Pierce County Medical Society
BULLETIN

January, 2003

The 2002 Annual Meeting

James Rooks, MD assumes the PCMS Presidency at the 2002 Annual Meeting

Lawrence A. Larson, DO recipient of the 2002 Community Service Award

More photos page 5

INSIDE:

The Bulletin is published monthly by PCMS Membership Benefits, Inc. Deadline for submitting articles and placing advertisements is the 15th of the month preceding publication.

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 PCMS. Acceptance of advertising in no way constitutes professional approval or endorsement of products or services advertised. The Bulletin reserves the right to reject any advertising.

Managing Editor: Sue Asher
Editorial Committee: MBI Board of Directors
Advertising Information: 253-572-3666
223 Tacoma Avenue South, Tacoma WA 98402
253-572-3666; FAX: 253-572-2470
E-mail address: pcmswa@pcmswa.org
Home Page: http://www.pcmswa.org

Pierce County Medical Society
BULLETIN

January, 2003

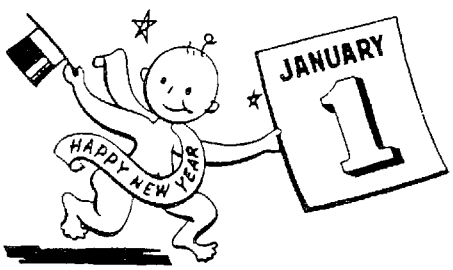


Table of Contents

President's Page

by J. James Rooks, Jr., MD

Looking forward to 2003

J. James Rooks, Jr., MD

It is an honor and privilege to have the opportunity to serve as your president for the coming year, which appears to be an exciting one. We physicians have so much facing us here in the beautiful Northwest: Increased malpractice insurance rates, decreased reimbursements, increased indigent populations, and increased recruitment difficulties, to name a few. One could develop a negative attitude, but I am working on attempting to remain upbeat concerning the practice of medicine in our fabulous community. In the operating room recently, I was working with a fellow physician I greatly admire and we were discussing the above problems. He made a great impression on me when he said, "Jim, I refuse to allow myself to become negative, I choose to remain positive and optimistic about our future." Realizing full well this attitude is easier/harder to maintain from day to day, I propose we all strive to maintain this position. One great way to do this is active participation in PCMS, which I believe is the one organization where we can all come together as a united profession to improve our delivery of service and in doing so improve our own positions. We have in our society members who practice medicine in every possible manner including academic, single primary, multiple primary, single specialty, group specialty, multiple specialty, hospital based, HMO, and administrative. We have numerous committees which are always in need of new members, and I hope that anyone who has an interest will let me know.

This month's Bulletin features an article by radiologist **Dr. Scott Carleton** that should spark great discussions. Articles from our members are always appreciated by the *Bulletin*, and they are an excellent way to communicate ideas on matters of concern to us all. I've enjoyed the contributions of **Dr. Teresa Clabots** (her husband Joe and I have designated her the Medical Erma Bombeck), and **Drs. Federico Cruz-Uribe, Andrew Statson, and Carl Wulfestieg** (I spelled it right, Carl) to name just a few.

Dr. Pat Hogan is planning interesting programs for our upcoming general meetings that we hope will have interest for all. These meetings are also a great opportunity to see old friends and to make new ones, and I look forward to seeing as many of you as possible at our next gathering. Speaking of meetings, I hope you'll be looking forward to the 2004 Spring CME meeting which will be held on the island of Kauai. **Dr Mark Craddock** and Les McCallum always arrange an outstanding program with lots of fun in addition. This past year on the Kona coast of the Big Island was no exception, featuring talks such as the affable **Dr. William Holderman's** "When your sister-in-law calls with ---," big **Dr. John Rowlands'** always enthusiastic informative presentation, and **Dr. Lael Duncan's** world-class ID talk just to name a few. The fun included basking, swimming, and snorkeling on the most beautiful beach imaginable, challenging golf courses, scenic side trips, and quality time with spouses and children. **Drs. Ron Taylor, Pat Hogan, Sam Insalaco, Mark Craddock, Dave Magelssen**, myself and several others ran on the challenging Ironman Triathalon Course every day. **Drs. Don Shrewsbury, Bill Martin** and their families found some excellent biking. The dining was just delicious! So, with that, I hope many more will make plans to come in 2004, and that we have a productive year in 2003. ■

New Board of Trustees will lead PCMS in 2003

J. James Rooks, Jr., MD 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.

Michael Kelly, MD is a family practitioner in Lakewood. He received his medical education from the University of Cincinnati College of Medicine and completed his residency at Oregon Health Sciences University.

Susan Salo, MD is a family practitioner with Group Health in Tacoma. She earned her medical degree from the University of Washington School of Medicine and completed her internship and residency at St. Joseph Hospital in Flint, Michigan.

Patrick Hogan, DO practices neurology in Tacoma. He graduated from the University for the Health Sciences in Kansas City, Missouri and completed his residency at Letterman Army Medical Center in San Francisco.

Kenneth Feucht, MD, Ph.D. is a Puyallup general surgeon. He graduated from the Oregon Health Sciences University School of Medicine and completed a surgical residency at the University of Illinois where he also completed a fellowship in surgical oncology.

Stephen Duncan, MD is a family practitioner with Group Health in Puyallup. He received his medical degree from the Indiana University School of Medicine. He completed his internship and residency at Union Hospital Family Practice in Terre Haute, Indiana.

Laurel Harris, MD is an ophthalmologist practicing in Tacoma and Puyallup. She received her medical degree from Emory University School of Medicine. She completed an internship at Georgia Baptist Medical Center and a residency in ophthalmology at Vanderbilt University Medical Center in Nashville, Tennessee.

Joseph Jasper, MD practices pain medicine in Tacoma. He attended medical school at the University of Cincinnati College of Medicine, followed by a residency in family practice at Tacoma Family Medicine, and in anesthesiology at the University of Colorado Health Sciences Center.

Ronald Morris, MD is a family practitioner in Puyallup. He graduated from the University of Washington School of Medicine. He completed his family practice residency with United Health Services, and at Wilson Memorial Hospital in Johnson City, New York.

Allison Odenthal, MD is a family practitioner in Tacoma. She graduated from George Washington University School of Medicine and completed her internship and residency at Silas B. Hayes Army Medical Center in Fort Ord, California.

Joseph Regimbal, MD practices internal medicine in Tacoma. He graduated from the University of Washington School of Medicine where he completed his internship, residency and a fellowship in geriatric medicine.

Matthew White, MD is a family practitioner in Lakewood. He graduated from Jefferson Medical College in Philadelphia and completed his residency at the US Naval Hospital in Jacksonville, Florida.

The trustees are responsible for governing the organization and subsidiaries, including maintaining, developing, and expanding programs and services for members, seeing that the organization is properly managed and that assets are being cared for and ensuring the perpetuation of the organization. Meetings are held on the first Tuesday of each month except for July and August. The Board of Trustees is comprised of the President, Vice President, Past President, Secretary, Treasurer, President-Elect and six trustees.

Annual Meeting Recap

2002 Annual Meeting - fun, festive, and social

The Sheraton Tacoma was alive with music and conversation on December 10 as PCMS members visited with old friends and new at the Annual Meeting, traditionally held the second Tuesday in December. The evening did not disappoint, providing social time, dinner, musical entertainment, education, and introduction of the new leadership for 2003.

President Susan Salo, MD, introduced members of the Tacoma Youth Symphony and thanked them for providing the evening's musical accompaniment and also introduced the sponsor for the evening, Pharmacia, and representatives Bill Case and Wayne Coulter. Pharmacia helped sponsor the dinner and speaker for the evening.

Dr. Salo called the meeting to order and introduced Nikki Crowley, PCMS Foundation Board member who orchestrated the Holiday Sharing Card and the raffle drawing. Nikki introduced Laura Yu, artist for the card, and explained that proceeds benefitted the Foundation and their charitable work for the betterment of health in Pierce County. Miss Yu has been the artist of the card for the past four years, and has generously donated her time and particularly her talent to the project. This year's raffle winners were Susan Marsh, wife of **Peter Marsh, MD** and Julia Mueller, wife of retired orthopedic surgeon, **Stan Mueller, MD**.

Dr. Salo asked for a moment of silence in honor of colleagues that died during the past year. **Drs. Don Gehle, Chris Reynolds, Herbert Kennedy, Dennis Wight, Vincent Murphy** and **Ernst Baur** were remembered.

The highlight of the evening was the presentation of the Community Service Award for 2002 to **Lawrence A. Larson, DO,** pediatric pulmonologist (see story page 7). Dr. Larson joined the ranks of previous recipients, **Drs. George Tanbara, Charles Weatherby, Terry Torgenrud, Gordon Klatt, Patrick Hogan, John VanBuskirk, David Sparling, Donald Mott** and **William Roes.**

With introduction of past presidents, and a keynote, entertaining speaker (see story page 6), Dr. Salo went on to thank the board of trustees for their support and service for the year. She thanked **Sumner Schoenike, MD,** for his two years of service and presented **Patrice Stevenson, MD** with a gift and particular thanks for her six years of service on the board, including service as a trustee, as secretary/treasurer, president-elect, president and past president.

Dr. Salo introduced and welcomed new board members for 2003 (see list page 4) particularly welcoming new trustees, **Drs. Laurel Harris, Joe Jasper** and **Ron Morris.** She then turned the gavel over to **Dr. Jim Rooks**, Lakewood ENT, and president for 2003.

Dr. Rooks commented that he is looking forward to serving as PCMS president, admitting that he is nervous about following not only one capable woman, but two. ■

Jim Rooks, MD, ENT and newly elected PCMS President thanks outgoing President Susan Salo, MD for her dedicated service as President in 2002

From left - Drs. and colleagues Jeff Jacobs and Larry Larson visit with Dr. and Mrs. Julia Mueller during the social hour

Left to right, Drs. Jim Rooks, Pat Hogan and Federico Cruz-Uribe seriously consider the fact that they are supposed to be enjoying themselves

Why Complex Systems Fail

by Jean Borst

Annual meeting speaker inspiring and entertaining for physicians and guests

"All accidents have three things in common," according to Richard Cook, MD. "They are all astonishing, unique and preventable."

Accidents and failure might not seem like appropriate topics for a light holiday gathering, but attendees at the December 10 PCMS Annual Meeting were treated to an informative, interesting and entertaining presentation by Dr. Cook.

In discussing "Why Complex Systems Fail," Dr. Cook provided insight into patient safety issues and complex system failures that effect all medical personnel. Dr. Cook, a physician, educator and researcher at the University of Chicago, is a recognized expert of medical accidents, complex system failures and human performance at the "sharp end" of these systems.

"The failures don't lie with a group of bad doctors or a group of bad nurses or bad administrators. The failures are embedded in the same things that produce our successes."

"There is a dynamic rather than a static quality to all of this," Dr. Cook explained, "and there are a variety of forces that push us in a variety of directions. We need to explore the kinds of forces that push us towards and away from the edge of disaster; towards and away from economic success, towards and away from workload kinds of issues."

What is going on with patient safety?

"There are five things I'd like you to know," Dr. Cook told the group.

1. Systems are made and broken in systems, not individuals. "Health care is a complicated business, and there are a lot of people involved in it," he said.

2. Progress in safety begins with understanding technical work. "This includes the little bits and details we never talk about that aren't in any textbook that make up the structure of the world," he explained.

3. Productive discussions of safety avoid confounding failure with error. "It is important to understand that these are two totally different things," Dr. Cook noted.

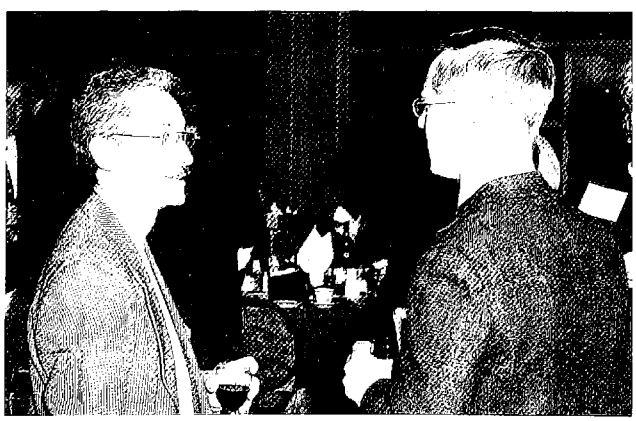
4. Safety is dynamic, not static. It is constantly being renegotiated. "It's made up and used fresh all the time," Dr. Cook said. "It doesn't last."

5. Trade-offs are at the core of safety. "Safety is actually produced by the trade-offs we have to make every day as we work," he said, "and those trade-offs and understanding how they are made is the kind of link into understanding what safety is and where is comes from."

"Why are we Talking About This?"

There have been several well-publicized medical accidents in recent years: the Willie King case of a Florida man who had the wrong leg amputated; the Betsy Lehman case, in which a Boston Globe health care reporter died from a massive overdose of chemotherapy; and the case of four Colorado nurses charged with manslaughter related to the injection of

See "Systems" page 8



Cardiologist James Cook, MD (left) visits with new member Bob Jensen, MD, liaison for public health emergencies and medical care access at the Health Department

From left, Bob Perna, WSMA staffer visits with Donna Jasper and Dr. Joe Jasper, newly elected trustee of Pierce County Medical Society

2002 Community Service Award

Lawrence A. Larson, D.O., recipient of 2002 Community Service Award

"I really don't deserve this award," was the first comment by community service award recipient **Lawrence A. Larson, DO**, pediatric pulmonologist and allergist, after receiving the award on December 10th at the annual meeting.

Aside from being humble, Dr. Larson doesn't recognize all the extra work he does in the community to help children, in one form or another, as true "volunteer" or "community service" work. He sees it as part of his duty of being a caretaker for children.

Nominated and presented the award by colleague, **Dr. Dan Niebrugge,** Dr. Larson practices with Pediatrics Northwest, based in Tacoma, with offices throughout Pierce County.

Dr. Larson has been an active member of PCMS since 1980, having served in numerous capacities including secretary/treasurer, PCMS and WSMA delegate, and as president in 1999. He remains on the grievance committee and currently serves as president of the PCMS Foundation, of which he is a founding board member.

His volunteer efforts are significant and include work on behalf on many non-profit organizations, including the American Lung Association of WA, the March of Dimes, and the Cystic Fibrosis Association. From the Clean Air for Kids program and Asthma Camps where he directly works with kids, to conducting a CME program for Pacific Island physicians, (spending an evening with one physician that showed up!) to teach them about treating asthmatic children, he gives his time freely and generously to ultimately help his patients.

PCMS congratulates Dr. Larson. ■

Lawrence Larson, DO (left) was awarded the 2002 Community Service award by his colleague and friend, Dan Niebrugge, MD who nominated him for the award

Susan Marsh, wife of Past President Peter Marsh, MD, "nosed" her way to win a gourmet basket

Nikki Crowley, PCMS Foundation Board member announced the winners of the raffle

Julia Mueller, wife of retired orthopedist Stan Mueller, MD, was a lucky raffle winner

Systems from page 6

benzathene penicillin in a newborn thought to have untreated congenital syphillis.

"Human error is considered the cause of accidents 85 percent of the time in health care, as well in a variety of other domains," Dr. Cook said, citing aviation, nuclear power generation, telecommunication, chemical manufacturing, shipping, and railroads. The studies of notable nonmedical accidents such as Three Mile Island, Chernobyl, and the Exxon Valdez have been applied to medical accidents. "The science does not come from health care," Dr. Cook noted, "but these cases have been important in health care to try and understand how accidents happen."

One such case is the Fox Grove, Illinois train vs. school bus accident. In this situation, a bus full of children was waiting at an intersection. The back end of the bus was on the train tracks. A train approached, hit the bus, dragged the back portion of the bus a distance down the tracks, killing all of the children in that part of the bus. Dr. Cook was in Chicago at the time and begin recording the results immediately following the accident. The popular view, which came out over the days following the accident was that an inexperienced bus driver under the stress or the effects of drugs had failed to safely cross the railroad tracks. After lengthy investigation, 16 causes were cited and 29 recommendations were made to 16 different bodies. The bus driver, by the way, was not at fault.

Accidents: What are They and why do They Happen?

How do we deal with accidents when they happen? There are five steps that occur with each accident:

1. The accident happens.
2. In the hour following the accident, we try to figure out what happened and who did what.
3. Patient-centered care rises in intensity - until we figure out exactly what is happening - and then gradually tapers off.
4. We prepare the accident story.
5. The formal investigation takes place, which can continue for weeks, months, and years.

"The real difficulty with this process is not because it is screwed up in a clinical or legal way," Dr. Cook noted, "but because it is screwed up in a fundamental way because it gets the story wrong. It misunderstands how accidents occur. As a consequence," he continued, "very little good comes from this process. We don't learn a great deal."

If you ask people inside the health care system and ask them why medical accidents happen, this is the typical response:

- If you ask the practitioners, they say it's human error by practitioners.
- If you ask the technologists, the people who build the information technology, they say it's human error by practitioners.
- If you ask the regulators, they say it's human error by practitioners.
- If you ask the administrators, they say it's human error by practitioners.

As a result, the collective reaction is to (1) blame and train the practitioner; (2) create technology to automate people out of the system; and (3) create more policies and procedures. "Essentially, you end up not fixing things, but shifting to a more complex system," Dr. Cook said.

The Science of Accidents

"There is a wall, a kind of mechanism that is supposed to prevent accidents from happening," Dr. Cook explained. "And looking back after an accident, you'll see that there is some sort of flaw - a hole in the defense - that allows the accident to happen. Wherever there are individuals, there is a team of people. Because there are multiple individuals, there are going to be multiple failures or holes. That brings us to the current understanding of how accidents happen." This phenomenon is what Dr. Cook terms the Latent Failure Model of Complex System Failure.

"There are various layers of defense that exist in the world, and they are there to prevent accidents, and most of the time they do," he explained. "The flaws are very small, and each individually is incapable of creating an accident. Only in combination can you produce the conditions necessary for an accident to occur. Now you know why accidents are astonishing, unique and preventable," he said. "Looking back, you can see that if any one of these holes had been closed, the accident wouldn't have happened. And in a strict sense, all accidents are preventable. But, of course, that's not really the case because you don't see all the variables coming together."

When you have all these variables come together, will there always be an accident? No. The difference between an accident and an incident is the outcome. **Accident is an incident with bad consequences. An incident is an accident with minor consequences.**

Consider this scenario: The regular OR desk nurse is ill and another nurse fills in. A surgeon calls the OR desk to cancel a scheduled procedure for the next day. The OR desk nurse on duty notes the cancellation on the desk copy of the OR schedule. The anesthetist looks at master list and finds the patient scheduled for surgery. He or she visits the patient and writes pre-operative orders. The ward clerk checks the schedule and finds the operative order. The floor nurse prepares the patient that morning for the procedure. The transport person delivers the patient to the OR. The anesthetist and nurse check the patient's ID to make sure this is the patient scheduled for the procedure. The anesthetist begins preparation for the anesthetic. The start time passes without the surgeon in the operating room. The OR nurse pages the surgeon. The surgeon comes into OR in his street close and says "I cancelled this case yesterday, what is going on here?"

Is the result an accident or incident? Incident. But, what if there was one additional step? The anesthetist

See "Systems" page 10

The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

Let's Take the Cuts and Keep Washington Healthy!

Federico Cruz-Uribe, MD

Like most people, I have nightmares from time to time. Right now, those midnight images are nothing compared to daily news. The steady stream of dreary articles about Washington's terrible fiscal crisis creates internal pictures that get worse as the budget does. When the state deficit reached $1 billion, I saw schools with boarded windows. At $1.5 billion, I glimpsed potholes that grew and never filled. The deficit then hit $2 billion and I imagined parks filled with litter that doesn't go away.

AND NOW OUR DEFICIT IS HOVERING AT $2.5 BILLION. That number is too big for my imagination. I try to convince myself that I am just an interested observer and that there is nothing magical about these numbers. But that isn't true. I am a father with children in public school; a husband whose wife works in the private medical community, which is in crisis; and, a taxpayer with a legislature about to meet that is being pressured to raise taxes. And I am worried.

It's clear our economy is in recession and tax revenues are down, with a voting public that doesn't want new taxes. So the state has to live within its current revenues. The problem gets really bad when you look at the programs that the state pays for. The three most expensive are education, criminal justice (jails) and healthcare. All three include built-in cost increases because they deal with services to people, and each year either the costs of services get more expensive, or more people expect them - or both. Costs for services rise and revenues drop, with no source for new money. Now what?

When stuck in a situation like this the knee jerk reaction is to either cut services or raise taxes. Or both. My "daymare" turns into living color at this point, until I look at issues differently.

I can see other options. We don't have to choose between A (cut services) and B (raise taxes). There are other solutions, but, to get there, we have to step out of our comfort zone. Human nature seems to require that when under stress we fall back on the familiar, even when that may be what got us into the predicament in the first place.

"The greatest impacts on this healthcare crisis will come from investments that strengthen our economy and that prevent illness, with a safety net for those who do get sick."

Let's look at healthcare, at the same-old-same-old thinking that fashions my late-night sweats. With great passion, people argue that the state-funded program doesn't work because we haven't put enough money in: "Just give us more money and we can make it work." It sounds so simple and yet this almost never works. Putting more money into a failing activity means more dollars lost on a failing activity. The "More Money" approach justifies the status quo. At the same time, voters say that the present situation stinks so why preserve it?

Look at how we invest our health dollars. We have the most sophisticated health care system in the world, and it is also the most expensive. I didn't say it is the best one because that's arguable. From the standpoint of advanced treatment approaches, it may be one of the best. From the standpoint of how healthy people in our country are compared to other countries we come up very short.

There are many powerful factors that affect the overall health of people; the economy, jobs, education, family support and of course health care. Jobs, education and the strength of the family are much more powerful contributors to health than is access to clinic care.

Our state has built a health care system that tries to copy the private sector by giving everyone an insurance card. This is based on certain notions:

See "Healthy" page 20

Systems from page 8

begins the anesthetic and has trouble with the air ways and the patient dies. Accident or incident? Accident.

So, Dr. Cook asked, "What's the problem here? Who is to blame? If the regular OR nurse is sick, do we close the hospital? The holes are too small to cause an accident when looked at individually. These multiple small flaws combined together, however, create the circumstance for an accident to occur. Why are we so focused on the operator as the cause of the accident? The occurrence of the event makes it seem that the event was probable and should have been thought to have been probable beforehand. This is hindsight bias. This is built into our brains. When the outcome is bad, standard of care is judged as not being met much more often than when the outcome is nominal."

When you combine these two factors of complex system failure and hindsight bias, you realize error is the result of a social process of attribution," Dr. Cook explained. "It is not how things go bump in the night."

How do we Make Some Progress?

"Gaps in the continuity of care are common," Dr. Cook noted. Recurring, recognized gaps are partly offset by cognitive artifacts that make up for the discontinuities produced by gaps. An example of a recognized discontinuity is patient transfer between facilities. The transfer documents partly offset the loss of continuity.

If you take a closer look at the continuity of care, you would see smaller gaps that also occur frequently. Examples include trips to the operating room, change of shift, or change in location. Defenses against lost continuity of care include formal artifacts (e.g., the surgeon's op note) and less formal measures such as communication between operating room, recovery room and ward personnel.

"When the evidence of gaps is discovered," Dr. Cook explained, "practitioners need to go back into the past and discover what is missing to reconstitute the continuity of care. And if you watch what people are doing in health care, you'll discover that they are doing this all the time - in emergency rooms, intensive care units, various locations in hospitals. In some cases, you will find people spending as much as 20 to 30 percent of their time doing this kind of activity."

For instance, if a patient comes into emergency and is taking a plethora of medications but has no medication card and no medical problems - a practitioner doesn't just say, "Let's take him to the operating room." They take measures to find out why the patient is taking so many medications - perhaps question the patient, the patient's family practitioner, or a spouse. "We don't recreate the continuity of care perfectly," Dr. Cook said, "but we bring up enough information to be able to proceed forward." Dr. Cook described this process as a "Type 1 gap."

"With Type 2 gaps," Dr. Cook explained, "we look at the present and see a pattern in the present that makes us believe that a gap is likely in the future. Using that information, we try to create some sort of bridge across the gap so that the gap does not occur, or if it does occur, does not have the impact of destroying the continuity of care.

"Experienced practitioners can foresee future gaps," Dr. Cook explained. "What we value most in practitioners - what we cherish in each other as we practice medicine - is that ability to fix the past. And what we really value is the ability to foretell the future and to correct the failures that have not yet occurred."

Summary

Dr. Cook left the group with the following paradoxes:

The error is the focus on error. "Trying to fix the error is a way of not doing anything," he said. "What we really want to do is understand how failure occurs and modify the processes that produce them, not to understand where the error lies."

There is no safe place to talk about safety. "The trade-offs we have to make to perform the work we do in hindsight will seem to be bad after an accident, such as the care of one patient versus another, our attention to one thing versus another, the amount of money spent on one thing versus another. It is a continuing activity we are engaged in. We must make those trade-offs," Dr. Cook stressed. "If we don't, the world will not work at all. The problem is, that after an accident occurs, those trade-offs look like bad choices. Before accidents, they are just how we get things done."

Finally, Dr. Cook offered the paradox that success and failure flow from the same sources. "Our success at doing the high technology, complex medicine that we do today is the source of the failures we have, he explained. "The failures don't lie with a group of bad doctors or a group of bad nurses or bad administrators. The failures are embedded in the same things that produce our successes. We cannot have progress without affecting both the sources of success and the sources of failure."

In summary, Dr. Cook condensed and reiterated the following points:

- Safety is made and broken in systems, not individuals.
- Progress in safety begins with understanding technical work.
- Productive discussions of safety avoid confounding failure and error.
- Safety is dynamic, not static; it is constantly renegotiated.
- Trade-offs are at the core of safety.

"The hope I have for you as you work on these problems," Dr. Cook concluded, "is that you try and build the kind of social consensus with your patients, hospitals, the professional with whom you work, about what it is that we are trading off and why it is necessary to do this in order to make progress."

But most of all, Dr. Cook said, "my wish for you is that the holes may not line up for you!"■

In My Opinion.... The Invisible Hand

by Andrew Statson, MD

The opinions expressed in this writing are solely those of the author. *PCMS invites members to express their opinion/insights about subjects relevant to the medical community, or share their general interest stories. Submissions are subject to Editorial Committee review.*

The Bad Apples

Andrew Statson, MD

"If we do not maintain Justice,
Justice will not maintain us."
Francis Bacon (1615)

I had a sheltered residency. Oh, we had our share of complications and concerns about the patients who took a long time to get well. We worried about making mistakes, because we wanted to do a good job. We worked hard and studied hard. We didn't get much sleep and had very little time to call our own, but we managed.

One thing we did not worry about was liability. Occasionally, we heard of someone being sued. We knew the threat was out there, but it did not touch us closely and we largely ignored it. In Ohio in 1967, during my first year out of residency, the liability premium was $360. I could pay it with the fee from two deliveries and still have some left over. A coverage of $100,000-$300,000 was considered excessive.

In 1968, my liability premium jumped a whopping 50% to $540. I had to do three deliveries to pay for it. The talk of malpractice grew to a higher pitch, but suits were still rare and our faith in the basic fairness of our judicial system remained solid. We thought that if someone got sued, he must have done something wrong. This view was expounded by the leaders of our profession, who came up with the bad apple theory.

Their point was that there were a few physicians out there who practiced bad medicine and if we could get rid of them, or get them to do a better job, the problem would be solved. That belief led to the requirement of continuing medical education and license renewal, hoping to assure the public that physicians kept up with the advances in medicine and maintained their proficiency in practice by learning the new techniques and treatments as they came up.

So far, so good. However, instead of making things better, that made them worse. What happened was that the public got disappointed because medical complications continued at the same rate. The difference was that this time the public was led to believe that perfection was possible and complications should not occur. So by 1976, the need for coverage had jumped to 1/3 million and the cost of insurance for obstetrics in California was $28,000.

The problem, therefore, wasn't about keeping up with the advances in medicine. Suddenly, everyone felt threatened. It wasn't just the bad apples. The question no longer was whether, but when. If you had been in practice for about ten years, you were due for a lawsuit. Oh well, we were told, liability is just one of those things. It can happen to anybody, nothing personal, consider it as a cost of doing business.

In the late 1970's and early 1980's, as liability costs rose together with the general inflation, we raised our fees to meet our increasing expenses. When the health insurance premiums went up, the big employers, who were the major purchasers of insurance, complained. As a result, the insurance companies forced us into contracts discounting and freezing our fees. Fortunately, by then the general inflation also abated so that, at least for a short time, the system worked fairly well. We got squeezed, but not too badly.

During the last 10-15 years, however, our costs have steadily risen, while the payments for our services have not kept up. The increases in liability premiums during the last two years have become more than a cost of doing business. Since we cannot pass them on to our customers, they are not a form of expropriation.

The bad apple theory is no longer with us. Data from ACOG as of 1999 show that about 75% of the fellows of the College have been sued at least once and fully 25% have been sued four or more times. That is a lot of bad apples. The average obstetrician, again as of 1999, can expect to be sued 2.5 times during his career. I suspect that now, in 2002, the statistics would be even worse than that.

The exposure to liability in the residency program has increased even more than that for the private practitioners. The threat of liability has had a

See "Apples" page 12

Apples from page 11

paralyzing effect on physician training, by increasing the amount of time devoted to paperwork, thereby reducing the time available for learning and for patient care.

A study about two years ago reported that in some areas of the hospital, the nurses spend 40-50% of their time on paperwork. The figures for the residents and attending physicians are probably of the same order. That documentation burden has not benefited patient care. On the opposite, it may have been detrimental.

There is more. The liability situation has had an insidious effect on the character of our people. That effect is not limited to the United States, but is present in every country with a legal system similar to ours, such as Canada, Australia and Western Europe. The situation may not be as bad over there, they may be behind us by several years, but they are catching up fast.

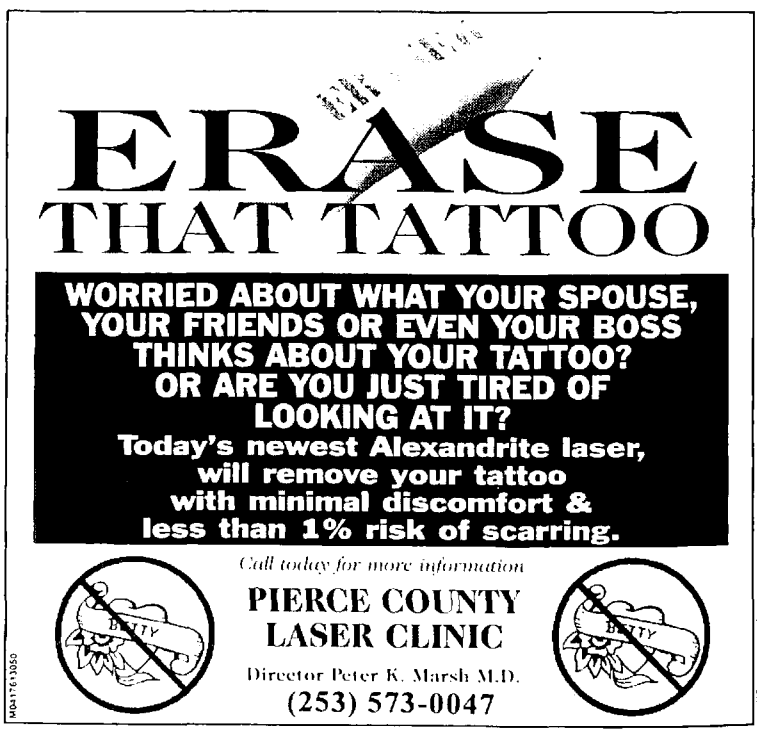
No, I cannot blame the attorneys in general for this problem. Most of them are caught in the cogwheels just as painfully as we are. Many attorneys are disappointed, if not outright disgusted, by the corruption in our judicial system.

Justice requires that the retribution be commensurate with the offense. Justice is denied when the retribution is too severe, just as much as when it is too light. When justice is denied, people can only feel contempt for the law.

Unjust laws and unjust verdicts are destructive to the social order. When justice is denied, the honest people fear for themselves and for their property, because they cannot trust that the judicial system will protect them. When justice is denied, the dishonest people use the judicial system to terrorize their neighbors or to cash in on the rich reward from the outsized verdicts.

The corruption of the judicial system eventually spreads to the entire community and destroys the social order. The social structure then breaks down, because society cannot exist without order. The bad apples in our society are not the physicians who make mistakes, we all do, nor most of the attorneys who take us to court. The bad apples are the people who claim injury and use the judicial system for personal enrichment and those who serve as jurors and judges and award them verdicts that have no correlation to the harm they may have suffered, if any.

One patient thought that her previous physician had done something wrong. She bluntly told me, "I have nothing against the doctor who did my first operation, I am not even mad at him. I just want to give him a little slap on the hand and get enough money so I can go on a trip to Europe." She did not get any money, but she certainly saw dollar signs flashing in front of her eyes and thought she had hit a jackpot. Those are the bad apples in our society and the system that allows them to flourish is corrupt and doomed to destruction. ■



In My Opinion....

by Scott H. Carleton, MD

The opinions expressed in this writing are solely those of the author. PCMS invites members to express their opinion/insights about subjects relevant to the medical community, or share their general interest stories. Submissions are subject to Editorial Committee review.

What Ever Happened to Physical Examinations, Clinical Histories, and Good Clinical Judgment?

As a diagnostic radiologist I get referrals from generalists and specialists alike. Most are good when ordering imaging studies within their own specialty or areas of interest but not as good otherwise. Recently there has been a definite increase in ordering of unnecessary or low-yield studies when no study or a better study is indicated. When I was in training in the late 70's there were many articles being written about the over utilization of x-ray exams. (Ultrasound and CT scanning were just getting started). One study showed that lumber spine films were very low-yield exams except in acute trauma. The patients with strains and chronic processes should be treated on a clinical basis and if that fails in 10 days then plain films may be of further benefit. Another study showed that patients with chest pain under age 40, with a negative physical examination did not need a chest x-ray as it was very low-yield. Those studies are now over 20 years old yet it seems every patient who enters the emergency room with these complaints still get lumbar spine films and chest x-rays without regard to the physical examination, clinical history, or whether they have had the same exam recently. This is just the tip of the iceberg.

In the early 80's when I was in the Air Force, in one week I had two patients referred for barium enema exams in whom the technologists could not insert the enema tips. Both had masses in the rectum that were palpable on digital rectal exams. Neither patient had a rectal exam in over a year prior to being sent for the barium enema. I asked the next 20 patients for barium enema if they had had a rectal exam (which should be automatic) in the last year and only seven said yes. One weekend, 11 skull series were ordered by the Emergency Room, essentially everyone with head trauma. A review of their charts was very revealing. Four patients did not have an eye exam documented. Eight patients did not have an ear exam documented. It was down hill from there. Only two had University of Washington criteria that would justify getting a skull series (now a CT scan). One of those two had a clinically palpable depressed skull fracture that was missed in the Emergency Room and on their review of the x-rays. The other skull series were negative. I thought things would be better in private practice. I was wrong.

"Now it seems that imaging has taken the place of a good physical exam, a complete history, and good clinical judgment."

A few years back when playing an indoor soccer game one of my teammates was seriously injured. He was a vascular surgeon here in town. I witnessed the injury and treated him on the field. It was certainly a closed head injury and possibly a neck injury. I went to the Emergency Room with him by ambulance with the EMT's doing a great job. At the Emergency Room, I told the ER physician exactly what had happened. He looked in the cervical spine, thoracic spine, and lumbar spine. I told him he did not have an injury to his thoracic spine or his lumbar spine and that those were unnecessary. His response to me was "We get C-spine, T-spine and L-spine films on every trauma patient." I felt very sorry for the x-ray technologist who had to take these x-rays and for the radiologists who had to read these on all trauma patients and I felt sorry for the patients who had to go through the x-rays and the delay it meant in treating the patients for their true injuries.

A few years ago, I went to the Emergency Room with flank pain. I thought it was a renal stone as I had passed several about 20 years ago. The Emergency Room physicians never made it past the doorway into my room. No physical exam was performed and no further history was obtained. I was simply sent for a CT KUB (certainly better than an IVP but not necessarily indicated in every case). A few years back I went to a general practitioner for a yearly physical (had been approximately six years since my previous one). The cardiac examination was a stethoscope in one position.

As an imager, I of course think imaging is great but it is great only for those who need it. For those who do not need it and get it, it is a waste of time and money and could put the patient at risk. They can be at risk if they

See "Judgment" page 16

Smallpox Vaccination Plan - Update

Tacoma-Pierce County Health Department to administer smallpox vaccines in January

As directed by the federal government, smallpox vaccination of health care workers will begin in late January, 2003. While the direct threat of intentional release of smallpox virus exists, being prepared for a potential smallpox case means vaccinating a limited number of people who will then be able to respond and protect the health of others. In Pierce County, **vaccine administration will be directed and controlled by the state Department of Health through the Tacoma-Pierce County Health Department**, once the vaccine is sent to the state by the federal government.

The plan for vaccination calls for two steps:

Stage 1 involves identifying public health and hospital staff who are willing to be vaccinated and have no contraindications, creating a core group of immune personnel who can safely investigate a potential case of smallpox, care for a smallpox patients, or vaccinate contacts. In hospitals, those to be immunized are primarily physicians, nurses and techs in emergency rooms, ICUs, and med-surg areas. A limited number of respiratory therapists, x-ray techs, security and support staff also will be vaccinated.

Stage 2 will target additional hospital, clinic and public health personnel, as well as first responders such as EMTs, fire, and police. This will follow shortly after Stage 1.

Currently, the plan anticipates that **vaccinations will begin as soon as President Bush signs the Homeland Security Act (expected to happen January 24th). It is possible the Congress, in response to an emergency, such as going to war, would move this up to as early as January 7th**. The Act provides legal protection for health departments, hospitals and individuals administering vaccine, from lawsuits arising from damages suffered by anyone involved with the vaccine program. This protection is critical.

Those receiving vaccine will be instructed to keep the site clean and covered with a 2x2 gauze pad and a semi-permeable dressing such as Tegaderm or Opsite. It is anticipated, however, that there could be a very limited number of adverse reactions among those receiving the vaccine or those close to them. TPCHD has posters and brochures that describe the possible side effects. Network Nurses are distributing them to hospitals, clinics and physician offices. If you would like a packet of material, call Sandy at: (253) 798-7687.

The Centers for Disease Control website is a good source of information about smallpox and the vaccination, and is updated regularly: http://www.bt.cdc.gov/agent/smallpox/index.asp.■

PCMS Foundation thanks Holiday Sharing Card contributors

Once again the annual Holiday Sharing Card project was a huge success. With over 200 contributions, the project raised over $15,000.

The card is mailed to all PCMS members with a listing of names of all contributors. It is an easy and effective way to extend holiday good wishes to colleagues and friends.

And a very big thank you must go to PCMS Foundation Board members **Mona Baghdadi and Nikki Crowley** who helped with all the work that accompanies such a project, particularly the printing and mailing preparation

Thank you to the following contributors whose donations were received after the card went to press:

Harold and Linda Boyd

Tim and Lael Duncan

Thomas Griffith, MD

Michael Jarvis

Dr. and Mrs. H. Richard Johnson

Mavis and Bob Kallsen

Art and Patty Knodel

Clyde and Sydna Koontz

Dr. Jane and Mr. Hugh Moore

Robert H. Wilson, MD

Judgment from page 13

need contrast for the study. They can be at risk just from the radiation exposure for many studies, especially CT scanning. The best imaging studies have a 90-95% sensitivity rate, however, most only have a 70-89% sensitivity rate. But that means that 1 in 4 to 1 in 20 will be falsely negative, giving false reassurance that things are all right. Both may delay the true diagnosis. And that is if the right study was ordered in the first place.

Now it seems that imaging has taken place of a good physical exam, a complete history, and good clinical judgment. It has taken the place of specialists seeing the patient first to determine whether a specialized exam is necessary. Instead they will not see the patient until the exam is done. Hence CT's are ordered seemingly on every head trauma patient and patients with headaches and dizziness at all times of the day and night. One afternoon I had three consecutive ER head CT scans ordered on patients with headaches, nausea and vomiting, body aches and diarrhea. We cannot be doing head CT's on every patient with headaches associated with flu, migraines, etc. We cannot be doing head CT's on every patient with head trauma without regard to history and physical findings. Using the University of Washington criteria cuts this to a reasonable number and includes the patients that need the examination. We do abdominal ultrasounds and body CT's at all hours of the day and night. Some are necessary and some are not. Most are not emergencies but are still being ordered in the middle of the night. Patients with chronic pain, no white count elevation, or fever are getting abdominal ultrasounds and sometimes CT's as emergencies (usually not fully prepped exams either) instead of being scheduled. Will this change what should be done with the patient in the middle of the night or on an emergent basis? Probably not! CT's for appendix are being done for every patient with right lower quadrant pain. This is great examination for patients in the "gray zone", or with questionable findings. Patients with a "surgical abdomen" should see a surgeon. Patients with a negative physical examination, no fever or white count should be followed. Because recommendations for this study are not being followed (essentially everyone gets it if appendicitis is a consideration), recent studies have shown that we have not changed the incidences of false positive or false negative surgeries for appendicitis at all, simply changed who is false positive or negative based on the CT scan. The same is true with kidney stones. The decision to admit a patient passing a kidney stone should depend on the clinical exam, on whether the patient's pain can be controlled on an outpatient basis or not, or whether the patient is infected or not. It should not depend on what the imaging examination shows. The patient can be totally obstructed and not have any pain or conversely in severe pain with a negative examination. The exam should not change what you do for the patient on an emergency basis in the middle of the night. Treat the patient and get the examination at a reasonable time. If the diagnosis is truly in doubt then get the examination to make the diagnosis. Most are not in doubt. When was the last time a urologist came in in the middle of the night to remove a stone anyway?

So what are the ramifications of the over-utilization of imaging at all hours? There is now a growing shortage of radiologists to cover the excess volume. We also have a severe shortage of technologists which is critical. They are leaving the field or they are switching to day jobs, without night call or weekends. The technologists are tired of coming in in the middle of the night for exams they know are not emergencies or are not even necessary (putting them at risk). This has become so prevalent that some modalities are occasionally not available. This has happened in ultrasound multiple times and recently St. Joe's and Good Samaritan Hospitals have stated that nuclear medicine will no longer be available at nights because of loss of technical support. This is critical for the hospital. Nobody has a problem with true emergencies. But it has become a little bit like the boy who cried wolf, we can not even tell what is going to be an emergency or not as we do not get appropriate indications for most examinations. A large number of these Emergency Room examinations are also unpaid. The hospitals eat the costs and should be doing something about it. We do not get paid but are still medically and legally at risk. The ER physicians will say that they are at legal risk if they do not get these examinations. I believe that that is not true if they use sound clinical judgment and follow-up. It is not a reason to double or triple the costs of treating patients without reimbursement and shifting the liability to someone else.

This is not to say that this is a problem with all physicians. There are defiantly some very good physicians who do an excellent job of evaluating their patients and ordering exams properly. These are also usually the physicians who are very good about consulting with us when they have a question as to what to order. These are also the physicians who not only do not mind us calling them but want us to call them if we think another examination might be more appropriate or if we think an examination is unnecessary. It is usually the physicians who do not know when or what examination to order that also do not want to be questioned about what they ordered even for the patient's good. When I am on call I look at the ER schedule to see who is on and I will know whether I will have a reasonable night (not necessarily a slow night but at least examinations that are emergencies and necessary) or a miserable night (busy with non-emergencies or unnecessary examinations to the point that I cannot tell what will be an emergency and it takes time away from the true emergencies). It ends up depend-

See "Judgment" page 22

Applicants for Membership

Darin G. Blackburn, MD
Family Practice
Sound Family Medicine
3908 10th St SE #200, Puyallup
253-848-5951
Med School: University of Colorado
Internship: Tacoma Family Medicine
Residency: Tacoma Family Medicine

Marthe L. Butzen, PA-C
Family Practice
Eastside Clinic - CHC
1720 E 44th St, Tacoma
253-471-4553
Training: University of Washington

Cleotilde C. Nimietz, PA-C
Family Practice
Sumner Clinic - CHC
1110 Fryar Rd, Sumner
253-863-0466
Training: University of Washington

Robert S. Emerick, MD
Cardiology
Cardiac Study Center
253-572-7320
1901 S Cedar #301, Tacoma
Med School: Columbia University
Internship: Beth Israel Medical Center
Residency: Beth Israel Medical Center
Fellowship: Columbia Presbyterian
Fellowship: St. Mary's Medical Center

Philip Furth, PA-C
Family Practice
NW Medical Specialties
1624 S I Street #405, Tacoma
253-627-4285
Training: University of Washington

Uma M. Krishnan, MD
Cardiology
Cardiac Study Center
1322 3rd St SE #330, Puyallup
253-841-4347
Med School: Thanjavur Medical College
Internship: Sparrow Hospital
Residency: Michigan State University
Fellowship: Michigan State University

Enrique C. Leon, MD
Family Practice
Eastside Clinic - CHC
1720 E 44th St, Tacoma
253-471-4553
Med School: Howard University
Internship: Swedish Hospital
Residency: Swedish Hospital

Tariq Salam, MD
Cardiology/EP
Cardiac Study Center
1901 S Cedar #301, Tacoma
253-572-7320
Med School: University of S Florida
Internship: University of Vermont
Residency: University of Vermont
Fellowship: University of Vermont
Fellowship: University of Rochester

Sundara R. Samavedi, MD
Internal Medicine
Franciscan Medical Group
2111 S 90th Street, Tacoma
253-539-9700
Med School: All India Inst of Medicine
Internship: U/C Michael Reese Hospital
Residency: U/C Michael Reese Hospital

Devendra K. Vora, MD
Cardiology
Cardiac Study Center
1901 S Cedar #301, Tacoma
253-572-7320
Med School: Nagpur University
Internship:; State Univ of New York
Residency: Baylor College of Medicine
Fellowship: UCLA Medical Center

Michael A. Waddick, MD
Family Practice
Eastside Clinic - CHC
1720 E 44th St, Tacoma
253-471-4553
Med School: University of Wisconsin
Internship: Swedish Medical Center
Residency: Swedish Medical Center

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

Warm Up with the Mariners March 5-9, 2003

College of Medical Education to offer CME program in conjunction with Mariners Spring Training

The Embassy Suites Phoenix North is the site for this spring's CME program with Mariners Spring Training. The course will offer 10 Category I credit hours and will cover several topics of interest including interesting infectious diseases cases, gastro "poopourri", headaches and heart failure. The large and beautiful hotel is conveniently located close to the Mariners Peoria stadium and offers greatly reduced and competitive rates ($119) for complete two-room suites that include a private bedroom and separate living area with sofabed. For the physically active, enjoy one of the largest pools in Phoenix, separate children's pool, fitness center, sauna, whirlpool, sand volleyball court, two lighted tennis courts, and two air conditioned racquetball courts. You can make your reservations by calling the hotel directly at 602-375-1777 or 800-527-7715. Be sure to mention are you with the College of Medical Education. ■

The Embassy Suites Phoenix - North

COLLEGE OF MEDICAL EDUCATION

Primary Care 2003 CME set for February 7

A new COME program designed for the primary care physician is set for February 7.

The one-day program will feature timely subjects faced in the daily routine of the primary care practice including presentations on:

- Depression
- Hypertension
- ADHD
- Metabolic Syndrome
- Geriatric Med Dosing
- Immunizations

The course is directed by **William Knittel, MD.** ■

Whistler CME Lodging Still Open - Today!

At press time rooms at the Chateau were still available for the CME program set for January 22-26, 2003 in Whistler - at the College's discounted rate.

To make reservations, you may call the Chateau at 1-800-606-8244 and be sure to identify yourself as part of the College of Medical Education group. ■

Continuing Medical Education

Make Air Travel Plans for CME and Mariner Spring Training - NOW!!

The College of Medical Education has set the dates of March 5-9, 2003 for its CME and Mariner's Spring Training program in Phoenix. The actual course is the mornings of March 6-8. **Richard Hawkins, MD** is the program director.

Flights to Phoenix during March often sell out in advance. In order to assure that you will have seats, we urge you to make reservations soon.

All Wanderlands Travel (new home of Olympus Travel) is handling the flight arrangements. Specifically, MARILYN is prepared to assist you in securing these seats. Please call Marilyn at 572-6271.

For lodging, the College has selected the Embassy Suites Phoenix/ North for conference headquarters. The large and beautiful hotel is conveniently located close to the Mariners Peoria stadium and offers greatly reduced and competitive rates ($119) for complete two-room suites that include a private bedroom and separate living area with sofabed. You can make your reservations by calling the hotel directly at 602-375-1777 or 800-527-7715. Be sure to mention are you with the College of Medical Education.

A program brochure was mailed in December. Questions? Call 627-7137. ■

Dates	Program	Director(s)
Monday, January 6; 13	Cardiology for Primary Care	Gregg Ostergren, DO
Wednesday-Sunday January 22-26	CME @ Whistler	John Jiganti, MD Rick Tobin, MD
Friday, February 7	Primary Care - 2003	William Knittel, MD
Wednesday-Sunday March 5-9	CME and the Mariners	Richard Hawkins, MD
Thursday-Friday March 13-14	Internal Medicine Review 2003	Maureen Nuccio, MD
Friday, April 4	Endocrinology for Primary Care	Ron Graf, MD
Friday, May 2	Allergy, Asthma & Pulmonology for Primary Care	Alex Mihali, MD
Friday, May 16	Advances in Women's Medicine	John Lenihan, Jr., MD

Healthy from page 9

1) that this approach is fair; 2) that it works in improving the actual health of the people it serves; and, 3) that it is reasonably affordable.

The sad truth is that these assumptions are not sound and that we have used faulty reasoning to set up our existing state system. Some unpleasant truths: 1) The system is not fair; there is a double standard. There is not free and easy access for the poor to care that is comparable to the private sector. 2) It does not work as promised - our communities are getting sicker and sicker. Many indicators that reflect the health of a community are worsening (unemployment, graduation rates, levels of violence, the obesity rates in our kids). 3) The costs are out of control - more than a double-digit inflation each year.

A solution should be based on what we know, not on the old assumptions. Instead of putting more money into a failing system, invest in what works to improve the health of our communities: put money into job creation, better education and into prevention. Funding these areas is effective and doesn't include the built-in, budget-killing cost increases.

In Pierce County, as in most communities, the major causes of poor health are not surprising: tobacco and drug use among kids, violence, and poor diet/exercise habits were the main culprits. They don't fit the sick-care model. Think about this: if we had no limits on resources and we gave every person an insurance card would these problems resolve? No. These problems are not solved in a clinic exam room. Each requires a change in people's behavior. And, since we know this, that argument to add more money to the old way of doing business doesn't hold up. We have limited resources which we must invest differently... and wisely.

I am not forgetting that we all can get sick at some point. We can address this need by constructing a safety net system for illness care which strengthens already-existing hospitals, clinics and community agencies.

When you don't change your life, your nightmares continue. The greatest impacts on this health care crisis will come from investments that strengthen our economy and that prevent illness, with a safety net for those who do get sick. Anything less is doing the same thing over and over again and expecting a different result. We can do better than that. ■

WSMA Legislative Summit set for February 3

Plan now to attend the WSMA Legislative Summit in Olympia on Monday, February 3. A full day of activities is planned. Tort reform, Medicaid funding, and funding for trauma services (among other issues) all need action.

Many physicians are seeing too many patients, not getting reimbursed adequately and feeling anger as their practice's viability is threatened. If you're tired of the current environment and want to change what is happening to the medical profession and health care, join us with your white coat and stethoscope as WSMA members tell state lawmakers that something has to be done to fix the state's health care system.

The summit is free for WSMA and WSMGMA members, and $160 for non-members. For more information about the summit or to register, contact Susan Peterson at the WSMA Olympia office at 360-352-4848 or 1-800-562-4546 (email skp@wsma.org), or call PCMS 572-3667 for a registration form that you can complete and fax back. ■

WSMA Legislative Summit
Monday, February 3, 2003
West Coast Olympia Hotel

AGENDA

8:00-8:30 am	Registration & Continental Breakfast
8:30-8:45 am	Opening Remarks & Introductions
9:00 am	Speakers & Program
11:30 am	**Lunch with Governor Locke** - *Invited*
12:30 pm	Busses to Capitol
1:00-4:00 pm	Individual Meetings, Committee Hearings
3:30-5:00 pm	Busses to Hotel

Physicians seek right to balance-bill under Medicare

The American Medical Association will advocate that physicians be allowed to bill Medicare recipients the difference between reimbursement rates and the actual cost of services.

The Association's House of Delegates passed the balance-billing resolution during the Interim Meeting in December 2002.

"It is imperative that we get back to a system where the economic arrangement is between the doctor and the patient," said Bohn Allen, MD, a Texas delegate. "This gives us the ability to not charge those who can't pay and to make the transaction a reasonable business transaction just like every other business person in this world does."

Physicians who take assignment from Medicare are not allowed to balanced-bill. Those who do not accept assignment can bill 10% over Medicare rates. The resolution calls for the AMA to lobby in favor of giving both types of physicians the ability to balance-bill and removing the 10% limit.

Doctors testified that such a change is vital to maintaining seniors' ability to access medical care, in light of reductions in Medicare payment rates. The reimbursement cuts are causing an increasing number of physicians to reduce the number of Medicare patients they will treat, if they take them at all.

"I continue to take care of Medicare patients, but it's a struggle," said Melvyn Sterling, MD, a California delegate. "It's a struggle of such magnitude that I've had to tell my office staff to check with me before they accept any new Medicare patients. It's a struggle that spans this entire country and hurts our profession."

Worries about image

Critics of the resolution accused doctors of attempting to give themselves a raise.

"If we're going to look at it only form the physician side, we'll have a bad PR image problem," said Arthur Traugott, MD, an Illinois delegate. "This is a Band-Aid solution that does not address the problem that the Medicare system is underfunded."

Supporters, however, said physicians are private business people who should have the right to charge as they see fit for their services. They also said that, if the issue is handled appropriately, patients would be amenable to balance billing.

"I'm the one, as an independent business person in a free country, who should be able to determine what my charge it," said Duane Cady, MD, an AMA trustee. "Under the previous system, when balance billing was allowed, I always talked to patients up front before I did any procedure. For example, I would tell them that my charge is $500. Medicare will pay $400, and we would like to be able to bill you for the difference. I can't remember one patient who refused to pay."

Consumer advocates said the onus for fair payment for medical services should be on the government, rather than Medicare beneficiaries.

"We're hearing from thousands of people a month who cannot afford their health care," said Diane Archer, the founder of the Medicare Rights Center.

"Primarily, they can't afford their prescription drugs. They can, today, afford to go to the doctor. That's a tribute to the fact that there are limits on doctors' charges for Medicare recipients. The issue is for the government to pay doctors at a fair rate."

The AMA has long had policies supporting balance billing where allowable by law or contract.

A spokesman for the Center for Medicare and Medicaid Services said an act of Congress would be required for physicians to be able to balance-bill Medicare patients. He added that agency officials would not want to see Medicare recipients unduly burdened by such charges. ■

Judgment from page 16

ing on who the physician working in the ER is, not on how busy the Emergency Room is or how many emergencies come in. While physicians and PA's in the ER's seem to be the worst abusers at this time, the hospitalists and their PA's aren't far behind.

My son and one of my daughters are both in medical school. I only hope that they are being taught how to do a good physical exam, take an appropriate history, and use good sound clinical judgment and not just how to order an imaging study for the appropriate body part in question. The art of medicine is being lost to the technology instead of the technology supporting and enhancing the art of medicine. We can recover from this but we better act quickly. The "table" below from a study by Phillip O. Ozuah, MD and Euguene Dinlevich, MD says it all! ■

Maneuver	USMGs (n=113)	IMGs (n=35)
Exposure of the abdomen	10 (9%)	22 (63%)
Inspection of the abdomen	29 (26%)	28 (80%)
Percussion of the abdoment	49 (43%)	24 (69%)
Light palpation	10 (9%)	25 (69%)
Deep palpation	34 (30%)	31 (89%)
Palpation for liver	9 (8%)	31 (89%)
Palpation for spleen	5 (4%)	26 (74%)
Palpation for kidneys	5 (4%)	27 (77%)
Rebound tenderness	9 (8%)	33 (94%)
Obturator sign	5 (4%)	20 (57%)
Ilopsoas sign	5 (4%)	18 (51%)
Rovsing sign	9 (8%)	24 (69%)
Localization of McBurney point	15 (13%)	33 (94%)

*All values are expressed in No. (%). USMGs indicates US medical graduates; IMGs, international medical graduates. $P<.001$ for all comparisons

WSMA sets tort reform agenda for 2003 Legislature

The Washington State Medical Association (WSMA), Washington State Hospital Association (WSHA), Physicians Insurance, and the Liability Reform Coalition have agreed upon the following agenda and bills for the 2003 legislative session.

They plan to tell Washington state legislators and the Governor that:

- There is a serious problem in this state with malpractice insurance premiums.
- It is quickly growing worse
- If reform of our tort law system is not enacted, our health care system in this state will further decline
- There is a solution that works, and it has been proven in California and it is called Medical Injury Compensation Reform Act (MICRA)

The following bills will be supported in 2003:

#1: Enact MICRA-like provisions in Washington State
#2: Approve a Constitutional Amendment to allow the Legislature authority to enact caps on non-economic damages
#3: Change the burden of proof in medical malpractice cases from a preponderance of evidence to a standard of having to be clear, cogent and convincing
#4: Change the provision of joint and several liability so that defendants will only be responsible for their proportionate share of the fault.

The primary objective is to make sure the Legislature understands that inaction on tort reform will seriously jeopardize the ability of our health care delivery system to provide necessary health care to our citizens. ■

Classified Advertising

POSITIONS AVAILABLE

Tacoma/Pierce County outpatient general medical care at its best. Full and part-time positions available in Tacoma and vicinity. Very flexible schedule. Well suited for career redefinition for G.P., F.P., I.M. Contact Andy Tsoi, MD (253) 752-9669 or Paul Doty (Allen, Nelson, Turner & Assoc.), Clinic Manager (253) 383-4351.

Tacoma, Washington. MultiCare Health System has immediate on-call occupational medicine opportunities available in its HealthWorks clinics. Qualified applicants must be B/C or B/E in Occupational Medicine or Family Medicine and have completed a U.S. residency program in one of these fields. Please fax your CV to 866-264-2818 or email to providerservices@multicare.org. For more information, please call 800-621-0301. Website: www.multicare.org. This position does not qualify for J-1 waivers.

Board certified family practice physician wanted for South King County Medical Clinic. Great opportunity for motivated doctor. Fax CV to 253-804-5797.

OFFICE SPACE

1,800 sq ft remaining on first floor at 1310-A South Union. All new tenant improvements included. Easy access, quiet, terms negotiable. Call Dr. Lovy at 756-2182 or 206-387-6633.

Price Reduced. Lakewood property for sale or lease - Class A. Ample parking. Highly visible. Easy access. 4900 sq ft available now. Total sq ft of 8733. Close to 100th & Bridgeport Way SW. Call Bob York or Cody Miller at 253-531-9400. Crescent Realty, Inc.

OFFICE SPACE

Medical space for sale and/or lease in rapidly growing South King County with 85,000 population service area. Need for pulmonary, pediatric, dermatology, orthopedic and gynecologic specialties. Call 360-825-1389.

POSITIONS WANTED

Transcription Specialists - We have years of experience in most specialties. We guarantee accuracy, fast turnaround time, free pickup and delivery and competitive rates. Outstanding references. Call 925-3276.

Pierce County Medical Society
223 Tacoma Avenue South
Tacoma, WA 98402

Return service requested

PRESORTED
STANDARD
US POSTAGE PAID
TACOMA, WA
PERMIT NO 605

Pierce County Medical Society

BULLETIN

February, 2003

PCMS says 'aloha' and 'mahalo' to Dr. Chris Jordan as he sails off into the Kauai sunset

See story page 7

INSIDE:

The Bulletin is published monthly by PCMS Membership Benefits, Inc. Deadline for submitting articles and placing advertisements is the 15th of the month preceding publication.

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 PCMS. Acceptance of advertising in no way constitutes professional approval or endorsement of products or services advertised. The Bulletin reserves the right to reject any advertising.

Managing Editor: Sue Asher
Editorial Committee: MBI Board of Directors
Advertising Information: 253-572-3666
223 Tacoma Avenue South, Tacoma WA 98402
253-572-3666; FAX: 253-572-2470
E-mail address: pcmswa@pcmswa.org
Home Page: http://www.pcmswa.org

Pierce County Medical Society
BULLETIN

February, 2003

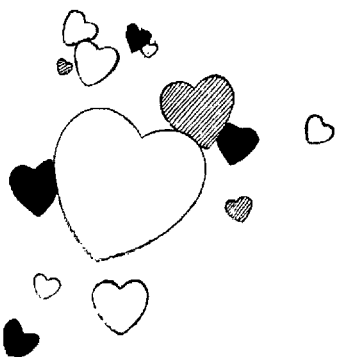


Table of Contents

President's Page

by J. James Rooks, Jr., MD

Staying Positive

J. James Rooks, Jr., MD

Last month I reported to you stating that I was going to focus this year on staying positive - a laudable goal for anyone in medicine today. THEN I got my malpractice insurance premium bill for 2003, up several thousand dollars, as I'm sure many of yours were too. Immediately, I was on the phone to my call partners hoping that this was indeed a fluke and that relief was in store. Alas, everyone else in the otolaryngology community was in the same boat, as were my ob/gyn friends, the general surgeons, and everyone else I could find to play that wonderful game of "ain't it awful." Well what can we do? One thing was to attend the Legislative Summit in Olympia, Monday, February 3, 2003 letting our legislators know what is happening and that relief is needed. In the long run it is not about our pocketbooks, but access to care for patients. I thank all of you who were able to attend.

Saturday, September 11, the Society's Board of Trustees met for our annual retreat where we discussed many topics. One interesting plan as communicated to us by Tom Curry, WSMA Executive Director, was a "Day of Action," not a strike, but a day where as many Washington State physicians as possible descend on Olympia in a show of action for the many reforms that are needed to insure practice viability, access to care for patients, and headway on tort reform. This day is only in the planning stages at this point, and if you are at all interested please let us know. In my opinion, this has opportunity to get the attention of our elected officials.

WSMA in association with the Washington State Hospital Association, Physicians Insurance, the Liability Reform Coalition and others have proposed the following tort reform agenda, which was presented to the PCMS Board by Len Eddinger, WSMA Director of Public Policy and Planning: 1) Enact MICRA-like provisions such as has been done in California. 2) A constitutional amendment to allow the legislature authority to enact caps on non-economic damages. 3) Changing the burden of proof in medical malpractice cases from a preponderance of the evidence to a standard of having to be clear, cogent and convincing. 4) Changing the provisions of joint and several liability so that defendants will only be responsible for their proportionate share of the fault.

Finally, I've asked Sue Asher to reprint elsewhere in this addition a recent, excellent article by Charles Krauthammer, a columnist for *TIME* magazine (see page 17). Charles is actually a physician himself, though not practicing because of physical disability. It's just outstanding and I hope you are as impressed as I was. Till next time, stay positive, remembering that we physicians possess some of the country's best minds, have lots of ambition and drive, made the best grades, and have survived countless tests and trials. We still have so much to be thankful for in this always challenging, never boring, noble profession. ■

L&I Blues?

Have you been experiencing difficulties in dealing with the Department of Labor and Industries?

Difficult time with claims?

Problems processing patients or paperwork?

*Please let PCMS know. Call us at **572-3667** and ask for **Sue**.*

Neighborhood Clinic

Thanks to the community, the Neighborhood Clinic was open ten more clinic nights and had almost 150 more patient visits in 2002 than in 2001 - a total of 813, with 50% being first time patients. Of the 813 visits, 26% were already pretty knowledgeable about their medical condition and 59% told us that their understanding was improved after their visit. Just 4.5% were seen on return visits for the same diagnosis.

Patients were: 54% female, 64% Caucasian and 21% African-American, with the remaining 15% being comprised of Asian, Hispanic, Native American, and mixed origins. Three fourths of patients live on less than $625 per month. Over 45% hail from the Hilltop area of Tacoma and zip codes 98401 through 98409. Age range of patients were 41% 19 to 40 years of age and 48% were 41 to 60.

Clinic overhead continues 24/7, rent, utilities, part-time salaries and supplies - all the expenses required of operating a clinic. None of this could happen without the support of our grantmakers and donors: A very big debt of gratitude is owed to United Way of Pierce County. Others to be thanked include United Way of Kitsap, Thurston and King Counties, Combined Federal Campaign and Combined Fund Drive, Boeing Good Neighbor Fund, **Pierce County Medical Society Foundation**, the Greater Tacoma Community Foundation, Medical Rentals of Tacoma, Automated Systems of Tacoma, the church communities of St. Andrew Episcopal, First Presbyterian, St. Leo the Great, St. Charles Borromeo and the Archdiocese of Seattle. Faithful family donors: Adolfs, Beldings, Bridges, Fleischmanns, Gallaghers, Harrs, Teodoros and the Yeager girls.

The Neighborhood Clinic extends many thanks and gratitude to all who generously and faithfully contribute to the clinic. ■

Elizabeth K. Miller, RNC
Acting Executive Director

January General Membership Meeting Recap

by Jean Borst

Creating an Efficient Practice Management Team: An Evening with Elizabeth W. Woodcock

Editor's Note: PCMS would like to thank the Tacoma Area Medical Managers (TAMM) for co-sponsoring this meeting with one hundred seventy physicians and managers.

"Efficiency is not elusive," according to Elizabeth W. Woodcock. "You are the system. This is your practice. You are the one who has created all the inefficiencies and processes. It's time to take your practice back." Ms. Woodcock, MBA, FACMPE, a nationally renowned speaker and Director of Knowledge Management for Maryland based Physician Practice, Inc., offered a thought-provoking, witty and valuable presentation on creating an effective practice management team at the January General Membership Meeting. "The core nature of our business, from a financial perspective, is the fact that physicians are paid in the United States based on efficiency," she said. "The idea of efficiency is very important to our bottom line," she explained. "Your costs are actually pretty steady - more than 80 percent are fixed." But there are two very serious issues going on that are getting in the way of running efficient practices, she said. Generation-X physicians are just now coming into the work force and are unwilling to see the volume of patients. And there is also the issue of burned out physicians, who are now burning out in their late 40s and early 50s because they spent the last 20 years saying, 'just work a little bit harder.' "Between the business concepts and what has really become a significant crisis in terms of our workforce of physicians on both the front end and back end of careers," she explained. "efficiency - really just a back-to-the-basics solution -

See "Team" page 6

PCMS Board members Matthew White, MD (left) and Mike Kelly, MD talk about office efficiencies after the meeting

Elizabeth Woodcock (left) answered many questions from physicians and managers on being more efficient

From left, office manager Ron Robinson visits with Dr. Michael Dunn and office manager Steve Jacobson

Right, Dr. Todd Kihara, vascular surgeon visits with his office staff after Ms. Woodcock's presentation

Team from page 5

is becoming much more important for medical practices across the country."

