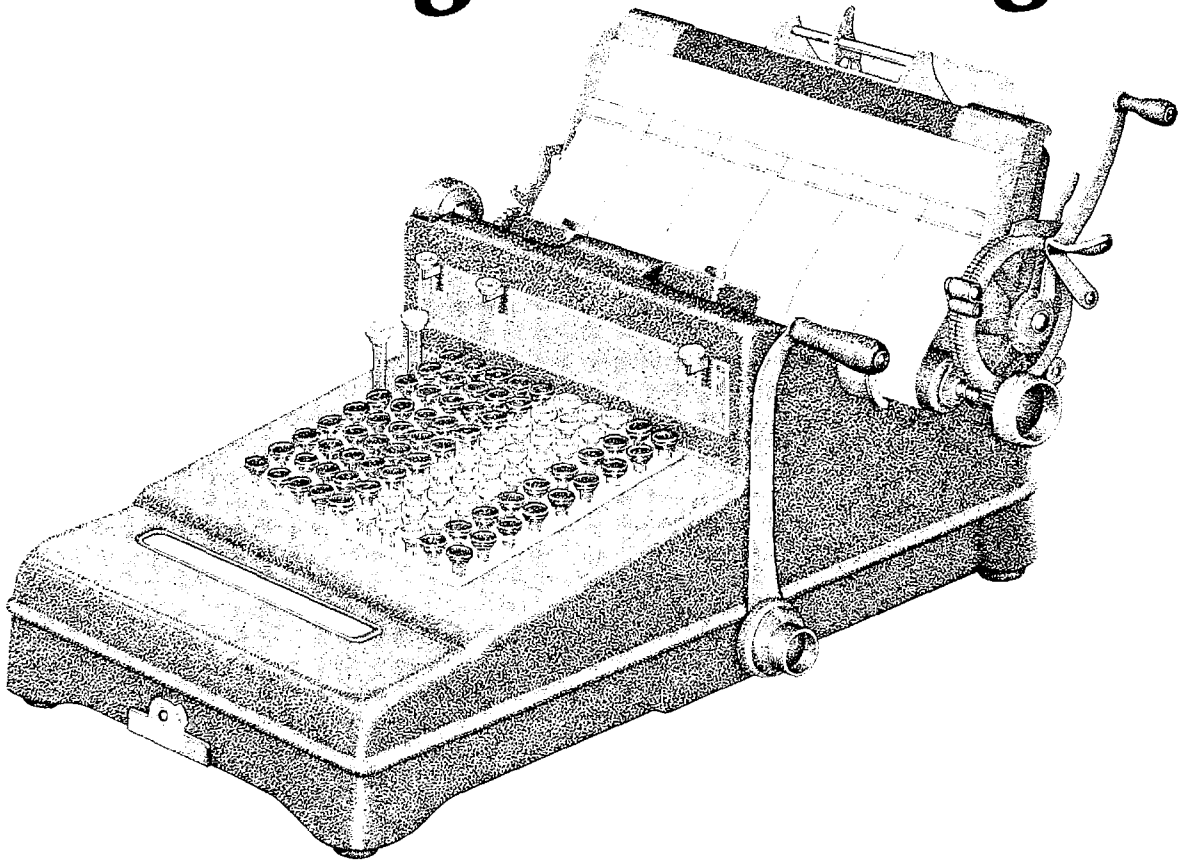
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# *Medical Society of Pierce County*

AUGUST 1982, Vol. LIV, No. 8, Tacoma, Washington



SEPTEMBER 14  
GENERAL MEMBERSHIP  
MEETING . . . See Page 4.

## **BULLETIN**

# How much of your medical practice are you giving away?

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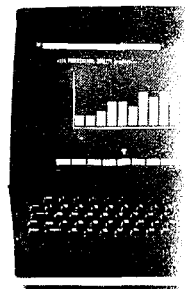
It consists of a computer terminal with telephone connection, giving you a "window" for entering data and making inquiries. Optional equipment, including a printer and a word processor with graphics, is available to augment the basic system. Software for the On-Line System has been exhaustively researched, and was approved only after thorough user-testing. The final product reflects Poorman-Douglas's long history in automated medical accounting, and incorporates refinements suggested by medical professionals.

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## COVER PHOTO

In the Rain Forest

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# Society News Briefs

A summary of Medical Society, and local medical and health news

## SEPTEMBER 14 MEMBERSHIP MEETING TO EXPLORE ADDITIONAL ETHICAL ISSUES

The Tuesday, September 14, general membership meeting will feature a panel discussion exploring further the primary care physician — specialist physician relationship. The program format will be similar to the highly successful May 11 general membership meeting.

Drs. Gordon Klatt, Stan Tuell, Richard Hoffmeister, Robert Ferguson, Richard Hawkins, and WSMA President Donald Keith will serve as panelists. Program moderator will be Dr. Gil Roller. The panel will discuss the issue of "Who Should Go Into The Surgical Suite?"

The program will also feature a brief status report of Physicians Insurance, the physician owned professional liability insurance company established in 1982, including a forecast of 1983 rates.

The meeting will be held at the Fircrest Golf Club. A social hour and dinner will precede the program. Dinner expense is \$10.75 per person. Members are encouraged to make their reservations as soon as possible as space will be limited. Deadline for reservations is Friday, September 10. Call the Medical Society, 572-3667, today to make your reservation for September 14 meeting.

## PHYSICIAN FINANCIAL SEMINARS SCHEDULED FOR SEPTEMBER — JANUARY

A series of five monthly financial skills seminars for Medical Society members will begin on September 15. The programs are intended to provide physicians with useful information relating to the business aspects of medical practice and personal financial planning. The seminars are offered by the Society's Membership Benefits, Inc. The seminar faculty includes representatives from the Society's accounting firm of Simonson, Moore and Olson; legal counsel, Adams, Gagliardi and Halstead; and, investment manager, the Tacoma office of Dean Witter Reynolds.

Other participants include MBI's endorsed medical practice consultant Management Resources (Dolores Lunstrum) of Tacoma and Schwartz, Shera and Associates, actuaries, brokers and consultants.

The seminars are scheduled for September, October, November, December and January. The programs will include a breakfast and will be held at St. Joseph's Education Center from 7:00 a.m. to 9:30 a.m. See page 8 for details.

## LONG-TERM CARE GUIDE AVAILABLE

A guide to long-term care in Pierce County is available to physicians and their office personnel through the Medical Society. The resource guide covers such subjects as: Choosing a long-term care facility, financing long-term care, nursing home care, congregate or residential care and community support services to support independent living.

The guide was prepared as a project of the Long-term Care Ombudsman Program of the Pierce County Area Agency on Aging in conjunction with the local Council on Aging. The guide has been reviewed by the Medical Society's Executive Committee and approved for distribution to doctors as a useful office aid for patients in need of such information. For copies of the guide, please call the Medical Society office, 572-3667.

(Continued on page 9)

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# Medical Society of Pierce County

## GENERAL MEMBERSHIP MEETING NOTICE

—THE PROGRAM—

### The Patient—Primary Care Physician—Specialist Relationship

#### *PART II: Who Should Go Into The Surgical Suite?*

"I will refer you this patient for procedure if you allow me to assist."

"The most skilled hands should do the work."

**PANELISTS:** Drs. Gordon Klatt, Stan Tuell, Richard Hoffmeister, Robert Ferguson, Richard Hawkins, and WSMA President Donald Keith.

**MODERATOR:** Dr. Gil Roller

### ALSO: Brief Physicians Insurance Status Report with Forecast of 1983 Rates

**DATE:** Tuesday, September 14, 1982

**PLACE:** Fircrest Golf Club  
6520 Regents Blvd., Fircrest

(Take Fircrest exit off of Hiway 16. Proceed on Regents Blvd. to the club which will be on your left.)

**TIME:** 6:15 P.M. - Social Hour  
7:00 P.M. - Dinner  
8:00 P.M. - Program

**COST:** Dinner, \$10.75 per person.  
Salad bar, chicken and baron of beef buffet  
(price includes tax and gratuity)

Register now. Mail this form, with a check for the appropriate amount, to the Medical Society office. Or, call the office, 572-3667, to confirm your attendance. Make check payable to Medical Society of Pierce County.

#### REGISTRATION:

Yes, I have set aside the evening of September 14 to meet with my colleagues.

\_\_\_\_\_ Please reserve \_\_\_\_\_ dinner(s) for me at \$10.75 each (price includes tax and gratuity).  
Enclosed is my check for \$ \_\_\_\_\_.

\_\_\_\_\_ I regret I am unable to attend the dinner portion of the meeting. I will attend the program only at 8:00 P.M.

DR. \_\_\_\_\_ Telephone No. \_\_\_\_\_

RETURN TO THE MEDICAL SOCIETY BY NO LATER THAN FRIDAY, SEPTEMBER 10

# THE TIME HAS COME . . . MEDICAL MALPRACTICE REFORM



Lloyd C. Elmer, M.D.

One year ago, the WSMA overwhelmingly passed Resolution Number 1 at the 1981 House of Delegates annual meeting. This resolution stated, "Therefore, be it resolved that the House of Delegates direct the Council on Member Services to establish an ad hoc committee for tort reform to develop a program of comprehensive tort reform in the State of Washington which sets forth objectives, implementation and budget. Such program to be presented to the Board of Trustees and House of Delegates at the annual meeting in 1982." This mandate is enthusiastically being carried out under the auspices of a special tort reform task force and is being planned in infinite detail by Glen Hudson, WSMA's highly capable staff member whose main level of expertise lies in legislative and lobbying affairs. Glen has already begun implementation of an intricate campaign that infuses a feeling of optimism and confidence in all who are touched by it.

The campaign will succeed when the prime goal is realized. That goal is the enactment of major malpractice tort reform legislation in the 1983 legislative session. The plan requires that a "climate" which will enhance legislative success be created. This will require involvement of physician and auxiliary leadership in the political and legislative process. Key groups of physicians and auxiliaries must be recruited to help in this effort, and the WSMA will help the medical community become *actively* and *personally* involved in the 1982 legislative contests. Once the new legislature is constituted, an intense lobbying effort will be instituted.

As practicing physicians, we can determine the success or failure of this project by our willingness to roll up our sleeves and get to work. Most of us have the ability to be opinion makers, and our thoughts are respected by our neighbors, friends and associates. We need to speak out

in a forthright fashion, not motivated by limited self-interest. Rather, we must make the public aware of the fact that *it* pays the price of the nearly 20 percent yearly increase in medical liability insurance premiums. We need to remind others in the professions and the business world that we need their active support not only to help hold their health care costs down, but ultimately and in a corollary fashion, their product liability and their professions' malpractice problems will be diminished with our success. Most of us know and, in many cases, we provide medical care for members or candidates for the legislature. We must take the initiative to inform these individuals and enlist their support in order to succeed.

The WSMA is geared up to help its members become spokesmen for the tort reform program. Educational meetings, forums, brochures, fact sheets, the use of speakers' bureaus, and the advice of our able lobbying staff will be readily available to all members. In June of this year, the Florida legislature met in special session to deal with a medical liability crisis that threatened the delivery of health care to every individual in that state. Florida physicians were faced with increased malpractice premiums of 400 percent. Because of legislative action, the increases will instead be about 36 percent.

The time for action is now. Let us not wait for a crisis to develop here in the State of Washington, and be forced to react to it. Let us work together to shape the legal climate in which we live. Our adversaries are formidable to be sure, but we can and shall win this battle because we will not be afraid to speak out and labor for principles that are right and just — for the profession and public.

L.C.E.

## MENINGOCOCCAL DISEASE SCARE: AN EPIDEMIC THAT MIGHT HAVE BEEN

### CASE REPORT

On Friday, June 11, 1982, the communicable disease nurse at the Tacoma-Pierce County Health Department received a call from the nursing director at Tacoma schools at 10:15 a.m. reporting that there had been two recent cases of meningitis. Both cases had the same babysitter. Further investigation revealed that the first child, age 8 months, had died six hours after admission to Mary Bridge Children's Hospital at 1:42 a.m. on June 9th; the coroner's report stated "10 x normal pus in CSF." Preliminary blood culture report at autopsy on Case #1 was *Neisseria* (species not yet determined); CSF culture was negative.

The second child, a 4½ month old female, with onset of symptoms the evening of June 10, 1982, was hospitalized at Madigan Army Medical Center. Cultures on Case #2 had been incubating for 12 hours; the laboratory would not give a definitive reading until June 12, 1982.

By 2:00 p.m., two other cases, of Case #1, had been brought to the Mary Bridge emergency room, a 5 year old female sibling (Case #3) and a 3½ year old female cousin (Case #4). Both children had temperature of 100-101 degrees, petechiae across the shoulders. Case #3 had headache (no nuchal rigidity), pharyngeal erythema. Tentative clinical diagnosis at the time was "R/O meningitis/meningococemia."

Case #3 was a regular attendee of the Headstart Program. Case #4 attended a day care center with 18 to 20 children under 4 years of age; last exposure was June 9th.

The decision was made to notify contacts and parents of possible exposure to *Neisseria Meningitidis* and recommend prophylaxis with Rifampin. (Rifampin was only available at two hospital pharmacies). Approximately 50 people were contacted by public health and school health nurses. The death certificate on Case #1, signed by the coroner on June 14th, listed "acute meningitis, viral" as the cause of death. Case #3 had a chest x-ray which was read as "left lower lobe consistent with pneumonia penumonitis" and was treated with ampicillin. Cultures from all four cases one week later were still negative for *Neisseria Meningitidis*. Slides from Case #1, examined July 12th, from the brain and four sections of cord showed diffuse polymorphonuclear infiltrate and petechiae. Lung lesions were typical of *H. influenza*; however no bacteria were identified. The death certificate was changed to "acute myelo-meningitis, viral."

### DISCUSSION

Most available data on secondary cases — defined by the Center for Disease Control as disease in a household contact that begins more than 24 hours and less than 30 days after the index case in the household is hospitalized<sup>1</sup> — have been based on studies of household members. However, there may be other persons who have been in close, intimate contact with a case for substantial length of time before onset of illness in that case, and these persons should also be identified.

The recommendation of antibiotic chemoprophylaxis for the prevention of meningococcal disease in household contacts is based on a number of observations.

1. The attack rate of meningococcal disease in household contacts of a case is significantly higher than the attack rate in the general population during both endemic (approximately 1,000 times higher)<sup>1</sup> and epidemic (as much as 15,000 times higher) periods<sup>5,7</sup>.
2. The carrier rate of the pathogenic strain in household contacts of cases is four to five times that observed in the general population<sup>7,9</sup>. Meningococcal carriers are probably at low risk of contracting systemic illness from homologous strains of meningococci since meningococcal carriage produces an antibody response<sup>4</sup>. The higher carriage rate in household contacts, however, leaves those contacts who are not carriers at increased risk of acquiring infection and illness.
3. Close surveillance of households for an uncertain time period can be reduced because the health of contacts probably requires such monitoring only during the first 24 hours after initiation of chemoprophylaxis<sup>1</sup>.

Since household contacts of meningococcal disease cases are at significantly higher risk of acquiring the disease than the general population, they should receive chemoprophylaxis as soon as possible, preferably within 24 hours, after the index case is diagnosed. As many as 33% of secondary cases occur within four days after the hospitalization of the index case<sup>8</sup>.

The health department relies on the report of the practicing physician so that household and other intimate contacts can be identified, given appropriate chemoprophylaxis, and managed properly.

Sulfonamides have previously been used to eradicate the carriers state, but by 1963, sulfonamide-resistant meningococci were the predominant organism<sup>10</sup>. Although penicillin and ampicillin are highly effective in treating the illness, they are not sufficiently effective in eradicating the carriage state to warrant their use for chemoprophylaxis. Minocycline and Rifampin have been proved to be 80% to 90% effective in eradicating carriage of meningococci. Minocycline is not now used for asymptomatic household contacts of uses because of significant and frequent vestibular reactions. Rifampin has been criticized because of expense, the possibility of Rifampin-resistant *mycobacterium tuberculosis* strains being produced in the population, and potential toxicity.

The maximum cost of treatment is \$5.00 (mean hospitalization cost of a case of meningococcal disease has been estimated at \$15,000). It is unlikely that the administration of four doses of Rifampin will lead to the emergence of a resistant strain of tuberculosis (the probability of such an occurrence has been estimated at  $9.9 \times 10^{-9}$ ). Rifampin may cause a transient mild hyperbilirubinemia, but liver injury is more frequent in patients with alcoholism or pre-existing liver disease or in patients concurrently receiving another hepatotoxic drug such as INH<sup>3</sup>.

The dosage schedule recommended for meningococcal chemoprophylaxis with Rifampin is four doses given orally separated by 12 hour intervals; each dose in 600 mg for adults, 10 mg/kg body weight for children 1 to 12 years old, and 5 mg/kg body weight for infants less than one year of age.

The development of serogroups A and C meningococcal polysaccharide vaccines during the past several years has produced very important and powerful tools for the control of meningococcal epidemics. The use of meningococcal C vaccine in military recruits in the United States has produced a clear and convincing reduction in serogroup C epidemics in the military<sup>11</sup>. Some authors advocate routine chemoprophylaxis with serogroup A or C meningococcal vaccine for household contacts<sup>1</sup>.

Surveillance of household contacts without chemoprophylaxis has been proposed as the method of choice for controlling secondary cases<sup>12</sup>. Such surveillance is a method of diagnosing suspected cases and is not designed to prevent disease but rather death. Because close surveillance is difficult to implement and meningococcal disease may take a rapid fulminant course, CDC authors do not recommend surveillance as the sole method of secondary case control.

In this outbreak meningococcal disease was suspected and the decision to use antibiotic chemoprophylaxis of close contacts was based on:


1. The time from onset of fulminant meningeal disease in Case #1 was four days, nearly one-third of secondary cases occur in the first four days after the index patient is hospitalized. With a weekend approaching, a delay of two additional days could have been catastrophic.
2. Persons at highest risk are household contacts; day care center contacts; medical personnel who resuscitated, intubated, or suctioned the patient before antibiotics were begun; and persons who had contact with the patient's oral secretions through intimate contact or through the sharing of food and beverages.<sup>2</sup>

If meningococcal disease due to serogroups A or C had been confirmed, vaccination with meningococcal vaccine of high risk contacts may have been helpful since at least half of the secondary cases in families of persons with meningococcal disease occur more than five days after the primary case<sup>2</sup>. In addition, vaccine may help control outbreaks of meningococcal disease in at-risk neighborhood populations.

*Bud Nicola, M.D.*  
Director of Health  
Tacoma-Pierce County Health Department

## FOOTNOTES

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# ENHANCING YOUR FINANCIAL SKILLS

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September 15, 1982

## INTERNAL CONTROL FOR MEDICAL PRACTITIONERS

- \*Know what embezzlement is.
- \*Understand how embezzlement occurs and is prevented.

October 13, 1982

## INVESTMENTS IN THE 1980's

- \*Understand tax sheltered investments.
- \*Differentiate common and preferred stock investments.
- \*Recognize new developments in the bond market.

November 10, 1982

## INCORPORATION - WHEN & WHY

- \*Increase understanding of personal economics & other non-tax considerations.
- \*Recognize tax and non-tax benefits.
- \*Conceptualize how to establish a professional service corporation.

December 9, 1982

## ESTATE PLANNING - SHIFTING ASSETS, TRUSTS AND OTHER CONSIDERATIONS

- \*Understand estate planning and the Economic Recovery Tax Act of 1981.
- \*Recognize value in shifting income property to lower tax brackets.
- \*Increase awareness of pension plans.
- \*Increase understanding of life insurance and retirement plans.

January 12, 1983

## EVALUATING A MEDICAL PRACTICE

- \*Analyze expense in relation to income to control expense.
- \*Define a method for establishing a fee for new service.
- \*Understand controlling accounts receivable.  
Including: Cash flow, improving collections and accounts receivable.

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**Non MSPC Physicians - \$30 Each Session, \$110 Entire Series**

Please register for the Financial Breakfast Seminars as follows:

Entire Series  Sept. 15  Oct. 13  Nov. 10  Dec. 9  Jan. 12

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I am not a member of MSPC

Enclosed is my check for \$\_\_\_\_\_ (Make checks payable to COME)

Name \_\_\_\_\_ Specialty \_\_\_\_\_

Address \_\_\_\_\_ Office \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Please address all registrations and correspondence to: Maxine Bailey, Executive Director  
College of Medical Education, Inc.  
705 South 9th, No. 203  
Tacoma, Washington 98405



**SOCIETY NEWS BRIEFS Continued**

**MSPC MEMBER HONORED  
BY NATIONAL ASSOCIATION**

Tacoma psychiatrist Dr. Hugh Van Dooren has been elected to the Board of Trustees of the 27,000 member American Psychiatric Association. Dr. Van Dooren began his three year term of office as a Western United States trustee at the APA's annual meeting in May. Dr. Van Dooren has practiced psychiatry in Tacoma since 1957. He is a Fellow of the APA and has served as president of the Washington State Psychiatric Association.

**COLLEGE OF MEDICAL EDUCATION  
SETS 1982-83 ACADEMIC CALENDAR**

The 1982-83 academic calendar for the College of Medical Education has been established. It includes 37 COME sponsored or coordinated programs for physicians and/or allied health personnel. Courses currently scheduled are listed on page 16 of this month's *BULLETIN*.

The calendar represents the most ambitious offering of courses yet in the 12 year history of the College. In some cases program dates remain tentative. A detailed brochure explaining each program will be mailed approximately one month prior to the actual program.

**NOTARY SERVICES AVAILABLE**

Free Notary Public Services are available to the members of the Medical Society through the Society's Membership Benefits office. The MBI office is located adjacent to the Society at 705 So. 9th (corner of 9th and G), Suite 202.

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**RSN** ANSWERING SERVICE NORTHWEST . . . provides efficient, professionally trained telephone secretaries to handle your after-hours calls for medical emergencies . . . or routine communication needs . . . 572-2550 or both, 24 hours a day.

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## THE DOCTORS HOSPITAL OF TACOMA

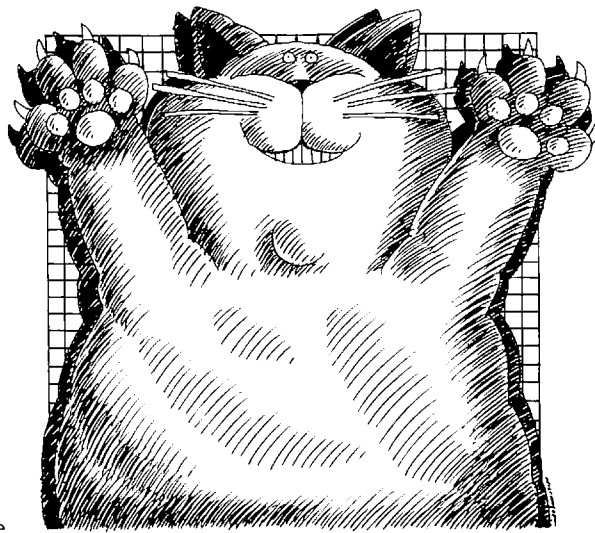
**Next General Medical Staff  
Meeting  
Monday, September 13  
Hospital Cafeteria  
Complimentary Lunch**

The popular "Back to Basics"  
Medical Staff Education Program  
will resume at the  
Medical Staff Meeting

Topic Suggestions  
may be directed to  
Raymond D. Dilworth, M.D.  
Coordinator



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We are continually upgrading our technology and equipment in a way that avoids duplication and higher costs to

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Tacoma-Pierce County Health Department

**Sponsored by:**

Tacoma-Pierce County Health Department  
Medical Society of Pierce County  
Pierce County Hospital Council

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- \*THE GROWING CONCERN
- \*CURRENT RESEARCH: PROPHYLAXIS, ADMINISTRATION,  
AVAILABILITY AND RATIONALE  
FOR DISTRIBUTION
- \*CENTERS FOR DISEASE CONTROL RECOMMENDATIONS

**Guest Lecturer:**

JAMES E. MAYNARD, M.D.  
Director, Hepatitis & Viral Enteritis  
Centers for Disease Control  
Phoenix, Arizona

---

**Credit:** Category I - AMA - AAFP

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**Registration:** \$30 - Includes buffet dinner

For further information and registration write or call:

COLLEGE OF MEDICAL EDUCATION  
705 South 9th, #203  
Tacoma, Washington 98405  
Phone 627-7137



# Membership

In accordance with the Bylaws of the Medical Society of Pierce County, Chapter Seven, Section A, MEMBERSHIP, the following physicians have applied for membership, and notice of their application is herewith presented. As outlined in the Bylaws, any member who has information of a derogatory nature concerning an applicant's moral or ethical conduct, medical qualifications or other such requisites for membership, shall assume the responsibility of conveying that information to the Credentials Committee or Board of Trustees of the society.

## FIRST NOTICE



**Keith M. Weigel, M.D., General and Internal Medicine.** Born in Seattle, WA 8/4/47; University of Washington School of Medicine, 1976; internship, Good Samaritan Hospital, Phoenix, AZ, 1976-77; residency, Good Samaritan Hospital, Phoenix, AZ, 1977-78; Washington State license, 1981. Has applied for medical staff membership at Good Samaritan Hospital. Dr. Weigel is practicing at 21120 Meridian East, Graham. **Sponsors:** Drs. Gail B. Strait, Richard D. Baerg.



**Sharon J. Michael, M.D., General Practice and Internal Medicine.** Born in Clarksburg, WV 7/21/51; Vanderbilt Medical School, Nashville, Tenn., 1977; internship, Good Samaritan Hospital, Phoenix, AZ, 1977-78; residency, Good Samaritan Hospital, Phoenix, AZ, 1978-79; Washington State license, 1981. Has applied for medical staff privileges at Good Samaritan Hospital. Dr. Michael is practicing at 21120 Meridian East, Graham. **Sponsors:** Drs. Gail B. Strait, Richard D. Baerg.

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MANAGEMENT RESOURCES

Endorsed by the Medical Society  
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## MEDICAL OFFICE ADMINISTRATION for the New — or established practice

Dolores Lunstrum  
4109 Bridgeport Way West  
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206/564-5600

## 1982 - 1983 BOARD MEETS

The members of the "new board" met for the first time June 21st at the home of Marlene Arthur, president. Plans and activities for the coming year were discussed and will be published in the membership booklet which will be available to paid members in the fall. A delicious lunch was served following the meeting. The next board meeting will be August 30, at 9:30 a.m. at Allenmore Medical Center, Building B.

Julia Mueller of the Community Health Committee reports a need for a volunteer to organize and implement a baby sitting curriculum developed by the Tacoma-Pierce County Health Department for young people. The health department also seeks volunteers to help in the Urban Health Initiative Clinics. Please contact June Ruth at the health department if interested.

Legislative Committee Chairman Sally Larsen (588-9839) needs two volunteers for each legislative district. Call if you are interested.

### NEWCOMERS COFFEES

September marks the beginning of the annual Newcomers Coffees. Mrs. Alberta Burrows, Mrs. Sharon Gilbert and Mrs. Mary Lou Jones, newcomers chairmen,

are trying to contact all new potential members with a personal invitation. Auxiliary members are invited and encouraged to attend their area coffee.

The coffees will be located as follows: *Thursday, September 9*, at the home of Mrs. Shirley Kemman (863-9152), corner of Sumner Heights and Monticello Lane, Sumner; *Friday, September 10*, at the home of Mrs. Susan Wulfestieg (851-6569), 3504 47th St. Ct., Gig Harbor; *Tuesday, September 14*, at the home of Mrs. Nadine Kennedy (759-8471), 4117 Madrona Way, Tacoma. All coffees are at 10:00 a.m. No reservations are necessary. **MARK YOUR CALENDARS!!**

### DUES

Dues are now being accepted for the 1982-1983 year. Lots of new and exciting programs and projects are planned. The dues are \$38.50 this year.

Please enclose your payment in the envelope which was mailed in the President's newsletter, or bring your check to the first fall meeting you attend. Mrs. Mary Whyte Lenard, dues treasurer, will be available at the meetings to accept payment. The membership booklet will be given to each member as dues are paid.

*Mrs. Judy Baerg*



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| Doug Dyckman, Jr. | B. Dennis Schmidt, CLU |
| John Toynbee      | P. Kathy Wardlow       |
| Wayne Thronson    | Bob Cleaveland         |

# Correspondence

## BE A LIFE SAVER — SUPPORT THE SEPTEMBER 14 LEVY

Dear Colleagues:

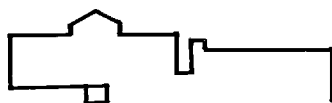
The emergency medical system in Tacoma has depended on private ambulances, the Fire Department and physician volunteers among others. In the 12 years since an organized prehospital care system was started, the delivery has steadily improved; however, further refinement and professional organization is needed.

On September 14, 1982, on the primary ballot, the Tacoma Fire Department will present an emergency medical services levy that, if passed, will significantly improve the delivery of emergency medical services to the citizens of Tacoma. This will include a third rescue unit, personnel to staff this unit, the position of an emergency medical services coordinator within the Tacoma Fire Department, overall emergency medical personnel and support funds for emergency medical services delivery apparatus.

No municipal funds are available for this campaign. The public must know why it is needed. Your support of fund raising efforts to help educate the public through ads in the local media will be greatly appreciated. Also, please take a few moments to educate your staff and patients about the need to support this levy. For an owner of a \$50,000 home, the annual cost of improved emergency medical services would be just \$9.75.

