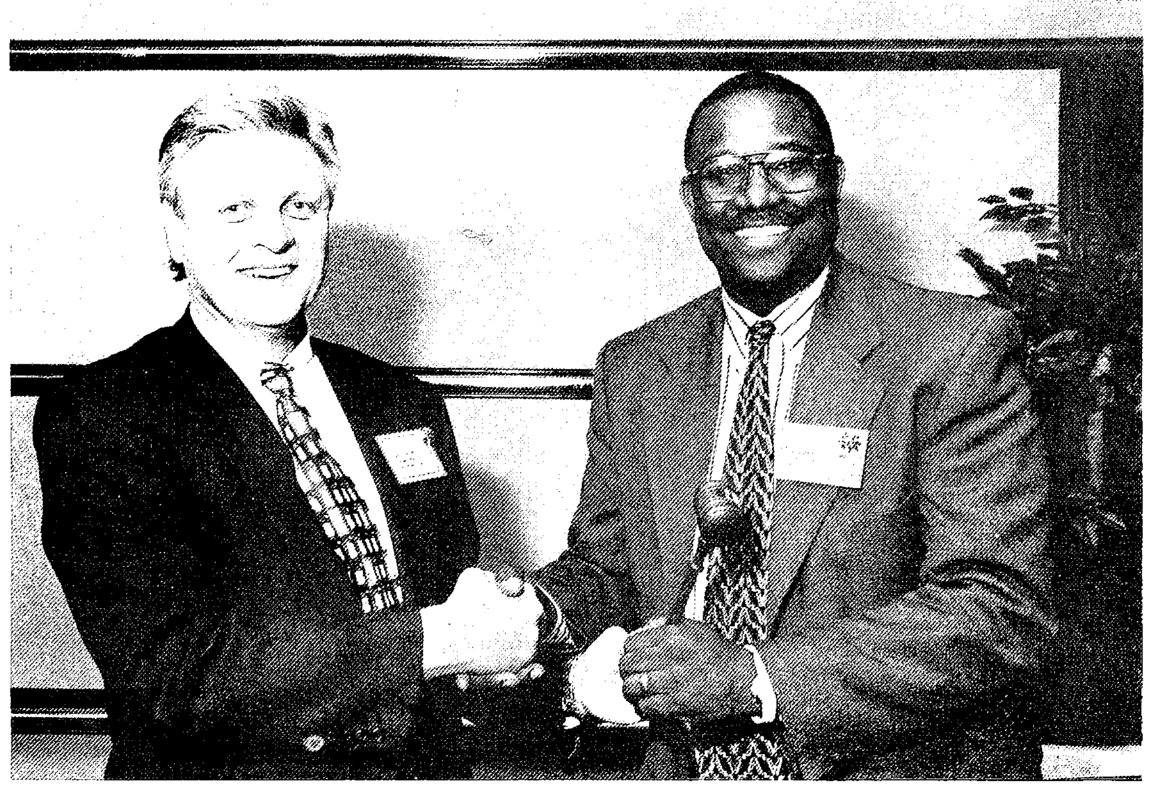
Pierce County Medical Society

BULLETIN

January, 2000



Lawrence A. Larson, D.O. (left) turns over the gavel and the PCMS Presidency to Charles Weatherby, M.D. at the 1999 Annual Meeting

See story and highlights beginning on page 3

INSIDE:

3	1999 Annual Meeting - fun and festive
5	David Sparling, MD, recipient of 1999 Community Service Award
6	New Officers and Trustees to lead PCMS in 2000
7	Physicians and staff meet with insurance representatives to air grievances
9	"Retirement - What to Expect," February General Membership meeting
11	"The Story of French Bread," by Andrew Statson, MD
13	"The Market is Always Right...Sometimes," by David Roskoph, MBA, CFP

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The Bulletin is dedicated to the art, science and delivery of medicine and the betterment of the health and medical welfare of the community. The opinions herein are those of the individual contributors and do not necessarily reflect the official position of the Medical Society. Acceptance of advertising in no way constitutes professional approval or endorsement of products or services advertised. The Bulletin and Pierce County Medical Society reserve the right to reject any advertising.

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Table of Contents

3 1999 Annual Meeting recap

5 Community Service Award goes to David Sparling, MD

6 New Board of Trustees to lead PCMS in 2000

7 Insurers and physicians at odds due to complex systems

9 February General Membership Meeting: Retirement: What to Expect

10 TPCHD: Operation Suds Handwash Program

11 The Invisible Hand: "The Story of French Bread"

13 In My Opinion: "Devaluation of the Doc"

14 Applicants for Membership

15 Special Feature: "The Market is Always Right..Sometimes"

17 Letter to the Editor: "Were You There?"

18 Welcome New Members

19 College of Medical Education

20 Women in Medicine experiences wanted
Letter of Thanks from Dr. Cuevas

21 PCMSA: The Pulse

22 New copying charges for Medical Records

23 Classified Advertising

1999 Annual Meeting recap - a fun and festive event

At the PCMS/PCMSA Annual Meeting on December 14, 1999, **Dr. Lawrence A. Larson,** completed his year as President just as his father, **Dr. Charles P. Larson** had done 32 years ago, in 1967. Mrs. Margaret Larson had the honor of experiencing both her husband and her son lead the physician organization, formed 111 years ago. Dr. Larson passed the gavel to **Charles Weatherby, M.D.** who will serve as President in 2000. Dr. Weatherby is a family physician in Tacoma.

Once again, the Tacoma Youth Symphony Quartet provided reception and dinner music. The annual raffle was sponsored by the PCMSA with Fran Thomas (William) and Yolanda Bruce (John) drawing the lucky names. **Jan Oravetz, MD** won the millennium basket, **Patrice Stevenson, MD** the gourmet basket and Yolanda Bruce was the winner of the monthly fruit basket from the Children's Home Society.

Dr. Larson asked for a moment of silence in honor of colleagues that died in 1999. They included **Drs. Clarence Anderson, Cletus Stevens, Richard Link, Samuel Adams, Charles L. Anderson, William Mattson, Rodger Dille** and **Kenneth Sturdevant.**

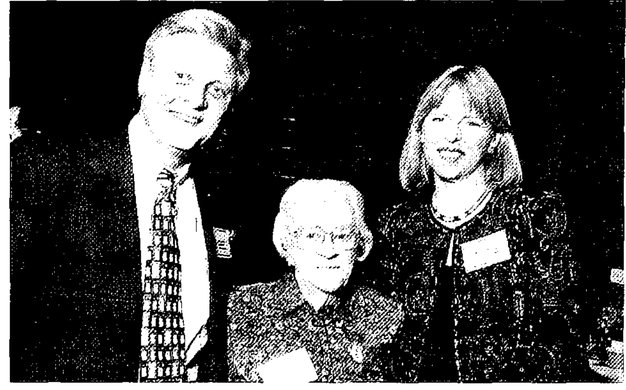
Mrs. Fran Thomas gave the PCMSA report noting that the organization has changed to doing primarily philanthropic work such as the Holiday Sharing Card and the Annual Dinner raffle. The Baby Think It Over dolls continue to be in demand from the schools in the county, while their education efforts in domestic violence continue. She thanked everyone for their contributions of gifts for the YWCA Support Shelter. She invited membership and participation from all physician spouses.

Dr. Larson introduced Mr. John Ulwelling, Executive Vice President of the Foundation for Medical Excellence and former Executive Director of the Oregon Board of Medical Examiners. Mr. Ulwelling spoke on Balancing the Medical Career, and his focus was on various forms of impairment whether they be mental, physical and/or emotional. He defined impairment as the inability to practice medicine which is normally caused by a mental or physical or drug related incapacity. He shared rules of living that he claims as mandatory, 1) show up, 2) pay attention, 3) tell the truth. His closing thoughts were questions and he asked folks to ponder them in relation to their own life.

- What inspired you today?
- What challenges did you experience today?
- What beauty did you appreciate today?
- What are you grateful for today?

Highlighting the evening was the presentation of the Community Service Award to **Dr. David Sparling** (see

See "Meeting" page 4



PCMS outgoing President, Dr. Lawrence A. Larson with his mother, Margaret Larson and his wife, Mary Larson

1999 Community Service Award recipient, Dr. David Sparling and his wife, Barbara. Dr. Sparling is a retired pediatrician

Newly elected officers, Drs. Susan Salo (left) and Patrice Stevenson. Dr. Salo will serve as Vice President and Dr. Stevenson as President-Elect in 2000

"Meeting"

from page 3

page 5). Dr. Sparling received a standing ovation from the audience; recognition that his colleagues appreciate his endless work for the betterment of the health of our community.

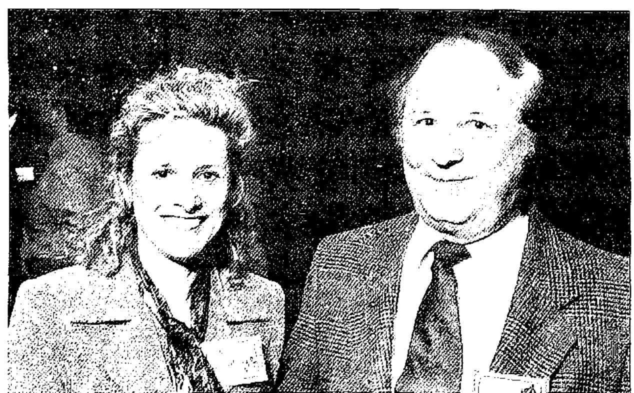
Dr. Larson thanked the outgoing Board of Trustee members for their support during the year and thanked the many members who are active with the Society in various ways. He introduced the 2000 President, Dr. Charles Weatherby.

Dr. Weatherby thanked Dr. Larson for his service to PCMS, particularly his work with insurers, trauma and access to care issues. He then specified his interest in welcoming new members to the Society, and ensuring that physicians stand together as one body against the many forces that are working against them in this era of health care delivery frustrations.■

PCMSA members Fran Thomas (Past-President) and Yolanda Bruce (President) drew names for the raffle drawing. The Alliance sponsored the raffle drawing

Dr. Stan Harris (Past-President, 1997) and Debbie Bowman (center) visit with Dr. Maria Mack (Trustee, 1998-99) and her husband, Dennis Mack

Dr. Jeff Jacobs, pediatric allergist/immunologist attended the meeting with his wife, Jan. Dr. Jacobs serves on the Public Health/School Health Committee



Dr. Jim Blankenship, retired Fircrest family practitioner was accompanied to the meeting by his daughter, Beth

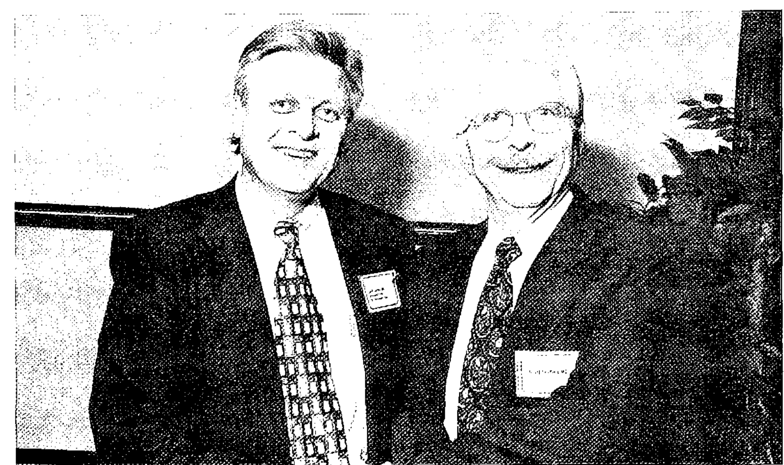
Tacoma Family Medicine's Dr. Jim Hubband and his wife Rachel attended to meet and mingle with colleagues

More photos page 5

David Sparling, MD, honored at Annual Meeting

Retired Pediatrician receives 1999 Community Service Award at 1999 Annual Meeting

"He is a colleague that most of you know and admire," noted **Dr. Lawrence Larson**, as he introduced the recipient of the 1999 PCMS Community Service Award. That recipient, fellow pediatrician, **Dr. David Sparling,** practiced pediatrics for almost 40 years in Tacoma after arriving here in 1960. "He has exemplified the quality and high ethical standard of medical care that is the hallmark of this community," added Dr. Larson.



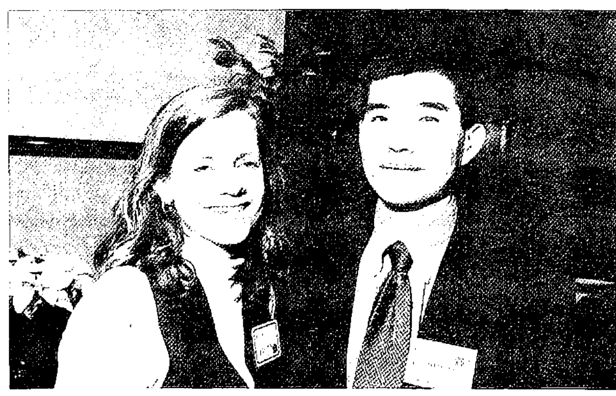
Dr. Lawrence A. Larson, (left), PCMS President congratulates Dr. David Sparling, recipient of the 1999 PCMS Community Service Award

Dr. Sparling was honored for the numerous ways that he has contributed to the community. He has served on and chaired so many committees and boards over the years "we'd be here all night if we named them all," quipped Dr. Larson. But, he did name a few, including, PCMS, WSMA, Pierce County Pediatric Society, Washington State Pediatric Society, American Academy of Pediatrics, Mary Bridge Children's Hospital and St. Clare Hospital. Community agencies include Family Service of Tacoma, Children's Home Society of Washington, Greater Lakes Mental Health Foundation, Pierce County Council, Campfire Girls, Washington Physicians for Social Responsibility, and Tacoma Opera Chorus.

Dr. Sparling is just ending a six year term as the Pierce County Medical Society's representative on the Tacoma-Pierce County Board of Health. This is a tremendous commitment of time including many meetings and major decisions that direct the county's health policies and procedures. For the last seven years, Dr. Sparling has coordinated the activities of the Mary Bridge-Chelyabinsk connection, an exchange of medical colleagues with Russia.

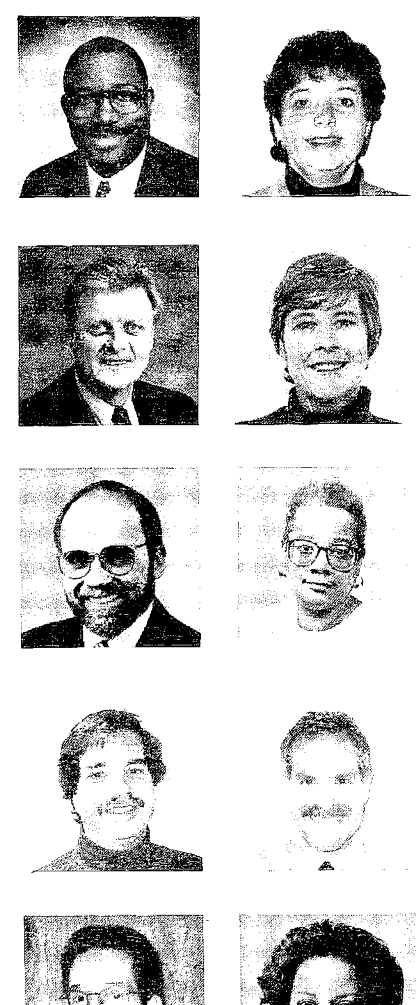
Dr. Sparling received a standing ovation from members as Dr. Larson congratulated and thanked him for his service.■

Drs. Vita and Ray Pliskow, anesthesiologist and radiologist respectively. And, both accomplished musicians.



New member, Dr. Todd Kihara and his wife, Eve. Dr. Kihara is a vascular surgeon with offices in Puyallup and Tacoma

New Board of Trustees to provide leadership for 2000



Pictured from top left, left to right: Drs. Charles Weatherby, Patrice Stevenson, Lawrence Larson, Susan Salo, James Rooks, Sabrina Benjamin, Drew Deutsch, Kevin Gandhi, Michael Kelly, Doris Page, Edward Walkley and Yolanda Bruce

Charles Weatherby, MD (President) is a family practitioner with MultiCare Medical Group. He received his medical degree from the University of Washington School of Medicine and completed his internship and residency at St. Luke's Hospital in Milwaukee. He and his wife, Shauna, live in University Place.

Patrice Stevenson, MD (President-Elect) practices physical medicine and rehabilitation in Puyallup. She graduated from the University of Washington School of Medicine and completed her internship and residency at the VA Medical Center in Los Angeles. She and her husband, Craig, live on Lake Tapps.

Lawrence A. Larson, DO (Past-President) practices pediatrics with Pediatrics Northwest Specialty Care, specializing in pediatric allergy/immunology/pulmonology. He graduated from the College of Osteopathic Medicine & Surgery in Des Moines, Iowa. He and his wife, Mary, live in Tacoma's north end.

Susan Salo, MD (Vice-President) is a family practitioner with Group Health in Tacoma. She earned her medical degree from the University of Washington School of Medicine and has practiced in Tacoma for 24 years. She lives with her husband, Robert, in Puyallup.

J. James Rooks, MD (Secretary/Treasurer) practices otolaryngology in Lakewood. He attended medical school at the University of Miami School of Medicine. He is a Fellow in the American College of Surgeons and American Academy of Otolaryngology/Head/Neck Surgery. He and Penny, his wife, live in Steilacoom.

Sabrina Benjamin, MD practices internal medicine with Internal Medicine Northwest in Tacoma. She received her medical degree from Uniformed Services University of the Health Sciences and practiced several years at MAMC. She and her husband, Selvius, live in Olympia.

Drew Deutsch, MD practices with Tacoma Radiology Associates. He received his medical degree from the University of Illinois College of Medicine and completed post medical education at Cedar-Sinai Medical Center in Los Angeles. He lives with his wife, Rebecca, in Gig Harbor.

Kevin Gandhi, MD is a pediatric/adult urologist. His practice is in Puyallup. He received his medical degree and completed his internship and residency at Loyola Stritch School of Medicine. He and his wife, Kassy, live in University Place.

Michael Kelly, MD is a family practitioner in Lakewood. He graduated from the University of Cincinnati College of Medicine and completed his residency at Oregon Health Sciences University. He and his wife, Bonnie, live in University Place.

Doris Page, MD is a family practitioner at Allenmore Medical Center in Tacoma. She completed her medical education at the University of Colorado in Denver and her internship at Mercy Hospital. She and her husband, Cedric, live in Tacoma.

Edward Walkley, MD practices pediatric emergency medicine at Mary Bridge Children's Hospital. He received his medical degree from Harvard Medical School and completed an internship in pediatrics at Children's Hospital. He and his wife, Kathryn, live in the north end of Tacoma.

Yolanda Bruce serves as President of the PCMS Alliance. She is married to John E. Bruce, DO, Tacoma emergency medicine physician. They reside in Gig Harbor.

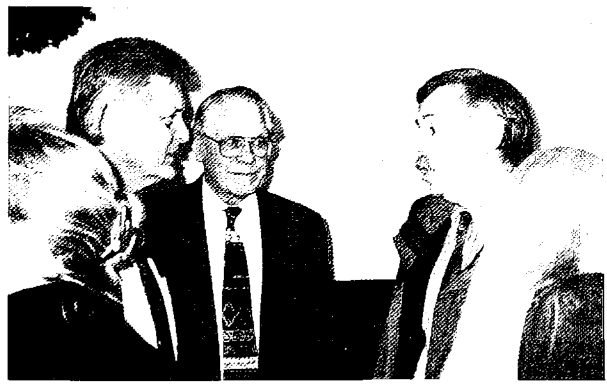
Complex system puts insurers and physicians at odds

A meeting to allow physicians and their office staff an opportunity to ask questions of insurance company representatives was very well attended, even at 7:30 a.m. Held December 9 at the Landmark Convention Center, the meeting featured Medical Directors, Drs. Nancy Fisher (Regence); John Lindberg (TransAmerica representing Medicare); Joe Nichols (Community Health Information Systems); Art Sprenkle (Premera); and Dick Whitten (Health Care Authority).

Attendees got right to business when a local orthopedic surgeon asked about his "scores of accounts over 90-120 days past due" and the amazing phenomenon of rejected claims being returned quickly while authorized claims never get paid. Each panel member had a response to the problem and they all admitted there needs to be a solution, but in spite of these admissions, they defended their way of doing business. "Claims processing is very complex," noted **Dr. Joe**

See "Insurers" page 8

Dr. Dick Whitten, left, Medical Director of the Health Care Authority (left) answered questions of many participants



From left, PCMS President, Dr. Lawrence Larson visits with Dr. John Lindberg and Dr. Joe Nichols after the meeting

Editor's Note: The following letter was submitted for comment on the current difficulties experienced with plans.

Editor:

Unfortunately, I have prior commitments on December 9th that prevent my personal attendance at the meeting regarding insurance woes. I do not want to miss the opportunity to contribute my opinion.

Physicians are at an unfair disadvantage when contracting with insurers. An insurance company unilaterally declares the rates of compensation for services without negotiation and without regard to physician expertise. Physicians have all too long accepted this. As a result, the insurance industry ratchets back compensation rates and imposes uncompensated burdens, such as pre-authorizations, on the physician.

When a supplier will accept less for his product, a buyer will continue to drop his offer until he cannot purchase the product for the price offered. Eventually, the supplier reaches a point where the offer is unprofitable and says no to the deal. The buyer must raise his offer or look for a willing discount supplier. This practice makes sense to business managers. Until physicians value themselves, what motivates the insurance industry to value physicians' services?

I call upon every member of the medical society to value himself. Negotiate the line item price of each service you provide. Refuse to sign a contract that includes unacceptable points. Dare to be an out of network provider. Every time I have dropped an unacceptable contract, my profit margin has increased. Wouldn't you like your profit margin to increase likewise?

Dare to be a non-provider of Medicare. Until enough of us do, I guarantee that the government will continue to cut back compensation. Do not be a discount supplier with a minimal or losing profit margin. Dare to make a profit. We live in a capitalist democracy, not a socialist country.

Do not accept clauses that are unreasonable. As an example, "Pre-authorization does not guarantee payment." Who created such an absurdity? Why should a surgeon spend valuable time and assume risks without guarantee of payment? I received a written pre-authorization form United Airlines, self-insured, performed the case and three months later

See "Jasper" page 8

"Insurers" from page 7

Nichols, PCMS member and orthopedic surgeon previously in private practice in Tacoma. "There are many, many roadblocks along the way and the systems are complex at best." He noted that insurance companies have nothing to gain from stalling claims. They make money from reserves. "There is no solution to the problem until plans and providers sit down together and work it out," said Dr. Nichols.

There was encouragement in the legislative arena as plans will be forced via legislation to pay interest. According to the insurance representatives, this makes things worse as the added burden of paying interest only slows down the payment system, just as claims that are submitted more than once place unnecessary burdens. The new OIC rules regarding clean claims turn arounds increases the operating costs and slows down the processing systems, according to the plan administrators.

A big issue was customer service. A challenge was made to the health plan administrators that they seriously look at this issue. "You need PROVIDER customer service, not member customer service," Ron Robinson, office manager for Eye and Skin Associates explained.

Dr. Art Sprenkle explained that Premera had over 4,000 provider changes in one month. They now have 1,400 left to do. He said they are continually looking for easier ways to accomplish their work but agreeing with his colleagues, "it is an incredibly complex system." He also agreed that plans and physicians need to work together. "Politicians are creating unrealistic expectations," noted Sprenkle. "We need to work together and all be responsive to market forces or our system will implode into a single payer model," he added.

There is no doubt that frustration abounds. Insurers need to make an investment in the physician community and both sides need to consider the perspective and frustration of the other. Bob Perna, WSMA Insurance Specialist summed it up as "plans and physicians are used to being on opposite sides, now they are both in the middle without realizing it."

The concensus of the meeting was to work together. Goals such as administrative simplification, claims processing efficiency, improved working relationships, standardizing systems as well as making them easier were recognized.

We need to simplify the systems and find ways for better communication, added Dr. Sprenkle, before giving his phone number to the attendees.

To contact any of the speakers at this meeting, you may call them at:

Nancy Fisher, MD	*Regence*	*253-573-3244*
Joe Nichols, MD	*CHIS*	*206-971-7266*
Art Sprenkle, MD	*Premera*	*425-670-5832*
Dick Whitten, MD	*HCA*	*360-923-2709*

Left, Art Sprenkle, Medical Director of Premera, talks with Ron Robinson, clinic manager for Eye & Skin Associates

Nancy Fisher, MD, Medical Director for Regence, explained to the group that Regence is studying staff workloads

"Jasper" from page 7

received a denial of payment. Why are we paying staff to obtain pre-authorizations required by the insurer? Increase your expected compensation to account for this cost.

Refuse to accept that disposables, such as dressings, will not be compensated. Either re-negotiate your contracts, or have your patients sign a financial responsibility form stating that such items may not be covered by their insurance and that they will likely be expected to pay at the time of service. Estimate the charge for them and collect it once provided. If one must go to the trouble of collecting a co-pay, why not collect the entire amount? Let the patient fill out insurance forms and try to collect.

I am an expert in my specialty. I value myself. Do you value yourself? Will you stand beside me if I stand against the mighty insurer?

Joseph F. Jasper, MD

Pierce County Medical Society

invites you and your spouse/guest to the

February General Membership Meeting

Tuesday, February 8, 2000
Social Hour: 6:00 pm
Dinner: 6:45 pm
Program: 7:45 pm

Landmark Convention Center
Temple Theatre, Roof Garden
47 St. Helens Avenue
Tacoma

Retirement: What to Expect

featuring:

Jim Early, MD
Bob Ferguson, MD
Ken Graham, MD
David Sparling, MD

- **Financial preparations**
- **Family/spouse considerations**
- **Psychological and emotional concerns**
- **Enjoyment of the "golden years"**
- **How to reap the benefits of early planning**

Name: (please print or stamp) ____________________

Please reserve _______ dinner(s) at $18 each. Enclosed is my check for $__________ OR

Charge my ☐ VISA ☐ MASTER CHG CARD # ____________________ Exp Date: __________

Signature ____________________

I will be bringing my spouse or a guest. Name for name tag: ____________________

REGISTRATION REQUIRED **by Friday, February 4**

Return this form to: PCMS, 223 Tacoma Ave S, Tacoma 98402; FAX to 572-2470 or call 572-3667

The Health Status of Pierce County

Operation Suds Handwash Program

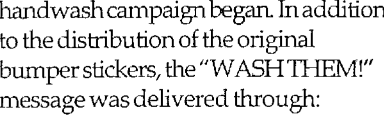
The Tacoma-Pierce County Health Department is encouraging Pierce County residents to wash their hands in order to prevent disease. Statistics show this simple procedure creates important results.

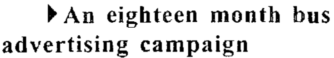
▶ According to the U.S. Center for Disease Control, "Handwashing is the single most important means of preventing the spread of infection." Unwashed hands can spread diseases such as hepatitis A, colds, flu, and even E. Coli. A study of coughing, sneezing, sinus trouble, bronchitis, fever, "pink eye", headache and acute asthma, abdominal pain, diarrhea, and vomiting showed there were 116.5 days of absence in a handwashing group versus 175 absences in the comparison group.

▶ In elementary schools, a scheduled handwashing four times a day can significantly reduce absences due to communicable illness. Rhinoviral particles (a major cause of colds) are spread more effectively by hand than by air. In an article in Family Medicine, Master says, "Just as we insist that children get immunized, brush their teeth, eat healthfully, etc., we should insist that they wash their hands regularly."

A hepatitis A outbreak in Pierce County ten years ago started the department's focus on handwashing. At its peak in 1989, hepatitis A infected over 800 people. TPCHD's Food and Community Safety Program developed and distributed "Dirty Hands Spread Disease...WASH THEM!" bumper stickers to clinics, hospitals, schools, and food service establishments in an effort to curtail the rapid spread of the disease. The outbreak subsided and by 1990 the number of infected individuals was approximately forty, the yearly average for Pierce County.

Hepatitis A follows a cyclical pattern, reoccurring about every ten years. The F&CS Program saw the threat of a potential repeat hepatitis A outbreak as an opportunity for prevention. In 1998 an extensive countywide handwash campaign began. In addition to the distribution of the original bumper stickers, the "WASH THEM!" message was delivered through:





- **An eighteen month bus advertising campaign**
- **Operation Suds, an interactive handwash curriculum training for teachers and school nurses by F&CS Food Safety Specialists**
- **Super Scrub and Bubbles activity workbook**
- **Handwash activities at events and fairs**
- **Development of a self-contained handwash trailer for countywide events**
- **The www.gotsoap.net website**

While counties surrounding Pierce County are seeing increased cases of hepatitis A, Pierce County is well below the average number of cases. In 1999, there were only 19 reported cases, well below the typical 40 cases annually. This can be attributed to more people washing their hands more often.

F&CS Program staff are available to present the Operation Suds train the trainer program. The program includes the Super Scrub and Bubbles workbook, a handwash curriculum with instructions, songs and stories, and the free use of a black light box so participants can see where germs can hid in bright florescent lotion on their hands. The Operation Suds train the trainer program is appropriate for children or adults.

In addition to the Operation Suds program, a self-contained mobile handwash unit complete with two sinks, hot and cold running water, soap and paper towels has been used at several community events. The handwash unit may be reserved on a first-come, first-served basis as long as the event meets criteria outlined by the F&CS Program.

For more information about the Operation Suds program or the handwash unit, contact Diane Westbrook at TPCHD, 798-6045. ■

The Invisible Hand...

by Andrew Statson, MD

"The Story of French Bread"

"What do these people want?"
"They want bread, Your Majesty. They are hungry."
"Bread? Can't they eat cake?"
Attributed to Marie Antoinette, Queen of France (1798)

Andrew Statson, MD

Hunger was a major motivating factor for the French Revolution. One of the first acts of the Revolutionary Government was to fix the price of bread. Their honorable intention was to feed the hungry. The result was famine. The price of bread was fixed in the government paper money, the "assignats", which suffered the same fate as our Continentals. The price was such that the farmers could not sell their wheat, the millers could not grind it into flour and the bakers could not bake the bread, and expect to remain in business. Food riots were common in many cities; bakers, millers and farmers were accused of hoarding; stores were ransacked and people were killed. Eventually, the price controls were adjusted and bread again became available on the market.

The bakers were still faced with a problem. They were barely able to survive on the profit they were allowed to make on bread. So, for the people who could pay a little more, they developed rolls and specialty breads that tasted better and eventually replaced the regular bread in the market.

The price of bread was still regulated when I was a student in Paris, living on a very limited budget. It came in peasant loaves of five kilograms and was a special order. In my student days, a loaf like that would see me through several days and it helped me make it during some tough times. The bakers did not have it on the shelf because there was no market for it. The baguettes tasted much better, and people were willing and able to pay extra to get them.

The crescent rolls in France are about one-third the size of the ones in this country. It is not because French appetites are much smaller than ours. At one time, their price was regulated as well and the market shrunk the size to match. Had the size been regulated also, they would have disappeared from the market.

The mistake of the French Revolutionary Government is an illustration, sadly very common, of the arrogance of power. To make bread, they needed plows and sickles, and the farmers to work them; mills and the millers to run them; ovens and the bakers to tend them. However, the only tools at their disposal were guillotines; and they thought that these were enough. Unfortunately, guillotines can only chop off heads. They did a lot of that, but couldn't bake a single loaf of bread.

Of course, people can be and have been forced at gunpoint to act against their will and against their best interests, but that can only work to a certain extent and for a short time. What finally assured the French their daily baguette was the industrial revolution, not the edicts of the Revolutionary Government. In the 18th century, more than one-third of the work force was in agriculture. Today it is about 6%. The changes were brought about by mechanization, fertilizers, irrigation, pest control, seed improvement, etc. I have doubts about the efficacy of price controls. The market probably would have done better on its own. But it is possible that, as inefficient as price controls may have been, they may have played a role as a social safety net. As the general prosperity of the population increased, however, the demand for peasant bread went down, while the baguettes took over the market. Today the only reason to want a loaf of bread would be to make French toast.

The honorable intention of 20th century government was to take care of the sick. In Eastern Europe, under Communist control, medical care was

See "Bread" page 12

"This country is working under an impossible handicap while trying to solve the problem of medical care for its people. It is the belief that equality under the law also means equality in everything else. The only direction in which such equality can be achieved is down. We can all be equal only when we all become beggars."

"Bread" from page 11

free. I will not bore you with the details. If you have never been there you would not be able to imagine the primitive facilities, the pervasive shortages of supplies, the desperate struggle of physicians and nurses to take care of their patients, the crushing burden of controls. For minor problems many patients went to the doctor's home after work hours and paid out of their pocket the fee for the visit. For major problems, those who had private funds got a permit to go to Western Europe for treatment. The government was all too happy to let them go.

In Western Europe, the situation varied from country to country. In Great Britain, the National Health Service developed a huge backlog with long waiting times for hospital services. Private hospitals appeared and the people who could afford to pay the charges went there. Others went to private hospitals in Switzerland or in this country. In France, patients paid for office visits up front and were reimbursed a centrally determined amount that, with inflation, rapidly became only a small percentage of the actual fee. In the public hospitals, they paid a percentage of the charges. Many small private hospitals and clinics, where patients paid higher charges and got better service, coexisted with the public hospital system.

This country is working under an impossible handicap while trying to solve the problem of medical care for its people. It is the belief that equality under the law also means equality in everything else. The only direction in which such equality can be achieved is down. We can all be equal only when we are all beggars. That is the equality Communism almost achieved in Eastern Europe. Almost, but not quite, because it fell apart before it could do it. We must learn from this experience and abandon the idea of economic equality. It is not attainable.

A fully egalitarian society cannot sustain itself economically. The incentive to produce is missing. Human action is motivated by two factors, the carrot and the stick. When we all are equal, we all get the carrot, whether we work for it or not. It loses its effect. What is left is the stick. However, the main motivating action of the stick is to induce people to cover their rear. It only marginally can motivate them to produce, and has no effect on motivating inventions, discoveries, or any other factors that lead to economic and social progress.

Even in prehistoric times, when people lived in the same cave, sat around the same fire and ate the same food, they were not fully, totally, completely equal. There were always some who slept closer to the entrance of the cave; who sat away from the smoke of the fire; and who ate the better morsels of food, or more of it.

I have read statements that multi-tiered health care is immoral. The people who advocate that should put their money where their mouth is, instead of forcing their morality on those who do not share it. Actually, what is immoral is to obtain through pressure, frequently with a gun not far behind. What one cannot get through is the voluntary exchange of one's efforts for the efforts of others. Under current conditions, no amount of laws, regulations or mandates can assure unrestricted access to high quality medical care for all. Only the continued growth of our economy can bring the general prosperity to a level at which all of us will be able to afford the medical equivalent of French bread.■

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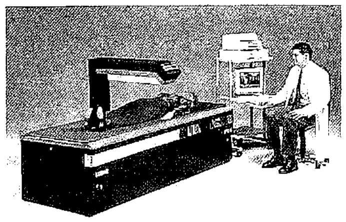

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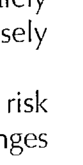

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In My Opinion....

by Nichol Iverson, M.D.

"Devaluation of the Doc"

I'm sorry. I am sic and tired of listening to Joey Gallowbladder or the Big Ugly Unit whine about making only seven million per year. Randy Johnson makes about five thousand per pitch whether it is a strike or a ball. Guaranteed! Who cares if you can't win in the playoffs? And all of this money is for the terrible and onerous task of playing a game. Society has completely lost its sense of values. Perhaps.

Nichol Iverson, MD

Agents for doctors. Can you imagine the kind of money that really important people, such as superstars or Presidents would pay if they could access the playing field of "Superstar Doctors of America"? Clearly having the opportunity for physicians to become free agents for somebody like Paul Ailing, founder of Mindersoft, and owner of the Seattle Freefallers Football franchise. As different teams of doctors around the country begin to assemble and form leagues and divisions, they would need to have some sort of playoff format, competing for the best outcomes. As the competition to build the best teams begins to increase, we will finally see the potential for free agency. Physicians will be traded, and new draft choices from medical schools will be auctioned off and given signing bonuses of ten or twenty million dollars. I can't hardly wait, nohow.

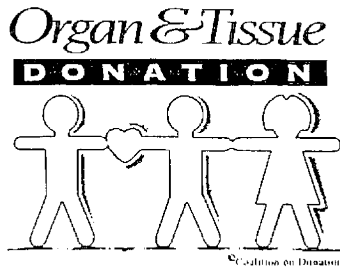
"It ain't over until the fat lady sings; then it's over."

Dr. Yo Yo Ma

In the meantime, we get notices like the one I received last week, asking me to send copies of my medical record, along with any necessary signed waivers, to a Medicare watchdog (half German Shepherd, half Rottweiler). My time, and the time of my staff, you see, has no value. As our government wastes bundles of money on projects such as polishing the squeaky owl project, or philanderers for peace, we are stuck wasting our time and energy in order to make some bureaucrat look good. Having the mind sharp as an antique adz, I have come up with a scheme to divert attention away from our day to day hassles, and have some fun, too.

We can demand the opportunity to invade the privacy of our elected officials, and rummage around in their offices, look through their checkbooks and computers. We will do this randomly, without warning and wearing surgical gloves and masks. All the information we collect can be given to well respected journals such as the National Ink Wire or "Scar" newspaper. Any money that is being wasted in this random search and seizure will be deducted from our senators, representatives and president's salaries.

By the time this tripe is published we will have survived the Y2K bug, launched an IPO Doctor Dolittle.com and created virtual hospitals. Patients will visit their holographic physicians e.g. Dr. Yahoo, HD, and all psychiatric help can be obtained on the Internet at **www.youarenuts.nut**. Lest all of you think that I am a total cynic, you are invited to apply to my "school of the future"...Morons of Mystery, which is available at the above web site.



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Practices at South Hill Family Medicine, 3908 10th St. SE, #200, Puyallup 98374; 848-5951
Medical School: Brown University
Residency: Valley Medical Center

Christopherson, Chad R., MD
Cardiology
Practices at Cardiac Study Center, 1901 S Cedar, #301, Tacoma 98405; 572-7320
Medical School: University of South Dakota
Internship: Mayo Clinic
Residency: Mayo Clinic
Fellowship: Rush University

Das, Sumit K., MD
Neurosurgery
Practices at Neurological Consultants of Washington, 1802 S Yakima, #306, Tacoma 98405; 627-7338
Medical School: University of Michigan
Internship: Mt. Sinai Hospital
Residency: Mt. Sinai Hospital
Fellowship: Texas Children' Hospital

Donner, Charles S., MD
Gastroenterology
Practices at Digestive Health Specialists, 1901 S Union, #B4006, Tacoma 98405; 272-5127
Medical School: University of Heidelberg
Residency: University of Illinois
Fellowship: University of Tennessee
Fellowship: Stanford University

Hamill, Lisa V., MD
Internal Medicine
Practices at 2420 S Union, #100, Tacoma 98405; 403-4444
Medical School: Loyola Stritch University School of Medicine
Internship: University of New York Health Science Center
Residency: Hershey Medical Center

Lee, Donald, MD
Internal Medicine
Practices at the Lakewood Clinic, 11311 Bridgeport Way SW, #100, Lakewood 98499; 581-6688
Medical School: Univ. of Wisconsin
Residency: University of Iowa

Momah, Kingson I., MD
Cardiology
Practices at Cardiac Study Center, 1901 S Cedar, #301, Tacoma 98405; 572-7320
Medical School: University of Nigeria
Internship: New York Hospital-Medical Center at Queens
Residency: Montefiore Medical Center
Fellowship: University of Connecticut
Fellowship: University of Massachusetts

Stegman, Roger J., MD
Internal Medicine
Practices at Lakewood Clinic, 11311 Bridgeport Way SW, #100, Lakewood 98499; 581-6688
Medical School: Tufts University
Internship: Montefiore Hospital
Residency: Maimonides Hospital
Fellowship: Anderson Hospital
Fellowship: University of Washington

Taggart, Kevin W., MD
Family Practice
Practices at South Hill Family Medicine, 3908 10th St. SE, #200, Puyallup 97374; 848-5951
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Internship: Valley Medical Center
Residency: Valley Medical Center

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Special Feature

by David Roskoph, MBA, CFP

"The market is Always Right...Sometimes"

If you're somewhere in the vicinity of a television or radio you're sure to know that the stock market has reached an almost magical status, enthralling everyone with its prodigious daily performances. Rarely does a day go by that *something.com* hasn't quintupled on its opening day and the venerable NASDAQ indices made another new high. If you're not in, you're lamenting each day that heralds another increase in someone else's portfolio. It's up, up and away and with little to nothing to slow it down because the U.S. economy has entered a "new era" with the advent of the Internet revolution Right?

David Roskoph, MBA, CFP

Every once in a while, including now, the parameters of our financial markets get stretched. The present stretch began when an already exuberant stock market met the Internet. Not only was the Internet the place to invest, it also became the medium for that investment. A new generation of investors was introduced to the market through on-line trading. Somewhere in the turmoil, traditional measures of market valuation (once again) became irrelevant, largely because *anything.com* meant instant profit without risk.

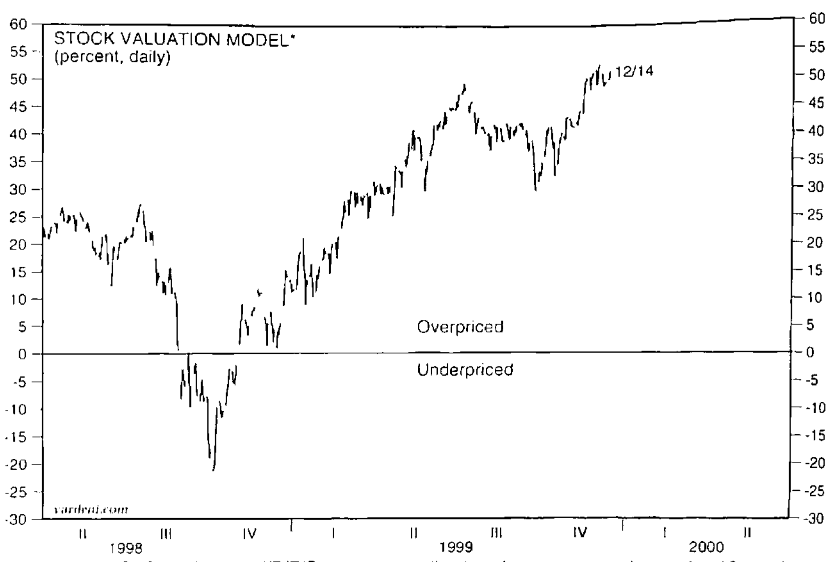
Take a minute to think about the changes in our financial world because things are remarkably different than at any other time. When were you able to mortgage 125% of your home's equity? How about receiving credit card offers every week or the opportunity to buy goods with 0% interest for up to a year? Though ubiquitous now, these are signs of an extraordinary expansion of credit. Creating credit creates money in our banking system through a normal operation that seeks to ensure an expansion of money in proportion to growth in the economy. The caution sign reads: *too lose a credit policy can create an artificial and unsustainable bubble.* The latest figures on U.S. consumer spending show a steady increase in the spending of disposable income. In fact, consumers are now spending 102% of their disposable income as reported in the September 1999 issue of the Economist. The creation of excessive credit and its attendant bloated money supply inflates something. The Federal Reserve is particularly scrupulous about monitoring monetary inflation since they control the money supply. The purchasing power of the dollar is not deteriorating through inflation. Consumer price inflation is being suppressed by the new and viciously competitive frontier of the Internet. Wage inflation is being held in check both by the soothing effect of rising pension accounts and the absence of job security. People are not paying more for goods, employers are not paying more for labor but investors are paying more for financial assets. A bubble has been created in financial assets through an incredible expansion of credit. Financial bubbles are by nature unsustainable and can only be deflated in two ways: 1) a decrease in the asset's value or 2) a substantial reduction in interest rates. The Federal Reserve is more likely to raise interest rates further in 2000 as a result of a booming gross domestic product (GDP), a 30 year low in unemployment and rising energy costs, which makes a market correction the odds-on favorite.

Without getting too technical, market valuation is tied to interest rates and earnings. All things being equal – when interest rates go down, the market becomes a better value. Conversely, when interest rates go up, the market becomes overvalued. Thus, when interest rates were cut three times in the summer of 1998, the market took off. The Federal Reserve raises short-term interest rates to control the growth of the economy. The curiosity of a rising market against an environment of rising interest rates raises a caution flag to experienced investors. On the earnings front, corporate earnings have traditionally determined stock value. The relationship between the price of a stock and its earnings has been reduced to a ratio known as price to earnings or PE. U.S. PE's have historically found their level between 10 to 15. In other words, if a company earned $1 it would sell for $10-$15 per share. As its earnings grew, so too would its share price. Now, however, it is almost impossible to even measure the PE's of many tech stocks since they have no earnings. I estimate the PE of the NASDAQ Composite at 175 and the NASDAQ 100 at about 280. The best measure of the overall market, the Standard & Poor 500 is around 36. The only explanation that makes any sense to me is that of a lottery mentality. Investors must feel that if they buy everything, a few companies will increase many times while most are consumed or fade. Either there is a new paradigm or an extremely overvalued market exists. If more money keeps poring into financial markets without regard to earnings, these trends will continue. If, however, the King feels a draft, look for a rapid correction.

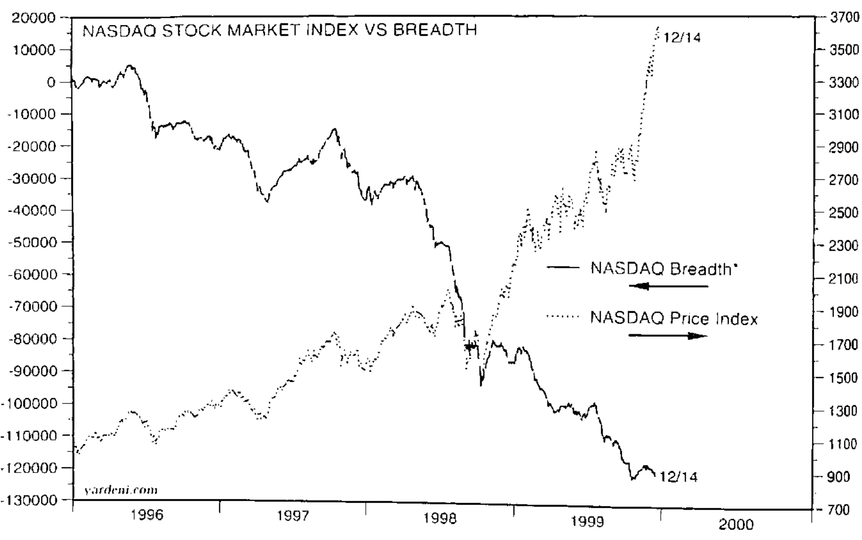
See "Market" page 16

"Market" *from page 15*

With popular indexes soaring to new levels each day, the media would have you believe that the economy has arrived at a new level of consciousness. This argument has been offered before, be skeptical. The stock market has been legitimately rising for many years as a result of increasing productivity and tame inflation. In other words, companies are more efficient, their profit margins stable and consumption of their products strong. In a bona-fide, sustainable market advance, however, there is broad market participation. Market breadth indicates the number of companies participating in a market's rise. Until last summer, (a critical intersection in U.S. fiscal policy), there was a strong correlation between rising indexes and market breadth. In other words, the economic tide was still coming in and most boats (stocks) were rising. Then came the anxiety over Russia, Brazil and the threat of an Asian contagion. In an effort to avert a global panic, our Federal Reserve dramatically expanded credit by lowering interest rates three times in rapid succession. The result was a somewhat curious split in the economic tide. A growing majority of companies began to lose buoyancy while a select group began a meteoric ascension. A global panic was averted but the breadth of U.S. markets began to turn negative and the majority of companies were no longer getting stronger.



* Ratio of S&P 500 index to I/B/E/S consensus estimates of earnings over the coming 12 months divided by the 10-year US Treasury bond yield minus 100.



* Breadth is measured by subtracting the number of declines from the number of advances, and adding the result to that of the previous day.

Presently a mania grips the market with an insatiable appetite for *anything.com*. Each day's rise in the popular market indexes stretches economic realities further. Since the broad market has been declining for over a year, the indexes are being pulled higher by an ever-narrower group of companies. Simply stated, only a handful of stocks are actually advancing and their ranks are dwindling. This can not continue indefinitely; either the broad market reverses or the few meteors re-enter the atmosphere. As of 12/15/99, traditional measures of value are stretched well past reason for the few remaining market leaders, with very optimistic growth projected into the hereafter. Other traditional measures of market health are also sour. Included are the Dow Jones Transportation and Utility indexes, the ratio of New York Stock Exchange (NYSE) new highs to new lows as rising interest rates. By most traditional measures this is a bear market not a bull. Be careful before throwing out 100 years of market history in deference to yet another "new era." ■

David Roskoph, MBA, CFP is a fee-based investment advisor in Gig Harbor

Letter to the Editor

by Mrs. Lorna Burt

Were You There?

Editor's Note: The following letter was submitted after the November General Membership Meeting by Mrs. Lorna Burt, wife of Retired Member, Dr. Robert Burt

A stunned silence swept over the assembled audience of doctors and guests at the PCMS general membership meeting on Tuesday, November 9. It was time for the program they were anticipating.

"Nice turnout," one doctor commented as they arrived for the meeting and gathered by the bar. "It's the free food," said another. One of the "golden age" doctors lamented that really so few of the 700 or so physicians in Pierce County were there and that he missed the rapport, the competitive spirit, and camaraderie of his era.

President Larson introduced the speakers, three editors from the News Tribune, who shall remain nameless for the purpose of this article. They, in turn, re-introduced themselves, explained their particular jobs at the paper and that was all. They simply asked, "Are there any questions?"

The quiet was deafening. Finally, one person in the back of the room spoke up for all of us and told them we were there to hear their analysis of what is happening in the field of medicine and what they know about HMOs condescending to give doctors more freedom of choice in the treatment of their patients.

The garbled responses were inadequate in my opinion and we were a disappointed group who left the meeting.

Once home, I couldn't sleep. I wished that Emily Walker, who was a reporter for the News Tribune many years ago as "Our Gal in Washington D.C." could have been there. Emily spent many years in our nation's capitol and kept us informed of what was going on in matters of health care. She feared that something was happening to reduce our fine medical care system; a socialist movement, which she called, "the camel's nose under the tent."

I was President of the Auxiliary (now the Alliance) at the time and we could see it coming. There were health research organizations around the country. We sent a representative to meetings held in Tacoma to find out what it was all about. She reported that these health care organizations were gathering information and statistics and were frantically trying to spend all of the government grant money so they could get more; therefore they were producing reams of non-essential paperwork. Our "golden age" doctors were too busy caring for patients to see what was happening.

I feel sorry for this younger generation of doctors – giants in stature; but helplessly caught in a spider web from which there seems to be no extrication. In this kind of situation perhaps a certain apathy sets in and a resignation to be eaten in small bites by the spider takes over.

Doctors are now referred to as "health care providers." A mother who bandages a child's skinned knee is a health care provider and she didn't spend 15 years going through college, medical school, internship and specialty training!

Once, in the past, before most present doctors were born, Tacoma had a trauma center and one of the finest health care systems of the time. Pierce County Hospital (now Puget Sound Hospital) was Tacoma's Harborview. It was staffed with excellent nurses, interns, residents and staff doctors representing every specialty. These doctors gave freely of their time for the poor, who couldn't pay, and gave immediate attention to all trauma victims.

But along came the "great society" and the government decreed it was not dignified for the poor to be in a county hospital, therefore welfare and poor patients should have the same privilege as others and be allowed to go to private hospitals at tax payers expense.

Perhaps the doctor's dilemma of the present cannot be changed, but the stranglehold on the doctor's position as far as using their judgment in the management of patient care, allowing more hospital time, etc. could be eased. So, rally around, you M.D.s...you do have a voice and it is called the Pierce County Medical Society. This is YOUR organization. Attend the meetings and work together to better your position in the medical community and give your patients the best care. Why not make Tacoma an exemplary city in health care for others to follow. Give the newspapermen something worthwhile to write about. Make your voice heard...USE IT,...DON'T LOSE IT. ■

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New Members

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Practices at Pediatrics NW, 316 MLK Jr. Way, #212, Tacoma 98405; 403-1419
Medical School: University of Pennsylvania School of Medicine
Internship: Children's Hospital of Philadelphia
Residency: Children's Hospital of Philadelphia
Fellowship: University of Washington
Fellowship: Rush Children's Hospital

Edgoose, Jennifer, MD
Family Medicine
Practices at Community Health Care, 9112 Lakewood Dr. SW, #230, Lakewood 98499; 589-7030
Medical School: Columbia University
Internship: University of Washington
Residency: University of Washington

Hoefle, Stephanie F., MD
Family Practice
Practices at MultiCare, 225-176th St. S., Spanaway 98387; 552-4777
Medical School: Louisana State University Residency: Texas Tech University Health Science Center

Johnson, Anthony G., MD
Family Practice
Practices at 9332 Bridgeport Way SW, Lakewood 98499; 403-4460
Medical School: University of California Irvine
Internship: University of California at Davis
Residency: University of California at Davis

Petrin, James H., MD
Dermatology
Practices at Puyallup Dermatology, 1706 S Meridian, #140, Puyallup 98371; 841-2453
Medical School: Univ. of Washington
Internship: University of Washington
Residency: University of Washington

Rynes, Richard I., MD
Rheumatology
Practices at 4905 108TH St. SW, Lakewood 98499
Medical School: Univ. of Pennsylvania
Internship: University of Michigan
Residency: University of Michigan
Graduate Training: Harvard University School of Medicine

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Bill Dean 272-4013
F. Dennis Waldron 265-2584

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Dates	Program	Director(s)
Friday, January 21	Cardiology for Primary Care	Gregg Ostergren, DO
Wednesday - Sunday February 2-6	CME @ Whistler	Richard Tobin, MD
Friday, February, 11	Advances in Women's Medicine	John Lenihan, Jr., MD
Thursday-Friday March 9 & 10	Internal Medicine Review 2000	Robert Corliss,MD
Monday - Friday April 10-14	CME @ Hawaii	Mark Craddock, MD
Saturday, April 29	Surgery Update 2000	Virginia Stowell, MD
Friday, May 5	Asthma, Allergy & Pulmonology for Primary Care	Alex Mihali, MD
Friday, June 2	Nuts, Bolts & Innovation: Gastrointestinal Disease V	Gary Taubman, MD Richard Tobin, MD

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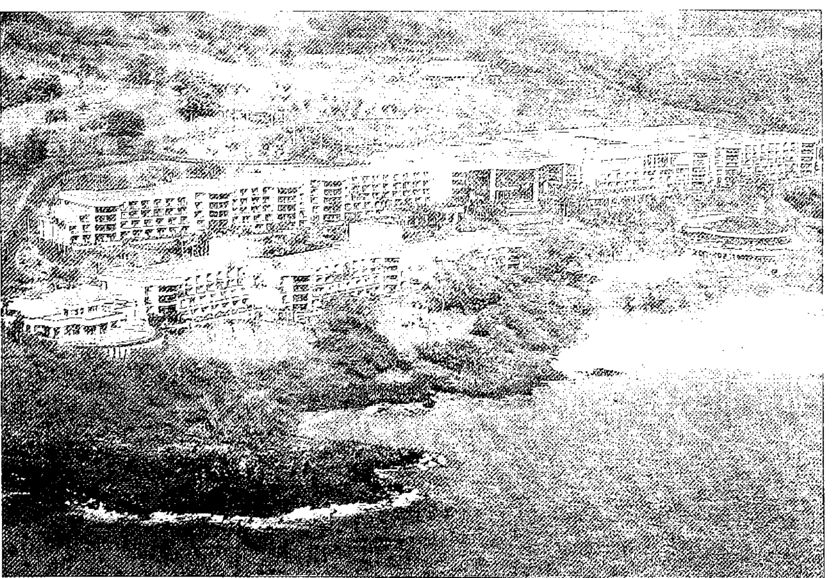
The Hapuna Beach Prince Hotel, on 32 acres edging on Hapuna Beach at the Mauna Kea Resort ,(hailed as "one of the world's 10 best"), is the site for the CME at Hawaii program for the year 2000. The College was able to secure a "world-class resort" at greatly reduced rates. Registrants may benefit from our negotiated group rates for ocean view rooms starting at $180. A second adjoining room for children under 18 is available at $50 below the group rate.

To take advantage of these savings, you must make your reservations soon. THE COLLEGE'S RESERVED BLOCK OF ROOMS WILL BE RELEASED AFTER **FEBRUARY 9, 2000.** Reservations can be made by calling the Hapuna directly at (800) 882-6060. You must identify yourself as part of the COLLEGE OF MEDICAL EDUCATION group.

Those planning to attend should also secure air transportation. To assure you are able to secure seats and get a reasonable price, we urge you to make your reservations NOW. A small refundable deposit will hold your seats.

The College is working with Marilyn at Olympus Travel (565-1213). Olympus has booked some seats at group rates and has access to other special options at the best rates. Call Marilyn today.



Cardiology CME registration open

Registration remains open for the College's fifth annual program featuring subjects on cardiology for the primary care physician. The program will be held on Friday, January 21. The course director is **Gregg Ostergren, DO.**

Call the COME at 627-7137 to register.

"First" Advances in Women's Medicine CME set February 11

The College of Medical Education's "first" program focusing on women's medicine is scheduled for Friday, February 11, 2000. **Dr. John Lenihan,** Tacoma Ob/Gyn, is the program director.

This one day program will address a variety of timely subjects relative to contemporary medicine for women. Designed for the primary care physician, this new CME program will feature issues related to diagnosis and treatment advances in treating illness in women.

The program brochure will be out in mid-January.

Whistler CME registration open

Registration continues to be open for the College's popular CME at Whistler/Blackcomb program. The conference is scheduled for February 2-6, 2000. Call the COME at 627-7137 for more information.

Letter of Thanks

Dr. Eduardo Cuevas, internist in Tacoma, and his family wishes to extend their deepest appreciation to colleagues and friends for their unselfish support, prayers and encouragment during his recent battle against cancer. He is expected to fully recover and be back to work soon.

Women in Medicine experiences wanted

The University of Washington is seeking your experiences of what it has been like to be a woman physician. What professional challenges have you faced? How have you balanced career goals with family needs?

Via request from Eliza Chin, MD an Assistant Clinical Professor of Medicine at Columbia University, they are collecting stories, poems, personal anecdotes, essays and words of advice for publication in a book.

Dr. Chin believes that women face unique challenges, in such an all-consuming profession, particularly when balancing work and family responsibilities. She says she regularly encounters medical students and residents who are grappling with competing concerns of career and family. And, they are looking to role models who have gone before them to see how they have patterned their lives and how they have made their choices.

This book will focus directly on the field of medicine, as opposed to the multitude of works addressing the experiences of motherhood, childcare, career and marriage.

The deadline for publication is February 28, 2000. Please submit both a hard copy and disc, including the author's name, address, phone number and e-mail address. Contributions will be acknowledged by e-mail or post-card.

Send to: Eliza Lo Chin, MD
Asst Clinical Prof of Medicine
Columbia University
16 East 60th Street, Suite 330
New York, NY 10022

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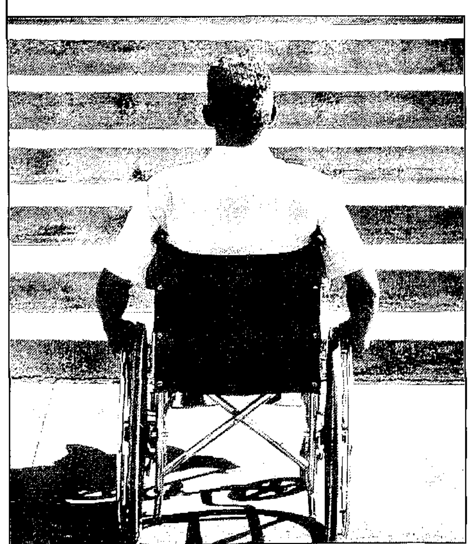

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President's Message

Membership is down to seventy four and volunteerism is at an all time low. The board is pondering the future of the Alliance and it's role in our community. As Medical Society membership increases, the Alliance membership is decreasing. It is extremely difficult to plan projects and programs without the support of our members. It is obvious the Alliance is failing to meet the interest of its members. The board will meet on Tuesday, January 18 at 9:30 a.m. at the PCMS office to evaluate the problem and seek solutions. Please plan to attend. If you are unable to attend, please e-mail your thoughts and comments to me at jebruce@ptinet.net, fax to 253-265-8298 or call me at 253-265-8190. It is imperative that we hear from you, especially from members who made the decision not to renew their membership. Help us change the direction of the Alliance.

Yolanda Bruce
PCMS President

Annual Meeting raffle drawing raises funds

PCMSA raised $436 from the sales of raffle tickets at the Annual Meeting on December 14. Raffle items included a gourmet basket, a millenium basket, two wine baskets and a monthly fruit basket.

The meeting was a festive way to begin the holiday season. If you were unable to attend this year, hopefully we will see you next year.

YWCA thanks PCMS and PCMSA

The YWCA of Tacoma-Pierce County thanks Pierce County Medical Society & Pierce County Medical Society Alliance for their generosity and love at this season of caring

The YWCA thanks you for your support of our Holiday Giving Program. Your contributions give warmth and a sense of a shared community to YWCA clients.

The donations you have made will be used to brighten the holidays of women and children alike. Your donation might be destined:

◆to be chosen by a young child for her mother

◆to be chosen by mom for her young son

◆to be given to a single woman reclaiming her life

◆to be given to a family that is in the YWCA transitional housing program

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We thank you for your generosity this holiday season and look forward to you being part of the YWCA family next year.

Holiday Sharing Card update

A big THANK YOU to the members of the Alliance and the Society for so generously supporting our annual fund raiser. Once again it was a great success. The total amount raised was $14,890, with 231 families participating.

Donations received after the November deadline:

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Each year we strive to have quality art work for our card. This year in particular many of you were impressed with the talent of **Miss Laura Yu.** Hold on to your '99 card. I have a feeling when this young lady reaches her peak your Alliance card may turn out to be quite valuable!

Thank you volunteers: Yolanda Bruce, Nikki Crowley, Mary Cordova, Fran Thomas, Dot Truckey, Rubye Ward, Loretta Macha, Kris White, Helen Whitney, Sue Wulfestieg and Alice Yeh.

Many of your donations were accompanied by cards and notes of appreciation for the work we do. Those of us who remain active in Alliance are very grateful for the support we receive from the medical community.

On behalf of my colleagues on the board of the Alliance...Thank you!

Mona Baghdadi, Co-chair
Holiday Sharing Card

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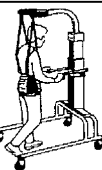

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1-Hesse et al. **Arch Phys Med Rehabil** 1994;75:1087-1093
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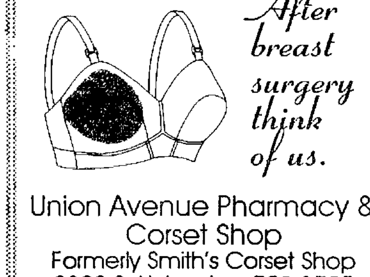

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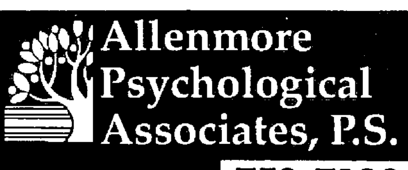

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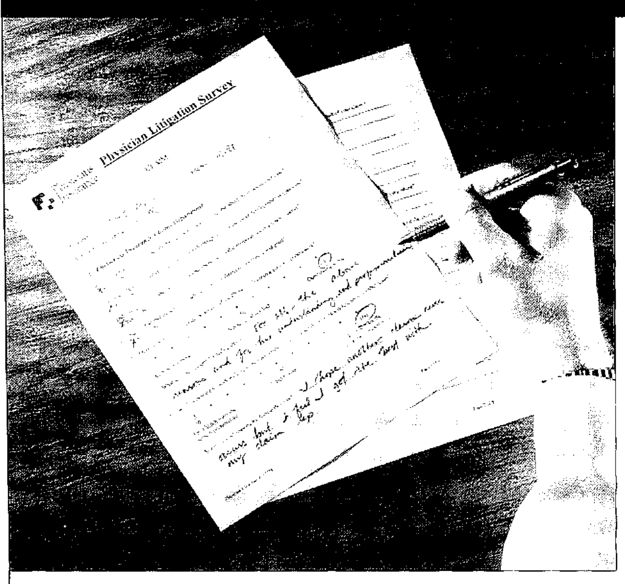

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Pierce County Medical Society

BULLETIN

February, 2000

Board Retreat brings health care leaders together

From left, Drs. Don Russell, Susan Salo, Jim Rooks, Len Alenick and Mike Kelly

See highlights beginning on page 5

INSIDE:

3 President's Page: "Medicine in the Millennium"
4 In Memorium: Dr. & Mrs. Hazelrigg pay tribute to Dumont Staatz, MD
5 Board of Trustees learn from Pierce County health leaders at January Retreat
9 "Viral Hepatitis in Pierce County," are you informed?
11 L & I Task Force working to improve claim process
15 "The Health Status of Pierce County," by Health Director Federico Cruz-Uribe, MD
23 PCMS Alliance Board recommends disbanding to their membership

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Pierce County Medical Society
BULLETIN

February 2000

Table of Contents

3 President's Page: Medicine in the Millennium

4 In Memoriam: Remembering Dumont Staatz, MD

5 Retreat offers education for PCMS Board of Trustees

9 Viral Hepatitis in Pierce County

10 February General Membership Meeting

11 L&I Task Force has worked to improve claims process

12 Go shopping on Support*My*Association.com

13 The Invisible Hand: "Fee for Service"

15 TPCHD: The Health Status of Pierce County

16 1999 Physician Directory changes
How to recycle used PDRs
Safe Handgun Storage brochure available

17 In My Opinion...."Meet Dr. Rocker"

18 Fee Policy recommended by Medical/Legal Commitee

19 In My Opinion..."Finding Beauty in Annie"

20 WSMA Physician Leadership Conference set for May
WSMA thanks you for your membership

21 College of Medical Education: Get ready for Hawaii

22 Legislative Health Clinic needs volunteers

23 PCMSA: Alliance to vote on dissolution

25 MD License Renewal and CME Requirements change

27 Classified Advertising

President's Page

by Charles Weatherby, M.D.

Medicine in the Millennium

Charles Weatherby, MD
PCMS President

What do we have to look forward to in the coming years? The AMA House of Delegates has endorsed the unionization of practicing physicians. The National Labor Relations Board (NLRB) has let it be known that they are going to support the unionization of interns, residents, and fellows.

With the steady decline of hospital admissions and inpatient care days, hospitals are becoming more involved with outpatient care services. As a result of this situation, hospitals spent the past several years employing physicians and acquiring private practices. Recently, however, the pendulum is swinging the other way, with physicians returning to private practice.

We are also starting to see the merger of multiple health insurance companies. The contracts that we are being asked to sign are becoming more complicated and more one-sided. (To the benefit of the health insurers, of course.) It seems that physicians are always being "asked" to take a decrease in our reimbursements. These contracts are requiring us to have MBAs or JDs just to interpret them or are requiring us to hire people with those degrees to interpret the contracts for us. My medical training didn't prepare me for this.

Some physician specialty groups are refusing to sign some of these contracts. Do their refusals, in effect, invalidate some of these contracts because the necessary specialty panel required by the State Insurance Commissioner doesn't exist? Can the office of the State Insurance Commissioner enforce the regulations regarding the pool of physicians necessary for a health insurer to operate within a specific geographic area? Will this requirement force the health insurers to interact more positively with physicians?

Our state legislature is considering legislation regarding a patient "Bill of Rights." This will even permit patients to sue their HMOs. Our WSMA is preparing for its CURE campaign. This is a media program that will promote physicians to the public in a very positive light.

What does all this mean? It's going to become more difficult to practice medicine "in the old way." Physicians are going to have to become more knowledgeable and cognizant of the forces that determine how physicians practice. Unfortunately, our busy practices preclude our involvement in dealing with some of these important issues. However, our voices need to be heard. That is why it is very important that we continue to support organized medicine; AMA, WSMA, our own PCMS as well as our respective specialty organizations. ■

IN MEMORIAM

DUMONT STAATZ, MD

1918-1999

Those who knew Dr. Dumont Staatz personally nearly always described him as energetic and a man in a hurry. He was impossible to pigeonhole though because he was also a man of contrasts so divergent as to be startling.

Professionally, Dr. Staatz was a well established orthopedic surgeon who was highly respected by his colleagues. He was interested in rehabilitation orthopedics and especially in helping patients who suffered from the effects of polio. He was president of the Northwest Orthopedic Association and a member of the Tacoma Rotary Club. He traveled repeatedly to India and Ethiopia and on the ship Hope teaching local physicians orthopedic technique. Dumont was an avid sailor. He also spent many happy hours restoring his antique Pierce Arrow.

His personality was vivid. He had a bluff hearty exterior but expressed an inner sympathy for his fellow beings by sharing his skills. He cared for his invalid wife for several years prior to her death.

He loved world travel but at the same time he was a solid member of the community, serving on the Advisory Committee of the Centre at Norpoint. He was highly distinguished professionally but at the same time he played Santa Claus with relish since 1994 for Norpoint's Annual Santa Breakfast. He was a serious thinker but loved the bon mot and apt witticism.

In the neighborhood he was noted for small kindnesses. He gave many rides to and from the airport, he took out neighbors garbage cans and brought in neighbors mail. When the awesome task of buying a wedding present fell to him, bluff Dumont courageously braved the china department and bought our daughter's gift. Seeing the gift and knowing Dumont brought tears to her eyes.

Those of us who live on the same road remember him roaring down the street drag strip style. "Here comes Dumont!" someone would say. Yet if he saw my husband in the yard, surprisingly, he would slam on the brakes and pass the time of day, seemingly unhurried. The conversation over, his car would lurch ahead resuming speed and disappearing over the hill. We would stand there a moment and someone would say, "There goes Dumont."

It seemed somewhat of an oxymoron that Dumont was a twin because he was definitely one of a kind-intelligent but funny, competent but kindly, eminent but unassuming.

Dumont became unexpectedly incapacitated with a heart ailment on Tuesday and by Thursday, he was gone. We couldn't believe it. We had just talked to him. We had plans with him for the future. We reminisced about a friendship that spanned 45 years and eventually somehow his departure began to seem consistent with his flamboyant style. He had a full life. He had a highly recognized career, a dear wife and five wonderful children. And when it was time to go, true to form, Dumont had simply left in a hurry.

Jim and Carol Hazelrigg

Retreat offers healthcare education for PCMS Board

PCMS Board hears about the future of healthcare from local hospital leaders

At the 2000 Board of Trustees Retreat held on Saturday, January 8 at Fircrest Golf Club, representatives of each hospital system gave, from their perspective, an overview of the future of health care in Pierce County.

Panelists George Brown, MD, VP Acute Care, MultiCare; Mark Gregson, CEO, Puget Sound Hospital; Ed Miller, CEO, Good Samaritan Hospital and Joseph Wilczek, President & CEO, Franciscan Health System agreed on several issues, one being the changes in hospital/physician relationships as well as the shift in the competition for dollars.

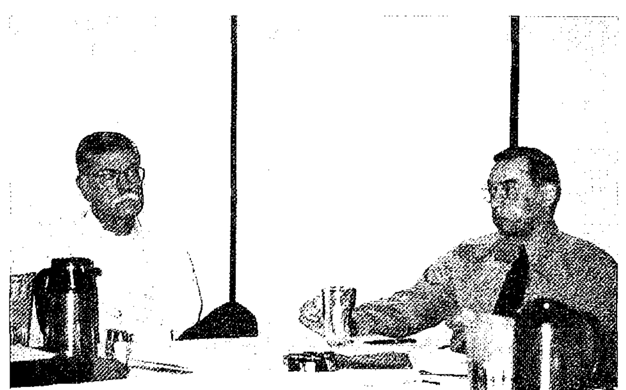
Many hospitals believed that they could work with primary care providers (PCPs) to direct health care and with payers to get better reimbursement rates. This did not occur and "we are now paying more to monitor the system than the system is saving," according to Joe Wilczek. He said, Franciscan Health System, his employer, purchased Western Clinic, developed an infrastructure, and secured 98,000 capitated contracts that initially lost $6.5 million and ultimately $38 million. Today, they have decreased their losses from $142,000 per physician to $40,000, and hope that by 2001 will meet the break-even point. "We will be joint venturing with specialists," but it is clear, noted Wilczek, "physician deals will be dissolved over the next three to five years." Good Samaritan Hospital's CEO, Ed Miller, agreed, "hospitals will be pulling back from employing physicians, no doubt," he said. Hospital/physician relationships have changed, with more hostility and competition, and he believes that "as long as reimbursement rates remain low, competition for dollars will continue." With physicians needing to be more efficient and withdrawing from hospitals, hospitalists are helping to cover patients. Mark Gregson explained, "providers will be pushed to keep up with growth in all specialties, more hospitalists included."

And, there continues to be bad news for an industry already in trouble. In 1999, 21 hospitals/health systems had their bond ratings down graded, which decreases their access to capital. Margins have dropped, with the average hospital operating with a 1.2% margin. "You need a four to six percent operating margin to do good business," noted Wilczek. "Things will get worse," he added.

Competition and challenge were words used freely throughout the discussion. Panelists agreed that the Internet will provide additional competition as consumer expectations are increased. Both referral advice and office visits will try to be replaced by on-line services. "Providers will be pushed to remain competitive," said Gregson. Challenges will be numerous, as each presenter discussed several, including

See "Retreat" page 6

From left, hospital administrator panelists, Joe Wilczek and Mark Gregson representing Franciscan Health System and Puget Sound Hospital, respectively



From left, hospital administrator panelists, Ed Miller, Good Samaritan Hospital CEO, and Dr. George Brown, Multicare, VP Acute Care

PCMS President, Charles Weatherby, MD, consults with Dr. Lynn Hankes, MD before his presentation at the Retreat

Retreat

from page 5

issues such as reimbursements, medical mistakes, a new trauma system, pain management, Wall Street, staffing, training/technology and federal government regulations, particularly fraud & abuse vulnerabilities. George Brown, MD believes that significant challenges will be "providing measurable outcomes that can be shared in efforts to hold the public's trust" and "the challenge to re-invest in our own facilities." He added that the competition of billing and coding will be significant and that anyone that "doesn't get" billing and coding will be in trouble.

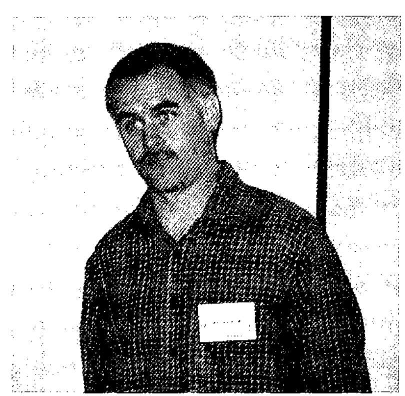
Creativity and change were words frequently used in summary. There is no doubt that these leaders believe that the status quo will not remain. "There will be more changes ahead," noted Gregson, while Miller believes "we have to develop new relationships and creative ways of working together." Dr. Brown sees "shared risk and equity models," as the next step, because you "have to watch the bottom line in addition to outcomes." But hopefully, physicians can hold one change at bay because Wilczek believes, "economic credentialing would be disastrous."

New trauma director looking forward to opportunity in Pierce County

Dr. Robert Winchell addressed the Board of Trustees at their retreat after just five days on his new job as Director of Trauma Services for the Pierce County Adult Trauma System. He began big, philosophically, with an overview that pictured medicine as an industry versus medicine as a ministry. As an industry, a person with an injured spleen and an empty wallet should be left on the street. As a ministry, everyone gets all the care they need provided for them regardless of the cost. "In fact, the current approach is not going to work in the long run," he added. "As a society we have some very difficult decisions to make. What is the industry piece, what is the ministry piece and how will we all support that," he said.

A self-described "trauma zealot," Dr. Winchell said he could cite numerous reasons why trauma needs to be addressed as a public health issue. Trauma is the leading cause of loss of life and productivity in the young, and a major health care issue across all age groups. An organized system approach to trauma care has been shown to reduce preventable deaths and improve outcome. Dr. Winchell just left a system in San Diego County, with five adult hospitals (one Level I, four Level II) serving 3.5-4 million people, that is arguably one of the best long-standing county operated systems in the country..

"To say that Pierce County does not have a trauma system is not correct," he said. "There is a trauma system, but it is sub-optimal. For 7-10% of trauma patients, this system, which includes long transport times to a trauma center outside the county, could be frankly detrimental to their outcomes," he noted. For the remainder of patients, this system creates significant problems for continuity of care and social support structures.



Robert Winchell, MD

He believes that Pierce County provides him with a "golden opportunity." With a governmental mandate, a political mandate and a popular mandate he sees an opportunity to create something of lasting value in this community. "With the pieces all gathered, the challenge will be figuring out how to put them all together," he said.

In response to questions from participants, Dr. Winchell admitted that he had never seen a community that had the luxury of saying no to the provision of trauma care. The situation is "unusual, going on unique," he quipped. Fortunately, the mandate for the development of a trauma system is larger than the few who oppose it.

He compared and contrasted the San Diego system with Pierce County. He explained that in San Diego County, trauma patients are a "target population." Due to the prevailing medical economics, their care is relatively well-reimbursed compared to other populations. With such a closed financial market, provision of trauma care has been profitable for the hospitals involved. In San Diego, physicians don't avoid being on the trauma panel, they fight to be there. For many physicians in Pierce County the financial rewards are not perceived to be worth the efforts. Another obstacle for some surgery sub-specialists is ending up with full responsibility for the patient's care from the time they do surgery. Dr. Winchell reassured participants that the new trauma delivery system will take full responsibility for the patient from the time they are transported until they go to rehab. If a sub-specialty surgeon is called in, they will be expected to evaluate the patient, perform the required medical procedure, and provide appropriate follow-up, but will not be responsible for continuing inpatient care. The trauma team will provide the inpatient continuity of care.

"There is no question that a trauma system will change the practice patterns of neuro and orthopedic surgeons more than anybody," said Dr. Winchell, when asked about trauma coverage for these two specialties. "This can be a blessing or

See "Retreat" page 7

Retreat from page 6

a curse depending on what their individual practice looks like," he added. We are working with the various subspecialists to arrive at an optimum solution.

"One of the blessings for me is that the hospitals are working on ways to provide incentives for sub-specialists to participate," said Dr. Winchell. "It is not an insolvable problem," he added.

When asked about the effects of Pierce County's trauma system on Harborview, Winchell noted, "We anticipate building a co-operative relationship with Harborview, which remains our tertiary referral center. As envisioned in the Washington State plan, Pierce County's trauma center and Harborview each have primary responsibility for their own geographically separate region. Our trauma center will provide a level of patient care that is second to none."

Director of Health speaks on Health Department activities and 'health' of Pierce County

Federico Cruz-Uribe, MD, MPH, Director, Tacoma Pierce County Health Department, gave his perspective on the health of Pierce County, particularly in light of the disastrous effects that Initiative 695 had on the Health Department's budget. "MVET (motor vehicle excise tax) caused the loss of 50% of our general fund," he lamented. "At the Health Department, we're not so concerned with market forces, but political forces," he explained.

Not one to be discouraged, however, Dr. Cruz said they are the same agency, just smaller. "We spent just ten percent on prevention when I first came and we continue moving toward 90%, but we're not quite there yet," he noted. The Department continues work on their three priorities, which are violence, tobacco and alcohol within their operational framework of assessment, prevention and partnerships.

Dr. Cruz believes they are proving that partnerships work. They turned over their Tuberculosis Clinic medical care to Infections Limited while they continue to provide prevention services, and they have partnered with several community clinics to provide direct care. CHC, SeaMar, CCPC and the PLU Wellness Center now make up the choice of community clinics for underinsured and uninsured Pierce County residents. The clinics totaled 26 providers in 1999 as opposed to just nine in 1995.

Dr. Cruz reviewed statistics on access to care (See TPCHD page 15).These statistics have helped his staff tailor programs and activities within the realities of Pierce County. "The most difficult aspects of setting a prevention framework is to use tactics that you know will work and to know the realities of your own community," noted Dr. Cruz.

Washington Physicians Health Program expanding, becoming more proactive, and focusing on stress related issues

Lynn Hankes, MD, reviewed the successes and failures during his tenure as Director of the **Washington Physicians Health Program (WPHP)** and discussed current trends. He is beginning his eighth year of assisting troubled physicians in Washington State.

Lynn Hankes, MD

The program began in 1986 and has evolved over the years. In 1999 there were 539 participants in the program, with 179 under contract and 360 cases in development. The vast majority of the professionals under contract are MDs. Of the 179, 143 are MDs, 23 are PAs, 3 are DOs, 2 are DPMs, and 8 are DVMs. WPHP offers a five year contract and then clients have an option to stay in the program voluntarily on a year to year basis. About 60% choose this option. Of the 179 contracts, 150 are voluntary and 29 are mandated by a Commission or Board.

