Pierce County Medical Society
BULLETIN

January, 2005

The 2004 Annual Meeting

Dr. Patrick Hogan (right) accepts the 2005 gavel and Presidency from Dr. Mike Kelly at the PCMS Annual Meeting

Dr. Mike Kelly (left) congratulates Dr. Leonard Alenick, recipient of the 2004 Community Service Award

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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.

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President's Page

by Patrick J. Hogan, DO

What is on the Menu for 2005 for the Pierce County Medical Society

Patrick J. Hogan, DO

Unity through diversity is on the menu for this next year. We have diverse great talents in your board members with diverse viewpoints all working on diverse issues toward the goal of an even stronger and healthier PCMS in the next year.

What is a tort?

Valiant leadership will be provided to reform Tort by **Dr. Mike Kelly** (the king of Tort Reform) and **Dr. Joe Jasper**. They will be spearheading the newly formed task force for successful passage of our statewide initiate for litigation reform. We are aware that not everyone in the medical community is as enthusiastic about this measure as others are. Yet these efforts will have a positive effect on all practices and need to be supported wholeheartedly.

Keep Practicing

Tort Reform is just one of many diverse issues directed specifically at keeping physicians in practice and maintaining access to care for patients.

We will also be involved with the Alliance for Patient Access dealing with working with insurance companies directly for policy change on reimbursement issues and approval of treatments recommended by physicians.

History will repeat itself

PCMS has historically always been the center for campaigns for promotion of issues to directly improve the health of our community. Promotion of disease prevention measures will be a major theme for this year. We are fortunate to have opportunities this year that will provide long term health benefits for our community.

Smoke out

The initiative to make Washington the 14th state to prohibit smoking in all public places will be reintroduced with greater support and organization in January. We will need the universal enthusiastic support of all medical society members to get it on the ballot and passed into law. Please watch for much more information in the PCMS *Bulletin* and mailings soon to come appealing for your help with this tremendous cause.

Over the next year all hospitals in Pierce County will voluntarily enact and enforce total smoke free campuses for patients, employees and visitors. Both of these tobacco control measures will directly result in the decreased use of tobacco in Washington State and achieve the objective of preventing tobacco related diseases. As people become more motivated for tobacco cessation, PCMS will help the medical community to become better prepared to provide their patients with effective assistance for permanent smoking cessation. **The best way to treat disease is to prevent it.**

Fit Happens

Along the same health promotion theme, one of the foremost objectives will be to implement programs to enhance physical fitness in the community. This is in part in response to a directive from the surgeon general who has stated that obesity has now become the greatest preventable cause of illness and death in our country and efforts need to be made to curb this epidemic. However, obesity control should not be the objective in itself. Instead of weight control, it is far better to emphasis **fitness** no matter what size a person is. The principle is not to diet to lose weight but to live in as healthy a manner as possible with exercise and proper nutrition being part of daily life.

Be All That You Can Be

As physicians we are often in the roll of firemen, responding to disease fires as they occur while accepting the patient in a sedentary capacity. It is even more rewarding to maximize the patient's quality of life by shifting our approach to helping each and every person to reach their potential maximal capacity and thereby avoid disease. This can only be done through an exercise program tailored for the individual patient.

Exercise as Medicine

Groups throughout the U.S. are re-

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sponding to this directive to promote fitness. Pediatric associations are implementing measures to increase fitness in children. **Dr. Jane Moore** is promoting a program *Action for Healthy Kids*. FHS will have a series of nutrition and fitness lectures at the convention center in the next three months. (See further details on enclosed insert.)

The AMAA (American Medical Athletic Association) has rolled out a 12-week program for schools called Run-Walk America. The AMAA leadership has challenged PCMS to develop a template for enhancing fitness through the medical community including all care providers and staff. We must lead our patients by our good example. It is the hope to modify the Run-Walk America program along with other motivational incentives that would then be promoted by the AMAA in medical communities throughout the country. Dr. Charles Schulman, the Boston-based cardiologist and president of the AMAA, will be scheduled to speak to our medical society and supporting staff this year on the concepts of "Exercise as Medicine."

There will be a monthly *Fit News* section of the *Bulletin* (see page 5) that will include guidance and motivation on the principles of exercise and nutrition that can be copied for medical staff and patients. Comments, additions, or objections about this information are very welcome to help refine the optimal programs for our community.

The city of Moses Lake has recently accepted the challenge from the Washington State Health Department's Obesity prevention program to increase fitness throughout the whole community. With a similar commitment we can meet the challenge to our medical community that will then become a living example to the general community. It has the eventual potential for improving the health and well being of millions of Americans.

These changes don't come easily for tort reform, tobacco control or fitness enhancement but can be accomplished with perseverance. As Margaret Mead said, "Never doubt that a small group of people can change the world. Indeed it is the only thing that ever has."■

Fit News/Nutrition - #1

by Joan Brookhyser, RD, CSRCD

Exercise: The prescription for prevention and treatment of all disorders

The best way to break the barriers to maintaining a regular exercise program is to provide ongoing motivation and pursuing an exercise goal. We all know that exercise makes muscles stronger but the benefits of fitness goes well beyond the muscles themselves. Below are some of the other benefits that will be expanded upon in subsequent *Bulletin* "Fit News" sections to enhance motivation for each individual. **Additions to this list are welcomed: Patrick J. Hogan, DO, hoganpsn@ aol.com.**

1. Fat and fit is healthier than thin and unfit.
2. Exercise improves bone health. Weight bearing impact exercise or resistance training reduces the risk of osteoporosis.
3. Exercise can help prevent and better manage diabetes. Exercise increases insulin sensitivity and has an insulin-like effect in consuming excessive blood glucose.
4. Exercise makes day-to-day life activity easier and thus **reduces fatigue**.
5. Exercise is fun and exhilarating once a person can establish fitness. Find the exercise program that you will enjoy on a long term basis. Diversity of types of exercise promotes persistent of an exercise program.
6. Exercise has been shown to lower the risk of breast cancer and improve the response to treatment if breast cancer is present.
7. Exercise helps prevent heart disease and is all important in recovery from a cardiac ischemic event.
8. Exercise helps prevent all vascular events including stroke. Exercise is what stimulates the cerebral synapses necessary for recovery from stroke deficits.
9. Exercise lowers cholesterol and raises the HDL and lowers blood pressure.
10. Exercise is a key factor in long term success for tobacco cessation or control of any drug addiction. Exercise activates the brain's frontal reward circuit that is integral in providing a substitute to the effects of tobacco or other addictions.
11. Exercise is one of the best measures to improve the sense of well being, quality of life perception, stress control, self esteem and has an actual antidepressant and antianxiety effect through direct cerebral neurochemical changes.
12. Exercise enhances the immune function. There are less viral processes and less time loss from work in those involved in a fitness exercise program.
13. Exercise improves sleep quality by many mechanisms to be discussed.
14. Exercise raises the pain threshold and is vital for any pain control program.
15. Exercise helps prevent migraine and is a part of any migraine disorder treatment.
16. Exercise improves balance, prevents falls, and forestalls the natural deterioration of postural balance usually associated with normal aging or Parkinson's.
17. Exercise stimulates brain connections as demonstrated in good studies showing the activation of synapses previously lost in some neurodegenerative diseases.
18. Exercise is the most important component by far in achieving and especially maintaining healthy weight loss.
19. Exercise allows a person to enjoy eating without guilt or weight gain.
20. Exercise enhances sexual function in both men and women through associated positive hormonal changes, vascular, and cerebral neurochemical activation.

-OVER-

Does Atkins Work?

When I first became a dietitian 25 years ago it was the beginning of the fat free eating era. People flocked to bagels and fat free pretzels. Soon to follow was a surge of "fat free" products, including fat free cookies, cakes and ice cream. However, without success, waistlines continued to expand into the millennium, obesity topping at 60 % of the American population.