Sincerely,

*James G. Billingsley, M.D.*  
Chairman of Citizens for  
Better Emergency Medical Services



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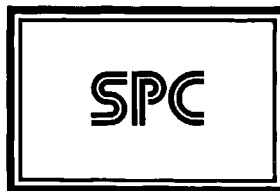
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# COLLEGE OF MEDICAL EDUCATION

A = Allied Health Personnel  
P = Physician

## Continuing Education Programs Projected for 1982-1983 Academic Year

*(Programming is subject to change — individual notices will be sent preceding each program)*

| Date       | Course/Topic   | Coordinator(s)                           |
|------------|--|--|
| September  |  |  |
| 10, 11, 12 | STRESS: DIAGNOSIS & MANAGEMENT AT ROSARIO*   | D. Cramer, D.O.                          |
| 15, 16     | HEPATITIS/HEPVAX (P/A)   | B. Nicola, M.D./E. Mares, R.N.           |
| 18         | ELECTROCARDIOGRAPHY FOR STAFF NURSES:<br>Corrolates With Clinical Patient Assessment (A) | Hilyard                                  |
| 30         | NEUROLOGY — THE OUTER LIMITS (A)   | M. Malden, M.D./P. Shull, R.N.           |
| 21, 22, 23 | DERMATOLOGY FOR THE NON-DERMATOLOGIST (P)  | J. Komorous, M.D.                        |
| 15         | ENHANCING YOUR FINANCIAL SKILLS (P)  | D. Hirz, M.D./T. Curry/L. Carras         |
| October    |  |  |
| 1, 2, 3    | INTERNAL MEDICINE* (P)   | TAIM/P. Schneider, M.D.                  |
| Open       | WOMENS HEALTH (P/A)  | G. Klatt, M.D./P. Shull, M.N.            |
| Open       | CENTRAL SUPPLY (A)   | R. Bramhall, R.N.                        |
| Open       | POTPOURRI MEDICAL/SURGICAL TOPICS (A)  | P. Shull, M.N.                           |
| Open       | RATIONAL USE OF ANTIBIOTICS (P)  | A. Tice, M.D./P. Marsh, M.D.             |
| 14         | ENHANCING YOUR FINANCIAL SKILLS (P)  | D. Hirz, M.D./T. Curry/L. Carras         |
| November   |  |  |
| Open       | BASIC EMERGENCY PROCEDURES (A)   | A. Chilton, B.S.N./<br>V. Turner, B.S.N. |
| 6          | ADOLESCENCE — GOOD NEWS/BAD NEWS (A)   | J. Short                                 |
| 11, 12     | FINANCIAL MANAGEMENT — HOSPITAL (A)  | B. Marcelia, M.T.                        |
| Open       | POTPOURRI — LABORATORY PROCEDURES (A)  | J. O'Neill                               |
| 11, 12     | MUSCULAR DYSTROPHY MEETING* (P/A)  | M. Malden, M.D.                          |
| Open       | SEXUAL DYSFUNCTION & DISEASE (P)   | J. Lincoln, M.D.                         |
| 11         | ENHANCING YOUR FINANCIAL SKILLS (P)  | D. Hirz, M.D./T. Curry/L. Carras         |
| December   |  |  |
| 3, 4       | PEDIATRIC ADVANCED LIFE SUPPORT (P)  | R. Scherz, M.D.                          |
| 9          | ENHANCING YOUR FINANCIAL SKILLS (P)  | D. Hirz, M.D./T. Curry/L. Carras         |
| January    |  |  |
| 22         | THE LAW & MEDICINE   | D. Pearson, M.D.                         |
| Open       | COMMON PAIN SYNDROMES<br>IN EVERYDAY PRACTICE  | H. Johnston, M.D.                        |
| Open       | LEGAL CONCERNS ASSOCIATED<br>WITH NURSING PRACTICE                                       | A. Moore, R.N.                           |
| 27         | PERINATAL — T.G.   | J. Mulligan, M.D./<br>P. Metcalf, R.N.   |
| 12         | ENHANCING YOUR FINANCIAL SKILLS (P)  | D. Hirz, M.D./T. Curry/L. Carras         |
| February   |  |  |
| Open       | HYPERALIMENTATION  | P. Schneider, M.D.                       |
| 5          | GERIATRICS WORKSHOP (A)  | J. Short                                 |
| Open       | DENTAL EMERGENCIES (P)   | C. Maier, D.D.S.                         |
| Open       | BASIC EMERGENCY MEDICINE (A)   | T. Kendrick, M.D.                        |
| 24, 25     | BURN (P/A)   | T. Irish, M.D.                           |
| Open       | PULMONARY (P)  | V. Nessian, M.D.                         |
| March      |  |  |
| 10, 11     | TACOMA ACADEMY OF INTERNAL MEDICINE (P)  | R. Ettlinger, M.D.                       |
| 19         | EMERGENCY MEDICINE/TOXIC SUBSTANCE (P/A)   | T. Kendrick, M.D.                        |
| Open       | MANAGEMENT CHALLENGE (A)   | B. Marcelia, M.T.                        |
| April      |  |  |
| 2, 3       | DAYS OF PEDIATRICS — GENETICS (P/A)  | R. Scherz, M.D.                          |
| 15, 16     | TACOMA SURGICAL CLUB — ANNUAL MEETING (P)  |  |
| May        |  |  |
| Open       | ADVANCED CARDIAC LIFE SUPPORT (P)  | T. Kendrick, M.D.                        |
| Open       | EVALUATION OF PATIENT REQUESTING DISABILITY/<br>FORENSIC/ABUSE BATTERING (P)             | D. Brown, M.D.                           |
| 19, 20, 21 | CARDIOVASCULAR DISEASE REVIEW (P)  | G. Strait, M.D.                          |
| Open       | OB/GYN (Speroff) (P)   | J. Sakakini, M.D.                        |
| June       |  |  |
| 31         | AMA OFFICE PERSONNEL   | L. Carras                                |

A detailed brochure will precede each program with approximately one month's advance mailing.

For further information write or call: Maxine Bailey, Executive Director, COLLEGE OF MEDICAL EDUCATION  
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Phone: (206) 627-7137

\*Non COME Course



# Classified

Classified and announcement copy may be mailed to: **Grawin Publications, 1020 Lloyd Building, 603 Stewart Street, Seattle 98101, or phoned to Seattle (206) 223-0861. 50c per word; \$10 minimum charge. Check must accompany copy.**

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*More Classifieds  
Page 18*

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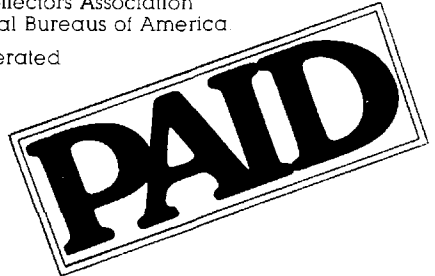
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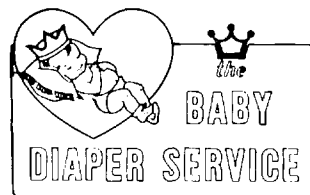
## DIAPER RASH is not a way of life

You can recommend with confidence professional diaper service

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**CAUTION TO YOUR PATIENTS.** It is illegal to dispose of human excrement in garbage. Mothers are doing this with paper/plastic diapers. "Disposable" is a misnomer.

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**FAMILY PRACTICE** locum tenens openings at Tacoma, Olympia. Federal Way Medical Centers of Group Health Cooperative. Board eligible/certified physicians for full scope primary care. Contact: Dr. Jesse Mantel, 1112 S. Cushman St., Tacoma, WA 98405, (206) 383-6120.

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*More Classifieds  
Page 17*

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**1983 DIRECTORY** for Pierce County Physicians and Surgeons is beginning production. Advertising rates available by calling Sally, (206) 223-0861, Grwin Publications.

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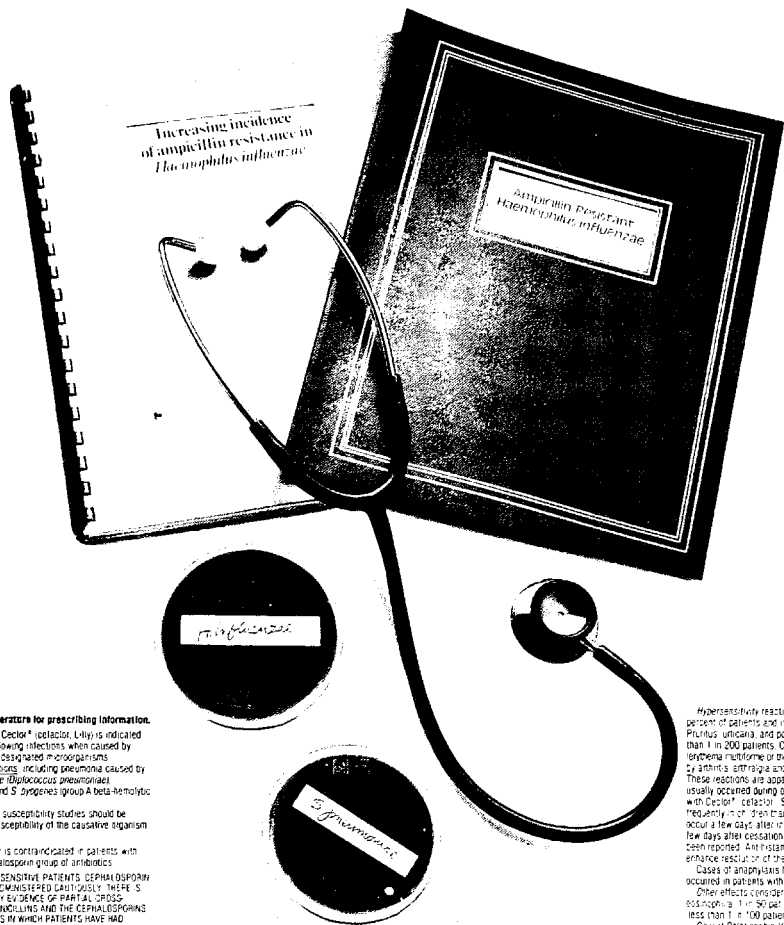
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Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

**Contraindications:** Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

**Warnings:** IN PENICILLIN SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGY OF THE PENICILLINS AND THE CEPHALOSPORINS AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS INCLUDING ANAPHYLAXIS TO BOTH DRUG CLASSES.

Ampicillin, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

**Precautions:** If an allergic reaction to cefadroxil occurs, the drug should be discontinued and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefadroxil may result in the overgrowth of non-susceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

**Positive direct Coombs tests** have been reported during treatment with the cephalosporin antibiotics. Immunologic studies or in transfusion cross-matching procedures when anglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinistix® tablets but not with Testape® Glucose Enzymatic Test Strip, USP, Lilly.

**Usage in Pregnancy:** Although no teratogenic or abortifacient effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

**Usage in Lactancy:** Safety of this product for use in infants less than one month of age has not been established.

**Adverse Reactions:** Adverse effects considered related to cefadroxil therapy are uncommon and are listed below. Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70), and nausea and vomiting (1 in 90).

As with other broad-spectrum antibiotics, colitis, including rare instances of pseudomembranous colitis, has been reported in conjunction with therapy with Ceclor.

## Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis\*—are sensitive to treatment with Ceclor.<sup>1-6</sup>

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.<sup>7</sup>

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include most, from eruptions (1 in 100), Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients. Cases of serum sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis, arthralgia, and frequently fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor® (cefadroxil). Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, most of which have occurred in patients with a history of penicillin allergy. Other effects considered related to therapy include dizziness (1 in 30 patients) and vertigo (1 in 10 patients), less than 1 in 100 patients.

**Causal Relationship Unknown:** Transitory abnormalities in clinical laboratory tests have been reported during therapy. They were of uncertain etiology. They are listed below to serve as alerting information for the physician.

**Weight:** Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

**Neutrophils:** Transient leukopenia, neutropenia, and/or prothrombatic lymphocytosis, occurring in infants and young children (1 in 40).

**Renal:** Slight elevations in BUN or serum creatinine, less than 1 in 500 or abnormal creatinine, less than 1 in 200.

\*Many authors have attributed acute infectious exacerbation of chronic bronchitis to the drug.

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin allergic patients.

For clinical use, a 500 mg. drug of choice in the treatment and prevention of otitis media with effusion in infants and young children of rheumatic fever. See prescribing information.

#### References

1. *Antimicrob. Agents Chemother.* 4:31 (1972)
2. *Antimicrob. Agents Chemother.* 11:440 (1977)
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4. *Antimicrob. Agents Chemother.* 1:490 (1971)
5. Current Chemotherapy (edited by W. Siegelstiner and H. Lilly), II 838, Washington, D.C., American Society for Microbiology, 1976.
6. *Antimicrob. Agents Chemother.* 11:561 (1976)
7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G. Mandel, R.G. Douglas, Jr., and J.E. Bennett), p. 487, New York, John Wiley & Sons, 1979.

# Ceclor®

## cefadroxil

Pulvules®, 250 and 500 mg



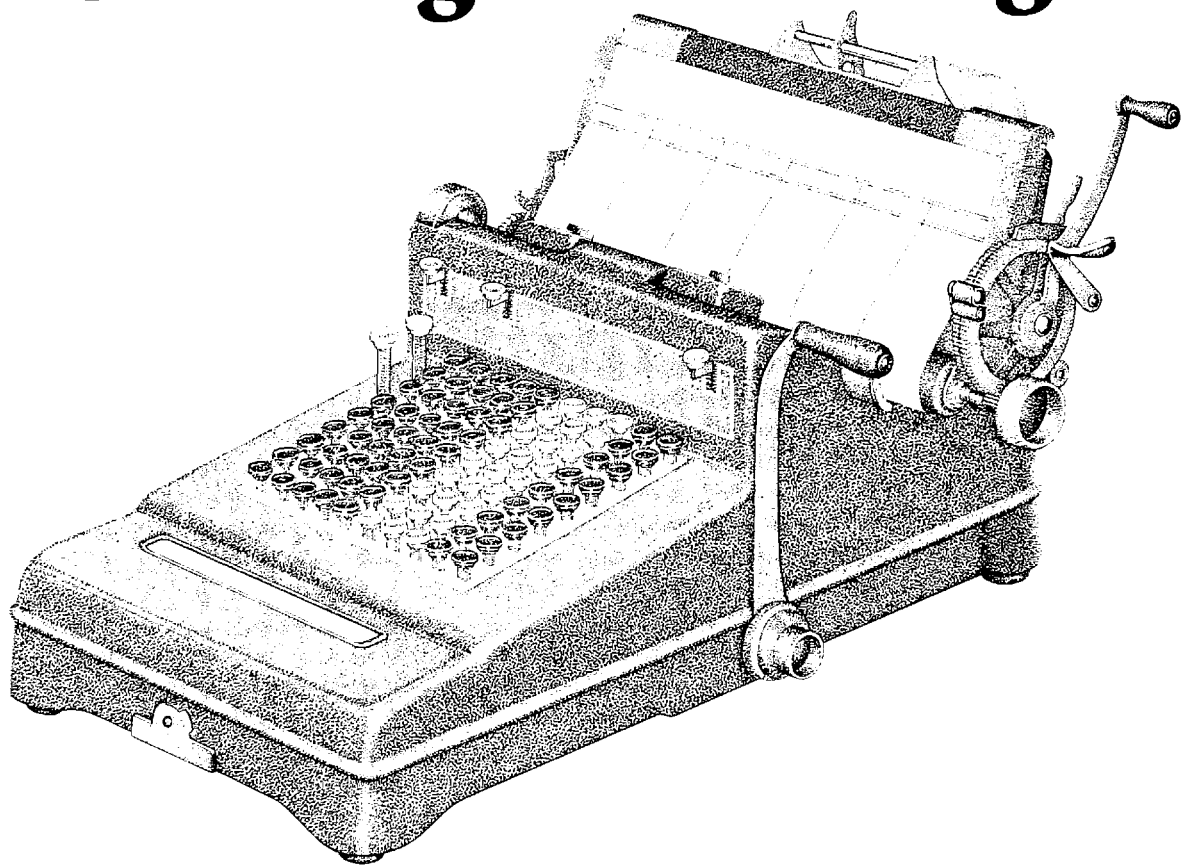
Additional information available to the profession on Ceclor from Lilly and Company, Indianapolis, Indiana 46285  
Eli Lilly Industries, Inc.  
Kansas City, Missouri 64633

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# The Bulletin

MEDICAL  
SOCIETY  
OF PIERCE  
COUNTY

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September, 1982

# How Poorman-Douglas can help you cure an occluded cash flow.

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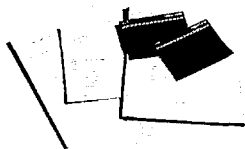
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# *The Bulletin* The official publication of the Medical Society of Pierce County

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Deadline for the submission of copy is the 25th of the month preceding the month of publication. However, final determination of publication date will be made by *The Bulletin*. *The Bulletin* reserves the right to edit all reader contributions for brevity, clarity and length, as well as to reject any material submitted.

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# Society News Briefs

*A summary of Medical Society, and local medical and health news*

## **Tort Reform Effort Underway**

Pierce County physicians joined their colleagues across the state in initiating the profession's tort reform campaign in August. Doctors, Auxiliaries and staff interviewed senate and house incumbents and candidates to explain the program and determine their degree of support.

Interviews will continue through the November general election. Reform of the state's tort system is a major feature of medicine's 1983 drive to control rapidly increasing professional liability expenses.

## **Cancer Study Kicks Off With Strong Pierce County Support**

One of the largest epidemiologic research projects ever undertaken in the United States began in September with the American Cancer Society's Cancer Prevention Study II. The study is the Society's second major research endeavor to learn how life style and environmental factors influence cancer and other diseases.

In Pierce County, 220 researchers have volunteered for the project as have 3,100 subjects. The subjects have agreed to be followed for six years and have completed a confidential questionnaire about their working, living and eating habits.

Covered in the four page questionnaire are such topics of concern as low-tar, low-nicotine cigarettes, birth control pills, coffee, hair dyes and saccharin. Also to be analyzed are air and water pollution, occupational exposures and low-level radiation. Nationwide, the goal is to enroll one million participants and more than 80,000 volunteer researchers.

Once every other year for the next six years, the research volunteers will keep track of study participants and report to ACS headquarters on their status and whereabouts.

## **Financial Seminars For Physicians Offered By Medical Society**

Monthly financial seminars for physicians are being offered through January, 1983. The seminars' objective is to provide physicians with a convenient, informal opportunity to increase understanding of basic concepts necessary to make sound financial decisions unique to individuals engaged in the private practice of medicine.

The seminars are being held at St. Joseph Hospital's Education Center, on Wednesday mornings from 7:00 a.m. to 9:30 a.m. The seminar faculty includes representatives from the Society's accounting firm, legal counsel, investment manager, insurance broker, and endorsed medical practice consultant. See page 14 for details.

## **Long-Term Care Guide Available**

A guide to long-term care in Pierce County is available to physicians and their office personnel through the Medical Society. The resource guide covers such subjects as: Choosing a long-term care facility, financing long-term care, nursing home care, congregate or residential care and community support services to support independent living.

The guide was prepared as a project of the Long-term Care Ombudsman Program of the Pierce County Area Agency on Aging in conjunction with the local Council on Aging. The guide has been reviewed by the Medical Society's Executive Committee and approved for distribution to doctors as a useful office aid for patients in need of such information. For copies of the guide, please call the Medical Society office, 572-3667.

## **Tel-Med Is Great PR For Medicine: It Needs Your Support!**

Each month an average of 2,000 of your neighbors call Tel-Med and hear a physician approved health or medical information tape. Each tape concludes with, "this message is brought to you by the Pierce County Medical Auxiliary and physicians of Pierce County.

Tel-Med provides an excellent patient education service and tremendous positive public relations for the medical profession as it meets a true community need.

Tel-Med also needs the support of physicians and physician families. The costs of upgrading the Tel-Med tape library and recent public awareness

*(Continued on Page 17)*

## President's Page

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# YAKIMA MEETING WILL CHART WSMA COURSE



In early October, Yakima will host the largest ongoing convention of physicians in the state of Washington when the WSMA gathers for its annual House conclave. Pierce County will be exceptionally well represented, both in the number and quality of its delegates. This is a standard that over the years has been a source of pride to the delegation and the Medical Society. When the house roll is called on Thursday, October 7, a smart bettor would put his money on 100% attendance from Pierce County. Pierce County, however, would make its presence felt immensely more if the number of non-delegate physicians at the meeting were greater. The annual meeting is a superb opportunity for all members to let their views be known and heard.

Each reference committee comes equipped with a soapbox and encourages it being put to good use. Reference committee chairmen always encourage the participation of members to the maximum extent possible in order that each will have a chance to expose his or her concerns and viewpoints in a meaningful setting. The House of Delegates will meet in three sessions, the last two are voting sessions the results of which will determine state association policy for the coming year and beyond. It is truly a democratic process which reflects the strength and vitality of our state association.

Pierce County alone is submitting 17 resolutions for consideration at the annual meeting. There will be constitutional amendments proposed, and the House will direct its councils, committees and AMA delegation regarding future policy and will judge past performance of the House's mandates.

If the House of Delegates is the heart of the meeting, then the reference committee hearings and subsequent recommendations must be its soul. But this corpus has many parts. Continuing medical education is provided through a variety of scientific sessions and specialty society programs.

On Friday, October 8, and Saturday, October 9, two socioeconomic sessions are planned. Current regional and national trends in medical economics and predictions for the '80s will be discussed. The

survival of the fee for service system, and the growth and influence of closed panel hospitals and physician groups will be addressed. Will the primary care physician bear financial risk on a capitation basis of remuneration? Will self-referral to specialists and subspecialists be eliminated and will these physicians' fees be discounted? Or, will they simply be salaried by law? What impact will contract and limited care have on medical liability?

The list of highly interesting speakers begins with Russell C. Coile, Jr., Deputy Director, Western Consortium for Health, San Francisco, California. Richard E. YaDeau, MD, a Saint Paul, Minnesota surgeon, will present a profile of a health care organization he organized with his hospital and medical staff which is competing successfully with conventional HMOs. Dr. David J. Gibson, MD, Santa Barbara Medical Foundation Clinic, Santa Barbara, California, will explain what is happening in the competitive medical care area in southern California.

Yakima should provide an enticing setting for this year's meeting during the height of the famous apple capital's harvest season. The choice of Yakima this year, and Vancouver in 1980, created a break in the Seattle-Spokane axis and established a precedent that may make it possible for Tacoma to host the WSMA annual meeting in the near future. A large enthusiastic turnout is expected with the hope that the number will be buoyed by many Pierce County physicians.

*Lloyd C. Elmer, MD*

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The following physicians will represent us as delegates at the annual meeting: Drs. Robert Lane, George Tanbara, Dale Hirz, Myra Vozenilek, Richard Bowe, Walter Arthur, Gilbert Roller, Bruce Buchanan, Juan Cordova, Robert Scherz, Thomas Clark, D. Terry Kendrick and Charles Anderson. I know they will welcome your comments and suggestions regarding the activities and priorities of our state association.

# The Medical Society . . .

## WORKING ON BEHALF OF YOU AND YOUR PATIENTS

*The Medical Society of Pierce County exists to promote the betterment of the health and medical welfare of the community and the art, science and delivery of medicine. It is a diverse organization involved in a wide variety of activities and programs designed to support the goals set by the membership. The following article summarizes the current activities and organization of our Society. — the Editor.*

Ethics, competition, the expanding scope of practice of non-physicians, government cutbacks in health care financing, continuing education, the increasing costs of health care, and community health needs are among the issues addressed on a daily basis by the Medical Society of Pierce County. Through its committees and affiliated corporations, the Medical Society provides physicians with the means to collectively deal with these issues and the changing environment in which medicine is practiced in the 1980's.

Only with a unified voice can physicians make the changes necessary to preserve their rights and those of their patients. Volunteer involvement is at the heart of the Medical Society.

### COMMUNITY SERVICES

The Society works to match the special talents of its physician members to the needs of the community. The various services provided by the Medical Society are important to the health and welfare of all Tacoma and Pierce County residents.

#### Physician Referral Service

When a family moves to our area, or needs a physician, the referral service helps them locate a doctor.

Prospective patients calling the service are provided with the names and telephone numbers of at least three members. At no time is a member promoted or endorsed, or implied as such, to a caller. The members participating in the Referral Service are categorized by specialty and geographical area.

Physicians participating in the service have agreed to accept patients without restriction as to ability to pay. An average of 20-25 calls a day are handled by the service which operates Monday through Friday from 8:30 am to 4:30 pm.

#### Speakers Bureau

Organized through the Society's Communications Committee, the Speakers Bureau finds physicians to speak at schools, clubs and professional organizations throughout Pierce County. Over 100 doctors have joined the Bureau.

Bureau coordination is provided by Auxiliary members as well as Society staff. The Bureau promotes good health and a positive relationship between the medical community and the public and is a very effective public relations tool for the Society.

#### Grievances

An average of three telephone complaints from dissatisfied patients are fielded each day by the Society staff. For those problems which cannot be resolved over the telephone, formal grievances are filed and referred to the Society's Grievance Committee. The committee investigates the complaints and endeavors to work with the physician and patient in resolving the situation in as fair and amicable a manner as possible, thus averting legal action.

The committee is chaired by the past president of the Medical Society and presently consists of a pediatrician, family physician, ophthalmologist, surgeon and obstetrician-gynecologist. All investigations are kept confidential. Although most complaints originate from patients or family members, some are referred to the committee by the Washington State Medical Association, local Better Business Bureau and Office of the State Attorney General.

#### Tel-Med

Each month, an average of 2,000 people call the Pierce County Tel-Med Society and hear a clear, concise and medically accurate information tape the concludes with, "brought to you as a public service of the Pierce County Medical Society Auxiliary and the physicians of Pierce County."

The Tel-Med Society is a separate non-profit corporation governed by its own Board of Trustees. The Medical Society's Tel-Med Committee reviews



"Americans of all ages, all conditions, and all dispositions constantly form associations. The Americans make associations to give entertainments, to found seminaries, to build inns, to construct churches. In this manner, they found hospitals, prisons and schools. If it is proposed to teach some truth or to foster some feeling by the encouragement of a great example, they form a society. Wherever at the head of some new undertaking you see the government in France or a man of rank in England, in the United States you will be sure to find an association."

—A. de Tocqueville, *Democracy in America*, 1835.

draft scripts for accuracy before they are recorded for the tape library.

Tel-Med operates from 10:00 am to 8:00 pm, Monday through Friday, except for holidays. Auxiliary volunteers staff Tel-Med for a number of hours each day, remaining operator services are provided by part time employees.

Physicians may obtain free Tel-Med brochures for office distribution by calling Tel-Med, 627-6181.

### **Assistance to Community Health Organizations/Health Needs Task Force**

Early in 1981, the Society established its Health Needs Task Force to work with local health agencies in meeting community needs during these difficult economic times and new era of reduced state and federal funding. The Task Force has met with agency representatives and a coordinating group is being established.

Physician support to specific agencies is promoted and the Society is assisting agencies in communicating their needs and objectives to the medical community.

### **Working With Schools**

Each year, the Society's Public Health/School Health Committee meets with Pierce County school districts and private school representatives. Issues discussed range from the impact of the state's immunization law to Child Find, scoliosis screening, athletic physicals and modified PE programs for the ill or injured.

### **Community Clinics**

The Society works with the health department to promote physician understanding and support of the four community clinics — Hilltop, Family, Sumner and Lakewood. Also, members of the UHI Quality Assurance Committee work with clinic staff and audit the care provided to assure that it is commensurate, to the greatest extent possible, with that available in the private sector.

### **Jail Health**

When Tacoma and Pierce County needed help in addressing health services problems at the city/county jail, they turned to the Medical Society. The Society proposed consolidation of health services in the two institutions and the establishment of minimum standards, and recommended that the health department be established as the jail health authority with an advisory group provided by the Medical Society. The resultant Jail Health Advisory Board established protocols for the delivery of services to jail inmates and works with the health department to promote the proper delivery of necessary services.

### **Improving the Emergency Medical Services System**

When it became apparent that emergency medical services in Tacoma and Pierce County required significant organizational assistance and a greater degree of medical control, the Medical Society worked with the local EMS Council to establish a project to improve EMS services.

Acting as a subcontractor to the EMS Council, and with a state grant, the Society currently employs a project administrator, secretary and paramedic training supervisor. Field protocols for advanced life support (paramedic) personnel have been established, training programs are being reviewed and paramedic testing standardized, and physician advisors to local ambulance companies are working to improve the quality of services provided the public.

At the request of the Medical Society, Pierce County Executive Booth Gardner established a task force to review the delivery of EMS and to make recommendations for the establishment of improved

emergency medical services. The task force issued its report in September, urging that a county EMS agency be formally established with necessary authority and continued funding.

## **MEMBERSHIP SERVICES**

### **Continuing Medical Education**

Pierce County's unique College of Medical Education provides high quality, low-cost continuing medical education programs for physicians and allied health personnel. Operating on a not-for-profit basis, the College produces between 30 and 35 programs each academic year.

It is governed by an eleven person Board of Directors — six physicians, and five hospital administrators. Programs are developed through the Medical Society's CME Committee and the College's Allied Health Professions Education Committee. Necessary funding assistance is provided by the hospitals and the Medical Society on a proportionate representation basis.

### **Pierce County Medical Library**

Comprehensive medical library services, including sophisticated search capabilities for material not on hand at the time of request, are provided through the library, currently housed at Tacoma General Hospital, and satellite libraries at each hospital. The Medical Society and Pierce County Hospital Council jointly fund the library. The Library Committee establishes library policy and oversees its activities.

### **Membership Benefits, Inc.**

Membership Benefits, Inc. (MBI) is the Society's tangible services vehicle and is a wholly owned subsidiary. It is governed by a physician Board of Directors. MBI understands the problems unique to physicians' medical practices and is dedicated to assisting in the resolution to those problems. The costs of its services are significantly less than those available in the commercial market.

Services provided by MBI include:

- The Medical Society Placement Service.
- Personnel related counseling.
- Management Resources — Practice Consulting.
- Collections (provided by Puget Sound Collections).

### **Medical Society Placement Service**

Since it was established in 1977, the placement service has assisted hundreds of physicians in finding quality medical and business personnel for their offices, clinics and laboratories.

When a member needs an employee, the service will advertise the position, pre-screen applicants through personal interviews and skills tests, and verify references. Qualified applicants are then referred for an interview with the employer.

The service works with all types of office personnel — medical assistants, nurses, physician's assistants, laboratory and x-ray technicians, transcriptionists, medical secretaries, insurance clerks, bookkeepers and other office specialists. It is a licensed employment agency under the laws of the State of Washington. Its fees are among the lowest in Pierce County and may be paid by employer, employee or both.

### **Practice Consulting**

In mid-summer, the MBI Board approved an endorsement of Management Resources, a local medical practice consultant. MR provides a high quality, "hands-on" service relating to office and bookkeeping organization.

Through MR and its own staff MBI provides a variety of other services — seminars, employee related consulting services, job descriptions, wage and benefit survey reviews, hiring and termination consulting, and awareness of state and federal employment and discrimination laws and regulations.

Each year, the Placement Service conducts a salary and fringe benefit survey of physician offices. This survey is available to doctors upon request and will be sent to the home address.

Linda L. Carras is manager of Membership Benefits, Inc. For further information about the services available through MBI call her at 572-3709.

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## **Insurance Programs**

Term life and disability insurance plans geared exclusively for physicians have been reviewed and endorsed by the Medical Society. Information about these programs can be obtained by contacting the Society office, 572-3667.

## **Office Services**

For a nominal fee, the Society coordinates mailings for member physicians. Services available include use of the Society's mailing list (in accordance with established policy), envelope stuffing and the actual mailing. For details, contact the Society office, 572-3667.

## **Specialty Society Support**

Secretarial services are provided to local specialty societies at cost. Currently, the Pierce County Chapter of the Washington Academy of Family Physicians, Tacoma Academy of Internal Medicine and the Tacoma Surgical Club receive secretarial support through the Society office. Support is readily available to other specialty societies as requested.

## **Collections (Puget Sound Collections)**

Puget Sound Collections is a highly effective, local collections bureau, endorsed by MBI. Society members receive a 10% discount in the normal collection fee.

The MBI Board of Directors serves as an advisory committee to PSC to assure its responsiveness to physician needs. PSC also offers, free of charge, accounts receivable management assistance to physician offices. Those needing PSC's services should call Frank Rossiter, president, at 383-5011.

## **ESTABLISHING POLICY AND DIRECTION: THE COMMITTEE STRUCTURE**

### **MSPC Board of Trustees**

The Board consists of the Society officers, seven additional trustees and the president of the Pierce County Medical Society Auxiliary. The Board meets ten times each year, normally on the first Tuesday of the month. It supervises and controls the finances of the Society, sets policies and oversees administration.

### **MSPC Executive Committee**

The president, president-elect, past president, secretary-treasurer and vice president form the Executive Committee which meets on the third Tuesday of each month. The committee assists the Board of Trustees in its overview of Society affairs and the establishment of policy.

### **Credentials Committee**

This committee reviews the qualifications of prospective Society members and meets with applicants to answer their questions and to explain the Society's organization and activities. The chairmen of the Credentials Committees of each hospital medical staff in Pierce County serve on the committee. The committee makes recommendations to the Board of Trustees regarding applicants' election to membership.

### **Editorial Committee**

Editorial and advertising policy for *The Bulletin* and annual *Directory for Pierce County Physicians and Surgeons* is set by this committee. Committee members suggest topics for articles, review controversial articles and monitor the relationship between the Society and the publisher of its magazine and directory.

### **Grievance Committee**

Patients who are unhappy with a Society member may take their complaints to the Grievance Committee. The committee provides patients with a forum for voicing dissatisfaction and assures them that the Society holds its members responsible for delivering the highest standard of care.

Following review of each complaint, the committee's findings are conveyed to the parties involved as are appropriate recommendations.