Managing *Both* Patient Flows

The average physician handles between 2,500 and 3,000 patients annually. That patient load generates 100 calls per day. "Often times, what I see is a medical practice that has actually shifted its focus from seeing patients in the office to just dealing with all of these stupid phone calls," Ms. Woodcock said. What types of calls are coming into your office? To find out, Ms. Woodcock suggests physicians distribute to all employees answering incoming telephone calls a tracking form that defines calls by type as well as hour of the day. Look at the log and ask yourself, "Am I getting paid for these calls? No." As for repeat calls, there is no revenue from these calls, and certainly no patient satisfaction. They are calling back because you haven't answered their call in the first place. Here are some ways to get control of the phones:

• Prescription refills: Ask the patient when they are in the office. (More than 30 percent of patients calling for refills are patients you have seen in the past week, Ms. Woodcock said.) And be sure to send them in legible format to avoid calls from the pharmacy.

• Test results: Establish realistic expectations and send normals out. "More and more patients want their lab results regardless of the results," Ms. Woodcock said. "It prevents calls to the office and helps empower the patients in regards to their own care."

• Phone triage: "If you don't do anything else," Ms. Woodcock said, "I encourage you to focus on this." These are all the patients calling you about everything from pre-op procedures to treating bee stings. Studies have shown that 40-50 percent of these patients were just seen. "Anticipate the patient's needs when they are in the office. It helps in terms of patient empowerment and education." She added that some physicians are now carbon copying their patients on dictation. These types of steps will prevent all the care calls that come in after the fact.

• Schedule appointments: Establish templates for a minimum of three months out.

"Pay attention to the two-patient flow, get away from the phones and back to patients in the office," she summarized.

Preparing for the Visit

The most efficient physicians don't leave the exam room before the end of an appointment. More than 40 percent of the time, however, a physician has to leave the exam room to get something to do their job. Be prepared before the visit is the solution. Anticipate the visit, and prepare much like the way you would in an operating room. "After all, the exam room is essentially your operating room in your practice," Ms. Woodcock said. "If you don't anticipate the visit it takes you longer to get information in the midst of chaos than it does in a controlled environment."

• Preview charts

• Have a staff/physician "huddle." ("Don't call it a meeting," Ms. Woodcock said. "No one will come.") The staff/physician huddle should always include the scheduler, and the day's schedule should be used as a meeting agenda. "This helps you get a rhythm for the day," Ms. Woodcock offered. "Why not take control of the day, instead of the day controlling you?"

• Prepare the exam room

• Ensure consistent support staff. It is very beneficial to all to have the same nurse, medical assistant, same LPN, etc, day in and day out. "The most efficient physicians work with consistent support staff," she said.

Space/Workstations

"Would you pay an employee $200 an hour to escort a charge ticket from the exam room to check out?" Ms. Woodcock asked the audience. "Of course not, so why are you carrying papers all around the office? Those extra steps can really add up," she continued. "Every unnecessary step is unproductive and unprofitable." You can make your space more efficient via two solutions: co-location and technology. Put people closer to people. Bring your technology resources closer to the people who use them. Ms. Woodcock explained that the typical medical practice uses their space less than 25 percent of the time. What steps can you take to ensure your are using your space most efficiently? Here are some suggestions:

• Operate a 12-hour day

• Operate through lunch or stagger lunch shifts

• Evaluate outpatient schedules

• Outsource the space

• Group visits

• Share exam rooms (a bullpen approach)

• Eliminate non-revenue-producing space

• Match supply to capacity

• Expand hours. Consider "fast access" morning clinics. Many practices have discontinued evening clinics because they are so difficult to staff. Morning clinics, however, are very popular with both staff and patients.

Batching vs. Real Time

"Avoid becoming a practice of professional organizers or 'batchers,'" Ms. Woodcock warned. Do you have batchers in your practice? Are your "professional organizers" spending the majority of their time organizing their work rather than doing their work? "If you see more than three colors of highlighters on your or a colleague's desk - be alert," she quipped. Be aware of professional organizers, and if you do have them in your practice, don't reward them. Recognize that the best way to deal with these people is to set guidelines and restrictions. Make them accountable - make them turn in their work - and help them recognize their lost and unproductive time. How do you, the physician, learn to recognize and avoid batches in regards to your dictation, messages, emails, voice mail. You don't want to save all the batches

See "Team" page 12

Dr. Chris Jordan: Sailing off into the Kauai Sunset (but only on his day off)

by Jean Borst

Aloha (ah loh' hah!) love, affection, compassion, mercy, sympathy, pity, kindness, sentiment, grace, charity; greeting, salutation, regards; sweetheart, love, lover, loved one; beloved, loving, kind, compassionate, charitable, lovable; to love, be fond of; to show kindness, mercy, pity, charity, affection; to venerate; to remember with affection; to greet, to hail. Greetings! Hello! Goodby! Farewell! Alas!

Mahalo (mah hah' loh). Thanks, gratitude; to thank.

"I guess you could say the state of Washington is responsible for me leaving," said **Dr. Chris Jordan**, a partner with Cedar Surgical Associates in Tacoma. "Between the situation with my home and medical practice issues, I feel like I had no choice but to move to Kauai."

No choice but to move to Kauai? Needless to say, has to be quite a story behind that statement. This decision wasn't a simple matter of retiring to paradise.

A Little Background

Dr. Jordan is board certified in general surgery, as well as colon and rectal surgery. Raised on the East Coast, he majored in Marine Biology at Boston University and attended the University of Massachusetts Medical School. Following his General Surgery training at Dartmouth, Dr. Jordan completed a fellowship in colon and rectal surgery in Pennsylvania.

Dr. Jordan and his wife, anesthesiologist Elaine Kubota, came to Tacoma in 1985 when Dr. Kubota was completing her residency at the University of Washington. "We fell in love with the area and knew this is where we wanted to live." So, Dr. Jordan answered an ad in a surgery journal for a position in Tacoma. "I called **Dr. Ron Taylor**, Tacoma general surgeon, we met, we talked, I helped him in the operating room, we hit if off well and he asked if I wanted to come to Tacoma. I said yes, we shook hands, and that was it! It doesn't happen like that anymore."

His timing was perfect. Dr. Jordan began working at Cedar Surgical the week that President Ronald Reagan had his colon cancer surgery. "It was great advertising," he said. "I was on television, in the newspaper, gave all sorts of talks. So, I was busy from day one."

The couple embraced the Pacific Northwest as their new home. The lived for a while in Gig Harbor and in 1988 purchased a piece of dream property on Vashon Island and built a home. In 1996, the county (despite neighborhood protests) installed a guardrail behind their house on a rather precarious bank. Within six months, two landslides came down on each side of the house. "The county tagged the house and essentially condemned it," Dr. Jordan said, and as a result, they were unable to live in it. "Here I was with this big, beautiful home on Vashon, paying taxes and mortgage on it, but I couldn't live in it." Dr. Jordan and his wife moved to a 900-foot condo in the North End, thinking the situation would last only a matter of months until building permits could be obtained and construction on a new home could begin. But it didn't happen that way. Six years and over $50,000 later, the building permit came through. The final straw was 11 pages of restrictions from the Department of Ecology including a requirement that a septic system could only be installed between July 15 and September 15. "The building permit came through September 11," he said, "which meant I had to wait an additional year to put in the septic or well. At that point, I wasn't waiting another year."

Chris Jordan, MD

But that's only half the story.

The State of Medicine in Washington State

Echoing current prominent sentiments among physicians in this state, Dr. Jordan said declining income, the high cost of malpractice insurance, and low reimbursement rates are putting an incredible financial squeeze on Washington physicians. The state ranks 45th in the nation on Medicare reimbursements. As a result, more physicians are retiring early or leaving the state. And it is becoming increasingly difficult to recruit physicians to come to Washington. "It's very hard to get people to come to this state unless they have a family member already here or some other strong reason to come," Dr. Jordan said. "The pay is so low compared to everywhere else. It's a real problem, and not just for general surgery, but for all the other groups, too."

The issue has hit close to home. **Dr. Stan Harris**, a former partner, retired from practice last year at the age of 57. In addition, he sees [illegible] doctors giving up their OB practices be-

See "Jordan" page 8

Jordan from page 7

cause of malpractice rates. "We also have an anesthesiologist crisis," he added. At Tacoma General alone, six individuals recently left and the hospital has been forced to close rooms. Dr. Jordan knows one anesthesiologist who is moving to Texas where he will make 50 percent more than his present salary.

The Kauai Connection

In the process of recruiting someone to replace Dr. Harris, the physicians at Cedar Surgical interviewed Dr. James McGreevy last February. A fellow Dartmouth grad, he and Dr. Jordan "really hit it off." The group hoped Dr. McGreevy would join them, but he instead accepted a position in Kauai. "He told me he had to go to paradise," Dr. Jordan said.

Months later, Dr. McGreevy called Dr. Jordan and invited him to join him in practice at the Kauai Medical Group. "I was already going to Maui in July on vacation," he recalled, "so I took a side trip to Kauai to interview. I liked them and they liked me. On August 14, I gave my six-months notice to the group, and I was going to Kauai!"

It was a shocker. The group was stunned. "But I was stunned, too," Dr. Jordan said. On the plane ride from Maui to Kauai, his wife wondered aloud why they were even making the trip and said, "I don't know why we're going. They don't have a job for me." During the interview, the CEO of the Kauai Medical Group turned to his wife and said, "By the way, we have a spot for an anesthesiologist, would you like a job, too?"

One more step toward fate. There had been several along the way. In December 2001, Dr. Jordan sold his sailboat. Cedar Surgical sold their office building the following February. His house in Vashon was an ongoing headache and the long-awaited building permit came through one month after he signed the contract to go to Hawaii. The decision to go nearly made itself. But things could have turned out much differently, if it wasn't for the state of Washington.

"If the state had given me my building permit in June, I would have begun building in July and would be in the middle of building a house right now. I would have stayed here and would never have left. So, between not giving me the building permit and the lousy pay..."

While Dr. Jordan and Dr. Kubota had never entertained the thought of relocating to a tropical paradise at this point in their respective careers, they do have a longtime connection to Hawaii. Shortly after arriving in Tacoma, Dr. Jordan began racing sailboats with **Dr. Tom Bageant**, a PCMS member and local anesthesiologist. They crewed together in the Victoria to Maui race and placed third. In all, he's done eight transpacific races to Hawaii. In addition, the couple vacations in Maui each year.

"I always thought I'd retire to Maui," Dr. Jordan said. "When this opportunity came up I thought, 'How many doctors do I see retire who are dead a year or two later?' Life is too short."

Regardless of the circumstances leading to his departure, Dr. Jordan admits that it's difficult to leave.

"Tacoma is a great place to practice medicine. I'll miss my partners. They are terrific, excellent surgeons. If things don't work out, I hope they will take me back.

"In addition, the consultants we have here in town are wonderful," he continued. "I can find someone to take care of anything. I almost never sent anyone to Seattle. I'm going to miss that, because I certainly won't have the same referral base in Kauai.

The departure is difficult for other reasons, as well. "I'll really miss all my sailing buddies here," he said, naming **Dave McCowen** (endocrinologist), **Ken Bodily** (vascular surgeon), **Tom Bageant**, **Phil Craven** (infectious disease specialist), **Don Hebard** (retired radiation oncologist) and **Ron Knight** (cardiac surgeon).

The reaction from his peers is predictable. His loss will be felt. "They say we'll miss you, it's a loss for the community," Dr. Jordan said, "but we understand why you're going."

People have offered to have parties, but Dr. Jordan has tempered that effort. "It's not like I'm retiring. I plan to work another 10 or 15 years before I hang it up. But I feel guilty because it's a little like I'm abandoning the community." The nurses at Allenmore did throw a Hawaii-theme surprise party complete with a Hawaiian shirt and a basket of local goodies to keep him from being homesick.

Many Contributions to Pierce County

Over the past 17-plus years, Dr. Jordan has played a very active role in Pierce County medicine. Along with **Drs. James Rifenbery** and **Alan White**, he was instrumental in establishing the trauma center. He was active for many years with the Pierce County Medical Bureau, and was chairman of the board in 1992. Dr. Jordan has also been very involved with Northwest Physicians Network, acting as president for one year and serving on its board for six. He has served on numerous hospital committees and was for many years actively involved with the Tacoma Surgical Club. "Dr. Jordan has always been a voice for physicians in this community," said Sue Asher, PCMS Executive Director. "He is an excellent communicator and always abreast of important issues." She noted that he was a frequent writer of letters to the editor and participated in editorial meetings between PCMS and *The News Tribune*. He also volunteered his time with the Society's Mini-Internship program and the College of Medical Education where his enthusiasm for the profession and love of teaching were tremendous assets to the various program's participants.

What Lies Ahead

Needless to say, Dr. Jordan will be stepping into a much different professional pace in Kauai. Approximately 60,000 people live on the island and are served by one 85-bed hospital. As part of the Kauai Medical Group, formed in 1967, Dr. Jordan joins approximately 65

See "Jordan" page 20

The Health Status of Pierce County

by Bob Jensen, MD, MPH

Recognition and Treatment of Smallpox Vaccine Adverse Reactions

Editor's Note: Bob Jensen, MD, MPH, is Liaison for Medical Care Access and Public Health Emergencies for the Tacoma-Pierce County Health Department.

Most all physicians in Pierce County have an opinion regarding the risk and feasibility of terrorists releasing the smallpox (Variola) virus onto the American public. We may also have a strong opinion on whether or not we join the effort for vaccination of health care workers and "first responders" (so-called Stage 1 and Stage 2 of pre-event smallpox vaccination planning). Finally, we may or may not believe that preparation and planning are necessary in order to "rush to action" after the first case of smallpox is diagnosed somewhere in the United States. The medical community must find the delicate balance between adequate preparation and real (in contrast to perceived) risk to immunocompromised individuals. Despite this healthy exchange of opinions, there remains the irrefutable fact that we will begin smallpox vaccination of health care and public health smallpox response teams in Pierce County and throughout the state of Washington beginning in February 2003. It is therefore imperative that physicians be aware of issues revolving around the use of Vaccinia virus for smallpox immunization, including the recognition and treatment of adverse reactions.

After a year and a half of hearing about bioterrorism, it is now time to do our homework. From the outset, it is important to note that the smallpox (Vaccinia) vaccine used today is the same that you received if you are over the age of 30. This vaccine safely eradicated smallpox from the face of the earth, with the exception of virus that remained stored in research labs. Vaccinia virus is delivered intradermally using a bifurcated needle holding a controlled dose of the vaccine between its tines. There is some question whether the CDC will recommend the 15 strokes of the needle utilized by the World Health Organization to eradicate smallpox disease, or the three strokes mentioned in the DryVax package insert. Once the vaccine is administered, virus begins to replicate at the site to form a papule. This papule progresses to a vesicle, then to the pustule or pock that is similar to that seen in smallpox. In primary vaccinees, the vesicle forms around day seven. If it does not form (a so-called non-take), the individual is judged to be a non-responder and must be revaccinated. Depending on the length of time between vaccinations, those previously vaccinated may move through the lesion evolution faster than for primary vaccinees. Since a live virus is used, normal reactions may fall outside of a physician's usual comfort zone. These include the formation of nearby satellite lesions, intense erythema, considerable local edema (viral cellulitis), local lymphangitis and tender lymphadenopathy. These latter reactions should not be confused with bacterial cellulitis requiring antimicrobial therapy. I highly recommend visiting the CDC website to become familiar with normal and adverse vaccine reactions (www.bt.cdc.gov/agent/smallpox). Accompanying local and systemic reactions to vaccination can include low-grade fever, malaise, myalgia, chills, nausea, fatigue, various erythematous and urticarial rashes and rarely, bullous erythema multiforme.

Approximately 1,000 adverse reactions per 1 million primary vaccinees were encountered previously, up to 1972 when the United States ended routine vaccination. As we are well aware, the complexion of our present population is different and these estimates will likely be higher. It should be noted that the risk of adverse reactions is much lower in individuals who have been previously vaccinated and 20% of adverse events occurred in contacts of vaccinees, largely due to poor hand and vaccination site hygiene. The major complications of smallpox vaccination are characterized below:

"It is imperative that physicians be aware of issues revolving around the use of Vaccinia virus for smallpox immunization, including the recognition and treatment of adverse reactions."

Inadvertent Inoculation

This represents over half of the adverse events (25-529/million primary vaccinations), caused by virus spread to any part of the vaccinees body or to other close contacts. The face, mucous membranes, and disrupted skin are the most frequent sites of involvement due to our propensity to touch these areas. Good hand and site hygiene are critical in preventing this complication. Although unsightly, most lesions heal without specific treatment.

Vaccinia Keratitis

This represents inadvertent inoculation of the cornea, potentially leading to blindness from corneal scarring if not untreated. Symptoms appear ten days

See "Vaccine" page 10

Vaccine from page 9

after virus transfer. Topical antiviral agents are the treatment of choice.

Eczema Vaccinatum

This complication has been seen in 10-39/million primary vaccinations. It represents local or systemic spread of virus to disrupted skin. Individuals with a history or active eczema or atopic dermatitis are at highest risk. The virus spreads quickly from cell to cell, causing extensive infections. Treatment should include hospitalization and urgent use of Vaccinia Immune Globulin (VIG) that is obtained through consultation with CDC. Mortality has been prevented in patients treated promptly and adequately.

Generalized Vaccinia

The appearance of vesicles or pustules appearing on normal skin distant from the vaccination site heralds bloodborne spread of Vaccinia virus. This was seen in 23-242/million primary vaccinations. Most of these rashes produce only minor illness with little residual damage, resulting in a self-limited process requiring only supportive therapy. VIG is indicated only for immunocompromised individuals who may have a toxic course, requiring hospitalization.

Vaccinia Necrosum (Progressive Vaccinia)

This a severe and potentially fatal illness characterized by progressive necrosis at the vaccination site, often with metastatic lesions distant from the site. This was previously seen in only 1-2 cases per million primary vaccinations. Defects in cell-mediated immunity are associated with nearly all cases and requires prompt hospitalization with aggressive use of VIG, often in massive doses.

Post-Vaccinial Encephalitis

Encephalitis or meningoencephalitis, seen in 3-12/million primary vaccinations, is believed to result from autoimmune or allergic reactions rather than direct viral invasion of the CNS. This is a severe disease with high mortality and morbidity. Approximately 15-25% of those affected die and 25% develop permanent neurological sequelae. No specific therapy is available. VIG is not effective and is not recommended.

Fetal Vaccinia

This is a very rare complication of smallpox vaccination and it usually results in stillbirth or death of the infant soon after delivery. Smallpox vaccine is not known to cause congenital malformations.

Death

Approximately 1-2 deaths occur per million primary vaccinations. The death rate is one fifth as high in those previously vaccinated. As described above, most deaths are associated with cases of eczema vaccinatum, progressive vaccinia and encephalitis.

Extensive photographs and information are available on the CDC website, covering all aspects of vaccine administration, site care, normal reactions and adverse events. I encourage you to visit this site regularly so that you will be prepared if vaccinees or their contacts walk through your clinic door. I would also contend that through proper screening and hygiene, many of these complications are preventable. ■

In My Opinion.... The Invisible Hand

by Andrew Statson, MD

The opinions expressed in this writing are solely those of the author. *PCMS invites members to express their opinion/insights about subjects relevant to the medical community, or share their general interest stories. Submissions are subject to Editorial Committee review.*

In the Vise

Andrew Statson, MD

"If this is the best of all possible worlds, what are the others like?"
Voltaire (1759)

As the economic vise threatens to crush our profession, the knowledge that we are not alone is a sad consolation. Benjamin Franklin was partially right. Whether we stick together or not, we all shall be crushed together. Many among us hope that tort reform will solve the problem. No, it won't.

At the meeting of the Washington State Obstetrical Association in December, a speaker presented the California experience. In the mid 1970's, the liability premiums in California were much higher than in the rest of the country. Now they are closer to the national average, presumably because of tort reform. It is also possible that California was ahead of every other state in the liability crisis and now the others are catching up.

Still, over twenty years, from 1977 to 1997, their liability premiums increased almost three-fold. Unfortunately, the speaker presented the figures up to 1997. Yet a major increase in liability costs occurred since then.

Until 1998, we didn't fare too badly in this state, either. Our premiums have doubled since then. One colleague from California reported that his premiums went up 25% in 2002, so they are not that much better off. Their rate of liability claims per capita is 50% above the national average.

I was in California in the early and mid 1970's. Our county medical society had a three-year contract with Hartford, 1973-1975, during which time our premiums did not change. In obstetrics we paid $7,000 for 1/3 million coverage. Remember, at that time insurance was based on occurrence, not on claims made. At the end of 1975, after suffering large losses, Hartford pulled out. Another company offered insurance on an individual basis for $28,000.

That year, one of my colleagues had to borrow a little to pay the first quarter premium, and some more to pay the second. He couldn't borrow enough to pay the third quarter, so he dropped his insurance.

"We look to the government for a solution, but that is the place where we are likely to find the problem."

Another colleague went without insurance from the beginning. He retired two years later, but was named in a suit while uninsured. The other parties had insurance and the verdict went against them. After their insurance company paid it, it turned around and sued him personally for his share of the judgment. He lost the case and that wiped out a large portion of his retirement fund. He had to go back to work.

Tort reform will slow down the rise in liability premiums, but it will not decrease them. Even though the cost for the average verdict may be smaller, the number of suits is growing, and so are the costs to defend them. As long as people sue for every complication, for every unsatisfactory result, for every perceived problem, whether real or not, the liability premiums will continue to go up.

Our problem, however, is much broader than liability. All our expenses have gone up over time, while our compensation has decreased. Twenty years ago, a report compared the cost (not the price) to an office to provide a patient visit. In a private office it was $9 per visit, versus $30 in a large non-profit clinic and $40 dollars in a government-run clinic, such as a county hospital, military clinic or the VA.

Today, the cost advantage of a private office is lower because of the increased overhead, due to the regulatory burden on the practice of medicine. A number of laws and the associated regulations from various agencies imposed administrative requirements on our practices, which raised significantly the cost of doing business. Even a solo practice now needs a manager.

See "Vise" page 13

Team from page 6

for the end of the day. A solution is to do dictation or documentation immediately after or during an examination.

Supporting the Billable Provider

Physicians have three different types of time: wasted, delegatable and productive - the latter of which is less than 60 percent of the time. "In the U.S., you are not reimbursed for wasted and unproductive time," Ms. Woodcock said. "In this room alone, think what that could mean in terms of revenue but also in terms of the additional patient care you could deliver to your communities. It's unbelievable. And yet, physicians spend a lot of time in wasted, delegatable activities." What can you do to help yourselves?

1. Start on time and stay on time. Ms. Woodcock said 90 percent of physicians start the day behind. "Many offices operate on two schedules - one for the patient and one for the physician. If a physician is to be at the office at 8 a.m., the appointment is scheduled for 7:30 or 7:45. Make sure the patient is ready to go in the exam room. "Part of the problem is that physicians hold documentation until the end of the day and leave a stack of charts on the nurses desk." Ms. Woodcock noted. "The nurse comes in the next day and finds 25 charts on their desk. If I'm that nurse, am I going to go out and get patients from the waiting room just to be sure they are ready and waiting for the physician at 8 a.m.? No way, I'm going to try to knock off at least 10 of those before I put a patient back in an exam room. It's a vicious cycle. Until you think about it, understand and recognize it, you'll never be able to stop that cycle. You'll continue to be inefficient." So, once you are able to start the day off on time, how do you stay on time? Work with clinical support staff, Ms. Woodcock stressed. One suggestion is the "Dr. Jones" solution. Instruct staff to come in to the exam room after a set amount of time and say, "Dr. Jones is on the phone for you." Of course, there is no Dr. Jones, but it sets up a signal for your staff to communicate the issue of time. Set up additional response signals, such as, "Tell Dr. Jones I will return his call," to alert the staff member that you need additional time with this particular patient.

2. Communicate with staff in writing. As a practitioner, you should never have to sit and wait for support staff to tell you something. Use a chart ticket/encounter form, utilize message boards, patient flow sheets, etc.- whatever you need to do to communicate as much as possible with support staff to avoid waiting.

3. Stay "on the court". Don't escort your patients to check out, don't go to your office, etc. Reduce your steps and stay in the area.

4. Create a fourth exam room. "This is a simple, yet powerful concept," Ms. Woodcock noted. Every fourth patient is a virtual one. This virtual patient includes your forms, prescription refills, phone calls, etc. You avoid batching/organizing work and leaving it until the end of the day and you are not waiting on support staff. "Help your support staff help you," she said. "Take care of the work - do it now. Avoid spending more time and effort in the future."

5. Dictate/document right after or (even better) during the visit.

6. Don't be trapped by your own schedule.

• Simplify your template. Reduce the number of "types" of patients

• Expand your hours and integrate the work (use that 4th exam room and start on time).

• Determine how to integrate acute patient visits. Consider "Advanced Access" - accommodating patient demand as it comes to you. "Understand your demand and match the supply to it." Ms. Woodcock said. Try "modified wave" scheduling by integrating short appointments with longer ones.

7. Reduce your no-shows.

• Implement automated reminder systems. For procedures or new patients, require a return call from patients to confirm.

• Reduce your time to next available appointment.

• Establish a policy for repeat offenders.

• Charge the no-show patient. Perhaps charge $15-$25, but don't let it be a nightmare for your billing office.

• Don't forget about "bumps," those physician-directed no-shows. More and more practices are establishing policies that prohibit physicians from bumping clinics within six weeks because of the cost as well as the issues regarding risk management.

8. Match your young physicians with a "mentor" to help them adjust to seeing patients and setting expectations. "We are seeing an incredible integration of Generation-X physicians who are now just coming into your practices," Ms. Woodcock explained. "They are coming out of what is the peak of inefficiency in terms of medical practice - residency practices. "And findings show that one out of every two physicians within 24 months out of their training programs leaves their practice."

9. Evaluate calls for potential visits/appointments if you are spending more than an hour on the phone each day. "You're not getting paid for those calls.," Ms. Woodcock reminded. "Set up appointments if necessary."

All these steps, tools and suggestions will help you and help your patients. It's time to get back to basics, Ms. Woodcock stressed. Take control. Alleviate the inefficiencies. "Take your practice away from the complexities, the nonsense," she said. "Simplify it. Believe me, at the end of the day, you will be much more efficient."

If you did not attend the January 14 program and would like additional information on efficient practice management, please contact the PCMS office at 572-3667.■

In My Opinion....

by Daniel R. Kyler, JD

The opinions expressed in this writing are solely those of the author. *PCMS invites members to express their opinion/insights about subjects relevant to the medical community, or share their general interest stories. Submissions are subject to Editorial Committee review.*

First Party Automobile Insurance Coverage for Medical Treatment...It's Easier Than it Looks

I have read with sympathy numerous articles by physicians and other health care providers regarding the growing disgust and dissatisfaction with reimbursement rates provided by health insurers, Medicare and Labor & Industries, and the glut of paperwork, forms and reports necessary to obtain and secure the inadequate level of reimbursement these sources provide. I have represented and been involved in a number of cases where health insurers have ostensibly undertaken "utilization review" under the guise of reducing, requiring reimbursement from or even terminating from a plan, physicians who are simply practicing standard of care medicine. While I have no solution about how to improve these situations, I do have some information for medical practitioners that may present one small silver lining in an otherwise dark and ominously growing cloud.

First party auto health insurance coverage (also call Personal Injury Protection - PIP): Just the phrase seems to strike fear and loathing into the hearts and minds of physician billing offices. Before the reasons for fear and loathing are reviewed and perhaps explained or mitigated, let me first explain the nature of first party automobile health insurance coverage. First party automobile health insurance in the area of medical benefits is **no fault** coverage for a person insured under an applicable auto policy. (When a person is injured in an auto accident, the first party automobile insurance is primary insurance and must be utilized and exhausted before the person's regular health insurance is obligated to pay.) This can be a passenger in the vehicle, the owner of the vehicle, the owner of the policy, or even a pedestrian struck by a vehicle that is covered by that type of coverage (a complete stranger to the insurance policy and even the named insured under the policy). What does no fault mean? It means that reasonable and necessary medical services will be paid for under the policy if the treatment is for injuries related to a motor vehicle accident on a more probable than not basis, even if the injured person was at fault for the accident.

"There are no contracted reimbursement rates under the no-fault medical coverage portion of auto policies...Imagine performing a medical service for a patient for $120 and actually being paid $120."

Any physician who has been deposed is probably familiar with the phrase "are the charges you made for the treatment 'reasonable?'" I have yet to receive an answer to that question in the negative. The next question is "was the treatment provided necessary to treat the condition the patient presented with?" Again, the answer is almost uniformly "yes," or it was a test or an evaluation necessary to rule out a condition or to reach a differential diagnosis for the patient. And finally, "was the condition which is being treated, related on a more probable-than-not basis to the motor vehicle accident?" The final question is usually the one that causes the most consternation for health care practitioners and physicians. It is really, however, a much easier question than it sounds. Put another way, "was the motor vehicle accident the most likely reason the person received the treatment?" If so, the answer to the first question is "yes." They are the same question.

If this trilogy of questions can be answered in the affirmative, the practitioner's billing for the services rendered under the no-fault medical coverage should be paid. The bill is paid at 100%. Let me state that again: the bill is paid at 100%. There are no contracted reimbursement rates under the no-fault medical coverage portion of auto policies. Therefore, whatever your reasonable rate is, it should be paid. Imagine performing a medical service for a patient for $120 and actually being paid $120.

In my experience, the reason most offices either will not accept a patient with automobile first party health insurance coverage or not see the patient without either payment up front, or a backup health insurer as a source of payment, is that many offices are not set up to computer bill the auto insurer and PIP departments for reimbursement. This means that someone in the billing department must prepare a billing by hand. Either the medical community should demand software that can accomplish such a task, or the billing de-

See "Insurance" page 14

Insurance from page 13

partment should be encouraged to do the manual work for a 100% reimbursement alternative that is available virtually nowhere else except for private pay patients who actually have money and are willing to write a check when they walk in the door.

A few things need to be obtained and documented when billing a first party automobile health insurer: The claim number; the PIP claim adjuster's name and telephone number; the address where the bill should be sent; and an understanding of what documentation needs to be presented at the time the bill is submitted for payment. Of these items, clearly the patient is in control and possession of the first three. This is not a difficult amount of information for patients to be expected to be able to provide when they arrive for treatment, and if an appointment is made with this type of coverage in mind, the patient should have it clearly explained that they will not be seen or evaluated unless they can arrive with these three basic pieces of information.

The health care provider's billing office also needs to know what the limits of coverage are on the particular automobile health coverage, and what is the amount of remaining coverage under that policy. There are a variety of no-fault plans in Washington which have coverage anywhere from $1,000 med pay, $5,000 med pay, $10,000 PIP, $35,000 PIP, all they way up to $50,000 of PIP. The only difference between medical pay policies and PIP policies is that PIP provides more coverage for different types of loss after an automobile accident than does the medical payments coverage. Medical payments coverages apply solely to medical treatment and care whereas PIP also has a wage loss reimbursement component and a household services component not provided under med pay policies. Both med pay policies and PIP policies, however, are no fault coverages.

Usually, first party automobile health insurers will request that a medical office provide the treatment chart note regarding the patient's visit. What they are looking for is the type of care and treatment provided in addition to some reference in the chart note that the treatment of care was caused as the result of the motor vehicle accident. ICD codes do not provide that information. Unfortunately, practitioners are frequently not in the habit of documenting or stating in their chart notes that the treatment was the result of the motor vehicle accident on a more probable-than-not basis. This can result in a delay in payment being made while the first party automobile health insurer's adjuster attempts to obtain documentation from the medical office either by report or additional writing that confirms the causal relation. Usually this exercise is not some sadistic pleasure being exercised by the adjuster, but simply a necessity of documentation for the file to confirm that the treatment being paid for was as a result of the motor vehicle accident.

There can be multiple levels of first party automobile medical insurance and this can cause some confusion and a measure of complexity which is again daunting to most medical provider billing offices. For instance, if I am a passenger in a vehicle driven by a friend who is not the owner of the vehicle, there may be as many as three separate no-fault automobile medical policies. The first policy is the PIP coverage on the vehicle I am in when the accident occurs. The second policy is my friend's own automobile policy who was driving the vehicle and the third policy may be my own PIP insurance coverage. There are defined ways in which the priority of who pays benefits is determined. Generally, the vehicle the person is in has primary coverage; second is the coverage of the person operating the vehicle, and third is the coverage that each person has under his or her own policy.

An additional document to add to your billing department's files may be of benefit when dealing with first party automobile health insurers. Have the patient sign an assignment of their first party automobile health insurance benefits to the extent of service provided in the practitioner's office. Include within that document an authorization that the insurer disclose to the physician's office the amount of coverage remaining, a copy of the PIP endorsement to the policy, and an authorization for the PIP adjuster to discuss directly with the billing office of the practitioner issues of reimbursement, timing of payment, etc. The assignment of benefits to the practitioner's office also allows the practitioner a direct cause of action against the auto insurer in the unlikely circumstance that payment is either refused or not forthcoming. Ensure that in the physician/patient agreement there is an attorneys' fees provision so that in the event an action is necessary for payment of the bill, the patient is responsible for attorneys' fees in obtaining the benefit and potentially, the first party automobile health coverage may also be responsible for your attorneys' fees when they wrongfully refuse to pay your billing.

Reasons for Fear and Loathing

1. No pre-approval/guarantee from the first party automobile medical insurer for a proposed visit, procedure or treatment;

2. Unclear and undefined chain of authority by the insurer for payment of a billing;

3. Potential of physician or health care practitioner involvement in the medical/legal process.

The foregoing is a list of my top three and is not meant to be an exhaustive list of reasons I have heard or seen for a medical office not accepting automobile medical insurance for treatment. Let us take a look at these three, however.

Pre-Approval

Unfortunately, pre-approval does not happen in the automobile medical insurance arena. The reason is some-

See "Insurance" page 16

In My Opinion....

by Daisy Puracal MD, ABHM

The opinions expressed in this writing are solely those of the author. *PCMS invites members to express their opinion/insights about subjects relevant to the medical community, or share their general interest stories. Submissions are subject to Editorial Committee review.*

Hopes and Dreams

Daisy Puracal, MD, ABHM

How does one maintain sanity in this crazy health care environment?

It seems that physicians are forever caught in the middle between policies and care for the patient. Principles for good care set out by Academia by research and clinical trials are thwarted by insurers/government agencies that look at economics rather than what works best for patient and community. We as physicians have been inundated with rules and regulations far more than any other industry that I know of and it is only getting worse - with HIPAA and many more acronyms on the horizon.

The list for daily aggravations in the practice of medicine goes on and on. Murmuring the serenity prayer does not quite take care of the distress generated for patients, staff or me.

To deal with my frustrations I was led to embark on a journey of self-discovery and personal growth. In my journey for authenticity and meaning in my work and life, I attended many conferences/courses in spirituality and healing and came into contact with alternative care practitioners. I saw in them the same dedication and desire to help/heal as I found in my colleagues practicing allopathic medicine. I know that we are all trying to do the best we can with the knowledge and training we have. I came to view healing in a broader perspective than dealing with disease processes and to recognize the limitations and inherent dangers in traditional medicine, just as in alternate medicine. One has only to look at the medications that were used for years as symptom relief for coughs and now is off the shelf because of the recognized harm it did. Thousands of people have ended up with fatal gastrointestinal hemorrhages from NSAIDS that probably did not appreciably change the course of their underlying disorder. I see in naturopathic medicine an enormous potential that has not been adequately researched. A good number of allopathic medications originated form plants and herbs.

Looking at a patient in a more holistic way and exploring their social and cultural background and lifestyles, a more comprehensive pattern of dysfunction becomes evident. Healing then becomes a team effort that includes patient participation rather than being reduced to taking a medication. (How this process should/should not be paid for as a benefit under the health insurance system however, is a totally different issue).

With this more holistic view, I decided to obtain my board certification in holistic medicine and am trying to walk my talk within the constraints of societal/economic barriers. The American holistic Medical Association defines holistic medicine as a philosophy of medical care emphasizing personal responsibility, fosters a cooperative relationship and emphasizes the whole person - physical, mental, emotional, social, spiritual and environmental, which includes nutrition. For me it takes me to deeper planes of patient / physician relationships, while honoring patient autonomy, that I had not experienced before.

I try to stay abreast of the plethora of herbal remedies that abound although I do not as yet feel comfortable prescribing this except occasionally, e.g. glucosamine/chondroitin sulphate. I guess you might say that I practice allopathic medicine in a holistic way. I recognize that no one person can completely serve the needs of any one patient and seeing health care as a team effort makes a lot of sense. Patients deserve the right to have control of what they see as right for them especially as to much information is available through the internet.

With the additional training I pursued, I find myself better equipped to sustain my equanimity in the face of aggravations having become a little stronger within myself.

My one true remorse is however, that I do not have the luxury to see all patients without consideration of their health insurance. I would love to be able to not have to worry about this aspect of clinical practice. One possible solution would be for government to pay for my office space and maybe malpractice premiums. After all, they paid for the ballparks even though the players and owners make millions of dollars and probably could afford to pay for the arena five times over. Or maybe the federal government could staff my office just as they did the airports when security was threatened. I am of the opinion that health care is gravely

See "Hopes" page 20

Insurance from page 14

what of a Catch 22 conundrum. The automobile health insurer will not pay unless the condition for which the patient is being seen is related to the motor vehicle accident. The physician cannot know whether the condition is related to the motor vehicle accident unless he sees and evaluates the patient. The patient's representations of its causal relation, while usually made in good faith, is a layman's uneducated judgment, many times based on the fact that the condition was not there before the person had an auto accident, and now the condition is there.

SOLUTION: While not an absolute solution, the best response to this concern is better triage. This may mean the person trying to make an appointment gets past the receptionist and speaks to a knowledgeable nurse within the physician's office who must also have a working understanding of what he or she is looking for in taking a history of the patient. Alternatively, a referral from another practitioner's office who has already made the judgment or conclusion that the condition is related to the motor vehicle accident or finally, a review of any prior treatment records documenting care the patient may have already received, such as an emergency room visit or an acute care facilities' record that would allow a practitioner to review a medical record and make an informed judgment as to whether the condition for which treatment is being sought is probably related to the motor vehicle accident.

Chain of Authority

The chain of authority in automobile medical insurance is actually probably easier than most traditional medical insurance companies' coverage process. There is always a med pay or PIP adjuster assigned to a claim. That person always has a supervisor. Armed with a claim number, the telephone number of the PIP adjuster, and the address of the PIP carrier, direct contact and action is usually available.

The Medical/Legal Process

Automobile medical insurance is no-fault medical insurance. Even when the person receiving treatment causes the accident, they are still entitled to the benefits of their no-fault medical insurance. Many, many automobile accidents are resolved by people on their own, every day, without the assistance or involvement of lawyers. In situations where a person does have a lawyer to assist them with their automobile claim, again, 95% of those cases resolve with the most intrusive contact to the physician or medical practitioner's office being a request for medical records. The actual risk of becoming involved in the medical/legal process in the context of meeting with attorneys, preparing declarations, being deposed, or heaven forbid, offering arbitration or trial testimony, either live or by utilizing a video preservation deposition, is really quite minimal.

From what I have seen, there is not much good news for physicians and health care providers in the medical insurance arena. Perhaps first party automobile health insurance is a little bit of help. ■

Daniel Kyler, JD is a Tacoma attorney with the Rush Hannula Harkins Kyler law firm.

Sick, Tired and Not Taking It Anymore

by Charles Krauthammer

Surgeons in West Virginia have gone on strike to protest the exorbitant cost of malpractice insurance. Good for them. Don't talk to me about the ethics of doctors going on strike. So long as they agree to treat emergency cases, they have as much right to strike as anybody else. The premise of a free market is that people can withhold their labor if they find the conditions under which they work intolerable.

Many doctors do. Many, especially those in the inherently risky specialties, such as surgery or obstetrics, have been forced out of business by malpractice premiums or hounded out by malpractice litigation. A totally irresponsible legal system, driven by a small cadre of lawyers who have hit the mother lode, have produced perhaps the most dysfunctional medical-liability system in the world. Juries hand out millions of dollars not just for lost earnings but also in capricious punitive damages in which the number of zeros attached to the penalty seems to be chosen at random.

As a result, innocent doctors who have devoted their lives to their patients are required to spend tens, even hundreds, of thousands of dollars a year on insurance. In effect, we are making doctors give up an entire chunk of each year laboring just to work off their insurance premiums. Why? To cover for the few offenders in their midst. To compensate the lucky few victims who stumble upon the most profligate juries. And, most important, to make a few trial lawyers very, very rich. (Herewith, the requisite full disclosure: I am a doctor, though I no longer practice.)

This in not a hard problem to fix. Tort reform is not rocket science. A reasonable bill passed the House of Representatives just last year but died in the Senate, where the trial-lawyer lobby rules. The elements of a fix are simple: no limit on plaintiffs' lost earnings or other costs, a reasonable cap on pain and suffering ($250,000 in the House bill), a similar cap on punitive damages, serious penalties for frivolous lawsuits.

For years, such remedies have had a tough time getting through legislatures, which are - surprise! - peopled overwhelmingly by lawyers. That is why you have never heard of a lawyers' strike. Lawyers have assured themselves pretty good working conditions. Some of my friends who graduated with me from medical school in the mid-70s are working 50 to 60 hours a week, almost as hard as they did as interns, just to make ends meet: to pay their rent and nurses and other office expenses on the highly reduced reimbursements they get from HMOs, Medicare and Medicaid. And then a huge part of what is left over goes to pay for malpractice insurance.

But the frustration of doctors is more than a matter of money. The real blow to the profession has been the assault on autonomy. Physicians spend endless days and long years acquiring an extraordinarily specialized skill and then find themselves being told by some 23-year-old HMO administrator a

See "Sick" page 22

Vise from page 11

whose job is to make sure the practice complies with the record keeping requirements, with the disability laws, with employee safety, with patient privacy, etc.

Today, just billing for an office visit costs more than $10. When you add rent, payroll, insurance, utilities, taxes, etc., our overhead cost per patient visit must be over $25 even in the most efficiently run office. Can we compensate for that by increasing the volume? Can anyone comfortably see six patients or more per hour, eight hours a day, five days a week? What kind of care can we give with such patient volume? What kind of records can we keep?

The other jaw of the vise is our pricing ability. We don't have any. As long as we continue to work, hoping to compensate for the reduction in payment by increasing the volume, things will not change. We look to the government for a solution, but that is the place where we are likely to find the problem. The solution is not there, it is within us.

For too long we have expected and hoped that the government will help us. It can't. The same vise that is crushing us is tightening around it. People learned that they can have services and benefits for nothing, why should they want to pay for them. So what is a government to do? It is approaching its limit just as we are getting close to ours.

Even though private practice is the most efficient way to deliver care, at some point the administrative burden will make it impossible to continue. With subsidies, the community clinics will survive a little longer. They have the advantage of high volume, less personal care. Eventually, they will get crushed, too. The only surviving facilities will be those operated by the government.

I will not comment on the quality of care we can expect to get under such circumstances. Ask people from the Soviet Union about their medical care. They will tell you. Of course, before we get to that point, some alternative may appear in this country, as long as we don't get squeezed to death in the meantime.

By now, it should be getting clear to more and more people that the disconnection between receiving benefits and paying for them is an economic and political time bomb. When we buy a car, we look at the base price and the cost of options, then we look in our wallet. We have to pay for any frills we buy. When the connection between what we get and what we pay is severed, there is no limit to our wants, whether they be roads, parks, schools or medical care.

The states are beginning to realize that and are setting user fees to pay for the services. Unfortunately, they look on those fees as a way to raise revenues. There is something about private management, for profit, in the presence of competition, which brings efficiencies and improvements in service that the states cannot achieve. Theirs is a good fist step, but it is not enough. They need to get out of the business.

The solution to this problem is to lift government controls, spin out all economic services to the private sector, and let the market take care of it. Governments have difficulty managing the economy. Every large institution faces the problem of waste, due to carelessness, ignorance or mismanagement. The private enterprises can deal with it informally. The public institutions have detailed regulations to assure accountability and are required to follow burdensome procedure protocols. The result is an expensive and inflexible management structure.

For the medical care of the indigent and other services to them, help from charitable institutions can satisfy most of their basic needs. The government, freed from the responsibility for the economy, will be able to concentrate on what it does best, police protections, courts and defense. ■

AMEDNEWS highlights their most intriguing medical facts of 2002

Editor's Note: To access any one of these articles call PCMS or go to ama-assn.org, click American Medical News under publications (top right), then search for "most intriguing medical facts," you can then highlight the "fact" you want to view the complete article.

- 80% of patients with uncomplicated infections recover within a week without antibiotics. (Dec. 23/30)
- In 19th century medicine, cataracts were not removed, just pushed down. (Dec. 16)
- 70% to 86% of people want to die at home, yet only 25% do. (Dec. 9)
- Children vaccinated for smallpox would have to stay out of school or day care for the next 30 days (Dec. 2)
- After a decade of decline, syphilis rates increased in 2001. (Nov. 25)
- A family physician discovered his Web site had links for sex toys. (Nov. 18)
- A drug approved for treatment of narcolepsy is attracting interest from sleepy type A's. (Nov. 11)
- Hearing loss is the No. 1 disability among the elderly. (Nov. 4)
- 92.7 million doses of flu vaccine will be available this season, 5.7 million more than in 2001. (Oct. 28)
- 85% of donor lungs are rejected for transplant. (Oct. 21)
- Acetaminophen misuse is linked to 100 deaths and 2,000 hospitalizations annually. (Oct. 14)
- A single CT scan gives roughly as much radiation as 100 x-rays. (Oct. 7)
- 20 million people miss work each year due to pain, costing business some $50 billion in replacement labor. (Sept. 23/30)
- Some physicians are trying liposuction to manage diabetes. (Sept. 16)
- Urban family doctors earned only $2,100 more than rural counterparts in 1999. (Sept. 9)
- Grateful patients raised $40,000 to pay their oncologist's liability premium. (Sept. 2)
- 50% of cardiothoracic surgeons now practicing will retire by 2010. (Aug. 26)
- There are 474 brains in a Maryland tissue bank. (Aug. 19)
- 20% of people with eating disorders will die as a result of the disease. (Aug. 12)
- Thong underwear may cause recurrent vaginal infections. (Aug. 5)
- Patients are being targeted for marketing campaigns based on their medical records. (July 29)
- Abused women experience a 50% to 70% increase in health problems. (July 22)
- 12 states are already in a liability crisis; 30 more are headed that way. (July 8/15)
- Genetics plays the strongest role in people who live to 100. (July 1)
- A quarter of parents miss children's doctor appointments because of work. (June 24)
- 25% of consumers always verify Web health information. (June 17)
- Medicare reimburses for telemedicine, but not for e-mail. (June 10)
- 1 in 5 seniors takes analgesics regularly. (June 3)
- Drug companies spend more than $12 billion a year marketing to doctors. (May 27)
- 60,000 people will undergo weight loss surgery in the U.S. this year. (May 20)
- Arizona's sanction rate against physicians in highest; the District of Columbia's lowest. (May 13)
- Hemophilia A affects one in 5,000 men; hemophilia B affects about one in 20,000 men. (May 6)
- 86% of Texas malpractice suits last year resulted in no award to the plaintiff. (April 22/29)
- 70% of all U.S. surgeries in 2000 were outpatient. (April 15)
- Almost half of HMO coverage denials going to external review are reversed. (April 8)
- 4 out of 5 adult smokers began smoking before age 18. (April 1)
- 87.7 million doses of flu vaccine were produced, but 10 million were not used. (March 25)
- 50,000 units of blood donated after the Sept. 11 attacks had to be destroyed. (March 18)
- 13% of internists failed on their first recertification attempt in 2000. (March 11)
- 42 states expect Medicaid budget shortfalls this year. (March 4)
- Uninsured women with breast cancer are more than twice as likely to die. (Feb. 25)
- In 1999, 19% of doctor pay incentives were based on quality, 72% on productivity. (Feb. 18)
- Diabetes increased 49% during the last decade. (Feb. 11)
- Montana screens newborns for 3 disorders, Iowa for 36. (Feb. 4)
- 1 in 4 Afghan children die before age 5. (Jan. 28)
- Florida is logging more deaths from painkiller overdoses than from heroin. (Jan. 21)
- Most physicians doing medical relief work abroad pay their own way. (Jan. 14)
- Medicaid is the largest and fastest growing element of most state budgets. (Jan. 7) ■

Jordan from page 8

physicians and mid-level providers offering 22 medical specialties at seven locations across the island. Their website boasts, "Kauai Medical Clinic combines the intimacy of neighborhood clinics with the resources of the largest community multi-specialty clinic in the State. Kauai Medical Clinic is the island's only multi-specialty medical group and one of Hawaii's largest and most comprehensive medical group practices."

In early January, Dr. Jordan's and Dr. Kubota's earthly possessions were loaded on a 45-foot container and shipped to Kauai. Dr. Kubota began work January 31, and Dr. Jordan starts February 17. "I'll have time to unpack, and maybe take up surfing," he said. He has already joined the local yacht club, and plans to continue sailboat racing. "The water's much warmer there."

There is price for paradise, and Dr. Jordan notes that, "this is a lifestyle change, not an income change. My income will essentially be the same. But I have a feeling I won't be working as much. The cost of living, of course, is much higher. But the coconuts, bananas, papayas and mai tais are cheap!" And, of course, the sunsets are free.

He extended an invitation to his friends and colleagues to find out for themselves next year. The College of Medical Education is holding a meeting in Kauai in 2004, and Dr. Jordan hopes to see some familiar faces and looks forward to sharing the island paradise he now calls home.

Aloha and Mahalo

And so, as Dr. Jordan sails off into the Kauai sunset, Tacoma says aloha and wishes him the best in his new adventure. At the same time, we say "mahalo," for his innumerable contributions to the medical community and the people of Tacoma and Pierce County and, most important, for his friendship. Happy sailing (and surgery), Dr. Jordan. ■

Hopes from page 15

threatened. Or perhaps I could have a subsidy so I could take time off for extended vacations five times a year and tide me through the lull times in my office.

On a more serious note, I am still hoping for equitable reimbursements commensurate with service rendered irrespective of insurance coverage for all patients. Consumers get charged the same for all other commodities, why should there be a "caste" system for health care? I continue to hope that my office will someday be able to open its doors to all rather than to select populations; that health care is an affordable part of the budget in every household; that health care becomes an unalienable right for every individual. My dream is that basic health, education, food and housing for all citizens take top priority in the agenda of officials voted to represent the people of this country. By doing so America can be a showcase of what democracy can do for a country. America can then become a true world leader by example without resorting to posturing and smoking guns. ■

COLLEGE OF MEDICAL EDUCATION

Plan now for Mariners CME in Phoenix

Registration is open for the March 5-9, 2003 CME and Mariner's Spring Training program in Phoenix. The actual course is the mornings of March 6-8. **Richard Hawkins, MD** is the program director.

Flights to Phoenix during March often sell out in advance. In order to assure that you will have seats, we urge you to make reservations soon.

All Wanderlands Travel (new home of Olympus Travel) is handling the flight arrangements. Specifically, MARILYN is prepared to assist you in securing these seats. Please call Marilyn at 572-6271.

For lodging, the College has selected the Embassy Suites Phoenix/ North for conference headquarters. The large and beautiful hotel is conveniently located close to the Mariners Peoria stadium and offers greatly reduced and competitive rates ($119) for complete two-room suites that include a private bedroom and separate living area with sofabed. You can make your reservations by calling the hotel directly at 602-375-1777 or 800-527-7715. Be sure to mention are you with the College of Medical Education.

A program brochure was mailed in December. Questions? Call 627-7137. ■

Continuing Medical Education

Internal Medicine Review 2003 schedule for March 13 and 14

The Tacoma Academy of Internal Medicine's annual two-day CME program set for March 13 and 14 is open for registration. The program offers a variety of timely internal medicine topics and has bee organized by **Maureen Nuccio, 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 St. Joseph Hospital, Lagerquist Conference Center, Rooms 1 A & B.

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

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

- Advances in the Diagnosis and Treatment of Prostrate Cancer
- Diagnosis and Treatment of Alzheimers in the Primary Care Setting
- Outpatient Management of Hypertension: An Algorithmic Approach
- Preventing Renal Injury in the Geriatric Population: Cautious Use of Good Stuff
- Limitations of Vancomycin in Surgical Wounds and Serious Pulmonary Infections
- Risk Stratification for Coronary Disease
- Stroke Prevention and Acute Management
- Atrial Fibrillation: Its Management and Complications
- Clinical Management and Pharmico Therapy of the Insulin Resistant Patient
- Management for Acute Coronary Syndrome
- Hemmingway's Brain: Depression in Geriatric Patient
- Pain Management in the Adult: Osteoporosis and More
- Hospital and Outpatient Management of Anemia
- Update on Venus Thrombolism ■

Dates	Program	Director(s)
Friday, February 7	Primary Care - 2003	William Knittel, MD
Wednesday-Sunday March 5-9	CME and the Mariners	Richard Hawkins, MD
Thursday-Friday March 13-14	Internal Medicine Review 2003	Maureen Nuccio, MD
Friday, April 4	Endocrinology for Primary Care	Ron Graf, MD
Friday, May 2	Allergy, Asthma & Pulmonology for Primary Care	Alex Mihali, MD
Friday, May 16	Advances in Women's Medicine	John Lenihan Jr. MD

Applicants for Membership

Kenneth S. Bergman, MD
Radiation Oncology
Tacoma Radiation Oncology Center
1318 3rd St SE, Puyallup
253-841-4312
Med School: University of California
Internship: Tucson Hospitals
Residency: University of Washington

Michelle F. Zhong, MD
Physical Medicine & Rehabilitation
Northwest Center for Integrative Med
2702 S 42nd St #310, Tacoma
253-472-7844
Med School: Tongji Medical University
Internship: Columbia University
Residency: University of Washington
Fellowship: Interventional Medical Associates of Bellingham

Sick from page 17

thousand miles away how many minutes they can spend with a patient, how long they can keep him in the hospital and what kind of treatment they are allowed to give him. The introduction of managed care may be societally necessary to keep down costs. But we should at least recognize its cost to the dignity and effectiveness of the profession it regulates. Forgive my obsession here, but lawyers would never put up with faraway bureaucrats dictating their methods and setting their fees.

A doctor wants to strike no more than does a textile worker. But the malpractice burden - indeed, the malpractice threat - is the final assault on the implicit contract society make with its healers: you give up the best decade of your youth, your 20s, to treat the sick and learn your craft, and we will allow you to practice it with autonomy, dignity and the kind of security - and freedom from capricious victimization - that, oh, say, lawyers enjoy.

The current system is crazy, ruinous and unfair. And it is easily changed. By lawyers. ■

Reprinted from TIME magazine, January 13, 2003

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

Classified Advertising

POSITIONS AVAILABLE

Tacoma/Pierce County outpatient general medical care at its best. Full and part-time positions available in Tacoma and vicinity. Very flexible schedule. Well suited for career redefinition for G.P., F.P., I.M. Contact Andy Tsoi, MD (253) 752-9669 or Paul Doty (Allen, Nelson, Turner & Assoc.), Clinic Manager (253) 383-4351.

Board certified family practice physician wanted for South King County Medical Clinic. Great opportunity for motivated doctor. Fax CV to 253-804-5797.

Gynecology/Infertility practice seeking physician (prefer OB) to share office space and expenses. Beautiful office space in a prime location near most hospital locations. Please contact Office Manager at GYFT Clinic, 253-475-5433.

OFFICE SPACE

Price Reduced. Lakewood property for sale or lease - Class A. Ample parking. Highly visible. Easy access. 4900 sq ft available now. Total sq ft of 8733. Close to 100th & Bridgeport Way SW. Call Bob York or Cody Miller at 253-531-9400. Crescent Realty, Inc.

EQUIPMENT

For Sale: Two IMEX ABCO 6355 Pocket Dopplers. Includes 2 and 3 mgz probes, battery charger. New $735. Both for $500. Call **Dr. Kulpa** at 851-2922.

For Sale: GE RT-3200 Advantage II ab-dominal and vaginal probe-transducers. Excellent condition. Low usage in solo practice. Price negotiable. Call **Dr. Kulpa** at 851-2922.

POSITIONS WANTED

Transcription Specialists - We have years of experience in most specialties. We guarantee accuracy, fast turnaround time, free pickup and delivery and competitive rates. Outstanding references. Call 925-3276.

Pierce County Medical Society
223 Tacoma Avenue South
Tacoma, WA 98402

Return service requested

PRESORTED
STANDARD
US POSTAGE PAID
TACOMA, WA
PERMIT NO 605

Pierce County Medical Society

BULLETIN

March, 2003

Dr. Julian Arroyo, Lakewood orthopedic surgeon, and wife Seleta get ready for skiing with daughters (front row, L-R) Vania and Alaina

More photos page 11

Ever popular "resort" CME programs offered through the PCMS College of Medical Education, continue to offer stimulating education and affordable vacations for physicians

Andrew Statson, MD recently retired from medicine but not from writing for the PCMS *Bulletin*.... See story page 5

INSIDE:

The Bulletin is published monthly by PCMS Membership Benefits, Inc. Deadline for submitting articles and placing advertisements is the 15th of the month preceding publication.

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 PCMS. Acceptance of advertising in no way constitutes professional approval or endorsement of products or services advertised. The Bulletin reserves the right to reject any advertising.

Managing Editor: Sue Asher
Editorial Committee: MBI Board of Directors
Advertising Information: 253-572-3666
223 Tacoma Avenue South, Tacoma WA 98402
253-572-3666; FAX: 253-572-2470
E-mail address: pcmswa@pcmswa.org
Home Page: http://www.pcmswa.org

Pierce County Medical Society
BULLETIN

March, 2003

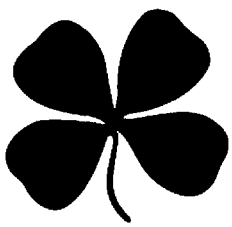


Table of Contents

President's Page

by J. James Rooks, Jr., MD

Contact Your Representatives

J. James Rooks, Jr., MD

Spring is almost upon us, and I had a brief foretaste of it the week of Presidents' Day. Since my wife is a public high school teacher and had the week off, we set out for Stuart, Florida to visit my father and stepmother. We had a funfilled time, but it's so great to come home to the beautiful Northwest. While I was there I followed with interest in their newspapers the stories of physicians of Martin and St. Lucie Counties as they held a Day of Awareness Rally to call for accessible and affordable health care and a fair reform of the insurance crisis (as we are doing here). They invited their patients and legislators and had a jazz band made up of physicians. They served refreshments, and basically got good media publicity in contrast to what has happened in other states. My wife commented that this seemed to her a positive and proactive approach - I heartily agreed. We are actively planning a similar happening for our area and would appreciate PCMS membership input, so let any Board member or Sue Asher know your feelings.

There seems to be a constant barrage of requests for legislative support that crosses my desk via fax, letter, e-mail or personal communication on a daily basis - many times with format letters, etc. to complete and send to the particular legislator, congressman, or senator. For those of you who have the time and inclination to write such detailed letters, please press on! For those of you who find it difficult or daunting to compose such communications, let me tell what I've done. I've written to all my state and national representatives on the malpractice crisis in Washington, but in very short two paragraph letters stating the problem with encouragement for their support. I've received word back from most so far. Whatever method you choose, I encourage all of you to let your representatives know your concerns. (If you need help - please call PCMS for information.)

Thank you to all of you who have already done so. ■

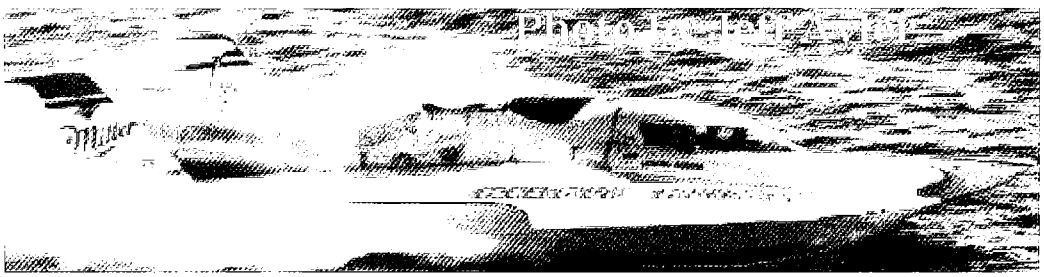
Pierce County Medical Society

welcomes

CHIP HANAUER

presenting his fascinating and inspiring life's story

"IN THE DRIVER'S SEAT"



- Seattle's favorite hydroplane driver; boat racing's "living legend"
  - Second in all time wins (62); Bill Muncey was third with 61
  - Winner of 11 Gold Cups (7 in a row) - the Gold Cup is the powerboats "Indy 500"
  - Youngest person ever inducted into the "Motorsports Hall of Fame"
  - The 19th Greatest Sports Figure of the last 100 years from the State of Washington, according to *Sports Illustrated*
  - A "dancer with the devil" who returned to driving after surviving many crashes, the "corporate culture" of boat racing and personal depression
- Special ed teacher! Accomplished auto racer! College "honors" graduate!
- A person who lives with and educates others about Spasmodic Dysphonia (SD)

March General Membership Meeting ⇨ Sponsored by Allergan ⇦

Tuesday, March 18, 2003 - *Social Hour*~6:00 pm, *Dinner*~6:30 pm, *Program*~7:30 pm
Landmark Convention Center - (Room will be posted) 47 Saint Helens Avenue, Tacoma

Complimentary for all PCMS members and their spouse/guest
$20.00 for each non-member and each additional guest

Return this portion of form to: PCMS, 223 Tacoma Ave S, Tacoma, WA 98402; Fax to 572-2470 or call 572-3667

Name: (please print or stamp) _____

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

Please reserve _____ dinner(s) at ***NO CHARGE for PCMS member (and spouse or guest)***
$20.00 for each non-member and each additional guest

REGISTRATION REQUIRED by Friday, March 14th

If you register and later find you are unable to attend PLEASE call and cancel
The parking lot across the street now costs $3, but there is usually ample street parking at no charge

Special Feature

by Jean Borst

The Write Stuff

Dr. Andrew Statson retires from medicine, but PCMS will still benefit from his Written Word

Andrew Statson, MD

Dr. Andrew Statson, OB/Gyn, has seen his share of changes in medicine over the years. And to the great fortune of PCMS members, he has shared his thoughts, concerns and visions of the profession for the past five years in his monthly opinion column in the PCMS Bulletin. Although Dr. Statson is retiring from medicine, he will continue his monthly written contributions. "My goal has always been to provide ammunition to my colleagues to fight for the profession," he said. "I'll keep writing until I run out of ideas."

Dr. Statson submitted his first article to the Bulletin, "The Fourteen Percent Fallacy," in February 1998. Writing as the "Invisible Hand," he has offered an array of thought-provoking columns such as: "One Size Fits All," "The Science and the Art of Medicine," "Medicine is a Harsh Mistress," "The Yellow Brick Road," "Professionalism and Commercialism," "Value for Equal Value," "The Sickness of Terrorism," "Cost, Value and Price," and "The Magic of Numbers."

"I started writing because there were a lot of things I wanted to get off my chest," Dr. Statson explained.

"In all the time Dr. Statson has been writing for us, he has always provided well-documented, well-researched, thoughtful and enlightening articles regarding the private practice of medicine," said Sue Asher, PCMS Executive Director. He has offered opinions on a variety of subjects, including:

Government and Medicine. "I believe a parallel system should be developed to go with the government-run system currently in place," he said. He has also proposed that government should get out of medicine. "It should be completely private," he said. "That's a much more efficient way to do things."

On Insurance. Dr. Statson has written several articles on the subject of insurance, and among his proposals is that small claims be removed from coverage. "There is no point in having insurance coverage for small claims," he said. "Unlike processing of large claims, small claims are expensive for everyone and are not worth processing. Just removing them from coverage would make insurance much cheaper and more affordable. If that can be accepted by society, it would make things so much better. But I'm not optimistic that it's going to happen."

Malpractice Awards. Statson worries about the trend to award huge sums of money in malpractice cases. "I understand that people are angry about the quality of care, and this is their way of getting back at us. Compensation I can understand but these awards are punishment, not compensation.

"People expect us to be perfect, but we're not. We can't be," he explained. His own specialty, OB/Gyn, has been particularly hard hit by malpractice suits. "I can understand some cases, but things happen and normal mistakes occur. Unfortunately," he said, "more and more physicians are simply going to drop out as a result of these outrageous awards. When people cannot find a physician, they'll see that things have to change."

The State of Medicine around the World. Statson has been keeping close watch on the plight of the European physician, and fears that what is befalling physicians in other parts of the world will come to pass in the US. "They don't want to do the work for what they are being paid," he explained. "Britain's system is falling apart, and they are bringing in physicians from other countries. I see the same thing happening here." He noted that physicians in several countries have gone on strike, and German physicians are talking about a strike right now. "There are problems everywhere," he said.

The Road from Bulgaria to Pierce County

Born in Bulgaria, Dr. Statson was the son of a physician and was exposed to the medical profession from a very early age. "I saw what medicine was like under communist rule," he recalled, "and it was not pretty." After completing his premed work at the University of Sofia in Bulgaria, Statson went for France. He completed medical school at

See "Write Stuff" page 6

Write Stuff from page 5

the University of Paris, with a goal of practicing medicine in the United States. Eventually, he landed in Cleveland, Ohio, and completed his externship and internship at St. Alexis Hospital and his residency at Mt. Sinai Hospital. Following two years of private practice in Cleveland, he answered the army's call and found himself stationed in California from 1969-70. He stayed in the Long Beach/Los Angeles area after leaving the military and was practicing in California when the state was experiencing its malpractice crisis in the mid-1970s. It was when he was practicing in Santa Ana that he picked up his pen and began writing "The Invisible Hand" for the local medical society.

Because of the dire situation in California, Dr. Statson began looking to other areas of the country to relocate and establish a new practice. He found that the medical profession in Washington State was in much better condition at the time. "But it's gotten very bad here," he said. "The difference between what is happening here now and what happened in California is that we still have a great deal of collegial rapport among physicians. In California, everyone was quick to blame everyone else. There was no loyalty or camaraderie among physicians."

Advice for his Colleagues

His advice to other physicians still practicing in this volatile environment? "It's difficult to remain positive," he said. "I suggest you try to put your financial affairs in order so you can get out. The other option, he says, is to take care of your patients and spend time with them. He points to physicians in Croatia. "They have two options," he said. "They can strike and not work, or they can work and follow the regulations to the letter. And the regulations say to spend 45 minutes with each patient. If you are working on a set salary, work slowly," he suggested. "Work eight hours a day, five days a week and

See "Write Stuff" page 8

Quotes from the Invisible Hand

"By now, it should be clear to more and more people that the disconnection between receiving benefits and paying for them is an economic and political time bomb. When we buy a car, we look at the base price and the cost of options, then we look in our wallet. We have to pay for any frills we buy. When the connection between what we get and what we pay is severed, there is no limit to our wants, whether they be roads, parks, schools or medical care."