We currently stand at the threshold of high protein diets, or better known on LCHP (Low carbohydrate, high protein) eating. "Low carbohydrate," "net carbohydrate" and high protein labeling has now replaced "fat free." My prediction, and studies are bearing this out as I write, is waistlines will continue to stretch and it won't be long until the public again searches for an easy answer to a complex, epidemical problem.

It is true some studies do show a benefit to a higher protein diet, compared to a lower protein, high carbohydrate diet of the same caloric level. An example of such diet plan would be the South Beach type diet. Keep in mind however, most of these diets are successful not for any magical food formula but because of one common thread; they eliminate all the concentrated calories that contributed to obesity in the first place. Whether Atkins, South Beach or Pritkin, all advocate a moderation of processed foods high in refined carbohydrates, saturated and hydrolyzed fats, minimal or no alcohol or desserts, and generally lower in overall calories. Many of the processed foods increase insulin resistance, leading to the new lingo "metabolic syndrome," thought to be the one cause of heart disease and Type 2 Diabetes. Probably the same weight losing benefit could be achieved by eliminating these foods alone; unfortunately though, not very glamorous or marketable.

For those that choose a high protein diet program, these diets do not come without risk for certain populations. Is the patient diabetic, do they have diabetic nephropathy, microal-buminuria, liver disease or at risk for osteoporosis? The high protein diet can lead to more progression of these diseases or complications of these diseases. In addition, the high protein diets are a trade off of other benefits that high complex carbohydrate diets can offer, more fiber, more phytochemicals and other nutrients we know to be disease preventing.

Most people who are searching for the magic diet have lost their common sense for healthy nutrition. They need to be reminded that losing weight is a lifestyle change, one that involves reducing their intake of processed foods, getting back to whole grain, fresh foods in moderation, moderation of alcohol and in addition increasing physical activity. They may need the gentle reminder that one does not gain weight overnight and as a result will not lose the weight overnight. A dietitian who specializes in weight management will help them understand their nutritional needs and how to incorporate healthy nutrition into their lifestyle. Long term support and reinforcement is often needed.

Patients do not always like reality; they come to you for the magic pill to make it better. This is one area where, as yet, there is no pill, just WILL!

This is the first in monthly articles that will be written on popular nutrition topics. Next month: *Are Eggs Bad For You?* ■

Annual Meeting Recap

2004 Annual Meeting - fun and provocative

The 2004 PCMS Annual Meeting brought the Sheraton Ballroom to life on December 14 as old and new colleagues and friends mixed and mingled. There was a full agenda for the night with awards, speakers, raffle drawings, introductions of incoming and outgoing leadership and other such happenings.

Highlights of the evening included a tribute to the Community Service Award recipient, **Dr. Len Alenick** (see page 9), an unfortunate farewell to long time College of Medical Education staffer, Les McCallum (see page 11), and a great speaker who inspired and motivated everyone about living a full and satisfying life.

President **Mike Kelly, MD** opened by thanking members of the Tacoma Youth Symphony for providing beautiful holiday background music. He introduced Nikki Crowley, PCMS Foundation Treasurer who each year orchestrates the holiday sharing card project. PCMS owes a debt of gratitude to Nikki for all her work in raising Foundation money. Nikki introduced Laura Yu, artist of the holiday sharing card for the past several years. Laura, daughter of **Amy Yu, MD**, donates her time and talent to production of the artwork which is a huge contribution to the Foundation, for which PCMS is grateful.

This year's raffle winners were **Dr. John Rowlands** and Spencer Kelly, son of Dr. Michael Kelly, who both won gourmet food baskets. **Dr. Tim Schubert** and his wife Arlene won five monthly food deliveries from Simply Northwest.

Dr. Kelly asked for a moment of silence in honor of colleagues that died during the past year. They included, **Drs. Michael Haynes, George Kunz, Lewis Litvin, Charles Vaught** and **William Wright.**

Having developed a "newfound appreciation" for past-presidents, Dr. Kelly asked that each of them stand and introduce themselves and note the year they served. In addition to Drs. Kelly and Rooks, the following were recognized: **Patrice Stevenson (2001), Charles Weatherby (2000), Larry Larson (1999), John Rowlands (1996), David Law (1995), Gordon Klatt (1990), Dick Bowe (1987), Pat Duffy (1984) George Tanbara (1981), David Hopkins (1976)** and **Jim Early (1975).** He thanked them for their service noting that they were wonderful leaders, even visionaries, with a poorly developed sense of fear and no concept of the odds against them.

Dr. Ken Feucht, PCMS Vice President had the honor of introducing the speaker for the evening, Mr. David Thomas. Mr. Thomas spoke on living a life of integrity and learning to focus on what matters most. He highlighted integrity as something that tests us when we are alone, tests us when we least expect it, and if and when we deviate from our integrity we will usually have a bad outcome.

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Past President Pat Duffy, MD is flanked by his wife Suzy, right, and PCMS Foundation treasurer Nikki Crowley

John Rowlands, MD - proud raffle winner

Dr. Tim Schubert with wife Arlene, also winners

Spencer Kelly, son of Dr. Mike Kelly, won a basket

Mike Kelly presents Pat Hogan with his gavel

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He spoke of integrity as a sphere, with different but equal parts. The first and most obvious is honesty, and although this is correct, when it comes to truthfulness, there is also depth. He summed it up in one sentence, "to tell the truth is to not merely state the facts, but to give the true impression (i.e., no exaggerations)."

Empathy, genuineness, and accepting responsibility are additional cornerstones of integrity. One must stand up for convictions and not play blame games to keep your integrity intact.

Doing the right thing **because** it is the right thing to do; with a clear knowledge of right and wrong is paramount to having integrity. Mr. Thomas reminded everyone that others may take away your health, your riches, or even fame, but nobody can take away your integrity.

He also talked about "the dash," which is the dash between the year you were born and the year you die. After citing an insightful verse about living life to the fullest, he reminded everyone to look after their own dash.

Dr. Kelly thanked Mr. Thomas for his excellent and provocative presentation and went on to thank the Board of Trustees and WSMA representatives for their service during the past year. He thanked **Drs. Jim Rooks, Pat Hogan, Ken Feucht, Sumner Schoenike, Joe Regimbal, Laurel Harris, Joe Jasper, Ron Morris, Jeff Nacht, Navdeep Rai** and **Carl Wulfestieg**. And, **Drs. Len Alenick, Patrice Stevenson and Nick Rajacich** for serving on the WSMA Board.

He also thanked his wife, Sam Kelly and presented her with flowers, noting that "without the understanding and encouragement of my wife to our shared goals of access to quality medical care and the medical-political agenda, I could not have been as available. (PCMS thanks Mrs. Kelly!) He thanked the PCMS staff for their work and recognized a sampling of his colleagues he called the "doers":

· **Federico Cruz,** our very own Health Department director, who led the way by running for governor.

· **Matt Rice**, local emergency department physician, who mounted a strong campaign to unseat incumbent Rep. Pat Lantz in the 26th district.

· **Ron Morris** who committed himself to the daunting task of running for the state house of representatives from the 25th district.

· **Pat Hogan** who led the statewide effort to make the Washington workplace smoke-free.

· **Dan Nehls** who became the lord of the overpass in Gig Harbor as he organized the early-morning sign waving for legislative candidate Matt Rice.

· **Joe and Donna Jasper** who gave generously of their time for many medically friendly candidates, including a fundraiser for Sen. Mike Carrell. And,

· **Ken Feucht** who went door-to-door with legislative candidate Wally Nash in Puyallup to energize Wally's campaign.

"These are but a sampling of the energized, organized and politicized physicians, friends and family who contributed to the medical political agenda this past year." While noting that he could not mention everyone who had contributed, he thanked everyone on behalf of the medical society, with the understanding that "we know who you are and greatly appreciate your efforts."

After explaining how the PCMS President's position had "stretched" him in ways he thought not possible, he thanked the audience for the opportunity. "It was daunting, time consuming, challenging, frightening, while at the same time rewarding, self-revealing and wonderfully satisfying," he explained.