Patients are assured they will be treated with concern and respect and their grievance will be carefully and objectively studied. If the committee's investigation shows there is no basis for the complaint, the committee will notify the person filing the grievance and clearly state the reason for its conclusion. When a complaint is justified, the committee reports its findings to the patient and may offer specific recommendations to the physician

for avoiding similar complaints in the future. In cases where there is a question of competence, the committee may refer the matter to the Ethics/Standards of Practice Committee or Board of Trustees.

The committee suspends review of complaints once an attorney is involved and legal action has been initiated or is imminent. Through its careful investigation and tactful response, the committee has averted a number of potential malpractice suits.

### **Legislative Committee**

Members of the Legislative Committee, with strong Auxiliary participation, present medicine's views to incumbents and candidates for office. Typically, candidates are interviewed by committee members in August and September of each election year. During the legislative session contact is maintained with office holders through the "Key Contact" program. In 1982, committee members are meeting with candidates to present medicine's proposed tort reform program.

### **Jail Health Advisory Board**

This group works with the jail health staff and health department to oversee the provision of health services in the jail. Physicians, lawyers, dentists, nurses and lay representatives serve on the board.

The board has completed a thorough review of the jail's health services. In addition, it has approved protocols for the delivery of health services in the facility.

### **Ethics/Standards of Practice Committee**

This is a new committee in the process of organization. It results from the membership's determination that ethics and professionalism should be the number one priority of the Medical Society.

At the June Board of Trustees meeting, which hospital medical staff presidents attended, support was expressed for the revised committee and approval granted for its formation. Hospital medical staffs will be represented on the committee. Due process procedures are being drafted as are neces-

sary amendments to the Society's Bylaws to encompass the expanded scope of authority envisioned for the group.

Future issues of *The Bulletin* will explain the evolution of this new committee.

### **Communications Committee**

The Communications Committee organized and oversees the Society's Speakers Bureau. Members of the committee represent the Society on the Washington State Medical Association Communications Committee and are available to review and make recommendations regarding local public relations and communications projects.

### **Public Health/School Health Committee**

Members of the committee identify and investigate school and public health problems, and work with school and public health representatives to initiate and monitor programs of benefit to students and the public.

Through the committee, annual meetings have been established with Pierce County school district and private school representatives, health screening programs have been established to assist individuals involved in such activities, and the Society's Health Needs Task Force was established. The committee was involved in the job definition and interview process for the health department director and established an interview committee that met with applicants.

Asian refugee health concerns, care for the medically indigent and compliance with the state immunization program are among the many other issues being addressed by the committee.

### **Inter-professional Committee**

Communications and coordination between physicians and pharmacists and other health care providers to solve problems of mutual concern are fostered by this committee. Physicians, pharmacists, dentists, nurses and other providers serve on the group. Office prescribing practices, office-pharmacy relationships, and general pharmaceutical issues are the current focus of the committee's concern.

## Medical-Legal Committee

This is a joint committee of the Medical Society and Pierce County Bar Association. The committee reviews and issues opinions on complaints that arise between physicians and lawyers.

Medical-legal guidelines for physicians and lawyers have been established and the committee is evaluating the possibility of adding an arbitration clause to the guidelines. The committee meets several times each year and serves as a forum for issues of mutual concern to the medical and legal professions.

## Emergency Medical Standards Committee

An improved emergency medical services system offering the public optimum access to medically sound pre-hospital care is the goal of the EMS Committee. Medical directors of hospital emergency departments, medical advisors to local paramedic services and other interested physicians serve on the committee.

Through the committee, the Medical Society initiated the EMS Medical Control Project currently funded by the State of Washington Department of Social and Health Services, EMS Division.

State law requires that paramedics function under physician control which is coordinated through the committee and EMS Council. Training, examination and certification of paramedics, and on-line and off-line physician involvement in the EMS system are being addressed by the group.

## Senior Citizens Committee

The quality of care provided to patients in the nursing home setting, procedural and administrative issues of adult health clinics, and other senior citizen issues are dealt with by this committee.

## Congressional Advisory Committee

Physicians have an organizational forum for discussion of issues with the district's congressman through this committee. Such liaison has proven helpful in the recent past, particularly with regard to funding of the community clinics for the medically indigent.

## Sports Medicine

This committee coordinates physician involvement in and provides medical review of sports programs or activities upon request.

## Tel-Med Committee

When your neighbors and patients call Tel-Med, they are assured of hearing accurate medical and health information through the efforts of this committee. Scripts for Tel-Med tapes, either drafted locally or based on scripts used by other Tel-Med organizations, are reviewed by committee members

*(Continued on page 17)*

# Professional Liability Seminar

## Medical Malpractice Insurance

Watch for details in the next medical society Bulletin.



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---

**November 18, 1982 — 8:30 a.m. to 4:30 p.m.**  
**Sea-Tac Red Lion Inn**

---

guest faculty:

**WILLIAM H. MASTERS, M.D.**  
Masters & Johnson Institute

---

Topics:

- Normal Sexual Response
- Feeling Comfortable Talking About Sex
- Sexual Dysfunction - Diagnosis/Management
- Sexual Exploitation & Aggression
- Physical Illness & Sexual Function
- Sex & Physical Disabilities
- Drugs & Sex
- Sex & The Aging Process

Registration:

- \$125 Medical Society of Pierce County Members
- 150 Other Interested Physicians
- 25 Dinner with Dr. Masters  
(separate from seminar fee)

Program coordinator:  
John A. Lincoln, M.D.

**ALL REGISTRATIONS MUST BE RECEIVED IN  
THIS OFFICE BEFORE NOVEMBER 1, 1982**

(If enough registrations have not been received before  
Nov. 1, 1982 - the program will be cancelled)

---

**Credit: 8 hours**  
**Category I - AMA/AAFP —**

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Call and/or register early to assure this Seminar for our medical community.



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OF THE SERIES.**

October 13, 1982

## **INVESTMENTS IN THE 1980's**

- \*Understand tax sheltered investments.
- \*Differentiate common and preferred stock investments.
- \*Recognize new developments in the bond market.

November 10, 1982

## **INCORPORATION - WHEN & WHY**

- \*Increase understanding of personal economics & other non-tax considerations.
- \*Recognize tax and non-tax benefits.
- \*Conceptualize how to establish a professional service corporation.

GREGG D. JORDSHAUGEN, CPA, Partner  
Simonson, Moore and Olson, Tacoma  
Accountant, Medical Society of Pierce  
County

BARRY D. BRUNT, CPA, Manager  
Simonson, Moore and Olson, Tacoma

ROBERT A. KING, Vice President & Manager  
Dean Witter Reynolds, Tacoma  
Investment Manager, Medical Society  
of Pierce County

WILLIAM W. JEUDE, CPA, Account Executive  
ENI Corporation, Bellevue  
High Technology, Oil and Gas  
Investments

JOHN R. HODDER, CPA, Partner  
Simonson, Moore and Olson, Tacoma

December 9, 1982

## **ESTATE PLANNING - SHIFTING ASSETS, TRUSTS AND OTHER CONSIDERATIONS**

- \*Understand estate planning and the Economic Recovery Tax Act of 1981.
- \*Recognize value in shifting income property to lower tax brackets.
- \*Increase awareness of pension plans.
- \*Increase understanding of life insurance and retirement plans.

January 12, 1983

## **EVALUATING A MEDICAL PRACTICE**

- \*Analyze expense in relation to income to control expense.
- \*Define a method for establishing a fee for new service.
- \*Understand controlling accounts receivable.  
Including: Cash flow, improving collections and accounts receivable.

### **FACULTY**

BARTON L. ADAMS, Attorney  
Adams, Gagliardi and Halstead, Tacoma  
Legal Counsel, Medical Society of  
Pierce County

JERRY R. ZANDER, CLU, Account Executive  
Schwartz, Shera and Associates  
Brokers, Actuaries and Consultants

DOLORES LUNSTRUM, CMA-A, President  
Management Resources, Tacoma  
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Please address all registrations and correspondence to: Maxine Bailey, Executive Director  
College of Medical Education, Inc.  
705 South 9th, No. 203  
Tacoma, Washington 98405





# Correspondence

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## Use Of The St. Joseph Burn Unit

To The Editor:

This letter is intended to clarify the status and use of the Firefighters' Burn Unit at St. Joseph Hospital. This is a specialized care unit analogous to an intensive care unit or coronary care unit, and this analogy extends to the fact that it is open to the utilization of all physicians who are qualified by virtue of staff membership, interest, and training to care for burns.

Through the years, the privilege of caring for burns in this area has fallen largely to our group. I am not writing this letter with any intent or desire to change this practice. However, I do wish to let those physicians and surgeons who may be interested in maintaining their role in the primary care, follow-up care, and/or surgical treatment of burns know that the opportunity to do so exists. The burn unit is not intended to be the private domain of any individual or group. A patient should not be referred "to the burn unit" any more than one would refer a patient with a myocardial infarction "to the coronary unit." They should, instead, be admitted by the physician or consultant who is familiar with or has been informed about the case and who will be responsible for their care as an inpatient. The burn unit policy states that all admissions are reviewed by the director or his designate, although this would be done on an informal basis unless a formal consultation has been requested.

The burn unit has a large outpatient population with over 3,000 visits during the course of the last year. This service can be utilized as an alternative to taxing and time-consuming office visits with extensive dressing changes. Outpatient visits could quite possibly be arranged at a time or day that would be more convenient to the patient or their family than the physician's office hours. The responsible physician could then see the patient at less frequent intervals in his office, or if several patients were being followed, arrange a time to see them simultaneously in the outpatient facility.

There is no single best way to care for all burns. The burn unit staff has over the course of the years developed techniques which have proved effective in their hands, and they are justifiably proud of their results. However, there is not an inflexible protocol and physicians wishing to direct the staff in the use of other recognized methods of treatment would be free to do so.

The burn unit is fortunate to be funded by the

Firefighters Union and by several other community organizations and individuals. It functions as a community service and should be utilized as one. Further information regarding the unit, or arrangements for patient care there, can be obtained from Betty MacDonald, RN, the clinical coordinator, or from me.

Sincerely,  
*Thomas J. Irish, Jr., MD*  
Plastic Surgeons Northwest, Inc.

## Treating Asian Refugees

Dear Dr. Elmer:

I am currently caring for a number of Asian refugees, many of whom have been affected by the change in federal policies concerning the number of months refugees are eligible for medical coupons. Over the past 18 months, I have done 15 deliveries and am currently following 8 more pregnant patients of whom approximately half are no longer on coupons. I have elected to provide care at no cost to them. Providing care at no cost may represent a monetary problem to me, but it is not the problem that I am addressing in this letter.

It was my understanding that the local hospitals — in particular Lakewood, Tacoma General and St. Joseph — had kindly offered, or should I say, been kindly coerced into providing free or low cost medical care to these Asian refugees. It was also my understanding that the physicians of Pierce County and King County were going to provide care in a timely fashion at little or no cost. Unfortunately, my experience has been that these people have been neglected by all but a few.

It is still very difficult to find a pediatrician willing to take on these children once they are delivered. It is even more difficult to find an obstetrician to follow them, at little or no cost. It seems as if a concentration of a few are doing a whole lot to keep this ship afloat, and those of us who are struggling are starting to find that we cannot carry the rest of the community.

The problem that stimulated this letter was one with St. Joseph Hospital. One of the sponsors, a registered nurse, working for two local physicians, went to the hospital trying to discuss the Asian refugees' financial situation. Rather than just showing up at the door step with someone in labor, she chose to go beforehand to try to work out something with the hospital. These attempts were

met with all kinds of problems at the lower levels. It took a personal call from myself to Mr. Dan Russell, president of the hospital, to clear this up. The problem at Tacoma General Hospital, which was similar to that at St. Joseph, has yet to be cleared up.

It is very obvious to me that in the lower echelons of the business offices the idea of helping these refugees is not communicated to those sponsors or patients. Why is it that at St. Joseph or Tacoma General one can't come in and talk to someone who understands the hospital policy? Why is it no one at Tacoma General Hospital knows anything about Title IX or Hill Burton funds?

I feel that there has been an immense amount of rhetoric concerning the Asian refugees and very little in the way of action. I frankly do not believe these people have been sufficiently supported by any group. I would ask that you, as President of the Medical Society, investigate through the Society the actual physician involvement with the care of these refugees, the hospital policies and how they are being administered, and how best as members of

our Society we can better serve these people.

I have talked to Dr. George Tanbara and have enlisted his group's support in care of these refugees, but we need more. A little from everyone would do, while a lot from a few will ultimately fall short.

Thank you,  
Anthony J. Lemanski, MD



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## **Modifying Private Pension Plans**

Dear Dr. Wagonfeld

Thank you for expressing your opposition to the provisions of the tax bill recently approved by the Senate Finance Committee which would affect private pension plans. I appreciate hearing from you.

In all candor, while I regret that these changes have been included in the committee's proposal, I cannot vote against the entire bill for this reason alone. If we are to see in the near future lower interest rates and a vigorous economic recovery, I believe that the huge projected budget deficits must be reduced. This tax bill will do just that. It will reduce next year's deficit by over \$21 billion and by even greater amounts in later years. All in all, I believe that this tax bill fairly distributes the burden of the needed deficit reductions.

Again, thank you for sharing your views with me.

Sincerely,  
*Slade Gorton*  
United States Senator

The Honorable Slade Gorton  
Russell Senate Office Building  
Washington, D.C. 20510

Dear Senator Gorton:

Thank you for your letter of July 19, 1982 in which you explained your position in support of the Senate Finance Committee Plan to alter private pension plans.

Your response has been forwarded to the Medical Society of Pierce County and Washington State Medical Association, hopefully for publication in their bulletins.

It is our sincere hope that other members of these organizations will recall your lack of opposition to this program, when you seek re-election. As you well realize, the perception that this program will affect only 180 thousand high-earning professionals and executives is simply not true. These programs cover approximately 45 million active participants, and practically all of these plans are 100% funded by the employer. They are designed to "key-off" the top earner. Everyone covered by these plans would be reduced in their retirement benefits. Therefore, the entire private pension system will be weakened.

and necessary changes made to insure a credible service of value.

## **Continuing Medical Education**

The planning and implementation of the numerous continuing medical education programs offered each year through the College of Medical Education are coordinated by the CME Committee. Committee members are also involved in course evaluation and accreditation applications.

At the time, when capital formation, and financial equity is essential for the survival of a free economy, we should be trying to strengthen not weaken the private pension system.

Sincerely yours,

*James B. Wagonfeld, MD*    *Richard D. Baerg, MD*  
*F. Dennis Waldron, MD*    *Jonathan A. Levant, MD*

# PSMB

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# Society News Briefs

(Continued from page 3)

program, coupled with reduced support from previous contributing sources, have reduced Tel-Med's reserves to the point where they are no longer capable of covering annual operating expense.

Earlier this summer, the medical community responded warmly to Tel-Med's request for support. To date, over 85 physicians and families have contributed to Tel-Med. Won't you please join them? Your tax deductible contribution will be greatly appreciated and will directly support an important community resource.

Tel-Med wishes to thank the following physicians or physician families who have supported the service in 1982:

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| Drs. Donald A. Carlyle | Robert B. Whitney   |
| Anthony S. Lazar       | Robert E. Lane      |
| Thomas K. Browne       | G. James Kenney     |
| Jack Nagle             | Murray L. Johnson   |
| James Crowley          | Orvis A. Harrelson  |
| Oris B. Houglum        | Robert Modarelli    |
| Kenneth S. Kilborn     | James F. Early      |
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| Dale D. Doherty        | Leo F. Sulkosky     |
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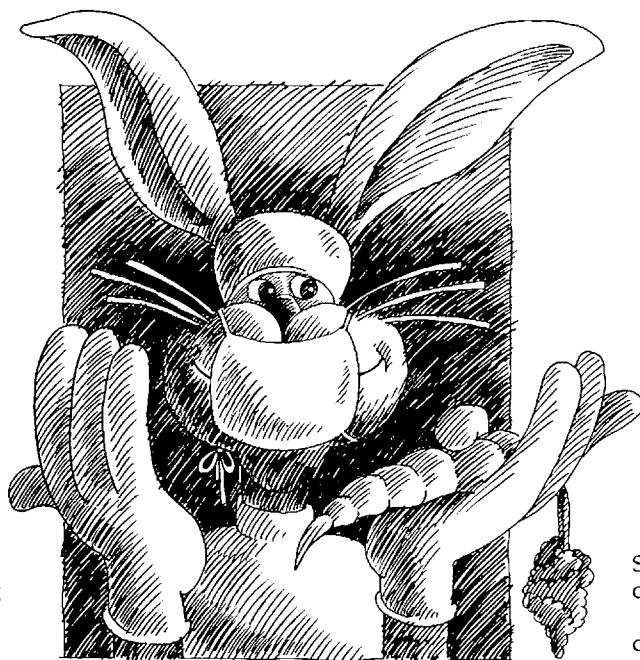
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# COLLEGE OF MEDICAL EDUCATION

A = Allied Health Personnel  
P = Physician

## Continuing Education Programs Projected for 1982-1983 Academic Year (Programming is subject to change — individual notices will be sent preceding each program)

| Date       | Course/Topic   | Coordinator(s)                           |
|------------|--|--|
| October    |  |  |
| 1, 2, 3    | INTERNAL MEDICINE* (P)   | TAIM/P. Schneider, M.D.                  |
| Open       | WOMENS HEALTH (P/A)  | G. Klatt, M.D./P. Shull, M.N.            |
| Open       | COMPUTER LITERACY (P/A)  | R. Bramhall, R.N.                        |
| Open       | POTPOURRI MEDICAL/SURGICAL TOPICS (A)  | P. Shull, M.N.                           |
| Open       | RATIONAL USE OF ANTIBIOTICS (P)  | A. Tice, M.D./P. Marsh, M.D.             |
| 14         | ENHANCING YOUR FINANCIAL SKILLS (P)  | D. Hirz, M.D./T. Curry/L. Carras         |
| November   |  |  |
| Open       | BASIC EMERGENCY PROCEDURES (A)   | A. Chilton, B.S.N./<br>V. Turner, B.S.N. |
| 6          | ADOLESCENCE — GOOD NEWS/BAD NEWS (A)   | J. Short                                 |
| 11, 12     | FINANCIAL MANAGEMENT — HOSPITAL (A)  | B. Marcellia, M.T.                       |
| Open       | POTPOURRI — LABORATORY PROCEDURES (A)  | J. O'Neill                               |
| 11, 12     | MUSCULAR DYSTROPHY MEETING* (P/A)  | M. Malden, M.D.                          |
| Open       | SEXUAL DYSFUNCTION & DISEASE (P)   | J. Lincoln, M.D.                         |
| 11         | ENHANCING YOUR FINANCIAL SKILLS (P)  | D. Hirz, M.D./T. Curry/L. Carras         |
| December   |  |  |
| 3, 4       | PEDIATRIC ADVANCED LIFE SUPPORT (P)  | R. Scherz, M.D.                          |
| 9          | ENHANCING YOUR FINANCIAL SKILLS (P)  | D. Hirz, M.D./T. Curry/L. Carras         |
| January    |  |  |
| 22         | THE LAW & MEDICINE   | D. Pearson, M.D.                         |
| Open       | COMMON PAIN SYNDROMES<br>IN EVERYDAY PRACTICE                                | H. Johnston, M.D.                        |
| Open       | LEGAL CONCERNS ASSOCIATED<br>WITH NURSING PRACTICE                           | A. Moore, R.N.                           |
| 27         | PERINATAL — T.G.   | J. Mulligan, M.D./ P. Metcalf, R.N.      |
| 21         | HOSPICE  | J. G. Katterhagen, M.D.                  |
| 12         | ENHANCING YOUR FINANCIAL SKILLS (P)  | D. Hirz, M.D./T. Curry/L. Carras         |
| February   |  |  |
| Open       | HYPERALIMENTATION  | P. Schneider, M.D.                       |
| 5          | GERIATRICS WORKSHOP (A)  | J. Short                                 |
| Open       | DENTAL EMERGENCIES (P)   | C. Maier, D.D.S.                         |
| Open       | BASIC EMERGENCY MEDICINE (A)   | T. Kendrick, M.D.                        |
| 24, 25     | BURN (P/A)   | T. Irish, M.D.                           |
| Open       | PULMONARY (P)  | V. Nessian, M.D.                         |
| March      |  |  |
| 10, 11     | TACOMA ACADEMY OF INTERNAL MEDICINE (P)                                      | R. Ettlinger, M.D.                       |
| 19         | EMERGENCY MEDICINE/TOXIC SUBSTANCE<br>MANAGEMENT CHALLENGE (A)               | T. Kendrick, M.D.                        |
| Open       |  | B. Marcellia, M.T.                       |
| April      |  |  |
| 2, 3       | DAYS OF PEDIATRICS — GENETICS (P/A)  | R. Scherz, M.D.                          |
| 15, 16     | TACOMA SURGICAL CLUB — ANNUAL MEETING (P)                                    |  |
| May        |  |  |
| Open       | ADVANCED CARDIAC LIFE SUPPORT (P)  | T. Kendrick, M.D.                        |
| Open       | EVALUATION OF PATIENT REQUESTING DISABILITY/<br>FORENSIC/ABUSE BATTERING (P) | D. Brown, M.D.                           |
| 19, 20, 21 | CARDIOVASCULAR DISEASE REVIEW (P)  | G. Strait, M.D.                          |
| Open       | OB/GYN (Speroff) (P)   | J. Sakakini, M.D.                        |
| June       |  |  |
| 31         | AMA OFFICE PERSONNEL   | L. Carras                                |

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# Membership

In accordance with the Bylaws of the Medical Society of Pierce County, Chapter Seven, Section A, MEMBERSHIP, the following physicians have applied for membership, and notice of their application is herewith presented.

As outlined in the Bylaws, any member who has

information of a derogatory nature concerning an applicant's moral or ethical conduct, medical qualifications or other such requisites for membership, shall assume the responsibility of conveying that information to the Credentials Committee or Board of Trustees of the Society.

## FIRST NOTICE



**Daniel T. Dugaw, D.O.**, Family Practice. Born in Chehalis, WA 10/19/50; College of Osteopathic Medicine and Surgery, Des Moines, Iowa, 1976; internship, Green Cross General Hospital, 1976-77. Washington State license, 1977. Has applied for medical staff membership at Allenmore, Doctors, Mary Bridge, St. Joseph, and Tacoma General Hospitals. **Sponsors:** Drs. Susan Salo, Jesse Mantel.



**Scott L. Havsy, D.O.**, Family Practice. Born in Brooklyn, NY 5/4/53; College of Osteopathic Medicine and Surgery, Des Moines, Iowa, 1975; internship, Brooke Army Medical Center 7/78-10/78, and Madigan Army Medical Center, 7/79-6/80. Washington State license, 1980. Has applied for medical staff membership at Good Samaritan, St. Joseph and Tacoma General hospitals. **Sponsors:** Drs. Dennis Koukol, William M. Dean.



**Peggy A. Hosford, M.D.**, Family Practice. Born in Denver, CO 10/11/49; Stanford University School of Medicine, 1976; internship, Providence Medical Center, Seattle, 1976-77; residency, Providence Medical Center, Seattle, 1977-79. Washington State license, 1981. Has applied for medical staff membership at Allenmore, Doctors, Mary Bridge, St. Joseph and Tacoma General hospitals. **Sponsors:** Drs. Susan Salo and Daniel Hayden.

## SECOND NOTICE



**Keith M. Weigel, M.D.**, General and Internal Medicine. Born in Seattle, WA 8/4/47; University of Washington School of Medicine, 1976; internship, Good Samaritan Hospital, Phoenix, AZ, 1976-77; residency, Good Samaritan Hospital, Phoenix, AZ, 1977-78; Washington State license, 1981. Has applied for medical staff membership at Good Samaritan Hospital. Dr. Weigel is practicing

at 21120 Meridian East, Graham. **Sponsors:** Drs. Gail B. Strait, Richard D. Baerg.



**Sharon J. Michael, M.D.**, General Practice and Internal Medicine. Born in Clarksburg, WV 7/21/51; Vanderbilt Medical School, Nashville, Tenn., 1977; internship, Good Samaritan Hospital, Phoenix, AZ, 1977-78; residency, Good Samaritan Hospital, Phoenix, AZ, 1978-79; Washington State license, 1981. Has applied for medical staff privileges at Good Samaritan Hospital. Dr. Michael is practicing

at 21120 Meridian East, Graham. **Sponsors:** Drs. Gail B. Strait, Richard D. Baerg.

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# Auxiliary News

## Mid-Year State Convention

The WSMAA Mid-Year Convention will be held in Yakima, October 7-9. The Auxiliary events will include workshops, speakers and participation in some of the men's activities. If you are planning to attend, contact Marlene Arthur, 845-1094, for more information.

## Save October 30th!!

October 30th is the date set for another great time at "Crowley's Square Dance Barn." Live music will be furnished by the "Wild Rose's," playing Scottish, Irish, English and Southern Fiddler tunes. Proceeds from the dance will be used to support our Student Recognition Award fund. Food and drinks, including beer and wine, will be provided for \$30.00 per couple. Please send money as your reservation to Barbara Patterson, 4028 154th St. Ct. N.W., Gig Harbor, 98335. Reservations are necessary.

## Dues

Dues are still being accepted for the 1982-83 year. The dues are \$38.50. Please send your check to Mary

Whyte Lenard, Rt. 1, Box 1047, Buckley, WA 98321, or bring your check to the first fall meeting you attend. The membership booklet will be given to each member as dues are paid.

## October 15th Meeting

The October 15th Auxiliary meeting will be held from 9:30 am to 2:00 pm at the University Place United Presbyterian Church, 8101-27th West. It will be a very informal day featuring new ideas, new friends and a delicious lunch. Child care will be provided in the church's excellent facilities.

Two events are planned. The first is a panel discussion to help sharpen your political skills. Barbara Granlund, state representative from the 26th District and currently a candidate for the State Senate, will share with us the joys, pitfalls and motivations of being a candidate. Shirley Winsley, state representative from the 28th District and member of the County Council, will tell us of the many small but so important ways volunteers can hold a campaign and a candidate together.\* Fund raising, door belling and the other important skills volunteers can use to help get their candidate elected will be discussed by other members of the panel.

Stress, with emphasis on the stresses faced by medical families, will be the other event. Judy Wagonfeld, one of our Auxiliary members and an RN with a master's degree in public health, will discuss stress and lead us in some techniques such as relaxation, brief exercises, and visualization. Decision making in medical families when one parent is frequently absent, the working wife, and other stressful areas particularly appropriate to physician families will also be included.

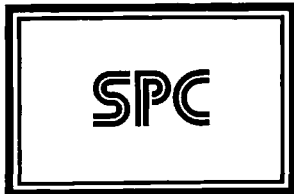
The political skills panel will be in the morning from 9:30 to 11:30 am only. The stress program will be presented twice, once during the same hours as the panel, and again after lunch from 12:30 to 2:00 pm. This will allow a choice of events for those only able to attend in the morning.

Come join us and stay as long as your schedule allows. Dress will be very casual, with comfortable clothing such as jeans or jogging outfits the order of the day.

*Judy Baerg*

\* According to Shirley, if she must choose between dollars and a good volunteer to assist a campaign, she will choose the volunteer every time.

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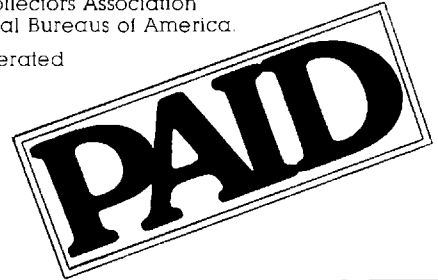
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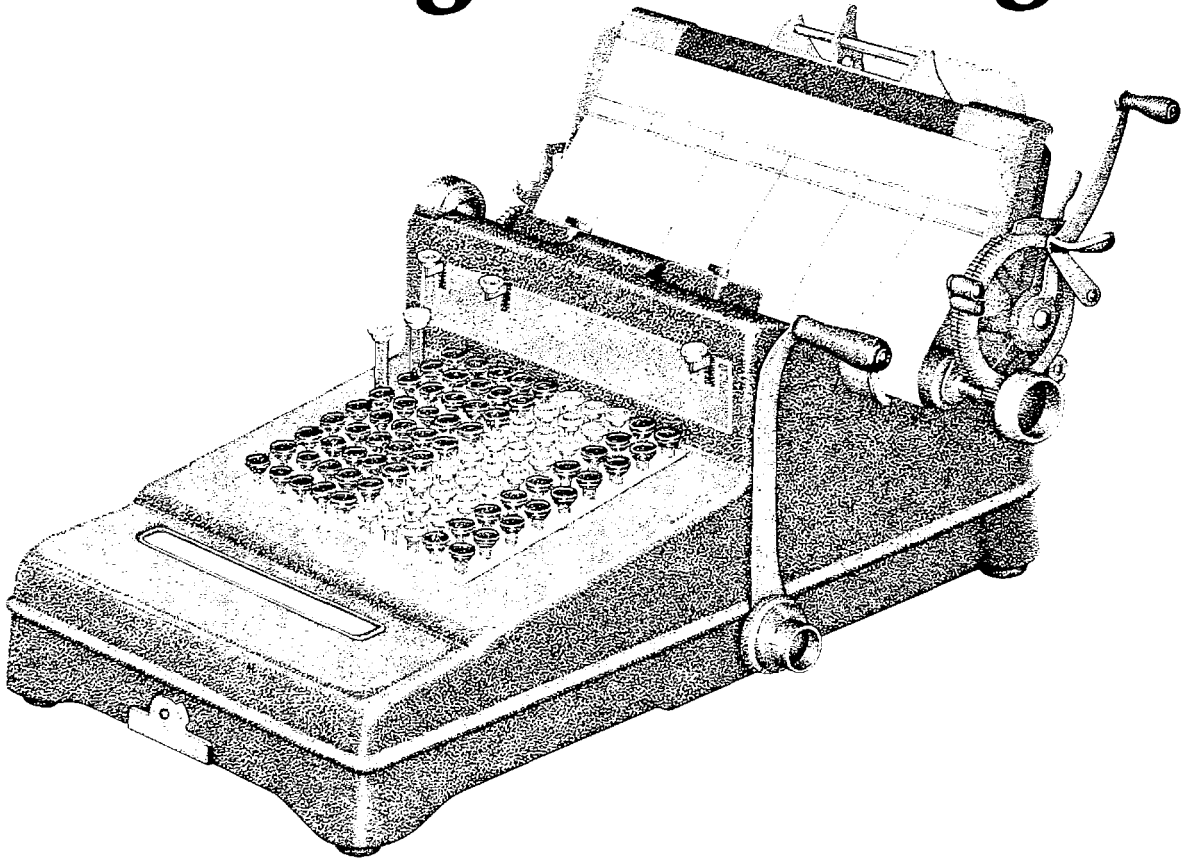
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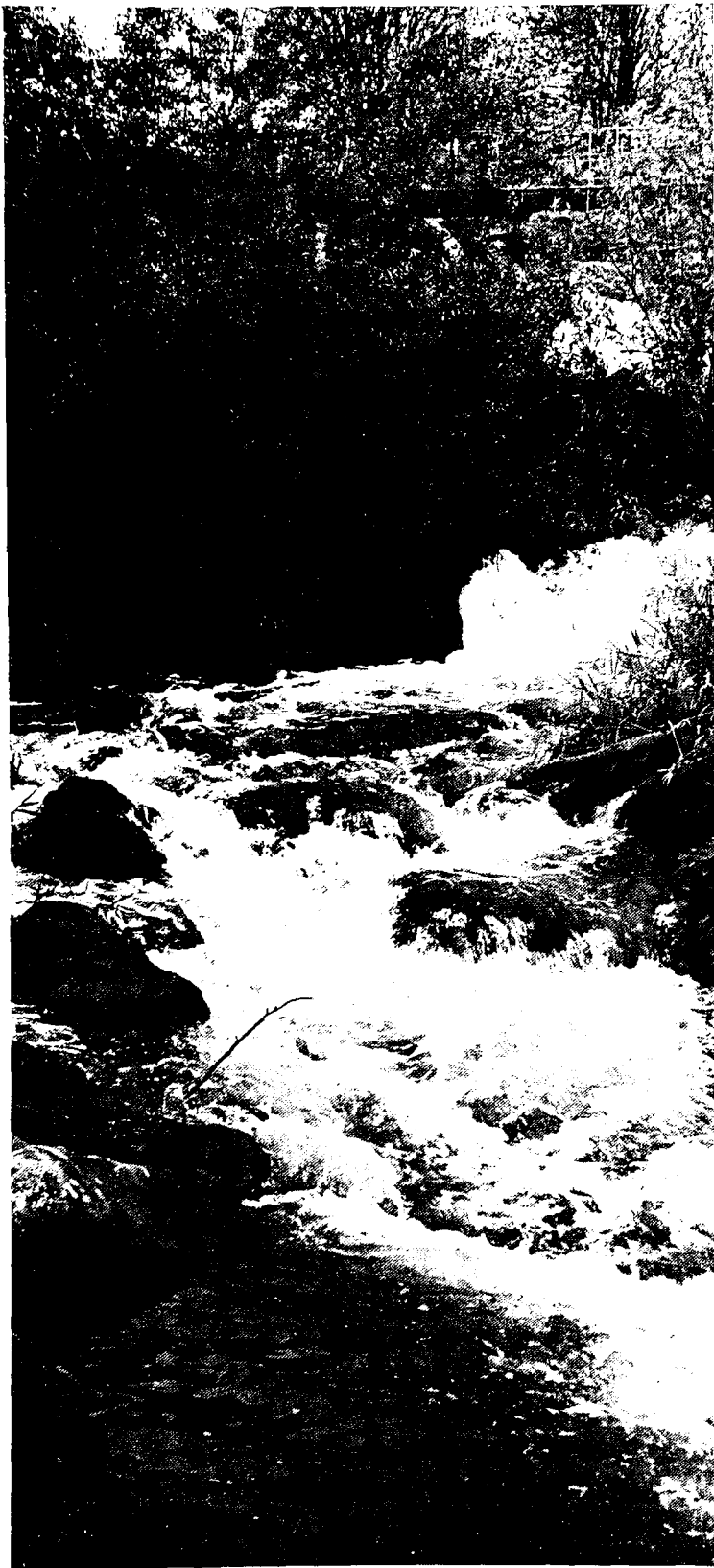
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# The Bulletin

MEDICAL  
SOCIETY  
OF PIERCE  
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In This Issue . . .