In 1999 there were 108 inquires to the WPHP compared to 93 in 1993. "While steady, this is not what we predicted," said Dr. Hankes. "We thought that health care reform with its attendant stress would generate a lot more calls," he said. Although the number of calls have not changed, the character of the calls has. They added a category to their roster for "difficult doctor" about a year and a half ago and in 1996 began treating physicians with just pure mental illness, without any chemical involvement. These two categories have skyrocketed with psychiatric calls doubling and difficult doctor calls tripling in the last year. WPHP is not funded to implement a program for these "difficult doctors" but is exploring resources.

Between January, 1993 and December, 1999 total program participants have increased 254% from 152 to 539, including a 75% increase in contract cases and a 620% increase in cases in development. "We continue to expand," he noted.

Unfortunately, he reported the bad news as well. "On

See "Retreat" page 8

Retreat from page 7

my watch, we've had three deaths, I'm sad to say," said Dr. Hankes. Two occurred after program discharge. "We know we are not going to win them all but when we don't, it is very sad," he added.

Dr. Hankes **expressed two major concerns. One is the extremely high level of discontent among physicians.** "Physicians frequently tell me, 'If I could do something else, I would'" he said. The second is the adverse relationship which currently exists between hospitals and physicians. Mental illness is surfacing, chemical dependency relapses might be increasing, health-care change is difficult to handle, and many doctors are angry and abusive. **Physicians know very little about self-care as they are trained to take care of others.** He said, "Asking for help and providing it are almost mutually exclusive." WPHP is trying to become more proactive and focus on stress related issues. "The program has recently signed a new contract with the state for almost six years." This will allow us to develop long-range strategic plans," said Dr. Hankes.

Additional speakers at the day long retreat included John Coniff, Deputy Insurance Commissioner, Managed Health Care, and John Gollhofer, MD, WSMA President.

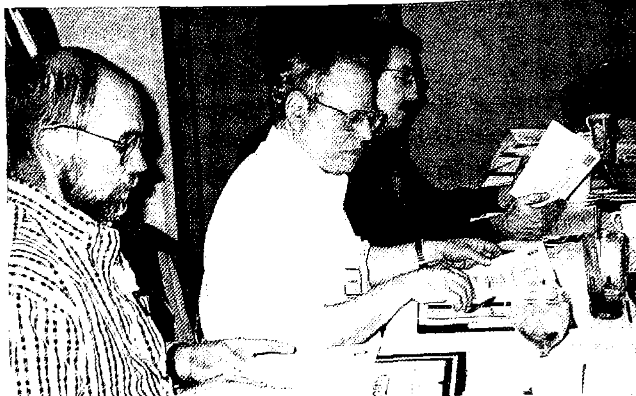
Mr. Coniff said the Office of the Insurance Commissioner (OIC) has little power as to how insurance companies do business. The OIC does review contracts and will continue to do so and he sees no reason why plans can't have standard provisions. He noted that they are working to get a handle on network adequacy. The way it currently works is that each plan must publish their own network adequacy. The Office of the Insurance Commissioner (OIC) monitors them to make sure they comply with their own requirements.

He believes physicians should demand:
- impartial and quick review of disputes
- competent reviews
- external reviews for big cases
- the right to sue plans
- a new process for cutting edge medicine

Patients should demand:
- right to choose care
- enough health care professionals
- care in the right place
- providers with the right skills
- the power to make decisions

The regulatory role should include saying NO to bad plans, bad networks, bad practices and bad contracts and YES to putting consumers first. "We must spread the risk without hurting access to care," added Coniff.

In closing, he outlined an ideal health care system and what it would provide:
- access to health care for those who need it
- health care financing that rewards quality
- health care delivery that honors diversity
- more money spent on care than on management



From left, Drs. Jim Rooks, Len Alenick and Mike Kelly study their packets in preparation for the day's speakers

From left, Board members, Drs. Lawrence A. Larson, David Law, Kevin Gandhi, Drew Deutsch, and speaker, Dr. Federico Cruz-Uribe

Dr. Gollhofer spoke of common problems and needs for solutions shared by all physicians. He noted that physicians, more than ever must not become adversarial, but recognize the need to focus on common issues. He reported that the economics of medicine is the worst ever as many practices are going broke, particularly in rural areas where it is very difficult to say no to patients. " The WSMA CURE campaign is working to help with several issues of concern to physicians," said Dr. Gollhofer. The CURE campaign will work to decrease the cost of transactions and increase the cost of payments, and will accumulate data on physician income to give to payers to give them perspective that perhaps they have been unable to see, he added.■

Viral Hepatitis in Pierce County

by Alan Tice, MD; Karen Mottram, RN; Frank Lyons, MD; Tim Schubert, MD; James DeMaio, MD

Viral hepatitis is not a new disease but it is emerging as one of the most significant infectious diseases in our community. Recent methods of identifying the viruses responsible and the potential for effective treatment as well as interruption of transmission to others make it worthy of review.

In brief, hepatitis A, B or C viruses cause most hepatitis. Hepatitis A is epidemic and usually self-limited. Fortunately, there is a good hepatitis A vaccine available for those at risk and with chronic liver disease. Chronic hepatitis B causes cirrhosis and hepatomas but is being controlled by vaccine use. Hepatitis C was only recently identified by a blood test which became available in 1992. It appears to infect about one in a hundred Americans and is only now surfacing as a major public health problem in the population who abused drugs or received contaminated blood transfusions over the last 20 or 30 years. Hepatitis C is now known to cause chronic disease like hepatitis B but usually without any history of an acute illness. It usually presents when a patient develops cirrhosis with it's complications of encephalopathy, intestinal bleeding or ascites. Cirrhosis may develop without consistently abnormal liver function tests. In addition, there are complications with patients who are co-infected with multiple agents such as Hepatitis C, Hepatitis B, HIV and Hepatitis D virus in addition to other medical problems which may contribute to liver disease or complicate therapy.

What is also new is the potential to treat hepatitis B and C through several oral and parenteral medications that have become available. Unfortunately, the medications are expensive and often toxic. Fortunately, there are a number of resources in our county, which can help with patient evaluation and management. This includes the Tacoma-Pierce County Health Department, which has been a "sentinel site" for the study of viral hepatitis by the CDC for over 20 years. Information on viral hepatitis in Pierce County has been published in many prestigious journals.

What does viral hepatitis mean to you as a practitioner? First, make sure you and all of your staff are vaccinated against Hepatitis A and B if they are at risk. Also be sure you have instituted procedures and protocols to prevent and to manage needle sticks or puncture wounds when they do occur.

> "When it comes to patient care, think more of asking patients about whether they ever used parenteral drugs or inhaled cocaine - even if it was 30 years ago and they never had a clinical case of hepatitis. Also ask if they ever had a blood transfusion before 1992..."

When it comes to patient care, think more of asking patients about whether they ever used parenteral drugs or inhaled cocaine-even if it was 30 years ago and they never had a clinical case of hepatitis. Also ask if they ever had a blood transfusion before 1992 when the blood banks began screening for hepatitis C. Some blood had a 10% chance of being contaminated a few years ago. Also check your chemistry screening panel for elevated liver function tests, especially alanine amino transferase (ALT). Even minor abnormalities may be significant as it is a slow, smoldering infection which may go unnoticed until cirrhosis or hepatic encephalopathy appear.

If you find a patient with viral hepatitis, ask about continued alcohol or drug abuse, which are essentially contraindications to the potentially toxic and expensive medications available. Also check for medications they may be receiving which may cause liver disease-such as acetaminophen, lipid lowering agents, and cardiovascular medications.

If they appear to have active liver disease and are interested in treatment, further investigations with a measurement of viral load and possibly a liver biopsy may be indicated. Depending on those findings, the age of the patient, the genotype of the virus, and the insurance company, treatment with interferon or antivirals for a year may be indicated.

Referral to local specialists may also be helpful to obtain advice about therapy and possibly obtain medications that may not otherwise be available. New oral agents and long-acting interferon injections (one shot a week) may soon become available on research protocols. It is also of value to enter patients into these studies so that we may promptly assemble the data and learn more of what treatments are most valuable and how we should best use the medications we have.

If you have any questions about hepatitis, please contact the health department or your local gastroenterologist or infectious diseases specialist. ■

How to contact the authors:
Dr. Tice or DeMaio:
Infections Limited, 627-4123
Dr. Lyons:
Digestive Disease Center, 272-8664
Dr. Schubert:
Digestive Health Specialists, 272-5127
Karen Mottram, RN:
TPC Health Department 798-6546

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Program: 7:45 pm

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No Medical Input to Dept. of Labor and Industries

The following letter was written by ***Dr. William Ritchie, MD,*** *Tacoma ENT, who has chaired the PCMS L&I Task Force for the last three years. The letter was sent to Mary Kay O'Neill, MD, Chair, WSMA Industrial Insurance and Rehabilitation Committee. As a result of the letter,* ***Drs. Ritchie, David Judish, Jeff Nacht*** *and* ***Mark Tomski*** *will be meeting with the WSMA Committee on February 16. All of them have served on the PCMS L&I Task Force since its inception. The letter addresses the frustration the Task Force members have with L&I.*

Dear Dr. O'Neill:

In the fall of 1996, discussions with Helen Vandergriff, a Nurse Consultant for the Department of Labor and Industries in Pierce County, led to the formation of a task force group that attempted to improve communication and the working relationship between the Pierce County medical community and the Department of Labor and Industries. The group was comprised of interested physicians, medical office personnel, and representatives of the Department, including Helen Vandergriff and Al Dunham. The first meeting was held on October 1, 1996, and several issues and concerns were identified. These included IMEs, consultations, pre-authorizations for procedures, billing issues, access to claims managers, coding problems, and the volume of claim loads for claims managers. Two more meetings were held in 1996.

The task force met eight times in 1997. The problems were discussed, and a great deal of time was spent on return to work delays and IMEs. In March, Bob Perna attended the meeting and helpfully informed the task force about the activities of the WSMA L&I Committee. Dr. Stockbridge attended a meeting in November of 1997 and was helpful in explaining issues, including a provider bulletin on vocational rehabilitation. In December, Carol Britton, RN, the IME project director and nurse consultant with the Department of Labor and Industries, gave a broad overview of the procedures for the annual 32,000 IMEs performed in the state.

The task force met only five times in 1998. Dr. Franklin attended the April meeting and discussed the difficulties with the independent medical evaluations. His particular concerns were the quality of IME exams, the training and certification of examiners, the appropriateness of the IMEs, and the fee schedules. He did remind the task force of the magnitude of trying to create change within the bureaucracy of the Department of Labor and Industries. In June of 1998, Dr. Lee Glass was introduced to the task force, and we were encouraged when he indicated that he would like to bring the medical perspective back into its proper role at the Department of Labor and Industries. A significant attempt to improve communication between medical offices and the Department was initiated. A poll of the offices in Pierce County indicated that at least 25 to 30 individuals felt it would be informational if medical office staff could meet on a one-to-one basis with the Department of Labor and Industries staff, including claims managers, in an attempt to learn Department procedures and improve communication. The individuals were willing to travel to Tumwater. The Department rejected this idea because they were too busy training new claims managers.

On December 7, 1998, Bob Perna, Doug Jackman, and Dr. Ritchie traveled to Tumwater and met with Assistant Director Doug Connell and several members of the Department staff. Dr. O'Neill and Dr. Stockbridge were in attendance. A discussion on numerous problems was held, but nothing of substance occurred because of this meeting.

In 1999 the enthusiasm of the task force members declined and only four meetings were held. The same concerns that had been aired previously were re-discussed. Mr. Perna informed us of the new WSMA Physicians Complaint Form. I personally submitted two separate complaints that illustrated a frustrating procedure used by the Department. The response by the Department, in effect, stated, "That's the way it is," with apparently no understanding that a change in procedure would alleviate the problem.

In our last meeting of 1999, the question as to the future direction of the task force was raised. The consensus was, the task force had few, if any, substantive accomplishments. Procuring an updated phone list of personnel to contact at the Department, and getting acquainted with the nurse consultants and supervisors have been helpful, but committee members were frustrated with their inability to be more useful. This is why we requested the opportunity to present to your committee our frustrations with the system. Our frustration is not directed at the personnel of the Department of Labor and Industries. There are many well-informed and helpful employees working with physicians and physicians' office personnel. The problem is that many procedures and policies of the Department do not made medical sense, and delay treatment of injured workers and makes the claims adjudication process difficult. Changes to policies and procedures of the Department are needed. We do not pretend to know how these changes can come about, but changes must be made to improve the treatment of injured workers in this state.

ACTIONS:

This task force strongly believes that there needs to be an increase of medical influence in the claims process.

See L&I page 26

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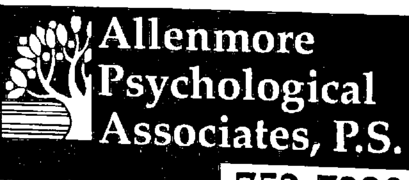

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The Invisible Hand...

by Andrew Statson, MD

"Fee for Service"

Andrew Statson, MD

"Every abuse ought to be reformed, unless the reform is more dangerous than the abuse itself."

Voltaire (1764)

There have been many criticisms of fee for service, but hardly any definitions of just what is being criticized. The major objection has been the perverse incentive. It claims that physicians have the incentive to perform more services, even though not needed, so they can get paid more. Very little mention has been made of the patients who request, and expect to get these services, no matter how much they may cost, when they do not have to pay for them. Insurers have discovered that the restrictions imposed on patients have not been well accepted, so they decided to shift the burden and the responsibility to the physicians. They used the gate keeper approach, which did not work well, and now the capitation approach, which will not work well either.

There are five types of fee for service, and the difference between them is significant. The common component of all is that the physician performs a service and gets paid a fee. The variable aspect is in what the patient pays.

Simple fee for service. The physicians treat, the patients pay the fee. There is no third party. The patients are aware of the costs and are directly and fully responsible for them. The patients determine, on the basis of their wishes and their resources, what and how much will be done. These transactions consist in the exchange of value for equal value. If the physicians charged more than the services were worth to the patients, they could look for a better value someplace else, or decide to forego the service.

Up-front payment with reimbursement. The patients pay the fee and file a claim. The insurance reimburses a flat amount. The patients are aware of the costs, but are not fully responsible for them. However, the patients have a strong incentive to keep the costs down, because the higher the charge, the more money they have to pay. Therefore they have the incentive to shop around for the best price and the best quality they can get. Compared to simple fee for service this system increases the demand for medical services and their price. There are two reasons for this. First, the patients value the services according to their out-of-pocket expenses. That determines their decision to purchase a service. Since they get some reimbursement, their personal expenses are lower, so their demand for services goes up. Their demand for better quality services rises also because they are better able to afford them. Second, the higher demand tends to increase the price.

Percent copay. Typically the insurance pays 80% of the fee up to a maximum allowable, the patients pay the balance. The patients are aware of the costs, but their incentive to keep them down is at the 20% level. They are more likely to want a service, since they only pay one fifth of the cost.

Flat copay. The patients pay a set amount. The insurance pays the balance, up to a maximum allowable. The patients usually are not aware of the costs of any one service and have no incentive to shop for lower cost, or to request a lower level of service. They may want to cut down the number of visits, but not their complexity, since they pay the same amount for each visit, no matter how extensive it may be.

No copay. The patients pay nothing. The insurance pays up to the maximum allowable. The main question these patients have about any treatment is whether it will hurt. They don't care how much it may cost.

The criticisms of fee for service are directed to the last three types, and only marginally, to type 2. Simple fee for service is a free market transaction of value for equal value. When the transactions are distorted by insurance payments, there is room for misuse and fraud. That may be on the part of the physicians, who may attempt to get what they consider a more reasonable compensation by using higher codes for their services than warranted. It also may be on the part of the patients, who want tests, procedures or medications on the basis of what they have seen on television or read in the popular magazines. Since their monetary cost is very little, and frequently does not depend on the cost of the treatment they get, they tend to request the more expensive tests, procedures or medications without having a clear indication for them. The factors that make them limit their utilizations are the risks, side-effects and complications; the pain and disability; and the time they will have to spend in connection with the treatments.

Yes, such a system is subject to

See "Service" page 14

Service from page 9

abuse. A similar problem exists with manufacturer warranties and car insurance. There must be outright fraud by repair shops, charging for things they did not do. I don't know how common that is. Much more common, I suspect, is the repair of defects, dents and scratches that people usually would not have done, except when the charges are paid by someone else.

The problem with health care is more complex, because there is a large gray area, where a wide range of options are acceptable. The insurance companies have tried to limit services to what is medically necessary, but the definition of medical necessity has eluded them. They have devised elaborate systems of coding and cross-checking. They have studied distribution curves of diagnoses, and related them to services. A whole industry has grown around the development of programs to track health care services. At the same time another industry caters to the education of physicians, their staff and hospital personnel on coding and billing requirements, so that they can get paid for what they do and avoid trouble with the law.

The recent fraud investigation in California is just one example of how vulnerable such a system can be. In order to prevent abuse it is forced to establish detailed rules, which make it cumbersome and inefficient. At the same time it has to be suspicious of everybody, including the majority of physicians and patients, who are honest, looking on them as guilty, expecting them to be able to prove at any time that they are innocent. The overhead costs of such a system are staggering. Recently United Healthcare admitted that the processing of authorization requests alone cost them over one hundred million dollars per year. What about their other costs? How much does it cost on our end?

This system, largely established by law and loaded with regulations, functions like a statutory law system. Societies are complex, dynamic organisms, both orderly and chaotic at the same time. The possibilities are endless. No laws or regulations can cover them all. There will always be unforeseen situations, new developments, unexpected individual variations and odd loopholes. This is even more likely in the field of medicine than in society at large.

One of the greatest contributions England has made to civilization is the development of a working modern common law system. The origin of common law goes back to biblical times ("In those days there was no king in Israel; everyone did what was right in his own eye"-Judg21:25). The beauty of the common law system is that it matches the characteristics of society itself. It is complex, dynamic, fairly predictable and adaptable. The judges rule on the basis of the knowledge and the circumstances of any individual case. There is an oversight mechanism. When they judge wrong, it affects only one case. Statutes are not only more likely to be wrong, but when they are, they affect the entire society and cause much more damage.

The basic problem with the current system is that it squeezes people who are honest, while encouraging the others to cheat. Patients can get care if they scream loudly enough that they need it. Since there are no laws without loopholes, cheats can still play the system and grow rich. A system that encourages such behavior and penalizes honesty cannot survive for very long. It is on the road to self destruction. ∎

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The Health Status of Pierce County

In January 2000, the Director of the Tacoma-Pierce County Health Department, Federico Cruz-Uribe, MD, MPH, made a presentation to the Pierce County Medical Society. The following summarizes that talk.

The focus of the Tacoma-Pierce County Health Department has changed from providing limited clinical services to: Assessment of community needs and assets, prevention of illness and death, partnerships with community organizations.

Federico Cruz-Uribe, MD

What's the health status of Pierce County within which the Health Department is doing this? One area to consider is access to health care. The following statistics cover the 1995-1998 time period.

In Pierce County, almost 60% of insured residents surveyed are covered by insurance paid by their employer; about 20% are covered by Medicare; Medicaid covers another 5%;5% of individuals buy their own insurance; and 10% are covered by military or Indian Health or some other insurer.

About 11% of Pierce County residents have no health insurance coverage, approximately 8% of women and 13% of men. For those households without insurance, 25% have an annual income of $15,000 or less.

People who are 18-24 years old make up 25% of uninsured people. Those who are over 65 years old make up less than 5% of uninsured people.

Comparing uninsured people by race or ethnicity shows that the largest group (17%) are people who are black (non-hispanic). Approximately 10% of uninsured are white (non-hispanic). Hispanic people make up about 8% of uninsured people.

In three different surveys, cost was the number one reason given for not accessing health care. This was followed by concerns about getting an appointment, hours of services, and not knowing where to get care. Transportation problems created a slight barrier, as did personal beliefs and language.

When asked how long it had been since their last routine check-up, about 65% of Pierce County residents surveyed reported it was less than one year. About 10% said it had been more than five years since their last physical.

In Pierce County, almost 70% of residents surveyed said they go to a physician's office or private clinic if they are sick or need health advice; almost 10% use an HMO or prepaid group; about 5% said they access care through a community/migrant clinic.

Community health centers in Pierce County are critical partners with the Health Department to address the needs of the indigent. There are four clinic systems, each governed by a local board: Community Health Clinics, Community Clinics of Pierce County, SeaMar and Pacific Lutheran University. In the twelve clinic sites across the county within the systems, the providers are on salary. The Health Department has invested clinical care funds in the systems and has seen a steady growth in their capacity to serve indigent clients. Over the last three years, their clinical load has almost doubled.

This investment and partnership in community health centers has allowed the Health Department to operate a prevention framework, to change those behaviors which lead to death and illness. Prevention priorities include: tobacco use reduction alcohol misuse reduction, and violence prevention.

The prevention work is multifaceted, informed by research and is population-based rather than consisting of one-on-one services. The Health Department's work is sustained through the community, including private providers.

Highlights of each prevention priority plan include the following: The Tobacco plan will increase the effectiveness of current tobacco laws and policies; reduce tobacco experimentation among youth; reduce exposure to environmental tobacco smoke; and decrease the smoking rate among adults and youth. Providers can participate in this plan by holding brief, in-office interventions with smokers.

The Alcohol Plan will reduce the availability of alcohol to underage youth; reduce the incidence of drinking and driving; develop and strengthen community networks; and increase screening and brief interventions. Private providers can participate in the alcohol plan by identifying alcohol misuse among patients and referring them to cessation programs.

The Violence Plan will promote the increased use of the Domestic Violence Helpline; promote safe storage of firearms; support early childhood and family programs and services; and strengthen efforts to reduce adolescent suicides. Private providers can help by identifying and referring victims of domestic violence and by referring patients who have guns to places where locking devices are sold. ■

1999 Physician Directory changes

Thomas Irish, MD
change suite to #202

Joseph Jasper, MD
(as of February 1, 2000)
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Tacoma, 98465
Phone: 253-564-2009
Fax: 253-564-7420
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Safe Handgun Storage

A new brochure about the importance of safe handgun storage is now available through the Health Department. The four-color brochure shows a picture of a bedside stand with a "door." When the door is opened, there is a picture of a handgun inside with the words, **"If you were curious enough to open it, just think about your child."** On the back is information about the importance of handgun locking and storage, the availability of push-button lock boxes and a toll-free number to call for more information. If you would like copies of the brochure for your office, please contact Fran Wood at 798-6426. ▪

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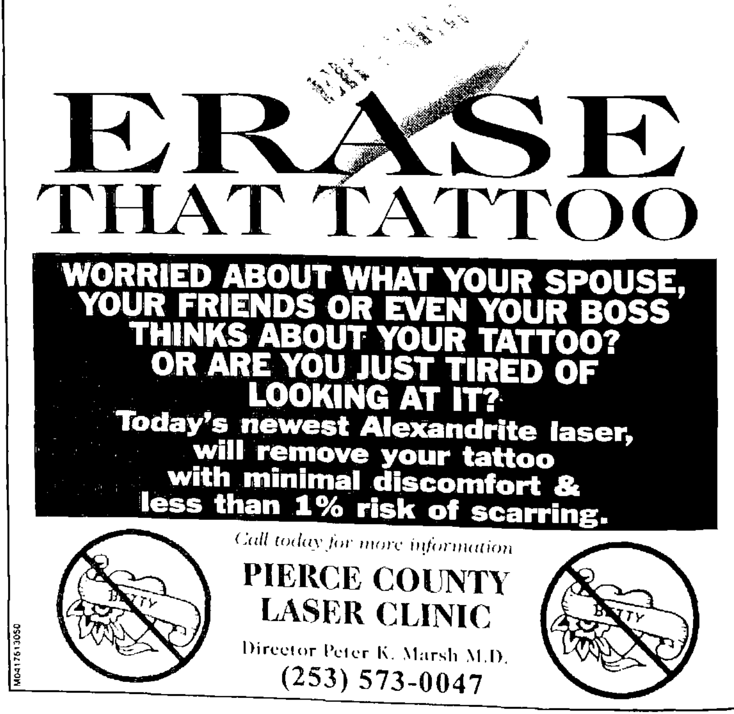

In My Opinion....

by Nichol Iverson, M.D.

"Meet Dr. Rocker"

"If the !@#$%^&* public @#$%^&* wants @#$%^&* care, then @#$%^&* do it or @#$%^&* 'em!"
Dr. Offiz Rocker

Nichol Iverson, MD

Unbeknownst to most of you, Dr. Rocker was known for his nefarious personality as a surgeon before making the big leagues. Being a precocious student, he entered Southern Red Neck University at the age eighteen, and graduated in three years summa cum louder. During his residency he was observed to throw a pair of metzenbaum's under a scrub nurses armpit, through an open window where it imbedded itself into a coconut palm one hundred and seventy one yards from the hospital. On a separate occasion, he was observed jumping up and down on a patient's bed screaming to the nurses that they, on a good day, had the brains of a @#$%^&* monkey. Rather than dealing with his threat of "I'll rip your @#$%^&* off, and stuff them up your @#$%^&*," the administration made him captain of the hospital softball team. Baseball scouts discovered him when he was observed to throw a softball through the backstop from center field after catching a routine fly ball for the third out. When "Dr. Offiz," as he was proudly nicknamed, found out that he could make much more money playing baseball, he went on to make a brave donkey look intelligent.

In a recent *Sport Illustrious* article, little mention was made of his brief medical career. Little did the world know that he had passed through the greatest training ground for egregious behavior -- medical school and a residency program. Learning the skills of medicine, especially empathy, caring, loving and sensitivity, were left to his later encounters with umpires, managers and understanding New York baseball fans. Had Dr. Rocker not been required to take 57 credit hours per quarter during school, then work 117 hours per week during his residency, he likely would have been one of the best loved relief pitchers on the Island of Atlantis. Unfortunately, his patterns of behavior had been pretty well compressed into his pea brain, shamefully being expressed to the consternation of Ted and Jane, precipitating their separation.

The lesson from John Rocker is simple. We can't tolerate his behavior on the baseball diamond, and we can't tolerate his behavior if he returns to medicine. Those of us who were not fortunate to make the big leagues of baseball, need to listen to the public outcry surrounding the statement of this fallen "star." Creating a Code of Cooperation among healthcare workers is going to be a necessary part of reengineering medicine. Failure to correct poor communication skills in the frustrating environment of medicine 2000 will inevitably lead to a deterioration of our profession, and we will be @#$%^&*ed. ■

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▸ Attorney Conference Time (telephone or in person)	$___.00 Per Hour
▸ Deposition (Please inform if videotape deposition and number of people attending so adequate space can be secured)	$___.00 First Hour and $___.00 Second Hour and thereafter
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▸ Court or Arbitration Testimony	$___.00 Per Hour
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If you have questions or concerns, please call the office at the above phone number.

In My Opinion....

by Teresa Clabots, M.D.

"Finding Beauty in Annie"

Teresa Clabots, MD

Annie walked into our clinic with her new insurance card. Prior to that she had never received care from a pediatrician, only from a school nurse and occasionally the mobile health clinic.

She was short, funny looking, and had coke bottom glasses. She was not a pretty child. Her mother was a frail elderly woman who was very concerned about her daughter, socially and because she was so short.

A complete workup including cardiology, renal and growth hormone evaluations would giver her a diagnosis she would carry the rest of her life: Turner Syndrome. A referral to an endocrinologist and growth hormone shots she received didn't really help her since she was diagnosed so late.

Annie wanted a "girl doctor" and she insisted on becoming my patient. She wanted to talk about her hopes, her dreams, and one day she ended up on my schedule and we talked for a long time. We talked about the future of a Turner's patient. We talked about the sadness she experienced on being told she could never be a mom. She told me about her future hopes - she wanted to get rid of her glasses. We talked about why depth perception and mathematics was so hard for her and her probable inability to drive in the future. We talked about entering her into a tutoring program and also last but not least getting her on DSHS and SSI. She was on Healthy Options (managed care), and I was sick of doing referrals.

I told Annie that when I was a med student in Kansas, one of my expectant mother's had twins. One was a Turner's patient and one was not. She was then told by a senior pediatric resident that she should never have more children and immediately went out and received a tubal ligation. This was actually not true advice and at that time Turner's was not considered genetic, although 10 years later in my practice I had another case where the child was a Turner's patient and the mother turned out to be Mosaic. Serendipity worked in that case and the hard part for that family to accept the Turner's diagnosis was that they were Mormon, placing a huge burden on the child to continue to procreate and become a mother.

> "I wanted to continue caring for her, and received a Medicare application form....... I pitched the partically filled out application into the trash. It was insulting and degrading."

I gave Annie the advice that I had given that family, that if at 63 years of age, an old Italian woman can bear children after menopause, thanks to hormonal intervention, I saw a terrific future ahead for her. God only knew if in 20 years the technology would be such that she would be able to carry an implanted fetus. I told Annie not to worry about it, that we would work on getting her contact lenses. This made her very happy, and we worked about getting her a pair of twins (our joke for getting boobs). When Annie left I dictated a 3 page letter eliciting all of her past medical history, complications, and future diagnosis. We applied for SSI and incredibly for me we got it on the first try for her. Her first goal was to get contacts.

Annie came in, she had on a little bit of make-up and contacts. Now an "acceptable" date, she had gone to her high school prom, and actually danced with a boy. She was so excited. We joked that there was at least ONE advantage to being short - she could get to dance with all the boys since they were all taller than her.

Now Annie is 18 and she has SSI insurance, and Medicare. I wanted to continue caring for her, and received a Medicare application form. After the 6th of approximately 40 blue pages, being asked yet again whether I had commited a felony, or fraud, or whether any of my staff had committed felonies, or frauds, I pitched the partially filled out application into the trash. It was insulting and degrading.

I see Annie for free now. On her last physical, I praised her for her grades, her grooming, her dental hygiene, her personal appearance. She was beaming. She has joined a Turner's club, and went camping for the first time in her entire life.

Her mother paid me in the only thing she could. A tiny little African violet blossoming under a thick bush of ugly leaves. It seemed it was a little Annie in itself. ■

WSMA Physician Leadership Conference set for May 12-13

The WSMA Leadership Conference has been scheduled for May 12-13 in Chelan. Physicians who are delegates, officers of county medical societies, state specialty societies, hospital medical staffs, group practices and other organizations should plan to attend. The conference will be held at Campbell's Resort.

The program will include plenary sessions addressing trends affecting the current and future environment of medicine as well as break-out sessions on interview techniques, speech writing, interpreting financial statements, and much more.

The program is offered with no registration fee and will be accredited for Category I CME credits.

A conference brochure and registration information will be mailed in February. For more information, contact John Arveson, at the WSMA Seattle office, 800-552-0612, email: jva@wsma.org. ■

PCMS and WSMA thank you for your membership

WSMA Annual Membership dues statements were mailed in November for the 2000 dues year. Don't let your membership lapse!

Did you know that 73% of your WSMA membership dues are tax deductible as an ordinary and necessary business expense?

And, **if you have professional liability coverage from Physicians Insurance, you receive a $200 discount on your premium.**

PCMS is a unified county making state membership mandatory. To belong to one organization you must belong to both.

If you have questions about your WSMA membership status, call WSMA's membership department 800-552-0612 or email kcc@wsma.org. ■

Check out the WSMA legislative priorities on the WSMA website, www.wsma.org

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February 9 is Hawaii Hotel reservaton deadline

The College's reserved block of rooms for CME at Hawaii will be RELEASED AFTER FEBRUARY 9, 2000. Reservations can be made by calling the hotel directly at (800) 882-6060. You must identify yourself as part of the COLLEGE OF MEDICAL EDUCATION group.

The Hapuna Beach Prince Hotel, on 32 acres edging on Hapuna Beach at the Mauna Kea Resort, (hailed as "one of the world's 10 best"), is the site of the CME at Hawaii program for year 2000, which will be held April 10-14. The College was able to secure a "world-class resort" at greatly reduced rates. Registrants may benefit from our negotiated group rates for ocean view rooms starting at $180. A second adjoining room for children under 18 is available at $50 below the group rate.

Those planning to attend should also secure air transportation. To assure you are able to secure seats and get a reasonable price, we urge you to make your reservations NOW. A small refundable deposit will hold your seats.

The College is working with Marilyn at Olympus Travel (565-1213). Olympus has booked some seats at group rates and has access to other special options at the best rates. Call Marilyn today.

Continuing Medical Education

Timely topics addressed in Women's Health CME

The College of Medical Education's "first" program focusing on women's medicine is scheduled for February 11, 2000. **Dr. John Lenihan** is the program director.

This one day program will address a variety of timely subjects relative to contemporary medicine for women. Designed for the primary care physician, this new CME program will feature issues related to diagnosis and treatment advances in treating illness in women.

Subjects scheduled to be covered include:

- Estrogens, Anti-Estrogens & Breast Cancer Risk
- New Hormone Therapies
- New Contraceptive Choices
- Incontinence
- Menstrual Migraines & Other Headaches
- Genetics of Reproductive Cancer: Who & How to Screen
- New Pharmacologic Approaches to the Management of Obesity

Dates	Program	Director(s)
Wednesday - Sunday February 2-6	CME @ Whistler	Richard Tobin, MD
Friday, February, 11	Advances in Women's Medicine	John Lenihan, Jr., MD
Thursday-Friday March 9 & 10	Internal Medicine Review 2000	Robert Corliss,MD
Monday - Friday April 10-14	CME @ Hawaii	Mark Craddock, MD
Saturday, April 29	Surgery Update 2000	Virginia Stowell, MD
Friday, May 5	Asthma, Allergy & Pulmonology for Primary Care	Alex Mihali, MD
Friday, June 2	Nuts, Bolts & Innovation: Gastrointestinal Disease V	Gary Taubman, MD Richard Tobin, MD

Legislative health clinic needs volunteers

Physicians are needed to staff the WSMA Legislative Health Clinic during this legislative session. The clinic is open weekdays 8:30 a.m. to 12:30 p.m. This year's session is scheduled until March 8. Being a legislative physician for a day provides a perfect opportunity to get to know your legislators.

There is a full-time clinic nurse for your assistance. You may take your family and visit the legislature in session as you will be given a beeper. Parking is provided. **All physicians are invited to participate.**

For more information, contact Susan Peterson at the WSMA Olympia office, 800-562-4546 or email skp@wsma.org.■

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The Pulse

PCMS Alliance

Alliance to vote on Dissolution

Pierce County Medical Society Alliance held a Board Meeting on January 18 to discuss concerns about the future of the Alliance. Members attending were **Yolanda Bruce, Fran Thomas, Mona Baghdadi, Alice Yeh,** and **Nikki Crowley**. Doug Jackman, Executive Director of PCMS and **Kris White**, Washington State Medical Society Alliance President were also present.

Considerable discussion was held as to options for the continuation of the organization. With a decrease of 40 members for this year, and with only one response after a *Bulletin* article asking for input, it is apparent that some decision was needed.

Positive projects like the Holiday Card, with its community outreach are important. As there is no manpower to do projects, the same people are rotating the same jobs and there is burnout occurring.

Doug Jackman stated that PCMS would like to have the philanthropic efforts continue and that should PCMSA disband he would approach the PCMS Board of Trustees to seek solutions.

Options discussed ranged from calling members to find out why they belong to PCMSA, going inactive and just doing the card fundraiser, to disbanding the organization. Questions were asked as to the difference between inactive status and disbanding. To remain a 501(c)(3) organization, PCMSA would be required to have a board of five officers and hold an annual meeting at the minimum. Disbanding the organization would require relinquishing 501(c)(3) charitable organization status and, after paying outstanding bills, the remaining funds would be given to other 501(c)(3) agencies.

After considerable discussion a motion was made to recommend to the general membership that PCMSA disband. The motion was seconded and carried. A General Membership Meeting will be held March 14 at the Society office at 11 a.m. to vote on the recommendation.

Old Business: Fran Thomas as Philanthropy Chair was authorized to allocate and disperse the funds from the Holiday Card as prioritized by the Board.

New Business: There is a snow-shoe trip date reserved for April 9, 2000 at Mt. Rainier (Paradise). For any interested people, over 10 years of age and without heart problems, the walk is 1 and 1/2 miles and $2.00 for shoe rental. Contact Alice Yeh, 756-0578, for further details or reservations for noon group. ■

Alice Yeh, wife of Hsushi Yeh, MD, staffed the Alliance booth at the 'Stop the Violence' fair at the Puyallup mall in October

Seated from left, Yolanda Bruce, Mona Baghdadi, Sonya Hawkins, Fran Thomas and Kris White visit at Welcomer's Coffee in September. Ginnie Miller is standing in the background

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MD License Renewal and CME Requirements change

With the year 2000, came a change in the license renewal and continuing medical education (CME) reporting requirements for MDs. (DO license renewal and CME reporting requirements remain unchanged). **The reporting cycles have changed from 150 hours every three years to 200 hours every four years.**

As of January 1, 2000, MDs whose birth year is an even number will renew their license for two years rather than one year. For those MDs with an odd number birth year, the license renewal period is for one year in 2000, then for two years beginning in 2001. The renewal fee for the two year licensure is $400 plus $50 for the substance abuse monitoring surcharge, which is the same rate as was charged for one year renewals.

Reporting cycles for CME have also changed. Physicians who will renew their license for two years in 2000 will not be required to report CME until their renewal in 2004. At this time they will be required to report 200 hours. Physicians renewing their license for one year in 2000 will only report CME if due. If not due, they will not be required to report 200 hours until 2005.

Physician Assistant (PA) requirements have also changed. Their reporting requirements will now be 100 hours every two years. Prior to 2000, PA requirements were 50 hours annually.

License renewal and reporting requirements for DOs remain unchanged at one year for renewal and 150 hours of CME every three years for CME.

For a copy of the Rule Making Order and Washington Administrative Codes (WAC) please contact PCMS, 572-3667 and they will be faxed to you.

If you have questions on the transition, you may contact Susan Anthony, Washington State Department of Health, 360-236-4787 or Mavis Pless at 360-236-4786 or PCMS. ■

L&I

from page 11

The proper treatment of injured workers in Pierce County and the State demands this. The following actions would be a start to bring this about:

➔ Claims managers decisions need greater medical input. Claims personnel without medical training are making decisions that affect the treatment of injured workers. There needs to be more authority placed on nurse consultants. Denied requests for a medical procedure or a consultation need a swift and easy appeals process.

➔ An appeals procedure involving medical directors should be instituted if there is a disagreement between a nurse consultant's recommendation and an attending physician.

➔ An ongoing review of independent medical examinations needs to be instituted. There are far too many IMEs performed and the quality needs improvement. Criteria for ordering IMEs need to be developed. A review of the quality of exams, the quality of examiners, the quality of the panel companies, and the charges of the panel companies needs to be instituted. Giving the nurse consultant authority to authorize IMEs would be cost effective by reducing the number of unnecessary IMEs.

➔ There needs to be a clarification of the communication lines between physician's offices and the department. Who do you call for what? The claims manager? The provider line? The bill payer? Periodic educational meetings between claims managers and office personnel could be helpful. Timely responses from claims managers are still a problem.

➔ There needs to be better coordination between self-insurers and the department. Especially on occupational diseases there is great confusion as to the responsible employer and where the physician needs to communicate. This could be helpful by having a common Physician Initial Report form for both the department and self-insured.

➔ There needs to be continued review of the timelines of payments for services. Payments for the original medical evaluation needed to file a claim are usually delayed until the claim is closed – often for months to years. Changes in policy result in retroactive retraction of payments. Disagreements between employer responsibility delay payments for services.

Thank you for your attention to our concerns. The task force does not desire an adversarial relationship with the department. The department members on our task force have been extremely helpful in explaining policies and procedures and why things are done the way they are. The task force desires that a collaborative effort can be made on behalf of injured workers for a better working relationship between the department and providers of service. ■

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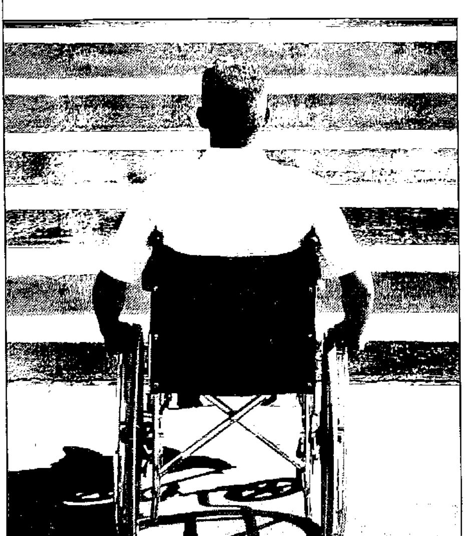

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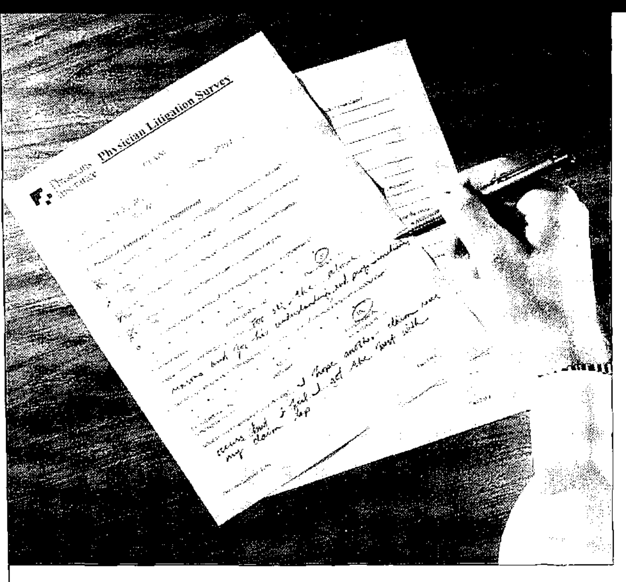

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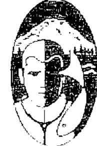

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BULLETIN

March, 2000

PCMS members, from left, Drs. David Law, Nick Hamill, Len Alenick, Lisa Hamill, Charles Weatherby and David Sparling in front of the State Capitol on Legislative Day

See highlights on page 7

INSIDE:

3 PCMS retired members advise colleagues about retirement issues
7 PCMS members participate in Legislative Day and meet with their elected officials
8 James M. Wilson, Jr., MD appointed to Pierce County Board of Health
10 Pierce County Hospital CEOs will speak at May General Membership Meeting
11 Professional Charges Fee Policy recommended by Medical/Legal Advisory Committee
15 In My Opinion: "Goodbye Regence" - local surgeon ends relationship with insurer
23 Whistler CME program pictures -- education and vacation for participants

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The Bulletin is published monthly by PCMS Membership Benefits, Inc. for members of the Pierce County Medical Society. Deadlines for submitting articles and placing advertisements in The Bulletin are the 15th of the month preceding publication (i.e. October 15 for the November issue).

The Bulletin is dedicated to the art, science and delivery of medicine and the betterment of the health and medical welfare of the community. The opinions herein are those of the individual contributors and do not necessarily reflect the official position of the Medical Society. Acceptance of advertising in no way constitutes professional approval or endorsement of products or services advertised. The Bulletin and Pierce County Medical Society reserve the right to reject any advertising.

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Pierce County Medical Society
BULLETIN

March 2000

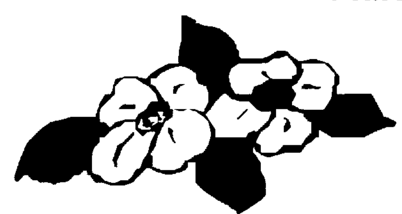


Table of Contents

3 "Retirement and What to Expect"

6 Absentee Ballot Application
Legislative Health Clinic seeks volunteers

7 Legislative Summit provides opportunities to be heard

8 James M. Wilson, Jr., MD appointed to Board of Health
Fact Witness v. Expert Witness: reimbursement issues

9 TPCHD: Tuberculosis Reporting

10 May General Membership Meeting

11 Professional charges fee policy template

12 WSMA organizes Medicare Fraud Work Group

13 The Invisible Hand: "Value for Equal Value"

14 Go shopping on "Support*My*Association.com"

15 In My Opinion: "Hey Nurse," by Nichol Iverson, MD

16 State MAA office searching for chief medical consultant

17 In My Opinion: "Goodby Regence," by Chris Jordan, MD

18 COME: Whistler program educational and fun

19 COME: Calendar and program activities

20 WSMA Physician Leadership Conference set for May

21 PCMSA Philanthropic Update

23 Classified Advertising

February General Membership Meeting Recap

by Jean Borst

"Retirement and What to Expect"

It's a likely assumption that most in attendance at the February 8 General Membership meeting could relate in some way to the evening's program topic. Regardless of age or years practicing medicine, everyone thinks about retirement - at least the process of getting there. The group was fortunate to hear from four of their own, a panel of retired PCMS members who shared their insights, personal experiences, and concerns about retirement.

Drs. Jim Early, Ken Graham and **David Sparling** retired in 1997, while **Dr. Bob Ferguson** retired in 1994. Each has been very involved in the PCMS, all are active in their communities, and all still maintain connections to the medical profession. And, it appears, they all are enjoying retirement.

Do they have all the answers for those among the membership considering retirement, either now or down the road? Of course not. But their candid and relatively informal discussion provided some interesting fodder for their audience.

Should I? When and How?

There are three big questions to consider when thinking of retirement: "Should I retire?"; "When should I retire?"; and "How should I do it?" No simple task to answer any one of the queries, much less all three.

"One day I knew," offered Dr. Early. "For 35 years, I was passionate about medicine. But I started to enjoy it less. It was taking time away from the things I liked doing. If you have other things you want to do, and you can afford to do them, that's a pretty good indication that it might be a good time to retire. And consider this - the average age at death for a man is 83 and for a woman it is 85. That helps put things into perspective."

Dr. Ferguson's road to retirement was fairly interesting. "I began talking to a medical management consultant in the late '70s, but I didn't heed his advice," he said. "Skydivers jump out of perfectly good airplanes. In 1985, I jumped out of a perfectly good practice." Dr. Ferguson turned his practice over to another physician and became medical director of United Pacific insurance company. When the company was sold in 1990, he found himself out of a job. He returned to practice at Community Health Care, doing locum tenens and also as ship physician on a few cruises. "It was quite an odyssey," he recalls. Official retirement came in 1994.

Dr. Graham started "thinking" about retirement at about age 65. He notes that having younger partners in his practice made the process of phasing out possible. "Talk with a financial consultant about retirement planning and work ahead," he suggested.

"I don't know if there is a right time," Dr. Sparling added, "but I suggest you prepare yourself for when the time does come."

Each panelist offered the Internet as a valuable resource regarding retirement issues.

Some options to consider.....

So, now you've made the decision to retire from practice. Is there any reason to keep your license? Dr. Graham encourages it. "It keeps you connected to the medical community - gets you to the meetings and in touch with other physicians. If you have hopes of doing any volunteer work in medicine, you are either required to have a license or you must carry your own liability insurance at an exorbitant fee." One of the first things Dr. Graham wanted to do when he retired was to

See "Retirement" page 4

Retirement preparation tips from AOL's Money.com

1. The rules for retirement success are changing. Retirees are living longer, staying more active and likely to spend 30 years or more in retirement. The standard of living you'll maintain during your Golden Years will depend in large part on how well you take advantage of tax-deferred savings options like 401(k) plans and IRAs and how skillfully you invest your money.

2. Set a savings goal. The only way to know whether you're on track toward a comfortable retirement is to project your retirement expenses, and then calculate how much you must save to accumulate a retirement nest egg large enough to supplement Social Security and other sources of income. Retirement planning software and web calculators can help crunch numbers.

3. Think stocks for long-term growth. Over long periods, stocks have the best track record for boosting the size of your retirement nest egg. Even more important, stocks are more likely to keep your retirement savings growing faster than inflation, increasing the future purchasing power of the money you sock away today.

4. There's no single "correct" mix of stocks and bonds. How you decide to divvy up your retirement portfolio between stocks and bonds will depend for the most part on your tolerance for risk and how long you have until you plan to retire. A reasonable starting point for investors whose retirement is 20 or more years away is 70% stocks and 30% bonds. If you feel comfortable shooting for higher gains despite the risk of short-term losses you can increase your stock holding a bit, or ratchet them back a bit if you're uncomfortable with the prospect of volatile stock prices.

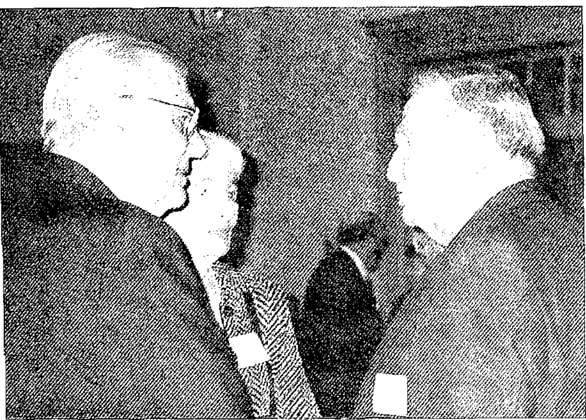
5. Avoid the urge to move too heavily to bonds once you retire. In search of steady income, many retirees stash most of their entire portfolio in bonds. Unfortunately, over the course of 10 to 15 years, inflation can easily erode the purchasing power of bonds' interest payments by a third or more. Even investors in the '70s and '80s should probably keep 20% or more of their holdings in equities.

See "Tips" page 5

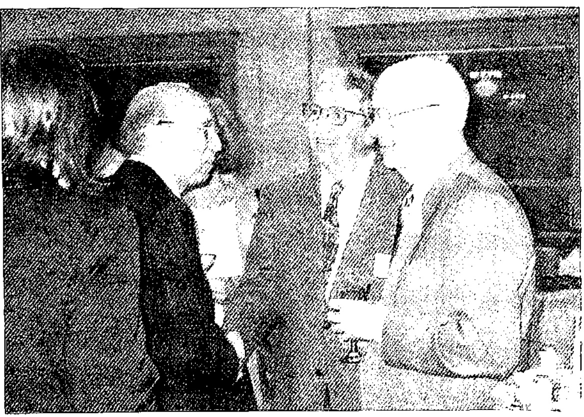
Retirement

volunteer at the WSMA clinic. He couldn't without liability insurance.

While none of the panelists chose this option, many physicians like to consider part-time practice after retirement. "For me," Dr. Early notes, "I was so happy once I made the decision to retire, that I became as passionate about retirement as I had been about my practice. Part time was not an option for me."



Left, Dr. Stevens Dimant and his wife, Sheila, visit with speaker and retired internist, Dr. Jim Early



From left, Dr. Mian Anwar and Dr. Thomas Bageant visit with speaker, Dr. Bob Ferguson

Dr. Sparling offered locum tenens as a good opportunity to consider in retirement. "This is a great option," he noted. "I have several friends who have done this. It's an excellent opportunity for those who want to continue in medicine in some way. One concern, he cautioned, is all the rapid change in medicine.

How to fill the time...Keeping active and keeping involved

"The minute you retire," said Dr. Sparling, "people think you have all the time in the world to volunteer."

For Dr. Early, once the word was out that he was retiring, the requests for his time began pouring in. "There are so many worthy things to do, but that doesn't necessarily mean that you are the one to do them all! Remember, when you retire, you finally have the chance to do what you really enjoy."

Financially speaking.......

"You have to realize that you're not going to be as financially well off as when you were in practice." Dr. Early noted.

In addition to early retirement planning, each physician agreed that there are major financial concerns that go with retirement. "The cost of health insurance is a major consideration," said Dr. Sparling. "Individual plans are out of sight, and many individual policies have been eliminated. This is a major topic of discussion in Olympia right now. I hope the situation will improve, soon."

The issue of insurance was much discussed among the panelists. "All insurance companies want to sell insurance," Dr. Ferguson continued, "but they must adhere to certain principles - the law requires insurance carriers to be solvent. Individual health insurance is a problem because there aren't enough individuals to spread the risk, and many of them are older."

"Look into the options," Dr. Graham urged. "There are companies out there offering long-term health insurance. You need to be prepared. We've all heard the horror stories, and many of us have friends who have had to deal with catastrophic illness." Dr. Graham recalled a close friend whose wife had Alzheimer's Disease. Her condition deteriorated to the point that she ended up in Western State Hospital. The catastrophe completely drained the couple's retirement.

Retirement and Changes in Lifestyle......

I've found that my greatest achievement in retirement is getting to the point where I don't worry about my patients." said Dr. Early. "But I do miss them. When I get lonely, my wife tells me to go to our local Safeway store. I'm sure to run into several former patients," he said.

"My patients have been very considerate about my retirement," Dr. Sparling added. "And by leaving a group practice, I had the satisfaction of knowing my patients were in the hands of my other partners."

"One of the most important lifestyle changes you experience is that you no longer have to feel hurried every minute of the day worrying about patients, telephone calls, etc.," Dr. Sparling noted. "You have the time for friends and for doing the things you really love." Last summer, he spent two weeks helping build a house for Habitat for Humanity. "There is no lack of interesting and different things to do." Dr. Sparling hasn't had much of a chance to consider boredom in retirement. In addition to retiring, he married, built a new house and experienced major cancer surgery - all over a period of just three years.

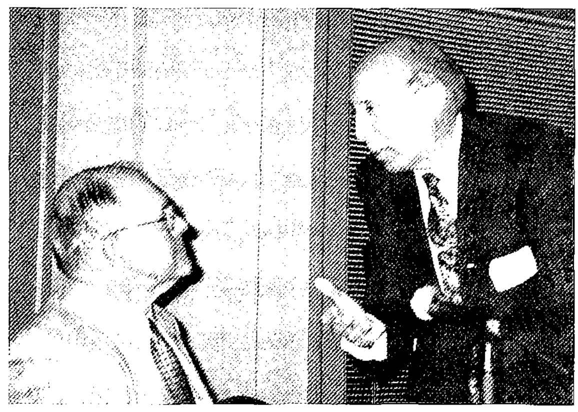
See "Retirement" page 5

Retirement

"I suppose the experts would think all that would cause too much stress."

Many retirees find they finally have the time to fulfill their travel dreams. The Sparlings are planning future Elderhostel trips and will be visiting France in April. For Dr. Early, on the other hand, travel is not a priority. Both he and his wife traveled extensively when they were in the Air Force. With the exception of a wonderful trip to Ireland (a surprise retirement gift from his wife), the Earlys simply want to stay put. "Except for those few weeks in the winter when you can reach up and touch the clouds, we think the Pacific Northwest is the greatest place to be," he said.

Dr. Sumner Schoenike, right, greets Dr.David Sparling; he now sees many of Dr. Sparling's former patients



Dr. Mian Anwar, right, retired anesthesiologist, asks speaker, Dr. Ken Graham a question after the presentation

Some Good Advice..

Overall, the following pretty much collectively summarizes the panelists' conclusions about retirement:

- Consult with a financial advisor. Early retirement planning is essential
- Stay connected to the medical community
- Get involved with old and new friendships, your church or synagogue, and the community at large
- Explore all your opportunities (The Internet is a great resource)
- Spend your time doing what you truly love
- And enjoy it! "It's a nice feeling to wake up in the morning and the big decision to make is where to go hiking," Dr. Early said. "Happiness is a journey, not a destination," Dr. Sparling offered. "It's important to remember that your satisfaction depends more on desires and interests than on acquisitions." ■

"Tips"

6. Contribute the max to your 401K. One of the surest ways of boosting the value of your retirement savings is stashing as much as you can in a 401(k) account. You get an immediate tax deduction of as much as $10,000, the possibility of a matching contribution from your employer (typically half of what you contribute to a maximum of 3% of your salary, although some firms are more generous), and tax deferred growth on your savings. There are few no-brainers in life, but this is one of them.

7. Check out IRAs. After a 401(k), an IRA is typically your next best choice for retirement savings. Choosing among the three basic flavors - a traditional deductible, a nondeductible and a Roth IRA - may require a bit of thought, and possibly some serious number crunching. But any effort you put into deciding among these plans today will pay off in a more comfortable retirement down the road.

8. Make tax-efficient withdrawals from your nest egg. The less you have to pay in taxes on the money you pull out of your retirement savings, the longer your money will last. Pulling money from taxable accounts first as much as possible and letting tax-advantage accounts continue to compound can stretch the life of your nest egg by several years.

9. Consider working in retirement. More than 80% of baby boomers polled by the AARP last year said they plan to work full or part-time after they retire because they find work stimulates them and keeps them socially engaged. Working even occasionally during retirement can benefit you in two other ways: it reduces the amount you have to save before you retire, and income from a job lowers the amount you must withdraw from your retirement savings, which reduces the chances that you'll run out of money before you run out of time.

10. Look for creative ways to stretch your retirement assets. You may not be able to save more in retirement, but you can probably get more mileage out of whatever you've managed to accumulate. One possibility: Relocate to an area with lower living expenses. Such a move can easily save you 20% or more. Another option is to transform the equity in your home into monthly income by taking out a reverse mortgage. The money you receive from a reverse mortgage isn't taxable because its considered proceeds from a loan, and you don't have to repay the loan as long as you continue to live in the house. ■

ABSENTEE BALLOT APPLICATION

If you have requested an absentee ballot or have a permanent request for an absentee ballot on file, please do not submit another application.

To be filled out by applicant. Please print in ink.

Registered Name: ______________________

Street Address: ______________________

City: ______________ ZIP Code: __________

Telephone: (Day) ______________ (Eve.) __________

For identification purposes only (optional): Voter registration number if known ________

Birth Date ________ Have you recently registered to vote? Yes ☐ No ☐

I hereby declare that I am a registered voter.

Date __________

Signature ______________________

To be valid, your signature must be included

Send my ballot to the following address (if different from above):

Mailing Address: ______________________

City: ______________ State: __________

ZIP Code: ______________ Country: __________

Mail this absentee ballot request form to your county auditor or election department. See previous page for your county's mailing address.

This application is for:

Presidential Primary only
February 29, 2000 ☐

Permanent Request
All future Elections ☐

For office use only

Precinct Code ________

Levy Code ________

Ballot Code ________

Ballot Mailed ________

To vote absentee, in the privacy of your own home, complete the form above and mail to: Pierce County Auditor, 2401 South 35th Street, Room 200, Tacoma, WA 98409.

Washington Medical Political Action Committee

1800 Cooper Point Road SW
Bldg 7, Suite A
Olympia, WA 98502
800-562-4546 (360) 352-4848

Legislative health clinic needs physician volunteers

Physicians are needed to staff the WSMA Legislative Health Clinic during this legislative session. The clinic is open weekdays 8:30 a.m. to 12:30 p.m. This year's session is scheduled until March 8. Being a legislative physician for a day provides a perfect opportunity to get to know your legislators.

There is a full-time clinic nurse for your assistance. You may take your family and visit the legislature in session as you will be given a beeper. Parking is provided. **All physicians are invited to participate.**

For more information, contact Susan Peterson at the WSMA Olympia office, 800-562-4546 or email skp@wsma.org.

Legislative Summit provides opportunities to be heard

Approximately 160 WSMA members marched to Olympia to hear and talk about the priority issues for the 2000 legislative session prior to meeting with their individual legislators. Priority legislation developed through the House of Delegates and the Interspecialty Council includes:

1) Access to care

2) Strong support for the "Patient Bill of Rights," Senate Bill 6199 and House Bill 2331.

3) Opposition to increasing the scopes of practice of other healthcare providers. WSMA will actively oppose allowing optometrists to determine their own scope of practice through a "as taught" legislation. They're also seeking to increase prescriptive authority and seeking to use the term physician as well as allowing optometrists to perform surgery.

WSMA will again oppose legislation allowing naturopaths to call themselves physicians and grant them prescriptive authority. And WSMA will oppose efforts by pharmacists to assert themselves in the physician/patient relationship

4) Preservation of funds from tobacco settlement agreement for tobacco prevention and control programs. During the 1999 session, the Washington State Legislature dedicated $100 million of the tobacco settlement proceeds to fund prevention and cessation activities by the state. Although the money has been allocated for these purposes, the legislature did not formally appropriate the money. Due to severe cutbacks as a result of I-695, some are fearful that the monies may go to repair "potholes."

Attendees at the meeting spent the afternoon visiting with their personal legislators on the above issues, attending the House Health Care Committee or touring the capitol campus.

The following PCMS members attended the WSMA February 25 Legislative Summit in Olymia. They are:

Leonard Alenick
Federico Cruz-Uribe
Nick Hamill
Lisa Hamill
Sidney Kase
Lawrence A. Larson
David Law
Joe Mancuso
Nick Rajacich
Don Russell
Cecil Snodgrass
Dave Sparling
Patrice Stevenson
George Tanbara
Charles Weatherby

LEFT: Drs. Lawrence A. Larson, Len Alenick, Seattle Internist, John Vassel, Charles Weatherby and George Tanbara

RIGHT: Dr. Nick Rajacich (center) and Len Alenick talk with Rep. Roger Bush, (R-2) left

LEFT: Dr. Joe Mancuso greets former WSMA President, Dr. Mark Adams

RIGHT: Drs. Nick Rajacich, Len Alenick, Charles Weatherby, David Sparling, David Law and Nick and Lisa Hamill tour the grounds

James M. Wilson, Jr., MD appointed to Board of Health

Dr. James M. Wilson, Tacoma Internist, has replaced **Dr. David Sparling,** who retired January 1, on the Pierce County Board of Health. He was appointed to the three year term by the PCMS Board of Trustees, who was asked to select a representative from the medical community.

James M. Wilson, MD

The Board is comprised of two representatives from the Tacoma City Council, three from the Pierce County Council, one from the Pierce County Cities and Towns, and one is at-large, typically from the medical community.

The commitment is a significant one. The board meets once a month, and often deals with major issues, such as HIV reporting, Pierce County landfill issues, tobacco regulations, etc. **Dr. Federico Cruz-Uribe**, Health Director for the Tacoma-Pierce County Health Department answers to the board for the operations of the Department.

Dr. Wilson is well prepared for the job. He has been very active in the medical community, particularly PCMS. He served as president in 1998 and president-elect in 1997, he has chaired the Grievance Committee and the Aging Committee, he was Vice President in 1996, Secretary-Treasurer in 1995 and served as a Trustee in 1992-1993.

As PCMS President he testified for numerous health issues, including before the Board of Health on the AIDS reporting issue.■

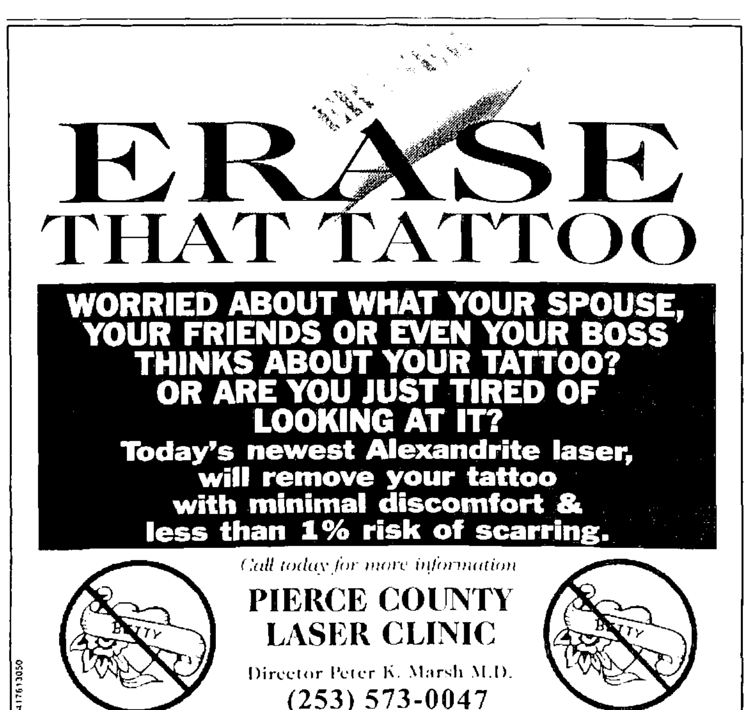
Fact Witness v. Expert Witness

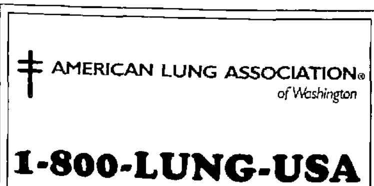
One of the most common areas of dispute between attorneys and physicians is reimbursement for providing testimony. Very often physicians are reimbursed the smallest amount or nothing at all.

The attorneys sitting on the Medical-Legal Liaison Committee have crafted forms to petition the court as an intervener to get expert witness fees established for the subpoenaed physician's testimony.

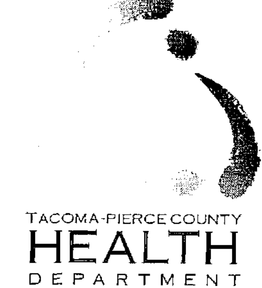
The Committee members agreed that once a couple of these orders have been entered in favor of the physician establishing a fee and a body of orders are available to future physicians to rely upon to address this, you are probably going to face a much easier time in Superior Court getting this issue resolved. It may take retaining an attorney the first couple times, but all agreed that in the long run it will be worth it.

Please call the Medical Society office, 572-3667 for a copy of the Motion, Affidavit and Order.■





The Health Status of Pierce County



At their January 5, 2000 meeting, the Tacoma-Pierce County Board of Health **adopted a resolution to require physicians, clinics and other health care facilities to report to the Tacoma-Pierce County Health Department positive skin tests for tuberculosis. This regulation takes effect March 1, 2000. The regulation also requires pharmacists to report to the Health Department when they dispense any anti-tuberculosis medications.**

Why the change? The purpose of the regulation is to identify individuals at risk for and assure prevention of active tuberculosis. By reporting the names of people who are being screened and treated for latent TB infection, active TB can be prevented in many patients. In addition, the Health Department's tuberculosis control program will be able to learn the extent of latent tuberculosis infection in the community to gather a complete picture of populations at risk in order to improve screening and prevention efforts.

Tuberculosis causes more deaths worldwide than any other infectious disease. Approximately one third of the global population is infected each year, causing eight million to develop active TB and three million to die.

Tuberculosis has re-emerged in the United States in recent years, probably because of several contributing factors:

- The HIV/AIDS epidemic, with the resulting decreases in immune function, leaves people who are HIV positive more susceptible to latent infection and increasingly at a risk for active infection.
- There are increased numbers of immigrants to the United States from countries where TB is very common; many of the immigrants are also economically disadvantaged, live in crowded conditions, and have limited access to medical care.
- Increased poverty, injection drug use, and homelessness may also lead to more cases of active TB as progression to active disease is more likely if one's overall health is poor or the immune system is weakened by alcoholism or drug use.
- People with latent TB who are homeless or abuse drugs may not adhere to treatment regimen. Not only do these individuals run the risk of active disease, they may develop a drug resistant strain of TB and infect others.

In 1997, there were 43 active TB cases in Pierce County. Of this number, 65% were foreign born and 39% were age 65 or older. **In 1998, 36 people in Pierce County had active TB,** of whom 39% were foreign born and 22 were over age 65.

Pierce County patients with suspected or confirmed active tuberculosis are referred to Northwest Medical Specialties (formerly called Infections Limited) if they do not have a primary care provider or insurance. The Health Department subsidizes care at Northwest Medical Specialties for all patients with active tuberculosis who cannot pay or do not have third party coverage. In addition, Health Department staff work in partnership with Northwest Medical Specialties staff and physicians by providing nurse case management and directly observe therapy for persons with active TB. The directly observed therapy component of care involves delivering the medications to the patient and observing the patient swallow the medication to insure adherence to the medical protocol.

In the state of Washington, medical providers are required to report over 60 communicable diseases to local health departments. There, nurse epidemiologists and communicable disease control staff investigate the reports to assure that the index patient receives the needed treatment and follow up and that contacts are screened and treated, thus breaking the chain of transmission.

Reporting positive TB skin tests to the Tacoma-Pierce County Health Department will contribute to increasing community wide prevention. The information gained will also offer a more complete picture of populations at risk and how they are being managed in the medical care system.

Staff in the Tuberculosis Control Program at the Tacoma-Pierce County Health Department are available to assist private doctors and other clinicians with questions about whom to screen and how to most effectively offer prevention therapy. Reports of positive TB skin tests can be made to our 24 hour Disease Reporting Line at 798-6534. The preferred method of reporting, however, is to use a fax form especially developed for this purpose, which you can obtain by calling the Medical Society office, 572-3667.

For more information about screening for tuberculosis and NIH prevention therapy, please contact the Network Nurse who visits your office, or call 798-7671.■

Pierce County Medical Society

announces the

May General Membership Meeting

Tuesday, May 9, 2000
Social Hour: 6:00 pm
Dinner: 6:45 pm
Program: 7:45 pm

Landmark Convention Center
Temple Theatre, Roof Garden
47 St. Helens Avenue
Tacoma

Pierce County Hospital CEOs view the future of health care

featuring:

- George Brown, MD; VP Acute Care, MultiCare
- Mark Gregson, CEO; Puget Sound Hospital
- Ed Miller, CEO; Good Samaritan Hospital
- Joseph Wilczek, President & CEO, Franciscan Health System

-MARK YOUR CALENDAR-
Watch your mail for registration information

Fee policy recommended by Medical/Legal Committee

The PCMS Medical/Legal Advisory Committee recommends that all physicians prepare a professional charges fee schedule. This will help tremendously in making arrangements for work performed for other professionals, particularly attorneys.

Below is a sample template that can be used in your office. PCMS will prepare your document for you if you fill in the blanks below and submit it for formatting.

The Medical/Legal Committee finds the number one complaint they receive is regarding misunderstandings of fees. It is very helpful to inform professionals what the fee will be prior to the transaction.

Please call PCMS, 572-3667 if you would like assistance preparing your fee schedule.

Professional Charges Fee Schedule

NAME: ____________________ **PHONE:** ________________
SPECIALTY: __________________ **FAX:** __________________
ADDRESS: ____________________ **TAX ID#:** _____________

* ◗ Review of Patient's Records	$___.00 Per Hour
* ◗ Special Reports/Letters	$___.00 Per Hour
* ◗ Attorney Conference Time (telephone or in person)	$___.00 Per Hour
* ◗ Deposition	$___.00 First Hour and
(Please inform if videotape deposition and number of people attending so adequate space can be secured)	$___.00 Second Hour and thereafter
◗ Office Setup Time for deposition	$___.00 Per Hour
◗ Court or Arbitration Testimony	$___.00 Per Hour
◗ Courtroom Waiting Time	$___.00 Per Hour
◗ Travel Time	$___.00 Per Hour
◗ Copying of Physician's Records	$ __ .00 Clerical Fee
	$.__ First 30 pages
	$.__ thereafter
** ◗ Charts greater than six months old may be in storage and will add a retrieval fee of:	$___.00

(In accordance with Washington State tax law, medical record copies are considered goods and are subject to local sales tax)

NOTE: Fees may be higher depending on complexity of case.

<u>LATE CANCELLATION POLICY - 48 HOUR NOTICE REQUIRED</u>

Cancellation of less than 48 hours will be billed at:

◗ Conference	$___.00
◗ Deposition	$___.00 Each Hour Scheduled
◗ Court or Arbitration Testimony	$___.00

Please understand that Dr. __________ carries a full schedule of patients daily, ____ to ____ weeks in advance. Rescheduling appointments within _____ weeks for the above may be difficult or impossible to accommodate. If you have questions or concerns, please call the office at the above phone number.

* Billed at 1 hour minimum, then billed in 15 minute increments
** Billed at 4 hour minimum, then billed in 15 minute increments

Medicare Fraud group organizing

Dr. Len Alenick, Lakewood Ophthalmologist, has agreed to participate in WSMA's new Fraud Work Group.

The primary goal of this work group will be to create a forum for physicians and representatives of HCFA and the Medicare carrier to examine concerns related to alleged and substantiated fraud and abuse behaviors. "We hope to develop an overview of what they are calling fraud, and how they are defining it in what could be ordinary misunderstanding of billings," explained Dr. Alenick. "There are always gray areas and little differences that need to be understood," he added.

Dr. Alenick sits on the WSMA Board of Trustees and is an AMA Delegate for WSMA.

If you would like to be involved in this work group, please call Bob Perna at WSMA, 1-800-552-0612.

WSMA Seeking Council/ Committee Members

The Washington State Medical Association is asking for suggestions for members to its councils and committees. If you have an interest or questions regarding any of the following, please call the Medical Society office at 572-3667.

Openings exist on the following Committees:

- Bylaws Committee
- Emergency Medical Services Standards Committee
- Finance Committee
- Industrial Insurance and Rehabilitation Committee
- Judicial Council
- Medical Education Committee
- Medical Practice Committee
- Medicare Liaison Committee
- Membership Promotion/Retention & Services/Benefits Committee
- Organized Medical Staff Section Governing Council
- PACE Issues Advisory Groups
- PACE Program Steering Committee
- Private Health Plan Liaison Committee
- State Health Plan Liaison Committee
- Women in Medicine Committee

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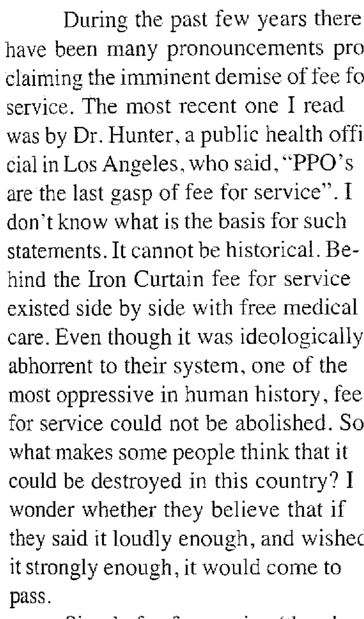
The Invisible Hand...

by Andrew Statson, MD

"Value for Equal Value"

Andrew Statson, MD

"There is nothing nameable but that some men will, or undertake to, do it for pay."
Herman Melville (1891)



During the past few years there have been many pronouncements proclaiming the imminent demise of fee for service. The most recent one I read was by Dr. Hunter, a public health official in Los Angeles, who said, "PPO's are the last gasp of fee for service". I don't know what is the basis for such statements. It cannot be historical. Behind the Iron Curtain fee for service existed side by side with free medical care. Even though it was ideologically abhorrent to their system, one of the most oppressive in human history, fee for service could not be abolished. So what makes some people think that it could be destroyed in this country? I wonder whether they believe that if they said it loudly enough, and wished it strongly enough, it would come to pass.

Simple fee for service (the physician treats, the patient pays, no third party) is not subject to abuse. It is the only true system of fee for service. It has been with us for many centuries. It appeared with the birth of Economic Man, and will not die until all humans vanish from the universe. It is at least as old as the world's oldest profession. As long as someone is willing and able to pay for a service, someone else will be willing and able to provide it. Some services have been declared illegal by rulers and proclaimed immoral by priests, but legal or not, out in the open or in hiding, fee for service has always existed. Its demise is only wishful thinking.

Health insurance is a 20th century development. It probably started in some high risk industries with company sponsored plans of workmen's compensation for accidents and injuries on the job. Prior to that, particularly in England, mutual help associations of foresters and miners took care of their members who got hurt on the job. The churches in Europe and America acted as extended families, helping the sick.

The first big jump in health insurance enrollment occurred during the Great Depression. The second came during and after WWII. The system we have today is the logical result of those early beginnings.

The move away from community and industry based mutual help associations was brought about by the socialist spirit of the 20th century. It was based on the belief that the government can and will solve all our problems. The Great Depression frightened and scarred the generation that lived through it. The requests for help overwhelmed the resources of the private relief organizations. Pressure built up for the government to step in. That worked well for a while. Money flowed into the health care system, hospitals expanded, the development of new medical technology exploded, there was no limit to what we could and did do. We have now reached the point where the government resources have been overwhelmed. The money spigot is drying up. Who is going to step in now to bail out the government? The taxpayers? The patients? The physicians? It looks like it will be all of the above.

Insurance is attractive because it spreads the risk of catastrophic losses horizontally, over a large number of people. Actuaries can project reasonably well the expected loss per number of people insured. At the cost of a relatively small surcharge for overhead we can budget our expenses and protect ourselves from big losses.

The problem with health insurance is that the overhead costs have grown excessively. In other lines of insurance, such as fire or casualty, the overhead is probably of the order of 5%, if that much. The most efficient medical plans now spend 15% of premiums on overhead. The average for the industry is probably 25%. Add to that the budgets of the federal and state agencies that administer and subcontract the health care programs, the cost to the tax collecting agencies to get the money from the taxpayers and the cost to the employers and other taxpayers to prepare their returns. Then, there is the cost to employers and individuals in signing up for health insurance. The large companies have whole departments in their personnel offices that handle the health insurance problems of their employees. Finally, there is the processing cost to physicians, hospitals

See "Value" page 22

Personal Problems of Physicians

Medical problems, drugs, alcohol, retirement, emotional, or other such difficulties?

Your colleagues want to help

*Robert Sands, MD, Chair	752-6056
Bill Dean, MD	272-4013
Tom Herron, MD	853-3888
Bill Roes, MD	884-9221
F. Dennis Waldron, MD	265-2584

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PCMS members may now enjoy the benefits of shopping online with over 200 of the world-wide-web's top merchants, all consolidated into one, easy to use shopping portal. Through a recent affiliation with Support*My*Association.com, PCMS will benefit by receiving a royalty from every purchase made from the numerous merchants.

It is a win-win. SupportMyAssociation.com (SMA) members will receive various promotions and specials. Shopping is easy and prices are competitive. Best Price Guarantee and

With ONLY 24 hours in the day, WHEN do YOU SHOP?

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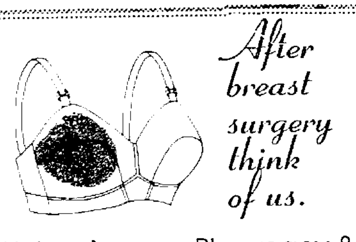
To get started, go to the PCMS homepage, www.pcmswa.org and click on the active "SupportMyAssociation.com" logo. Click on Association Members and find Pierce County Medical Society - Membership Benefits, Inc. Log in your email address and you are on your way. ■



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Karen Perz, MS, PT, MultiCare Vestibular and Balance Clinic

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Differentiating between central and peripheral nervous system disease, toxicities and various metabolic disorders can be very complex. The attendee will acquire an understanding of the available diagnostic and treatment plans appropriate to the patients they frequently encounter.

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In My Opinion....

by Nichol Iverson, MD

Nichol Iverson, MD

"Hey Nurse"

"Hey, Nurse! Can you please help me?" "Yo, dude, you be so old you stink. Wutcha makin me git up fo; there ain't nobody gonna be here 'til the sun comes up anyway. Shuddup and goadda sleep." Not in my wildest dreams did I expect to spend my eightieth birthday sucked into the hospital as a vacuum cleaner robot victim, and have to put up with inhumane treatment by some high school dropout at three in the morning.

When was the last time you wondered why nurses were so difficult to find? We are in the midst of the nurse reduction conspiracy. Our central government is secretly herding nurses away from a vocation that has had more than its share of heroines and heroes. In the absence of nurses, how much will Medicare cost??? Nothing! The introduction of DRG's (Drastic Reductions in Geriatrics) has produced a tinkle down effect in hospitals across America. Nursing shortages have begun to take hospital care to new frontiers of mediocrity, a portent of worse things to come. Baby boomers and their progeny, the baby bangers, will take part in the largest experiment of elderly cleansing in about the year 2025, just in time for my fetoblast transplant.

The nurse shortage is symptomatic of the overall decrease in the valuation of medical care. As technology has increased the ability to diagnosis and treat illnesses, we have experienced the great HMO experiment, and the drastic drop in reimbursement from the federal government. At the same time, the person on the street has

Where have all the nurses gone,
long time passing...?
Florence Nightingale

come to expect medical care to be a right, and has increased the demands and expectations of the ability of us to produce miracles and cures. One does not need to be a rocket scientist to figure that increased costs of nursing, technology, the aging of the population, expectations of the public and bureaucratic oversight have all combined to create a more costly medical system. Cuts in insurance, decreased Medicare reimbursement and increased overhead are the opposing forces that will make us choose good medical care, or a Canadian conundrum of waiting lists, rationing of care and lousy facilities. The Canadians were boasting that their system, with only one insurance company, the government, would hold down costs, and provide a viable system for everybody. Unfortunately, the money was not made available to produce a good product of quality medicine. Canadians have not yet suffered enough to change.

As we experiment with different forms of healthcare and reimbursement, one aspect of our system is being overlooked. Nurses. Nursing schools have fewer graduates. Nurses are leaving their time honored profession.

> *One does not need to be a rocket scientist to figure that increased costs of nursing, technology, the aging of the population, expectations of the public and bureaucratic oversight have all combined to create a more costly medical system*

Without a strike, without a word, nurses are creating a scary prospect for our medical care of the future. I am not aware of any virtual nurses that will hold our hands, change our nasty stinky dressings or notice that we just don't look right. This task will need to be done by decent human beings, dedicated to the sole purpose of helping sick people through their suffering, while nursing them back to health. If we do not recognize that changes in our policies have destroyed the infrastructure of our medical care, we are doomed to die by ourselves surrounded by machines. ■

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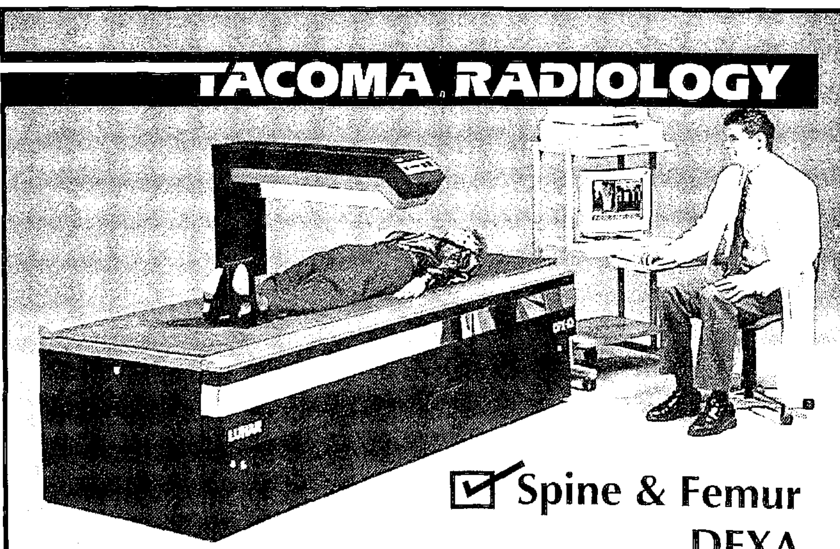
State MAA office searching for chief medical consultant

The State of Washington is searching for a Chief Medical Consultant for the Department of Social and Health Services, (DSHS), Medical Assistance Administration, (MAA), Disability Determination Services.