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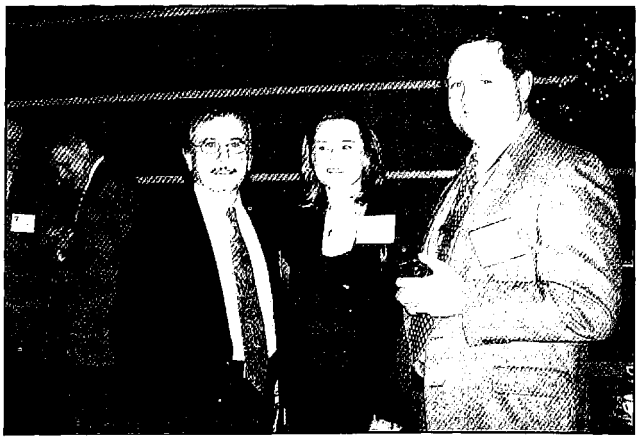

Dr. Nick Rajacich (right) visits with Dr. Maan Salloum and Laurel Lunden during the social hour. Dr. Rajacich serves as a trustee on the WSMA Board

Dr. Tim Schubert and wife Arlene (center) visit with Dr. Steve Duncan and wife Lynda. Both Drs. Schubert and Duncan sit on the PCMS for-profit subsidiary Board of Directors

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With one last thing to do before turning the gavel over to Dr. Pat Hogan, Dr. Kelly asked **Dr. Jim Rooks** to come to the podium. "Seven years of service is quite significant," he noted. He extended his thanks on behalf of the board and membership to his friend and colleague Dr. Rooks for serving as a trustee, secretary, treasurer, vice president, president-elect, president and immediate past president. "You will be missed, but not forgotten," Dr. Kelly noted as he presented a gift and thanks to Dr. Rooks.

Dr. Kelly asked about the future. And he had two words for an answer. Pat Hogan. He introduced the President for 2005, Pat Hogan, and presented him with his gavel, thanking him for his willingness to serve as PCMS President.

Dr. Hogan thanked Dr. Kelly for his tireless efforts, particularly in the tort reform arena, and presented him with a plaque and a gift. He christened him "King of Torts," explaining his Irish descent, his fighting spirit and how he had raised the bar. (After investigation, however, Dr. Hogan learned that his grandfather had "owned" the bar.)

Dr. Hogan introduced new trustees for 2005, **Drs. David Bales** and **Loren Finley** and previewed his plans for the year to continue works on tort reform and smoke free public places, particularly the finalization of hospitals to have smoke free campuses. He will focus on campaigns of health promotion in the arena of nutrition and exercise to improve the health of our medical community. Fitness and better dietary choices will be emphasized. ■

Vice President Ken Feucht, MD, Puyallup general surgeon, introduces the speaker for the evening

President Mike Kelly and speaker David Thomas visit before the meeting

Sam Kelly, wife of Mike Kelly, was thanked by her husband for her support and given flowers by her son Spencer

Drs. Yu Zhu and David Bales (from left) with Dr. Neville Lewis and wife Susan and Jim Patterson and wife Barbara

New Board of Trustees will lead PCMS in 2005

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.

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.

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.

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.

Sumner Schoenike, MD practices pediatrics in Lakewood. He graduated from Baylor College of Medicine. He completed his internship and residency at Maricopa County General Hospital and a fellowship in psychiatry at Oregon State Hospital.

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

David Bales, MD is a Tacoma internist. He graduated from the University of Arkansas Medical School. He completed his internship at William Beaumont Genebral Hospital, internal medicine residency at Madigan Army Medical Center as well as a fellowship at University of COlorado Health Science Center in infectious diseases.

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.

Loren Finley, MD practices ob/gyn in Gig Harbor. He graduated from Oregon Health Sceinces University. He completed his internship and residency at Blodgett Memorial Medical Center in Grand Rapids, Michigan.

Jeffrey Nacht, MD is an orthopaedic surgeon in Tacoma. He graduated from the University of British Columbia. He completed his internship and residency at Mount Zion Hospital and Medical Center as well as a residency and fellowship in orthopedics at the University of Pennsylvania.

Navdeep Rai, MD is a Tacoma pulmonologist. He received his medical degree from Ohio State University. He completed his internship and residency in internal medicine at Cleveland Clinic in Ohio as well as a fellowship in pulmonary and critical care medicine.

Carl Wulfestieg, MD practices otolaryngology in Tacoma. He graduated from UCLA School of Medicine and completed his internship at the Hospital of the University of Pennsylvania and residencies at Philadelphia Jeanes Hospital, Jefferson University Hospital and the University of California San Diego Hospital.

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.

2004 Community Service Award

Leonard Alenick, MD, receives honors as the 2004 Community Service Award recipient

Dr. Mike Kelly presented the 2004 Community Service Award to **Leonard Alenick, MD**, Lakewood ophthalmologist, for his unending contributions to the profession and the community.

Dr. Kelly's introduction of Dr. Alenick, as outlined below, is an excellent summary of exactly why Dr. Alenick is so deserving of this award:

Each year the Society seeks to recognize one of our members who has contributed to the well-being of Pierce County with what is known as the "Community Service Award."

There is a community of physicians and there is a community of patients – and there is one man who, through his persistent brilliance and commitment has served both very well. He is our recipient of the 2004 Community Service Award.

The question of how to measure the influence of such a person on these two communities is somewhat daunting. It is difficult since most of the time such influence is hidden from general knowledge. It is up to those of us who are familiar with the true impact of such a person to speak up in order to acknowledge his valuable contributions.

Our recipient is a person who is always present but who is little recognized. For many years, he has been the "consigliore" - the Tom Hagen to many Don Vito Coreleones (presidents of the PCMS and WSMA). He has been so transparent he might be compared to "Mr. Cellophane," a persona some of you may remember from the musical "Chicago."

His wise, consistent council has had direct and significant effects on the health and well-being of the citizens of Pierce County and Washington State.

He serves on many committee & trustee posts bringing the lessons from each with him, "cross-pollinating," to use his own words, as he attends these numerous meetings.

He was born in Brooklyn, NY – received his MD degree from Johns Hopkins University School of Medicine, did his ophthalmology residency at Brooklyn Eye & Ear Hospital and served as Captain in the U.S. Medical Corps from 1966-1968 (including service in Vietnam).

Since 1973 he has been a member of PCMS, WSMA and AMA.

He has also been:

- *a liaison to the PCMS board of trustees from the WSMA board where he has served as a trustee since 1987*
- *a board member of Northwest Physicians Network since 1995*
- *a board member of the Washington Society to Prevent Blindness since 1980 and served as president from 1983-1987*
- *on the boards of St. Clare Hospital and Washington State Academy of Ophthalmology*

Leonard Alenick, MD, a deserving recipient of the 2004 Community Service Award

It is time for recognition. It is time to say thanks to a man who shuns the limelight, who is content with his role as advisor, and who does not pretend to any adulation.

Pierce County and the State of Washington owe him their thanks. We salute the recipient of this year's Community Service Award, Dr. Len Alenick. Come on up, Len.

Let me add comments from five past presidents:

***Jim Rooks**: "Len is a true physician – an excellent ophthalmologist, dedicated to the profession. He was drafted out of Johns Hopkins – served in Vietnam and has always done his duty."*

***Susan Salo:** "No one deserves this honor more than Len. His political savvy is incomparable!"*

***Patrice Stevenson:** "Len is a sincere, knowledgeable and dedicated physician. He is encyclopedic - knowing both background and facts – and knows how politics works. He is also a devoted husband, father and caretaker."*

***Charles Weatherby:** "Len is studious, learned and always well-prepared. He makes us presidents look good."*

***Larry Larson:** "Persistence is Len's strong suit – like a dog with a bone. He is meticulous, bright and focused. He gets a project started and sees it through to the finish."*

Len, thanks for being you.

PCMS congratulates Dr. Alenick and is truly grateful for his contributions.■

Dealing with noncompliant behavior

All health care providers, regardless of specialty, encounter patients who are noncompliant with medical advice or treatment recommendations. In many cases, the patients are not being deliberately noncompliant, and their providers can help them become more compliant.