Assisting at Surgery, page 6

November Meeting, page 13

October, 1982

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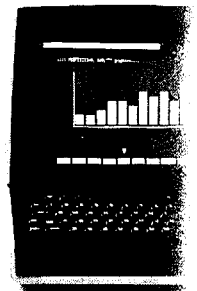
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Physicians and school district representatives met in August to discuss a number of joint issues.  
A summary is presented.

**Editor:** David S. Hopkins

**Managing Editor:** Thomas J. Curry

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Deadline for the submission of copy is the 25th of the month preceding the month of publication. However, final determination of publication date will be made by *The Bulletin*. *The Bulletin* reserves the right to edit all reader contributions for brevity, clarity and length, as well as to reject any material submitted.

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# Society News Briefs

*A summary of Medical Society, and local medical and health news*

## Trauma Center Criteria Approved

Amended criteria for hospital trauma center designation have been approved by the Medical Society Board of Trustees. The action was taken at the Board's October 5 meeting.

Modifications to the criteria included the addition of neurology as a specialty "on-call and promptly available inside or outside the hospital" and its specification as essential for levels I and II and desired for level III institutions; and, the upgrading of "operating microscope, equipment or instrumentation to be provided in the operating suite", from desired to essential for a level II facility.

The criteria were originally proposed by the Society's Emergency Medical Standards Committee and were published in the July issue of *The Bulletin*.

The Board's decision relative to criteria did not address designation. The criteria have been forwarded to the Pierce County EMS Council with a recommendation for Council adoption and that they be incorporated in the local EMS plan.

Trauma center designation will be addressed at a later date. Formal Medical Society recommendations regarding designation will follow applications for EMS Council designation by local institutions.

Medical Society leadership met with five local specialty societies in September to solicit comments regarding the criteria and the related issue of trauma center designation. Many individual physicians have written to express their views on both issues.

## November Meeting to Tackle Costs

Who will control medical care dollars in the future? Will we return to contract medicine with a new twist—the application of sophisticated business concepts for all important cost effectiveness? Will hospitals be allowed to organize physicians and the delivery of health care services?

These issues will be discussed at the Tuesday, November 9 general membership meeting. The meeting will be held at the Fircrest Country Club and will be preceded by a 7:00 p.m. dinner.

The program will have a panel discussion format. Panelists are: Drs. Richard Baerg, William Jackson, Cordell Bahn and Keith Tucker, PCMB

medical director. In addition, Dr. John Lindberg, chairman of the WSMA committee on medical services and a Seattle internist, Mr. Frank Baker, vice president of the Washington State Hospital Association, and former executive director of the State Hospital Commission, and Mr. Mark Steinsager, executive director of the Health Care Purchasers Association of Puget Sound, will participate. Program moderator will be Dr. Bob Kapelowitz.

Make your reservation now for what promises to be a very stimulating discussion. Questions from the floor will be encouraged.

## How Do You Feel About Trauma Centers?

All Medical Society members are urged to complete the brief trauma center questionnaire included in the mailing for the November 9 general membership meeting. Letters from individual physicians and local specialty societies have been received by the Medical Society urging a position on the issue.

Now, the entire membership has an additional opportunity to express its views on this important local issue. Questionnaires must be returned to the Medical Society office no later than Friday, November 5.

## Physicians Join Society

Congratulations to the following provisional members who were elected to membership in the Medical Society of Pierce County at the September and October Board of Trustees meetings: Drs. John Kooiker, Sharon Michael, Robert Sands, Edgar Steinitz, James Taylor, Keith Weigel, Daniel T. Dugaw, and Peggy A. Hosford.

## People and Places

Marcel Malden, MD, FACP, has been elected to the Royal College of Physicians of Edinburgh, Scotland. The College has many functions, one of which is the administration of specialty examinations and certifications, equivalent to the American boards.

Physicians are elected to their fellowship on the basis of standing in the profession, on the basis of recommendations of other fellows and as a

*(Continued on page 20)*



# President's Page

## MEDICARE — AT THE CROSSROADS



The social revolution that in 1964-65 led to the passage of the King-Anderson Bill and Titles XVIII and XIX of the Social Security Act created an institution in America — Medicare was born. It was this country's first experiment in national health insurance.

American medicine at first fought it tooth and nail, predicting all sorts of dire results, not the least of which was the imminent demise of the freedom of choice for patients and free enterprise for physicians. Now, after 17 years of dealing with Medicare with all of its faults, the images have blurred and a 180 degree change in perspective has developed.

Of all the arguments made in 1964 by organized medicine in opposing Medicare, none has been vindicated as much as the argument concerning the future costs of the program. The Medicare advocates in the conceptual years refused to believe, or for political reasons chose to ignore, their own actuaries' cost projections. Medicine now could point to Medicare's current financial woes and gloat, saying, "We told you so." But, this is not the time for gloating, and organized medicine realizes that after one and a half decades of Medicare its creation has resulted in so many benefits that all efforts must be made to insure its survival.

Medicine realizes now, more than ever, that Medicare has resulted in access to medical care in a dignified and quality mode that did not exist for a large segment of the population prior to 1964. Medicare has become the principal source of health care for 30 million Americans, which includes about 3 million seriously disabled. It generates 35% of the total income of America's community hospitals, and 17% of the total health care dollar in the United States.

In 1983, as much will be spent through Medicare every month as was spent in the entire neonatal year, 1967. Medicare's financial base is rapidly eroding and is in serious danger of collapse. The Hospital Insurance Trust Fund will not be able to

keep up with expenses without significant changes. In 1981, Congress allowed the Old Age and Survivors Fund to borrow Medicare fund monies in order to keep the former from going under any further. Currently, Medicare spends \$12,000 per minute more than it takes in.

A number of remedies to insure the survival of Medicare have been proposed. They include short-term and long-term corrections such as: 1) Cost sharing — increase deductibles; 2) Establish a needs requirement for Medicare eligibility; 3) Raise taxes, either payroll taxes and/or the income tax; 4) Include HMO's; 5) Raise the age of eligibility for Medicare recipients; 6) Decrease Medicare benefits; 7) Establish a cap on tax deductibility of employer contributions to health benefits; 8) Require federal employees who do not participate in social security to pay the Medicare payroll tax; 9) Redefine Medicare's basic benefit package to emphasize primary care and preventive medical service; 10) Eliminate self-referral to specialists; 11) Establish budgetary caps on overall Medicare expenses; 12) Establish fixed prices for all categories of provider services and goods, i.e., "prospective reimbursement"; 13) Promote procompetition programs; 14) Establish a catastrophic program; 15) Remove Medicare from social security funded through general revenues.

Many of the above remedies would be a hard pill to swallow, but they must at least be considered if for no other reason than reality dictates it. These and other options at this very moment are being considered by Congress and the administration.

Please spend some time thinking about this problem and let your viewpoints be heard, both to your congressional representatives and to the federation of organized medicine. We must not sacrifice quality of care and access to care for the elderly on the altar of cost containment.

*Lloyd C. Elmer, MD*

# Exploring the Generalist-Specialist Relationship

## ASSISTING AT SURGERY DEBATED AT SEPTEMBER MEETING

The role of the primary care physician as surgical assistant, referral practices and related ethical considerations were discussed at the Society's September general membership meeting. The panel discussion, the second in a series proposed by the Ethics/Standards of Practice Committee, attracted over 135 physicians.

Following dinner and a status report of Physicians Insurance by PI President Mr. Ted Linham, the surgical assistants issue was explored by a panel of Drs. Robert Ferguson, Richard Hawkins and WSMA President Donald Keith (representing generalists) and Gordon Klatt, Stan Tuell and Richard Hoffmeister (representing surgeons). Dr. Gil Roller, chairman of the Ethics/Standards of Practice Committee, moderated.

Spokesmen from both sides of the issue responded to questions previously submitted to the moderator. The meeting is summarized below:

*Dr. Roller:* This is a continuation of our very successful May meeting. We hope to incorporate the results of these discussions into a document to be published by the Ethics/Standards of Practice Committee which we are in the process of organizing. We hope this educational process will have a beneficial long-term impact on the practice of medicine in Pierce County and on our interpersonal relations, professionalism and ethics.

As you may recall, last May we discussed communication, continuity of care, and we touched on the "team effort" while acknowledging that somebody has to be in charge. We discussed courtesy. We briefly touched on surgery and the role of the surgical assistant which brings us up to this evening.

In our discussions, we will keep in mind the impact of preoperative care, the surgeon, the surgical assistant and the postoperative care issues, because they all relate.

*Question:* What are your criteria for selecting a surgeon to whom to refer a patient?

*Family Physician:* Obviously, the surgeon must be well qualified. I am certainly not going to send my patients to someone who is not able to deal with a specific problem. Interpersonal relationships with

me, my ability to communicate with the surgeon, and my patient's ability to communicate with the surgeon, and vice versa are very important.

The question being begged is, would one of my criteria be whether or not he's going to ask me to assist. I don't know that I would list this very high on my set of criteria. I would think it is maybe an element of my ability to communicate with him. I am probably going to pick a surgeon who I can talk to and who I feel is going to talk to me so that we can decide what is most appropriate. If it is pretty clear that it is appropriate for me to assist and there are no questions about it, or if it is very clear that it is inappropriate, maybe it is not an issue. But in those borderline situations.



Over 130 members attended the meeting, hearing a status report on Physicians Insurance, a brief presentation by WSMA President Dr. Don Keith, and the panel discussion.



*Question: Can a system be devised where we can screen family practice physicians according to their abilities in the operating room?*

*Surgeon:* Certainly when we screen surgeons in surgery committees, we look at their credentials very closely and we look very closely at what they check off as to what they are going to do. In my experience, when a family practice doctor applies for surgical privileges, the whole list of operations is checked in the assistant's column. We say fine, we don't look at it that closely.

*Question: Should the family doctor be present to judge the diagnostic and technical skill of the surgeon?*

*Family Physician:* Any physician who has spent any number of years in the operating room and scrubbed on a variety of cases is reasonably familiar with anatomy and with surgical procedures in general and is in a position many times to judge whether or not he wants that surgeon to operate on his next patient.

In Tacoma, we are very fortunate to have extremely competent specialists and sub-specialists. At the same time, most of us who have practiced for a number of years, have been trapped in an operating room one or more times with a terrifying situation. Admittedly, this was much more common 20 or 30 years ago. I don't think this can happen much any more, but the memory kind of sticks with you.

I feel much more comfortable in referring one of my patients to a surgeon with whom I have scrubbed. I can relate much better to that individual patient if I know the competence of the surgeon. Admittedly, most of them know far more than we do, but I think it is still possible to judge them.

*Question: In a specialized procedure, should not the assistant have the ability to perform the operation so that he or she can make constructive observations and recommendations during the procedure? In other words, a specialized surgeon — should he have a specialized assistant at times?*

*Surgeon:* At least in sub-specialties there are procedures which are very technical. Two surgeons who are trained to do the procedure can not only accomplish the surgery faster, but one can be checking the other. There are some procedures where a family physician is qualified to assist.

I gather that one of the reasons the panel was put together tonight was that perhaps the question of "Can I assist?" was placed quite high. The message has got to be that we're interested in the best care for the patient, not whether there's going to be a fee for assisting. If two specialists working together can shorten a lengthy operative procedure by an hour or more, it is less anesthesia time for the patient and results in less charges.



*Question: Is there a policy by the American College of Surgeons regarding an assistant being present and capable of finishing an operation?*

*Surgeon:* The initial sentence in the College's guidelines for who should assist sounds rather strict and is similar to what was attributed to the College some years ago — that, theoretically, in doing major surgery the assistant should be another major surgeon, supposedly capable of taking over if the first surgeon falls over dead or something. In no way has that been followed through the years.

Even though they say "ideally" this should be the situation, the next several lines from the guidelines back down and are very flexible, saying basically that the person assisting should be someone who is qualified to do it. They don't even object, depending on the situation in the hospital or community, to having a RN or PA assisting in major surgery. They stress that if this is done, there should be some way of evaluating those people and seeing if they are qualified.

If a PA or RN come in, they are required to list qualifications. That goes through our committee system before they are approved. We don't really

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have that for general practice doctors, but I'm not so sure we need it. It is very rare in my years of experience to have a GP come in who really should not be in the operating room.

I feel a slow-down in the OR is often more than made up for by my appreciation of the fact that the primary care physician is there. I can talk freely with the patient who says before or after the operation, "Is doctor 'so and so' going to be there?" The patient has established a rapport with his family physician and has yet to establish it with me and it is very comforting for him to know his doctor is going to be there.

*Question: Will participation by family practitioners aid in other subsequent preoperative evaluations and in the immediate postoperative care of the patient?*

*Family Physician:* In many situations it is a very distinct advantage for the family physician to be involved in the preoperative care. Rapport with the family, with the patient, and knowledge of other medical problems can be very important.

I guess this is a good place to comment on the general internist. Most of our conversation centers around family physicians because internists tend to avoid the operating room as if there's some sort of bacteria in the air or something and there is often not a good place for the general internist to be involved in the preoperative care of the patient. Sometimes it is important because of other medical problems. Again, I get back to one of my primary criteria in making a referral, there has to be communication.

*Question: Are there operations that do not require an assistant?*

*Surgeon:* Yes. That is self-evident. You cannot collect for assisting in many of these cases. However, I have had family physicians come in and assist just to know what is going on, to be closer to the patient and to be able to inform the patient.

*Question: What if that patient requests that the family physician be present at an operation that does not require an assistant? How should this be resolved?*

*Surgeon:* The family physician and the surgeon

can talk to the patient. I have never seen that to be unresolvable. I think the patient is pretty well satisfied when you explain the situation.

Interestingly, I have had two cases where the patient requested that the family physician not be present in the operating room. It was not the same physician each time. I asked why and they said, "He's not a surgeon, is he?" I asked the patient to talk to the family physician as it was something between the two of them, as I felt comfortable with the family physician assisting.

*Family Physician:* I can appreciate that. I have patients who sort of ask that question. In a more general sense, I run into the situation fairly frequently of whether I am going to take care of something or if a referral has to be arranged. Patients ask me that frequently and you have to deal with it on an individual basis. If it is a problem or procedure that is really over my head, I don't like to get into trouble. If it is something that I am competent in dealing with, I will tell the patient. If the patient is still reluctant about it, then I will find somebody else because I don't want him to be uncomfortable either.

Patients wonder what the circumstances are and we have to talk about it. Maybe I am not sure that I want to assist with an operation, but I feel that the patient wants me to be present, so that's the road you go down.

*Family physician:* The other thing I want to say is about the unnecessary assistant. Unfortunately, that is not something I can always judge. I am not in the operating room enough. I deal with a wide range of different kinds of problems. I need help from the surgeon as to whether or not I should be there. Maybe our hospital committees should generate a list of procedures that generally do not require an assistant.

*Family Physician:* It is not common for a patient to request that the family physician be there in a procedure that really and truly does not require an assistant. When it does occur, it is incumbent on the family physician to either be in the operating room, perhaps unnecessarily and without charge, or to explain that another pair of hands is not needed. People do understand this.

As far as unnecessary assistants at things like hemorrhoidectomies, I do not think it is necessarily up to the family practitioner. There are surgeons who may prefer an assistant at a hemorrhoidectomy, a hernioplasty and so forth. If it aids



*Dr. Ted Haley, state senator, spoke briefly of his candidacy for the U.S. Congress. Haley faces incumbent democrat Norm Dicks for the Sixth Congressional seat.*

them in any way, if it makes any difference, say on a hemorrhoidectomy which is one of the most important surgical procedures anyone can have — there have been more lives ruined by bad hemorrhoidectomies than by bad gallbladder removals, believe me — that's acceptable. I don't think you would be able to develop a list of "non-assistable" procedures unless the surgeons themselves want to try.

*Question: Do you feel participation in the surgery will reinforce your knowledge of the symptomatology and that you will benefit in sharing the surgical findings?*

*Family Physician:* I am old fashioned enough to believe that anatomy is still one of the cornerstones of medicine. The further we get from anatomy, the less well we will be able to diagnose our patients. I would personally feel terribly cheated if I could never see the results of what I have diagnosed.

A few years back it was expected that the general practitioner assist at surgery; there weren't that many surgeons. I can't imagine not being in a situation where I could not at least follow when I feel competent in assisting.

*Family Physician:* It stands to reason that any primary care referring physician looks for confidence. You're just not going to send patients to someone because you like him, you're going to refer to someone who is competent. Beyond that, I

send patients to doctors that they will like, because when they don't like them and when they have had good technology but bad medical care they come back and bitch to me. They don't bitch to the surgeon. I try to match up personalities.

In this decade of competition, you people who are in the specialties, having patients referred to you, should look to your personalities. Look to the way you care for patients, how you talk to them beforehand and afterwards. We have a lot of physicians to whom patients are referred where the patient comes back and says the physician was brusque, he didn't have time, he didn't explain anything. If you do not talk to these patients, pretty soon you do not get the referrals.

If you want to talk economics, it sure doesn't pay me to go into an operating room and serve as an assistant surgeon. They don't pay enough to make up for the time lost out of my office. It is important to that patient, if I have been his physician for many years, not just to know that I am there, but also that I can help translate the surgeon's talk into their kind of talk. I am there as an advocate for the patient and to help manage things if we get into a problem where we have a number of specialists involved.

Does the family physician being there help him correlate what is going on? It sure does. If you have taken care of a patient over a number of years, the chart has a lot more meaning to you if you were actually there at the time the abdominal surgeon took out the gallbladder and the orthopedic surgeon worked on the back.

*Question: Can the referring physician be truly objective if he or she stands to benefit financially by assisting in a surgical procedure? Does the assistant's fee have a bearing?*

*Family Physician:* From the family physician's standpoint, he is often expected to make contact or do something for preoperative and postoperative care and there is no way to reimburse him. At other times, the surgeon is put in a spot where he is doing a procedure where he really doesn't need an assistant and money obviously enters into that sort of situation. Does anyone want to say anything about costs or fees?

*Surgeon:* I don't think much of the question really. It's the same as asking of the surgeon, "Is it

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right to decide he is going to operate on somebody if he is going to get a fee for it?" We all know that this is wrong. We assume, and I hope it has been proven in our community, that such decisions are made on the basis of the patient's need.

Coordination between the family physician and specialist is something that worries me, but it never comes to a head and I think that's because of the rapport and communication we have. When do I tell the GP that we may have to get some of the super specialists in? I guess when I come face to face with the issue and talk to the GP. He has usually made that decision himself before I get there and when I do bring it up, he is more than willing to make the switch. Do the physicians think this is a problem? Do they think we're going over their heads in calling in the super-specialists?

*Family Physician:* I feel it is the surgeon's job to say that very thing. If he is uncomfortable, he better communicate with the general practitioner. If he steps on a toe or two, tough. I don't think this is going to happen too often.

*Family Physician:* The primary thing I like to do is stay out of trouble. If a medical problem is developing that is going over my head, I do not like to deal with it. The same question goes both ways. Sometimes, I am watching the case and I am not really sure how to raise that suggestion. Please be cautious though about making an automatic assumption that I cannot take care of somebody's postoperative congestive heart failure or whatever. Family physicians differ in their training, their experience and their interests. I encourage surgeons not to involve another specialist without having talked to the family doctor. By the same token, if you feel that is something that needs to be done, bring it up.

*Surgeon:* I just want to bring up something that bothers me. It is the case where a patient is referred to me and it is clear the physician will be assisting. It may be that a family physician would be qualified to help, but I know this particular family physician does not have the qualifications to help me expeditiously. It may slow the case down and make it less safe. Those are the situations that make me feel uncomfortable. That's why I brought up that first point of looking more into the qualifications, to get some guidelines for specific family practice people. Do the other surgeons here have any comments on that?

*Surgeon:* Are there not those who call and say they will refer the case if they can assist? I think that is wrong. No matter how you look at it, that implies to a certain extent that you are putting something ahead of getting the best care for the patient. Does that 20% assistant's fee make a difference in the family practitioner's income? Is it perhaps somewhat at the back of the mind in certain referrals?

*Family Physician:* Many years ago, it was not to our financial advantage to assist. With the current fees, I do not think there is any question that on the majority of operations, unless unusually prolonged, it is worth the assistant's time financially to be in the operating room. If that fee is the only consideration, it is unethical.

*Family Physician:* One of the other problems that comes up for the referring physician who assists at surgery, depending upon his particular ethics, is charging for seeing at patient post-operatively if the patient did not have a particular need for your medical skills at the surgery. A number of days postoperative, if your fee was 20%, sure doesn't come out too well. If your skills were medically needed and you assisted, then you would charge for those days like any other consultant coming in. If you were seeing the patient only because he wanted you there, most of us do not end up charging.

*Surgeon:* About the doctor calling and saying, "I'll refer this patient if you let me assist." This sounds like we are immediately supposed to jump to the conclusion that there is something wrong with this. That this guy wants to assist because he wants the 20% fee. I have never had anyone say that to me, but his reason might very well be that he wants to be there to see the anatomy, to correlate this with his diagnosis and management of the patient afterwards, as has been mentioned several times. That is why he wants to be there. Even though it sounds blunt when you say it, he might very well choose a surgeon on the basis of whom he can come and assist. For the very good reasons mentioned, not because he is eager for the dollar.

*From the Floor:* I am an anesthesiologist and we see things from a little different point of view. We do not depend on referrals from the family practitioner, nor do we have to be very polite to them for fear they won't refer to us again. With that as a preface, there are a few things I would like to

mention that just refer to ethics and common sense. Where I work, there are offices very close to the operating room and the assistant can run in late, run out early, and still not miss one beat with the patients in his office and still charge very nicely for it. I do not think that is right.

As far as the technical aspects, today at the end of a case, the nurses have to count everything. They count sponges, needles, instruments, assistants, patients. They count everything. They have to do that at the end of a case. If the assistant takes off before that is done, then they have to assist, they also have to count and this is where errors are made. I think the assistants should be there on time and I think they should be there until the end of the case. They owe that to the patient who is under my anesthetic. Thank you.

*Family Physician:* I think that what we are touching upon is that other "half a percent," or whatever it is, and as a family physician I am concerned about that. I imagine there probably are physicians who do things that we all agree are improper and probably they would agree that it was improper if you asked them. How do we deal with that?



Panelists included (left to right) Drs. Stan Tuell, Bob Ferguson, and Don Keith.

*Question: Is it unethical and detrimental to the patient's best interest to refer only to surgeons who let the family practitioner participate? Does the American Academy of Family Physicians have an official position on that issue or any of the things that we have touched upon tonight?*

*Family Physician:* It certainly would be a problem. The physician who says "I will refer to

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How come? Because we have been selective and because you are practicing good medicine. Unfortunately, we had to formally decline coverage to about 13 physicians. We turned away about another 20 and said it would probably be in your best interests if you don't apply.

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you only if I am allowed to assist," is that bad or good? Is it really an economic thing, or does he have other reasons? It becomes important for surgeons and their referring physicians to understand each other and to understand what the surgeon wants to do in the case and when cases are complex. If a referring physician insists on being there and his reason is economic, that is bad medical practice and I would question the ethics of that. But I am not so very sure there are very many of those kinds of physicians.

The position of the American Academy of Family Physicians is that people should be allowed to do those things they are trained for.

*Dr. Roller:* We obviously did not solve everything tonight. We touched on surgical privileges for the assistant, and thanks to our anesthesiologist, these privileges would mean complete assistance. We explored coming up with a list of operations that do not require assistance. We talked about choosing a surgeon, good care, competency, the ability to communicate with the family, and fees. Thank you very much.



*Other program participants (left to right) included panelists Drs. Gordon Klatt, Richard Hawkins, and Dick Hoffmeister, and moderator Dr. Gil Roller.*

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# Medical Society of Pierce County

## GENERAL MEMBERSHIP MEETING NOTICE

### —THE PROGRAM—

### **COSTS: What Can Be Done? Who Will Control the Medical Care Dollar?**

*Will we return to contract medicine—with the application of sophisticated business concepts for all important cost effectiveness*

*Will hospitals be allowed to organize physicians?*

*What will be the role of medical practitioners relative to costs?*

**PANELISTS:** Drs. Keith Tucker, PCMB Medical Director  
Cordell Bahn  
Richard Baerg  
William Jackson  
John Lindberg, chairman, WSMA Medical Services Committee  
Mr. Frank Baker, vice president, Washington State Hospital  
Association and former executive director, Washington State  
Hospital Commission  
Mr. Mark Stensager, executive director, Puget Sound Health  
Purchasers Association (business coalition)

**MODERATOR:** Dr. Bob Kapelowitz

**DATE:** Tuesday, November 9, 1982

**PLACE:** Fircrest Golf Club  
6520 Regents Blvd., Fircrest  
(Take Fircrest exit off of Hiway 16. Proceed on Regents  
Blvd. to the club which will be on your left.)

**TIME:** 6:15 P.M.—Social Hour  
7:00 P.M.—Dinner  
8:00 P.M.—Program

**COST:** Dinner, \$10.75 per person.  
Salad bar, chicken and baron of beef buffet  
(price includes tax and gratuity)

Register now. Mail this form, with a check for the appropriate amount, to the Medical Society office. Or, call the office, 572-3667, to confirm your attendance. Make check payable to Medical Society of Pierce County.

### **REGISTRATION:**

Yes, I have set aside the evening of November 9 to meet with my colleagues.

\_\_\_\_\_ Please reserve \_\_\_\_\_ dinner(s) for me at \$10.75 each (price includes tax and gratuity)  
Enclosed is my check for \$\_\_\_\_\_.

\_\_\_\_\_ I regret I am unable to attend the dinner portion of the meeting. I will attend the program only at 8:00 P.M.

DR. \_\_\_\_\_ Telephone No. \_\_\_\_\_

RETURN TO THE MEDICAL SOCIETY BY NO LATER THAN FRIDAY, NOVEMBER 5

# Guest Editorial

## THE PHYSICIAN AS ADVOCATE

The poor, ah, the poor that are ever with us, the deserving poor and undeserving; the new poor and the old poor; the medically poor and the technologically poor; the transient poor and the refugee poor; the Medicaid, the Medicare, the Medichex and the welfare poor; also, not to be forgotten, the poor in spirit. Physicians encounter the myriad of poor in groups, families and alone, in offices, clinics, hospitals and nursing homes, and what are we to do? With the government retreating from its former policy of social responsibility, there is an avalanche of medically poor. What is our responsibility?

There are probably as many ways for the profession to respond to the needs of the medically poor as there are poor people. Understanding our dual responsibility to the poor should start with our dual responsibility to all patients: (1) to apply our scientific knowledge to remove pain, and (2) to understand the human condition with which we give meaning to the patient's suffering. Out of these two responsibilities flow the countless thoughts and actions that make up quality medical treatment. When treating the poor, however, we are often remarkably adept at the former and understandably slow at the latter.

### Preserve Their Dignity

An easy mistake for any physician to make when treating a poor patient (I detest indigent as a mealy-mouth word) is to think he can remove the pain without dealing with the suffering. Perhaps the most undeniable example of the suffering of the medically poor is found in the proud but unemployed man who brings his sick child for a treatment he cannot pay for. We all know the twinge that comes with recognizing his plight. Preserving his sense of dignity calls for the art of medicine and can serve as a model for the entire profession's response to the poor.

But then a host of voices clamors with examples of the undeserving poor, citing their missed appoint-

ments, personal neglect, ignorance, ingratitude, and sometimes, insolence. The voices ask whether physicians are to serve these undeserving patients as well. The answer, older than Hippocrates, is "yes," even if there is a qualification or two. The answer has to be "yes" if we are to continue as a profession.

The curious fact is that the undeserving poor are a litmus, a radioactive tracer, searching out the real ability of the medical profession and the individual physician to use the art of medicine in giving meaning to the suffering patients. To begin with, the poor have no monopoly on indolence, ignorance, insolence and self-inflicted disease. In my experience those "undeserving" traits have been found in every class of society. For example, there is the wealthy matron who pays her bill, yet is the bane of a busy physician with her persistent hypochondriacal complaints. She often is believed to be undeserving and is labeled a "crock." What the poor proud man has and what the wealthy matron lacks—the difference between deserving and undeserving—is simply that with deserving patients the physician understands the suffering as well as the pain, but with the undeserving he is only prepared to see the pain.

### The Greatest Gift

More than the difference between rich and poor, to be able to appreciate the difference between deserving and undeserving patients is the key to meeting the present challenge the profession faces. Once our appreciation of the suffering of the medically poor is firmly in place, we can then give them our greatest gift, we can assume our role as their articulate advocates.

Treating poor people, as any practitioner can attest, takes more time, not less, than treating self-sufficient patients. The suffering of the poor is more complex, confused with social issues and often hidden behind a foreign ethnic background. Spending more time, the physician's income suffers;



more is going out and less is coming in. In this bind he is tempted either to speed up the flow of patients or, by raising his fees, to shift the burden to his paying patients. If he serves the poor well, and he should, he becomes poorer in the process, though never poor.