—"In the Vise," February '03

"Prevention has had a number of great success stories in medicine. The practical eradication of smallpox is one. I only hope we did not drop our guard too early on that one. The role of the Pap smear in the prevention of cervical cancer is undeniable. The lifetime risk for cancer of the cervix has dropped from 3 percent to less than one in a thousand. Here, also, some researchers claim that we don't need to do Pap smears every year, that it is too expensive and the risk is not that high. Perhaps, but should we drop our guard because we have been successful? How much prevention is too much? Who should decide?"

—"The Cost of Prevention," June 2002

"How business and government would participate in the purchase of insurance for people is for them to decide, but they must relinquish control over how the money is to be spent. That control can only be in the hands of the patients. The patient participation in paying for it will assure their vivid interest in the costs of care."

—"Guns and Butter," March 2002

"I don't know for sure what the reality is. It probably varies from patient to patient. The evidence from the medical studies can light our way, but neither we, nor the authorities who dictate to us how to practice medicine, must allow it to blind us so much that we do not see the reality it can hide."

—"Evidence and Reality," May 2002

"Yes, patients are less satisfied now than they were in the past. The insurance companies can do much better than survey and analyze the situation. They can pay better for the services we provide. Elimination of the hassles to practice medicine and better compensation for physicians would be much more effective in achieving patient satisfaction. It may be more expensive, even though that is debatable. A recent report stated that the cost of care in short-staffed ICUs was higher than those in well staffed. Such a step by the insurance companies is too much to expect. Things will have to get much worse before they get better."

—"Patient and Physician Satisfaction," January 2002

"Patient rage will have to shake up the health care system and make it more responsive to their needs. The deterioration in patient care we have witnessed cannot continue indefinitely. We will have to heal the health care system. The alternative is much too gloomy even to consider."

—"Patient Rage," September 2001

"If managed care had appeared in 1930 instead of 1990, it probably would have been readily accepted by the people. At that time, it would have given them something they did not have. Its appearance in 1990, however, was intended to take away from them something they already had. That is why it has been so unpopular. Once a benefit has been given to the people, it is very difficult to take it away from them. They will want more, not less. Such is human nature. The Romans yelled, 'bread and circuses" even when the Roman Empire was crumbling and the barbarians were at the gates of Rome."

—"The Genesis of Managed Care," February 2001

The Health Status of Pierce County

by Federico Cruz-Uribe, MD
Director of Health

Is it Real to Just Say No?

Federico Cruz-Uribe, MD

Having a heart-to-heart conversation with my teenage daughter is a delicate thing. We both have sensitivities. Some of the issues she brings up make me squirm and I know that I embarrass her at times with my comments. I can be so clunky bringing up stuff with her.

So here we are. A 52-year-old guy, supposedly secure in memories and experiences, trying to share my knowledge with my daughter so that she will pay attention and maybe learn something. SEX comes up and I get awkward. Understand, I am a physician and one that practices public health. We deal with sexually related issues all the time. You want to discuss pregnancies, just ask. How about gonorrhea or venereal warts? Don't hesitate to ask. Unless you're my daughter, and then I tend to stammer for a while.

In public health, we deal with many people who have been ravaged by unwanted pregnancies and sexually transmitted diseases. This happens every day. What they need from us, more than anything, is clear, honest and direct information. How did this happen? What effect will this have on me now and in the future? How do I protect myself and those I care about the most?

This education role in public health is straightforward and relatively easy to take on. But what about our role with those in our community who have never been hurt in this area? Especially, what about those kids who are not sexually active? Some people say, "don't talk about sex, it will only intrigue them and they'll try it out of curiosity." Others feel strongly: "Give 'em the info. Engage in full, free and open dialogues with kids." This feels rational. Why not talk honestly with our sons and daughters? They are potentially at risk if they don't have all the information they need.

But I hesitate. I find myself not jumping on the bandwagon to pass out boxes of condoms and to show explicit videos on safe sex to kids. Hypocritical? I don't think so. On the one hand, I am a public health physician, pledged to advance science-based approaches to protect the health of my community. On the other hand, I am the father of a teenage daughter, deeply wanting to protect her and educate her on the ways of the world. I'm just not sure graphic images about sex is the way to do that.

I don't know if I can stand the discomfort of sharing something I feel is personal with a teenager - my own child or someone else's.

I know from research data that the only way children can be protected from the dangers of early sexual activity is to not be sexually active. The answer is contained in that old-fashioned word: ABSTINENCE. Abstinence is as clunky and out-of-touch-sounding a word as you'll find. We live in a permissive society; one that is permeated with sexual messages. People, even young people today, don't want any limits placed on their personal behaviors.

"We live in a permissive society; one that is permeated with sexual messages. People, even young people, don't want any limits placed on their personal behaviors."

However, the concept of abstinence contains important truths. For example: being sexually active as a teen is both unhealthy and dangerous. This is not something anyone made up. At the Health Department we see one sad individual after another, each of whom engaged in sex as teens and discovered, as a result, rather huge amounts of physical pain and emotional misery.

Okay, maybe I can get to it in a different way. I won't talk about sex. I'll engage her on other important things: Be patient with yourself and others (and me). Set goals for yourself, that extend beyond next week or next month. These are things I feel comfortable talking about.

But the truth of the matter is that we, as parents, have a powerful role to play. We set down rules, establish limits, pass on values and beliefs to our kids. Who of us has not said "Don't

See "Real" page 14

Applicants for Membership

Rebecca L. Benko, MD
Family Medicine
Tacoma Family Medicine
521 Martin L King Jr Way, Tacoma
253-403-2900
Med School: Michigan State University
Internship: Tacoma Family Medicine
Residency: Tacoma Family Medicine

Estevan A. Garcia, MD
Pediatrics/Ped Emer Med
Mary Bridge Emergency Dept.
317 Martin L King Jr Way, Tacoma
253-403-4901
Med School: U of Texas Southwestern
Internship: Children's Medical Center
Residency: Children's Medical Center
Fellowship: Children's Medical Center

Chan S. Hwang, MD
Phys Med & Rehab
Electrodiagnosis & Rehab Associates
2201 S 19th St #104, Tacoma
253-272-9994
Medical School: Loma Linda University
Internship: Northwestern University
Residency: Northwestern University

Write Stuff from page 6

spend the time necessary when you see patients. Many of your patients will simply not be seen. When enough of us do this, things will change," he said.

"I wish I could be encouraging, but I can't be," he said. "I have no faith that our political system will help."

Plans for Retirement

Dr. Statson will certainly not be idle in his retirement. He plans to do a great deal of reading, and he is also writing a medical science fiction novel, set in the future. "When you start writing, the story leads you to many places," he said.

And, of course, he will continue to share his views, thoughts, ideas, and concerns with his PCMS colleagues. After all, he still has a lot to get off his chest.

"I love my profession, and I hate to see what is happening," he lamented. "I'm very concerned because the quality of care is getting so bad, and I'm getting to a point where I will need medical care. I wonder, who will be left to take care of me?"■

In My Opinion.... The Invisible Hand

by Andrew Statson, MD

The opinions expressed in this writing are solely those of the author. *PCMS invites members to express their opinion/insights about subjects relevant to the medical community, or share their general interest stories. Submissions are subject to Editorial Committee review.*

Absolute Safety

Andrew Statson, MD

"He that is secure, is not safe"
Benjamin Franklin (1748)

No, my topic is not homeland security. It is the practice of medicine, although we can borrow a statement from our government officials on the issue of homeland security and apply it to our field. Our leaders told us that no matter how cautious we are, no matter how thorough the searches, how exacting the investigations, how strict the rules, how careful the agents, we cannot be certain that we will never be subjected to another terrorist attack. On the opposite, most likely we will be. In sum, there is no such thing as a foolproof system against a determined fool.

In medicine we face a similar situation. No matter how cautious we are, no matter how thorough our training, how exacting our tests, how strict our protocols, how careful our treatments, we cannot be certain that our patients will never suffer a complication. On the opposite, we can be sure that they will. The "fool" here is Nature herself, determined to withhold from us some of her secrets, no matter how hard we try to discover them. We, who believe that we have an answer to everything, are the real fools.

A recent report in the New England Journal of Medicine made a big splash with journalists across the country. It appeared in the media. It triggered editorials and cartoons. It is easy to crack jokes at physicians and the less you know about medicine, the easier it is.

In case you missed it, the report estimated that, out of the millions of operations we perform each year, we inadvertently leave foreign material in about 1,500 patients. Most of the time it is sponges, but occasionally it is instruments.

Of course, reporters never make typos, never misuse words, never misrepresent facts, never mislead. Legislators never enact laws with loopholes, nor with unintended consequences. Courts never make inappropriate judgements, never condemn the innocent, never exonerate the guilty. Oil companies never drill a dry well. Yes. Sure.

"Too many people are ready to hurl insults at us for any bad outcome, without considering the conditions under which we work."

This is not to say that leaving a sponge in a patient's body is a proper operating procedure. This is not to deny a mistake. This is to say that in real life, under certain circumstances, mistakes are unavoidable, no matter how hard we try to prevent them. We can and must do everything in our power to reduce the number of errors, but we cannot eliminate them completely.

Of course, we count sponges, needles and instruments before and after every operation, but the more we have to count, the more likely we are to make a mistake. Does anyone remember the vote counts during the 2000 presidential election?

Once, I assisted a surgeon who did a hernia repair on a patient that was not exactly slim. He used a sponge, which he tucked under the skin, to help clear the fascia and develop a flap. When the repair was done and we were ready to close, the nurse announced that the sponge count was correct. The surgeon reached in the incision and pulled out the sponge he had left there. The next count was even more correct, amid the red faces.

Frequently we get an incorrect count, even though we are sure that we have not left anything behind. The usual procedures is that case is to take an x-ray while the patient is still on the operating table. I was told that some institutions routinely take x-rays on all their patients before they leave the operating room, even with correct counts.

Wise precaution, but...can anyone be confident, when looking at an x-ray of a 300 pound patient, with all the su-

See "Safety" page 10

Safety from page 9

perpositions of imaging, that there definitely is no sponge inside that abdomen? How many times have people missed a bone fracture on first reading of a film?

We are most likely to make mistakes in harried situations. It happens in the emergency room, in the ICU, in the operating room. It happens when a patient is in shock, in cardiac arrest, or bleeding so much that we can't see anything in the field but the red welling up. It happens when people around us are hurrying and bumping into one another, while getting supplies, equipment, help. We are rushed. We have to work fast. Then we may clamp blindly in a desperate effort to stop the bleeding. Then we may inadvertently get stuck with a needle. Then we may lose count and miss an item.

Another problem is our workload. True, we can slow down, but can we really? We have patients waiting to be seen, others call with problems, we try to handle several situations at the same time, we get distracted and we set ourselves up for errors. We work hard, we get calls at night, we keep going even though tired, because we feel that we must answer the request for care our patients make of us.

We deal with complex situations, where the exceptions to the rules outnumber the conditions governed by them. The possibilities of problems are unlimited and so are the chances of error.

Yes, ladies and gentlemen, we are human. Contrary to expectations, we are not gods, we do make mistakes. If you don't want to take a chance, if you cannot accept the risk, don't come to us, don't come to our hospitals. If you want a god for a physician, visit the temple of Aesculapius.

There are no simple solutions. One thing we can do is slow down, for real. Take care of the one patient in front of us and let the others wait, no matter how urgent their problems. The complaints we already hear about how long people have to wait for care, in the office, in the emergency room, on the hospital ward, will become louder. We can let them get worse. Then we will see cartoons showing a waiting room full of sick patients, while we are pictured talking to our broker or making arrangements for a game of golf. Yes. Sure.

Perhaps, when we have spent a sleepless night, we should tell our patients, "Sorry, I can't take care of you, I am too tired. Go someplace else." We can dump the work on others, but who is there to pick it up? Besides, we'll be guilty of abandonment. Then someone will draw a cartoon, showing us quietly sleeping in bed, the phone off the hook, while a frantic patient is trying to reach us, all under a quote from the Hippocratic Oath, stating our commitment to take care of the sick. Yes. Sure.

Our task is made harder by all those who watch over our shoulder. There is a big difference in the performance of people, depending on whether they are driven by the expectation of a reward for a job well done, or by the fear of punishment if they should make a mistake. I am afraid the practice of medicine has sunk to the latter, a sure sign that our performance will tend to get worse rather than better. Fear does not stimulate the mind, it paralyzes it.

The practice of medicine isn't what it used to be. Nothing is. The outlook for us is grim, notwithstanding the effort at tort reform. Society wants us to do the impossible. Too many of our professional leaders acquiesce to that desire, even though they should know that we are unable to deliver. Too many people are ready to hurl insults at us for any bad outcome, without considering the conditions under which we work.

Improving safety costs money. Absolute safety is not only unaffordable, it is impossible. We are getting closer to the time when people will have to decide what kind of medical care they want and pay the price. Whatever their decision, they'll get exactly what they deserve. In the long run, they always do. ■

Whistler CME program - education AND vacation

The CME at Whistler course, the College of Medical Education's winter resort program, was a big hit this year, providing excellent medical education, great skiing and great vacationing.

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 is not only known for excellent CME opportunities, but for family vacationing, as well.

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 John Jiganti, MD** and will be offered again next year at the Whistler resort area. ■

Eric Elam, MD addresses the CME at Whistler participants on "Controversies in Radiology: CT Screening"

Brenda Kodama, MD answers a question from Gary Taubman, MD following her dermatology update presentation

Nick Rajacich, MD responds to questions from Drs. Tom Miskovsky and Mark Craddock following his address on children's orthopedics

Steven Dagg, MD and family, wife Mary Beth and sons (l-r) Sam and Ben, anticipate the slopes of Whistler. Little Sam is dreaming of future Black Diamond runs

Dr. Enrique Leon and family, wife Kristen and Madison, anticipate the slopes. Little Madison is thinking about Sam as a future ski partner

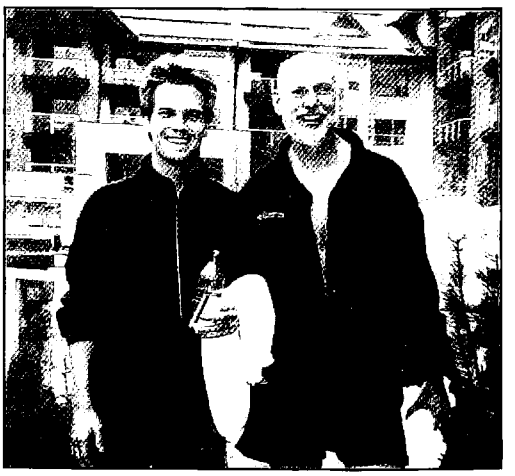
Family practice physicians Drs. Marc Aversa and Christopher Young, and Dr. Young's daughter Caitlin, pose for the COME camera at the pizza reception

(L-R) Gary Taubman, MD, Jennifer Tobin, Jinny Craddock, and Rick Tobin, MD during the pre-conference reception

Dr. Mark Craddock and wife Jinny finish a challenging day on the mountain. Dr. Craddock is a family practitioner in Gig Harbor

Gregg Ostergren, DO and Ron Graf, MD stop on the slopes for a photo. Dr. Graf addressed the conference on management of common thyroid problems

John Lenihan, MD, Tacoma ob/gyn, finishes a day of skiing. He addressed the conference on HRTs



Dr. Pat Hogan and son Patrick stop for a photo on the way to the hot tub. Dr. Hogan is a Tacoma neurologist

COLLEGE OF MEDICAL EDUCATION

Internal Medicine Review CME set for March 13-14

The Tacoma Academy of Internal Medicine's annual two-day CME program set for March 13 and 14 is open for registration.

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

- Advances in the Diagnosis and Treatment of Prostrate Cancer
- Diagnosis and Treatment of Alzheimers in the Primary Care Setting
- Outpatient Management of Hypertension: An Algorithmic Approach
- Preventing Renal Injury in the Geriatric Population: Cautious Use of Good Stuff
- Limitations of Vancomycin in Surgical Wounds and Serious Pulmonary Infections
- Risk Stratification for Coronary Disease
- Stroke Prevention and Acute Management
- Atrial Fibrillation: Its Management and Complications
- Clinical Management and Pharmico Therapy of the Insulin Resistant Patient
- Management for Acute Coronary Syndrome
- Hemmingway's Brain: Depression in Geriatric Patient
- Pain Management in the Adult: Osteoporosis and More
- Hospital and Outpatient Management of Anemia
- Update on Venus Thrombolism ■

Continuing Medical Education

Endocrinology for Primary Care scheduled for April 4, 2003

Registration is open for the Endocrinology for Primary Care CME program set for April 4, 2003.

The new COME program willb e held at St. Joseph Hospital and is directed by **Ron Graf, MD.**

Dr. Graf has assembled mostly local endocrinologists to present on timely and appropriate subjects. The program is complementary and offers six Category I CME credits.

The program brochure was mailed in early March. Subjects planned include the following:

- Recent Advances in Diabetes Management
- Islet Transplantation for Type I Diabetes: The Seattle Experience
- Treating Obesity Today: Diet, Drugs or Scalpel?
- Polycystic Ovary Syndrome: The Most Common Endocrine Disorder?
- Managing Common Thyroid Problems
- Can Hormone Therapy Prevent Aging?
- The Endocrine "Incidentaloma" - You Found It - Now What? ■

April of 2004 CME at Hawaii Slated for Kauai

The College's very popular semi-annual program held in Hawaii is set for the week of April 12, 2004 on the island of Kauai.

The exceptional Hyatt Regency Kauai Resort and Spa has been selected for the conference site. A block of rooms at greatly discounted rates have been reserved. Details of the conference, including a problable block of airplane seats, will be detailed in the Bulletin in coming weeks.

Plan now for a trip to Kauai in 2004. ■

Dates	Program	Director(s)
Wednesday-Sunday March 5-9	CME and the Mariners	Richard Hawkins, MD
Thursday-Friday March 13-14	Internal Medicine Review 2003	Maureen Nuccio, MD
Friday, April 4	Endocrinology for Primary Care	Ron Graf, MD
Friday, May 2	Allergy, Asthma & Pulmonology for Primary Care	Alex Mihali, MD
Friday, May 16	Advances in Women's Medicine	John Lenihan, Jr., MD

Real from page 7

get into cars with strangers." This is the most normal of messages when your child is 4 or 5 or 7 years old. What about 14 or 18? You picture the scene: your 18-year-old heading out the door on a date and you shouting from your easy chair, "Now, dear, don't get into a car with a stranger!" I know what they would be thinking: "Has dad been working too hard?" "Does he need to adjust his medication?" At some point we have to trust that they got the message and will act accordingly.

It's no different with these SEX issues. Give them the information they need to hear at that decision-making time in their life. Don't be afraid or reluctant. Just blurt out the uncomfortable truth: "You know, being sexually active right now is just not the smartest thing in the world. I want you to be the coolest, strongest most attractive person around. This sex thing just doesn't get you there."

It's no more difficult than telling your six-year-old to avoid strangers. You can do it.

Yeah, I can do it. I have to do it. This is an issue too important to crawl under a rock about. Being the parent, the adult, is a wonderful role to play with your children. Enjoy it!

I'm trying, I'm trying.... ■

Liability Reform Coalition - ending lawsuit abuse

The Liability Reform Coalition (LRC) is an association of organizations committed to ending lawsuit abuse. The mission of the LRC is to limit the expansion of tort liability, to reduce the cost of defending lawsuits, to speed resolution of civil actions, and to improve the fairness and certainty of our civil justice system for everyone.

The following is the Liability Reform Coalition's 2003 Legislative Agenda:

1. Joint and Several Liability Reform - Under current law, one party in a multi-party lawsuit can be required to pay 100% of all damages even if they have been found legally responsible for only 10% (or less). We propose to protect injury victims and consumers by tying money awards to actual fault.

2. Medical Malpractice Liability Reform - There is a crisis in this state with rapidly escalating medical malpractice insurance premiums. The solution to this problem is three-part: (1) To enact the overwhelmingly successful California reform model, **MICRA** (Medical Injury Compensation Reform Act). This balanced legislation provides a cap on non-economic damages, evidence of collateral source payments, a sliding scale of contingent attorneys' fees, an advance notice of claim, a statute of repose, allowing periodic payments for future damages and allows for binding arbitration in health care matters. (2) In addition to MICRA the LRC advocates for **health care provider joint and several liability reform**. In medical malpractice cases, health care providers sometimes must pay damages for in excess of the amount of fault they are found to have in a lawsuit. We work to change the law so the monetary amount a defendant health care provider is responsible for paying matches to the provider's actual portion of fault. (3) The third leg of the medical malpractice liability reform effort we support is to **change the burden of proof**. In medical malpractice cases the burden of proof is set very low: preponderance of the evidence. This standard is unfair and invites frivolous lawsuits. We will work to advance legislation to change the burden of proof in medical malpractice cases to a standard of clear, cogent, and convincing.

3. Constitutional Amendment Allowing a Cap on Non-Economic Damages - In 1986 a bipartisan legislature and a Democrat Governor enacted legislation allowing for a cap on non-economic damages (for example, pain and suffering). Unfortunately, the Supreme Court ruled this legislation as unconstitutional. Our constitutional amendment will provide the legislature the authority to enact caps on non-economic damages only.

4. Employer Reference Check Bill - This proposal is designed to protect employers while improving workplace safety. Under this proposal, employers who in good faith disclose job performance, on-the-job conduct or other work-related information about an em-

See "Coalition" page 16

Liability Reform Coalition Members

AGC of Washington
AIA Washington Council
Am. Council of Engineering Companies
American Insurance Association
Architects & Engineers Leg. Council
Association of Washington Business
Association of Washington Cities
Association of WA Health Care Plans
AstraZeneca Pharmaceutical
Aventis
Avista Corporation
BIAW
BP
Burlington Northern Santa Fe
Capital One Financial Corp.
Farmers Insurance
Fire Services Fund of Washington
GlaxoSmithKline
Greater Seattle Chamber of Commerce
Group Health Cooperative
Johnson & Johnson
MultiCare Health Systems
Mutual of Enumclaw
National Assn. of Independent Insurers
NFIB Washington State
PACCAR, Inc.
Pacific Northwest Ski Areas Association
PacifiCare
PEMCO Financial Services
Pfizer
Pharmacia & Upjohn, Inc.
Philip Morris Management Company
PhRMA
Physicians Insurance
Plum Creek Timber Co.
PREMERA Blue Cross
Progressive Insurance
Puget Sound Energy
Regence
SAFECO Corporation
Simpson Investment Company
State Farm Insurance Company
The Boeing Company
The Doctors Company
Washington Assn. of REALTORS
Washington Casualty Company
Washington Cities Insurance Authority
Washington Defense Trial Lawyers
Washington Food Industry
WA Governmental Entities Pool
Washington Health Care Association
Washington Restaurant Association
Washington Retail Association
Washington Self Insurers Association
Washington Society of CPAs
Washington State Hospital Association
Washington State Medical Association
Weyerhaeuser Company
Yakima Valley Memorial Hospital

Coalition from page 15

ployee would be protected from lawsuits. The Governor's 1998 Small Business Conference attendees identified this as the second-highest concern facing small business.

5. Tort Judgment Interest Rate - This sensible proposal would simply revise old statutory language that has defendants currently paying tort judgment interest rates of *at least 12%* when they lose an appeal. The language was written in the 1970s as an attempt to cap then skyrocketing interest rates in the appeals process. Today, interest rates are much lower, and this proposal would tie tort judgment interest rates to a rate two percentage points above the 26-week Treasury Bill rate (as of January 2003 the "T-Bill" rate was 1.182%).

6. Contractor Liability Insurance - The insurance industry is pulling out of the contractor liability insurance market in Washington State. New contractors, both general and subcontractors, are being refused coverage, and existing contractors are finding renewals extremely difficult to obtain, particularly those who build multi-family housing. The LRC supports legislation which will reduce unnecessary litigation while protecting valid construction defect claims.

7. Seatbelt Defense - Under current law, in auto accident litigation a defendant is not allowed to enter into evidence whether a plaintiff was wearing his/her seatbelt at the time of the accident. We support legislation which will simply allow this information to be presented to a jury. *(WSDOT Request Legislation)*

If you have any questions regarding the Liability Reform Coalition, please call 206-956-3627 or visit their website at www.walrc.org. ■

How to contact your state and national lawmakers

President may be reached by mail: 1600 Pennsylvania Ave NW, Washington D.C. 20500; his message phone is 202-456-1111

U.S. Senators and Representatives:

Sen. Maria Cantwell (D), 464 Russell Senate Building, Washington, D.C. 20510; 202-224-3441 (DC) or 206-220-6400 (Seattle) FAX: 202-228-0514 or email: maria_cantwell@cantwell.senate.gov

Sen. Patty Murray (D), 173 Russell Senate Building, Washington, D.C. 20510; 202-224-2621 (DC) or 206-553-5545 (Seattle) FAX: 202-224-0238 or email: senator_murray@murray.senate.gov

Rep. Norm Dicks (D-6th), 2467 Rayburn House Building, Washington D.C. 20515; 202-225-5916 (DC) or 253-593-6536 (Tacoma) FAX: 202-226-1176

Rep. Adam Smith (D-9th), 116 Cannon House Office Building, Washington D.C., 20515; 202-225-8901 (DC) or 253-593-6600 (Tacoma) or toll free 1-888-764-8409; FAX: 202-225-5893, email: adam.smith@mail.house.gov

State Offices:

Governor Gary Locke, Legislative Building, PO Box 40002, Olympia 98504-0001, 360-902-4111, FAX: 360-902-4110, home page: www.governor.wa.gov

State Representatives: Washington House of Representatives, PO Box 40600, Olympia, WA 98504-0600
State Senators: Washington State Senate, PO Box 40482, Olympia, WA 98504-0482. The central Senate FAX: 360-786-1999

To leave a message for lawmakers or to learn the status of legislation, call the Legislature's toll-free hotline, 800-562-6000. The hearing impaired may call 800-635-9939,. The Legislature's Internet home page address is **www.leg.wa.gov.**

Legislators by district with Olympia phone numbers (ALL 360 AREA CODE) and email addresses:

2nd District, (South Pierce County)
Sen Marilyn Rasmussen (D) 786-7602; rasmusse_ma@leg.wa.gov
Rep Roger Bush (R) 786-7824; bush_ro@leg.wa.gov
Rep Tom Campbell (R) 786-7912; campbell_to@leg.wa.gov

25th District, (Puyallup, Sumern, Milton)
Sen Jim Kastama (D) 786-7648; kastama_ji@leg.wa.gov
Rep Dawn Morell (R) 786-7968; morell_da@leg.wa.gov
Rep Joyce McDonald (R) 786-7948; mcdonald_jo@leg.wa.gov

26th District, (NW Tacoma, Gig Harbor, South Kitsap)
Sen Bob Oke (R) 786-7650; oke_bo@leg.wa.gov
Rep Pat Lantz (D) 786-7964; lantz_pa@leg.wa.gov
Rep Lois McMahan (R) 786-7802; mcmahan_lo@leg.wa.gov

27th District, (North Tacoma, East Side)
Sen Debbie Regala (D) 786-7652; regala_de@leg.wa.gov
Rep Dennis Flannigan (D) 786-7930; flanniga_de@leg.wa.gov
Rep Jeannie Darneille (D) 786-7974; darneill_je@leg.wa.gov

28th District, (West Tacoma, U.P., Fircrest, Lakewood)
Sen Shirley Winsley (R) 786-7654; winsley_sh@leg.wa.gov
Rep Mike Carrell (R) 786-7958; carrell_mi@leg.wa.gov
Rep Gigi Talcott (R) 786-7890; talcott_gi@leg.wa.gov

29th District, (South Tacoma, South End, Parkland)
Sen Rosa Franklin (D) 786-7656; franklin_ro@leg.wa.gov
Rep Steve Kirby (D) 786-7996; kirby_st@leg.wa.gov
Rep Steve Conway (D) 786-7906; conway_st@leg.wa.gov

31st District, (East Pierce County)
Sen Pam Roach (R) 786-7660; roach_pa@leg.wa.gov
Rep Jan Shabro (R) 786-7866; shabro_ja@leg.wa.gov
Rep Dan Roach (R) 786-7846; roach_da@leg.wa.gov

For more specific information about the legislative process or for a copy of the 2003 Guide to the Washington State Legislature which includes listings for elected state and federal officials, please call PCMS, 572-3667.

The "Just Because" Rules Of Reimbursement

1. Just because you provide the service doesn't mean there is a code for it.
2. Just because it has a code doesn't mean it's covered.
3. Just because it's covered doesn't mean you can bill for it.
4. Just because you can bill for it doesn't mean you'll get paid for it.
5. Just because you've been paid once doesn't mean that you'll be paid again.
6. Just because a provider in one part of the country is paid for it doesn't mean that you will be.
7. Just because you read all the bulletins, policies, and regulations carefully doesn't mean that you know the rules.
8. Just because you are a motivated, intelligent, rational human being doesn't mean that you will ever understand the rules.

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

Classified Advertising

POSITIONS AVAILABLE

Tacoma/Pierce County outpatient general medical care at its best. Full and part-time positions available in Tacoma and vicinity. Very flexible schedule. Well suited for career redefinition for G.P., F.P., I.M. Contact Andy Tsoi, MD (253) 752-9669 or Paul Doty (Allen, Nelson, Turner & Assoc.), Clinic Manager (253) 383-4351.

Established Auburn Family Practice seeking Board Certified or Board Eligible physicians to join our group. Base salary plus incentive program for motiviated Doctor. Part time or full time hours available. Fax CV to 253-839-5565.

POSITIONS WANTED

Transcription Specialists - We have years of experience in most specialties. We guarantee accuracy, fast turnaround time, free pickup and delivery and competitive rates. Outstanding references. Call 925-3276.

OFFICE SPACE

Lease amount discounted 49% off market rents - Class A. Ample parking. Highly visible. Easy access. 4900 sq ft available now. Total sq ft of 8733. Close to 100th & Bridgeport Way SW. Call Bob York or Cody Miller at 253-531-9400. Crescent Realty, Inc.

EQUIPMENT

For Sale: Two IMEX ABCO 6355 Pocket Dopplers (Ob). Includes 2 and 3 mgz probes, battery charger. New $735. Both for $500. Call **Dr. Kulpa** at 851-2922.

For Sale: GE RT-3200 Advantage II ab-dominal and vaginal probe-transducers. Excellent condition. Low usage in solo practice. Price negotiable. Call **Dr. Kulpa** at 851-2922.

Pierce County Medical Society
223 Tacoma Avenue South
Tacoma, WA 98402

Return service requested

**PRESORTED
STANDARD
US POSTAGE PAID
TACOMA, WA
PERMIT NO 605**

Pierce County Medical Society
BULLETIN

April, 2003

Enact Medical Liability Reform

Watch for the Red and White Banner at the *"Rally for Medical Liability Reform"*

Wednesday, April 9
12:30 - 1:30 pm
UPS Fieldhouse

INSIDE:

The Bulletin is published monthly by PCMS Membership Benefits, Inc. Deadline for submitting articles and placing advertisements is the 15th of the month preceding publication.

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 PCMS. Acceptance of advertising in no way constitutes professional approval or endorsement of products or services advertised. The Bulletin reserves the right to reject any advertising.

Managing Editor: Sue Asher
Editorial Committee: MBI Board of Directors
Advertising Information: 253-572-3666
223 Tacoma Avenue South, Tacoma WA 98402
253-572-3666; FAX: 253-572-2470
E-mail address: pcmswa@pcmswa.org
Home Page: http://www.pcmswa.org

Pierce County Medical Society
BULLETIN

April, 2003

Table of Contents

President's Page

by J. James Rooks, Jr., MD

Are you ready to Rally?

J. James Rooks, Jr., MD

By now all of you have received information about Pierce County Medical Society's RALLY FOR MEDICAL LIABILITY REFORM, to be held Wednesday April 9, 2003 from 12:30 PM to 1:30 PM at the University of Puget Sound Field House. We will have media coverage, politicians present, and invited patients. We encourage all to come and bring as many members of your staff as you can. We encourage all the retired physicians to come and support us also. We have support from all three major hospital systems in the county, we'll have light lunches available, and most of all we'll be the first county society in the state to take a public stand on this issue!! All we need is plenty of our members there to make an impression on our legislators, so that we show solidarity for this important issue. We have an uphill battle to say the least—I received my reply for support from Senator Cantwell who upholds the trial lawyer's party line of no-change in the laws, yet supports the effort to address the rising premiums for medical malpractice insurance. Unfortunately, the senator offered no other solutions, illustrating to me what an uphill battle we face.

So much needs to be done and we are at a crisis in American medicine illustrated graphically by Dr. Josef E. Fischer in an excellent article "Whither Goest?" appearing in the February 2003 edition of the *Bulletin of the American College of Surgeons*, where he states: "The criminalization of medicine and the assumption that a physician is a criminal until proven otherwise has taken its toll in the standing of the medical profession. One cannot hope for physicians who are paid less and unable to educate their children in the schools they themselves attended (which is probably the line in the sand) to urge other people, including their children, to go into medicine.

No one wants to get paid less than the neighborhood plumber and at the same time be subject to the barbs and arrows of society." I encourage all of you to read this article in its entirety, and come to the rally prepared to let the media and our legislators know where we stand—ultimately this is all about access to care for patients.

On a different note, as I write on the second day of the second Gulf War, I urge everyone regardless of your political views to support our troops—especially our brother and sister physicians serving in the military and in harm's way. If you know a physician serving in the Mideast, write to them, e-mail them, or whatever you can do keep in touch with them—it means so much to their morale as they serve and care for our young soldiers, marines, sailors, and airmen. Let us pray for a quick end to the situation and the safe return for our friends and colleagues.■

Editor's Note: For a copy of "Whither Goest?" call 572-3667 and provide your fax number.

In My Opinion.... The Invisible Hand

by Andrew Statson, MD

The opinions expressed in this writing are solely those of the author. PCMS invites members to express their opinion/insights about subjects relevant to the medical community, or share their general interest stories. Submissions are subject to Editorial Committee review.

Strikes and Other Options

Andrew Statson, MD

"When work is a pleasure, life is a joy.
When work is a duty, life is slavery."
Maxim Gorky (1903)

In the spring of 1975, if I remember correctly, the physicians in California went on strike. It lasted about three months. It possibly prompted the governor and the legislature to appoint a commission, which studied the problem of malpractice and led to the adoption of MICRA.

The strike consisted of refusing to give non-urgent care. I don't know how it worked for the family physicians and internists. Some offices reported a drop in visits of about 80%. In obstetrics, we still had to see the patients, so that our office visits did not go down as much. We did the deliveries, but we did not do postpartum tubals. In the operating room, we did only emergencies. The hospitals went on weekend-type coverage. Where they ran ten or twelve operating rooms at a time, during the strike they cut down to one or two.

Economically, I think surgeons and anesthesiologists suffered the most, but we went through with it and survived. A few hospitals could not handle the loss of revenue and filed for bankruptcy. I heard of only one hospital in Orange County which had to do that.

The newspapers reported that the mortality rate had dropped during the doctors' strike. Some people got a chuckle out of it. Of course, what else are doctors good for, except to make people die?

My first memory of a strike goes back to when I was a surgical resident in France. I don't remember what the issues were, nor how they were resolved. I think the physicians made their point.

The French Medical Association called the strike which lasted several months. It was a paperwork strike. We took care of the patients as we always had, but we refused to sign their insurance forms. The French system allowed physicians to charge patients their regular fees. The patients were reimbursed by the Health Service at the government fee schedule. During the strike, the Health Service accepted the forms without our signature.

Another part of the protest was our refusal to give disability leave for longer than one week. If the patients needed more time, they had to come to the office every week, get a new form and pay for the office visit. That increased paperwork for the Health Service and overloaded both the health and the disability insurance offices.

For more than a year now, I have followed the economic and political developments in the health systems of various countries. Underfunding and cost overruns are everywhere. Physician dissatisfaction is widespread and job actions occurred in many countries in Europe. Currently the situation in Germany is tense, because of rapidly rising costs.

The Health Ministry decreed a freeze on payments to physicians at the level of 2002 and the physicians are not happy about it. They are preparing to strike. They plan to close their offices one day a week, the same day across the country. They expect that 90% of the physicians will participate. The Health Ministry says that they cannot refuse care. They retort that they will handle emergencies.

In Croatia, the physicians went on strike in January, asking for a 50% raise in salaries. They took care only of emergencies. They Health Ministry tried to force them to go back to work because they were considered civil servants and were not allowed to strike. The Ministry also claimed that during the month of the strike, thirteen people had died and blamed the physicians for that.

The physicians dispute the claim and state that, if forced to do so, they will return to work, but they will work strictly by the rules. According to regulations, for instance, they are expected to spend 45 minutes with every new patient. They will do everything right and take all the time they are required to take. They intend to bottleneck the system by obeying the rules.

The customs agents in France did something similar. As civil servants, they did not have the right to strike. In their job action they followed the government regulations to the letter. They inspected every piece of luggage, every car, every truck, exactly according to the procedure books. The result was such a long wait at border crossings, such a back-up in transportation across Europe, that after about two weeks, the government gave in.

Those of us who have been in the Army may remember that there are regulations for everything. If we de-

See "Strikes" page 6

March General Membership Meeting Recap

Physicians as pit crew

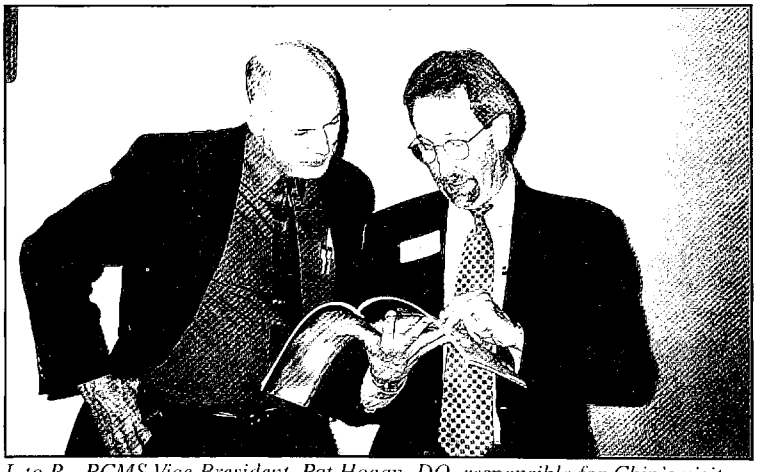
Chip Hanauer's story, as he told it at the March General Membership Meeting, was not only about fame as Washington's beloved hydroplane racer, but about personal medical experiences and appreciation of and concern for physicians and their profession. Having suffered broken bones, concussions, punctured lungs, torn ligaments, a broken back and assorted other "speed bumps" as he called them, "physicians became my pit crew," said Hanauer.

The first hydroplane he "drove" had a string attached to it and was pulled behind his bicycle. Shortly after, at age ten, he began his organized racing career behind the wheel of a real race boat. He babysat, delivered papers and did other odd jobs to earn money to go racing. A special education teacher by profession, racing beckoned him away and he went on to become of the sport's most successful drivers.

He spoke profoundly of many lessons he learned along the way. "Racing made me become somebody I wasn't," he explained. And as a driver you either get all the credit or all the blame, which makes you very visible. Being a shy person, this spot wasn't the most comfortable for him. The more he won, the more pressure there was to perform, and as expectations got higher, the enjoyment got lower. "I'm glad I did it, but I am glad it is done and I can now be who I really am," he said. He switched to auto racing for a while - "I was terrible but I had fun" he said, "there were no expectations."

Chip contracted Spasmodic Dysphonia, robbing him of his ability to speak. He had sought answers from over twenty doctors for over three years, leading him to a period of severe depression. After being diagnosed he has coped well and receives treatment every three months at the UW Hospital. He now serves as a national spokesperson for the National Spasmodic Dysphonia Association.

Chip Hanauer, youngest person ever inducted into the "Motorsports Hall of Fame" addressed PCMS participants



L to R - PCMS Vice President, Pat Hogan, DO, responsible for Chip's visit, and John Hautala, MD, one of Chip's biggest fans

Retiring after winning his 11th Gold Cup, he now travels and is involved in numerous charities, particularly focused on children and animals. He loves playing the guitar and spending time with his dog, Bella. He was insightful enough as a young man to never live beyond the means of a special education teacher because he knew that "racing was a flaky business," and would one day be gone. He still lives in the same tiny house in Seattle that was built for his grandmother. When he speaks to schoolchildren the first question they ask is what car he drives. "They are always very disappointed when I tell them I drive a 1992 stationwagon," he said. ◙

Strikes from page 4

cided to apply them all, little work would get done. A common saying was, "If you have to ask, you'll find a rule that says you can't do it, so don't ask. If it has to be done, just do it."

The more we get mired in regulations, the easier it will be to induce such a work slowdown. We wouldn't be able to take care of anything but the most urgent situations. So far, the physicians in this country have had minimal involvement in job actions. As we find ourselves with our backs to the wall, we may have to do more.

We are pushed around too much. When we reach the point at which we can't take it any more and react to the situation, people will realize that there is a limit to how much we are willing to do for them, while they spit in our faces. They expect us to continue at their service and to take whatever they dish out. So far, they have been right. After all, we swore to dedicate our lives to tending to the sick.

Yes, we did, but at the time of Hippocrates, lawyers did not outnumber healers three to one. The healers took care of the indigent at no charge, but those who were able to pay did so in full. Judges did not punish the physicians when the patients did poorly. The one exception was Babylonia and the code of Hammurabi effectively destroyed the medical profession in that country. The way things are going here, we may be not far behind.■

CME and Mariner Spring Training find Phoenix Sun

The CME and Mariner Spring Training course, College of Medical Education resort program, was a big hit this year, providing excellent medical education, great baseball and sun.

The program is not only known for excellent CME opportunities, but for family vacationing, as well.

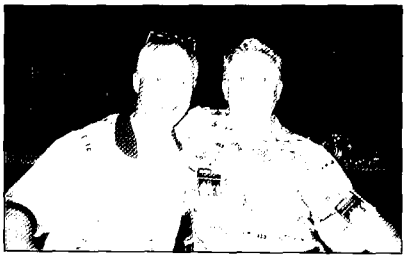
The program featured a potpourri of educational subjects of value to all specialties. Conference attendees particularly enjoy the opportunity to have in-depth discussions about clinical situations.

When not in the classroom, participants and their families enjoyed three Mariner spring training games in close by Peoria, the Mariner's home field. Participants saw great games against Oakland, San Francisco and Kansas City.

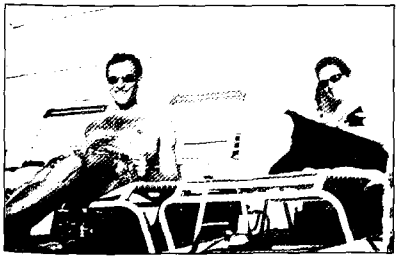
The program was directed by **Richard Hawkins, MD** and will be offered again in a couple years. ■

Frank Senecal, MD "updates" physicians on hematology advances

Dr. David Law and wife, Bev, enjoy the sun in the Mariner Spring training ball park in Peoria, Arizona



Golf buddies, and Puyallup physicians, Dr. Gerald Davis (left) and Dr. Cecil Sandgrass, during a break in the CME program



Dr. Ralph Katsman and wife, Lisa, enjoy the Arizona sun around the hotel pool. Dr. Katsman practices gastroenterology in Tacoma

Dr. Needham Ward and daughter Kate also enjoy the [illegible] sun in Phoenix. Dr. Ward practices cardiology

Gary Taubman, MD and friend Tracy Gage plan the next day's activities at the Peoria practice facilities

Judy and Dr. Patrick Donley share a table with CME presenter Dale Overfield, MD at the hotel's social hour

Mariner fans Steve Duncan, MD and wife, Lynda, enjoy great baseball in the Peoria stadium

Frank Senecal, MD and son Aidan enjoyed the Phoenix hotel's very large pool

COLLEGE OF MEDICAL EDUCATION

Plan Now for 2004 Hawaii CME

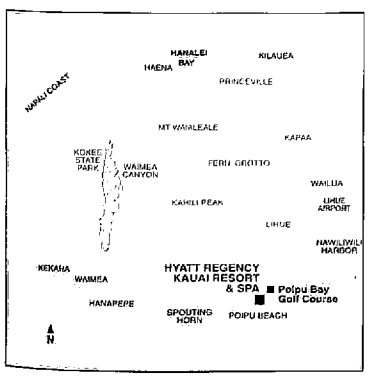
The College's very popular semi-annual program held in Hawaii is set for the week of April 12, 2004 on the island of Kauai.

The exceptional Hyatt Regency Kauai Resort and Spa has been selected for the conference site. The Regency is located on a 50-acre oceanfront parcel on beautiful Keonela Bay in the Poipu area of Kauai Island. The hotel offers a 500-yard oceanfront white sand beach, a riverpool, freshwater pools and five acres of natural, beach-rimmed lagoons.

A block of rooms at greatly discounted rates have been reserved. Details of the conference, including a probable block of airplane seats, will be detailed in the *Bulletin* in coming weeks.

The course brochure with CME content and other registration details should be available in May. **Mark Craddock, MD** is the course director.

Plan now for a trip to Kauai in 2004.■



Continuing Medical Education

International Experts Featured in Women's Health CME

Internationally recognized expert Dr. Leon Speroff will keynote this year's Advances in Women's Medicine CME scheduled for May 16, 2003. The conference will be held at St. Joseph Hospital.

Dr. Speroff will lead this one-day program directed by **John Lenihan, MD** that will address a variety of timely subjects relative to contemporary medicine for women. Designed for the primary care physician, this Category I CME program will feature issues related to diagnosis and treatment advances in treating illness in women.

Dr. Speroff will address the continuing controversial use of HRTs and will specifically respond to the WHI. Dr. Speroff is a professor for the Oregon Health Sciences University in Portland and will speak on "Now What? Hormone Replacement Therapy: 2003."

National expert Sheryl A. Kingsbery, Ph.D., a professor from Cleveland University will address "Sexual Dysfunction: The Woman's Role."

Other topics to be addressed include:

- Common Reproductive Emergencies - What Now?
- New Approaches to Pelvic Floor Relaxation
- Now Available for Women: Office Based Sterilization, Thermal Balloons and other Minimally Invasive Wonders
- Is There a Role for Hormone Replacement in Breast Cancer Survivors?
- Do condoms Really Work?

The course will be held at the Lagerquist Conference Center - Rooms 1A&B at St. Joseph Medical Center.

A program/registration brochure will be mailed in April. Those wishing to register can do so by calling the College at 627-7137■

Allergy, Asthma and Pulmonology CME for Primary Care - May 2

Registration for this year's CME program focusing on subjects on allergy, asthma & pulmonology remains open for Friday, May 2 at St. Joseph Medical Center. The course is under the medical direction of **Alex Mihali, MD**.

Special guest, KOMO TV's meteorologist Steve Pool, will join physician faculty to discuss the weather and its influence of allergies and more.

Subjects will cover:

- Weather Patterns in the NW
- Allergic Rhinitis in the 21st Century
- Community Acquired Pneumonia: An Update
- Asthma Quest for Control
- COPD: Optimizing Management
- Current Management of Asthma
- Laryngopharyngeal and the Airway

Call COME at 253-627-7137 to register. ■

Dates	Program	Director(s)
Friday, May 2	Allergy, Asthma & Pulmonology for Primary Care	Alex Mihali, MD
Friday, May 16	Advances in Women's Medicine	John Lenihan, [illegible]

Applicants for Membership

William C. Bilnoski, MD
Cardiology
Cardiac Health Specialists
1802 S Yakima #307, Tacoma
253-627-1244
Med School: University of Washington
Internship: Maricopa Medical Center
Residency: Maricopa Medical Center
Fellowship: Mercy Hospital & Med Ctr

Ajit S. Deol, MD
General Surgery/Trauma
314 ML King Jr Way #202, Tacoma
253-403-7537
Med School: Dayanand Medical College
Internship: Dayanand Medical College
Residency: Memorial University
Fellowship: University of Minnesota

Address Change

Patty Kulpa, MD
Change office address to:
PO Box 2237, Gig Harbor 98335

Classified Advertising

POSITIONS AVAILABLE

Tacoma/Pierce County outpatient general medical care at its best. Full and part-time positions available in Tacoma and vicinity. Very flexible schedule. Well suited for career redefinition for G.P., F.P., I.M. Contact Andy Tsoi, MD (253) 752-9669 or Paul Doty (Allen, Nelson, Turner & Assoc.), Clinic Manager (253) 383-4351.

Established Auburn Family Practice seeking Board Certified or Board Eligible physicians to join our group. Base salary plus incentive program for motiviated Doctor. Part time or full time hours available. Fax CV to 253-839-5565.

POSITIONS WANTED

Transcription Specialists - We have years of experience in most specialties. We guarantee accuracy, fast turnaround time, free pickup and delivery and competitive rates. Outstanding references. Call 925-3276.

Pierce County Medical Society
223 Tacoma Avenue South
Tacoma, WA 98402

Return service requested

PRESORTED
STANDARD
US POSTAGE PAID
TACOMA, WA
PERMIT NO 605

Pierce County Medical Society

BULLETIN

May, 2003

"Rally" Review

PCMS Board of Trustee members joined PCMS President Jim Rooks and speakers on stage to kick off the PCMS sponsored "Rally for Medical Liability Reform," the first of its kind in Washington State.

See articles and pictures pages 4-8

"Nobody is going to have an impact on my decision making as much as my doctor from my own community. Destiny is in your hands. Please don't sit on them."
- Senator Dale Brandland (R-42)
Speaker at PCMS Rally

INSIDE:

The Bulletin is published monthly by PCMS Membership Benefits, Inc. Deadline for submitting articles and placing advertisements is the 15th of the month preceding publication.

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 PCMS. Acceptance of advertising in no way constitutes professional approval or endorsement of products or services advertised. The Bulletin reserves the right to reject any advertising.

Managing Editor: Sue Asher
Editorial Committee: MBI Board of Directors
Advertising Information: 253-572-3666
223 Tacoma Avenue South, Tacoma WA 98402
253-572-3666; FAX: 253-572-2470
E-mail address: pcmswa@pcmswa.org
Home Page: http://www.pcmswa.org

Pierce County Medical Society
BULLETIN

May, 2003

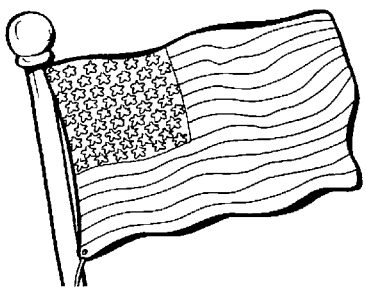


Table of Contents

President's Page

by J. James Rooks, Jr., MD

We've only just begun

J. James Rooks, Jr., MD

Well, April 9th was a great day!! Thanks to all of you who came to the rally and showed the society's commitment to fair Medical Liability Reform. Thanks also to all of you who had other commitments and were unable to attend, yet showed your support. I believe we got attention to our cause, but we've only just begun.

It would be a wonderful happening and indeed a miracle if we could get reform passed this year, but more work is needed—even if it takes more time.

This was a very peaceful rally, no emergency services whatsoever were disrupted in Pierce County, and I believe we have gotten the message across that we mean business.

In the coming months, your board will be discussing other alternatives that we may use to further this cause should desired results not be forthcoming in a timely manner.

I am proud of the unity we showed and I fully believe that we can do a lot more. I urge all of you to write, call, or talk to your legislators about what we want:

- A cap on non-economic damages
- Modification of Joint and Several Liability that fairly apportions responsibility.
- Modification of the statute of repose to reasonable levels.
- A constitutional amendment to allow a cap on non-economic damages to be implemented as public policy.

A cap on non-economic damages is necessary as they are the most unpredictable and rapidly growing component of settlements and jury awards. They threaten the very survival of liability insurance companies, which if go bankrupt threatens physicians and more importantly patients.

We do not want:

- A cap on economic damages, which would not help injured patients, as they need to be compensated fairly.

Along the same note, it has been brought to my attention that somewhere along the way we should address another important point of necessary reform: REIMBURSEMENTS. This of course is most crucial to practice survivability in private, academic, and HMO milieus. Many private practices are now forced to cut back on the number of welfare patients they are able to assimilate into their practices. I have spoken with an academic counterpart at the University of Washington, who has informed me that because many private practices (in all areas of medicine) are no longer able to accept DSHS they are now inundated with these patients to the point that they are now threatened economically. In the long run, this will have to be addressed, and I for one, believe we can effect a change there also.

Though, we have so many challenges before us I am thrilled by the enthusiasm and zeal of the members of this society to fight for change. With continued unity that we demonstrated April 9, 2003, I believe we can accomplish great things. Please continue to pressure our legislators with calls, letters, or e-mail. So many of you are extremely articulate in both the written and spoken word, and if you have the inclination to speak or testify in Olympia let us know—we can use your voice. I have been called to speak with a Senator in the morning as I write this letter—feel somewhat nervous and inadequate about it, and it's definitely out of my comfort zone. If any of you get a similar opportunity, please take it if you can.

In closing, I especially want to thank Sue Asher, our Executive Director and Les McCallum, our CME Program Administrator along with all the Medical Society staff in the outstanding work they did on our behalf in the set up of the rally. Our society is truly blessed to such very capable facilitators and co-workers. ■

Rally for Medical Liability Reform

What a Success!

Editor's Note: Based on the overwhelming success of the PCMS-sponsored rally, WSMA is encouraging all county medical and/or specialty societies to follow suit and organize rallies in their communities to demonstrate to the legislature the dire need for medical liability insurance reform.

It is no wonder that PCMS President, **Dr. Jim Rooks** was so happy and relieved when about 900 people showed up at the PCMS sponsored "Rally" on Wednesday April 9th at UPS. Being the first medical society in the state to organize such an event, and knowing first hand how difficult it is to get physicians away from their busy workloads, fear of failure loomed large. Because of such great support from colleagues and the Pierce County medical community, coupled with the dire need for tort reform, the event was about as far away from failure as one could get.

The PCMS Board of Trustees at their February board meeting voted to proceed with a "day of action" in Pierce County. **Drs. Jim Rooks (President) Mike Kelly, Pat Hogan, Ken Feucht, Steve Duncan, Susan Salo, Laurel Harris, Joe Jasper, Ron Morris, Allison Odenthal, Joe Regimbal, Matt White, Nick Rajacich, David Law, Patrice Stevenson, Len Alenick** and **Don Russell**, heard a cry from the membership to "do something." After a quick survey found significant support for some type of action, they felt the time was right to act and take a first step. They had two subsequent meetings to determine that they wanted to focus solely on the issue of medical liability reform, they would ask local hospitals to stand with them, and they would organize a one hour rally at the UPS Fieldhouse with an eye toward accomplishment of two objectives.

The first objective was to call attention to the need for medical liability insurance reform. Capturing the attention of the public, patients and particularly legislators was a goal. The second objective was to build solidarity in the Pierce County physician community. Helping physicians feel unified and powerful was a goal. Having their objectives and goals before them, the PCMS Board of Trustees and staff went to work devising a campaign to help them succeed.

The campaign had numerous facets, the largest being the media and rally components. Two full page advertisements were planned for *The News Tribune* calling for tort reform and signed by as many physicians and physician assistants that were willing to provide permission for their name to appear in the ad. There were 585 names listed in the full page document (reduced and printed on page 4) as well as logos for all the sponsors of the campaign including Franciscan Health System, Good Samaritan, MultiCare, Physicians Insurance A Mutual Company, and the WSMA. PCMS gratefully acknowledges the financial support of these sponsors that helped defray the cost of the two full page ads. (Sit down - before we tell you that they cost $18,000!)

Along with asking members to attend the rally and include their name in the advertisements, PCMS asked each member for a $30 contribution to help pay for campaign costs. After only one request, 272 members contributed. PCMS is grateful to each and every member that helped defray campaign costs. The $8,185 collected helps immensely toward the numerous rally expenses.

The media campaign was conducted with the assistance of the three Pierce County hospital systems. Their media relations staff, Gale Robinette from Franciscan Health System, Amanda Tobin from Good Samaritan and Todd Kelley from MultiCare provided professional assistance working

See "Success" page 6

Television Channels 4 (KOMO) and 5 (KING) both reported that night on the evening news

Franciscan Medical Group (FMG) physicians were well represented at the event

Success from page 5

with the media and oversight for press releases and on-site coverage of the event. PCMS owes these three individuals a debt of gratitude for their contributions.

Drs. John Lenihan, Peter Marsh, Ron Morris and **Joe Jasper** volunteered to be media spokesmen and were well prepared for the job. PCMS is grateful for their willingness to serve on the front line. The Rally was covered by NBC (channel 5) and ABC (channel 4); print media including *The News Tribune* and the *Puget Sound Business Examiner*, as well as a host of smaller papers and radio stations. Dr. Marsh was featured on KIRO radio at drive time the morning of the rally with many people commenting that they heard him.

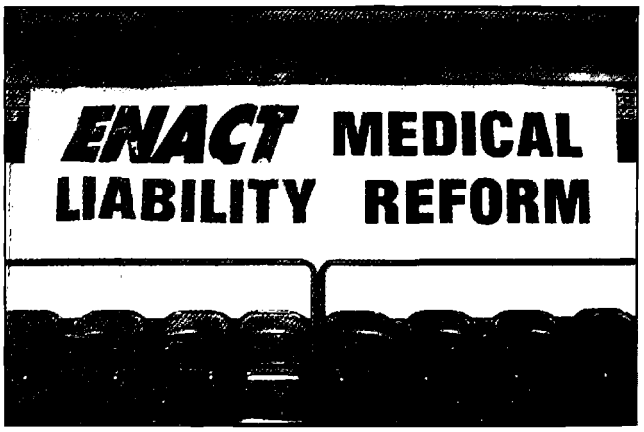
With signs and buttons and banners and substantial lunches from SubWay, participants were festive and upbeat as the hand-selected "motivating" music filled the gym. It's no wonder that the *Tacoma News Tribune* caught **Dr. Charles Weatherby** dancing. With tunes such as 'I Feel Good' by James Brown, 'Respect' by Aretha Franklin, 'Start Me Up' and 'Satisfaction' by the Rolling Stones filling their ears, it was impossible to remain still.

Once the music stopped however, the mood changed as everyone realized the seriousness of the issue. **President Jim Rooks** immediately fired up the crowd and introduced and thanked the board members, media representatives sponsors and emcee for the hour, **Dr. John Rowlands**.

After several inspiring and motivating speakers (see article page 7), Dr. Rooks gave a legislative recap, reminding everyone to call Senators Patty Murray and Maria Cantwell to support HR5 in Congress and to call Rep. Pat Lantz (D-26). Rep. Lantz has continually denied any tort reform legislation with caps to be heard in the House Judiciary Committee, which she chairs. She has blocked any movement of the legislation and says she does not support caps on uneconomic damages and doesn't believe that caps work. Attendees were given information on how to contact their legislators as they left.

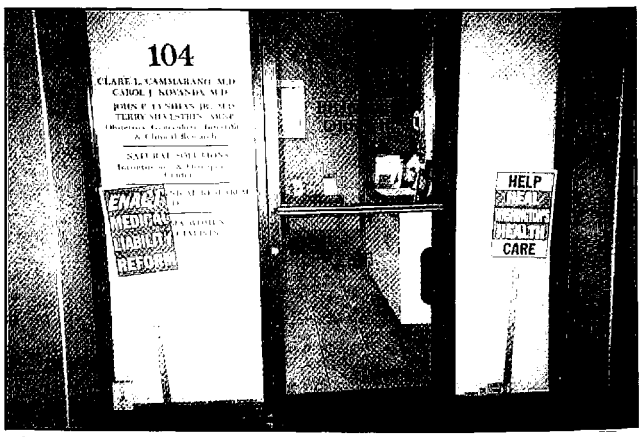
Dr. Rooks promised to keep everyone informed and to keep the momentum going as he adjourned the rally to the instant beat of the theme song from 'Rocky.'■

Rally organizers on stage prior to the event, L to R - Drs. John Lenihan, Pat Hogan, Dave Law, Joe Jasper, Patrice Stevenson, Allison Odenthal, Matt White, Nick Rajacich, Peter Marsh and WSMA President Maureen Callaghan



The big red and white banner, calling for medical liability reform, provided a perfect background for the stage in hopes of television coverage

Six buses transported participants from Tacoma, Lakewood and Puyallup and helped build camaraderie for the passengers



The Tacoma ob/gyn office of Dr. John Lenihan sports signs from the event for patients' viewing

Rally for Medical Liability Reform

by Jean Borst

The Time is Now!

They came bearing signs, buttons and the heavy burden of rising medical liability premiums. For the nearly 900 physicians, staff members, hospital representatives and patients attending the April 9 Medical Liability Rally at the UPS Fieldhouse, it was a day of unity, a call to action, and a loud-and-clear message that now is time for health care liability reform in Washington State.

The rousing event was sponsored by the Pierce County Medical Society and supported by the county's three major hospital systems and Physicians Insurance A Mutual Company. With classic, blood-pumping rock-and-roll playing over the speakers, **Dr. Jim Rooks**, PCMS president, welcomed the crowd and made many introductions before turning the program over to an impressive panel of speakers: Dr. Richard Stubbs, vice president of medical affairs, MultiCare Health System; **Dr. Don Mott**, chief medical officer, Good Samaritan Hospital; **Dr. Mike Newcomb**, senior vice president for medical affairs, Franciscan Health System; Tom Myers, president/CEO, Physicians Insurance A Mutual Company; Senator Dale Brandland (R-42); Dr. William Plested, AMA Trustee; and Dr. Maureen Callaghan, WSMA president.

They came to support and rally the physicians, and they came with one overriding message: meaningful tort reform must happen now. With continued effort, physicians will ultimately prevail in their fight.

"It warms my heart that we gather here today to speak as one voice - physicians and hospitals alike," said **Dr. John Rowlands**, who emceed the event. "We are here to raise a genuine concern that access to care for our patients, our families and for us may be in jeopardy." He added that the dilemma is putting physician recruitment and retention at risk in Washington State and warned that patient access to care and our current health system will deteriorate rapidly. "We are not trying to reinvent the wheel here - tort reform has worked in California for 30 years."

Dr. Rowlands, of course, was referring to the highly successful Medical Liability Reform Act (MICRA) passed in California in the 1970s. HR5, a bill modeled after MICRA that calls for a $250,000 cap on non-economic damages, recently passed the U. S. House and has gone on to the Senate. And in Washington State, similar medical liability reform legislation was introduced in the session that ended April 27. The bill stalled, but supporters are optimistic and already gearing up for 2004. And Pierce County physicians, as evidenced by their enthusiastic turnout at the Rally, appear to be ready for the fight.

The Health System Perspective: MultiCare, Franciscan, Good Samaritan

"This is one of the most desirable places to live in the nation," said Dr. Richard Stubbs. "We have three excellent health care systems and specialists and subspecialists in all disciplines. We have an excellent medical community. So, why do we see doctors leaving utopia to go practice in other states? Why is it so difficult to recruit doctors to come to our state? One of the answers is that we can no longer afford the costs of medical liability premiums." The current impact of this phenomenon is that doctors are leaving the state, and recruiting physicians is becoming increasingly difficult. "And now we are told that many bright young minds aren't even bothering to apply for medical school," Dr. Stubbs lamented. "They don't want to be doctors anymore."

Dr. Stubbs is fearful of the future impacts of this dire situation. For example, an expectant mother might not be able to find an OB to take care of her much-needed prenatal care. "That's not so hard to imagine," he said. "Nine of our OBs stopped seeing patients January 1." A loved one needs surgery and gets to the hospital only to find out there is no anesthesiologist. A child with a head injury comes to the ER, but there is no neurosurgeon available. "These impacts are real," he said. "It's time to change the system now. I am speaking for all 175 employee doctors at MultiCare when I remind you that there is no force strong enough to stop an idea whose time has come. And the time has come for health care liability reform in the state of Washington."

Dr. Don Mott echoed Dr. Stubbs' sentiment. "I think we need to assure the public that Pierce County physicians are acutely aware that we need to reduce medical errors. I doubt that any profession spends more time or effort on error reduction and prevention," he said. "Unfortunately, a broken liability insurance system may limit our ability to provide this guarantee. Unreasonable payments ordered by courts have lead to skyrocketing liability rates today. Physicians can only control one thing - the quality of care they provide. They can't control the broken liability award system," he said.

"We have to start somewhere," Dr. Mott continued. "We have to begin by fixing this broken system. We are in a crisis, and we need to take action now."

To take action, the message must be conveyed to the legislators. Dr. Mike Newcomb called on representatives from

See Rally, page 8

Rally from page 7

both sides of the aisle to come together to discuss their differences and develop a package that is amenable to all. "The future of Washington's health care system is in the hands of you - our elected representatives. Pass meaningful medical malpractice tort reform that will help ensure now and in the future that the people of Washington state are going to continue to have access to the right doctors with the right training in the right hospital when and where they need it."

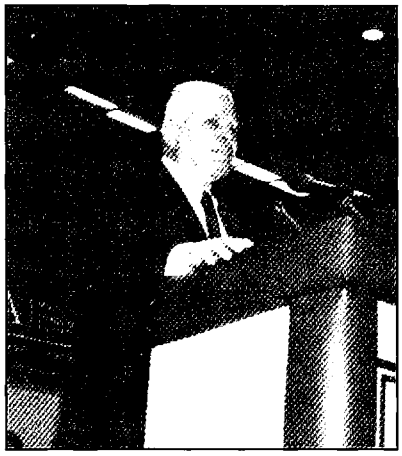
Dr. Newcomb conveyed a recent conversation he had with an attorney friend. "He told me that the reason physicians have trouble in Olympia is because when they need the legislature to act, the physicians don't show up. He said schoolteachers show up, firemen show up, lawyers show up, but doctors don't show up. I'm here to tell you, counselor, that the doctors of Pierce County have shown up today, and they have a message they want to transmit loud and clear to the legislature in Olympia and the congress of the United State: pass meaningful malpractice tort reform, now!"

A Voice from the Insurance Industry

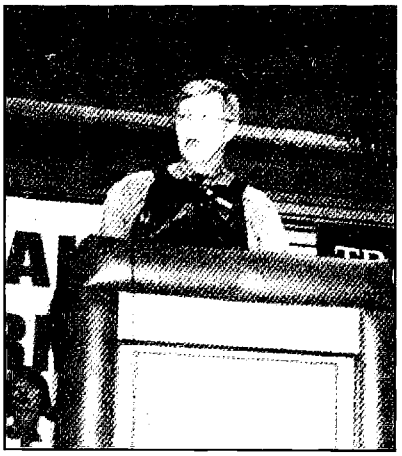
Physicians Insurance A Mutual Company serves roughly 6,000 Washington state physicians, and according to Tom Myers, represents a last line of defense between a functional health care system and chaos in Washington State. "The fight for tort reform is an extraordinarily frustrating one," he said. The trial lawyers are formidable opponents, and Myers noted that they have the ability to spend millions of dollars to further their cause. He recently learned that the American Trial Lawyers Association has earmarked $7 million to fight the tort reform efforts taking place in congress this year. "Our Liability Reform Coalition, which our company under the WSMA participates in, is struggling to raise $500,000 in response," he said. "Needless to say, we are at a significant public relations disadvantage." Myers also added that while the Coalition has been careful to gather accurate and defendable information, "I cannot say the same for our opponents."