Good communication skills, including active listening, are essential for good patient care and compliant behavior. A provider's choice of words, body language, and even silence all play a role in how a patient receives the provider's information and advice. A provider who appears rushed and doesn't allow a patient time to fully explain symptoms or ask questions may be setting the patient up for failure. Other factors that can lead to patient noncompliance include the following:

- Misunderstandings due to medical terminology
- Misunderstandings due to language, a hearing disability, or mental barriers
- Patient not realizing the seriousness of the condition or urgency of the situation
- Patient not having insurance coverage or money to pay for the recommended medications, tests, or treatment
- Patient believing the treatment will be embarrassing or uncomfortable
- Patient deciding to go elsewhere for treatment
- Patient simply forgetting

It is important to provide patients with enough information regarding their condition and your treatment recommendations, and to provide it in a format that is easy to understand. Stressing the significance of the condition and the need for timely follow-up should help with patient compliance.

A patient certainly has the right to refuse recommended treatment or tests. You are responsible for informing the patient of any risks associated with a refusal of care and documenting this discussion in the patient's chart.

You may choose to dismiss a habitually noncompliant patient. Allowing a patient to continue noncompliant behavior can not only be detrimental to the patient's health but can also increase your professional liability exposure. Any dismissal letter to the patient should include a reiteration of your treatment recommendations and the risks associated with not receiving the recommended treatment.

Generally, you can terminate your relationship with a patient at any time and for any reason. The exceptions are that you may not stop treating a hospital inpatient, a patient in unstable condition, or a number of patients from any specially protected population or socioeconomic group. In addition, federal and state law protecting the disabled may prevent you from discharging a patient whose noncompliance is the result of a physical or psychological disorder.

See "Noncompliant" page 18

Les McCallum honored for 17 years of service to PCMS and the College of Medical Education

Les McCallum recently retired from the College of Medical Education and will perform his final duties at the Whistler CME course January 26-30 at the Whistler Ski Resort in B.C., Canada.

On behalf of PCMS, **Dr. Jim Rooks**, PCMS Past-President, and devout CME at Hawaii attendee presented honors to Les at the PCMS Annual Meeting in December:

Pierce County physicians have been very fortunate to have an organization working on their educational behalf, the College of Medical Education. Initially started in 1977, in conjunction with the University of Puget Sound and a local neurologist, the College provided both nursing and physician accredited programs.

In the mid-eighties, for numerous reasons, the College floundered and suffered severe financial difficulties. Maxine Bailey, the long term and original CME coordinator left in 1986 in pursuit of other interests. The organization was in question.

In 1987, the College Board of Directors reorganized the College and they did two things.

First, they changed their mission to provide education solely for physicians.

Second, they shifted administrative responsibilities to the Pierce County Medical Society.

The third thing that happened, and certainly the best, was they hired Les McCallum. What they didn't really know was how organized, energetic, creative and engineering he is.

Les has created a very successful College, and, an ambitious one. He organizes a slate of eleven courses each year that feature prominent speakers in addition to local talent. The average course attendance is over 100 – almost unheard of for local CME programs. He is the mastermind of resort CME programs including Hawaii every other year and Whistler annually. He is relentless in negotiating "deals" for air travel and hotel rates. As one PCMS past-president said, "he can sell anything to anybody."

Most remarkably, he has developed and fostered relationships with representatives of the pharmaceutical industries to secure monies necessary to keep the programs at either very low or no cost. He works tirelessly, recognizing the necessity of anticipation in making sure that every piece of the puzzle comes together for a successful program. The continued quality of each program speaks to his dedication and professionalism, his commitment and his character.

And, of course all these qualities wouldn't be the same with a person that wasn't fun and engaging. Les works with a smile and has an infectious, positive demeanor.

Les McCallum was honored by the PCMS Board and membership for his outstanding service

Les McCallum thanked staff and many physician course directors for contributing to his success

We have been very fortunate to be the recipients of Les McCallum's work for the past 17 years. We owe him a debt of gratitude; he will be sorely missed.

After very enthusiastic and lengthy applause, Les thanked the PCMS staff and many physicians that served as course directors. "Without the help of staff, and particularly assistance from course directors, my job would have been impossible," noted McCallum.

PCMS thanks Les for his work and wishes him well. And, Dr. Rooks is correct, he will be missed.

South Sound Health Communication Network is electronically connecting our health care community

ANNOUNCEMENT

The Pierce County Medical Society and Northwest Physicians Network are co-sponsors of a **major physician initiative** to electronically connect all physicians in the Pierce County area with each other, their patients and with all community partners (hospitals, labs, pharmacies, SNFs, etc.) who create clinical information on patients. This community-based system is financially supported by all participants. The initiative specifically responds to the Institute of Medicine's call for a safer, more reliable and more efficient health care delivery infrastructure. The *South Sound Health Communication Network (The Network)* was launched October 28th with a pilot team of 33 community providers. Community partner recruitment has started.

NATIONAL ATTENTION

On November 30th we were invited to Washington for a private meeting with Dr. David Brailer, M.D., Ph.D., newly appointed National Health Infrastructure Technology Coordinator, to present *The Network* model in detail. He said that he "applauds" the model and what we are doing in Pierce County because it addresses major critical policy issues which his office will be working on to help open the pathways for safe electronic communication in health care across the country. He was very impressed with the physician-patient communication design and tools and its capability to remove institutional silos for the physician.

HOW CAN MY PRACTICE GET ON *THE NETWORK*?

The only equipment you need to get on *The Network* is a PC (P-III+) with a DSL or cable connection.

The first 250 physicians to be installed on the Network will receive the service at no cost for the first year. Thereafter a nominal fee will be charged, similar to a DSL or cable connection fee.

HOW IT WORKS

The Network is a single sign-on, Web-based ASP which is HIPAA compliant and secure. The network communication and security infrastructure was developed by Siemens Medical Solutions USA, Inc. and RMD Networks and has been successfully used in Colorado for over two years. It employs push technology, enabling physicians inside *The Network* to receive clinical information about their patients from wherever it is created — no searching with browsers for data residing on others' sites. The communications software (RMD Networks) was designed by physicians and allows both physician-to-physician communication and physician-patient communication. Patients can communicate with their physician's office for refilling prescriptions, arranging office visits and resolving billing questions. Designated patients may also communicate directly with their physician regarding clinical matters and have access to physician-designed self management tools. This premium level of service is offered to patients for a fee, which becomes an added source of revenue to the physician.

Functionally, *The Network* looks like many of the communications systems in use by area hospitals *except* that it is not limited by institutional scope. It is capable of including every practicing physician in the geographic area. Its clinical utility is based on community partners pushing patient data into the system. To guide its development as it spreads, a Physician Advisory Council, representing many areas of medicine and institutions, has been established.

HOW TO REGISTER

If you would like to register or would like more information, please call Rick MacCornack, Ph.D. (253.207.4341) or Maureen Pence, RN (253.627.1151) at Northwest Physicians Network. ■

In My Opinion

by Ronald Taylor, 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.*

It's time to say goodbye

Ronald Taylor, MD

It's time to say goodbye.

After starting a solo practice of general surgery in the Allenmore B building in 1978 (after 5 years as an attending in the Army), and growing into Cedar Surgical Associates with offices in the Cedar Medical Building and moving to our current location at 2121 South 19th Street, I've decided to leave behind the clinical and practice stresses of the current medical milieu.

I've had the privilege of working with incredible colleagues, nurses and paramedical personnel. I will continue to have fond memories as I make new ones with some of you, Ann, our friends, children and my grandchildren.

Many patients and their families continue to linger in my thoughts - their strengths in the face of crisis - but I must let go of those obligations.

I have confidence the legacy of **Chris Jordan**, Carrie Thoms, **Stan Harris**, **Jim Schopp**, **Ginnie Stowell**, **Leaza Dierwechter** and **W. Mike Johnson** - held together by my manager of 26 years, Paulette Groves - will continue to provide unsurpassable surgical care to the community for the foreseeable future.