A wise and ancient observation points out that a man who gives away 10 percent of his income tithes, 20 percent and he is generous, 30 percent and he is in need of charity for himself. A concerned physician who sees his care of the poor amounting to more than 20 percent of his practice has reason to stop and think, what am I to do? The answer for some is, "Dammit, if we give to the poor, the government will never carry its share. So let the poor go elsewhere." For others, the answer lies in an appreciation that the suffering of the poor needs a greater understanding than the physician is able to give and so he finds himself maturing into an advocate of the poor. Long ago Rudolf Virchow pointed out that this is a necessary role for a physician: "Physicians are the natural attorneys of the poor, and social problems fall to a large extent within their jurisdiction." Thus, the physician evolves into someone who secures help rather than giving it directly for he best understands the dynamic social forces that lie behind the suffering.

### Help Others Understand

The advocate's role calls for the physician in professional and public forums, at local, state and national levels, to describe clearly the needs of the medically poor and to point to possible solutions for the community to consider. In acting as advocate the physician must continually detail the specific needs, measured sometimes in dollars, always in human suffering, for no one else can voice the combination of pain and suffering as well as a physician. Also, he must continually address the common response that the poor "have made their bed and now they can lie in it." He must work with the easy confusion people have in converting a social problem into a moral one.

Whether with the patient directly, at a hospital committee meeting, on the floor of the state legislature or a cocktail party, physicians have an endless

responsibility for understanding the plight of the poor and helping others to understand it. The charity of advocacy can never become greater than generous acts, but together they remain the quiet unquestioned trust that the poor place with the medical profession. Our responsibility remains to serve the poor, all the poor, in every way and restore their dignity as fellow human beings.

*Ralph Crashaw, MD*

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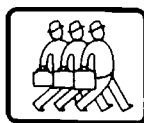
## Professional Liability Seminar

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# UNTANGLING THE COMPUTER QUANDRY

*"I understand that computers have rapidly become a fact of business life in the medical practice. But how should I get started? What kind of automation is right for my practice."*

The last five years have witnessed a veritable computer technology explosion. Choices of computers and computing systems offered for physicians seemingly increase on a daily basis. How does the physician know which, if any, method is right for his or her specific practice?

Unfortunately, as the number of offerings and selections has increased, so has the complexity and difficulty of making an intelligent and successful computer decision.

This article attempts to provide some useful guidelines. In particular, there are some important concepts to understand before selecting the broad approach to computing—service bureau, on-line time-sharing, or in-house—that's right for each individual situation.

The increasing number of choices has generally been a positive force, bringing the very real benefits of automation to more medical practices. The right computer system can help improve cash flow, strengthen a practice's finances, offer better patient service, free up doctor and staff time, and allow office staff to concentrate more on matters requiring the human touch.

## **Improved Cash Flow**

Any computerized system helps increase collection rate, strengthening the practice's financial well-being. Typically, the professional-looking statements, consistent billing dates, and collection tools provided by a computerized system enable medical practices and clinics to collect from a greater percentage of patients billed each month. Checks are generally built into the system to ensure that all charges are billed in the proper amounts through tracking and control of all charge slips or fee tickets.

Computerized systems also speed up collections by shortening the time that elapses between the patient's treatment and billing date, and by hastening the payments from both patients and third-party agencies. With faster collections, accounts receivable can be reduced while production remains constant or even increases.

There are three ways to obtain the benefits of computerized accounting. They are:

## **Service Bureaus ("Batch Services")**

Many practices find a computer service bureau provides a convenient way to automate accounting procedures. Practice records are periodically "batched" and sent in a pouch to the service bureau. There they are entered into the computer which produces the billing and financial and practice analysis statements. There is no computer "hardware" in the doctor's office.

## **On Line (Time Sharing) Systems**

An on-line system in the doctor's office consists of one or more computer terminals connected by telephone lines to a host computer to provide a "window" for entering data or making inquiries.

Customer fees are generally based on time and services used. Optional equipment, including a printer and a work-processing unit, may be available to augment the basic system.

## **In-House Computers**

Not long ago, in-house computers were out of the question for most doctors. They were too expensive, and required far more expertise and personal involvement than a medical clinic or group practice could justify.

In a very short time all that has changed. The ongoing revolution in electronic technology has produced a whole new generation of minicomputers. Smaller and more compact than earlier models, they no longer require special facilities or specially-

trained operators and programmers to operate them. Today's in-house computer systems will include one or more terminals and printers, disk storage and central processing unit ("CPU" — the "brains" of the operation). An in-house system is relatively inexpensive to own and maintain, putting it within reasonable range of a busy medical practice or clinic.

There is a very good reason why such a range of options exists: there is no single approach that will be right for every practice.

### **Service Bureau: A Practical Option for the Small Practice**

Many practices have found the service bureau their most practical option. Usually the most cost-effective solution for the small practice, this approach requires lowest monthly cost with little if any initial investment. There is no equipment in the doctor's office because the service bureau does all data entry and processing.

Some innovative service bureaus have recently begun offering one-way data entry equipment as part of their service, enabling your office staff to enter the data on diskettes, which are then sent to the service bureau for processing rather than sending loose forms. This one-way equipment allows data entry only; it does not permit inquiry.

Another advantage of the service bureau approach is that little or no staff training is required. You delegate the computing work to the center. Your staff will fill out data entry forms, or key information onto diskettes much as they would use a typewriter.

Additional space requirements for the office using a service bureau are minimal. At most, a data entry terminal would be required; there may be no hardware at all. In addition to the monthly billing statements, the service bureau prepares extensive reports dealing with both the financial health of the practice, and with practice analysis.

Finally, a service bureau is a good test approach for the physician trying to decide whether automation is right for his or her particular practice. With only a basic fee, there is no long term commitment made, and minimal risk to get started.

### **On-Line (Time Sharing): Benefit of Owning Your Own Computer with Minimal Investment**

For many practices an on-line service provides the best of both worlds: access to a powerful, fast medical information system to provide the valuable decision-making support of an in-house computer, without the investment involved in owning one. One or more computer terminals, connected by telephone lines to a host computer, will be located in the doctor's office to provide a "window" for entering data or making inquiries while the system is actually connected to the host computer.

It's a simple matter for your staff to register the patient, post charges and make account inquiries in a matter of seconds. Information is always current.

There are several investment options available for putting an on-line system in your office, varying from rental to lease to purchase. In any case, the initial investment will be low.

An optional printer and a word processing unit may be available with some systems, allowing you to print out information being called up on the terminal. A few systems also allow the substitution of an optional microcomputer for the terminal which, with the optional printer, allow you to produce typed medical dictation and correspondence, and to handle your overall office accounting in one sophisticated space-saving system located in your own office.

The latter option may also make it possible for you to tap into a nationwide computer data network that gives you a valuable resource for medically-oriented information, national and business news, airline schedules, investment analyses and commodity and stock reports.

### **Your own Computer In-House: Total Control for the Larger Group Practice or Clinic**

For the practice that can justify it, an in-house computer provides the ultimate in computer service: instant retrieval of patient data and practice information; easiest patient registration and immediate access to it; maximum security; and

billing statements produced in-house.

Your own in-house computer gives you total control. Nothing leaves your office. You establish your own cutoff and billing dates, scheduling work to fit your practice schedule and generating reports as necessary. There are no regular monthly charges, beyond maintenance contracts, and by investing in this substantial asset, you qualify under the 1982 tax law for Accelerated Cost Recovery System (depreciation) benefits.

An in-house system is generally considered cost efficient if it generates sufficient dollar savings to offset the cost of the system — whether the system is being purchased or leased. While it's difficult to generalize in dollar volume terms, a 3- or 4-doctor practice, particularly if it's growing rapidly or considering additional office staff, may well consider the in-house computer option. While an in-house computer is unlikely to replace office staff, it may mean existing members could be transferred to more satisfying responsibilities.

A high-volume one- or two-doctor practice, particularly one with excellent growth prospects, or a clinic with "satellite" clinics would also be good in-house candidates.

Specifically, if you require the fullest measure of available computing services, and if your office requires four or more work stations, you're quite likely to find an in-house system to lowest-cost approach.

While it's possible to produce virtually any in-house computing activity with the on-line system, as a practical matter the in-house system may be far more economical for certain advanced applications. Patient scheduling and sophisticated collections features, for two examples, are usually best done on an in-house system.

There it is: There is no single decision that will be "right" for every practice. The right decision will depend upon your practice's unique requirements. You may well have more than one reasonable option. It's important to select a supplier who respects your right to consider all three approaches, and to decide on the one that best fits your practice objectives.

## **MAJOR ADVANTAGES OF . . .**

### **Service Bureaus ("Batch Services")**

1. Lowest monthly costs.
2. Little if any investment cost.
3. Fewest new responsibilities for office staff; little or no training necessary.
4. Minimum space requirements.
5. Extensive practice reports and profiles.
6. No need to make a multi-year decision.

### **On-Line (Time-Sharing) Systems**

1. Instant data recall on a terminal.

2. Immediate data updates ensure that data is always current.
3. Low investment cost.
4. Minimum space requirements.
5. Places the responsibility for hardware maintenance, printing statements, and "backing up" data outside the practice.
6. Ability to try interactive computing without making a multi-year commitment.

### **In-House Computers**

1. Instant data recall on a terminal.
2. Immediate data updates ensure that data is always current.
3. Advanced applications such as patient scheduling and sophisticated collections are more feasible and economical.
4. Practice retains total control over data, work schedules and most costs.
5. Greatest investment tax credit (ITC) and depreciation (ACRS) tax benefits.
6. Usually most economical when 4 or more work stations (terminals) are required.

## **10 TIPS TO HELP YOU MAKE THE RIGHT COMPUTER DECISIONS:**

1. Be sure to involve your office staff every step of the way.
2. Make a list of what you want your computer system to do for you.
3. Get an expert survey of your facilities by an experienced supplier or consultant.
4. Look for an established software vendor — experienced in dealing with the medical profession — who is financially strong, and has more than one programmer dedicated to medical applications.
5. Choose a good medical system that's already available. Avoid custom programs unless you absolutely cannot find what you want.
6. Get a system that's easy to use.
7. Talk to others who are now using the medical system you're considering.
8. See the system in action, compare features, and try it out with some of your tough problems.
9. Select a supplier who provides strong initial training and is available for continuing follow-up trouble shooting.
10. Ask suppliers for proposals that specify exactly what is to be included, with pricing clearly spelled out.

*By Harry D. Turvey and Murray Ahlquist. Harry D. Turvey is director of marketing and Murray Ahlquist is director of software development for Poorman-Douglas Corporation.*

*Article reprinted courtesy of Portland Physician, June, 1982, vol. 37, no. 26.*

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and The Edwin C. Yoder Memorial Trust**

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# Society News Briefs

(Continued from page 4)

result of evaluation by a specially constituted council and subsequent approval of all other fellows.

The Royal College of Physicians of Edinburgh was established in 1681, and last year celebrated its tercentenary.

Dr. Surinderjit Singh has been elected to the Professional Standards Committee of the American Association of Electromyography and Electrodiagnosis. He will serve on the association's Standards Committee for the 1982-83 term. Dr. Singh is a diplomate of the American Board of Physical Medicine and Rehabilitation and is a member of the American Association of Electromyography and Electrodiagnosis.



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## THE DOCTORS HOSPITAL OF TACOMA

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October 13, 1982

## INVESTMENTS IN THE 1980's

- \*Understand tax sheltered investments.
- \*Differentiate common and preferred stock investments.
- \*Recognize new developments in the bond market.

November 10, 1982

## INCORPORATION - WHEN & WHY

- \*Increase understanding of personal economics & other non-tax considerations.
- \*Recognize tax and non-tax benefits.
- \*Conceptualize how to establish a professional service corporation.

December 9, 1982

## ESTATE PLANNING - SHIFTING ASSETS, TRUSTS AND OTHER CONSIDERATIONS

- \*Understand estate planning and the Economic Recovery Tax Act of 1981.
- \*Recognize value in shifting income property to lower tax brackets.
- \*Increase awareness of pension plans.
- \*Increase understanding of life insurance and retirement plans.

January 12, 1983

## EVALUATING A MEDICAL PRACTICE

- \*Analyze expense in relation to income to control expense.
- \*Define a method for establishing a fee for new service.
- \*Understand controlling accounts receivable.  
Including: Cash flow, improving collections and accounts receivable.

### FACULTY

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Accountant, Medical Society of Pierce County

BARRY D. BRUNT, CPA, Manager  
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College of Medical Education, Inc.  
705 South 9th, No. 203  
Tacoma, Washington 98405



# Auxiliary News

## NEWCOMERS WELCOMED

Three coffees were held in September to welcome new and prospective Auxiliary members. Gift bags given to the newcomers were filled with "fun items" such as the Auxiliary cookbook, maps, and Tel-Med brochures. A special "thank you" is due to the Newcomers Committee—Mary Lou Jones, Alberta Burrows and Sharon Gilbert—and to the hostesses—Shirley Kemman (Puyallup), Nadine Kennedy (Tacoma), and Susan Wulfestieg (Gig Harbor).

### Barn Dance October 30th

There still might be time to sign up for the Barn Dance to be held at the Crowley's Square Dance Barn. Live music, food, great company and a good time for all is promised. If you're interested, call Barbara Patterson (851-4833) for more information.

### AMA-ERF Project

Have you sent in your check for the AMA-ERF Holiday sharing card? Helen Whitney reminds us that November 1 is the deadline for having your names printed on the card. Save yourselves the expense and labor of addressing all those cards to medical friends and let your Auxiliary committee do the work.

### Holiday Greeting Cards

AMA-ERF is once again offering personal Christmas cards for sale. Personalized stationery also is available. AMA-ERF receives 40% of all card sale proceeds. Stephanie Tuell has samples for you to review. Call her at 927-1117 to set up a time to see the samples.

### Cookbooks — While They Last!!

The Auxiliary Cookbooks will be available for sale at \$4.00 per set. Shirley Murphy has set up several cookbook depots to make it easier to obtain copies. They are as follows: Nicky Crowley (Valley-922-7233), Jane McDonough (Stadium-572-6840), Glenna Blackett (North End-752-3970), Jo Roller (North End-752-6825), Kit Larson (Lakewood-584-3802), and Shirley Murphy (North End-759-5350). A

Gig Harbor depot is still needed; if interested call Shirley Murphy. These cookbooks make excellent thank you gifts for teachers, friends and family.

### November General Meeting

On Friday, November 19, 1982, there will be a morning coffee meeting at the home of Mrs. James Littlefield, 4702-26th St. N.E., Puyallup. B. J. Hash, Director of Volunteer Services for United Way and author of the "Linda Hands" column, will speak on "Volunteerism". We will also be able to browse through the PCMS Auxiliary "Projects Fair." Hope to see you on the 19th!

*Judy Baerg*

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# PHYSICIANS AND SCHOOL REPRESENTATIVES ADDRESS ISSUES OF MUTUAL CONCERN

A number of issues of mutual concern were discussed when the Medical Society's Public Health School Health Committee met with Pierce County School representatives late in August. Seven school districts were represented as was the health department. Issues of particular importance to practicing physicians discussed at the meeting were:

## **Implementation of the School Medication Law**

Dr. Harlan, Office of the Superintendent of Public Instruction, summarized the law, noting that it includes *all* medications given by mouth. Medication given by injection is not included.

The law does not specify what should be done if medication is to be given for less than 15 days. The State Attorney General's office has issued an opinion that the law is ambiguous on this point and that school districts should use the same procedure regardless of the length of time the medication is to be given.

In all cases, statements from physicians and parents authorizing the giving of the medication should be obtained.

It was pointed out that it may be best to give some medications — penicillin, for example — before and after school hours. The use of a single form was recommended as such a form requires the parent to discuss the situation with the child's physician. Use of a standardized county-wide form (similar to the Health Report form created several years ago) was discussed. School representatives were asked to forward a copy of their existing form, if any, for review at a future meeting of the Public Health/School Health Committee.

## **Modified Physical Education for the Ill or Injured**

It is very difficult at the junior high school level to provide such programs, it was pointed out. The

group agreed that parents, physicians, and the schools have a role to play in providing modified programs for students in need.

Such students include the acutely ill, chronically ill, the physically disabled (long or short term) and, in some circumstances, those experiencing difficulty in participating in such activities as a result of non-physical conditions. McIlvaigh Junior High School was cited as having a particularly effective modified PE program for such individuals. It was pointed out that PE is not a graduating requirement as many have assumed. The problem is not confined to Pierce County. It was suggested that the matter be referred to the Washington State Medical Association and the Washington Academy of Pediatrics.

## **Medical Clearance for Sports**

Dr. Stan Mueller reported there are no new developments on this issue. Physician difficulties with regard to the revised WIAA regulations appear to have been resolved.

## **Child Find**

Genevieve Fisher, Tacoma Public Schools, reviewed the Child Find Program. She noted that every district in the county has an identified coordinator. The biggest asset to the program is the degree of coordination between physicians, the health department, school districts and day care centers, she said. Efforts are being made to simplify the forms that parents complete. A modified screening summary form was distributed. The form includes instructions used in screening and professionals involved. A copy would be sent to the child's pediatrician or primary care physician.

The need to remind physicians that every school district has an opportunity to identify such children was noted.

## **Health Screening Activities**

Peggy Zurfluh, health department, reported that

140 people took part in last January's initial screening program. A new program is planned which will involve the neonatal intensive care unit follow-up effort. Efforts are being made to track these children at two and one-half years following birth. Gross and fine motor skills, speech and language levels will be evaluated. The first clinic is scheduled for October.

### **Immunizations**

Dr. Harlan reviewed the immunization law and school district compliance. CIS forms have remained unchanged. Ninety percent of children have been shown to be completely immunized in accordance with state law. There have been 37 cases of indigenous measles reported in the past school year, however.

The state immunization manual is being revised and will likely be ready for distribution in November. Also, the new "Red Book" of the American Academy of Pediatrics is now available. Copies may be obtained by writing the AAP, 1801 Himan Avenue, Evanston, Illinois 60204. It was reported that the health department has hired several nurses to assist private pre-schools with their compliance with state immunization laws.

Regarding scoliosis screening, state-wide 220,393 children were screened out of a possible population of 241,000 children last year. Scoliosis brochures are available in Spanish and five southeast Asian language versions. Copies may be obtained by contacting the Office of the Superintendent of Public Instruction, Olympia.

### **Asian Refugees**

There appears to be a considerable number of refugees affected by the July 1, 1982 funding reduction. It also appears that some refugees are relocating to other states — California, for example — that provide a higher level of support. Overall, about 10,000 refugees are coming into the United States each month.

Health department funding for the refugee screening program has not been cut, and refugees are eligible for the program up to three years from the date of their arrival in the community.

The Refugee Forum, formed in 1978, has worked hard to coordinate various refugee related efforts. Language barriers remain a significant problem,

although some interpreters are available through the health department and local organizations.

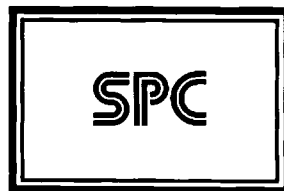
Use of the Medical Society's referral service was suggested and refugees and/or their sponsors have been encouraged to work through any existing primary care physician relationship that may exist, requesting lowered or no fee services until such time as they are employed.

### **Adolescent Pregnancy Project**

State funding for the project will continue after January 1, 1983 and will be sufficient to support three outreach workers and a project coordinator, it was reported. A prenatal clinic has been established for girls with financial problems (following denial of benefits by DSHS). Approximately 80 patients per year can be handled by the clinic.

*David Sparling, MD, Chairman*  
Public Health/School Health Committee

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# Correspondence

## Premature Followup Clinic Established

To The Editor:

Neonatal intensive care outcomes — the number of small premature infant and sick newborn survivors and the quality of their life — have rapidly improved with improvements in technology which have occurred since regional newborn intensive care first became a reality less than a decade ago. Our own Southwest Washington Regional Newborn Intensive Care Nursery, established at Tacoma General Hospital in 1977, has provided the quality of care which makes healthier outcomes possible with sick babies referred from throughout this region. Similar high quality care is available to military

dependent infants at Madigan Army Medical Center's NICU.

Assessing the outcome requires monitoring the sickest infants after graduation from newborn intensive care. Though major developmental and neuromuscular problems can be identified during the first year, the increased risk of physical, developmental, behavioral and learning problems incurred in the sick newborn cannot be fully evaluated until school age.

Heretofore, regular followup evaluations of sicker infants graduating from the two NICU's, because of funding from the March of Dimes and the military, have been possible up to one or one and one-half years of age.

Now a progress assessment will be offered to each of these higher risk infants at two and one-half years of age. The premature followup clinic providing this evaluation has been developed by cooperation between the two NICU's, the Medical Society of Pierce County, the Tacoma-Pierce County Health Department, Mary Bridge Children's Health Center, the division of Developmental Disabilities, DSHS, and the Department of Pediatrics at Madigan, as a part of the state regionalized premature infant followup program. It is offered as a service to high risk infants from throughout the Southwest Washington area, including those of similar background who did not receive care in the two NICU's.

The clinic, to be held monthly at Mary Bridge, will provide screening evaluations of infants between 27 and 33 months of age who were under 3.5 pounds (1500 grams) or 33 weeks gestational age at birth, required prolonged respiratory support, had severe newborn infectious or metabolic disorders, or have other factors indicating high risk.

Screening for possible problems in the areas of physical health, social and behavioral development, fine and gross motor skills, and receptive and expressive language ability, is designed to identify as early as possible children who give some indication of performing below expected levels and who may need further diagnostic study, and perhaps therapy. Systematic evaluation of the high risk child by professionals expert in these areas opens new opportunities for many such children to grow and develop up to their potential and later be as ready as possible for school and other growth experiences.

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Assessment in the clinic, which is by a team consisting of pediatric nurse practitioners (Donna Libby and Peggy Zurfluh), a physician specializing in child development (Dr. Carl Plomski), a pediatric occupational therapist (Barbara Reynolds), and a speech pathologist (Cindy Fincher), is meant to supplement, not replace, periodic health supervision examinations by the child's personal physician, which are particularly important for the child who has had previous health problems. All screening assessments are done with the knowledge of the child's physician who receives a report after the clinic session and is involved whenever recommendations are made for a child to have further diagnostic study or referral.

Referral to the clinic is handled by Donna Libby, CHN, 593-4807, who will be happy to answer questions regarding plans or procedure.

*David Sparling, MD, Chairman*  
Public Health/School Health Committee  
Medical Society of Pierce County



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*Proceeds benefit the Outreach 80's expansion of St. Joseph Hospital and Health Care Center Rehabilitation Programs, which help persons with temporary or permanent disabilities achieve optimum levels of functioning in their communities.*

# Membership

In accordance with the Bylaws of the Medical Society of Pierce County, Chapter Seven, Section A, MEMBERSHIP, the following physicians have applied for membership, and notice of their application is herewith presented.

As outlined in the Bylaws, any member who has

information of a derogatory nature concerning an applicant's moral or ethical conduct, medical qualifications or other such requisites for membership, shall assume the responsibility of conveying that information to the Credentials Committee or Board of Trustees of the Society.

## Second Notice



**Daniel T. Dugaw, D.O.**, Family Practice. Born in Chehalis, WA 10/19/50; College of Osteopathic Medicine and Surgery, Des Moines, Iowa, 1976; internship, Green Cross General Hospital, 1976-77. Washington State license, 1977. Has applied for medical staff membership at Allenmore, Doctors, Mary Bridge, St. Joseph, and Tacoma General Hospitals.  
**Sponsors:** Drs. Susan Salo, Jesse Mantel.



**Peggy A. Hosford, M.D.**, Family Practice. Born in Denver, CO 10/11/49; Stanford University School of Medicine, 1976; internship, Providence Medical Center, Seattle, 1976-77; residency, Providence Medical Center, Seattle, 1977-79. Washington State license, 1981. Has applied for medical staff membership at Allenmore, Doctors, Mary Bridge, St. Joseph and Tacoma General hospitals.  
**Sponsors:** Drs. Susan Salo and Daniel Hayden.

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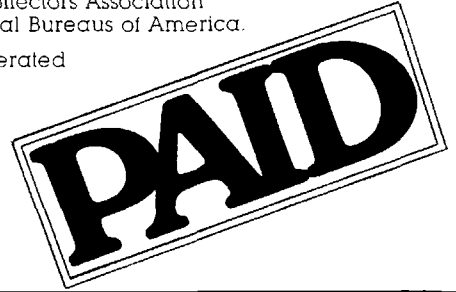
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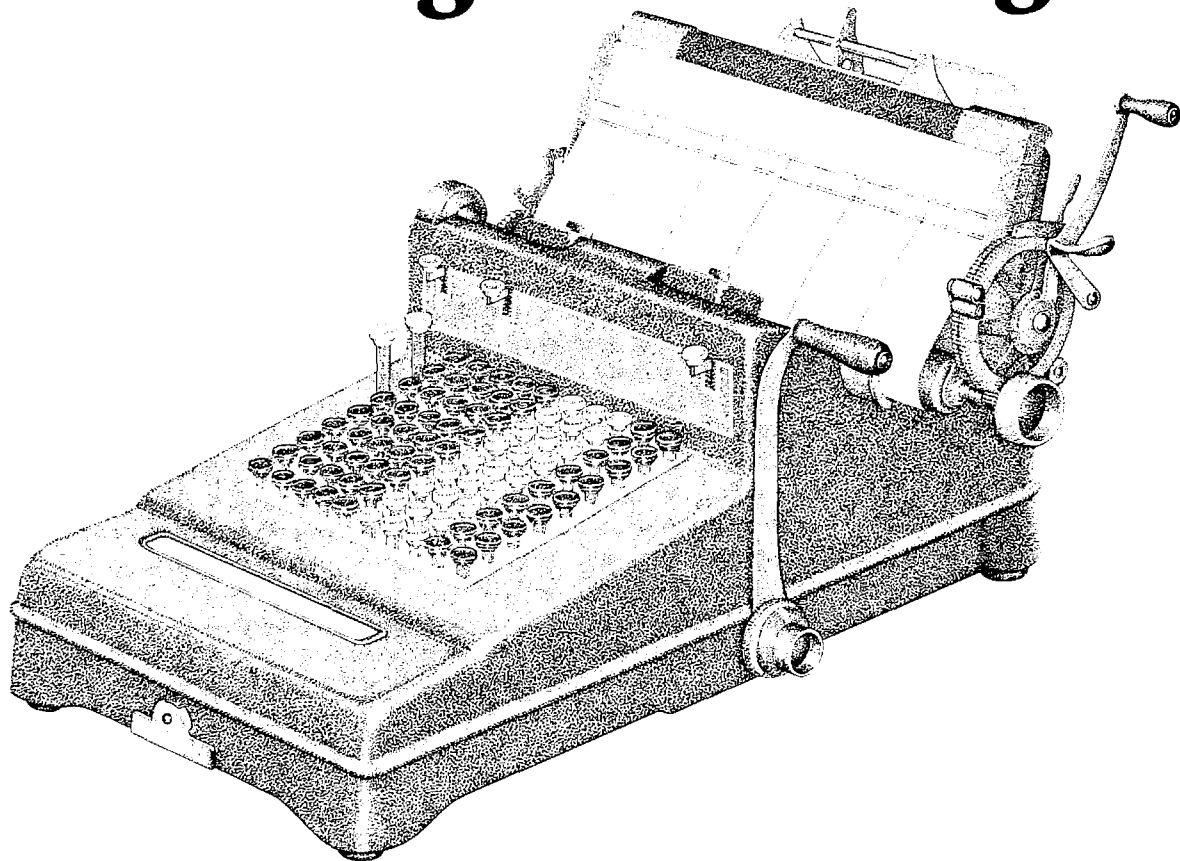


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# The Bulletin

MEDICAL  
SOCIETY  
OF PIERCE  
COUNTY

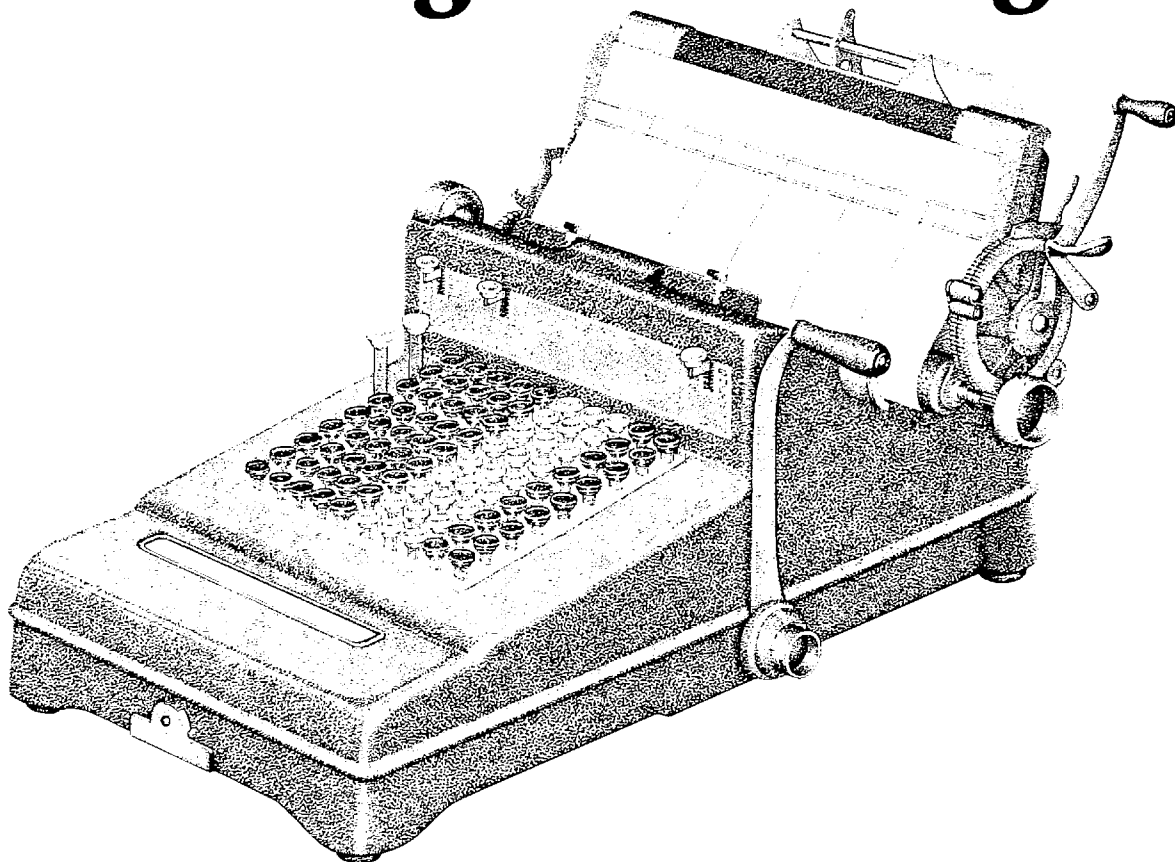
In This Issue . . .

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Hepatitis B Vaccine, page 8

November, 1982

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# *The Bulletin* The official publication of the Medical Society of Pierce County

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**Managing Editor:** Thomas J. Curry

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Deadline for the submission of copy is the 25th of the month preceding the month of publication. However, final determination of publication date will be made by *The Bulletin*. *The Bulletin* reserves the right to edit all reader contributions for brevity, clarity and length, as well as to reject any material submitted.

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# Society News Briefs

*A summary of Medical Society, and local medical and health news*

## Board of Trustees Approves 1983 Budget

A 1983 Medical Society budget, drafted to support the Society's efforts to better the health and medical welfare of the community and to provide a variety of membership benefits, was approved at the November Board of Trustees meeting. Budget highlights include:

- Increased support to the Pierce County Medical Library;
- Continued support for more frequent and improved membership meeting programs;
- A 5% increase in overall expense;
- Maintaining county Society dues at their current rate for the *fourth* consecutive year, \$255 per active member;

All members will be sent a billing for 1983 dues late in November. Payment of the tax deductible dues *prior* to December 31 is encouraged and appreciated.