Requirements for the position include a medical license to practice in the U.S., six years of clinical experience, one year of administrative experience in a health care program, board certification in a primary care specialty, and advanced writing skills are desired.

The Director will manage the state-wide Medical Policy Program to assure compliance with Social Security Administration's regulations and policies. Administrative oversight of 67 part-time Medical Consultants is included. The position pay range is $95,000 - $104,030, with office headquarters in Tumwater.

For a copy of the job announcement call PCMS at 572-3667.■



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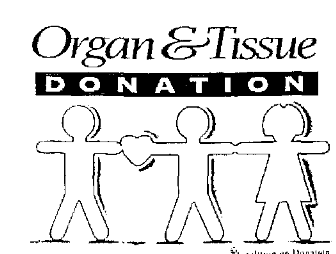

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In My Opinion....

by Chris Jordan, MD

"Physician leaving Regence A Letter to Patients"

Chris Jordan, MD

Editor's Note: The following letter was submitted by Dr. Chris Jordan. Dr. Jordan is a general surgeon who practices in Tacoma. He is sending this letter to his patients to inform them that he will no longer be accepting Regence patients

Dear Valued Patient:

My records show that you may be insured by Regence Blue Shield. I want to notify you of a change in my relationship with Regence. Effective April 15, 2000, I have cancelled my contract with Regence.

This has not been an easy decision. Over 150 surgeons in the Seattle-Tacoma area have also cancelled their contracts. Regence will not engage in a meaningful negotiation on their new contract. Surgeons have been working longer and harder for less compensation. It has finally reached a point where Regence reimbursement rates are unacceptable.

I would like to continue to provide surgical services for you outside of the Regence network. There are various ways to do this and my office would be happy to discuss this with you.

If your employer offers a choice of other health insurances, you may wish to choose a different plan. I am contracted with Premera, First Choice, Cigna, One Health Plan and Sound Health.

If you would like to let Regence know that they need to come to a fair agreement with surgeons, you can call Regence Customer Service at 1-800-328-7273. Your feedback is very important.

Sincerely, Chris Jordan, MD

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Whistler CME program - education AND vacation

The CME at Whistler course, the College of Medical Education's winter resort program, was very successful this year, providing excellent medical education, great skiing and even good weather.

Pierce County physicians that attended the program, held at the British Columbia ski resort, were joined by other physicians from around the country. The program not only is known for excellent CME opportunities, but also for family vacationing.

The program featured a potpourri of educational subjects of value to all specialties. Conference attendees particularly enjoy the opportunity to have in-depth discussions about clinical situations.

When not in the classroom, participants and their families enjoyed great skiing, resort activities and lots of sun and snow.

The program was directed by **Rick Tobin, MD** and will be offered again next year at the Whistler resort area.

Whistler CME leader and speaker, Rick Tobin, addresses the audience

Team faculty (left to right) Drs. Bill Martin, Frank Senecal, Diane Tsia and Mark Yuhasz delivered a multi-disciplinary approach to breast cancer

Dr. Michael R. Jackson (left) confers with Dr. Alex Mihali outside the Rendezvous lodge on Blackcomb Mountain

Dr. Mark Craddock, and wife Jinny, enjoy the sun after a great day of skiing

Left, Dr. Phil Craven answers a question about infectious diseases posed by a participant

COLLEGE OF MEDICAL EDUCATION

Hawaii CME registration remains open

Space is still available to join your colleagues and their families for spring vacation in beautiful Maui, during the College's "resort" conference April 10-14, 2000.

Reservations can be made on a space available basis by calling (800) 882-6060. You must identify yourself as part of the College of Medical Education group.

To help with airline reservations to Maui, the College is working with Marilyn at Olympus Travel (253)565-1213. For additional information or a program brochure, call the College at (253) 627-7137.

Allergy, Asthma & Pulmonology CME - May 5

The College's CME program featuring subjects on allergy, asthma & pulmonology is set for Friday, May 5 at St. Joseph Medical Center. The course is under the medical direction of **Alex Mihali, MD.**

A brochure with details regarding the conference is scheduled to be mailed in late March.

Continuing Medical Education

Internal Medicine Review 2000 scheduled for March 9 and 10

The Tacoma Academy of Internal Medicine's annual two day CME program is open for registration. The program offers a variety of timely internal medicine topics and has been organized by **Robert Corliss, MD.**

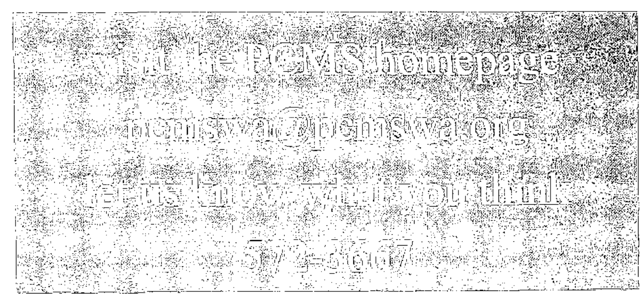
The program offers 12 Category I CME credits and is available to both Academy members and all other area physicians. The program will be held at the Washington State History Museum in Tacoma.

To register or for more information please call the College at 627-7137.

This year's program includes presentations on the following topics:

- Intractable Pain in the Community Setting
- Update in the Diagnosis & Treatment of Osteoporosis
- Management of Type II Diabetes
- What's New in Alzheimer's Disease
- Primary Care Management of Parkinson's Disease
- Psychiatric Issues in the Management of the Geriatric Patient
- Antimicrobial Update in the Treatment of Respiratory Infections
- Thromboembolism in Medical Patients
- Where are we with Lipids in the New Millennium?
- Dietary Management of Vascular Target Organ Disease
- Cardio-Renal Connection: Micro Albuminuria as a Predictor of Cardiovascular Disease
- Progress in Hepatitis C Treatments

Dates	Program	Director(s)
Thursday-Friday March 9 & 10	Internal Medicine Review 2000	Robert Corliss,MD
Monday - Friday April 10-14	CME @ Hawaii	Mark Craddock, MD
Saturday, April 29	Surgery Update 2000	Virginia Stowell, MD
Friday, May 5	Asthma, Allergy & Pulmonology for Primary Care	Alex Mihali, MD
Friday, June 2	Nuts, Bolts & Innovation: Gastrointestinal Disease V	Gary Taubman, MD Richard Tobin, MD



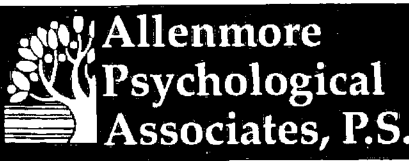
WSMA Physician Leadership Conference set for May 12-13

The WSMA Leadership Conference has been scheduled for May 12-13 in Chelan. Physicians who are delegates, officers of county medical societies, state specialty societies, hospital medical staffs, group practices and other organizations should plan to attend. The conference will be held at Campbell's Resort.

The program will include plenary sessions addressing trends affecting the current and future environment of medicine as well as break-out sessions on interview techniques, speech writing, interpreting financial statements, and much more.

The program is offered with no registration fee and will be accredited for Category I CME credits.

A conference brochure and registration information will be mailed in February. For more information, contact John Arveson, at the WSMA Seattle office, 800-552-0612, email: jva@wsma.org.



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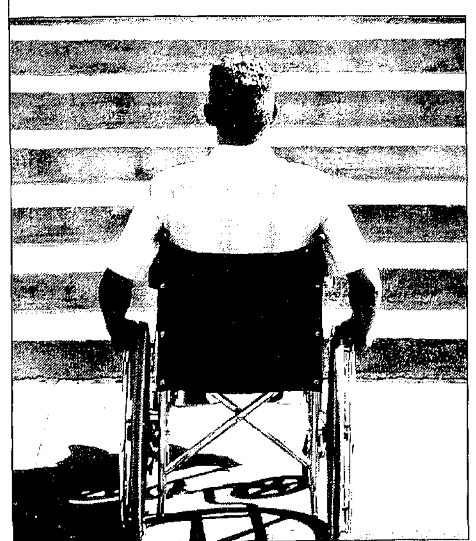

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The Pulse

PCMS Alliance

PCMS Alliance Philanthropic Update

On January 31, **Alice Yeh, Yolanda Bruce** and **Fran Thomas** met to plan the distribution of the Holiday Sharing Card proceeds. After the expenses were subtracted from the net money collected, there was $12,900 to distribute.

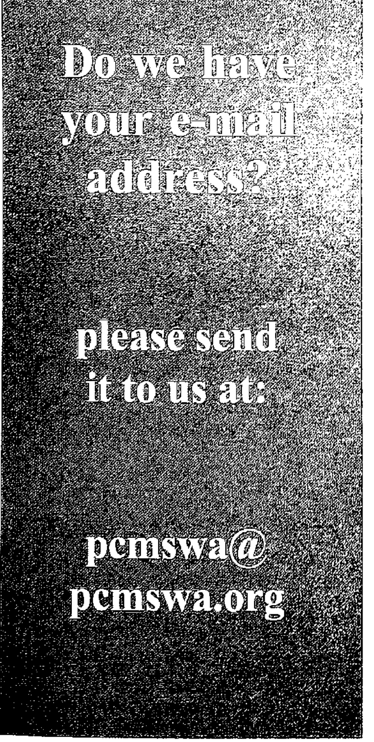
The PCMS Alliance Baby Think It Over program continues. Four of the latest model dolls were ordered for Dorothy Hudson's Family Life classes at Wilson High school in Tacoma. Also ordered is GAMBLE - the new learning module dealing with using drugs or alcohol during pregnancy. The module includes a drug-affected baby and a FAS manikin plus a seven day curriculum and supplies for activities - a great learning tool.

PCMSA thanks you again for your generous support.

Fran Thomas
Philanthropic Chair

The money will be distributed to the following organizations in the amount indicated:

$4,000	YWCA Women's Health Program
$3,800	Trinity Neighborhood Clinic
$1,500	PLU Wellness Center
$ 500	American Lung Association Asthma Camperships
$ 500	P.C. AIDS Foundation Basic Needs Program
$2,538	Baby Think It Over



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Value from page 13

and others in filing claims and waiting for payment. The total of these overhead costs of our insurance system probably exceeds 50% of all expenditures on health care.

The medical savings accounts are a halfhearted attempt to spread the risk vertically, over time, rather than horizontally. They have not been successful so far. One reason is the inflated cost structure due to the large insurance overhead. Our contracts require us to bill the insurance companies no more than what we could charge cash-paying patients. So the patients with medical savings accounts cannot get a discount for cash payment, even though our services to them do not have the same record-keeping, billing and collection overhead. For example, some colleagues, who see only cash paying patients, have been able to cut their charges by half.

The medical savings accounts, by their nature, would be best for young people, who will have time to build a large reserve while they are healthy. They are lifelong contracts. Only very farsighted individuals can see the benefit of such a program when they are young and healthy. Perhaps an even bigger hindrance is our income tax code. We are nowhere near solving that problem.

As the quality of health care under the current system continues to deteriorate, the people who are willing to pay for them will search for better medical services. Many people pay their taxes to the school districts, but send their children to private schools and dig into their pockets to pay the tuition. They are disappointed by the performance of our public schools and are willing to pay whatever it takes so their children can get a better education. There will be people who pay for medical insurance through their employer, but when they want care, they will look for something better than what their insurance company will allow them to have. The trade of value for equal value, as expressed by the simple fee for service system, will need to find new ways to express itself, unencumbered by the crushing administration burden of our current system.

Simple fee for service is the only system under which the patients have a right to medical care. There is only one thing that allows a service, any service, to be yours by right, the cash in your pocket. You have earned it through your own effort and you can exchange it for the best value that the effort of others can give you. When someone else pays for your care, it is no longer yours by right, but yours by permission. You have to beg for it. That permission can and will be denied, if those who grant it think that they can get away with it. Remember, he who pays the piper calls the tune. ■

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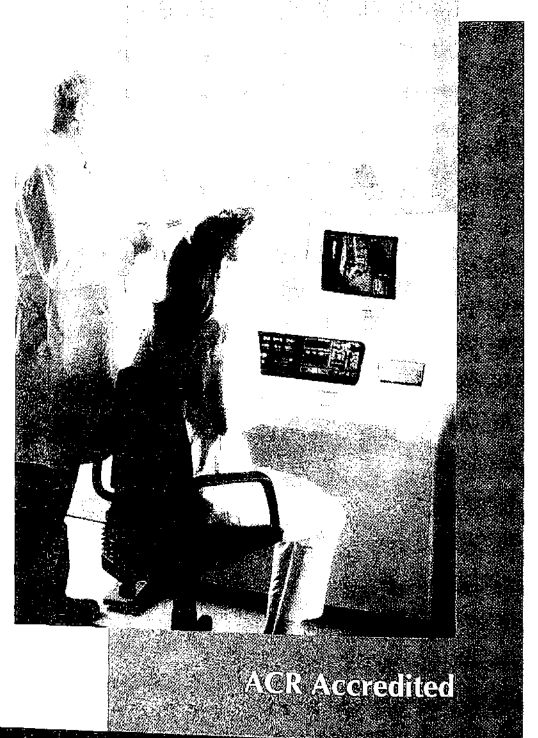

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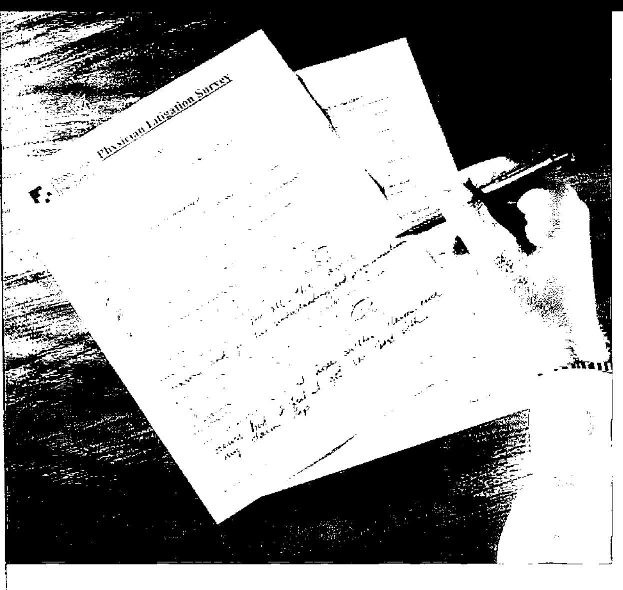

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BULLETIN

April, 2000

INSIDE:

3 President's Page: "Health Care Access"
4 Cascade Regional Blood Services provides area blood supply
5 "If you have a Real Problem, Go to a Real Doctor," by Thomas Bageant, MD
6 Retired Members will experience "African Adventures" at April luncheon
7 The Invisible Hand: "Handwriting and Hand Wringing," by Andrew Statson, MD
9 "What doesTax have to do with Asset Allocation?" by David Roskoph, MBA, CFP
13 Regence leaders meet with Board of Trustees to discuss many issues

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The Bulletin is published monthly by PCMS Membership Benefits, Inc. for members of the Pierce County Medical Society. Deadlines for submitting articles and placing advertisements in The Bulletin are the 15th of the month preceding publication (i.e. October 15 for the November issue).

The Bulletin is dedicated to the art, science and delivery of medicine and the betterment of the health and medical welfare of the community. The opinions herein are those of the individual contributors and do not necessarily reflect the official position of the Medical Society. Acceptance of advertising in no way constitutes professional approval or endorsement of products or services advertised. The Bulletin and Pierce County Medical Society reserve the right to reject any advertising.

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Pierce County Medical Society
BULLETIN

April 2000

Table of Contents

3 President's Page: "Health Care Access"

4 Cascade Regional Blood Bank provides area blood supply

5 "If You Have a Real Problem....." by Thomas Bageant, MD

6 "African Adventures," April Retired Physician Luncheon

7 The Invisible Hand: "Handwriting and Hand Wringing"

8 "Nostalgia of WW II," by John Stutterheim, MD

9 Tax and Asset Allocation, by David Roskoph, MBA, CFP

11 TPCHD: Prevention priorities determine department direction

13 Regence leaders meet with PCMS Board of Trustees
Patrice Stevenson, MD chairs WSMA Women's Committee

15 COME: Surgical Update, Allergy, and GI courses upcoming

16 Doctors' notes on patients' charts

17 The Pulse: PCMS Alliance thanked for charitable gifts

19 Classified Advertising

President's Page

by Charles Weatherby, M.D.

Health Care Access

Charles Weatherby, MD
PCMS President

It is estimated that there are almost 44 million uninsured Americans. Approximately 700,000 of the residents of Washington State are uninsured. In 35 of 39 counties, it is virtually impossible to obtain health insurance for individuals. This will probably decrease access for more people. Legislation is currently being debated to "encourage" insurers to provide coverage to individuals. It appears that Governor Locke is prepared to sign such legislation into law.

Health care access remains at the top of the WSMA's priority list. What are we doing as practicing physicians to improve the access of our citizens? We are fortunate in Pierce County to have a system of community clinics as well as a nationally renowned Family Practice Residency Program. However, these programs can only do so much. We must continue to dialogue among ourselves and other organizations to do more.

Are changes needed in our current system? One recent national survey of the public, employers, physicians, and health plans discovered that 83% of practicing physicians believe that fundamental changes are needed or that the system needs to be completely overhauled. This compares to 51% in 1984 and 67% in 1997.

This same survey found differences in the perception of the aforementioned groups regarding certain aspects of health care. For instance, managed care was supposed to save cost and improve the quality of care. While a large majority of the health plans and employers believe that managed care has improved the quality of care and has contained costs, the large majority of physicians and the public do not. The American public and physicians are now thinking similarly with regards to the needs of our health care system. Somehow, we are going to have to get the employers and health plans to think more clearly like "the rest of us."

However, we can't just sit around and wait for someone else to "fix the system" for us. The American public is becoming quite angry and impatient. They've grown tired of the rhetoric of our legislators, our Congressmen, and even our state and national medical organizations. The public is resorting to the initiative process for more and more of their issues. We recently experienced how public sentiment enacted Initiative 695 despite its long range negative impact on some important programs. An initiative drive is now in place to establish a single payor system. It is very important that we become actively involved with this process - individually and collectively. Just like I-695 limited license fees to $30, we can't afford to let others put limitations on our abilities to practice medicine. The single payor system may be or not be the best alternative, but physicians need to be involved in the decision making.■

Cascade Regional Blood Services provides area blood supply for doctors and hospitals

Since 1946, when it was founded by a group of Pierce County physicians and local labor leaders, Cascade Regional Blood Services (formerly known as the Tacoma-Pierce County Blood Bank) has been providing a safe and constant supply of blood and blood products for thousands of area patients.

"We are proud of our record of service and look forward to working with local doctors and hospitals for many years to come," said Charles H. Drummond, executive vice-president of the blood bank.

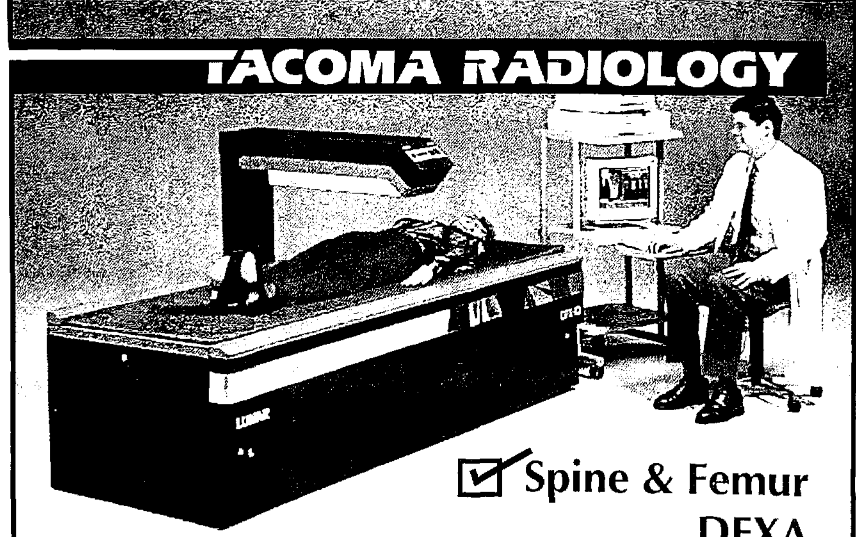
"And, because we've always been responsive to our local doctors and their patient needs for blood supplies, local surgeons have not had to cancel surgeries or inconvenience patients," Drummond continued. "In fact, because of our close proximity to area hospitals and because of our collection efforts throughout the county, we are proud that we can supply the blood products and services when and where they are needed."

Cascade Regional Blood Services has been in the news lately as contract negotiations continue with local hospitals. The blood bank is requesting an increase for a unit of blood, up to $79. This is the first increase they've requested in more than five years and puts the blood bank at the low end of the national scale for the cost of a unit of blood.

"We are doing everything we can to cut costs and increase our blood drawing capacity," Drummond said. "That's why we are in the middle of a fund-raising campaign to add another mobile unit to our fleet of on-site collection vehicles and services. We expect to finish raising more than $150,000 for that five-bed bloodmobile within the next few months."

"We are a financially mature and stable organization, but we are also realistic in knowing that as we move ahead into the future we must be cost-competitive in providing quality, local service for area doctors and hospitals," Drummond said. "Our biggest strength is also our biggest weakness. Because it seems we've done our job so effortlessly, most people don't even know we are here."

"But we are here...and we intend to stay," Drummond said. "And if our local doctors and more than 19,000 current volunteers and thousands of area businesses continue to support our efforts as they have in the past, we'll continue providing the blood and services needed by patients who now rely on us for the gift of life."■



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In My Opinion....

by Thomas Bageant, MD

"If You Have a Real Problem, Go to a Real Doctor"

Thomas Bageant, MD

The innovative approach, quality, efficiency, and availability of American Medicine is in decline. Several groups must change their expectations, demands, intrusions, and approaches if this decline is to be reversed. Over the last one hundred years in the United States, conventional medical care has extended the average life span of our citizens by approximately thirty years. No other paramedical discipline, like chiropractics, massage therapy, acupuncture, naturopathy, aroma therapy, nutritional supplements, music therapy, or herbal therapy can make such claims. Our medical system should provide efficient, quality, medical care that meets the individual needs of each patient. All medical approaches should be put to blinded studies and statistical analysis prior to acceptance by patients or mandated coverage by medical insurance.

Patients must understand that medical care is expensive and, as medical advances are made, that cost will increase at rates that are higher than the increase in cost of living. Patients must take more responsibility for their care costs and the health care policies that are purchased for them. Patients should expect available, efficient, quality, conventional medical care. They should demand that their third party payers cover their needs as deemed necessary by their physicians. Patients' insurance premiums should cover only the needs of the individual being covered. Examples: Only fertile women need obstetric coverage; childless people do not need pediatric coverage, etc. Patients should not expect their insurance companies, HMOs, Medicare, or welfare to pay for any paramedical modality that has not been subjected to blinded studies or statistical analysis.

Third party payers should put forth plans that meet patient specific needs. These plans should be concise and easily understood; clearly stating what is and isn't covered. Administrative "speed bumps" that delay, divert, inhibit, or deny proper care should be abolished. Examples: Mandatory "gate keepers" delay care and cause a conflict of interest for physicians; mandated "second opinions" delay care and do not save money.

Health care workers and medical facilities should be paid quickly for services provided. Denied claims should be subject to rapid, efficient, arbitration policies. Physician contracts that restrict access to specialists withhold compensation when specialists are used, restrict physicians from discussing options with patients, or deny care based only on cost should be abolished. All third parties should be held liable when their policies have delayed or denied proper health care. Administrative costs must be lowered. Too little of the health care premium actually goes toward the payment of health care services. Huge bonuses, given to administrators who have collected funds and found ways not to pay for services, should go toward lower patient premiums.

Government should define "medical care." They should not yield to special interest paramedical groups that demand funding for modalities that remain unproved. Medical care should include conventional care, from obstetrics to psychiatric care. It should also include eye care, dental care, extended care, and medications. It should not cover those modalities mentioned before as paramedical groups.

Government should limit the liability of drug companies that have properly tested, reported, and won FDA approval for their products. Sole rights to drug company products should be limited, such that developmental expenses, testing expenses, and a reasonable profit can be made.

Tort reform that limits punitive damages, restricts layers' compensation, holds third parties liable, and shortens statutes of limitation will decrease the costs of medical care. The contingency system for lawyers compensation should not be allowed for malpractice claims.

Government should not mandate that insurance plans cover anything but conventional medical care. Nor should these plans be forced to fully cover recently found preexisting conditions like pregnancy or recently diagnosed cancers.

Government should provide tax incentives for health care premiums, health care expenses, and extended care expenses.

State Insurance Commissioners should be held accountable when their policies force companies to stop writing health care policies, or when afford-

See "Problem" page 12

Pierce County Medical Society

invites you and your spouse/guest to the

Retired Physician Luncheon

C. I. SHENANIGANS	Friday, April 7, 2000
3017 Ruston Way, Tacoma	12:00 (noon)

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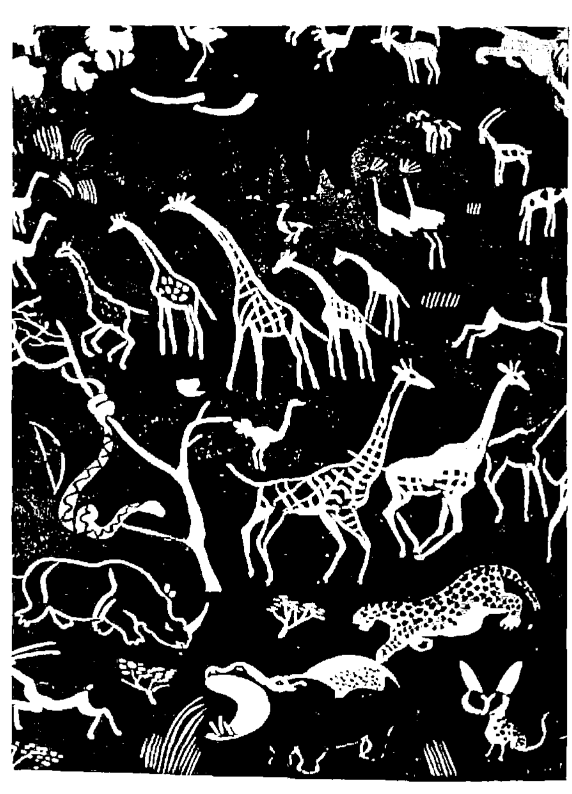
featuring:

JOE WEARN, MD

and

PAT WEARN, RN



(Please clip and mail in the enclosed envelope to PCMS or call 572-3667, no later than Monday, April 3rd)

YES, I (we) have reserved Friday, April 7th to join retired members, (including spouses, guests, and widows) of the Medical Society for lunch. Name (please print) ______________________________

Please reserve _____ lunch(es) for me at $16.00 per person (includes tax and tip). My check is attached.

I will be bringing my spouse or a guest. Name for name tag: ______________________________

Thank you!

The Invisible Hand...

by Andrew Statson, MD

"Handwriting and Hand Wringing"

Andrew Statson, MD

"The greatest blunders, like the thickest ropes, are often compounded of a multitude of strands. Take the rope apart, separate it into the small threads that compose it, and you can break them one by one. You think, 'That is all there was!' But twist them all together and you have something tremendous."
Victor Hugo (1862)

At a medical meeting a few years ago, the moderator was reading questions from the audience addressed to the panel. He looked at one of the slips of paper and said, "I can't read this handwriting. Is there a pharmacist in the house?" Physicians are notorious for their bad handwriting. The pharmacists are famous for their ability to read it. Our handwriting today is not worse than it has always been. Why, then, the recent noise about it?

Reading is a form of pattern recognition. Recognition requires cognition. Without knowledge of the patterns and what they may mean, one cannot hope to recognize them. To read a Greek text, you have to know the Greek alphabet. You also have to know the Greek language. I suspect the main reason for the concern now has to do with prescriptions and the possibility of medication errors. During the last few years this risk has increased. Several new developments have contributed to this change.

Patients used to get their prescriptions filled at their local drugstore. The pharmacist there knew the local doctors and their prescribing patterns, as well as the patients and their medication history and needs. With this knowledge, it was easy to interpret a prescription and, if there was a question, it was easy to call the doctor and verify it. Now many prescriptions are filled by mail order, by people who don't know the patients at all, and who, perhaps, are not even pharmacists, but are pharmacy technicians, with little knowledge of the medications and the proper way to take them.

Illegible handwriting is not a problem and never has been. If the handwriting is not legible, it does not convey any information, right or wrong, and cannot be acted upon. The problem is the misinterpretation of legible handwriting. There are several safeguards to prevent mistakes of this type, and they have lost some of their effectiveness in recent years.

The most important safeguard, probably, are the patients themselves. They usually know what medications they are taking, how to take them, what works for them, what has caused untoward reactions in the past. The problem they have in recognizing their medications is the generic substitution. They start on one type of pills, change to another, then to another. They are told the pills are the same, but look different because they are from another manufacturer. They cannot know for sure that they are taking what they took before. The name of the medication on the label also is different, usually difficult to pronounce and even more difficult to remember.

The pharmacists are another safeguard. If the prescription is difficult to read and could be confused, if the instructions don't make sense, the best thing to do is to call the doctor and verify. We can get huffy sometimes when our orders are questioned ("Why, any idiot, including myself, can read this prescription!"), but we need to remember that we are human. We make mistakes and the pharmacists are the people best placed to detect them and to help us correct them. I have seen some very legible prescriptions, filled on military bases by pharmacy technicians, who did not know enough about the medications to pick up a mistake by the prescribing doctor.

Another safeguard are the physicians themselves. I have caught myself writing a prescription for an antibiotic and putting down one every three hours as needed, when I intended that instruction for the prescription for codeine, which I was going to write next. The problem here is not illegible handwriting. It is the problem of being rushed or distracted by something else that leads us to make mistakes.

What makes our job and that of the

See "Writing" page 18

In My Opinion.....

by John K. Stutterheim, MD

"Nostalgia of WW II"

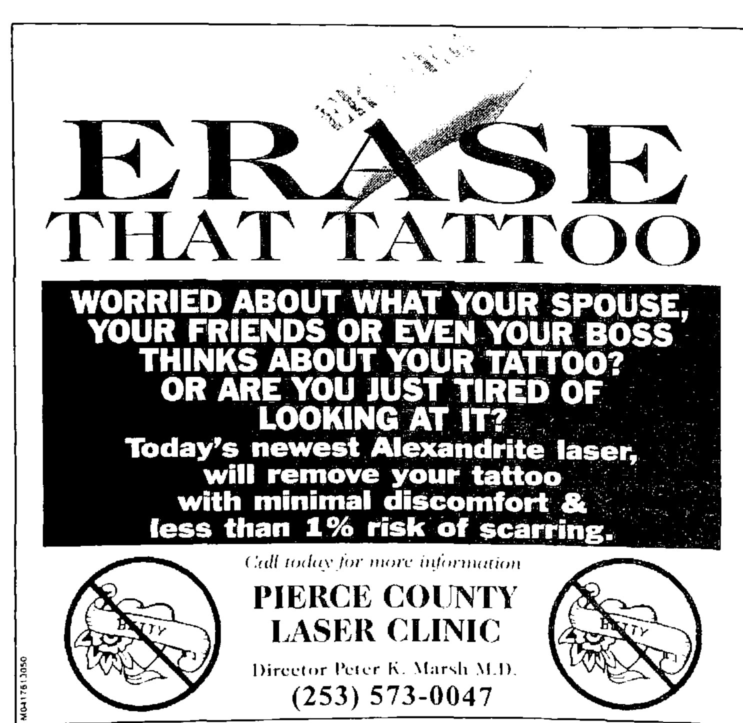
John Stutterheim, MD

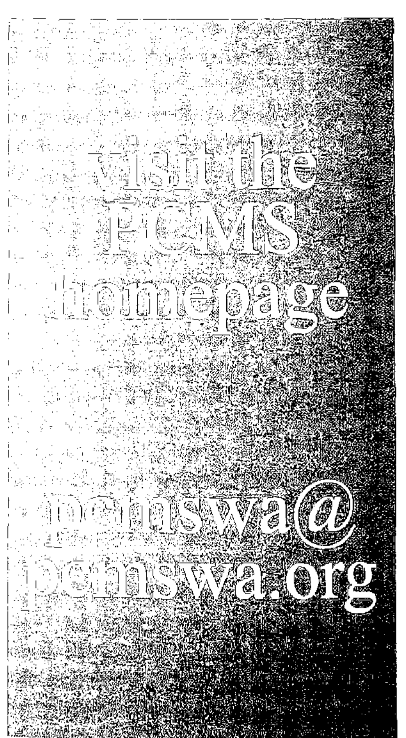
During January 1942 we were living in Malang, Java. My Father worked under Governor Van Der Plas in Surabaja, the naval harbor. Dad became in charge of finances, when Van Der Plas fled for Australia. Mother decided in February '42 to join Dad and we stayed with my aunt Loes in Embong Kenongo. At the time Surabaja was bombed daily by Japanese planes. At a height not reachable for our anti-aircraft, they usually showed off about seventeen silvery birds. They dropped their bombs at will. The harbor Tandjung Perak was a major target for these Japanese bombers. One U.S. WWI forestacker was hit and placed in drydock in Surabaja, in 1942 - it was ineffectively destroyed at the time of surrender and raised and restored by the Japanese. After Japan surrendered the U.S. navy brought her to the west coast and sank her while target practicing. Another U.S. war ship, a submarine, lowered herself to the bottom of the harbor when under attack.

During 1960, when I was working as an intern in the E.R. of Tacoma General Hospital, I was confronted by Dr. Hoskins who recognized my Dutch accent. He had been aboard that submarine at that particular time. We were silent for a brief moment of time, recalling both our memories of that period, finally to discuss the circumstances evidenced by emotions. Adjacent to us, the patient I was examining while he was lying on his back, suddenly said, "Tell me more, what a story - I would not have missed this for the world." That pulled me back to the present reality and we apologized to the man, who waved his hand as a signal that this was quite all right.

My grandson of fourteen read this story and snickered. He asked, "Opa, is this story going to be in your book?"▪

Dr. Stutterheim is a retired family physician





In My Opinion....

by David Roskoph, MBA, CFP

What Does Tax Have to do with Asset Allocation?

What do you think of when you hear the phrase Asset Allocation? You probably think about the relative percentages of Large Growth vs. Small Value or Domestic vs. International or possibly equities vs. debt (stock vs. bonds). Few independent investors appreciate the virtue of creating a tax allocation of their assets. Since the 1997 Tax Reform Act, the disparity between capital gains and ordinary income tax is potentially double or net 20%. If your income tax bracket is 39%, so too are your short-term capital gains. However, assets held for more than one year qualify for long-term capital gains and are unrelated to your income tax bracket. Long-term capital gains are presently 20%*. For example, if you are furiously day trading stocks you might well consider a realistic profit potential in light of the tax bite**. Assuming you are in the 39% bracket and you make $10,000 of short-term profits; that's equivalent to $6,100 of after-tax gains. If, however, you let the $10,000 profit ride through one year you could net $8,000 of after-tax gains! To exemplify the disparity between the two stated tax rates, you would have to make $13,115 profit at the highest short-term rate of 39% just to break even with the $10,000 profit from long-term capital gains rate of 20%. The moral of the story: ***The higher your marginal rate, the more careful your short-term investment decisions.***

Your assets are your assets; even if they are scattered over 8 or 10 separate accounts. Your appetite for risk does not have to be replicated in each separate account as long as the composite picture and timelines make sense. Take a minute to consider the investment allocation versus the tax

David Roskoph, MBA, CFP

ramifications in each of your investment accounts. Each separate account probably has several investment allocation options. For instance, your 401K or other qualified plan is likely to offer you several investment alternatives. As well, your variable annuity and variable life insurance plans probably offer similar alternatives. On the non-qualified side, virtually every investment is

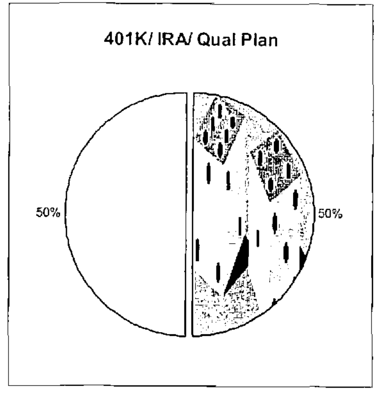
See "Tax" page 10

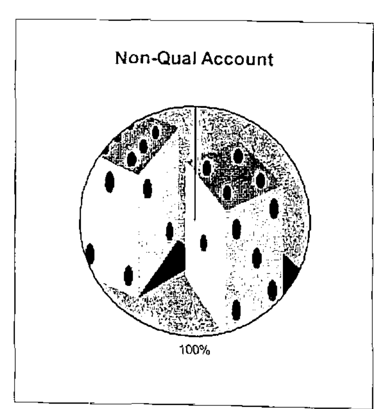
Original Asset Allocation

Variable Annuity/Life

50%

50%





☐ Investments intended for long-term hold   Investments subject to short-term trading

See page 10 for Tax-Smart Asset Allocation graph

Tax

from page 9

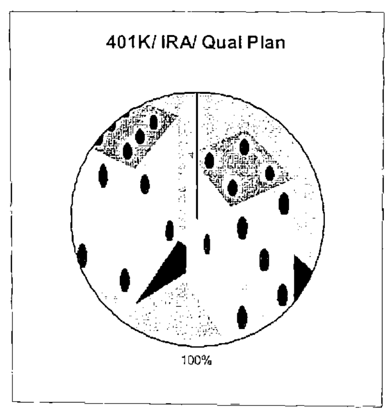
available. Let's look at the big picture of a hypothetical investor who has 1/3 invested in index funds, which he intends to let compound until he draws them down in retirement. Our investor likes to play the market with the remaining 2/3 taking advantage of opportunities regardless of their tax consequences. This investor might consider some tax-smart allocation by placing as much of his trading portfolio into his qualified plan and or variable insurance products as possible. There the tax consequences of short or long-term transactions are irrelevant; the funds come out to him as ordinary income when withdrawn. For that portion of his investments more or less committed to a long-term horizon (in this case index funds), he should consider shifting them out of his qualified vehicles. By separating the assets into those likely-to-be-traded-within-one-year and those not-likely-to-be-traded-within-one-year, the investor maximizes his after-tax gain by minimizing short-term gains (ordinary income) without compromising his desired asset allocation.

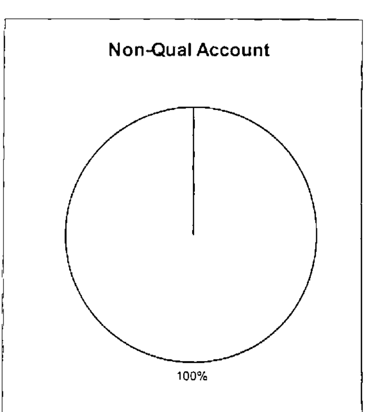
As your marginal tax bracket rises, it becomes a progressively better deal to pay long-term capital gains over ordinary income tax. Do the math. The difference can be dramatic and well worth the energy it takes to make a composite picture of your portfolio and reallocate among tax-qualified and non-tax-qualified accounts. You might do well to consider a financial planner who can collect the pieces of your scattered investments and create a homogenized, consistent and tax-efficient portfolio which makes sense from a tax and asset allocation perspective. ■

Tax-Smart Asset Allocation

Variable Annuity/Life

100%





☐ Investments intended for long-term hold ⁘ Investments subject to short-term trading

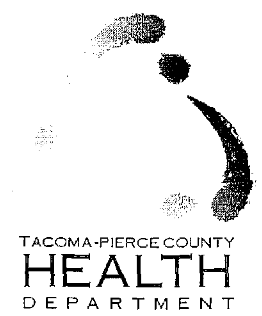
** For taxable years ending after 2000, property held for 5 years qualifies for an even lower 18 %, 8% for brackets below 28%.*

*** According to the NASAA (North American Securities Administration Association), Independent analysis finds that at least 70% of day traders lose money and only 11.5% showed profitable short-term trading.*

David J. Roskoph, MBA, CFP is president of Total Asset Management, Inc. in Gig Harbor. 858-2745.

Securities offered through Pacific West Securities, inc. Member NASD/SIPC

The Health Status of Pierce County



Prevention priorities determine department direction

"Tobacco use is the major preventable cause of illness and death in the United States. It causes diseases at a rate four times greater than alcohol use and fifty times greater than street drugs. Tobacco use or exposure kills more than 1300 people each day in the U.S. alone."

The Tacoma Pierce County Board of Health established three prevention priorities – behaviors which, if changed, would drop mortality and morbidity statistics. The three areas the department is focusing social marketing campaigns on, to change unhealthy behaviors are: tobacco use, alcohol abuse, and violence. **Physicians play a key role in these areas. By asking questions and referring patients to community resources, you too can help lower the incidence of illness and death from these causes.** Over the next several months, the health department's column will include practical ways physicians across the county can help to change individual's behaviors.

One system that has proven to be effective – and not time consuming – is the 4-A Model of Tobacco Cessation. During an office visit, the physician:

- **Asks about tobacco use**
- **Advises tobacco users to quit**
- **Assists the patient with a quit plan**
- **Arranges quit programs/ therapies or connects to other resources**

Here are some ideas for implementing this model.

Ask about tobacco use: Set up an office-wide system that asks about tobacco-use status and records that information in the patient's record. One way to do this is to include tobacco use in the vital signs data collected. Another is to put tobacco-use status stickers on patient's charts. You can also add indicators in computer files to show who uses tobacco and who does not.

Advise tobacco users to quit: It is valuable for a patient to hear from her/his physician that tobacco use is a health problem. In a clear, strong and personalized manner, urge every tobacco user to quit and add that you will help. If it is appropriate, add a personal note, such as "You've had one heart attack already," or, "Your child has asthma and environmental smoke only adds to her condition."

Assist the patient with a quit plan: Advise the patient to set a quit date within two weeks of your conversation. Then suggest that she/he inform friends, family and coworkers of his/her plans to stop and ask for their support. Recommend that she/he remove tobacco from his/her home, car and workplace. Finally, talk with the patient about previous attempts to stop tobacco use, identifying what worked and what led to a relapse.

Arrange for a support program. Consider using nicotine replacement therapy, prescribing gum or the more effective patch system. Then you or your medical assistant can connect the patient to intensive smoking cessation programs. One resource is the Health Department's cessation line at 253-798-4743.

Finally, make a follow-up appointment. Congratulate the patients on successes and help her/his recommitment after a lapse. Review the benefits quitting gives to the patient-especially health-related. Inquire about specific problems and help her/him problem solve, getting to another commitment to abstain from tobacco use.

Tobacco use is the major preventable cause of illness and death in the United States. It causes diseases at a rate four times greater than alcohol use and fifty times greater than street drugs. Tobacco use or exposure kills more than 1300 people each day in the U.S. alone. Asking questions, advising a patient to quit and then helping her/him with a plan and a program to stop using tobacco will make a difference in the lives of your patients and the overall health of the community. Thanks for working with us in helping people to quit.■

Problem from page 5

able coverage becomes unavailable. Commissioners should not be allowed to mandate coverage for special interest paramedical groups.

The Federal Government's intrusion into American Medicine must be questioned. Both the VA medical system and military medicine represent single payer socialized government sponsored programs. Neither system is known for efficient care or cost containment. Many veterans and military dependents have difficulty finding physicians and facilities for care. Socialized medicine would not improve medical care in this country. Medicare's original mandate was to pay 80% of reasonable physician and hospital fees. This chronically under funded program has never lived up to expectations.

Drug companies should continue to research, develop, test, and market new drugs. They should be liable for any withheld negative test results or any fraudulent tests. For FDA approved drugs they should relinquish their sole rights when expenses and reasonable profits have been achieved. Generic drugs must be as effective and safe as brand name drugs. If not, the manufacturer should be liable.

Lawyers should be liable for all expenses and fees when their claims are frivolous or unfounded. The contingency system for compensation should not be allowed for malpractice claims. All malpractice claims should be subjected to an arbitration hearing and the findings of the hearing should be allowed in court.

Hospitals should reaffirm their primary mission of efficient, quality patient care. Hospitals should trim their administrative staffs. They should stop writing long, poorly written, overlapping, impossible policies.

Hospitals should, once again, use their medical staffs as a resource rather than treat them as a necessary evil. This could lead to great savings. Several examples exist where very expensive pieces of equipment have been purchased that now sit idle or fail to meet the needs of physicians. Consultation with a broader spectrum of medical staff members could have vastly improved efficiency, increased utilization, and saved money. How can a hospital system justify this waste and then buy cheap soap, cheap scrub suits, cheap toilet paper, cheap paper towels, etc.?

Hospitals should improve materials management, stenography, computer hardware and software, and communication.

Hospitals and States can reduce costs in other ways. The following are three examples of policies that have horrible cost benefit ratios and should be abolished.

1) Hospitals should stop seeking JCAHO review. The benefits in no way justify the expense. This commission has become a bureaucratic disaster and does not improve patient care.

2) State mandated CMEs seem politically correct and sound good but they have not been proven effective. CMEs are effective tools for physicians but state mandated programs waste money.

3) Certificate of Need requirements have never been shown to reduce the cost of care. This requirement should be abolished.

Academic Medicine must reassess its effect on our medical system. These centers are geared up to educated people, but with the decreasing number of physician candidates, these centers are training physician assistants, nurse practitioners, podiatrists, and nurse anesthetists. All of these people have a place in our medical system but cannot, and should not, replace experienced clinical physicians. Patients should not be led to believe that these people are the equal of physicians.

Academic Centers must recognize and teach efficient clinical medicine. Physicians in clinical practice do not have the luxury of medical students, interns, residents, fellows, or nursing students. Clinical physicians must often stand-alone, render proper care, and run a business. Our teaching center must teach more than academic medicine.

Physicians must avoid contracts that produce conflicts of interest or burden them with unnecessary liability. Their first responsibility is to their patients, not their employer, not their hospital, and not some contract. Physicians must be willing to speak out when they witness poor care by peers, unethical conduct, impaired physicians, or improper care. Physicians must set reasonable fees and demand just compensation for services rendered.

All parties concerned need much better communication. We must define the needs of citizens and limit care to those modalities that have the best chance of helping our patients. Modern medicine is very expensive and all citizens must pay if this care is going to be available in the future. Patients deserve good medical care and physician and health care facilities deserve adequate compensation. All of us deserve a better effort from our politicians, judicial system, and legal system. A great deal of work must be done. ■

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Regence leaders discuss issues of concern with Board of Trustees

John Holtermann, VP, Provider Relations and Jeff Robertson, MD, Medical Director for Regence, met with the PCMS Board of Trustees at their March 7th meeting. They were invited to discuss issues of concern, particularly contract terminations, network adequacy, reimbursements, etc.

John Holtermann explained that they had been meeting with physicians' groups since last fall and they have been getting feedback that has been helpful. He explained that Regence needed to return to a profit mode as they have experienced significant underwriting losses in the last few years. Their investment gains are market driven and are not dependable for future planning. However, the gains have been considerable recently. Regence has set a goal of one-half percent underwriting gain, which they have not yet achieved. They found claims have been going up 15-17% each year, due to, in part, their requirement to cover alternative practitioners. Outpatient costs have skyrocketed, increasing 12-15% per year, and pharmacy costs have become astronomical. They said they are just trying to plug the dikes. Five years ago they spent $5 per every $100 on pharmacy costs, now they spend $25, a 20% increase, which they expect will continue to increase. They are working on many angles for reductions, including their administrative costs. They feel they are very efficient as a health payer. They reported a $15 million increase in physician payment, which included significant devaluation of surgical procedures. They explained that if you calculate the new rate, over time, with weights, it does reduce payment by 30%. They have received intense feedback from surgeons and they believe they really insulted their professional integrity and are sorry for this, **but the rates will not be changed.** They had 140 surgeons terminate, but feel they still maintain an adequate network as they meet their standards for adequacy. But, they have many very upset specialists. They are in the process of starting a professional fee advisory committee, which will be multi-specialty and all members will be physicians.

They are already thinking about January 1, 2001, (new contracts) and are working on options. They are thinking about a CPI adjustment every year, or an inflation factor built in each year, or a new policy or a split conversion factor, one for cognitive, one for procedural. They did note that their policy to not negotiate on fees has caused grief for them and that as they have negotiated on other things **perhaps they need to reconsider this policy and negotiate on fees as well.**

They noted that they are really trying to reduce administrative hassles, particularly prior authorizations. They are trying to eliminate referral systems but they noted that the purchasers are not agreeable. They will be putting together focus groups to study this issue. **They did note that authorizations can be done electronically and suggested that offices do this and to call Regence if they are interested.**

For the year, 2000-2001 they will be working on a new pharmacy system that will be three tiered. The system will put the cost of highly advertised drugs on to the consumer. ■

Patrice Stevenson, MD chairs WSMA Women in Medicine Committee

Patrice Stevenson, MD, PCMS President-Elect, is chair of the WSMA's Women in Medicine Committee. The committee's focus is issues confronting women physicians, particularly balancing professional and personal responsibilities and women's health issues. Another goal, according to Dr. Stevenson, is mentoring women in leadership roles.

The Committee is sponsoring an educational program in conjunction with WSMA Annual Meeting in September which will focus on cardiovascular disease and breast cancer.

If you would like more information about Women in Medicine activities, please call Dr. Stevenson at 841-5849. ■

Personal Problems of Physicians

Medical problems, drugs, alcohol, retirement, emotional, or other such difficulties?

Your colleagues want to help

***Robert Sands, MD, Chair**	**752-6056**
Bill Dean, MD	**272-4013**
Tom Herron, MD	**853-3888**
Bill Roes, MD	**884-9221**
F. Dennis Waldron, MD	**265-2584**

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Dr. Teresa Clabots, a refugee from Cuba has relatives that are taking medical supplies, equipment and books back to Cuba this summer after a 40 year embargo. If you have anything that you think might help, please don't hesitate to call **Dr. Teresa Clabots,** 588-6574 or 582-0430(evenings).

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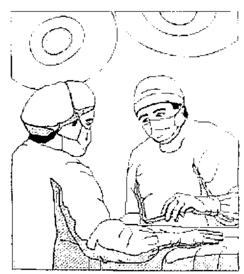
COLLEGE OF MEDICAL EDUCATION

Surgical Update-dissections, CME set April 28 & 29

Dr. Virginia Stowell, Tacoma general surgeon, is directing the 69th Annual Surgical Club meeting which will be held Friday and Saturday, April 28 and 29, 2000. The very popular dissections, demonstrations and lectures presented annually by the Tacoma Surgical Club will be held at Tacoma Community College in the Lecture Hall, Building 16.



On Friday afternoon, April 28, dissections and demonstrations on cadavers will be performed for health care providers and interested students. Beginning Saturday morning, several short lectures featuring the latest developments in surgery will be presented by local physicians and Army Medical Corps doctors.

The Surgical Club Annual Dinner, open to Surgical Club members and invited guests will be held Saturday evening, April 29 beginning at 6:30 p.m. at Tacoma Country and Golf Club in Lakewood.

Call the College, 627-7137 for registration information.

Continuing Medical Education

Allergy, Asthma, Pulmonology CME scheduled May 5

The College's CME program featuring subjects on allergy, asthma and pulmonology is set for Friday, May 5. The course is under the direction of **Alex Mihali, MD.**

This is a one-day update designed for the primary care provider. It will focus on diagnosis and management of common allergy, pulmonology and asthma problems.

This program is complimentary to all area physicians. An annual conference, it has been developed with support from local pharmaceutical companies.

The program will be held at the new Lagerquist Center in St. Joseph Hospital.

This year's program will feature presentations on:

- Asthma
- Sinusitus
- Allergic Rhinitis
- Pneumonia and COPD
- Lung Cancer Screening & Management
- Atopic and Contact Dermatitis

For registration information call the College at 627-7137. Although no registration fee is required, physicians wishing to attend must complete and return a registration form. The conference is anticipated to fill, so early registration is encouraged.

Gastrointestinal Disease CME - June 2

A GI Update CME program offered bi-ennially is set for Friday, June 2, 2000. The program, directed by **Drs. Gary Taubman and Rick Tobin**, is a one-day course for primary care physicians. It will feature faculty from the Tacoma Gut Club whose members represent a diverse group of expert physicians from Seattle to Olympia, both in academic and private practice. Recognized experts from outside our region will also be featured.

The course will reflect the multi-disciplinary approach used commonly in managing patients with gastrointestinal illness.

Dates	Program	Director(s)
Monday - Friday April 10-14	CME @ Hawaii	Mark Craddock, MD
Saturday, April 29	Surgery Update 2000	Virginia Stowell, MD
Friday, May 5	Asthma, Allergy & Pulmonology for Primary Care	Alex Mihali, MD
Friday, June 2	Nuts, Bolts & Innovation: Gastrointestinal Disease V	Gary Taubman, MD Richard Tobin, MD

Doctors' notes on patients' charts - Unedited!

Patient has chest pain if she lies on her left side for over a year.
On the 2nd day the knee was better and on the 3rd day it disappeared completely.
She has had no rigors or shaking chills, but her husband states she was very hot in bed last night.
The patient has been depressed ever since she began seeing me in 1993.
The patient is tearful and crying constantly. She also appears to be depressed.
Discharge status: Alive but without permission.
Healthy appearing decrepit 69 year-old male, mentally alert but forgetful.
The patient refused an autopsy.
The patient has no past history of suicides.
Patient has left his white blood cells at another hospital.
Patient's past medical history has been remarkably insignificant with only a 40 pound weight gain in the past three days.
Patient had waffles for breakfast anorexia for lunch.
Between you and me we ought to be able to get this lady pregnant.
Since she can't get pregnant with her husband, I thought you might like to work her up.
While in the ER, she was examined, X-rated and sent home.
The skin was moist and dry.
Patient was alert and unresponsive.
She stated that she had been constipated for most of her adult life, until she got a divorce.
The patient was to have a bowel resection. However, he took a job as a stockbroker instead.
The pelvic examination will be done later on the floor.
Patient has two teenage children, but no other abnormalities.
The lab test indicated abnormal lover function. ■

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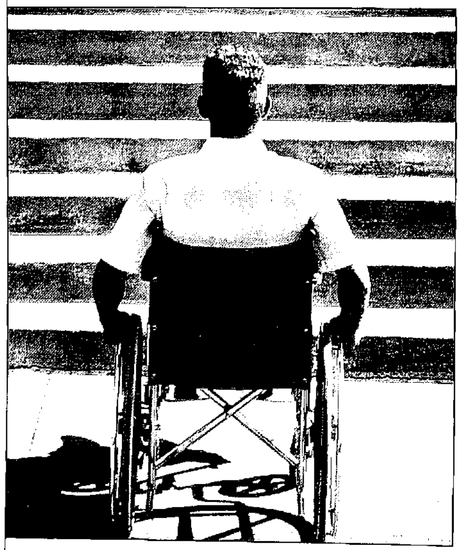

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The Pulse

PCMS Alliance

Agencies thank PCMSA for philanthropic gifts

Dear Ms. Thomas:

Thank you for the generous donation for Asthma Camp at Camp Sealth from the Pierce County Medical Society Alliance. As you know, the group's donation will be used to send a needy child from the Pierce County area to Asthma Camp.

Each Fall, we send out an Asthma Camp newsletter to all campers, sponsors, volunteers and donors. The Pierce County Medical Society Alliance will be featured as a donor in the 2000 newsletter. I will send you a copy when it is printed, along with the most recent edition of our annual report.

On behalf of the **American Lung Association of Washington** and our asthma campers, thanks once again.

Penny Grellier
Asthma Camp Coordinator

Ms. Thomas & PCMSA Members:

Thank you so much for the financial support for the **YWCA Women's Health Program**, as well as for the vote of confidence.

You may expect quarterly reports on program performance, and we look forward to recognizing your contribution in our newsletter. Thank you!

Tacoma YWCA

Dear Ms. Thomas:

Thank you for your generous gift to **Trinity Clinic.** Our prescription costs have risen and it is very much appreciated. We stamp each free prescription, acknowledging your contribution. Thank you again.

Jeanne McGoldrick

Left: Mrs. Fran Thomas, (left) wife of pediatrician William Thomas, MD, with students posing as parents of the infamous "Baby Think It Over" doll

Dear Fran:

You were certainly a bright spot in my day. In my thirty years of teaching I've never had someone call and ask for my wish list. Thank you so much for your part in helping us get the four new realistic babies, gear, and The Gamble Learning Model.

Monday after Monday I see students drag in to class saying, "Take this baby, now!" We appreciate your support for our program. We are all working together to reduce teen pregnancy. Thank you so much.

Dorothy Hudson
Family/Consumer Science Teacher
Woodrow Wilson High School

Dear Ms. Thomas:

On behalf of the Board of Directors, staff, volunteers and clients of the **Pierce County AIDS Foundation** let me offer my warm thanks for the contribution of $500 made by the Pierce County Medical Society Alliance. This generous commitment has made it possible to help support critical care services for clients: emergency grants, home delivered food bags, products for the essential needs bank, and other products which help our clients address the exacerbating affects of poverty on an immune system already compromised by HIV.

Last year, the Pierce County AIDS Foundation served its 1,804th client, and, in 1999 we served a total of 94 new clients. Increasingly, our clientele has been distinguished from the state as a whole by a clientele which is poorer, has a lower average educational level and contains a higher percentage of women, people of color, youth, and individuals who are double or triply diagnosed with HIV/AIDS as well as mental illness and chemical dependency. This is a constituency which has even more need for the essential services provided by PCAF, and of the generous support that our donors provide

Nancy Ryan
Deputy Director

Writing from page 7

pharmacists even harder is the flood of new preparations on the market about which we are not properly informed, but which the patients clamor to get because they have seen the ads on television or on the Internet. In the past, I used to see five to ten drug representatives per week, telling me about new products and giving me literature to review, so I could learn about them. Now I don't even see one drug representative per week. New drugs and new dosages appear on the market with very little notice to us. How are we going to prescribe them, if we don't know they exist, let alone their possible side-effects, cross-reactions or complications? All of these are important items to know in order to prescribe properly.

Another aspect of legible handwriting concerns our chart notes. The insurance companies want documentation of services so they can pay. If our chart notes are not legible, we don't have the documentation. Of course, we can read our own handwriting (we can, can't we?) and interpret it for them. But that may or may not be acceptable.

I usually can read what I have written on the chart, but I admit I have a hard time reading someone else's handwriting. I can make out the words most of the time, but I get lost in the abbreviations. We all use abbreviations. We have to. The problem is that every school and every specialty has its own that they understand. Those who did not go to that school or are not of that specialty have to guess, sometimes correctly, sometimes not. We know AMA means American Medical Association, we can guess when it may mean against medical advice, but how many among us know that it really stands for advanced maternal age? A patient in labor may deliver with PCB, which may mean paracervical block, but also, prepared childbirth.

Let us forget handwriting. Maybe all notes and prescriptions should be typed. They will be neat, easy to read, definitely legible. Would that eliminate errors? Unfortunately, no. You know the errors your dictated hospital notes can have. It's like playing Pass-it-on. We all have seen those lists of hilarious transcription errors. Here is one not funny at all. The dictation was "The patient was prepped and draped." The transcription was "....and raped." There it was, neatly typed, perfectly legible. It is amazing what those gremlins called typographical errors can do. We also could misspell the name of the drug. Usually, alert pharmacists can catch most errors, but can they always? The opportunities for human error are always present. Fortunately, most of the time they are minor and easily corrected. Sometimes they are serious and potentially deadly.

The extensive experience with our residents has proven that when they are overworked, tired and sleep-deprived, they are more likely to make mistakes, and their mistakes are more likely to be serious. These findings led to significant changes in their work load and call scheduling.

In practice we work as part of a team, with office medical assistants, pharmacists and nurses. When someone makes a mistake, another member of the team will usually pick it up and help correct it. It is when someone drops the ball and no-one picks it up that patients can get hurt.

During the past several years we have been asked to work more for less pay, the hospitals have cut down on their personnel and services, we all are rushed, trying to take care of more patients and to do more chart documentation. In sum, we have had to run much faster just to stay in the same place. Now we are asked to provide all those services not only in less time and at a lower cost, but also without errors. Unfortunately, one cannot get Mercedes quality at Yugo prices. The only way to reduce medical errors is by constant vigilance on the part of the entire medical care team, preferably with the participation of the patients. To achieve that, we need to have knowledgeable and alert medical team members. We need to pay them what they are worth, so they don't have to work overtime, or moonlight on another job, just to make ends meet. We need to relieve them of what is gradually becoming an impossible paperwork burden.

Knowledge and alertness are the best tools to reduce medical errors. They come at a price and if our goal is fewer mistakes, we should be willing to pay it. But we cannot expect to eliminate mistakes altogether. That is not possible. We are human. Let the legislator who has never written a law with a loophole cast the first stone.■

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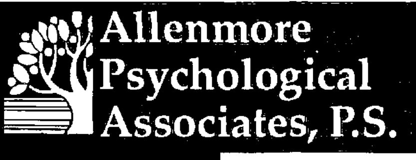

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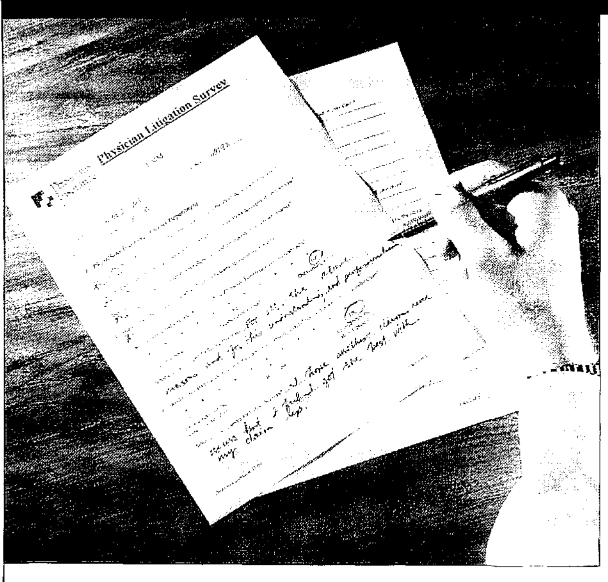

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Pierce County Medical Society

BULLETIN

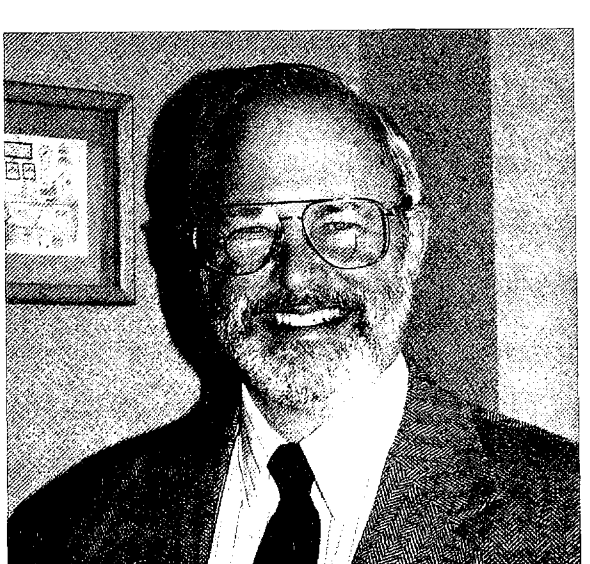
May, 2000

Left, DeMaurice Moses MD, retired Puyallup pediatrician was recently recognized by the Rotary Clubs of Pierce County for his service to the community

see story, page 9

Right, Joe Wearn, MD was honored by the Franciscans for thirty-three years of commitment to medicine at his recent retirement celebration

see story, page 5



INSIDE:

3 EMTALA: A Primer

4 Retired members see Africa in extraordinary pictures taken by Joe and Pat Wearn

6 "Tacoma's controversial agent of change," Dr. Federico-Cruz Uribe shakes up the system

7 June General Membership meeting features an evening with Dr. Cruz-Uribe

8 Dystonia Foundation recognizes Dr. Pat Hogan, Tacoma Neurologist

13 TPCHD: Handgun Safety for Pierce County

14 Online Medical Resources

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The Bulletin is dedicated to the art, science and delivery of medicine and the betterment of the health and medical welfare of the community. The opinions herein are those of the individual contributors and do not necessarily reflect the official position of the Medical Society. Acceptance of advertising in no way constitutes professional approval or endorsement of products or services advertised. The Bulletin and Pierce County Medical Society reserve the right to reject any advertising.

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Pierce County Medical Society

BULLETIN

May 2000

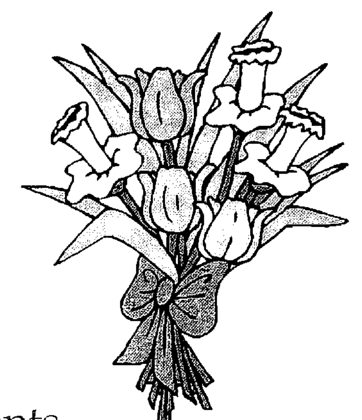


Table of Contents

3 EMTALA Issue: A Primer

4 Retired members tour Africa with Joe Wearn, MD & his wife Pat

5 Joe Wearn, MD honored for retiring after 33 years of service

6 Dr. Federico Cruz-Uribe, Tacoma's agent of change

7 June General Membership Meeting features Dr. Cruz-Uribe

8 Dystonia Foundation honors Patrick Hogan, D.O.

9 Rotary Clubs of Pierce County honor DeMaurice Moses, M.D.

10 Mark your calendar for September 12th General Meeting

11 The Invisible Hand: "On Rights and Wrongs"

12 Go shopping: Support*My*Association.com

13 TPCHD: Handgun Safety

14 OnlineMedical Resources

15 COME: Allergy and GI courses upcoming; Watch for May surv

17 "$15 for a Kawasaki," by Teresa Clabots, M.D.

19 PCMSA: March meeting updates

22 A Different Perspective

23 Classified Advertising

Special Feature

by Mary Giannini, JD
Witherspoon, Kelley, Davenport & Toole

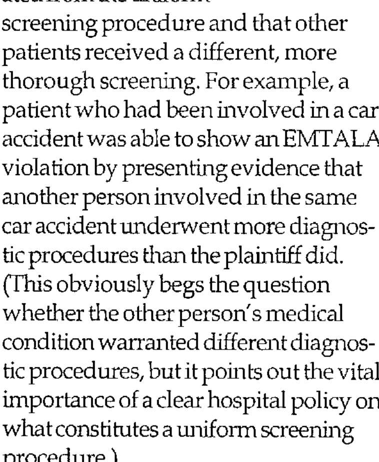
EMTALA Issues: A Primer

Editor's Note: In light of the recent discussions regarding mandated trauma call and EMTALA, the following is presented for clarification of the act. Both Tacoma General/Allenmore and St. Joseph/St. Clare medical staffs received letters regarding mandated trauma call which initiated lots of questions and concerns. The PCMS Board of Trustees also discussed the issue at their most recent board meeting and determined that more information would be helpful. This article is reprinted from the Spokane County Medical Society Bulletin.

The Emergency Medical Treatment and Active Labor Act ("EMTALA") became law in 1986. The law applies to all hospitals that participate in Medicare and provide emergency services.

EMTALA protects all persons who come to a hospital emergency room, regardless of insurance coverage or ability to pay. The hospital must provide an "appropriate screening examination" within the ER's capability (including ancillary services available to the ER) to each person who requests an exam or emergency treatment. The law specifically applies to pregnant women in labor. The hospital may not delay an examination or stabilizing treatment to ask about a patient's insurance or ability to pay, though a recent (11/99) Health Care Financing Administration ("HCFA") Special Advisory Bulletin focusing on EMTALA and managed care authorizes a hospital to seek payment authorization for payment from a managed care plan "after providing a medical screening examination and once necessary treatment is underway."

To meet the requirements of an appropriate screening exam, the hospital must show that it uses a uniform screening procedure for every patient, regardless of the patient's ability to pay. A number of courts have interpreted "appropriate medical screening" to mean uniform treatment rather than correct diagnosis, stating that EMTALA was not designed to be a federal remedy for misdiagnosis or medical malpractice. In a court case the burden is on a plaintiff to show the hospital screening deviated from the uniform screening procedure and that other patients received a different, more thorough screening. For example, a patient who had been involved in a car accident was able to show an EMTALA violation by presenting evidence that another person involved in the same car accident underwent more diagnostic procedures than the plaintiff did. (This obviously begs the question whether the other person's medical condition warranted different diagnostic procedures, but it points out the vital importance of a clear hospital policy on what constitutes a uniform screening procedure.)



"Emergency medical condition" is defined in EMTALA as "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in :

1) placing the patient in serious jeopardy;
2) serious impairment to bodily functions; or
3) serious dysfunction of any bodily organ or part."

If a patient has an emergency medical condition, then the hospital must provide treatment to stabilize the emergency medical condition or provide for an "appropriate transfer" to another medical facility.

The definition of "stabilize" or "stabilization" is key to potential liability for the hospital. The EMTALA definition of "stabilize" is broader than normal physician usage: it means "to provide medical treatment as necessary to assure that within reasonable medical probability no material deterioration is likely to result from or occur during the transfer." Stabilization does not require that a patient's emergency medical condition be completely removed prior to a transfer or discharge. Further, a patient bringing an EMTALA claim must prove that his or her condition at discharge or transfer would not have been considered stable for any other patient. Unfortunately, HCFA enforcement officials typically try to hold hospitals to the higher standard of actually removing the emergency medical condition before transfer or discharge.

It is important to realize that "transfer" as defined by EMTALA encompasses "any movement of an individual outside of the hospital's facilities at the direction of any person employed by or affiliated with the hospital." This definition includes discharge to a patient's home, or to a physician's office during regular office hours. Hospitals have recently been cited for EMTALA violations for routine discharges where patients were later discovered to have undetected medical problems or complications. For that reason, hospitals have

See "EMTALA" page 20

Retired members tour Africa with Joe and Pat Wearn

Retired members and widows, spouses and guests took a trip to Africa with **Dr. Joe Wearn** and his wife Pat at the April 7th retired member luncheon at Shenanigan's Restaurant in Tacoma. Fifty people attended the luncheon which is held three to four times each year.

The program was particularly delightful due to the quality and nature of the photographs shown by the Wearns. Using top quality photo equipment including an easy clip-on style tripod, Dr. Wearn's slides were extraordinary. He captured nature at it's finest. Numerous birds, African animals of the wild including giraffes, elephants, monkeys and rhinoscerous and flowers unheard of.

Dr. Wearn's presentation was his initiation into the group as he was just completing his first full week of retirement. (see story page 5) ■

Speaker Joe Wearn, MD (center) visits with Dr. Bob Florence, retired orthopedic surgeon and his wife, Helen

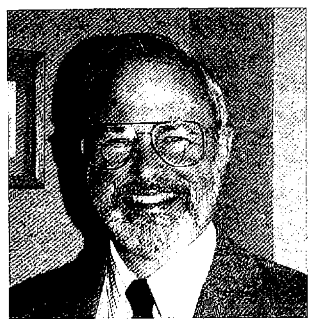
From left, Dr. David Sparling and wife, Barbara, and Dr. Richard Hoffmeister and wife Juley visit after the meeting

Dr. Kiyoaky Hori, reitred anesthesiologist (right) and wife Patricia Palms (left) with speaker, Pat Wearn

Widows Rubye Ward (center) and Marilyn Mandeville (right) visit with Dr. John Colen

From left, Julia Mueller, Barbara Sparling, and Patricia Palms enjoy African treasures shared by Pat Wearn

Special Feature



Joe Wearn, MD

JOE WEARN, MD

HONORED BY PATIENTS, COLLEAGUES AND FAMILY ON HIS RETIREMENT

Joe Wearn, MD, Tacoma pediatrician, hung up his stethoscope for the last time on March 31, 2000. He said goodbye to long time patients and colleagues, having practiced in Pierce County for thirty years.

Dr. Wearn completed medical school at the University of Pennsylvania, then served in the Army from 1963-1970, completing both an internship and residency. He began his pediatric practice in Tacoma at Western Clinic in 1970. Western Clinic was eventually purchased by the Franciscans. He experienced many changes in medicine during his career but maintained his responsibility to his patients, never lost sight of his integrity, and remained devoted to the profession of medicine.

An avid supporter of organized medicine, Dr. Wearn was very active in PCMS activities. He was a member of the Public Health/School Health Committee since 1974, serving as chair in 1998 until his retirement. He has served as a board member of the PCMS for-profit subsidiary, Membership Benefits, Inc. since 1990, and was president from 1992-1995, leading the way to operation of the temporary services division of the placement service. He was Secretary-Treasurer for PCMS for two terms, in 1990 and 1991, being instrumental in the purchase of the building at 223 Tacoma Avenue South in 1990. Too numerous to mention, he belonged to and supported many other organizations and associations throughout his career.

The Franciscans honored Dr. Wearn at a retirement party on April 9th. Patients, friends and colleagues attended to thank him, honor him and wish him well. The Franciscan leadership expressed their gratitude for his professional contributions and steadfast service to their organization. Patients expressed their gratitude as they gave tribute to their doctor and friend.

Colleagues and family members couldn't remain silent. "He has made me the doctor I am today," said fellow pediatrician, Dr. Brian Berry. "I owe him a gratitude of debt for all he has done for me," he added. Son Matt, paid his respects and admiration, and wife Pat, was all smiles, "Now I get him all to myself," she beamed!

PCMS extends congratulations and best wishes to Dr. Wearn and his family. ■

Tacoma's controversial agent of change

Health chief Cruz shakes up the system

by Jack Hopkins, PI Reporter

TACOMA - Tacoma-Pierce County Health Department Director **Federico Cruz-Uribe** was working in the Guatemalan highlands more than 20 years ago when government death squads began systematically killing the people who were helping him set up a program to provide medical care for the poor.

So, he is not at all troubled by the lawsuits, complaints, threats and outrage he has generated the past few years as he has waged war against the tobacco industry and taken controversial stands on keeping lists of everybody who tests positive for the AIDS virus or for tuberculosis.

Federico Cruz-Uribe, MD

His problems here are insignificant in comparison.

Cruz went to Guatemala in 1978 after graduating from medical school in Wisconsin. He quickly got caught up in the civil war raging in that land.

"It was emotionally devastating," Cruz said, tears welling up in his eyes and his voice breaking as he recalled the deaths of co-workers.

"What was striking was that the people still volunteered - even though they knew they would be killed."

He spent a year in Guatemala before the upheaval made it impossible to continue.

"But, it really burned a space in my brain. And when decisions come up as I work for health systems here...well, they seem pretty pale by comparison," he said. "It made it pretty easy for me to say: "Well, Federico, what are your values and what are you trying to accomplish?" If it is the right thing to do, you should do it. And if people give you grief, you deal with it...Pressure and threats don't make much of a dent on me."

Cruz, 50, head of the Health Department since 1992, lives by those words.

One of the first things he did after being named health department director was close every clinic operated by the agency and get the private medical community to start providing health services for poor people.

Changing the agency's focus from providing patient care to disease prevention led to massive staff turnover and lighted the fuse for controversies that have swirled around the department ever since.

Almost immediately, he targeted the powerful tobacco industry. At his urging, the health department board approved a groundbreaking ban on outdoor advertising of tobacco products throughout the county.

Pierce County was the first in the state to enact such a ban. King County and Snohomish County followed with similar efforts.

Then, with the board's consent he began keeping the names of everyone who tested positive for the AIDS virus permanently on file at the health department. He still does that, even though state regulations say the names must be purged after 90 days.

Next, the health agency began compiling a list of the names of everyone who tests positive for tuberculosis, even though no other county health department in the state tracks the names of people who are in the non-infectious stage of that disease.

The controversy over AIDS and HIV patients has led the Governor's Advisory Council on AIDS/HIV to ask the state Department of Health to declare the Tacoma-Pierce County Health Department out of compliance with state rules.

But Cruz says it makes no sense to put a 90-day limit on the time county health departments can keep tack of the names of people who have HIV when they pose a threat to the rest of the community for the rest of their lives.

"With the new drugs available for treatment today, they are feeling much better and...can fall into their old habits," Cruz said. "And the last thing we need is people with the HIV virus behaving as if they don't have it."

"Cruz-Uribe is completely out of control," said Richard Jackman, a spokesman for Resist the List, a Seattle-based organization that has sued the Tacoma-Pierce County Health Department to force it to purge the names of HIV patients from its records. "First he breaks the law to play sex police and now this," Jackman said, referring to the decision to begin collecting names of people who have non-contagious TB infections.

Cruz, an informal person whose milltown background shows in his distaste for neckties - he keeps a supply in his car only for those times he cannot avoid wearing one - has plenty of supporters.

Count Francea McNair, deputy county executive and a health board member, among them.

"He is a bright, goal-oriented activist, and you fill find him on the cutting edge of health issues," McNair said. "He is courageous and not afraid to take chances when he believes his position is right and will benefit the community."

Continued on page 16

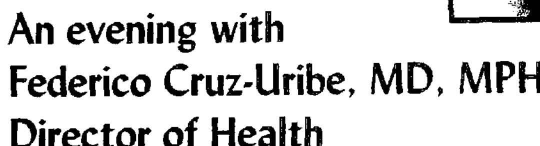
Pierce County Medical Society

June General Membership Meeting

Tuesday, June 13, 2000
Social Hour: 6:00 pm
Dinner: 6:45 pm
Program: 7:45 pm

Landmark Convention Center
Temple Theatre, Roof Garden
47 St. Helens Avenue
Tacoma

From Vince through Che to Behrhorst: A Journey on the Edge of Public Health



An evening with
Federico Cruz-Uribe, MD, MPH
Director of Health

(Registration required by June 4. Return this for to: PCMS, 223 Tacoma So, Tacoma 98402; FAX to 572-2470 of call 572-3667)

Please reserve _____ dinner(s) at $20 per person (tax and tip included)

Enclosed is my check for $_______ or credit card # is ____

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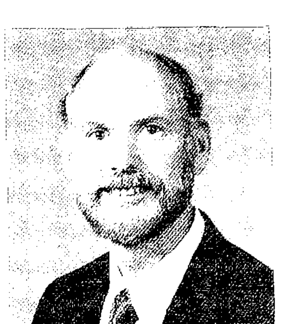
I will bring my spouse or a guest. Name for name tag: ____

Signed ____ Thank you!

Dystonia Foundation recognizes "Doctor of Excellence," Pat Hogan, DO, Tacoma Neurologist

by Ruth Anderson

The national Dystonia Medical Research Foundation is proud to announce the selection of **Dr. Patrick J. Hogan, III,** Tacoma neurologist, as a "Doctor of Excellence" in the diagnosis and treatment of dystonia. Dr. Hogan, Director of the Puget Sound Regional Movement Disorder Clinic in Tacoma and the Puget Sound Neurology Headache Center, was the only physician in Washington State to receive the honor.



Patrick Hogan, DO

Dystonia is a neurological movement disorder characterized by involuntary muscle contractions and postures. Patients with this affliction often experience pain, loss of employment because of an inability to control movements, and acute embarrassment from knowing their appearance has been altered.

Dr. Hogan is the Northwest's leading provider in the administration of botulinum toxin injections as the most safe and effective treatment of dystonia. Patients treated with this medication experience considerable lessening of their involuntary muscle contractions, freeing them to pursue more active lives.

Following his medical and neurological training, Dr. Hogan left Madigan Army Medical Center for private practice in Tacoma. Throughout his career, he has retained a great interest in community health. He currently serves on several boards and committees: Stroke Advisory Board and Tobacco Control Task Force for the Franciscan Health System, the Northwest Parkinson's Advisory Board, and the Washington State Stroke Medical Advisory Committee.

Both the Seattle and Tacoma Dystonia Medical Foundation Support Groups were delighted to learn of the Foundation's intent to single out certain doctors who are working to find cures and to treat dystonia patients. Support group members had no problem recommending their advisor, Dr. Hogan, who routinely meets with the groups to promote proper treatment and to help patients cope with the inherent disabilities they face. Pat Stolp, Tacoma Dystonia Support Group Leader says: "Dr. Hogan is our lifeline for coping with our debilitated health. He offers concrete treatment, compassion and hope. We couldn't ask for a more tireless mentor."

The dystonia "Doctor of Excellence" award is both an honor for Dr. Hogan, and a way of bringing awareness of this often misdiagnosed disorder to the public's attention. Tacoma is fortunate to have this community-minded, caring professional among its medical providers. ■

Ruth Anderson is the Northwest Regional Coordinator for the Dystonia Medical Research Foundation. She can be reached at 360-893-4412.
Patricia Stolp, Tacoma Support Group Leader, Puget Sound Dystonia Awareness & Support Group may be reached at 847-2368

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§ The program provides opportunities for networking with professionals in health services management.