"For myself, there are some places to see, some books to read, some questions to answer, some races to run - all at my own pace without night calls or crises."

For myself, there are some places to see, some books to read, some questions to answer, some races to run - all at my own pace without night calls or crises. My plants and animals will like that.

And though I no longer have that strength which in the old days seemed to move heaven and earth - time and fate *have* taken their toll; I plan to continue to strive, to seek, to find and not to yield - for at least another 30 years.■

PCMS congratulates Dr. Ron Taylor on his retirement and thanks him for many years of active membership and support. We wish him many miles and smiles during his next, at least, 30 years.

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 member **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:

James M. & Fumiko N. Baker
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Kerry Watrin
Charles & Shauna Weatherby
Keith Weissinger
Matthew White

Medical Quality Assurance Commission's newsletters

The Department of Health has determined to provide the *Medical Quality Assurance Commission's Update* Newsletters via email with a Web site link to the newsletter. This will be a significant cost savings and an opportunity to provide more frequent informational newsletters to physicians and physician assistants.

An electronic emailing list has been created to notify you when the most recent newsletter is available. To add your name to the list, please go to www.mqac-update@listserv.wa.gov, select participation on listserv and click on "m," and follow the directions. Or you may contact Beverly Thomas, Program Manager by Fax to 360-236-4768 or by email to beverly.thomas@doh.wa.gov and request your name be added to the list.

For those who do not have access to the Internet and would like to automatically receive a hard copy of the Update Newsletter, please contact Beverly Thomas, Program Manager at (360) 236-4788 or by Fax to 360-236-4768. ■

PCMS has a new e-mail address

PCMS has changed their e-mail address to:

pcms@pcmswa.org

Please make a note in your directory

The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

Be Ready

Federico Cruz, MD

As of the writing of this article we still do not know who our next governor will be. In a way, it is fitting. Whoever is our next chief executive here in our beautiful state faces much uncertainty. In our own profession of medicine, the only certainty we have is that the existing system is so dysfunctional that it cannot continue in its present form. I don't think I am being a doom and gloom kind of guy on this one. Our system is so expensive and doesn't reach huge parts of our population and most importantly our country keeps getting more unhealthy. Something has to give.

I bring all this up as it is the end of the year and the beginning of a new one. This is a time of making New Year pledges, a time of hopefulness, even if it is only momentary. Medicine is going to change. There are many major drivers for this train. The Payers: Industry states clearly that we cannot compete on the global marketplace with the kind of escalating costs that we keep experiencing; government has reached a tipping point in being able to afford the costs of the huge federal health programs (Medicare and Medicaid); the Public expresses anger and anxiety at the high cost of accessing basic care; and, the Providers, starting with us as physicians, feel frustrated with the hostility and inflexibility of the current environment in which we practice.

There will be much discussion in the upcoming legislative session of the current deficits in the publicly funded state health care system. Solutions will be thrown around like water balloons. If we are not active and nimble, we are going to get wet. The hospitals, the drug companies, and the insurance industry, to name a few, will push their own solutions. And I suspect that close consultation with physicians is not a step in their agenda creation.

DO NOT BE PASSIVE! In the last election, we did put our toes in the political waters. This brought a mix of successes and failures. **Now is not the time to stop**. Medicine needs to change and we need to be at the table as this happens. The balance between the art of medicine and the business of medicine can only be properly established when the voice of the providers is heard. This place at the table won't come to us easily. We see ourselves as the good guys. We see ourselves as the ones you can trust riding up on white horses. The truth is many people do not have this picture of us. They see us as much more self serving, an elite group that is often seen as distant and insensitive to the needs of the public, overly concerned with making a good living.

The pride, compassion and discipline we bring to our work are not seen as clearly, especially by elected officials. We are going to have to intrude on their discussions. We have to transmit, in every situation where health policy discussions occur, an aggressive certainty that this is where we belong.

The legislative caucus meetings, committee hearings, community discussions around health care issues must have physicians attending and participating. A clear vision of who we are and what we want to see happen in medicine would carry us far in these venues.

This will take time. This will take an investment of energy and passion. This will require some anxiety as we meet with each other and try to come up with come common themes that all physicians can support. It is easy to rally around tort reform and fight with the trial lawyers and their lackeys. It may not be as easy for the pediatricians and cardiologists for the family practice folks and the neurosurgeons to agree to the same vision for the future of medicine. It would be nice to wait and plod forward with a lot of prep time. But the truth of the matter is these things will be moved along by other agendas not by whether we are ready or not.

We have to be ready. We have new leadership stepping forward in our county society. We need to get behind them and empower them to push for the needed changes in medicine. But we also have to tell them what those changes look like. I hope that you will all join me in giving this some serious thought and be willing to communicate this to Pat Hogan and the rest of the Board of PCMS. We want our leaders to sing clear and powerful songs. We now need to write these songs before they go on the stage.

The happiest of new years to each of you and your families.

Noncompliant from page 12

Risk Management Strategies for Combating Patient Noncompliance

- Educate patients regarding the recommended treatment or test and why it is necessary.
- Inform patients regarding any alternatives, benefits, risks, and complications associated with the proposed treatment or test.
- Provide clear oral and written instructions to patients, using interpreters as necessary.
- Emphasize the seriousness of the condition and the urgency of the recommended treatment or test.
- Schedule referral and follow-up appointments before the patient leaves.
- Place reminder calls to patients regarding upcoming appointments.
- Follow up on failed appointments.
- Document all noncompliant behavior including no-shows, cancellations w/o reappointments, and failure to follow recommendations regarding treatment, diagnostic studies, referrals to specialists, medication use, etc.

It is reasonable to expect a patient to share responsibility for compliance with your follow-up recommendations. However, court decisions nationwide have placed significant responsibility for patient follow-up with the health care provider. In the event of a lawsuit, the most crucial element in your defense is documentation in the medical record indicating your instructions and advice to the patient regarding treatment recommendations, referrals, and follow-up care. ■

Reprinted from Physicians Risk Management UPDATE, Volume XV, Number 6

Physicians Insurance workshops

The Physicians Insurance Risk Management Department is offering the following two-hour education workshops for physicians of all specialties. Both workshops will be held in Tacoma at the Landmark Convention Center and are free of charge. Register on-line at phyins.com or call 1-800-962-1399 to ensure your place. Physicians Insurance designates each educational activity for a maximum of two Category I credits towards the AMA Physician's Recognition Award.

"A Bitter Pill to Swallow: Medication and Malpractice"
Wednesday, February 23, 2005
5:45 pm - 8:30 pm (dinner included)
Agenda items include:

- Current malpractice trends
- The most dangerous medications
- Drug-seeking patients
- Complimentary/alternative medications
- Patient education
- The role of technology
- Communication issues
- Off-label prescribing

"Pulling Together: Managing Handoffs, Conflicts, and Coordination of Care"
Thursday, March 10, 2005
5:45 pm - 8:30 pm (dinner included)
Agenda items include:

- Medical team performance model
- Tracking medications and diagnostic tests
- Determining primary responsibility
- Managing conflict
- Dealing with criticism and jousting
- Guidelines for patient handoffs
- Documentation involving multiple providers
- Addressing concerns about care
- Building support
- Conducting effective debriefings
- Resources for physicians

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.*

Medicare and Disease Management

Andrew Statson, MD

"A decision is the action an executive must take when he has information so incomplete that the answer does not suggest itself."
Arthur William Radford (1957)

On October 13, 2004, Douglas Holtz-Eakin, Director of the Congressional Budget Office, submitted a report to Senator Don Nickles, chairman of the Senate Committee on the Budget. That analysis is about twenty pages long and you may read it in its entirety on the web page of CBO (www.cbo.gov). I summarized it here and added some comments.

The question Senator Nickles asked was whether disease management programs can reduce the overall cost of health care and how such programs might apply to Medicare. I suspect that, had such a benefit been found, Congress would have enacted some measure to "encourage" both patients and physicians to participate in such a program.