For additional budget information, this issue of *The Bulletin* includes a report from the secretary-treasurer. See page 6.

## Pediatric Advanced Life Support Program Planned

A pediatric ALS program for pediatricians, emergency room physicians, pediatric nurses and emergency room nurses is planned for December 3 and 4, 1982. The program will be held at Mary Bridge Children's Health Center.

Subjects to be covered include: Special needs of the pediatric patient, pharmacologic agents for pediatric ALS, respiratory distress in infants and children, cardiac emergencies, shock, intravascular access and monitoring, neonatal resuscitation, the severely injured child, and advanced pediatric life support.

Workshops will be held as part of the program. They will cover: Basic CPR, airway intubation, dysrhythmia recognition, megacode, intra-arterial and intra-venous techniques, arterial and CVP lines, intra-cardiac injections and emergency throacotomy. Robert G. Scherz, MD, is program coordinator.

Tuition has been set at \$120. There is a \$50 charge for wet lab. For additional information, contact the College of Medical Education, 627-7137.

## Tel-Med Brochures Available

Over 50,000 Tel-Med brochures have been distributed in Pierce County since July by Auxiliary volunteers. Brochures have been distributed to physician offices, dental offices, pharmacies, local hospitals, the military, libraries and schools, among other locations.

Regional Tel-Med distribution chairpersons are: Susan Clark, Fircrest/University Place; Nikki Crowley, Puyallup/Sumner; Joan Sullivan, Lakewood; Ann Fulcher, Ann Thiessen and Mimi Jergens, Gig Harbor; and, Helen Whitney, Tacoma. These Auxilians were also assisted by Jo Roller, Glenna Blackett and Gloria Virak, reports coordinator Carol Hopkins.

Additional Tel-Med brochures are available as well as posters. Please contact the individuals named or the Medical Society office if you desire additional brochures or posters.

## Society Mailing List Use Policy Reaffirmed

Several recent requests for use of the Medical Society's mailing services and membership list have prompted a policy review by the Executive Committee

*(Continued on page 19)*

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## President's Page

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### WILL PIERCE COUNTY IMPROVE EMS SERVICES?



In May of 1982, Pierce County Executive Booth Gardner convened the first meeting of the EMS Task Force, and with this impetus a document was produced with all good speed that makes recommendations of far-reaching importance for the Medical Society and the citizens of Pierce County.

The Task Force was represented by a broad spectrum of individuals from our community, and had technical support from Mr. David Vance, the administrator of the Medical Society's EMS Medical Control Project, Dr. Terry Kendrick, designated advance life support (ALS) program director for Pierce County, and Dr. R. M. (Bud) Nicola, director of the Tacoma-Pierce County Health Department. The Medical Society thus had conceptual and directive input in the document produced. It was also well represented by various physicians who submitted testimony to the Task Force.

The significance of the trend setting programs that were initiated in Pierce County in the preceding decades were recognized by the Task Force. However, as the years went by other communities used our early experience for a cornerstone in their own EMS plans, and built upon it, whereas in Pierce County we perpetuated the status quo. As the Task Force's report states, "... the lack of a coordinated 'systems' approach to EMS has developed a 'non-system' of Emergency Medical Services that is operating on a structure developed ten years ago which is no longer responsive to the changing needs of the surrounding community."

Based on the testimony received and written material submitted, the Task Force reached a number of conclusions. Major recommendations include:

- Develop an administrative/managerial structure to coordinate emergency medical services.
- Grant legislative authority to the new structure to coordinate all aspects of EMS.
- Develop local funding to support the managerial structure and the continued improvement of EMS in Pierce County.
- Develop an enhanced 911 citizen telephone access system and an improved EMS communications system including centralized dispatch.
- Designate trauma center(s) and define trauma patient indices.

In these times of economic adversity, the greatest probable impediment to acceptance and implementation of the Task Force's recommendations will be money, or more specifically, the lack of it. The funds must be found by the Pierce County Council so that these vitally important recommendations can become a functional reality.

Representatives of your Board of Trustees, members of the Pierce County Hospital Council, and members of the Society's Emergency Medical Standards Committee have agreed to expend their time and efforts in informing the County Council of the urgent need to adopt the Task Force's report, and to fund the program. Your enthusiastic support is needed. Please take the time to let the county government know how you stand before time expires and our efforts are lost.

*Lloyd C. Elmer, MD*

# Secretary-Treasurer's Report

## 1983 MEDICAL SOCIETY BUDGET APPROVED



A 1983 budget sufficient to maintain the variety of services and programs to support the objectives of the Medical Society was approved at the November meeting of the Board of Trustees.

The total budget of \$178,651 represents a net increase in expenses of 5.02%. A minimal increase in income is projected. As a result, we may have to draw on our reserves in 1983. The Society has maintained modest reserves in recent years.

Society expenses are grouped into four categories. The first, Membership Benefits, includes funding of the Pierce County Medical Library, the College of Medical Education (COME) and the Placement Service (MBI). Membership Benefits will account for 26% of our expenditures in 1983.

### Membership Benefits

Library support is budgeted at \$32,303 in 1983, a per member contribution of approximately \$57.00 (compared to approximately \$50.00 per active member in 1980 when dues were last increased). The Society's contribution to the library will increase 10.1% in 1983. We are obligated for 40% of the library's net operating expense under the terms of the agreement negotiated with the Pierce County Hospital Council in 1974.

The Budget Committee discussed increasing the library component of the dues to reflect the increased library contribution; however, it was decided that the additional expense could be supported out of general Society revenues, at least in 1983. For comparison, the 1983 per physician library contribution in Spokane will be \$80 and in Central Washington \$100.

Support for the College of Medical Education has been set at \$11,788, a reduction compared to 1982. Under the terms of the agreement with the Pierce County Hospital Council, the Society funds 55% of the college's net operating expense and the hospitals fund 45%. This ratio reflects the composition of the College's Board of Directors. Actual financial support of the College has decreased substantially since 1979 when we established our joint funding base. While a 1983 budget has not been formally approved by the COME Board of Directors, and will not be considered until later in the year, our projected level of support appears reasonable.

The committee was pleased to report to the Board of

Trustees that it projects no net subsidization of the Placement Service (Membership Benefits, Inc.) in 1982 or 1983. Staff has worked diligently to place the Placement Service on a fiscally sound basis in recent years and we were gratified to report that this goal has been achieved.

It should be remembered by members that many services provided by the MBI (Placement Service) staff are not directly income producing. The staff is service oriented and your continued support of the Placement Service and other offerings through MBI is encouraged.

### Other Expenses; Internal Support

The second category of expenditures is Policy and Program Development which includes support of the annual WSMA House of Delegates meeting, the annual Board of Trustees goal setting retreat and related general travel and administration. It is worth noting that the Society maintains a policy of having officers and trustees pay for their own direct expenses for the WSMA annual meeting, board meetings and for other regularly scheduled Society activities. A great deal of time and effort is contributed to committees and the Board without personal gain.

The major expense category is Internal Support which includes the expenses of maintaining our office, staff and direct support of the many committees, programs and activities of the Society (see "Working on Behalf of You and Your Patients," *The Bulletin*, September, 1982). The budgeted increase in Internal Support expense in 1983 is 8.8%. Internal Support will represent 70.7% of expenses, down fractionally from 1982. We will maintain the current staffing level of 2.75 employees (compared to 2.5 employees in 1977).

### 1982 Dues

There will be no dues increase in 1983. They will remain unchanged at \$255 per active member. Solid administration, aggressive management of our resources and increasing membership have allowed the Society to go three years without an increase. (The last increase, in 1979, was 6.5%.)

### Other Income

Two years ago, the Society established a \$50.00 application charge to cover the costs of processing Medical



Society and hospital medical staff applications. The 1983 budget includes an increase in the application filing fee to \$65.00, a portion of which will be used to pay for the breakfasts that are a part of the regular Credentials Committee meetings with applicants.

For many years, the Medical Society has provided mailing services to members free of charge as a courtesy. The 1983 budget includes a \$25.00 per mailing charge for this service. The charge approximates the actual cost of providing the service and will be used to help cover our office expense.

### State Dues

In 1983, the Washington State Medical Association dues will be held at their current level of \$225. Beginning next year, WSMA has also introduced an incremental dues structure for new members. No dues will be charged for members during their first year, 25% will be charged during their second year of membership, and 60% and 100% of the dues will be charged during the third and fourth full year of membership, respectively.

Regrettably, AMA regular membership dues will increase to \$315 in 1983 compared to the current \$285. This was a hotly debated issue at the last AMA House of Delegates meeting.

*Myra S. Vozenilek, MD*  
Secretary-Treasurer

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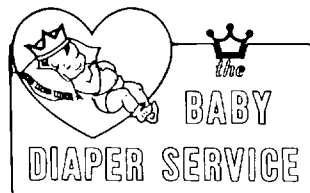
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## Public Health Report

# INACTIVATED HEPATITIS B VIRUS VACCINE



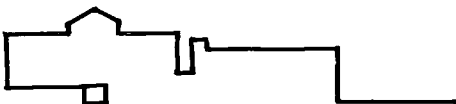
In Pierce County, as in the rest of the United States, there is a low incidence of hepatitis B virus (HBV) infection. Certain high risk groups, including certain health professionals, however, have an increased risk of HBV infection (Table 1; MMWR Vol. 31, No. 24; June 25, 1982). Between 6 and 10% of young adults with HBV infection become carriers. Although one-quarter of those infected with hepatitis B become ill with jaundice, the subclinical infection is more likely to result in the chronic carrier state. And, as Dr. James Maynard, the director of the CDC's Hepatitis Lab in Phoenix, explained at a recent workshop at the health department, the chronic carrier status itself leads to the burden of the disease: chronic sequelae in 10 to 20% of

carriers including chronic active hepatitis, chronic persistent hepatitis, cirrhosis, and primary hepatocellular carcinoma.

Until recently the only protection from HBV was passive protection with Hepatitis B Immune Globulin (HBIG), a \$300 treatment which is only 60% effective. CDC is enthusiastic about the recent development of inactivated hepatitis B virus vaccine (Heptavax), a vaccine which induces the development of protective antibody in over 90% of vaccinees after three doses. This vaccine is produced in a manner very different from the production methods of other current vaccines — human plasma from healthy carriers is ultracentrifuged into a suspension of 22 nm surface antigen particles (non-infectious) which are inactivated by a three step chemical process. Field trials of the vaccine have shown 80-95% efficiency in preventing HBV among susceptible people. Primary adult vaccination consists of three intramuscular doses of 1.0 ml of vaccine (20 micrograms per 1.0 ml) each; the second and third doses are given one and 6 months after the first. For patients undergoing hemodialysis and for other immunosuppressed patients, three 2-ml doses (40 micrograms) should be used; in children under 10 years of age, three 0.5-ml doses (10 micrograms) are sufficient.

Universal pre-exposure vaccination of infants and children is a goal in countries of the world where HBV prevalence is high (90%) or intermediate (25-50%). In the United States, high risk groups as noted above will be targeted for the vaccine. Health care workers ideally should be vaccinated prior to entrance into the field.

Those health care workers who have frequent exposure to blood are at highest risk; for example, emergency room nurses, dialysis staff, and surgical staff. Pre-vaccination screening is cost effective only for those high risk groups whose serological prevalence of HBV is 30% or above. The vaccine (\$120 for the series) and pre/post serological screening will be available at the health department. For information, call Evelyn Peterson or Allene Mares at 593-4060.



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*Bud Nicola, MD, Director,*  
Tacoma-Pierce County Health Department

TABLE 1. Expected Hepatitis B Virus Prevalence in Various Population Groups

|   | Prevalence of serologic markers of HBV infection |                 |
|---|--|-----------------|
|   | HBsAB (%)  | All markers (%) |
| <b>High Risk</b>  |  |                 |
| Immigrants/refugees from areas of high HBV endemicity . . . . . | 13   | 70-85           |
| Clients in institutions for the mentally retarded . . . . .     | 10-20  | 35-80           |
| Users of illicit parenteral drugs . . . . .                     | 7  | 60-80           |
| Homosexually active males . . . . .                             | 6  | 35-80           |
| Household contacts of HBV carriers . . . . .                    | 3-6  | 30-60           |
| Patients of hemodialysis units . . . . .                        | 3-10   | 20-80           |
| <b>Intermediate Risk</b>  |  |                 |
| Prisoners (male) . . . . .                                      | 1-8  | 10-80           |
| Staff of institutions for the mentally retarded . . . . .       | 1  | 10-25           |
| Health-care workers   |  |                 |
| Frequent blood contact . . . . .                                | 1-2  | 15-30           |
| <b>Low Risk</b>   |  |                 |
| Health-care workers   |  |                 |
| No or infrequent blood contact . . . . .                        | 0.3  | 3-10            |
| Healthy Adults (first-time volunteer blood donors) . . . . .    | 0.3  | 3-5             |

**Public Health Emergency Telephone Numbers For Communicable Disease Reporting Established**

*The following emergency telephone numbers have been established for medical community use in the event of a suspected or actual communicable disease problem:*

- Bud Nicola, MD . . . . . 752-5781
- Evelyn Peterson . . . . . 847-1485
- 24-Hour Physician Call Number,  
Health Department Clinics . . . . . 272-4740
- 24-Hour State Epidemiology . . . . . 1-464-6289
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October 13, 1982

## **INVESTMENTS IN THE 1980's**

- \*Understand tax sheltered investments.
- \*Differentiate common and preferred stock investments.
- \*Recognize new developments in the bond market.

November 10, 1982

## **INCORPORATION - WHEN & WHY**

- \*Increase understanding of personal economics & other non-tax considerations.
- \*Recognize tax and non-tax benefits.
- \*Conceptualize how to establish a professional service corporation.

December 9, 1982

## **ESTATE PLANNING - SHIFTING ASSETS, TRUSTS AND OTHER CONSIDERATIONS**

- \*Understand estate planning and the Economic Recovery Tax Act of 1981.
- \*Recognize value in shifting income property to lower tax brackets.
- \*Increase awareness of pension plans.
- \*Increase understanding of life insurance and retirement plans.

January 12, 1983

## **EVALUATING A MEDICAL PRACTICE**

- \*Analyze expense in relation to income to control expense.
- \*Define a method for establishing a fee for new service.
- \*Understand controlling accounts receivable.  
Including: Cash flow, improving collections and accounts receivable.

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# Inter-Professional Relations Committee

## WORKING WITH YOUR PHARMACIST(S) CAN IMPROVE PATIENT CARE



I suppose today's generic beer is just one more sign of our times. Even my neighbor buys it, though acknowledging that while cheaper, it does not have the flavor of a certain name brand. In the same way, not all generic drugs are as effective as the name brands. I have noticed this in my practice and I am sure you have, too.

The use of generics was a lively topic of discussion at the last meeting of your Inter-professional Relations Committee. The pharmacist members pointed out that some generics on the market have really never been tested. While it is true that the Federal Drug Administration (FDA) requires all pharmaceutical firms manufacturing generic drugs to make a new drug application to insure efficacy of that drug, the FDA, if called, will not or cannot tell you if a certain drug manufacturer is approved! It was the feeling of our committee that it comes right back to the physician to prescribe what he or she is sure of, watching the effect of the drug(s) on patients and, in the long run, relying on the pharmacist (or most pharmacists, that is) to give sound advice about generics.

### Phoning In Your Prescription

There are certain advantages to phoning in a prescription (if it is legal to do so). Your telephone call really does take less time than writing the prescription form and, most importantly, it gives you an opportunity to establish contact with the pharmacist. Many times this will allow you to discover other drugs the patient may be taking. It can also reassure you about the efficacy of a generic preparation. The opportunity to establish rapport with the pharmacist can pay great dividends later.

### "PRN" Refills

The length of time that a "prn" refill of a prescription can be legally dispensed is one year. Some of our pharmacy friends have established a house rule of six months with which they are more comfortable.

Most pharmacists will dispense medications such as Lanoxin and Orinase in smaller amounts to give the patient time to contact his or her physician or, in the case of a physician who has retired, the new physician who has taken over the practice. Sometimes this is a problem for the pharmacist and it may take up to 90 days to get the refill situation straightened out.

### Another Helpful Hint

Physicians would be well advised to urge their patients to go to one pharmacy, whatever is their choice,

to avoid duplications and overlappings in medications with the resultant possible dangerous results. An example of this situation is the patient who gets his Coumadin at one store and then purchases Dristan at another. We all know what that combination can do!

### Pet Peeves and Other Assorted Concerns

One of the pet peeves that pharmacists aired at our meeting was the case where a physician calls in a prescription without telling the pharmacist that the patient is on DSHS coupons. If the pharmacist finds out too late, he or she must completely re-dispense what the DSHS formulary permits and this costs time and, of course, money. Please let the pharmacist know when the patient is on some form of medical coupon.

Another problem alluded to before in this column is the practice of some doctors' offices where the pharmacist calls for authorization of a prescription refill and the office personnel says, "Oh, sure. Go ahead," without any checking of the patient's record or with the physician, for that matter. One pharmacist has solved this problem by asking the name of the person giving the verbal authorization and in this way he feels that he can at least be partially relieved of the responsibility that he bears.

### The Time Has Come

The final portion of our September committee meeting was devoted to a presentation by MSPC Executive Director Tom Curry on "The Time Has Come," the tort reform program our state medical association is presenting to state legislators. Rather frightening statistics were included, such as the skyrocketing costs of professional liability insurance (an average of \$890 per physician in 1970 compared to a projected \$36,000 in 1990) and the impact of this on the overall cost of medical care.

We should all read this information avidly and understand why there is a malpractice crisis, what the real role of malpractice awards should be, and the proposed legislative measures that will combat this horrendous problem. The WSMA has a program. Let's get behind it!

Other professionals at our committee meeting were very attuned to the problem and expressed support for our effort. Clearly, tort reform is an issue that cuts across professional lines and other professions, if they are not already, should be supporting our position.

Herman S. Judd, MD, Chairman  
Interprofessional Relations Committee

# Auxiliary News

## CHILDREN'S HOLIDAY PARTY

The Children's Holiday Party is scheduled for Thursday, December 2, 4:00 - 6:00 p.m., at the University Place United Presbyterian Church, 8101 27th St. West, Tacoma. Nikki Crowley, party chairman, reports that planning for the party is well underway. Call Nikki if you would like to help during the party. Mark your calendars and don't forget to bring Dad - the whole family will really enjoy this event.

P.S. . . . We're hoping that Santa will again visit us that day!

### Gala Holiday Dinner Planned

The annual joint Medical Society-Auxiliary holiday dinner will be held on Tuesday, December 14, at 6:30 p.m. at Tacoma's Bicentennial Pavilion. The evening will feature light entertainment, announcements of the 1983 officer and trustees elections, the introduction of the 1983 Medical Society President Dr. Robert E. Lane, and

other presentations. Invitations are in the mail. Be sure and make your reservations with the Medical Society office for this delightful evening.

### October General Meeting

The Auxiliary's first 1982 fall general meeting was held at the University Place United Presbyterian Church. We used the nursery for over 30 children of all ages.

The main hall housed our morning political skills workshop and lively red, white and blue decorated tables for our delicious lunch.

In one of the study rooms, Judy Wagonfeld led both morning and afternoon "full-housed" workshops on "stress for the physician's family." Lots of sharing and caring evolved.

Over 50 participated in the day's activities. Our thanks go to Debby McAlexander, general chairperson, and to Verna Bergmann and Carol Lovy, both dieticians, who along with their Cooking Committee (Debby McAlexander, Marilyn Bodily, Shirley Murphy, Betty Virtue, Cris White and Mary Lou Jones) not only served us a delicious lunch but also provided us with recipes and explanations for meals for diabetics, and low sodium, low cholesterol and calorie control meals.

Guest panelists at the political workshop were Barbara Granlund, Shirley Winsley, Peggy Peterson and Thelmajeane Collings. Our own Cindy Hammer was moderator and Sally Larson was MC and quiz master. Guests included Mary Randolph, president of the Washington State Medical Society Auxiliary, from Olympia, and Nancy English, state legislation chairperson, from Mercer Island. It was a fun and rewarding day for all who participated.

Anyone interested in forming a "sharing network," is asked to call Marlene Arthur at 845-1094.

### AMA-ERF Sharing Card

Many thanks to all those who donated so generously to the AMA-ERF Holiday Card project. If you have a last minute addition call Helen Whitney at 564-4345 immediately!

Appreciation is due to the hard workers who helped with the mailings, they are: Marilyn Bodily, Syd Wasley, Alair Sheimo, Shirley Murphy, Shirley Kemmen, Helen Whitney, Cindy Anderson, Dot Truckey and Carol Hopkins.

*Judy Baerg*

November 1982

## YOUR PROFESSION DESERVES THE BEST

**RPT** RADIO PAGE OF TACOMA . . . #1 in radio paging. Your own personal beeper will help you keep in touch 24 hours a day, if you choose.

**383-PAGE**

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# Medical Society of Pierce County

705 South Ninth Street • Suite 203 • Tacoma, Washington 98405 • Telephone (206) 572-3666

You are cordially invited to join the  
**Medical Society of Pierce County**  
and  
**Pierce County Medical Auxiliary**  
at their

## ***ANNUAL JOINT DINNER MEETING***

-----

Tacoma's Bicentennial Pavilion  
1313 Market Street  
Tuesday, December 14, 1982

-----

Installation of 1983 Medical Society Officers and Trustees

Special Holiday Entertainment by  
The Tacoma Youth Symphony Brass Ensemble

*Cocktails (no host) 6:30 p.m.*

*Prime Rib Dinner 7:15 p.m.*

*Program 8:30 p.m.*

\$19.00 per person, \$38.00 per couple  
(Price includes wine, tax, gratuities)

**Special Auxiliary Request:**

Please bring a wrapped gift suitable to be given to one of the women at Tacoma's Women's Support Shelter (an Auxiliary project). Label gift as to contents. Suggested items: stationery and stamps, pocketbooks, cosmetics, toilet items.

**Also:**

A raffle will be held to benefit the Student Recognition Program. Prizes: a handmade afghan for her and a box of fine wine for him. Tickets: 6 for \$5.00. Tickets will be available at the cocktail hour.

Please complete the reservation form and mail it, with a check for the appropriate amount, to the Medical Society office. Or call the Society, 572-3667, to confirm your reservation.

**Reservations are requested by Wednesday, December 8, 1982**

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### **1982 Medical Society/Medical Auxiliary Annual Joint Dinner Meeting**

**I (we) have set aside the evening of December 14, 1982, to join members of the Medical Society of Pierce County and Pierce County Medical Auxiliary at their Annual Joint Dinner Meeting and Installation of Officers.**

Please reserve \_\_\_\_\_ dinner(s) at \$19.00 per person/\$38.00 per couple.

Wine, tax and gratuity included. Enclosed is my check for \$\_\_\_\_\_

Dr. \_\_\_\_\_  
(please print)

Please make check payable to Medical Society of Pierce County

## Correspondence

### Restraint Urged in Prescribing Kits

To The Editor:

In the past few weeks, discussions have taken place with the Tacoma School District Ad Hoc Medical Advisory Committee and with the Medical Society's Public Health/School Health Committee regarding the fact that many physicians are prescribing bee sting kits for children and these are being taken to school by the children.

Most children have just a local reaction to bee stings and do not require the use of a bee sting kit. Also, there is no longer a full-time school nurse or health professional in the majority of schools who can administer the kit. Therefore, it is advised that physicians in the county, who feel very strongly that certain children have a bee sting kit available must see to it that these children have been thoroughly instructed in use of the kit. If it is such an urgent situation that the child may need the bee sting kit, then he or she should be fully instructed in its use. However, if it is not an urgent situation, then bee sting kits should not be sent to school.

We would appreciate the cooperation of physicians, patients, and school personnel throughout the county in this effort.

Sincerely,

*Terry W. Torgrenud*, MD, Member,  
Public Health/School Health Committee

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## THE DOCTORS HOSPITAL OF TACOMA

**Next General Medical Staff  
Meeting**

**Monday, December 6th**

**Noon**

**Hospital Cafeteria  
Complimentary Lunch**

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**the popular  
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# WE'VE HAD A 'HEALTHY YEAR' THANKS TO YOU.



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and where we, through your use of our  
services can care for more of your patients.

So, we'd just  
like to take this  
time to "thank  
you" for a great

year and wish you and yours the best of  
holidays and a joyous new year.

And when you're in on Fridays before  
Christmas, be sure and pick up your free  
'Darigold Eggnog' for the holidays.

It's just one of the ways we can make  
your day a little brighter.

## DOCTOR'S HOSPITAL

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# Membership

In accordance with the Bylaws of the Medical Society of Pierce County, Chapter Seven, Section A, MEMBERSHIP, the following physicians have applied for membership, and notice of their application is herewith presented.

As outlined in the Bylaws, any member who has

information of a derogatory nature concerning an applicant's moral or ethical conduct, medical qualifications or other such requisites for membership, shall assume the responsibility of conveying that information to the Credentials Committee or Board of Trustees of the Society.

## First Notice



**Stephen J. Annest, MD**, General & Vascular Surgery. Born in Tacoma, WA 2/22/49; University of Washington School of Medicine, Seattle, WA 1975; internship, Virginia Mason Hospital, Seattle, WA 1975-1976; residency, Albany Medical Center, Albany, New York, 1976-1981; graduate training, Baylor University Medical Center, Dallas, TX, 1981-1982; Washington State license, 1982. Has applied for medical staff

privileges at Allenmore, Doctors, Good Samaritan, Mary Bridge, Puget Sound, St. Joseph and Tacoma General hospitals. Dr. Annest is practicing at 1106 South Fourth Avenue, Tacoma. **Sponsors:** Drs. Leo Annest and Edmund A. Kanar.



**David M. Christopher, MD**, Pediatrics. Born in Seattle, WA 8/15/52; University of Washington School of Medicine, Seattle, 1979; internship, University of Colorado Affiliate Hospital (pediatrics), 1979-1980; residency, University of Colorado Affiliate Hospital, 1980-1982; Washington State license, 1982. Has applied for medical staff membership at Good Samaritan, Lakewood General, Mary Bridge Childrens, St. Joseph and

Tacoma General hospitals. Dr. Christopher is practicing at 1322 3rd St. S.E., Puyallup. **Sponsors:** Drs. Donald Mott and Robert Alston.



**Peter A. Cooley, MD**, Radiology. Born in Oak Ridge, Tenn. 2/5/52; University of Wisconsin School of Medicine, Madison, WI, 1978; internship, Milwaukee Children's Hospital (pediatrics), 1978-1979; residency, St. Luke's Hospital, Milwaukee, WI, 1979-1982; Washington State license, 1982. Has applied for medical staff membership at Allenmore, Good Samaritan, Lakewood General, and Mary Bridge hospitals.

Dr. Cooley is practicing at Gross, Larson, Whitney and Associates. **Sponsors:** Drs. Kenneth E. Gross and John A. Flood.



**Steven C. Dronen, MD**, Emergency Medicine. Born in Chicago, IL, 10/3/51; Abraham Lincoln School of Medicine, Chicago, 1977; internship, Henry Ford Hospital, Chicago, 1977-78; residency, Henry Ford Hospital, Chicago, 1978-80. Washington State license, 1982. Dr. Dronen is currently a staff physician at MAMC. **Sponsors:** Drs. Robert E. Stuart and Kenneth Frumkin.



**Richard J. Jerde, MD**, Diagnostic Radiology. Born in Milwaukee, WI 11/01/50; University of Wisconsin School of Medicine, Madison, 1973; internship, Swedish Hospital, Seattle, 1977-1978; residency, Diagnostic Radiology, University of Washington, 1978-1981; Washington State license, 1982. Has applied for medical staff membership at Doctors, Puget Sound, St. Joseph and Tacoma General hospitals. Dr. Jerde is practicing at Tacoma

Radiological Associates, P.S. **Sponsors:** Drs. Gilbert Roller and George Barnes.



**David R. Kennel, MD**, Family Practice. Born in St. Louis, MO 12/24/52; University of Michigan Medical School, Ann Arbor, 1979; internship, Providence Hospital, Southfield, Michigan, 1979-1980; residency, Providence Hospital, Southfield, Michigan, 1980-1982. Washington State license, 1982. Has applied for medical staff privileges at Lakewood General, Mary Bridge and St. Joseph hospitals. Dr. Kennel is practicing at 5900 100th St. S.W., Tacoma. **Sponsors:**

Drs. David M. Gimlett and James Furstoss.



**Michael R. Lory, MD**, Rheumatology. Born in Detroit, Michigan 10/11/50; University of Michigan School of Medicine, 1972; internship, Henry Ford Hospital, Detroit, 1975-76; residency, Henry Ford Hospital, 1978-79; graduate training, rheumatology, Hammersmith Hospital, London, England, 1979-1980, and University of Colorado, 1980-1982. Washington State license, 1982. Has applied for medical staff privileges at

Allenmore, St. Joseph and Tacoma General hospitals. Dr. Lory is practicing at Cedar Medical Center, Tacoma. **Sponsors:** Drs. Robert E. Ettlinger and George H. Krick.



**John H. Rowlands, MD**, Pulmonary Diseases. Born in Pittsburgh, PA; University of Washington School of Medicine, Seattle, 1976; internship, Good Samaritan Hospital, Phoenix, AZ, 1976-1977; residency, Good Samaritan Hospital, Phoenix, AZ, 1977-1979; graduate training, Good Samaritan Hospital, Phoenix, 1980-1982; Washington State license, 1982. Has applied for medical staff privileges at St. Joseph, Tacoma

General and Puget Sound hospitals. Dr. Rowlands is practicing at 1718 South I Street, Tacoma. **Sponsors:** Drs. James G. Billingsley and Lawrence A. Larson.



**Andrew N. Statson, MD**, Obstetrics/Gynecology. Born in Bulgaria 10/16/34; University of Paris, France, 1962; externship, St. Alexis Hospital, Cleveland, Ohio; internship, St. Alexis Hospital, Cleveland, 1963-1964; residency, Mt. Sinai Hospital, Cleveland, Ohio, 1964-1967. Washington State license, 1973. Has applied for medical staff privileges at Mary Bridge, Puget Sound and St. Joseph hospitals. Dr. Statson is practicing at Cedar Medical Center, Tacoma. **Sponsors:**

Drs. J. Antonio Garcia and Robert A. Padgett.



**Keith B. Tucker, MD**, Administrator. Born in Seattle, WA 7/8/32; University of Washington School of Medicine, 1958; internship, Harborview Medical Center 1958-59; residency, University of Colorado, 1959-61. Washington State license, 1961. Dr. Tucker is the medical director, PCMB. **Sponsors:** Drs. Arnold Hermann and Ben Blackett.



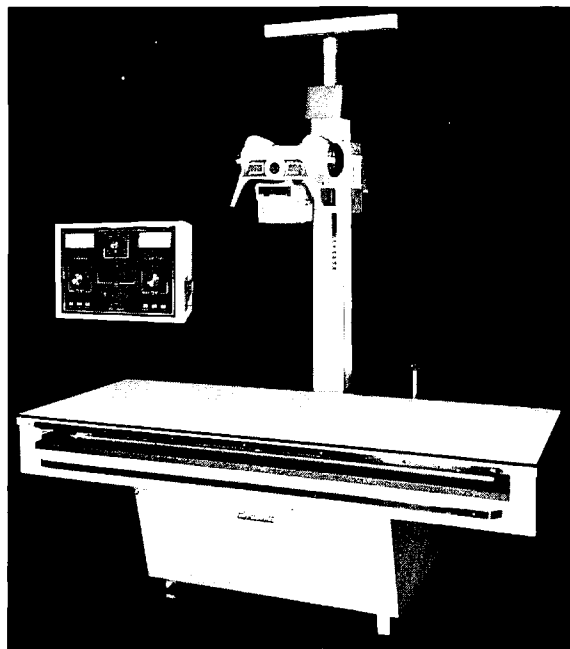
**James M. Wagner, MD**, Cardiology. Born in Richmond, VA 8/20/43. Oregon Health Sciences University, 1976; internship, Sinai Hospital, Detroit, MI, 1976-1977; residency, Good Samaritan Hospital, Portland, OR, 1977-1979; graduate training, Oregon Health Sciences University, Portland, OR, 1979-1980; and University of Utah, Salt Lake City, Utah, 1980-1981. Washington State license, 1982. Has applied for medical staff privileges at Mary Bridge, St. Joseph and Tacoma General hospitals. Dr. Wagner is practicing at 126 Auburn Avenue, Auburn. **Sponsors:** Dr. Anita D. Silverman.