§ The integration of professional, organizational and societal perspectives and values in the management of health care organizations is stressed. Theory, case studies, best practices and the experiences of participants are used to strengthen practical management skills.

§ To facilitate the sharing of diverse experiences and management problems, classes are made up of medical professionals from diverse settings.

§ Participants proceed through the sequence of courses together -- developing a strong cohort.

§ Team teaching is an important element of the program, combining the skills of active practitioners and professionals from the local health care community with University faculty.

§ The MHA Program is fully accredited by the Accrediting Commission on Evaluation in Health Services Administration (ACEHSA).

Application Deadline:

The application deadline for autumn 2000 admission has been **extended to July 31 -- provided space remains available**. We will begin reviewing applications after April 30.

For More Information or an Application Packet

Please contact the Program Office (donnaj@u.washington.edu or 206-616-2976) or visit our Web site at *depts.washington.edu/mhap* .

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ROTARY CLUBS OF PIERCE COUNTY HONOR

DEMAURICE MOSES, M.D.

Buck Moses, MD

Dr. DeMaurice (Buck) Moses was the recipient of the 2000 Rotary Clubs of Pierce County Community Service Award. This year, seven outstanding individuals were nominated for the award because of their dedication to the people of Pierce County. Dr. Moses, who retired in 1999, cared for over 35,000 patients after coming west as a medical pioneer in the 1960s. He established his office in Puyallup in 1964 and in 1967 he ventured to Tacoma to volunteer his medical help in the Hilltop neighborhood. The first five years, Moses saw 4,000 patients at his Hilltop Children's Clinic, where patients were not charged fees and the doctor was not compensated.

Dr. Moses also served as Medical Director of the children's therapy unit at Good Samaritan Hospital in the late 60s. He teamed up with his wife, Grace, to create a program called Equest, which provided free horseback riding for disabled children at the couple's farm. Tacoma attorney, Donald Anderson, introduced Dr. Moses to the Downtown Tacoma Rotary 8 audience on Thursday, April 13, noting "Dr. Moses' practice was characterized by his indifference to the 'business' of medicine. Not only did he routinely provide free medical care to patients, he provided follow-through care and additional attention to patients and their families that was well beyond the reimbursable 'procedures' of today's practice. He also overcame the obstacles of being an African-American professional in an all white community, earning the love and respect of thousands. At the time of his retirement last summer, he was widely recognized as a priceless community resource.

Upon accepting the award, Dr. Moses said, "I simply do what comes along." He went on to say that the family physician today is being replaced by a collective called "HMO" and we need to all work together to make it work for the benefit of all.

Other physicians who have been recipients of this very prestigious Rotary Club Award include **Dr. George Tanbara,** who received the first community service award presented in 1974, and **Dr. and Mrs. David Hellyer**, retired pediatrician and his wife, who were recipients in 1996. ▪

Expedition leader to speak at September membership meeting

Dramatic tale of high adventure resolving 1924 mystery
Mark your calendar for the September General Membership Meeting

Reserve Tuesday, September 12, 2000, 6:00 p.m. for an evening of high adventure as Eric Simonson speaks on, "Finding Mallory."

Simonson, owner and active partner in International Mountain Guides (one of the oldest mountaineering companies in the country) as well as owner and operator of Mt. Rainier Alpine Guides will speak on the experiences of the expedition that set out to solve two of exploration's greatest mysteries: Did George Mallory and Sandy Irvine reach the summit of Mt. Everest in 1924, and what became of them?

This expedition stunned the mountaineering community with the discovery of the remains of Mallory. Two major television documentaries have focused on the expedition. He will relate the mysteries, the quest to solve them, and what the expedition did at the September meeting.

Simonson's climbing resume includes Mt. McKinley, Aconcagua in Argentina, Cho Oyu in Tibet, Mt. Elbrus in Russia, and Mt. Vinson in Anarctica.

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The Invisible Hand...

by Andrew Statson, MD

On Rights and Wrongs

"He that would make his own liberty secure must guard even his enemy from oppression."
Thomas Paine (1795)

Andrew Statson, MD

"I want an interpreter present at my visit," she said through the Teletype operator. "It's my right." She was a deaf-mute who had come to my office a few times before. We had communicated by writing on paper. Now she wanted a sign language interpreter. When I got paid for the visit, subtracted the fee of the interpreter and figured my overhead, there was nothing left. Some colleagues have reported they had to pay an interpreter even though the patient did not keep the appointment and they could not charge for a visit. In this country only the self-employed can legally work for less than the minimum wage.

At the dawn of the American republic, the state assemblies discussed the inclusion of the Bill of Rights into the constitution. Some people argued that these amendments were not necessary. These rights were so elementary, so basic, so natural, that there was no need to spell them out. Of course people should be secure in their homes and in their property. Of course there could be no unreasonable seizure of private property, and when a seizure was reasonable, the owner would be compensated justly. Of course.

Those opposed to the inclusion of the Bill of Rights into the constitution turned out to be right, but for the wrong reason. The Bill of Rights becomes a useless document when Congress and the courts twist its meaning to suit their purposes.

Human society is a complex dynamic living organism. People band together for a number of reasons. Through joint effort and specialization they can produce more than they can by themselves. They can concentrate on doing what they do best and trade with others to get what they are not as able to produce. In the process of their work they make discoveries and acquire knowledge, which they also trade with others. Thus they develop a pool of knowledge which becomes the basis of civilization.

Together they can better protect themselves from enemies who would rob them of their property and of their life. The mutual benefit of life in society is expressed by the exchange of effort for effort, of value for value, it is expressed by trade. Neither trade nor society itself can exist without order. The root of order is justice. Justice consists in giving and getting what is earned, the deserved, no more and no less. Justice therefore is the opposite of charity, which consists in giving and getting the unearned, the undeserved. Yet all over the world and throughout history one custom has been an integral part of social interactions, the custom to help people in distress. This type of help frequently is called charity, but it does not quite meet the definition.

Helping people in distress is based on some assumptions. One of them is the realization that one day we may be in distress and will welcome help then. In this respect the help we give now, while we are able to do it, is a loan to the person receiving it and to the community at large. One day we may have to call this loan and we expect that it will be repaid. Another assumption is that the person in distress now will recover and eventually be able to repay us in some way later.

Of all the peoples in the world Americans have been the most generous in helping others. A major reason is that they have been the most prosperous and the most able to do so. After the devastation of WWII this country established the Lend-Lease Program to help Europe rebuild itself. Those were loans that were repaid, but America also set up a very generous foreign aid program. What we expected for our gifts was not the love, but at least the respect of the people we helped. Instead, our embassies were vandalized, our people were taken hostage and sometimes killed, their only crime being that they were Americans. We gave the undeserved and we received the undeserved. That was charity and justice operating at the same time.

The twentieth century saw charity become institutionalized. What was a loan or an investment became a legal right, to be paid by those who produce to those who don't, in defiance of justice. Medical care as a right means that some people will have to work and earn money, which they will not receive, so that others can get medical

See "Right" page 18

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For more information, call PCMS, 572-3667. ■

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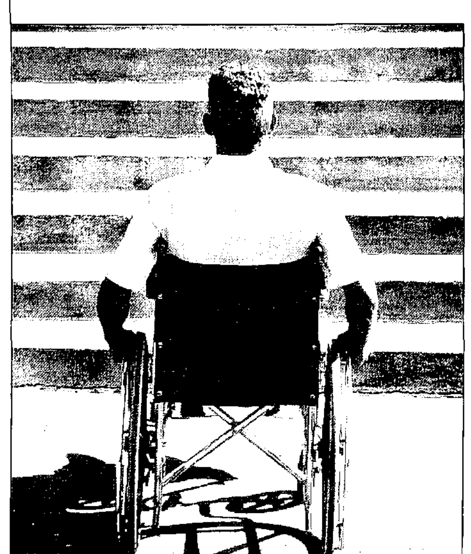

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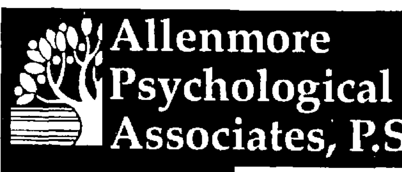

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The Health Status of Pierce County

Handgun Safety

The Tacoma-Pierce County Board of Health established three prevention priorities-behaviors which, if changed, would drop mortality and morbidity statistics. The department is focusing social marketing behavior change campaigns on: tobacco use, alcohol abuse, and violence. Physicians play a key role in these areas. By asking questions and referring clients to community resources, you too can help lower the incidence of illness and death from these causes. Over the next several months, the health department's column will include practical ways physicians across the county can help to change their patient's behaviors. This month's column spotlights handgun safety.

Recent tragedies in Pierce County, and across the nation, have demonstrated what happens when firearms fall into the wrong hands. Statistics to note:

- Firearm homicide is the second leading cause of injury or death for 15-19 year olds in Pierce County.
- During the five year period from 1992 to 1996, the homicide rate in Pierce County was 84% higher than the rate for the entire state (5.9 deaths per 100,000 people in Pierce County compared to 3.2 deaths per 100,000 in Washington state).
- In Pierce County from 1996 to 1998, 37% of households with children under the age of 18 owned firearms, exposing approximately 75,000 children to handguns, rifles or shotguns.
- The 1996-98 survey showed that 57% of firearm owners store their guns unlocked, 22% store them loaded, and 14% stored firearms both loaded and unlocked.

Healthcare providers should be aware that many of their patients possess firearms or live in homes where guns are stored. Some of these firearms are stored loaded and unlocked, fostering a real risk for injury or death.

The American Association of Pediatrics (AAP) released an updated policy on firearms in April 2000 (for more information, see their website at www.aap.org). The association states that "the most effective measure to prevent firearm-related injuries to children and adolescents is the absence of guns from homes and communities." **They also suggest that physicians and other health care professionals inform patients about the dangers posed by guns in the home. AAP suggest an educational approach with families, similar to the following:**

❶Discuss with parents the real danger keeping a gun in the home poses. Suggest the safest thing is not to have a gun, particularly a handgun, in the house at all.

❷If, however, an individual decides to keep a firearm, recommend strongly that the gun be kept unloaded and locked up. Advise locking and storing bullets in separate locations to which children do not have keys. Advocate that those who have handguns use locking devices.

❸Even if parents do not keep guns, draw their attention to the need to teach children about gun safety anyway. Suggest they talk with their children about the risks of playing with a gun and to steer clear of them. Recommend that they speak with the parents of their children's friends about keeping firearms in their homes empty and locked up.

The Tacoma-Pierce County Health Department has begun a campaign to encourage handgun owners to store their firearms with a locking device. Lock boxes, for example, keep guns out of the wrong hands and yet are quickly accessible for those who have guns for protection. **Give adults the following phone number to call for more information about handgun locking devices – lock boxes and trigger or chamber locks: 1 877-LOK-IT-UP (1-877-565-4887). This number connects to individuals who can provide information and also a coupon for discounts on locking devices.**

For many physicians, it has become routine to ask risk factor questions during an annual physical: Do you smoke? How much do you drink? Do you exercise regularly? Add questions about handgun possession and storage to that list. Protect your patients and their families from preventable harm. ■

Family Support Centers/ Maternity Support Services

Working with families who could use additional support and resoucres? Public health Nurses and Family support Workers are available throughout the county through the Family Support Center system.

Nursing services focus primarily on prenatal to age three, assessing families in their homes and creating an individualized plan of care. Social workers, nutritionists and family support workers connect families to community resources and assistance. Together, nurses and other professionals provide a seamless system of early prevention, parenting education and support.

Refer families to the Family Support Centers by calling Becci at the Health Department: 253-798-6403 or faxing information to her at 253-798-2872.

Questions?
Call Sue Walen, RN, at 253-798-6517 or Allison Kemmer, RN at 253-798-4700.

Online medical resources

MEDLINE ACCESS
Direct: www.nlm.nih.gov
Basic search: www.ncbi.nlm.nih.gov/PubMed/
Advanced search: http://ncb.nlm.nih.gov/PubMed/Medline.html
Image-based: www.nlm.nih.gov/research/visible/
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Delivery: http://tendon.nlm.nih.gov/ld/loansome.html

MEDICAL JOURNALS
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Am Medical News: www.ama-assn.org
Am Family Phys: www.aafp.org

OUTCOMES DATA
Medicare database: www.carescience.com
Stateistics: www.mdnetguide.com
Evidence-based med: www.cochrane.org

IMMUNIZATION/DISEASE OUTBREAK
Center for Disease Control: www.cdc.gov

PROFESSIONAL "COMMUNITY"
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List servs, newsgroups: www.hon.ch

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Phys. Desk Reference: www.pdr.net
Rx info: rxmed.com

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Prescribing: www.iscribe.com
Handheld internet access: www.ephysician.com
NIH Stroke Scale: www.neurotools.net
Transcription online: www.e-docs.net
Hist./phys.chklst: www.medinfo.ufl.edu
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COLLEGE OF MEDICAL EDUCATION

COME to survey for physician CME interest

The College of Medical Education will again survey member physicians for general and specific topic interest for course offerings. The survey will rate physician interest in macro areas of medicine citing the specialty breakdown listed in thePCMS Directory.

The survey will seek more specific topics of interest within the macro specialty areas. The survey will allow the College to respond to local physician need in designing and implementing courses.

The College will also solicit for specific physician interest inside the many annual courses designed for primary care. The courses offered annually focus on infectious diseases, mental health, cardiology, and allergy, asthma, and pulmonology.

The survey will also seek feedback on possible topics for the annual Internal Medicine Review and Surgery Update, organized annually by the Tacoma Academy of Internal Medicine and the Tacoma Surgical Clubs respectively. And the survey will seek topics for the College's multi-specialty conferences, such as the annual course held in Whistler. Finally, suggestions for new courses will be sought.

The survey will be conducted in May, and will aid the College Board in preparing next year's CME program schedule.

Continuing Medical Education

GI Disease Course Designed for Primary Care Physicians

Registration is open for the 5th Annual G. I. Course set for **June 2, 2000** at the Washington State History Museum. Co-directors of the course are **Drs. Gary Taubman & Richard Tobin.**

This one-day course is designed for the primary care physician and should also appeal to the specialists and ancillary health professionals with an interest in abdominal and gastrointestinal medicine. The course emphasizes a practical and multi-disciplinary approach.

Specifically called "Nuts, Bolts and Innovation in Gastrointestinal Disease" this course is co-presented by the College and the Tacoma Gut Club.

Club members represent a diverse group of expert physicians from Seattle to Olympia, both in academic and private medicine. The following are a few of the topics that will be addressed:

- Gastrointestinal trauma
- End stage liver disease
- Thinking about PEGS

Allergy, Asthma, Pulmonology CME scheduled May 5

The College's CME program featuring subjects on allergy, asthma and pulmonology is set for **Friday, May 5.** The course is under the direction of **Alex Mihali, MD.**

This is a one-day update designed for the primary care provider. It will focus on diagnosis and management of common allergy, pulmonology and asthma problems and is complimentary to all area physicians.

The program will be held at the new Lagerquist Center in St. Joseph Hospital.

This year's program will feature presentations on:

- Asthma
- Sinusitus
- Allergic Rhinitis
- Pneumonia and COPD
- Lung Cancer Screening & Management
- Atopic and Contact Dermatitis

For registration information call the College at 627-7137. Although no registration fee is required, physicians wishing to attend must complete and return a registration form. The conference is anticipated to fill, so early registration is encouraged.

Dates	Program	Director(s)
Friday, May 5	Asthma, Allergy & Pulmonology for Primary Care	Alex Mihali, MD
Friday, June 2	Nuts, Bolts & Innovation: Gastrointestinal Disease V	Gary Taubman, MD Richard Tobin, MD

Cruz

from page 6

Cruz acknowledges he is not likely to back down from the stands he has taken, regardless of what his opponents do.

"I like conflict," said Cruz, who was born and reared in Green Bay, Wis. "I don't mean I'm looking for fights. But if I am engaged in my job and it upsets people and they get in my face about it, this helps me get focused."

Cruz's critics say he violates privacy rights. They say people who carry HIV or have TB in the inactive stage will not be tested or seek medical help if they know their names will be reported to the health department. Cruz insists those fears are unwarranted.

"The public doesn't understand the way we handle that information," he said. "Everything is under lock and key...There are multiple levels of security, and staffers know that if they violate the confidentiality of patients, they lose their job and have a chance of going to jail."

Sometimes privacy rights just have to take a back seat, Cruz says.

"Individual rights always come in second to the rights of the community to protect itself," he said. "When you don't have a cure for something, you have to figure out a way to protect the community."

Cruz completed his medical residency in obstetrics and gynecology after returning from Guatemala. And he held a number of public health positions in Georgia and Florida.

By then, he was earning a reputation as a merchant of change. He would go into an agency, shake it to its core, stay three or four years and move to another agency to do the same thing again.

The Tacoma-Pierce County Health Department was going through troubled times when Cruz packed up his family and moved here. City and county officials were unhappy about a major budget shortage. The department's leadership was being criticized for threatening to slash vital services without even looking at other possible cuts. And there was a sexual-harassment scandal brewing.

"They wanted change...and I'm good at making change," Cruz said. "That's my personality. That's my style...I'm not a long-distance runner. I'm a sprinter."

Cruz says he promised his children that the family would not move again until they were through school. His son has graduated, but he has a daughter in the sixth grade.

Future battles?

Violence prevention, gun locks, programs to stop alcohol abuse by young people.

There is much that needs to be done, and we need to be aggressive," Cruz said. ■

Reprinted from The Seattle Post-Intelligencer, April 4, 2000

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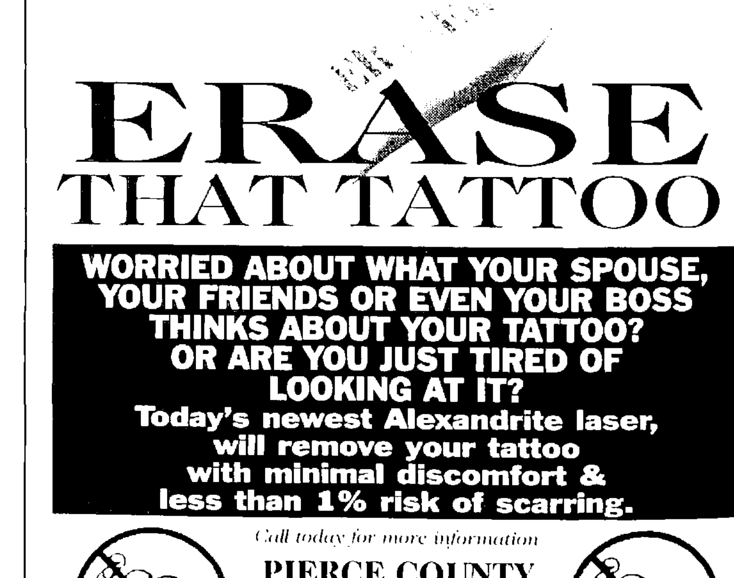

In My Opinion.....

by Teresa Clabots, MD

$15 for a Kawasaki

Teresa Clabots, MD

I started my solo practice in 1998, after being with a group and a multi-specialty clinic for several years. Many of my patients followed me, and I worked diligently to transition them to my new office.

After 4 months of working without pay, I asked my biller why this was happening. I presumed it would take three months, but four seemed a little much. Patients had my name on their insurance card and came to me for their care, I submitted the claim, but the money continued to go to my former employer. What a fiasco. I learned very quickly what the rules of the insurance company are - whoever "owns the contract" receives the money. Although I performed the work, the insurance company continued to mail payment to the doctor that the insurance company had "reassigned" the patient to. They did not contact the patient or receive their permission to do this.

One newborn I saw daily, did a newborn check, and a two week, and two month follow up. After several attempts at collection, the plan admitted that the baby was mine, but informed me I had to re-apply to the plan. I explained that I had been with their company since 1986, and I saw no reason 13 years later that I should have to re-apply. They told me that they had been informed I had quit medicine, (which was not true). I submitted my application. The mother was told that yes, I could be her provider. The infant came in with a fever, and I couldn't find the source. I re-examined the infant 24 hours later. He was more irritable, he had erythematous conjunctiva, and at the time I was reading the book called, "the Hot Zone." The first thing that came to my mind was Ebola virus.

I referred the infant to the inpatient service at Mary Bridge. They soon diagnosed Kawasaki's. I called the infectious disease doctors and called the CDC, who faxed me the form to fill out, and I went to see him at lunch. From red conjunctivitis and irritability and fever, he had developed a desquarnative rash, mucosal hemorrhaging, and his echo showed coronary aneurysms. Surrounded by his family members and an IV running with Immunoglobulin, he was very, very sick. I went back to my office and filled out a referral form to the Mary Bridge inpatient team, since I was the primary care physician. The plan denied the referral. They said that I was not the primary care physician. I said, "well you are going to pay for the Mary Bridge services, aren't you?" They said, "no, we have to have a valid referral to do that." I argued, "I have been on your plan for 13 years, you reassigned him to a doctor without the parent's authorization, I have been seeing the baby since he was born, and he is now four months old, and even though you won't pay me you must pay Mary Bridge." They told me that I needed to contact the physician that the baby had been assigned to, get them to return the $15.00 monthly capitation fee, and then they would assign the baby to me, and I could then do the referral to Mary Bridge.

This baby ran up quite a bill, and the parents had paid for insurance. It seemed only right that they should get full advantage of their paid benefits.

I contacted my colleague and explained the situation. I asked her to just make the referral to Mary Bridge so that the inpatient service, MBCH, and the cardiologist could get paid. She refused. I called the plan and they suggested that she return her $15.00 capitation fee, which would allow me to do the referral once the patient was reassigned to me. This would also record the hospital statistics under my name rather than hers. I called her again and asked her to return the $15.00 to the plan for the last month, so that I could receive assignment for the patient, and consequently do the referrals. She refused. I got angry and called her boss. He also very politely refused. By now I was furious. I could not believe it. For just $15.00! The insurance company said, "our hands are tied."

I called the WSMA, I called the Attorney General's office, I called the Insurance Commissioner. I wrote a letter of complaint to Deborah Senn.

One month later, thanks to Deborah Senn's office, Mary Bridge was paid in full. It took me almost eight hours of the little free time that I have to get this accomplished Our system is broken.

Last month United Healthcare decided to stop requiring "preauthorizations." They had spent 100 million dollars to "manage" 100 million dollars of health care. About time. I sure hope other plans will see the light. ■

Right from page 11

care they cannot earn, in defiance of justice. A society may exist for some time in defiance of justice, but it certainly cannot prosper and eventually it collapses from internal or external pressure because it lacks the will to defend itself.

Before Medicare and Medicaid many hospitals had charity wards. The physical facilities were simple, the amenities were minimal, privacy was nonexistent, the care was given by students and residents. The patients paid some cash for their care, but the cost was low, and if they couldn't pay they still got care. They paid by allowing the young physicians to learn medicine by taking care of them. That was their contribution to the community. That is how they earned the care they received. Payment does not always have to be in cash, but justice requires payment. A right cannot be right if someone is wronged as a result.

This does not exclude the need for a social safety net. Destitute and sick people potentially can be a source of disorder in society and there should be a way to take care of them. In the past this was done by hospices, usually run by the churches and supported by private contributions. The recipients of such help were fully aware that what they received was a gift, not theirs by right, but given to them through the good will of others, to be repaid as best they could.

Unfortunately, there is no going back to the "good old times." When something has been given to the people, it cannot be taken away. Instead, something else happens. What is given free gradually exhausts the resources allocated to it and loses its value. By the time it becomes almost worthless, the system falls apart. At some point along this line, before the old system breaks down completely, we will have to build a new one. However, if we want it to last, we will have to base it on the principle of justice, on the trade of value for equal value. Somewhere in there we will find that helping people has some value, but they also will have to know that this help is not theirs by right and they will have to earn it.

Every system is based on some give and take, and these have to be fairly balanced in order for the system to survive for long. If there is more give and not enough take, the system will use up its resources and wither away. If there is more take and not enough give, the system becomes bloated and dysfunctional, eventually bursting at the seams and destroying itself. Justice requires a balance. I would like to close with two proverbs, an English one, "right wrongs no man," and a German one, "he who refuses to submit to justice must not complain of oppression." ■

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The Pulse

PCMS Alliance

A general meeting was held on March 14, 2000 at the Medical Society office in the board room. The meeting was called to order at 10:10 a.m.

Members attending included **Kathy Samms, Mona Baghdadi, Kris White, Alice Yeh, Helen Whitney, Fran Thomas, Nikki Crowley** and **Ginnie Miller.** President **Yolanda Bruce** presided. Karen Bolin, WSMAA Membership Chair was also in attendance.

Minutes of the January, 18th meeting were approved as amended. Treasurer's report noted a balance of $3,200 after dispensing the philanthropic funds. There were no outstanding bills.

Committee Reports:

Philanthropy - Fran Thomas read thank you notes from recipients of funds from the Holiday Sharing Card.

Health Promotion - Alice Yeh reported information on the April Stop TV Viewing for one week project, suggesting an aim for family time that week. Also mentioned was the Milton MOM March scheduled in Washington D.C. on Mother's Day to advocate gun control.

Cell phone collection for use in family shelters for emergencies was discussed.

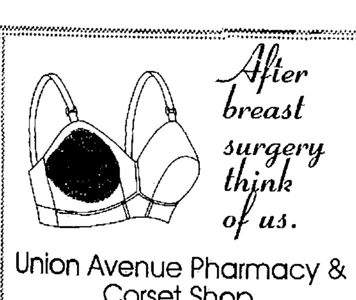
Recall list for car seats will be made available through Safe Kids Coalition to take to thrift stores.

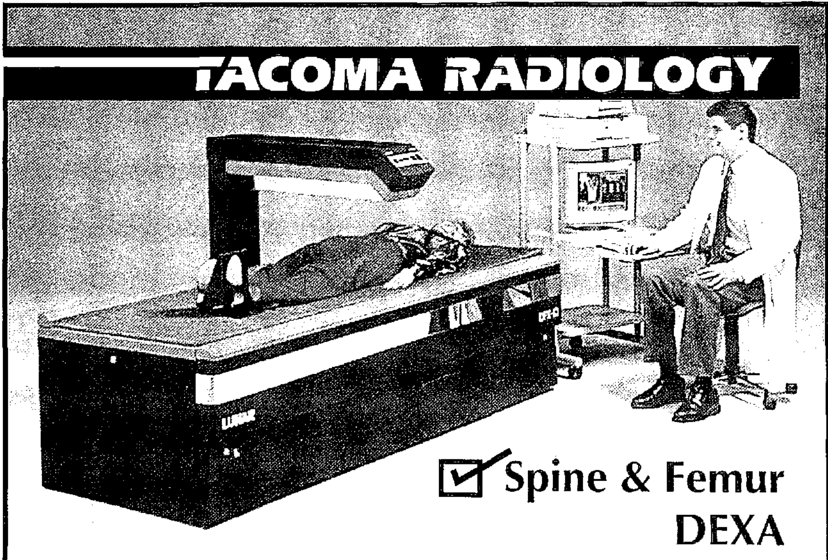
Anton's Law requiring booster seats for children out of car seats and still under 80 pounds will be signed into law in this session of the Legislature.

Comments from guests: Karen Bolin stated that WSMAA wanted to show support to PCMSA when they sent their letter in January. Cindy Berger expressed concern about the loss of philanthropic funding if going inactive or disbanding. Kris White spoke as WSMAA president regarding the changes occurring at the State; the change for the WSMAA into a committee of the WSMA.

Discussion was held concerning the status of the Alliance and the recommendations from the Board to the membership. Ballots were distributed and counted. The vote was to disband. No further action will be taken until the Pierce County Medical Society has formed their Foundation and received nonprofit status. The PCMSAA will maintain their 501(c)(3) status as needed to continue with the Holiday Sharing Card and its Philanthropy Outreach until that time.

On Wednesday, May 17, 11:30 a.m. a luncheon will be held at Grazies. To make reservations, call Nikki Crowley at 253-922-7233. ■





EMTALA from page 3

become very sensitive to decisions made by on-call physicians who may not actually see the patient, but who determine the patient can be discharged, or can be seen the next day during office hours, or can be followed up at a later time. ER physicians are now required to document the fact that an on-call physician fails or refuses to come to the ER to see a patient (under EMTALA law, because the patient can't pay, but in HCFA's view, for pretty much any reason) and the on-call physician and the hospital may be subject to a substantial fine. Not surprisingly, hospitals would like to require that an on-call physician come to the ER every time he or she is called, because it minimizes the hospitals' liability. Clearly this kind of requirement would put a huge burden both on physicians and on the health care system generally.

An "appropriate transfer" must be carefully documented. If a transfer must be made without stabilizing the patient because the hospital does not have the capability to do so, then written certification of the transfer has to include the medical conclusion that the medical benefits reasonably expected from transfer outweigh the increased risks to the patient. If the transfer is a discharge to home or to a physician's office for follow-up, then the certification must include the physician's documentation that the patient's condition is stabilized.

The purpose of EMTALA was to prevent patient "dumping". Dumping is defined as "the practice of hospital emergency departments, despite being capable of providing the needed medical care, transferring patients to other facilities or turning them away because these patients are unable to pay." Dumping includes discharging a patient who is not stabilized, and not providing an appropriate screening exam. "Constructive dumping" includes long delays in providing treatment; for example, if the hospital is unable to locate an on-call physician willing to come to the hospital to see the patient because the patient is indigent. Again, this situation causes hospitals to be very concerned about on-call physicians not coming to the hospital to see a patient. If the on-call physician, in conjunction with the ER physician, determines in good faith that he or she does not need to see the patient in the ER, then that determination must be clearly documented by the ER physician.

EMTALA allows an individual who suffers personal harm as the result of a hospital's violation of EMTALA to bring a civil action against the hospital. Physicians cannot be sued directly for EMTALA violations, though hospitals who are sued could seek contribution from a physician for damages the hospital is required to pay. Hospitals and physicians are also subject to civil fines of up to $50,000 for each violation. Finally, both hospitals and physicians may be excluded from the Medicare program.

Local Issues and Recent Cases

The Emergency Medical Treatment and Active Labor Act ("EMTALA"-The Patient Anti-Dumping Law) is getting increased attention from both government officials and patients and their lawyers. A recent survey of "hot" health care issues for the year 2000 included EMTALA enforcement as a high government priority. The figures bear this out: in fiscal years 1987-1997, OIG reached a total of 79 settlements and judgments for EMTALA violations, worth about $1.84 million. In fiscal year 1998 alone, the agency reached 53 settlements and judgments, and in the fiscal year 1999, 61 settlements and judgments. In OIG's Region 10, which includes Washington, there were 11 EMTALA enforcement cases in fiscal year 1999.

The Department of Health and Human Services, Office of the Inspector General ("OIG") recently published a special advisory clarifying hospitals' responsibility to provide emergency care, particularly with respect to managed care patients. One of OIG's particular concerns is that patients may routinely be kept waiting so long for services that they leave without being seen. Another concern is that hospitals will delay performing the required screening exam of a managed care patient in order to get authorization from a managed care company for payment.[1]

While hospitals bear the primary responsibility for EMTALA, physicians are affected as well. Emergency room physicians and other emergency room staff must perform the appropriate screening exams, stabilize, or arrange for stabilization of, patient, and document the entire process, including the need, if any, for transfer. On-call physicians are specifically identified in regulations as being part of the capability of the emergency department, and hospitals are required to maintain a list of on-call physicians to provide treatment necessary to stabilize patient emergency medical conditions after the screening exam. On-call physicians are included in the definition of a "responsible physician" subject to monetary fines for EMTALA violations. Of the 11 Region 10 enforcements in fiscal year 1999, two cases involved on-call physicians: one a refusal of a physician to accept a transfer; the other a physician who refused to come to the emergency room at the request of an "on-call" emergency room physician. (Most of the other cases, according to Region 10 HCFA officials, involved charges of inadequate screening exams.) The emergency physicians are expected to report on-call physicians who refuse to see a patient without a reasonable basis.

A case last year from West Virginia points out the level to which government officials may be involved in deciding whether physician's actions were appropriate. In that case, five auto accident patients, two with severe head and abdominal injuries and bleeding, were brought to a small rural hospital with no trauma center, and a

See "EMTALA" page 21

EMTALA

from page 20

longstanding policy of transferring such patients to larger hospitals. Dr. Cherukuri, the surgeon on-call that night, was charged with violating the "stabilization" language of EMTALA, because he transferred the two patients with head injuries to a larger trauma center before operating on their stomach injuries to stop internal bleeding. The charge was that where there is internal bleeding, stabilization required an abdominal operation by the surgeon before transfer.

The court ultimately dismissed the charges against the surgeon, concluding that he had sufficiently stabilized the two patients prior to transfer without performing surgery, and that he did not even have anesthesiology available so that he could operate. There was no evidence at all the hospital intended to "dump" the patients, and it was undisputed that the conditions of the two patients did not deteriorate during the transfer to the trauma center. The case demonstrates, though, the extent to which government officials can "second guess" medical decision making.[2]

The American College of Emergency Physicians recently released a study (available at its website, <www.acep.org> "Defending America's Safety Net"), which discusses on-call coverage in relation to EMTALA. It is already difficult for hospitals to fulfill their legal duty to provide on-call coverage. Physicians, dealing with restrictions of managed care, heavier work loads, anticipation of retirement, or just the desire for a saner lifestyle, are less inclined to take trauma call. Hospitals are being forced to enforce mandatory call coverage requirements as a condition of medical staff membership, very unpopular with physicians; or to pay stipends for physicians, especially specialists, to serve on-call. EMTALA is an "unfunded mandate"–a huge additional financial burden to hospitals and physicians already facing declining reimbursement. Yet increasing enforcement efforts, and the fact that many plaintiffs' lawyers treat EMTALA as an extension of medical malpractice law, are unrelenting pressures.

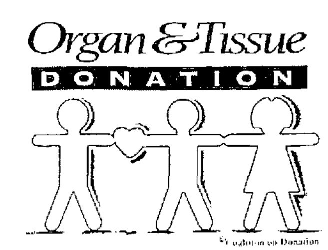
Local hospitals feel (pursuant to HCFA interpretive guidelines on EMTALA) they must create an on-call list of each specialty practiced in the hospital, but in some specialties the burden then falls on very few physicians. Specialists may be very hesitant to be on a specialty list for an area of practice they haven't spent time with since medical school. It may well be that to do so would constitute a standard of care problem, generating malpractice issues along with EMTALA problems.

Hospitals also have a tendency to want an absolutely uniform procedure (requiring on-call physicians to come to the ER for every call, for example), an expensive and probably unnecessary solution. Physicians, on the other hand, need to acknowledge that a very few of their colleagues may unreasonably refuse to respond to calls, and that puts hospitals and other physicians at risk. Determinations about screening, stabilizing treatment, and possible transfers need to be made by emergency physicians or other personnel in conjunction with on-call doctors on a case-by-case basis, reasonably and in good faith being sure the process is documented.

What is the solution? The regulating climate makes it imperative that hospitals and physicians collaborate to solve a community wide problem. ■

[1] 64 Federal Register 61353(11-9-99)

[2] Cherukuri v. Shalala, 175 F.3d 446 (6th Circuit, 1999)



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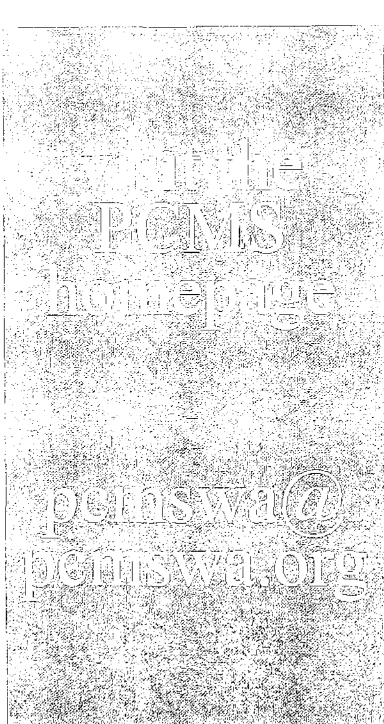

A Different Perspective

If we could shrink the earth's population to a village of precisely 100 people, with all the existing human ratios remaining the same, it would look something like the following. There would be:

57 Asians
21 Europeans
14 from the Western Hemisphere, both north and south
8 Africans
52 would be female
48 would be male
70 would be nonwhite
30 would be white
70 would be non-Christian
30 would be Christian
89 would be heterosexual
11 would be homosexual
6 people would possess 59% of the entire world's wealth and all 6 would be from the United States.
80 would live in substandard housing
70 would be unable to read
50 would suffer from malnutrition
1 would be near death
1 would be near birth
1 (yes only 1) would have a college education
1 would own a computer

When one considers our world from such a compressed perspective, the need for acceptance, understanding, and education becomes glaringly apparent.■

Phillip M. Harter, MD, FACEP
Stanford Univ School of Medicine

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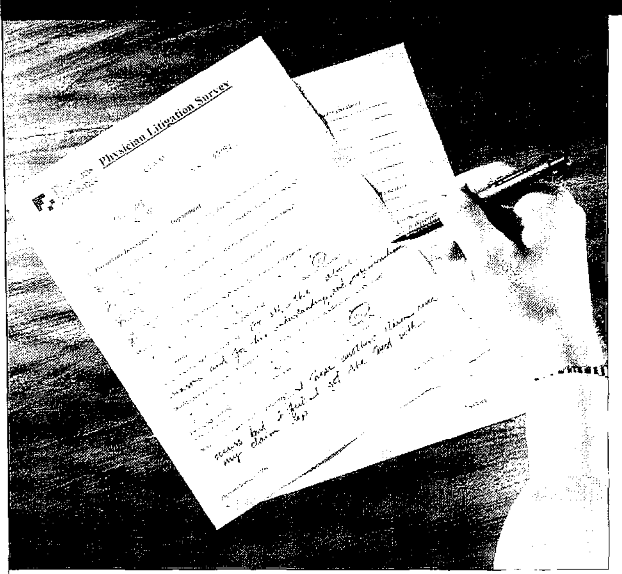

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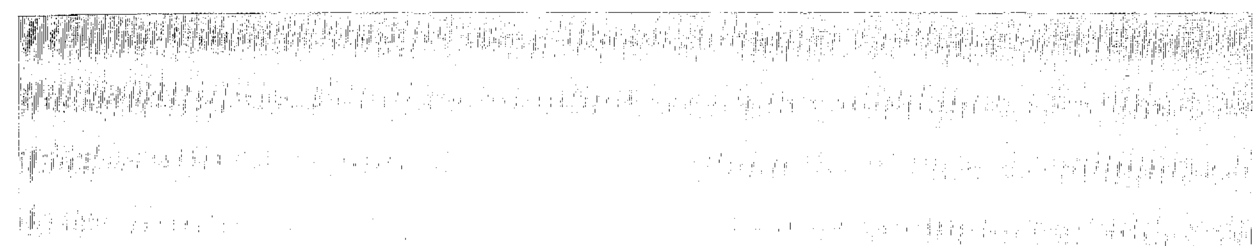
BULLETIN

June, 2000



INSIDE:

3 President's Page: The New Physicians
4 Mimi Pattison, MD and End-of-Life Care program earn national recognition
6 Area hospital leaders discuss the future of healthcare in Pierce County
7 June General Membership meeting features an evening with Dr. Cruz-Uribe
8 Update your 2000 PCMS Physician Directory with recent changes
10 PCMS Welcomes new members
12 TPCHD: Hepatitis B and D Update

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The Bulletin is dedicated to the art, science and delivery of medicine and the betterment of the health and medical welfare of the community. The opinions herein are those of the individual contributors and do not necessarily reflect the official position of the Medical Society. Acceptance of advertising in no way constitutes professional approval or endorsement of products or services advertised. The Bulletin and Pierce County Medical Society reserve the right to reject any advertising.

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Pierce County Medical Society

BULLETIN

June, 2000

Flag Day
June 14

Table of Contents

3 President's Page: The New Physicians

4 Mimi Pattison, MD/End-of-Life program honored by AHA

5 "Disappearing Nurses," by Lorna Burt
Letter to the Editor, from Grace Moses

6 May General Membership Meeting well attended

7 June General Membership Meeting to feature Dr. Cruz-Uribe

8 2000 Physician Directory Changes
Important L&I phone numbers

9 The Invisible Hand: "Reputation vs. Regulation"

10 Welcome New Members

11 TPCHD: Hepatitis B and D Update

12 Applicants for Membership

13 PCMS Bicycle Club members pedal 50 miles in Daffodil Classic

14 "Nostalgia of World War II," by John Stutterhiem, MD

15 "Dr. GENIUS and the RED SNAPPERS," by Teresa Clabots, MD

17 College of Medical Education

21 Expedition leader to speak at September General Meeting

23 Classified Advertising

President's Page

by Charles Weatherby, M.D.

The New Physicians

Charles Weatherby, MD
PCMS President

Chiropractors. Naturopaths. Acupuncturists. Aroma therapists. Massage Therapists. Complementary and Alternative Medicine. Many of us "real physicians" laugh and even scoff at these alternative providers. How dare these providers try to use their unproven and nonscientific anecdotal treatment regimen on the American public. After all, in what "real" journals do we see their research being published? What does the FDA say about their latest drugs? My question is, who's fooling who?

I recently attended the Washington State Medical Association Leadership Conference. At this conference, I learned that Complementary and Alternative Medicine (CAM) is now becoming a large part of the American Health Care System. Americans are now spending $24 billion annually on CAM. That number is growing exponentially yearly. Almost all of this is out-of-pocket. That's right. Cash money. They don't have to worry about that middle man called health insurance. However, they soon may. These providers as well as their patients are lobbying nationally for health care coverage for these services. There is legislation being introduced in our state every year in support of this. Our own state insurance commissioner is on record as supporting this legislation.

> "If our patients are flocking to these CAM providers and are now willing to pay these bills out-of-pocket without insurance reimbursement, it is time for us "real physicians" to wake up."

When you are talking about a $24 billion market, it is no longer a laughing matter. The health care market is definitely a finite market. So, if $24 billion is going to one portion of the market, $24 billion must be removed from another portion. If legislation is passed, we will then see less out-of-pocket patient expenditure and more insurance reimbursement. One study estimated that 75% of patients who use CAM providers don't inform their "real physicians." At the conference, I was quite surprised that with a show of hands, over one third of the physician attendees had received care from a CAM provider during the previous year. What does that tell us about our fellow physicians?

Our medical leadership is at least trying to make us aware of the CAM situation. How we respond to the situation is up to us as individual physicians as well as us as a medical society. If our patients are flocking to these CAM providers and are now willing to pay these bills out-of-pocket without insurance reimbursement, it is time for us "real physicians" to wake up. What are these CAM providers doing that we are not? Are we making our patients feel too rushed in our average eight to ten minute encounters while they are spending 30-45 minutes? Are we becoming more distant and impersonal? Do patients prefer their hands-on/manipulative approach to our perceived just-take-a-pill approach? Do the CAM providers actually listen to the patient while we just expect the patient to listen to us? Whatever the reason, it's time that we realize that there are non MDs/DOs providing health care and the American public is seeking them out. There must be ongoing discussion and debate about this issue on a local, state, and national level. We must realize that despite how we view ourselves as the expert in regards to health care, the American public is seeking other options. So, in our discussions regarding the future of health care, let's not forget to include the American public at our roundtable.■

End-of-life care program and medical director Mimi Pattison, MD earn national AHA recognition

Franciscan Health System's innovative way of caring for patients at the end of life recently earned national distinction as one of three programs in the nation to win the American Hospital Association's Circle of Life Award.

Mimi Pattison, MD

Emmy Award-winning television journalist Bill Moyers presented the award to Franciscan's Improving Care Through the End of Life program at the annual meeting of the American Hospital Association's (AHA) subsidiary, Health Forum, held in Orlando, Florida in early May.

"It has been my privilege to work with a team of caring professionals and volunteers who have developed this program and provide a unique approach to care at the end of life," said the program medical director **Dr. Mimi Pattison,** a primary care physician at Franciscan Medical Group's Gig Harbor Clinic.

The main goal of Franciscan's medical clinic program is to help patients choose how they want to live the rest of their lives, not just how they want to die. Their program also lends supports to family members. The program is not hospital-based, but is developed for clinics, three of which are already operating through Franciscan Medical Group. The program relies on a nurse coordinator, chaplain, physician, and a corps of volunteers to marshal the resources in the community, clinic, and hospital to ensure that dying patients have the support they need and want so they can live full and more meaningful lives.

The program and services are tightly linked to the patient's physician. The coordinator regularly checks with physicians in the clinic to find out "if they would be surprised if any of the patients with certain conditions died in the next year." If the answer for a particular patient is, "no," the patient is a candidate for this innovative program that will connect them to people and community programs. The program also educates patients and their families about their hospice benefits, resulting in earlier hospice referrals.

"It's an honor to be recognized nationally for something we started as a very simple approach of reaching out to patients and families," said program director Georganne Trandum, RN. "Chronically ill patients need support and easy access to their doctor's care. Improving Care through End of Life fills a gap and builds a bridge until the time is right for Hospice."

The three programs were the first recipients of the new *Circle of Life Award: Celebrating Innovation in End-Of-Life Care,* which will be given annually to up to three programs. The awards are funded by the Robert Wood Johnson Foundation, Princeton, N.J. (RWJF), initiated by the AHA, and co-sponsored by the American Medical Association, the National Hospice and Palliative Care Organization, and the American Association of Homes and Services for the Aging. The sponsors collectively represent the majority of hospitals, physicians, hospices, nonprofit nursing homes, and elder services in the nation.

Franciscan Health System includes St. Clare Hospital in Lakewood, St. Francis Hospital in Federal Way, St. Joseph Medical Center in Tacoma, Franciscan Medical Group (a multi-specialty provider network), and the Franciscan Care Center at Tacoma, a continuing care facility. Franciscan Health System is a part of Catholic Health Initiatives, one of the largest not-for-profit health care systems in the country.

Congratulations, **Dr. Pattison.** ■

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In My Opinion.....

Disappearing Nurses

by Lorna Burt

Dr. Nichol Iverson's article in the March, 2000 PCMS Bulletin, "Hey Nurse" prompted me to look up the notes I took on a program that Barbara Walters presented November 26, 1999 on 20/20 "Your Life Is In Their Hands." Barbara interviewed Dr. Nancy Snyderman, a staff member of ABC TV, about "Disappearing Nurses." Dr. Snyderman's answers were chilling! It seems that to save money, hospitals in some areas are replacing nurses with people who have had less than a month of training. Some go from mopping up to bedside care in as little as three weeks. In one instance, a hospital was using people from a penal institution. They cost about a third as much as trained nurses. These employees are called PCAs (Patient Care Aides). They are unlicensed and learn on the job how to take a pulse and blood pressure, change IV lines, draw blood, and give medications.

They are not able to recognize a serious problem and take vital signs; therefore they may neglect to see that a patient gets prompt attention from the nurse on duty. The patient's life depends on the nurse's quick action to take care of the problem and notify the doctor.

Many more infections are showing up and are not being recognized; consequently more deaths are occurring as a result.

Dr. Snyderman declared that nurses are being discriminated against by the hospitals and are dismissed if they make any complaints. One nurse, when agitated for increased staff, was fired.

How do the hospitals in Pierce County measure up? Hopefully, better than other parts of the country. Perhaps some RNs in our area will answer this question for us anonymously, of course!

From the personal experience of a family member, I can say that Allenmore Hospital has excellent personnel. The nurses and technicians in the ICU were excellent, as well as the personnel on the surgical floor. Also, a gold star goes to the St. Joseph Rehab Department for the follow-up.

In the conclusion of the Barbara Walter's interview, Dr. Nancy Snyderman suggested that if you are a patient, ask, "Who is my nurse?" and then ask for assurance that any aides entering your room are licensed. In addition, have a family member and your doctor back you up. ■

Lorna Burt is the wife of retired general surgeon, Robert Burt, MD

Letter to the Editor

To the Editors:

Re: "Hey Nurse" by **Nichol Iverson, MD** (*Bulletin* March, 2000)

I found the first paragraph of your article so offensive that it certainly invalidated the content of your article.

I am offended that you assume that everyone would "get it as a joke" when you use "Black slang" to denote poorly trained hospital employees who lack compassion for patients.

You are using Black stereotypes to call attention to what you are saying and you are insulting Black people in the process.

Some attempts at humor are not clever or funny, just unpleasant.

Aggrieved, annoyed, and outspoken.

Grace Moses

Grace Moses is the wife of Dr. Buck Moses, retired Puyallup pediatrician.

(Editor's Note: PCMS apologizes for any misunderstanding.)

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Local hospital leaders draw large crowd at May Membership Meeting

Editor's Note: For a complete reporting on this program, please see the PCMS Bulletin, February, 2000, page 5.

Leaders from Franciscan Health System, Good Samaritan Hospital, Puget Sound Hospital and MultiCare Medical Center each gave their perspective on the future of health care at the May General Membership Meeting. Speaking were Joseph Wilczek, President & CEO for Franciscan Health System; Ed Miller, CEO, Good Samaritan Hospital; Mark Gregson, CEO, Puget Sound Hospital; and George Brown, MD, VP Acute Care, MultiCare Medical Center. Over 125 people attended the meeting.

All speakers agreed that changes in hospital/physician relationships and competition for dollars will continue.

Competition and challenge were words used often by all presentors. Challenges included issues such as reimbursements, medical mistakes, pain management, Wall Street, staffing and, of course, government regulations.■

Dr. Susan Salo, PCMS Vice President introduced the speakers and moderated the panel discussion

Federico Cruz-Uribe, agent-of-change Health Director, will tell his story at June General Meeting

Federico Cruz-Uribe, MD, MPH, Tacoma-Pierce County Health Department Director will speak at the June General Membership Meeting. The meeting will be held on Tuesday, June 13 at the Landmark Convention Center in Tacoma (see facing page, for details.)

Dr. Cruz will share his personal public health story and relate his own life-changing experiences, particularly his year in the Guatemalan highlands before the upheaval that made it impossible for him to remain there.

Federico Cruz-Uribe, MD

His accounts will bring him to Pierce County and encompass the philosophy and determination he uses everyday in battling traditional public health beliefs and other behemoth issues, such as tobacco advertising.

Since beginning his job as Health Director in 1992, he has implemented sweeping changes in the administration of the department, including a total shift in the philosophy of how public health is planned and administered in Pierce County. His first major change was to focus on disease prevention, leaving direct patient care to community health care providers.

FAX your registration (facing page) to 572-2470.■

From left, Drs. Steven Litsky, Carlos Moravek and Richard Dehlinger listen intently as hospital representatives share their thoughts about the future of health care

L to R: Drs. John McGowen, Col. Howard Cushner, Gerry McGowen and Leonard Alenick. Col. Howard Cushner, MC is Chief of Medicine at Madigan Army Medical Center

May 12, 2000

Medical
Oncology
Hematology
Associates

Lauren K.Colman, M.D.

Sujata Rao, M.D.

Jay B. Zatzkin, M.D., F.A.C.P.

M. Chris Chen, M.D.

Dear Doctor;

I am writing to request your financial support in our fund-raising efforts for the American Cancer Society, Pierce County Unit's Golf Championship, to be held July 28, 2000 at The Classic Country Club Golf Course in Spanaway, WA.

As the reverse side of this flyer indicates, the opportunity exists to provide support at many levels. The fight against cancer is an important issue for all of us who provide medical care in this region. I hope that you will consider providing generous sponsorship for this event. We would be thrilled to have you participate in the golf tournament as well, either as an individual or as part of a team.

If you have questions, please don't hesitate to page me or contact my office directly to discuss this matter further. My pager number is 207-7310.

Thank you very much for your time and consideration in this matter.

Very truly yours,

Jay B. Zatzkin, M.D., F.A.C.P.
Medical Oncology-Hematology

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AMERICAN CANCER SOCIETY GOLF CHAMPIONSHIP

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$2,500 Eagle Sponsorship	•One foursome	•May detail the event. •Company name included in all publicity and advertising •Company banner at awards ceremony. •Introduction of company representative at awards ceremony.	•Program listing by sponsorship level. •1/2 page ad in program.	•Two hole signs.
$1,000 Birdie Sponsorship	•Two individual entries	•May detail the event. •Company name included in all publicity and advertising. •Company banner at awards ceremony. •Introduction of company representative at awards ceremony.	•Program listing by sponsorship level. •1/4 page ad in program.	•One hole sign.
$500 Par Sponsorship	•One individual entry.	•May detail the event. •Company name and logo displayed by sponsorship level at awards ceremony.	•Program listing by sponsorship level.	•One hole sign.
$200 Hole Sponsorship		•Company name and logo displayed by sponsorship level at awards ceremony.	•Program listing by sponsorship level.	•One hole sign.

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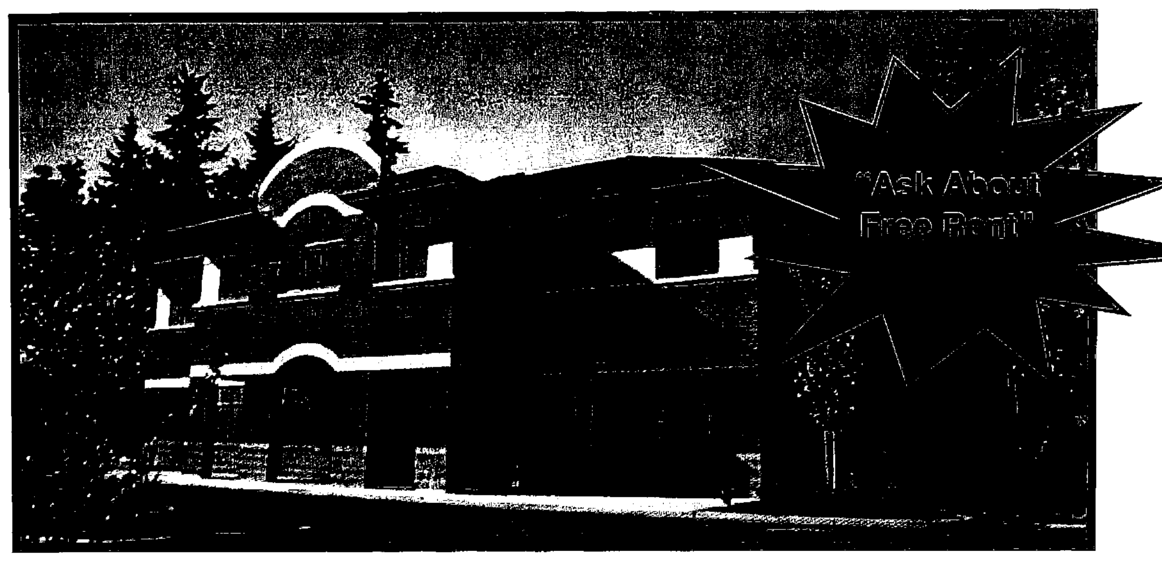

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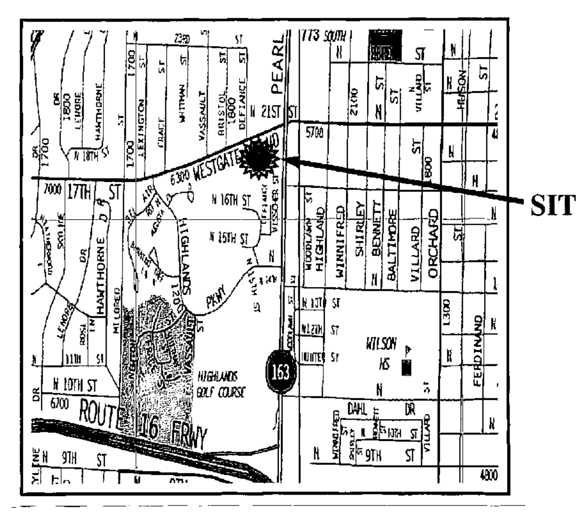

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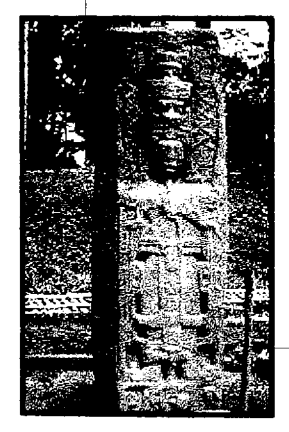

An evening with
Federico Cruz-Uribe, MD, MPH
Director of Health

(Registration required by June 4. Return this for to: PCMS, 223 Tacoma So, Tacoma 98402; FAX to 572-2470 of call 572-3667)

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Signed ______________________________________ Thank you!

2000 PCMS Directory changes

Please make note of the following changes to your 2000 PCMS Physician Directory. Updates will be made each month in the Bulletin.

Archer, Bryan, MD (Retired)
Change address to: 3230 W 51st Vista
Ferndale, WA 98248
Phone: 360-312-9460

Becker, Herbert, MD
Add pediatric ophth to specialty

Brachvogel, Max, MD
Retired 4/28/2000

Stephen Duncan, MD
Change address to: Group Health 611
31st Ave SW Puyallup, WA 98373-3723

Ginsberg, Daniel, MD
Change 552 phone prefixes to 403

Gustafson, Julie, MD
Change address to: 104 27th Ave SE
Puyallup, WA 98374

Hamill, Lisa, MD
Physician only phone # 403-6059

Huang, Dur, MD
Change address to: 2223 S Meridian #A
Puyallup, WA 98371-7503

Klatt, Gordon, MD
Change address to: 1307 South 11th
Street, Tacoma, WA 98405
Phone: 274-9732
Physician only phone: 274-9737
FAX: 274-9736

Mihali, Alex, MD
Change 552 phone prefixes to 403

Pratt, David, MD
Change specialty to Orbital and Facial
Plastic Surgery

Realica, Ross, MD
Change middle initial to M.

Roller, Gilbert, MD (Retired)
Change address to: 805 61st St. Ct. W.
University Place, WA 98467

Schmitz, Bradley, MD
Change 552 phone prefixes to 403

Stringfellow, Steven, MD
Physician only phone # 403-6059

Wilson, James M., Jr., MD
Change 552 phone prefixes to 403 ■

Important L&I phone numbers

Nurse Consultant:
Lindsay Shuster 360-902-9105
Nurse Consultant Supervisor:
Pat Patnode 360-902-5030

Claims Unit
360-902-9105
360-902-6666
Claims Unit Supervisor:
360-902-4742

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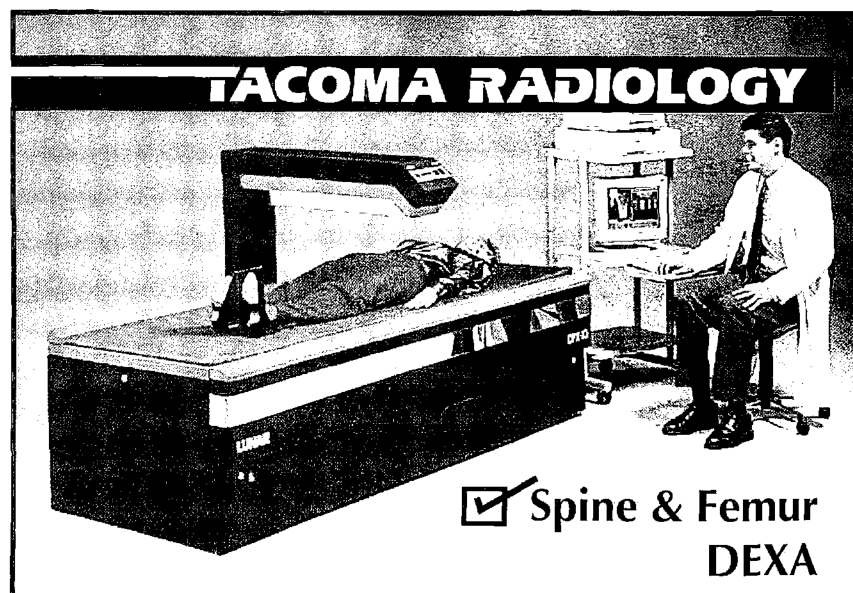

In My Opinion.... The Invisible Hand

by Andrew Statson, MD

Reputation versus Regulation

Andrew Statson, MD

Escaping with your reputation is better than escaping with your property.
African Proverb

In 1976, the Bellevue-Stratford hotel in Philadelphia entered the name of the American Legion into the annals of medicine and into the textbooks of internal medicine and microbiology. The outbreak of what became known as Legionnaires disease was traced to the air conditioning system of the hotel. I remember the rumor that the hotel had been inspected by the local health department a few months earlier. This is not unusual, since all establishments offering food and lodging to the public are inspected periodically. Of course the health inspectors could not have been expected to detect or, if detected, to realize the significance of a little known germ, which, until then, had not been implicated as a human pathogen.

The hotel cleaned up its air conditioning system, was re-inspected and certified fit for occupancy by the health department. The market, however, had a different idea. After two years of financial losses the hotel had to close its door. You may argue that the action of the market was too harsh. The hotel perhaps did not deserve that punishment. After all, the management could not have known about the contamination with legionnella, so how could it have prevented it?

That is true. The management could not have known of the contamination with this specific germ. However, it should have known that air conditioning systems gather moisture and dust, and these two together represent a favorable environment in which germs can grow. It should have known that such growth can be prevented by regular and thorough cleaning of the water collecting trays, the filters and the ducts. Removing the moisture and the dust would have done it. They did not live up to the quality of service the market expected of them and they suffered the consequences.

In the early days of the Old West there were no regulations, no inspections. People made it or failed on the basis of their reputation. In his book "Doctors of the Old West" Robert Karolevitz writes, "No-one will ever know how many men called 'Doc' practiced their own version of medicine with neither degree nor formal education. At the time, they filled a gigantic void and, to their great credit, many of them achieved a professional level which few 'diploma doctors' could boast. But, at best, it was on-the-job learning process with success or failure measured in terms of life or death. In retrospect, it is obvious now that even the school-trained physicians were more ignorant of the science they pursued than they could possibly have imagined."

Texas was the first state in the West to establish a board of medical examiners in 1873. Three years later, California passed the first medical practice law. When William Worrall Mayo opened his office for the practice of medicine in Rochester, all he had to do is put up his shingle. His two sons established the Mayo Clinic, which was destined to become one of the most prestigious medical institutions in the world. It achieved this stature not on the basis of certifications, inspections, licenses, credentials, evaluations or any other actions of any medical or political organization or authority; but on the basis of a very simple factor, its reputation for good work.

More from "Doctors of the Old West": "Wherever several medical doctors of serious intent congregated, they soon were meeting to discuss the formation of an association, to advance the causes and the knowledge of their profession, to eliminate the unworthy and to banish the quack. Education and licensing were heated topics. In the Old West, until territories and states were created, legal restrictions were virtually nonexistent, and, in many places, a doctor was a doctor simply if he said he was.... Out of this medical melange, however, evolved a professional unity which rose above the charlatans and the montebanks. But people being gullible as they are, quackery never did disappear; it merely changed its form."

With minimal knowledge and training, the doctors of the Old West had to learn their limitations and do the best they could to treat frontier people under frontier conditions. Those who did earned the respect of the people they served. Those who didn't were run out of town. Granted, they could go someplace else and start all over, but unless they mended their ways, they were bound to get into trouble again. At least, they had another chance and an

See "Reputation" page 20

New Members

Druet, Jack J., MD
Pain Management
Practices at Allenmore Anesthesia Associates, 1901 S Union St., Tacoma, 98411; Phone: 596-5131
Medical School: UCSF
Internship: USCF
Residency: USC
Fellowship: Stanford

Haberlin, Polly R., MD
Internal Medicine
Practices at MultiCare Internal Medicine, 521 MLK Jr Way, Tacoma, 98405; Phone: 403-1590
Medical School: Univ of Washington, School of Medicine
Internship: Veterans Administration Medical Center
Residency: Internal Medicine Spokane

Hills, Sandra L., PA-C
Family Practice
Practices at Lakes Medical Center, 19820 Hwy 410, #101, Bonney Lake, 98390; Phone: 862-9969
Medical School: Univ of Washington

Kahlstrom, Richard A., MD
Pulmonary Disease
Practices at Pulmonary Consultants PLLC, 316 MLK Jr Way #401, Tacoma, 98405; Phone: 572-5140
Medical School: Univ of Washington
Residency: Univ of Washington
Fellowship: Univ of British Columbia

Kuehler, Bianca M., MD
Anesthesiology
Practices at Advanced Pain Medicine Physicians, 1628 S Mildred St. #105, Tacoma, 98465; Phone: 564-2009
Medical School: Justus Liebig Universitat, Giessen, Germany
Internship: Winterberg Hospital, Jaarbrucken, Germany
Residency: Oregon Health Sciences University

LeDoux, Edward J., MD
Pulmonary Disease/Critical Care
Practices at Pulmonary Consultants PLLC, 316 MLK Jr Way #401, Tacoma, 98405; Phone: 572-5140 Medical School: Oregon Health Sciences University
Internship: Oregon Health Sciences University
Residency: Oregon Health Sciences University
Fellowship: Oregon Health Sciences University

Malhotra, Vinay, MD
Cardiology
Practices at Cardiac Study Center, Inc., PS, 1901 S Cedar #301, Tacoma, 98405; Phone: 572-7320
Medical School: Armed Forces Medical College, Pune India
Internship: University of Illinois Hospital Residency: University of Illinois
Hospital Fellowship: University of Illinois

Marsh, Gregory B., MD
Anesthesiology
Practices at Pacific Anesthesia, PO Box 2197, Tacoma, 98401; Phone: 779-6313
Medical School: Univ of Washington
Residency: Stanford University Hosp.

Mohr, K. Scott, PA-C
Orthopaedic Surgery
Practices at The Orthopaedic Center PLLC, 1112 6th Ave #300, Tacoma, 98405; Phone: 272-2224
Medical School: Interservice Physician Assistant Program, Houston Texas

Sandler, Andrew S., MD
Internal Medicine
Practices at Northwest Medical Specialties PLLC, 1624 S I Street, #405, Tacoma, 98405; Phone: 383-3366
Medical School: Mount Sinai School of Medicine
Internship: Mount Sinai Med Center
Residency: Mount Sinai Med Center
Fellowship: UCSF

Wilson, Alexandra K., MD
Pediatrics
Practices at Pediatrics NW Specialty Core PS, 316 MLK Jr Way #305, Tacoma, 98405; Phone: 552-1434
Medical School: Stanford University
Internship: Childrens Hospital Oakland
Residency: Childrens Hospital Oakland
Fellowship: University of California

Yuan, Jessie S., MD
Family Practice
Practices at CHC at Lakewood, 9112 Lakewood Dr. S #203, Lakewood, 98499; Phone: 589-7030
Medical School: Brown University School of Medicine
Residency: Community Hospital, Santa Rosa California ■

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The Health Status of Pierce County

Hepatitis B and D Update

Communicable Disease Control staff at the Tacoma-Pierce County Health Department are continuing to screen intravenous drug users for hepatitis B and D. As of May 15, 2000, fourteen cases of the disease have been detected; three of those infected have died. In 1999, only seven cases of hepatitis B were reported and no one died of the disease. The sudden increase in numbers activated the Health Department's disease outreach response and prompted the Centers for Disease Control in Atlanta to send investigators to help set up a screening process and analyze results.

Hepatitis B is more common in developing countries – an epidemiological map of the world shows more cases in Africa, South America, and Southeast Asia. In most developed countries, including the USA, the incidence of Hepatitis B is considered low. Most infections occur among certain adults high-risk populations that include intravenous drug users, people with multiple homosexual or heterosexual partners, household or sexual contacts of people with chronic hepatitis B infection, people on hemodialysis, people receiving frequent blood transfusions, and people with occupational exposure to blood or body fluids.

An acute Hepatitis D infection does not occur alone, it needs the B virus in order to replicate. Infection with hepatitis D generally occurs in one of two ways: 1) an acute co-infection with hepatitis B – meaning someone is infected with both viruses at the same; 2) a super-infection of a person who has chronic hepatitis B – so an individual has chronic hepatitis B and then can be infected with D because of the presence of B.

"As of May 15, fourteen cases of the disease have been detected, three of those infected have died. In 1999, only seven cases of hepatitis B were reported and no one died of the disease."

Like hepatitis B, the spectrum of clinical disease in acute D co-infection or super-infection varies from no symptoms to the fulminant-type of hepatitis. Chronic infection can also be asymptomatic or quickly progress to cirrhosis of the liver and death due to liver failure.

Who gets the disease parallels who gets hepatitis B: higher in developing countries, lower in developed countries. The risk groups are similar: injection drug users especially. The prevalence of hepatitis D infection is lower among homosexual men, persons with multiple heterosexual partners, and household contacts of people with chronic hepatitis B infections. Hepatitis D infection in the USA is found in about five percent of cases of acute hepatitis B.

Since there is no treatment for hepatitis, only prevention through immunization, Health Department staff are planning to screen all intravenous drug users and their sexual and needle-sharing partners in Pierce County. Each person screened will also be vaccinated against hepatitis B Because of the connection between the B and D viral infections, immunizing against hepatitis B prevents hepatitis D.

The screening process includes a series of questions, answers to which are voluntary, to get a picture of how the disease is spread within Pierce County. The questions take about ten minutes. The individuals will have blood drawn, to be tested. They will then be given the first of three injections to immunize them. Based on CDC recommendations, the immunizations will be given on an expedited basis: one month and four months after the first injection (instead of the typical one month and six month regimen). All three are needed to prevent the disease, so people being screened can expect to be encouraged to return for the rest of the series.

There is no charge for the screening or for the immunization.

Screening occurs at a special clinic held every weekday from 1:00 – 4:00 PM, at the 3629 South D Street, Tacoma. Please refer patients who are at risk for hepatitis B and/or hepatitis D, especially injecting drug users or their partners, to the Health Department's clinic. For more information, you or anyone can call 798-2987. ■

Applicants for Membership

Editor's Note: The following physicians have made application to PCMS for membership

Colombini, Rose-Marie J., DO
Family Medicine
Practices at Lakes Medical Center, 19820 Hwy 410, #101, Bonney Lake 98390; Phone: 862-9969
Medical School: Western University of Health Sciences, College of Osteopathic Medicine of the Pacific
Internship: San Bernardino County Medical Center
Residency: San Bernardino County Medical Center, Arrowhead Regional Medical Center

Jenner, Carrie L., MD
Pediatrics
Practices at Franciscan Medical Group, St. Joseph Clinic, 1708 S Yakima Ave, Tacoma, 98405; Phone: 593-8407
Medical School: Georgetown Univ
Internship: University of Washington
Residency: University of Washington

Lahrs, Anthony E., MD
Diagnostic Radiology
Practices at Tacoma Radiology, 3402 S 18th, Tacoma 98405; Phone: 383-1099
Medical School: University of Toronto
Internship: University of Toronto
Residency: University of Toronto
Fellowship: Hospital of University of Pennsylvania

Long, Jeffrey P., MD
Radiation Oncology
Practices at MultiCare Radiation Oncology, 1003 S 5th Street, Tacoma 98405; Phone: 403-4994
Medical School: University of Iowa College of Medicine
Residencies: University of Arkansas for Medical Sciences, University of Louisville Hospital, University of Iowa Hospital

Loomer, Jeffrey B., MS, MD
Rheumatology
Practices at Tacoma South Medical Clinic, 2111 S 90th St, Tacoma 98444; Phone: 539-9700
Medical School: St. George's University School of Medicine
Internship: Greater Baltimore Medical Center
Residency: New Britain General Hospital
Fellowship: Dartmouth-Hitchcock Medical Center

Louie, Douglas H., MD, PhD
Family Practice/Geriatrics
Practices at Franciscan Medical Group at St. Joseph, 1708 S Yakima Ave, Tacoma 98405;
Phone: 593-8456
Medical School: Univ of Washington
Internship: Univ of California, Irvine
Residency: Univ of California, Irvine

Thorpe, Robert J., MD
Family Practice
Practices at St. Joseph Medical Clinic, 1708 S Yakima, Tacoma 98405;
Phone: 593-8456
Medical School: Univ of Oklahoma
Internship: University of Kansas
Residency: University of Kansas ■

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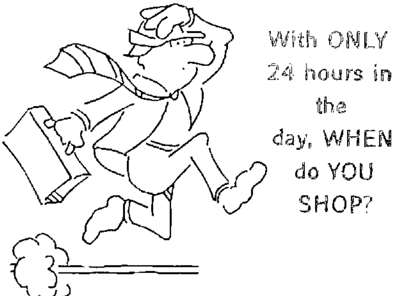

Volunteer at asthma camp

Calling all licensed medical professionals! A unique opportunity exists to help children with asthma learn how to manage their conditions. The American Lung Association of Washington is looking for volunteers to help staff Asthma Camp at Camp Sealth on Vashon Island, June 26 to July 1, 2000. Volunteers provide medical supervision to children ages 6 to 14 with moderate to severe asthma. These children participate in a wide range of camp activities along with receiving education on asthma management, proper use of medication and identifying triggers.

We need volunteers to commit to at least two days and one night at asthma camp. Please call Penny Grellier at the American Lung Association of WA at (253) 272-8777.

Clean Air for asthmatic kids

An Asthma Outreach Worker is available to assist families affected by asthma. The Asthma Outreach Worker is part of the Clean Air for Kids program, a partnership between the American Lung Association of WA, Tacoma-Pierce County Health Department and local agencies. She helps families identify triggers along with simple solutions, comply with or organize an asthma management plan, and communicate with healthcare providers about asthma issues. This service is available to families in Pierce County and is free of charge to those who qualify. Please call Genevieve Schmidt at the American Lung Association of WA at (253) 272-8777.

PCMS Bicycle Club members pedal 50 miles

Ken Graham enjoys strawberry shortcake provided by the Tacoma Wheelman's Bicycle Club after completion of his miles

From left, Drs. Nick Iverson, Henry Retailliau, Pat Hogan and Ken Graham were among the 1200 riders in the Daffodil Classic

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Please visit us on the PCMS homepage

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Help PCMS Paint Tacoma Beautiful

PCMS, along with numerous other organizations and individuals will be helping "Paint Tacoma Beautiful" this summer as we participate in the Associated Ministries program that helps low income people with house painting projects. About 75 homes will be painted this year.

Watch the PCMS FAX News and your July Bulletin for details. We will be seeking volunteers on behalf of PCMS to help with painting in late July and August.

Call PCMS, 572-3667 for early registration and more information.

In My Opinion....

by John Stutterhiem, MD

Nostalgia of World War Two

John Stutterhiem, MD

This is the story of the train station Gubeng, in Surabaja, Java, during February, 1942. Mother, Anton and I had joined Dad in Surabaja, and we were living with my Aunt Loes. Our actual home was in Malang, but Mother wanted to be close to Dad, willing to risk the dangers of the Japanese bombardments. During the final days of February we were shocked by the news of the defeat of the combined naval forces, Australian, British, Dutch, and American. The battle of the Java Sea had been an attempt to stop the invasion of the Japanese. Dad now felt that it would be safer for Mother to return to Malang, 90 km to the south.

Our farewell was short and difficult; we did not see Aunt Loes until after the war again. Dad was not able to bring us away; as a result the three of us were waiting at the platform of the railway station Gubeng. Surprisingly, Gubeng had been spared bombardments from the Japanese planes, in contrast with the marshalling yards of the harbor. Trains were delayed. We had to wait for two hours under the sun at its zenith. The temperature was over 100 degrees. Suddenly, coming from Tandjung Perak, the naval harbor, a long goods train, pulled by a jumbo engine, steamed at a very slow pace toward us. All the brakes squealed and steam hissed at the engine's side when she managed to come to a stop. All the short boxcars were painted white, and covered by red crosses on all sides and on top. This train was packed with wounded and survivors from various navies, rescued after the battle of the Java Sea. I was thirteen and I will never forget the commotion, the sight of all these stretchers, bandages, the smell of old fashioned iodoform, nurses running around, everybody trying to bring water and food. Even to this day, I can still see this scene and hear the moaling of the sailors on the stretchers. Mother squeezed our hands, refused to let go, but never said a word. More soldiers and United States airmen entered the platform to board this pitiful train.

In the late seventies I sutured here in Tacoma the arm of an older man, who had cut himself with a chainsaw. He recognized my accent and informed me that he had been a navigator aboard a B-17, a Flying Fortress. Coming from Hawaii, their destination had been Clark Air Force base on Luzon, Philippines. Their traditional route, Midway, Guam became blocked by the Japanese advance. They were diverted to Singosari, Java, eight km from my home in Malang. He lost his plane due to bombardments, and was being evacuated. We discovered that both of us had been at Gubeng, at the same time, each leaving that station in a different direction. He had boarded that hospital train.

After a long delay the engine shrieked and set itself in motion, the big wheels slipping and grabbing at first, given the immense weight it had to pull. At every rotation of its wheels pumping out steam on the sides, hauling off this endless row of cars full of human misery, each car slowly passing by, revealed a different picture of wounded sailors through the opened doors. Several sat in the doorway, legs dangling, resting against the doorpost. So many of them were smoking, some wrapped in bandages and some just staring. We then became even more aware of the disaster that had struck our defenses. The people who were left behind were so quiet and many women had tears in their eyes. This train's destination was Tjilajap, the harbor on the southern coast of Java, not sealed off yet by the Japanese.

Later on that day, we finally managed to catch a train packed full of refugees heading for Malang. Mother was silent, for she had left Dad behind. We were deeply influenced by the

See "Nostalgia" page 16

In My Opinion.....

by Teresa Clabots, MD

Dr. GENIUS and the RED SNAPPERS

Teresa Clabots, MD

I was training at County Hospital in St. Louis in the 1970s, (long since it closed). I had to get up at 5:00 a.m., shovel the snow, and drive all the way out to County. It was a race behind the snowplow to get to the County Hospital. I didn't dare pull off the road fearing I would get stuck in a snow pile, so the window was always open in case my nausea overwhelmed me (since I was pregnant). I thought as a medical student that we delivered outstanding, if not in fact superb, medical care to these indigent patients who were ever so grateful. This was probably one of the finest experiences of my medical training career. The attending was brilliant. He was knowledgeable, thorough, and could spout out more answers than all of us put together. He knew the answers before anybody else, and was always finding "zebras" in our diagnostic workups. I always suspected he paid the mailman extra to get his New England Journal of Medicine delivered a day early.

No one EVER asked questions on rounds.

I was particularly petrified of him. He liked to pick on girls. I had two patients on the ward. The first was Hiawatha, a gentle alcoholic who also happened to have diabetes, and who loved to control his medications, his I.V., his food, and his medical students. He was particularly belligerent at night, and tended to play with his I.V., disconnect it, making the floor sticky and making the medical student clean it up in the morning.

My problem was that Hiawatha usually consumed all of my time, cleaning his nightly flood, examining him, restarting his I.V., tracking down his lab values, and catching his morning sputum with a daily run to the lab, checking for TB. That was my morning job. We were always hunting for those little "red snappers."

I was late to go look at my other patient in the ICU, sick with pancreatitis from binging on alcohol. I said, "hi" to Mr. Richards, grabbed his labs, and flew onto rounds. (Since being late to rounds was declaring professional suicide). If you were late to rounds you were <u>sure</u> to be picked on. I broke out in a cold sweat. My nausea from my pregnancy didn't help any. I felt faint, and started biting the inside of my cheek to stay conscious. As I moved to the back of the group to try to lean against the wall, my Resident said, "What's wrong with you" with his eyes. I whispered back, "I didn't get to see Mr. Richards," in a tiny voice. He looked at me with daggers and said, "Fake it."

Much to my chagrin, Dr. Genius said calmly, "and who has Mr. Richard's today?" I squeaked out, "I do, sir." "And how is he this fine morning?" Mr. Genius said. I looked at my Resident, looked at Dr. Genius, swallowed my panic, and said, "I am really, really sorry sir, but I ran out of time, and I didn't get a chance to see him but...." You could now hear a pin drop. I had broken all of the rules. Everyone waited to hear the tirade.

I was female, I was pregnant, and now I hadn't performed my duties on pre-rounds, (for which I was paying a hefty tuition to do) in ounces of my blood that I sold to support myself.

"Oh well, well." He turned to the Resident. "Let's see, Dr. Resident. Did you examine the patient? Aren't you supposed to be supervising and helping Ms. Pregnant here?" I could have crawled under the tile. Not only was I in deep, deep trouble, but also I was now in double trouble, and now from my Resident, and from my Attending.

"Well," he said as he started strolling down the hallway. "Let's go see Mr. Richards. I hope he's the only patient who was not examined appropriately. This morning, we shall ALL go to examine him." We followed him like little ducklings into the ICU, which was already full of glum faces. The patients didn't like groups of doctors surrounding their beds. It was usually NOT good news. He lifted the sheet, and my God, there looked like there was this huge basketball inside his abdomen. I was absolutely huge, tense, and swollen. He was not a happy camper. Dr. Genius smiled, and passed onto us his pearls, " ..for you see ladies and gentlemen, if anyone of you had said they had examined Mr. Basketball here, and missed this obvious pancreatic pseudocyst, well I would have had to flunk them from my course." That was my pearl from Mr. Pancreatic Pseudocyst. Never ever "fake" it. "Now, Ms. Garcia, do your examination and join us in the hallway. You have 5 minutes."

That stuck in the back of my mind through thick and thin all of these years. The day was really not a total loss. Even though it was the last day of the service, after six weeks of taking Hiawatha's sputum to the lab on a daily basis, he finally coughed up a good one, and we found his "red snappers." I had been exposed to TB for all six weeks of my medicine rotation, while pregnant. ■

Nostalgia from page 14

sight of that hospital train.