He credited physicians for becoming more involved in the fight. "Your willingness to be here today represents a quantum leap from where you were

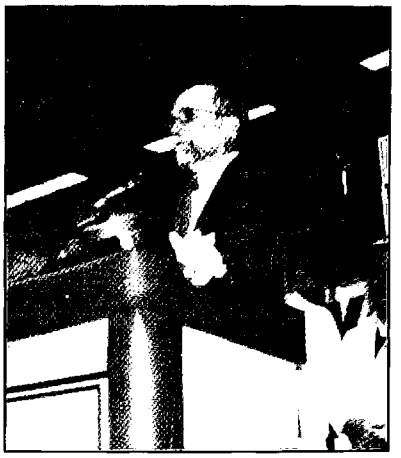
See "Rally" page 18



William Plested, MD, AMA Trustee from Los Angeles, CA

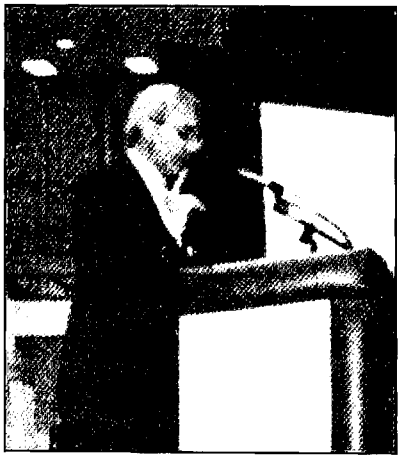


Senator Dale Brandland (R-42) protected in his bullet-proof vest

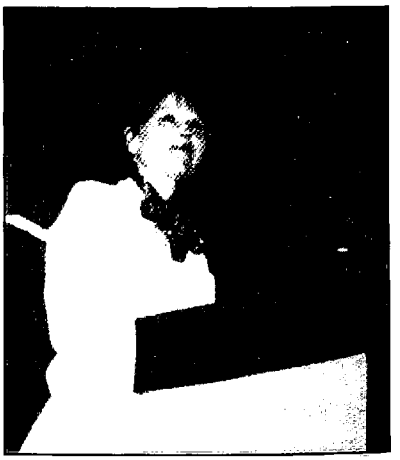


PCMS President, Dr. Jim Rooks

Dr. Don Mott, Chief Medical Officer, Good Samaritan Hospital



Dr. Mike Newcomb, Senior VP Medical Affairs, Franciscan Health System



Maureen Callaghan, MD, President, WSMA and Olympia neurologist

The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

Severe Acute Respiratory Syndrome

Federico Cruz-Uribe, MD

SARS - Severe Acute Respiratory Syndrome - continues to make the local news and to raise concerns among the public and medical providers. We urge health care providers to be alert for patients with febrile respiratory illness and who match the case definition (see below) identified by the Centers for Disease Control and Prevention (CDC). Please report such patients immediately to TPCHD Communicable Disease Control Staff at 253-798-6534 or 253-798-6410 (and press "0" for an operator).

Resources

As a new disease, the CDC maintains communication with physicians around the world and regularly posts updates about the case definition and treatment recommendations on their website: www.cdc.gov. The World Health Organization (WHO) also revises information on their website: www.who.int. The April 10, 2003 edition of the *New England Journal of Medicine*, contains articles on SARS, which can be accessed at www.nemj.org.

Case Definition

The CDC has provided the following as the case definition of SARS (updated April 10, 2003):

SARS is a respiratory illness of unknown etiology with onset since February 1, 2003, and the following criteria:

- Measured temperature greater than 100.4 degrees F, **AND**
- One or more clinical findings of respiratory illness (e.g., cough, shortness of breath, difficulty breathing, hypoxia, or radiographic findings of either pneumonia or acute respiratory distress syndrome, **AND**
- Travel within 10 days of onset of symptoms to an area with documented or suspected community transmission of SARS (People's Republic of China; Hong Kong; Hanoi, Vietnam; and Singapore). This excludes areas with secondary cases limited to healthcare workers or direct household contacts. Travel includes transit in an airport in an area with documented or suspected community transmission of SARS. **OR**
- Close contact within 10 days of onset of symptoms with either a person with a respiratory illness who traveled to a SARS area or a person known to be a suspect SARS case. Close contact is defined as having cared for, having lived with, or having direct contact with respiratory secretions and/or body fluids of a patient known to be a suspect SARS case.
- NOTE: Suspect cases with either radiographic evidence of pneumonia or respiratory distress syndrome; or, evidence of unexplained respiratory distress syndrome by autopsy are designated "probable" cases by the WHO case definition.

Additional Information for Diagnosis

The CDC provides the following information on their website to help diagnose a suspect case of SARS:

- The majority of patients identified as having SARS have been adults between the ages of 25 and 70 years old who were previously healthy.
- The incubation period for SARS is typically 2-7 days; however, isolated reports have suggested an incubation period as long as 10 days.
- The illness generally begins with a prodrome of fever (over 100.4 F), sometimes accompanied with chills and rigors. Other symptoms seen in patients include: headache, malaise, and myalgia. Some have shown mild respiratory symptoms at the onset and some have reported diarrhea during the febrile prodrome.
- After 3-7 days, a lower respiratory phase begins with a dry, nonproductive cough or dyspnea, which might be accompanied by or progress to hypoxemia. In 10-20% of the cases, the respiratory illness is severe enough to require intubation and mechanical ventilation.
- Chest radiographs can be normal during the febrile prodrome and throughout the course of the illness, however, in a substantial number of patients, the respiratory phase is characterized by early focal interstitial infiltrates progressing to more generalized, patchy, interstitial infiltrates. Some x-rays from patients in the late stages of SARS have also shown areas of consolidation.
- The absolute lymphocyte count early in the disease is often decreased. Overall white blood cell counts have generally been normal or decreased. At the peak of the disease, approximately 50% of patients have leucopenia and

See "SARS" page 10

SARS from page 9

thrombocytopenia or low-normal platelet counts (50,000 - 150,000/uL). Early in the respiratory phase, elevated creatine phosphokinase levels (as high as 3,000 IU/L) and hepatic transaminases (two to six times the upper limits of normal) have been noted. In the majority of patients, renal function has remained normal.

• Initial diagnostic testing should include chest radiograph, pulse oximetry, blood cultures, sputum Gram's stain and culture, and testing for viral respiratory pathogens, notably influenza A and B and respiratory syncytial virus. Clinicians should save any available clinical specimens (respiratory, blood, and serum) for additional testing until a specific diagnosis is made.

• At present, the most efficacious treatment regimen is unknown. Regimens utilized have included several antibiotics to presumptively treat known bacterial agents of atypical pneumonia. Therapy in several areas has also included anti-viral agents such as oseltamivir or ribavirin. Steroids have been administered orally or intravenously to patients in combination with ribavirin and other antimicrobials.

• The severity of the illness appears to be highly variable, from mild illness to death. Although a few close contacts of patients with SARS have developed a similar illness, the majority have remained well. Some close contacts have reported a mild, febrile illness without respiratory signs or symptoms, suggesting the illness might not always progress to the respiratory phase.

• A diagnostic test is not yet available, but is being developed. On April 14, 2003, the genome of the virus had been identified, a key step in acquiring an assessment tool.

Clinicians evaluating suspected cases should use standard precautions (e.g., hand washing) together with airborne (e.g., N-95 respirator) and contact precautions (e.g., gowns and gloves). Until the mode of transmission has been defined more precisely, eye protection also should be worn for all patient contact.

You should also be aware of the stigma that has developed for people of Asian ethnicity. Fears related to the close association between China and SARS have isolated some individuals. Across the state anecdotes suggest some people of Asian heritage are avoiding seeking treatment for colds, flu, or other respiratory ailments. ■

Pierce County's successful rally leads to other counties following suit

WSMA is encouraging all county medical societies or specialty societies to follow Pierce County's lead and host a rally for tort reform or some sort of attention getting activity in their community. Pierce County was given kudos at the WSMA Interspecialty Council Meeting on April 19 for taking the first step.

Staff from Spokane, Thurston-Mason, Yakima and Snohomish attended the Pierce County Rally on April 9 to learn how such an event might work in their communities. County Medical Society staff debriefed Executive Director Sue Asher at an April 23 quarterly meeting of County Medical Society/WSMA staff.

Spokane County Medical Society will host a half day of CME culminating in a rally on May 29. Thurston-Mason County Medical Society (Olympia) got front page coverage in *The Olympia* on April 23 with headlines, "Doctors ponder 1-day walkout." The article cited the society has considering a one-day walk out, - not a strike but more of a rally. The Thurston-Mason Medical Society board will be voting on whether to walk out or stage a public event at the Capitol.

Our infamous Gig Harbor Representative Pat Lantz (D-26) was quoted in the article, "it is my hope that we can still make some progress on this important issue, but in doing so, I hope we will not destroy the rights of our citizens." Representative Lantz, as many know, chairs the Judiciary committee and blocked a motion to let physician supported tort reform legislation pass out of her committee.

It is believed that the malpractice situation will get much worse before it gets better. With county societies starting the momentum, a groundswell of support could demonstrate to WSMA that a time in the not-too-distant future would be right for a statewide call to action. Stay tuned. ■

Next HIPAA hurdle - six months

It may be too early to panic, but it's time to start getting ready for federal standards for electronic transactions.

Electronic transaction provisions of the Health Insurance Portability and Accountability Act require payers, clearinghouses and physician practices to conform to a national standard for maintaining and transmitting patient claims and other forms.

Physicians have until October 16 to come into compliance with these standards. But the Department of Health and Human Services set April 16 as the deadline for clearinghouses and software vendors to begin testing their upgrades so that doctors, in turn, can make their deadline.

The types of electronic transmissions covered in the rule include claims (or encounter information), coordination of benefits, remittances, eligibility verification, pre-certification or authorization for referrals, and claims status inquiry.

The transaction rule calls for claims to take on a standard format and to include a baseline of required patient and practice information.

Forms filed under the rule also may contain so-called situational content, which includes any information that is only required under specific circumstances. For example, claims for a patient who was in a car wreck would require the date of the crash.

Physicians who use a clearinghouse to file patient claims also may find those entities asking for additional information to fulfill the rule's new data requirements.

It is because of these considerations that HHS mandated the six-month window between testing the new transaction procedures and compliance by physicians' offices.

It is time to check in with vendors, as the clearinghouses and vendors can't begin testing their systems and software until payers upgrade their claims processes, which some have been slow to do.

Those delays could get passed to doctors' offices, some of which are already getting the runaround from software vendors who are not ready to begin testing upgrades.

The Workgroup for Electronic Data Interchange has encouraged HHS to prepare for the growing pains of implementing the new system. The group

See "HIPAA" page 20

Patient Materials on Tort Reform Available from WSMA Website

The Washington State Medical Association has developed patient education materials on the need for tort reform.

A patient newsletter is available that is perfect for physicians' waiting and exam rooms. Also available is an 11x14 poster for physicians to display, as well as a sample letter. The letter can be downloaded and mailed to patients on practice letterhead.

These education materials warn of the dangers of passing tort reform without caps and urge patients to write to their state lawmakers. The letter outlines the serious effects of skyrocketing medical liability insurance premiums on our healthcare delivery system. It also calls for support of MICRA-based legislation that has been in California for over 25 years as a solution.

To view and order the materials for your practice, go to www.wsma.org and click on Tort Reform Campaign. ■

Antibiotic Resistance Task Force introduces new "Peer to Peer" program

Tacoma-Pierce County Health Department (TPCHD) and the Antibiotic Resistance Task Force are pleased to introduce a new program funded by a grant from the Centers for Disease Control and Prevention (CDC) and the Washington State Department of Health (DOH).

The program entitled, "Peer to Peer" was designed to use health care practitioners to bring information to offices or clinics about antibiotic use and resistance. Practitioners can volunteer as presenters to their group, or an outside facilitator will be provided. Presenters receive a Power Point presentation entitled "Best Practices in Treating URIs." The presentation is an overview of antibiotic resistance, with an emphasis on Streptococcus pneumoniae.

Practitioners interested in scheduling a presentation, volunteering as a presenter to your group or requesting additional information about the "Peer-to Peer" program can call Shirley Knudson at the Health Department. She can be reached at (253) 798-4779.

Call today and schedule your presentation. Health Department staff will provide you with the Power Point presentation, necessary equipment, program material, handouts, antibiotic resistance educational material and lunch or breakfast goodies for practitioners attending the educational session. ■

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

In My Opinion.... The Invisible Hand

by Andrew Statson, MD

The opinions expressed in this writing are solely those of the author. PCMS invites members to express their opinion/insights about subjects relevant to the medical community, or share their general interest stories. Submissions are subject to Editorial Committee review.

Playing by the Rules

Andrew Statson, MD

"I know of no method for the repeal of bad and obnoxious laws so effective as their stringent execution."
Ulysses S. Grant (March 4, 1869)

Institutions have a life of their own. They are born with a burst of energy from a kernel of ideas. In their infancy they have a spurt of growth and development. They establish their identity during the turbulent questioning of the teen years. Finally they settle into a more sedate, but still dynamic, early adulthood. By then, they have acquired a company culture and outlined the basic aspects of their traditions.

As they age, they acquire wrinkles, the comfortable creases and grooves of habit. To any suggestions for improvement, instead of "Let's try it," old-timers in the institution, but also newcomers, now frequently say, "That's how we do things around here." It is a sure sign that the company motto has changed from "Innovate or die" to "Stay out of trouble and survive."

The company follows techniques and procedures, which no longer arise from the fire of invention, but from the ashes of errors. "We must prevent mistakes" replaces "we must break new ground." The rules designed to avoid problems multiply and, in the process, stifle the quest for improvement and smother the spirit of adventure, the core things that launched the company. The advice to the staff becomes "keep to the beaten path" instead of "dare to evolve." The company culture changes. It becomes sclerotic, the sign of old age. Its management is satisfied to avoid problems.

Unfortunately, problems don't happen as expected by the rules. Frequently, they occur outside the projections of the rule-makers. The regulations are based on past experience, while the future never exactly mirrors the past.

Over time, the rules become a burden. They hamper the ability of the company to adjust to changes in circumstances, so that it no longer is eager to handle the challenges of the future and becomes unable to meet them. At that point, following the rules would lead to a company downfall. Survival is assured only by breaking or ignoring them. The Soviet Union lasted as long as it did precisely because people had to break the rules in order to survive. They relied on the black market to provide for their needs and to keep the economy from collapsing.

Our health care system is approaching the level of sclerosis preceding death. We keep it going by bending the rules, because we care about our patients and want to do a good job for them. If we were to work according to the rules, hardly anything would get done. We have to do what is best for the patients, but by subverting the rules, we keep a bad system alive. We allow the rule-makers to believe that the system is working.

Our best approach to get rid of the rules that hamper us is to obey them, strictly and to the letter. I would call this approach "Civil obedience," contrary to the civil disobedience, propounded by Gandhi. Our problem is that we cannot bring ourselves to do something stupid, even though it is required by the rules. We continue to support the current system by disobeying it and putting ourselves at risk for censure.

The insurance companies, public and private, send us numerous algorithms for the treatment of just about any condition. They cover URI, bronchitis and pneumonia, middle ear infections, UTI, depression, diabetes, hypertension, asthma, Pap smears, etc. They tell us what they want us to do. Who are we to disobey? Who are we to want to use our judgment? The people in the know have made it clear. We are here to follow their instructions. Our role is to apply the rules, whether they come from our professional organizations, the FDA, the CDC, or from the private and public insurance plans.

When I did anesthesiology in France, a surgical resident related a story. He was the only person I met who had spent a considerable amount of time reading the procedure book of the Paris Public Hospital System. He found it amusing.

The public hospital administration

See "Rules" page 14

Rules from page 13

of Paris was created during the French Revolution, when the Republic took over from the Church the management of the hospitals. The procedure book dated back, with amendments of course, to the time of Napoleon I. Among other things, it prescribed the amount of meat and wine to be served to the residents each day.

One night, at about 2 a.m., that resident was called to pronounce a patient dead. Since he couldn't do anything for the patient anyway, he asked whether that process could be delayed till the morning. The nurses insisted. He decided to teach them a lesson by doing it according to the rules. First, he listened to the chest and did not hear a heartbeat. Next, he asked for a handheld mirror. It took some doing, but they got one for him. He held it in front of the patient's face and observed no clouding.

Then he asked for a sterile tray, did a cutdown and injected fluorescein dye into the vein. He asked for a fluorescent light to examine the eyes. That took awhile to get, but after some running around, the nurses did it. Ten minutes after the injection, there was no dye in the eyes, confirming the lack of circulation but, according to the book, that was not enough.

The final step was to open the femoral triangle and incise the femoral artery. If it did not bleed, he could in good conscience, according to the rules outlined in the procedure book, declare that the patient was indeed dead. It took him two hours to perform the ritual, while the nurses ran around, getting the equipment and supplies he needed. I should add that he never again was called in the middle of the night, except in dire emergency.

So, let's do it. Let us follow the recommendations of our betters. They have the authority. We are the peons. We are not entitled to make decisions, just to execute them. Let us follow the arrows of the algorithms and document our findings and the reason for our actions. When we write down the history of the patient and the result of our examination, when we point to the arrows on the algorithm display, we cannot be faulted if the outcome is less than perfect.

An insurance company tells us that a patient must take a certain medication for his condition, rather than what we want to prescribe. After three or six months, when the condition is not better, we may be allowed to give him what we wanted to begin with. Instead of objecting and fighting with the insurance, let us explain to the patients the requirements of their policy and follow the instructions. Let us prescribe the medications the companies want, order the tests they recommend, do the procedures they allow.

The more we do that, the faster the rule-makers will realize they are out of line. One example from my practice was a patient with pelvic pain and excessive bleeding. The insurance denied her request for hysterectomy. Their reviewer said that she had to take birth control pills and Motrin in maximum doses for three months. If she still had pain, she should undergo a psychiatric evaluation. Only then would she be approved for a hysterectomy.

I wrote a letter to the patient, relating what the reviewer had said. As you can imagine, she was not happy. We, the physicians, had objected strongly to the requirement for prior authorization, but were ignored by the insurance companies. When the patients begin to fight, the requirement was lifted.

To submit to the insurance companies and follow their guidelines, we may have to act against our better judgement. The patients might suffer but, as good citizens, we did as we were told. Yes, Your Honor, I followed the protocols. I did exactly as the algorithms directed. ■

Applicants for Membership

Linda D. Burkhardt, MD
Pathology
Puget Sound Institute of Pathology
PO Box 34245, Seattle
206-622-7747
Med School: Bowman-Gray
Internship: Medical College of Virginia
Residency: Medical College of Virginia

Renato A. Geralde, DO
Family Practice
Good Samaritan Family Medicine at South Hill
16515 Meridian E #104A, Puyallup
253-840-1859
Med School: Chicago College of Osteopathic Medicine
Internship: Tripler Army Medical Center
Residency: Tripler Army Medical Center

Edward J. Knoll, MD
Radiology
Puyallup Radiological Associates
800 S Meridian #B, Puyallup
253-845-9511
Med School: University of Missouri
Internship: Madigan Army Med Center
Residency: Tripler Army Med Center

Haven Silver, MD
Family Practice
East Main Family Medicine
2732 East Main Ave, Puyallup
253-848-9760
Med School: Finch University of Health Sciences Chicago Medical School
Internship: Harborview Medical Center
Residency: Cheyenne Family Practice

Todd M. Willcox, MD
Plastic & Reconstructive Surgery
222 N J Street #B, Tacoma
Med School: Oregon Health Sciences U
Residency: Mayo Clinic, Scottsdale
Fellowship: Mayo Clinic, Rochester

In My Opinion....

by Michael J. Kelly, MD

The opinions expressed in this writing are solely those of the author. *PCMS invites members to express their opinion/insights about subjects relevant to the medical community, or share their general interest stories. Submissions are subject to Editorial Committee review.*

The Tao of HIPAA Privacy

Michael J. Kelly, MD

Ever notice how every season has its own atmosphere, its own feeing, its own Karma? Remember how we geared up for January 1, 2000? Didn't want to loose any data. Later we discovered the joys of five-digit E&M coding so as not to be labeled criminals by the Office of Inspector General? Most of these adventures were accompanied by their own cottage industry of entrepreneurs filled with the fervor to educate us in regard to navigating these new treacherous seas of change.

So it is time for another challenge. This time it's HIPAA TIME. After much discussion, investigation and reflection, I believe I have discovered one solution for HIPAA privacy. I call it my HIPAA getaway weekend.

No, I did not go to an exotic resort where my family had a wonderful time on Disney-like excursions while I remained firmly planted to my lecture chair. This journey was more of a cerebral coming to terms with the government. It was just me, my 3-ring binder from a recent WSMA conference, my "Field Guide to HIPAA Implementation" and quality time away from the family including my dog Freckles, from whom I gain great insight at times, such as the time she chewed up and digested some very important summary sheets on the penalty aspects of HIPAA.

As I was slipping into the bureaucratic mind-set necessary to adapt the HIPAA material to my practice, I realized that this is about RIGHTS! Throughout the presentation at that WSMA meeting and throughout the field manual from the AMA, the concept of privacy rights, transaction rights and security rights resonates. This is why the Office of Civil RIGHTS is certain to one day prosecute me for leaving out a critical HIPAA paragraph or not saving a significant signature for the proscribed time. So many bureaucratic details, so little attention span.

Because the act of handing out the mandated "Notice of Privacy Practices" requires some sort of explanation, I decided to standardize this approach so as to answer some of my patients' questions and concerns which are certain to arise as we ask them to digest another form and sign another document. I will be instructing my overburdened but talented staff to hand out **our** document, **"A Prelude to HIPAA Privacy"** (AKA "The Tao of HIPAA Privacy") prior to dispensing the "Notice of Privacy Practices."

"Tao is about truth, also known as 'the path of virtuous conduct.' Governmental bureaucracies are about rules, policies, procedures and documentation, not necessarily truth."

Tao is about truth, also known as "The path of virtuous conduct." Governmental bureaucracies are about rules, policies, procedures and documentation, not necessarily truth. As the patient is handed THE NOTICE, they will assume you believe in its content and feel it is important. This is false. The patient may understand that their signature on a special form entitled "Notice of Privacy Practices Acknowledgment" is something we desire to make our lives complete. This is also untrue. The patient may feel that since we are spending time away from direct care to distribute, discuss, document and archive such material, it must be something to which we have deep feelings, devotion and emotional attachment. This, as we all know, could not be further from the truth.

It became clear that we physicians also have the right to communicate to our patients about HIPAA Privacy. We should share our thoughts with them as well as with each other. Since sharing is the first concept I learned in kindergarten, I decided to continue my earliest imprinted directions by sharing this "Tao" with you. Any reproduction of this for your practice has the expressed, herein written consent of the author. Use it at your own peril, however. I will not bail you out of jail.

See "Tao" page 16

Tao from page 15

Prelude to HIPAA Privacy Notice
(AKA "The Tao of HIPAA")

TO OUR PATIENTS:

This notice is to dispel any misconceptions and answer questions you may soon have in regard to what you will come to know as a "Notice of Privacy Practices."

My staff will soon make available to you, under threat of governmental penalties including fines and sanctions, a document the federal bureaucrats now require physicians to circulate. This new form will explain how we handle your health information (known by them as protected health information - PHI). Although we have been protecting your health information for the 25 years I have been in practice, the government now requires us to give you this notice and, if you wish, secure your signature on an Acknowledgment form.

Your rights in regard to the "Notice of Privacy Practices"

1. Our office does not require you to read it, the federal government does.
2. Whether or not you read this document, you are still considered a patient in good standing and may continue treatment with us.
3. Your signature or failure to sign an acknowledgment of receipt are not held against you by the government or our office (but we aren't certain about the government).
4. You may take a copy of this "Notice of Privacy Practices" home to study or line the cat's litter box.
5. *The generation and execution of this document was mandated by politicians and bureaucrats under the title, "The Health Insurance Portability and Accountability Act of 1996" (Public Law 104-191)* ***not*** *by treating physicians or organized medicine.*
6. This "Notice" will not interfere in our continued efforts to offer you the quality of medical care you have come to expect from us, despite the burdensome and threatening federal government we face.
7. We welcome any comments or suggestions from you.
8. Feel free to communicate your thoughts to your congressional representative.

I was recently asked by a patient how I felt about this new intrusion into our physician lives. It brought to mind the final words spoken by Rhett Butler to Scarlet O'Hara in "Gone With the Wind:" "Frankly my dear, I don't give a ..."■

IN MEMORIAM

DOUGLAS A. TAIT, MD

1927-2003

Douglas A. Tait, MD was born March 9, 1927 and died March 23, 2003. He suffered from a heart attack and lived only a few days.

He received his medical degree from Toronto Medical School in 1956, completed his internship at Emanuel Hospital in Portland and a residency at Virginia Mason. Dr. Tait was a family practitioner in Buckley for 40 years until his retirement in 1995.

Dr. Tait was among the first to propose what later became the Foothills Trail and has made arrangements with the nonprofit Cascade Land Conservancy to preserve his century-old 64-acre Buckley farm as an agricultural and historic property.

Dr. Tait was a member of the Pierce County Medical Society since 1964.

PCMS extends sympathy to his wife Donna and their family.

Rally from page 8

just a few months ago. The fight for meaningful tort reform in our state has gone further than many ever believed it would. Without question, we have significantly increased the level of anxiety on the part of trial lawyers here in Washington State. This is despite the fact that they will do or saying anything regardless of the facts to prevent meaningful tort reform from becoming a reality."

Myers went on to say that even though the number of claims received per 100 insured physicians actually went down in 2002, the cost of indemnity payments to claimants and the cost of defense council and expert witnesses rose from $55.8 million in 2001 to $81.2 million in 2002. "The irony being that the money passed through the hands of the trail attorneys who deny it exists," he said. "An estimated $25 million of that total ended up in their pockets."

"We are united in the same battle," he explained. "You for the long-term economic viability of your private practices, and we for the long-term economic viability as your company. Neither of us can afford to lose."

Support from Olympia

Senator Dale Brandland is one of the sponsors of this year's tort reform bill that would cap at $250,000 the amount that juries could award to victims of medical errors for "pain and suffering." The bill stalled in the legislature, but Brandland told the crowd that the issue was not dead and assured physicians that their voices are being heard in Olympia. "I want you to know right now that I believe you," he said to a cheering crowd. "I say that with a certain amount of conviction, because I'm very sad to tell you that there are people in Olympia in positions like mine who do not. However, you have to understand that it's not just one person standing here advocating on your behalf. We recognize that you have a problem, and we want you to know that we believe in you, we will stand up for you, and we will help you find a solution to these problems. I can imagine a life without lawyers; I can't imagine a life without doctors."

A 25-year law enforcement veteran, Brandland drew laughs as he removed his jacket to expose a bulletproof vest. "When I realized I was going to Olympia, I thought I might need this for my back," he told the crowd. "When I knew I was coming to this rally, I thought about how you might be feeling about legislators, and thought this might be a good opportunity to wear it!"

A first-term senator, Brandland said he quickly became attuned to the plight of physicians in the state. "Doctors in my community and members of the Liability Reform Coalition came to me to talk about what is going on with health care in this state," he said. "It didn't take me long to jump on board." He explained the kind of doctors he's been dealing with in Olympia - "spin doctors" - are spinning a whole lot of information, and it's very difficult to get accurate information.

He encouraged physicians to continue to be involved, and urged everyone to know their representatives and senators - contact them and find out their position on this issue. **"Get political, folks," he said. "No one in my position will listen to a lobbyist if they can listen to you. Nobody is going to have an impact on my decision making as much as my doctor from my community. Destiny is in your own hands. Please don't sit on them."**

AMA: Willing to Help in Any Way

Washington State is on the AMA's list of 18 crisis states identified in an AMA analysis released last month. "There is a crisis in Washington State," Dr. William Plested said, "and we don't want a catastrophe." The cause of the crisis, he said is an out-of-control tort liability system that must be fixed.

When Dr. Plested opened his cardiac surgery practice in Los Angeles in the mid-1970s, he quickly realized that he could not pay the premium and start a fledgling practice. "Little did I know that I had trained myself to be a high-risk specialist," he said. At that time, California faced a terrible crisis that was disrupting health care delivery and had hospitals on the verge of closing. Health care providers saw their liability premiums spike 400 percent, due to runaway litigation and open-ended awards. Dr. Plested's wife was one of many phy-

See "Rally" page 22

COLLEGE OF MEDICAL EDUCATION

Continuing Medical Education

Advances in Women's Medicine CME program set for May 6

Registration remains open for the College's Advances in Women's Medicine CME scheduled for May 16, 2003. The conference will be held at St. Joseph Hospital.

Dr. Leon Speroff, an internationally recognized women's health expert, will lead this one-day program directed by **John Lenihan, MD** that will address a variety of timely subjects relative to contemporary medicine for women. Designed for the primary care physician, this Category I CME program will feature issues related to diagnosis and treatment advances in treating women.

Dr. Speroff will address the continuing controversial use of HRTs and will specifically respond to the WHI.

National expert Sheryl A. Kingsberg, PhD, a professor from Cleveland University will address "Sexual Dysfunction: The Woman's Role."

Other topics to be addressed include:

- Preventing Unintended Pregnancy: Advances in Hormonal Contraception
- Sterilization for Women: Past, Present & Future
- The Impact of HRT on the Detection, Stage and Prognosis of Breast Cancer
- Sexual Health and Condoms: New Controversies in the 21st Century!

Those wishing to register can do so by calling the College at 627-7137. ■

2004 Whistler CME set for January 28-31, in Aspens

The College's CME at Whistler/Blackcomb conference is scheduled for January 28-31, 2004.

The College of Medical Education has again 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 last year, 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 program is under the direction of **Drs. John Jiganti** and **Richard Tobin**. A course brochure should be available this summer. ■

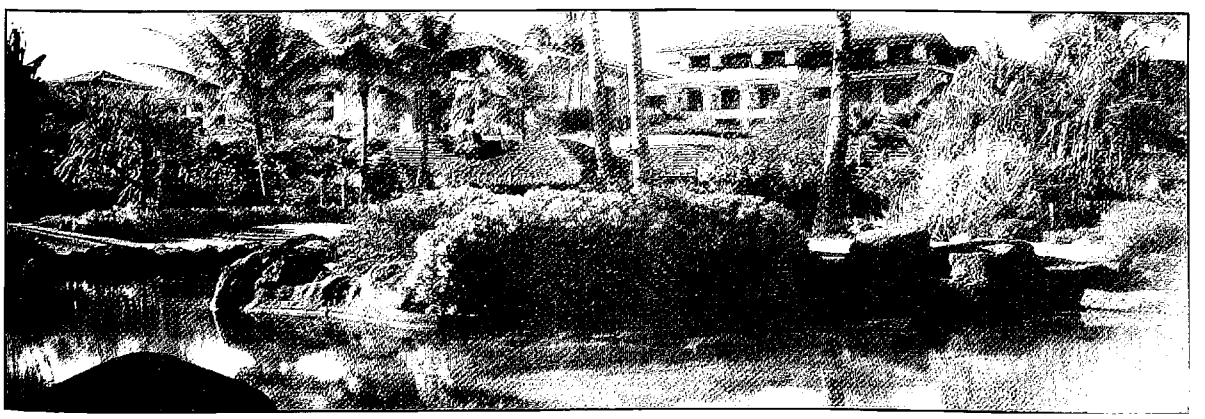
Hawaii CME set for Kauai, 2004

Plan now for the College of Medical Education's semi-annual program held in Hawaii for the week of April 12, 2004 on the island of Kauai.

The exceptional Hyatt Regency Kauai Resort and Spa has been selected for the conference site. The Regency is located on a 50-acre oceanfront parcel in the Poipu area of Kauai Island on a 500-yard oceanfront white sand beach.

A block of rooms at ***greatly discounted*** rates have been reserved. Details of the conference, including a probable block of airplane seats, will be detailed in the *Bulletin*.

The course brochure with CME content and other registration details should be available in May. **Mark Craddock, MD** is the course director. ■



The Hyatt Regency Kauai Resort and Spa

HIPAA from page 11

foresees problems with physicians inadvertently submitting noncompliant claims.

Some industry watchers are also worried that some small physician offices will decide to move back to paper claims to avoid compliance hassles.

"Enforcement activities will focus on obtaining voluntary compliance through technical assistance," HHS said. "The process will be primarily complaint-driven and will consist of progressive steps that will provide opportunities to demonstrate compliance or submit a corrective action plan."

But physicians also may find their claims denied by Medicare and other payers if their forms don't fit the correct format. If their claims do meet the format requirements but lack required information, they still could be rejected.

It is unlikely that the government will start throwing physicians in jail if they are not ready in time, but it would be wise to have a compliance plan before the October deadline.

Excerpted - AMedNews 4/21/03

Hospital/Medical Associations at odds over specialty hospital legislation

A rapid rise in physician-owned specialty hospitals across the country has general hospitals worried that they'll lose their most profitable patients, according to a study released this month by the Center for Studying Health System Change (Center).

Hospitals are worried that they'll be left with the sickest, costliest patients, while physicians want quicker access to operating rooms, more efficient and less expensive care delivery methods and "carrots" for recruiting new physicians to their community.

In states with certificate of need requirements, physicians face a difficult process as application for certificate of need is time consuming and expensive and also opens the doors to challenges from competitors.

While the country has a long history of certain types of specialty hospitals, such as pediatrics and rehabilitation, heart and orthopedic hospitals are relatively new but are growing rapidly. According to the Center, a Washington based organization that studies health care policy, 11 specialty hospitals have emerged since 1997 in 12 local markets, and there are estimates that 50 to 100 specialty hospitals are operating across the country.

In Washington state, the Hospital Association was at odds with the state Medical Association over ESSB5949 which would have prohibited physicians, at least for a year, from competing with hospitals to promote cost-effective services for the community. While physicians and hospitals share many common concerns, the recent battle in Olympia over this issue has strained relations between the associations. ESSB5949 died in the House Rules Committee at the end of this legislative session. ■

The 9th Annual Tacoma Rainiers Community Fund Golf Classic

The Tacoma Rainiers Community Fund is proud to present the 9th Annual Golf Classic at McCormick Woods Golf Course in Port Orchard. This year's tournament will take place on Wednesday, June 25 with a 1:00 p.m. shotgun start.

- Single Golfer - $150
- Foursome - $500
- Golf Includes: lunch, tee prize, green fees, cart rental, range balls, dinner & awards banquet
- Each foursome will be matched up with a Rainiers player or other special guest
- For more information please contact Rachel Marecle at 253-752-7707

The Tacoma Rainiers Community Fund was founded in 1992 as a nonprofit division of the Rainiers to support various civic organizations, foundations and scholarships in the Tacoma-Pierce County community. We encourage everyone who is interested in golfing to join in this great event and support our local community.

In My Opinion....

by Teresa Clabots, MD

The opinions expressed in this writing are solely those of the author. *PCMS invites members to express their opinion/insights about subjects relevant to the medical community, or share their general interest stories. Submissions are subject to Editorial Committee review.*

The Coulter Counter

Teresa Clabots, MD

My father wanted to visit the dermatologist and show her his foot ulceration. During the visit to my friend, he refused to get undressed. (The last time he had disrobed for a doctor was in jail in Germany during the 1930s, when he was in medical school and all of the medical students had ended up incarcerated.)

So he gingerly lifted up his trouser leg and showed her his ankle. The questions were expected. Did you have a history of diabetes? No. Any broken bones? No. Any IVs? Yes.

Apparently while doing an experiment one day, he had blown hard into a pipette to clean it. It had exploded under the pressure and the acid had backflashed and been blown into his mouth and his windpipe. Due to the edema and burns in his mouth, he could not swallow, and had an IV for fluids in his leg where the ulcer now was.

After careful inspection of his pulses, circulation, and the ulcer, several ointments were prescribed, with strict instructions to elevate the foot, and we said goodbye.

We then went to the laboratory to visit my pathologist friend. I knew my father would be interested in seeing a modern medical laboratory. A retired pathologist, he had always built his own medical equipment from scratch.

We entered the lab and greeted Dr. Tillzer. He happily showed us around the gleaming apparatuses, and stopped in front of a huge new automated machine that was pipetting blood samples and clicking along. "This is my new coulter counter," Dr. Tillzer said.

I was not sure if my father knew what that was. He had retired many years ago. So I started to tell him that it was a special machine that counted cells and did differentials, which used to be done by hand in the olden days. He looked at me indignantly, looked at the machine and shook his head. "I KNOW what a coulter counter is," he said proudly. I felt like apologizing, but instead said nothing, and looked at Dr. Tillzer. My father continued. "I worked with the Coulter brothers from Miami."

Now it was my turn to look surprised. "Yes, I helped them develop this machine." Dr. Tillzer was grinning ear to ear. He encouraged my father to talk, by asking, "Really?" My father was on a roll.

"Yes, sir. I developed the cuvette. It took me many times to get the size of the darn hole in the cuvette just right for the cell size. The perfect measurement was 18 microns. Yep. And the Coulter brothers also lived in Miami, which was very hot and humid, so their pumps were always rusting. I talked them into converting to a mercury pump. That solved the day. They offered me stock in their company."

I was getting excited. Maybe America WAS the land of opportunity. Maybe we owned stock in one of the biggest companies that manufactured medical equipment in the United States. Maybe we were rich.

So I gingerly asked him, "Do we really own stock in the Coulter company?" He answered, "No, I tore that up. I gave them the cuvette for their Birthday."

That was my father. Brilliant and evergenerous to his friends. ▫

Rally from page 18

sicians' wives who camped out at the governor's office demanding to be heard. "He found out that these women had a cause, and that they were right, and he helped us," Dr. Plested recalled. Ultimately, Plested and his colleagues saw the passage of MICRA, which solved the crisis and holds down medical liability insurance costs even today. "We passed it because physicians cared, because physicians wanted to save their patients, and because physicians were not ready to let there be people lying in the streets to prove that there was a crisis," he said.

The states in this country that are not in crisis have one thing in common, Dr. Plested noted. They have caps on pain and suffering. "That is what we need," he stressed. "That is what will stabilize this patient while we fix this underlying tort disaster. The way to stop the hemorrhage is to pass HR5."

He told the crowd to be sure to contact Senators Patty Murray and Maria Cantwell to urge their support of HR5 and to remind them that "this is not a partisan issue. This is an issue of health care. There is a crisis. There is a solution."

We are here because we are Physicians

While it may have gone without saying, WSMA President Dr. Maureen Callaghan reminded the group of just why they were all there. "I am here to remind you that we are physicians. We are men and women who have chosen to be healers. We chose medicine because of our drive to know and understand the science of the human body. We chose medicine because of our compassion for people. We chose medicine because we are called to use our knowledge and training to help others. And it is because we are physicians, who want to be able to continue the practice of medicine, that we are all here today."

Dr. Callaghan reiterated that physicians are angry and frustrated about what is happening to medical practices and patients. "We are here to demonstrate our commitment to demand that our elected officials deal with the urgent need for tort reform now. We are here because we can't afford not to be here, because our livelihood depends on it, and because we don't want what is now a crisis of affordability of medical malpractice insurance to become a crisis of availability. We are telling our legislators to support fundamental tort reform."

She told the group that they have a duty to do their best to provide good medical care and to be responsible and accountable for what they do. Patients who have been injured as a result of negligence must be fully and fairly compensated for all past, present and future economic damages, and that physicians do not favor capping those damages in any way. "Like physicians," she said, "legislators have duties and responsibilities. And now, they have a choice - they can act now to restore balance to our tort system and allow the public to vote on the cap on the non-economic damage issue, or they can do nothing and watch the delivery system further decay with the resulting loss of practicing physicians and access to care for the people of Washington. For we as physicians may no longer have a choice to practice medicine if this problem is not solved now."

Dr. Callaghan reminded the physicians of the hard fight ahead. "We are here campaigning for meaningful tort reform not because it is easy to achieve, but because it is hard and because it is worth doing. Believe you me, I don't need to tell any of your physicians that we know how to do hard! We will be persistent in this battle and we will prevail - not because it is easy but because it is hard, and because our livelihood and the health and wellbeing of the people of Washington depend on it."

The Momentum Must Continue

In closing the rally, Dr. Rooks again encouraged physicians to remain involved and said that PCMS plans to keep the momentum going. He urged everyone to contact state and national representatives, specifically Representative Pat Lantz (D-26th), chair of the House Judiciary Committee, as well as Senators Maria Cantwell and Patty Murray. "We need to get them on our side," he said. ■

Classified Advertising

POSITIONS AVAILABLE

Tacoma/Pierce County outpatient general medical care at its best. Full and part-time positions available in Tacoma and vicinity. Very flexible schedule. Well suited for career redefinition for G.P., F.P., I.M. Contact Andy Tsoi, MD (253) 752-9669 or Paul Doty (Allen, Nelson, Turner & Assoc.), Clinic Manager (253) 383-4351.

Established Auburn Family Practice seeking Board Certified or Board Eligible physicians to join our group. Base salary plus incentive program for motivated Doctor. Part time or full time hours available. Fax CV to 253-839-5565.

OFFICE SPACE

For Rent: 3300 sq ft Class A medical office in Tacoma Medical Center. Third floor, elevator, underground parking, close to hospitals. Call 253-272-2224.

Western Institutional Review Board (WIRB) is currently seeking new staff physicians to serve as members of the board. Staff physicians are involved in medical, scientific and ethical review of research protocols and studies to ensure the protection of the human research subjects. WIRB is the oldest and largest independent IRB. Located in Olympia, it offers the opportunity to be involved in a different aspect of medicine. For more information on WIRB and the functions of IRBs, please visit the website at www.wirb.com.

If you are interested in discussing opportunities with WIRB, please forward a CV to Mike Farrell, SPHR, Director-HR at mfarrell@wirb.com. For further information, please feel free to call at 360-252-2431 or in the evening at 253-548-8148.

Retired Physician's Wives

Retired physicians' wives will meet for lunch at Affairs Cafe', 2811 Bridgeport Way, University Place, Wednesday, May 28, 2003 at 11:30 am. For reservations call Judy Brachvogel, 564-4308 or Marilyn Baer, 564-6374. All are welcome.

Pierce County Medical Society
223 Tacoma Avenue South
Tacoma, WA 98402

Return service requested

PRESORTED
STANDARD
US POSTAGE PAID
TACOMA, WA
PERMIT NO 605

Pierce County Medical Society

BULLETIN

June, 2003

Mt. Rainier Yellowstone Cliffs

Photo by Sam Insalaco, MD

INSIDE:

The Bulletin is published monthly by PCMS Membership Benefits, Inc. Deadline for submitting articles and placing advertisements is the 15th of the month preceding publication.

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 PCMS. Acceptance of advertising in no way constitutes professional approval or endorsement of products or services advertised. The Bulletin reserves the right to reject any advertising.

Managing Editor: Sue Asher
Editorial Committee: MBI Board of Directors
Advertising Information: 253-572-3666
223 Tacoma Avenue South, Tacoma WA 98402
253-572-3666; FAX: 253-572-2470
E-mail address: pcmswa@pcmswa.org
Home Page: http://www.pcmswa.org

Pierce County Medical Society
BULLETIN

June, 2003

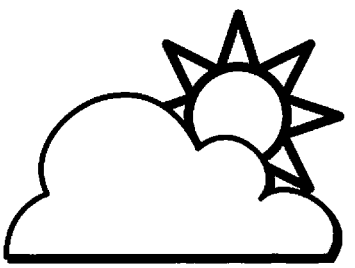


Table of Contents

President's Page

by J. James Rooks, Jr., MD

Toward Political Action

J. James Rooks, Jr., MD

Well, here it is coming up on June, and I'm still just sittin' over here in Steilacoom tryin' to still figure "it" all out! As promised in my last communication, I went on down to Olympia to meet with Senator Kastama (D-26) who contacted me after the rally. After pleasant introductions, I worked up to fever pitch, even to the point of empassionment, about the need for medical liability reform and its impact on access to care for his voters; but the good Senator felt that nothing we physicians would like was going to happen this year. He did have a rather interesting proposal of a "coalition" of physicians and reasonable (if such exists) attorneys to study the problem and perhaps find a solution. I allowed I'd help, some of the board members from Puyallup met with him the following week, and things looked good for some possible action.

Senator Kastama presented the idea to the Speaker of House, Frank Chopp, who lived up to his name and chopped the idea. Senator Kastama just won't quit though and several us will be meeting with him soon to discuss other legislation. I'll keep y'all posted on this tact, but I'm beginning to feel, as do some others on the board, that stronger action on our part may become necessary—i.e., work slow-downs or the like as far as elective procedures etc. are concerned. While they haven't changed things completely in other areas of the country, they do keep the issues before the public. Seems to me, at least in our state, that things don't get changed unless there is a crisis. Please let me or your favorite board member know how you feel on this issue.

Meanwhile, if you keep up with the PCMS Member Memo's we've been sending out, you noticed that Physician Insurance lost $19.4 million bucks last year while the Doctor's Company lost $44 million. I'm sure we'll all hear more about this later — I'm sure it won't be dividends or rollbacks for us. We have been hearing of several physicians in many parts of Puget Sound who've been with one company or the other and now are having difficulty finding coverage elsewhere. Rumors seem to abound, but these are all the facts that I know at this point.

In the long run, I'm choosing to believe that the above problems will get solved, and in a fashion that will be satisfactory to us and our patients. In that vein, I hope as many of you as possible can attend the June 10 General Membership Meeting where we will be discussing ways and means of better and more effectively convincing our state lawmakers that change is necessary. See you there! ■

Pierce County Medical Society

As we maintain momentum in our fight for medical liability reform no member should miss the June General Membership Meeting

Our medical system is in crisis
We are "rallying" for reforms
What will be our next steps in.....

Building Effective Political Action!

anticipated cameo appearances:

- **President George Bush?**
- **Governor Gary Locke?**
- **our infamous Rep. Pat Lantz?**
- **other political dignitaries???**

moderated by:

Federico Cruz-Uribe, MD, MPH

Director of Health

Tacoma Pierce County Health Department

Tuesday, June 10th, 2003 - *Social Hour* - 6:00 pm; *Dinner* - 6:30 pm; *Program* - 7:10 pm

Landmark Convention Center - Temple Theatre Roof Garden, 47 Saint Helens Avenue, Tacoma

---

Return this portion of form to: PCMS, 223 Tacoma Ave S, Tacoma, WA 98402; Fax to 572-2470 or call 572-3667

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

Enclosed is my check for $ _____ or my credit card # is _____

☐ Visa ☐ Master Card Expiration date: _____ Signature: _____

Name: (please print or stamp) _____

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

REGISTRATION REQUIRED by Friday, June 6th

The parking lot across the street charges $3, but there is usually ample street parking at no charge

The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

Do Your Part to Prevent Domestic Violence

Federico Cruz-Uribe, MD

Puget Sound's newspapers feature daily updates on the Brame tragedy. Allegations about domestic violence and the police department's failure to respond to Crystal Brame's cries for help intensify feelings about the late Tacoma Police Chief and his wife.

In U.S. society today, domestic violence continues to be prevalent. Nearly one-third of American women reported being physically or sexually abused by a husband or partner at some point in their lives, according to a 1998 Commonwealth Fund survey. A 1996 study by Liberman Research, Inc., indicated that 30 percent of Americans claim they know at least one woman who had been physically abused by a male spouse/partner during the preceding year. Each year, about 240,000 pregnant women (6% of all pregnant women) in this country are battered by the men in their lives. Although men can also receive violence from their partners, a 1999 study (by the Bureau of Justice Statistics) showed that 15% of intimate partner violence was perpetrated on men, 85% on women.

Traditionally, prevention of domestic violence has focused on precluding further violence by connecting victims to crisis lines and getting them into shelters. Averting battering would be even more preferable. Primary prevention of domestic violence involves changing our social norms, having zero tolerance for family brutality. That means that every one of us should find opportunities to speak out, demanding changes.

And even if every one of us said, "Domestic violence is wrong," it would take a long time to make the crucial changes required.

In the meantime, early intervention is also key. For health care providers, early intervention involves a couple of things. First, screening clients for domestic violence. Second, be aware that some of your staff may be victims, so set up an environment and policies that will allow individuals to seek help.

Screening clients for domestic violence may seem impossible, given everything else that's expected during a visit. Is it possible, however, to add a question related to relationships which are abusive in the list of questions during someone's annual physical? Between "Do you use tobacco?" and "How much alcohol do you consume?" you could ask a question like, "Since the last time you were here, has anyone hit you, hurt you, threatened you or made you feel afraid?" If the individual responds that her relationship has times of violence, then a referral to the Domestic Violence Helpline would help: 253-798-4166.

We never expect someone we know to be a target of abuse, however, it can happen. Make sure your office policies are supportive of victims and be ready to respond to colleagues who ask you for help.

The Tacoma-Pierce County Health Department can also consult with you about early intervention, screening tools, and other resources for addressing domestic violence in your office. Call Alisa at 253-798-3540 for more information.

The responsibility to work to prevent domestic violence belongs to all of us. If we do our job, we won't have repeats of the Brame tragedy.■

Applicants for Membership

Stephen G. Cook, MD
Family Medicine
Community Health Care
101 E 26th St #100, Tacoma
253-597-4550
Med School: U of Cal, San Francisco
Internship: Tacoma Family Medicine
Residency: Tacoma Family Medicine

Jos A. Cove', MD
Orthopedic Surgery
Puget Sound Spine Institute
1515 ML King Jr Way, Tacoma
253-572-2663
Med School: Utrecht State University, The Netherlands
Internship: University of Hawaii
Residency: Harvard University
Fellowship: Queen's Medical Centre, UK

Anastasia Fyntrilakis, MD
Family Practice
St. Joseph Medical Clinic
1708 S Yakima, Tacoma
253-593-8456
Med School: Boston University
Internship: Tufts University
Residency: Tufts University

Dennis J. Galvon, MD
General/Family Practice
4700 Pt. Fosdick Dr NW #209, Gig Harbor
253-851-8545
Med School: University of Calgary
Internship: Victoria General Hospital

Carolyn D. Jordan, MD
Pathology
Puget Sound Institute of Pathology
PO Box 34245, Seattle
206-622-7747
Med School: Oregon Health Sciences U
Internship: Massachusetts Gen Hospital
Residency: Massachusetts Gen Hospital
Fellowship: Dartmouth Hitchcock Med Ctr
Fellowship: Syracuse Health Science Ctr

Jeremiah Ojeaburu, MD
Int Med/Gastro
Digestive Health Specialists
1901 S Union #B4006, Tacoma
253-383-8348
Med School: Univ of Ibadan, Nigeria
Internship: Univ of Connecticut
Residency: Univ of Connecticut
Fellowship: Georgetown Univ Hospital

Jaime G. Pugeda, MD
Cardiology
Cardiac Study Center
1901 S Cedar #301, Tacoma
253-572-7320
Med School: U of Santo Tomas, Philippines
Internship: Cardinal Santos Med Ctr
Residency: College of Albert Einstein
Fellowship: Yale University

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

In My Opinion.... The Invisible Hand

by Andrew Statson, MD

The opinions expressed in this writing are solely those of the author. *PCMS invites members to express their opinion/insights about subjects relevant to the medical community, or share their general interest stories. Submissions are subject to Editorial Committee review.*

Trial by Jury

Andrew Statson, MD

"Power tends to corrupt and absolute power corrupts absolutely. Great men are almost always bad men. There is no worse heresy than that the office sanctifies the holder of it."
Lord Acton of Aldenham (1887)

Through the thousand odd pages of *The Lord of the Rings*, Tolkien describes the tantalizing attraction of power and its corruptive effect on people. He shows the insidious changes in the character of those who hold power in their hands. Even the best cannot escape its influence and struggle with themselves and with others when they have to relinquish it. Of course, that is fiction. We can dismiss it.

Unfortunately, the reality is not much different. The abuse of power by people great and small affects many humans and hurts many more. The holders of power turn into monsters, and their victims, into brutes.

The birth of our republic resulted from a protest against the abuse of power. The framers of our constitution carefully established a structure of checks and balances, designed to counter any attempt by anyone in position of power to abuse it. That structure consists of three types of power, legislative, executive and judicial, pit against one another at three levels of organization, federal, state and local.

Our success in preserving our liberties is due to the ability of the different centers to curb one another if any one of them should grab for power exceeding its prescribed limits. Another power we confer to fellow citizens, when they serve on jury panels, allows them to judge issues of life and death, freedom and imprisonment, economic windfall and financial ruin.

According to *Black's Law Dictionary*, in jurisprudence, justice is the constant and perpetual disposition to render every man his due. Commutative justice consists in rendering to every man the exact measure of his dues, without regard to his personal worth or merits. Distributive justice assigns to each the rewards which his personal merit or services deserve, or the proper punishment for his crimes. In the most extensive sense, justice consists in a man taking such a proportion of good or evil as he ought. (It takes a legal mind to give such a definition.)

The OED defines justice as the conformity to moral right, or to reason, truth or fact; rightfulness, correctness, fairness, propriety. To Random House, justice is administration of deserved punishment and reward, equitableness. According to Webster, it is impartiality; fair representation of the facts; merited reward or punishment; the impartial adjustment of conflicting claims.

Since the beginning of our republic, millions of Americans have served on juries. To their credit, most of them did their job responsibly, without letting the power in their hands cloud their good sense. During the past thirty years, however, we have seen verdicts calling for compensation way out of proportion to the damages the plaintiffs may have suffered.

The appellate process used to be the defense against such abuse of power. Judges in the past overturned excessive verdicts or significantly reduced the amount. Such judicial intervention arises out of the constitutional prohibition of cruel and unusual punishment. During the past several years, even on appeal, the judgments have stood at levels much in excess of what would be a reasonable compensation.

In the presence of the current overreaching by the judicial system, the legislative bodies have a duty to step in and put limits on the excessive awards the courts too readily hand out. The main point of contention right now is the compensation for pain and suffering.

It would be great if we could go through life without pain. It would be great if we could live forever. Unfortunately, that is the realm of dreams. Reality is different. Pain and suffering are part of life, and death is the final cure.

I want to concentrate here on one aspect, that of the pain and suffering from the death of a loved one. We hurt when someone we love dies, even when we know it was time for him to go. The unexpected death of someone we love is even more tragic. In fact, life is invariably fatal. Death can take us away at any moment, sometimes unexpectedly.

About 2.4 million Americans die

See "Trial" page 8

Trial from page 7

each year. Almost all of them have had some medical care during the weeks or months preceding their death. Looking back at their medical record, we can always find something we could have done differently. Had we taken a different turn at this point or that, perhaps we wouldn't have run into an ambush or stepped on a mine. Perhaps our patient would have lived a little longer, perhaps a lot longer. It is also possible that they would have died sooner. We never know for sure.

Among the many fields of human endeavor, the practice of medicine stands out as a subject that does not readily submit to procedure protocols. The human organism is a complex system. There is a limitless variation in the presentation of symptoms, the result of tests and the reaction to treatment.

When things end well, we are happy. If we looked back, it would be with the satisfaction that whatever we did worked. When the outcome is bad, we always wonder whether we could have done better. We look back and analyze everything, even in the most clear-cut and in the most desperate situations. We cannot help thinking about that, because we have a scientific mind. We want to learn from the experience. Yet, we cannot know what would have happened had we done something else. We cannot say that a compensation is warranted because the outcome would have been much better. We simply don't know.

To complicate things, no matter what we do, all of us will die one day. We don't know whether most of what we do delays or brings closer that inevitable outcome and by how much. One of the big areas of litigation is the diagnosis of breast cancer. The claim is that early diagnosis assures survival. That is probably true in many cases, but there is a good reason to believe that breast cancer is a systemic disease early in its course, so that earlier diagnosis probably would not have made a big difference in the long-term outcome. There simply are different kinds of breast cancer.

Through the pain of a loss, the question remains, what is reasonable compensation? Tragedies happen. People die, even without medical mistakes. How much they or their relatives value their life is expressed in the amount of life insurance they have. If they had died from any unpreventable sudden death, their loved ones would be compensated for the resulting pain and suffering, and also for the loss of the income, at the level of their life insurance.

That is the value they have put on that person's life. That is how much they felt they should be compensated in the event of his death. On what basis, then, can a jury decide that the family of the deceased receive a much higher compensation in case of a medical mishap? While "Do everything you can, doctor," used to be a prayer, now it has become an order. We are expected to match the near miracles, the one-in-a-lifetime brilliant successes of some centers, which the press puffs as the coming standard for all medical care. Those can seldom be duplicated, even by the centers that achieved them.

There always will be things we did not foresee, tests we did not do, steps we did not take. Should we be held responsible for the 2.4 million deaths each year? What about for only 1% of them? At the current rate of compensation, exceeding one million dollars, that alone would cost over $24 billion, or $40,000 per physician per year. In that respect, limiting the awards to $250,000 would still average to $10,000 per physician. Such a limit would be a step in the right direction, but much more would need to be done to make the equitable compensation for medical liability a fair and just process. ■

In My Opinion....

by Daisy Puracal, MD, ABHM

The opinions expressed in this writing are solely those of the author. *PCMS invites members to express their opinion/insights about subjects relevant to the medical community, or share their general interest stories. Submissions are subject to Editorial Committee review.*

Medicamentoses or Medication Ailments

Daisy Puracal, MD

I wonder if you remember the days when we wrote prescriptions for 2-300 pills at a time for anti-hypertensive agents and signed it at the bottom right hand side. Our signature meant that THAT WAS WHAT THE DOCTOR ORDERED. These days our signature has to be on the left and the right side is for the pharmacist to change as needed, according to the vagaries of the insurance company.

"Only a 30-day supply of pills at a time is allowed," say some insurance companies. They make no allowances for patients traveling abroad or other emergencies. Imagine lining up at the pharmacy every month for your pills - it is enough to raise one's blood pressure! I guess we have to guard our patients from overdosing on ACE inhibitors.

"A 90-day supply is allowed with a mail order," say others. A 90-day supply would be sufficient for three months that included February. Any other three-month combination would run more than 90 days. What is a patient to do? Go with drug-free days? I always thought that supply bottles of medications came in 100's. What do pharmacies do with the extra 10 pills? I suppose they need it to dispense 10 pills to patients when the mail is delayed.

The latest I heard from a patient is that the Rx has to be for a years supply to maximize savings. Apparently patients do not need to have drug adjustments or disease monitoring.

We were taught to be careful in prescribing large quantities of drugs that have a potential for abuse like anti-psychotic/anti-anxiety meds. Now these are freely allowed at the 90-day limit. Sure, it is quite all right to have 180 buspar/lorazepam tablets lying around the house for someone to overdose on.

There were multiple reasons for keeping medications as prescription only...not just the drug profile but also erroneous self-diagnosis and long term consequences of not seeking proper care. These considerations have now gone by the wayside as more and more drugs are going OTC. This happens every time a drug loses its patent and a newer "more powerful" medicine is out.

The concept of "more is better" is pervasive in our society even with medications. This is contrary to the old "prudent" ways of the past where the adage was to use the minimum effective dose. It aggravates me when a drug representative comes out with "this is 5x stronger than..."

Lately, patients are being made to split their pills to cut costs. Fragmentation still does occur and loss of protective coating of the remaining half is not considered. The poor old lady with gnarled arthritic fingers has a tough time holding a pill, much less cutting it into 2's or 4's. The whole purpose of convenience packaging is gone awry.

I miss being able to pick up the phone and confer with a pharmacist about some aspect of patient care. Now there is the interminable press 1/press 2 messages followed by long holds. I guess this is true in medical offices, the phone company and especially governmental agencies for that matter. Hmmmmm.

"I miss being able to pick up the phone and confer with a pharmacist about some aspect of patient care."

There has been an explosion in direct to consumer drug advertisements. Pandora's box was opened when health care advertising became legal. Patients find this "in your face" advertising to be very offensive and the general thinking is outrage that they are having to pay for this with inflated drug costs. Especially since most of the time the drug is not relevant to them and the message is "you need the blue pill or the purple pill" without information on indications or side effects. Of course patients are machines, generally helpless and have no immune functions whatsoever and they "need" the blue pill.

See "Medicamentoses" page 10

Medicamentoses from page 9

Consider that the average amount spent by a pharmaceutical company to promote a drug is $13,000/doctor/year (Journal of F.P. Sep 2000). The average Medicare beneficiary's drug costs are about $1500 /yr. Much as I appreciate the pens, knick-knacks and sample medications, priorities are skewed. Resources are not being maximized for societal good.

More and more patients are using cross-border pipelines to buy medicines that they need. In an effort to stop this, Glaxo - a company that had profits of almost $10 billion and whose CEO makes $20 million a year - has stopped selling its products to Canadian mail order pharmacies that sell to Americans. Why has going through a foreign middleman made drugs cheaper? Apparently it is because Canada regulates drug prices. Does it not follow that to keep drug prices down, the U.S. has to REGULATE drug prices? Physicians and other providers of health care are regulated in minutiae. Why is the drug industry exempt?

The Bush drug benefit proposal offers incentives to switch from Medicare to private health insurance in return for drug coverage. This in my opinion adds to the great divide - segments of populations, the haves and the have-nots. Those who elect to stay in traditional Medicare are left high and dry. This proposal is backed by the drug industries that have contributed millions of dollars to the GOP. It is indeed a benefit proposal - a benefit to the drug and insurance industries. This is a clear demonstration of how the power of money works in the political system.

Members of congress and federal workers already enjoy comprehensive drug benefit options. We have to have these same benefits across the board for all citizens. These options can be possible for all with altruistic political will and without contamination from special interest groups. Whatever has happened to "government of the people, by the people, for the people"? ■

Paid Advertisement

A 21st Century Depression ?

Yes; we just survived our first, modern-day Depression.

It wasn't devastating because the Federal Reserve and the Administration did the right things!

Don't believe it? What will the recovery look like? Find out by attending . . . .

Life After a Modern Depression

Presented by David J. Roskoph, MBA
Certified Financial Planner®

Monday, June 23, 2003
-Or-
Wednesday, June 25, 2003

To be held at CI Shenanigans
6:00 – 8:00 PM

10 seats per evening - reservation only

858-2745 or david_roskoph@totalassetmanagement.biz

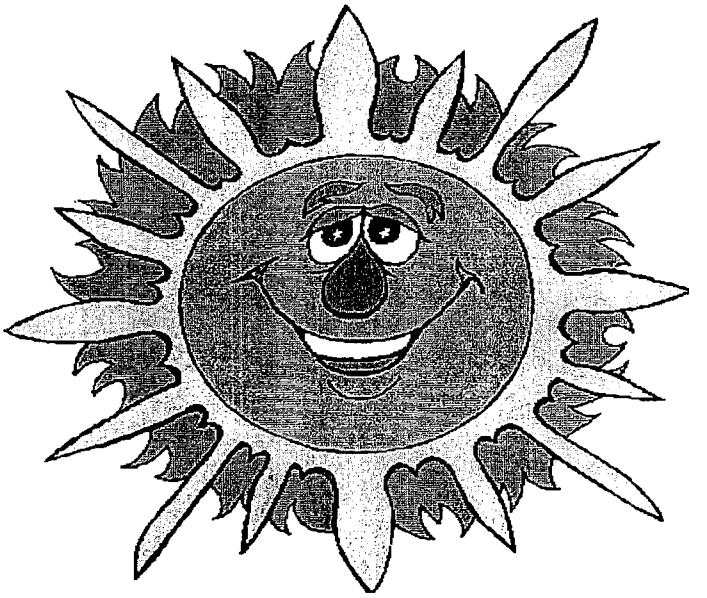
Total Asset Management, Inc.
Registered Investment Advisory

Securities offered through Mid Atlantic Capital Corporation
Member NASD/SIPC

Paid Advertisement

Pierce County Medical Society

It's summertime again!



Vacation time is quickly approaching. Just a reminder that we are here to fill all of your temporary employment needs.

We are a medically exclusive, physician owned employment service.

FROM RECORDS TO NURSING & EVERYTHING IN BETWEEN
1 DAY TO 3-MONTH ASSIGNMENTS.

Please contact Deborah or Melissa at (253) 572-3709

NOT JUST TEMPS...

FULL TIME AND PART TIME EMPLOYEES ALSO AVAILABLE.

IN MEMORIAM

THOMAS R. WEST, MD

1919–2003

Thomas R. West, MD

Dr. West died on April 23 in Tacoma at the age of 84. A lifelong Tacoma resident, he was born in February, 1919. He attended St. Patrick's grade school, Mason Junior High, Stadium High and Bellermine Preparatory schools. After attending Seattle College he completed his medical education at Creighton Medical School in 1946.

As a physician, he served his patients for over 35 years at his medical practice in Fife. He applied for membership to Pierce County Medical Society on November 8, 1950 and was elected on December 12, 1950.

PCMS extends condolences to his wife, Mrs. Margaret West and their family.

Please make the following changes to your 2003 Physician Directory:

Dali Chen, MD
Change specialty to Endocrinology

Mark Crowe, MD
Change office address to 929 E Main #210

C. Stevens Hammer, MD
Add name to Surgery-General list in "Membership by Specialty" section

Patrick Hogan, DO
Change physicians only number to 627-3547

Chan Hwang, MD
Add Electro/EMG to specialty

Jacob Kornberg, MD
Remove Gen Surgery specialty and remove DSHS Billing #

David E. Lee, MD
Change office address to 4700 Pt. Fosdick Dr NW #209, Gig Harbor 98335
Change office phone number to 851-6820
Change fax number to 851-6821

John Luber, MD
Change office address to 1812 S J St #210
Change phone number to 572-8777
Change fax number to 572-8835
Change E-mail address to johnl_nwheartcenter@msn.com
Delete website

Gary Park, MD
Change office address to 314 Martin L King Jr Way #9
Change fax number to 403-1150

J. Rodney Schmidt, MD
Change day off to F

Janice Strom, MD
Change last name to Olson

Donald Trippel, MD
Change office address to 1901 S Cedar #103
Change office phone number to 272-1812
Change fax number to 682-1455

Alexandra Wilson, MD
Change office address to 314 Martin L King Jr Way #9
Change fax number to 403-1150

Richard Wohns, MD
Change second office address to 1519 3rd St SE, Puyallup 98372
Add third office and phone: 34503 9th Ave #230, Federal Way 98003, 253-943-5289
Change cell number to 732-6130
Change fax number to 445-0756
Remove DSHS Billing #

COLLEGE OF MEDICAL EDUCATION

Continuing Medical Education

Whistler CME Returns to Aspens Condos

The College of Medical Education has again selected the Aspens Condos for accommodations for the 2004 Whistler conference 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 last year.

The CME at Whistler/Blackcomb conference is scheduled for January 28-31, 2004. ■

Steve Pool Addresses Asthma, Allergy and Pulmonology CME

KOMO TV meteorologist Steve Pool joined a group of physician faculty at this year's Allergy, Asthma and Pulmonology for Primary Care CME on May 2 at St. Joseph Hospital.

Pool spoke on the weather, its patterns, and of course, its influence on pollen and resulting allergies.