**R. Ivan Zbaraschuk, MD**, Urology. Born in Canada 5/22/42; Loma Linda University School of Medicine, Loma Linda, CA, 1976; internship, Loma Linda University Hospital, Loma Linda, CA, 1977-1977 (internal medicine), and Virginia Mason Hospital, Seattle, WA, 1977-1978 (cate. surgery); residency, University of Washington, 1978-82. Washington State license, 1979. Has applied for medical staff privileges at Good

Samaritan, Mary Bridge, St. Joseph and Tacoma General hospitals. Dr. Zbaraschuk is practicing at 2709 East Main, Puyallup. **Sponsors:** Drs. Robert C. Winegar and Kenneth H. Sturdevant.

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# For Medication Given at School

## PHYSICIAN ORDER FORM APPROVED

*Recent changes in state law permit the giving of oral medication to students during school hours provided proper authorization from physicians and parents is obtained. Use of a standardized county-wide form has been suggested (see The Bulletin, "Public Health/School Health Report," November, 1982).*

*The Public Health/School Health Committee has approved the following form for physician use. The form is published in this issue for the convenience of physicians. Please have your office staff reproduce the form as needed. — The Editor*

### Medical Society of Pierce County Physician's Orders for Medication at School

Medication is ordered to be given to a student at school only when absolutely necessary. Whenever possible, the parent and physician are urged to design a schedule for giving medication outside of school hours. If this is not possible, it must be understood by the parent that the medication will be dispensed by the principal or his/her designee in the absence of the school nurse.

Only prescription oral medication will be administered. The principal will designate the person responsible to dispense medication on an individual basis.

The school accepts no responsibility for untoward reactions when the medication is dispensed in accordance with the physician's directions.

Is it necessary to dispense this medication during school hours?      \_\_\_\_\_ Yes      \_\_\_\_\_ No

If yes, please give diagnosis or reason: \_\_\_\_\_  
\_\_\_\_\_

Name of patient: \_\_\_\_\_

Drug and dosage form: \_\_\_\_\_

Dose and mode of administration: \_\_\_\_\_

Hour(s) to be given: \_\_\_\_\_

Duration without subsequent order: \_\_\_\_\_

Side effects of drug (if any) to be expected: \_\_\_\_\_

Date: \_\_\_\_\_ Physician's signature: \_\_\_\_\_

### Parent's Permission

I request that the principal or a staff member designated by him/her be permitted to dispense to my child, (name of child)

\_\_\_\_\_ the medication prescribed by (name of physician)

\_\_\_\_\_ for a period from \_\_\_\_\_ to \_\_\_\_\_.

The medication is to be furnished by me in the original container labeled by the pharmacy or physician with the name of the medicine, the amount to be taken, and the time of day to be taken. The physician's name is on the label. I understand that my signature indicates my understanding that the school accepts no liability for untoward reactions when the medication is administered in accordance with the physician's directions. This authorization is good for the current school year only. In case of necessity the school district may discontinue administration of the medication with proper advance notice. If notified by school personnel that medication remains after the course of treatment, I will collect the medication from the school or understand that it will be destroyed. I am the parent or the legal guardian of the child named.

Date: \_\_\_\_\_ Signature of parent or guardian: \_\_\_\_\_

Student's home address: \_\_\_\_\_ School: \_\_\_\_\_

# Society News Briefs

(Continued from page 4)

and Board of Trustees. The policy is reprinted below for the benefit of all members:

"Use of the society's mailing list generally will be restricted to medical or society related matters where the best interests of the profession and society are served (announcement by a member of establishment of a practice, or meeting notices, for example).

"Use of the mailing list may be permitted where the general best interests of the community, particularly as they relate to health care or its delivery, are concerned. The list also may be used to mail information to the membership about society endorsed programs provided through commercial firms.

"Requests for use of the mailing list to solicit contributions or when use of the list may not serve the best general interests of the profession or society will be authorized only by the Executive Committee or Board of Trustees. Permission to use the mailing list will be determined solely and specifically by the purpose to be served by the mailing.

"Except in the case of a society endorsed program, use of the mailing list will be denied to persons, groups or organizations where the primary goal is that of economic gain. Use of the list will likewise be denied to any person, group or organization where purely political motives are evident. This would exclude political activity which is designed to benefit the community, the society, or the profession.

"The Medical Society of Pierce County has the right to refuse any request. For all approved requests by non-profit organizations, the Society's established per hour secretarial service fee will be charged. In the case of approved use of the mailing list by a for-profit organization, the rate charged will be twice the non-profit rate."

## Salary/Fringe Benefit Survey Results Available

The annual salary and fringe benefit survey has been conducted and tabulated by the Medical Society's Placement Service. Survey results are available to members upon request. Results will be mailed to the physician's home. For your copy, please contact the Placement Service, 572-3709.

## People and Places . . .

Dr. Robert F. Kapelowitz wishes to announce to the membership that he has changed his name to Robert F. Kapela.

## Annual Joint Dinner Set for December 14

The annual joint Medical Society-Auxiliary dinner meeting will be held on Tuesday, December 14 at the Bicentennial Pavilion. A prime rib dinner, brief introduction of officers ceremony, and a performance by the Tacoma Youth Symphony Brass Ensemble highlight an evening of medical community camaraderie.

The price of \$38 per couple (\$19 per person) includes the prime rib dinner (with wine), tax, gratuity. If you have not yet made a reservation for the holiday dinner, contact the Medical Society office, 572-3667, today.



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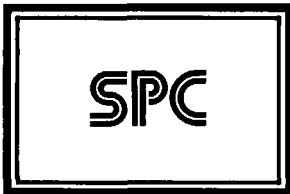
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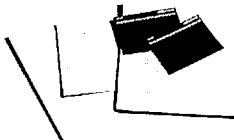
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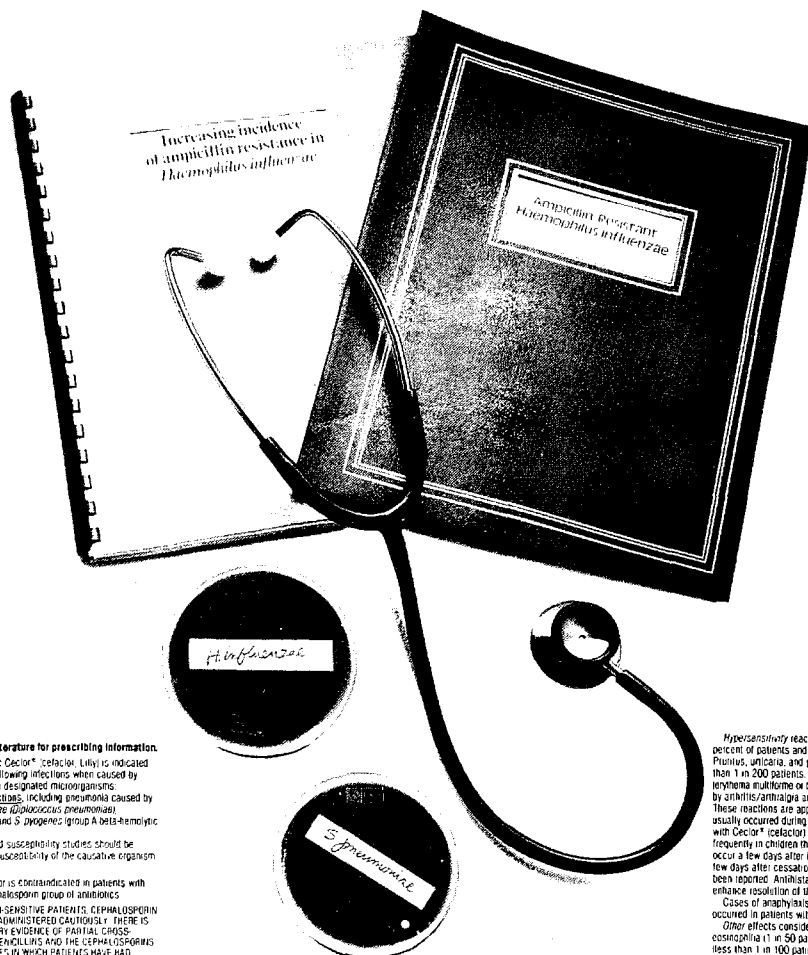
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# An added complication... in the treatment of bacterial bronchitis\*



**Brief Summary.**  
Consult the package literature for prescribing information.  
**Indications and Usage:** Ceclor<sup>®</sup> (cefactor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:  
**Lower respiratory infections,** including pneumonia caused by *Streptococcus pneumoniae* (*Streptococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).  
Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

**Contraindications:** Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.  
**Warnings:** IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES. Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

**Precautions:** If an allergic reaction to ceclor occurs, the drug should be discontinued and, if necessary, the patient should be treated with appropriate agents, e.g. pressor amines, antihistamines, or corticosteroids.  
Prolonged use of ceclor may result in the overgrowth of non-susceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.  
Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.  
Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinistix<sup>®</sup> tablets but not with Test Tape<sup>®</sup> Glucose Enzymatic Test Strip (Lilly).  
**Usage in Pregnancy:** Although no teratogenic or antiteratogenic effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in fetuses given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.  
**Usage in Infancy:** Safety of this product for use in infants less than one month of age has not been established.

**Adverse Reactions:** Adverse effects considered isolated to ceclor therapy are uncommon and are listed below.  
**Gastrointestinal symptoms** occur in about 2-5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).  
As with other broad-spectrum antibiotics, colitis, including rare instances of pseudomembranous colitis, has been reported in conjunction with therapy with Ceclor.

Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis\*—are sensitive to treatment with Ceclor.<sup>1,6</sup>

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.<sup>7</sup>

Hypersensitivity reactions have been reported in about 1-5 percent of patients and include morbilliform eruptions (1 in 100), Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (myalgia, malaise) or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor<sup>®</sup> (cefactor). Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.  
Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.  
**Other effects** considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).  
**Causal Relationship Uncertain**—Transient abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.  
**Hepatic**—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).  
**Hematopoietic**—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).  
**Renal**—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

\*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.  
Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.  
Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.  
**References**  
1. Antimicrob. Agents Chemother., 8:91, 1975.  
2. Antimicrob. Agents Chemother., 11:470, 1978.  
3. Antimicrob. Agents Chemother., 13:584, 1978.  
4. Antimicrob. Agents Chemother., 12:490, 1977.  
5. Current Chemotherapy edited by W. Siegenthal and R. Luby, II, 880, Washington, D.C. American Society for Microbiology, 1978.  
6. Antimicrob. Agents Chemother., 13:661, 1978.  
7. Data on file, Eli Lilly and Company.  
8. Principles and Practice of Infectious Diseases edited by G. L. Mandell, R. G. Douglas, Jr., and J. E. Bennett, p. 497. New York: John Wiley & Sons, 1979.

# Ceclor<sup>®</sup>

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285. Eli Lilly Industries, Inc., Carolina, Puerto Rico 00630.

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# The Bulletin

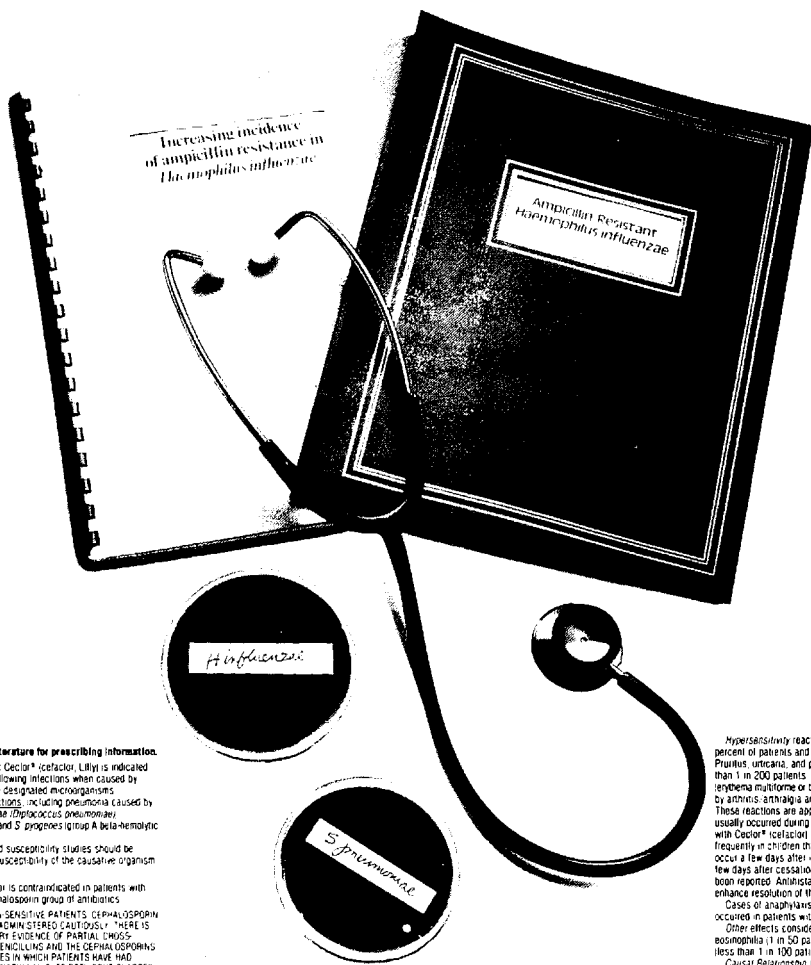
MEDICAL  
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page 11

December, 1982

# An added complication... in the treatment of bacterial bronchitis\*



**Brief Summary**  
Consult the package literature for prescribing information.  
**Indications and Usage:** Ceclor® (cefactor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms.

**Upper respiratory infections:** including pneumonia (caused by *Streptococcus pneumoniae* (Streptococcus pneumoniae), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci)).

\*Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

**Contraindication:** Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

**Warnings:** IN PENICILLIN SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGICITY OF THE PENICILLINS AND THE CEPHALOSPORINS AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics including Ceclor should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

**Precautions:** If an allergic reaction to ceclor occurs, the drug should be discontinued and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prophylactic use of ceclor may result in the overgrowth of non-susceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies on transfusion cross-matching procedures with antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because side-effects may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinistix® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

**Usage in Pregnancy:** Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose in all fetuses given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

**Usage in Lactation:** Safety of this product for use in infants less than one month of age has not been established.

**Adverse Reactions:** Adverse effects considered related to ceclor therapy are uncommon and are listed below.

**Gastrointestinal symptoms** occur in about 2.5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

As with other broad spectrum antibiotics, colitis, including rare instances of pseudomembranous colitis, has been reported in conjunction with therapy with Ceclor.

Increasing incidence of ampicillin resistance in *Haemophilus influenzae*

Ampicillin Resistant *Haemophilus influenzae*

*H. influenzae*

*S. pneumoniae*

## Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis\*—are sensitive to treatment with Ceclor.<sup>1,2</sup>

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.<sup>3</sup>

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100), Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthralgia, arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor® (cefactor). Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

**Causal Relationship Uncertain**—Transient abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

**Hepatic**—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

**Hematologic**—Transient fluctuations in leukocyte count (predominantly lymphocytosis occurring in infants and young children) (1 in 40).

**Renal**—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal analysis (less than 1 in 200).

\*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin allergic patients.

Ceclor is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

**References**

1. Antimicrob. Agents Chemother., 6:91, 1975.
2. Antimicrob. Agents Chemother., 11:470, 1977.
3. Antimicrob. Agents Chemother., 13:584, 1978.
4. Antimicrob. Agents Chemother., 12:490, 1977.
5. Current Chemotherapy, edited by W. S. Hoogstraal and R. L. Luthy, in 850 Washington, D.C.: American Society for Microbiology, 1978.
6. Antimicrob. Agents Chemother., 13:861, 1978.
7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases, edited by G. L. Mandell, R. G. Douglas, Jr., and J. E. Bennett, p. 497. New York: John Wiley & Sons, 1975.

# Ceclor®

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Pulvules®, 250 and 500 mg



Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285. Eli Lilly Industries, Inc., Carolina, Puerto Rico 00630.

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Deadline for the submission of copy is the 25th of the month preceding the month of publication. However, final determination of publication date will be made by *The Bulletin*. *The Bulletin* reserves the right to edit all reader contributions for brevity, clarity and length, as well as to reject any material submitted.

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# Society News Briefs

## Your Involvement is Important

Talented and able people are needed to serve on a variety of Medical Society committees. For the Medical Society to be truly representative of all physicians, physician involvement at the committee level is very important.

Physicians interested in serving on any of the following standing committees are encouraged to contact the Medical Society office or the committee chairman (committee chairmen are listed on page 3). In cases where a committee seat is not immediately available, the member's interest will be considered at the first opportunity.

Ethics/Standards of Practice Committee  
Credentials Committee  
Emergency Medical Standards Committee  
Interprofessional Relations Committee  
Jail Health Advisory Board  
Legislative Committee  
Library Committee  
Continuing Medical Education Committee  
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Professional Relations Committee  
Public Health/School Health Committee  
Senior Citizens Committee  
Sports Medicine Committee  
Tel-Med Committee  
UHI Quality Assurance Committee

Committee appointments are made by the president and chairman with the concurrence of the Board of Trustees. Every effort will be made to accommodate expressions of interest.

## Physicians Elected to Medical Society Membership

Congratulations are extended to the following provisional members who were elected to membership in the Medical Society of Pierce County at the December Board of Trustees meeting:

|                        |                    |
|------------------------|--------------------|
| Drs. Stephen J. Annest | James M. Wagner    |
| David M. Christopher   | Michael R. Lovy    |
| Peter A. Cooley        | John H. Rowlands   |
| Steven C. Dronen       | Andrew Statson     |
| Richard J. Jerdee      | Keith B. Tucker    |
|                        | R. Ivan Zbaraschuk |

## Physician Representative to March of Dimes Committee Needed

The March of Dimes reports an opening on its professional advisory committee. The committee meets on the second Monday of the month at 7:30 a.m. Meetings last a maximum of one hour.

Any pediatrician, obstetrician-gynecologist, or family physician interested in lending his or her expertise to the March of Dimes is asked to contact Executive Director Carleen Jackson, 752-9255, or Advisory Committee Chairman, Gentry Yeatman, 967-6512.

## Medical Trip to Malaysia Prompts Request for Journals

Dr. Kenneth H. Sturdevant reports he will be traveling to Malaysia early in January to work in the Penang Hospital for a period of three months, perhaps longer. The hospital is trying to upgrade its medical library.

Among other things, the hospital needs the past three years' issues of *Medical Clinics of North America*, and *Surgical Clinics of North America*. Physicians willing to donate all, or a portion, of these journals are asked to call Dr. Sturdevant at 848-2232.

(Continued on page 7)

## President's Page

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# ON THE THRESHOLD OF A REVOLUTION



*"We accept the verdict of the past until the need for change cries out loudly enough to force upon upon us a choice between the comforts of further inertia and the irksomeness of action." — Justice Learned Hand.*

December is a month for memories. It is the time of year to take a deep breath and dare to gaze backward and critically reflect upon what has been. 1982 will always be a most memorable year for me in that it has been the year I have been privileged to serve as the president of our Medical Society.

In January 1982, your Board of Trustees met and tried to set a straight course, and to see ahead to deal with potential issues and problems. Alas, no soothsayers are we. Who could have foretold what issues would face us?

The areas of involvement that demanded your Board's time and thoughts ranged from local and national politics and government, to important decisions that impact on ethics of practice, professionalism, access to care, improved emergency medical services and public relations. Your Board has been responsible for administering a \$180,000 budget and has been a good steward.

The long hours spent on behalf of the Society by the various committee and Board of Trustee members may never be recognized individually, but directly and indirectly, their efforts have enormously influenced each

and every member of our organization. I wish to take this opportunity to say thank you to these dedicated physicians.

December, too, is an exciting month of anticipation for what the future shall hold in store. I feel that we are on the threshold of a revolution in the practice and delivery of medical care, and like all successful species, we physicians must be able to adapt to the rapid changes ahead or perish. The stresses on our professional and ethical fabric will grow greater with the innovations of the future. In order to avoid coming apart at the seams, we must properly inform ourselves and be prepared to help shape the new form of medical practice that will be emerging shortly.

Special areas of concern deal with increasing levels of competition between fellow physicians, complex and changing relations between hospitals and physicians, and the emergence of powerful and extremely adept industrial health purchasing groups. The need for *organized* medicine is greater now than probably ever before in our history. We must be prepared to take up the gauntlet, to meet the challenge of change, and to preserve all that is good in our profession, while being inexorably dedicated to averting chaos.

We must be colleagues in the truest sense, willing to serve our patients and one another.

*Lloyd C. Elmer, MD*

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# THE LAW & MEDICINE - for physicians

## Saturday, January 22, 1983

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- 8:00 Breakfast - The Judicial Annex
- 9:00 RECENT CHANGES IN THE CORPORATE TAX LAWS  
THAT IMPACT ON PRIVATE CORPORATIONS  
'Will Private Corporations Survive?'
- 9:45 PANEL - FEE DISPUTES BETWEEN ATTORNEYS  
AND PHYSICIANS
- 10:15 Break
- 10:30 FEE DISPUTES - continued -  
Discussion from the Floor
- 11:00 PREVENTATIVE LAW  
'How to Build Protection into your Practice'

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Program coordinator: Don C. Pearson, M.D.

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**Category I**

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#### **AMA**

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Please address all registrations, inquiries and correspondence to:

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**College of Medical Education**  
Medical Society of Pierce County  
705 South 9th, No. 203, Tacoma, WA 98405  
(Phone: 627-7137)

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Zip

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# Society News Briefs

(Continued from page 4)

## Emphysema Club Supports Lung Disease Patients

Respiratory therapist Connie Mills will speak to the Tacoma Emphysema Club on Wednesday, January 12, on "Breathing Exercises, Postural Drainage Positions, and General Health Hints."

The Emphysema Club is a support group for lung disease patients supported by the American Lung Association. Its January 12 meeting will begin at 1:00 p.m. and will be held at the Southpark Community Center, 4851 South Tacoma Way. There is no charge for attending. For more information call the Lung Association, 474-9547.

## Dr. Richard Vimont Elected to State Disciplinary Board

Dr. Richard T. Vimont, pathologist, has been elected as the Sixth Congressional District Representative to the State Medical Disciplinary Board. Dr. Vimont was nominated by his colleagues earlier this Fall and his election became official in September. He will serve a two year term on the Disciplinary Board.

Dr. Vimont has served in numerous Medical Society offices, most recently as vice-president in 1978.

## Tel-Med Needs Your Support

The Pierce County Tel-Med Society—a joint Medical Society and Medical Auxiliary project—provides an excellent patient education service and positive public relations for the medical profession.

Each month an average of 2,000 people call Tel-Med and hear a physician approved health or medical information tape concluding with, "This message is brought to you by the Pierce County Medical Auxiliary and Physicians of Pierce County."

Greater medical community support of Tel-Med is needed to allow it to meet its basic monthly operating expense (Auxiliary volunteers assist in operating the Tel-Med switchboard and serve on numerous Tel-Med Society committees).

Tel-Med thanks the following physicians or physician families who responded to the request for additional support made by Dr. Anthony S. Lazar, chairman of the Medical Society's Tel-Med Committee, earlier in November:

Drs. Stanley Mueller  
Milton Bleiweiss  
Walter Arthur  
Johann Duenhoelter  
James Early  
Ben Blackett  
Donald Weber  
Bruce Buchanan  
John Ehrhart  
Robert Thiessen  
H. Irving Pierce

Charles Galbraith  
Robert Lane  
Ken Graham  
Max Thomas  
David R. Kennel  
Surinderjit Singh  
Charles Vaught  
Robert Ferguson  
J. Gale Katterhagen  
Ronald Goldberg

## Pierce County Gains Additional Representation on WAMPAC Board

Auxiliary Cathy Schneider, Gig Harbor, has been appointed to a two-year term on the Washington Medical Political Action Committee (WAMPAC). WAMPAC is a 24 member board representing each of Washington's eight congressional districts.

Each district is represented by two physicians and one auxiliary member. Dr. James D. Krueger also represents Pierce County on the WAMPAC board. He currently serves as secretary-treasurer.

WAMPAC is a voluntary, non-profit, non-partisan association of physicians, their spouses and others. Its only source of candidate support money is voluntary contributions.

WAMPAC had a significant impact on this year's election. Involvement by the medical community was much greater than in recent years. Over \$40,000 was distributed to 93 WAMPAC-supported candidates, 77 of whom were successful.

Individual support of WAMPAC is strongly encouraged. The 1983 Medical Society dues statements give physicians an opportunity to contribute to WAMPAC, AMPAC (American Medical Political Action Committee), or both. For additional information on WAMPAC please call the Washington State Medical Association, 1-800-552-0612, or the Medical Society, 572-3667.

(Continued on page 16)

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Bob Cleaveland

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## MEDICAL SOCIETY ESTABLISHES POSITIONS ON COUNTY TRAUMA CENTER ISSUES

*Over the past several months the issues of trauma center criteria and designation have received a great deal of attention from physicians in Pierce County and from the Medical Society.*

*The Society has recommended criteria for trauma center designation which are being reviewed by the Pierce County EMS Council. The Pierce County EMS Task Force, created by County Executive Booth Gardner, included designation of a trauma center(s) as one of its main recommendations to improve EMS services.*

*Representatives of the Board of Trustees met with local specialty societies during the Fall to solicit their opinions on trauma center concepts and designation. Medical Society members were surveyed in November.*

*This information gathering process culminated in a decision by the Board of Trustees at its December 1 meeting to establish the following positions on the issue of trauma center designation — the editor*

Ray M. Nicola, M.D.  
Chairman, Pierce County EMS Council  
c/o Pierce County Health Department  
3629 South D Street  
Tacoma, Washington 98406

Dear Dr. Nicola:

At its December 1, 1982 meeting, the Board of Trustees of the Medical Society again considered the general issue of trauma centers in Pierce County as well as the specific issue of designation of a local trauma center (or centers). Our position that the appropriate forum for actual designation of a trauma center (or centers) should be the EMS Council remains as stated in my letter to you dated October 15, 1982.

Nonetheless, it was the feeling of the Board that since our research on the issue—including meetings with local specialty societies and a survey of the general membership—has been completed, it would be appropriate to communicate to you our position at this time. A formal statement from the Society, submitted as one of the voting members of the EMS Council, will be forthcoming once the Council invites formal comment.

The following positions were defined at our December Board meeting:

1. Designation of a local trauma center(s) in Pierce County is appropriate and would be of benefit to the community. There has been a consensus of opinion expressed by local specialty societies and the general membership regarding this point.

2. One Level II trauma center should be designated. The November survey of the Medical Society membership substantiated the opinions previously expressed in our meetings with specialty societies that one facility should be formally designated as a trauma center even if more than one facility meets the criteria. A multiple designation is not considered desirable.

3. St. Joseph Hospital should receive the EMS Council's designation as the Level II trauma center for Pierce County. This preference has been expressed not only through our meetings with the specialty societies, but in the general membership survey as well.

4. The treatment of pediatric trauma has received considerable attention. Over seventy percent of those responding to our survey expressed the opinion that multi-system pediatric trauma should be integrated into the total emergency medical services trauma center system.

The Southwest Washington Pediatric Society expressed the recommendation that a single designated Level II trauma center be established, that such a center be closely affiliated with Mary Bridge Hospital for pediatric trauma patients, and that after initial stabilization of the pediatric patient at the trauma center, the patient should be hospitalized at Mary Bridge for continuing care. The pediatric society has expressed the intent to develop criteria for the management of critically injured children and to send its recommendations to the Society for discussion and eventual referral to the EMS Council for its review.

It was felt by our Board of Trustees that the Society's position on the designation issue, appreciating the fact that the entire EMS Council will be involved in the ultimate designation, should be articulated at this time. Further, we are establishing our position with the understanding that incorporation of the EMS Medical Control Project under the direction of the health department provides assurances that its authority will be operational at the time of the EMS Council's designation thus assuring that trauma patients and other pre-hospital care patients who enter the EMS system will be transported to the appropriate facilities.

As stated, we will be pleased to forward a formal statement to the Council once it proceeds with its solicitation of member and general EMS community opinion on the designation issue.