Upon our arrival in Malang, it looked as though life had resumed its steady routine, until the next morning. I happened to be in the front yard when all of a sudden two Zero Japanese fighters strafed the street and the park in front of our home, so close I could see the pilot's head. They flew in so low that nobody could hear them coming. Two young native men would try to run for the shelter, but were killed. I was stunned and at first could not walk away. This was the first time that I had seen dead people. They were just lying there. They seemed so quiet, so still; but I knew some how that they would never move again. I felt again how desperate our situation had become. I picked up a spent casing from a shell, but I had to drop it fast because it was so hot.

Mother ran outside to round us up. She forced us unto the shelter at the very moment that the "all clear" sirens sounded. My brother and I started to laugh. That broke the ice. We thought it was hilarious to get there at the wrong time. However, mother placed two mattresses in the shelter and we had to sleep there every night. She was totally deaf to our complaints. ■

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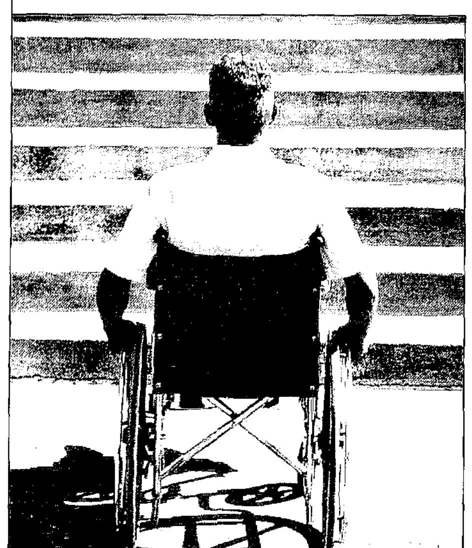

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COLLEGE OF MEDICAL EDUCATION

Watch for CME interest survey

PCMS physicians are reminded to watch their mail for the College survey that will ask you to help the College Board set program priorities for their new fiscal year, July, 2000 to June, 2001.

The survey seeks specific topics of interest within specialty areas, and specific physician interest for annual courses designed for primary care.

The survey also seeks feedback on possible topics for the annual Internal Medicine Review and Surgery Update, solicits input for best times and days to schedule courses as well as probes for technology educational interests and needs.■

Continuing Medical Education

GI Disease Course for Primary Care scheduled for June 2

The 5th Annual Gastroenterology Course is set for June 2, 2000 at the Washington State History Museum. Co-directors of the course are **Drs. Gary Taubman** and **Richard Tobin.**

This one-day course is designed for the primary care physician and should also appeal to the specialists and ancillary health professionals with an interest in abdominal and gastrointestinal medicine. The course emphasizes a practical and multi-disciplinary approach.

Specifically called "Nuts, Bolts and Innovation in Gastrointestinal Disease" this course is organized in conjunction with the Tacoma Gut Club.

Club members represent a diverse group of expert physicians from Seattle to Olympia, both in academic and private medicine.

A sampling of topics include Management of End-Stage Liver Disease, Ethical Issues in End-of-Life care, abdominal trauma, and Colon Cancer Surveillance in Inflammatory Bowel Disease.■

Dates	Program	Director(s)
Friday, June 2	Nuts, Bolts & Innovation: Gastrointestinal Disease V	Gary Taubman, MD Richard Tobin, MD

CME at Hawaii includes education, family, and sun

CME at Hawaii, a College of Medical Education resort program was termed a huge success by conference participants. The program brought together Pierce County physicians for family vacationing and quality CME on the island of Hawaii.

The program featured a potpourri of educational subjects of value to all specialties. Conference attendees particularly enjoyed the rare opportunity to have in-depth discussions about various case studies.

Out of the classroom, conference participants and their families enjoyed exploring Hawaii, water sports and great weather.

This year's group included many families taking advantage of their school spring vacations. Participants enjoyed Hawaii's opportunities for sun, swimming, golf, surfing, windsurfing, tennis, exploring, great food and just relaxation.

The College continues to offer resort CME conferences both in ski locations and in sunny resort areas. The next ski program will likely be held again in Whistler, British Columbia in January of 2001. The next CME at Hawaii program will likely be scheduled for spring vacation of 2002.■

(More photos page 19)

David Magelssen, MD, Lakewood Ob/Gyn, addressed current therapies for ectopic pregnancy

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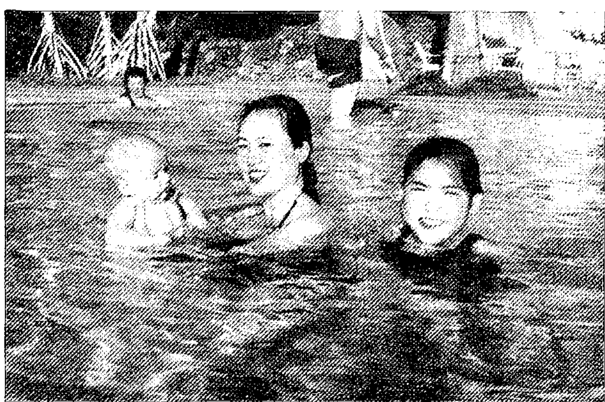
Jim Rooks, MD, Lakewood otolaryngologist and PCMS Secretary-Treasurer, spoke on advances in otolaryngology

From left, Ann & Ron Taylor, MD; Debbie & Alex Mihali, MD, & Jim Fry, MD and his wife Janet enjoy the program reception

Dr. Frank Senecal and family enjoy the Hawaiian surf; front row from left, Clare and Aidan; in back Maura and wife, Mary



Amy Yu, MD (center) enjoys the hotel pool with her children; son David Jr., and daughter Laura

Left, Dr. Craig Rone and his wife Belinda with Dr. Mark Craddock and his wife Jinny at the welcoming reception

Many physicians attending the conference enjoyed having their families accompany them

Reputation from page 9

opportunity to learn from their experience. Another problem of the time was the peddling of various patent medicines, usually harmless, sometimes poisonous, seldom helpful. Over time, these also disappeared.

At first, the only requirement for doctors was to take a test by the medical examiners of the state to get a license. For a long time that was sufficient. Then hospitals started looking into the qualifications of physicians before allowing them to admit patients. Then some physicians were accused of never opening a medical book after they completed their training, so continuing medical education became a requirement for license renewal.

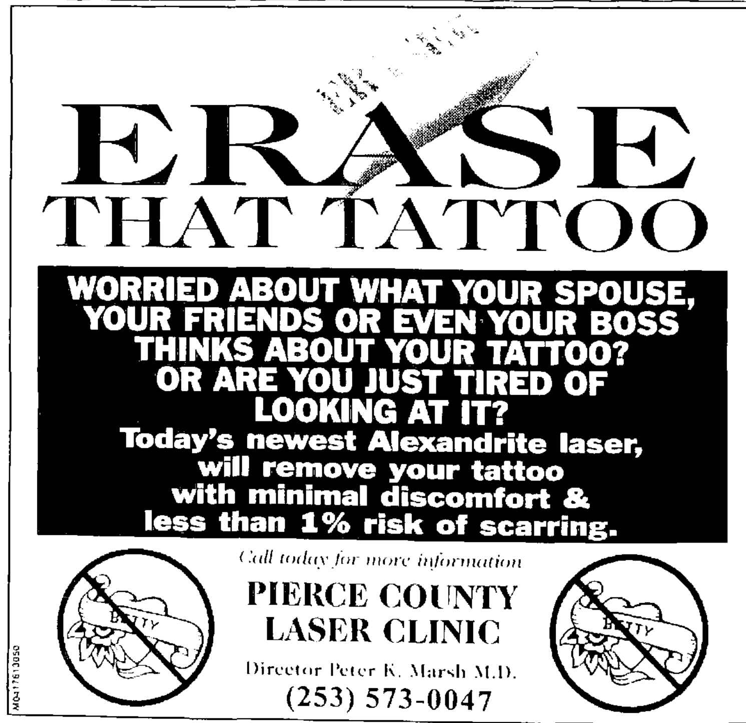
Almost at the same time, for legal reasons, hospitals were urged to review the credentials of their physicians every two years. Soon afterwards, insurance companies started contracting physicians and had to go through the same process of credentialing every few years. All of that was done in interest of better patient care. Have we achieved it?

One big argument for CME was the steep rise in malpractice claims. The idea was that if we could get rid of the few bad apples that spoiled it for all of us, things would be much better. I don't know whether we did or not, but malpractice claims are still a big problem, insurance a major part of our overhead, and the physician data banks are multiplying.

Granted, we got rid of the quacks and the patent medicines. Instead we now have a variety of health care providers, but at least they all are licensed. Most of them know their limitations and do a good job. We also have health food stores that sell unproven remedies, but they are food supplements or herbal teas. Most are harmless, some are poisonous, a few are helpful. Obviously we have made great strides forward during the past century.

What is the cost? Hospital credentialing probably costs 100 dollars per physician. Since many hospitals have merged, the paperwork is less, but even if two hospital systems have to credential the physicians every other year, assuming there are 400,000 practicing physicians in the country, it costs 40 million dollars per year. Add to that the credentialing by the insurance companies, both health and liability, the paperwork of other payors, the paperwork on our end of it, the cost of this exercise probably runs at 100 million dollars per year. Then we have the cost of the medical examining boards, quality assurance commissions, medical disciplinary boards, etc. This regulatory burden was intended to give us a sense of security. What, then, is that noise about medical errors? Why is the Senate investigating the matter? If our rocket scientists can mix up their centimeters with their inches, how can we, ordinary people with ordinary minds, be expected to go through life without making a mistake? What kind of law do you suspect will be able to stamp out human error? Will regulation be better able to do it than reputation?

Here is some food for thought, a fable by Aesop, titled "The Horse, Hunter and Stag": A quarrel had arisen between the horse and the stag, so the horse came to a hunter to ask his help to take revenge on the stag. The hunter agreed, but said: "If you desire to conquer the stag, you must permit me to place this piece of iron between your jaws, so that I may guide you with these reins, and allow this saddle to be placed on your back so that I may keep steady upon you as we follow the enemy." The horse agreed to the conditions, and the hunter saddled and bridled him. Then, with the aid of the hunter, the horse soon overcame the stag, and said to the hunter: "Now, get off, and remove those things from my mouth and back." "Not so fast, friend," said the hunter. "I have now got you under bit and spur and prefer to keep you that way." ■



Expedition leader to speak at September 12 General Membership Meeting

Dramatic tale of high adventure resolving 1924 mystery

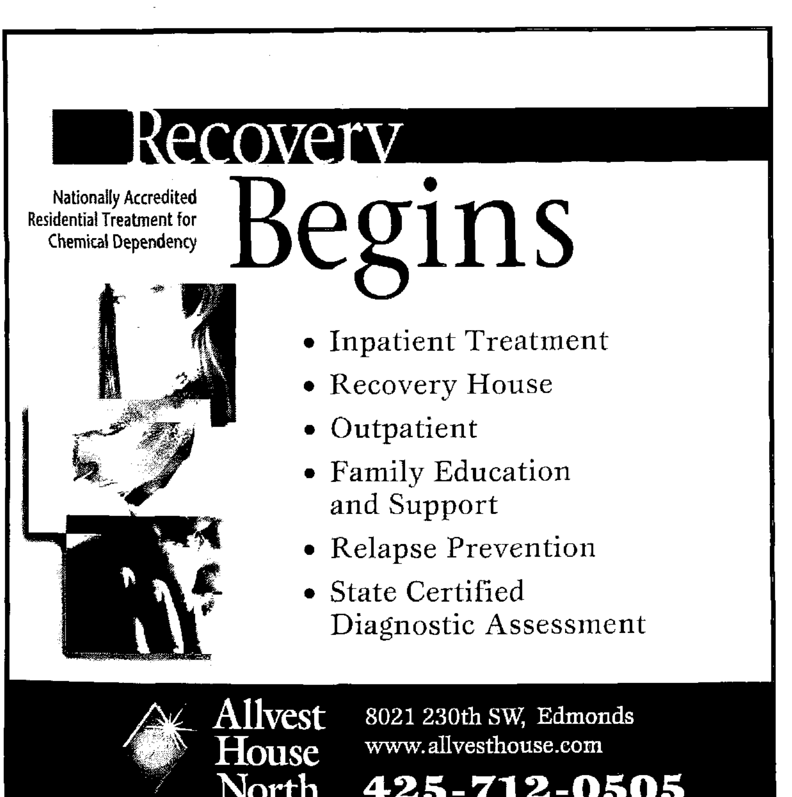
Reserve Tuesday, September 12, 2000, 6:00 p.m. for an evening of high adventure as Eric Simonson speaks on, "Finding Mallory."

Simonson, owner and active partner in International Mountain Guides (one of the oldest mountaineering companies in the country) as well as owner and operator of Mt. Rainier Alpine Guides will speak on the experiences of the expedition that set out to solve two of exploration's greatest mysteries: Did George Mallory and Sandy Irvine reach the summit of Mt. Everest in 1924, and what became of them?

This expedition stunned the mountaineering community with the discovery of the remains of Mallory. Two major television documentaries have focused on the expedition. He will relate the mysteries, the quest to solve them, and what the expedition did at the September meeting.

Simonson's climbing resume includes Mt. McKinley, Aconcagua in Argentina, Cho Oyu in Tibet, Mt. Elbrus in Russia, and Mt. Vinson in Anarctica.

Watch your mail for details. ■



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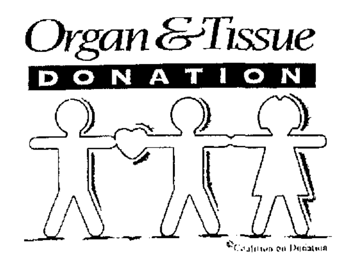

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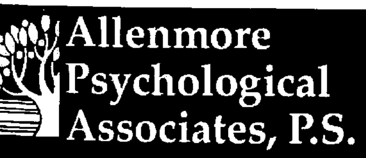

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Pierce County Medical Society

BULLETIN

July, 2000

Dale Overfield, MD (left), Puyallup neurologist passes the gavel to John Jiganti, MD, Tacoma orthopedic surgeon incoming president of the College of Medical Education

See story page 17

INSIDE:

3 **Federico Cruz-Uribe, MD, well received at June General Membership Meeting**
4 **Check out these medical directory errors!!**
5 **I-725: Shall a state health benefit package be developed for Washington residents?**
6 **Join PCMS colleagues and "Paint Tacoma-Pierce Beautiful"**
7 **Sound to Narrows continues to keep physicians running**
9 **Ski to Sea, an 82 mile relay, challenging and rewarding for Pierce County team**
17 **College of Medical Education welcomes new board members and officers for 2000-2001**

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The Bulletin is dedicated to the art, science and delivery of medicine and the betterment of the health and medical welfare of the community. The opinions herein are those of the individual contributors and do not necessarily reflect the official position of the Medical Society. Acceptance of advertising in no way constitutes professional approval or endorsement of products or services advertised. The Bulletin and Pierce County Medical Society reserve the right to reject any advertising.

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Pierce County Medical Society
BULLETIN

July, 2000

Table of Contents

3 Dr. Cruz-Uribe addresses June Meeting crowd

4 Check out these medical directory errors!

5 I-725: Shall a state health benefit package be developed?

6 Join PCMS colleagues and Paint Tacoma-Pierce Beautiful!

7 Sound to Narrows 2000 recap

9 Ski to Sea: an 82 mile relay

10 Updated DSHS Contact Numbers

11 TPCHD: Breast and Cervical Cancer program update

12 Drs. Ron Goldberg and David Sparling honored

13 "The Yellow Brick Road" by Andrew Statson, MD

15 "The Silver Bullet" by Teresa Clabots, MD

17 College of Medical Education elects new board members

19 Classified Advertising

June General Membership Meeting Recap

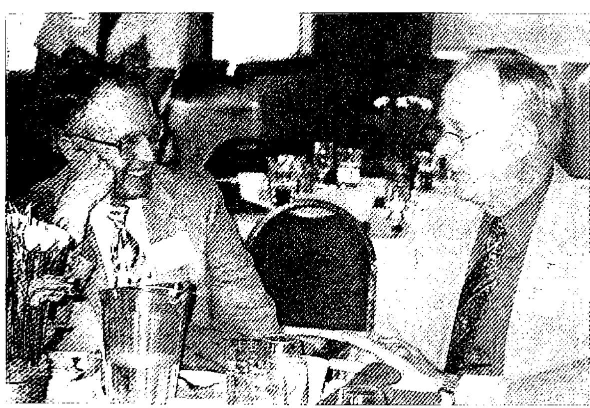
Federico Cruz-Uribe, MD, Director of Health for the Tacoma-Pierce County Health Department entertained and educated over 50 members that attended the June 13th General Membership Meeting at the Landmark Convention Center.

In his humorous and easy-going manner, Dr. Cruz shared his personal experiences regarding public health and how he came to know that listening, more listening and understanding is how you implement change in public health. "You cannot bring solutions, but you can bring interest and enthusiasm," noted Dr. Cruz.

He understands why he is controversial. He believes that public health is dynamic, while most health departments follow the more traditional, status quo model. He believes that to solve problems communities have to change, issues need to change and people have to get passionate about solving problems.

Dr. Cruz was well received and found support and gratitude for his non-traditional public health efforts. ■

Dr. Federico Cruz-Uribe answers questions regarding his tenure



Dermatologists Sid Whaley (left) and Bob Martin have an opportunity to visit after the meeting

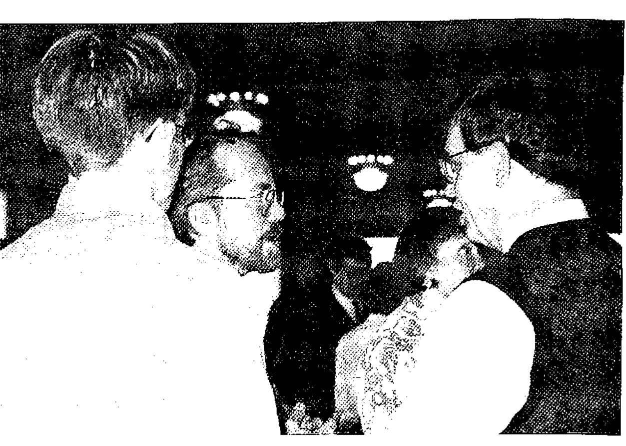
Dr. Joseph Clabots (left) asks a question of Dr. Cruz while Dr. Teresa Clabots looks on

From left, Drs. George Tanbara, Bob Ferguson and Ken Graham enjoyed having time together

PCMS President, Dr. Charles Weatherby, (left) visits with Drs. George Krick and Rich Dehlinger on the deck

More photos page 4

Dr. Cruz (right) visits with Dr. John McCloskey, pediatric cardiologist and his wife, Susan



Phil Craven, MD, talks with Dr. Cruz while his son, Dylan, who will go to Guatemala this summer, listens

Regence Provider Directory chock-full of errors

Editor's Note: The following is taken from the Regence Preferred Provider Directory (11/99) which was given to patients and physicians to help find referrals in the Gig Harbor area. It was forwarded to PCMS after a member noted a "couple of mistakes."

INFECTIOUS DISEASES
DEAN, DIANA, CCC-S
LIVINGSTON, ROBERT, MD
MARTIN, ROBERT J., MD

INTERNAL MEDICINE
ANDERSON, SHEILA, CMHC
BLEIWEISS, MILTON, MD
CARDILLO, TANYA, PT
ELDERKIN, PAMELA, CMHC
FINKLEMAN, LOWELL, MD
FISHER-HAVENS, J., CMFT
HALLEY, JOAN, DO
KRUMINS, PETER, MD
MARTIN, ROBERT J, MD
MENDIOLA, DANIEL, OT
OTTO, RANDOLPH, MD
PEIXOTTO, JOHN, MD
PINGREY, GARY, DO
RAFTER, ROBERT, MSW
SAMMS, JOHN, MD
VENUTO, GAIL, MD
WORTHEN, EDWARD, OD

NEUROSURGERY
JACKSON, WILLIAM B, MD

PHYSICAL THERAPY
BERNDT, KATHERINE, ARNP
BROWN, JAMES, MD
DALE, CHARLES, OD
DAY, LAURA, CCC-A
DEAN, DIANA, CCC-S
DEAN, WILLIAM, MD
DIAZ, KIMBERLY, ARNP
HAMMER, DORIS, ARNP
HENRY, MELVIN, MD
KATSMAN, RALPH, MD
KENNEDY, KEVIN, DO
CRAMER, CAROL, CMHC
LANG, TIMOTHY, MD
MURRAY, JOHN, OT
O'BRIEN, MARY, MD
OZOLIN, ARTHUR, MD
PATTISON, MARILYN, MD
SCHUBERT, TIMOTHY, MD
TAUBMAN, GARY, MD
TRAN, KHAI, MD
WAGONFELD, JAMES, MD
WORTHEN, EDWARD, OD

PHYSICIANS ASSISTANT
DIMANT, JOHN, MD
FALOTICO, GEORGANN, CMHC
KENDRICK, TONJA, CMFT
O'CONNELL, SHELMAR, MD
OSTERGREN, GREGG, DO
PEARSON, MICHAEL, MD
STUART, ROBERT, E., MD

PODIATRY
PINGREY, GARY, DO

PSYCHIATRY
HASSAN, DOUGLAS, MD
KONICEK, STEVEN, MD
KUNKLE, ROBERT, MD
SORENSEN, ALLAN PT
SPORL, SUSAN, MSW
STANLEY, SHARON, CMHC
YANCEY, ROBERT, MD

RADIOLOGY
HARRIS, CHRISTINE, ARNP
KOFFMAN, SANDRA, ARNP

UROLOGY
BROWN, SHARON, CMHC
DOWD, MICHAEL, MD
STUART, ROBERT, E., MD ■

Initiative 725 - finds support and reservations

Editor's Note: The Initiative 725 campaign hopes to turn in 230,000 signatures by July 7 to qualify for the 2000 ballot. Following is a listing of frequently asked questions prepared by Health Care 2000. More information is available on the website www.healthcare2k.org. Robert Fithian, MD a founding member of Health Care 2000 appeared before the PCMS Board of Trustees June 6 and discussed the initiative

Initiative 725, if enacted, would establish a health security trust to operate a health coverage system for state residents not covered by federal programs. The trust would develop a single uniform benefits package funded by mandatory premiums, a 9.75% payroll assessment on employers, existing taxes and co-payments. Payments to providers would be negotiated. For residents keeping private insurance coverage, state coverage would be secondary with premiums remaining mandatory. Funds would be appropriated for fiscal 2001 and 2002.

In theory there appears to be broad based support for such a system. However, there are many concerns, particularly in regard to funding. Many questions have been posed such as:

Q. How much will it cost me: Premiums will be $75 per month for everyone over 18 whose monthly income is above 250% of the federal poverty level (about $1666 for a single person, $2083 for a family of four). Those making 150-250% would pay reduced rates and those below 150% pay nothing. Your employer can pay the individual premium for you. Employers will pay 9.75% of payroll, which is less than most are currently paying for health benefits.

Q. You're going to turn health care over to the government? No, I-725 is not government run health care. Its funding is independent of the legislature and will be run by an independent 'Health Security Trust' with its own board of trustees representing citizens, business, labor, and health professionals.

Q. Won't this system eliminate competition? No, competition will be based on quality as perceived by the patient, not the insurance companies' bottom line.

> ***Official ballot title:***
> ***Shall a state health agency be created and develop a health benefits package for state residents, funded by mandatory premiums, employer assessments, and existing taxes?***

Q. Wouldn't doctors lose control of their practices? No, Doctors have less control now than they will under the new system. Payments will be based on collective negotiations between the Trust Board and providers and facilities, not on take-it-or-leave-it one-sided contracts under the current private profit system.

Q. Will I have to pay for the poor, unemployed, etc? You already do under the current system through taxes and through cost-shifting by health providers. Since everyone is covered under the new plan, the poor will be more likely to seek care early on before their conditions get worse which will result in net savings. Furthermore, the costs will be spread out over the entire population.

Q. Isn't this going to mean higher taxes? No, there will be a 9.75% payroll assessment paid by employers, much less than they are currently paying for private profit driven plans.

Q. Then you are making businesses pay for health insurance reform? No, businesses currently spend 12-15% of payroll for health insurance so the new system will actually save them money immediately.

Q. Will there be enough money to pay for comprehensive services for everyone? Yes, the estimated revenue from all sources will cover the costs (presently at $16 billion per year in WA). We will save over 2 billion alone in current administrative costs compared with the present system.

Q. What will happen to Medicare? Until federal waivers are obtained, Medicare recipients will continue to be covered under their current plans. The Health Security Trust will replace Medigap policies for a $50 monthly premium.

Q. I've got good health insurance now. Why should I want a change? Under the new health law, you can never lose your health insurance even if you lose your job, retire, or are unable to afford it if your employer expects you to pay the cost of rapidly rising premiums. And, you never have to change doctors because your employer changes insurers.

For more information on I-725 please contact PCMS, 572-3667. ■

Personal Problems of Physicians Committee

Medical problems, drugs, alcohol, retirement, emotional, or other such difficulties?

Your colleagues want to help

*Robert Sands, MD, Chair	752-6056
Bill Dean, MD	272-4013
Tom Herron, MD	853-3888
Bill Roes, MD	884-9221
F. Dennis Waldron, MD	265-2584

Confidentiality Assured

Directory changes

Please make note of the following changes to your 2000 PCMS Physician Directory. Updates will be made each month in the Bulletin.

Bennett, Randall, MD
Change address to: 104 27th Ave SE
Puyallup, WA 98374-1145

Biljan, William, MD
Change address to: 5814 Graham Ave
#100, Sumner, WA 98390-2756

Burrows, William, MD (Retired)
Change address to: 7413 144th Ave E
Sumner, WA 98390-8255

Corliss, Robert, MD
Change address to: 5814 Graham Ave
#100, Sumner, WA 98390-2756

Cowell, Pamela, MD
Change address to: PO Box 98865
Lakewood, WA 98498-0865

Deyo, Glen, MD
Change office zip code to 98418

Duffy, James P., MD (Pat)
Change address to: 5814 Graham Ave
#100, Sumner, WA 98390-2756

Edmond, Charles, MD
Change address to: 104 27th Ave SE
Puyallup, WA 98374-1145

Leitz, Fred, MD
Change address to: 5814 Graham Ave
#100, Sumner, WA 98390-2756

Sumner Schoenike, MD
Physician only phone to: 582-6477

Tan, Darryl, MD
Change Physicians only phone to: 582-6477

Help PCMS Paint Tacoma-Pierce Beautiful

Volunteers needed to help prep and paint a local home

PCMS, along with numerous other organizations and individuals will be helping "Paint Tacoma-Pierce Beautiful" this summer as we participate in the Associated Ministries program that helps low income people with house painting projects. To date, 112 homes, a record high, have been scheduled for painting.

PCMS has been assigned a home near Tacoma Mall, on South Puget Sound avenue and work parties are being formed. The house is one story and will require minimal power washing, scraping, sanding, and priming prior to painting.

Work crews are being scheduled for the first week in July and the last week in July.

Family members and friends are welcome.

Call PCMS, 572-3667 for more information.

Members complete Sound to Narrows 2000

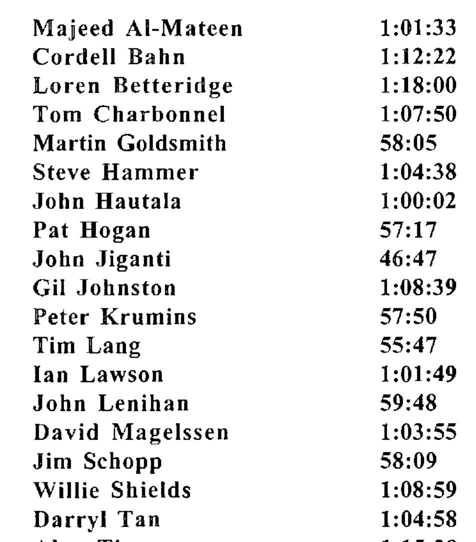
On a day made for running, overcast and a light rain, 5,678 runners participated and finished the 28th running of the popular, but tough 12k race. Tacoma orthopedist **John Jiganti,** led PCMS members by doing a tremendous time of 46:47 and placing 58th overall. This was two seconds slower than his time last year.

Dr. Jiganti had a lot of competition from his fellow orthopedists. **Dr. Tim Lang** came in with a time of 55:47 followed closely by colleagues **Drs. Peter Krumins** with a 57:50 and **Ian Lawson** at 1:01:49. Great times for all.

Neurologist **Pat Hogan** improved his time three minutes over last year by doing a 57:17. Pediatrician **John Hautala** had an excellent time of 1:00:42, but trailed badly behind his children, Eric and Laura, who finished 4th and 8th in their respective age groups. Eric, at age 18 had a 42:51 time. **Dr. Cordell Bahn,** retired cardiovascular surgeon was one of a remaining few who has run in every Sound to Narrows since the first one, 28 years ago.

More photos, page 8

John Jiganti, MD, Tacoma orthopedist, finished 58th of 5,678 runners in 46 minutes and 47 seconds



Congratulations to PCMS finishers:

Name	Time
Majeed Al-Mateen	1:01:33
Cordell Bahn	1:12:22
Loren Betteridge	1:18:00
Tom Charbonnel	1:07:50
Martin Goldsmith	58:05
Steve Hammer	1:04:38
John Hautala	1:00:02
Pat Hogan	57:17
John Jiganti	46:47
Gil Johnston	1:08:39
Peter Krumins	57:50
Tim Lang	55:47
Ian Lawson	1:01:49
John Lenihan	59:48
David Magelssen	1:03:55
Jim Schopp	58:09
Willie Shields	1:08:59
Darryl Tan	1:04:58
Alan Tice	1:15:28

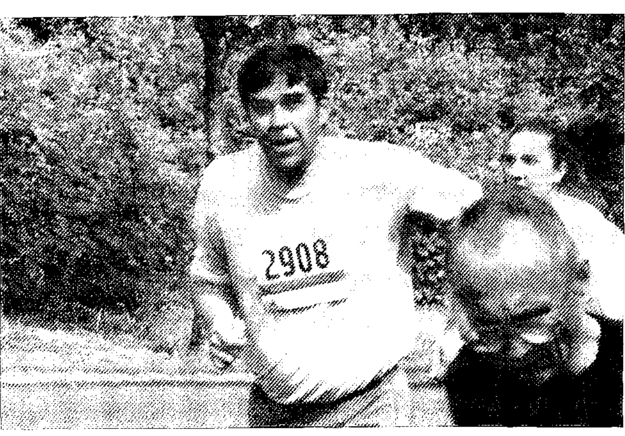
John Hautala, MD, Fircrest pediatrician, finished in one hour and two seconds, 18 minutes behind his son, Eric

Jim Schopp, MD, Tacoma general surgeon, finished with an excellent time of 58:09

More photos page 8

Sound to Narrows from page 7

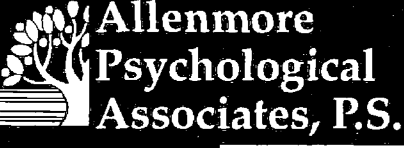
John Lenihan, MD, Tacoma Ob/Gyn signals positively as he finishes just under an hour in 59:48



Alan Tice, MD, infectious diseases physician, coming up the hill after leaving the park, finished the tough 12k run in 1:15:28

Gil Johnston, MD, Tacoma cardiovascular surgeon finished feeling good after a 1:08:39 run

Stevens Hammer, MD, (right) Tacoma general surgeon completed the course in 1:04:38



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Ski to Sea - seven modes of transport in nine hours

by **Mark Craddock, MD**

The Bellingham "Ski to Sea" race was originally a marathon started in 1913. Participants could take the train or a car to the starting point on Mt. Baker and then they were required to run to the top of Mt. Baker and back. This race was stopped in 1913 when one of the participants fell into a crevasse and nearly died. The current race called the "Ski to Sea" was started in 1973. The race involves seven legs.

The first leg is four miles of cross-country skiing, the second is 2.5 miles of downhill skiing. The third leg is running for eight miles down the Mt. Baker Highway followed by a 36 mile bike ride on the same road. The fifth leg is canoeing in the Nooksack River for 18 miles, and the next is mountain biking for nine miles. The seventh and final leg is a five mile kayaking trip across Bellingham Bay.

We got up at 5:00 a.m. and drove up to the Mount Baker ski area. The race started in cold, blowing snow. I did the cross-county skiing leg. Imagine 400 cross-country skiers trying to jockey for position and ski on a cross-country run no larger than 10 feet across. About two thirds of the way through that part of the race I fell and broke a pole. I had to ski the rest of the race with a broken pole in my left-hand. I then handed off to **Dr. David Law.** The intrepid Law then had to hike 900 feet up the side of a ridge, and then ski down.

At that point he handed off to Dr. Duane Hulbert (a U.P.S. music professor and concert pianist), who ran eight miles down the wet, windy mountain road. Mitch Blakney, (a physical therapist with a practice in Gig Harbor) rode bike 36 miles down to the next hand off point at Nooksack River. Dr. Fletch Taylor and Hillary Law than ventured out into the river, for 18 miles of continuous paddling. Many canoes flipped after their initial entry into the water but fortunately were righted, and most were able to complete the race.

Among the things Hillary and Fletch saw on the river was a canoe devoid of paddlers, floating half-submerged down the river. Fortunately, they made it to the next hand off point. The mountain bike leg was muddy. At one point I carried my bike through a puddle about fifteen feet across, up to my ankles in mud. There were also three bridges under which I had to carry my bike, slipping and sliding in the loose embankment dirt. Finally I completed the nine miles and handed off to **Dr. Pat Hogan** at Squalicum Harbor. He then paddled his kayak 5 miles to Marine Park and the finish. We had started at 8:30 a.m. and we finished at 5:20 p.m.!

We were tired, but happy! We had finished the Bellingham Ski to Sea race in a respectable time, without injury! We did lose a life jacket, and of course there was the broken ski pole. Next year, we'll be a whole lot faster. ■

Ski to Sea Team: Front Row (from left, Dr. David Law and daughter Hillary, back row Dr. Duane Hulbert, Mitch Blakney Drs. Pat Hogan and Mark Craddock

Dr. David Law (left) and Dr. Mark Craddock, down hill and cross country skiers, extraordinnaire

Dr. Pat Hogan, master kayaker and anchor man, paddled five miles to complete the 82.5 mile event

Updated DSHS Contact numbers:

BHP PLUS	1-800-826-2444
CLIENT ASSIST/BROKER TRANSPORT/INTERPRETER INFORMATION	1-800-562-3022
COORDINATION OF BENEFITS HOTLINE	1-800-562-6136
DISABILITY INSURANCE	1-800-562-6074
DME PROSTHETICS & ORTHOTICS (PROVIDERS ONLY)	1-800-292-8064
ELECTRONIC BILLING QUESTIONS	(360) 725-1267
FRAUD HOTLINE	1-800-562-6906
HEALTHY OPTIONS DISENROLL/EXEMPTIONS/COMPLAINTS (CLIENTS ONLY)	1-800-794-4360
HEALTHY OPTIONS ENROLLMENT	1-800-562-3022
HOME HEALTH/P.O.T.	(360) 725-1582
HOSPICE NOTIFICATION	1-800-545-5392
PM&R AUTHORIZATION	1-800-634-1398
MEDICAL ELIGIBILITY DETERMINATION SERVICES/MEDS	1-800-204-6429
PHARMACY AUTHORIZATION (PROVIDERS ONLY)	1-800-848-2842
PHARMACY POINT-OF-SALE HELP DESK	1-800-365-4944
PROVIDER RELATIONS HOTLINE (PROVIDERS ONLY)	1-800-562-6188
TDD ONLY/DISENROLLMENT	1-800-461-5980
TDD ONLY/ENROLLMENT	1-800-848-5429

Provider Field Representatives:

Rita Honc	**360-725-1024**
Dee Dee Howden	**360-725-1027**
Peggy Strong	**360-725-1022**
Debbie Wingfield	**360-725-1023**

Provider Enrollment: 360-725-1026 or 360-725-1033 or 360-725-1032

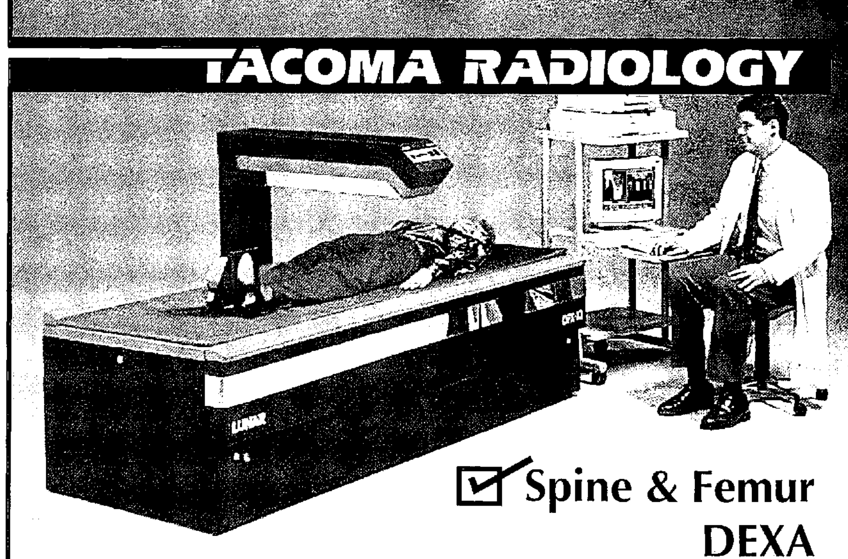
Provider Field Representatives are available for one to two hour consultations in physician offices at no charge. Call one of the above numbers for more information. ■

TacomaRadiology launches web site

Tacoma Radiology Associates (TRA) has developed a new web site. The site provides extensive information about the diagnostic examinations and interventional procedures performed in the outpatient clinics, MRI centers and hospitals served by the physicians of Tacoma Radiology.

Patients, medical personnel and physicians should find the site a valuable resource.

Visit TRA at www.tacomarad.com. ■



The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

The Breast and Cervical Health Program of Pierce County provides low cost screenings

Here are two statements that are not new, not unique, but are very true in vital ways:

1) Early detection of breast cancer and/or cervical cancer saves lives.

2) Patients are more likely to get screened if a physician tells them it is important to do.

For both breast and cervical cancer, the factor that most increases chances for overcoming the disease is early detection. Finding the malignancy early, through pap smears and mammograms, greatly increases the effectiveness of treatment.

Convincing an individual to get screened is not always an easy process. For some women, the extra nudge needed must come from someone in authority, often a medical provider. That sometimes puts physicians in a difficult position, especially when they know the individual has no insurance. Without insurance, a low-income woman's fragile budget can be threatened by any medical care beyond real emergencies.

The Breast and Cervical Health Program of Pierce County (BCHP) can help.

Almost six years old, BCHP provides health exams and mammograms for women between the ages of 40 and 64 years, emphasizing early detection of cervical and breast cancer. To date 18 cases of these cancers have been diagnosed in women in Pierce County who would normally not have been screened.

Beginning in the year 2000, the state no longer works directly with healthcare providers, but contracts with the Tacoma-Pierce County Health Department to arrange for screening and diagnostic services outreach. Healthcare providers subcontract with TPCHD to provide services and reimbursement.

> Currently, seventeen sites throughout Pierce County provide women's health exams, which include a pap smear and clinical breast exam and referral for a mammogram......limited resources allow some follow up diagnosis for abnormal results discovered in the exam if the provider suspects breast or cervical cancer.

Currently, seventeen sites throughout Pierce County provide women's health exams, which include a Pap smear and clinical breast exam and referral for a mammogram. During the exam, the provider encourages women to begin or to continue monthly self-breast exams, teaching proper techniques, if necessary. In addition, limited resources allow some follow up diagnosis for abnormal results discovered in the exam if the provider suspects breast or cervical cancer.

Unfortunately, BCHP supplies screening only; treatment funds continue to be challenging for many women to find. Congress is currently wrestling with this problem.

To make an appointment, women can call the Health Department at (253) 798-2987. Operators will determine eligibility, by checking age, income, and insurance coverage. If you know a woman who should be screened but who is hesitant because she has no insurance, feel free to share this information, and encourage her to get screened. Our promotion of early detection is important, and the BCHP can help to make that screening possible. ■

BRIEFS...........

Home Care Association honors Ron Goldberg, MD

Puyallup oncologist **Dr. Ron Goldberg** was honored by the HomeCare Association of Washington (HCSA) at their April meeting in Bellevue. Dr. Goldberg received the "physician of the year" award. He serves as medical director for In-Home Services.

Mary Lou Bresee, administrative director for In-Home Services, nominated him for the award, explaining that he is involved in patient care and physician education for Home Health and Hospice programs. She went on to say that he is a very integral part of their care team. ■

David Sparling, MD receives City of Destiny award

On June 13, the Tacoma City Council announced the winners of the 14th annual City of Destiny awards. **Dr. David Sparling** received the award in the adult leadership category.

Dr. Sparling, a retired pediatrician, has been active on many local boards and comissions, as well as in efforts to keep kids out of gangs and in school. He has advocated naming those people diagnosed with HIV for the purposes of education and counseling and he arranged the shipment of $2.5 million in donated medical supplies to Russia. These are just a sampling of the projects and activities that Dr. Sparling dedicates his time and expertise to.

Winners received a glass sculpture created by students in the Hilltop Artists-in-Residence program. ■

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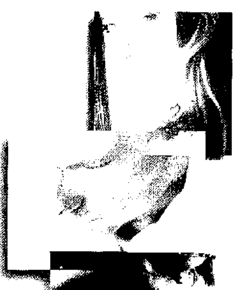

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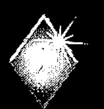

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In My Opinion.... The Invisible Hand

by Andrew Statson, MD

The Yellow Brick Road

Andrew Statson, MD

> *"The height of ability in the least able consists in knowing how to submit to the good leadership of others."*
> Duc Francois de la Rochefoucauld (1665)

We harbor a child within us who is afraid of the dark, when the monsters under the bed come out and those outside the window come in, and they all threaten to devour us. To calm our own children, we have devised a fairy tale world where good triumphs over evil, the good fairy overcomes the wicked witch, and everybody lives happily ever after. That way, they can sleep through the night, without fear that anything bad will happen to them.

For the child within us, we have devised algorithms. By following the yellow brick road, we will get to the City of Emeralds. This is expressed in our desire to have rules. Just follow the procedures in the protocol, and everything will be fine. If something bad happens, no one can blame us. We followed the instructions. We could not be at fault. "We followed the orders," said Hitler's lieutenants at their trial in Nuremberg. How simple, how enticing, how so dreadfully wrong.

The people attempting to solve the problem of medical errors claim that we can learn from the airline industry. Pilots and others have been encouraged to report incidents and errors without the threat of punishment. In doing so, the airlines have been able to develop procedures and protocols to handle various flight problems and reduce the risk of accidents. Perhaps we could do something similar in the practice of medicine. If we could remove the threat of disciplinary action or malpractice, people may come forward with a report of errors. We can learn a lot from mishaps and errors, ours and those of others. As a result, we may also be able to devise a system that eliminates errors. Perhaps, but unfortunately, airplanes still fall from the skies.

On March 6, 2000, The Wall Street Journal carried two stories, at first glance unrelated. The first one discussed the crash of Alaska Airlines flight 261. The landing is probably the most dangerous step of any flight. In the presence of mechanical trouble, it is even more dangerous, so the usual approach is to keep flying, while following the protocol for troubleshooting the problem. Pilots are trained to deal with malfunctions, "but training sessions and cockpit maneuvers don't cover every possible problem. 'Unfortunately, in the life of an aviator, few things happen precisely as those books describe,' said Captain Edmond Soliday, vice-president of safety at United Airlines. 'We pay pilots to use good judgment' Captain Lindsay Fenwick, chief accident investigator for the ALPA branch at Northwest Airlines said, 'In emergency situations all bets are off.' One lesson from this disaster is that mechanical problems deemed manageable can become unmanageable in an instant." So while the pilots were going down the troubleshooting checklist approved by the FAA, the plane went down into the ocean.

The second story was about the success of many new high technology companies in Israel. It reported that "The Israeli military, which is as informal as it is formidable, has served as the incubator for a generation of hugely successful startups. Limited in size and number, the Israeli Army has survived by tapping every drop of its resources. It gives enormous responsibility to relatively junior officers and encourages them to use their guile and ingenuity to solve problems. The chain of command is lean, unstructured and goal oriented, typical more of a startup than of a military bureaucracy."

Do you see the common point? The first story describes the failure of the officially approved checklist. In emergencies all bets are off. What does that mean? That the checklist is a waste of time in the face of a serious problem, perhaps. They pay pilots to use good judgment, they say. What does that mean? To ignore the checklist when they are really in trouble, perhaps. The second story describes the success of individual initiative and daring. That is how Americans were in the 19th century. That is how our ancestors tamed this continent of wilderness.

See Road, page 14

Road from page 13

What happened to us during the last 100 years? Why are we so afraid to make decisions? We got cowered into thinking we can't stand on our own two feet. We are so deathly afraid of failure that we cling to our protocols, hoping to be relieved of all responsibility when something goes wrong. Unfortunately, the responsibility remains ours, if not legally, at least morally, whether we admit it or not. Perhaps we don't care about that any more.

When some authority has approved our procedure manuals, troubleshooting checklists and various protocols and algorithms, we can relax, we don't have to think. All we need do is obey. We expect someone else to tell us what to do and to solve our problems. Yes, it is very simple, very enticing, and so dreadfully wrong. Just follow the yellow brick road. Do we really know where it will lead us?

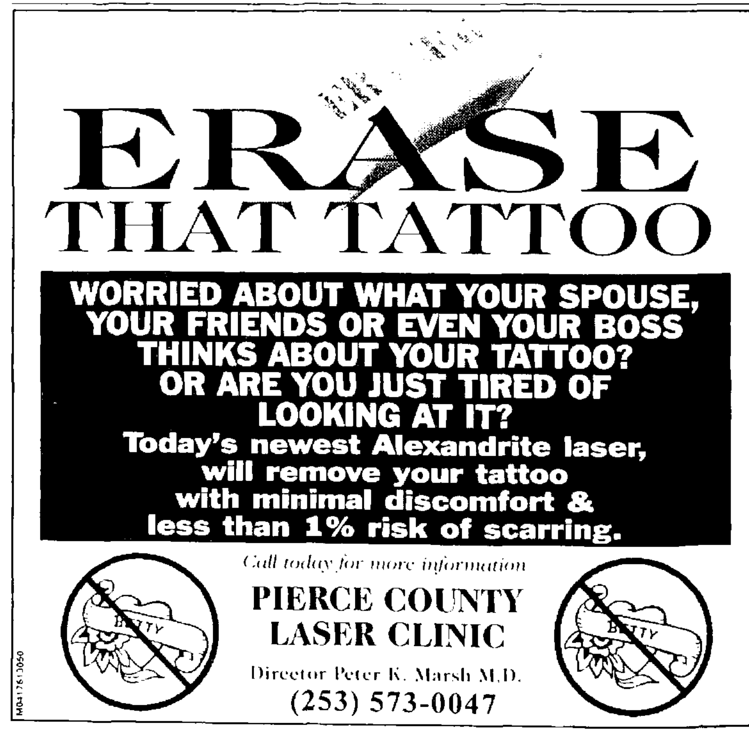
Granted, some people are not able to make decisions. Then they should not be in positions where emergencies can occur. The burden of decision making should not be on their shoulders. They do not belong in such an environment. Wherever they are, checklists and protocols will help them do their job. In general, checklists are useful in long, repetitive tasks. Following them, we can remind ourselves to do certain things, which sometimes we might forget, like ordering a laxative for a postoperative patient.

Establishing rules on how to handle problems does not help, because problems don't know they are supposed to happen according to the rules. When all bets are off, the people who are able to make decisions must feel free to make them. They need to have the knowledge and skill to do their job or they shouldn't be at the controls, but once there, they must be relied on to use their head and not be expected to follow a procedure protocol when there is no time for that. If they are paid to use their judgment, they deserve to be respected when they do so, and supported in their decisions, not subjected to censure. A judgment call is a judgment call and only the person who is there can make it.

In obstetrics we were under a significant amount of pressure to reduce the Cesarean section rates. No-one could say what the ideal section rate was, but the authorities in the field developed protocols to define fetal distress, failure to progress in labor, or the other conditions that are considered to be indications for a section. Did that mean we needed to wait until fetal distress was demonstrable before we could do a section? If, in our clinical judgment, we anticipated such a problem, why would we have to wait until we could prove the baby was in trouble?

Life presents us with problems that go from pure white to pure black through all shades of grays and colors. Life situations are a continuum. The rule-makers try to draw a line here and there, but no matter how precise they are in doing so, these lines remain arbitrary and unenforceable. The decisions of what to do and when remain based on the individual judgment of the people who are there and who have the responsibility to make these decisions. The rules may be helpful for people who don't know. They are an encumbrance and a hindrance for those who do. The best thing the people who don't know can do is to recognize their situation, step aside and let those who know do what has to be done.

Yes, sometimes we will fail. Yes, sometimes we will be wrong. If so, we will be ready to accept the responsibility, and move on. Overall, we are more likely to be right and to succeed, than are the rule makers who are far removed from the situation at hand. Sure, they will criticize us. Which Sunday game hasn't been on Monday morning. But they weren't there, so they should respect our decisions and let us do our work. If they claim they can do better, let them take call in our emergency rooms. There is nothing like direct personal experience to teach people some humility. ■



In My Opinion.....

by Teresa Clabots, MD

The Silver Bullet

(my dad's 1959 Porsche)

Teresa Clabots, MD

My father always wanted us to become extremely handy at anything that we did. So, in order for us to survive, he wanted us all to learn how to fix cars. Now, fixing cars to him meant something totally different than what it meant to us (his children). For him it meant rebuilding the motor, redoing the bodywork, and reupholstering the inside.

He purchased a dead, old Porsche from a junkyard that had been in an accident and rolled. It was our job to make this thing run again. The majority of the dirty, oily work fell to my brother and twin sisters, who are older than us. They were in the garage, tinkering with the engine, learning all about the intricacies of a 1959 German automobile engine. My sister and I were instead charged with: A) Reupholstering the inside B) Carpeting the inside C) Doing the putty work on the dents and body work and D) Painting the darn thing, which meant, of course, taping everything, and praying that it wouldn't rain.

Let me tell you that was no easy task. But, we were very proud of our accomplishment. Despite the fact that we had spent months doing the putty work, we were still annoyed to see a drip in the paint, a spot of glue on the carpet, or an uneven stitch. We were very, very proud of the silver Porsche that he had bought from a junkyard and resuscitated.

One weekend my father happened to go to his weekend moonlighting job at an inner city hospital. But, he came home to tell us that while in the hospital, he came out when it was rather dark, and leaning against the light posts were a couple of young men, laughing at his shocked surprise when he saw his car up on blocks. Now, as you know it is not unusual to find a car up on blocks in St. Louis, which I consider the car thief Mecca of the world, (second only now to Miami, which is getting even faster at stealing cars). But, they don't usually take your car in St. Louis. They just take your tires, and your battery and leave your car on blocks. Anyway, here comes my dad after a full day of work to find his little silver Porsche up on all four bricks. He was not a happy camper, and the angrier he became, the more the young men laughed at him.

Standing by the car, leaning against the lightpole was a gang of young men laughing at his face. When nervous, my father would light up a cigarette. Huffing, and puffing on his cigarette, he went over to the young men and asked, "Do you know who did this?" They said, "no." He said, "damn it, damn it, damn it. I'm never coming back to this hospital again." They looked at each other for a minute, turned to my dad and said, "ya'll a doc here?" He said, "of course I'm a doctor, what do you think I am?" They said, "Hey, doc. Wait a minute. Why don't you go back inside, and grab yourself a cup of coffee or something." (11:00 p.m.) He stormed into the patient waiting area, grabbed himself a cup of coffee, lit up a couple more cigarettes and went outside 30 minutes later.

There, by moonlight he could see that his silver Porsche had four brand new tires. He laughed and said, "I can't believe this."

The young men passed by in their car, waved at him, and said, "Good luck doc, next time park in the doctor's lot so it won't happen to you again."

He chuckled to himself and said, "Que Sera', Sera' what will be will be," hopped in his little silver Porsche, and took off. He was able to come home that night with brand new tires for his Porsche. As he said, "at least there was one good thing about being a doctor, if they stole your tires, they can always give you better ones." ■

Before Online Services Will Work in Healthcare, They Need to Work Like Healthcare.

The Internet may be global. But healthcare is still a local business. That's why, amid all the hype about online healthcare services, there's one company actually delivering on the promise of enhanced communication, reduced costs and improved quality of care: Pointshare.

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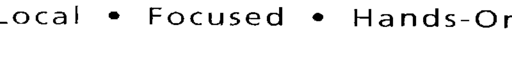
Every element of Pointshare's service is designed to streamline communication without disrupting workflow. Most important, Pointshare provides the on-site support and training to get entire healthcare communities up and running.

While others are talking about the future, Pointshare is delivering today … with proven, practical solutions that are online now, saving time and lowering costs.

Find out how Pointshare can work for your healthcare community, Call 1-800-531-1033. Or visit our website at www.pointshare.com.



COLLEGE OF MEDICAL EDUCATION

Continuing Medical Education

College Board announces new board members and officers for 2000-2001

The College of Medical Education has new board members and a new president for their 2000-2001 course and fiscal year. **John Jiganti, MD** accepted the president's gavel from **Dale Overfield, MD,** who has served as president since 1998. Dr. Overfield will serve one more year on the board, and will then have completed eleven years of service to medical education in Pierce County. Dr. Jiganti has served seven years.

New board members are: **Drs. Marjorie Krabbe** and **William Lee** and they will be replacing Drs. **Robert Alston** and **Mark Ludvigson.** Current board members include**Drs. J.D. Fitz, Barbara Fox, William Holderman, Steve Konicek, Gregg Ostergren, Brad Pattison, Judy Pauwels, Cecil Snodgrass, Virginia Stowell, Richard Waltman and Tod Wurst;** Sister Anne McNamara representing the Franciscans, Victoria Fletcher from MultiCare and Rick Campbell, Good Samaritan Hospital. Nine board members are appointed by the PCMS Board of Trustees and serve three year terms while three members serve one year terms and are appointment by the College Board.

In other business the board of directors approved the 2000-2001 operating budget. The College finished fiscal year 1999-2000 with $176,433 in income and $169,016 in expenses. The College reserve level is currently $22,618. ▪

Whistler CME program set for January 24-28

The dates for the annual Whistler CME program have been set for January 24-28, 2000. A program brochure with course details and registration will be available in September. Watch your mail! ▪

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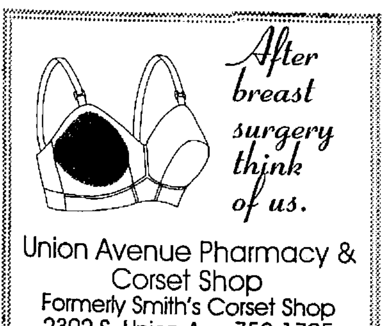

Preliminary survey results suggest changes in course offerings

The recent survey of the membership regarding continuing medical education needs was utilized by the College of Medical Education Board of Directors to set course direction for next year's programs.

Survey responses, as of their June 16 meeting, indicated that there was significant interest in a course on technology. Specifically, the Internet and medical information, computers in the medical office, and how to respond to "Internet educated" patients.

Evening programs also were of interest with 52% indicating a preference for attending at night rather than the traditional work day offerings.

The ever popular infectious diseases specialty again ranked number one in interest; the top eight were:

- #1 Infectious Diseases
- #2 Gastroenterology
- #3 Pain Management
- #4 Dermatology
- #5 Pulmonary Disease
- #6 Orthopedics
- #7 A tie between Cardiology and Endocrinology

In addition to the new technology course that will be added to next year's program schedule, a pain management program will be offered. These two new courses will replace the Hawaii and Gastroenterology courses that are traditionally held every other year.

Watch your August and September *Bulletin* for complete survey results and for announcement of the 2000-2001 course calendar. ▪

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For Lease – Medical/dental suite. North 26th & Alder. 1500 - 2000 sq. ft. Available immediately. Contact Dr. Bob Williams 584-2298.

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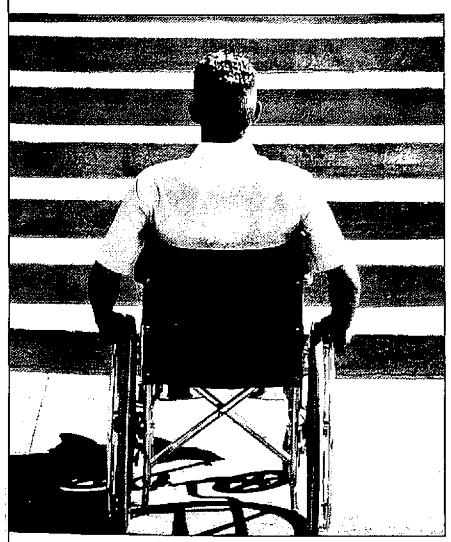

As you know, disability insurance policies for physicians are changing rapidly—and not for the better. High claims have caused many major carriers to limit the most important benefits.

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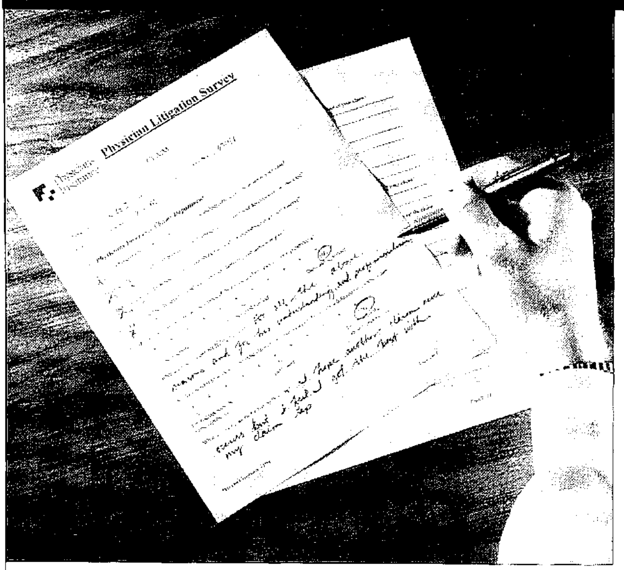

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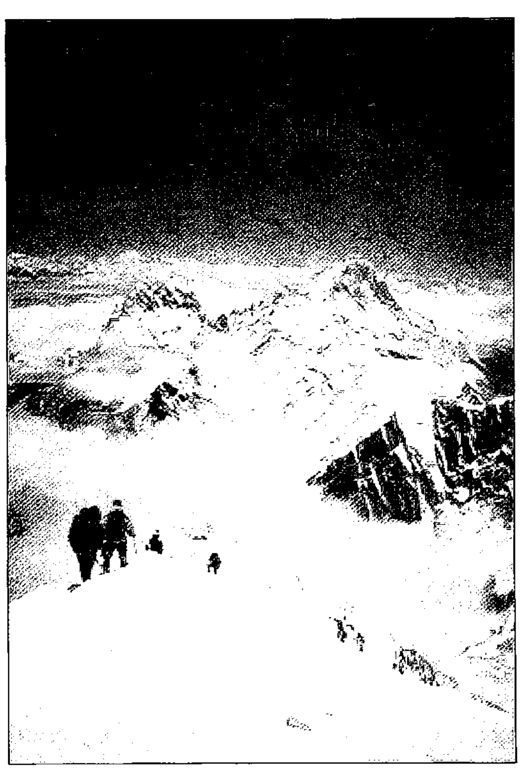
Pierce County Medical Society
BULLETIN
August, 2000

Mt. Everest - Finding Mallory

George Mallory on the descent of the Moine Ridge, August, 1909



Descending the Southeast Ridge May, 1998

More information page 3

INSIDE:

3 Climbing Everest in the Search for Mallory & Irvine - September General Meeting
4 Mini-Internship teaches community leaders about the profession of medicine
5 PBS to feature Bill Moyers' End-of-Life care program, "On Our Own Terms"
9 "The New Economy Math Just Doesn't Add Up," says David Roshkoph, MBA, CFP
10 Tacoma Youth Symphony goes to Carnegie Hall
11 Helping patients with tobacco cessation
19 College of Medical Education announces 2000-2001 program schedule

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The Bulletin is published monthly by PCMS Membership Benefits, Inc. for members of the Pierce County Medical Society. Deadlines for submitting articles and placing advertisements in The Bulletin are the 15th of the month preceding publication (i.e. October 15 for the November issue).

The Bulletin is dedicated to the art, science and delivery of medicine and the betterment of the health and medical welfare of the community. The opinions herein are those of the individual contributors and do not necessarily reflect the official position of the Medical Society. Acceptance of advertising in no way constitutes professional approval or endorsement of products or services advertised. The Bulletin and Pierce County Medical Society reserve the right to reject any advertising.

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Pierce County Medical Society

BULLETIN

Table of Contents

3 "Finding Mallory" September General Membership Meeting

4 The Alf Gunn Seattle to Spokane One Horse Relay
4 Mini-Intern program teaches aobut the medical profession

5 PBS to feature Bill Moyer's End-of-Life program series
5 Draft of Fraud & Abuse Guidelines released

6 Applicants for Membership
6 Directory changes

7 "Full Disclosure" by Andrew Statson, MD

8 New Members

9 "The New Economy Math Just Doesn't Add Up" by David Roskoph, MBA, CFP

10 Tacoma Youth Symphony goes to Carnegie Hall

11 TPCHD - Helping Patients with Tobacco Cessation

13 "At First Do No Harm and the Airplane Ride" by Teresa Clabots, MD

15 "Nostalgia of World War II" by John Stutterheim, MD

19 College of Medical Education

23 Classified Advertising

Pierce County Medical Society

invites you and your spouse/guest to the

September General Membership Meeting

Tuesday, September 12, 2000
Social Hour: 6:00 pm
Dinner: 6:45 pm
Program: 7:45 pm

Landmark Convention Center
Temple Theatre, Roof Garden
47 St. Helens Avenue
Tacoma

FEATURING: ERIC SIMONSON

FINDING MALLORY:

A 1924 MYSTERY UNFOLDS

Join us for an evening of amazing tales, told by the man who lived them. Eric Simonson shares his personal experiences in solving two of exploration's greatest mysteries: Did George Mallory and Sandy Irvine reach the summit of Mt. Everest in 1924, and what became of them? Simonson, whose climbing resume includes Mt. McKinley, Aconcagua in Argentina, Cho Oyu in Tibet, Mt. Elbrus in Russia, and Mt. Vinson in Antarctica led the 1998 expedition. The team stunned the mountaineering community with their findings. The expedition set out searching for answers. Join us at the September meeting to hear what he discovered!

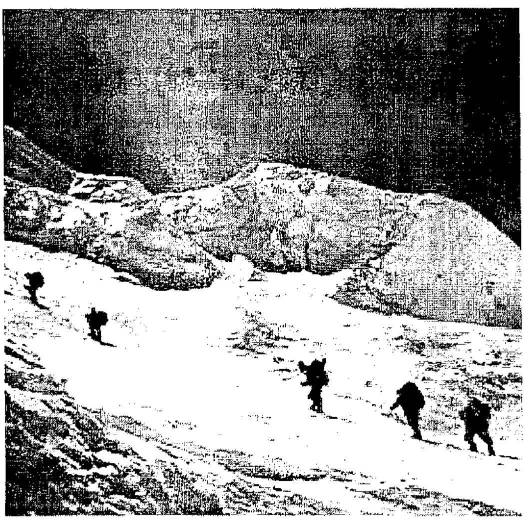

Photo by Eric Simonson

(Registration required by September 8. Return this form to: PCMS, 223 Tacoma Ave S, Tacoma 98402; FAX to 572-2470 or call 572-3667)

Please reserve _________ dinner(s) at $20 per person (tax and tip included)

Enclosed is my check for $ _______ or my credit card # is ______________________________

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The Alf Gunn Seattle to Spokane One Horse Relay

by Marsden Stewart, MD
Anesthesiologist, St. Joseph Hospital

On June 17, **Dr. Marsden Stewart** and others participated in the first and only "Alf Gunn Seattle to Spokane One Horse Relay." In essence this is a take-off of how two cowboys used to ride one horse in the old days: one cowboy would start running while the other would ride the horse for a ways, hobble the horse and then start walking himself. When the first cowboy would arrive at the horse, he would mount up, overtake the other cowboy, leave the horse for him farther down the trail, and in this manner they would arrive at their destination. Our destination was Spokane, and our "trail" was I-90.

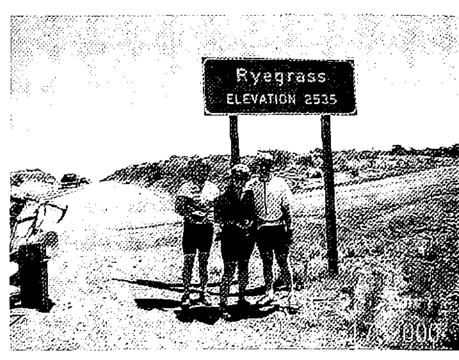
We had eight riders divided into two groups of four: Marsden and Leelee Stewart and another couple, Dave and Leslie Pearce, were one team. Alf Gunn, Rob Argyle, Mark Caviness, and Ryan Fisher, 15, comprised the second team. We actually used two vans for support, full of food and drinks.

Team 2 started riding at the park at the west end of the I-90 bridge bike tunnel, at 4:50 am. The sunrise was silhouetting the Cascades, and there was a full moon. It was beautiful. They didn't have to get onto I-90 until the far end of Issaquah, then it was easy to get to North Bend, where the vans were waiting. Marsden and team 1 had driven to North Bend, then started riding over Snoqualmie Pass. For the last few miles up to the pass, the route bypassed the freeway using Denny Creek road. Unfortunately Denny Creek Road was gravel, so Team 1 got in several miles of single-track mountain biking that day as well.

Team 2 rode Easton to Ellensburg as it got warmer. Alf was spared some major grief when his downtube water bottle cage came off and went into the rear wheel spokes, crumpled up and went around and around. Fortunately, only one dented spoke, wheel still in true, no further damage. Totaled the water bottle–which had a little hole in it. So they rode on.

Team 1 drove from Easton to Ellensburg, and started riding to Vantage. They

See Relay, page 18



Above, Team 1 members Marsden Stewart, and Dave & Leslie Pearce at Ryegrass

Mini-Intern program teaches community leaders about the profession of medicine

In June, four community leaders experienced medicine from a different perspective. All were partnered with physicians of four different specialties to see how the practice of medicine is carried out on a day to day basis.

Rick Allen, President of United Way of Pierce County; Karl Anderson, President, Concrete Tech; Bill Harrison, Mayor of Lakewood; and Debbie Winskill, Tacoma School Board member had the opportunity to spend a half day each with **Drs. Marsden Stewart** (anesthesiology), **Lawrence A. Larson** (pediatric allergy/immunology), **Philip Craven** (infectious diseases) and **Carlos Garcia** (cardiovascular-thoracic surgeon). **Drs. Brad Pattison,** Larry Vercio and **Jim DeMaio** also served as physician faculty.

From left: Interns, Karl Anderson, Rick Allen and Debbie Winskill, Drs. Charles Weatherby and Larry Larson, and Intern Bill Harrison

"It was a great experience," said Rick Allen of United Way. His sentiment was also echoed by the other interns. "I was mostly impressed by the amount of detective work and team work required in treating patients. The team work was remarkable," he added. Bill Harrison, Mayor of Lakewood noted that "the paperwork requirements are overwhelming."

The Mini-Intern program, implemented by PCMS in 1992 has helped educate many community leaders, such as legislators, media, attorneys, etc. about medicine. It is an effective way to show lay people about the profession. "I got an exceptional view of the system," noted Allen, "and it was ugly - but the people were exceptional!" ∎

PBS to feature Bill Moyers' special on end-of-life care

'On Our Own Terms,' a national four-part 90-minute PBS series produced by Bill Moyers' Public Affairs Television will report on the national movement to improve care at the end of life and showcase models of where it is being done well. The series will premier September 10-13, 2000 and will air on KCTS Channel 9, from 9:00 to 10:30 each night.

Program highlights include:

Program I: Living with Dying

This program explores America's search for new ways of thinking about death. It focuses on people - patients and caregivers - who are finding ways to overcome the fear and denial that dominate mainstream American culture and open a conversation that helps us live with dying.

Program II: A Different Kind of Care

A second program examines the evolution of a new kind of care - commonly referred to as "palliative care." Leaders in this movement emphasize a full spectrum of pain management, symptom relief and support - including physical, psychological and spiritual care.

Program III: A Death of One's Own

Dying well to many, means a measure of control over how we die. We fear dying in pain; we fear that too much will be done to keep us alive, or we fear that not enough will be done. This program will look at the issues surrounding efforts to control how we die and the implications for family, institutions and communities.

Program IV: A Time to Change

This program will follow crusading individuals who are working to change public policy to improve care of the dying. They are creating models for change that deal with issues including insurance coverage, the training of doctors, and building communities of volunteer caregivers to relieve the burden on families of the dying.

"These programs will present central stories and focus on the challenges we face to improve care," said **Mimi Pattison, MD,** Medical Director of Palliative Medical Services for Franciscan Health System. Successful programs and people, including patients and caregivers, will be highlighted to demonstrate how improvements can be made, she added.

For more information about the series "On Our Own Terms" visit the website www.thirteen.org/onourownterms or www.pbs.org/onourownterms.■

OIG releases draft version of its fraud and abuse guidelines

The Office of the Inspector General recently released a draft version of its long-awaited compliance program for physicians in solo or small group practices. The draft includes an outline that physicians and their staffs can use to help detect and prevent errors, fraud and abuse in dealings with government health care programs, such as Medicare and Medicaid.

The new plan has adapted to the physician's office the same key elements found in compliance plans the OIG has released for other sectors of the health care industry including:

- creating written policies and procedures
- designating a compliance officer
- conducting effective training
- developing effective lines of communication
- auditing and monitoring
- enforcing standards through well-publicized disciplinary guidelines
- responding to and acting on detected offenses.

With many physician offices unable to afford a full-time compliance officer, they may appoint another staff member to be responsible for overseeing the compliance mechanism.

The top four areas most in need of internal checks and balances to prevent Medicare payment errors and possible fraud are:

1. CODING AND BILLING:

Billing for services never rendered, billing twice for the same service and upcoding the level of service provided are among the most frequently investigated coding and billing practices, OIG says.

2. PROOF OF THE NEED FOR SERVICES:

When asked, physicians must produce documentation, like a patient's medical record or physicians' orders, that show that a service was "reasonable and necessary" for the diagnosis and treatment of a patient.

3. DOCUMENTATION

Among other things, patient records should include the reason for the encounter; relevant history; physician examination findings; prior diagnostic test results; assessment, clinical impressions or diagnosis; plan of care; date; and legible identity of the observer.

4. RELATIONSHIPS

Problems here could lead to allegations of kickbacks, inducements or self-referrals. Violations arise from office and equipment leases with entities to which the physician refers patients or from accepting gifts at more than their nominal value from those who could benefit from a physician's referral.■

Applicants for Membership

Baker, James M, MD
Family Practice
Practices at Gig Harbor Medical Clinic, 6401 Kimball Dr, Gig Harbor 98332;
Phone: 858-9195
Medical School: State University of New York at Buffalo
Internship: Providence Hospital
Residency: San Bernardino County General Hospital

Dobbins, Jill M, MD
Radiology
Practices at Diagnostic Imaging Northwest, 222 15th Avenue SE, Puyallup 98372
Phone: 841-4353
Medical School: University of Washington School of Medicine
Internship: Maine Medical Center
Residency: Maine Medical Center
Fellowships: University of Florida Medical Center

Fahmy, Jana L, MD
Diagnostic Radiology
Practices at Tacoma Radiology, 1901 South Cedar #108, Tacoma 98405
Phone: 383-1099
Medical School: Loma Linda University
Internship: Loma Linda University Medical Center
Residency: Loma Linda University Medical Center
Fellowship: Childrens Hospital of Los Angeles

Ge, Zheng, MD, PhD
Nephrology
Practices with Gerard W Ames MD, PS, 1802 South Yakima #208, Tacoma 98405
Phone: 627-5755
Medical School: Shanghai Medical University
Internship: Mt Sinai Medical Center
Residency: Mt Sinai Medical Center
Fellowship: Stanford Medical Center

Kwon, Eun K, MD
Family Practice
Practices at Community Clinics of Pierce County, 11225 Pacific Ave, Tacoma 98444
Phone: 531-6198
Medical School: Ponce School of Medicine
Residency: North Shore University Hospital

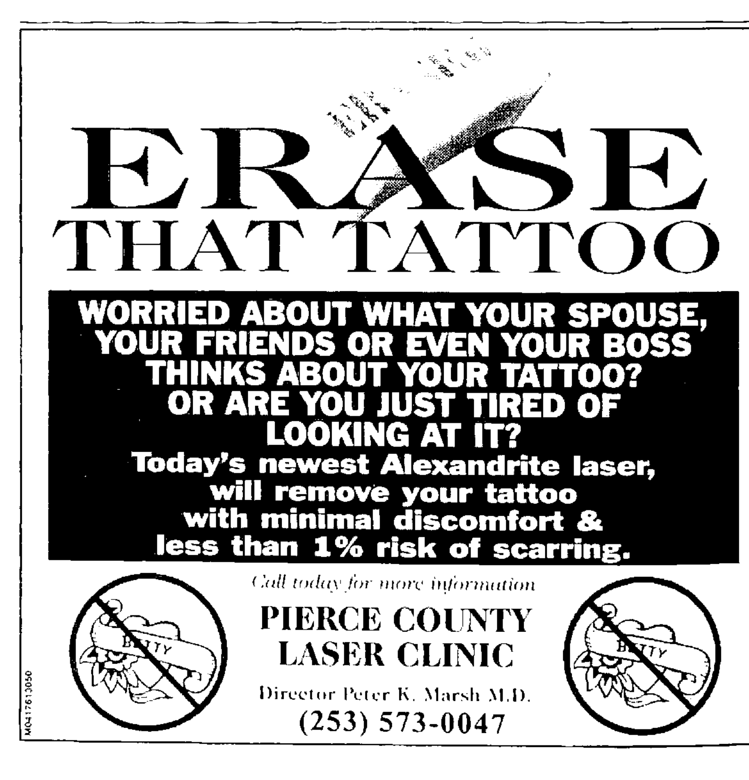
Kwon, Eunhee, MD
Family Practice
Practices at Community Clinics of Pierce County, 3418 E McKinley Ave, Tacoma 98404
Phone: 404-0737
Medical School: Ponce School of Medicine
Residency: North Shore University Hospital

Nerkar, Manisha S, MD
Internal Medicine
Practices at St Joseph Medical Clinic, 1708 S Yakima Ave, Tacoma 98405;
Phone: 627-9151
Medical School: Indira Gandhi Medical College
Internship: Thomas Jefferson University Episcopal Hospital
Residency: Thomas Jefferson University Episcopal Hospital

Directory changes

Please make note of the following changes to your 2000 PCMS Directory.

Lynne P. Clark, MD
Change address to: 6002 N Westgate Blvd #150 Tacoma, WA 98406
Phone: 752-8882 Fax: 752-8907
DSHS# 1110477



In My Opinion.... The Invisible Hand

by Andrew Statson, MD

Full Disclosure

Andrew Statson, MD

> *"Surely the glory of journalism is its transience."*
> Malcolm Muggeridge (1966)

The Atlantic Monthly from April 2000 carried an article on regulation by shaming. After discussing a California law requiring disclosure of toxic compounds in various products or emissions and federal laws doing the same, the article stated, "momentum for national disclosure of serious medical mistakes has been growing rapidly since the Institute of Medicine, part of the National Academy of Sciences, reported last November that 44,000 to 98,000 people die each year as a result of medical errors. Several states require hospitals to disclose mistakes that result in death or serious injury. For example, New York recently revamped its reporting system to release such information on the Internet when the state takes action against a hospital. General Motors, General Electric, and six other large employers have said that they will steer employees toward those hospitals that make the fewest mistakes."

For several years our hospitals have been exposed to such pressure to disclose complication rates and deaths after heart surgery. Length of stay and other data have appeared in the press already. Of course, the hospitals were concerned that such data might be misinterpreted. I don't know whether they have been or not. Not too long ago, there was a report that patients covered by managed care plans were directed toward the hospitals that had a higher rate of medical errors. I suspect you can guess the reason. I don't know whether such reports have affected hospital admissions and have made a difference in patient choice. The idea sounds attractive. As most ideas it is not new. Let me show you how it worked in one instance.

When a medical student in France, I spent a year as a resident in the public hospital of Dieppe, a city of 20,000 in Normandy. We served the surrounding villages within a radius of 20-30 miles and a population of 60,000. We had four surgeons in town, in two groups of two.

One of the surgeons told me their referrals from the various villages came in waves. For a while they would have a number of patients from one village. Then something would happen, they would have a complication or a problem patient, and suddenly the referrals from that village will go to the other surgical group. This system worked through word of mouth. There were no reports, no published rates of complications, no inspections, just word of mouth. The sea of human beings acts like the ocean, the waves going back and forth, back and forth.

A few years ago Money Magazine rated Bremerton as the best place in the country to live. That was an ephemeral glory. Every year since then a different city was so rated. This means that the ratings, which are based on past performance, are outdated almost as soon as they are published. How useful!

What will happen when a hospital in the area is declared as having the lowest complication rate? Even if the physical structure of the hospital would allow an increase in the census, our hospitals are badly understaffed already. Any one of them will have difficulty handling a significant increase in volume. The quality of care is already marginal for the volume they have, so it will drop rapidly with any increase. The good rating may also bring in sicker patients, so the complication rate will go up and by the time of the next rating, the hospital will be down the list.

Referrals will come in waves, just as they did in Dieppe. The ratings will be obsolete by the time the various companies that want to use them run the data through their committee structures and get around to acting on them. Eventually people will realize what the effect is of the rating system and will start going to hospitals that are lower on the list, or disregard the ratings altogether. In the long run the ratings will be another exercise in futility, as the many others we have already witnessed. The Consumer Union is a testing organization which has rated products for many years. How many people base their purchasing decisions on those reports?