The one-day update, designed for the primary care provider, focuses on diagnosis and management of common pulmonology, allergy and asthma problems

This year's annual program included addresses on Rhinitis, Asthma, COPD, and Laryngopharyngeal and the Airway. The course is under the direction of **Alex Mihali, MD**. ■

Steve Pool

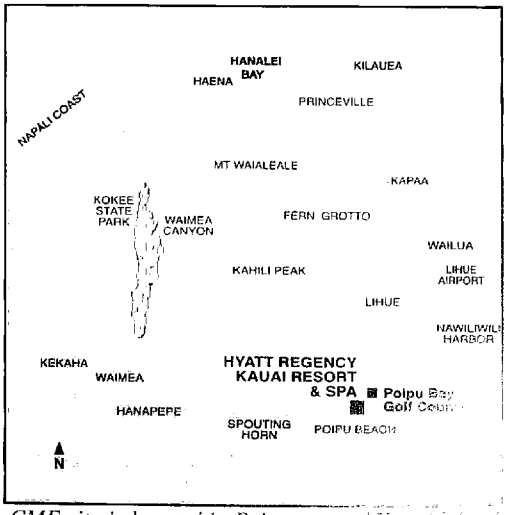
Island of Kauai set for 2004 Hawaii CME

Plans are now nearly complete for the College of Medical Education's Hawaii CME program for the week of April 12, 2004 on the island of Kauai. The program is held once every two years.

The exceptional Hyatt Regency Kauai Resort and Spa has been selected for the conference site. A block of rooms at ***greatly discounted*** rates have been reserved.

A program brochure will be available in June. ■

Ocean views from the Hyatt Regency Kauai Spa and Resort



CME site is located in Poipu area of Kauai Island

American Academy of Professional Coders - local chapter

The American Academy of Professional Coders is an association for health care professionals, which was founded in 1988 in an effort to raise the professional standards of coders by providing education, recognition and certification.

The AAPC has members in all 50 states and several foreign countries. AAPC is supported by a National Advisory Board, which includes members representing clinics, facilities, payors and consulting firms across the nation. The AAPC National Advisory Board provides direct input into the certification programs, educational curricula, and membership services offered by the Academy.

The general purpose of the AAPC is to provide an association for health care professionals who share a common interest in the reimbursement and technical aspects of accurate procedural coding by:

- Establishing and maintaining professional, ethical, and educational standards for procedural coders.
- Providing a national certification and credentialing process.
- Supporting the national and local membership by providing educational products and opportunities to network.
- Increasing and promoting national recognition and awareness of procedural and diagnostic coding.

Local chapters are chartered extensions of the AAPC and are designed to:

- Promote AAPC by expanding the organization's visibility and membership.
- Support the national membership by providing educational and networking opportunities on a local level.
- Provide a forum for the certification examinations to be administered.

The Tacoma Area AAPC Chapter's first meeting is July 16, 2003 from 6:00 pm to 8:00 pm.

We will be meeting every 3rd Wednesday of the month. The meeting will be within the MultiCare Hospital conference rooms. Location will be confirmed by mid June.

An information packet will be mailed to you upon request. **Please contact Betty Houser at the office of Neal H. Shonnard, MD**, 253-840-4095 or (Email: elizabethhouser@CS.com). ■

HIPAA: Are you compliant?

For many months now, the WSMA has been offering a series of highly regarded educational seminars for physicians' practices on all aspects of the Health Insurance Portability and Accountability Act (HIPAA) regulations and their impact on practices from a legal and operational standpoint. HIPAA regulations established numerous requirements that over the course of its staged implementation will affect medical privacy, data security and "administrative simplification" standards for health related information. Now that the April 14, 2003 deadline for implementing the Privacy standards has arrived, the time has come to ask yourself: "**Am I compliant?**"

HIPAA requirements should not be ignored. This seminar will guide you step-by-step on the specific actions your practice needs to undertake to achieve compliance with the HIPAA Privacy standards.

What You'll Learn:

- Washington State Laws vs. HIPAA: Which do you follow and when?
- What is "Protected Health Information?": What are appropriate uses and disclosures of PHI?
- Understanding the Various HIPAA Forms: What does each one do? What are your responsibilities?
- What situations are exempt from HIPAA regulations?
- Office of Civil Rights: Are you at risk for a complaint? What do you do if a complaint is filed?
- Authorizations: When do you need one? When don't you? Do they expire?
- Sample Scenarios: What should you do in these situations?

> Patient refuses to sign the acknowledgment of Privacy Practices.

> Patient wishes to restrict the use of their PHI beyond your privacy practices.

Who Should Attend:

This seminar is designed for ***all practice staff*** (clinical and non-clinical) and will be held in Tacoma on Wednesday, June 11 at the LaQuinta Inn. WSMA members and staff, $189.

Call 1-800-552-0612 for more information. ■

Classified Advertising

POSITIONS AVAILABLE

Tacoma/Pierce County outpatient general medical care at its best. Full and part-time positions available in Tacoma and vicinity. Very flexible schedule. Well suited for career redefinition for G.P., F.P., I.M. Contact Andy Tsoi, MD (253) 752-9669 or Paul Doty (Allen, Nelson, Turner & Assoc.), Clinic Manager (253) 383-4351.

Established Auburn Family Practice seeking Board Certified or Board Eligible physicians to join our group. Base salary plus incentive program for motivated Doctor. Part time or full time hours available. Fax CV to 253-839-5565.

GENERAL

Three bedroom, 3.5 bath University Place home with Sound view. 3300+ sq. ft., four fireplaces, and deck. $1,995/mo. Available mid-July. No smoking/pets. Call 253-230-5325 or 253-565-3818.

Uniform Laundry Service. Get acquainted offer - 10% discount on first order. Prompt, dependable, quality service. Pick-up and deliver. 253-537-3670 or e-mail donohue44@msn.com.

POSITIONS WANTED

Transcription Specialists - We have years of experience in most specialties. We guarantee accuracy, fast turn-around time, free pickup and delivery and competitive rates. Outstanding references. Call 925-3276.

OFFICE SPACE

For Rent: 3300 sq ft Class A medical office in Tacoma Medical Center. Third floor, elevator, underground parking, close to hospitals. Call 253-272-2224.

Professional Medical Facility. 2900 sq. ft. single story building. Reception area, business and file rooms, two private offices, sterilization/x-ray, darkroom and develop area, seven patient treatment rooms, three bathrooms, plus extras. Call Wayne 253-475-2536. Pacific Rim Real Estate.

Pierce County Medical Society
223 Tacoma Avenue South
Tacoma, WA 98402

Return service requested

PRESORTED
STANDARD
US POSTAGE PAID
TACOMA, WA
PERMIT NO 605

Pierce County Medical Society

BULLETIN

July, 2003

Washington Physicians "Rally" for Reform

Above: At the WSMA statewide rally on May 29, several hundred physicians carried signs indicating Washington does have "a medical emergency"

See story and photos page 6

Sound to Narrows Recap page 13

INSIDE:

The Bulletin is published monthly by PCMS Membership Benefits, Inc. Deadline for submitting articles and placing advertisements is the 15th of the month preceding publication.

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 PCMS. Acceptance of advertising in no way constitutes professional approval or endorsement of products or services advertised. The Bulletin reserves the right to reject any advertising.

Managing Editor: Sue Asher
Editorial Committee: MBI Board of Directors
Advertising Information: 253-572-3666
223 Tacoma Avenue South, Tacoma WA 98402
253-572-3666; FAX: 253-572-2470
E-mail address: pcmswa@pcmswa.org
Home Page: http://www.pcmswa.org

Pierce County Medical Society
BULLETIN

July, 2003

Table of Contents

President's Page

by J. James Rooks, Jr., MD

Things Could Be Worse...

J. James Rooks, Jr., MD

Here it is! Our alleged summer and we've actually had some hot weather so far. We all live for these days, hiking in the mountains, sailing, golf, running and all the activities we've been longing to do. I hope each and every one of you gets some much deserved time off and do the things you like to do. In the meantime I encourage everyone to keep thinking about solutions to the medical liability program especially as it applies to our state. There have been many good articles and treatises written in recent months. I commend to everyone's attention the June 9, 2003 edition of *Time Magazine* in which almost the entire issue deals with the costs of malpractice. There is an especially good opinion article by Phillip K. Howard, a lawyer no less, who is the founder of Common Good, a legal reform coalition (hard to believe, I know). His statement on the problem of malpractice was quite interesting. "The villain, I believe, is our legal system, which has become a free-for-all, lacking the reliability and consistency that are essential to everyone, especially doctors and patients." Mr. Howard goes on to list several interesting solutions.

Another interesting essay appeared in the June 16, 2003 issue of *U.S. News & World Report* by Mortimer B. Zuckerman, the Editor-in-Chief. Mr. Z concludes that medical reform "will not come easily, given that trial lawyers have become the most powerful special interest group in American politics, bankrolling politicians, especially Democrats. But tort litigation is costing us all. The current estimate is $200 billion a year, and rising. As author John Naisbitt said in Megatrends, "Lawyers are like beavers. They get in the mainstream and dam it up. This is one dam we must dynamite - now." Well, Mr. Z, I can sure name many a doc who'd be more than glad to help set the charge.

You know, this problem of increasing liability costs for physicians is international, and I have gotten first hand knowledge for what is going on in Australia. First a little story - like many of you who finished medical school in the 60s, I was part of the "doctor draft" or The Berry Plan (a lottery plan). Well, I didn't get selected for specialty deferment so into the service I went after internship and on over across the pond to lovely DaNang, Vietnam. Well I finally got a week's R&R, and went to Australia. After a day in Sydney (especially the Kings Cross area), I realized I was probably going to get into er, ah, "trouble" if I stayed there one more minute. Long story short, I ended up staying with a family physician and her husband on their sheep farm in the town of Forbes, New South Wales. Had a fabulous week, and we correspond to this day. They inform me that most specialists in their area are closing their private practices and working in government hospitals where their liability is carried by the government. What's really scary is the fact that physicians as of July 1st will have to carry "tail" coverage forever - not just till retirement. So you see it could be worse here, which is the big reason to keep up the fight.

I'd like to end on a personal note. As we've been told many times, all physicians become patients themselves - recently it was my turn. For some reason my right retina decided to detach itself. I underwent laser surgery and a pneumatic retinopexy and all is now well. I was very frightened by this event and very grateful to all of you who knew of the situation and called with words of encouragement, sent cards, and let me know you cared. It meant so much! I especially want to thank **Laurel Harris, MD** for her quick reaction and compassion, and to **Hsushi Yeh, MD** for his skill, kindness, and thoroughness. I have had the best of care!! Have a great summer and plan on coming to the September general membership meeting, rescheduled from June.

In My Opinion....

by Patrick Donley, MD

The opinions expressed in this writing are solely those of the author. *PCMS invites members to express their opinion/insights about subjects relevant to the medical community, or share their general interest stories. Submissions are subject to Editorial Committee review.*

Dr. Patrick Donley closes office, will work for the Amen clinic

Patrick Donley, MD

June 2, 2003

To my patients and colleagues,

It is with great distress and sadness that I am announcing the closing of my office for the practice of Psychiatry effective August 15, 2003. This decision has been one of the most difficult of my life and one I have been struggling with for some time. There are many reasons that I am forced to do this but the most critical are my health, my family and financial considerations.

For many years, my doctors have ordered me to "slow down" or there will be life-changing consequences. I agreed, but in reality I have not been able to reduce my heavy professional demands and as a result, my health is quickly loosing ground. Family, friends, colleagues and even patients have repeatedly told me it is time that I "practice what I preach" regarding self-care.

Exploring all options, I have finally agreed to a position with the new Amen Clinic NW in Tacoma. The Amen Clinics have a national reputation for utilizing brain SPECT imaging for a wide variety of neuropsychiatric problems including: Attention Deficit Disorders; Depressive Disorders; Obsessive-Compulsive Disorders; Anxiety; Aggressiveness; Brain Trauma and Dementia with its sub-types.

My office will do our best to help you in whatever way we can during this very difficult time. This closing process will be very stressful for all of us and for some of us it will entail dealing with profound losses. We will do what we can to help you through this transition. Please ask if you have any questions and discuss with me alternative local treatment options. Please ask, as we want to help you.

I want to thank each of you for what you have gifted me with by allowing me to be one of your guides in your journey towards experiencing greater joy and satisfaction in your life. You have shown me by your courage and tenacity, insights into my own life and how to be a better person, husband, father and doctor.

Respectfully,

Patrick J. Donley, MD

In My Opinion....

by Eileen Toth, MD

The opinions expressed in this writing are solely those of the author. *PCMS invites members to express their opinion/insights about subjects relevant to the medical community, or share their general interest stories. Submissions are subject to Editorial Committee review.*

Dr. Eileen Toth announces retirement

Eileen Toth, MD

June 18, 2003

Dear Colleagues,

I regret to announce that I have recently retired from my practice of internal medicine for medical reasons. Although I am not severely ill and my condition is not life-threatening, my physicians have advised me that it is time for me to step down from my 31- year career in medicine.

Some of you probably remember when I came to Tacoma in 1975 to practice at Sound Health, one of the first HMOs in the country. I left there for private practice at Allenmore Medical Center in 1978. In 1994, I became employed by MultiCare Health System and have stayed there until the present time.

I can recall how warmly I was welcomed by the physicians in Tacoma, and how many of you supported me in my early practice. That support never waned, and I have been proud to be a part of the Pierce County medical community.

Some of the most rewarding time in my practice has been time spent on various committees and positions in the Pierce County Medical Society. The high point was my tenure as president. I was deeply honored that you entrusted me with serving you in that capacity.

My plans for the future are not well formulated, but I believe that as one door is closed for me, another will be opened. I have a delightful nine-month-old granddaughter, Isabella, and I fully expect Katherine and Amy to provide me with a few more grandchildren. Right now, baking cookies and baby sitting sound fine to me.

Thank you for the years of support and friendship that you have extended to me.

Sincerely,

Eileen Toth, MD

Pierce County leads the Rally charge

Olympia, Spokane, WSMA, Walla Walla and Pullman follow suit

In April, 850 Pierce County Medical Society physicians and staff rallied for medical liability reform at the UPS Fieldhouse in Tacoma. Soon after rallies abound:

• On May 15, **Olympia** physicians rallied at the Capitol Campus in the pouring rain and hand delivered a message to legislative leaders that medical liability reform had to happen this session and if not, a special session should be called. About 200 physicians huddled under the protective canvas roof.

• On May 29, 1400 **Spokane** physicians and staff rallied at noon after a morning of CME to learn about grass roots political activism.

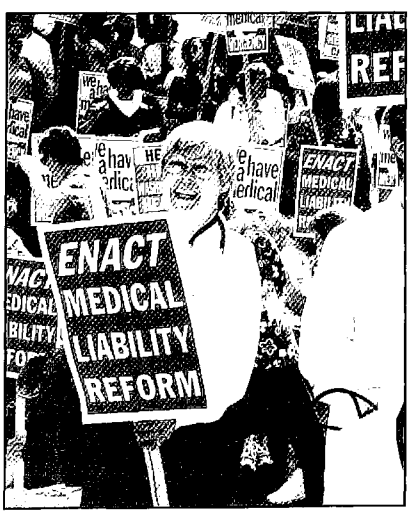
• On May 29, several hundred physicians rallied in **Seattle** at a WSMA statewide rally at Freeway Park, downtown Seattle. It was at this rally that WSMA President Maureen Callaghan, MD announced that ten neurosurgeons were being dropped by their insurance company. Many of the neurosurgeons were at the rally with signs reading, "when the brain surgeons have gone, get a TRIAL LAWYER to remove your tumor!!"

• On May 29, a couple hundred physicians rallied in **Walla Walla** and another couple hundred in **Pullman** joining forces with WSMA and Spokane physicians to show signs of solidarity and statewide presence for the media and legislators.

"*Help Heal Washington's Health Care*," "*We Have a Medical Emergency*," "*Our Patients Deserve Quality Health Care*," "*Enact Medical Liability Reform*," "*Keep the Care in Health Care*," and "*Save Washington Medicine*" all colorfully designed signs used by ralliers to capture the attention of the media. Designed in Pierce County and used statewide, the signs were a state trademark for reform. Seen in papers and on television statewide, they captured the attention of many.

Pierce County physicians attending the WSMA Rally were **Drs. Joe Jasper, Ron Morris, Nick Rajacich, Susan Salo** and **Terry Utt**, while **Drs. Keith Demirjian** and **Mike Kelly** and staff attended the Olympia event. (If you attended either rally and we missed you, our apologies.)

Your PCMS Board of Trustees has discussed what steps PCMS should take next in the battle for medical liability reform. They acknowledged it as a priority issue. They discussed many options at their June meeting and agreed that physicians should become more politically savvy and more politically active. We will continue efforts to raise the public's consciousness and carry the torch for reform. Patient education will be a focus as will media awareness. Many legislative activities will be planned this summer and fall by legislative district. Letter campaigns will ensue for the federal reform. Stay tuned. We will keep you informed by mail and fax. If you are not receiving information from us by fax, please call the Society office 572-3667 and let us know. Each member is on our fax network and you should be receiving membership memos and updates periodically. ■



Past President Dr. Susan Salo, Group Health family practitioner, in the middle of the crowd at Freeway Park

Board of Trustee member Joe Jasper, MD, does double duty, with a sign for each hand

Dr. Terry Utt, Puyallup family practice physician hopes to continue the ob portion of his practice

Federal Tort Reform action set for July

The United States Senate has set the week of July 8 for their debate on the tort reform issue. The debate will be on S-607, The Health Act of 2003, modeled after MICRA, California's model law, and includes a cap of $250.00 on non-economic damages. It is the equivalent of House Bill HR5, The Health Act.

It is more important than ever for every physician to contact, at minimum, their own senator. Particularly Senator Cantwell because she has given indications that she could be swayed. Tell your senator that tort reform is an access to care issue, tort reform is absolutely essential at the federal level, and ask them to give their full support to the Senate debate for meaningful tort reform and to legislative action for tort reform. And by all means, tell them your personal stories and stories you have heard from your colleagues. Real life stuff that impacts physicians every day.

To contact Senator Cantwell: email her at Senator_cantwell @cantwell.senate.gov or fax to 202-228-0514.

To contact Senator Murray: email her at Senator_murray @murray.senate.gov or fax to 202-224-0238. ■

Nick Rajacich, MD, center (with shades), at downtown Seattle rally, flanked by Donna Jasper (Joe, MD) on left and neurosurgeon on right with his own rally sign

Ron Morris, MD, with rally paraphernalia (rally hat, coat, sign and stethoscope) with his office manager at downtown Seattle Rally

Standard and Poors Report confirms industry loss

In a June 6 Standard and Poor's Research Release, it was substantiated that recent increases in medical liability premiums have been driven by loss costs. S&P analyst Alan Koerber said, "If tort reform is unsuccessful, ultimately this would affect the ability of doctors to continue practicing..If severity trends continue to escalate in the absence of effective tort reform, we could arrive at a point where the whole industry structure is in peril."

In addition, S&P's medical liability industry specialist, Shellie Stoddard said, "There is so much volatility in the industry that the current financial strength of the industry will not hold....." ■

Several hundred physicians carrying famous Tacoma [illegible] signs lined Freeway Park in downtown Seattle [illegible] high medical liability insurance rates and call [illegible] of tort reform

Supporting Invisible Patients

by Bob Riler, Pierce County Aging & Long Term Care

Making a diagnosis is hard enough. How does a physician diagnose when the patient isn't complaining, the symptoms aren't evident, and the actual cause is hidden?

About a quarter of the people in Pierce County, and that means a quarter of the people walking into doctors' offices, suffer from a condition that is a potentially serious health risk - family caregiving.

The evident impact on caregivers is clear. They experience high levels of stress and overload - symptoms of depression and burnout. This is exacerbated by felt and real isolation, sleep loss and poor nutrition. They experience a greater use of psychotrophic drugs. And they tend to neglect their own health.

It's easy to minimize the effects of caregiving on both the giver and the recipient. But the truth is that the impact of caregiving leads to serious consequences. Perhaps that is why many caregivers die before their loved ones. Caregiver stress and burnout cannot be discounted.

"I can't tell you the number of times we make contact with family caregivers who are literally at the end of their rope," said Sally Nixon, Coordinator of Pierce County Aging and Long Term Care.

"They go and go and go until they are ready to collapse. Most caregivers don't complain. They are, after all, doing what good spouses, children, relatives and friends do for one another. What they don't do well is care for themselves."

Physicians and their office staffs - receptionists, nurses, and billing specialists - are in the unique position to help. There is a relationship of trust, openness, and confidence that can allow caregivers to give subtle clues or open up.

The best care to provide may have nothing to do with medicine. The best care may be to refer family caregivers to free services available in the community. And the easiest gateway is through Pierce County's Senior Information and Assistance telephone helpline, 253-798-4600.

The key is identifying caregivers who often remain invisible and linking them with experts in the community who can help reduce and/or ease their caregiving burden. Caregivers need respite care, caregiving advice, training, counseling, low cost assistive devises, and basic supportive services.

One in four households in Pierce County is either involved as a care giver or a care recipient. The typical caregiver is a woman in her mid-40's who works full time outside the home. She balances the demands of raising a family, working a full-time job, and the requirements of caring for an older relative. That being said, there are as many exceptions to the norm as there are examples.

"Senior I & A makes the link that physicians and their staffs may not have the time or resources to provide."

We also know some startling statistics that paint a difficult picture. Family caregivers have no particular training but are called on to provide semi-professional care. Half of all caregivers are clinically depressed. They feel isolated and dismayed in situations that may continue for many years. Affirmation is typically absent for their work. Finally, the caregiver's health has a direct bearing on the quality of care they provide and consequently the health of their care recipient.

Until recently there has been no concerted effort to reach out to caregivers. But as the population rapidly ages, that is beginning to change. The Older Americans Act of 2000 sparked a national caregiver system, the Family Caregiver Support Program, that is making inroads to support caregivers. The result is higher quality of care, better health for care recipients, and less strain on the healthcare system.

Pierce County Senior Information and Assistance (253-7989-4600) is the easiest way to access the wide array of services available to family caregivers. Many services are available regardless of income. Senior I&A makes the link that physicians and their staffs may not have the time or resources to provide.

The Family Caregiver Support Program is one of many programs and services Pierce County's Senior I&A is able to access. Nixon commented, "The goal is simply to keep caregivers healthy and effective in their roles and, as a result, improve the quality of care provided. It's preventative medicine at its best."

The investment of $125 million in federal funding in the Family Caregiver Support Program is small but well worth it. Family caregivers provide an estimated $200 billion in service, about 20% of what the nation now spends on health care, and nearly twice the amount that goes toward home-health and nursing home care combined.

To learn more about Senior Information and Assistance or the Family Caregiver Support Program, call 253-798-4600. Brochures, and small refrigerator magnets are available from Senior I&A for free distribution. Brief presentations to physician's office staffs and other community groups are available at any time and are tailored to meet the needs of the specific groups. ■

The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

Pertussis and Monkeypox

Federico Cruz-Uribe, MD

The following provides information on a "Health Alert" level - for one disease that has been common in the United States since the last century, **Pertussis**, and for one disease that hasn't been seen here before, **Monkeypox**. We ask that you consider these diagnoses when faced with relevant symptoms. Both diseases require reporting to our 24-hour Disease Reporting Line: 253-798-6534.

Pertussis

TPCHD has observed a rise in the number of Pertussis cases across Pierce County in the past six months. The disease has been found in adults as well as children, and in all parts of the county. Consider Pertussis in patients ***of all ages*** who evidence any of these symptoms:

- Severe cough with paroxysm of coughing, of any duration; or,
- Inspiratory whoop, any duration; or,
- Post-tussive vomiting without other apparent cause; or,
- Cough illness lasting longer than two weeks

This disease should be considered, regardless of age or immunization history. Pertussis appears to be under-diagnosed in older children and adults.

Vaccination does not always confer immunity. Acellular Pertussis vaccine is only 80-84% effective after three doses; in addition, immunity wanes within a few years, resulting in rising vulnerability to the bacteria among adolescents and adults. No vaccine is available in the United States for anyone over the age of seven.

The best response for a suspect case of Pertussis is to treat the case immediately (waiting for a culture confirmation could delay treatment for more than a week), and to prescribe antibiotic prophylaxis for everyone in the household and other close contacts, regardless of immunization history. TPCHD can provide contact tracing and follow-up. Also, treatment should continue for suspect Pertussis cases, even if the DFA is negative. In Pierce County, 58% of the culture-confirmed cases showed a negative DFA.

Pertussis is a reportable disease. To report a suspect or confirmed case, call 253-798-6534. For additional information, contact the Communicable Disease Control staff at 253-798-6410, and press "0."

Monkeypox

The Centers for Disease Control and Prevention published a health alert for human Monkeypox on June 11, 2003.

A number of prairie dogs infected with the Monkeypox virus were sold in the U.S. Midwest in early May, 2003. Humans have shown the typical clinical presentation of Monkeypox and the number of cases through mid-June increased. As of June 13, 2003, cases have only been seen in Wisconsin, Illinois, Indiana and New Jersey, including person-to-person infection. At least one healthcare worker became infected through contact with an infected individual.

There is a high need for diligence to control this infection.

Consider Monkeypox if you see patients with the following clinical presentation:

- Macular, popular, vesicular, or pustular rash, generalized or localized, discrete or confluent; with
- Fever above 99.3 degree F (37.4 C);
- Exposure to an exotic mammalian pet, obtained on or after April 15, 2003, with clinical signs of Monkeypox (e.g., conjunctivitis, respiratory symptoms, and/or rash);
- Exposure to an exotic mammalian pet with or without clinical signs of illness that has been in contact with a known case of Monkeypox either in a mammalian pet or in a human;
- Exposure to a suspect, probably, or confirmed human case

Risk groups for exposure may include individuals who have adopted exotic mammals, pet shop workers, animal shelter staff, and veterinarians. Exotic mammalian pets include: prairie dogs, Gambian giant rats, and rope squirrels.

Report suspect and confirmed cases to the TPCHD 24-hour Disease Reporting Line: 235-798-6534.

Additional information on Monkeypox can be found on the CDC website: http://www.cdc.gov/ncidod/monkeypox/index.htm. ■

Applicants for Membership

Barbara Ann Blankenship, MD
Diagnostic Radiology
Medical Imaging Northwest
222 - 15th Avenue SE, Puyallup
253-841-4353
Med School: Wake Forest University
Internship: Swedish Medical Center
Residency: University of Washington
Fellowship: Oregon Health Sciences Univ

Jerry R. Shields, MD
Ophthalmology
Cascade Eye & Skin
1703 S Meridian #101, Puyallup
253-848-3000
Med School: Medical College of Georgia
Internship: University of Washington
Residency: University of Washington

John N. Wettlaufer, MD
Urology
Northwest Urology Center
1624 South I Street #204, Tacoma
253-272-8444
Med School: Georgetown University
Internship: William Beaumont Army Hosp
Residency: Walter Reed General Hosp

Rogelio H.A. Ruvalcaba, MD
Ped/Endo
Mary Bridge Children's Hospital
311 South L Street, Tacoma
253-552-1419
Med School: Universidad De Guadalajara
Internship: Hotel Dieu Hospital
Res: Hospital Civil de Guadalajara
Res: Hotel Dieu Hospital
Res: Children's Memorial Hospital
Res: Creighton Memorial Hospital
Fellowship: University of Washington

Personal Problems of Physicians Committee

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

Your colleagues want to help

Travelers'
Health Service
A Service of
Northwest Medical Specialties, PLLC

INTERNATIONAL TRAVEL CAN BE HAZARDOUS TO YOUR HEALTH

• PRE-TRAVEL CARE • POST-TRAVEL CARE

HOURS
MON - FRI 9 - 5

CALL EARLY WHEN PLANNING

VISA 253-428-8754 or 253-627-4123 MasterCard

A SERVICE OF
INFECTIONS LIMITED PS

220 – 15th Ave SE #B, Puyallup WA 98372

*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

In My Opinion....

by Timothy Schubert, MD

The opinions expressed in this writing are solely those of the author. PCMS invites members to express their opinion/insights about subjects relevant to the medical community, or share their general interest stories. Submissions are subject to Editorial Committee review.

A Change of Plans

Timothy Schubert, MD

On June 5 at 5:40 PM I had a change of plans. I got off work early at 4:00 and decided to go for a quick bike ride before dining out and hearing a visiting professor. I biked the 3.5 miles from our house to Point Defiance Park and completed 2 laps around the Five Mile Drive. The sun was bright (one of the 10 days of summer in Tacoma), there was a gentle sea breeze, traffic was light and I was feeling great. I was making very good time (14.6 mph) and would be home in plenty of time to shower before the dinner. I headed down 51st Street towards Ruston Way. I approached the right angle turn at the bottom of the hill. There, 51st Street detours onto Gallagher Way which tunnels under the railroad. I was going a bit too fast for the turn and gently applied the brakes. Not gently enough. Not soon enough. I landed in my lane around the turn. I was on my right side and the bike was on top of me the left leg still cleated in. Something was wrong. Dreadfully wrong. My right leg was at an improper angle and hurt terribly. I couldn't move the leg. I couldn't move from the road. I had to let go of the desire to stand up. I was not going to brush myself off and walk or ride away from this one.

I was no longer directing my course. I was suddenly and completely in the hands of my fellow citizens, that notorious much maligned person on the street. I felt very vulnerable and wondered if the next car around curve would run over me. A red car came to a gentle stop well in front of me and shielded from other cars. Two young ladies quickly came over to me and asked excitedly, "Are you ok mister?" I grimaced and said, "No, I am not ok. I think I broke my hip." One shielded me from the bright sun. I was feeling parched and faint. At another level I felt intensely alert and calm. The other young woman was using her cell phone to call for help. I later found out a Jim, who lives in a house overlooking the turn, had already called 911 and the Ruston volunteer fire department was on the way. Don, the chief, and the volunteers arrived like the cavalry in old westerns, just in the nick of time as I was feeling weak and fearful. They were a lifeline for me and I knew I would be ok. They also promised to take care of my bike from whom I was parted.

An ambulance arrived and the volunteers worked with the EMTs to stabilize me for transfer into the ambulance. My right thigh was beginning to feel huge, like it was 90% of my body. It felt like a deep dark hole into which the rest of me was being sucked. The slightest motion of my right leg was excruciating. They tried hard to minimize my suffering. They cared for me. The ambulance headed for Tacoma General. Vu, the EMT, reassured me and joked with me. He said, "Pardon my pepperoni breathe but I was eating pizza when the call came in." Then he added, "You thought you were going to get up and dust yourself off didn't you?" He also loaned me a cell phone. I called my wife. I let her know there was a change in dinner plans. There was a change in a lot of plans.

My right femur had a cork screw fracture. "It looks like one of Sammy Sosa's cracked bats," quipped one of my colleagues. After a 3 and 1/2 hour operation the femur was pinned and put back together. Three days later, on Sunday, I left the hospital and returned home to continue mending and rehabilitation. I am becoming skilled in wheel chairs, crutches and get my workouts going upstairs to shower instead of biking. I am back on course again because a host of people came together at one moment in time and did the right thing and extended a caring hand. They worked together in a coordinated, concerted fashion to provide for a fellow human in need. I recognize and applaud their action. I am grateful they were there for me. I feel exceedingly blessed in my life. I hope you do as well.■

Directory Changes

Please make the following changes to your 2003 Physician Directory:

Gina Bell, MD
Change office address to:
10510 Gravelly Lk Dr SW, Lakewood 98498

Bruce Brazina, MD
Change office address and phone to:
4620 Bridgeport Way W, University Place 98466
Phone: 564-0170
Add FAX # 207-4240

Theresa Froelich, DO
Change office address and phone to:
4620 Bridgeport Way W, University Place 98466
Phone: 564-0170
FAX: 207-4240

Phoebe Ho, MD
Change office phone number to 475-1885

Ralph Johnson, MD
Change office address to:
708 Broadway #400, Tacoma 98402

Robert Yancey, MD
Change specialty to: Ortho Surgery/Ped Ortho

Members complete Sound to Narrows 2003

Nearly 6,000 runners participated in the Sound to Narrows on Saturday, June 14 and the 59th overall person to cross the finish line was **Dr. Tom Herron**, Gig Harbor pediatrician. He finished third in his division with a time of 47:37.

Dr. Ron Taylor, Tacoma general surgeon, was the 162nd person to cross the finish line. He finished first in his division with an excellent time of 53:03.

Dr. Bill Jackson, Tacoma radiologist, finished fifth in his division with a time of 1:05:21.

Congratulations Drs. Herron, Taylor and Jackson!

One of the remaining few who has run in every Sound to Narrows for 31 years, was **Cordell Bahn, MD** retired cardiovascular surgeon, who finished with a time of 1:16:55.

Congratulations to all PCMS members and their family members for a great accomplishment:

Michael Bateman, MD, Tacoma family practitioner, running the 5K in 1:02:20

Loren Betteridge, MD, Tacoma family practitioner, 1:03:01

Lauren Colman, MD, Tacoma oncologist, 1:05:03

Stephen Elder, MD, Tacoma anesthesiologist, a competitive 52:48

Martin Goldsmith, MD, pediatrician, 56:56

William Hirota, MD, gastroenterologist, 1:09:10

New member **George Jackson, MD**, Tacoma psychiatrist, a very respectable 54:22

David Law, MD, Tacoma internist, 1:08:11

Michael Lyons, MD, gastroenterologist, 1:28:34

Michael Priebe, MD, gastroenterologist, 1:06:13

Craig Rone, MD, Tacoma otolaryngologist, 55:59

Harald Schoeppner, MD, Tacoma gastroenterologist, 56:36

James Schopp, MD, Tacoma general surgeon, 1:03:27

William Shields, MD, ophthalmologist, 1:06:20

Darryl Tan, MD, Lakewood pediatrician, 1:03:20

Lawrence White, MD, ophthalmologist, 1:02:34

Carl Wulfestieg, MD, Tacoma otolaryngologist, 2:07:43

Congratulations to all Pierce County Medical Society members and their families on completing such a challenging run.

Please forgive us if we failed to list your name and contact the PCMS office (572-3667) so we can include your name in the next issue of the *Bulletin*.

Family finishers - 10k

Phyllis Bales, 1:42:27
Bryce Betteridge, 1:03:01
Rachel Betteridge, 1:17:21
Laura Hautala, 1:05:16
Verna Herron, 55:45
Eve Kihara, 1:02:27
Toni Loomis, 1:05:20
Allison Rone, 1:02:22
Collin Stevenson, 54:41
Shauna Weatherby, 2:30:00
Donna White, 1:02:54
Susan Wulfestieg, 2:07:43

Have you suffered from Shingles in the last year?

Advance Medication with Northwest Kinetics

Do you fit these criteria?

-18 years or older

-Experiencing pain related to a previous Shingles rash

If you answer yes to these questions, join our team in studying an investigational medication designed to help pain associated with Postherpetic Neuralgia.

Receive a stipend of up to $200.00.

Contact the recruiters at 1-877-NWSTUDY or 779-8815, or email recruiters@nwkinetics.com.

Refer your friends and you may be eligible for a $50.00 referral bonus.

In My Opinion.... The Invisible Hand

by Andrew Statson, MD

The opinions expressed in this writing are solely those of the author. PCMS invites members to express their opinion/insights about subjects relevant to the medical community, or share their general interest stories. Submissions are subject to Editorial Committee review.

Equitable Compensation

Andrew Statson, MD

"Vittoria: A rape! A rape!
Monticelso: How?
Vittoria: Yes, you have ravished justice,
Forced her to do your pleasure."
John Webster (1612)

In our efforts to curb the rapidly rising malpractice premiums, we have concentrated on the provisions of the California MICRA. We hope that its enactment in our state and across the country will reduce the premiums we pay. Perhaps, but the chances that it would do so are rather slim. What it is more likely to accomplish is to slow down the increase in premiums.

That would be no small achievement in its own right, but it is more like palliation than like cure of the malpractice problem. The underlying reason for the current legal atmosphere is the subversion of justice. This is not a problem new to human history. Justice is the basic framework of the social structure. A society cannot function well without justice. In the past, its subversion has repeatedly led to popular rebellions and revolutions.

OB-GYN Management is a monthly journal, which for years has reported on court cases in our field. *Contemporary OB-GYN* started a review of court cases within the past few months. I want to quote several of the recent cases they reported.

A 49-year-old Chicago woman had a tubal ligation. During the operation the bladder was punctured, producing an abdominal infection, soon followed by necrotizing fasciitis. She died nine days later. The family claimed that the doctors ignored the infection, and that at her age the chance of pregnancy was low, so a tubal was not indicated. The jury awarded $6.5 million.

A 23-year-old Chicago woman was delivered by section because of abruption. The baby did fine, but the mother had disseminated intravascular coagulation and died 36 hours later from cerebral hemorrhage. The family claimed that the physician was not properly notified of the elevated blood pressure. The physician claimed that the patient's preeclampsia was sudden and unexpected. The jury awarded $9.9 million.

A New York woman was admitted by her midwife at 42 weeks for induction of labor. After two hours of second stage, an obstetrician was called to evaluate. He recommended that the patient continue pushing. Soon after that the head was delivered, but the midwife in charge called an obstetrician and a pediatrician because of shoulder dystocia. The delivery was completed within three minutes. The baby required resuscitation, had neurologic depression, series of seizures and intracranial bleeding. It has cerebral palsy and mental retardation.

The mother claimed that the head was delivered by a midwife in training, that shoulder systocia should have been suspected and the baby delivered by section. The midwife in charge argued that the care was excellent and any brain damage occurred in utero. The jury awarded $8,651,000 to the infant and $150,000 to the mother.

A New York woman presented to a hospital with twins. She was monitored continuously by nurses and residents and the first twin was delivered by a resident in the presence of an attending physician. Slight meconium staining was present. Then the contractions stopped, oxytocin was given, and the remaining fetus monitored by auscultation. Thy physician delivered the second twin 42 minutes later. The baby was depressed, with Apgars of 6 and 7. The child has cerebral palsy, motor skill deficit in hands and right arm, and uses a walker.

The mother claimed there were decelerations two hours before the delivery of the first twin, therefore both should have been delivered by section; also, had continuous monitoring been used for the second twin, fetal distress would have been noted. The obstetrician argued that auscultation is as reliable as continuous monitoring, there were no signs of fetal distress and no reason to do a section. The neurologist testified that the infant's brain damage occurred in utero before 35 weeks of gestation. The jury awarded $61,882,500.

A New York woman was admitted with the complaint of abdominal pain and suspected labor. The mother

See "Compensation" page 16

Compensation from page 15

showed some decelerations. An hour and a half later the fetal heart rate became nonreassuring and a resident decided to prepare the patient for section. The obstetrician came 15 minutes later, the heart rate had recovered, and he decided to wait a little longer. About one hour later, the fetal heart rate became nonreassuring again and the attending decided to proceed with a section, which was done 46 minutes later and showed a 20% abruption. At age 5, the child cannot walk, stand, sit, use her arms, or talk.

The mother claimed that her pain was due to the abruption, the diagnosis of labor was wrong and the delay of the section was the fault of the physician and caused the injuries of the child. The physician argued that the diagnosis of labor was correct and the abruption must have occurred immediately before the delivery. The hospital settled before the trial for $6 million.

The jury agreed with the plaintiff's experts that the life expectancy of the infant was 70 years. The experts also testified that the gross future costs of caring for the child at home would total $78,279,000 and that institutional care would cost $191,259,913. The plaintiff's attorneys asked the jury for home care. They jury awarded $75 million for that, $13,179,875 for future medical expenses, $2 million for loss of future earnings, $60,000 for past and $700,000 for future pain and suffering. The total against the physician came to $90.9 million.

I would not dare to disagree with the experts, but I am curious. How could one expect a bedridden, vegetative patient to live 70 years? I thought we needed active exercise to live that long. What kind of institutional care has a net present value of $191,259,913? At 3% interest that money would earn over $5.7 million a year. What kind of home care has a net present value of $78,279,000?

The above cases have one thing in common. The compensation in every one of them is higher than the policy limits most of us carry. I don't know the actual coverage my colleagues have, but I would guess that most obstetricians have at least a $2 and probably $3 million policy limit. The maximum limit WSPIE writes is $5 million. There must by very few obstetricians, if any, who could pay the verdicts reported above.

Lawyers know about money and how to collect it. They will not ask for those kinds of awards if all they will get is a letter from a bankruptcy court. The reason, and there is only one reason for claiming such high damages, was that the physicians involved were employees of an institution with a deep pocket.

Those cases are tragic, no doubt about it. The sympathy of the jury went to the patients and their families. However, the tragedy included the physicians and nurses who cared for them. They suffered, too. We all suffer when our patients don't do well. The tragedy also includes our judicial system, which allows such verdicts, and our society, which tolerates them.

Our State Supreme Court declared that compensation is a matter for the jury to decide. Perhaps it is time to reconsider that position. Perhaps it is time to limit the jury decisions to apportioning the responsibility for a bad outcome among the patients, their families, the physicians, the nurses and all others involved in their care, while determining the amount of compensation be referred to a judge or to a panel of independent experts.

I would like to close with a quotation from Charles Caleb Colton: "The victim of too severe a law is considered a martyr, rather than a criminal." The current judicial system is creating our martyrs. ■

COLLEGE OF MEDICAL EDUCATION

Continuing Medical Education

C.O.M.E. Board Announces 2003-2004 CME Program Schedule

The College of Medical Education's Board of Directors announced its CME schedule for 2003-2004 at the 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. ■

Common Office Problems CME will be held October 3

Topics are set for the College's Common Office Problems CME scheduled for Friday, October 3, 2003. 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:

- Dermatology
- Diagnostic Imaging and Interventional Radiology
- New Hypertension Guidelines
- WHI
- Meds in Bipolar Illness
- ADHD
- Orthopedics Update
- Osteoporosis and Osteopenia
- Dementia Management

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 a.m. and 5:00 p.m. ■

Dates	Program	Director(s)
Friday, October 3	Common Office Problems	Mark Craddock, MD
Friday, November 7	Infectious Diseases Update	James DeMaio, MD
Friday, December 5	Advances in Men's Health	TBA
Tuesdays January 13; 20	Cardiology for Primary Care	Gregg Ostergren, DO
Wednesday-Sunday Jan 28 - Feb 1	CME @ Whistler	John Jiganti, MD Rick Tobin, MD
Friday, February 6	Primary Care	William Knittel, MD
Friday, February 27	Endocrinology for Primary Care	Ronald Graf, MD
Thursday-Friday March 11-12	Internal Medicine Review 2004	Gurjit Kaeley, MD
Monday-Friday April 12-16	CME at Hawaii	Mark Craddock, MD
Friday, April 30	Allergy, Asthma & Pulmonology for Primary Care	Alex Mihali, MD
Friday, May 21	Advances in Women's Medicine	John Lenihan, Jr., MD

Help get our messages heard - join WAMPAC

WAMPAC is the only political action committee in Washington State that represents physicians. It is WAMPAC's job to help elect candidates to the legislature who are pro-medicine - supporting issues important to physicians and their patients as well as the WSMA's legislative agenda.

Like it or not, political campaigns require money. They very best way to get the legislature's attention is through a well-funded PAC.

WAMPAC offers physicians a mechanism for pooling their resources together to have the greatest impact. It's the old adage "money talks." WAMPAC uses its dollars to help elect pro-medicine candidates to the state legislature and to make sure our issues are addressed in Olympia as well as Washington, DC. Some political consultants have likened the legislature to a dance, with PAC dollars being the ticket. Your WAMPAC contribution is our ticket to the dance.

In order to make a significant difference, we need to build up WAMPAC's coffers. Today, only a small fraction of WSMA members contribute to the PAC. When we are competing against the interest of other politically astute groups such as the Washington State Trial Lawyers, we need all member physicians contributing to the PAC.

What does this cost? $150. How can I contribute? Go to the WAMPAC page on the Legislative Affairs page of the WSMA website www.wsma.org. Questions? Contact Carl Nelson at the WSMA Olympia office at (360) 352-4848 or 1-800-562-4546 (e-mail: can@wsma.org). ■

Classified Advertising

POSITIONS AVAILABLE

Tacoma/Pierce County outpatient general medical care at its best. Full and part-time positions available in Tacoma and vicinity. Very flexible schedule. Well suited for career redefinition for G.P., F.P., I.M. Contact Andy Tsoi, MD (253) 752-9669 or Paul Doty (Allen, Nelson, Turner & Assoc.), Clinic Manager (253) 383-4351.

Established Auburn Family Practice seeking Board Certified or Board Eligible physicians to join our group. Base salary plus incentive program for motivated Doctor. Part time or full time hours available. Fax CV to 253-839-5565.

OFFICE SPACE

For Rent: 3300 sq ft Class A medical office in Tacoma Medical Center. Third floor, elevator, underground parking, close to hospitals. Call 253-272-2224.

For Sale or Lease - Professional Medical/Dental facility. Three separately metered buildings. Located on main arterial. 2500 sq. ft. dental office presently leased. Available 1400 sq. ft. new carpet and paint. Available 2900 sq. ft. designed medical w/rec, storage and file rooms, 2 private offices, sterilization/x-ray, darkroom and dev. area, 7 patient treatment rooms, 3 bathrooms, excellent parking. Call Wayne 253-475-2536. Pacific Rim Real Estate Group.

POSITIONS WANTED

Transcription Specialists - We have years of experience in most specialties. We guarantee accuracy, fast turn-around time, free pickup and delivery and competitive rates. Outstanding references. Call 925-3276.

GENERAL

Three bedroom, 3.5 bath University Place home with Sound view. 3300+ sq. ft., four fireplaces, and deck. $1,750/mo. Available mid-July. No smoking/pets. Call 253-230-5329.

New Options for Women is a non-profit organization that offers free image assessment workshops and interview clothing to low income women striving to become self-sufficient in Pierce County. We have a boutique that is stocked solely by donations form the community, and in general we are always looking for good quality clothing and accessories.

However, we are in particular need of maternity clothing. Most of our pregnant clients are expected to continue in their job search up until their sixth month of pregnancy, so we need professional maternity items. Your clothing donations will help an expectant mother in her efforts to secure a more stable life for herself and her family.

For more information, please call (253) 383-2680, or visit our website at www.newoptions.org.

Pierce County Medical Society
223 Tacoma Avenue South
Tacoma, WA 98402

Return service requested

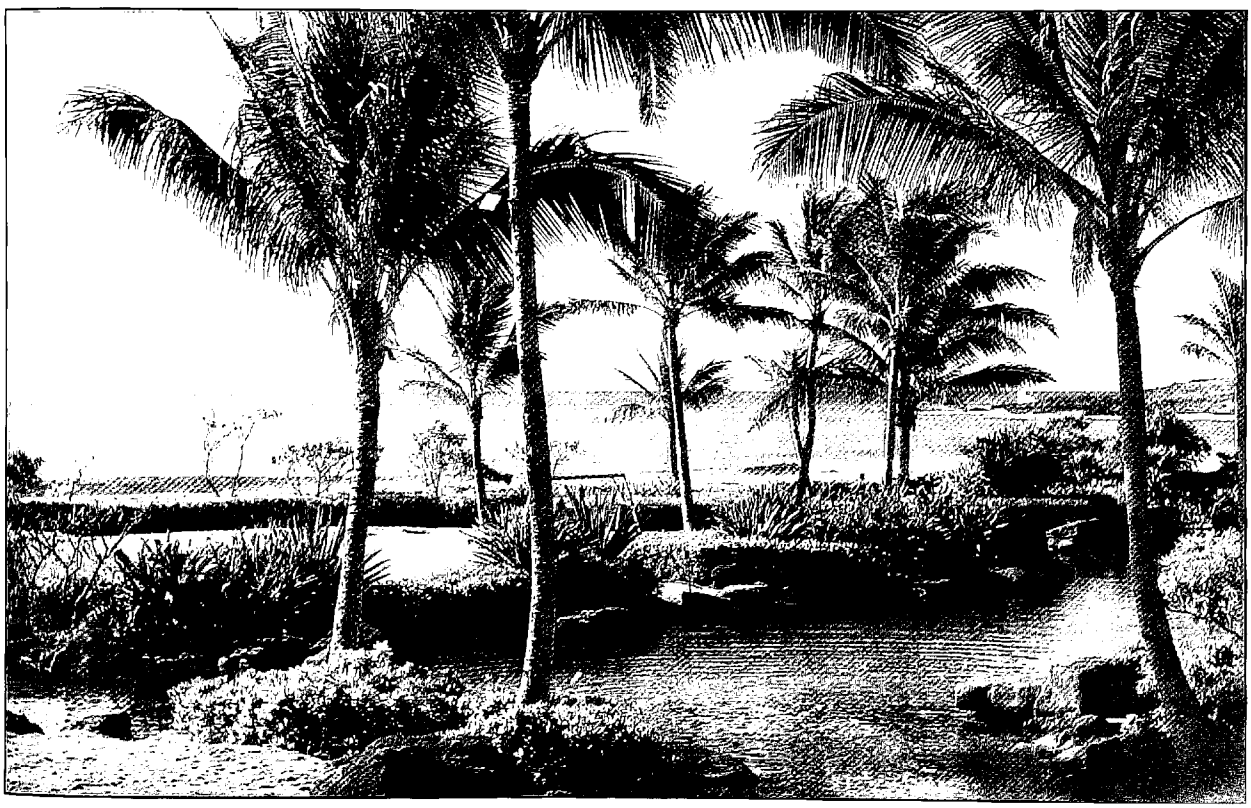
PRESORTED
STANDARD
US POSTAGE PAID
TACOMA, WA
PERMIT NO 605

Pierce County Medical Society
BULLETIN

August, 2003

Hyatt Regency Kauai Resort and Spa
Koloa, Kauai, Hawaii
CME at Hawaii, April 2004

For reservations see page 17



INSIDE:

The Bulletin is published monthly by PCMS Membership Benefits, Inc. Deadline for submitting articles and placing advertisements is the 15th of the month preceding publication.

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 PCMS. Acceptance of advertising in no way constitutes professional approval or endorsement of products or services advertised. The *Bulletin* reserves the right to reject any advertising.

Managing Editor: Sue Asher
Editorial Committee: MBI Board of Directors
Advertising Information: 253-572-3666
223 Tacoma Avenue South, Tacoma WA 98402
253-572-3666; FAX: 253-572-2470
E-mail address: pcmswa@pcmswa.org
Home Page: http://www.pcmswa.org

Pierce County Medical Society
BULLETIN

August, 2003

Table of Contents

President's Page

by J. James Rooks, Jr., MD

The Battle Continues...

By now I'm sure all of you have gotten the word that the U.S. Senate voted down the malpractice reform bill; however, I believe that they have gotten the word that the issue is just not going away. The vote was 49-48 for the legislation, but was defeated thanks to a Democrat led filibuster. Both Senator Murray and Senator Cantwell voted with the Democrats. It is predicted that in the next elections this will be a big political issue that politicians will not take lightly. President Bush has stated repeatedly that the issue deserves a national solution. It is my fervent hope that the medical profession does our part to see that this is accomplished. In an article by Jeremy Reynalds published July 10, 2003 by the Talon News Service, I read about the tremendous amounts of money contributed by the Association of Trial Lawyers of America (ATLA) to leading Democrats. Mr. Reynalds goes on to state that: Research reported by the Republican National Committee showed that among others, Sen. John Kerry (D-MA) has received over $700,000 in trial lawyer-related contributions since 1991, and Sen. Bob Graham (D-FL) has received over $225,000 in trial lawyer-related contributions in the same time period.

Sen. Joe Lieberman (D-CT) has received over $60,000 in trial lawyer-related contributions since 1991, and Minority Leader Tom Daschle (D-SD) over $250,000. Sen. Ted Kennedy (D-MA) received over $625,000 in trial lawyer-related contributions since 1991, and Sen. Hillary Clinton (D-NY) has received over $160,000 in trial lawyer-related contributions since 1999.

So there you have it! Whatever your political leanings, I hope those of you who feel so inclined will continue to let your representatives know the importance of this issue which in the long run affects access to care for their voters. As I go about the city and talk with many of you, I am impressed with the ideas, opinions, and solutions that you have for the myriad of problems that face this wonderful profession. I urge you to write those opinions to us so that we can share them in the *Bulletin*, i.e., effective ways to influence legislators, ways to improve reimbursements, or ways to improve administration. Together we can solve many problems and I feel we have the ability to surmount the impediments thrown at us by the ATLA or antitrust laws (which don't seem to bother insurance companies or the rest of the corporate world).

A moment of levity comes from a throwaway journal/advertisement from one of the Seattle hospitals, noting that the California legislature is getting a bill passed that imposes a five cent tax on every alcoholic drink sold at the wholesale level in the state. Seems this will pay back emergency departments, trauma centers, and docs who have to deal with drunk people. What a concept!

The question for the month in my mind came from an editorial that appeared in the *Seattle Times*. Seems our legislature granted a four million dollar grant to Swedish Hospital to establish the Seattle Heart Center (bet we have a cardiologist or CV surgeon in Tacoma that'd have an opinion or two on the necessity of that) but won't do anything to solve the medical liability problem. I went and figured on it for awhile, but have no solutions.

On a pleasant note, consider attending the College of Medical Education's CME meeting in April 2004 on the island of Kauai at the Hyatt Regency. Les McCallum has arranged great prices and Dr. Mark **Craddock** has lined up a great program. See you there.

A Help Sheet for Brokered Interpreter Services: Tips & Facts

In 2002, the Legislature directed the Department of Social and Health Services to find a more efficient way to deliver interpreter services, including the Medicaid interpreters optionally underwritten by the state. The new system, which went into effect on January 1, 2003, operates through contract brokers; it is modeled after a system used by the Medicaid transportation unit.

Questions and answers:

How is the system working? After several months, brokers are reporting few problems and complaints to MAA have decreased dramatically. If you have a complaint, please direct it first to the broker. If you are still not satisfied, report it to: Tim Roth, 360-725-1316 or Nora Guzman-Dyrseth, 360-725-1313.

Why does the state pay for interpreters? The legal responsibility actually is the medical provider's under Title VI of The Civil Rights Act of 1964 (http://www.usdoj.gov/crt/cor/). However, to assist medical providers, Washington is one of a few states that has traditionally paid the cost of non-emergency medical interpreters.

Why were brokers needed? The Legislature originally considered scrapping the entire program to save money. Instead, legislators kept the program but directed MAA to find a way to cut its costs substantially.

How can my office better use the broker system? Plan ahead. Regular requests for interpreter service appointments should be faxed to brokers at least two full business days in advance, and preferably three days ahead.

What it I have an urgent need? "Urgent" means the requester has determined the client must be seen on the same day, or on the next day. Minimum advance notice needed to set up an urgent appointment is about four hours. These short notice requests should be telephoned to the broker, followed by a faxed paper copy. Brokers will try to fill urgent requests, but they cannot guarantee success.

Other tips:

Advance scheduling: Medical providers are not normally allowed to request services more than 30 days ahead since MAA program eligibility is determined monthly.

Unfilled requests: Some appointment requests can't be filled even if requesters meet all the guidelines. In such cases, requesters will need to seek interpreters at their own expense.

Confirmation: When brokers fill a request, they should confirm it with the requester. This normally occurs within two business days. However, some requests take longer to fill than others, especially in remote locations or with unique languages. Requesters should not fax in a repeat request just because a confirmation is late. Allow additional, reasonable time for the confirmation to arrive, or call the broker one business day (or 24 hours) before the scheduled appointment time.

Feedback: DSHS staff, DSHS contract service providers, and medical providers should notify brokers whenever interpreters do not show up for appointments, or when they show up but provide unprofessional services. Feedback is also important to prevent inappropriate billings. It also helps brokers develop sanctions to prevent future problems.

Specific interpreter requests: Brokers cannot guarantee specific interpreters will be available. Providers should request specific interpreters only when it is medically necessary.

For more information regarding brokered interpreter services in Pierce County, please call 1-800-925-5438.■

In My Opinion....

by George Tanbara, MD

The opinions expressed in this writing are solely those of the author. PCMS invites members to express their opinion/insights about subjects relevant to the medical community, or share their general interest stories. Submissions are subject to Editorial Committee review.

Thank you - Pierce County Medical Society

George Tanbara, MD

Having gone through recent double coronary artery bypass surgery, I look back on:

- being fitted for hearing aids
- eye refraction for glasses
- ptosis of the eyelids
- bilateral artificial lens for cataracts
- obstructive sleep disorder
- acromio-clavicular separation
- Achilles tendon repair
- intestinal obstruction with removal of three feet of ileum
- colonospic removal of a polyp

Excellent medical care provided by members, utilizing pharmacies, physical therapists and other health care facilities and equipment. I am thankful your medical society and members attracted quality care for all of us.

These are my personal suggestions, 51% prevention, 35% intervention and 14% treatment. These preventative measures have been helpful to me but all need to be cleared through your physician and could be applied to your family and personnel:

- Systematic treadmill stress test. Mine was done pre-symptomatic.
- Systematic Hgb A.C. and/or fasting blood sugar.
- Attain body mass index of 24 or lower.
- Low cholesterol diet and nonfat milk.
- Initiate colonoscopy at an appropriate age. I had a polyp.
- Tobacco and all illegal drug cessation.
- Regular exercise at the least at recommended minimum level.
- Keep recommended appointments with your physician, especially for preventive care.
- Violence cessation.
- Participation in all applicable anonymous 12-step groups, as well as family support groups.
- Regular reinforcement of values, whether religious or family.
- For your family, better to see your physician as a worried well than symptomatic.

My suggestion to the Medical Society is to continue to be a leader and participant in the health of the community by focusing on the following:

1. Community health care issues.
2. Support and initiate anonymous health groups and family support utilizing the 12-step groups.
3. Automated external defibrillators, as well as pediatric when available and feasible (first aid and CPR classes teach utilization so your personnel, if updated, will be knowledgeable).

WSMA Campaign Fund for Tort Reform

Editor's Note: An open letter to PCMS physicians from WSMA

It is time to turn up the heat on our battle for tort reform. We need your support more than ever. Tort reform is closer than it was a year ago. We, however, need additional funding to succeed.

The Washington State Medical Association is asking all Washington State physicians to contribute $250 towards the WSMA Campaign Fund for Tort Reform.

Through support of physicians around the state, it will be possible to implement a statewide liability reform campaign to apply pressure to the Washington State Legislature through:

- Mobilizing grassroots activists,
- Galvanizing public support,
- Targeted media activity.

Like it or not, political and public policy campaigns require money.

The very best way to get a legislator's attention is through a well-funded political action committee. That's why $150 of each $250 contribution will go directly to the WSMA's political action committee - WAMPAC.

The only way the legislature will act is when its members see physicians making a real commitment to political action. In 2002 the trial lawyers' PAC spent $681,222. In comparison, WAMPAC spent $173,000.

We *have* to do better than this.

We *can* do better than this.

Our ability to practice medicine is at stake.

Everybody has to give.

To contribute to the WSMA tort reform campaign call WSMA at 1-800-552-0612 for a contribution form or go to the WSMA Web site at www.wsma.org/tort_registration.html.

$150 of your contribution will go towards WAMPAC. If you are currently a WAMPAC member, your full contribution will go towards the WSMA Campaign Fund for Tax Reform. Contributions are not tax deductible ($50 of contribution over $100 goes to AMPAC and $10 of student/resident goes to AMPAC). WAMPAC and AMPAC are separate segregated funds established by WSMA and AMA, respectively. Contributions are not limited to the suggested amount. Neither WSMA nor AMA will favor or disadvantage anyone based on the amounts or failure to make contributions. Contributions are subject to FEC regulations. A portion of non-corporate contributions to AMPAC may be used to make campaign contributions running for federal office in Washington State.■

Peel-off Privacy Solution

Charles M. Key, a Memphis, Tennessee attorney specializing in health care law, offered a practical solution for sign-in sheet privacy in a letter sent to *AMNews*. For sign-in sheets, Key recommends use of standard peel-off address labels on 8 1/2 x 11 inch sheets. The labels can be peeled off by the receptionist after sign-in and placed on the chart or a separate sheet behind the counter.

Labels cost only a little more than plain paper and easily solve patient privacy concerns. All you need to do is decide how many columns of information you need, set up your word processor to label the columns on the top row and print whatever you need.

If enough doctors start doing this, the paper companies likely will respond with custom products.■

Sound to Narrows Update

In the July issue of the *Bulletin* the Medical Society congratulated members who completed the Sound to narrows run in Tacoma on June 14. We recognized family members' accomplishments as well. We inadvertently failed to include:

Lynn Smelser, PA-C, orthopedics, who completed the 5K run with an excellent time of 26:43, placing her 4th finisher in her age group!

Daughters of **Lawrence White, MD**, Caroline and Elizabeth, completed the 12K run with times of 55:50 and 59:04, respectively.

Our apologies for the omission and congratulations on a great run!

Applicants for Membership

Kyle James, MD
Family Practice
Puyallup Clinic
800 South Meridian #A, Puyallup
253-845-6645
Med School: Texas Tech University
Internship: Lake Charles Memorial Hosp
Residency: Lake Charles Memorial Hosp

The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

End of Life Care

Federico Cruz-Uribe, MD

A death in the family...A long illness...Pain and suffering enough to batter down anyone's defenses...We just went through this in our family. My sister-in-law, 50 years old, mother of two teenagers, dying inches at a time. My brother, her husband, gave up nearly everything for more than a year to be the caregiver for a steadily weakening spouse.

When we got the call that "it was time," my wife and I went to help. More than a month later she died. I have to admit that during the four-hour drive to their home after the call, I felt like listening to chalk being drawn across a chalkboard at a bad angle. No one likes to think about death but my discomfort wasn't just that. I dreaded the awkwardness of unmade plans, the tragedy of unvoiced desires, the heartbreak of reacting to crises instead of following agreed-upon final steps.

Death did come to our family. My wife and I grieved with my brother's family during her final months. We all knew, however, that the efforts we made were not fulfilling my sister-in-law's vision or my brother's desires for the end of her life. The physicians, too, agreed that her care should be different. But she was still young when she lost her ability to articulate her hopes. Those plans that would have directed all of our actions, were never created. So her final days, despite the fact that she could not survive, consisted of standard medical care.

Many families go through similar situations. To gain some understanding for myself during this sad time, I kept looking at what I could learn. I hoped that I might find something to better prepare others. As a Director of Health, I know that only 10% of people die suddenly and unexpectedly, 90% die following a prolonged course of illness, so I wondered if there wasn't something I could learn from our grief. Even though most people have time to voice their hopes, we often see a disconnect between how people want to die and how they do die. Much of this disconnect is due to lack of planning.

"Even though most people have time to voice their hopes, we often see a disconnect between how people want to die and how they do die."

Sadly, today, powerful forces press us toward a more open discussion of death: Money and Suffering. These IMPERSONAL and PERSONAL forces now act as a one-two punch. Health care costs more daily. Many people go without needed care, yet 25% of the money spent in Medicare for the elderly is spent during the last month of life. Many billions of dollars spent when death is all but certain. We can't afford this and I don't think that most of us would want to see our scarce resources spent so heavily on end of life care.

On top of economic concerns, the end of life care that many people get is not the care they want. The vision many hold: A peaceful death at home surrounded by family and friends and familiar objects. Yet time and again we see death come to loved ones in an institution after heroic and often invasive procedures.

Why the disconnect between what people want and the care they actually receive? The answer is simple: Lack of planning. People put off the discussions. It's difficult to look mortality in the face. It's painful to speak of it with others. It feels grotesque to write it down. In the end, the hope of "Please let me die at home with dignity," is replaced with, "Do whatever you can to keep her/him with us a little longer."

Our feelings and hopes for our loved ones trap us. We forget what they wanted for their own end of life.

What should we do? PLAN. It's a simple word but one we all struggle with at some time in our lives. Each of us needs to say, "This is what I want

See "Cruz" page 12

Fund Raising Strategy Targets Physicians

Editors's Note: This article is printed as a result of physicians in Pierce County having recently been contacted and asked to join the Physician's Advisory Board. This article does not offer advice about joining, but provides more information about the board so you can be better informed if you should receive one of their phone calls.

Don't be surprised or flattered if you receive a phone call inviting you to join a select panel of doctors who advise congressional Republicans on health care issues. While the "Physician's Advisory Board" does counsel GOP leaders on such topics as HMO reform and reducing government interference in medicine, the Board is used as an avenue for the Republican campaign committee as a hook for soliciting contributions.

Thousands of physicians have been invited to join the board, only to find they are the targets of a fund-raising solicitation by the National Republican Congressional Committee (NRCC), which raises money for House GOP campaigns. More than 1,000 physicians have accepted the GOP's invitation to join the board. "While perhaps distasteful to most, it is hardly unusual for a political party to invite someone to join a 'club' as part of a pitch to get them to contribute money," according to Candice Nelson, Ph.D., director of the Campaign Management Institute. "It's a way to draw people in," Dr. Nelson said. "People want to feel like their views matter. But it basically is a fund-raising pitch."

To many doctors, the call seems designed to flatter as well as appeal to any desire they may have to influence national policy-making. They are often told that they have been nominated to be one of its "honorary chairmen." They are also told if they join, their name will be among those listed in a full-page advertisement in *The Wall Street Journal*. In addition, they are told they will be able to meet with top members of Congress. In a follow-up letter to doctors they reference legislators that look forward to meeting with them personally if they join the Board, but physicians interviewed by *AMNews* said they had never received an invitation or opportunity to meet with leaders.

"Doctor's are notoriously bad contributors," according to Nelson. That may be the precise reason the NRCC created the physician board. The panel would serve as a "natural hook" for trying to encourage more doctors to contribute to the party."

NRCC officials were not able to provide any information on how input from the Physician's Advisory Board may have actually reached House GOP leaders or affected their policy-making.

Nor would they provide an exact number of doctors who have joined the board since it was established in January 2000, nor how much money they had raised. And, they have no plans to end the project any time soon. They think the program is successful, otherwise they wouldn't do it, according to a program official.

"Doctors are notoriously bad contributors," according to Nelson. That may be the precise reason the NRCC created the physician board. The panel would serve as a "natural hook" for trying to encourage more doctors to contribute to the party, she added.

The Democratic Congressional Campaign Committee said it didn't have a fund-raiser targeting doctors. ■

In My Opinion.... The Invisible Hand

by Andrew Statson, MD

The opinions expressed in this writing are solely those of the author. *PCMS invites members to express their opinion/insights about subjects relevant to the medical community, or share their general interest stories. Submissions are subject to Editorial Committee review.*

The Preponderance of the Evidence

Andrew Statson, MD

"That trial is not fair where affection is judge."
Thomas Fuller (1732)

In its complexity, life presents us with a gamut of colors and shades. The law, however, judges in black and white, guilty or not guilty, with a sharp dividing line between. In cases of civil liability, the courts use the rule of the preponderance of the evidence. With a 49.99% chance that the accused caused the problem, he would be proclaimed not guilty. With a chance of 50.01%, he would be guilty. Such a minute difference in the interpretation of the evidence, usually based on a difference of opinion, can decide whether millions of dollars will change hands.

As Wilkins Micawber explained to David Copperfield, income of twenty pounds and expenses of 19/19/6 means happiness; income of twenty pounds and expenses of 20/0/6 means misery. Yes, but counting money has the advantage of precision. We can count with an accuracy to a penny.

The practice of medicine is different. One of our perinatologists said that if you ask a question from ten perinatologists, you are likely to get ten different answers. That is true of medicine in general. While we usually agree on the general principles, we vary on the specifics. When we are faced with the details of a particular situation, every one of us may handle it a little differently.

During my study of anesthesiology, the question of which anesthetic is better frequently came up. One professor told us, the best anesthetic is the one the anesthesiologist is the most comfortable giving.