Sincerely,

Lloyd C. Elmer, M.D., President  
Medical Society of Pierce County

## Trauma Center Designation Survey Results

*Included in the notice for the November General Membership meeting was a brief questionnaire on the trauma center designation issue. The results of the survey are reproduced below and were considered by the Board of Trustees when it established Society positions on the trauma center issue. — The editor*

- Do you feel that a trauma center(s) should be designated in Pierce County?  
8.7% Yes (168) 12.4% No (24) .5% No Answer (1)  
 If yes, do you feel that all facilities that meet Level II criteria should be allowed that designation?  
34.7% Yes (67)  
53.4% No (103)  
11.9% No Answer (23)
- How many Level II facilities do you feel should be designated in Pierce County?  
50.3% One (97) 1.6% More (3)  
19.2% Two (37) 11.9% No Answer (23)  
6.7% Three (13) 5.2% Other (10)  
5.2% Four (10)
- If more than one hospital meets the criteria for Level II, do you feel that only one should be designated?  
50.8% Yes (98) 39.9% No (77) 9.3% No Answer (18)  
 If yes, which hospital?  
54.1% St. Joseph (53) 1.0% St. Joseph or Puget Sound (1)  
13.3% Tacoma General (13) 1.0% Consolidated (1)  
5.1% St. Joseph or Tacoma Gen. (5) 1.0% St. Joseph or Allenmore (1)  
1.0% Tacoma Gen. & Mary Bridge (1) 23.5% No Answer (23)
- Do you feel a multiple designation is desirable?  
39.4% Yes (76) .5% Both (1)  
50.8% No (98) 9.3% No Answer (18)  
 If yes, should the multiple designation be:  
85.7% Concurrent (66) 3.9% Alternate on a 6 month basis (3)  
2.6% Alternate on an annual basis (2) 7.8% Other (6)
- How should pediatric trauma (multi-system) be handled in Pierce County?  
17.6% Treated separately (34)  
72.5% Integrated into the total EMS trauma center system (140)  
.5% Both (1)  
9.3% No Answer (18)
- Do you feel there will be excessive capture of non-trauma patients by a designated trauma center(s)?  
39.4% Yes (76) 1.0% Both (2)  
48.7% No (94) 10.9% No Answer (21)
- Response Rate 32.2% (193)  
(600)

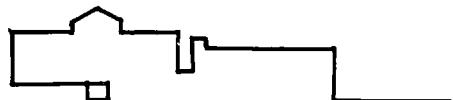


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## Continuing Education Programs Projected for 1982-1983 Academic Year (Programming is subject to change — individual notices will be sent preceding each program)

| Date       | Course/Topic   | Coordinator(s)                           |
|------------|--|--|
| October    |  |  |
| 1, 2, 3    | INTERNAL MEDICINE* (P)   | TAIM/P. Schneider, M.D.                  |
| Open       | WOMENS HEALTH (P/A)  | G. Klatt, M.D./P. Shull, M.N.            |
| Open       | COMPUTER LITERACY (P/A)  | R. Bramhall, R.N.                        |
| Open       | POTPOURRI MEDICAL/SURGICAL TOPICS (A)  | P. Shull, M.N.                           |
| Open       | RATIONAL USE OF ANTIBIOTICS (P)  | A. Tice, M.D./P. Marsh, M.D.             |
| 14         | ENHANCING YOUR FINANCIAL SKILLS (P)  | D. Hirz, M.D./T. Curry/L. Carras         |
| November   |  |  |
| Open       | BASIC EMERGENCY PROCEDURES (A)   | A. Chilton, B.S.N./<br>V. Turner, B.S.N. |
| 6          | ADOLESCENCE — GOOD NEWS/BAD NEWS (A)   | J. Short                                 |
| 11, 12     | FINANCIAL MANAGEMENT — HOSPITAL (A)  | B. Marcellia, M.T.                       |
| Open       | POTPOURRI — LABORATORY PROCEDURES (A)  | J. O'Neill                               |
| 11, 12     | MUSCULAR DYSTROPHY MEETING* (P/A)  | M. Malden, M.D.                          |
| Open       | SEXUAL DYSFUNCTION & DISEASE (P)   | J. Lincoln, M.D.                         |
| 11         | ENHANCING YOUR FINANCIAL SKILLS (P)  | D. Hirz, M.D./T. Curry/L. Carras         |
| December   |  |  |
| 3, 4       | PEDIATRIC ADVANCED LIFE SUPPORT (P)  | R. Scherz, M.D.                          |
| 9          | ENHANCING YOUR FINANCIAL SKILLS (P)  | D. Hirz, M.D./T. Curry/L. Carras         |
| January    |  |  |
| 22         | THE LAW & MEDICINE   | D. Pearson, M.D.                         |
| Open       | COMMON PAIN SYNDROMES<br>IN EVERYDAY PRACTICE                                | H. Johnston, M.D.                        |
| Open       | LEGAL CONCERNS ASSOCIATED<br>WITH NURSING PRACTICE                           | A. Moore, R.N.                           |
| 27         | PERINATAL — T.G.   | J. Mulligan, M.D./ P. Metcalf, R.N.      |
| 21         | HOSPICE  | J. G. Katterhagen, M.D.                  |
| 12         | ENHANCING YOUR FINANCIAL SKILLS (P)  | D. Hirz, M.D./T. Curry/L. Carras         |
| February   |  |  |
| Open       | HYPERALIMENTATION  | P. Schneider, M.D.                       |
| 5          | GERIATRICS WORKSHOP (A)  | J. Short                                 |
| Open       | DENTAL EMERGENCIES (P)   | C. Maier, D.D.S.                         |
| Open       | BASIC EMERGENCY MEDICINE (A)   | T. Kendrick, M.D.                        |
| 24, 25     | BURN (P/A)   | T. Irish, M.D.                           |
| Open       | PULMONARY (P)  | V. Nessian, M.D.                         |
| March      |  |  |
| 10, 11     | TACOMA ACADEMY OF INTERNAL MEDICINE (P)                                      | R. Ettlinger, M.D.                       |
| 19         | EMERGENCY MEDICINE/TOXIC SUBSTANCE (P/A)                                     | T. Kendrick, M.D.                        |
| Open       | MANAGEMENT CHALLENGE (A)   | B. Marcellia, M.T.                       |
| April      |  |  |
| 2, 3       | DAYS OF PEDIATRICS — GENETICS (P/A)  | R. Scherz, M.D.                          |
| 15, 16     | TACOMA SURGICAL CLUB — ANNUAL MEETING (P)                                    |  |
| May        |  |  |
| Open       | ADVANCED CARDIAC LIFE SUPPORT (P)  | T. Kendrick, M.D.                        |
| Open       | EVALUATION OF PATIENT REQUESTING DISABILITY/<br>FORENSIC/ABUSE BATTERING (P) | D. Brown, M.D.                           |
| 19, 20, 21 | CARDIOVASCULAR DISEASE REVIEW (P)  | G. Strait, M.D.                          |
| Open       | OB/GYN (Speroff) (P)   | J. Sakakini, M.D.                        |
| June       |  |  |
| 31         | AMA OFFICE PERSONNEL   | L. Carras                                |

A detailed brochure will precede each program with approximately one month's advance mailing.

For further information write or call: Maxine Bailey, Executive Director, COLLEGE OF MEDICAL EDUCATION  
705 South 9th, No. 203, Tacoma, Washington 98405  
Phone: (206) 627-7137

\*Non COME Course



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## CHANGE, COMPETITION, COSTS DISCUSSED AT NOVEMBER MEMBERSHIP MEETING

Change and the impact of competition and the activities of employer groups on the cost and delivery of health care services were discussed before over 120 members of the Medical Society at the November membership meeting.

The meeting was held to create awareness of the forces impacting on medicine. As program chairman Dr. Bruce Buchanan pointed out in his introduction, "Physicians must participate in the changes because they are going to happen—with or without our involvement."

Mr. Mark Stensager, executive director of the Puget Sound Health Purchasers Association (business coalition); Mr. Frank Baker, vice-president of the Washington State Hospital Commission; Dr. John Lindberg, chairman of the WSMA Medical Services Committee; and Dr. Keith Tucker, medical director of the Pierce County Medical Bureau, began the program with brief presentations.

Fellow panelists, Dr. Cordell Bahn, Richard Baerg, and William Jackson served as "reactors" to the opening statements. Dr. Robert Kapela moderated.

*Dr. Kapela:* Our first speaker is Mr. Mark Stensager, executive director of the newly formed Puget Sound Health Purchasers Association. The employers involved in this association include Boeing, First-Interstate, Nordstroms, Tacoma Public Schools and many more. The organization has put up over \$100,000 to begin its operation and group Mr. Stensager heads will determine how these corporations can get the best return on their health care benefit expenditures. Their expenditures are very large and the leverage they can bring to the system speaks for itself.

### WHAT CAN BE DONE ABOUT COSTS?

### HOW WILL BUSINESS IMPACT MEDICINE?

*Stensager:* In effect, this is the association's first time out and I think it is totally appropriate that we start here.

What you will hear are the perceptions of the business community, the benefits managers, who represent approximately one-half million patients in this region.

It is important for you to deal with those perceptions.

One of the things I was encouraged to say by virtually every business person I talked to was that the cost problem has to be resolved with the assistance of physicians. We are going to fare horribly without your assistance, but we are going to try to contain health care costs.

Our coalition is limited to employers, at least to this point. We are one of the largest in terms of the contributions from our members. Business coalitions have been in response to ever increasing health care costs. In 1955, health care premiums amounted to about .7% of employee costs. Today, they average around 7%. Businesses have become increasingly concerned and they are saying we need to get active in the health care business.

We are adding additional members almost every month. Our goal is to contain health care costs without compromising quality.

Our work program for this year includes development of a claims data base using information obtained through insurance carriers to identify utilization patterns within each corporation and to compare costs among providers. We will be developing a buyers' guide for employers that will include specific cost containment strategies (second surgical opinions, out-patient surgeries, increasing deductibles, increasing co-payments, rebates, pharmaceutical mail order, etc.).

One of the things that needs to be said this evening and needs to be said over and over is that this coalition intends to proceed wisely, cautiously and slowly. Some concern is expressed by our business coalition members as to what they see in California and elsewhere in terms of businesses running headlong into preferred provider organizations and other alternative strategies.

There will be movement and experimentation in this region, though. There will be some dramatic changes. We will be looking carefully at alternative delivery systems; specifically, HMOs to see if there is enough competition, to see why HMO participation is relatively low, to see if it should be increased. We will be participating in the government regulatory and legislative process.

I see three ways that business will impact the health care system. I see a reduction in solo practice. I see a greater emphasis on larger organizations competing within the system. A variety of physicians and hospital administrators already have met with our operating committee, saying, "We can provide you with lower cost health care and maintain the quality."

The medical world out there is beginning to organize and compete. The formation of an HMO by Swedish and other hospitals in Seattle is being very seriously explored and it looks as if they are going to conduct a

demonstration project. As a response, physicians elsewhere in King County are organizing to corner their share of the market. Businesses are looking for the best opportunity for them.

I see increasing power for administrative and financial types in organizations. The power of hospital administrators, that kind of position, will be enhanced. Increasing weight will be given to the financial variables in terms of medical decision making.

#### *HOW DO EMPLOYERS VIEW HEALTH CARE BENEFITS TODAY?*

*Stensager:* This may be somewhat irritating to you, but this is the perception of the people I am dealing with: These business leaders believe that, because of the fee for service, first dollar coverage orientation of the medical system, costs will not be controlled without fundamental change.

#### *WHAT CAN BE DONE ABOUT COSTS?*

#### *WILL HOSPITALS HOLD DOCTORS CAPTIVE?*

#### *WILL CONTROL OF HEALTH CARE DOLLARS MEAN CONTROL OF PATIENTS?*

*Baker:* To answer you have to first ask, costs in the eyes of which group? Because what is a cost to one is an advantage to someone else.

I personally become quite concerned when I hear the increasing unilateral approaches being discussed and proposed by certain hospitals, groups of physicians, businesses, underwriters and third party insurers. The ultimate result will undoubtedly lead to the same thing we have criticized government for—arbitrary adoption of positions on costs, reimbursement and mandating a preferred position.

You can look at costs from at least four different perspectives—that of health systems; that of the payor or the employer; that of the government; and, that of the provider. Strategies to reduce costs depend upon your perspective.

What is done to save costs on one hand, as government has proven to us, simply increases costs to everyone else. There are probably few strategies that can be effectively employed—substitution of less costly settings and options; less utilization; prioritization and cuing; and rationing.

Obviously, substitution is a viable and acceptable option. It is being pursued by a number of providers, but it has only recently been encouraged by third party payors and employers. It still holds promise for some further gains in cost control. The less utilization option seems to be very acceptable and appropriate. It is difficult to accomplish unless patients reduce their initial

demands on the system and recognize that they, too, have responsibility for costs. Prioritization and cuing are not rational alternatives in this country.

One could look at the opportunities of the elimination or reduction of costs that are being shifted to the private sector as a result of the government's payment practices. That is a viable option. The substitution of less costly options within the delivery system will save the payors, insurers and employers.

Negotiations between individual payors and selected providers—PPO's, IPA's—represent the new alternative approaches. I am not sure they are really viable because they are simply different ways of establishing preferential treatment for certain selected employers, insurers and providers. It simply shifts costs to the other groups.

There has been an increasingly amount of effort on the part of underwriters and insurers to be more selective in who they insure, to increase co-pays and deductibles, to increase the sensitivity of the individual to costs. That does have some interesting ramifications. It tends to be successful in the short run, but we find that it probably will produce cost shifts to others, due to adverse selection. The probability is no systems savings over the long run.

Cutbacks traditionally have been the preferred choice of government and politicians. It produces cost shifts to the other payors and essentially represents a form of hidden taxation. But, as Mark has indicated, that alternative is no longer acceptable to the payors, employers or providers. Negotiations, such as under the Medi-Cal program and California's Healthcar, simply lead to the same results as the payment limitations of government.

What can be done to reduce costs? Probably not very much because as some of these other programs or options are implemented the cost per unit of service may go up.

What can be done from the hospital perspective? We think we can still increase hospital staff productivity and hospital efficiency and reduce capital costs. If those are not successful, you know there is going to be a reduction in quality. We are talking about marginal changes in the total cost. The expansion of existing capacities, however, can be deferred if the other strategies are successful, especially substitution and utilization control. We are already seeing some of that as in-patient utilization throughout the state has generally plateaued over the past 18 months.

No one is going to accept reduced quality unless forced by the changes adopted by government programs and/or third party and employer programs. It is a very real danger and I think we have to be very careful not to allow that to happen.

The viable options of substitution of less costly alternatives, reduction of system utilization, improvement in provider productivity and efficiency, and reduction or deferral of capital costs seem to be the only ones that are going to be effective in the immediate future.

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*IS THERE A WAY TO AVOID UNFAIR COMPETITION?*

*IS THERE A PLACE FOR THE SOLO PRACTICE OF MEDICINE IN THE FUTURE?*

*Lindberg:* The reality is that nothing stays the same. Being part of what is changing in our lives gives us a sense of being alive and I guess that's the way I want to feel.

More people are saying we do not want to pay more for medical care without having a say in how the money is spent. Never has more money been spent for medical care so more people will want more of it. We in medicine will not be the only ones who decide what is fair and what the ground rules will be.

The new ground rules will affect us from a professional, social and economic point of view. Advertising now occurs that we did not think possible a short time ago. This is not a particular threat because there is always room and opportunity for the person in a profession with integrity, education and a desire for the pursuit of excellence, and a devotion to the needs of patients.

Economic realities will determine what is and is not fair. Society is saying that doctors cannot set fees. More medicine will be practiced by contract regardless of what we think about contracts. We are going to have to devise acceptable ways of developing contracts by which medicine will be practiced.

More people outside of medicine will be grasping for medical care dollars. One way in which I see this optimistically is that our associations have the opportunity of becoming more important than ever.

They will be important for us in working out our differences, in-house, because we are not all going to come at this the same way. As an internist, I am certainly going to look at the whole scene differently than the cardiovascular surgeon. Yet, the two of us are going to have to come together and knock heads in an organization such as this and work out some of our problems.

Our associations will be important, I think, to help develop and refine the ground rules, to learn and understand the socio-economic climate in which we work, to strive for an atmosphere in which good medical care can be practiced and made available, and to be a place where we can interact and play interest against interest which may eventually then produce a synthesis. So, I see this is an important means, these associations in which we are involved, in deciding what is and isn't fair.

The opportunities for solo practice will become more limited, especially in population centers. The other thing affecting decreasing solo practice opportunities is that in order to gather a patient base, the role of marketing and

administration is increasing and, consequently, the demand for that skill is costing more money than we individually cannot afford.

Another reality is franchised medicine. For example, if Sears announced next month that it was going to establish clinics in all its stores, providing through its credit card service a means of records and financing, and that these clinics would be open for franchise in a community, you can see what that would do to any given community. Not all of it may be bad, but it certainly is different.

*DOES COST EFFECTIVE MEDICINE MEAN LOWER QUALITY?*

*Lindberg:* The risk to quality of care is going to be no greater in the future than it is now. We find it very difficult when we see an illustration of "less than the best" and to know what to do about it. Of course, the concept of quality is very elusive.

The financial management committee is probably going to come up to a level equal with the way in which quality of care is determined and is going to be a strong force in how we develop our medical care programs. Bylaws will decrease in importance and contracts will increase in importance.

Contracts have the ability to limit the maximum cost, but also have the ability to insist on a level of performance and, therefore, quality. I think contracts are going to be increasingly important in the area of quality.

*WHO WILL CONTROL THE MEDICAL CARE DOLLAR?*

*Tucker:* I think we are in a unique position here and we must take advantage of it. The Bureau is in a unique position. Remember President Truman said, "The buck stops here." Well, at the Bureau, the buck passes through here and we get a good look at it.

We are processing about 44% of your average practice. It can grow or it can diminish and you can influence it.

Thirty-five percent rate increases every year for the past three years is unbearable to the individual and to the employers who are now squirming. That's why we have the gentlemen to my left.

The Bureau will accept some of the blame. Carte blanche medicine has been promoted. Maybe this has stimulated over-utilization. Recognizing that and realizing that we are going to have to change that approach, the deductibles are coming in and we are selling them.

There have been studies that say that some of these deductibles have been cost-saving. PCMB is doing another good thing in promoting wellness programs. This effort will grow.

We send the patient a copy of his bill and, if he has been using services, he can become more cost conscious.

We have computers analyzing your practice patterns. Certain things begin to be very obvious. Our utilization

and other key committees are approaching doctors and some changes in practice patterns are occurring.

We also notice that the rank and file doctor has been increasing his utilization. Perhaps this is because of economic need, competition, or because there are more doctors in the community. Maybe people are demanding more care, maybe not. But speaking of the majority of doctors, you are increasing the units of care per disease.

Is this good medicine or not? We are wondering at the Bureau whether more is best, not withstanding quality. We are going to provide information that you can use. I think the doctors have the control.

We have to pay more attention to our office and the hospital overhead. What are we demanding of the hospitals and our office facilities that is really raising costs?

Doctors must participate even more in hospital utilization and quality review activities.

In most organizations of this size, there are enough doctors in each specialty to be critical. All of us have to insist on having input on what is happening at the hospitals. They're blaming you for what's happening there anyway. We have not had enough input in hospital decision making.

We've got to attend the meetings to become educated so that we can handle all the new aspects of medicine. Three years ago, 55% of the Pierce County Medical Bureau dollar went to the physicians and 45% went to the hospitals. This year, this month, it is reversed.

You have to appoint leaders in your group, you have to support them and you have to be in on all of these discussions.

People think they can get the best possible care and we'll do everything possible for them. That isn't the way; they aren't going to get the total care and we are going to have to handle the way they travel through their health history in a more conservative and efficient manner.

There are no other answers. None of these systems will do it. The control is up to the physician alone. The Pierce County Medical Bureau will work with you. The leadership is here and it is beginning to show itself.

*Bahn:* About two years ago, I asked the comptroller in one of the hospitals if he could give me a breakdown on just what would be billed for cardiac care in that particular hospital. He was unable to tell me. Are there any financial committees in hospitals where physicians have taken an active part? I've always felt very much left out in terms of evaluating various types of equipment or treatments on a ward care level.

I'm also interested in what became of the second opinion program. Have these really been cost effective?

*Lindberg:* I am not aware of physicians participating in financial management programs at the level at which I have been involved. There is still not a consensus that second opinion programs really do something beneficial.

*Tucker:* My challenge was yes, get on these types of committees, get into that decision-making. I don't think it exists in our community. Some second opinion studies

have been done where there has been excess surgery and they have been effective. In other communities, there has been no cost effectiveness. It has to be a local phenomenon.

*Baerg:* One of the principal causes of increased utilization has been increased first dollar coverage. It was a bargain which had been negotiated between the corporations and labor unions. I am appalled that physicians are being asked to bear the brunt of incredible increases in costs they have really had no control over.

Also, the responsibility of a corporation is to its stockholders and not necessarily to its employees. There may be conflicts of interest when health care coverage is bargained for, which may not be in the best interests of the patients. Why not spend more for health care, rather than less? Maybe we could make an even bigger impact on health.

Lastly, I would like to point out that we could all send away for mail order medications; maybe we should point out to Nordstroms that we could also send away for mail order shoes.

*Stensager:* On the issue of the first dollar coverage the point is well taken. The correlation between first dollar coverage and over utilization is recognized by employers and labor unions. In fact, a number of labor unions are interested in joining the association and that could possibly happen in the future. The labor unions are as concerned about costs.

I see considerable concern over the quality of care issue. I see employers recognizing that if they institute cost containing strategies that are only short-term, and if these strategies compromise care, that those issues will come back to the bargaining table. The people leading this association have considerable experience in health care and are wise decision makers. I see us going slowly and bearing those issues in mind.

In terms of mail order pharmaceuticals, that is taking taking place. What is being said here is that we need to get involved, you need to get involved. If that is not a wise decision, you need to let us know.

*Jackson:* What is the time frame of the association's study? When do you anticipate seeing some of these new programs or new approaches?

*Stensager:* What we want to do is outline for our members the various options, perhaps 15 to 20 options, some of which I have mentioned earlier.

There is a lot of talk about preferred provider organizations. That is one area we might look at. By the end of our first fiscal year, I would see us having a buyers' guide that would specifically evaluate cost effectiveness, at least in terms of national experience and other experiments.

In terms of developing a claims data base, I see us having a plan in place and to begin developing a data base within the next few months. In terms of looking at alternative delivery systems, I see that a couple of years down the road.



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*IS IT NOT POSSIBLE THAT WE MAY PAY MORE IF TECHNOLOGY CONTINUES TO GROW?*

*Stensager:* I think the issue for you to decide is what is the result. A lot of companies are spending a lot of money on alcoholism programs, occupational health care and so forth, so we are seeing an increase in that particular area. If the results are positive, I see more dollars being spent.

At this point, the attitude of the employers is that the system is not cost effective. It is not producing results, they don't see a correlation in terms of outcomes.

*Baker:* I think a very pragmatic answer to spending more is that no one wants to pay for it. It doesn't matter what the results are.

Everyone is willing to accept the highest and most frequent and most technologically advanced level of care—if someone else pays for it. We have reached the point that the issue is not how much is appropriate, it is how much our society is willing to commit to medical care as compared to a lot of other options.

*HOW DO YOU ENVISION ORGANIZATIONS SUCH AS THE PUGET SOUND HEALTH PURCHASERS ASSOCIATION OR THE PIERCE COUNTY MEDICAL BUREAU IMPACTING A SYSTEM WHERE THERE IS A WIDE DISCREPANCY IN CHARGES BY VARIOUS SPECIALISTS AND SUB-SPECIALISTS WHEN THE END RESULT MAY NOT*

*BE SIGNIFICANTLY DIFFERENT THAN THAT RENDERED BY THE PRIMARY CARE PHYSICIAN?*

*Stensager:* Those kinds of cost differentiations, not only between specialties, but between individual cases, is a major dilemma facing us. It is something we will be focusing on, again, hopefully with some of your assistance.

I have to be frank in terms of what is happening and that is society, companies, the government, are not willing to pay more. The message here tonight is that this is a reality. If, in fact, it is an adversary relationship and you are saying, "you can't do that to us, we're not going to allow you," that's really shortsighted.

I'm not here this evening to be an adversary. I think that's very important. It's just like the tax base in this country. We have gotten to the point where we've said we can't increase it any more. That's what we are faced with in terms of medical care.

*Tucker:* The debate of cognitive versus technical ability isn't new. This group is going to have to approach this issue. Why should an internist get the same for his 30 minutes with the patient as an emergency physician gets for a 3 inch back of the hand laceration? There are some inequities that have to be approached.

I think there is elasticity in our system. We've got some great savings to be found and then we can get on with the high technology and incorporate it at the same time.

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## Society News Briefs

(Continued from page 7)

### Auxiliary Sunshine/Support Group Works to Assist Medical Community

The Auxiliary wishes to remind physicians and spouses that its Sunshine/Support Committee stands ready to assist those in need. The group is organized on a regional basis as follows: Puyallup/Sumner, Marny Weber, 863-8161; Gig Harbor, Diana Dean, 1-858-8270; Tacoma, Rubye Ward, 272-2688.

Physicians or spouses aware of a colleague or medical family in difficulty are encouraged to contact the Auxiliary members listed.

**General Internist** seeks practice opportunity in Spring, 1983. Graduate, George Washington University Medical School, 1973; internship, internal medicine, Michigan State Affiliated Hospitals, 1976; residency, same, 1978. Diplomate, National Board of Medical Examiners. Board eligible, American Board of Internal Medicine. Member, American College of Physicians. Licensed to practice medicine in the State of Washington, 1980. Listing #1201.

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## Auxiliary News

# BEST WISHES FOR THE HOLIDAYS AND A GREAT 1983 TO ALL!

### Auxi-Quad Luncheon Scheduled

The Auxi-Quad luncheon, which includes spouses from the dental, law, medical and pharmacy auxiliaries, will be held at the Tacoma Country and Golf Club on January 21. Wine will be served at 11:00 a.m. with a delicious lunch following at 11:45.

Special invitations will be sent to all Auxiliary members; however, reservations can be made through Nancy Kennedy, 582-7584. The luncheon speaker is Jean Brickell, RN, speaking on, "Techniques for Survival."

### AMA-ERF Holiday Sharing Card Great Success

Thank you for your generous donations to the AMA-ERF holiday sharing card project. At press time the total contributed was \$12,500!

A special "thank you" goes to Auxiliary member Cindy Anderson for her beautiful artwork featured on this year's card.

### Dues-Membership

Please send your membership dues (\$38.50) to Mary Lenard before February 10, 1983.

Auxiliary needs your membership! The more members Auxiliary has, the more delegates Pierce County has at the State Medical Auxiliary Convention held each Spring. *And*, the more state delegates Pierce County has, the better we can impact medical legislation, practices, and projects.

*Sharon Ann Lawson,*  
Membership chairman

### 1982-1983 Nominating Committee Established

Nikki Crowley, chairman, reports the following Auxilians are serving as Nominating Committee members: Gloria Virak, Shirley Murphy, Ane Fulcher, Sharon Lawson, and Marilyn Mandeville. Nominations for office will be announced at the January Board meeting and the February general membership meeting.

Elections will be held at the April general meeting with installation of new officers at the May meeting.

### November General Meeting

The November meeting was held at the Puyallup home of Dr. and Mrs. James Littlefield (Aldea). Thanks are extended to the Coffee Committee, chaired by Barbara Lindblad, and her committee of Barry Mott and Margaret Grandquist. During the coffee members were able to browse through the PCMS Auxiliary Projects Fair.

After a short business meeting, B.J. Hash, director of volunteer services for United Way and author of the Linda Hands column, gave an informative talk on "Volunteerism."

State Auxiliary president Mary Randolph gave a short talk on state auxiliary projects for the year.

*Judy Baerg*

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October 13, 1982

## INVESTMENTS IN THE 1980's

- \*Understand tax sheltered investments.
- \*Differentiate common and preferred stock investments.
- \*Recognize new developments in the bond market.

November 10, 1982

## INCORPORATION - WHEN & WHY

- \*Increase understanding of personal economics & other non-tax considerations.
- \*Recognize tax and non-tax benefits.
- \*Conceptualize how to establish a professional service corporation.

December 9, 1982

## ESTATE PLANNING - SHIFTING ASSETS, TRUSTS AND OTHER CONSIDERATIONS

- \*Understand estate planning and the Economic Recovery Tax Act of 1981.
- \*Recognize value in shifting income property to lower tax brackets.
- \*Increase awareness of pension plans.
- \*Increase understanding of life insurance and retirement plans.

January 12, 1983

## EVALUATING A MEDICAL PRACTICE

- \*Analyze expense in relation to income to control expense.
- \*Define a method for establishing a fee for new service.
- \*Understand controlling accounts receivable.  
Including: Cash flow, improving collections and accounts receivable.

### FACULTY

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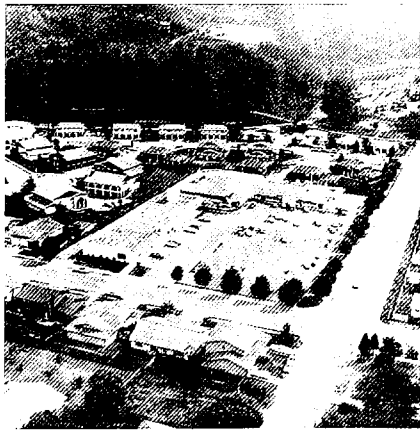
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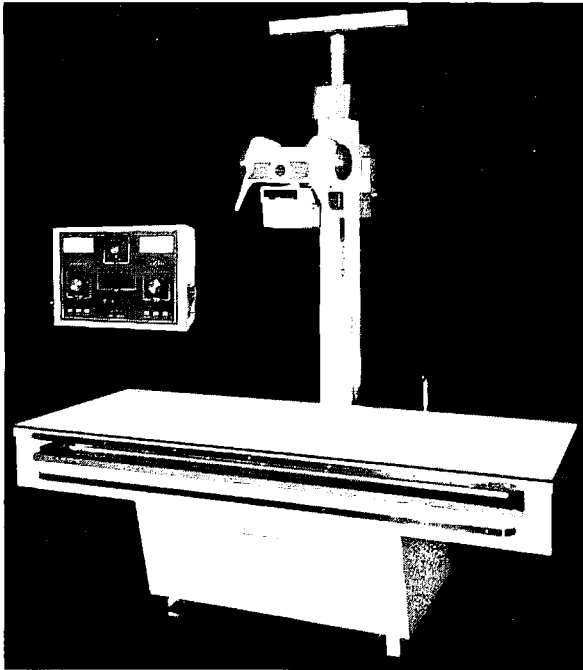
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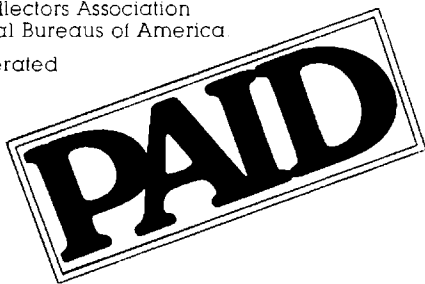
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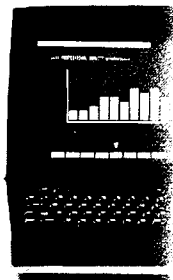
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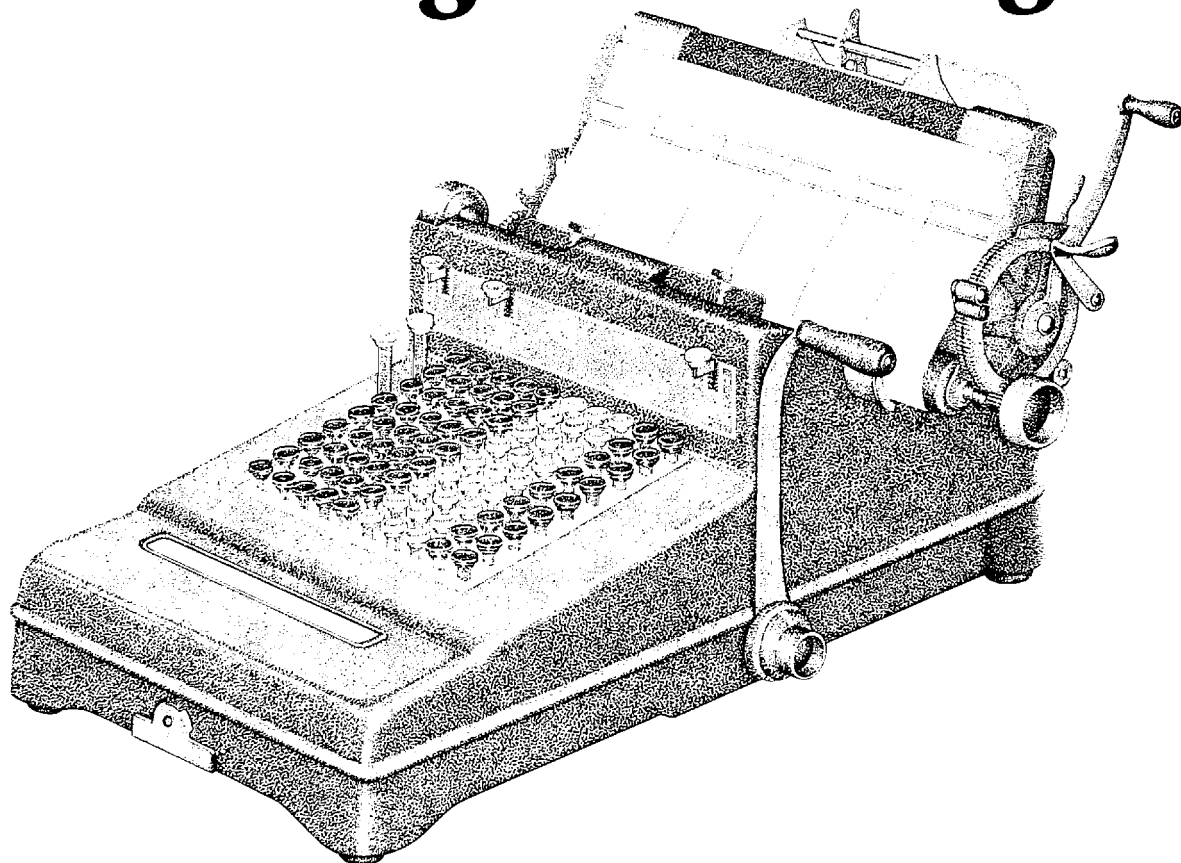
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