Our reputation is based on the quality of the services we provide to our patients. Whether our results are

See "Disclosure" page 12

New Members

Colombini, Rose-Marie J, DO
Family Medicine
Practices at Lakes Medical Center, 19820 Hwy 410 Ste 101, Bonney Lake 98390
Phone: 862-9969
Medical School: Western University of Health Sciences, College of Osteopathic Medicine of the Pacific
Internship: San Bernardino County Medical Center
Residency: San Bernardino County Medical Center, Arrowhead Regional Medical Center

Jenner, Carrie L, MD
Pediatrics
Practices at Franciscan Medical Group, 1708 S Yakima Ave, Tacoma 98405
Phone: 593-8407
Medical School: Georgetown Univ
Internship: University of Washington
Residency: University of Washington

Lahrs, Anthony E., MD
Diagnostic Radiology
Practices at Tacoma Radiology, 3402 S 18th, Tacoma 98405
Phone: 383-1099
Medical School: University of Toronto
Internship: University of Toronto
Residency: University of Toronto
Fellowship: Hospital of University of Pennsylvania

Lazarus, Marlene L., MD
Cardiology
Practices at 1408 3rd Street SE, #100, Puyallup 98372
Phone: 864-6848
Medical School: Rush Medical College
Internship: LAC USC Medical Center
Residency: LAC USC Medical Center

Long, Jeffrey P., MD
Radiation Oncology
Practices at MultiCare Radiation Oncology, 1003 S 5th St, Tacoma 98405
Phone: 403-4994
Medical School: University of Iowa College of Medicine
Residencies: Univ of Arkansas for Medical Sciences, Univ of Louisville Hospital, Univ of Iowa Hospital

Louie, Douglas H., MD, PhD
Family Practice/Geriatrics
Practices at Franciscan Medical Group 1708 S Yakima Ave, Tacoma 98405
Phone: 593-8456
Medical School: Univ of Washington
Internship: Univ of California, Irvine
Residency: Univ of California, Irvine

Thorpe, Robert J., MD
Family Practice
Practices at Franciscan Medical Group, 1708 S Yakima, Tacoma 98405
Phone: 593-8456
Medical School: Univ of Oklahoma
Internship: University of Kansas
Residency: University of Kansas

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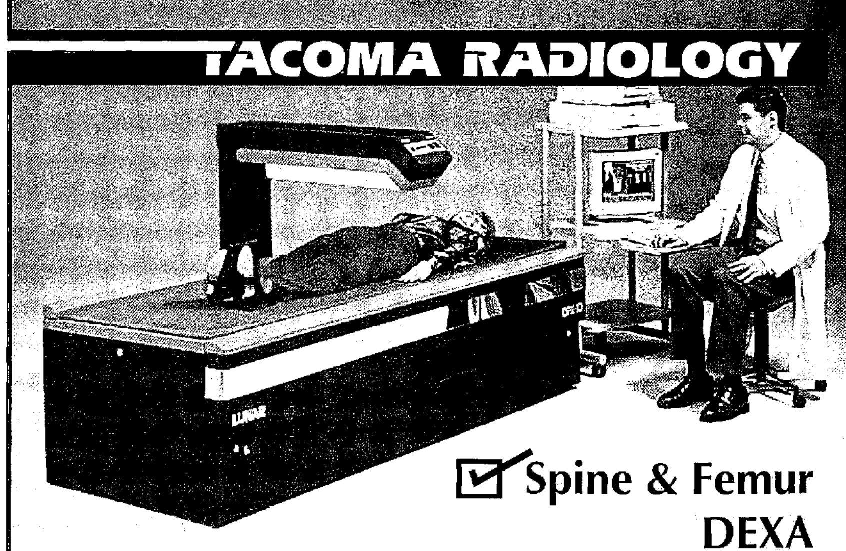


In My Opinion.....

by David Roskoph, MBA, CFP

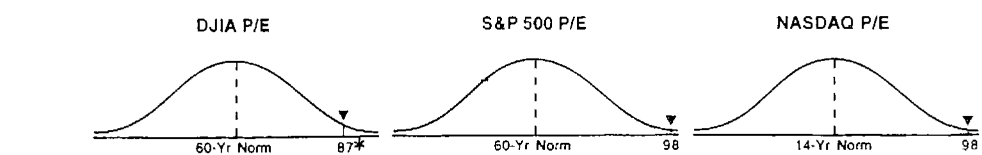
The New Economy Math Just Doesn't Add Up

David Roskoph, MBA, CFP

One of the things that makes investing an art, at least as much as a science, is the fact that the financial markets are only tangential to reality. At times, there are only brief glimpses of rationality between the other periods of alternate mania or depression. Right now I'd say our financial markets are in some kind of mania. The mania has (once again) been dubbed a new economy and is (once again) heralded as a time when conventional and traditional means of valuing future cash flows just don't fit the new model of stock valuation. For a while any fad can resemble rational behavior and, with enough participants, the theories will actually look valid. Sooner or later this party will end. That it has carried on this long and to this extent is a testament to the willing suspension of disbelief evidenced by the public and marketing that would make P.T. Barnum proud. However, there are two elements to this New Economy that warrants closer examination because they just don't add up - profit margins and corporate finance. The Internet undisputedly provides two major improvements in getting goods to consumers: 1) it opens up a heretofore-unimaginable plethora of choices and, 2) it reduces the transactional friction thus lowering prices. Consumers who once strolled through a mall, now more efficiently scroll down a screen. Access to a variety of goods never before available has sent consumers on a buying spree and the lack of salespeople has sharpened their shopping skills. Let's look at two icons of the New Economy that arrived early and dominated their arenas, Amazon.com and Ebay.com. Their share prices soared, then swooned then.....anyway, Amazon.com is still spending $1.53 for every $1.00 of revenue it takes in and Ebay is trading at over twelve hundred times its earnings. Although they were first, ask yourself what makes their market share secure? There are no proprietary goods, no big patents, in other words, nothing that cannot be duplicated. Competitors need only set up a few computers and a web presence to erode their business. Consumers need only SEARCH for a new and more aggressive competitor with a simple click of their mouse. Herein lies the fundamental problem with this New Economy: once distribution is universal, items become commoditized. As commodities, there is no pricing, and certainly no monopoly power. Profit margins must continue to shrink. The other shoe of New Economy will eventually fall; few of the hundreds of distributors, all vying for the same consumer's dollars, will succeed. Those who do will have to advertise heavily just to hang on because the friction to compete has also been removed. How much advertising will have to be done and how low will prices eventually have to go to get the business? And after all that, will there be any loyalty as more competitors enter the arena? The ultimate question investors must ask - where's the profit margin? The euphoria surrounding a change to Internet distribution has created an a-historic overvaluation of the Dow Industrials, S&P 500 and most notably the NASDAQ. With no pricing power whatsoever, how can this bubble sustain? In a rush reminiscent of the great Tulip mania, investors

See "Math" page 14

HISTORIC VALUATION RISK:



* 87th percentile means the DJIA has been more overvalued only 13% of the time.

POTENTIAL LOSS:

Risk-to-Norm: -30.2% (DJIA @ 7367) -50.9% (S&P 500 @ 722) -80.6% (NASDAQ @ 776)

Investech research http://www.investech.com

Tacoma Youth Symphony goes to Carnegie Hall

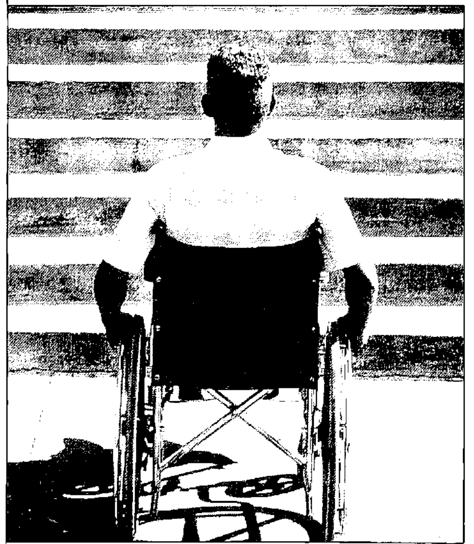
On May 7, 2000 the young musicians of Tacoma Youth Symphony Association realized a dream that every classical musician shares; to play at Carnegie Hall. After a competitive audition in 1998, the TYSA was invited to perform in one of the world's most renowned musical venues. Conductors Paul-Elliott Cobbs and Dale Johnson, over 100 student musicians and staff made the trip to New York to perform Shostakovich's "October" and Tchaikovsky's "Francesca da Rimini." **Three members of the Pierce County Medical Society (Leslie Fox, MD – board president, James Billingsly, MD – former president, and Vita Pliskow, MD) are members of the Tacoma Youth Symphony Board of Trustees who helped raise the money to send the Youth Symphony to New York.**

"Our Youth Symphony played with true inspiration," said Dr. Fox, who attended the concert. "The usually reticent New York audience gave an immediate standing ovation in response to the enormous emotion and intensity of the performance." As a result of the outstanding quality of the concert, the Tacoma Youth Symphony has been invited to represent the United States at the Cultural Olympiad immediately preceding the Olympic Games in Greece in 2004. Three American Youth Symphonies were selected for this honor, the New York Youth Philharmonic, the Houston Youth Symphony and the Tacoma Youth Symphony. To be in such company is an amazing honor for a small city the size of Tacoma.

The Tacoma Youth Symphony Association is a very important part of the cultural landscape of this city. In the 35 years since it was formed, the organization has grown from a group of 50 students practicing in a church basement, to one of the premier Youth Symphony organizations in the country. The TYSA serves over 500 students of all races, religions, and economic backgrounds from all over the Puget Sound area, extending from Bellingham to Chehalis. "The community is really behind these kids," Dr. Fox said. "The Tacoma Youth Symphony is one of the important reasons why our city is a great place to live." ■

Editor's Note: Tacoma Youth Symphony members provide musical enjoyment each year at the PCMS Annual Meeting in December at the Sheraton/Tacoma Hotel

Will a disability put you out of commission?



As you know, disability insurance policies for physicians are changing rapidly—and not for the better. High claims have caused many major carriers to limit the most important benefits.

At Physicians Insurance Agency, there's still time to secure the specialty-specific coverage you need. In addition, we can help you find superior life and long-term-care coverage for you and your family.

To discuss the ways you can best protect your future income, call Physicians Insurance Agency today: (206) 343-7150 or 1-800-962-1399.

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The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

Helping patients with tobacco cessation

The Public Health Service distributed the following news release in June, 2000 encouraging health professionals to take action against tobacco use. The Health Department has resources for you to access to respond to this Public Health Service request.

WASHINGTON, June 27 (Reuters Health) – The US Public Health Service (PHS) urged all healthcare professionals to make smoking cessation a top priority in treating patients.

To back up this call, a new set of guidelines issued by the PHS provides clinicians with new tools to help smokers kick the habit.

U.S. Surgeon General Dr. David A. Satcher said helpful and proven strategies aimed at getting smokers to quit can take as little as 3 minutes of a physician's time per patient during a visit.

"Starting today, every doctor, nurse, health plan, purchaser and medical school in American should make treating tobacco dependence a top priority," Satcher said in announcing an updated clinical guideline to treat tobacco dependency.

The guidelines, which demonstrate the effectiveness of smoking cessation efforts that combine medication and counseling, is designed to allow physicians and other health professionals to more easily incorporate smoking cessation programs into their practices.

Only about half of all US smokers who see a physician have been urged to quit, even though smoking is the single greatest preventable cause of illness and premature death in the country.

"Approximately 20 million Americans will try to quit (smoking) this year...Regrettably, most of them will try to do so on their own," Dr. Michael C. Fiore, guidelines panel chairman, said during a briefing here Tuesday. "As a result, only 1 million of them will be able to quit and stay tobacco-free," he added.

"Effective cessation treatments are now available and every patient who uses tobacco should be offered these treatments," said Fiore, who is also director of the Center for Tobacco Research and Intervention and the University of Wisconsin Medical School in Madison.

"The treatment recommendations outlined in the guideline...will substantially increase the success rate," Fiore said. "In fact, if every doctor, nurse, dentist or other healthcare provider and health plan uses this tool in practice across America, we can more than double quit rates."

"(We) need to call tobacco dependence what it is – a chronic disease not unlike high blood pressure or diabetes," Fiore said. "This recognition provides clinicians with a model for helping their patients quit."

President Clinton also instructed federal agencies "to encourage federal employees to stop smoking, to promote greater use of available smoking cessation programs, and to review current federal tobacco cessation programs in light of these new guidelines," according to the Department of Health and Human Services. And the Office of Personnel Management will also send a copy of the guideline to all health plans enrolling federal workers encouraging them to promote smoking cessation.

The updated, evidence-based guideline advises healthcare professionals that they should be consistently identifying, documenting and treating tobacco users at every visit. The guideline labels tobacco dependence as a "chronic condition" that demands repeated treatment efforts until abstinence is reached, and that "every tobacco user should be offered at least brief treatment."

"The science is pretty compelling," said Dr. Mark W. Banks, president and CEO of Blue Cross and Blue Shield of Minnesota. The Blue Cross plan was the first, and still one of the few health plans, to cover smoking cessation. "This is a no-brainer. (Smoking cessation) saves lives, improves health and saves money."

The Tacoma Pierce County Health Department has an effective approach for talking with clients about their use of tobacco. The 4A Model involves a short series of questions, with ideas for tracking the discussion in the patient's chart, and following up at subsequent visits. Training is offered regularly throughout Pierce County, or Network Nurses can meet with you and your staff in your office to provide information about the model. Also, the Health Department has packets of material clients can access for no charge. If you would like more information, talk with the Network Nurse who visits your office, or call Nancy McKindsey at TPCHD: (253) 798-6461. ■

Disclosure from page 7

known by word of mouth, through the newspapers or through radio and television broadcasts, is irrelevant. Patients already compare notes and experiences. We all hear comments about the service at this or that hospital. They have a reputation, too. It usually is built on their performance over a long time, not just the last year or two. It may not be in the newspapers, but it is in the grapevine. When people want to know, they ask around and they find out. When something bad happens, people learn about that, too.

People want to know how we have performed before they come to us and the information is always available. The services we provide are very personal and the patients' choice of physician is usually based on many factors, not least of which is the comfort level they have in their interpersonal communication with the physician. Since that varies from patient to patient, it is not something that can be described by the method of ratings, which is statistical.

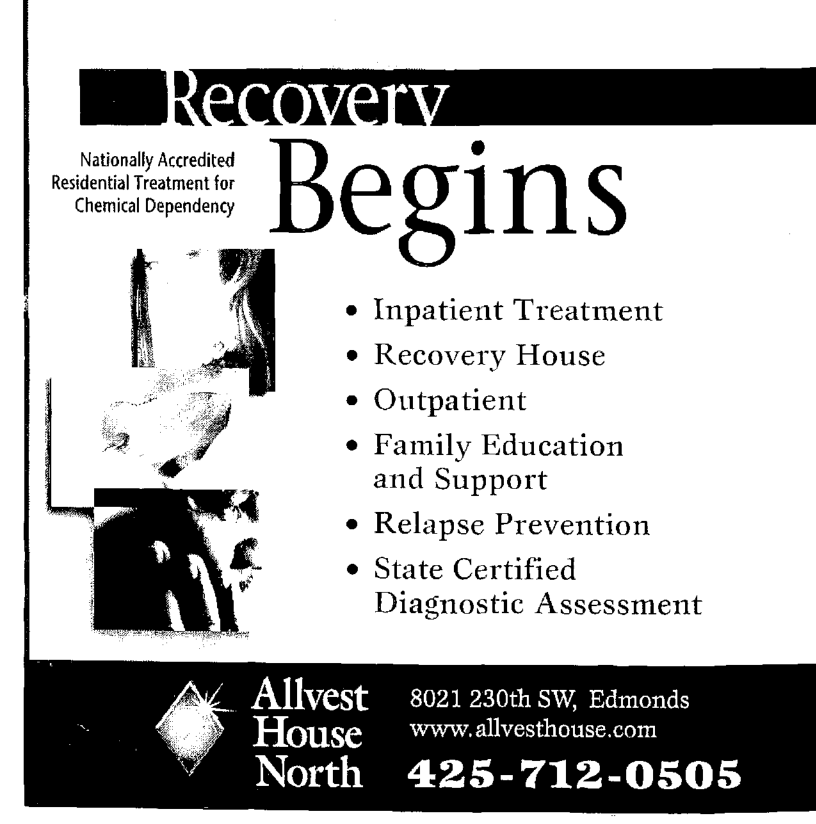
It has been said that we are in the information age and we suffer from information overload. That is a misnomer. We are in the data age and suffer from data overload. Data do not become information until they are interpreted properly. Unfortunately, many people are not able to do that. They misinterpret the data and end up with misinformation. Eventually, they give up, ignore the data and do what they were going to do anyway. Giving them more data is not likely to change the situation very much. It is more likely to confuse people even more, rather than to help them. Of course, well informed patients are better able to make decisions and to participate in their care. Confused patients are not.

As an example, one patient requested to have an IUD inserted. She and her husband read the information booklet and decided the IUD was too risky, because she could die from it. The death rate was listed as 0.8 per 100,000 per year. For the pills in her age group it was 0.5. In women who did not use any birth control it was 22.5. How does that compare with a death rate from a car accident per year? For 1995, in this country, it was 16.5 per 100,000. Perhaps the difference in the death rate between the pills and the IUD was significant enough for her to make her change her mind. Or she may have had other reasons to decide against an IUD, which, perhaps, she did not want to mention.

Neither we nor the hospitals have much to fear from making public more and more data about medical outcomes. There is the problem of costs. The people who compile and publish the data will have to be paid. Depending on how encompassing are the requirements for disclosure, the cost can easily run into the millions of dollars. Someone will have to pay for that and it is likely to be the hospitals and the physicians. This will be another straw on the camel's back.

The main concern would be that the data would be manipulated by competitors to put them in a better light. Even then, the likelihood that patients would be swayed one way or the other is small. People look at the data, one or several things ring a bell, and they make their decision on that basis, without a clear view or understanding of the whole picture.

You probably read the write-up in The News Tribune. How useful did you find the data? We see patients come to the office and ask for this product or that treatment, because they have seen it on TV or a friend of theirs is taking it, without knowledge of the possible side-effects, cross-reactions or other considerations. The best we can do is give them as much information as we can and let them make their decisions. ■



In My Opinion.....

by Teresa Clabots, MD

At First Do No Harm and the Airplane Ride

Teresa Clabots, MD

We enjoyed our annual family vacation, and we were all returning exhausted on an airplane from a hard working vacation. My baby was stretched out across my lap, when the ding-dong sounded. "If there is a doctor in the house, please come forward, we need your assistance immediately." I looked around me, and I could see that my husband was half asleep. So, I gently moved the baby over to his lap, and went to the front of the cabin where the commotion seemed to be happening. There was an elderly lady who was short of breath, huffing and panting. She was also coughing intermittently. I tried to judge how old she was. Hmm, multiple wrinkles, triple chin, blonde dyed hair fluffed up. As far as I could tell she was anywhere between 60-80, and she was a massive woman tightly squeezed into her chair. The man next to her, who I presumed to be her husband, was trying his best to look cool and ignore the whole situation. I squeezed into the opening of the aisle, and asked her what kind of medicines she was taking. With the oxygen mask to her face, she pulled out a 33-gallon freezer Ziploc bag from her monster purse. (They looked like horse pills to me. There must have been 30 different rainbow colored pills, gels, and spansules.) She said, "Oh these are my morning medicines, pills, and herbs, and I didn't get a chance to take them. So, I got a headache, and asked the stewardess for an Aspirin because the coffee was so bad." So I asked, "Oh, so the stewardess gave you an Aspirin?" She said, "Yes, the coffee they were serving was nasty, I had to take an Aspirin for my headache." I said, "So you must be allergic to Aspirin." I asked the stewardess, "Do you have any Benadryl on this plane?" The stewardess answered, "Yes we sure do." I asked if she would go and get it. I gently adjusted the oxygen mask over the lady and looked at the canister. It was empty. The lady looked at me with eyes wide with fear. She said, "No, no Benadryl, no Benadryl." I asked, "Why not?" She said, "I am allergic to Benadryl." I sat down beside her at the seat that her husband had vacated, held her hand, and felt her pulse. She wasn't clammy, her pulse was rapid but steady, and she was breathing a little bit easier with the new oxygen canister. I thought to myself what did I get myself into:

1. I am a pediatrician, what in the world am I doing here with a geriatric patient. 2. She is not having a heart attack; she doesn't say she has chest pain. 3. At first do no harm. 4. I wonder if we're flying over a state where The Good Samaritan law takes effect. 5. Am I liable for anything that I do in the airplane as a Good Samaritan? 6. As soon as the stewardess came back, she took down my name, medical license number, and she wanted to see my DEA number. I thought, oh great, I am liable. She said, "Oh, it's just for record keeping. We'll probably send you a free ticket or something." (They never did.) 7. I finally decided that the best thing to do was to give her oxygen, and wait until the ambulance got there. We raced through the sky and got to the airport a little earlier. When the ambulance got to the end of the ramp, the lady and I walked off, and the first thing I told the attendant was that this lady is allergic to Benadryl, so for God's sake, don't give her any Benadryl. (I have heard of rare cases of patients being allergic to Benadryl.) A month later I was sitting at a dinner conference and talking to one of the hospital pharmacists, and telling him this very interesting story of being up in an airplane with a lady who was allergic to Benadryl. He said, "Well, it's a good thing you didn't give her any epinephrine." I was stunned. I asked, "Why not?" He said, "Well, believe it or not, there are people that are also allergic to epinephrine." By this time I was shocked. I said, "Are people allergic to steroids? What do you give to someone who is allergic to epinephrine? Steroids?" He said, "No, there are people that are also allergic to steroids." I replied, "Gee whiz, what do you use on <u>those</u> people?" He said, "Well, a lot of luck, prayer, fluids, and some sort of special steroid preparation." After talking to my friendly allergist, Pierre, I found that metabisulfite is both in epinephrine and some steroid preparations. Methylparaben is also in epinephrine, Lord knows what for. As I was getting off the plane, a well-dressed lady approached me and said, "I am so glad that you went out to help first." I said, "Why?" She said, "Because I am an internist, and I didn't really want to help out." My new motto: At First Do No Harm. I sure wish I had gotten a free airplane ticket, or an upgrade to first class out of it. ■

Math from page 9

could not get enough new paper hitting the street. New paper refers to Initial Public Offerings (IPO's) in which billions were invested last year. IPOs are generally a good bet for investors because the underwriter (who finances the company by buying the stock to be offered) prices the issues to sell out quickly. After carefully calculating the company's worth, they may give the company $10/share and offer the stock at $11/share thus collecting their commission. Last fall, new issues were doubling, tripling or more above their offering price, which led many to believe they were being priced too low. Although that sentiment has tempered somewhat, the market is again primed to receive billions of soon-to-be worthless IPO's. The reason so many live the ballistic life of a signal flare is because the euphoria surrounding most of them is subverting the normal flow of corporate finance. Once the companies spend all the money they raised in the IPO, they're painted into a corner as far as new money is concerned. Companies have three basic means of gaining finance:

1) sell stock - which dilutes their equity,

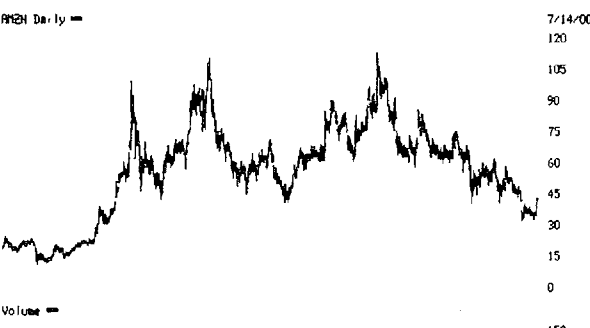
2) float a bond - which places a lien on their assets or

3) go to the bank for the money.

Presently, companies are able to offer stock easily to a voracious public; which is the least expensive and least restrictive way to get the cash. Usually, as companies continue to expand, they don't want to sell more shares because that would only dilute their equity as well as that of their existing shareholders. Bonds, however, would be junk out of the blocks and demand a very high yield, and banks generally need some assurance of receiving payment of principle let alone interest. What most investors don't understand is that 60-80% of the new paper is sold to institutional buyers and the remainder of the float goes to the brokerage's loyal, royal few. Only the chosen get the stock for its IPO price, the frenzy that then ensues finds them selling to the unwashed public, who have been bidding the companies up as if they had some sort of pricing power, not to mention earnings. This scenario, which worked so well last year, is about to be rolled out again with approximately 12 billion dollars of new issues just waiting for confidence to re-inflate the NASDAQ. It takes two sets of participants to make this equation work, A) frenzied public, and B) parties interested in maintaining that fever pitch. Proponents of the digital age would have us believe that the economy is now primed for explosive growth. That the medium of the Internet has broken all boundaries to each and every endeavor a business uses to produce goods and services. However, when markets become this volatile, emotion is usually the overriding force. Forty percent swings without change in fundamental monetary policy or leading economic indicators show no rationality. Such extreme movement rarely ends well. ■

David Roskoph, MBA, CFP is a fee-based investment advisor in Gig Harbor

AMZN (Amazon.com) Two year price history charts EBAY (Ebay.com)



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In My Opinion....

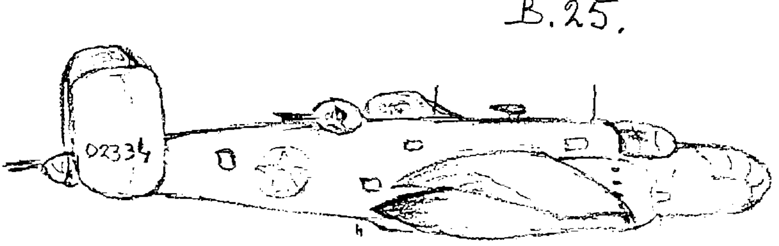
by John Stutterheim, MD

Nostalgia of World War II

John Stutterheim, MD, is a retired family physician. He was living in Indonesia with his family prior to WWII and is writing a book about his WWII experiences

John Stutterheim, MD

This is the story of our liberation, after Japan surrendered on the 15th of August, 1945. I was one of the 1400 kids in Camp Bangkong, Semarang, Java, a teenage boys' labor camp. Around mid-August, the Japanese guards' behavior suddenly deteriorated; arrogance and brutishness were replaced by volatility and an immeasurable nervousness. They hit us at the slightest provocation and seemed always to be looking over their shoulders. We were ordered to dismantle the sawmills and we accomplished that in three days, a record time. We were happy to be able to use the wood of the dismantled mill in the kitchen where we desperately needed dry fuel. It never occurred to me that we were eradicating the evidence of teenage hard labor by destroying those mills. Nobody was called upon anymore to work in the fields. There was a change in the air and we could only guess why. Hope became almost tangible. On the sixteenth of August some adult male prisoners were brought in. They spread the rumor that American troops had landed in western Java. I found I could not believe them.



Suddenly the Javanese Hei-Ho's were replaced by ten Japanese soldiers on the eighteenth. On the following two days we were sent to the patjol fields (15 acres of swamps where we worked with hoes), but only to harvest vegetables and they were all for our own use! As a further reward, we received a double ration of food. A bigger miracle came yet when two days later 180 pounds of meat was carried through the gate together with twenty pounds of bones. We were so surprised and elated that we could not believe our eyes. Good food! I ran outside to look and in no time hundreds of us were crowding the parade grounds. Two bombers were circling over our city, flying lower and lower. It became apparent that they were looking for something. Then it dawned on us, they were looking for our camp! Finally these planes flew so low and thundered right over us. They were so close that we could see the head of the pilot, and the tail gunner wiggling his two machine guns in salute. The planes were B-25's, Mitchell's, with red, white and blue markings. Leaflets separated from these aircraft and fluttered and sailed through the air slowly, past the camp, missing us totally. I wondered how they knew about our camp's location or its existence, for that matter. The Japanese just stood there silently and did nothing. For once they were as helpless as we had been for so long. The two Mitchells circled over us three times. Later on we found out that they flew a triangle over the three camps in Semarang: Halmaheira, Lampersari, and Bangkong. They apparently knew the locations of each camp. After a moment of deep silence and admiration for the passing aircraft, we understood: "The war was over!" The entire group of boys went uncontrollably wild, we danced, jumped, and screamed until we became hoarse. We climbed on each other's shoulders to wave at the planes. Sick kids had crawled onto the veranda in order not to miss anything, some with tears in their eyes. Still there were the real ill, who remained inside unable to witness this exhilarating event. All the nuns came outside and for the first time did we see them all together. They started to sing the Dutch national anthem. This solemn ceremony quieted the boys down. Then the reality set in again. The planes were gone. There was a sinister quiet, followed by a grumbling. We wanted more than this ending; we needed food, medicines, and much more. We demanded for the gates to be opened. The Japanese

See War, page 16

War from page 15

refused, but this time they did not beat anyone to show their superiority. We could not understand why. That afternoon in the dry, blistering heat of around 100 degrees, we were herded together by the guards. This was the last time that they forced us to obey. We had to face the camp commandant, Beautiful Charles, as he stood before us on a three-foot platform. He told us that a terrible bomb had been dropped on Japan, that Nippon had lost the war and had surrendered on the fifteenth of August. We looked at each other, shocked, for it was now the twenty-third of August. However, Beautiful Charles continued, the Japanese were already preparing for the next war, which they would certainly win. Was this the seed of revenge, or was it the old arrogant Bushido attitude? We were confounded and could not absorb what we had just heard. The commandant bowed and descended. All the Japanese went inside, not to appear anymore. Crowds of Javanese and Chinese gathered outside the barbed wire. Without interference from the Japanese who apparently intended to remain in camp with us, we pulled the bilik, the woven bamboo, out of the barbed fences in order to communicate with the outside world. Some persons on the outside started to throw djeroeks, orange-like fruits, over and through the barriers. They looked so good and they were so welcome! We had not tasted those for years. To me the juice was a delicacy and I saved some for Anton, who was lying on his mat, too weak to realize the scene. I stood fairly close to the front main gate and looked at the people outside. They were normal human beings, people who were not sick, not emaciated, but properly dressed, with shoes or slippers on their feet. I could not feel a part of them. Emotions bubbled up, tears came to my eyes. Was it possible that the war was truly over? The end of this terrible, deadly camp had come? Could we start to live a normal life again? The thought of any normalcy seemed absurd when I turned to look around me in camp. There were so many sick kids, many of whom were so severely malnourished that other diseases like malaria had laid them motionless on their cots or on the floors. Hundreds of other boys had

See War, page 17

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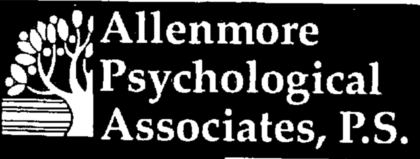

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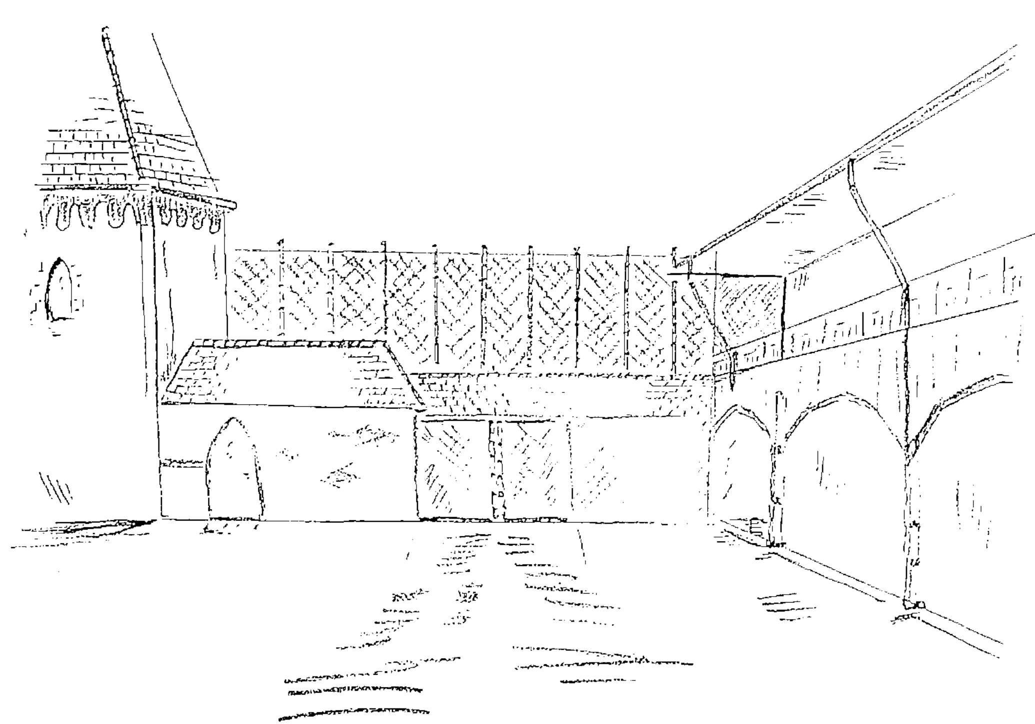
War from page 16

minor ailments, but even so, were still barely able to function. Nearly all of us needed medical attention, and some of the boys needed long-term care. That first afternoon I spent with my brother who was still so terribly ill that he was scarcely aware of the events of the past days. He was emaciated, and bedridden, and harbored symptoms of malaria, amebiasis, anemia, beri-beri, pellagra, and scurvy. At the time, I wondered if the war had ended too late for Anton. Later that same afternoon, when it was time to get in line for food, I walked under the long overhang of the school. A few doors down from our room I spotted an easy chair, one of the few we had in camp. The chair was pushed into a corner where a flight of stairs would lead to the second floor. On that chair lay on his back my former neighbor from Malang, Dutrie van Haaften, who was just a year older. I stopped and noticed how beri-beri had made his body so swollen that on his legs the skin had cracked and body fluids oozed out. The sudden realization that he was not breathing, that he had died, brought tears to my eyes. In anguish, I asked other kids when this happened, but they shrugged their shoulders and kept moving. He must have died there in the corner, all alone. So many had become callous to death, they could not afford to care anymore. I did not know how long Dutrie had been dead. I wondered if he had seen the planes and if at least he had experienced the joy of knowing the war had ended, but I realized as I stood there that I would never know. ■



Bangkong's gate, seen from the parade grounds.
From L.to R.: Church, death room and guard house,
gate and the two tier classrooms.
Above it all the woven bamboo with barbed wire.
Once we stood there for over 24 hours dressed only in shorts.
That evening it rained and the mosquitos ate us alive.
No wonder malaria was rampant.

J.K.S.

Relay from page 4

climbed to Ryegrass (seen in the picture) then went screaming down to the Columbia river at Vantage by 12:45 PM, just after team 2 had arrived. Both teams shared lunch.

Team 2's third leg was the killer leg-- Vantage to Moses Lake, 43 miles, starting at 1 pm. Darned hot, with a side wind from the south, sometimes in the face. After two difficult flats, they dragged into Moses Lake at 5:15 pm. Mark was wasted from the heat, and put himself on the disabled list.

Marsden's team was in great spirits; they had done most of their climbing early. After leaving the cars in Moses Lake, they rode a fairly flat stretch to Ritzville. There, they were forced to wait for the automobiles to arrive. This did nothing for morale, as the day was marching on. As soon as Team 2 arrived with the cars, Team 1 threw their bikes on the rack and took off for Sprague, WA. Team 2's last leg, starting at about 7 pm, was only 24 miles. Ryan, going strong, went with the other team, and Rob and Alf enjoyed the cooler evening and smooth pavement to Sprague, their finish. They then drove into Spokane.

Team 1 was now racing daylight, and two more flat tires didn't help. They rode from Sprague toward Spokane. After fixing a flat, Ryan, Marsden and Dave Pearce flew like the wind as it grew dark, trying (successfully) to catch Leelee and Leslie. They finished riding at 9:30 pm. Team 1 had ridden 142 miles, and Team 2 rode 139 miles. Seven flats for team 1 and two flats for team 2.

Everyone said it was a great ride. But Alf said it is a great one to do once, brag about forever, and never do it again. ■

Health Care 2000 Campaign short on signatures

Initiative-725 supporters failed to gather the required 179,248 valid signatures to place the measure on the November ballot. However, they have re-filed the measure as an Initiative to the Legislature, and it is now known as I-245. This campaign will once again seek the same amount of signatures, but they must be new as transfers are not allowed. The deadline for gathering the new signatures is December 29th.

If the Initiative receives certification, the Legislature must act on it by adopting it as proposed, rejecting it and placing it on the next general election ballot, or approving an amended version, which must be placed on the ballot along with the original version. ■

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COLLEGE OF MEDICAL EDUCATION

Common Office Problems CME will be held October 20

Topics are set for the College's Common Office Problems CME scheduled for Friday, October 20, 2000. The conference will be held at St. Joseph Medical Center, Rooms 1 A&B.

The program will offer 6 Category I CME credits and is again directed by **Mark Craddock, MD.**

This year's course will cover:

- New Antibiotics
- Congestive Heart Failure
- Evaluation of New Onset Seisures in children
- Irritable Bowel Syndrome
- Common Knee Problems
- Hormone Replacement Update
- Treatment of LumbarRediculopathy
- Prostate Cancer

The course is designed for the primary care clinician and focuses on practical approaches to the most common dilemmas faced in the daily routine of medical practice. Look for the registration brochure in the mail just after Labor Day.

For more information, please call the College of Medical Education, 627-7137 between 7:45 and 5:00 p.m.■

Continuing Medical Education

C.O.M.E. Board Announces 2000-2001 CME Program Schedule

The College of Medical Education's Board of Directors announced its CME schedule for 2000-2001 at their June meeting. Courses are offered in response to local physician interest and are designed and directed by local physicians. All courses offer AMA and AAFP Category I credit.

A course calendar identifying the course title, dates, brief description and course directors will be mailed in early September. For additional information on next year's offerings, please call the College at 627-7137.■

2001 Whistler CME Program set January 24-28

The annual Whistler CME program has been set for January 24-28, 2001 at the Aspens Condos, with rates the same as last year. A program brochure with course details will be available in September. Watch your mail! ■

Dates	Program	Director(s)
Friday, October 20	Common Office Problems	Mark Craddock, MD
Friday, November 20	Infectious Diseases Update	David McEniry, MD
Friday, December 1	Medicine & Mental Health	David Law, MD
TBA (evening)	Cardiology for Primary Care	Gregg Ostergren, DO
Wednesday-Sunday January 24-28	CME at Whistler	Richard Tobin, MD
Friday, February 9	Advances in Women's Medicine	John Lenihan, Jr., MD
Friday, February 26	Pain Management	TBA
Thursday-Friday March 8-9	Internal Medicine Review 2001	Ulrich Birlenbach, MD
Saturday, April 28	Surgery Update 2001	Glenn Deyo, MD
Friday, May 4	Allergy, Asthma & Pulmonology for Primary Care	Alex Mihali, MD
Tuesday, May 16 and Tuesday, May 23 (evenings)	Medical Technology	TBA

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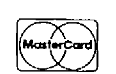

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The University of Washington Department of Health Services in the School of Public Health and Community Medicine (in cooperation with the UW School of Medicine and UW Educational Outreach) invites you to learn more about its **Certificate Program in Medical Management**. This evening program is designed to assist clinicians and other experienced health care professionals in developing management knowledge and skills applicable to their everyday work situations. It is comprised of four three-credit courses, each of which focuses on distinct and important aspects of management (medical practice quality measurement and management, leadership and change management, strategic management of health care organizations and financial management). The program curriculum provides participants with basic knowledge and practice-oriented skills in health services management, and helps them to determine if they would like to go further in their management training. Each cohort goes through the sequence of courses together -- providing its participants with the additional benefit of learning through their sharing of experiences and management problems. Courses are taught by UW faculty in conjunction with professionals from the local health care field. CME* and CNE credits may be earned.

To learn more about this program, please contact the Program Office at donnaj@u.washington.edu or 206-616-2976.

* (The University of Washington School of Medicine is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians. The University of Washington School of Medicine designates this continuing medical education program for up to 30 credit hours per course in Category 1 of the Physician's Recognition Award of the American Medical Association.)

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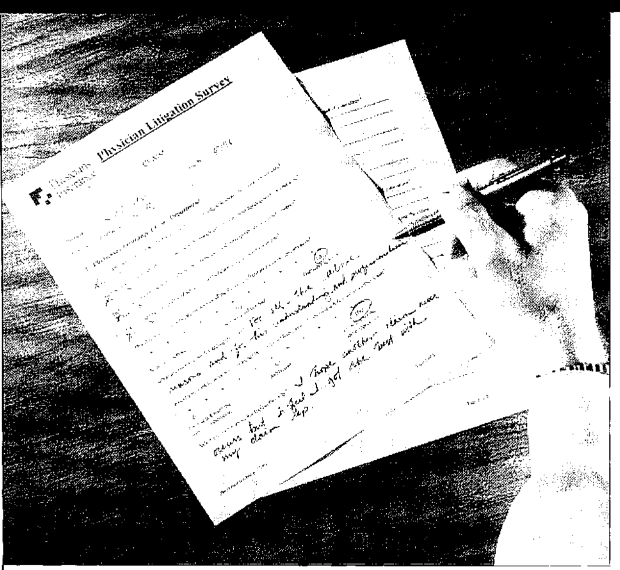

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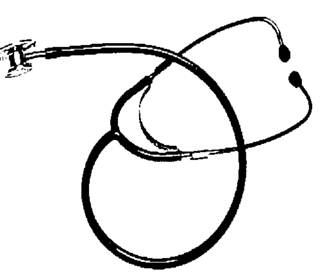
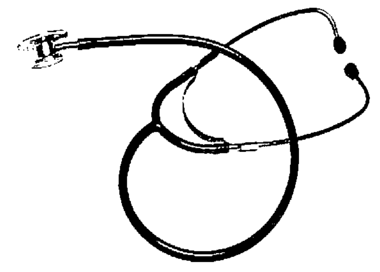
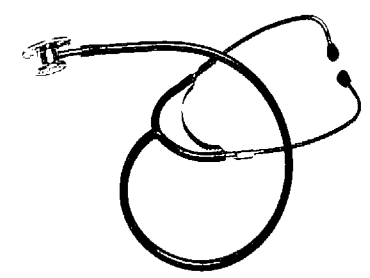
Pierce County Medical Society
BULLETIN

September, 2000

Restoring Health to Health Care

Washington State Medical Association
2000 Annual Meeting
Wenatchee, WA
September 22-24

More information page 4

INSIDE:

3	President's Page: Vote YES for Health Care
4	Expedition leader to speak at September General Membership Meeting
5	Many thanks for volunteers who painted Tacoma-Pierce Beautiful
7	Hats Off to Candidate Interviewers!
7	Pierce County Adult Trauma Center celebrates its operation
9	Influenza Vaccine Availability for 2000-01 Season
11	September is Women in Medicine Month

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The Bulletin is published monthly by PCMS Membership Benefits, Inc. for members of the Pierce County Medical Society. Deadlines for submitting articles and placing advertisements in The Bulletin are the 15th of the month preceding publication (i.e. October 15 for the November issue).

The Bulletin is dedicated to the art, science and delivery of medicine and the betterment of the health and medical welfare of the community. The opinions herein are those of the individual contributors and do not necessarily reflect the official position of the Medical Society. Acceptance of advertising in no way constitutes professional approval or endorsement of products or services advertised. The Bulletin and Pierce County Medical Society reserve the right to reject any advertising.

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Pierce County Medical Society

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September, 2000

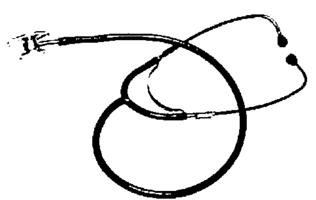


Table of Contents

3 President's Page: Vote Yes for Health Care

4 Expedition leader to speak at September Meeting
4 WSMA Annual Meeting: Restoring Health to Health Care

5 PCMS Volunteers Paint Tacoma-Pierce Beautiful

7 HATS OFF to Candidate Interviewers!
7 Adult Trauma Center Underway
7 Cascade Regional Blood Services meets needs of community

8 Seven Steps to Avoiding Fraud & Abuse

9 TPCHD: Influenza Vaccine availability for 2000-01 Season

10 Influenza Vaccine Schedule

11 September is Women In Medicine Month
11 Support*My*Association has new services

12 Hepatitis C information from the Surgeon General

13 Invisible Hand: "The Patient and the Disease"

15 Seattle-to-Portland Bike Riders Face Head Wind

17 College of Medical Education

19 Classified Advertising

President's Page

by Charles Weatherby, M.D.

Charles Weatherby, MD
PCMS President

Vote Yes for Health Care

The Democratic and Republican conventions are making their quadrennial appearances. Regardless of the outcome, we are guaranteed a new President. Have you made your decision yet? We will soon be witnessing Presidential and Vice-Presidential debates. Once again, health care will be one of the major issues. Do you want the Democratic plan or the Republican plan? Why not for once can there just be a health care plan? After the smoke of the political rhetoric and partisanship clears, will there finally be a plan for national universal health coverage? Will there be a prescription drug coverage plan for Medicare recipients? Will there be a national patient "bill of rights"? Will there be a national plan regarding health care plan liability?

Some states have grown weary of national politics and are passing their own health care laws. Our own state had a plan for universal coverage, in the form of Initiative - 725 (HealthCare 2000), which fell short of the requirement of valid signatures to be placed on the November ballot. This initiative was an initiative to the people, which meant that its passage would have made the initiative into law. The initiative is now being reintroduced as an initiative to the legislature. If this initiative process gathers the necessary valid signatures, there are three options for our state legislature.

(1) Immediate adoption of the initiative and placing it into law. This would be similar to if the original Initiative - 725 had the valid number of signatures and the voters ratified it
(2) Rejection of the initiative, but placing it on the ballot for the voters to accept it or reject it
(3) Development of an amended version, however, placing both the amended version and original version on the ballot and letting the voters decide

If nothing else, if enough signatures are gathered, it would force discussion and debate in our legislature to hopefully get more serious about our health care concerns. With our current state House of Representatives deadlocked at 49 Democrats and 49 Republicans and with a Democratic co-House Speaker and a Republican co-House Speaker, its going to require bipartisanship compromise.

We are, however, fortunate, that our state legislature has been more progressive than many states with regards to the passage of health care legislation. Much of the credit can be given to our own WSMA leadership and our legislative lobbyists. ■

Expedition leader to speak at September Meeting

Reserve Tuesday, September 12, 2000, 6:00 p.m. for an evening of high adventure as Eric Simonson speaks on, "Finding Mallory."

Simonson, owner and active partner in International Mountain Guides (one of the oldest mountaineering companies in the country) as well as owner and operator of Mt. Rainier Alpine Guides will speak on the experiences of the expedition that set out to solve two of exploration's greatest mysteries: Did George Mallory and Sandy Irvine reach the summit of Mt. Everest in 1924, and what became of them?

This expedition stunned the mountaineering community with the discovery of the remains of Mallory. Two major television documentaries have focused on the expedition. He will relate the mysteries, the quest to solve them, and what the expedition did at the September meeting.

Dramatic tale of high adventure resolving 1924 mystery

Simonson's climbing resume includes Mt. McKinley, Aconcagua in Argentina, Cho Oyu in Tibet, Mt. Elbrus in Russia, and Mt. Vinson in Anarctica.

Call 572-3667 to register.■

WSMA Annual Meeting -Restoring Health to Health Care

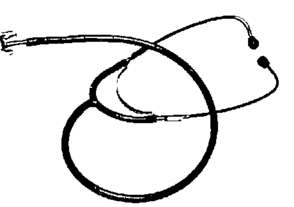
110th Annual Meeting will be held in Wenatchee

The Washington State Annual Meeting will be held September 22-24, Friday - Sunday, at the West Coast Wenatchee Center Hotel in Wenatchee.

The 2000 meeting will feature a multi-faceted program that speaks directly to the needs of the medical profession and patients. The theme of this year's meeting, "Restoring Health to Health Care" is an extremely timely and apt focus for the programs and deliberations that make up the meeting's content.

This year the meeting has been changed to begin on Friday afternoon with reference committee meetings on Saturday. Scientific sessions will run Friday and Saturday, while the primary House of Delegates session will be on Sunday.

The opening session will feature a panel of health care experts offering their opinions of what should be done to restore health to the health care system. They will articulate health care system reform options and their relative trade-offs.



Mamta Gautam, MD, a psychiatrist in private practice in Ottawa, Canada will address techniques for dealing with physician stress and burnout in a rapidly changing environment. Dr. Gautam is a specialist in physician stress. Hailed as the "Doctor's Doctor," over 99% of her patients in clinical practice are physicians. She serves as a special consultant to the University of Ottawa Dean's Task Force on Faculty Stress, as well as to the Task Force for the Provision of Emergency psychiatric Care to Physicians. This presentation is designed to assist physicians in identifying their own sources of stress, and learning how to better manage it. The opening session is accredited for 3 hours of Category I CME.

Scientific sessions of the meeting will include Risk Management Issues in Electronic Medicine, Addiction Medicine, HIV/AIDS, End-of-Life issues, Allergy & Asthma, MQA Training, Ophthalmology Psychiatry, Women in Medicine, Health Care Economics, Reducing Your L&I Headaches, and the annual Senior Physicians Meeting & Luncheon.

The WAMPAC Luncheon will feature incumbent Governor Gary Locke square off against his Republican challengers to discuss their perspectives on health care issues. A question and answer period will follow.

The WSMA is member driven. The Annual Meeting is an open and democratic process. The House of Delegates sets the broad policy course for the Association. Your participation is welcomed and encouraged.

Please call PCMS for more information, 572-3667.

Thanks for 'Painting Tacoma-Pierce Beautiful'

PCMS Members **Drs. Mian Anwar, Teresa Bell, Ken Graham, David Judish, Eric Luria, Philip Perkins, Rick Schoen, Roger Simms, Maureen Smith and Dwight Williamson;** volunteers Jennifer Larson and Denise Zinno from NPN; Janice Ritala, Jena Rivero, Tracey Sanabria and Fred Simmons from the office of **Dr. William Shields**, along with PCMS staff members Sue Asher, Deborah Pasqua, Angela Kraemer, Juanita Hofmeister Doug Jackman and Melissa Schimmel contributed many hours helping the Medical Society participate in the 'Paint Tacoma-Pierce Beautiful' program sponsored by Associated Ministries of Pierce County.

See "Paint Tacoma-Pierce" page 6

David Judish, MD, Puyallup Physical Med & Rehab, expertly paints the back side of the house via ladder

Dwight Williamson, DO, retired family planning, scrapes loose paint in preparation for primer and new paint

Drs. Ken Graham, (top) retired family physician and Phil Perkins, psychiatrist, visit as they paint atop their ladders

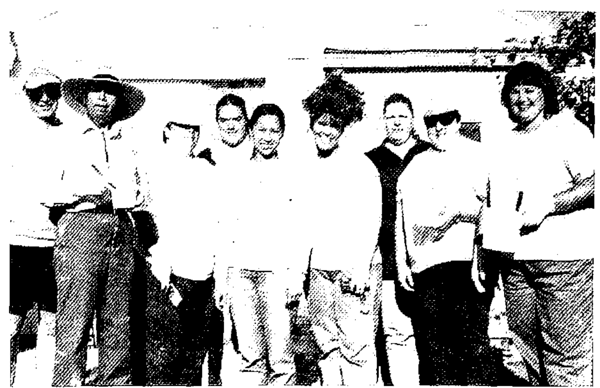
Dr. Eric Luria, Gig Harbor family physician goes high while Mian Anwar, retired anesthesiologist, goes low

Philip Perkins, DO, reaches new heights as he preps the upper trim for new paint

Tracey Sanabria (front) and Janice Ritala, both from Dr. William Shields' office, were great contributers

Paint Tacoma-Pierce (from page 5)

Deborah Pasqua, PCMS Placement Coordinator, took on the meticulous task of scraping old paint from the back door frame



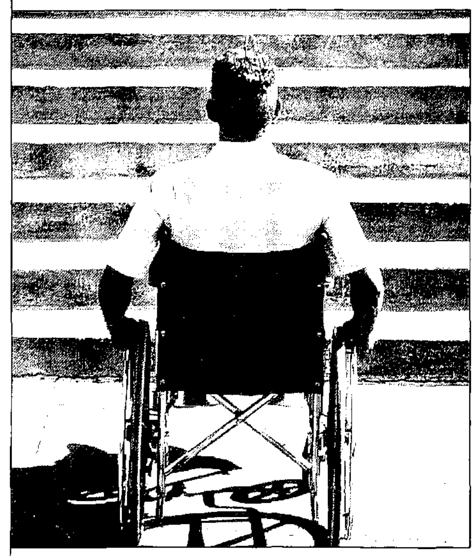
From left, Drs. Phil Perkins, Mian Anwar, Juanita Hofmeister, Melissa Schimmel, Jena Rivero, Tracey Sanabria, Denise Zinno, Angela Kraemer and Jennifer Larson

These volunteers worked four evenings painting a small home near the Tacoma Mall. The home is owned by an 86 year-old widow with a limited income and numerous health problems.

The home owner was extremely appreciative of the time and effort so generously given by these volunteers and is happy to have a freshly painted home for the first time in 15 years.

PCMS extends a big thank you to all participants. ■

Will a disability put you out of commission?



As you know, disability insurance policies for physicians are changing rapidly—and not for the better. High claims have caused many major carriers to limit the most important benefits.

At Physicians Insurance Agency, there's still time to secure the specialty-specific coverage you need. In addition, we can help you find superior life and long-term-care coverage for you and your family.

To discuss the ways you can best protect your future income, call Physicians Insurance Agency today: (206) 343-7150 or 1-800-962-1399.

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Sponsored by the Washington State Medical Association

HATS OFF to Candidate Interviewers!

Many members spent long evenings interviewing candidates for the state legislature from their particular legislative districts. The interviews are for the WAMPAC Board to get recommendations and feedback from the members in the local districts. The interviewers can recommend to the Board that a certain candidate receive financial support from WAMPAC in the primary or general elections.

Each candidate is asked the same series of questions dealing with their campaign and healthcare issues. The interviewers can ask questions on any issue that interests them. Each candidate is given about 40 minutes to state their position on the various issues. Health care issue questions centered around funding for Medicaid patients; scope of practice issues, tort reform, particularly with the statute of limitations clause and mental health parity.

Special thanks go to the following members who gave their time and summer evenings to participate in this very important cause. They are:

25th Legislative District Interviewers: Internist, **Greg Blackburn;** Family Physicians, **Bill Marsh, Steve Duncan, Ron Morris, Becky Sullivan** and **Doug Robson.** Emergency Medicine, **Michael Brooks.**

26th Legislative District Interviewers: Radiologist **Scott Carleton;** Dermatologist, **Robert Martin;** and Anesthesiologist **Ali Afrassiabi.**

27th Legislative District Interviewers were: **Richard Hawkins, Pat Hogan, Don Russell, Richard Schroeder** and **George Tanbara.**

No interviews were conducted where an incumbent was in the race. ■

Did You Remember?

WAMPAC

Washington Medical Political Action Committee

1800 Cooper Point Road SW
Bldg 7, Suite A
Olympia, WA 98502
800-562-4546 (360) 352-4848

Adult Trauma Center Underway

Tacoma General Hospital and St. Joseph's Medical Center hosted a celebration in honor of the opening of the Adult Trauma Center. George Brown, MD, Vice President, MultiCare, moderated the hour and a half program that acknowledged the contributions of many organizations and individuals in bringing about the adult trauma center to Pierce County and Region V. There were many smiles of satisfaction and accomplishment surrounding the nearly 100 attendees at the Landmark Convention Center.

Mr. Ron Weaver from the Washington State Department of Health presented the designation certificates to Tacoma General Hospital, St. Joseph Hospital and Madigan Army Medical Center.

Many dignitaries were on hand to contribute to the celebration. **Robert Winchell, MD,** Director of the Trauma Center, introduced his staff of Drs. Teresa Bell and Lori Morgan and PA-C's James Martin, Kathleen McDaniel, Ralph Mitchell, and Carlos Vasquez. Dr. Winchell noted that in the first month of operation, the trauma center had seen over 100 patients, far surpassing the original estimate of perhaps 400-500 anticipated trauma patients in a year. ■

Cascade Regional Blood Services gears to meet needs of community

With the recent opening of the new trauma care services in Pierce County, Cascade Regional Blood Services (CRBS) has worked to increase donations by increasing their volunteer base. They have notified more than 30,000 active volunteer donors that their continual support is needed. The need for additional blood and blood products has increased just because of the area's population increases over the last few years, as well. According to Charles Drummond, Executive V.P., "we are well prepared to meet the needs of our community."

In further efforts to prepare for the increased demand, CRBS raised funds for a new five-bed bloodmobile. With the majority of their blood supply coming in because of mobile units and on-site drawing programs, CRBS will begin seeking funds for a three-bed unit. ■

Seven Steps to Avoiding Fraud and Abuse

The office of Inspector General, Department of Health and Human Services, will publish the final version of the "Compliance Program Guidance for Individual and Small Group Physician Practices," produced to help doctors develop and implement compliance programs to adhere to federal health care and private insurance program requirements.

Although the OIG recognizes that smaller practices may have limited resources, they clearly expect all physician practices to implement appropriate compliance policies and practices. The OIG does believe that every compliance program should begin with a commitment by the physician practice to the following seven elements.

1) Developing written policies and procedures

The key here is written policies and procedures. These are essential to all practices, regardless of size and capability. In particular, is development and availability to employees of a written compliance manual, and updated clinical forms to make sure they elicit the data required for different levels of coding. The policies should also address relevant fraud and abuse risk areas.

2) Designating a compliance officer

The practice should identify an individual responsible for the compliance program. The person should be independent in his or her position to protect against any conflicts of interest in assigned duties. Compliance activities may be divided among employees, provided that duties are well defined.

3) Developing effective training

Training can be provided in-house or by an outside source. Simply giving individuals documents for their own reading is seldom sufficient. Each employee should be made to understand that compliance is a condition of continued employment.

4) Developing effective communication

Employees must report conduct that a reasonable person would believe to be fraudulent or erroneous, and there must be a user-friendly mechanism for reporting, such as an anonymous drop box. It must be noted that failure to report is a violation of the compliance program.

5) Auditing and monitoring

Policies and procedures should periodically be reviewed as well as bills and medical records to ensure compliance with requirements. An annual audit should follow.

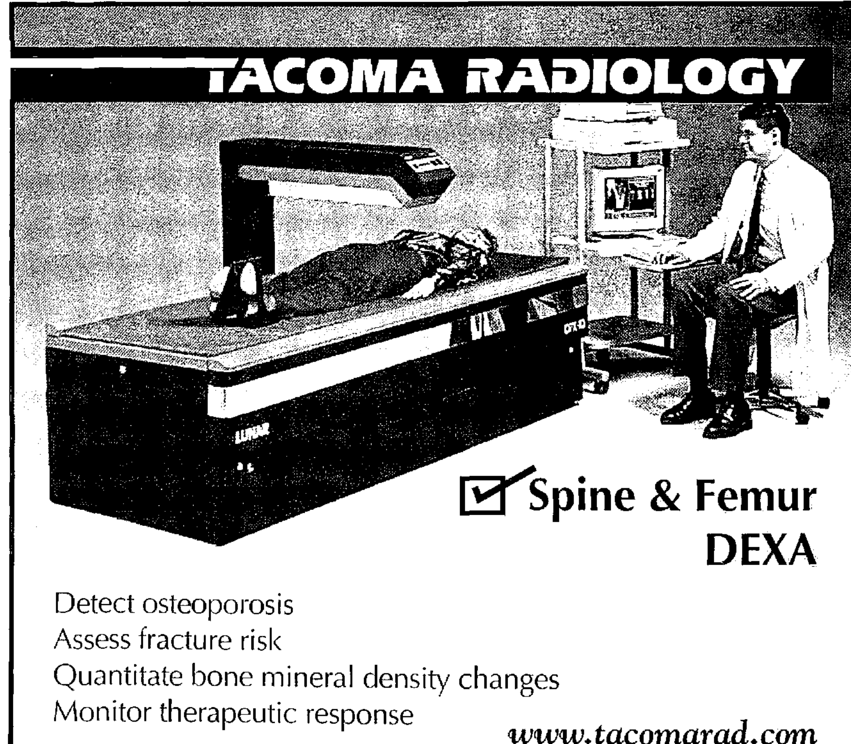
6) Enforcing standards through well-publicized disciplinary guidelines

Noncompliant conduct should be documented by date, name of reporting party, name of responsible person and follow-up action.

7) Responding to detected offenses and developing corrective action initiatives

Fraudulent or erroneous conduct that has been detected, but not corrected, can seriously endanger the reputation and legal status of the practice. It is imperative that the person responsible for compliance take decisive steps to correct any problem that is discovered. ■

Reprinted from AMNews, July 31, 2000



The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

Influenza Vaccine Availability for 2000-01 Season

It appears that the distribution of flu vaccine will be delayed this year.

The Centers for Disease Control and Prevention (CDC) published a notice titled "Delayed Supply of Influenza Vaccine and Adjunct ACIP Influenza Vaccine Recommendations for the 2000-01 Influenza Season" in the July 14, 2000, issue of the *MMWR*. **Production problems are expected to cause a significant delay in the distribution of influenza vaccine and possibly substantially fewer total doses of vaccine for distribution than last year.**

The CDC's recommendations state that

1) Implementation of organized influenza vaccination campaigns should be delayed until early to mid-November. The purpose of this is to minimize cancellations of vaccine campaigns and wastage of vaccine doses resulting from delays in vaccine delivery.

2) Influenza vaccination of persons at high risk for complications from influenza and their close contacts should proceed routinely during regular health-care visits. Routine influenza vaccination activities in clinics, hospitals, nursing homes, and other health-care settings (especially vaccination of persons at high risk for complications from influenza, health-care staff, and other persons in close contact with persons at high risk for complications from influenza) should proceed as normal with available vaccine.

3) Provider-specific contingency plans for an influenza vaccine shortage should be developed to maximize vaccination of high-risk persons and health-care workers. These plans should be available for implementation if a vaccine shortage develops.

Once vaccine is available, it should be given to persons at high risk for complications from influenza as is normally done. In the United States, 70 to 76 million persons are at high risk for serious complications from influenza infections, including hospitalizations and deaths. This figure includes: approximately 35 million persons aged more than 65 years; 33 to 39 million persons aged less than 65 years with high-risk medical conditions; and 2 million pregnant women.

In 2000, ACIP broadened its influenza vaccine recommendations to include all persons aged 50-64 years. This recommendation was based, in part, on an effort to increase vaccination coverage of persons in this age group with high-risk conditions. In the context of a possible vaccine shortage, it would be appropriate for contingency plans covering this age group to focus primarily on vaccinating persons with high-risk conditions rather than this entire age group.

Influenza vaccine is routinely recommended for persons in close contact with anyone at high risk for complications from influenza because of the ease of transmitting the virus. Vaccination of health-care workers has been highlighted in particular because they have frequent and close contact with many different high-risk persons at a time when high-risk persons are particularly vulnerable.

The Vaccines for Children Program – state-supplied vaccines distributed by the Tacoma-Pierce County Health Department – does not anticipate a shortage of flu vaccine this season. However, we need to emphasize that flu vaccine through this program is available only to high-risk children, not to their siblings or provider's office staff.

In previous years, the ACIP has recommended that organized campaigns take place during October through mid-November. Flu vaccine administered after mid-November can still provide substantial protective benefits. For the 2000-01 season, it is particularly important for vaccine providers to continue to administer vaccine after mid-November.

Minimizing wastage of influenza vaccine is important. In particular, **influenza vaccine purchasers should refrain from placing duplicate orders with multiple companies to minimize the amount of vaccine that is returned to a manufacturer and discarded.** Options to promote redistribution of vaccine that otherwise would be returned or discarded are being developed.

According to the report, CDC and the FDA will continue to issue updates as new information becomes available. If an influenza vaccine shortage appears imminent, CDC and ACIP will issue further recommendations.

Please refer to the chart on page 10 for a prioritized vaccination schedule.

See "Vaccine Schedule" page 10

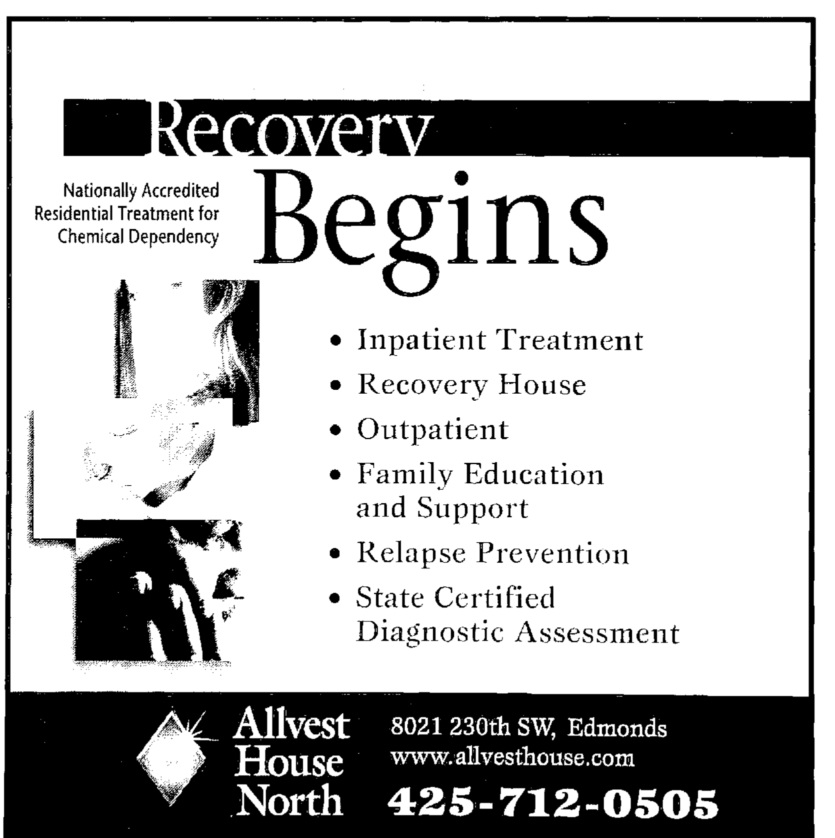
CDC and ACIP Recommended Prioritized Influenza Vaccination Schedule

NOTE:
1) This applies to the 2000-2001 vaccination season only.
2) Utilize this schedule only if delays/shortages in influenza vaccine supply are experienced.

	Vaccinate during:			
Risk Category	October	November	December	January
Persons at high risk for complications of influenza*.	■	■	■	■
Health care workers or persons in close contact with those at high risk.	■	■	■	■
Persons likely to transmit influenza virus to those at high risk.			■	■
Persons at lower risk.				■

National Coalition for Adult Immunization, Bethesda, Maryland, July 2000.

* Refer to ACIP Guidelines to determine risk for influenza-related complications.



Personal Problems of Physicians Committee

Medical problems, drugs, alcohol, retirement, emotional, or other such difficulties?

Your colleagues want to help

***Robert Sands, MD, Chair**	**752-6056**
Bill Dean, MD	**272-4013**
Tom Herron, MD	**853-3888**
Bill Roes, MD	**884-9221**
F. Dennis Waldron, MD	**265-2584**

Confidentiality Assured

Women in Medicine - Making a Difference

September is Women in Medicine Month

Representation of female physicians in medicine continues to show steady increases. In 1970, women comprised 7.6% of the physician force, in 1980, 11.6% of the physician force were women, but by 1998 they accounted for 22.8% of the total physician population. In 1997, the AMA Women Physicians Congress (WPC) was formed to enhance the role and influence of women in organized medicine and the profession. The WPC addresses critical women's health and professional issues. Its goals include:

- Increasing the percentage of women physicians in leadership positions.
- Providing a forum for mentoring and networking among women physicians
- Advancing the womens health agenda
- Monitoring trends and emerging issues that affect women in the profession
- Increasing the membership/ participation of women in organized medicine
- Enhancing professional options for balancing family/career responsibilities

They are meeting with success. In 1998, Nancy Dickey, MD became the first woman AMA President while WSMA's first woman president was Anna Chavelle, who served in 1992-1993. Pierce County Medical Society was led by their first woman president, **Eileen Toth, MD,** also in 1992 and will see their second woman leader next year, as **Patrice Stevenson, MD,** Puyallup Physical Med & Rehab physician will be installed at the December Annual Meeting.

In keeping with the growing trend of female physicians, they are younger than their male counterparts. In 1998, the greatest percentage of women physicians, 36%, were between 35 and 44 while the percentage of men in this category was 25%. Women physicians age 44 or under represented 65% of female physicians, while male physicians in this same age group represented 39% of male physicians.

Two specialties, ob/gyn and pediatrics, were the exception to a higher total number and percentage of men by specialty. The percentage of women in pediatrics was 15%, while men comprised 5%, and ob/gyn was the choice of 7.3% of women, but only 5% of men.

For more information about Women in Medicine you may contact the AMA Women Physicians Services at 312-464-5622 or join on line at www.ama-assn.org/WPS. Or, contact PCMS if you are interested in local activities for women in medicine, 572-3667. ■

Support*My*Association.com has new Member Services Portal

Support*My*Association.com (SMA) affords PCMS members the benefits of shopping online with over 200 of the world-wide-web's top merchants, all consolidated into one, easy to use shopping portal. PCMS benefits by receiving a royalty from every purchase made from the numerous merchants.

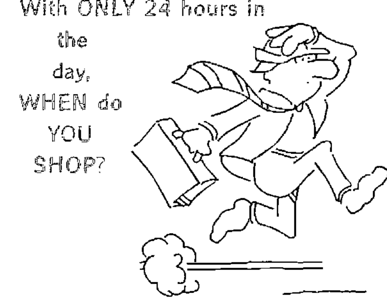
Members receive various promotions and specials. Shopping is easy and prices are competitive. Best Price Guarantee and Free Next Day Shipping is granted on all orders over $25.

SMA has added a new program that allows each individual a page called MyPAGE consisting of areas such as MyLINKS and MySTORES that can be customized. The concept allows for the member to be one click away from anywhere on the Internet on a consistent basis. MyPAGE also includes a personal address book and calendar.

And, for ease in shopping, members no longer have to log on to SMA, but will log on to www.PCMSmembers.com. Another benefit is free email service, with the same extension for your address, (i.e.: yourname@PCMSmail.com.

Be sure and check out the new service of SMA. You can begin by going to the PCMS homepage, www.pcmswa.org and clicking on the SMA.com logo.

Please call PCMS and let us know how you like the upgraded services.■



Go shopping on Support*My*Association.com

Hepatitis C information from the Surgeon General

(Please post for patients)

Dear Citizen:

Our country is facing a silent epidemic in the form of Hepatitis C, a liver disease caused by the Hepatitis C Virus (HVC). **An estimated 4 million Americans have been infected with HCV, and a majority of them probably are not aware that they are infected.** With that in mind, Members of Congress have joined with the Office of the Surgeon General to distribute this letter so you can take the appropriate action for yourself and your family.

Hepatitis C spreads by contact with an infected person's blood. You should get tested if you:

- have ever injected illegal drugs, even if you experimented a few times many years ago
- received a blood transfusion or solid organ transplant before July, 1992
- received a blood product for clotting problems produced before 1987
- have ever been on long-term kidney dialysis
- have ever been pricked with a needle that has infected blood on it
- or were born to a mother with hepatitis C

In rare cases, you can get hepatitis C by having sex with an infected person, especially if you or your partner have other sexually transmitted diseases. **You can NOT get hepatitis C by shaking hands with an infected person, hugging an infected person, kissing an infected person, or sitting next to an infected person.**

While some people with hepatitis C experience flu-like symptoms, many don't have any symptoms. **If you think you might have been exposed to hepatitis C, go to a doctor.** The doctor will test your blood. For many people, hepatitis C is treatable with a drug called interferon, taken either alone or in combination with the drug ribavirin.

It is important to get help, because over time, hepatitis C can cause your liver to stop working. For more information, please contact the Centers for Disease Control and Prevention's **Hepatitis C Hotline at (888) 443-7232** or check the following websites:

http://www.cdc.gov/ncidod/diseases/hepatitis/c/index.htm
http://www.niaid.nih.gov/information/search.htm

Sincerely,

David Satcher, M.D., Ph.D.
Assistant Secretary for Health and Surgeon General

In My Opinion.... The Invisible Hand

by Andrew Statson, MD

The Patient and the Disease

Andrew Statson, MD

> *"It is more important to know what sort of patient has the disease, than what sort of disease the patient has."*
> William Osler

Once upon a time, not too long ago, the powers that be decided to ennoble primary care. This was going to be the basis of our medical care system. The fields of family practice, internal medicine and pediatrics were named as primary care specialties. The authorities pumped money into the primary care residencies. The students were urged to choose those fields. The road we traveled was paved with the good intentions of total care, gate keeping, capitation and cost containment.

Treatment by specialists was declared overrated and wasteful. The primary care physicians were profiled and gently chided for referring to specialists anything but the most complicated and serious problems. They were expected to do a variety of procedures for their capitated patients, from eye examinations to sigmoidoscopies. Managed care and other insurance plans required the medical groups which they contracted to have a minimum number of primary care physicians.

Like other roads paved with good intentions, this one did not lead us to health heaven either. Now managed care is discovering disease management. Various groups, specializing in the management of diabetes or asthma, are contracting with the insurance plans to treat these conditions. This is not only specialized care, it is superspecialized. They claim it is more cost effective, meaning cheaper, and the results are better. Treatment decisions are made according to evidence based medicine and everything is wonderful.

According to the Disease Management Association, the goal is to identify the population at risk for a disease or already affected by it, to treat it so as to prevent future complications and to improve the quality of life for the patients, while saving money for the insurance companies. Disease management is a technique of managed care. It is a prospective approach to chronic diseases, involving the identification of patients, the treatment according to evidence based medicine and the follow-up, including results of care, to prove that the system is working and saving. "The aim is to prevent the costly complications of chronic diseased down the line by managing the patients in a conservative manner today."

American Healthways is one company specializing in the treatment of diabetes. "All patients are assigned to a nurse manager, who teaches self-management techniques and identifies patients at high risk for complications. High risk patients are assigned to a complex case manager, who works with the physician and patient to modify risk." According to American Healthways their program showed a savings of 50 dollars per patient per month. Other companies specialize in the treatment of asthma, congestive heart failure and cancer.

One aspect of disease management is that it checks on physician performance to make sure the recommended tests and procedures are done. In diabetic patients, for instance, it requires annual examinations for retinopathy, neuropathy, hypertension and tests for cholesterol and urine albumin. Such examinations were performed by a minority of family physicians prior to the establishment of disease management.

Most of the information above is from the May-June 2000 issue of Physician Practice Digest. As I understood it, the patients remain under the care of their family physicians and the disease management company provides its treatment algorithms for the physicians to follow and helps with patient education. They show an improvement of care compared with the care given in the past by the family physicians. That still does not tell us whether this type of care is better and cheaper compared to the care of diabetic patients by an endocrinologist.

The good aspect of disease management I see is the collection of evidence and the performance evaluation of the physicians. The knowledge of treatment results in our

See "Patient" page 14

Patient from page 13

patients compared to others is helpful. In order to improve our outcomes we need to know how others handle certain problems and what seems to work best in our type of practice. Now this information comes to us from our professors, from studies done in university settings, with clinic patients. This is not the type of population we serve in private practice.

In the 1930s, a professor of medicine at the University of Paris was quoted as saying, "The generations of physicians that preceded us were the artists of medicine. We are the craftsmen. The generations that will follow us will be the assembly line workers."

Disease management is the expression of the assembly line. However, the present day assembly lines are much different from the early ones. At the time, Henry Ford declared that a car could be any color, just so it was black. This dogmatic position allowed General Motors to develop and grow, so that eventually it overtook Ford Motor Company. Today the assembly lines can produce customized cars with the options the buyers have requested. That is what the market wanted.

It remains to be seen whether a disease management company can give individualized service better and cheaper than the treatment the specialist can give in his private office. The patients are individuals and they will remain so. Evidence based medicine notwithstanding, the treatment of the disease will have to be modified to fit the patient who has it. In medical school we learned to treat diseases. In practice we treat patients. There is a significant difference between the two.

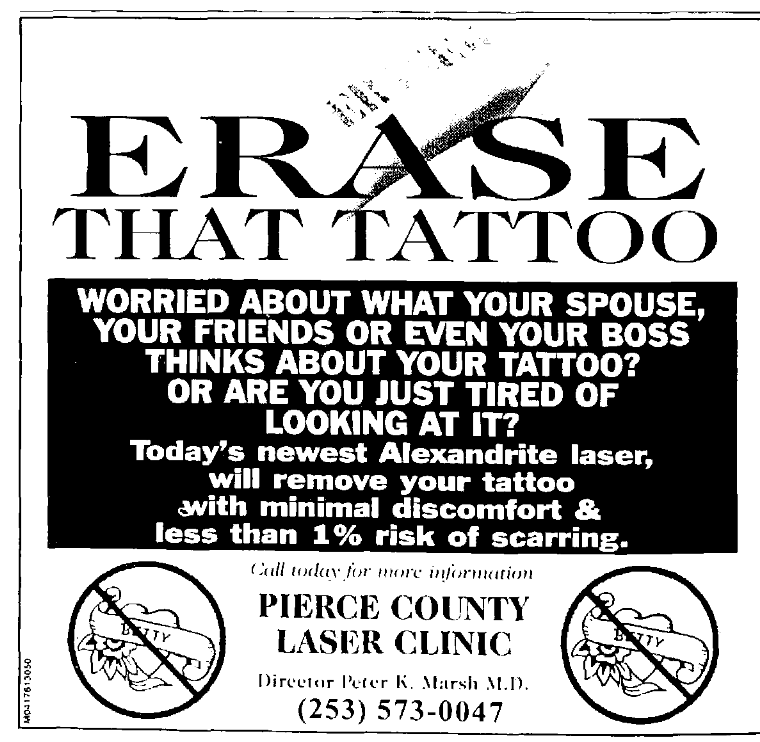
We could disregard the wishes of the patients and impose on them the treatment protocols determined by evidence based medicine. If that is what their insurance companies will cover, the patients will take it, at least for a while. However, the claim that all patients with a certain condition are best treated the same way, because that is what evidence based medicine has established, is wishful thinking.

If you have tried to take a pill at the same time every day for any length of time, or worse, three or four times a day, at predetermined times, for more than a few days, you must know that it is practically impossible to achieve by any active person leading a reasonably normal life. Even our hospital patients don't get their medications that regularly. Any treatment has to be adjusted not only to the individual patient and his lifestyle, but also to the day to day variations in his condition, is his activities, in his life.

In his book *Man the Manipulator* Everett Shostrom relates the story of a school teacher. After a number of group therapy sessions, she was able to see her students as human beings, with their individual interests and abilities. As a result, she changed the way she taught them. "I used to teach math, now I teach children," she said. This is the potential pitfall of disease management. It treats diseases, but diseases don't exist independent of patients.

The aphorism of Osler was much more significant in his time than it is in ours. We have powerful tools to treat diseases, which he did not have. In acute conditions, the kind of patient is probably not as important as it was then. In chronic conditions, however, the kind of patient still makes a big difference in the success or failure of the treatment. ■

After breast surgery think of us.
Union Avenue Pharmacy & Corset Shop
Formerly Smith's Corset Shop
2302 S. Union Ave 752-1705



Seattle-to-Portland Bike Riders Face Head Wind

Several PCMS members took part in the 21st Annual 200 mile Seattle-to-Portland (STP) Bicycle Classic Ride July 8-9. Most of the 9000 riders stay the first night in Centralia or Chehalis, which is 94 miles from the University of Washington starting point. About 1500 of them do the ride in one day and that is what Neurologist, **Pat Hogan** did this year. Pat had a time of 12 hours in the saddle. Not only did he do it in one day, but the riders had a continuous head wind most of the way down. Congratulations Pat!!

General Surgeon **Bill Martin** and his wife Karyl were among those who rode to Longview the first day. Joining them in Longview were: Pathologists **Sam Insalaco, George Hodges** and **Mike Flaherty**; Pediatrician **Richard Ory,** Emergency Room physician **Jim Fulcher,** Internist **Henry Retailliau** and his 16 year old son Daniel.■

From left, pathologists Mike Flaherty, George Hodges and Sam Insalaco replenish lost liquid during their ride

Dr. Sam Insalaco, at the finish line of STP 2000

Dr. George Hodges at the finish line of STP 2000

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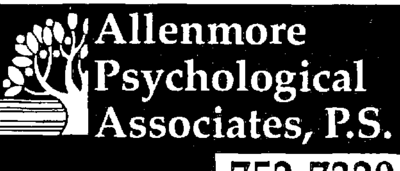

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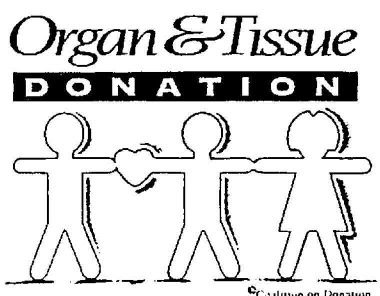

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COLLEGE OF MEDICAL EDUCATION

CORRECTION: ID Update CME set November 10

The annual Infectious Diseases Update is set for Friday, November 10, 2000, NOT November 20th as printed in the calendar in the August *Bulletin*. The very popular course will be held at the Sheraton Tacoma Hotel. The program is directed by **David McEniry, MD** and will feature specialists and sub-specialists from the community joining Infections Limited physicians as they give presentations on specific disease areas. The course is designed as an update on common outpatient and inpatient infections.

The registration brochure will be mailed in September.■

Whistler CME Program set January 24-28

The annual Whistler CME program has been set for January 24-28, 2001 at the Aspens Condos, with rates the same as last year. A program brochure with course details will be available this month. Watch your mail!■

Continuing Medical Education

Common Office Problems CME offers timely Primary Care Topics

Registration is underway for the very popular Common Office Problems CME program. This year's conference is scheduled for **Friday, October 20, 2000.** The conference will be held at St. Joseph Medical Center, Rooms 1 A&B.

The program will offer 6 Category I CME credits and is again directed by **Mark Craddock, MD.**

This years course will cover: New Antibiotics, Congestive Heart Failure, Evaluation of New Onset Seizures in Children, Irritable Bowel Syndrome, Common Knee Problems, Hormone Replacement Update, Treatment of Lumbar Rediculopathy, and Prostate Cancer

The course is designed for the primary care clinician and focuses on practical approaches to the most common dilemmas faced in the daily routine of medical practice. Look for the registration brochure in the mail just after Labor Day.