There is no single answer. The same condition can be treated in different ways and no single one is intrinsically better. One of them may be more appropriate and work better than another in a specific clinical situation with a specific patient. For some reason, patients with the same disease respond differently to the same treatment. Even more, the same patient, at different times and different stages of the disease, may react differently.

The difference in treatment is partly due to the personal comfort level of the physician with one approach or another. It also results from a choice the physician makes in an effort to fit the treatment to the expression of the disease and the degree to which the individual patient is affected by it. The physician who is there, who examines the patient and follows the progress of the treatment, is the best person to make the management decisions about further care.

When someone else reviews the record afterwards, he can always state that the treating physician should have done something else. If the outcome had been good, he probably would not argue strenuously. If the outcome had been bad, the reviewer might claim that another approach would have avoided the problem. Maybe. Maybe not.

Here we come to another point of law. The courts judge on the basis that the action of the defendant is one of the contributing causes to the problem, even though it may be one of several, and not a major one at that.

One serious legal problem in obstetrics is the child with cerebral palsy. In the past, hypozia during labor was considered the main cause of CP. In spite of the tremendous increase in fetal monitoring and cesarean sections, the incidence of CP has remained stable. Recent data have shown that in less than 10% of CP cases a problem during labor contributed to its development. The chance that a problem during labor is the major or the only cause of CP is much smaller than that, probably closer to 1%.

Frequently, these babies have heart tone abnormalities during labor because they are already sick, but that does not stop patients and attorneys from claiming that, had a section been done earlier, the problem would have been prevented. Even when a neurologist testifies that the disease developed several weeks before delivery, the juries still award millions of dollars to the plaintiffs.

Another serious legal problem is the claim of delayed diagnosis in cancer cases. When a patient develops cancer, we can look back at their mammogram or Pap smear and we can say,

See "Evidence" page 10

Evidence from page 9

"Oh, yes. Here it is. You should have recognized it." Yet the people who read the slides and the X-rays see thousands of similar patterns that are not cancer.

If I remember correctly, the University of Washington reported that 10% of women would have a false positive mammogram over a period of ten years. Granted, it is better to have a false positive than a false negative, yet some patients, instead of being happy that they don't have cancer, have objected to the scar and to the changed shape of their breast after an excisional biopsy. "What's wrong with you?" they ask. "Can't your tests tell whether I have cancer or not? Why did I have a biopsy?"

In their mind, there should be no difficulty. Either it is cancer or it is not and the tests should not be wrong. That misunderstanding of what medicine can and cannot do, of what tests can and cannot show, is at the basis of many court decisions. Unfortunately, when a patient develops cancer and is disfigured or dying, the sympathy of the jury goes to her.

There are several possible approaches to solving this problem. One of them is to change the rules of evidence. Compensation should be justified only in the presence of clear, concrete and convincing evidence that the problem was the result of mismanagement.

Another approach is to apportion responsibility. Complications may occur because of the patient's general condition, genetic makeup, smoking, weight, previous medical problems, personal or family neglect, noncompliance, etc. When a medical error occurs, its contribution to a bad outcome may be minimal, compared to all the other causes. The liability exposure should therefore be limited to the extent the error contributed to the problem.

Finally, compensation must be reasonable and consistent, determined on the basis of actual costs, not on the basis of pity, compassion, or even outrage.

Our tort system has become dysfunctional. Every entity with a deep pocket is at risk. An attorney, Philip K. Howard, speaking at the annual meeting of ACOG in April, said that he was appalled at what his profession was doing to ours. (Mr. Howard is the author of *The Death of Common Sense: How Law is Suffocating America* and the founder of the organization "Common Good." Their web page is interesting. Look it up at www.cgood.org.)

He is right to be appalled. The liability problem in medicine, added to the other costs we face, is rapidly bringing us to the point where we will be forced to close our offices. However, the overall situation is worse than that. What his profession is doing to us, it is also doing to the entire country. That is not only appalling, it is outright dangerous. It is destroying justice, which is the framework holding our society together. Justice is the source of order. Without order, our social structure will disintegrate. ■

The Power of an Apology - Preventing Lawsuits

Editor's Note: Washington's RCW 5.66.010 allows protection from gestures of sympathy being admissible as evidence in a civil action

While doctors and lawyers have been battling over tort reform in state legislatures, two states passed bills that could impact malpractice lawsuits by extending physicians' freedom of speech to include two words: "I'm sorry." Both Colorado and Oregon joined a few other states, including Washington, with laws allowing physicians to make statements of sympathy and condolence with the assurance that these statements would not be used against them later in court.

Many doctors and hospitals are discovering that, even without legal protection, acknowledging and apologizing for errors and adverse outcomes has its own rewards, both ethical and financial. There also is optimism that disclosure will lead to better communication that might help prevent errors in the first place.

When errors do occur, studies indicate that it's not necessarily the medical error itself that causes patients or their families to sue, but the response to it. A study in the February 26 *Journal of the American Medical Association* reported that after an error occurs, patients want information about why it happened, how consequences will be mitigated and what's being done to prevent reoccurrence. They also want emotional support from doctors - including an apology.

"Patients will keep looking until their questions are answered," said Ilene Corina, president of Persons United Limiting Substandards and Errors in Health Care, an advocacy group for people affected by medical errors. "If all the doors are closed to them, they will go to lawyers."

The typical post-error scenario, Corina said, is that the patient or family can't reach doctors and instead are circled by risk managers who won't give straight answers. "The classic line you hear is, 'We're looking into it,'" said Corina, whose 3-year-old son died 13 years ago after surgery to remove his tonsils and adenoids. "In my case, the doctor said he was sorry but never acknowledged that something went wrong."

Corina said apologies for errors are still so rare that she has never heard a case of one backfiring, with a patient suing only after disclosure and apologies were made. Like many others involved in these cases, Corina points to the Veterans Affairs Medical Center in Lexington, Kentucky, as an example of how the process should work.

A Better Way

Since 1987, the Lexington VA Center, affiliated with the University of Kentucky College of Medicine, has operated under a policy of full disclosure. A study published in the December 21, 1999 *Annals of Internal Medicine* reported that between 1990 and 1996 there were 88 medical malpractice claims

See "Lawsuits" page 14

Care from page 7

the end of my life to look like." We have to give the people who love us guidance on what we want for our final days.

With my sister-in law, I saw the problems. Then I looked for answers. One movement that many communities have adopted is called POLST (Physicians Order for Life Sustaining Treatment). Filled with common sense and compassion, this approach provides a plan for end of life care in cooperation with physicians. Physician orders are written after discussion with the ill person and family. The wishes of the patient and family are spelled out clearly in the orders, which follow the patient wherever s/he goes. If someone with this plan ends up in the emergency room or if the family doctor is on vacation or the individual is in another community, the plan is there to guide the providers to give care that is wanted.

All of us need to think about how we wish to be treated when we are seriously ill. As painful as it feels to talk about it when we are well, think about our families who are watching helplessly as we begin to fail. Doesn't love mean we help our families with tough decisions? Have that discussion. Give a meaningful give of love.■

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

In My Opinion....

by Teresa Clabots, MD

The opinions expressed in this writing are solely those of the author. PCMS invites members to express their opinion/insights about subjects relevant to the medical community, or share their general interest stories. Submissions are subject to Editorial Committee review.

The Meaning of Time - A Slave to the Time Clock

Teresa Clabots, MD

My baby brother began to lose weight when he was four. Sick and fatigued, he developed a fetid breath. My father diagnosed him with diabetes, and it was the start of many years of rigid schedules, urine testing, shots and meals.

My mother lived by the clock. Every three hours she would test him, feeding him three meals and three snacks a day, and getting up twice in the middle of the night to check on him. The regimen was strict and unforgiving. She did it with kindness and love, making sure he always had fresh fruit and vegetables in his special drawer, even though she couldn't afford those luxury items for the other nine kids. She often went without, and would give up her share of the meat or rice to whomever was hungriest.

My brother would at times sneak cookies or the homemade mulberry jam or sugar. She could always tell when he had been sneaking carbohydrates, and would give him a little extra insulin.

I could hear her when she got up early in the morning, to sharpen the needle and could hear her rubbing and clanking the insulin bottles together to get them to warm up before injecting him. She would often put them under her robe to warm them to her body temperature. He hated to get up early, but he needed to void so she could test his urine for sugar and ketones. He would then whimper at the shot, and go lay down a little longer while waiting for the effect of the insulin before he could eat his breakfast.

"Having been a slave to a rigid schedule for so many years, she rebelled and became free."

You could hear her in the kitchen making him breakfast and packing his snacks and lunches. Always the first one up, she was a slave to the clock.

Many years later, my mom was visiting. She pestered me for the time, and I knew she didn't like being late, so I bought her a nice watch, a glow in the dark Timex with big numbers. She refused to take it.

In her eyes, she now had freedom, and told me that when my brother left home, she threw her watch away. She never cared to know the time after that. Having been a slave to a rigid schedule for so many years, she rebelled and became free.

I put that watch to good use. Many a night on call I would look at the time when I was paged in the dark, and think of my mom waking up at night to check my brother.

I wonder when I will be free of my watch, beeper and cell phone. ■

Lawsuits from page 11

against the facility, but the average payment was only $15,622.

Linda Cranfill, quality manager at the facility, explained after a potential adverse event or error is reported, the medical record is extensively reviewed, a timeline is established, and peer review is conducted.

If an error is determined, a meeting with the patient or patient's family is called to disclose what happened.

The process is complicated and can take anywhere from a few weeks to several months, and Cranfill said some families do get agitated along the way. In these cases, she said it's important to maintain contact with the patient or family.

"One thing we've learned is that , in the beginning, the clinicians are often harder on themselves" in assessing blame, Cranfill said. "But in the ultimate medical-legal analysis, it doesn't come out that way."

Although the policy has worked in the center's favor financially, she said there was no way of knowing the strategy would pay off when it was started. "It honestly started with a very simple decision that we needed to do the right thing."

While statistics indicate there are financial incentives for acknowledging and apologizing for errors, according to Mark A. Levine, MD, Denver internist, he said there is a more compelling reason for doing so. "This is all about professionalism and what it means to be a physician."

Timing is Everything

Sometimes, however, apologies and settlement offers can come too late. That's the case for Leonard Joseph, whose wife, Marlene, died during childbirth in July 1999, apparently due to complications from an epidural received at the Jack D. Weiler Hospital of the Albert Einstein College of Medicine Division, part of the Montefiore Medical Center in New York City.

"Only because our doctor-friends asked the right questions did they admit they caused my wife's death," said Joseph, who works in the finance department of a different hospital.

Joseph said an apology would have gone a long way, and when a settlement offer was made, it was too late and he was too angry to accept it. "It would have been easier to forgive. But the first thing they did was treat me with disrespect, and lie and cover up."

Dr. Levine is hopeful that new laws like the ones in Colorado and Oregon will change the current atmosphere, and that more institutions will adopt disclosure policies.

"If you wanted to design a system that would drive errors underground," he said, "you'd pick the kind of system we have now."

What to Say, How to Say It

Experts say it is both ethically correct and financially prudent to disclose and to apologize for medical errors and adverse outcomes. Fortunately, there are other experts giving advice on the bast ways to do it.

Sherry Kwater, director of quality and performance improvement at St. Francis Medical Center in Peoria, Illinois, recommends that doctors rehearse what they plan to say, avoid jargon and steer clear of words like "mishap" and others that suggest blame.

At the recent AMA Annual Meeting, James W. Pickert, Ph.D., professor of education at the Vanderbilt University School of Medicine in Nashville, Tennessee, also recommended practicing the disclosure beforehand but warned against using a script.

In describing the "balance beam approach to disclosure," Dr. Pickert said there are five basic strategies, with each carrying its own set of risks and benefits. These are:

- No disclosure.
- Disclosure of just the "safe" facts.
- Limited disclosure of established facts with a promise to disclose more as they become known.
- Full disclosure right away.
- Full disclosure with assigning of responsibility.

His general advice is to offer support and to focus on the patient and not on one's own reaction. "Don't start by saying how hard it is for you to do this."

Dr. Pickert, who has worked with fellow Vanderbilt professor Gerald B. Hickson, MD, in studying the reasons why patients file lawsuits, said it's hard to learn why they don't. "Administrators discourage researchers from calling people up and asking, 'Why didn't you sue us?'"

For a copy of RCW 5.66.010 please call PCMS, 572-3667. ■

Excerpted from AMNews 7/28/03

In My Opinion....

by Daisy Puracal, MD

The opinions expressed in this writing are solely those of the author. *PCMS invites members to express their opinion/insights about subjects relevant to the medical community, or share their general interest stories. Submissions are subject to Editorial Committee review.*

Tort Reform

Daisy Puracal, MD

What an amazing accomplishment it was to bring large numbers of physicians together to rally for tort reform across the nation. The rally was to urge legislators to vote for a cap of $250,000 on non-economic damages. It was very heartening for me to witness this solidarity of action. It reflects the urgency of the problem we face of mounting malpractice premiums and patient's access to health care.

Physicians have put in many years of hard work and learning to attain their level of expertise in their respective fields. Today we are saddled with a liability system that can push us out of our skills because of high malpractice premiums. We are facing a massive brain drain with specialists dropping services they were trained to perform. Insurance companies, by virtue of the premiums charged, and not academic institutions are dictating what we can and cannot do.

Medical organizations have done much to police our profession but there is a limit to what is humanly possible to control. Given the myriad ways a human body responds, perfection in outcomes every single time is unrealistic. Error is part of being human. Even nature has an inherent error factor e.g. spontaneous miscarriages, or genetic defects.

Even though we recognize that no monetary award can ever replace loss of health or life, there is no question that there should be a mechanism to compensate for bad outcomes in medical care. The current system is ineffective in administering fair and consistent awards and has created a disastrous situation. Our mechanism for malpractice dispute resolution caters to perverse incentives and unenlightened, emotionally charged verdicts that are disproportionate to the injury. Dispute resolution as it stands is not about fairness and justice (even though we refer to it as "the justice system") as often verdicts go contrary to the weight of evidence and are dependant on the skill and persuasion of the plaintiff's attorney. The size of the judgment is totally up to the vagaries of the swayed jury.

Most tort cases in America are brought on a contingent fee basis with a percentage of the winnings going to the attorney. Hence the incentives to try for ever increasing pay offs and speculative litigation. The insurance companies thrive on tort - the attorneys and insurers feed off of each other. But the genie is out of the bottle and has become an enormous monster that refuses to be contained. All of society is paying for this with rising health care costs, poor access to health care, and a threat of not having a qualified physician available.

Although we rallied for a cap on non economic damages, putting a cap on contingency fees and setting guidelines for damages is a more rational way to effect long term change. There is already in place an elaborate system to quantify disability in the AMA "Guides to Evaluation of Permanent Impairment." This system rates the severity of human impairments in workers compensation claims. It can easily be adapted to setting a value on injury sustained, be it physical or mental, in malpractice cases. Other factors such as time loss from work and earning capacity over lifetime can factor into the equation for monetary compensation. This, with a more predictable attorney fee not to exceed a set multiple of usual and customary fees, will make for a more stable environment for tort.

Another proposal for change has been to do away with civil jury trial for medical malpractice and replace it with a medico-legal panel of peers to determine evidence and compensate the injured. With an efficient system of guidelines and standards for compensation in place, compensation is easily calculated and there may not be a need to change the jury system.

Our society has increasingly favored a litigious attitude. We need to put in place educational programs to convert this mentality of need to blame into an attitude of tolerance and mutual respect. We need a collaborative effort to foster a sense of responsibility not just for physicians but for lawyers, insurers and patients, too. So often in tort cases a patient's response is "I would not have..... if I had known." It is impractical to expect physicians to go through every possible side effect and complication known with each [illegible] I suggest that insurance agencies [illegible]

See "Tort" Page 2

In My Opinion....

by David Roskoph, MBA

The opinions expressed in this writing are solely those of the author. PCMS invites members to express their opinion/insights about subjects relevant to the medical community, or share their general interest stories. Submissions are subject to Editorial Committee review.

A 21st Century Depression

Just as the economy was recovering from the popping of the Internet bubble, tragedy struck in the form of terror. After 9/11 the market plunged and then reflexed up in defiance of the near-mortal injury. Unfortunately, the damage had already been done - a 21st century depression began. The public had not only made a dramatic change in their travel habits as a result of the calamity, they simply stopped buying. That was enough to initiate a deflationary environment: one in which goods and services decrease in value against currency (Figure 1). With steadily declining prices, producers have no ability to make a profit. The cycle of idling factories and reducing the workforce begins. The depression unfolds when that deflationary cycle repeats and intensifies into a spiral. During the Great Depression, consumers held out for lower prices to the extreme that manufacturers couldn't afford to produce goods at the prices consumers were willing to pay. Without the tremendous deficit spending, do-or-die cataclysm of WWII, the Great Depression may have felled this great nation from within.

Can Depressions Be Averted?

In 1963, Milton Friedman challenged the economic orthodoxy by suggesting that the Federal Reserve could have averted the Great Depression with correct intervention. He postulated that inflating the money supply at such an intersection could stop deflation before it had a chance to spiral out of control. An opportunity to prove his theory arrived with the post-9/11 economy. Three consecutive months of price declines and a public numbed into near catatonia set the stage for a depression. Alan Greenspan and Co. recognized the gravity of the situation and acted both monetarily and fiscally. The Feds bought government securities in the open market and flooded the economy with cash - in essence trading an immediate promise for a future promise. In addition, the most aggressive interest rate easing in history before 9/11 was accelerated to near-historic lows. Interest rates are at 45-year lows for consumers and never-before-seen lows on loans directly from the Feds to member banks. By releasing money into the system (monetary policy) and/or decreasing interest rates (fiscal policy) the Feds actually created inflation to combat deflation (Figure 1). Lower interest rates stimulate bank lending, which in turn further inflates the monetary base through a process known as hypothecation. Both the level of interest rates and the creation of money have been historic. Figure 2 illustrates the aggressiveness of the intervention - over 500 billion in new money has been created since the attacks.

A Near Miss

Since the inception of the Federal Reserve in 1913, there have been ten recessions and one Depression. The recessions have ranged from mild (1990-91) to severe (1973-74) and we've struggled our way out of them with a little help from the Feds. When the

See "Depression" page 18

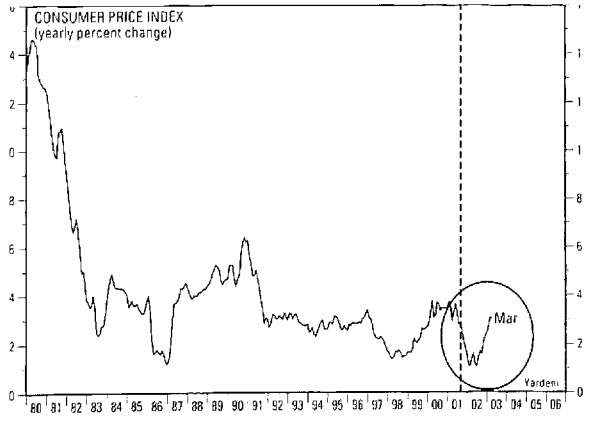


Figure 1: CPI (2.1% on 7/03/2003)

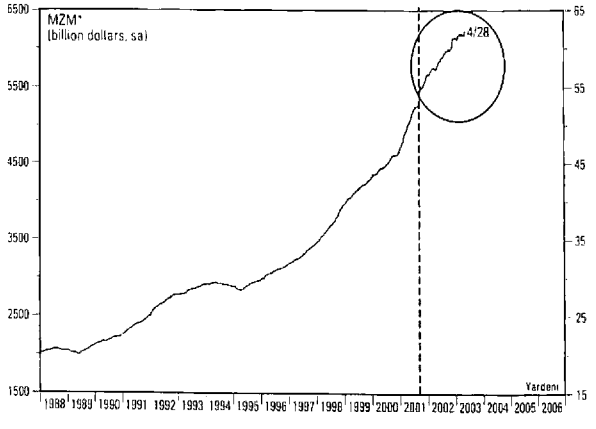


Figure 2: MZM Money Supply

COLLEGE OF MEDICAL EDUCATION

Continuing Medical Education

CME at Hawaii Open, Flight Reservations Urged

Plans are set for CME at Hawaii, scheduled for next spring - April 11-17, 2004. A program brochure was mailed in July.

Those interested in attending are urged to make plans now for both air transportation and lodging.

All Wanderlands Travel, specifically Jeanette, 572-6271, is prepared to assist you in securing your seats.

In addition to other flight arrangements, the College has block-booked seats on Northwest Airlines. This package is at an attractive group rate, includes car rental, and must be reserved well before our conference. Jeanette can assist you with all airline flights to Hawaii.

To take advantage of the reduced rates at our conference hotel - The Hyatt Regency Kauai - you can call directly to 1-808-742-1234.

We've negotiated an exceptional rate for our room categories - royal garden, partial ocean, and deluxe ocean. Our rates are nearly 50 percent off the rates offered by the resort through your local travel agent. We checked! And, connecting rooms for children 18 years and younger are available at a reduced rate.

For more information, please call the College of Medical Education, 627-7137 between 7:45 a.m. and 5:00 p.m. ■

CME at Whistler, Blackcomb Lodging Reservations Available

Plans are set for CME at Whistler scheduled for next January 28-31, 2004. A program brochure was mailed in late July.

Those interested in attending should secure their condos soon. The College has arranged for accommodations primarily at the Aspens Condos at the same rates as 2003. Reservations for the condos can be made by calling *Aspens on Blackcomb*, toll free at 1-866-788-5588. You must identify yourself as part of the COME group. Likewise, you are encouraged to make your reservations soon to ensure space - at least by December 1, 2003, when any remaining condos in the block will be released. ■

Dates	Program	Director(s)
Friday, October 3	Common Office Problems	Mark Craddock, MD
Friday, November 7	Infectious Diseases Update	James DeMaio, MD
Friday, December 5	Advances in Men's Health	TBA
Tuesdays January 13; 20	Cardiology for Primary Care	Gregg Ostergren, DO
Wednesday-Sunday Jan 28 - Feb 1	CME @ Whistler	John Jiganti, MD Rick Tobin, MD
Friday, February 6	Primary Care	William Knittel, MD
Friday, February 27	Endocrinology for Primary Care	Ronald Graf, MD
Thursday-Friday March 11-12	Internal Medicine Review 2004	Gurjit Kaeley, MD
Monday-Friday April 12-16	CME at Hawaii	Mark Craddock, MD
Friday, April 30	Allergy, Asthma & Pulmonology for Primary Care	Alex Mihali, MD
Friday, May 21	Advances in Women's Medicine	John Lenihan, [illegible]

Depression from page 16

stock market collapsed in 1929, the teenage Federal Reserve Bank (FRB) responded too slowly and a deflationary accident known as the Great Depression occurred. Depressions are not simply ugly recessions; they are fundamentally different. Recessions are two or more consecutive quarters of negative growth as measured by the Gross Domestic Product (GDP). We've come to expect recessions as uncomfortable but necessary "breathers" on our relentless path higher: cyclical events that resolve imbalanced growth. We think of depressions, however, as relics from a time less enlightened and we just don't expect them to reoccur. At its peak, the Internet bubble was every bit as economically grotesque as the conditions preceding the Great Depression. Fortunately for us, the bubble's excesses had been pared down significantly in the 18 months before the terrorism occurred. Had the attacks come closer to the bubble's top, the spiral would have been much, much harder to arrest. For now, Milton Friedman has been proved correct. Timely intervention can arrest a deflationary spiral. We are now in a recovery from a depression, having been denied the recovery from the preceding recession. With enough monetary and fiscal stimulants already in place, all that is missing is the (psychological) recognition that we aren't going to fall off the edge. When the investing crowd comes to that collective realization, I believe the Dow 30 will reach its fair value of 12,000 and the NASDAQ of 2,000. The road back is likely to be far more volatile than any before because of the deflationary threat. ■

David J. Roskoph, MBA is a fee-based investment advisor and Certified Financial Planner in Gig Harbor. www.TotalAssetManagement.biz

Tort from page 15

sor a web site that patients can be directed to for detailed information regarding their illness/procedure.

In conclusion, placing a dollar cap on non-economic damages is too narrow a focus, does not allow for inflation and is just a band- aid. Our current efforts at tort reform are being stymied at different levels by legislators. We need a fresh new way to effect change. Having guidelines for fair and consistent awards, standards for attorney fees, and comprehensive educational programs is a viable alternative. Change will not come easily or quickly, but setting our sights in the direction we need to go can set the course for effective long-term change. ■

Classified Advertising

POSITIONS AVAILABLE

Internal Medicine. Auburn, WA. IM group of 10 seeks a B/C part-time physician to job share with a female internist. Position has both inpatient and outpatient responsibilities. The practice is located within 30 minutes of downtown Seattle. Excellent benefit package and salary guarantee. Three year Internal Medicine residency in accredited U.S. program required. Please visit our website at www.multicare.org to learn more about MultiCare Medical Group. Submit CV with references to: Provider Services, MultiCare Health System. Email: providerservices@multicare.org. Fax: 866-264-2818. Or Mail to: Provider Services, PO Box 5299, H2-PHYS, Tacoma WA 98415-0299. This position does not qualify for J-1 Visa waiver. "MultiCare is a Drug Free Workplace"

Tacoma/Pierce County outpatient general medical care at its best. Full and part-time positions available in Tacoma and vicinity. Very flexible schedule. Well suited for career redefinition for G.P., F.P., I.M. Contact Andy Tsoi, MD (253) 752-9669 or Paul Doty (Allen, Nelson, Turner & Assoc.), Clinic Manager (253) 383-4351.

Established Auburn Family Practice seeking Board Certified or Board Eligible physicians to join our group. Base salary plus incentive program for motivated Doctor. Part time or full time hours available. Fax CV to 253-839-5565.

OFFICE SPACE

For Rent: 3300 sq ft Class A medical office in Tacoma Medical Center, 1112 6th Avenue, third floor. Elevator, underground parking, close to hospitals. Call 253-272-2224.

POSITIONS WANTED

Transcription Specialists - We have years of experience in most specialties. We guarantee accuracy, fast turnaround time, free pickup and delivery and competitive rates. Outstanding references. Call 925-3276.

Pierce County Medical Society
223 Tacoma Avenue South
Tacoma, WA 98402

Return service requested

PRESORTED
STANDARD
US POSTAGE PAID
TACOMA, WA
PERMIT NO 605

Pierce County Medical Society
BULLETIN

September, 2003

Making a Difference

Washington State Medical Association
2003 Annual Meeting
Yakima, Washington
September 19-21

See page 8

INSIDE:

The Bulletin is published monthly by PCMS Membership Benefits, Inc. Deadline for submitting articles and placing advertisements is the 15th of the month preceding publication.

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 PCMS. Acceptance of advertising in no way constitutes professional approval or endorsement of products or services advertised. The Bulletin reserves the right to reject any advertising.

Managing Editor: Sue Asher
Editorial Committee: MBI Board of Directors
Advertising Information: 253-572-3666
223 Tacoma Avenue South, Tacoma WA 98402
253-572-3666; FAX: 253-572-2470
E-mail address: pcmswa@pcmswa.org
Home Page: http://www.pcmswa.org

Pierce County Medical Society
BULLETIN

September, 2003

Table of Contents

President's Page

by J. James Rooks, Jr., MD

Out of the comfort zone

J. James Rooks, Jr., MD

Well if it's not a crisis now, I don't know when it ever will be in the minds of our legislators, politicians, or other alleged leaders. In Pierce County several of our leading surgeons in vital areas have lost their liability insurance and, at the time of this writing, are unable to replace it. These are physicians who have practiced for many years rendering outstanding service to this community, and the result is early retirements, unwanted practice style changes, and frenzied searches for other forms of protection. The ranks of our ob/gyns continue to be decimated with one hospital deleting the entire service line (their words), all attributable to liability and risk issues. Now we have primary care and ER physician groups losing their coverage, further limiting access to care for the citizens of this county. Where will it all end? I don't know, but I have asked our executive director to ask Physician's Insurance to speak at one of our monthly meetings in the near future.

In addition to liability crises, several of you have called me and pointed out that we have a reimbursement crisis as well - with expenses rising to the point that many physicians are forced to stop accepting certain plans. Again this limits access to care for patients, especially those who are poor and in many instances adhere to unbelievably unhealthy lifestyles. They then descend upon our most expensive entrance for care - emergency rooms - in a further state of declined health. A vicious cycle begins with which you are all completely aware.

What are our options at this point? Though it does have its place, merely throwing money at politicians and PACs who spout out what we'd like to hear at election time doesn't get things changed. I believe that this year we have established the necessity for active participation on our part - witness our rally this past spring. In the words of Chef Emeril, it's time to "kick it up another notch." Whether this notch is a work walkout, office closure, strike, or other 'attention focusing' method of change, I know not - just it's time for physicians to move out of our comfort zone and into a more aggressive movement for change. You can be sure that this movement will be discussed at WSMA's convention in Yakima this month. More to come.

In the face of all of the above, it is always a sense of comfort and joy to me to have the wonderfully satisfying experience of one-on-one contact with my patients and the opportunity to help them with their problems as relate to my area of expertise. Further, it is a privilege to practice in a community with so many outstanding and talented physicians. In the long run, I believe this wonderful profession will prevail. ◻

Seattle-to-Portland, 200 miles, 1 or 2 days...

Several PCMS members took part in the 24th Annual 200-mile Seattle-to-Portland (STP) Bicycle Classic Ride July 12-13. Most of the nearly 8,000 riders stay the first night in Centralia or Chehalis, which is 94 miles from the University of Washington starting point. About 1500 complete the ride in one day.

Congratulations to all riders!

From left: Dr. Bill Martin, general surgeon, his wife Karyl, and Dr. Robert Osborne, orthopedic surgeon

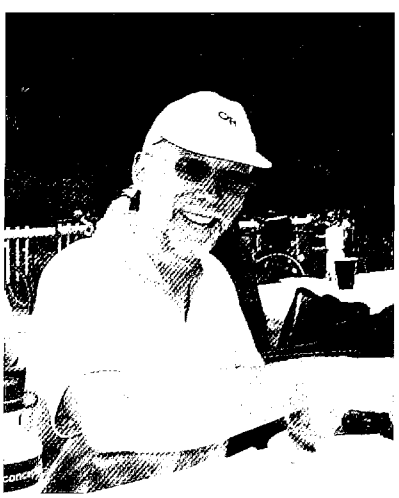
Dr. Nick Iverson (second from left), internal medicine, with friends at Longview stop

Courage Classic, 172 miles, 3 days...

Congratulations are in order to PCMS riders who rode this year's Courage Classic.

The weekend started in Snoqualmie with the first day ending 57 miles later in Cle Elum. The second day took riders to Leavenworth after a 55 mile ride. The third day riders end up in Skykomish after completing the final 60 miles of the ride. Total elevation gain for this ride is 10,036 feet!

This year's 12th Annual Courage Classic bicycle tour took place on August 14-16. Proceeds from the Courage Classic benefit Rotary Endowment for the Intervention and Prevention of Child Abuse and Neglect at Mary Bridge Children's Hospital.



Dr. Steve Settle, physical medicine & rehab

Dr. James Rifenbery, general & thoracic surgeon

MultiCare team: Dr. George Brown and Diane Cecchetini

Physicians meet with Representative Darneille (D-29)

Left to right - Len Eddinger, Daisy Puracal, Carl Wulfestieg, Don Russell, Rep. Jeannie Darnielle, Steve Hale, Allison Odenthal, James Buttorff, Sandra Reilley and Jane Berger

Several PCMS physicians met with Representative Jeannie Darneille (D-29) and members of her staff to discuss issues of concern to physicians, particularly tort reform and reimbursement concerns. The meeting, chaired by WAMPAC chair **Dr. Don Russell**, Puyallup pediatrician, was held July 30th at Mary Bridge Children's Health Center.

Rep. Darneille acknowledged the very difficult circumstances facing physicians and the health care system in general. She is aware of the particularly hard hit rural areas, but openly expressed that each side in the fight for tort reform have legitimate positions. "The Medical Association has one side, it's side and the attorney's have the other side, their side, and both have legitimacy," she stated.

Rep. Darneille believes we have to come together to negotiate. "You have to be willing to be flexible, progress doesn't come easily," she added. In the political process, change takes time, and the issue has to be worked, she explained. Alternatives have to be considered as well, such as a patient compensation fund, a surcharge for medical liability coverage, or other ways of funding.

Physicians attending the two hour meeting in addition to Dr. Russell included **Drs. Carl Wulfestieg, Allison Odenthal, Daisy Puracal, James Buttorff, Sandra Reilley, George Tanbara and Steve Hammer**. Others in attendance included Steve Hale, PA; legislative staffers, Jane Beyer, Senior Counsel for the House Democratic Caucus and Josephine Quiles-Negroni, legislative assistant; Len Eddinger, WSMA and Sue Asher, PCMS.

Rep. Darneille noted that she is available on most Fridays to meet or discuss issues by phone and she encouraged physicians to contact her by calling 253-593-2343. ■

Fall Back Series

The Fall Back to School Series, building partnerships for healthy kids, had it's inaugural meeting in August with about 50 attendees. Speakers covered the oral medication act, immunization forms and legislation covering life threatening conditions. Physicians, school nurses and others that care for children were invited to attend.

The next two sessions will be Friday October 17 and Thursday, November 20, both from 7 - 8:15 am at Jackson Hall.

The series is sponsored by the PH/SH Committee of PCMS, chaired by **Dr. Sumner Schoenike**, Lakewood pediatrician. For a flyer, or more information call PCMS 572-3667. ■

The Pliskows greet President Bush

*Ruthie Troy, granddaughter of **Drs. Ray and Vita Pliskow**, welcomes President George W. Bush to Seattle on August 22nd at Boeing Field. Dr. Vita Pliskow, her daughter and son-in-law were also there to greet and welcome the President. Six-month-old Ruthie made national news for her welcoming abilities.*

Applicants for Membership

Holli S. Banister, MD
Family Practice
Summit View Clinic
11019 Canyon Rd E #A, Puyallup
253-537-0293
Med School: Eastern Virginia Med School
Residency: St. Peter's Family Practice

Garrick D. Brown, MD
Int Med/Gastro
Digestive Health Specialists
1901 S Union #B4006, Tacoma
253-272-5127
Med School: University of Tennessee
Int & Res: University of Tennessee
Fellowship: University of Tennessee

Jane S. Dunham, MD
Internal Medicine
Virginia Mason Medical Center
33501 1st Way S, Federal Way
253-874-1602
Med School: University of Washington
Int & Res: Providence Portland Med Ctr

Angela Fields, MD
Pathology
Digestive Health Specialists
1901 S Union #B4006, Tacoma
253-383-8342
Med School: University of North Carolina
Int & Res: Emory University
Fellowship: Emory University

Amber F. Hsiao, MD
Diagnostic Radiology
Medical Imaging Northwest
222 15th Ave SE, Puyallup
253-841-4353
Med School: Northwestern University
Int & Res: Northwestern University
Fellowship: Women's Hospital

W. Michael Johnson, MD
General Surgery
Cedar Surgical Associates
2121 S 19th Street, Tacoma
253-383-5409
Med School: Kansas University
Int & Res: Good Samaritan Hospital, OH

Ronald R. Louie, MD
Pediatric Hematology/Oncology
Mary Bridge Children's Hospital
311 South L Street, Tacoma
253-403-3481
Med School: Medical College of Ohio
Int & Res: University of Chicago
Residency: University of Wisconsin
Fellowship: FHCRC/UW

William H. Stover, MD
Pediatrics
MultiCare Medical Group
718 S Fawcett, Tacoma
253-459-8311
Med School: Johns Hopkins
Internship: U of Arizona Affl. Hospitals

Veronica L. Ventura, MD
Ob/Gyn
Tacoma Women's Specialists
314 ML King Jr Way #104, Tacoma
253-272-5572
Med School: Tulane Medical School
Int & Res: Madigan Army Med Ctr

The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

Physician-Based Dental Exams

Federico Cruz-Uribe, MD

By now, Pediatric and Family Practice providers should have received a letter from me, encouraging you to incorporate dental assessments in your "well child exams." This is important because children's dental health continues to be a public health issue, and one that can be prevented. The data are sobering: "(D)ental caries remains the single most common disease of childhood that is not self-limited or amenable to a course of antibiotics. By the age of nine years, 56 percent of U.S. schoolchildren have dental caries." (*American Family Physician*, January 1, 2000.)

We know about the school days lost to fever and tooth pain. And the self-image issues that darkened, broken teeth can cause. You can help prevent these affects by recognizing early signs of decay and encouraging parents to seek care. During each child's physical, take a few minutes to look for obvious signs of decay. Pain is not the only indicator of oral health problems, looking at teeth and gums will also reveal infections and early decay.

> *"(D)ental caries remains the single most common disease of childhood that is not self-limited or amenable to a course of antibiotics. By the age of nine years, 56 percent of U.S. schoolchildren have dental caries."*
>
> American Family Physician, January 1, 2000

Network Nurses from the Tacoma-Pierce County Health Department will hand-carry information to you on physician-based dental exams and where to refer children with problems.

In addition, consider joining us at the TPCHD-sponsored Oral Health Summit, October 24, 2003 at the Tacoma Sheraton to learn more about preventing caries and oral infections.

For those of you who are interested in this topic, but may not have received information on the dental assessment process or the conference, call Linda Gillis, TPCHD Dental Hygienist, at (253) 798-6579.

Become an important partner with public health and dental providers by looking for dental infections as part of every well-child exam.

Thanks! ■

Washington State Medical Association Annual Meeting

This year's annual meeting of the Washington State Medical Association (WSMA) House of Delegates will be held in beautiful downtown Yakima.

The WSMA Annual Meeting and House of Delegates meeting is the opportunity for members to set the policies and goals for the association.

It is an open and democratic process. While it is impossible for the House to arrive at policy positions with which every physician agrees, the thoughtful process by which our policies are set helps assure that the WSMA's voice continues to command respect during these tumultuous times.

The theme of this year's meeting is *Making a Difference*. Making a difference, something we do every day in our practice - make a difference in the lives of our patients. It's also something we attempt to accomplish through our state medical association. The WSMA strives to make a difference - to make the practice of medicine better for Washington's physicians and for our patients.

At this year's opening session, we'll hear from physicians making a difference in their communities and in their profession. Specifically, our panel of speakers will address issues pertaining to access, patient safety and high quality care.

On Friday and Saturday a variety of scientific sessions will be available, all providing additional CME Category I credit. Sessions include, but are not limited to:

- Addiction Medicine 101
- Ruling Out Misdiagnosis: Evaluation and Management of Chest Pain
- STD/HIV Update
- Advances & Controversies in Ophthalmology
- Evaluation and Management of Pediatric Asthma
- DIGMA: You Can Improve Access, Quality & Productivity
- Health Care Economics Program
- Advances in Women's Health

The policy "heart" of the meeting will be reference committee meetings on Saturday morning, followed by the House of Delegates session on Sunday. It is the House that sets the policy course for the Association.

There are two opportunities for debate on every item of business brought before the House. The first comes during the reference committee hearings that are open to every WSMA member. Following these hearings, each of the four reference committees prepares a report recommending specific action and takes these recommendations to the entire House of Delegates for its final action.

The WSMA Annual Meeting brings Washington state physicians together in a forum like no other. If you are interested in participating in the WSMA Annual Meeting, please call the Pierce County Medical Society office at 572-3667. ■

In My Opinion.... The Invisible Hand

by Andrew Statson, MD

The opinions expressed in this writing are solely those of the author. *PCMS invites members to express their opinion/insights about subjects relevant to the medical community, or share their general interest stories. Submissions are subject to Editorial Committee review.*

We Lose Even When We Win

Andrew Statson, MD

"When a rock falls on a pitcher, woe to the pitcher:
When a pitcher falls on a rock, woe to the pitcher."
Jewish proverb

The lawyers are the rock; we are the pitcher. We are in a no-win situation. No matter how things work out, the lawyers win, while we lose. Yes, I know. They are only doing their job.

One of my friends grumbled during his trial about the slow pace of the proceedings. He wanted to be done with it and to go on with his life. The judge told him, "Don't fret. Consider yourself on vacation." Some vacation.

Another colleague went to the Court on the trial date and was told that neither a judge nor a chamber was available. He had a list of patients who needed to be seen, so he went to his office and started calling. He did that for two more days, until his trial started. During the two or three weeks, while it lasted, he went to his office from 6 to 9 p.m., to see patients who could not wait several weeks for an appointment.

That is the normal approach for a physician in private practice. Yes, we have to worry about our overhead. We have to meet the payroll and pay the rent. However, the loss of income is a small part of our problem. We also feel the obligation we have to our patients. We cannot abandon them for several weeks while the attorneys, as one of them told me, perform theatrics in the courtroom.

Our meaning of urgency requires action within hours, or perhaps minutes. The legal situation of present and immediate danger calls for action within weeks. We do not attach the same meaning to words as lawyers do. Our minds function differently, too. We examine a gray and say, "Yes, it is gray, but the way it looks, I think this treatment will work well. If not, we'll try something else." They look at a gray and bring arguments to make us believe that it is black or white, depending on which side of the fence they are.

There was a time when 80% of the malpractice suits were decided in favor of the defendant physicians. Not any more. The latest figure I saw was that only half of the verdicts now go for the defense. Does that mean there is more malpractice now than there was twenty or thirty years ago? Hardly. It means that people expect more from us and are less forgiving when things don't work out as they had hoped.

People hear about the extraordinary feat of a medical team at some institution and they believe that modern medicine can perform miracles. They feel let down when that does not happen in their case. They hear the trial lawyers claim that incompetent physicians are the cause of bad results. They hear about the million dollar awards and they want a piece of the action. They consult an attorney who tells them, "Don't worry about your doctor. It's not money out of his pocket. He has insurance. Besides, you have been hurt and you deserve to be compensated."

What happens when the patients win? Are they really compensated? Sure, they get a lot of money. What does it do for them? They may buy a big house and go on an expensive trip. Then what? Did the money help them get over their grief? Did it erase the memory of the misfortune? Were they made "whole," as the attorneys like to say? Easy money can have a corruptive effect. How did it affect them? Were they able to control it or did it control them?

The purpose of the above questions is to bring the issue of resolution. Considering the total effect of the system on the plaintiffs, on the defendants, and on those who work under the threat of malpractice but have not been involved in a case yet, do the courts make our community better? The role of the judicial system is to settle disputes, to resolve conflicts. It is expected to be better than having us shoot it out with one another on Main Street. Does it achieve its purpose? Is justice served?

To take the example of children with cerebral palsy, more than 90% of the cases have nothing to do with their medical care. Malpractice awards are used to relieve social distress. That is a social, not a medical problem. In essence, the courts function as social engineers.

The result is a system [illegible]. We blame the lawyers for running the

See [illegible] page 10

Lose from page 9

flames of malpractice and the third party payers for controlling our fees. The trial lawyers blame the bad apples among us for practicing poor medicine and the insurance companies for overcharging us. The third party payers refuse to acknowledge the problem and to improve our compensation.

The economic burden under which we work is bringing us close to the breaking point. The system is too expensive. How long will we be able to continue? Is there an alternative solution?

Unfortunately, even when we win, the cost to defend a suit is $300,000 and up, frequently exceeding $500,000. The time we spend preparing for our defense and attending the trial can amount to several months. Also, the emotional impact on physicians affects their personal and professional life. That effect is probably strongest during the three or four years awaiting the trial, but its effect lingers for a long time afterwards, if it ever goes away completely.

Surviving a lawsuit is a psychologically painful experience, even when we win. Nobody will give us back the life we lost. Nobody will compensate us for the turmoil we endured. There is more. We begin to look on every patient as a potential litigant. As we search for ways to protect ourselves, the patient-physician relationship changes and becomes adversarial, while previously it had been a mutually trusting one.

When patients come to us with their problems, their fears, their reasonable and unreasonable demands, in the back of our mind we wonder what are they really after. We look on the patients no longer as cooperative participants in their care, but as irresponsible children, who are likely to misunderstand their condition, misinterpret our instructions, follow their own whims rather than the treatment regimen we prescribe and, when things go wrong, they are likely to blame us for the result.

A few patients who had a bad outcome hinted to me that their friends or relatives had urged them to file a suit, but they decided against it. While discussing the malpractice situation, other people have told me that something bad had happened to them, but they did not go to court, because that could not bring them back what they had lost.

How can we practice medicine under such circumstances? What keeps us going is that most patients are decent. They come to us for help and they appreciate what we do for them, even when things don't work out as well as they had hoped. They like us as physicians. They confide in us, trust us and we respond to them in kind. Those patients make our work worthwhile. If all of them could be like that, we would have no problem. ■

IN MEMORIAM

WILLIAM C. KNITTEL, MD

1943–2003

The Pierce County medical community was shocked and saddened to learn of the death of William C. Knittel, MD from complications of a stroke in mid-August.

William Knittel, MD

Dr. Knittel was a family practitioner in Puyallup. He was born in Bellingham in 1943 and graduated from the University of Washington Medical School prior to opening his Puyallup practice in 1972. He completed his pre-med education at Yale University and his internship at Lincoln Hospital in New York City.

Dr. Knittel was a valued PCMS member. Most recently, he served as the program director for the Primary Care 2003 College of Medical Education CME course and was scheduled to direct the course in February, 2004 as well. Sadly, the College will seek a replacement.

Memorial donations may be made in Dr. Knittel's name at any branch of Venture Bank for distribution to local children's charities.

PCMS offers condolences to Dr. Knittel's wife, Norma and their family.

Project to Study Fall Prevention Strategies for Seniors

The NorthWest Orthopaedic Institute is launching a two-year, grant-funded research project designed to evaluate strategies to prevent falls among older adults, the leading cause of injury hospitalization for Washington State and Pierce County residents.

Pierce County has been selected as one of two implementation sites in Washington State for the research study, funded by the Centers for Disease Control and Prevention (CDC) and coordinated by the Washington State Department of Health.

Falls are a major threat to the independence and quality of life of older adults. In September 2002, the Washington State Department of Health published the report "Falls Among Older Adults: Strategies for Prevention" which is available online at http://www.doh.wa.gov/cfh/Injury/pubs/Publications.htm. Report findings included the fact that in 2001, falls resulted in more than 12,000 hospitalizations and 400 deaths among Washington State residents age 65 and older. By comparison, there were fewer than 3,000 hospitalizations due to motor vehicle crashes, for all ages combined. In Pierce County in 2001, there were nearly 1,300 hospitalizations due to falls among seniors.

"Although falls are a common cause of fractures and other injuries in older adults, they are not an inevitable consequence of aging," explained **Dr. Steven Teeny**, an orthopaedic surgeon with Lakewood Orthopaedic Surgeons, and President of the NorthWest Orthopaedic Institute. "There are proven, effective strategies for preventing falls that can be learned by seniors. Through this research study, we hope to develop a best practices model that blends the skills and resources of public health professionals, social service agencies, and health care providers to provide a solid foundation for an effective senior falls prevention program."

The study will evaluate the effectiveness of a falls prevention program that includes strength and balance exercise classes, medical care management and education. On September 2nd, the NorthWest Orthopaedic Institute will begin recruiting 240 eligible seniors, age 65 and older, to participate in the project. There is no charge to participate, and individuals selected will be offered a cash incentive in exchange for a one-year commitment. The study activities will be held at the Lakewood Family YMCA and the City of Tacoma's Lighthouse Senior Center. Study participants who are randomized for the exercise program intervention will also have their fall risk assessment findings and literature-based recommendations for medical management (if indicated) sent to their physicians.

"Research has found that regular exercise and learning about how to prevent falls are very important fall prevention strategies for older adults," according to Sally York, RN, Clinical Coordinator of the NorthWest Orthopaedic Institute, and the Pierce Site Coordinator for the Senior Falls Prevention Study. "Many older adults live with a fear of falling, and become less active because of this fear. This actually increases their risk for falls because it results in weaker muscle strength and balance."

As Washington's population ages, falls are an increasing threat to the independence and quality of life of older adults. "Almost two-thirds of seniors in Washington who are admitted to hospitals with fall-related injuries such as hip fractures will need to be admitted to skilled nursing facilities for additional rehabilitation. These injuries often result in long-term or permanent placement in a nursing home," noted York. "By studying how to prevent falls, we can learn how to help seniors stay healthy, active and independent and reduce the number of serious fall-related injuries."

The Senior Falls Prevention Study is intended for adults age 65 or older, in good general health, and not currently in a regular exercise program. If you have any questions, or are interested in referring patients to participate in the study, please contact the Northwest Orthopaedic Institute at (253) 984-6964 (984-NWOI). Patients may also call NWOI directly if interested in participating in this study. ■

COLLEGE OF MEDICAL EDUCATION

Infectious Diseases Update CME set November 7

The annual Infectious Diseases Update is set for Friday, November 7, 2003. The very popular course will return this year to the Sheraton Hotel - in the hotel ballrooms.

The program is directed by **Jim DeMaio, MD** and will feature nationally known expert David Nicolau, PharmD, FCCP, 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.

This year's program includes presentations on:

- Update on Immunizations
- A Bug In Your Eye: Ophthalmologic Infections You Need to Know
- Prevention and Worrisome Diseases: Monkey Pox, SARS, West Nile Virus and other Arboviruses
- Common Respiratory Germs: How Contagious Are They?
- Contemporary Issues in the Management of Clinically Acquired Respiratory Diseases
- New Hot Topics in the ID Literature
- Innovations in Understanding and Treating Hepatitis B and C
- Maternal Fetal HIV ■

Continuing Medical Education

Common Office Problems CME offers timely subjects, October 3

Registration is underway for the very popular Common Office Problems CME program. This year's conference is scheduled for Friday, October 3, 2003. The conference will be held at St. Joseph Medical Center, Rooms 1A & B.

The program will offer 6 Category I CME credits and will be directed by **Mark Craddock, MD**.

This year's program includes timely addresses on the following topics:

- New Hypertension Guidelines
- Diagnostic Imaging and Interventional Radiology
- Management of Dementia in Primary Care
- Treatments of Bipolar Disorder
- WHI: What Does it Mean?
- Current Strategies for ADHD
- Diagnosis of Hand Injuries
- Osteoporosis and Osteopenia ■

Dates	Program	Director(s)
Friday, October 3	Common Office Problems	Mark Craddock, MD
Friday, November 7	Infectious Diseases Update	James DeMaio, MD
Friday, December 5	Advances in Men's Health	TBA
Tuesdays January 13; 20	Cardiology for Primary Care	Gregg Ostergren, DO
Wednesday-Sunday Jan 28 - Feb 1	CME @ Whistler	John Jiganti, MD Rick Tobin, MD
Friday, February 6	Primary Care	TBA
Friday, February 27	Endocrinology for Primary Care	Ronald Graf, MD
Thursday-Friday March 11-12	Internal Medicine Review 2004	Gurjit Kaeley, MD
Monday-Friday April 12-16	CME at Hawaii	Mark Craddock, MD
Friday, April 30	Allergy, Asthma & Pulmonology for Primary Care	Alex Mihali, MD
Friday, May 21	Advances in Women's Medicine	John Lenihan, Jr., MD

Hiring to Avoid Firing

In today's tight labor market, unemployment remains a concern for many people in our community. While this "employer's market" may seem like a blessing for the person looking to hire, it could be a time of high turnover. The extremely qualified job seeker may settle for a mediocre job until something better comes along, and the unqualified applicant will struggle to get anything they can to get a paycheck, only to be terminated for not being able to handle the position.

Both cases are a no-win situation and may cause employee turnover. Any time there is a change in staff, it is costly to the employer, affects the moral of the entire office team, and/or may prompt a lawsuit.

Hiring an employee shouldn't be taken lightly. Creating a strong team begins with the hiring process. By taking a little extra time during the initial hiring process will be beneficial in the long run. Hiring does not have to lead to firing.

Following are a few basic guidelines to assist with your hiring process:

APPLICATIONS

- Have each candidate fill out an application in full (no "See Resume")
- All applications should include a "termination at will" statement
- Compare the information on the application with the resume (does it match - dates, titles, job duties, reason for termination)

RESUME VS. APPLICATION

- Review the paperwork in detail prior to interviewing
- What questions or concerns are presented (any red flags?)
- Gaps in dates? Reasons?
- Job-hopping? Ask for details on what prompted the job changes

INTERVIEWING

- Set aside enough time to interview
- Compare the applicant's skills with the written job description
- Prepare questions ahead of time
- Use standard questions for everyone, as well as applicant-specific
- Avoid discriminatory questions (race, age, disability, marital or family status, religion, sex, pregnancy, country of origin, transportation, etc.)
- Do not make statements that could be thought of as a job offer
- Have the candidate meet with co-workers

REFERENCE CHECKS

- Obtain a signed release from the applicant
- Speak directly with the supervisor
- If company policy does not allow release of information, obtain names of co-workers
- Ask open-ended questions
- Listen carefully to what isn't being said

Taking a few extra minutes at the beginning of the hiring process could save many hours of headaches later. Hire now to avoid firing later.

If you would like sample forms or interviewing tips, please call Deborah Pasqua at 253-572-3709. ■

The Pierce County Medical Society Employment Service currently has qualified Physician Assistant, RN, LPN, MA, and clerical staff in search of employment.

Classified Advertising

POSITIONS AVAILABLE

Tacoma/Pierce County outpatient general medical care at its best. Full and part-time positions available in Tacoma and vicinity. Very flexible schedule. Well suited for career redefinition for G.P., F.P., I.M. Contact Andy Tsoi, MD (253) 752-9669 or Paul Doty (Allen, Nelson, Turner & Assoc.), Clinic Manager (253) 383-4351.

Established Auburn Family Practice seeking Board Certified or Board Eligible physicians to join our group. Base salary plus incentive program for motivated Doctor. Part time or full time hours available. Fax CV to 253-839-5565.

Internal Medicine. Auburn, WA. IM group of 10 seeks a B/C part-time physician to job share with a female internist. Position has both inpatient and outpatient responsibilities. The practice is located within 30 minutes of downtown Seattle. Excellent benefit package and salary guarantee. Three year Internal Medicine residency in accredited U.S. program required. Please visit our website at www.multicare.org to learn more about MultiCare Medical Group. Submit CV with references to: Provider Services, MultiCare Health System. Email: provider services@multicare.org. Fax: 866-264-2818. Or Mail to: Provider Services, PO Box 5299, H2-PHYS, Tacoma WA 98415-0299. This position does not qualify for J-1 Visa waiver. "MultiCare is a Drug Free Workplace"

PRACTICES AVAILABLE

Family Practice with equipment for sale in Federal Way, WA. Max Waldron, DO is retiring in December, 2003. Excellent opportunity/ very reasonable terms. Call 253-925-0672 or e-mail: maxwdoc@sysmatrix.net.

OFFICE SPACE

For Rent: 3300 sq ft Class A medical office in Tacoma Medical Center, 1112 6th Ave, third floor. Elevator, under-ground parking, close to hospitals. Call 253-272-2224.

Retired Doctor's Wives Luncheon

There will be a no-host luncheon Wednesday, September 24, 2003 at 11:30 am at Affairs Restaurant located at 27th and Bridgeport in University Place. Wives of retired and semi-retired doctors are welcome. To make a reservation call Judy Brachvogel (564-4308) or Maryln Baer (564-6374) by September 20. Come and renew friendships!

Pierce County Medical Society
223 Tacoma Avenue South
Tacoma, WA 98402

Return service requested

PRESORTED
STANDARD
US POSTAGE PAID
TACOMA, WA
PERMIT NO 605

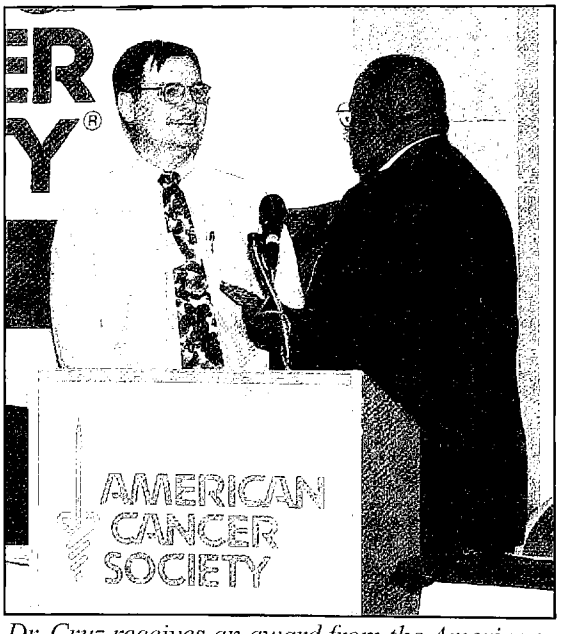
Pierce County Medical Society
BULLETIN

October, 2003

Federico Cruz, MD for Governor

- PCMS endorses Dr. Cruz's candidacy (see page 5)
- WAMPAC endorses Dr. Cruz's candidacy (see page 4)

Dr. Cruz is relieved to be in the "command" Aikido position after five years and a black belt



Dr. Cruz receives an award from the American Cancer Society for his work in cancer prevention

INSIDE:

The Bulletin is published monthly by PCMS Membership Benefits, Inc. Deadline for submitting articles and placing advertisements is the 15th of the month preceding publication.

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 PCMS. Acceptance of advertising in no way constitutes professional approval or endorsement of products or services advertised. The Bulletin reserves the right to reject any advertising.

Managing Editor: Sue Asher
Editorial Committee: MBI Board of Directors
Advertising Information: 253-572-3666
223 Tacoma Avenue South, Tacoma WA 98402
253-572-3666; FAX: 253-572-2470
E-mail address: pcmswa@pcmswa.org
Home Page: http://www.pcmswa.org

Pierce County Medical Society
BULLETIN

October, 2003

Table of Contents

President's Page

by J. James Rooks, Jr., MD

Positive Changes

J. James Rooks, Jr., MD

It seems that this month we can begin to see some positive changes on the horizon. For starters, at the September General Membership meeting it was unanimously recommended by those in attendance that the Society endorse **Dr. Federico Cruz's** candidacy for Governor of Washington State. If he's elected, this will greatly aid our search for liability and reimbursement reform. I encourage all of you to consider supporting him in this campaign. The WSMA annual meeting has just ended and PCMS proudly introduced Dr. Cruz to the attendees, while WAMPAC voted to endorse Federico and lend financial support for both the primary and the general elections.

PCMS has scheduled a special meeting for the general membership on the medical liability insurance issue featuring the CEO of Physician's Insurance. This will be an informal meeting where we can ask questions and have our concerns discussed. Jeff Collins, MD, WSMA President (Spokane) and Tom Curry, WSMA Executive Director, will also be on hand to elaborate plans at the state level. The meeting will be held October 9th, 7 pm at Jackson Hall.

Several members have met with state legislators to discuss the problems we face. In fact, **Dr. Mike Kelly** and I met today with Rep. Mike Carrell (R-28) (at his request) to discuss medical liability reform. It was a very informative meeting on both sides. Mike and I informed Rep. Carrell of the crisis that exists in our community. It is hard for physicians to accept that politicians will not step up and do the right thing regardless of the political ramifications. Mr. Carrell listened intently and Mike and I believed his sincerity. He proceeded to tell us the political realities. If he were chairman of the Judiciary Committee, most likely we would have the reform bill we all seek. BUT, he is only one member and the chairmanship rests with the other side who are greatly influenced by the trial lawyers. He related how organized and active the trial lawyers are in letter writing campaigns on just about every issue that affects them. Physicians are not! He suggested that we institute a massive letter writing campaign with one page letters in our own writing/typing using our respective letterheads stating the following three items: 1) What the problem is (we all know the problem is high cost liability insurance and reimbursements). 2) Ask what the legislator intends to do about it. 3) How and when the legislator can reach us, home phone, e-mail - whatever method is preferred by the doctor. He went on to say that we should write all legislators, encourage our colleagues to do likewise and send a copy to the PCMS so we have a record of who's been contacted. He recommends we not use form letters or sign-the-post-cards. This, he said, is the political reality of what we must do. He also recommended small one or two physician informal meetings over coffee or lunch with individual representatives and senators, which could be very effective as a follow up. Many of you are already taking the time to inform your patients of the crisis we face in health care, and you have written letters and spoken with your legislators. More of us must follow suit.

These ideas are all a good plan of attack, but in the long run more aggressive action such as work slowdowns, long vacations, etc., anything affecting access to elective care, may be necessary to get the attention of lawmakers. Our Pierce County delegation to the WSMA House of Delegates did their best to rally the troops statewide, but once again it may be up to Piece County physicians to lead. It has come to my attention that small groups of physicians are holding impromptu meetings on these issues. This is great! Keep it up and share your conclusions with all of us.

WAMPAC Supports Cruz

The WAMPAC Board of Directors voted at their September 19th meeting to endorse and financially support **Dr. Federico Cruz** in his bid for the governor's seat in 2004. They will contribute funds for both the primary election and the general election. If he does not proceed to the general election the funds will be returned immediately after the primary.

The Board did not take the endorsement lightly. After much discussion and consideration, and the recommendation of the PCMS members (decided at the September General Membership Meeting), they voted to endorse his campaign. WAMPAC has not endorsed a candidate in a statewide race for many years.

PCMS representatives on the WAMPAC Board of Directors are **Don Russell, DO**, Puyallup pediatrician and **Len Alenick, MD**, Lakewood ophthalmologist. Dr. Russell serves as chair. Both Drs. Russel and Alenick encouraged the WAMPAC Board to endorse Dr. Cruz and were instrumental in the Board's decision.

Dr. Cruz was a featured speaker at the WAMPAC luncheon on September 20, along with Congressman George Nethercutt (R-5), running for Senator Patty Murray's Senate seat and Roger Stark, MD who will be seeking the congressional seat in the First District. All candidates supported medicine's agenda, particularly the urgent need for tort reform. ■

Retirement Reception

for

Pat Duffy, MD

(PCMS President, 1984)

When: Sunday, October 19, 2003

Time: 2:00 - 4:00 pm

Where: St. Andrew's Catholic Church
1401 Valley Avenue
Sumner WA 98390

Please join fellow physicians and members of the community in recognizing and celebrating the career of Dr. Pat Duffy, who is retiring after more than 50 years of practicing medicine in Sumner.

WSMA Annual Meeting Recap - Tort, Tort, Tort...

Editor's Note: This is a preliminary report of the WSMA Annual Meeting at press time - a more comprehensive report will be published in November.

Delegates at the WSMA Annual Meeting came to consensus on tort reform following a thorough and thoughtful debate in reference committee and at the house session.

A lot of attention and concern was focused on the plight of rural physicians and primarily family practitioners, who are trying to continue to provide obstetrical services in their community - and who face very difficult, wrenching decisions about whether or not they can continue to do so.

Points well made by a variety of delegates included:

- Once dropped, OB services are not easily - if at all - restarted.
- All physicians share the problems and burdens of the current tort system. Emergency medicine, surgical specialties and non-surgical specialties are all affected.
- Meaningful change will come when society realizes the broad access-to-care crisis that is growing.

Stressed repeatedly by delegates was:

- The need for all of medicine to stick together to get this job done. Some government officials are working to offer would-be solutions (i.e., symptom reduction only) as a way to reduce the pressure for reform. The House determined that this is not the way to go if we want to really solve the problem.
- Actuarially driven solutions (such as a cap on non-economic damages) must be part of the solution.
- It is intensely frustrating for physicians - trained and motivated to treat their fellow citizens - to see access to care suffer due to the problems of the tort system, but this is how the political system works.

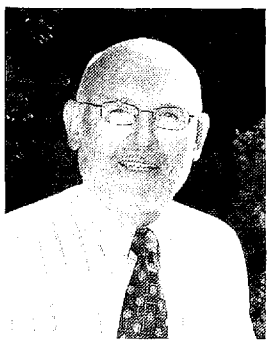
The House added a resolve to the campaign report that the WSMA work with all specialties, particularly those most urgently affected, to advance the need for immediate reform of the tort system. This was in addition to the resolves to work with the Liability Reform Coalition and that because an emergency exists in medical malpractice insurance and the tort law system that the WSMA make tort reform their highest priority at both the state and federal levels. ■

MultiCare

MultiCare Pain Management Service

Introducing...

Dr. Louis Jacobson



Dr. Brian Ready

DR. BRIAN READY, Pain Specialist, and the MultiCare Pain Management Service are pleased to announce that **DR. LOUIS JACOBSON** has joined the practice beginning Sept. 3, 2003. Dr. Jacobson will provide services at the Covington MultiCare Clinic in south King County as well as the Baker Center in Tacoma. ***To schedule patient appointments for either physician, please call 253-403-1375 or 1-866-235-1201.***

Dr. Jacobson was most recently with the University of Washington and practiced at the VA Hospital as the Co-Director of the Pain Service. Dr. Ready has practiced with MultiCare for more than two years as the Medical Director of the Pain Management Service and previously, he was the Interim Director of the University of Washington Multidisciplinary Pain Center. Both physicians provide a wealth of knowledge and experience to enhance the care of patients in pain.

The MultiCare Pain Management Service specializes in an interdisciplinary approach to complex pain management that offers comprehensive and holistic evaluations and treatments of acute pain, chronic pain and cancer pain. Multiple disciplines are utilized for treatment including high-tech interventional procedures, medical management and clinic massage. The MultiCare Mind/Body Medical Institute supports the Pain Management Service with an outpatient pain management clinic designed at Harvard Medical School to assist patients to manage and reduce their pain experience.

Services Include:

- **Comprehensive pain evaluations**
- **Diagnostic and therapeutic procedures**
- **Medication management strategies**
- **Multimodal therapy tailored to individual patient needs**
- **Patient self-care program, in collaboration with the MultiCare Mind/Body Medical Institute**

MultiCare Pain Management Service
253-403-1375 or 1-866-235-1201

General Membership Meeting Recap

by Jean Borst

Dr. Federico Cruz for Washington State Governor

Dr. Federico Cruz is running for governor because he believes he is "bold enough to move forward, sensitive enough to the needs of the people and their communities, and smart enough to take approaches that will actually work."

Appearing at the PCMS September General Membership Meeting, Dr. Cruz, director of the Tacoma-Pierce County Health Department, discussed his accomplishments, outlined his campaign strategies and convinced the audience why he should be governor. Above all, he came to ask for the Society's support. And before the night was over, that's exactly what he got.

In introducing Dr. Cruz, **Dr. Pat Hogan,** PCMS vice president and program chair, detailed his extensive professional background, humanitarian efforts, and devotion to preventive medicine. Since taking the helm at the Health Department in 1992, Dr. Cruz has made great strides and accomplishments. Dr. Hogan, who has worked closely with Dr. Cruz on tobacco issues over the years, said "he is one of the few individuals with the courage to face the tobacco industry head on without worrying about political fallout." He contended that same courage is what is needed in Olympia.

"We need someone who can make a change," Dr. Hogan continued. "This is an individual who is not afraid to stick his neck out and take chances. That's what it's going to take in our government to really shake things up. We can use this man as our agent of change. But he needs our endorsement, support and financial backing," he said. "There can be no better investment. He is a sincere, honest physician. He is a doctor who can make a change."

Dr. Cruz responded to the warm and welcoming reception saying, "I am proud to be here tonight, standing in front of you as a candidate for governor. Tacoma-Pierce County is my home, and you are my friends and colleagues. I'd like to think I've accomplished a lot here and tried to take on tough issues in the community. But I've had a lot of help. And I want to publicly thank you. We took on issue after issue, battle after battle. Quite honestly, without your support, we wouldn't have succeeded."