Fortunately for our patients and for us, the CBO did not find sufficient evidence that disease management programs reduce health care spending. Most of the studies in the literature center on the procedural aspect of disease management and discuss intermediate measures of health, but no conclusion can be made on the overall impact on spending.

The few studies that report cost savings were done under controlled settings and usually did not account for the cost of the intervention itself. Disease management proposes to use broad screening and monitoring of patients, combined with education of both patients and physicians in the use of best medical practices, and to treat chronic conditions earlier and more effectively. Thus it hopes to slow the progression of diseases and presumes that better care today will mean better health and less expensive care tomorrow.

Of course, the CBO is interested in any effect on the budget and analyzed the studies according to whether the programs can reduce health care costs and how they might apply to Medicare. The analysis admits that improving health outcomes may be worthwhile even if it did not reduce health care spending.

The CBO examined peer-reviewed studies of disease management for congestive heart failure, coronary artery disease and diabetes. The literature published so far does not show conclusively that these programs can generally reduce the overall cost of health care services. The evidence on cost savings is limited and the few studies that report costs do not account for all health care costs, including the cost of running the program.

Any reported savings were achieved in limited settings. If the programs were to include a broad population, such savings might not be attainable and the programs could even raise costs. If disease management can prevent the onset of complications, as measured in the case of diabetes, for instance, with the rate of amputations, heart attacks and death, such result will not be known for many years. Therefore, they are not typically measured in the short term studies currently available.

Medical treatments affect both the quality of life and the utilization of health care. The quality of life is difficult to measure, even though an attempt is made to determine costs per quality-adjusted life year.

To determine the cost of disease management, we must include the administrative cost of the program, the cost of identifying and enrolling the target population, and providing the services. The cost of all care, including physician visits, outpatients medications and tests must be added, as well as the cost of the newly diagnosed patients, who otherwise would not have been treated.

Unintended consequences, such as errors in identification (false positives), the complications and side-effects of the additional treatment and testing add to the cost of the program.

The studies also are subject to selection bias and other confounding factors. Determining the cost of treatment if the patients did not get the intervention is difficult in the absence of a randomly assigned control group.

The CBO concluded that while there are cases of clinical and economic benefit by specific programs for particular groups of patients, whether those re-

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sults can be achieved for a broader population is not clear.

For instance, some studies of congestive heart failure suggest a reduction in costs for severe disease, but the cost for patients with mild disease was 288% higher at six months. A review of twelve studies of coronary artery disease reports that the programs' impact on survival and recurrent infarctions and on cost-effectiveness remains uncertain. The studies reporting improved control of diabetes also show a reduction in costs of care, but in well selected population, so the result of a general application of the program remains uncertain.

Ofman reviewed 102 studies published between 1987 and 2001, (*JAMA*, 117, 2004, pp. 182-192). He concluded that "the economic return on investment of these programs would be questionable." Other reviews of the literature have reached similar conclusions.

Concerning the Medicare program, translating lower cost treatments into savings for Medicare is not straightforward. Even if reduced costs could result over an extended period of time for people with several simultaneous chronic conditions, it is not clear that the payment system of Medicare would capture those savings because the payment structure is revenue neutral.

Another important difference between Medicare and the private plans is the different duration of enrollment. Any savings in treatment that may accrue could be offset by additional spending on other medical conditions that enrollees may develop over their lifetime. New spending on other conditions would cancel out savings for the managed disease. Medicare beneficiaries accrue a substantial portion of their lifetime program costs in the year that they die, costs that probably would be incurred one way or another. Indeed, if beneficiaries ended up dying from diseases that are more expensive to treat (such as cancer), the total cost for the program could actually increase.

If disease management cuts providers' costs of delivering Medicare services, that would not automatically yield savings for the program because of Medicare's payment structure. For instance, if the length of hospitalization or costs of treating a given condition during a hospital stay decreased, all those savings would accrue to the hospital sector, because Medicare pays a fixed fee for each admission. Conversely, if disease management led to an increase in the use of physician services and associated lab and diagnostic tests, Medicare's payment system for physicians could prevent an increase in overall costs. Under Medicare's sustainable growth rate payment system, the initial costs from more services would be offset by reductions in the rates for payments to physicians, and there would be no long-term impact on Medicare spending. In effect, physicians as a group would bear the increased costs instead of the Medicare program.

One thing I did not see in the entire report was a comparison of costs between disease management programs and treatment by specialists of the respective conditions. A large part of the disease management programs has been to assist primary care physicians in treating complex cardiac or endocrine problems, which probably should be treated by specialists in those fields. A few reports in the past showed that such specialized care leads to both lower cost and better outcome.

I thought that this review of the subject by the CBO reflects the goals of the Medicare program and would interest you. I hope you enjoy it. ■

COLLEGE OF MEDICAL EDUCATION

Last Chance for Cardiology... January 11 & 18

Sign-up now!

The College's eighth annual *Cardiology for Primary Care* program will be held at St. Joseph Hospital in the Lagerquist Conference Center.

Course Director, **Gregg Ostergren, DO** notes that this evening program, for your convenience, will be held on two consecutive Tuesdays, January 11 and January 18, 2005.

The programs run from 5:00 pm to 9:00 pm on both nights, so please register ASAP by calling 253-627-7137. ■

Gastroenterology for Primary Care... Coming Soon

Register now for the *Gastroenterology for Primary Care* program scheduled for Friday, February 4, 2005. The Course Director for this all-day program is **Ralph Katsman, MD**. This program will be held at St. Joseph Hospital in the Lagerquist Conference Center.

This program is a review and update on the diagnosis, treatment and management of gastroenterology issues faced in the primary care and internal medicine practice.

Register now by calling 253-627-7137. ■

Continuing Medical Education

Snow Is Calling - Make Your Whistler CME and Condo Reservations Today

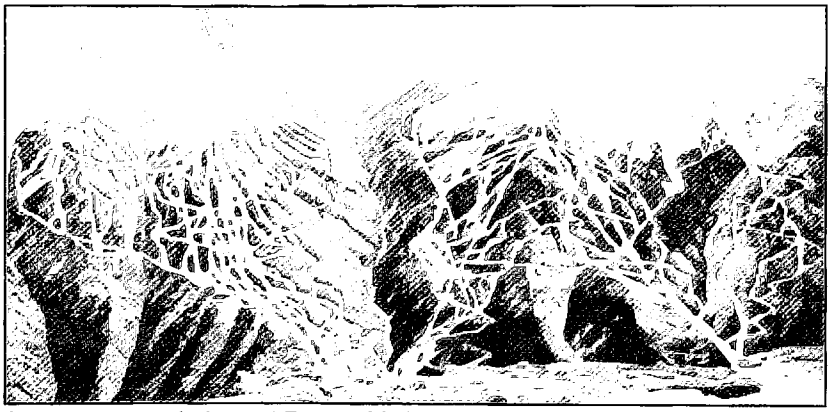
Registration continues to be open for the College's CME at Whistler/ Blackcomb program. The conference is scheduled for January 26-30, 2005.

Although at press time reservations in the Aspen's Condos are likely full, options in other close-by condos managed by the same management company are available - **at a discount**. If you still need a condo, please call 1-866-788-5588 and mention you are with the COME group.

Similar to last year, for those of you who might need to rent ski equipment, we have secured a 20% discount at very close by Spicy Sports. A coupon for this discount will be mailed to all anticipated registrants and also available at the opening reception.

Registration for the actual CME conference is also open. Course directors **Drs. Richard Tobin** and **John Jiganti** have arranged another quality multi-specialty conference featuring timely topics.