For more information, please call the College of Medical Education, 627-7137 between 7:45 and 5:00 p.m.■

Dates	Program	Director(s)
Friday, October 20	Common Office Problems	Mark Craddock, MD
Friday, November 10	Infectious Diseases Update	David McEniry, MD
Friday, December 1	Medicine & Mental Health	David Law, MD
TBA (evening)	Cardiology for Primary Care	Gregg Ostergren, DO
Wednesday-Sunday January 24-28	CME at Whistler	Richard Tobin, MD John Jiganti, MD
Friday, February 9	Advances in Women's Medicine	John Lenihan, Jr., MD
TBA	Pain Management	David Paly, MD
Thursday-Friday March 8-9	Internal Medicine Review 2001	Ulrich Birlenbach, MD
Saturday, April 28	Surgery Update 2001	Glenn Deyo, MD
Friday, May 4	Allergy, Asthma & Pulmonology for Primary Care	Alex Mihali, MD
Tuesday, May 16 and Tuesday, May 23 (evenings)	Medical Technology	TBA

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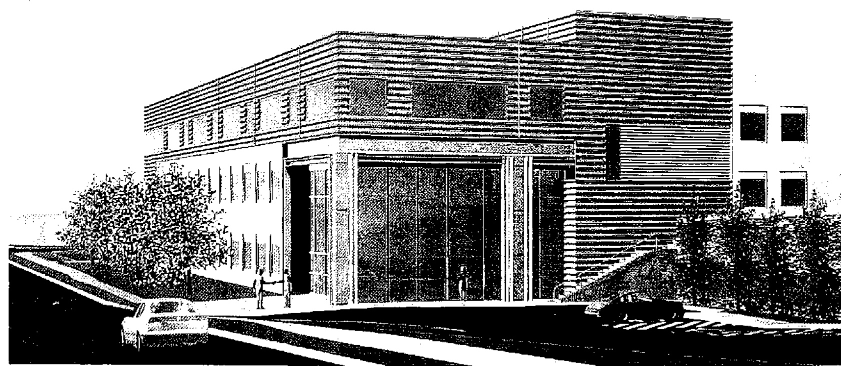

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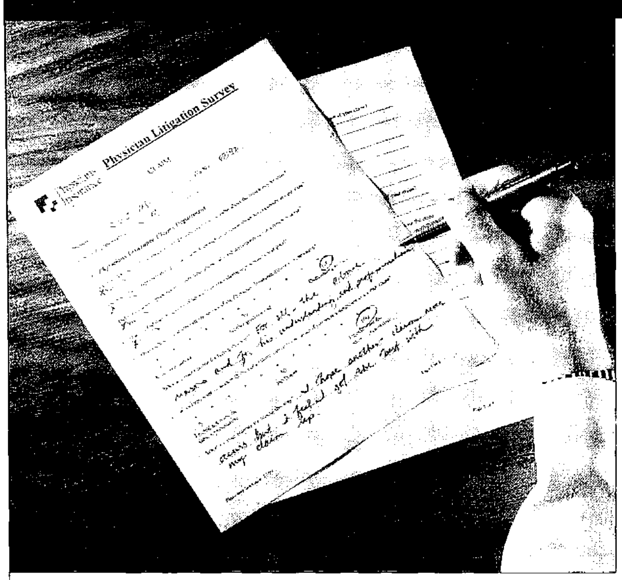

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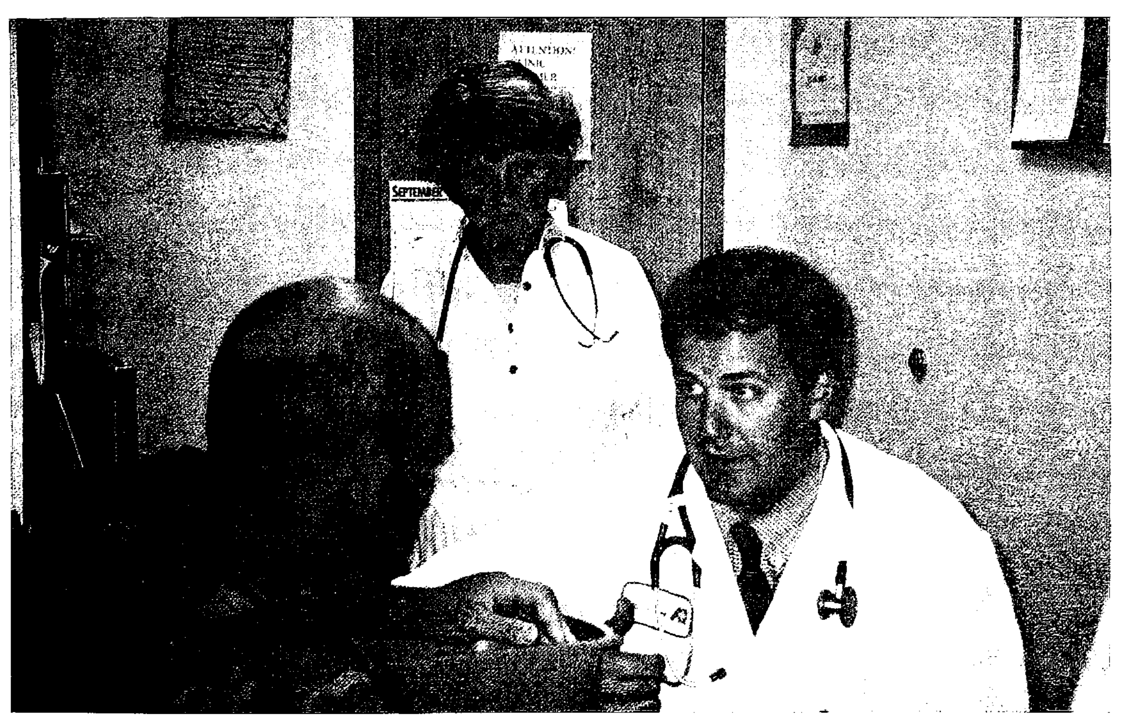
Pierce County Medical Society
BULLETIN

October, 2000

The Neighborhood Clinic..........
Bringing Health Care to the People



Jim Hubbard, MD, third-year TFM Resident treats the hand of a Neighborhood Clinic patient, while Pat Schueller, LPN assists

See story, page 3

INSIDE:

3 The Neighborhood Clinic-Bringing Health Care to the People
5 High Adventure of the Mallory/Irvine expedition draws big crowd at October Meeting
7 Members complete the 163 mile Courage Classic bicycle ride
9 Robert Winchel, MD to give Adult Trauma Center update at November General Meeting
11 Pierce County's Community Health Status Report released
18 College of Medical Education plans Whistler course for January, 2001 - Register now!
21 Yoder lecture Friday afternoon, November 10

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The Bulletin is published monthly by PCMS Membership Benefits, Inc. for members of the Pierce County Medical Society. Deadlines for submitting articles and placing advertisements in The Bulletin are the 15th of the month preceding publication (i.e. October 15 for the November issue).

The Bulletin is dedicated to the art, science and delivery of medicine and the betterment of the health and medical welfare of the community. The opinions herein are those of the individual contributors and do not necessarily reflect the official position of the Medical Society. Acceptance of advertising in no way constitutes professional approval or endorsement of products or services advertised. The Bulletin and Pierce County Medical Society reserve the right to reject any advertising.

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Pierce County Medical Society
BULLETIN

October, 2000

HALLOWEEN

Table of Contents

3 The Neighborhood Clinic-Bringing Health Care to the People

5 High Adventure draws big crowd at October meeting

7 Members complete Courage Classic

8 Richard Wohns, MD and son complete STP on tandem
8 PCMS Executive Director announces retirement

9 Trauma Update scheduled for November General Meeting

10 Applicants for Membership
10 Directory changes

11 TPCHD: Community Health Status Report

12 Organ Donation website offers resources and information
12 CPT-5 Project lays groundwork for Electronic Future

13 Physicians should covert to limited liability partnerships

15 Invisible Hand: "Saving on Penicillin"

17 "Nostalgia of World War Two"

18 College of Medical Education - Whistler CME set
19 College of Medical Education

21 The Edwin C. Yoder Lecture

23 Classified Advertising

Special Feature

by Jean Borst

The Neighborhood Clinic......... Bringing Health Care to the People

> *"It's hard to say no to people who have limitless needs."*
>
> John VanBuskirk, D.O. on the Neighborhood Clinic

Its presence in the community is limited with services available only a few hours, two evenings a week. But for the short time the Neighborhood Clinic opens its doors each week, its impact and presence is far-reaching and significant.

"Each time I work at the clinic," says **John VanBuskirk, D.O**. "I hear stories from people, have the opportunity to work with other dedicated volunteers, and see fascinating medical problems and issues. I come away feeling energized, and I am continually reminded that it's the right thing to do." Dr. VanBuskirk, who has been associated with the clinic since 1989, was originally encouraged by friends to volunteer some time with the project. "I really couldn't imagine how I would be able to do it, he recalls. "Like most physicians, I was swamped. But, it didn't take me long to recognize its importance.

Since that time, he has regularly volunteered at least one night a month at the clinic, located at 1323 South Yakima, in downtown Tacoma. His involvement wasn't exactly a reach for him, however. Dr. VanBuskirk has been helping underserved patients throughout his career. He worked four years for the Tribal Health Authority before joining Tacoma Family Medicine. In addition to serving the urban underserved population at his practice, he also trains residents to provide care to the same population. The clinic, he notes, is an excellent outlet for that training.

"For residents," he said, "this is wonderful exposure to health care. It's a whole different world that new physicians should be exposed to. It takes only a few minutes at the clinic to see how broken the health care system is."

"It was a way to work with people with real needs," recalled **Joan Halley, D.O.,** who was a resident with Tacoma Family Medicine when she began working at the Neighborhood Clinic over ten years ago. "And, as a resident doctor, it was a place to work hard and be appreciated." Dr. Halley is now a family practice physician with Peninsula Family Medical Center in Gig Harbor, but continues her volunteer time at the clinic.

"Very few physicians go into the field of medicine saying, 'I'm doing this because I want to be rich and famous,'" Dr. Halley noted. "They do it because they want to use their skills and abilities to help other people. For me, that's never changed."

Like Dr. VanBuskirk, Dr. Halley is at the clinic about once a month and attends monthly board meetings. Both physicians agree that balancing volunteer time, a full-time practice, and family life is challenging. "Family time is an issue," Dr. Halley said. "An evening at the clinic is another night away from home. But when I think that it's only once a month, two to three hours at a time, I realize that there's no question that this is something I can do. I can give up other commitments to be at the clinic."

Time is an issue for Dr. VanBuskirk, as well, but "my family knows how valuable this is to me and to the community. It's a huge piece of what works for me."

Humble Beginnings

The Neighborhood Clinic was established in 1983 to provide free medical care to those in need who lacked medical insurance, Medicare or public assistance to cover medical costs. The brainchild of a local RN and a Jesuit priest, the clinic opened its doors on a shoestring budget, providing limited health care. While supported by St. Leo's Parish and the surrounding community, the clinic and church have no formal affiliation.

"We've come a long way," noted Dr. Halley, who recalled that the clinic was originally housed in the basement of St. Leo's. Sheets and bookcases separated exam areas, and water had to be heated in a coffeepot because there was no hot water available in the building. Today, the clinic is located in the remodeled Mt. Tahoma building and features four exam rooms, a waiting room, two toilets and a play area. The clinic rents the space from the building owners at a low rate.

Today, the Neighborhood Clinic continues to serve the homeless, unemployed and the "working poor" - those who are employed but do not have insurance benefits. The facility is open Monday and Thursday evenings. No fees are charged, and patients are seen on a first-come, first-served basis. Any-

See "The Neighborhood Clinic" page 4

The Neighborhood Clinic from page 3

one who walks in the door will be seen. Patients are primarily young adults. There are very few pediatric or OB patients, Dr. VanBuskirk notes. "These people are eligible for state resources. Basically, it's difficult for society to say 'no' to children and pregnant women." Approximately 8-15 patients are seen each night. While most visits are short and directed, mentally ill patients and those clients with sexually transmitted diseases require additional time. Dr. VanBuskirk estimates that approximately half the patients they see each night are new to the clinic. Clients come primarily from downtown Tacoma, but the clinic also sees patients from as far away as Roy, Purdy, Lakebay and Olympia.

The clinic offers routine care and treats such cases as flu, colds, sprains, etc. Providers draw blood, order EKGs, make referrals, and dispense medication. "We cannot take care of ongoing chronic problems," Dr. Halley noted, "but we can get those people connected to the appropriate agencies to get help."

"Medication is the biggest issue in the community," Dr. VanBuskirk explained. "We can provide chronic medications for one or two months, then refer the patient to an outside clinic, physician or appropriate agency. In many cases, when the medications run out, the patients don't have the ability to pay for more."

"We try to get people to an agency that can help them, but often the services really aren't out there," Dr. Halley added. "Invariably, we see them again after their medications are gone. We have people who have been coming to the clinic for five years. They try to get the services they need, but they're still here. What can we do?"

Drs. Halley and VanBuskirk ask that ERs and clinics do not send people to the Neighborhood Clinic for prescription medication. "We simply can't help them," Dr. Halley said.

Operating much like a resource clearing house, the clinic makes referrals for eye care, dental care, shelter, food and clothing. Clinic Coordinator Ruth Roath, who runs the facility and coordinates staffing, is at the clinic Mondays and Thursdays to review charts and determine follow up.

In addition to two to three primary care physicians - typically family practitioners - the clinic is staffed by desk volunteers, volunteer nurses, nursing students, and other health care professionals with day jobs. Some specialists are involved and active in the clinic, and some assistance comes from physical therapists, counselors, massage therapists, and education service support specialists.

Last year alone, physicians, physician assistants and nurse practitioners provided over 370 hours of free care. Numerous uncounted hours of free care was provided by community medical specialists for needs that couldn't be met in the clinic. The donated hours of care would have cost over $50,000. Student nurses volunteered 180 hours, and Ruth Roath noted that nursing hours were too numerous to calculate.

The clinic is a 501(c)(3) nonprofit organization and is funded by United Way contributions, private donations, grants, annual support from the PCMS Auxiliary and local parishes/churches. The success of the program depends on the support of volunteers and generous contributions from St. Joseph's Hospital, Tacoma Radiology, AKE Laboratories, local pharmacies, pharmaceutical company representatives, and medical suppliers throughout the Tacoma community.

Thanks to the generosity of the medical community, the clinic is able to stock ample supplies. "St. Joseph's has been a miracle for the clinic," says Dr. Halley. "We send clients to their lab for tests at no charge. They also offer cut-rate pharmacy costs, selling us meds at a low rate. Their generosity has been amazing. Without them, we couldn't do what we do."

The key to the clinic's success, Drs. VanBuskirk and Halley agreed, is ongoing support from the medical community. Many of the facility's volunteers are residents and staff members from Tacoma Family Medicine who already have daily experience with indigent health care. "It's of great value,

See "The Neighborhood Clinic, page 14

"The Neighborhood Clinic is grounded on the belief that healing occurs where physical/medical care is accompanied by consistent emotional support and a regard for the whole person.
Therefore, in response to the gospel of Jesus and the call of the spirit, we endeavor to meet each patient as an individual, to heal, to bind up wounds, to teach and to advocate for those in need. We strive to foster an emotionally supportive atmosphere, focusing on holistic care for all of those we welcome through our doors."

Mission Statement,
The Neighborhood Clinic

Tale of High Adventure on Mt. Everest Brings Big Crowd to October General Membership Meeting

Over 175 attendees at the October General Membership meeting were taken back to 1924, for the third time that the British had tried to scale Mt. Everest. They tried in 1921 and 1922, both unsuccessfully, and for their third attempt in 1924, the eyes of the entire nation were upon them. George Mallory and Andrew Irvine led the expedition. Mallory, who had been on both previous attempts informed his friends that he did not intend to come back undefeated.

While all eight men on the 1924 attempt were strong and determined, just getting to Mt. Everest in 1924 was in itself a challenge. They took a boat from England to India, then once in Bombay, had to travel all the way across India on a train. Once they reached Kathmandu, India they walked for the better part of another month just to get to base camp.

They set their base camp on the north side of the mountain, in Tibet, the exact same spot that 75 years later, Eric Simonson and his team would set their base camp in search of their remains. Part of their team climbed to 28,000 feet without oxygen, an amazing accomplishment which was not exceeded until 1978.

On June 8, 1924, Mallory and Irvine attempted their summit bid and they were last seen on the summit ridge by one of their climbing partners, as just a few minutes later they were quickly obscured by fast moving clouds and they were lost to history. Did they make the summit? What happened to them? This mystery has prevailed for 75 years.

In 1999, two Everest historians approached Eric Simonson and asked him to lead an expedition. He agreed, but there was one small problem. About $300,000 to fund the expedition. In the fall of 1998, he started fund-raising. And, just like the British did in 1924, he raised funds by selling film and photo rights. He quickly raised 200,000 then went to the outdoor industries and slowly raised the last $100,000.

He organized the team, including Sherpa support, but mostly a searching team, not just a summit team. Late March, 1999 they placed their camp and were the first expedition of the year. They had exceptional conditions, which they needed to find Andrew Irvine.

They were looking for Irvine because his ice axe had been found and they were looking for his camera and could hopefully develop pictures that would unravel the details of the 1924 adventure.

Although they were not successful in finding Irvine, they did find George Mallory, his watch (which still worked) and other paraphernalia. And, their search for Irvine will continue in the spring of 2001 as they attempt another climb to locate his remains.

For more information about Eric Simonson and his mountain climbing adventures, visit www.moutainzone.com or www.pbs.org. ■

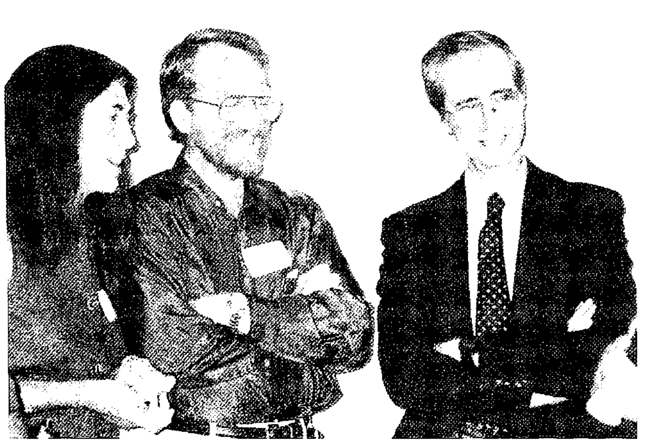
More photos page 6

Right, Eric Simonson autographs his book for Dr. Sam Insalaco, left and his wife, Sandra. PCMS placement Coordinator Deborah Pasqua, standing, helps his assistant with book sales

Steven Litsky, MD inspects an oxygen tank that Simonson's crew found on the mountain from Mallory and Irvine's climb

From left, Drs. Jonathan Hurst, Needham Ward and Doug Gant wait in line to have their books autographed

October General Membership meeting brought out the crowds...



Dr. Henry Retailliau, internist, (right) visits with Dr. Phil Craven , and his wife, Karen, after the meeting. Dr. Craven's specialty is infectious diseases

Drs. Vern Nessan, Puyallup pulmonologist, center, gets his book autographed while Drs. Jonathan Hurst and Needham Ward prepare to meet Eric Simonson

Dr. Susan Salo, PCMS Vice President, visits with Trustee Dr. Mike Kelly. Both are family physicians, Dr. Salo is with Group Health and Dr. Kelly practices in Lakewood

Dr. Sam Insalaco, Tacoma pathologist and his wife, Sandra, peruse Eric Simonson's book prior to meeting with him and having him autograph their copies of the book

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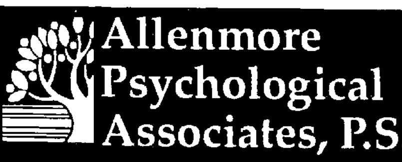

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Members Complete Courage Classic

Over 100 flat tires set the tone for the first day of the Ninth Annual Courage Classic. **Dr. Richard Ory**, his wife Jan and brother Peter, and **Dr. Dan Niebrugge** had nine flats with 15 miles remaining before reaching Cle Elum at the end of a 57-mile day. Glass and small pieces of wire from shredded tires were the big culprits. Most of the flats occurred while the riders were on Interstate 90. Kathy Eddinger, NW Specialties and spouse of WSMA's chief lobbyist, Len Eddinger, had three herself. She is one of twelve riders who has ridden in all nine Classic rides.

The three-day ride took the 520 riders from the Snoqualmie Winery just west of North Bend up Snoqualmie Pass (old highway) to the football field of Cle Elum High School for the first day.

The second day takes you through the beautiful Teanaway Valley and the "gentle" ascent of Blewett Pass as described by the Courage Classic brochure. It was beautiful, but not necessarily "gentle." The night is spent in Leavenworth with another superb meal and entertainment at the Bavarian Beer Garden. PCMS has some pretty sharp dancers amongst its ranks. The third day of riding finds you riding through gorgeous Chumstick Valley. It is worth the hills to see this lovely spot. On to Stevens Pass at the 45 mile mark. The remaining 15 miles are all virtually downhill to Skykomish to catch a bus back to North Bend and call it a day.

The proceeds of the annual event go to Mary Bridge Children's Hospital and the Children's Trust Foundation, which is devoted to the prevention of child abuse and neglect throughout the state of Washington.

Other PCMS riders were: Anesthesiologist **Marsden Stewart** and his wife, Internist LeeLee; OB/Gyn **Patty Kulpa**, who was also a major sponsor of the event. Internists **Henry Retailliau** and **Steve Stringfellow**; ENT **Don Shrewsbury**, Pediatric Oncologist, **Dan Niebrugge**; Pediatricians **Richard Ory** and his wife Janice Sack-Ory and **Karen Holdner**. Orthopedist **Jack Stewart** and his wife Teri, General Surgeon **Bill Martin** and wife, Karyl and Physical Med & Rehab physician, **Steve Settle.** ■

More pictures page 7

Editor's Note: The Bulletin staff invites pictures and articles on activities involving members. Be it sailing, tennis, golf, camping, etc., please send us the information. You may review copy before publication.

Jack Stewart, Tacoma orthopedist, on the second day of the ride. He and his wife, Teri have done the ride several times

From left, Drs. Bill Martin, Jack Stewart and Don Shrewsbury on the summit of Stevens Pass. The remaining 15 miles of the 163 mile ride will be downhill for them

Anesthesiologies Marsden Stewart and his wife, internist LeeLee at Stevens Pass. This year they rode on a tandem

Courage Classic shots.....

Tacoma Pediatrician, Richard Ory awaits the bus ride back to his car after pedaling 163 miles over three mountain passes. His wife, Janice Sack-Ory also completed the ride

From left, internists Steve Stringfellow and Henry Retailliau with son, Daniel Retailliau, get ready for the third day after breakfast in Leavenworth's City Park

Richard Wohns, MD and son complete Seattle to Portland bicycle ride on tandem

Dr. Wohn's said, "Anthony and I trained during the spring and early summer with tandem rides around Seattle, Tacoma and in the Methow Valley. He is a great stoker and appears to enjoy hills! We did the ride in two days. We spent the first night at the Red Lion Inn in Longview/Kelso. Riding time was around 15 hours. Anthony is now only riding his own little mountain bike and would like to do the STP again, but next time on his own bike. I told him that I would like to draft behind him!" ■

PCMS Executive Director to Retire

Doug Jackman, PCMS Executive Director since 1984 informed the Board of Trustees at their September meeting that he planned to retire effective January 1, 2001.

Patrice Stevenson, MD, President-Elect has been named to chair a national search committee. Other members of the search committee are past presidents, **Lawrence Larson** and **David Law; Michael Kelly, Doris Page** and **Sabrina Benjamin.** ■

Please visit us at the PCMS homepage www.pcmswa.org

Pierce County Medical Society

invites you and your spouse/guest to the

November General Membership Meeting

Tuesday, November 14, 2000
Social Hour: 6:00 pm
Dinner: 6:45 pm
Program: 7:45 pm

Landmark Convention Center
Temple Theatre, Roof Garden
47 St. Helens Avenue
Tacoma

Adult Trauma Update

Robert Winchell, MD
Director, Adult Trauma Services

The Adult Trauma System has been operational in Pierce County since June. Plan to attend the November meeting to hear about the new system, what is working, and what isn't. And:

- Adult Trauma System - Successes, Failures
- Availability of Surgical Suites
- Impact on Trauma Call Roster
- Hospital Rotation - is it working?
- Funding Outlook

egistration required by November 10. Return this form to: PCMS, 223 Tacoma Ave S, Tacoma 98402; FAX to 572-2470 or call 572-3667

Please reserve ________ dinner(s) at $20 per person (tax and tip included)

Enclosed is my check for $ ______ or my credit card # is ______________________

☐Visa ☐Master Card Expiration Date ________ Signature ______________________

I will be bringing my spouse or a guest. Name for name tag: ______________________

Signed: ______________________

Applicants for Membership

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Bill Dean, MD	272-4013
Tom Herron, MD	853-3888
Bill Roes, MD	884-9221
F. Dennis Waldron, MD	265-2584

Confidentiality Assured

Brown, George J, MD
Gastroenterology
Vice President, MultiCare Health System, 315 Martin Luther King Jr Way, Tacoma 98405; 403-1855
Medical School: Boston University School of Medicine
Internship: Fitzsimons Army Medical Center
Residency: Fitzsimons Army Medical Center
Fellowships: Walter Reed Army Medical Center

Fahmy, Raed N, MD
Cardiology
Practices at Cardiac Health Specialists, 1802 S Yakima #307, Tacoma 98405; 627-1244
Medical School: George Washington University
Internship: UCLA – SFVP
Residency: Loma Linda University Medical Center
Fellowship: UCLA – SFVP

Hirota, William K, MD
Gastroenterology
Practices at Tacoma Digestive Disease Center, 1112 6th Ave #200, Tacoma 98405; 272-8701
Medical School: Georgetown Univ.
Internship: Walter Reed Army Med Ctr
Residency: Walter Reed AMC
Fellowship: Walter Reed AMC

Pickett, James D, MD
Cardiology
Practices at Cardiac Health Specialists, 1802 S Yakima #307, Tacoma 98405; 627-1244
Medical School: Baylor College of Med
Residency: St Joseph Hospital
Fellowship: Baylor College of Medicine

Thomas, Kathy J, MD
Family Medicine
Practices at CHC - Parkland Clinic, 11225 Pacific Ave S, Tacoma 98444; 531-6198
Medical School: University of Pennsylvania School of Medicine
Internship: Swedish Family Medicine
Residency: Swedish Family Medicine

Directory changes

Please make note of the following changes to your 2000 PCMS Directory.

LoGerfo, Peter, MD
Change address to: PO Box 731009
Puyallup, WA 98373-0030
Phone: 770-7600
Fax: 864-6144

Moore, Jane MD
Change address to: 6002 N Westgate Blvd #160 Tacoma, WA 98406
Phone: 759-9902 Fax: 759-5504

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The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

Community Health Status Report

Ever wonder what an organization outside of Pierce County might say about the health of this community? Ever wonder how Pierce County, Washington, compares to other communities with similar demographics? If so, your curiosity should be satisfied. The Health Resources and Services Administration (HRSA), part of the US Department of Health and Human Services, has released their annual Community Health Status Report for Pierce County. The report shows that in many categories, Pierce County is healthier (comparing specific standards) than many of our peer counties and even of the national median. **Categories that show Pierce County to be favorable compared to peer counties are: Black infant mortality, post-neonatal infant mortality, breast cancer, and lung cancer.**

For key areas, however, Pierce County ranks lower than other communities. Categories that fit into this status are: no care in the first trimester, White infant mortality, stroke, and suicide.

The chart at right gives the statistics and comparisons to peer counties and the nation. Peer counties include: Fresno County, California; San Francisco County, California; The District of Columbia; Orange County, Florida; Baltimore City, Maryland; Multnomah County, Oregon; Milwaukee County, Wisconsin.

The Health Department's mission is to improve health across Pierce County. Even for categories that are favorable, compared to peer counties or the nation, the agency would like to improve statistics in the future. Relevant activities that will hopefully make a difference in these numbers include:

• Adolescent Health: Youth who are at-risk dropping out of school, getting involved with gangs, and other potentially-dangerous behavior are counseled, with their families, on ways to improve their self-image and social skills, stay in school, avoid or cease substance use, and make appropriate choices (which may help to avoid teen pregnancy, suicide, and violence).

• Family-Based Services: Public health nurses visit families in their homes, encouraging effective pre- and post-natal care and monitoring child development; families deemed to be at-risk by hospitals and Child Protective Services are referred to the Family-Based Services for follow-up.

• Prevention Priorities: Staff are involved with communities throughout the county, to find ways to prevent or cease tobacco use, alcohol misuse, and violence (such as locking up guns or

See "Health" page 20

Category	Pierce County	Compare: Peer County	Compare: US
BIRTH MEASURES	Numbers are percentages per total births.		
Low Birth Weight (<2500 g)	6.1	6.4-10.8	7.5
Very Low Birth Weight (<1599 g)	1.1	1.1-2.4	1.4
Premature Births (<37 weeks)	10.0	9.8-15.6	11.4
Teen Mothers (<18 years old)	4.4	4.4-7.8	12.7
Older Mothers (>40 years old)	1.5	1.4-2.6	2.1
Unmarried Mothers	29.7	29.7-48.3	32.4
No care in First Trimester	26.3	12.9-35.1	17.0
INFANT MORTALITY	Numbers are incidents per 1,000 live births.		
Infant Mortality	6.9	5.4-11.3	7.2
White Infant Mortality	6.4	5.0-7.8	6.0
Black Infant Mortality	15.0	9.6-18.8	13.7
Neonatal Infant Mortality (<29 days)	4.3	3.3-7.9	4.8
Post-neonatal Infant Mortality (1-12 months)	2.6	1.7-4.1	2.5
DEATH MEASURES	Rates are age-adjusted to year 2000 standard; per 100,000 population		
Breast Cancer (Female)	30.6	24.0-36.6	28.6
Colon Cancer	19.1	17.9-26.2	21.6
Coronary Heart Disease	214.1	170.7-263.9	216.0
Homicide	7.0	5.8-21.0	7.2
Lung Cancer	60.1	45.3-72.9	58.1
Motor Vehicle Injuries	13.0	7.7-21.8	15.8
Stroke	75.9	49.9-75.9	62.0
Suicide	17.0	6.4-16.8	11.4
Unintentional Injury	17.9	12.6-28.1	33.3

Organ Donation Website offers Resources and other Information

With Hundreds of thousands of Americans currently awaiting an organ or tissue transplant, the AMA encourages you to educate your patients about becoming organ donors. The AMA's Organ Donation Program Web site offers visitors resource links to organ donation coalitions, Council for Scientific Affairs reports, frequently asked questions and more. For more information, go to **http://www.ama-assn.org/ama/pub/category/1945.html** ■

Our Apologies

The PCMS Bulletin apologizes to **Drs. Rick Schoen** and **Phil Perkins** for an error in the September issue.

Dr. Schoen was inadvertently identified as Dr. Perkins in a photo on page 6. The photo identified several people that participated in Paint Tacoma/ Pierce Beautiful organized by PCMS. Both Drs. Perkins and Schoen volunteered for the project.

PCMS apologizes for the error.

CPT-5 Project continues to lay groundwork for Electronic Future

With physicians and insurers increasing their use of the Internet and other electronic management tools, the American Medical Association is continuing its efforts to make significant improvements to electronic versions of its Current Procedural Terminology coding set (CPT).

The CPT-5 Project aims to enhance the ability of users to find the correct code more quickly, allow for researchers to effectively use the codes, and better integrate CPT with electronic products. In a move that will help minimize physicians' administrative burden, the U.S. Department of Health and Human Services recently announced that it would be using the CPT coding set as a national standard.

Go to **http://www.ama-assn.org/ama/pub/article/1616-3050.html** for more information. ■

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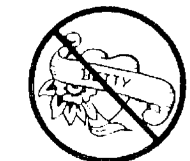

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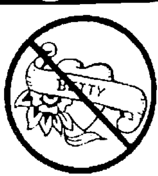


Why physicians should convert to limited liability partnerships

by Adrew Dolan, JD

Are you and your practice partners still using the partnership model as your form of legal organization? Physicians are encouraged to consider converting to **limited liability partnerships.** Here's why:

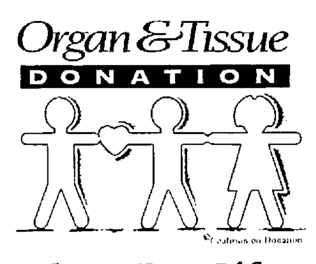
Before 1995 in Washington, physician groups that wanted to be taxed as partnerships under federal law had to accept the liability implications of being a partnership. That meant that the physicians and their personal assets were vulnerable to the liabilities of the partnership, including malpractice, debt and so on. However, in 1995, Washington, like all other states, established limited liability companies and shortly thereafter, limited liability partnerships.

These new entities meant that physicians could enjoy the limited liability of corporations and still be taxed as partnerships, as with subchapter S corporations, without complying with all the requirements for subchapter S election. With limited liability partnerships, physicians can still be liable for their own professional negligence and the liability of those they supervise. However, under corporate liability principles, there is no personal liability for the other liabilities of the company. Examples of this other liability would be premises liability, for the negligence of most other physicians in the practice and company debts.

Physicians can form limited liability companies or limited liability partnerships. The conversion usually costs less than $1,000 in attorney fees if there is an existing partnership agreement that is otherwise satisfactory. There is virtually no legal reason not to convert, and the additional insulation from the catastrophic liabilities is usually more than worth any cost. ■

Andy Dolan is an attorney in Seattle. He specializes in medical issues and works extensively with the WSMA.

Reprinted from WSMA Reports, September, 2000



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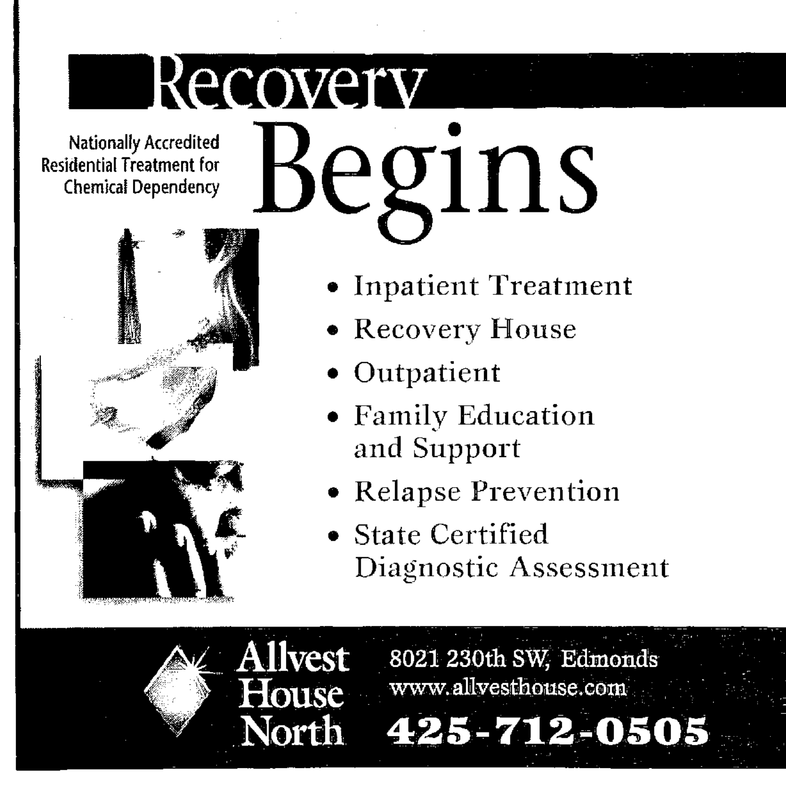

The Neighborhood Clinic from page 4

however, for other members of the medical community to experience the clinic. It's important for doctors and medical office personnel to come to the clinic, see the needs that exist, and go back to their practices with an awareness of what's out there."

Now in it's 17th year, the clinic continues to serve a tremendous need in the community. "Overall," Dr. VanBuskirk notes, "access to health care is the biggest need of all. These patients need to feel they are important and valued by society. Having volunteers at the clinic who care makes them feel as if they do have value."

Last year, over 1,000 patients visited the Neighborhood Clinic - 56 percent were first time visits; over 60 percent were Caucasian; 15 percent were African American; and 15 percent were of mixed racial background. Over 50 percent of the patients seen were women. Twenty percent were from the Hilltop area of Tacoma.

In her annual report to the Board of Directors, Ruth Roath noted, "I know that there will always be a need for places like the Neighborhood Clinic. The causes for their presence among us are too numerous for us, as a small clinic, to fix entirely. So, probably our best bet is to provide medical treatment and most medications for episodic illness, cure when we can, palliate when we cannot cure, advocate for those with chronic needs and continually challenge ourselves to tackle some of the causes for the lack of care among the needy. As always, we provide a safe place for our patients to gather in their need and receive compassionate care, hopefully, without the discomfort that judgement can bring."

A Need that Won't Go Away

When health care reform came to the forefront a few years ago, Dr. VanBuskirk was cautiously optimistic that there would be no further need for the clinic's services. However, that wasn't the case, and the Neighborhood Clinic continues to play a critical role in the lives of many. Medical volunteers, particularly specialists, are always needed and welcomed at the clinic. "We have a small network of amazingly generous people in the community who have provided their services - cardiologists, dermatologists, gastroenterologists. But we can always use more. Just one person makes an incredible difference in what we can do."

Dr. VanBuskirk extends a special invitation to retired physicians interested in offering their services. The Washington Retired Provider Program makes it possible for retired health-care providers to offer an important and much needed service to low-income residents in the community. While you do not receive compensation, the program pays for malpractice insurance. All non-

See "The Neighborhood Clinic" page 20

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MEDICAL LICENSURE ISSUES

Mr. Rockwell is available to represent physicians and other health care providers with issues of concern before the State Medical Quality Assurance Commission. Mr. Rockwell, appointed by Governor Booth Gardner, served for 8 years as the Public Board Member of the Medical Disciplinary Board from 1985-1993. Since then, Mr. Rockwell has successfully represented over 60 physicians on charges before the MQAC. Mr. Rockwell's fees are competitive and the subject of a confidential attorney-client representation agreement.

Gregory G. Rockwell
Attorney at Law & Arbitrator
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email: grocket@msn.com • website: "ggrockwell.wld.com"

In My Opinion.... The Invisible Hand

by Andrew Statson, MD

Saving on Penicillin

Andrew Statson, MD

> *"A man often pays dear for a small frugality."*
> Emerson

A textbook on obstetrics from 1934 recommended that women with heart disease do not marry; if married, do not get pregnant; if pregnant, get aborted. Those who refused abortion had a mortality rate in excess of 60%. In 1960, two percent of pregnant women had rheumatic heart disease. Most of them went through their pregnancy without too much difficulty. The incidence of congestive heart failure was about two per thousand. Fortunately, if women in congestive heart failure could be called fortunate, most of them had mitral stenosis and responded well to commissurotomy. The mortality rate was "only" about 5%. The patients with mitral regurgitation or aortic valve disease still frequently were aborted, or if not, had a mortality rate approaching 50%.

During the past 20 years, in my practice, I have seen several pregnant women with congenital heart disease, but not one with rheumatic heart disease. The current medical textbooks confirm that in this country rheumatic fever has virtually disappeared within the past 50 years. We no longer see the usual sequellae, rheumatic heart disease, chorea of Sydenham and acute glomerulonephritis. Perhaps the main reason was the indiscriminate use of antibiotics.

Starting at about 1950, and probably even a little before that, most children with a sore throat or a cold were treated with penicillin. Probably many of them did not need the antibiotic. However, the cost of penicillin was a small price to pay for the eradication of rheumatic fever. It is true that many colds are viral and penicillin has no role in their treatment. It is true that we now have rapid strep tests, which can tell us within minutes whether a significant streptococcal load is present. It is also true that the longer the delay from the onset of infection to the onset of treatment, the more likely is a child to develop rheumatic fever.

Our rapid tests are positive only when there is a large number of cocci present. We don't know whether viral pharyngitis could stimulate bacterial growth in colonized children. We don't know how fast a subthreshold colonization can become a full-blown infection. We don't know whether viral pharyngitis can change the mucosal permeability and the immune system so that a larger amount of toxin could be absorbed from a subclinical number of organisms. We may be able to safely reduce the number of children treated with penicillin, but we don't know whether our tests can tell us where to draw the line. There is no animal model we could study to answer this question. The only experiments we could carry out have to be on humans. What we do know is that what we have done in the past obviously has worked.

There are two objections to what has been called the indiscriminate use of antibiotics, cost and resistance. When the economic squeeze of the hospitals started over ten years ago, one of the items to cut was the budget for antibiotics. The approach was to give lower doses and less frequently. Studies were done to show that patients still got well without a significant difference in length of treatment or of hospital stay. The dosing of penicillin went from every 3 hours to every 4; of ampicillin, from 4 to 6; of cefazolin, from 6 to 8; of cefotetan, from 8 to 12. That reduced dosing worked most of the time and we thought we saved a lot of money.

Within the past few years we started hearing much about antibiotic resistance. Some strains of organisms have shown resistance to all antibiotics at our disposal. These occurrences are still very rare, but they are worrisome. We are urged to cut down on antibiotic use even more, in order to avoid the development of resistance.

Bacterial resistance to antibiotics develops through 3 mechanisms, plasmid exchange, conjugation and mutation. When bacteria are in a favorable environment, they grow and divide. For instance, E. coli would easily undergo 500 or more divisions before they would feel the need to conjugate. Bacteria in an unfavorable environment, as when exposed to sublethal doses of antibiotics, are much more likely to seek plasmid exchange or conjugation. Dead bacteria don't acquire resistance. Stunned bacteria do. Dr. Robert Guthrie, professor of medicine and pharmacology at Ohio State University, reports that under typical circumstances the drug concentration

See "Penicillin" page 16

Penicillin from page 15

drops to subtherapeutic levels in the latter half of the dosage period and that allows the organisms to become resistant.

The most effective antibiotic treatment and the one least likely to induce resistance consists in short courses of high and frequent doses. That is the opposite of what we have been doing. The only reason to reduce the initial dose of an antibiotic is the concern about a toxic effect, such as a Jarisch-Herxheimer reaction.

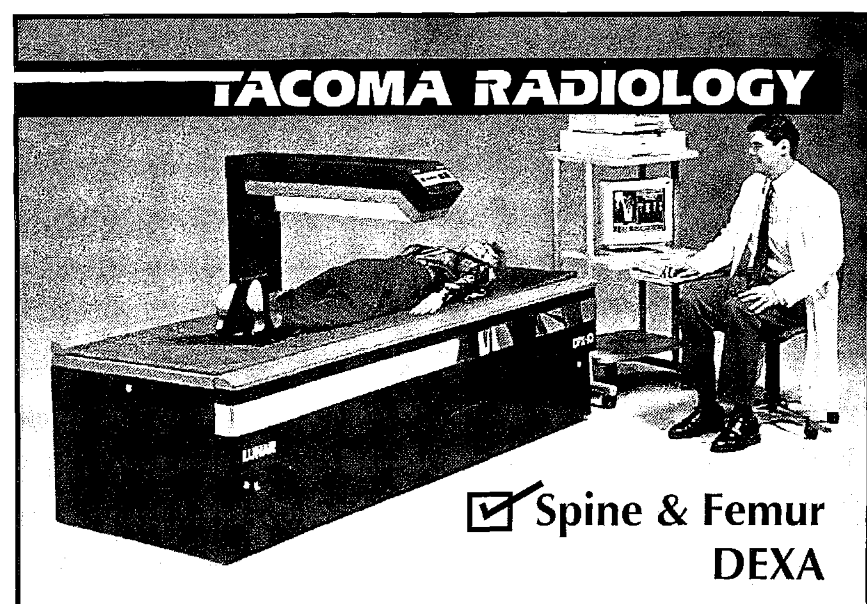
There is another threat on the horizon, even more serious than the developing resistance to antibiotics. It is the looming control on the price of drugs. Price controls will squeeze the pharmaceutical companies and reduce their ability to carry out drug research. That is a bigger problem in the face of emerging bacterial resistance to antibiotics than anything else.

Bacteria will always try to outwit us. That is how Nature operates. However, we developed the antibiotics we have now, didn't we? We have brains, don't we? We are mapping the bacterial genomes, we are studying their enzymes and structural proteins, their systems of communication with one another. We will be able to design drugs specifically directed at the pathogenic bacteria, their toxins and their mechanisms for resistance. We will not be able to do that if we cripple our pharmaceutical industry.

I know, if the pharmaceutical companies cannot fund this research, our government will step in and do that. I will not venture to guess how much it will cost and how long it will take just to do the paperwork on the desirability and feasibility of such studies. How much the studies themselves will cost, how long they will take and what results we will get for the expended funds is beyond anyone's guess. I wonder whether anyone will do an economic analysis on the human genome project, review the public and private funding for this program and compare the respective results and their usefulness according to the money and time spent.

I agree. It is not fair that Americans should pay more for the same drugs than Canadians or Europeans. It is not fair that our taxpayers should subsidize the treatment of AIDS in Africa, either. Out of the 300 million dollars our government plans to spend on this program, the amount that will eventually trickle down to the patients with AIDS will barely be enough to pay for one day of treatment. How helpful!

Private foundations may want to raise the money and do the job. They may want to help people in this country and abroad who cannot purchase their medications. Americans have been generous in the past and they will be generous in the future. Their private efforts will be more effective and less expensive in helping others than will be government grants. Fairness in international drug pricing is important, but there must be a better way to establish it than through government controls. ■



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In My Opinion....

by John Stutterheim, MD

Nostalgia of World War Two

John Stutterheim, MD

This is the story about little boys in a labor camp, named Bangkong, Semarang, Java, former Dutch East Indies, during November 1944. In September of 1944, the Japanese had brought together a population of 1,400 teenagers, existing mainly of boys, ages ten through seventeen, and some adults.

After we had been in Bangkong, for about three months one of the youngest boys, an eleven-year-old, died. No one knew how to explain this to the other little boys, of whom the two youngest ones were nine years of age. It seemed as if they were not really paying attention; they were always so playful. Death was a daily occurrence, especially among the fifty old men who came through camp, but this was the youngest one of our companions to die, and his death affected everyone deeply. When his little body was carried out in a small coffin, all the little guys lined up spontaneously to give the last salute, some with trembling lips, but silent and stalwart nevertheless.

The Japanese paid no attention to our attempts at a funeral observance. They were only concerned that the body be duly removed from camp. At least some of our middle-aged men, the leaders, such as Mr. Vetter, or Jacob the Jew, a kind man in his thirties, would be present as we paid respects, but I never saw the Luxemburger, our so-called chief, who was obviously too cowardly or indifferent to attend even this child's service. Usually some words were read out of the Bible.

The ten-year-olds were achingly brave to manage in this crowded camp by themselves. During the day they would play some game while sitting between their mattresses; sometimes they were ordered out, to work at the tables cleaning vegetables. One area where they liked to congregate was in front of the goedang, the storage area, looking over the vegetables being stored, while they emphasized the tasty vegetables with very wise old faces, nodding at each other. As young as they were, some were still ordered to work in the fields. Mr. Vetter, their Hancho, was kind to these kids and never drove them hard. As a result he received many a beating for work not accomplished. He was in his forties and had been heavy before the regimen of the camps. He always wore a straw hat and stood in the fields, leaning on a stick, supervising these little ones. They had to pull weeds and while doing that work many got sunburned.

Skin problems always became less tolerable in the fatigue and hunger of the evenings. At night the little boys felt miserable with their skinburns and had nobody to console them. Sometimes at night we could hear them crying and asking for their mothers as they lay in their beds.

During the daytime the nuns in our camp were truly helpful to the little ones. They hovered over them and listened to their concerns. Especially for the many sick ones the nuns were a Godsend.

We older boys had no choice but to silently accept these circumstances. I wondered over and over again why this had to happen. ■

John Stutterheim, MD is a retired family physician. He was living in Indonesia with his family prior to WWII and is writing a book about his war experiences.

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Whistler CME set January 24-27, 2001 Condo Reservations/Course Registration Open

Registration is open for the College's CME at Whistler/Blackcomb program. The conference is scheduled for January 24-27, 2001.

The College of Medical Education has selected the Aspens Condos for accommodations because of the very competitive rates (compared to hotels and other condos) and quality of the lodging. These negotiated group rates will remain the same as the 2000 rates, and combined with the Canadian/U.S. exchange rate, result in major savings for the conference registrant.

A collection of one and two bedroom luxury condominiums just steps from the Blackcomb chair and gondola are available. Space is available on a first come first served basis in the Aspens.

The College is offering family vacationing, skiing and the usual quality continuing medical education to PCMS members and other physicians. With Category I credits, the CME program features a potpourri of subjects of interest to all specialties.

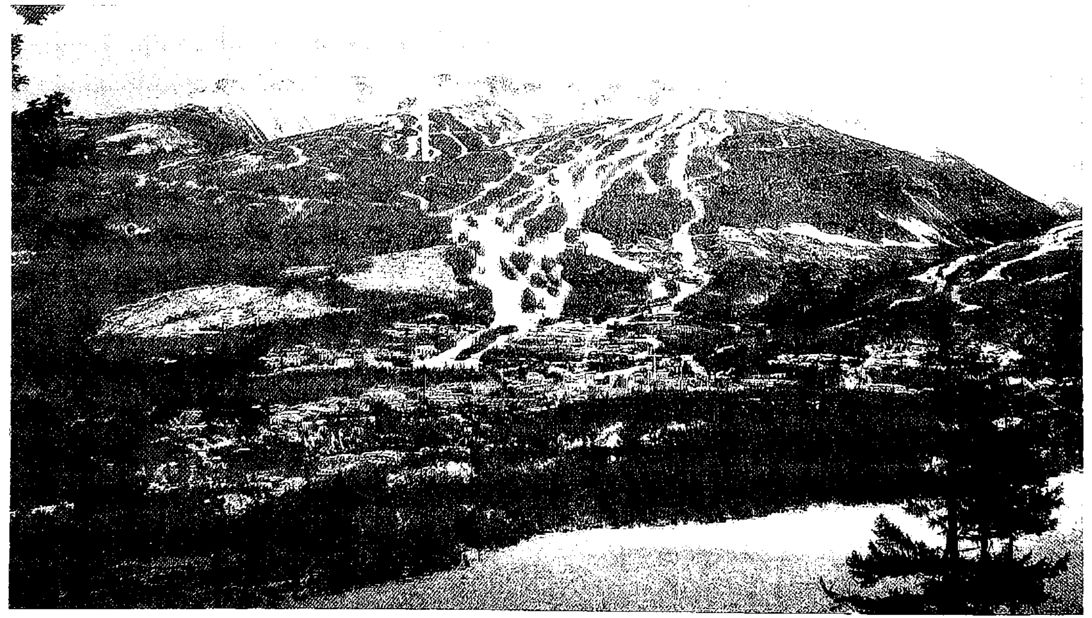
The program is under the direction of **Drs. John Jiganti and Richard Tobin.** This year's subjects include addresses on: Update on the Management of Inflammatory Bowel Disease Advances in Treating Your Geriatric Patient Review of Skin Cancer: The Role of the Mohs' Technique Recent Advances in Insulin Therapy Common Hand Problems "The Plague" Advances and Retreats in Infectious Diseases Interesting Case Studies ■

Whistler Condo Reservations Deadline December 1

CME at Whistler participants are urged to make their condo reservations early. Reservations for the block of condos, ALL IN THE ASPENS AND AT LAST YEAR'S RATES, are available. To take advantage of these savings, you must make your reservations soon, as conference dates are during the high ski season. The College's reserved block of rooms **will be released after December 1, 2000.**

Reservations can be made by calling ***Aspens on Blackcomb*** toll free at 1-877-408-8899. You must identify yourself as a part of the C.O.M.E. group. For more information call the College at 627-7137.■

Blackcomb Mountain



Aspens Condo/Meeting Room

COLLEGE OF MEDICAL EDUCATION

Common Office Problems CME October 20

Registration continues for the very popular Common Office Problems CME program. This year's conference is scheduled for Friday, October 20, 2000. The conference will be held at St Joseph Medical Center, Rooms 1 A & B.

The program will offer 6 Category I CME credits and is again directed by **Mark Craddock, MD.**

The course is designed for the primary care clinician and focuses on practical approaches to the most common dilemmas faced in the daily routine of medical practice.

For more information, please call the College of Medical Education, 627-7137 between 7:45 and 5:00 p.m.

This year's topics include:

- Appropriate Use of New Antibiotics
- Congestive Heart Failure
- Evaluation of New Onset Seizures in Children
- Primary Care Evaluation and Treatment of Irritable Bowel Syndrome
- Evaluation and Management of Common Knee Problems
- Hormone Replacement Update
- Treatment of Lumbar Rediculopathy
- Prostate Cancer: Options for Treatment ■

Continuing Medical Education

Infectious Diseases CME is set for November 20, topics selected

Diseases Update CME is set for Friday, November 10, 2000 and will be held at the Sheraton Tacoma Hotel. The program, this year directed by **David McEniry, MD,** will feature presentations by Infections Limited physicians and a national keynoter.

This program is designed for physicians as an update on common outpatient and inpatient infections. A brief review and clinical update will be made on a variety of important topics. This year's keynoter is Steven Mostow, MD from the University of Colorado. He will speak on Infectious Disease emergencies. This year's conference will feature presentations on:

Teeth and Terror: Animal Bites; Antibiotic Associated Colitis; Staph at a Glance; Infectious Diseases Emergencies: When and How to React; What to do About the Flu; Advances and Retreats in Infectious Diseases; and Antibiotics 2000: An Update.

The registration brochure will be mailed in early October. ■

Dates	Program	Director(s)
Friday, October 20	Common Office Problems	Mark Craddock, MD
Friday, November 10	Infectious Diseases Update	David McEniry, MD
Friday, December 1	Medicine & Mental Health	David Law, MD
TBA (evening)	Cardiology for Primary Care	Gregg Ostergren, DO
Wednesday-Sunday January 24-28	CME at Whistler	Richard Tobin, MD John Jiganti, MD
Friday, February 9	Advances in Women's Medicine	John Lenihan, Jr., MD
TBA	Pain Management	David Paly, MD
Thursday-Friday March 8-9	Internal Medicine Review 2001	Ulrich Birlenbach, MD
Saturday, April 28	Surgery Update 2001	Glenn Deyo, MD
Friday, May 4	Allergy, Asthma & Pulmonology for Primary Care	Alex Mihali, MD
Tuesday, May 16 and Tuesday, May 23 (evenings)	Medical Technology	TBA

Health from page 11

avoiding teen suicide). These activities should help to reduce death rates due to heart disease, lung cancer, stroke, motor vehicle injuries (often related to alcohol misuse), homicide, and suicide.

For more information on the Community Health Status Report, go to the Health Resources and Services Administration webpage: www.communityhealth.hrsa.gov You'll find a number of additional statistics on Pierce County and other communities on that page.

If you have ideas about activities, particularly ways Pierce County medical providers and TPCHD can work together to improve the county's health, contact the Director of Health, **Federico Cruz-Uribe, MD, MPH,** with your suggestions: 253-798-2899. Your ideas are important. ∎

The Neighborhood Clinic from page 14

invasive primary care services, except obstetrical, are covered. The program is funded by the Washington State Department of Health and operated through the Western Washington Area Health Education (WWAHEC) Center and the Washington Statewide Office of Rural Health. **For information or to sign up, interested retired physicians can contact Trudy Arnold, WWAHEC, 2203 - 6th Avenue, Suite #310, Seattle, WA 98121-2526 or call 206-441-7137; FAX 206-441-7158 or email: wwahec@u.washington.edu.**

"There are such great rewards working at the clinic," Dr. Halley summed up. "Consider it a very small investment for an incredible gift in return. Remember, we as physicians have so much, and these people essentially have nothing. They respect us and they need our help."

"We do the best we can," Dr. VanBuskirk added, "and we really do a good job at enabling people to help themselves. But, the fact remains that the needs out there are huge. And, they're universal."

"There is such a need for this facility," Dr. Halley noted. "We have a dedicated board, great support from the medical community. I think we'll be here a while. As long as there are sick people and the volunteers to help them, we'll be here. ∎

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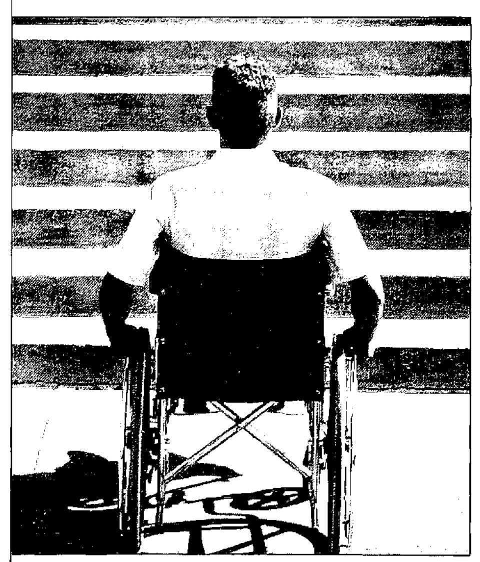

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Friday, November 10, 2000

SPECIAL PRESENTATION by Mary-Claire King, Ph.D. American Cancer Society Research Professor in the Departments of Medicine and Genetics at the University of Washington. Dr. King was the first to prove that breast cancer is inherited in some families and is now investigating how the normal products of these breast cancer genes can reveal pathways critical to the development of breast and ovarian cancer among women generally. Dr. King will explain the technology of gene mapping and discuss the implications for clinical medicine.

Location: St. Joseph Medical Center

Physician Lectures: This course is accredited for 2.0 Category 1 hours

12:30 PM Complimentary Catered Luncheon - Rooms 1AB

1:00 - 2:00 PM *First Lecture - Rooms 1AB*
Mary-Claire King, Ph.D.

2:00 - 3:30 PM Wine and cheese reception with the speaker in the Physicians' Lounge

3:30 - 4:30 PM *Second Lecture - Rooms 1AB*
Mary-Claire King, Ph.D.

Reservations required for lunch and each lecture; - limited seating available

Invitations will be mailed in October. For more information, call
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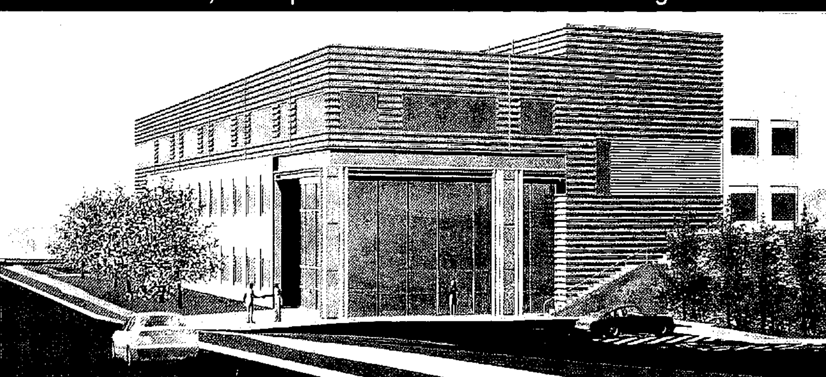

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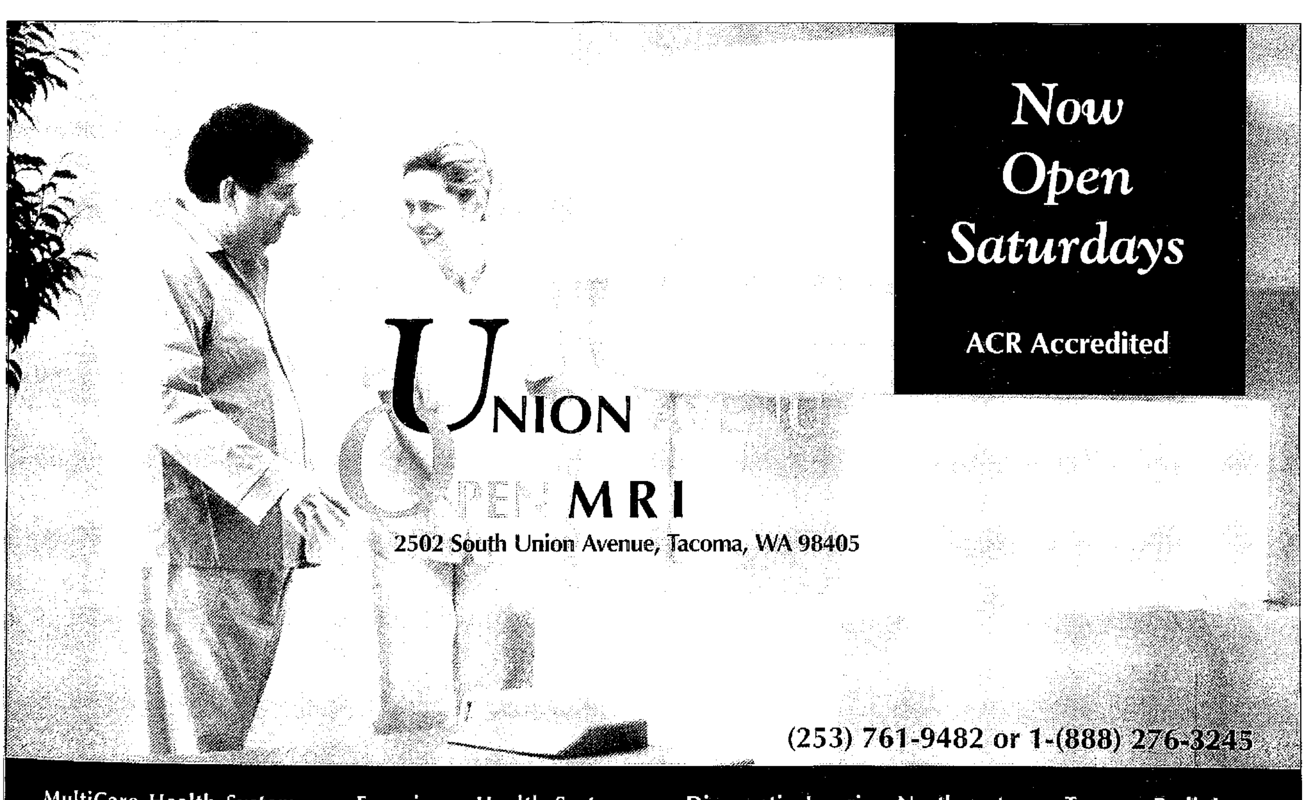

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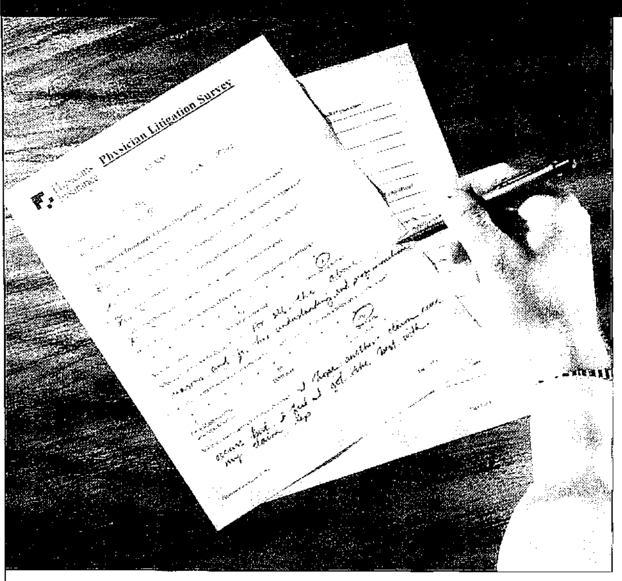

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Pierce County Medical Society

BULLETIN

November, 2000

THE PCMS FOUNDATION

Susan Salo, MD, President of the newly formed PCMS Foundation (right) is presented a check by Nikki Crowley, Treaurer. The money was forwarded to the Foundation from the PCMS Alliance to continue the philanthropic work of the medical society

See story, page 3

INSIDE:

3 The PCMS Foundation: The philanthropic arm of the medical society
5 Pierce County Delegates participate in WSMA Annual Meeting
7 "Endings," by John Last, MD
9 "Trauma," is subject of November General Membership Meeting
11 Support the Great American Smokeout, November 16th
13 "Will the Kings Recent Draft Become a Cold," by David Roskoph, MBA, CFP
15 "Staffing Shortages," by Andrew Statson, MD

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Patrice N. Stevenson, MD.........President Elect
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The Bulletin is published monthly by PCMS Membership Benefits, Inc. for members of the Pierce County Medical Society. Deadlines for submitting articles and placing advertisements in The Bulletin are the 15th of the month preceding publication (i.e. October 15 for the November issue).

The Bulletin is dedicated to the art, science and delivery of medicine and the betterment of the health and medical welfare of the community. The opinions herein are those of the individual contributors and do not necessarily reflect the official position of the Medical Society. Acceptance of advertising in no way constitutes professional approval or endorsement of products or services advertised. The Bulletin and Pierce County Medical Society reserve the right to reject any advertising.

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Pierce County Medical Society
BULLETIN
November, 2000

Table of Contents

3 PCMS Foundation - philanthropic arm of the medical society
3 Entertainment 2001 Books on sale now

4 In-Home Behavioral Healthcare Services

5 Pierce County Delegates participate in WSMA Annual Meeting

7 "Endings," by John Last, MD

9 Trauma Update scheduled for November General Meeting

10 WSMA sets legislative priorities for 2001

11 TPCHD: Environmental Tobacco Smoke

12 Healthy Options moving forward to year 2001

13 "Will the King's recent draft become a cold?" by David Roskoph

15 Invisible Hand: "Staffing Shortages"

17 Physician Good Samaritan Law

18 Medical Malpractice Statute of Limitations

19 College of Medical Education

21 AMA Organized Medical Staff Section 2000 Meeting

22 It's Time to Vote

23 Classified Advertising

Special Feature

PCMS Foundation - philanthropic arm of the medical society

The PCMS Board of Trustees voted at their April, 2000 meeting to form a charitable foundation administered by PCMS. Prompting the decision was the disbanding of the Alliance and the loss of the philanthropic work they accomplished. The Alliance contributed over $20,000 each year to charitable organizations in Pierce County. The Board of Trustees wanted to ensure this work would continue.

At their May, 2000 meeting the Board named **Drs. Susan Salo and Lawrence A. Larson**, former Alliance members Nikki Crowley and Mona Baghdadi and staff member Sue Asher as first directors of the corporation. Dr. Salo will serve as President, Dr. Larson as Vice President, Sue Asher, Secretary, Nikki Crowley, Treasurer and Mona Baghdadi, Director. The terms of office are one year or until successors are named.

The Foundation's first project will be continuation of the Holiday Sharing Card. A popular and successful fund-raising activity, the Holiday Sharing Card allows every contributor to send holiday wishes to colleagues without having to send one card.

The Foundation Board hopes that members will identify with the Foundation as a means of consolidating and enhancing the philanthropic outreach of the Medical Society as well as directing funds to exactly where the need exists. Candidates for funding will submit an application to the Foundation detailing the organization's purpose and specific needs. To receive consideration, applicants must have proof of 501(c)(3) status. PCMS members may forward requests for donations or request grant applications from the Medical Society office.

Previous grant recipients have included, Trinity Neighborhood Clinic, YWCA Women's Health Programs, Pierce County AIDS Foundation, American Lung Association of Washington Asthma Camp, PLU Wellness Center, Family Renewal Shelter, Camp Fire Boys and Girls, and University Place School District for Baby Think it Over dolls. Additional organizations have received funding in previous years. Recipients must complete an application and submit appropriate documentation to be considered by the board as a grant recipient.

The PCMS Board of Trustees and the Foundation Board of Directors will explore various avenues of fund raising. PCMS members will be encouraged to donate to the 501(c)(3) Foundation via dues statements or when a specific request is made or at any time a member wants to contribute. Donations are welcome any time.

Additional fund raising activities will be considered. Entertainment 2001 Books are being sold and raffle sales at the December Annual Meeting will bring in additional income.

If you have suggestions about raising funds or know an organization that would like to receive funding from the PCMS Foundation, please call Sue at the Society office, 572-3667. ∎

Entertainment Books Available

The PCMS Foundation is selling Entertainment 2001 Books. The books offer an array of discount coupons and book sales will raise funds for the PCMS Foundation to sponsor charitable organizations in Pierce County (see adjacent article).

Entertainment coupon books contain hundres of 50%-off and two-for-one discount offers on fine dining, family dining, fast food, movies, sporting events, activities, special attractions and hotels.

The South Puget Sound/Peninsula edition includes over 650 bargains and offers for, among others Altezzo Ristorante, E.R. Rogers, Old House Cafe, Tacoma Bar & Grill, Tides Tavern and many, many more.

Books cost $35 with a portion of each book sold supporting the Foundation. They make great holiday gifts, particularly for staff members or people that are difficult to buy gifts for.

To order your book call the Medical Society office, 572-3709. We will be happy to deliver them to your office. Books will also be on sale at the PCMS Annual Meeting, Tuesday, December 12th at the Sheraton/ Tacoma Hotel. ∎

In-Home Behavioral Healthcare Services

Good Samaritan In-Home Services has a program to provide psychiatric services in the home under the direction of a primary care physician and/or psychiatrist to patients whose mental and/or physical illness makes it difficult to receive outpatient mental health services.

The benefits of such a program are many and varied: it is known to be a cost-effective adjunct to medical/surgical patients with stress related illness and/or depression secondary to their diagnosis; it can prevent unnecessary hospitalization and/or re-hospitalization of homebound patients with serious and persistent mental illness; it provides patients with mental healthcare services in the least restrictive environment; it can provide support, education and assistance to the family or caregiver; it enables patients to stay within the setting of their choice; it assists patients in being involved in their care and taking responsibility for treatment; and, it enhances multi-disciplinary services coordination.

The services are for anyone suffering from a form of mental illness-from depression and anxiety following medical events such as stroke to chronic illnesses such as schizophrenia and bipolar affective disorder as well as dementias with behavioral disturbances. Any patient who is homebound because of a mental health or behavioral problem or who suffers from a physical disability or medical problem is eligible.

The primary care physician or psychiatrist provides authorization for the in-home services. Then, based on need, professionally trained staff will or may include psychiatric registered nurses, physical and occupational therapists, social workers, speech pathologists and home health aides.

The program works primarily with patients who meet criteria for Medicare Home Health and Hospice, private insurance and managed care contracts.

To make a referral, simply call Good Samaritan Home Health 253-841-5668. Referrals can be made from doctors, hospitals, other home health disciplines, mental health centers and other community service agencies.

If you have questions or want more information, call Good Samaritan In-Home Services at 253-841-5668 or Good Samaritan Older Adult Services at 253-848-5571. ■

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Pierce County Delegates participate in WSMA Annual Meeting

Pierce County was well represented at the WSMA Annual Meeting in Wenatchee. Participating in this year's decision making process for the state association were **Drs. Charles Weatherby, Patrice Stevenson, Lawrence A. Larson, Susan Salo, Sabrina Benjamin,** and **Doris Page. Drs. Sumner Schoenike, Ron Morris, Steve Konicek,** and **George Tanbara** also served as delegates. **Dr. Richard Hawkins** presided as Speaker of the House, **David Law, MD** represents Pierce County on the WSMA Board and **Leonard Alenick, MD** serves as a Delegate to the AMA. **Dr. Don Russell** is the 9th District WAMPAC representative.

These are not particularly happy times in the house of medicine and the current health care environment is rife with frustration. While there was not unity on any specific strategy for a solution, there were some common grounds where physicians did come to agreement.

The House did vote to not support Initiative 245, the single payer initiative that is now an Initiative to the 2001 legislature. While they voted to not support I-245, they also voted to not support the opposition of the campaign. The House defeated both requests for support.

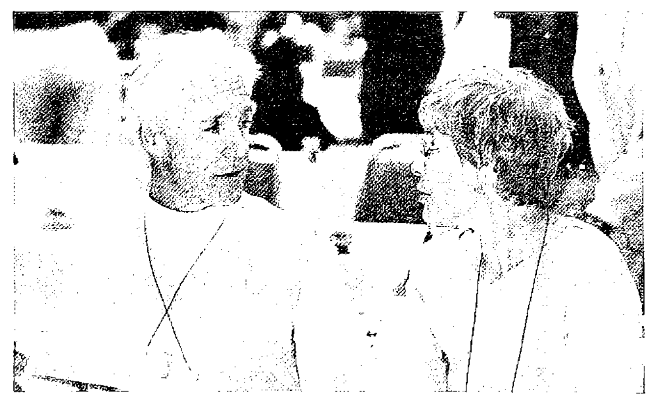
They redirected their energies to Executive Committee Report N - Restoring Health to Health Care. This report directs the WSMA to promote a policy agenda that supports

- Building on the patient-physician relationship as the focus of the healthcare system
- Empowering the patient with real freedom of choice
- Acknowledgment of the responsibilities and accountabilities for the various stakeholders in the health care system and to define the overriding concept controlling allocation of resources
- Achievement of real administrative simplification in health insurance
- Working with payers, where possible, to solve the problems in the health care system, particularly reducing variation in the administrative requirements between health plans
- Adequate funding for public and private health care programs
- Revisiting the definition of health insurance
- Use of information technology to promote efficiencies in the delivery of care and the administration of the health care system
- Tort law reform
- A limited role for government in promoting viable insurance markets and equalized tax incentives for health insurance

Continued on page 6

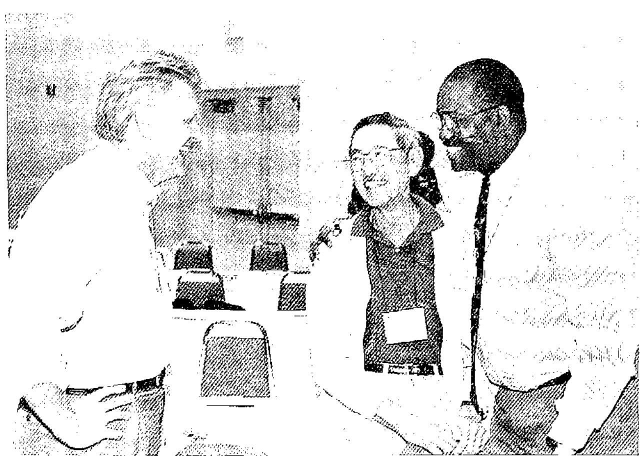
Trustees/delegates Drs. Doris Page (left) and Sabrina Benjamin enjoyed studying House of Delegate issues

Drs. Don Russell (left) and Nick Rajacich take advantage of free time to visit. Dr. Russell is a Puyallup pediatrician, Dr. Rajacich a Tacoma pediatric/adult orthopedist



Drs. Sumner Schoenike and Susan Salo decide on an issue. Dr. Schoenike is a Lakewood pediatrician, Dr. Salo is a family practitioner with Group Health in Tacoma

WSMA Annual Meeting highlights and photos



From left, Immediate Past-President Larry Larson, enjoys a good joke with Drs. George Tanbara (President, 1981) and current President Charles Weatherby

The Pierce County delegation applauds House accomplishments. From left Drs. George Tanbara, Leonard Alenick and Ron Morris. Drs. Sumner Schoenike and Susan Salo are seated in front

Dr. Richard Hawkins, MultiCare family practitioner, serves as Speaker of the House. He is known as a superb parliamentarian

Dr. Leonard Alenick, Lakewood ophthalmologist, addressed Reference Committee D on the new proposed structure of AMA

The WSMA was also directed to form a task force to develop a financing reform proposal for submission to "Congress, the State Legislature or the people of Washington" once it is ratified by a future House of Delegates.

Other organizational priorities included

• Educating the public, business community, policy makers and health plans on the deteriorating medical practice environment and the degree to which it makes it impossible for physicians to practice medicine Working with patients, Physicians Insurance, the state hospital association, medical groups and practices to conduct this campaign

• Identifying and publicizing examples of administrative duplication and waste that affect the patient/ physician relationship and add costs to the transactions so that these burdens are removed

• Seeking reduction in health plan administrative requirements that will also reduce waste and duplication

• Advocating for adequate funding of state and federal health care programs.

• Reporting back to the 2001 annual meeting on the progress of its reform proposal.

For more Annual Meeting details go to: www.wsma.org. ∎

Special Feature

by John Last, MD, FRACP, FRCPC

Endings

An old friend is dying, the fifth this year. Soon there will be more. My wife and I, most of our friends, our siblings, are in the decades when the ranks thin out. We are getting used to the notion, and though not morbidly preoccupied, putting our affairs in order, shedding surplus possessions, handing on others to our children.

I've discussed with some the fate they knew was in store. They had rejected heroic treatments, seemed well adjusted, as I hope I will be when my notice arrives. Some used the time left to realise a cherished wish: visit family and friends on the other side of the world, travel to exciting places, see the Grand Canyon, New England in the Fall. Better that than fruitless surgery, shrivelling radiation, nauseating chemotherapy. Better than glumly, fearfully awaiting the Reaper.

When the newspapers report someone's death, they often say, "After a long battle with cancer." Why a battle? Many cancers are eminently treatable, even curable, but sometimes the condition can take hold and advance relentlessly. There is no "best" way to die, but I hope for cancer as my terminal illness. It is better than brain failure that banishes you to the land of the partly dead; or an affliction of the nervous system that paralyses limbs, causes you to wet and soil the bed. Better than choking with lungs gone bad after a lifetime of smoking. Above all, better than instant extinction in a plane crash or a massive heart attack or stroke, leaving an untidy mess of unfinished business for grieving families to clear away as best they can, and no farewells among loved ones. That's a selfish way to die. Such sudden exits can leave the bereaved feeling angry and cheated, with emotional scars that are slow to heal. I don't want that to happen to those I love. Incurable cancer allows time to prepare for departure, and the unpleasant parts can mostly be dealt with effectively nowadays.

We have gone backwards in dealing with dying. There was once a mixture of cocaine and heroin, sometimes laced with morphia, for patients with the painful cough of incurable cancer that involved the lungs, or advanced tuberculosis – the Brompton cocktail. You can't get it in this continent of wowsers. That's too bad, because heroin relieved the pain as well as the cough, and that cocktail left the mind unclouded while allowing, perhaps everso slightly hastening, a peaceful end of life.

Our culture botches the inescapable truth that all of us die. Our forebears were more matter-of-fact. They knew and saw death more often in their larger families and far more often felt the pain of having their children cut down before their carefree childhoods had ended. Death more often took young adults too, in the bright blossom of their lives. Death still takes young men and many others, innocent bystanders as well as fighters in the vicious wars that lacerate our quarrelsome species.

Postponing death has been a growth industry throughout my professional life. Fifty years ago when I first began to see people die, we didn't have the fancy technology of life support systems that decorate a modern intensive care unit, and what we had we used sparingly. Not, I fancy, because it cost a lot (it didn't in those days) but because we were creatures of older traditions and more wholesome customs. We didn't fight vainly against the inevitable.

Some of those deaths were horrible. When I was a medical student I looked after a lad exactly my age. His kidneys had shut down and metabolic waste products soon would stupefy and kill him. But for a day or so his mind was razor-sharp. We withheld unpleasant truths from patients in the 1940s but he had found out he was doomed, and shouted in rage and terror at being robbed of a life that until then had been an exultant and unalloyed delight.

Before dialysis the death of a youngster from kidney failure may have been the hardest to watch helplessly from the sidelines. That fate befell an occasional pregnant woman. Terminating the pregnancy might save her. When abortion was unthinkable as well as illegal except in such dire circumstances, deciding whether or when to intervene to save the mother's life was probably our toughest ethical problem.

A mother's death in pregnancy or childbirth has always been a dreadful tragedy. It still is, for half a million women every year in the developing countries. I think of Mary Wolfstonecraft as the archetype of countless victims through the ages. Her last three notes to her lover and husband William Godwin were lively, cheerful, a few hours before she gave birth to her daughter who would become Mary Shelley, and didn't know what lay ahead. I get tears in my eyes when I read those final letters.

Now, in the rich and peaceful parts of the world anyway, most deaths occur around or after, often long after, our allotted three score years and ten. We have taken postponing of the inevitable to extremes that can be a tragic perversion of what the healing professions, medicine and nursing, ought to be about. Death is put off for many by

See "Endings," page 8

Endings

from page 7

mere weeks. Half or more of all lifetime personal medical expenses can occur in that brief period. It's called expenditure on "health care" but it's sick care, money that we invest in care of the terminally ill. I'm not suggesting the money would be better spent on other things, but it ought to be spent with compassion and common sense. I don't think it's compassionate to prolong the dying process by poking tubes into every bodily orifice, making extra holes that nature didn't provide, to pour fluids into veins and arteries, to force air into lungs that only want to rest after eight, nine or ten decades of breathing every few seconds. It isn't compassionate when loving ones can't talk to each other in those final days because the paraphernalia of life support systems makes speech impossible. Above all it isn't compassionate when the drawn out process is painful, as it often is despite liberal use of pain-suppressing drugs. If the drugs deaden the pain they usually deaden consciousness too, so what's the point? I have a "living will," with explicit instructions that no one shall do these futile things to me.

Are these so-called heroic measures a sacrifice on the altar of the medical profession's vanity? Is it vanity, or stubborn refusal to admit defeat, which leads physicians to deploy such weaponry to prolong the process of dying? Some members of the medical profession can't admit that the forces of nature are more powerful than they are. We doctors are an arrogant lot, always so sure we know what's best, yet often wrong. My epigraph is from John Donne's sonnet to proud Death, but it is the doctors, not death, who are full of pride nowadays.

Perhaps our culture, not the doctors, should be blamed. The loving ones want to cling to the last spark of life in the dying, don't want to hear if told that it is kinder not to prolong the suffering. The sorrow of bereavement is a universal human quality that we see often on television screens in pictures from war zones, a sorrow we all experience when those we cherish are taken from us, a sorrow we prefer to delay. It is one of the core values of our culture to believe that every life is precious to its very end, and so we delay that end as long as we can.

Are these culturally driven values and beliefs immutable? Some values have changed in my lifetime, perhaps in response to changes in family structure and function. When I was a boy, my family, like most, was large and close-knit. We made our own entertainment by opening our homes and hearts to each other; we supported one another in hardship or crises; we took care of our own frail elderly who mostly died at home in the bosom of the family. Divorce was rare and carried a stigma, single mothers were not welcome in respectable society. Now single motherhood by choice, divorce and remarriage, serial monogamy – and depositing elderly relatives in retirement homes -- are everyday events, socially acceptable.

As the baby boomers reach their seventies, eighties, and beyond, in a society of fragmented families, many of them will lack frequent contact with, or even easy access to close kin. Instead of the networks that once united families in mutual support and affection and occupied much of their leisure time, they may have only television for company. Perhaps they will not have the social safety nets we have, and they may have few resources of their own after a lifetime of precarious employment without pension plans. Will they have the same values we have? Will isolated indigent old people receive food and shelter at public expense? Or will values change with these new realities? The baby boomers as they grow old, and the generation who come after them, will have to confront and respond to these questions. They may be less inclined than we are now to postpone death, to invest so much effort and money in the infirm elderly. More readily than we, they might entertain the notions of assisted suicide and euthanasia. A timely death can be cause for rejoicing. A good wake is a celebration of a life well lived, a time for the living to give thanks for all that the dead one did with the life that has ended.