Dr. Cruz admitted that he's been asked - and sometimes wonders himself - why he is taking on the daunting task of running for governor. "A reasonable person would ask, 'Why are you doing this? Is it some midlife crisis? Do your meds need adjusting?' I have a wonderful job," he continued. "I feel like I've been very successful at it. I actually get paid more money than the governor makes. So what gives?"

"Our state is sick, and it needs a healer."

Dr. Federico Cruz
Candidate for Washington State Governor

Dr. Cruz explained that he strongly believes in this state and its people. "We have a lot going for us," he said. "We have a motivated work force. We're a transportation and military hub. We have a lot of high technology expertise here and tremendous natural resources. Yet," he continued, "things are sliding. Our economy is not in good shape. Many of our school systems are startling. We have transportation gridlock. The health care system is in crisis."

The roots of this decline are straightforward, he explained. "We lack leadership in our state government."

Simply put, Dr. Cruz is running for governor because he believes he is the type of leader we need now in this state. "I am not a professional politician," he said. "I'm a change agent. I have shown over and over again that I can take on the tough issues that undermine the health of our communities with heart, brains and guts. Our state is sick, and it needs a doctor."

A self-described tenacious individual, Dr. Cruz believes tenacity is exactly what is missing in our leadership. "The problems facing this state are deep seeded," he said. "They require a long-term commitment. They don't require quick actions driven by opinion polls. They require real solutions."

With health care obviously the overriding concern among the meetings attendees, Dr. Cruz explained that other candidates and the current leaders in Olympia do not have health care on their agenda. "Despite intense efforts and a clear message by organized medicine, there has been very little action," he explained. "And at the same time, health care costs are cannibalizing the state budget, and we have a medical malpractice insurance problem that is really undermining practices across the state.

"Health care is at the top of my list," he continued. "It's what I do. When I'm governor, we will have tort reform with MICRA at the heart of it. I will spend the energy and the political capital to see that it happens, so that our two favorite legislators — Pat Lantz

See Dr. Cruz, page 6

Dr. Cruz from page 5

and Frank Chopp — will not be able to delay the necessary legislation.

But, of course, Dr. Cruz said, health care is not the only area of concern. "I am a public health physician, so I am trained to treat sick communities," he explained. "Many parts of our state are sick, not just the health care system. I also have a great deal of experience working with criminal justice systems, public school systems, and private enterprise. Until state government operates differently, we are not going to make any progress unless change happens."

In his campaign for governor, Dr. Cruz carries a message of hope. "You can change state government. It's not just the structure that needs to be changed, it's the attitude. When you look at state government, they have a very clear attitude. They don't trust anyone. They battle, try to control everything, create more rules and regulations."

At the heart of the problem, Dr. Cruz explained, is the fact that with big government, it's virtually impossible to determine who is really responsible. "This really has to stop," he insisted. "We've got to break up this huge central bureaucracy and decentralize. We need to move resources back to the communities with the authority to make decisions. Big government smothers new ideas and initiatives. It makes a mockery of cost effective approaches. Our economy is suffering, and yet our state government really strangles the job creation. We literally cannot afford that."

The answer, he said, is to make government smarter. It's the only solution, and it can be done. "We need to elect a governor who cares about people in their communities, of course. But we need to elect a governor who understands discipline and who can bring new ways of doing business in state bureaucracy. Most important," he continued, "we need to elect a governor who has courage to take on the tough issues and stick with them. Our state is sick and it needs a healer. I am that person."

From Wisconsin to the Governor's Race

Most PCMS members are aware of Dr. Cruz's responsibilities and accomplishments during his tenure in Tacoma-Pierce County, but there is more to the journey that has brought him to where he is today - a journey that has taken multiple paths.

In a career that has spanned over 25 years Dr. Cruz has:

- Implemented health screening in migrant camps in central California.
- Provided basic health services for Native Americans on a North Dakota reservation.
- Volunteered in a disease prevention and hygiene program for Mayan Indians in the highlands of Guatemala for a year. From his experiences in Guatemala, Dr. Cruz recognized the need for and importance of preventive health. It has been his mantra ever since.
- Directed public health departments in Georgia, Colorado and Florida before coming to Tacoma.

Dr. Cruz has received numerous awards and recognition for disease control and prevention programs.

In addition, Dr. Cruz recently earned his black belt in Aikido after five years of intense study. Aikido is a martial art with a focus on self defense rather than punches and kicks. Just another demonstration of his commitment and tenacity.

Born in Wisconsin, Dr. Cruz's father was an immigrant from Mexico. In the United States, his father worked as a maintenance man in a factory and also acted as an interpreter for migrant workers. Dr. Cruz accompanied his father to migrant labor camps where he saw first hand the need for public health measures. He recognized early that his professional path would be in medicine. Following his undergraduate education at the University of Chicago, Dr. Cruz received his medical degree from the University of Wisconsin and masters degrees in public health and tropical medicine from Tulane University.

Vocal Support from PCMS

Following his brief speech and extended Q and A, PCMS Past President **Dr. Larry Larson** stood and said, "Dr. Cruz is an honest and hardworking person. I think he's crazy to run, and I've told him that before. We have a great opportunity to support a physician in our community who is willing to put himself on the line and run for state office in order to make our lives and our patients' lives better. I applaud Dr. Cruz for that."

Dr. David Sparling concurred. "I can't agree more that Dr. Cruz is indeed a tenacious individual," he said. "He has consistently demonstrated that he can identify and prioritize problems, and has the necessary expertise to carry out a thorough analysis of those problems. He also has the ability to bring together representatives of the community to collaborate to find solutions." Dr. Sparling then addressed Dr. Cruz directly. "If you do get into the governor's seat," he said, "I hope you will be able to carry on that same type of analysis and hopefully develop some resources and respect in the legislature so you are not beating your head against the wall."

Dr. Larson noted that the Republican Party as well as the local media haven't "exactly jumped up and down to support you," and asked Dr. Cruz point blank what he needed to become a successful candidate.

"I'm running as a physician," Dr. Cruz responded. "The public, the elected officials, the party leaders need to see organized medicine support me. If my base doesn't support me, what kind of candidate am I? First, I need physician endorsements across the

See "Dr. Cruz" page 8

The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

Federico Cruz-Uribe, MD

Meningococcal Disease

Washington's Department of Health has released information to educate college-bound students about meningococcal disease. Legislation passed recently requires higher education institutions with residential campuses to provide information on both the disease and the preventative vaccine. Colleges/universities must provide information to students including symptoms, risks, treatment, current vaccination recommendations from the CDC, and location of clinics that provide vaccinations.

While that information may prevent students from getting the disease, it will likely result in many questions. Here is some information that you may find useful.

• Meningococcal disease, an infection of the fluid of a person's spinal cord and the fluid surrounding the brain, is usually caused by a viral or bacterial infection and causes symptoms including: fever, headache and stiff neck in meningitis cases, and sepsis and rash in meningococcemia. The severity of illness and the treatment differ according to whether the disease is caused by a virus or bacteria. Viral meningitis appears to be less severe and resolves without specific treatment; bacterial meningitis may result in brain damage, hearing loss, or learning disability. *Streptococcus pneumoniae* and *Neisseria meningitidis* are the leading causes of bacterial meningitis; *Haemophilus influenzae* type b (Hib) led causes of bacterial meningitis until the early 90's, but new vaccines routinely given to all children have reduced the occurrence of invasive disease due to *H. influenzae*.

• Meningococcal disease strikes about 3,000 U.S. citizens annually, a number that has risen in the past ten years. College students, living in close contact with others in dormitory settings, comprise an average of 100 to 125 cases each year, of whom approximately 15 die from the disease.

• Students can transmit meningococcal disease to one another. Transmission generally occurs through direct contact with respiratory secretions from a nasopharyngeal carrier. Students should be reminded that sharing items such as food utensils or glasses, cigarettes, or engaging in intimate contact with an infected person increases the risk of many diseases, including meningococcal. A person in close contact with someone who has meningitis caused by *N. meningitidis* should receive antibiotics. The CDC no longer recommends use of antibiotics for contacts of a person with Hib meningitis disease if all contacts four years of age or younger are fully vaccinated against Hib disease.

•According to the CDC, in addition to college students in dorms, those at risk include infants and young children (for endemic disease), refugees, household contacts of case patients, military recruits, and people exposed to active and passive tobacco smoke.

• Vaccines exist against Hib, some strains of *N. Meningitidis* and many types of *Streptococcus pneumoniae*. In particular, the vaccines against Hib are very safe and highly effective. Vaccines to prevent meningitis due to *S. pneumoniae* (or pneumococcal meningitis) can also prevent other forms of infections from *S. pneumoniae*. The CDC recommends pneumococcal polysaccharide vaccine for all persons over 65 years of age and those who are at least two years old who have certain chronic medical problems. In addition to college-bound students, people with the following characteristics should consider vaccination:

- Anyone travelling or living in Sub-Saharan Africa or wherever the disease is common.
- Anyone with a damaged spleen or whose spleen has been removed.
- People with certain immune system disorders.
- Laboratory workers who may be exposed to the bacteria.

For more information, see the following websites:

The CDC:
http://www.cdc.gov/ncidod/dbmd/diseseinfo/meningococcal_g.htm

The DOH Immunization Program:
www.doh.wa.gov/cfh/immunize

Meningitis cases should be reported to the Tacoma-Pierce County Health Department (253-798-6410) to assure follow-up of close contacts and manage potential outbreaks.

Dr. Cruz from page 6

state, and I am starting with you. I need PCMS to formally endorse me. Second, I need you to help me make contact with your colleagues and get them involved. Third, I need to raise money - thousands and thousands of dollars. You are not a player if you don't have money. I don't like it, but that's the way it is. It's a long process. We have a year until the primary, so I have the time to take a grassroots kind of approach and raise the money step by step."

Without delay, a motion was put before the group to endorse Dr. Cruz in his candidacy for governor. It was seconded, a vote taken, and the motion passed.

It's just one step, but Dr. Cruz is optimistic about the road ahead. Anyone interested in helping make that road a little smoother is invited to contribute to Dr. Cruz's campaign. If you would like to make a donation, please make your check payable to "Dr. Cruz for Governor" and send it to:

Dr. Cruz for Governor
P. O. Box 11324
Tacoma, WA 98411-0324

Dr. Cruz can be reached at (253) 383-7744. ■

Questions and Answers with Dr. Federico Cruz

Dr. Cruz chose to set aside an extended formal speech at the PCMS General Membership Meeting and instead invited members to ask questions. Here is a summary of that exchange.

Q. **Why are you running as a Republican?**

A. Throughout my career, I have always had support from Republicans. I didn't have that support from the Democrats. I am at home with Republicans. The party believes that government can be changed.

Q. **You mentioned that you are an agent of change. Describe examples of changes you've made during your career?**

A. When I arrived here, the Tacoma-Pierce County Health Department was basically a large clinical agency — about twice the size it is now. We closed our clinics, changed our direction to focus on prevention, and shifted patients to private clinical settings. when I arrived, we probably spent 10 percent of our budget on prevention. And today, we probably spend 60 percent. That is a huge shift in direction.

In addition, I've taken on the most important issues that face our county: violence, drugs/alcohol/tobacco, and childhood obesity.

Another major accomplishment came about when the department became involved in the Tacoma-Pierce County criminal justice system about eight or nine years ago. One of our responsibilities was to get the system to think preventively, and our goal was to try and prevent crimes from happening in the first place. We targeted at-risk kids in middle school, and have seen great success with this program. The crime rate among kids has plummeted.

Q. **What is your position on women's reproductive choice/abortion?**

A. The question comes up all the time, and I have my public health response, which is choice is the law of the land and I support it, of course. But the real key is how do we avoid unwanted pregnancy. In public health, we do it two ways. We make family planning available and as accessible as possible in communities. And we do prevention. Focus on the old-fashioned word 'abstinence' and try to reach kids early with a clear message that it's better to wait. As a parent, this is absolutely the message we need to be giving our kids.

Q. **What is your plan for improving public education?**

A. My prejudice is to have local control and establish a local school board that actually sets rules for their school system. And the money raised centrally for the state should go to the local school board. If it doesn't work, we all know where responsibility lies.

School districts call the Health Department all the time about a variety of issues. To address these issues, we learned that we need to get in to the family setting to find out what is going on with these kids. We want the teachers to focus on teaching, not be social workers, mental health counselors, crisis counselors, housing counselors or surrogate parents. We pulled together community volunteers and developed a program that has been very effective. We reached 2,000 families last year. It's something that all school systems should put in place.

Q. **What are your views on mass transit?**

A. I'm all for mass transit, but there is no magic answer. But I have seen this state spend a huge amount of money and resources on studies and blue ribbon panels, but they tend not to go anywhere. Part of the problem is a leadership issue, and part of the problem is the reluctance of voters to spend the money. One thing is certain, we need to add capacity to the current system. I know we need to look at alternatives to cars, but first we need more lanes. How do we get people to change their behavior and convince them to

See "Q & A" page 16

In My Opinion.... The Invisible Hand

by Andrew Statson, MD

The opinions expressed in this writing are solely those of the author. *PCMS invites members to express their opinion/insights about subjects relevant to the medical community, or share their general interest stories. Submissions are subject to Editorial Committee review.*

Medical Courts

Andrew Statson, MD

"A great deal may be done by severity, more by love, but most by clear discernment and impartial justice."
Johann Wolfgang von Goethe (1825)

If you have visited the website of Common Good, you may recognize some of the following. Common Good is a strong advocate of Medical Courts. They see them as separate from the jury system, patterned after the Tax Courts and the Traffic Courts. The cases would be tried by judges who are familiar with medical procedures and terminology and who can call on experts to advise them on the issues.

At Common Good they also envision that compensation would be based on a table of injuries and disabilities, of a predetermined amount, similar to the workmen's compensation system. Virginia and Florida have made a weak attempt to do something like that with their Birth Related Injury Act. Its purpose was to take the children born with severe neurological impairment out of the tort system and compensate them based on their injuries and the evidence of malpractice.

Those systems work to the extent that they are used, but many people have tried to circumvent them and to go to a regular court. For that reason, the medical courts *must* replace jury trials. The problem with juries, stated briefly, is that they are inconsistent, unpredictable and emotional.

Jury selection is probably more important than the trial itself. It is an art, but it is helped by a significant amount of scientific material, describing the connection between the type of people and the kind of decisions they are likely to make as jurors. We are told we are judged by a jury of our peers, but we are not. The attorneys want jurors who are the least knowledgeable, so they cannot understand the complexities of scientific arguments, and who are the most emotionally unstable, so they can be swayed by the human tragedy when it is exhibited to them.

Guidebooks on jury selection proclaim that there is no such thing as an impartial juror and teach attorneys how to select winning juries. To quote Mark Twain, "The jury system puts a ban upon intelligence and honesty and a premium upon ignorance, stupidity and perjury. We swear in juries composed of fools and rascals, because the system excludes honest men and men of brains."

Several institutions have looked at the connection between medical errors and malpractice awards, among them Harvard and the Robert Wood Johnson Foundation. The Harvard Medical Practice Study reviewed 30,000 patient records at 53 hospitals in New York State and 67,000 court records. They found that only 2% of patients hurt by medical errors filed a claim. They also found that 80% of those who won a jury award were not injured by medical negligence.

Since juries are unpredictable, defendants, and even more so their insurers, are leery of going to court and are more inclined to settle a questionable claim, rather than to risk a disproportionate judgment. Since the jury decisions are inconsistent, we have no frame of reference to guide our conduct. Anything we do can be questioned. There is always someone who can say that we should have done something else.

Our tort system is out of control. In New York, 60% of the obstetricians, 60% of the orthopedic surgeons and 70% of the neurosurgeons have been sued at least once during the past five years. In Florida, depending on their location, obstetricians paid between $143,000 and $203,000 in liability premiums this year. For an obstetrician who does one hundred deliveries a year, that comes to $2,000 per delivery.

So getting the juries out of the picture will help enormously. The next questions about the Medical Courts is whether they should even consider negligence as a basis for awards or whether they should compensate patients regardless, simply on account of their injuries. There are advantage and disadvantages to both approaches.

If they compensate only for medical errors, the courts would have fewer cases, but the proceedings would be more involved, requiring proof of negli-

See "Courts" page 10

Courts from page 9

gence. Since many patients may have complications not related to medical errors, there will be fewer awards. However, as in the case of cerebral palsy children, more than 90% of them will not be eligible for help and their care will be taken over by the public assistance system.

The other option is to consider these courts as the solution to a social problem, similar to the workmen's compensation courts, where injured workers are compensated without consideration for any negligence on the part of their employer. If so, any patient with a serious complication will receive compensation. By removing the issue of fault from the court system, we may be better able to address the issue of medical errors openly and work on reducing them, without the veiled threat of a lawsuit now hanging over our head.

At the end of July, Wyoming Senator Michael Enzi introduced a bill, called the Reliable Medical Justice Act. The stated purpose of the bill is to restore reliability to the medical justice system and to foster alternatives to medical tort litigation that promote early disclosure of health care errors and provide prompt, fair and reasonable compensation to patients.

The bill aims to support and assist states in developing such alternatives by establishing state demonstration programs. It will provide up to seven grants for up to ten years to states willing to participate in this pilot study. Among the possible alternatives is the creation of special medical courts. The bill also provides for caps on noneconomic damages and for periodic payments. You can read the text of the entire bill in the library of Common Good on their website. It is sixteen pages.

This bill is a step in the right direction and, if passed, is much more likely to help us than any possible caps on awards. Only, I don't know whether we can last ten years to see the results of that pilot project, absent a massive increase in our reimbursement levels of at least 50%. We will not survive that long.

So far this year, two states have passed caps on pain and suffering. Nevada set it at $350,000 per defendant with a provision for higher awards at the discretion of the judge. Florida set it at $500,000 per defendant, with up to $2.5 million in "egregious" cases.

As I see it, the pain and suffering limitation is not for the patients' pain and suffering, but for the physicians'. They limit it for every individual physician, but the total award to the patient can still run into the millions. That only gives an incentive to lawyers to name as many individuals as possible in the suit. The more defendants there are, the more they can get for pain and suffering. So how is that going to reduce our premiums? ■

Holiday Cards

available from

PCMS Foundation

The Pierce County Medical Society Foundation is offering a special selection of Holiday cards this season for a special price of $12 for eight cards.

These beautifully designed cards feature the artwork of Laura Yu, daughter of **Dr. Amy Yu**. Laura designed the cards from 1999-2002 and they have been featured on the Holiday Sharing Cards for the past four years.

The four distinct water color designs are beautiful and creative and the inside of every card is blank so they may be used to send any holiday message. Envelopes included.

For more information, or to have cards mailed to you, call the Pierce County Medical Society at 572-3667.

IN MEMORIAM

ROBERT G. SCHERZ, MD

1929 - 2003

Robert Scherz, MD

Dr. Robert Scherz was born on August 13, 1929 in Alturis, California and died September 6, 2003 in Tacoma. He was 74.

After receiving his medical degree from the University of Oregon Medical School, Dr. Scherz completed his internship at Tripler Army Hospital and residency at Walter Reed Army Medical Center. In 1974 he retired from the military and served as Medical Director of Mary Bridge Children's Hospital and Health Center in Tacoma for the next 14 years. He is credited with helping to build Mary Bridge from a small community facility into a referral center for ill children from throughout Southwestern Washington who require specialized care.

Dr. Scherz excelled in the study of genetics and birth defects. He established a clinic which offered genetic counseling services while Director at Mary Bridge Children's Hospital and became a nationally renowned geneticist.

He also pioneered research, clinical studies and lobbied for the implementation of child resistant safety packaging to prevent accidental childhood poisonings. This effort led to a consumer protection bill that required hazardous household substances be marketed in child-proof containers. He was also an activist in the drive for child safety restraints in vehicles and for recreational safety.

Dr. Scherz joined the Pierce County Medical Society in 1974 and served on numerous committees and was active with the College of Medical Education.

Memorial donations may be made to the Mary Bridge Children's Foundation..

PCMS offers condolences to Dr. Scherz' wife, Joyce and their family.

Applicants for Membership

Bahram Kakavand, MD
Pediatrics
Northwest Children's Heart Care
314 ML King Jr Way #303, Tacoma
253-396-4868
Med School: University of Munich
Residency: University of Maryland
Fellowship: Medical College of Virginia
Addl: Med University of South Carolina

Kyong H. Kim, DO
Anes/Pain Medicine
Puget Sound Pain Clinic
11318 Bridgeport Way SW #A, Lakewood
253-983-9390
Med School: U of N Texas Hlth Science Ctr
Internship: Oakland General Hospital
Residency: Illinois Masonic Med Ctr
Fellowship: New England Med Ctr

Chris B. Stefanelli, MD
Pediatrics
Northwest Children's Heart Care
314 ML King Jr Way #303, Tacoma
253-396-4868
Med School: Creighton University
Residency: UW Children's Hospital
Fellowship: University of Michigan

Roland J. St. Hilaire, MD
Int Med/Gastro
Digestive Health Specialists
1901 S Union #B4006, Tacoma
253-272-5127
Med School: Northeastern University
Internship: Emory University
Internship: University of Cincinnati
Residency: University of Washington
Fellowship: University of Washington
Fellowship: UC San Francisco
Addl: University of Tennessee

Michelle M. Thurman, MD
Family Practice/Ob
Good Samaritan Family Medicine at South Hill
16515 Meridian E #104A, Puyallup
253-840-1859
Med School: Univ of California, Davis
Internship: The Williamsport Hospital
Residency: The Williamsport Hospital

SIDS Community Education Campaign

The United States' infant mortality rate dropped to another record low in 2001, in part because of an 11% decline in deaths from sudden infant death syndrome (SIDS). But the rate is still higher than that of other industrialized countries. According to the latest government statistics, the 2001 U.S. rate fell to 6.8 deaths per 1,000 live births from 6.9 the previous year, according to the Centers for Disease Control and Prevention. The rate has declined 38% since 1983. The CDC said that SIDS declined because of public health campaigns that encourage mothers to take such steps as making their babies sleep on their backs.

A national campaign (the "Back to Sleep" campaign) was launched in 1994 to promote supine positioning during sleep. Periodic surveys have confirmed that the prevalence of prone sleeping among infants in the United States has decreased from approximately 75% in 1992 to less than 25 % in 1995. Provisional mortality statistics suggest that the death rate from SIDS has simultaneously decreased by over 25 % - by far the largest decrease in SIDS rates since such statistics have been compiled.

The Tacoma-Pierce County Health Department has kicked off a community education campaign to help parents and caregivers reduce the high incidence of death from Sudden Infant Death Syndrome in the African American community. National Research has revealed that African American babies are twice as likely to dies of SIDS than white babies. The campaign is designed to bring together parents, grandparents, caregivers, and everyone concerned about the health of infants.

Please contact the Tacoma-Pierce County Health Department, 798-2860, for additional information or contact Shauna Weatherby at charlaloncarl@comcast.net.

For additional information about SIDS, the following resources are available:

Tacoma-Pierce County Health Department website:
www.tpchd.org/sids.htm

DSHS Safe Babies:
www. dshs.wa.gov/geninfo/babysafe.html

Washington State Dept. of Health Maternal and Infant Health:
www.doh.wa.gov/cfh/mch/MIHhome.htm

SIDS Foundation of Washington:
www.sidsowa.org

Back to Sleep Campaign:
1-800-505-CRIB ■

COLLEGE OF MEDICAL EDUCATION

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, 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, 2002.

Reservations can be made by calling toll free at 1-866-788-5588. You must identify yourself as a part of the C.O.M.E. group. For more information call the College at 627-7137. ■

Whistler CME set January 28-31, 2004 Condo Reservations/Course Registration Open

Registration is open for the College's CME at Whistler/Blackcomb program. The conference is scheduled for January 28-31, 2004.

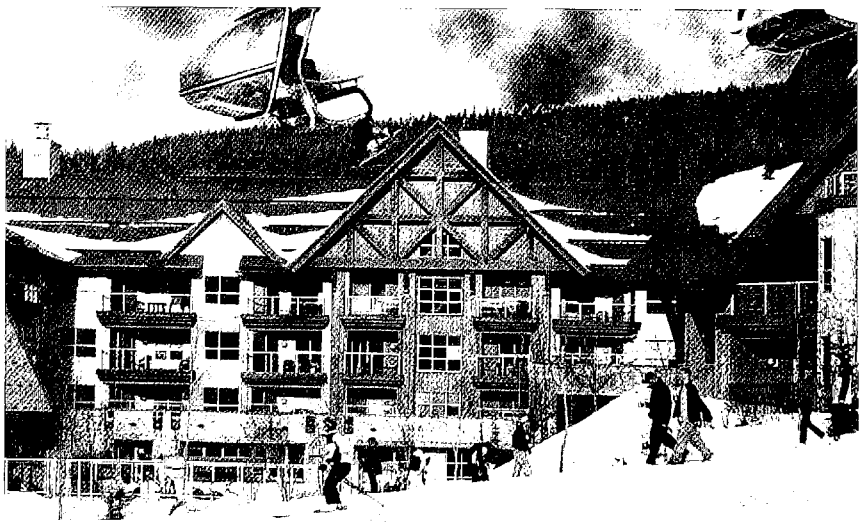
The College of Medical Education has again selected the Aspens Condos for accommodations because of the very competitive rates (compared to hotels and other condos) and quality of the lodging. These negotiated group rates will remain the same as last year, and combined with the Canadian/U.S. exchange 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 program will focus on *prevention* and *wellness* and will include addresses on:

- Advances in the Prevention and Early Detection of GI Malignancies
- Mood Enhancement and the Regulation of Feeling
- Proactive Approach to Musculoskeletal Injury and Degeneration
- Type II Diabetes and Metabolic Syndrome: Prevention and Management
- The Top 10 Nutrition Strategies for Wellness
- Screening for Colon Cancer with CT Colonography
- Avoiding Cardiac Disease: New Guidelines and More
- Domestic Pox and Parasites We Can Prevent ■



The Aspens, the conference loding and meeting location, is situated on the slopes of Blackcomb Mountain with ski-in/ski-out steps to the chair

COLLEGE OF MEDICAL EDUCATION

Continuing Medical Education

ID Update set for November 7, returning to Sheraton this year

The annual Infectious Diseases Update is set for Friday, November 7, 2003. The very popular course will return this year to the Sheraton Hotel - in the hotel ballrooms.

The program is directed by **Jim DeMaio, MD** and will feature nationally known expert David Nicolau, PharmD, FCCP, joining Infections Limited physicians as they give presentations on specific disease areas.

This year's program inlcudes presentations on:

- Update on Immunizations
- A Bug In Your Eye: Ophthalmologic Infections You Need to Know
- Prevention and Worrisome Diseases: Monkey Pox, SARS, West Nile Virus and other Arboviruses
- Common Respiratory Germs: How Contagious Are They?
- Contemporary Issues in the Management of Clinically Acquired Respiratory Diseases
- New Hot Topics in the ID Literature
- Innovations in Understanding and Treating Hepatitis B and C
- Maternal Fetal HIV ■

New Men's Health CME set for December 5, 2003

A new program dedicated to men's medicine for the primary care physician is set for December 5, 2003

The one-day review, directed by **Michael Kelly, MD**, will address a variety of timely subjects relative to contemporary medicine for men. Designed for the primary care physician, the course will cover a broad spectrum of topics including erectile dysfunction, prostate cancer, BPH, and much more. The program will focus on diagnosis and treatment advances in treating illness in men. ■

CME at Hawaii - Hotel, Flight Reservations Urged

Those interested in attending CME at Hawaii are urged to make plans now for both air transportation and lodging.

All Wanderlands Travel, specifically Jeanette, 572-6271, is prepared to assist you in securing your seats.

To take advantage of the reduced rates at our conference hotel - The Hyatt Regency Kauai - you can call directly to 1-808-742-1234. ■

Dates	Program	Director(s)
Friday, November 7	Infectious Diseases Update	James DeMaio, MD
Friday, December 5	Advances in Men's Health	Michael Kelly, MD
Tuesdays January 13; 20	Cardiology for Primary Care	Gregg Ostergren, DO
Wednesday-Sunday Jan 28 - Feb 1	CME @ Whistler	John Jiganti, MD Rick Tobin, MD
Friday, February 6	Primary Care	TBA
Friday, February 27	Endocrinology for Primary Care	Ronald Graf, MD
Thursday-Friday March 11-12	Internal Medicine Review 2004	Gurjit Kaeley, MD
Monday-Friday April 12-16	CME at Hawaii	Mark Craddock, MD
Friday, April 30	Allergy, Asthma & Pulmonology for Primary Care	Alex Mihali, MD
Friday, May 21	Advances in Women's Medicine	John Lenihan, Jr., MD

Questions and Answers with Dr. Federico Cruz (cont. from page 8)

use alternative transportation? It's a tough sell with our geography, but we need to try. There needs to be some type of rail system and some way of increasing telecommuting, ride share and other alternatives.

Q. How far should state government go in offering special favors to big companies to keep their business in the state?

A. If you're trying to lure a business to a community from the outside, that's one scenario and it has been very successful. Once they're here, they should be treated like all the other businesses, because frankly there are many small businesses that when you add them all up employ more people than Boeing. Should we make a special deal for Boeing? No.

Q. Can you expand on access to doctors?

A. The piece that the state needs to be most concerned with is how we provide care to the disabled, the poor elderly and to mothers and children who are low income. We have a poor system now, as you know, for many reasons. Bush is trying to change Medicaid and is proposing to states that they will receive a certain amount of funding based on past usage and cap it. In return, states will have control. What a wonderful opportunity to look at redesigning the system with common sense. Because there would be a cap, there are not unlimited dollars. It will be difficult. Everyone will have to work hard to make it work right.

In 1992 when I got here, we spent about a billion dollars on state health care in Washington. Last year, we spent $17 billion. You just can't sustain that kind of growth.

Q. The State makes it difficult for doctors to do their job if they are accepting Medicaid. What are your thoughts on that?

A. It's a very complicated issue, but the simple model I've pushed with the state legislature has the money going to a local consortium - hospitals, clinics, providers, health departments. You design the basic package of services that makes sense for your community. You decide on a local level. I wouldn't look for an answer from Washington, D.C. They don't have an answer. I wouldn't look for an answer in Olympia. They don't have an answer. You have to build your answers locally. The trick is getting the resources that are controlled now by the legislature and federal government and have them filtered down locally.

Q: You are looking at a room full of business people. Many of us have our own businesses. There is a business unfriendly environment here in this state. What specific ideas do you have to deal with this issue?

A. I talk to many business people around the state and they say the same thing. They talk about how unfriendly and how unresponsive state government is. At the Health Department, we regulate the food industry in the county. Anyone who handles food in any shape, way or form — we inspect. When I started my job at the department, I asked to be shown the rules and regulations the state gives us to enforce. The pile of paper was huge. I asked, 'How many of these papers deal with real public health threats?' Twelve pages. So my direction to my manager and staff was, 'Enforce the 12 pages. The rest of it, you can talk about it and educate people about it, but those 12 pages are what you need to enforce.' That was a tremendous weight lifted from the business owners and provided them a great deal more flexibility and the ability to be more profitable. For us, we still protect the public's health. You have to step in and say, 'What's important?' That's a mindset change, and it has to start at the top. ■

In My Opinion....

by Teresa Clabots, MD

The opinions expressed in this writing are solely those of the author. PCMS invites members to express their opinion/insights about subjects relevant to the medical community, or share their general interest stories. Submissions are subject to Editorial Committee review.

The Biggest Sacrifice of All

Teresa Clabots, MD

My big brother was climbing a dresser when it fell over on him. He broke his toe and received lots of attention. I was the one who ran to get help for him. I was barely five years old. I decided right then and there it would be cool to be a doctor.

Grades were very important in our family. We were rewarded with one dollar for each "A." My grades were excellent in Cuba and in Spain, but when we came to America, I had to learn English. My grades were D's the first year, then within two years I had gone from D's to A's.

My most difficult subject was spelling. English was not at all phonetic, and it was hard to figure out how many f's were in giraffe, how telefon was incorrect, and other archaic rules that made no sense. I worked so hard at it with my mom, that eventually I was the school spelling bee champ, and went to compete downtown against other schools.

My father was very proud, and he took me to the event. I really wanted that college scholarship, but I missed a word. So as a consolation prize he took me to get my first real hamburger and a real chocolate malt shake. It was delicious. It was American.

College expenses and medical school expenses were paid with the help of my sister. While I sold my blood and worked as a hospital technician on the weekends, she worked as a waitress (giving me all her tips) and also worked in a blood bank. She put herself through nursing school and then went on to become a nurse anesthetist.

I paid her back slowly over the years. She never charged me interest. It has been 20 years since I paid my sister back.

Many years later, as we were discussing our children's educational aspirations, their colleges, their grades, and possible things we would have done different, she said to me, "I wish I had gone to medical school."

I wasn't sure what to say. I knew she was just as smart and even harderworking than me. I had assumed she had gone to nursing school because that was what she wanted.

No, she said. She had given up her aspirations to go to medical school to help put me through school financially. She knew that as soon as she finished nursing school she could start making money and helping the rest of the family financially.

I am not sure I can ever repay her for the ultimate sacrifice she made for me. ■

Directory Changes

Please make the following changes to your 2003 Physician Directory:

Marvin Brooke, MD
Change office address and phone to:
1011 E Main Ave #302, Puyallup 98372
206-362-2464

Efren Caratao, MD
Change office address to:
24400 - 104th Ave SE, Kent 98031

Eduardo Cuevas, MD
Change office address to:
1901 S Union #A114, Tacoma 98405

Mazen Dahan, MD
Change office addresses to:
120 14th Ave SE #A, Puyallup 98372 and
6002 N Westgate Blvd #290, Tacoma
98406
(All mail to Puyallup address)
Change fax # to 841-1801

Tammy D'Souza, DO
Change office address and phone to:
3908 10th St SE #200, Puyallup 98374
848-5951
845-7073 fax

Kenneth Feucht, MD
Change office address to:
1519 3rd St SE #230, Puyallup 98372

Sandra Frister, MD
Change office address and phone to:
1409 2nd Street SE, Puyallup 98372
770-3939
770-9931 physicians only
770-9982 fax

Michael Jarvis, MD
Change office suite number to #104

Douglas King, MD
Change office address to:
1519 3rd Street SE #230, Puyallup 98372

Michael McDonough, MD
Change office address and phone to:
1802 S Yakima #103, Tacoma 98405
272-1077
272-7054 fax

Robert Marsh, MD
Change office address to:
1519 3rd St SE #230, Puyallup 98372

Carlos Moravek, MD
Change office address and phone to:
1901 S Union #B7011, Tacoma 98405
627-0762
572-9562 physicians only
572-9560 fax

Timothy Neff, MD
Change office address to:
521 ML King Jr Way, Tacoma 98405

Larry O'Bryant, MD
Change office address and phone to:
407 14th Ave SE, Puyallup 98372
770-5647
770-5181 fax

Esther Park-Hwang, MD
Change office address to:
521 ML King Jr Way, Tacoma 98405

Bradley Pattison, MD
Change office address and phone to:
PO Box 1956, Tacoma 98405
627-4930

Sandra Reilley, MD
Change office address and phone to:
1401 N 5th Street, Tacoma 98403
593-5304 (ext. 382)
686-2840 physicians only
305-9890 fax

Mary Ellen Martinez, MSN ARNP
(Nurse Practitioners Section - page 271)
Change address and phone to:
5920 100th St SW #30, Lakewood
98499
584-1700
581-1470 fax

Classified Advertising

POSITIONS AVAILABLE

Internal Medicine. Auburn, WA. IM group of 10 seeks a B/C part-time physician to job share with a female internist. Position has both inpatient and outpatient responsibilities. The practice is located within 30 minutes of downtown Seattle. Excellent benefit package and salary guarantee. Three year Internal Medicine residency in accredited U.S. program required. Please visit our website at www.multicare.org to learn more about MultiCare Medical Group. Submit CV with references to: Provider Services, MultiCare Health System. Email: provider services@multicare.org. Fax: 866-264-2818. Or Mail to: Provider Services, PO Box 5299, H2-PHYS, Tacoma WA 98415-0299. This position does not qualify for J-1 Visa waiver. "MultiCare is a Drug Free Workplace"

POSITIONS AVAILABLE

Washington State Division Of Disability Determination Services. Medical Consultant Positions Available. The State of Washington Division of Disability Determination Services seeks physicians, including psychiatrists to perform contract services in the Olympia office. Contract services include the evaluation of mental impairment severity from medical records and other reports, utilizing Social Security regulations and rules. Medical Consultants function as members of the adjudicative team and assist staff in determining eligibility for disability benefits. **Requirements**: Current Medical License in Washington State. Board certified desirable. **Reimbursement**: $57.01/HR. Interested physicians should contact Gene Profant, MD, Chief Medical Consultant at (360) 664-7454 or Mary Gabriel, Regional Manager, North at (360) 664-7362 or Sheila Davidson, Regional Manager, South at (360) 664-7365.

POSITIONS AVAILABLE

Tacoma/Pierce County outpatient general medical care at its best. Full and part-time positions available in Tacoma and vicinity. Very flexible schedule. Well suited for career redefinition for G.P., F.P., I.M. Contact Andy Tsoi, MD (253) 752-9669 or Paul Doty (Allen, Nelson, Turner & Assoc.), Clinic Manager (253) 383-4351.

Established Auburn Family Practice seeking Board Certified or Board Eligible physicians to join our group. Base salary plus incentive program for motivated Doctor. Part time or full time hours available. Fax CV to 253-839-5565.

PRACTICES AVAILABLE

Family Practice with equipment for sale in Federal Way, WA. Max Waldron, DO is retiring in December, 2003. Excellent opportunity/ very reasonable terms. Call 253-925-0672 or e-mail: maxwdoc@sysmatrix.net.

OFFICE SPACE

For Rent: 3300 sq ft Class A medical office in Tacoma Medical Center, 1112 6th Ave, third floor. Elevator, underground parking, close to hospitals. Call 253-272-2224.

Pierce County Medical Society
223 Tacoma Avenue South
Tacoma, WA 98402

Return service requested

PRESORTED
STANDARD
US POSTAGE PAID
TACOMA, WA
PERMIT NO 605

Pierce County Medical Society

BULLETIN

November, 2003

WSMA Delegates - Your Leadership

Pictured above are delegates that represented Pierce County at the WSMA Annual Meeting in Yakima. Pictured clockwise from back left: Drs. Joe Regimbal, Patrice Stevenson, Steve Duncan, Pat Hogan, Sumner Schoenike, Ron Morris, Richard Hawkins, Don Russell, Nick Rajacich, Joe Jasper, Laurel Harris, Sue Salo, David Munoz and Ken Feucht

See story page 4

INSIDE:

The Bulletin is published monthly by PCMS Membership Benefits, Inc. Deadline for submitting articles and placing advertisements is the 15th of the month preceding publication.

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 PCMS. Acceptance of advertising in no way constitutes professional approval or endorsement of products or services advertised. The Bulletin reserves the right to reject any advertising.

Managing Editor: Sue Asher
Editorial Committee: MBI Board of Directors
Advertising Information: 253-572-3666
223 Tacoma Avenue South, Tacoma WA 98402
253-572-3666; FAX: 253-572-2470
E-mail address: pcmswa@pcmswa.org
Home Page: http://www.pcmswa.org

Pierce County Medical Society
BULLETIN

November, 2003

Table of Contents

President's Page

by J. James Rooks, Jr., MD

Positive Changes

J. James Rooks, Jr., MD

Recently, our President-Elect, **Mike Kelly, MD** brought an interesting article to my attention from the *American Medical News*. The state of Texas recently passed a medical malpractice ballot initiative, Proposition 12, which appears to actually do something that helps physicians decrease their liability premiums. This measure amends the Texas Constitution to allow caps on noneconomic damages in medical malpractice lawsuits. Apparently, within days of the passing of this bill some insurers in that state announced plans to reduce liability insurance rates, i.e., the Texas Medical Liability Trust, the state's largest medical liability insurer, said it would cut premiums 12% beginning January 1, 2004. The article went on to say that the AMA contributed $100,000 to support the initiative. This leads me to believe that such action could take place in Washington, if we all continue the work that we have started this year, and it looks like there's support out there from national organizations if we care to use them.

Dr. Bill Roes will soon be contacting all Gig Harbor physicians about a plan to give patients cards to sign and send to their state representatives outlining the crisis we face in health care and their support for corrective action. We really appreciate his volunteering on his own to undertake this project, and I hope all of you will assist him in this effort. The cards for patients to sign and mail will be available to any Pierce County physician who wishes to use them. This was Bill's own idea, and I know that many of you out there have similar great ideas - LET US KNOW! In the long run, actions like this can cause positive changes.

Another idea came out of the state of New Jersey which was noted on the American College of Surgeons website. The doctors there conducted a campaign that they termed "House Calls" in which they went door-to-door in their own neighborhoods informing people of the liability crisis that they face. From what we are told, this was met with successful encounters with the public and received positive publicity for change. This may be an intermediary step before more radical measures are undertaken.

On October 21, President-Elect Mike Kelly and I attended a meeting with WSMA leadership for county society leaders; and we found it quite informative. They told us there are 6,489 licensed physicians paying malpractice insurance premiums, and they estimate the average payment is $20,000 per year per physician (I'd love to see one that low). That's $129,780,000 we're all spending on insurance! The average lawyer gives over $200 to fight for their causes, yet the average physician payment to WAMPAC is around $8. WSMA is starting their Campaign for Tort Reform (one of our members recommended the term "lawsuit reform" instead), and will be sending out more information soon. Many of you have already contributed to WAMPAC - I recently sent in my own $250 for this cause and thank all of you who have done likewise. It will require a state constitutional amendment, and the latest thinking is that more can be accomplished at the state level than at the national level.

Finally, I hope all of you will attend the annual meeting in December. Mr. Rick Steves, who has the "Europe Through the Backdoor" series on PBS and is from Edmonds, WA, will be our speaker. He is fascinating to hear and I believe it will be an enjoyable time. Hope to see you there. ■

WSMA Annual Meeting Recap

WSMA sets organizational priorities

The WSMA Annual Meeting, held at the Yakima Convention Center in late September, was well attended by representatives from Pierce County.

Representing Pierce County were PCMS Board members - **Drs. Pat Hogan, Steven Duncan, Ken Feucht, Laurel Harris, Joe Regimbal, Ron Morris, Susan Salo** and **Joe Jasper**; WSMA Board members **Len Alenick, Nick Rajacich** and **Patrice Stevenson**; WAMPAC Chair **Don Russell**; and alternate delegates **Sumner Schoenike, Federico Cruz, Richard Hawkins** and **Robert McAlexander**.

The following outlines the organizational priorities approved by the House of Delegates, the policy setting body of the organization:

WSMA Organizational Priorities (Report G)

RESOLVED, that the WSMA focus its priorities in support of its mission to:

A. Promote and protect:
The value of medicine
The "soul" of the profession
The joy of being a physician

B. Ensure for our communities and patients that "your physicians will be there for you"; and

C. Continue to work in our communities and legislature to improve patient access to physicians: and BE IT FURTHER

RESOLVED, that the WSMA focus its resources on the following organizational priorities:

I. Enacting tort reform by:

A. Using our public education and media advocacy programs to build further support for tort reform[1].

B. Raising additional funds via the Campaign Fund For Tort Reform to support our efforts.

C. Working with allies on this issue to push for legislative action.

D. Supporting incumbents and candidates for office who support tort reform and opposing those who do not.

II. Promoting medical practice viability, including administrative simplification, by:

A. Educating the public and promoting specific solutions to the funding and marketplace problems of health care today, including Medicare and Medical Malpractice/Tort Reform as focal point issues in the campaign.

B. Maintaining and building medical practice revenue whenever - and by whatever means possible - including (but not limited to):

1. Seeking better funding for public programs (Medicare, Medicaid, Basic Health Plan), working with any coalition that will promote adequate funding of public programs via legislative action, initiative and/or legal action; conversely, opposing legislation or initiatives that would weaken existing funding.

2. Taking legal action as necessary to support a more balanced relationship between health plans and medical practices, and government and medical practices.

3. With regard to Medicare:

a. Seeking more funding for physician services while reducing state-by-state per capita funding disparities, with the definition of "adequate funding" to be that which is sufficient to bring physicians back into the program (i.e., it is, ultimately, a market issue), and reducing the disparities from state-to-state[2] (rejecting the customary argument that Medicare funding must be a "zero sum game").

b. Continuing to educate members on how to "opt out" of Medicare or go "non-par" within the Medicare program.

C. Seeking changes in the private marketplace to promote new products or market approaches that support medical practice needs.

D. Seeking reduced medical practice administrative expense, administrative simplification, reduced opera-

See "WSMA" page 16

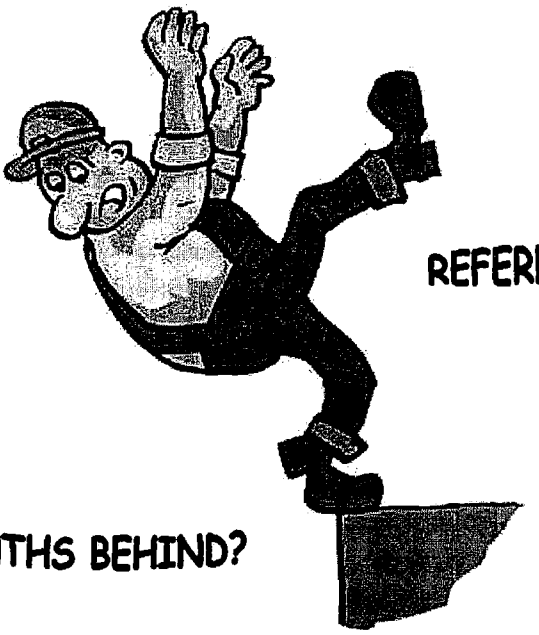
[1]As has been the case in the past, this effort will include companion work to promote patient safety, quality, accountability and error reduction.

[2]It has not failed notice that there appears to be a significant correlation between states that have a much higher per capita Medicare expenditure history and their higher than normal utilization rates.

Pierce County Medical Society
Membership Benefits, Inc.

FALLING BEHIND?

FILING ADDING UP?



REFERRALS STILL ON HOLD?

COLLECTIONS MONTHS BEHIND?

We have a surplus of top notch, experienced candidates
for all clerical and clinical positions.

FROM RECORDS TO NURSING
& EVERYTHING IN-BETWEEN

1 DAY TO 3 MONTHS

Pierce County Medical Society
Medical Employment Service
(253) 572-3709
Ask for Deborah or Melissa

NOT JUST TEMPS...

FULL TIME AND PART TIME EMPLOYEES ALSO AVAILABLE

Please visit our website or give us a call for more information
(253) 572-3709 pcmswa.org

Special Feature

by Jean Borst

A Good Life, a Wonderful Career, a Happy Ending, a New Beginning

Pat Duffy, MD

After more than 50 years of practicing medicine in Pierce County, **Dr. Pat Duffy** attributes a simple philosophy to his longevity and success. "My minor contribution in how to be successful is to always sit down and look your patient in the eye, ask them to talk to you, and listen," he said. "As my professor once told me, if you listen long enough, they'll tell you 90 percent of the time what is wrong with them." This youthful 80-year-old Sumner resident spent a career listening to the needs and concerns of his patients, his family and the community. And while he made his retirement official this month, his legacy will likely go on forever.

How the Journey Began...

Dr. Duffy was born and raised in the small mid-western town of Bussey, Iowa. "There were 400 people when I was growing up, and there are 410 now," he joked. "Not much has changed in all that time." One of seven children, Dr. Duffy's father was a dentist who shared an office with a local physician. "The original plan was that my older brother would be the dentist in the family, and I would be the doctor," he recalled. His brother ended up choosing a life-long career with the government while Dr. Duffy followed the "original" plan.

Dr. Duffy was only 16 when he began college at the University of Iowa in 1940. "I was green, green, green," he recalled. During his junior year, he married his first wife. He entered medical school in 1943, and essentially attended classes year round. "One school year would end on Saturday and the next would begin on the following Monday," he explained. At the time, there were two options for someone in Dr. Duffy's situation. "You had to either attend school, or get drafted and shot," he said. "I really didn't like the last option." Dr. Duffy was only 22 when he completed medical school in February of 1946, and still holds the record as the second-youngest graduate of the U of I medical school.

The military paid for two years of Dr. Duffy's schooling in return for two years of military service. After finishing his internship at Providence Hospital in Detroit, Dr. Duffy arrived in Seattle and prepared to ship out to Japan. Two days before his scheduled departure, he was pulled off orders and assigned to the base hospital at Fort Lawton (now Seattle's Discovery Park) for two years. "There were 12 physicians there, and we were all in same boat," he recalled. "We were all young, foolish, and married with children. It was a great two years off," he continued, adding that the group spent most of their time playing tennis and golf.

The week he was discharged from the army, Dr. Duffy returned to Bussey under unhappy circumstances. His father had passed away, and he was returning to help settle the estate. He stayed for a year- practicing in Dewitt, Iowa - but suffered severely with hay fever and asthma he had contracted while in the army. Following a 20-day stay in the hospital, his allergist told him he needed to live in a different climate and offered two options: the state of Maine or within 30 miles of Seattle, Washington. "It was an easy decision," he said. He and his wife and three children headed back to the Northwest. He had been working at the new Indian Hospital - which was recently torn down - for a year when he heard that a Sumner practice was looking for a physician. Dr. Duffy met with **Dr. Charles Denzler**, a senior partner at the time, and summed up the interview:

Dr. Denzler: "Are you married?"
Dr. Duffy: "Yes."

Dr. Denzler: "Do you have children?"
Dr. Duffy: "Yes."

Dr. Denzler: "Have you ever been in jail?"
Dr. Duffy: "No."

Dr. Denzler: "Do you have a license?"
Dr. Duffy: "Yes."

Dr. Denzler: "Come to work for $750 a month."

"And nearly 52 years later," he said, "I'm still here."

A Career that's Spanned over 50 Years

In over 50 years practicing medicine in East Pierce County, it's an amazing understatement to say Dr. Duffy has seen his share of changes.

Dr. Denzler, **Dr. Tom Clark** and Dr. Duffy were the original partners. "Dr. Denzler and Dr. Clark were excellent mentors," Dr. Duffy recalled. "The three of us worked 35 years together."

There have been numerous changes over the years: **Dr. Fred Leitz** eventually joined the practice and when Dr. Duffy became seriously ill, Dr. William Biljan

See "Dr. Duffy" page 7

Dr. Duffy from page 5

joined the practice, followed by **Dr. Robert Corliss**. Dr. Corliss' father, the late Dr. Joe Corliss, was an optometrist and very good friend of Dr. Duffy's. When Robert graduated from high school, Dr. Corliss asked Dr. Duffy, "Do you suppose you can hold on until Robert gets out medical school?" "I told him, 'Joe, I cannot hold on that long.' He's been with us almost eight years." The newest member of the practice, Dr. Bruce Baker, joined the group two years ago.

"It's been a great career," he said. "When I first started here, we did everything," he recalled. "Whatever walked in the door, we took care of it - from fractures to upper respiratory infections. We did it all."

It was not unusual, Dr. Duffy recalled, to see 50 patients in one day. "We worked from dawn until dark." During one June, the physicians performed 35 tonsillectomies in the office. "We never lost anyone," he said. "We never even had any serious consequences."

As time went on and more specialists came into the area, the practice took on fewer emergencies. But until that time, "We were expected to deal with everything," Dr. Duffy said. He recalled an evening when a patient arrived at the office with a compound leg fracture. There was only one orthopedic specialist in Tacoma at the time, and he was unavailable. "All three of us were in the office that night and all three of us were determined to save this man's leg," Dr. Duffy said. "So, we went down to the hardware store to get a large screw with a nut on the end of it. We came back and put it through his tibia. In a year, he went back to work. It was an unbelievable recovery."

Over the years, Dr. Duffy delivered about 2,500 babies at Good Samaritan Hospital. "I told my patients that every fifth baby I delivered was free," he recalled. "I think I gave away four."

Those first few deliveries were made under the light of a gooseneck lamp in the old hospital. In the mid-1950s when the new hospital opened, the conditions weren't much better. The facility was struggling to stay in operation and was unable to pay its bills. "They asked each of the 14 physicians to contribute $1,000 to keep the hospital open," Dr. Duffy said. Thirteen made the contribution without a second thought. "I don't think physicians would do that kind of thing today," he said. "It's a totally different climate, and there are a lot of negative feelings out there. When I hear negative comments from other physicians, I try to joke and tell them, 'You're getting paid too much.' It breaks the ice and hopefully makes them realize how fortunate they are."

But, he admits, "It was much easier to practice medicine in those times. For several years, Dr. Duffy visited a homebound patient once every two weeks. "I always made sure that was the last house call of the day," he said, "because her husband always insisted I have a glass of his wine. Then I'd walk the two blocks to my house."

His memories are fond, and he says he was "lucky enough to practice during the best medical climate. Now, we are reaching a crisis-not only in regards to malpractice insurance, but in the way we take care of patients and the way we get reimbursed for taking care of patients. Something is going to change," he continued, "and I'm very much afraid that we might end up with a two-tiered system — those who have and those who have not. I hope that never happens. I think we're making progress in regard to malpractice reform, but it's very slow progress. We need to get that situation somewhat straightened out, along with Medicare and financial drug support. I don't think the government can print enough money to have drugs totally taken care of by Medicare." In addition, Dr. Duffy is concerned because, "so much of the medical dollar is spent for defensive medicine."

So, in this volatile climate, what does he offer to his colleagues currently practicing medicine or those considering a medical career? "I can't totally endorse the profession anymore," he said. "It's a good living if you want to work hard, but I don't know if I would encourage anyone to become a physician."

"Everyone should have this Kind of Life..."

Once Dr. Duffy arrived in Sumner, he arrived for good. "I never thought about leaving," he said. "God's been good to me. Life's been good to me." But the road wasn't always smooth. His first wife died in the 1960s, leaving her husband and six children behind. Two years later, he married his second wife, Susie, a widow who had two children of her own. Theirs is a story of his, hers and ours. Their combined family of eight children later welcomed the arrival of a daughter. "It's been an unbelievable life," he said. "Most everybody should have the kind of life I've had. Even with the bumps we've had." The Duffy's recently celebrated their 37th wedding anniversary.

"For the first 25 years of our marriage," Dr. Duffy said, "all we did was raise children. Our goal was to get them all through college, which we did." Four of the kids went on to get advanced degrees.

Dubbed "Mr. Sumner" by daughter Jill Duffy-DeGoede, Dr. Duffy has been an integral part of the East Pierce County community he's lived and worked in for so many years. He has been the physician for Sumner Spartans football team for over 40 years, and was also involved in the building of the high school football stadium. He remains actively involved with his church, St. Andrews Catholic Church, and he still attends Sumner City Council meetings. In the 1980s, Rotary International led a campaign to eliminate polio, and Dr. Duffy spearheaded the efforts in the Sumner branch. Two of his daughters are elementary school teachers, and he makes regular "house calls"

See "Dr. Duffy" page 14

IN MEMORIAM

JAMES T. GILLESPIE, MD

1931 - 2003

James Gillespie, MD

James Gillespie, MD died in a small plane crash in Oregon on October 18, 2003 with his wife Jessie. He died while flying his plane which has given him a great deal of joy since his retirement from clinical practice in 1997.

Jim was born in Honolulu, Hawaii in 1931 and raised in a military family. He was a retired Colonel in the U.S. Army having served for 22 years (1956-1978). He was trained as a general and thoracic surgeon and served as chief of surgery at Madigan Army Medical Center from 1974-1978. After retiring from the military he practiced in the Tacoma medical community until his retirement in 1997.

Jim earned his undergraduate degree from Stanford University as well as his Medical Degree from the Stanford University School of Medicine. He joined the Army after graduation and did both his internship and residency at Walter Reed Army Hospital. He completed his graduate training in thoracic surgery at Letterman from 1965-1967.

Jim and I first met in 1969 when he was chief of thoracic surgery at Madigan and I was a first year resident in general surgery. He had completed a tour of Viet Nam at the 91st Evac Hospital in 1968. We have practiced in the same medical communities since we first met and he was a friend, a teacher, a mentor, a mountain climbing partner and a patient of mine. He was a cancer survivor.

We were both members of Pierce County Medical Society and Washington State Medical Association, Fellows of the American College of Surgeons and members of the North Pacific Surgical Association. Our professional affiliations are numerous. Jim practiced at Western Clinic after he retired from the Army and remained with the original group from 1978-1997 including the time they transitioned to the Fransiscans (Medalia).

My memories of Jim are too numerous to recount here and could fill a whole evening of story telling. He was truly a unique individual who was not easy to get to know, but once you learned how to relate to him he was fun to be around. Understanding his sense of humor was key and he was an expert at verbal jousting. He loved to "live on the edge" and he took part in many activities throughout his life that challenged him physically and mentally. He recounted many stories of polar bear hunting in Alaska, scuba diving in the South Pacific, mountain climbing in Africa, Asia and the United States, flying his plane all over America and being a paratrooper and physician in the U.S. Army Special Forces. He ran one mile a day most of his life.

Jim touched the lives of many people in this community and in the short time since his death I have talked to physician colleagues, patients and hospital personnel who worked with him. They have described his as "a man for all seasons," "a man of few but well chosen words," "a crusty, unique individual" and "a teacher in his own way." Knowing Jim for the last 34 years has certainly effected me and has made me a better person, physician and surgeon.

Jim and Jessie celebrated their 40th wedding anniversary last July. They are now survived by their two daughters, Kathryn and Margaret. The thoughts and prayers of our medical community go out to them.

Gordon Klatt, MD

Texas tort caps victory is a model for physician grassroots advocacy

Editor's Note: The following Letter to the Editor from Charles W. Bailey, Jr., MD, President, Texas Medical Association, appeared in the November 3, 2003 edition of AMNews.

Regarding "Texas tort reform vote signals lower liability rates," (AMNews, October 6): This cover article certainly reported a tremendous victory for Texas physicians. But the article missed the chance to show other state medical societies how they, too, can win big on a critical issue by working with the AMA and grassroots physicians.

The story behind the story demonstrates the relevance and power of organized medicine. Political observers on both sides of this fight credit our narrow victory to the grassroots activism of the physicians of Texas. And organized medicine gave them the tools to do the job. Organized medicine trumped a $20 million trial lawyer effort against Proposition 12.

The components of organized medicine were unified behind Proposition 12. Texas Medical Association staff worked tirelessly, producing patient and physician education materials, raising more than $1.2 million, and traveling to physician meetings across the state. The TMA print shop cranked out more than 1.8 million "appointment-to-vote" cards for physicians to hand out.

Yes, the AMA contributed $100,000. More important, AMA President Donald J. Palmisano, MD made an AMA "House Call" to Dallas and Houston to visit with physicians and stump for Proposition 12. AMA's Advocacy Research Center provided research that anchored our new tort reform law and set the stage for Proposition 12.

At emergency membership meetings, county medical society leaders energized physicians to engage their patients, the public, and the press. County societies became distribution centers for signs, bumper stickers, and "appointment-to-vote" cards. The Border Health Caucus, which first raised awareness of the Texas liability crisis, again carried the access-to-care message to an audience that well understood its implications. State specialty societies were enormously successful in fund raising. Our medical student chapters even went toe-to-toe, "yes" sign to "no" sign, with Teamsters Union members outside a Fort Worth polling place.

TMA devised the "21 for 12" strategy, based on the math of winning a low-turnout election. It encouraged all doctors to recruit 21 committed voters from among their families friends, staffs,

See "Grassroots" page 22

Opting out of third-party payment is key to preserve profession's integrity

Editor's Note: The following Letter to the Editor from John Vogel, DO, Atlanta, Georgia, appeared in the November 3, 2003 edition of AMNews.

Regarding "Reimbursement limbo pushes doctors lower and lower" (See column, October 6) and "Look to tax credits" (Editorial, October 6): Physicians know the value of their work, and so do insurance companies and the federal government. The 800-pound gorillas, both private and federal, continue to lower payments for services for one simple reason: They can, and we let them.

Insurers sold American doctors and employers on a system that would reimburse physicians fairly and contain premium costs for employers. As the Commentary column by AMA Board Chair William G. Plested III, MD details, they failed on both promises. Yet an *AMNews* editorial in the same issue, "Look to tax credits," suggests that we get the federal government to give tax credits so that our patients can further subsidize this failing system.

Because of the economic and political power of the insurance industry, physician attempts to resuscitate the system through legal or political means will fail. We cannot strike because it is unethical and unprofessional, but we do not have to accept third-party payments for patient care. The present payment system continues only with our daily servitude and inability to wean ourselves from the relationship between physicians and the insurance

See "Integrity" page 22

The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

Flu Prevention is the Best Intervention

Federico Cruz-Uribe, MD

This year, in addition to high-risk children and their household contacts up to the age of 19, **you can use the TPCHD Vaccine For Children Program vaccine for your healthy 6-23 month old children and their household contacts up to the age of 19.**

Reported estimates of deaths related to influenza-related complication have increased by 16,000 according to Thompson et al in a 2003 article in the *Journal of the American Medical Association*. A study by Nichol et al published in the *New England Journal of Medicine* recently found that vaccination against influenza decreased both hospitalization and deaths related to influenza. CDC data estimate national influenza-related deaths at 36,000 per year and influenza-related hospitalizations average 114,000 per year.

During the 2002-2003 flu season, surveillance laboratories statewide reported 220 positive influenza isolates. The isolates included 83% being influenza A, and 14% influenza B. Of the 94 influenza A subtyped, 56 were A, H1N1 (60%), and 37 were A, H3N2 (39%), one was A, H1N2 (1%). The influenza strains circulating in Washington State and nationwide were the same as those contained in the 2002-2003 vaccine (A/NewCaledonia/20/99-H1N1, A/Moscow/10/99-H3N2, and B/Hong Kong/330/01).

Those most susceptible to the flu and related complications include people over the age of 65, those of any age with chronic complications, and children between the ages of 6 and 23 months. Vaccination rates are lowest among African Americans and Hispanic American seniors. The overall national average is 67%; however, only 52% of African Americans and 47% of Hispanic Americans reported receiving a flu shot in the past 12 months. **Last year, twenty-six percent of Washington State surveillance isolates were four years or younger, 33% were ages 5 thru 19 years, 28% were aged 20 thru 59 and 5% were 60 years or over.** Seven percent of cases reported no age.

The time to immunize is now. There is no flu vaccine shortage this year. October and November are the optimal months for flu vaccination. You can continue to vaccinate people in December and later. Who should be vaccinated this year? Well children 6 to 23 months of age and their household contacts up to the age of 19; those with chronic conditions, people over 50 and anyone else who wants to be protected. Health care workers and close contacts of those at highest risk should also be vaccinated to prevent flu transmission. You can use vaccine from the Vaccine for Children Program to immunize all children with chronic conditions and their household contacts up to the age of 19, and all healthy 6 to 23 month olds and their household contacts up to the age of 19.

For more vaccine information or locations of clinics, please contact the Tacoma-Pierce County Health Department at 253-798-6410. The three major websites for flu are:

www.tpchd.org/cdc/immunizations.html

www.cdc.gov/nip/flu

www.doh.wa.gov/FluNews/default.htm ■

The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

Preparing for the Re-Emergence of Severe Acute Respiratory Syndrome (SARS)

As of this writing, no known cases of Severe Acute Respiratory Syndrome (SARS) exist in the world. But, like many viral illnesses, the potential for re-emergence of SARS is high. The Tacoma-Pierce County Health Department has been working with hospitals throughout Pierce County to prepare a plan for responding, should the disease appear here. We also recommend guidelines for all practitioners to control the spread.

SARS, as you will remember, is caused by a unique coronavirus, which scientists have named SARS-associated coronavirus (SARS-CoV). First seen in Asia last February, the disease spread to several countries in Asia and to Europe, South America and Canada. Worldwide, according to the World Health Organization, 8,098 people became sick with SARS; 774 of those infected died. U.S. physicians identified a number of suspect cases, of which the CDC confirmed 192, with no deaths.

SARS generally shows itself as a high fever (greater than 100.4 degrees F). Other symptoms include headache and body aches. At the outset, some people experience mild respiratory symptoms and 10-20% have diarrhea. Between day two and day seven, patients may develop a dry cough which then develops into pneumonia.

SARS seems to be spread via respiratory droplets, although airborne and other routes of transmission have not been ruled out. People become infected by the droplets deposited on mucus membranes or when an individual touches a surface contaminated with infectious droplets and then touches her/his mouth, nose or eyes.

Understanding the possibility exists for a new outbreak of SARS this winter, and that the virus transmits easily, especially to healthcare workers, TPCHD is working with Pierce County hospitals on a plan for preventing the spread and responding to the disease. Surveillance will rely on reporting of conditions by medical providers. Since SARS qualifies as a high priority condition, TPCHD staff will begin investigating as soon as credible information comes into the department.

Controlling the spread of SARS starts early, and relies on help from practitioners. TPCHD recommends the following guidelines:

1) Any patient with a cough of infectious or unknown etiology should be masked when s/he arrives in a medical office. The use of surgical masks will help decrease transmission of not only SARS, but other respiratory illnesses such as flu, TB and pertussis.

2) If you hospitalize a patient with CXR-confirmed pneumonia or ARDS, screen that individual for SARS risk factors. Ask:

a. Do you work in a healthcare facility?
b. Have you traveled to or been in close contact with someone with a respiratory illness who traveled to a country previously affected by SARS, within the past ten days?
c. Are you in close contact with someone who has pneumonia of unknown etiology (documented by CXR)?

3. If you see a patient who has been hospitalized with one of the SARS risk factors (as outlined in #2 above) or who is part of a cluster of patients hospitalized with unexplained pneumonia (especially a person who provides healthcare, has traveled recently, or is in close contact with someone with respiratory disease):

a. Call TPCHD, 253-798-6410
b. Immediately isolate the individuals and institute droplet precautions.

4. Finally, rule out common causes of community-acquired pneumonia by completing the following tests:

a. Rapid antigen tests of respiratory specimens: for influenza A & B, parainfluenza, and RSV;
b. Sputum Gram's stain and bacterial culture;
c. Blood cultures, pneumococcal and *Legionella* urine antigens, if indicated.

Call TPCHD (253-798-6410 during working hours; 800-726-6404 after hours and weekends) to ask about a SARS test if you do not receive an etiology or alternative diagnosis within 72 hours of admitting a patient to the hospital with the above symptoms.

For more information:
Centers for Disease Control and Prevention website:
www.cdc.gov/ncidod/sars/index.htm
Washington State Department of Health, Communicable Disease and Epidemiology: 877-539-4344 ■

In My Opinion.... The Invisible Hand

by Andrew Statson, MD

The opinions expressed in this writing are solely those of the author. *PCMS invites members to express their opinion/insights about subjects relevant to the medical community, or share their general interest stories. Submissions are subject to Editorial Committee review.*

The Straws of Regulation

Andrew Statson, MD

"There is one quality more important than 'know-how' and we cannot accuse the United States of any undue amount of it. This is 'know-what' by which we determine not only how to accomplish our purposes, but what our purposes are to be."
In *The Human use of Human Beings*
Norbert Wiener (1954)

Every little rule, added to the list of those with which we already have to comply, has a certain economic impact on our practices. Separately, any one of them has a minimal effect, just like another straw added to our burden.