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



So many runs, so little time! Two world-class mountains, Blackcomb and Whistler offer unlimited runs and trails to the Medical Society skier and their family. Sign up for the January "CME at Whistler" program today

Dates	Program	Director(s)
Tuesday (evenings) January 11 & 18	Cardiology for Primary Care	Gregg Ostergren, DO
January 26-31	CME at Whistler	Rick Tobin, MD John Jiganti, MD
Friday, February 4	Gastroenterology for Primary Care	Ralph Katsman, MD
Thursday-Friday May 5-6	Internal Medicine Review 2005	Art Knodel, MD
Friday, April 22	Radiology for the Non-Radiologist	Rick Tobin, MD Andy Levine, MD
Friday, May 20	Primary Care 2005	Steve Duncan, MD

Applicants for Membership

Eric W. Arntson, MD
Pathology
Western Washington Pathology
407 14th Ave SE, Puyallup
253-697-2630
Med School: Oregon Health Sci Univ
Internship: St. Vincent Hospital
Residency: St. Vincent Hospital
Fellowship: Swedish Hospital

Marissa C. Fernandez Kiemele, MD
Family Practice
Pathways Family Health
4700 Pt. Fosdick Dr #208, Gig Harbor
253-857-8867
Med School: University of Alberta
Residency: University of Ottawa

Matthew M. Rice, MD, JD
Emergency Medicine
Northwest Emergency Physicians
3455 S 344th Way #210, Federal Way
800-336-8614, ext. 2118
Med School: Penn State University
Internship: Tripler Army Medical Center
Residency: Brooke Army Medical Center

Rachel R. Thomas, MD
Internal Medicine
Sound Family Medicine
11102 Sunrise Blvd E #102, Puyallup
253-848-5951
Med School: Ross University
Internship: St. Agnes Hospital
Residency: St. Agnes Hospital

Herbert L. Wang, MD
Radiation Oncology
Tacoma Radiation Oncology
314 ML King Jr Way #11, Tacoma
253-627-6172
Med School: UC Davis
Internship: California Pacific Med Center
Residency: University of Chicago

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 looking for P/T to F/T Board Certified or Board Eligible Physician to join a group practice. Work 3-4 days a week with a great support staff. Base salary plus incentive. Fax your CV to 253-847-9630.

Tacoma, WA – Occupational Medicine MultiCare HealthWorks, a division of MultiCare Health System seeks a board certified occupational medicine physician/MRO to join an established program. Qualified applicants must be flexible, self-motivated, committed to program development and have at least 3 years experience. Excellent benefits, income guarantee and incentive bonus. Please email your CV to *MultiCare Health System Provider Services at providerservices@multicare.org or fax your CV to 866-264-2818. Websites: www.multicare.org; www.multicare healthworks.org.* "MultiCare Health System is a drug free workplace."

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, ownership options. Call 253-272-2224.

Canyon Road and 512 freeway intersection. Amazing exposure, access, and parking. Adjacent to long-established Summit Medical Clinic. Serves: Puyallup, Southeast Tacoma, Parkland, Spanaway, Fredrickson, Graham, Eatonville and Summit. Contact Dr. Nordberg, kimnordberg@msn.com or 253-535-5432.

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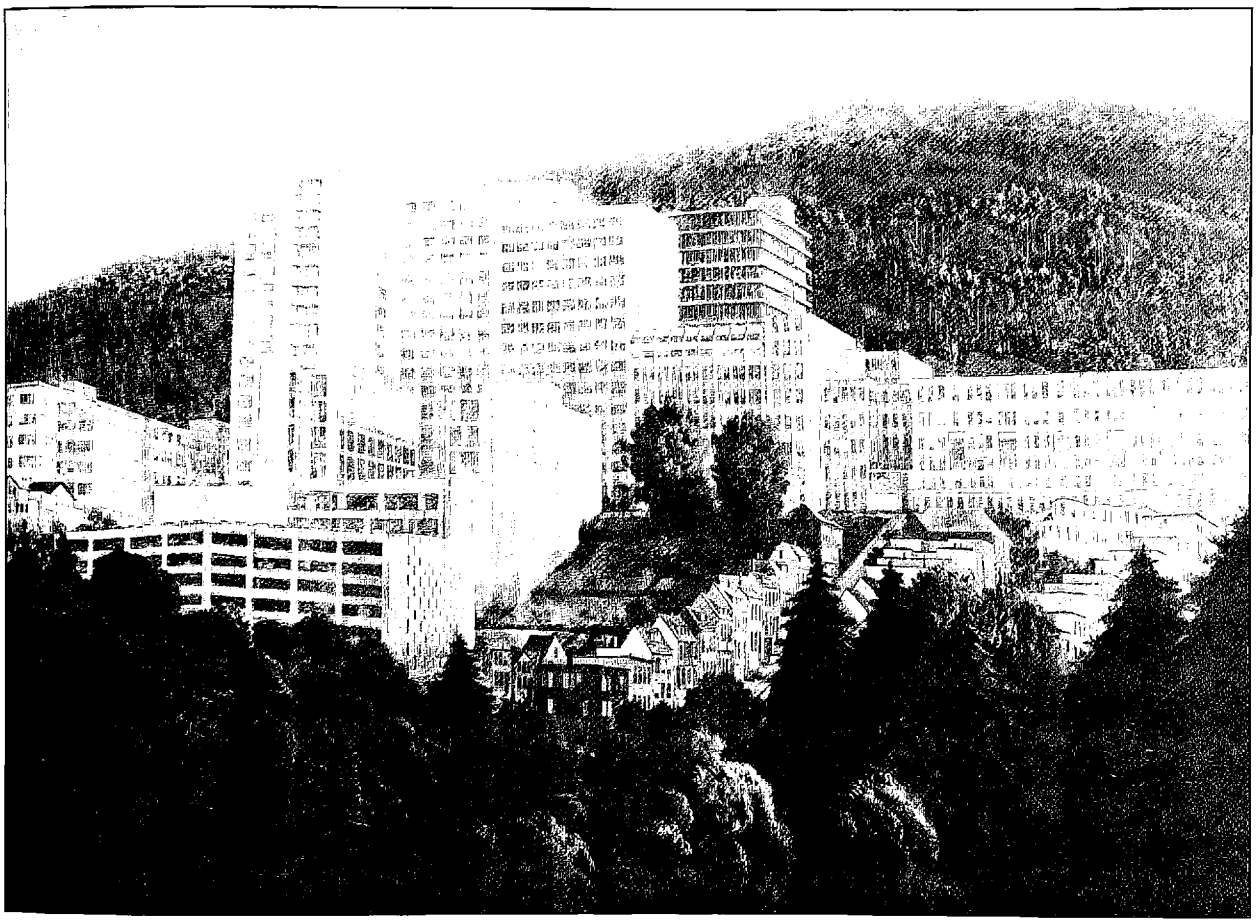
BULLETIN

February, 2005



University of California School of Medicine, San Francisco Medical Center

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.

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Pierce County Medical Society
BULLETIN

February, 2005

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President's Page

by Patrick J. Hogan, DO

Blending medicine as a profession and a business

Patrick J. Hogan, DO

The positive aspects of the profession of medicine still outweigh the negativity of the stressors on our profession. The gratification of making a difference in the quality of people's lives continues to be our greatest reward and continues to make ours the greatest profession.

The challenge is to maintain the positive attitude toward medicine amidst the detractors of rising costs of malpractice, office overhead costs and unfair insurance reimbursements.

A positive aspect of practice is improving the lives of patients with emphasis on **disease prevention measures**. These measures will be given considerable emphasis on the 2005 PCMS agenda.

Fitness

We are in an epidemic of diseases due to the overweight and unfit state of the majority of Americans. We are on the verge of more catastrophic consequences unless we can change the course of our youth. In fact, a recent staggering CDC report stated that America's youth will be the first to **not outlive their parents' life expectancy** because lack of fitness and obesity have become accepted ways of life. If a child grows to adulthood overweight and unfit, there is a 70% chance that this pattern will continue through adulthood.

Fortunately, foresighted members of our PCMS have taken active stands on the childhood obesity/unfit issue. Drs. **Ken Feucht**, **Sumner Schoenike** and **Rebecca Sullivan** have taken the lead to develop a resolution to the WSMA to make obesity control and fitness of our youth a priority in our medical community and legislature. Multiple organizations, including the YMCA, Action for Healthy Kids and the American Running Association have started active campaigns for improving childhood fitness. The American Heart Association is lobbying the legislature to bring fitness back to our schools.