My father lived a long and active life, enjoyed it with gusto until his mid-eighties when things began to fall apart. His intellect was intact to the end but he lost his sight and balance, his supple joints and strong muscles, control of his bladder and bowel. He didn't lose his sense of humour though, and recovered a long-forgotten ability to curse coloufully at his infirmities. He died in a foreign land where he had come to rest a few years before, with no family close by, and funeral rites of a religion he had scorned - he was a sincere and blasphemous atheist.

It was a bitter cold day for a funeral, the first day of a new year with snow to within a few hundred meters of sea level on Sicily across the Mediterranean whence the penetrating north wind blew, and we stood shivering while the priest hurried through the final words of the burial service. There were glitches. Earlier, in the part of the service in the nursing home where he had died, background electronic carol music couldn't be turned off, and the priest's solemn remarks were intoned to the tunes of "Jingle bells" and "Rudolph the red-nosed reindeer," bringing giggles from acquaintances who accompanied me, the solitary family mourner. There was another hitch when time came to place his coffin in the carved stone crypt that is customary in Malta. The attendants were busy in a distant part of the cemetery and left us standing about for twenty minutes or more, shuddering with cold.

See "Endings," page 12

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PCMS homepage

www.pcmswa.org

invites you and your spouse/guest to the

November General Membership Meeting

Tuesday, November 14, 2000
Social Hour: 6:00 pm
Dinner: 6:45 pm
Program: 7:45 pm

Landmark Convention Center
Temple Theatre, Roof Garden
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Tacoma

Adult Trauma Update

Robert Winchell, MD

Director, Adult Trauma Services

The Adult Trauma System has been operational in Pierce County since June. Plan to attend the November meeting to hear about the new system, what is working, and what isn't. And:

- Adult Trauma System - Successes, Failures
- Availability of Surgical Suites
- Impact on Trauma Call Roster
- Hospital Rotation - is it working?
- Funding Outlook

(Registration required by November 10. Return this form to: PCMS, 223 Tacoma Ave S, Tacoma 98402; FAX to 572-2470 or call 572-3667

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WSMA sets priorities for 2001 Legislative Session

With the 2001 Legislative Session coming soon, the WSMA is busy preparing their annual agenda. The agenda is based on organizational priorities and action taken at the annual meeting in September. Priority items include:

- **Adequate funding for public health programs and physician practices**
- **Opposition to other health care groups' perennial attempts to intrude into the scope of practice of physicians**
- **Supporting the Liability Reform Coalition (LRC) agenda and introducing, if necessary, separate tort legislation germane to the medical profession.**
- **Opposing legislatively mandated sharps protections as unnecessary due to WISHA workplace regulations**
- **Aggressively fighting efforts to further fraud and abuse legislation in our state**
- **Preserve funds from Tobacco Settlement for tobacco prevention/control**

The agenda will be adjusted as the legislative session nears. The WSMA expects to review over 2,000 pieces of legislation and will be actively engaged in several hundred bills as part of their work to represent physician interests.

Mark your calendar for the WSMA Legislative Summit in Olympia, on Tuesday, January 23rd. More information to follow. ■

Personal Problems of Physicians Committee

Medical problems, drugs, alcohol, retirement, emotional, or other such difficulties?

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Bill Dean, MD	272-4013
Tom Herron, MD	853-3888
Bill Roes, MD	884-9221
F. Dennis Waldron, MD	265-2584

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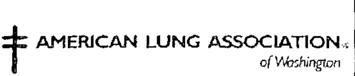

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The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

Environmental Tobacco Smoke

On November 16, 2000, many Pierce County restaurants will ban cigarettes in their facilities for the day. As part of the American Cancer Society's "Great American Smokeout," the Tacoma-Pierce County Health Department staff have invited restaurants to go smoke free for one day, to try the idea out on clientele and employees.

At the heart of the effort to create smoke-free restaurants is the negative health impact of tobacco smoke: both on the smoker and on those who either inhale the secondhand smoke or absorb smoke components, such as a fetus. Data on the health effects of using tobacco have been mounting for years. The latest, from a Danish study published in the Archives of Disease in Childhood, shows that 30-40% of all cases of Sudden Infant Death Syndrome (SIDS) could be avoided if all pregnant women quit smoking during pregnancy. Surveying 25,000 pregnant women on their smoking habits, researchers found that the SIDS risk increased with the number of cigarettes the mother smoked, regardless of other factors such as alcohol and caffeine intake, maternal height and weight, and the number of prenatal care visits.

Environmental Tobacco Smoke (ETS) is a mixture of chemicals given off by burning tobacco and exhaled from the lungs of people smoking. According to the National Cancer Institute, more than 4,000 individual compounds have been found in tobacco smoke. Of these, approximately 60 compounds have been classified as carcinogens, tumor initiators, and tumor promoters. Although ETS is less concentrated than that inhaled by a smoker, research has shown that the health risks from inhaling smoke - even ETS - is significant. Nationally, the National Cancer Institute estimates that 3,000 people die from ETS-induced lung cancer annually. In 1992, the U.S. Environmental Protection Agency categorized ETS as a Group A carcinogen.

The impact of ETS on children is sobering. Since the 1970s, studies have consistently shown that children exposed to ETS at home have significantly elevated rates of respiratory symptoms and infections. For example (from the national Cancer Institute's webpage at **http://cancernet.nci. nih.gov):**

- Each year, 150,000 - 300,000 U.S. children under the age of 18 months, who are exposed to ETS (mostly from their parents) experience lower respiratory tract infections (pneumonia and bronchitis); 7,500 -15,000 of these cases require hospitalization.

- The EPA estimates that ETS worsens the condition of 200,000 to one million asthmatic children each year. And ETS increases the number of new cases of asthma in children.

- ETS exposure *in utero* can affect lung function and structure to predispose children to long-term pulmonary risks.

What are some things you can do as a physician to change statistics on ETS?

- Talk with your patients about their smoking habits and encourage them to quit, especially during pregnancy. The Health Department offers an easy-to-learn and use process for asking people about smoking and encouraging them to stop. For more information on the 4-A Model, contact Nancy McKindsey at 253-798-6461.

- Use symptoms such as asthma or bronchial infections in children to discuss the affects of ETS and, again, encourage parents or grandparents to stop smoking.

- Encourage patients and employees to take their families out to dinner in a restaurant where smoking has been banned. For a list of restaurants, see the Health Department's webpage:

http://www.healthdept.co.pierce.wa.us/smokeout.htm

Endings from page 8

No wake then, but a splendid one a few months later on a sunny day in Los Angeles among the circle of friends who had worked with him in the Department of Anatomy at the University of California for two decades after he retired from the Royal College of Surgeons in London. Throughout it all, from that cold New Year's Day in Malta to the eucalyptus-perfumed comfort of the UCLA campus, there was relief that my father's travail had ended, and rejoicing at what he had done with his long and interesting life. Some day I hope my life will be as cheerfully recalled and celebrated. ■

John Last, MD, is on the Faculty of Medicine, University of Ottawa, Ottawa, Canada, KIH 8M5

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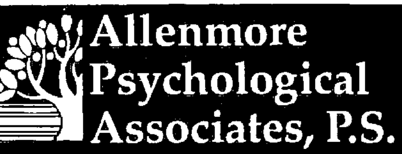

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Healthy Options moving forward to year 2001

Several major health plans, particularly in Pierce County, will uproot about 135,000 Medicaid patients statewide (22,000 in Pierce County) from their existing relationships with medical practices, beginning January 1, 2001, at which time many of them will cease participation in the Healthy Options medicaid program. The Medical Assistance Administration (MAA) is proceeding with administration of contracts for Healthy Options patients for 2001 in spite of the major shake-up.

MAA is currently assessing the adequacy of the practitioner networks that each participating plan must have to fulfill the contractural arrangements. Medical practices may wish to prepare for the change by:

(1) Determining if the health plan(s) you currently contract with have been selected for your county in 2001. If they have not and you wish to continue in the HO program, contact the health plan(s) that are listed and open negotiations to contract with them. (Primary care physicians with a population of HO patients are usually in a strong negotiating position.

(2) Tell your patients - Physicians are "invited" by MAA to "pro-actively notify" their patients as to which health plans their practice will be participating in next year (to download a sample letter, approved by MMM, go to www.wsma.org/newsevents/101300.rft.

MAA will be sending material to Medicaid clients advertising the various health plans, which could lure your patients away to other plans with which you have no contract. MAA claims they want to preserve the patient/physician relationship where possible. Please note that any communications with your patients should be objective in tone and content, should not disparage any plans, and should avoid making inflated claims.

In addition, if you will be participating in Healthy Options in 2001 but are changing health plan affiliations, your patients must call MAA, 1-800-562-3022 to request a change in health plan assignment in order to remain your patient.

If you will not be participating in Healthy Options in 2001, your patient must call MAA's Exemption/Disenrollment line 1-800-794-4360 and request a temporary disenrollment for the duration of her pregnancy and two months postpartum. By doing this, the patient can continue with you, and your services will be reimbursed as Medicaid fee-for-service.

For a listing of participating plans for 2001, you may access the MAA web page https://ww2.wa.gov/dshs/maa/HealthyOptions/index.html or call PCMS, 572-3667. ■

In My Opinion.....

by David Roskoph, MBA, CFP

Will the King's recent draft become a cold?

David Roskoph, MBA, CFP

Since this "New Era" began I have been asking you not to dispense with all those old, tried-and-true, rules that have established financial markets for the past century. New Eras have been heralded before with their attendant market exuberance as that change was assimilated into the economy. The economy was not reinvented or fundamentally altered with these innovations but rather, it assimilated them. So too will the economy adapt to the internet. The internet will change the way business is done and over the next few months the ambiguity of that change will gradually disappear. What seems clear is that some things will remain forever changed, such as product and information distribution. Unclear however, is the degree to which the new technologies will alter existing consumer patters. Equity prices are often credited with the omniscience to represent the future until it becomes the present. The market has bought into a lot of future profit through technology. Popular stock indexes like the Standard & Poors 500 have been greatly affected by the most recent New Economy. Due to the violent shift toward technology within the S&P 500, it is likely to disappoint investors as the euphoria of what could be is distilled down to tangible corporate profits.

A distinction must be drawn between, the internet as a source of retail commerce and, the internet as a source of information. As a source of commerce, the internet was built too quickly to ensure profits. There was little time for a protracted and calculated evolution because the rush to be first-to-market obscured the bottom line of profitability. In a historical instant, consumers were freed from centuries of middlemen and costly intermediaries; catapulted past decades of thumbing through catalogues or shuttling between malls. Freed from the encumbrance of such friction buyers plunged, wallet first, into a sea of cheap buying opportunities. We all love a bargain and after all, the internet built itself as the ultimate price leader. Consumer confidence remains lofty as American consumers consume themselves into a collective deficit. The problem for internet commerce is unlimited competition for virtually the same goods = no pricing power. In addition, the cost of entering the competitive fray is minimal; thus the perpetual price war is ensured longevity. With no time to evolve a sound profit strategy, internet distribution of products, was doomed from its inception. As explored in the last article (*The New Economy Math Just Doesn't Add Up, Aug. 2000*), dot.com retail profit margins alone cannot support the cost of maintaining present customers let alone acquiring new ones in light of the apparent lack of conventional loyalty. As Amazon is proving-if the biggest and the best can't make it, what is supposed to happen to the rest?

As the new versus the old cataclysm rages, even the venerable S&P 500 Index is brought into the fray. Over the last decade the S&P 500 has gained great fame as an investment vehicle because it has outperformed most mutual funds with the same objective and risk parameters. The S&P 500 is capitalization weighted and considered passive because companies are rotated in or out dependent upon their capitalization, i.e. the performance of their stock. Alternatively, an actively managed fund is directed by the manager's theory of the future performance of a collection of stocks, not tied to market capitalization. Tremendous amounts of money have flowed into S&P 500 Index funds because of their stellar and steady performance, 28.69% (before costs) average annual return from 1995-1999. The S&P 500 has ten components or sectors such as utilities, financials and technology. Not long ago, technology represented only 3% of the S&P 500 Index; today technology represents approximately 33%! This happened because over the last two years, investors could not put enough money into New Economy companies like Yahoo, Palm and Qualcom. As money poured in their stock, their capitalization rose and they were invited into the S&P 500 family. Each of these companies is trading at stratospheric earnings multiples well into the hundreds, based upon very questionable growth projections. The inflows of capital into these companies and the resultant 1000% increase in the technology component of the S&P 500 has clearly gotten out of control. Already each has

See "King" page 14

King

from page 13

lost between 65-75% of its highest market value. As the profit potential of the New Era settles in, the S&P 500 is likely to be overweighted in technology to the detriment of overall performance. Investors may be disappointed with the returns of the S&P 500 versus many actively managed funds over the next five years because the popular rush to technology stocks has corrupted the indexing process itself.

Presently, the public considers the internet the rebirth of capitalism. In fact, the prospects of selling information over the internet for a profit are real, however, we are not yet that dependent upon information alone. Each time major innovation occurs, everyone forgets the experiences of the past while they are mesmerized by the seemingly endless possibilities that the new technology portends. It seems that each generation must experience this phenomena for themselves and turn a deaf ear to history. Unfortunately the dead can't communicate with the deaf. ■

David Roskoph, MBA, CFP is a fee-based investment advisor in Gig Harbor.

Do you have patients in your practice with asthma?

The Clean Air for Kids Program provides trained volunteers who can assist families and medical providers with

- a comprehensive home assessment to help identify environmental triggers of asthma
- practical recommendations to reduce asthma triggers and improve home air quality
- a written report of the assessment and recommendations to the medical provider

Volunteers do not give medical advice, and would welcome referrals from medical providers. The service is free. To make a referral, or to get more information about the program, contact Sarah Curran at (253) 798-2954.

Clean Air for Kids is a partnership of the American Lung Association of Washington, Tacoma Public Schools, University of Washington, Puyallup Tribal Health Authority, Washington State Department of Health, Mary Bridge Children's Health Center, and The Tacoma-Pierce County Health Department which is dedicated to helping people learn more about ways to reduce asthma and health risks from pollutants in their home.

MEDICAL LICENSURE ISSUES

Mr. Rockwell is available to represent physicians and other health care providers with issues of concern before the State Medical Quality Assurance Commission. Mr. Rockwell, appointed by Governor Booth Gardner, served for 8 years as the Public Board Member of the Medical Disciplinary Board from 1985-1993. Since then, Mr. Rockwell has successfully represented over 60 physicians on charges before the MQAC. Mr. Rockwell's fees are competitive and the subject of a confidential attorney-client representation agreement.

Gregory G. Rockwell
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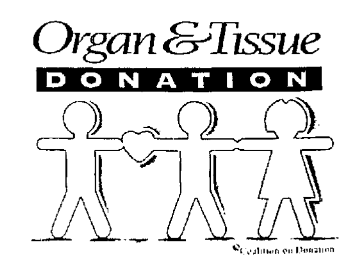

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In My Opinion.... The Invisible Hand

by Andrew Statson, MD

Staffing Shortages

Andrew Statson, MD

"Ask not what your country can do for you.
Ask, instead, what it is doing to you."
With apology to President Kennedy

A recent bulletin from the State Department of Health reported a serious shortage of laboratory technicians. There are about 800 open positions in the clinical laboratories of this state. Many current technicians are asked to work overtime and the work load is such that the likelihood of lab errors is increased. The DOH is going to study the problem and is planning to go to the high schools and entice students into entering this line of work.

The weird feeling here is a flashback to WWII. You can see the recruiting stations, the marching bands, the posters saying "Uncle Sam wants YOU." Of course, an appeal to patriotism was justified then. Our country was threatened and we rose to defend it. Today, the situation is different.

When someone does not want to pay you what your work is worth, he makes it sound like it is your patriotic duty, your social responsibility, your moral obligation to the community, etc., to do the job. You may get a plaque or a medal in recognition of your contribution and you are expected to consider yourself honored for having been called to serve your fellow men. Payment? What payment? Didn't you get a medal?

The laboratories in this country have been on the receiving end of an economic squeeze, together with the rest of us. They have been subjected to significant reductions of payment for their services and to a significant increase in regulations, which have raised their costs. Many small laboratories have been taken over by national chains. They have used large amounts of capital to mechanize and to automate their operations, but there is just so much they have been able to do. The costs are still there and they cannot afford to pay their technicians well enough to keep them. For some unknown reason, the technicians want to be paid better, so they leave and find other jobs in other fields. How socially irresponsible!

The situation with the pharmacies is the same. The small ones have disappeared. The big chains have taken over. They have kept prices lower, at the cost of impersonal service, high work load for their staff and increased opportunity for error.

Several months ago there was a study on the staffing shortages in nursing homes. The conclusion was that there were not enough RNs and LPNs to take care of the patients. Congress was going to mandate that there should be at least a certain number of nurses for a certain number of patients. The nursing homes will be required to meet these quotas. The unanswered question is how will these nurses be paid. The nursing homes will have to get the money from somewhere. Are they going to charge more? Is Medicare going to pay them more? Perhaps the nurses will take a cut in pay and work for less because it is their moral obligation to the community to do so.

The result for the nursing homes will be the same as for the laboratories. There will be a lot of positions open and no nurses to fill them. Care will remain bad and probably will get worse. Some nursing homes may have to turn away patients, or even discharge some of those they already have, if they cannot get the required quota of nurses. At the same time their charges will go up, so that nursing home care will be beyond the reach of most people. The final result will be that someone in the family will have to quit her job and take care of mother and father until they die. That is a type of nursing care Congress probably will not attempt to regulate.

The situation in our hospitals is barely better. The number of nurses per patient is slightly lower than in the past, but not too low. The problem is different. Most RNs are burdened with so much paperwork that they have very little time for patient care. At the same time, the shortened hospital stays have resulted in increased intensity of care.

In the past, as patients got better,

See "Shortages" page 16

Shortages from page 15

they required less and less nursing care. Now they go home early, so they need rather intensive care up to the day of discharge. Yet the nurses still are assigned about the same number of patients. So if two of their patients should develop some problem at the same time, as it happens more and more frequently now, the nurses can only take care of one of them and may not even be aware that another one needs their attention.

The nurses aides are asked to give more and more care, which they are not able to do well, because they are not properly trained. Even worse, they are not able to detect the early warning signs of problems the patients may show before they get very sick. By the time they realize something is happening, a patient may be in serious trouble. The hospital pharmacies are also understaffed, so that on busy nights the patients may have to wait for hours to get their medications.

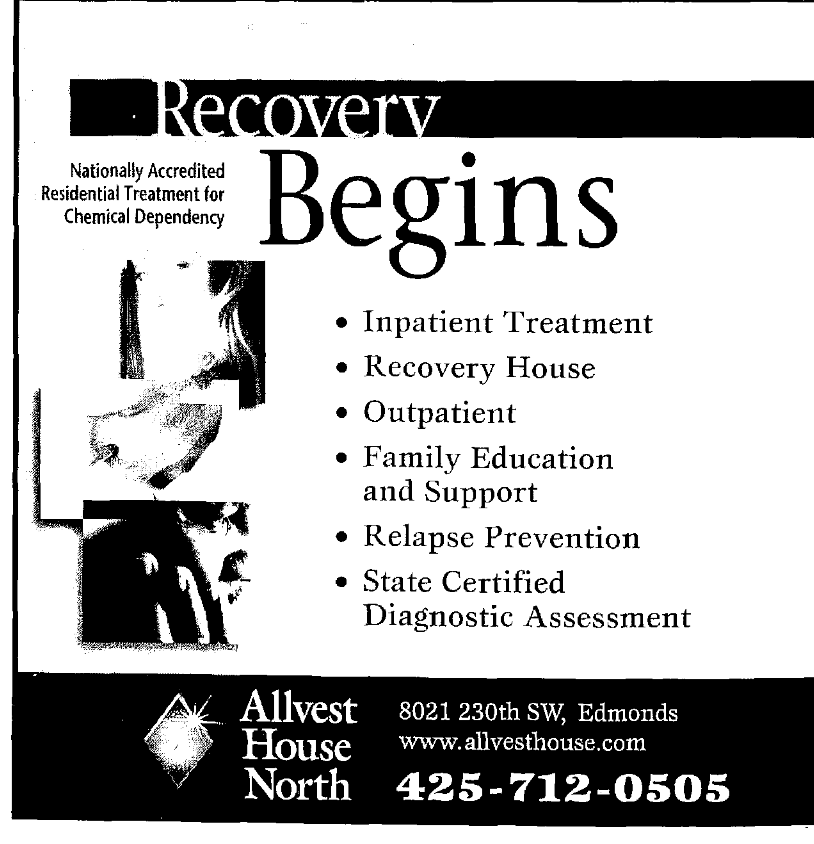
The recent poll of physicians by Merritt, Hawkins and Associates, reported in the PCMS FAX News is another example. Among physicians 50 years old or older, 38% plan to retire within three years and 12% plan to seek jobs in nonmedical settings. Intention does not necessarily translate into action, but that means 50% of the physicians in that age group are deeply dissatisfied with the practice of medicine. Probably most of them love their profession and their work and entered the medical field with great enthusiasm.

To have reached the point of wanting to get out in such massive numbers is a sad reflection on the current condition of our profession. The people who are going to replace them will have neither their experience, nor the incentive to work hard. It will take more new people to replace those that will leave. When the quality of medical care has dropped enough to be noticed by the authorities, it may take a long time to repair the damage. To make someone a physician in name, it takes at least eight years. To make someone a physician at heart, it takes much more than years.

In 1998, Germany enacted strict controls on the budget for health services. One of these controls had to do with prescriptions for drugs. If the general practitioners in a region overspent their budget on medications, they all could be fined up to 15,000 DM (about 7,000 dollars) per practice. The fines were waived for 1998, but in 1999, ten of the 23 German Lander had exceeded their budget for drugs and now the government wants to collect. A health ministry official has said, "If we offer an amnesty again, we might as well give up on the budget."

As a rule, the Germans are a disciplined people, respectful of authority. Yet the association of general practitioners plans to oppose the fines. This is a confrontation in which there can be no winner. The effect on the morale of the physicians and on the quality of medical care the people are going to receive will be such, that neither the physicians nor the country can come out of it without major bruises. No nation can punish its physicians in such a manner and expect that its people will receive good medical care when they get ill.

If they can, some physicians will retire, find other jobs or leave the country. Those that are left will have lost their desire to perform. They will go through the motions all right, but their heart will not be in their work. The health care system will limp along, while for most patients a free market alternative, in Germany, Switzerland, or some other country, will be the only way to get good medical care. When a country spits on its physicians, it will get for physicians the sort of people who don't mind being so treated. The kind of medical care they will give, such a country will fully deserve. You can only get what you pay for, and frequently not even that much. ■



Physician Good Samaritan Law

May a physician be held liable for services voluntarily rendered at the scene of an emergency?

Generally, no. Under the "good samaritan law," a physician who renders emergency care at the scene of an emergency, without compensation or the expectation of compensation, is not subject to civil liability for any act or omission in the rendering of such emergency care, unless the physician's acts or omissions constitute gross negligence or wilful or wanton misconduct.

If, however, the physician renders emergency care in the course of regular employment and receives or expects to receive compensation for such care, the "good samaritan law" does not apply and the physician may be held liable for his or her negligent acts or omissions.

May a physician be held liable for failing to obtain consent to the rendering of emergency medical or surgical or health services?

Generally, no. A physician is not subject to civil liability for failure to obtain consent in rendering medical or surgical services where the patient is unable to give consent for any reason and no other person legally authorized to provide consent is reasonably available, so long as the physician acted in good faith and without knowledge of facts negating consent. ■

From: Washington Physicians' Guide to Health Law

Directory changes

Please make note of the following changes to your 2000 PCMS Directory.

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3418 McKinley Ave E, Tacoma 98404
Phone: 404-0914, FAX 552-2441

Lee, David E., MD
Change address to 1901 South Union, Suite B6007, Tacoma 98405

Moore, Jane, MD
6002 North Westgate Blvd, #160
Tacoma 98406; Phone: 759-9902

Sullivan, Rebecca, MD, CEO
Puyallup Valley Healthcare
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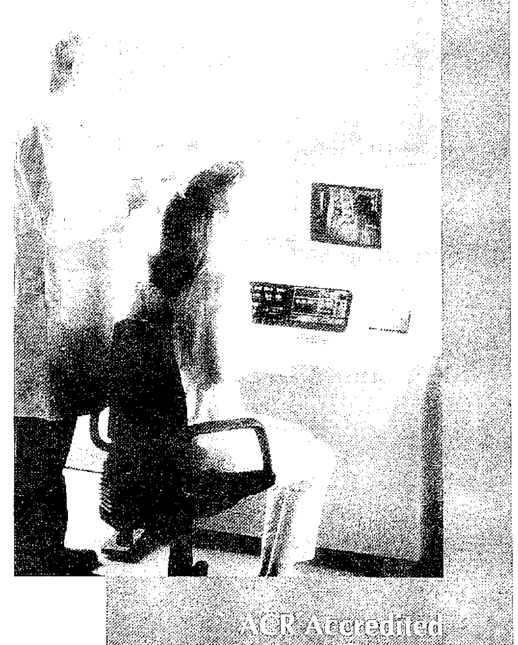


MultiCare Health System | Franciscan Health System | Medical Imaging Northwest | Tacoma Radiology

Medical Malpractice Statute of Limitations

What is a statute of limitation?

It is a time limit beyond which a person may not bring a lawsuit.

What is the medical malpractice statute of limitations in Washington?

A medical malpractice action in Washington must be brought within the later of:

- Three years of the act or omission alleged to have caused the injury or condition
- One year of the time they patient or his representative discovered or reasonably should have discovered that the injury or condition was caused by the action or omission.

A medical malpractice action, however, may not be commenced more tan eight years after the act or omission, unless the patient is a minor or is incompetent.

For purposes of a claim of continuing negligent medical treatment, the statute of limitations begins to run on the date of the last act or omission alleged to have caused the harm.

When is the medical malpractice statute of limitations tolled?

The medical malpractice statute of limitations is tolled (does not run) in the following circumstances:

- Upon proof of fraud
- Upon proof of intentional concealment
- Upon proof of the presence of a foreign body not intended to have a therapeutic or diagnostic purpose or effect
- During the minority of a patient
- During the incompetency of a patient
- For one year following a written, good faith request for mediation before filing a lawsuit.

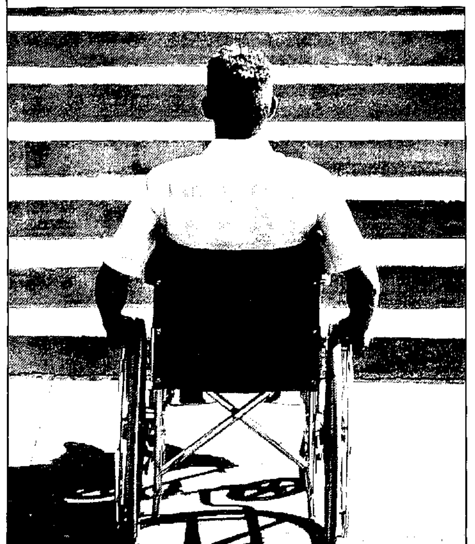
Does the medical malpractice statute of limitations apply to every medical malpractice action against a physician?

No. The medical malpractice statute of limitations does not apply in a civil action based on intentional conduct brought against a physician for recovery of damages for injury as a result of childhood sexual abuse.

It also does not apply to an action for wrongful death against a physician. The patient's personal representative has three years from the date of the patient's death to bring a wrongful death/medical malpractice action.■

From: Washington Physicians' Guide to Health Law

Will a disability put you out of commission?



As you know, disability insurance policies for physicians are changing rapidly—and not for the better. High claims have caused many major carriers to limit the most important benefits.

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COLLEGE OF MEDICAL EDUCATION

ID Conference is set for November 10

Registration remains open for the Infectious Diseases Update CME set for Friday, November 10, 2000. The program will be held at the Sheraton Tacoma Hotel.This year the course is directed by **David McEniry, MD** and will feature presentations on:

- Teeth and Terror: Animal Bites
- Antibiotic Associated Colitis
- Allergy to Antibiotics
- Infectious Diseases Emergencies: When and How to React
- What to do About the Flu
- Advances and Retreats in Infectious Diseases
- Antibiotics 2000: An Update

Call 627-7137 for registration and more information. ■

Condo reservation deadline for Whistler is December 1

Reservations for the College's block of condos in the Aspens at Whistler are available. Call toll free 1-877-408-8899 and identify yourself as part of the College of Medical Education to receive the negotiated reduced rates. ROOMS WILL BE RELEASED AFTER DECEMBER 1, 2000. ■

Continuing Medical Education

Medicine and Mental Health Conference offered December 1

A continuing medical education focusing on the diagnosis and management of mental health complaints faced in the primary care and internal medicine practice is set for Friday, December 1.

The complimentary program, directed by **Drs. David Law** and **Mark Craddock,** offers 6 Category I CME credits. Topics include:

- Diagnosis and Treatment of Chronic Depression
- Optimal Management of Psychosis and Agitation in the Elderly
- Depressive Disorder in Children and Adolescents
- The Many Faces of Addiction
- Update on Insomnia: Diagnosis and Management
- Double Trouble: Anxiety and Depression
- Recent Development in the Diagnosis/Treatment of Alzheimers

The program is scheduled for the Lagerquist Conference Center of St. Joseph Hospital Medical Center. Call 627-7137 for registration information. ■

Dates	Program	Director(s)
Friday, November 10	Infectious Diseases Update	David McEniry, MD
Friday, December 1	Medicine & Mental Health	David Law, MD
Tuesdays, January 9 and 16 (evenings)	Cardiology for Primary Care	Gregg Ostergren, DO
Wednesday-Sunday January 24-28	CME at Whistler	Richard Tobin, MD John Jiganti, MD
Friday, February 9	Advances in Women's Medicine	John Lenihan, Jr., MD
TBA	Pain Management	David Paly, MD
Thursday-Friday March 8-9	Internal Medicine Review 2001	Ulrich Birlenbach, MD
Saturday, April 28	Surgery Update 2001	Glenn Deyo, MD
Friday, May 4	Allergy, Asthma & Pulmonology for Primary Care	Alex Mihali, MD
Tuesdays, May 16 and 23 (evenings)	Medical Technology	TBA

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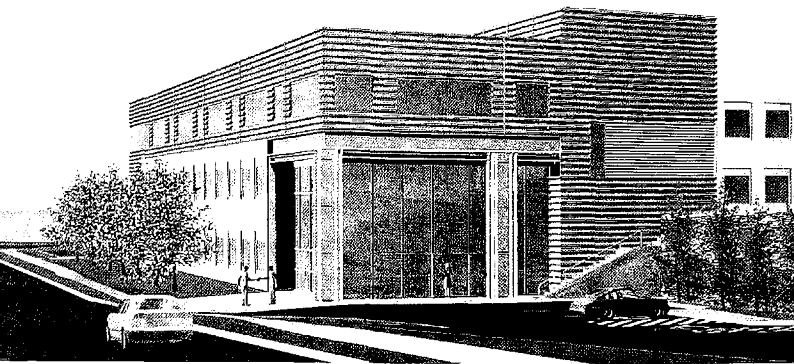

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Your new door to the

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opens this fall.

Save the date. Take the floor. Raise the roof.

For the first time ever, the American Medical Association Organized Medical Staff Section will open its door at the Interim Meeting to all physicians — regardless of practice affiliation or membership status — at a unique "Open House" gathering in Orlando, Florida, November 30 through December 4, 2000.

Your advocate for positive change.

The AMA wants to help you overcome the incredible challenges you face. Reduce onerous regulations and managed care demands. Protect your autonomy and patient relationships. Ensure appropriate reimbursement. Make sure no one treats physicians like commodities.

Your place to speak up.

To help unify the AMA and the nation's front-line physicians, this one-of-a-kind meeting offers you a direct avenue for raising your issues and concerns and proposing solutions.

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The AMA will open the door. It's up to you to step through. And because your participation is so important, there's no fee. Just sign up and attend. For more information, call **800 262-3211**, or visit us online at **www.ama-assn.org/omss**

Register today!

AMA Organized Medical Staff Section (OMSS)
2000 "Open House" Meeting
November 30-December 4, 2000
The Hilton in the Walt Disney World Resort
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American Medical Association
Physicians dedicated to the health of America

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It is time to elect a world leader and your vote counts. Here's the scoop on the three leading candidates:

Candidate A: associates with faith healers and consults with astrologists. He's had two mistresses. He chain smokes and drinks 8 to 10 martinis a day.

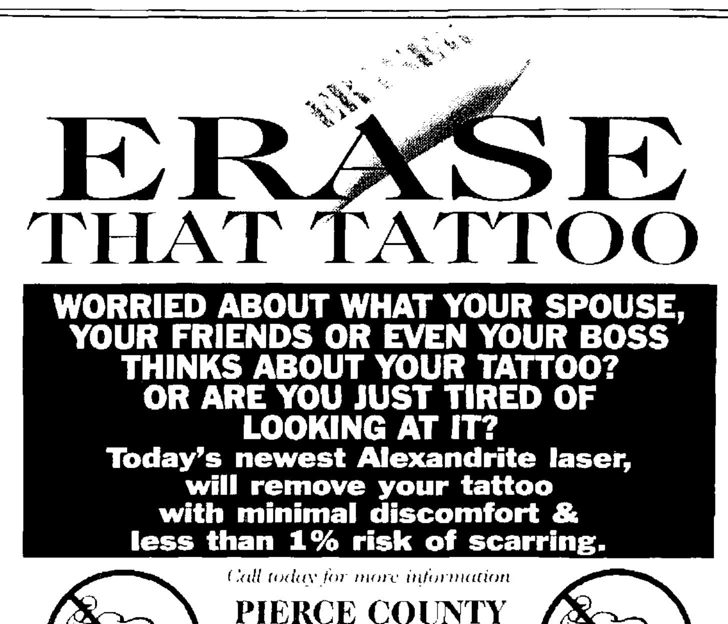
Candidate B: was kicked out of office twice, sleeps until noon, used opium in college, and drinks a quart of brandy every evening.

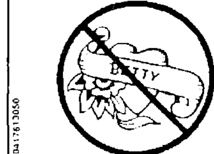
Candidate C: is a decorated war hero. He's a vegetarian, doesn't smoke, drinks an occasional beer and hasn't had any illicit affairs.

Which of these candidates is your choice?

Who are the candidates?

Candidate A is Franklin D. Roosevelt; B is Winston Churchill and C is Adolph Hitler





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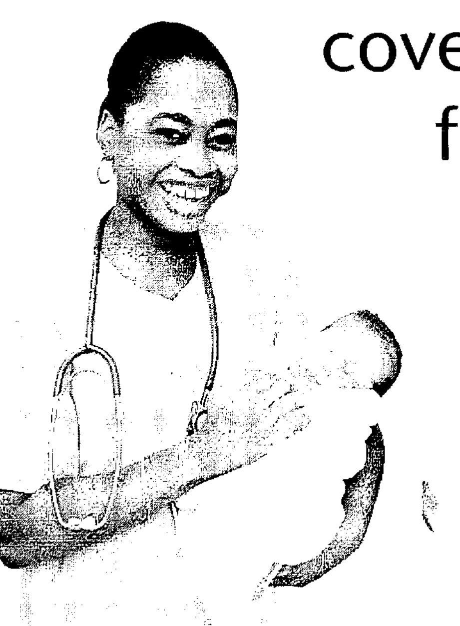

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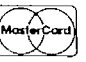

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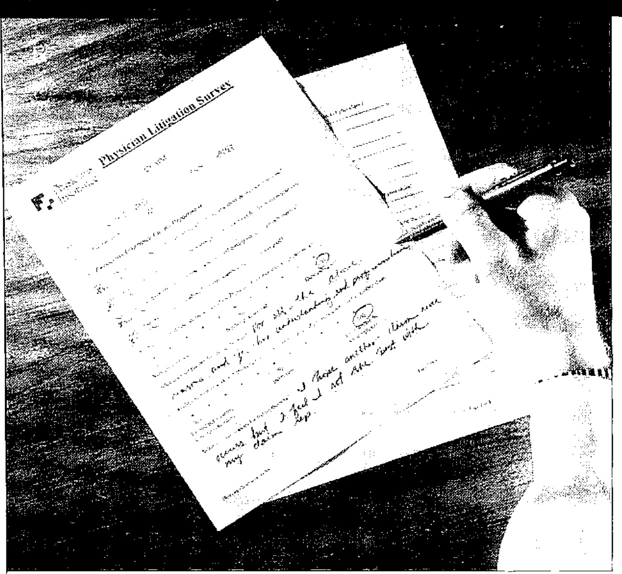

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Pierce County Medical Society

BULLETIN

December, 2000

INSIDE:

3 President's Page: "Reflections"
4 Medicaid Reminder: Monitor Healthy Options Plan Affiliations
5 PCMS Annual Meeting will feature Allen A.M.E. Gospel Choir
7 Be Aware of New "Managed Care" Developments
9 Clean Air For Kids: A Partnership to Fight the Crisis of Asthma
11 The Emergence of Antimicrobial Resistance
13 "Purchasing Power," by Andrew Statson, MD

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The Bulletin is published monthly by PCMS Membership Benefits, Inc. for members of the Pierce County Medical Society. Deadlines for submitting articles and placing advertisements in The Bulletin are the 15th of the month preceding publication (i.e. October 15 for the November issue).

The Bulletin is dedicated to the art, science and delivery of medicine and the betterment of the health and medical welfare of the community. The opinions herein are those of the individual contributors and do not necessarily reflect the official position of the Medical Society. Acceptance of advertising in no way constitutes professional approval or endorsement of products or services advertised. The Bulletin and Pierce County Medical Society reserve the right to reject any advertising.

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Pierce County Medical Society
BULLETIN

December, 2000

Table of Contents

3 President's Page: "Reflections"

4 Medicaid Reminder: Monitor Healthy Options Affiliations
New Drunken Driving Standard
More Doctors Advising Patients to Quit Smoking

5 PCMS Annual Meeting: Fun and Entertaining

6 WSMA Legislative Priorities for 2001

7 Be Aware of new "Managed Care" Developments

8 Fees for Duplicating and Searching Medical Records

9 Clean Air For Kids: Partnership fights Asthma

10 PCMS New Members
10 Directory Changes

11 TPCHD: Antimicrobial Resistance

13 The Invisible Hand: "Purchasing Power"

15 College of Medical Education

16 Antibiotic Prescribing for Children is on the Decline

19 Classified Advertising

President's Page

by Charles Weatherby, M.D.

Reflections

Charles Weatherby, MD
PCMS President

As my Presidency comes to an end, I would like to reflect on some of the things that have transpired. A trauma system has returned to Pierce County. Several of my predecessors were deeply involved in negotiations with getting the trauma system reestablished. I'm the fortunate one to have seen the system come to fruition during my term of office. I would like to thank all of those responsible. As with any new system, there will be some kinks and growing pains. There are probably still some who oppose the system. Let us all support Dr. Winchell and his trauma team. Hopefully, next year we will be celebrating a successful first anniversary.

While medical societies in general are demonstrating decreasing numbers of members, our Pierce County Medical Society has maintained its membership numbers. I would like to thank you for renewing your membership and continuing to support organized medicine, at least at the county and state levels. Also, at one of our recent general membership meetings, we had one of the largest crowds in some time. I would like to also thank you for attending.

PCMS remains concerned about issues extremely important to patient care and viability of medical practices. While trying to prepare ourselves for the future, we met some of the major "players" in the area. These included the top executives of Good Samaritan, Puget Sound, The Franciscans, and Multicare. We were given some of their goals and plans for the millennium.

The mergers of the various insurance plans are creating concerns for many of us. Our own Regence Blue Shield is one such plan. It is because of this concern that members of your Board of Trustees met with Regence representatives several times. Most recently, we met with the new physician liaison representative, Dr. Larry Donahue. He is the "physician ombudsman." He seems to be very willing to listen to our concerns and assist us. However, he also informed us that he will be retiring shortly.

At the state level, WSMA is continuing to support legislation that improves access to care and remains concerned about physician reimbursement and medical practice viability. In prioritizing legislation for the upcoming session next year, the list includes: adequate funding for public health programs and physician practices, opposition to other health care group's intrusion into the scope of physician practices, and preserving funding from the tobacco settlement for tobacco prevention and control.

A recent survey indicated that funding for state health programs, i.e. Healthy Options and Basic Health, remains inadequate to meet the programs' demand. Medicaid payments for health services remain at one-half of the private insurance carriers. Medicare payments in Washington state rank 45th nationally. Meanwhile, as premiums for commercial health insurance continue to climb, payment to those who actually provide the services continues to fall. These are some of the issues that require our support of organized medicine.

Your Pierce County Medical Society support staff led by Doug Jackman, has kept Pierce County at the forefront of organized medicine, especially at the state level. At the time of the printing of this Bulletin, our executive director, Doug Jackman will be just several weeks from a well deserved retirement. I am very honored to have been the last president to have served with Mr. Jackman. On behalf of the PCMS, I would like to wish Doug and his lovely wife, Connie, a glorious and wonderful retirement. May God continue to bless them and their family. When you see them at the Annual Meeting just give them an extra hug. Also, at the time of this Bulletin, your PCMS Search Committee, chaired by President-elect, **Patrice Stevenson,** will have selected a new executive director. Let us all warmly welcome the new director to the PCMS. So, I'll conclude by saying thank you to all of you for your support of me.

Happy Holidays. Merry Christmas. Happy Hanukkah. Happy Kwanzaa.

Doug, we're all going to miss you.

--CMW

New national drunken driving standard set

President Clinton signed legislation last month setting the national blood-alcohol level -- the standard for drunken driving -- at .08. This step is consistent with AMA policy, which calls for an even lower national BAC level.

At 0.08% BAC, a 170-pound man could consume four drinks in one hour before reaching the limit, while a 137-pound woman could have three drinks. Currently, 31 states set the drunken driving limit at .10. The remaining 19 states and the District of Columbia, already have the 0.08% BAC on the books. Based on the new law, the 31 states without the .08 laws will lose a significant amount of federal highway funds if they fail to implement the new standard by 2003. Supporters of the new standard say it will save an estimated 500 lives a year and prevent thousands of injuries.

Washington State's drunk driving limit is .08%. ■

Reprinted from AMNews, 11/20/00

More doctors advising patients to quit smoking

Doctors may be doing better when it comes to advising their patients to quit smoking, according to data published in the September 8 Centers for Disease Control and Prevention MMWR Weekly Report.

The HCFA and the CDC examined information gathered from the 1998 Health Outcomes Survey in order to characterize smoking and the frequency of doctors' cessation advice to Medicare managed care patients. About 13% of enrollees reported that they were current smokers. Among those who visited a physician in the past year, approximately 71% reported receiving smoking cessation advice. This figure represents a significant increase over statistics from the early 1990s. Overall, the advice to quit increased with the number of doctors' visits. ■

Reprinted from AMNews, 11/20/00

Medicaid Reminder: Monitor Healthy Options Plan Affiliations

It's important to check the Medical Assistance Administration (MAA) Web site to confirm their health plan affiliations. Health plans are required to have adequate networks of practitioners, so it's important to ensure those networks are represented accurately. To check your affiliations:

1) Go to the state's "Internet Provider Director" at https://ww2.wa.gov/dshs/maa/ipndweb/ - there is a "How to Use" section for guidance

2) The simplest approach: search "By Provider Name," by entering the physician's name

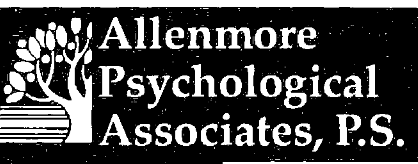
3) Enter a "Program" section. For Medicaid, select "Healthy Options" (you may also review other state programs if you wish)

4) **IMPORTANT**: If the search results display a plan or plans that you DO NOT participate in, **NOTIFY THAT PLAN IMMEDIATELY** advising them to remove your name from their roster(s)!

Also, please notify **both** MAA, using the "contact us" reference at the bottom of that web page, and the WSMA by sending an email to our general email address, www.wsma.org. The WSMA is monitoring these problems and will present that evidence to MAA.

WSMA is working to prevent any misrepresentation of the physician networks of the health plans in Medicaid Healthy Options. For questions, contact Bob Perna at the WSMA office, 1-800-552-0612 or rjp@wsma.org. ■

Reprinted from WSMA Membership Memo, November 10, 2000



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Go Online for AMA dues discount

If you haven't already renewed your AMA membership, you can now do so online - and receive reduced rates in the process. Members who renew their membership through the AMA Web site will receive a 10 percent discount on their membership dues. The offer also is good for first-time members, so now is the perfect time to encourage your colleagues to join. Go to: **www.ama-assn.org/mem-data/mem-main/how.htm** for more information.

Pierce County Medical Society

invites you and your spouse or guest to the

2000 ANNUAL MEETING

Tuesday, December 12, 2000
Sheraton Tacoma Hotel, Ballroom
1320 Broadway Plaza, Tacoma

Social Hour: 6:30 p.m.
Dinner: 7:00 p.m.
Program: 8:15 p.m.

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- Introduction of the 2001 Officers
- Please bring an unwrapped toy (child) and/or a wrapped gift (woman) for YWCA Shelter residents

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Please return before Friday, December 8 to: PCMS, 223 Tacoma Avenue South, Tacoma, WA 98402
You may fax to 572-2470 or call 572-3667 for more information

Please reserve ______ dinner(s) at $40 per person. Enclosed is my check for $__________

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Please join us!

WSMA sets priorities for 2001 Legislative Session

With the 2001 Legislative Session coming soon, the WSMA is busy preparing their annual agenda. The agenda is based on organizational priorities and action taken at the annual meeting in September. Priority items include:

- **Adequate funding for public health programs and physician practices**
- **Opposition to other health care groups' perennial attempts to intrude into the scope of practice of physicians**
- **Supporting the Liability Reform Coalition (LRC) agenda and introducing, if necessary, separate tort legislation germane to the medical profession.**
- **Opposing legislatively mandated sharps protections as unnecessary due to WISHA workplace regulations**
- **Aggressively fighting efforts to further fraud and abuse legislation in our state**
- **Preserve funds from Tobacco Settlement for tobacco prevention/ control**

The agenda will be adjusted as the legislative session nears. The WSMA expects to review over 2,000 pieces of legislation and will be actively engaged in several hundred bills as part of their work to represent physician interests.

Mark your calendar for the WSMA Legislative Summit in Olympia, on Tuesday, January 23rd. **(See page 7)** ■

Personal Problems of Physicians Committee

Medical problems, drugs, alcohol, retirement, emotional, or other such difficulties?

Your colleagues want to help

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Be aware of new "Managed Care" developments

A new strategy for carriers to save money is being coined "the new managed care."

Health insurers now know that the old managed care, with insurers' heavy-handed controls on care decision is no longer acceptable. Yet, there are strong indications that a new form of managed care is being implemented, which is potentially worse than its predecessor.

For example, insurers can conduct audits of your practice, through which they have broad discretion to scrutinize and pronounce your medical records to be "inadequate," judge your selection of CPT codes to be guilty of "upcoding" and allege that your billing practices are "fraudulent" and "abusive," in whatever manner the insurers choose to define those terms. Such allegations can result in huge demands for refunds from your practice, termination of your agreement with an insurer with or without cause, and filing a report with a national data bank for performing fraudulent or abusive billing activities.

These accusations can easily cause you to incur considerable expense, in defending your professional reputation and your continued ability to practice. Under practice agreements with insurers, physicians may not have any effective remedies.

There is such concern in the medical community regarding this issue that Andy Dolan, JD, will be presenting at seminars statewide to educate physicians and their staff members. Mr. Dolan, an attorney in private practice, specializing in health care law, represents physician practices throughout Washington. He has worked closely with organized medicine for many years.

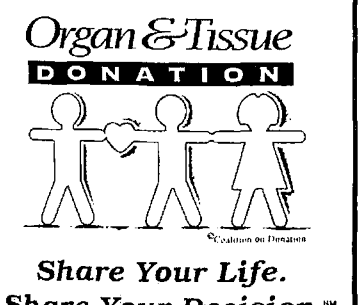
The seminar, "Health Insurers' "Fraud and Abuse" Enforcement: The New Managed Care?" is sponsored by WSMA and will be held on Friday, December 15 in Tacoma at the Sheraton Tacoma Hotel, 12:30 to 4:30 p.m.

Topics include:

- Cost Containment Strategies of Health Insurers
- Fraud & Abuse Enforcement and What it Means for You
- White Collar Crime Enforcement
- Sequelae of health Insurers' Decisions about Physicians
- Strategies for Physicians-Prevention, Defense, Offense
- Disassociating Your Practice from Health Insurers

For registration information, you may call PCMS and we will fax a registration form to you or you may call Becky Harrington, 1-800-552-0612 at the WSMA office. ■

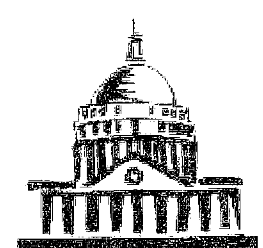
Excerpted from WSMA Membership Memo, November 10, 2000



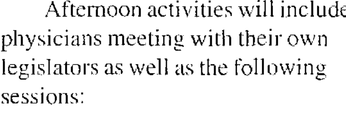
WSMA Legislative Summit Tuesday, January 23 in Olympia

The annual WSMA Legislative Summit will be held on Tuesday, January 23 at the West Coast Olympia Hotel in Olympia.

The morning's activities include continental breakfast and presentations by legislative speakers such as the Speaker of the House, Committee Chairs, Executive Branch Leaders,etc.



During the lunch session, WSMA will present their legislative priorities for the session, as well as offer talking points and tips on how best to influence your own senators and representatives.



Afternoon activities will include physicians meeting with their own legislators as well as the following sessions:

- House Health Care Committee Hearing (as well as other hearings)
- "New to the Process," A learning experience about the Legislature
- Guided Tour of the Legislative Campus
- Meetings with Executive Branch leaders

There is no charge for WSMA members to attend the Legislative Summit. Please call PCMS, 572-3667 for a registration form or you may call Patti Smith at the WSMA 1-800-552-0612 for more information. ■

Fees for searching and duplicating medical records

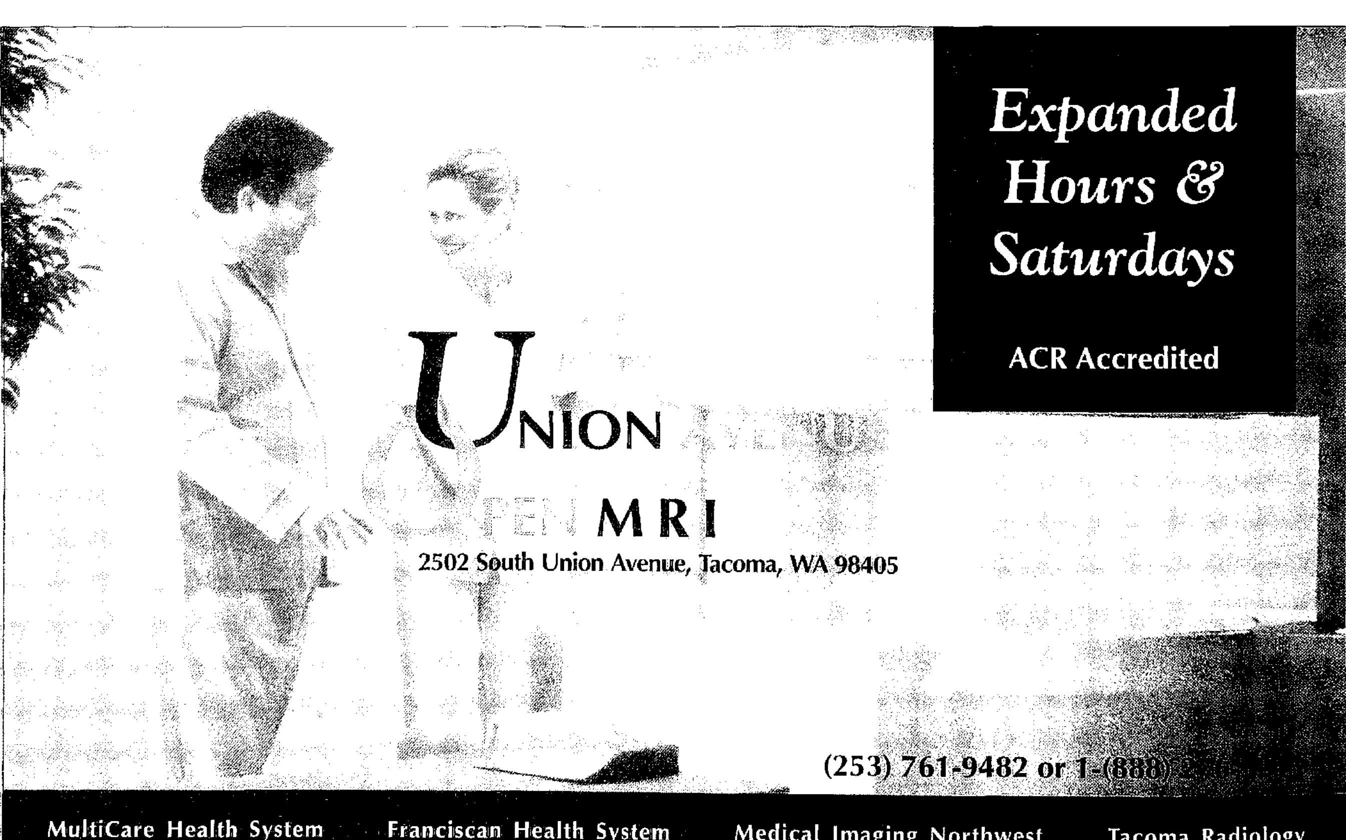
As of July 1, 1999, fees that WAC 246-08-400 allows medical providers to charge for searching and duplicating medical records increased. The WAC allows for Statutory Authority RCW 70.02.010 and states the following:

RCW 70.02.010(12) allows medical providers to charge fees for searching and duplicating medical records. The fees a provider may charge cannot exceed the fees listed below:

(1) Copying charge per page:
(a) No more than seventy-nine cents per page for the first thirty pages;
(b) No more than sixty cents per page for all other pages.

(2) Additional charges:
(a) The provider can charge an eighteen dollar clerical fee for searching and handling records;
(b) If the provider personally edits confidential information from the record, as required by statute, the provider can change the usual fee for a basic office visit.

(3) This section is effective July 1, 1999 through June 30, 2001.■



Clean Air For Kids™: A Partnership to Fight the Crisis of Asthma

by Marina Cofer-Wildsmith

I arrived early in the office in May to prepare for a meeting. The phone rang at 7:00 am and when I answered I heard a sigh and then, "thank you so much for being there I need your help." After I sat down in my chair, I heard a story about a woman and her son that is becoming far too common.

Penny, the woman who called, was a middle aged mom, recently divorced and scraping for every dollar by piecing together part-time jobs, while trying to care for her son, 3 and ° year old Jake. Jake had been diagnosed a year earlier with moderate persistent asthma but had changed homes so much during the separation and ultimate divorce of this parents, that his care was sporadic at best.

Jake's asthma was originally treated with Cromolyn but when the medication and prescription ran out, he only had a small supply of albuterol remaining.

Penny had moved with her son into an apartment, and was finally feeling that her life was settling down. Only two days after moving in, however, Jake's coughing at night was so bad that Penny had to call someone. She did not feel she could call the primary care provider because her ex-husband still had not paid an outstanding bill and she could not afford it. So, she called the American Lung Association of Washington and asked us, one early morning, for help. And help for Penny, Jake and others like them is what we intended to provide.

Through a grant from the National Heart, Lung and Blood Institute, the Tacoma-Pierce County Health Department and the American Lung Association of Washington have initiated an asthma prevention partnership to alleviate the impact of asthma on children and families in Pierce County. The program is called *Clean Air For Kids™* and is based on the American Lung Association of Washington's Master Home Environmentalist™ program and the Asthma Outreach Project that is conducted by James W. Stout, MD, MPH and LaTonya Rogers at the Odessa Brown Children's Clinic in Seattle, WA.

The first step in our process to help Penny was to send her to the Tacoma-Pierce County Health Department to speak with Frank Dibiase, Community Environmental Health Specialist, who recommended that he come out to her house with a volunteer to conduct an environmental assessment of the home.

Home environmental assessments are free to any resident of Pierce County who is affected by allergies or asthma. A trained volunteer from the Master Home Environmentalist™ (MHE) program* is assigned to a family upon their initial inquiry. The volunteer then goes to the home and conducts an assessment of the environment, focusing on things that can trigger allergies or asthma episodes. The volunteer is trained to offer low or no-cost solutions for improvement of the home environment, and then does a follow-up phone call two weeks later to see if the family needs additional assistance. A copy of the home action plan is left with the family and a second copy is sent to the physician, with the family's permission.

The most significant problems for Jake were two fold: there were large amounts of mold growth in the home and on-going water damage; and, the mother smoked in the house. The immediate need and recommendation was to have the exposure to mold problem fixed.

Frank called the American Lung Association of Washington and we introduced our Asthma Outreach Worker, Genevieve Schmidt, into the team approach. Genevieve worked with the landlord to relocate the family while the problems were being mitigated. In the meanwhile, Genevieve scheduled multiple visits with the family which allowed her to assess not only the environmental factors contributing to Jake's ongoing asthma symptoms, but to determine the economic and social issues facing the family. Here's what she found:

°Jake and Penny were not enrolled in Basic Health Plan of Washington
°Jake had not seen a doctor for his asthma in the last 4 months
°Jake had very little medication left in the house
°Jake did not have consistent medical care
°No asthma management plan was present for Jake
°Mother smoked in the house and around Jake
°Dog slept in Jake's bedroom
°No dust control plans existed

Here's what the Clean Air Kids™ program did for Penny and Jake. The team:

1) Supervised the mitigation of the apartment and ensured that all improvements were sound and relatively permanent.
2) Provided an application for the Basic Health Plan of Washington
3) Worked with the primary care provider to handle the overdue payments and clear the way for Penny to schedule a medical appointment for Jake.
4)Made sure Jake received, posted and adhered to the asthma management plan through follow-ups with the family.
°5) Recommended the mother quit smoking and provided information on

See "Clean Air" page 12

New Members

BAKER, JAMES, MD
Family Practice
Practicing at Gig Harbor Medical Clinic, 6401 Kimball Drive, Gig Harbor 98335
Phone: 858-9195, FAX 858-4348
Medical School: State University of New York at Buffalo
Internship: Providence Hospital, Seattle
Residency: San Bernardino County General Hospital

DOBBINS, JILL, MD
Radiology
Practing with Diagnostic Imaging NW, 222 15th Ave SE, Puyallup 98372
Phone: 841-4353
Medical School: Univerity of Washington Medical School
Internship: Maine Medical Center
Residency: Maine Medical Center

FAHMY, JANA L., MD
Radiology
Practicing with Pacific Nephrology Assoc. Phone: 383-1099, FAX 383-3919
Medical School: Loma Linda University School of Medicine
Internship: Loma Linda University Medical Center
Residency: Loma Linda University Medical Center
Fellowship: Childrens Hospital of LA

GE, ZHENG, MD, PH.D
Nephrology
1802 S Yakima, #208, Tacoma 98405;
Phone: 627-5755; FAX 627-5755
Medical School: Shanghai Medical University
Internship: Mt. Sinai Medical Center
Residency: Mt. Sinai Medical Center
Fellowship: Stanford Medical Center

NERKAR, MANISH S., MD
Internal Medicine
1708 S Yakima, Tacoma 98405
Phone: 627-9151, FAX 593-8418
Medical School: Indira Gandhi Medical School
Internship: Thams Jefferson Univ
Residency: Thomas Jefferson Univ

YOUNG, CHRISTOPHER, MD
Family Practice
South Hill Family Medicine, 3908 - 10th Street SE, #200, Puyallup
Medical School: Univ of Washington
Internship: Valley Medical Center
Residency: Valley Medial Center

Directory changes

Please make note of the following changes to your 2000 PCMS Directory.

Deyo, Glen, MD
Change Zip Code to 98418
Phone: 474-5530; FAX 475-1185
Physicians only: 474-4861

Etzkorn, Eugene, MD
3611 South D Street, #21, Tacoma 98408
Phone: 474-4667; FAX: 476-1437

Knight, Ronald W., MD
1802 S Yakima, #102, Tacoma 98405
Phone: 272-7777
Physicians only: 383-4564
FAX: 383-9109; UPIN # A08776

Sullivan, Rebecca, MD, CEO
Puyallup Valley Healthcare
1317 East Main, Puyallup 98372
Phone: 435-7181

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Mr. Rockwell is available to represent physicians and other health care providers with issues of concern before the State Medical Quality Assurance Commission. Mr. Rockwell, appointed by Governor Booth Gardner, served for 8 years as the Public Board Member of the Medical Disciplinary Board from 1985-1993. Since then, Mr. Rockwell has successfully represented over 60 physicians on charges before the MQAC. Mr. Rockwell's fees are competitive and the subject of a confidential attorney-client representation agreement.

Gregory G. Rockwell
Attorney at Law & Arbitrator
3055 – 112th Avenue SE, Suite 211
Bellevue, WA 98004

(425) 822-1962 • FAX (425) 822-3043
email: grocket@msn.com • website: "ggrockwell.wld.com"

The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

The Emergence of Antimicrobial Resistance

Few physicians alive today know what it was like to treat patients in the pre-antibiotic era. The rapid development of antimicrobial agents in the 1940s and 1950s revolutionized medical and surgical care, leading some to predict that infectious diseases would one day be eliminated. Today, with newly emerging, reemerging, and drug-resistant pathogens threatening to reverse the gains of the last half century, we are humbled by the realization that evolution is perhaps one of the strongest forces in nature.

By engaging in an arms race with microorganisms, the ammunition we previously relied on is no longer effective. We must continuously find new, stronger weapons. But is this an arms race we can win? Only one new class of antimicrobial agent has been developed in the last 30 years. We are running out of novel ways to kill pathogens. And if we do not judiciously use new drugs, every new agent will have a short useful life because resistance will inevitably develop.

At the present time antimicrobial agents are used fairly indiscriminately in the United States. The CDC estimates that 50% of antibiotic prescriptions written by physicians are unnecessary. A recent study of Washington state hospitals found that 39% of vancomycin orders were inappropriate. Antibiotics are sometimes used to treat non-infectious conditions such as decreased gastric motility. Many veterinary antibiotics can be purchased without a prescription. Livestock are fed antibiotics in subtherapeutic amounts to promote growth, and whole-herd-dosing for prophylaxis or therapy is common. Antibiotics are also used in fish-farming, bee-keeping, and are sprayed on fruit trees to treat or prevent infections. Antimicrobials have been found in sewage effluents. Although the impact of environmental residues is not known, we do know that chronic low-dose exposure to antibiotics selects for resistant strains of bacteria.

Antimicrobial resistance is a rapidly growing problem in Pierce County. Between 1995 and 1999 the percent of *S. aureus* isolates resistant to methicillin (MRSA) doubled in Pierce County, growing from 10% to over 20%. MRSA is usually multi-resistant, and we are seeing decreased sensitivity in *S. aureus* to almost every available drug. Only 84% of E. Coli isolates were sensitive to trimethoprim/sulfamethoxazole in 1999. National data on streptococcus pneumoniae resistance to penicillin, which rose from 0.2% in 1989 to 18/7% in 1996-1997, has prompted consideration of doubling the dose of amoxicillin for acute otitis media.

The problem of antimicrobial resistance has many causes. Because of this, the solutions will involve almost every sector of society, from industry to health care to private citizens. The Tacoma-Pierce County Health Department is bringing together people from a variety of disciplines to collaborate on finding and implementing strategies to this growing health threat. This task force will work on factors that impact antimicrobial resistance in inpatient and long-term care setting, outpatient and community settings, and agricultural and veterinary settings.

Because physicians have a great deal of control over the use of antimicrobial agents, they will play a significant role in stemming the tide of resistance. And ensuring that effective agents are available to treat serious infections in the future is in everyone's interest. As a physician, you can do a great deal to promote judicious antimicrobial use and reduce resistance, such as:

•Making accurate diagnoses by using culture and sensitivity testing whenever possible, so that treatment can be well-targeted at the offending microbe

•Revising empiric treatment based on lab results, if necessary

•Using narrow spectrum agents whenever possible, in order to preserve broad spectrum agents for serious infections

•Reminding patients who are given an antibiotic to finish the entire course

•Not giving in to patient demands for a prescription or for a specific drug is such treatment is not indicated

•Following guidelines for treatment of common infections

•Avoiding the use of antibiotics to treat infections likely to be viral, such as the common cold

•Practicing rigorous infection control in every aspect or practice

•Keeping patients' immunizations up-to-date

•Educating patients about antimicrobial resistance

•Educating resident physicians about antimicrobial resistance

And, if you are interested, you can participate in the Interdisciplinary Task Force on Antimicrobial Resistance. For information about antimicrobial resistance or to join the Task Force, contact Monica Raymond, Epidemiologist, Antimicrobial Resistance Program, Tacoma-Pierce County Health Department at 253-798-2873 or monica_raymond@healthdept.co/

See "Antimicrobial" page 17

Clean Air from page 9

smoking cessation classes. Until then, educated the mother on the necessity to smoke outside and wear a smoking jacket that should stay outside as well. And, again, followed up with home visits to determine if smoking was really occurring outside.

6) Provided dust covers for the bed mattress and pillow. Talked about cleaning techniques for Jake's bedroom and sheets.

7) And, became an advocate for the family to help them get to the fresh start they were longing to achieve. As an advocate, the outreach worker will assist primary care providers by working with the families to make sure the asthma management plan is understood and being used appropriately. The outreach worker can also provide valuable feedback to providers as she spends time with the family and gets to know them in their every day environment.

The services of the Clean Air for Kids™ program can be accessed in a variety of ways. The family can contact the program directly, the physician can initiate contact, or a school nurse or childcare provider can call with a referral. Contact Frank DiBiase at 798-7674 or Genevieve Schmidt at 272-8777.

Please keep this initiative in mind when you see your next motivated family who could use some help!

* MHE volunteers have passed a Washington State Patrol criminal history check and serve under the supervision of the Tacoma-Pierce County Health Department. They have also completed a 30-hour training that covers basic information on asthma, landlord tenant issues, cultural sensitivity, biological hazards, dust, toxicology, behavior change theory and an overview of common indoor air quality problems. Volunteers backgrounds range anywhere from physician assistants and nurses to college students and real estate agents and people who have a general concern about the environment overall. Many of the volunteers have asthma and allergies themselves. ■

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In My Opinion.... The Invisible Hand

by Andrew Statson, MD

Purchasing Power

Andrew Statson, MD

"Plurality which is not reduced to unity is confusion; unity which does not depend on plurality is tyranny."
Blaise Pascal (1662)

The cost of prescription drugs has created quite a stir lately. When patients paid for their prescriptions out of pocket, they were the only ones to complain and were all too often ignored. As various insurance companies and government programs started covering prescription costs, they felt the pinch as well. At the same time, partly because of prescription drug coverage, but also because many new and better drugs appeared on the market, the spending on pharmaceuticals rose faster than that on medical services and became a much larger part of total health care expenditures.

A number of options are being considered to remedy this situation. For instance, Governor Locke recently suggested the formation of a purchasing group for senior citizens, a prescription drugs buyers club, which will have a membership fee and will be connected with the state Uniform Medical Plan. By using the purchasing power of the state, he hopes to reduce the cost of medications for this population.

Purchasing cooperatives have appeared periodically on the scene, usually at turbulent economic times, to help people through a crisis. Some of them have been private; some, public. The latter are more likely to have been recorded. The biblical story of the seven fat years and the seven lean years is one example. The information given is sketchy and there are no details of how that distribution system worked. In any event, sensible management of government programs, such as buying in times of plenty, when prices are low, and selling in times of scarcity, when prices are high, is rare.

There are records of the Roman Republic from the second century BC, which show that in times of shortages the state purchased grain at the market price and sold rations to the citizenry at lower prices, at the expense of the Roman Treasury. I think this program started with the populist laws of the Gracchus brothers, enacted when they were tribunes, and continued through most of the years of the Roman Empire, as illustrated by the slogan "bread and circuses."

During the inflation of the 1970s, many people got together to buy groceries on the wholesale market, trying to save money. The results were rather disappointing and these purchasing groups slowly faded away. They could not compete with the grocery stores on fresh produce. There was too much work and too much spoilage during the distribution process to make it worthwhile. The system worked reasonably well for dry goods, mostly because the people who did the buying and the distributing worked at no pay. Eventually, the system broke down. It required too much effort to justify the benefit.

The idea of purchasing cooperatives, however, was picked up by some enterprising managers, who started commercial ventures. Perhaps the most successful of these is Costco. It is a commercial organization with a membership fee. This fee has both an economic and a psychologic effect. It assures the company a certain minimum income. At the same time, the members are encouraged to shop there, because, after all, they paid for the privilege. The prices are low, because the stores concentrate on high volume items in large packages. The choice is limited to the most popular products, frequently sold in only one size. Costco has been successful because it has used its purchasing power where it could do the most good.

How can the state emulate that? The difference in cost between wholesale and retail is due to the work of the retail stores. They provide a useful service, or they would not be around. The people who work in the distribution channel expect to be paid for what they do. If the need for their services can be reduced or eliminated, the cost of the product will drop. For instance, the state of Oregon requires that gas station attendants pump the gas. They have no self-service stations. This requirement certainly is not based on economics and, as a result, Oregon motorists pay about 20 cents more per gallon than we do in Washington, where

See "Purchasing" page 14

Purchasing

from page 13

we hardly have any contact with an attendant.

A bottom of 100 Tylenol tablets in the drugstore costs about the same as one tablet to a hospital patient, in spite of the purchasing power of the hospitals. In the drugstore the patient walks through the aisle, picks up the bottle and pays at the checkstand. The people involved in this service are a stocker and a checker. In the hospital, the physician has to write the order on the chart; the nurse has to check the time of the last dose, request the next dose from the pharmacy, take it to the patient and wait to make sure he took it, then go back to the chart and record the event; the pharmacist has to dispense the medication and make an entry in his own record. Somewhere along the line billing clerks, insurance companies and accounting department get involved. No wonder it costs so much.

To save money on prescriptions, the patients should be able to buy them in bottles of a hundreds, three hundred, or perhaps even a thousand. When a pharmacist has to open a bottle of a hundred and count out thirty or ninety tablets, because that is what the insurance company requires that he dispense, he has to be paid for this service. The final cost frequently is more than to just hand out a bottle of a hundred tablets. Even though the state may pay for a large amount of rescription drugs, the cost of distribution will not be reduced if they have to be dispensed in bottles of thirty. The people in the distribution channel will still have to be paid.

The state could establish drugstores, where people could buy their medications. If the example of the liquor stores means anything, it is not going to be cheaper. In spite of the purchasing power of the state, liquor is more expensive here than in states like California, where it is retailed by private stores.

While this discussion is going on in this country, some border towns in Canada are setting up clinics for American patients where, for a nominal fee, we can get a brief examination and a prescription, so that we can buy our drugs there, at lower prices. It seems the main reason for the difference in drug prices is the restriction on the importation of medications to this country. If our pharmacies could buy their drugs from international suppliers on the open market, the cost of medications may drop by 50%. The end result would be the same as if the federal government had paid for half the prescription costs, as it has proposed to do for Medicare patients.

If our goal is to reduce government, as Mr. Bush proposes, or to reinvent it, as Mr. Gore suggests, allowing unrestricted access to the international market would be a step in the right direction. The argument that such imported drugs may not be pure or safe enough for our use is a spurious one. We have not heard that Canadians or Europeans are having problems with the purity or safety of their drugs. We also import large amounts of foodstuffs from other countries and so far we have not suffered from any significant food poisonings. We have had more problems with our domestic products. I am afraid such a solution is much too simple to be adopted, but we can always hope.■

COLLEGE OF MEDICAL EDUCATION

Continuing Medical Education

Cardiology CME scheduled for consecutive Tuesday evenings

This year's Cardiology for Primary Care CME program will be offered on two consecutive Tuesday evenings in January, instead of the traditional 6 hour program on a Friday, This year's program is scheduled for Tuesday, January 9th and Tuesday, January 16th from 6:00 p.m. to 9:00 p.m. on both nights.

The program will begin with speakers on the 9th - three hours of CME and end with three additional hours of CME on the 16th. The change is in response to expressed interest by physicians from the College's recent CME survey. Many physicians are finding it more difficult to take time from their daytime office hours.

The College's sixth annual program featuring subjects on cardiology for the primary care physician will be held at St. Joseph Hospital, Laqerquist Conference Center Rooms 1A and B. The course director is **Gregg Ostergren, DO.**

Topics include Genetics & Hyperlipedemia; ACE/ARB Combination?; Are Beta Blockers Underutilized?; New Strategy in Treating Hypertension: Optimizing in Patient Outcomes; Women's Cardiology: Evaluation, Diagnosis and Management and Lipid Intervention for Primary and Secondary Prevention oif CAC. ■

Dates	Program	Director(s)
Tuesdays, January 9 and 16 (evenings)	Cardiology for Primary Care	Gregg Ostergren, DO
Wednesday-Sunday January 24-28	CME at Whistler	Richard Tobin, MD John Jiganti, MD
Friday, February 9	Advances in Women's Medicine	John Lenihan, Jr., MD
TBA	Pain Management	David Paly, MD
Thursday-Friday March 8-9	Internal Medicine Review 2001	Ulrich Birlenbach, MD
Saturday, April 28	Surgery Update 2001	Glenn Deyo, MD
Friday, May 4	Allergy, Asthma & Pulmonology for Primary Care	Alex Mihali, MD
Tuesdays, May 16 and 23 (evenings)	Medical Technology	TBA

Whistler CME January 24-27, condos full

The CME at Whistler program is most popular this year. The College's reserved block of condos at Blackcomb's Aspen Lodge have all been reserved. The usual block and additional Aspen condos were booked prior to the December 1 deadline.

At press time, four Chateau Whistler Hotel rooms (part of a block of ten) were available. Those interested should inquire on availability and call 1-800-606-8244 and mention the College. Those still interested in other possible lodging should call individual facilities or a central toll free number, 1-800-WHISTLER.

This year's program is under the direction of **Drs. John Jiganti** and **Richard Tobin.** Program topics include:

- Management of Inflammatory Bowel Disease
- Advances in Treating Your Geriatric Patient
- Review of Skin Cancer: The Role of the Mohns' Technique
- Recent Advances in Insulin Therapy
- Common Hand Problems
- "The Plague"
- Advances and Retreats in Infectious Diseases
- Interesting Case Studies

Antimicrobial from page 11

pierce.wa.us

Just as it was naive to believe in the 1950s that infectious diseases would be eliminated, it is naive for us to believe today that we will always develop a new drug to kill resistant organisms. Even without restrictions on funding and lengthy approval processes, this is an unrealistic goal. Our technology simply cannot outcompete the evolutionary prowess of single-celled organisms. If we wish to avoid returning to the pre-antibiotic era when we were virtually powerless against infectious diseases, we must learn to view antibiotics as they truly are: precious, life-saving agents.

RESOURCES:

General information about antimicrobial resistance: Alliance for the Prudent Use of Antibiotics:
http://www.healthsci.tufts.edu/apua/

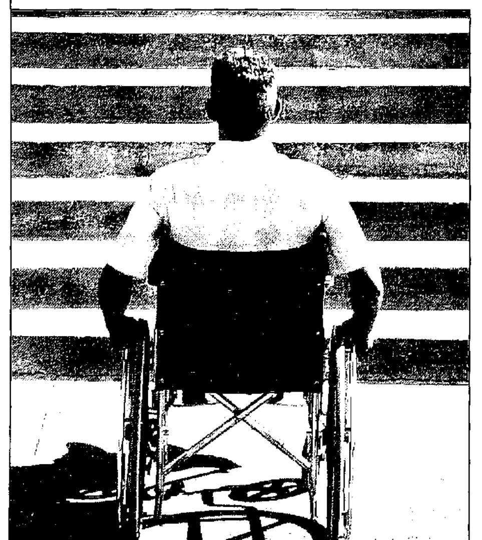
Detailed treatment guidelines for the judicious use of antimicrobial agents in upper respiratory tract infections, otitis media, pharyngitis, acute sinusitus, cough illness/bronchitis, and the common cold:
http://www.cdc.gov/ncidod/dbmd/antibioticresistance/other.htm

Brief treatment guidelines (Academic Detailing Sheets) for otitis media, rhinitis/sinusitis, pharyngitis, cough illness/bronchitis:
http://www.cdc.gov/ncidod/dbmd/antibioticresistance/materials.htm

Guidelines for the prudent use of vancomycin: Recommendations for Preventing the Spread of Vancomycin Resistance:
http://aepo-xdv-www.epo.cdc.gov/wonder/prevguid/m0039349/m0039349.htm

Recommendations on prophylaxis for traveler's diarrhea:
http://www.heatlhsci.tufts.edu/apua/Newsletter/Borbach.html

Will a disability put you out of commission?



As you know, disability insurance policies for physicians are changing rapidly—and not for the better. High claims have caused many major carriers to limit the most important benefits.

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Antibiotic prescribing for children is on the decline

Physicians are prescribing antibiotics less frequently to treat children with respiratory illnesses, according to results of a Centers for Disease Control and Prevention survey presented at last month's meeting of the Infectious Diseases Society of America.

"Our survey suggests that physicians are getting the message that the overuse of antibiotics can be harmful," said Linda F. McCaig, MPH, a survey statistician at the CDC National Centers for Health Statistics, in a statement issued by IDSA.

According to the CDC, about half of all antibiotics prescribed during office visits are for colds, coughs and other viral infections that do not respond to antibiotics and are therefore not appropriate indications for antibiotic use.

The study demonstrated a steady decline. For example, the annual rate at which office-based physicians prescribed antibiotics in cases where the patient was younger than age 15 and diagnosed with infectious respiratory diseases; middle-ear infections; upper respiratory infections including the common cold, bronchitis and sinusitis; and sore throats decreased by 34% between 1989 and 1998. In 1989 and 1990, approximately 669 prescriptions were written for every 1,000 children. Between 1997 and 1998, the rate was 439 per 1,000 children.■

Reprinted from AMNews, 11/20/00

please send your email address to us at: pcmswa@pcmswa.org

Did You Remember?

WAMPAC

Washington Medical Political Action Committee

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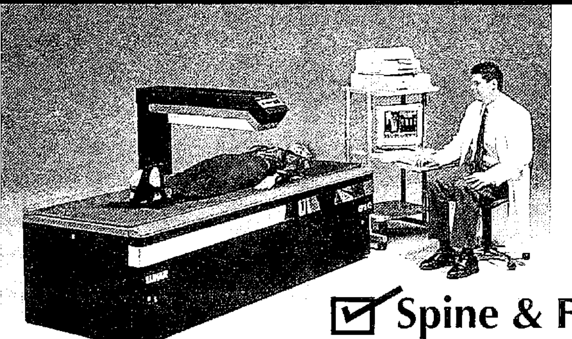

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2. Individuals with vertebral abnormalities
3. Individuals receiving long term gluccocortoid therapy
4. Personal history of primary hyperparathyroidism

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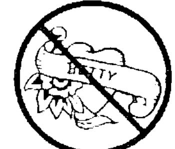

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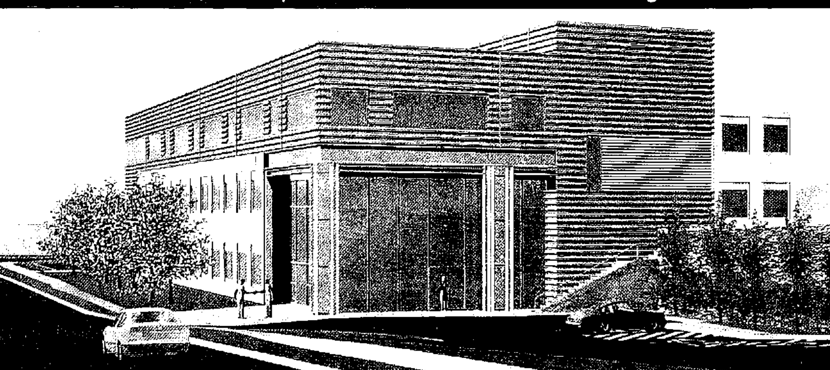

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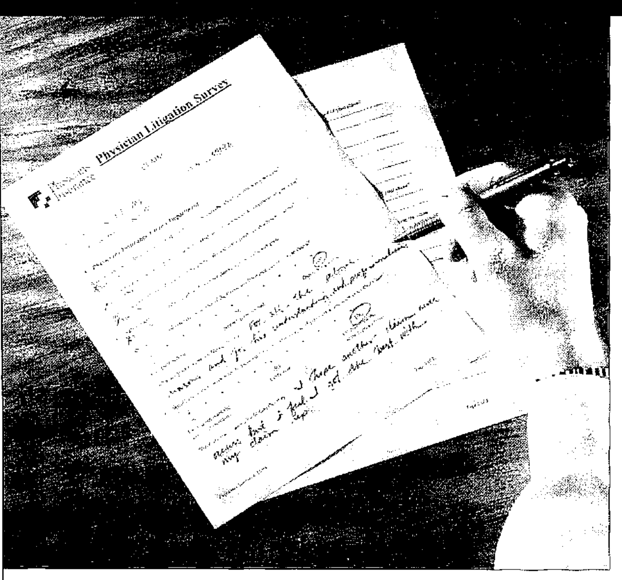

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