This economic impact of every action is determined by the alternatives we have to forgo in order to carry out that action. What would we do instead with our time and money? The cost always is figured in money, but in fact it has two elements, the expenditure of money and the expenditure of time. In order to combine them, I have to estimate the value of our time.

Anesthesiologists and psychiatrists charge according to time, but most of us seldom do, so I have to make some assumptions about its value. I hope our legal friends will not be offended if I assumed that our time is worth as much as theirs. The going rate lawyers charge is of the order of $250 per hour. To make it even, I'll assume our time is worth $4 per minute, or $240 per hour.

The first regulation affecting the practice of medicine came up in the last quarter of the nineteenth century. It was the state licensing provision. At first that was a nominal expense, involving the initial testing. Then came annual registration, again costing a small amount, until the beginning of the liability crisis some 30-40 years ago.

The state medical boards embraced the bad apple theory promoted by the trial lawyers, became disciplinary boards and added CME as a requirement for license. The annual registration fee jumped ten-fold to a few hundred dollars per credit hour. For fifty hours a year, that amounts to $1000. That is a small part of the total. While attending the meetings, we still have to pay our overhead and forgo the income we would have generated.

"That data bank has been in existence for ten years. It was going to rid us of the bad apples. They wouldn't have any place to hide. Why then is the liability crisis worse now than it was ten years ago? It didn't work, did it? The reason is simple. The bad apple theory is wrong."

The courses give an average of six credit hours per day. Very seldom they go as high as eight credit hours, but not consistently, not for every day they last. Most of the programs run for two days, some three, and rarely for more than that. If we were to count on the basis of days away from the office, it costs us one lost day of work for about every four credit hours.

We therefore have to spend twelve days a year to meet the CME requirements. How many hours a day do we work. Most of us put in ten hours a day, perhaps more. At that rate, the opportunity cost of CME is $2,400 a day, $28,000 per year. That is only the cost of the time we spend away from the office. It does not include travel and living expenses.

Don't misunderstand me. I think that CME is an essential part of our practice. Before it became mandatory, we had professional organizations, educational meetings, medical journals, etc. These things are not new. We worked on keeping up with the new developments in our field. However, before mandatory CME, the costs were lower. The paperwork and record keeping did not exist.

Now, every course has to be approved by a credentialing agency in order to be acceptable for credit. The organization offering the course has to pay for that and provide the documentation both of content and attendance.

See "Straws" page 10

Straws from page 9

to the meetings, make sign-in lists for every session, collect speaker evaluations, run pre- and post-course tests to prove that learning resulted, etc.

When I joined ACOG, back in the dark ages, the registration for our meetings, district and national, was part of our annual dues. We didn't have to pay extra to attend them, and we had free access to all seminars and lectures, except for the special post-graduate courses. Now, we have to pay for every one of the seminars we attend, in addition to a registration fee for the meeting. The latter essentially entitles us to see the industrial exhibits at no charge.

In summary, the opportunity cost for 50 hours of CME is probably $30.000. I would venture to guess that we spend half of that spinning our wheels to meet the regulatory requirements, rather than to learn something.

True, there are cheaper ways to get credits. There are tapes, mail programs, internet sites and others. The cost is seldom less than $15 per credit hour and the time spent is seldom less than two clock hours. The opportunity cost still is close to $500 per credit hour, or $25,000 per year.

All that was intended to solve the liability problem and reduce premiums. It was going to eliminate the bad apples among us and force those who would not learn on their own initiative to keep up. Then why is the liability crisis worse? It didn't work, did it?

Compared to thirty years ago, our outcomes are better in almost every respect. Whether we look at maternal or infant morbidity and mortality, general quality of life of diabetics, hypertensives and others, our patients are doing much better. Then why is the liability crisis worse?

Other entities keep track of our performance, too. The hospitals have to credential their medical staff every two years. The same is true of the insurance companies and their physician panels. Our cost here is in the time we spend to fill out the forms. Assuming we belong to two hospital staffs and five HMO or PPO plans, we have to fill out seven applications. At fifteen minutes each, the cost is $60 per form, $420 every two years.

For their part, the hospitals and the insurance companies, even with automated credentailing on line, probably spend $100 per physician per year. That may include the expense related to checking expiration dates of licenses, DEA registrations and other little things like that. Again, it is not much, just another straw.

Every time hospitals and insurance companies query the practitioner data bank, as they must, they pay a certain amount. I don't know how much it is. The figure I heard is $4.25 per request. Add the time value of their credentialing clerk. Another straw.

That data bank has been in existence for ten years. It was going to rid us of the bad apples. They wouldn't have any place to hide. Why then is the liability crisis worse now than it was ten years ago? It didn't work, did it? The reason is simple. The bad apple theory is wrong.

So far I have looked at only a few of the straws that we carry on our back. There are many more before I get to the latest one, HIPAA, but that is another story in itself. ■

IN MEMORIAM

BARTHOLOMEW KUBAT, MD

1917 - 2003

Dr. Bartholomew Kubat was born on March 8, 1917 in Berehovo, Czechoslovakia and died in August, 2003. He was 86.

After receiving his medical degree from Charles' University Medical School in Prague in 1947, he practiced general surgery there for 18 years. In 1966 he began an internship and residency at United Hospital in Port Chester, New York and practiced general surgery in Pierce County from 1968 until his retirement in 1984.

Dr. Kubat joined PCMS in 1969.

PCMS offers condolences to Dr. Porter's wife, Irene and their family.

IN MEMORIAM

ALAN S. PORTER, MD

1925 - 2003

Dr. Alan Porter was born on March 16, 1925 in Salt Lake City, Utah and died September 26, 2003. He was 78.

After receiving his medical degree from the University of Utah College of Medicine in 1949, Dr. Porter was a general practitioner in Redlands, California for twelve years. In 1962 he completed a residency in anesthesiology at the University of Washington and worked at Tacoma General Hospital, St. Joseph Hospital and St. Francis Hospital until his retirement in 1994.

Dr. Porter joined PCMS in 1965.

PCMS offers condolences to Dr. Porter's wife, Sundy and their family.

Applicants for Membership

Todd L. Chambers, MD
Family Practice
Community Health Care
134 188th Street S, Spanaway
253-847-2304
Med School: University of Oklahoma
Internship: Tacoma Family Medicine
Residency: Tacoma Family Medicine

Iftikhar A. Chowdhry, MD
Int Med/Rheumatology
Internal Medicine Northwest
316 Martin L King Jr Way #304, Tacoma
253-272-5076
Med School: Allama Iqbal Med College
Internship: Cabrini Medical Center
Residency: Cabrini Medical Center
Fellowship: Albert Einstein College of Med

Maha J.D. Coles, MD
Family Practice
Primary Care Northwest
1812 South J Street #102, Tacoma
253-552-4900
Med School: Creighton University
Internship: Providence St. Peter
Residency: Providence St. Peter

Daniel C. Ene-Stroescu, MD
Int Med/Rheumatology
Internal Medicine Northwest
316 Martin L King Jr Way #304, Tacoma
253-272-5076
Med School: Carol Davila School of Med
Internship: New York University
Residency: New York University
Fellowship: Rush Presbyterian-St. Lukes Medical Center
Fellowship: Univ of Chicago Hospitals

Stephen Hillis, MD
Family Practice
Primary Care Northwest
1812 South J Street #102, Tacoma
253-552-4900
Med School: Loma Linda University
Internship: Santa Monica Family Practice
Residency: Santa Monica Family Practice

Feng Hua, MD
Neurology
Neurology & Neurosurgery Associates
915 6th Avenue #200, Tacoma
253-403-7299
Med School: Beijing Medical University
Internship: SUNY at Buffalo
Residency: SUNY at Buffalo
Fellowship: University of Michigan

Ling Lee, MD
Family Practice
Community Health Care
10510 Gravelly Lake Dr, Lakewood
253-589-7188
Med School: National Univ of Singapore
Residency: Group Health Cooperative

Vidya P. Menon, MD
Internal Medicine
Internal Medicine Northwest
316 Martin L King Jr Way #304, Tacoma
253-272-5076
Med School: Seth GS Medical College
Internship: Lincoln Medical Center
Residency: Lincoln Medical Center

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

Tort Update

Tort strategy for success in impacting rates

Organized medicine has remained steadfast in supporting changes to the tort system that will be meaningful to physicians.

They remain:

1. A $250,000 cap on non-economic damages - no cap on economic damages.

2. Sliding scale cap on contingency fees to enable more of the settlement or judgment to go directly to the injured patient.

3. Repeal of the collateral source rule and elimination of subrogation by health plans, disability plans, etc.

4. Amendment of the current law allowing periodic payment of future damages.

5. A small change to the modified joint and several liability reform adopted in 1986 to give defendants the right to reduce verdicts by the amount of all pretrial settlements by former codefendants.

6. Permit contracts with patients to submit professional negligence cases to binding arbitration.

Part of the strategy of those who would "do something," but not really fix the problem, is reliance on splitting one or more specialties, or categories of physicians, off of our coalition - singling them out for special relief.

Some are shopping around expansive lists of supposed remedies. They are a mix of old and new, modest and marginal ideas - and a sure sign that our campaign is gaining serious political traction as those previously opposed to reform, or sitting on the fence, now suggest that something be done. Now, more than ever, all specialties must hold together.

Our criteria for evaluation reform proposals remains:

Does the proposal:

1. Moderate the rising cost of medical malpractice insurance premiums?

2. Accelerate settlements to the injured party in the event of negligence?

3. Reduce wasteful tort system transactional expenses so that more of the settlement goes to the injured party?

4. Increase the focus of the tort law system on fairly compensating victims of negligence?

5. Reduce the dramatic rise in awards for non-economic damages, which drive premium increases?

If the proposal keeps the current system in place, while perhaps offering...

- A state Joint Underwriting Association (JUA),
- A state sponsored patient compensation fund,
- A screening mechanism for suits, or
- Subsidies for liability insurance premiums...

...it reduces the chance for real reform, undercuts all physicians, and keeps the trial bar in clover.

See "Tort" page 21

Frustrated physicians hear liability insurance update

Pierce County physicians filled Jackson Hall auditorium on October 9 to hear Tom Myers, President/CEO of Physicians Insurance A Mutual Company address the crisis situation in securing affordable medical liability insurance coverage. Also on the agenda were WSMA President, Dr. Jeff Collins of Spokane, and the CEO of Washington State Medical Association, Mr. Tom Curry.

The meeting was scheduled due to the number of Pierce County physicians that had found themselves being not renewed for 2004 coverage. "Pierce County was hit particularly hard," admitted Mr. Myers, "although there was no particular reason." While Mr. Myers did have some positive news to report, the immediate relief from rising costs of insurance is not at hand. There will be a five percent premium increase for 2004, with an estimated 13.3% capital call accompaniment. Look for overall cost increases to be in the 15-20% range. The good news was that Physicians Insurance did rescind the non-renewal of two large Tacoma groups of physicians who had submitted appeals for reinstatement.

The meeting was rife with physician enthusiasm for becoming politically active in efforts to "fix" the problem. Many gave testimonials for the need to get involved and support the WSMA Tort Reform Campaign, contact legisla-

See "Update" page 22

WSMA from page 4

tional hassles, and improved patient care by:

1. Implementing tangible administrative simplification projects - first seeking implementation of such projects through the Washington Healthcare Forum (WHF).

2. Continuing the Association's promotion of best practices and a practice environment that supports a systems approach to reducing medical errors.

III. Building the strength and viability of the WSMA as a primary resource for physician and medical practice support and assistance, and as an information and support resource, by

A. Further developing the Annual *Leadership Development Conference* to include the identification and recruitment into leadership positions those physicians who are broadly representative of the demographics of the practicing physician community.

B. Fostering a governance mechanism that reflects the demographics and dynamics of the practicing physician community; in the current medical practice environment, and which reflects the following values:

- Representation
- Involvement
- Efficiency

C. Continuing to build the Interspecialty Council as a vehicle to maximize specialty society involvement in shaping WSMA policy.

D. Promoting greater engagement of physicians by communicating the substance of policies/programs/issues using whatever technology is appropriate to their setting and preferences. ■

In My Opinion....

by Nichol T. Iverson, MD

The opinions expressed in this writing are solely those of the author. PCMS invites members to express their opinion/insights about subjects relevant to the medical community, or share their general interest stories. Submissions are subject to Editorial Committee review.

Getting Fit for a Law Suit

Nichol Iverson, MD

Add rendered animal fat, birdseed and peanuts, and "Voila," you have a suet.
Martha Stewart's *Schlepping around the Justice System*

Recently Nerd Warehouse had a sale on Law Suits. These are cleverly designed garments, complete with Kevlar linings, telephone tapping devices and have built in Knight Vision visors. Mandatory accessories include an MP-3 player, capable of belting out 173 decibels of The Ride of the Valkyries with a twitch of one's latisimus dorsi muscle, AND you will need the microphone capable of recording and analyzing all conversations in a seventeen-mile radius, AND perform voice recognition on these people. Simultaneously. These clothes allow the user to walk nonchalantly among potential litigants.

Medical practices are full of charts containing grenades, some of them with the pins pulled. Like terrorists these bombs go off randomly. We never know when one will get us. Lawyers a.k.a. Land Minds, assume that all bad medical outcomes represent bad medicine. In some circles this is called malpractice.

I managed to practice critical care medicine for twenty seven years without being named in a lawsuit until 2002. You bet I was furious! A subpoena was delivered to me and our Corporation at my office, and when I got home, I had another subpoena delivered to me personally. The Corporation was named; my wife was named, and unto the third generation of my unborn great grandchildren were named. Ain't that sweet?!! As I looked out the front window, the same dude was chasing the two deer, Bambi and his mother, then he ran unsuccessfully after "bandit" the raccoon, and then tried to get my cat. They all managed to escape without leaving their signatures. I think he tried to go after my dad, too, but he has been dead for twenty seven years, thanks to cigarettes.

After cleaning up my shorts, I sorted through my pea brain to try to remember the case in question. The subpoenas were delivered on the very last day before the statute of limitations ran out, precisely three years after I last laid hands and eyes on this unfortunate man. I kid you not. After poring through the seventeen-inch thick chart five times, I could not for the life of me find any evidence of bad medical care in the chart. The patient in this case arrived in the emergency room in extremis with a problem that is universally fatal without immediate complicated management. The mortality of his problem was probably eighty to ninety percent, no matter where he had been admitted. Apparently, no consideration was given to his personal responsibility to take care of himself. He was a two pack per day smoker, he was fat, out of shape, and had chosen not to obtain regular medical care, in spite of wearing designer underwear. Speedo did not have a contract with this guy! His lipids made suet look palatable.

I spent time talking to the defense lawyer on the telephone, then drove to his office and spent a wonderful evening with one of my colleagues involved in the case discussing the game plan for the case. A court date was set for March of 2004 (yes, next year). After repeated reviews of the chart, conversations with the lawyer, review of the literature and multiple episodes of jumping up and down yelling words containing precisely four letters, I was satisfied that the case had no merit. Weeks later, I received a call from an insurance person to see how I was doing. "Fine," I blurted, "until now." I had put this case to rest for two years. I was dropped from the case a year later.

The personal toll on me is not measurable, and was much more disturbing than I could have imagined. I was angry, afraid and ashamed. I did not sleep well, was second-guessing myself for several months, and had difficulty concentrating on just practicing medicine. I had also wasted hours talking to lawyers, reviewing the chart several times, and talking to my cat. When Tort reform is discussed, I rarely hear about the intangible personal costs of going through this brutal process. Obviously the amount of grief I suffered is nothing compared to the prospect of going to trial. Perish the thought that I will experience the "full meal deal' in my lifetime. My only regret, I suppose, is not having the chance to testify to make the plaintiff's lawyer look like the money grubbing jackass that he is. In my new suit! ■

Dr. Duffy from page 6

to their elementary school classrooms to share hisknowledge and warmth and to simply spend time with the kids. He once brought along his black bag and asked the children if they could tell him what it is. "None of them could identify the bag," he said. "Things have really changed."

Through the years, he's kept his fingers in many projects in the community, and among those he is most proud of is the Sumner's Daffodil Sports Complex. Dr. Duffy recalled the day when he and a group of project committee members were out digging a ditch. "We realized that between the six or seven of us who were there that we had 40 some years of college between us, and here were are out digging a ditch for the sports complex!" But, he added, it was worth the planning, organizing, and even ditch digging. "It's a beautiful complex, and it's so wonderful how beneficial it has been. Over 100,000 people use it annually."

With a busy practice, his large family, and numerous church and community obligations, the Duffy's have also found time over the years to be involved and give back to PCMS. A member since 1952, Dr. Duffy has been involved in numerous Society committees, projects and causes. He was PCMS president in 1989. His wife, Susie, was PCMS auxiliary president in 1988 and state president the following year.

Tom Curry was PCMS Executive Director when Dr. Duffy was asked to run for president of the Society. "When I was considering running," Dr. Duffy recalled, " Tom told me not to worry because he'd be with me every step of the way." A week later he left to work for the WSMA. Subsequently, Doug Jackman took the helm at PCMS. "Boy, were we green!" Dr. Duffy recalls. "It was the blind leading the blind that year," Dr. Duffy laughed, but went on to praise Jackman for a stellar career at the Society.

Retirement...Years in the Making

Dr. Duffy's retirement has been a well-planned, meticulous process that began about 10 years ago. He has been working in the office two days a week for the past seven years, and for the previous six years, he worked three days a week. It was only a few months ago that he made the decision to retire. It was time, he said, although he really didn't want to retire at all, which is why it's taken this long to make it official. He admits that he would continue to work if he thought it was plausible. "It's time to go," he said. And while he's still somewhat reluctant, he admits, "it's an ideal way to retire. The process has made it easier for me and easier for my patients."

After easing into retirement over the last 14 years, Dr. Duffy admits that his routine really won't change that much. "I will miss coming into the office, and I certainly have a lump in my throat when I think about it," he said, "but I don't regret retiring."

Understandably, his patients are sad to see him leave his practice. And some are angry. "My wife said that I have an awful lot of make up on my white coat when I come home," he joked. It's a unique and very emotional situation. Dr. Duffy's patients include children, parents and grandparents from the same families. These are more than patients. These are friends. "It tugs at me," he admitted, although he says he's dealing with it better than he did a couple of months ago when he made the final decision. " It's tough to say goodbye, for both me and my patients." One long-time patient told Dr. Duffy point blank that he would come to his house for treatment. "They are taking this very personally," he said,

See "Duffy" page 20

COLLEGE OF MEDICAL EDUCATION

New Men's Health CME set for December 5, 2003

A new program dedicated to men's medicine for the primary care physician is set for December 5, 2003

The one-day review, directed by **Michael Kelly, MD**, will address a variety of timely subjects relative to contemporary medicine for men. Designed for the primary care physician, the course will cover a broad spectrum of topics including erectile dysfunction, prostate cancer, BPH, and much more. The program will focus on diagnosis and treatment advances in treating illness in men. ■

CME at Hawaii - Hotel, Flight Reservations Urged

Those interested in attending CME at Hawaii are urged to make plans now for both air transportation and lodging.

All Wanderlands Travel, specifically Jeanette, 572-6271, is prepared to assist you in securing your seats.

To take advantage of the reduced rates at our conference hotel - The Hyatt Regency Kauai - you can call directly to 1-808-742-1234.

We hope to see you there! ■

Continuing Medical Education

Don't Forget to Make Those Whistler Condo Reservations

Registration continues to be open for the College's CME at Whistler/ Blackcomb program. The conference is scheduled for January 28-31, 2004.

CME at Whistler participants are urged to make their condo reservations early. 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.

Reservations for the block of condos, ALL IN THE ASPENS, 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, 2002.

Reservations can be made by calling toll free at 1-866-788-5588. You must identify yourself as a part of the C.O.M.E. group. For more information call the College at 627-7137. ■

Dates	Program	Director(s)
Friday, November 7	Infectious Diseases Update	James DeMaio, MD
Friday, December 5	Advances in Men's Health	Michael Kelly, MD
Tuesdays January 13; 20	Cardiology for Primary Care	Gregg Ostergren, DO
Wednesday-Sunday Jan 28 - Feb 1	CME @ Whistler	John Jiganti, MD Rick Tobin, MD
Friday, February 6	Primary Care	TBA
Friday, February 27	Endocrinology for Primary Care	Ronald Graf, MD
Thursday-Friday March 11-12	Internal Medicine Review 2004	Gurjit Kaeley, MD
Monday-Friday April 12-16	CME at Hawaii	Mark Craddock, MD
Friday, April 30	Allergy, Asthma & Pulmonology for Primary Care	Alex Mihali, MD
Friday, May 21	Advances in Women's Medicine	John Lenihan, MD

Dr. Duffy from page 14

"but I've been toying with this retirement for 10 years. And now I've made up my mind. I'm glad I did."

The Duffy's will continue with their community and church activities, and are thoroughly enjoying their recently remodeled home. "I also like to monkey with the computer like everyone else," Dr. Duffy said, "but I don't know too much about it. Now I'll have time to learn more," along with playing golf and cards, hunting and fishing. He's also a fan of horse racing - he even owned a racehorse for a short time in the 1960s - and still visits the track on occasion. He and his siblings still own and maintain the family home in Bussey, and he will continue to take his an annual hunting trip to Iowa the first two weeks of November as he has the past 29 years. The Duffy's also enjoy travelling together and will be taking a trip next month to Juneau, Alaska to attend their son's wedding.

Dr. Duffy will also continue his visits to elementary schools three or four times a year. "I always take a bunch of candy, and we have a mathematics lesson," he said. "If a student answers a question right, they get a piece of candy. Of course, I make sure they all get some candy."

He will also have more time to spend with fellow PCMS retirees. "**Dr. Doug Buttorff** kept calling me and saying, 'I wish you would retire so you could come to the retired physicians gathering.' I guess that's something I can do now."

Recently, Dr. Duffy joined with his family and friends to mark his 80th birthday. The celebration lasted five days. "For an old man, that's a lot of celebrating," he laughed. The main event was held at the Windmill Garden in Sumner and attended by 200 friends and family members. Dr. Duffy has 33 blood relatives - 31 attended the celebration, most of who live on the East Coast.

And the milestones and celebrations continue. To officially recognize his retirement, a mass in Dr. Duffy's honor was celebrated at St. Andrews Catholic Church October 19, followed by a reception at the church. Colleagues, patients, family and friends joined to reminisce about a wonderful career, and celebrate a caring man.

Dr. Duffy, the Pierce County Medical Society commends your stellar career and thanks you for your innumerable contributions. ■

Tort from page 15

There is Strength in Numbers and Hanging Together

As Association of Washington Business (AWB) Governmental Affairs Director Gary Chandler, a former legislator himself, told the WSMA Interspecialty Council in October, the business community, government and municipalities, physicians, and hospitals, must hold firm in the LRC. The LRC has the requisite energy, funding and organization to push us to success - provided we work together.

They are working the following plan:

1. Its public opinion research project is "in the field" and 600 Washington "perfect voters" (those who have voted in three of the past four elections) are being interviewed by professional pollsters. The data will drive our targeted legislative effort, and will help shape the message we take to legislators and the public.

2. The LRC is in final negotiations with professionals to bring manager(s) on board for the grassroots portion of the campaign.

3. The omnibus tort reform bill is being finalized.

Tort Reform Work Continues at the Federal Level

The AMA continues to lobby the U.S. Senate leadership concerning the next floor vote on medical liability reform. The next floor vote (on access to obstetrics services) may occur as early as the next 10-14 days. The key is which base bill (there are two options) the Senate leadership will use as the vehicle.

As potential action approaches, the Campaign Update will provide more information on how we can support this effort.

But, Senators Murray and Cantwell Voted this Week to Kill Class Action Tort Reform Bill

Senators Murray and Cantwell were among 39 senators who voted Tuesday to oppose cloture (to thus prevent a filibuster) on the Class Action Fairness Act of 2003 (S. 1751). Fifty-nine voted for cloture and two did not vote. Had sixty voted for the procedural motion, the bill could not be filibustered and this would have virtually insured passage.

S. 1751, which has strong bipartisan support, would place large, nationwide class action lawsuits in federal court - where the Founders intended them to be - rather than local courts. Plaintiffs' lawyers refer to their favorite local courts as "magnet jurisdictions" due to their ability to get even frivolous call actions certified so that defendants will be forced to settle rather than litigate.

The WSMA joined with the business community in this state to urge that our two senators support this part of tort reform.

WSMA Tort Reform Campaign

The WSMA's Campaign Fund for Tort Reform has raised $250,000 at press time.

Your contribution is money well spent. All of these funds are designated for tort reform efforts. If you have not done so, please take a moment to log on to the WSMA Web site and contribute today - go to http://www.wsma.org/tort_registration.html.

They can also take your contribution over the phone. Call them at 206-441-9762 or 1-800-552-0612. If you prefer to send a check, send it to WSMA, 2003 6th Avenue, Suite 1100, Seattle, WA 98121.

We are asking for a minimum contribution of $250. Of that, $150 will go towards WAMPAC (if you are currently a member of WAMPAC, then the entire contribution will go towards the campaign fund). If you prefer your total contribution go directly towards the Tort Campaign Fund, please let us know. ■

Annual Meeting will highlight Rick Steves

The Pierce County Medical Society invites you and your spouse/guest to the

2003 Annual Meeting

featuring the candid, funny and quotable **Rick Steves.**

Rick Steves is a recognized authority on European travel. He hosts the popular public television series Steves' Europe and has authored 27 European travel books encouraging travelers to become "temporary locals." His tour program "Europe Through the Back Door" has grown from a couple of minivan tours each year to 200 annual bus tours that escort over 5,000 Americans through Europe. Rick is one of public televisions' top pledge drive hosts and he travels throughout the U.S. teaching travel classes. He is known for his lively and irreverent sense of humor.

Rick's topic is "The Value of Travel in 2004." The meeting will be held Tuesday, December 9, 2003 at the Sheraton Tacoma Hotel, Ballroom. Social hour begins at 6:30 pm, dinner at 7:00 pm and the program will begin at 8:00 pm.
To register or for more information, please call the PCMS office at 572-3667.

Integrity from page 8

industry, when what we need is a divorce.

Most physicians believe that course is too extreme, but inaction will result in a single-payer system. In the not-too-distant future, as premiums continue to increase, employers and the public will create a tidal wave of pressure on our elected officials to solve the problems that we have failed to solve. Organized medicine will be impotent to stop it once we have reached public perception of a crisis.

Years ago, health insurance served a useful purpose by providing a shared risk pool for catastrophic events. We called it "major medical." When you were a little sick, you paid a lot; when you were a lot sick, you paid a little. It worked quite well. Cost control was still a problem, but better than the present situation. This much is certain: Any payment system that does not place patients as the primary agents of cost control will fail.

The private insurance industry will not willingly reduce its sphere of influence on the health care landscape. In small but growing numbers, physicians have completely withdrawn from their insurance contracts. Some fail, and most struggle following their liberation. I have struggled for four years but can see no other path to protect the integrity of my profession and the relationship with my patients. ■

Grassroots from page 8

colleagues and patients. They made reminder calls to their lists when early voting began and on election eve.

Proposition 12 passed by a scant 33,000 votes, and the family of medicine made the difference. At an electrified TMA leadership conference one week later, physicians gathered in the hallways to share victory stories. They told how the campaign had galvanized members back home. They touted the energetic young physicians who were now excited about the value of organized medicine. They spoke confidently of the new battles they were eager to engage.

For physicians in other states, the message is: You can do it. Organized medicine can do it. What a great story!■

Dr. Esuabana receives degree

Asuquo Esuabana, MD of Federal Way has achieved the degree of Fellow of the American Academy of Family Physicians (AAFP), the national medical association representing 94,300 family physicians, residents and medical students. The degree was conferred to approximately 400 family physicians during a convocation on October 4.

Criteria for receiving the AAFP degree of Fellow consists of a minimum of six years of membership in the organization, extensive continuing medical education, participation in public service programs outside their medical practice, conducting original research and serving as a teacher in family medicine.

PCMS extends congratulations to Dr. Esuabana. ■

Update from page 15

tors, and not ask what organized medicine is doing for you, but ask what you can do individually to assist in the battle. The WSMA's campaign includes working with the Liability Reform Coalition as well as targeting legislators that do not support the issue and working for the election of their opponent.

Pierce County Medical Society will be setting up meetings with legislators in the next three months so physicians can meet their legislator and discuss the issue. Meetings will be scheduled with legislators who support the issue to thank and bolster their efforts as well as those who do not to advise them that we will not support their campaign if they don't vote for tort reform. ■

Classified Advertising

POSITIONS AVAILABLE

Tacoma/Pierce County outpatient general medical care at its best. Full and part-time positions available in Tacoma and vicinity. Very flexible schedule. Well suited for career redefinition for G.P., F.P., I.M. Contact Andy Tsoi, MD (253) 752-9669 or Paul Doty (Allen, Nelson, Turner & Assoc.), Clinic Manager (253) 383-4351.

Established Auburn Family Practice seeking Board Certified or Board Eligible physicians to join our group. Base salary plus incentive program for motivated Doctor. Part time or full time hours available. Fax CV to 253-839-5565.

POSITIONS AVAILABLE

Washington State Division Of Disability Determination Services. Medical Consultant Positions Available.
The State of Washington Division of Disability Determination Services seeks physicians, including psychiatrists to perform contract services in the Olympia office. Contract services include the evaluation of mental impairment severity from medical records and other reports, utilizing Social Security regulations and rules. Medical Consultants function as members of the adjudicative team and assist staff in determining eligibility for disability benefits.
Requirements: Current Medical License in Washington State. Board certified desirable. **Reimbursement**: $57.01/HR. Interested physicians should contact Gene Profant, MD, Chief Medical Consultant at (360) 664-7454 or Mary Gabriel, Regional Manager, North at (360) 664-7362 or Sheila Davidson, Regional Manager, South at (360) 664-7365.

PRACTICES AVAILABLE

Family Practice with equipment for sale in Federal Way, WA. Max Waldron, DO is retiring in December, 2003. Excellent opportunity/ very reasonable terms. Call 253-925-0672 or e-mail: maxdoc29@yahoo.net.

OFFICE SPACE

For Rent: 3300 sq ft Class A medical office in Tacoma Medical Center, 1112 6th Ave, third floor. Elevator, underground parking, close to hospitals. Call 253-272-2224.

Medical Office Space For Lease. Prime location across the street from Good Samaritan Hospital. Approximately 3,200 sq. ft. Turn-key, beautifully appointed, excellent floor plan, perfect for multiple physicians. For more information contact Norma, 360-458-3752.

GENERAL

Messenger Courier Service. Anywhere. anything, anytime. No job too small or too big. Ron Brock. 253-549-2128.

Pierce County Medical Society
223 Tacoma Avenue South
Tacoma, WA 98402

Return service requested

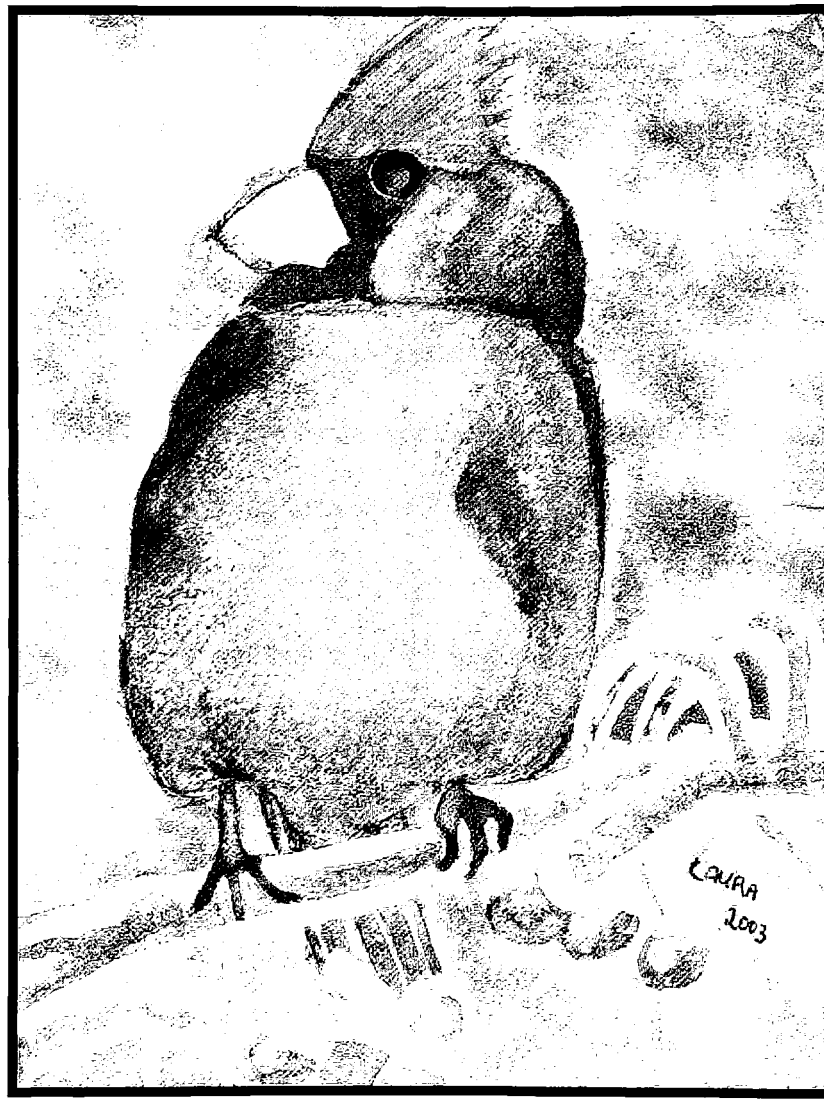
PRESORTED
STANDARD
US POSTAGE PAID
TACOMA, WA
PERMIT NO 605

Pierce County Medical Society

BULLETIN

December, 2003

Happy Holidays



Holiday Sharing Card, 2004

Artist & Designer
Laura Yu

INSIDE:

The Bulletin is published monthly by PCMS Membership Benefits, Inc. Deadline for submitting articles and placing advertisements is the 15th of the month preceding publication.

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 PCMS. Acceptance of advertising in no way constitutes professional approval or endorsement of products or services advertised. The Bulletin reserves the right to reject any advertising.

Managing Editor: Sue Asher
Editorial Committee: MBI Board of Directors
Advertising Information: 253-572-3666
223 Tacoma Avenue South, Tacoma WA 98402
253-572-3666; FAX: 253-572-2470
E-mail address: pcmswa@pcmswa.org
Home Page: http://www.pcmswa.org

Pierce County Medical Society
BULLETIN

December, 2003

Table of Contents

President's Page

by J. James Rooks, Jr., MD

Changing of the Guard

J. James Rooks, Jr., MD

The end of the year is at hand, and once again it's time for a changing of the guard. It has been a great privilege and an honor to serve as president of your society, with many fond memories and challenging situations. The year has been consumed by our push for medical liability reform, reimbursement issues, and practice viability, and though we have made much progress, much more needs to be done. I feel that the Pierce County Medical Society represents the one organization that we have to discuss and act on issues that affect our wonderful profession as a whole. I can't thank our fabulous Executive Director, Sue Asher, and her staff for all that she has done for all of us, both this year and every year. All members of your Board of Trustees have been faithful in their attendance and active in their participation in 2003, and you can be sure that our new President, **Dr. Michael Kelly**, will lead us to even greater achievements in 2004.

However one feels about the delivery of healthcare, it is certain that the events will not be boring! I plan to stick around for some time and do my best to enjoy the challenges. The above problems will be ongoing, and new situations arise all the time. Hospital systems are becoming more and more competitive with each other, specialty hospitals wish to make inroads, physician recruitment to our area remains challenging, and methods of practicing medicine are becoming more diverse. As I see it, the need for solidarity as a community of physicians is even greater and yet it is becoming more and more difficult. Our local medical society and this *Bulletin* represent effective means to stay connected.

I thank all of you who attended the annual meeting on December 9. I'm sure you enjoyed our speaker, Rick Steves. It was a fun evening. Most of all I thank all of you for your support of Pierce County Medical Society - it has been an honor to serve you.■

Pierce County Health Report Form Updated

The PCMS Public Health/School Health Committee, chaired by pediatrician **Dr. Sumner Schoenike**, recently updated the county school health report form. The committee, an active, involved group of school nurses, health department representatives, and others involved in the health care of children, updated the form.

The committee recommends that all schools and physicians in the county use the same form for standardization and familiarity. The updated form is printed on page 5 for reproduction, or may be accessed from the PCMS homepage at www.pcmswa.org, click on school health forms, then health report. ■

Pierce County

HEALTH REPORT

☐ Forwarded to School Nurse/RN for review

TIME OF EXAMINATION: For athletics, exams must be given during the12-month period prior to first participation in interscholastic athletics in middle school and prior to participation in high school. Clearance for continued participation is to be provided on this form prior to each subsequent year of interscholastic athletics. A yearly clearance from the examiner is needed for continued participation.
CHOICE OF EXAMINER: It is recommended that each child have a personal physician knowledgeable regarding each aspect of his/her health. Examination may be performed by a licensed physician (MD or DO), a licensed physician s assistant or a cetificated pediatric or family nurse practitioner working under the direction of a physician whose name is to be stated.

THIS SECTION TO BE COMPLETED BY THE PARENT OR GUARDIAN BEFORE EXAMINATION BY THE PHYSICIAN. PLEASE PRINT.

Last name: First Middle Birthdate: Month/Day/Year Sex: M or F Name of school, camp, organization

Name of parent or guardian Address City Zip Home phone Work phone

Usual physician or source of health care Phone Dentist Phone

CIRCLE PURPOSE OF REPORT: **SCHOOL** - Preschool ChildFind Head Start ECEAP kindergarten elementary school middle school high school
To enter grade: ____ September, 20___ **INTERSCHOLASTIC ACTVITIES** - baseball basketball cross country football gymnastics soccer swimming tennis track volleyball wrestling **OTHER:** daycare developmental center child study park board recreation boys club camp lifesaving other (specify) _____

IS THERE ANY ILLNESS,DISABILITY, LIFE THREATENING CONDITION or other situation which might affect performance? (please explain)

CHILD HAS HAD THE FOLLOWING: Circle the appropriate item(s) and explain on the right. Name other doctors important in child s care

SKIN: acne, eczema
VISION: glasses, contacts
HEARING: aids
NOSE: bleeding
MOUTH: dental decay, orthodontia
LUNGS: asthma, bronchitis
HEART: congenital, rheumatic
GASTROINTESTINAL: ulcer, colitis, hepatitis
GENITOURINARY: kidney or bladder infection
If female, menstruating: Yes ( ) No ( )
If child is under 3 years, give birthweight _____

ORTHOPEDIC: fracture or sprain, scoliosis, congenital hip
NEUROLOGICAL: convulsions, meningitis, cerebral palsy
METABOLIC: diabetes
BLOOD: anemia, sickle cell disease
ALLERGIES: ☐ food_____ ☐ insect_____ ☐ pollen _____ ☐ peanut ____ ☐ contact ____ ☐ drugs _____
other (specify)_____
HOSPITALIZATION(S): (year and reason) _____
OPERATION(S): (year and reason) _____
DISABILITY: physical( ) mental( ) behavioral( ) social( ) learning( ) vision( ) hearing( ) speech( ) ADHD( )
Has child had: rubeola( ) rubella( ) mumps( ) chicken pox( ) whooping cough( )
Describe unusual factors regarding birth or health immediately after birth: _____

IMMUNIZATIONS	*None*	*Doses received* 1	2	3	4	5 or more	*Month/Day/Year*	*Immunizations*
Diphtheria, Tetanus, Pertussis Any combination of DTaP								*DTaP/TD (circle dose given)*
Oral Polio Vaccine (OPV) Injectable Polio Vaccine (iPV)								*OPV/IPV (Circle dose given)*
MMR (Measles. Mumps, Rubella)								*MMR*
Hemophilus Influenza B Vaccine								*Hemophilus*
Hepatitis B								*Hepatitis B*
Varicella								*Varicella*

THIS SECTION IS THE RESPONSIBILITY OF THE PHYSICIAN. PARENT(S) SHOULD BE PRESENT FOR EXAMINATION.

Date of Examination Height Weight Blood Pressure Hearing: Right Left Tympanogram: Right Left Hematocrit Hemoglobin Sickle Cell Urinalysis

Vision: Right 20/ Left 20/ Vision Corrected: Right 20/ Left 20/ Glasses - Contacts (circle one) Color Vision Tuberculosis risk screen circle one: Low *High *Tuberculosis skin test: Date Type Result

CIRCLE ABNORMAL AREAS - DISCUSS AT RIGHT

Appearance	Scalp	Throat	Neurological
Development	Head	Chest	Dental
Nutrition	Eyes	Lungs	Genitalia
Acne	Ears	Heart	Extremities
Rashes	Nose	Abdomen	Back (shows no evidence of Kyphosis or Scoliosis)

An additional narrative report is attached or will be forwaded - Yes ( ) No ( )

ANY CONDITION (CIRCLE):
Eczema Allergy
Asthma/exercise induced asthma
Obesity Lung
Heart Orthopedic
Diabetes Other: _____

INTERVAL NOTE: Identify any occurrences since examination which could affect participation in school, athletics or other activities

REFERRAL(S) (circle) eye, ear, dental, orthopedic, other (describe) _____ Parents need help to obtain - Yes ( ) No ( )
Please name other doctors involved in care of child:

RECOMMENDED PHYSICAL ACTIVITY:
- ☐ Full day care, preschool, physical education, sports or camp activity
- ☐ Swimming
- ☐ Modified or restricted activity (describe)
- ☐ Interscholastic athletics. If wrestling, not to go below what weight? _____lbs.

MINIMUM WEIGHT - ***REQUIRED FOR WRESTLERS ONLY***
101 108 115 122 129 135 141 148
158 168 178 188 Unlimited

A physician s written release is required to resume participation following an illness and or injury serious enough to require medical care. Give details above.

Date signed Next recommended date of examination Physician s name (please print or samp) Signature and title Phone

Prepared by the Pierce County Medical Society in cooperation with Tacoma and Pierce County preschools and schools, Tacoma-Pierce County Health Department, DSHS, child care, youth and camping organizations. Please call PCMS, 572-3666 or visit website www.pcmswa.org for master copy. Updated 10/2003.

The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

Secondhand Smoke: Frequently Asked Questions

Federico Cruz, MD, MPH, will present a comprehensive clean indoor air resolution to the Board of Health at their regular meeting in December. If adopted, this resolution will eliminate tobacco use from all public indoor spaces in Pierce County. This will protect thousands of workers in restaurants, bars, bowling alleys and other indoor workplaces, as well as the people who frequent those facilities.

The debate on this resolution will raise a number of questions, some of which may find their way to your office. The following responses to frequently asked questions about secondhand smoke may be useful to you.

How harmful is secondhand smoke?

Exposure to secondhand smoke has been shown to be responsible for increased lung cancer deaths and deaths from heart disease. Other effects of secondhand smoke include: low birth weight, asthma, and other respiratory diseases.

The 10th Report of Carcinogens from the U.S. Department of Health and Human Services lists the individual components of secondhand smoke as carcinogenic and also lists secondhand smoke itself as a human carcinogen. Secondhand smoke has been identified as a human cancer-causing agent and condemned as a health hazard by all U.S. environmental health, occupational health, and public health authorities, including: the National Toxicology Program, the National Cancer Institute, Occupational Safety and Health Administration, the Environmental Protection Agency, the National Institute for Occupational Safety and Health, the Surgeon General, and the National Academy of Sciences.

Here are some key quotes on the harmful nature of secondhand smoke:

"Smoke from the burning end of a cigarette contains more than 4,000 chemicals and at least 43 compounds that have been identified as carcinogens, including: formaldehyde, cyanide, arsenic, carbon monoxide, methane and benzene."

National Cancer Institute, "Health Effects of Exposure to Environmental Tobacco Smoke: The Report of the California Environmental Protection Agency." *Smoking and Tobacco Control Monograph* 10. 1999.

"Twenty minutes of exposure to secondhand smoke causes a nonsmoker's blood platelets to get sticky, which reduces the ability of the heart to pump, and puts a nonsmoker at an elevated risk of a heart attack."

Glantz, S.A. and W.W. Parmley. "Even a Little Secondhand Smoke is Dangerous." *JAMA* 286:462--3. 2001.

"Secondhand tobacco smoke is responsible for 53,000 deaths in the United States each year. Of those 53,000 deaths, 37,000 are from heart disease, 12,000 are from various forms of cancer and 3,700 are from lung cancer."

National Cancer Institute, *op cit.*

"It is estimated that secondhand smoke is responsible for seven lung cancer deaths, twenty-four deaths due to cardiovascular disease, twelve low birth weight infants, and seventy-one new cases of asthma (among children under five) each year in Pierce County."

The Impact of Secondhand Smoke Exposure in Washington State (Preliminary Findings). Washington State Department of Health, Tobacco Prevention and Control Program.

Aren't workers already protected?

The Washington Clean Indoor Air Act of 1985 provided a foundation of protection to the public from secondhand smoke exposure, but restaurants, bars, bowling alleys, casinos and other workplaces have been excluded. Given the young age of many hospitality workers and the current economic climate, those individuals have little choice but to continue to work in these hazardous settings.

Will non-smoking areas or extra ventilation take care of the problem?

Non-smoking sections and ventilation equipment reduce the odor and irritation of smoke, but are not able to eliminate the health risk from exposure. No safe level of exposure to secondhand smoke has ever been established. Neither the tobacco companies nor the ventilation engineers claim that ventilation addresses the harmful health effects of secondhand smoke exposure.

What does the public think about this?

Studies show that ninety-eight percent of Pierce County residents know that secondhand smoke is harmful. The majority of the public believes that all people should be protected from secondhand smoke. As of September 2, 2003, there were a total of 1,627 municipalities in the U.S. that have local laws in effect that restrict where smoking is allowed. Sixty of these municipalities require workplaces, restaurants, and bars to be 100% smoke free. There is growing support around the nation for smoke-free environments.

Where can I get additional information?

See "Smoke" page 12

The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

Federico Cruz, MD

Become Involved

"Legislators use facts the way a drunk uses a lamp post: more for support than illumination."
Anonymous

In my job as a public health director, I meet physicians in private practice on a pretty regular basis. I talk with them about pertussis, HIV testing or the newest protocols for SARS evaluation and quarantine. Invariably, however, after any other topic, the conversations come back to one theme: the mess that organized medicine has fallen in. Actually, the phrase "organized medicine" is very misleading as it implies something that often doesn't' really exist. What exists is high levels of anxiety, frustration, anger, and disillusionment. These have been building for a long time, so they are not new to anyone. I am continually surprised, though, at the reaction by physicians to these feelings.

These emotions should be a clarion call to action. A kind of "I'M MAD AS HELL AND I'M NOT GOING TO TAKE IT ANYMORE!" But the response has been muted, a general reluctance to get into the fray.

It's not a matter of not knowing how to take on an issue. In addressing tort reform, we know of the lobbying efforts of trial lawyers. They have guided the legislative process for years and have effectively killed any real reform efforts. We can see how it is done. How an organized group can influence the legislative process. But we have held back.

I have seen a similar phenomenon in public health. We are part of government. We pride ourselves in being driven by science. We take the facts (our assessments and game plans filled with best practices) to our policy setters, to our elected officials and ask them to do the right thing, to invest resources and establish sound public health policy. We share responsibilities with police and fire: protecting the public. Yet, over the last twenty years, we have been ignored, written out, underfunded, and misperceived. The public health system has practically fallen apart, resulting in our inability to protect our communities from public health threats.

A couple of years ago I attended a retreat with my Board of Health (they are all elected officials from city and county government). Part way through my presentation, one of the members interrupted me and said, "Dr. Cruz. Stop it! I know what you are doing. You are trying to confuse me with the facts. But I don't make decisions based on facts." At the time I stared at him flabbergasted at such an admission.

I didn't know what to say as the public health ethic is based on facts. But I was wrong and he was right. Many, if not all, politicians make decisions based on many factors, one of which may be facts, but there are many others: power, control, ambition, loyalty, vendettas, debt repayment, gamesmanship...the list is long but the point is we are very naive to think that facts alone will carry us through to the desired outcome. It doesn't happen. You must enter the political arena and learn all the factors that are in play. And then and only then can you make progress.

If we wish tort reform or other changes in medicine to happen, we have to get off our backsides and become more involved with politics. This means putting in the time and your own resources. It's just that simple.

For some people, running for office makes sense. You can force issues among other candidates, argue your points intensely and in public, and encourage others to either join you or state they are opposed. For others, a less dramatic approach makes sense. How hard would it be to attend a political caucus meeting and raise the issues that impact "organized medicine?" How about writing a letter to the editor, to your congressional delegation, or state legislators. Don't forget, simple facts don't work. Look at elected officials' voting records and connect something you care about to something they care about.

Taking action beats whining and resting on hope. Make your voice heard! ■

In My Opinion.... The Invisible Hand

by Andrew Statson, MD

The opinions expressed in this writing are solely those of the author. *PCMS invites members to express their opinion/insights about subjects relevant to the medical community, or share their general interest stories. Submissions are subject to Editorial Committee review.*

Relative Value

Andrew Statson, MD

"Everything is worth what its purchaser will pay for it."
Publilius Syrus (first century BC)

What is the relative value of hamburger and pork chops, or carrots and green beans, of oranges and peaches? Foolish question. Their price is determined by the market and varies according to supply and demand. The role of the marketplace is to bring sellers and buyers together and to determine the price at which the supply matches the demand, so that for every seller there is a buyer.

Any interference with that balancing act distorts the economy. When the price is artificially set too low, there is an increase in demand and a drop in supply, leading to shortages. When the price is set too high, the demand decreases and the supply rises, resulting in a wasteful glut.

A subsidized price raises the payment to the producer, thereby increasing supply, and at the same time reduces the cost to the consumer, thereby increasing demand. The result is a jump both in prices and in volume of consumption. That happened in medicine with the enactment of Medicare. Most of our patients, the consumers of medical services, received subsidies to purchase what we offered. The jump in demand led to a shortage of hospital beds and OR time. New hospitals were built and old hospitals expanded.

The inflation of the seventies aggravated the situation, but even adjusted for inflation, medical spending rose sharply. Total expenditures on personal health care increased fifty-fold between 1960 and 2000, from $24 billion to $1.2 trillion. During the same time, the value of the dollar dropped ten-fold. This increase in spending exceeded the wildest projections made during the debate on the Medicare bill. Yet comparisons are difficult. The population is larger and older. Our diagnostic and therapeutic methods are more effective, but more expensive.

The third parties paid the bills and wanted a fee schedule. In response, the California Medical Association published its Relative Value Schedule in the mid-sixties, while the AMA developed the CPT coding system. Then, Medicare came up with its DRG for hospitals and RBRVS for us. Our services are not priced by the market any more. The paperwork burden we face today is the result.

Simple fee-for-service means that we provide the service and the patient pays the fee. No longer. Now we must prove that the patient needs the tests we order and the treatments we prescribe. We must code the diagnosis and the treatment, submit our bill and wait for payment.

I have heard the argument that we need to document our findings anyway and the coding itself shouldn't take more than a minute, at a cost of only four dollars of our time. Perhaps, but does it really take only a minute? When documenting for the patient, we don't need to detail most of the negative findings. They do not affect care. To satisfy the third parties, however, we have to list the questions we ask and the findings we observe, to substantiate what we did.

Even so, the above is only the actual time for coding every visit, assuming that we know the correct code. It does not include the time and the cost to learn the codes and their yearly updates, nor the time to look them up when we don't know them.

Computerized medical records may help, but computer programs cost money, too, and take time to learn. They also have other problems, but I won't go into that now.

I doubt that our cost per statement is less than $10, equal to 2.5 minutes of our time, and may be closer to $20. If we saw one hundred patients every week, at $40 per statement, that would amount to $1,000 per week, $50,000 per year. That is time we would not have to spend in a simple fee-for -service system.

The questions here is, "Yes, but will the patients pay?" or maybe, "They might pay for office visits, but will not be able to pay for operations and procedures, or for hospital care." That is a valid question. The answer has two parts.

The first is that the prices are distorted because the free market does not currently operate in medicine. Our prices probably would be lower and our

See "Value" page 14

In My Opinion....

by Daisy Puracal, MD

The opinions expressed in this writing are solely those of the author. *PCMS invites members to express their opinion/insights about subjects relevant to the medical community, or share their general interest stories. Submissions are subject to Editorial Committee review.*

Autumn

Daisy Puracal, MD

Driving down a road lined by evergreens interspersed with maple trees, to my delight, a single wrinkled red brown leaf descends directly down in front of me, settles on the hood of my car for a moment before it drifts off again to the ground. The descent was gentle and unhurried, swaying in time to a lazy beat - a prediction of things to come - the first fallen leaf of autumn.

Autumn - a word that generates romance and warmth; a season of warm vibrant colors shocking the senses with its spectacular deep shades of reds, purples, yellows and browns. I thrill to the vision of ravishingly flaming charm. Growing up in tropical Singapore, I had no idea that leaves on trees could be so stunningly beautiful, leaving one with a heady sensation. And yet, there is a cool chill in the air, a tantalizing hint of winter to balance the sultry tones. "A season of mists and mellow fruitfulness,"says Keats. It is a season of "in betweens" - of summer and winter, of warmth and cool, of maturity and incipient decay. It is a season of subtle layers and depth.

There is a feeling of regret that summer is over, a feeling of anticipation of the snows to come, a feeling of buoyancy with each un-anticipated sunny day - a surprise package to be lingered over and savored, knowing that dark days wait around the corner.

The pine needles will blow into my driveway to be picked up by the rotating tires of my Toyota and trampled into the foyer. The leaves from the trees in the back yard will shed and lie in piles on the ground and chase around in circles in its play with the wind.

The winds will soon be blowing stronger to huddle me into my jacket. Feeling the cold wind whip through me I will marvel at the Tibetans practicing Ptumo - a dedicated, meditative practice of mind over matter. I will breathe in the cool air, the breathe of God, the ruach, and feel it permeate my body with its transforming and rejuvenating spirit.

It soon will be time to change the sheets from cotton to flannel and to pile on the layers of bedding. It will be time to barricade the window side of the bed with pillows as a shield from the penetrating cold. There was a time when a man was that physical shield - a fantasy dream in a child's mind.

This is the autumn of my life - a delicate balance of growth, life and death.

I can choose to view my fall years as a period of maturity or of decay, the two faces of a season. It is as I shift my lens to the positive that I know I can make it through another season. ■

Attention Deficit Disorder Resources

Attention Deficit Disorder Resources (ADDR) is a non-profit organization dedicated to supporting, educating, and serving as a resource for those whose lives are impacted by Attention Deficit/Hyperactivity Disorder (AD/HD).

Their mission is to educate the public about AD/HD and its effect on individuals, families, classrooms, workplaces, and communities. They provide information, support, and education services to help people with AD/HD so they may achieve their full potential.

ADDR is a nonprofit organization located in Tacoma and serves the local Puget Sound community with support meetings, educational events, and office services. Through their website, they reach people across the U.S., Canada and beyond. Visit them at www.addresources.org.

They conduct monthly support meetings for adults with AD/HD and parents of children with AD/HD. The "Adults with AD/HD" support meetings are held the second Wednesday of each month form 7:00-9:00 pm at Jackson Hall. They also offer a "Parents and Teachers of Children with AD/HD" support meeting the third Monday of each month from 7:00-9:00 pm at Jackson Hall (across from Tacoma General), 314 ML King Jr Way, Tacoma. The meetings are free and open to the public. No registration needed. Usually there is a speaker for the first hour, followed by questions and answers for 30 minutes, followed by time for visiting with others, purchasing books and memberships, or borrowing from the lending library.

ADDR periodically sponsors workshops and conference for adults with AD/HD, parents of children with AD/HD, teachers and other helping professionals. They are offering "Master Class for ADHD Clinicians and Therapists" on February 7, 2004 for those who want to take their knowledge to the next level.

Additional services provided by ADDR are a quarterly newsletter, a lending library featuring over 450 titles including audiotapes, books and videos on AD/HD and related subjects, a bookstore which features quality books and tapes on AD/HD-related topics, and public directories to help find coaches, clinicians and support groups in your area.

New members can join ADDR for $20 with annual dues of $25. Please contact Attention Deficit Disorder Resources at 253-759-5085 for more information. ■

Applicants for Membership

Pamela A. Girres, MD
Occupational Medicine
Group Health
9505 S Steele Street, Tacoma
253-680-6703
Med School: Tufts University
Internship: Emory University
Residency: Emory University
Fellowship: Emory University

Susan E. McDonald, MD
Family Practice
Sound Family Medicine
19820 Hwy 410 E, Bonney Lake
253-848-5951
Med School: University of Washington
Internship: Valley Medical Clinic
Residency: Valley Medical Clinic

Adam Mays, PA-C
Orthopedics
Puget Sound Spine Institute
1515 Martin L King Jr Way, Tacoma
253-572-2663
Training: University of Washington

Lisa R. Nordberg, DO
Family Practice
Summit View Clinic
11019 Canyon Rd E Suite A, Puyallup
253-537-0293
Med School: University of Health Sciences College of Osteopathic Medicine
Internship: Park Lane Medical Center
Residency: University of Missouri

Tammara S. Stefanelli, MD
Family Practice
2517 N Washington, Tacoma
253-759-3586
Med School: Creighton University
Internship: San Joaquin General Hospital
Residency: University of Washington
Residency: University of Michigan

Sean S. Stout, MD
Family Practice
Sound Family Medicine
19820 Hwy 410 E, Bonney Lake
253-848-5951
Med School: University of Utah
Internship: Memorial Hosp of South Bend
Residency: Memorial Hosp of South Bend

Keyi Yang, MD
Neurology
Mt. Rainier Neurology
1708 S Yakima #118, Tacoma
253-573-0460
Med School: Shanghai Second Med Colle
Internship: Hermann Hospital, Texas
Residency: Hermann Hospital, Texas

Smoke from page 6

Centers for Disease Control: www.cdc.gov/tobacco

10th Report on Carcinogens - U.S. Department of Health and Human Services: http://ehp.niehs.nih.gov/roc/toc10.html

Americans for Non-Smokers' Rights: www.no-smoke.org

Surgeon General's 1986 Report on Secondhand Smoke: www.cdc.gov/tobacco/sgr/sgr_1986/index.htm

American Cancer Society (put "Secondhand Smoke" into the search window for their fact sheet): http://www.cancer.org

International Agency for Research on Cancer (World Health Organization) monograph: http://monographs.iarc.fr/htdocs/indexes/vol83index.html

Tacoma-Pierce County Health Department: John Britt, Prevention Coordinator, 253-798-2881 or e-mail at jbritt@tpchd.org ■

Tort Reform Contributions

In a effort to "turn up the heat" on the battle for tort reform, the Washington State Medical Association's "Campaign for Tort Reform" is seeking your support. They are asking all Washington State physicians to contribute $250 towards the campaign.

Through the support of physicians around the state, it will be possible to implement a statewide liability reform campaign to apply pressure to the Washington State Legislature through: mobilizing grassroots activists, galvanizing public support, and targeted media activity.

The very best way to get a legislator's attention is through a well-funded political action committee. The only way the legislature will act is when its members see physicians making a real commitment to political action.

One Tacoma office in particular is demonstrating their commitment to political action this holiday season by replacing the fruit basket or plant they would normally send to all of their colleagues' offices with a card and donation made in the name of that doctor(s) to the WSMA Tort Reform Campaign.

Please contact the Washington State Medical Association at 800-552-0612 for more information on supporting tort reform. ■

COLLEGE OF MEDICAL EDUCATION

Whistler Condo Reservations Urged

Ski-in/ski-out condos at the Aspens Condos (the conference meeting location) may be available for the College's CME at Whistler/Blackcomb program set for January 28-31, 2004 - on a space available basis.

If you're interested in the program, and a great ski vacation and location, reservations can be made by calling toll free at 1-866-788-5588. You must identify yourself as a part of the C.O.M.E. group.

For more information call the College at 253-627-7137. ■

Hawaii Hotel, Flight Reservations Urged

Those interested in attending CME at Hawaii are urged to make plans now for both air transportation and lodging.

All Wanderlands Travel, specifically Jeanette, 572-6271, is prepared to assist you in securing your seats.

To take advantage of the reduced rates at our conference hotel - The Hyatt Regency Kauai - you can call directly to 1-808-742-1234.

We hope to see you there! ■

Continuing Medical Education

Primary Care Cardiology CME set for evenings of January 13 & 20

The College's seventh annual program featuring subjects on cardiology for the primary care physician will be held at St. Joseph Hospital, Lagerquist Conference Center Rooms 1A & B. The course will be directed by **Gregg Ostergren, DO**.

This year's Cardiology for Primary Care CME program will again be offered on two evenings in two consecutive weeks in January, instead of the traditional 6-hour program on a Friday. This year's program is scheduled for Tuesday, January 13 and Tuesday, January 20 from 6:00 pm to 9:00 pm on both nights.

The program will begin with three hours of CME on the 13th and end with three *additional* hours of CME on the 20th. The change is in response to expressed interest by physicians from the College's recent CME survey. Physicians are finding it difficult to take time away from their office hours.

Topics will include:

- Current Testing Strategies for Assessing Your Patients' Cardiac Issues
- Congestive Health Failure and Diabetes
- Understanding Cardiac Disease in Women
- Comorbidity of Depression, Anxiety and Cardiovascular Disease
- Cholesterol and Cardiac Risk and Disease
- Diagnosing and Treating PFO ■

Dates	Program	Director(s)
Friday, December 5	Advances in Men's Health	Michael Kelly, MD
Tuesdays January 13; 20	Cardiology for Primary Care	Gregg Ostergren, DO
Wednesday-Sunday Jan 28 - Feb 1	CME @ Whistler	John Jiganti, MD Rick Tobin, MD
Friday, February 27	Endocrinology for Primary Care	Ronald Graf, MD
Thursday-Friday March 11-12	Internal Medicine Review 2004	Gurjit Kaeley, MD
Monday-Friday April 12-16	CME at Hawaii	Mark Craddock, MD
Friday, April 30	Allergy, Asthma & Pulmonology for Primary Care	Alex Mihali, MD
Friday, May 21	Advances in Women's Medicine	John Lenihan, Jr., MD

Value from page 8

costs definitely would be. The few physicians who have dropped out of all insurance plans and see patients on cash only basis usually charge a fraction of what we bill, but get paid in full at the time of service.

The second is that many patients today pay for services they want, including operations, which are not covered by insurance. Ask any plastic surgeon or alternative medicine physician for details. I have seen patients barely scraping by for essentials, who paid for their liposuction or breast implants, even to the point of borrowing thousands of dollars to do it. Economic activity is about ordering priorities and people do just that.

Reuters recently reported that in Britain, patients forgo home improvements and vacations, or tap friends and relatives for cash gifts for birthdays and holidays and use the money for cosmetic procedures.

There is a new coding system on the horizon. The IDC codes will increase from the 10,000 we now have to 14,000. How much will it cost us to learn them? How much time will we spend to code every individual service? Do you think it will be less than five minutes per statement? Coding costs could easily double as a result. Applied to 100 patients per week, at $20 per statement, they will amount to $100,000 per year. That will be another straw, added to the burden we already carry.

To add insult to injury, we are faced with various civil and criminal penalties if we should make a mistake in our coding. Some experts say that both overcoding and undercoding are illegal and subject to penalties, yet most of us tend to undercode, because we think that we are less likely to be audited. That is probably true, but we also shortchange ourselves in the process.

We also have to warn patients in advance when we provide a services that may not be covered. They have to sign a statement agreeing to the charges, so we can collect from them. How many times do we treat, then receive a letter from the insurance company that the patient is not eligible for the service, or that we have done something wrong in filing the claim? All too frequently, in such situations, we have no recourse but to write off the account.

Yet most of us cannot afford to drop our contracts with Medicare and Medicaid. We are stuck. We hope that they will relax the rules and make things easier for us. That is not going to happen. As our governor said when defending the Payment Integrity Program, he is responsible to the taxpayers and has to make sure their money is spent according to the law. The same is true of the federal programs. That is why they have their Correct Coding Initiative, Operation Restore Trust, and all the other regulations pertaining to documentation in the practice of medicine. For our part, we have to have a compliance program and pay for it. Another straw.

Things are not going to change. Uncle Sam will not suddenly open his wallet and let us help ourselves to our content. My hope is the development of a parallel system of health care, in which the government is not a part. We provide the services and the patients pay the fees. If they have insurance, they file for reimbursement. We don't get involved in that.

In France, the patients go to their physicians and pay the fee. Then they file for reimbursement. If they don't want to pay full price, they can go to the public clinics for care. In Australia also the fees are not controlled. The physicians can charge the patients directly and let them get reimbursed by the Health Service according to the official schedule. ■

Classified Advertising

POSITIONS AVAILABLE

Tacoma/Pierce County outpatient general medical care at its best. Full and part-time positions available in Tacoma and vicinity. Very flexible schedule. Well suited for career redefinition for G.P., F.P., I.M. Contact Andy Tsoi, MD (253) 752-9669 or Paul Doty (Allen, Nelson, Turner & Assoc.), Clinic Manager (253) 383-4351.

Established Auburn Family Practice seeking Board Certified or Board Eligible physicians to join our group. Base salary plus incentive program for motivated Doctor. Part time or full time hours available. Fax CV to 253-839-5565.

Family Practice office in search of a motivated team member: DO, MD, ARNP. Please send curriculum vitae and references to 253-566-4620 or e-mail to sharonlmgr@aol.com.

Washington State Division Of Disability Determination Services. Medical Consultant Positions Available.
The State of Washington Division of Disability Determination Services seeks physicians, including psychiatrists to perform contract services in the Olympia office. Contract services include the evaluation of mental impairment severity from medical records and other reports, utilizing Social Security regulations and rules. Medical Consultants function as members of the adjudicative team and assist staff in determining eligibility for disability benefits.
Requirements: Current Medical License in Washington State. Board certified desirable. **Reimbursement**: $57.01/HR. Interested physicians should contact Gene Profant, MD, Chief Medical Consultant at (360) 664-7454 or Mary Gabriel, Regional Manager, North at (360) 664-7362 or Sheila Davidson, Regional Manager, South at (360) 664-7365.

OFFICE SPACE

For Rent: 3300 sq ft Class A medical office in Tacoma Medical Center, 1112 6th Ave, third floor. Elevator, underground parking, close to hospitals. Call 253-272-2224.

Medical Office Space For Lease. Prime location across the street from Good Samaritan Hospital. Approximately 3,200 sq. ft. Turn-key, beautifully appointed, excellent floor plan, perfect for multiple physicians. For more information contact Norma, 360-458-3752.

Choice office space in Medical/Dental complex in Gig Harbor available January, 2004. 2,354 sq. ft. on main floor. Two entrances, offices with decks and outside doors. Large reception and front office. Lab space, consultation room, heat, electricity and water included. Beautiful, wooded setting. 5122 Olympic Dr NW, Suite A203. Call Dr. Mary Griffith 851-7550, 468-3539.

Pierce County Medical Society
223 Tacoma Avenue South
Tacoma, WA 98402

Return service requested

PRESORTED
STANDARD
US POSTAGE PAID
TACOMA, WA
PERMIT NO 605