As was discussed last month, one thing we can do immediately is to accept the challenge to **lead by example** by increasing the fitness of our medical community including physicians, other health providers, nursing staff and clerical staff. Making fitness as important in life as any other bodily function will not only provide the 20 benefits discussed in last month's *FitNews*, but will be the impetus to help change society attitudes. We are being looked at by the American Medical Athletic Association as providing a template for working with medical communities throughout the nation to improve fitness in their ranks as well as their communities.

Just as the attitudes toward tobacco use and exposure have changed over the past dozen years, so can the pervasive attitudes toward fitness improve over the next decade as the critical mass of collective thought is reached. We have to start now to eventually reverse the numbers of the 80% who do not routinely exercise and the 20% who do make exercise a near daily part of their lives.

Seattle was recently ranked as the nations most "fit" city. Tacoma did not make the top 25. The communities of Pierce County can help pave the way for all of Washington to be the **nation's most fit state**.

As you will see in this issue of *The Bulletin*, we have been working with exercise facilities to help remove the barriers to exercise. **The YMCA has agreed to wave the $75 initiation fee** for members and their staff (see insert). They will work with anyone to begin their 12 week exercise initiation program in a non-intimidating environment. Announcements on other exercise facilities will follow. **Offices are encouraged to enroll their entire staff in these programs as well as physicians themselves.** (*See further details on removing barriers to exercise in this month's PCMS FitNews and other inserts on fitness tips which can be copied and distributed to office staff and patients.*)

Tobacco News

Great news **for all people who breathe** in Washington State! The initiative to make Washington free from second hand smoke has been validated

See "Blending" page 4

Blending from page 3

by the state. We now have the opportunity to gather the necessary signatures to get that initiative on next November's ballot. PCMS will be providing further information on how everyone can help with this critical process.

Business of Medicine: Tort Reform

What is a tort anyway? It is defined as a wrongful act or wrongful injury. Physicians are being subjected to **wrongful financial injury** and we need to reform that injustice. **Dr. Mike Kelly** has continued his work on this campaign with two talks in January at the Lakewood Rotary and the Association of Health Underwriters. Work is underway to assure that the legislature does not pass alternate bad legislation.

It will then be the role for all Washington physicians to counter the trial lawyer framing of I-336 as the injured patient vs. rich doctor, with the truthful framing of I-330 as the **caring doctor and patient vs. the greedy, money stealing trial lawyers**.

Adequate education of the public rather than emotional voting will carry I-330 to victory next November. ■

Participate in the WSMGMA Annual Salary and Benefits Survey and Get the Results Free

Each year, the Washington State Medical Group Management Association (WSMGMA) conducts a Salary and Benefits Survey for medical groups in Washington. It is a valuable resource in determining compensation for your employees. Data is broken down by group specialty, size and geographic location.

Results of the survey are shared at no cost to medical groups who participate. The cost to purchase the results of the survey is $500. Save yourself this money and get the results free by participating in the survey.

The deadline to participate is February 28, 2005. Results will be available by April 1, 2005. To obtain a copy of the WSMGMA Salary Survey, contact the WSMGMA office at 1-800-552-0612, ext. 3026; or email JAL@wsma.org. ■

FitNews #2

by Patrick Hogan, DO

In PCMS *FitNews #1*, the far reaching benefits of a regular exercise program were reviewed. Here is further information to help motivate and design your exercise program. Let me know of additional barriers and your solutions to these barriers.

Remove the barriers to exercise:

1. Not enough time for exercise.

Establishing exercise as part of your life does not take a large amount of time. Just 20 minutes of sustained exercise 3-4 times per week is a good start. This can even be done in two 10 minute blocks in the day. A treadmill or exercise bike in front of the TV in the evening works. As you become more conditioned, you will increase this amount to average **30 minutes a day where the benefits really start showing**.

2. Don't know how to start.

Just monitoring your steps with a pedometer is a start. It is recommended that a goal of 10,000 steps per day should be pursued. You can do this just by adding steps to your day with parking farther away than usual, taking stairs instead of an elevator, walking instead of driving short distances and "**walk your dog daily for 20 minutes** even if you don't have one."

The American Running Association has a 12 week program for establishing a walk/ run routine. Ask for this through the PCMS or your doctor.

The YMCA has a 12 week program to get people started that is guided and separated from the intimidating public weight and exercise rooms.

Each of the exercise club facilities has guidance on beginning a program. See listing of exercise facilities in next month's *FitNews* to get you started.

3. Too much effort /Don't like to sweat.

Although a heart rate during exercise of 60-80% of the maximum heart rate is ideal for maintaining fitness eventually, **a lower effort level will still enhance initial fitness.** Once fitness is built, there is a **tremendous sense of well being of bringing your heart rate into the ideal fitness range** during the exercise period.

4. I'm too tired to exercise.

As difficult as it is to get up to exercise in the morning, people who do have **a higher energy level throughout the day, have lower appetite levels, and have greater energy reserve by later in the day.** The more fit you are the less energy is needed to carry on your daily activities.

5. It will aggravate my condition.

Almost all medical disorders are improved by a regular exercise program to include arthritis, osteoporosis, diabetes, cancer, vascular disease, fibromyalgia, migraine, neurological disorders etc. Ask you doctor for guidance on initiating an exercise program in your circumstance.

6. It's too monotonous.

The best way to sustain an exercise program is **with diversity of activities.** Cross training means using different muscles on different days. A typical balanced program mixes run/walk with biking and strength training or any activity that fits your personality profile. Having a group or exercise buddies are great ways to sustain exercise. Other options that keep people motivated are ball room dancing, yoga, exercise classes, tennis or whatever can provide rejuvenation of your day.

7. Strength training is for muscle men.

A weight bearing exercise program **benefits every single person.** There is no better way to **load the bones** to prevent osteoporosis. A strong core and extremities are the key to **injury prevention and maximal performance** in any sport activity.

- OVER -

Nutrition #2

by Joan Brookhyser, RD, CSRCD

Are Eggs Good For You?

Eggs have been given a bad rap. For years, the mere mention of cholesterol has often conjured up fear and enough concern to banish eggs entirely from the diets of many Americans.

Today, thanks to years of research, we know more than ever about the relationship between diet, lifestyle and **fitness**. There is growing evidence that diet and health relationships are a function of both what is in the diet and what is missing from it. It is also becoming clear that many of our perceptions about various dietary factors are inaccurate. For example, when it comes to dietary cholesterol, many people believe that it is an extremely important factor in high blood cholesterol. Studies have now shown that many people on a low-fat diet can eat one or two eggs a day without measurable changes in their blood cholesterol levels. As reported in a recent publication, Dr. Wanda Howell and colleagues at the University of Arizona conducted a statistical analysis of 224 dietary studies carried out over the past 25 years investigating the relationship between diet and blood cholesterol levels in over 8,000 subjects. What these investigators found was that saturated fat in the diet, not dietary cholesterol, is what influences blood cholesterol levels the most [Howell et al. 1997. Am J Clin Nutr. 65:1747-64.1.]. Therefore, the results of this meta-analysis indicate that for most healthy people saturated fat is a greater concern than dietary cholesterol, and that eggs can readily fit into a heart-healthy, nutritious and enjoyable dietary pattern.

In addition, eggs offer many other benefits. They are an easy, economical, complete protein to prepare and eat. Eggs are also high in two carotinoids called lutein and zeaxanthin that have been found to be important in the prevention of macular degeneration. The egg provides lutein in a lipid form, which helps its absorption better than other forms of this nutrient.

So, before banishing the egg from the American diet, other food sources that are cholesterol rising should be eliminated first; saturated (this includes hydrogenated and trans) fats. Examples are pastries, donuts, fried foods, packaged dessert items, fast foods, convenience foods and snack foods. A diet without eggs but high in these foods is far worse than a diet with an egg, more fruits, vegetables and whole grains.

Pierce County Medical Society has a new e-mail address

PCMS has changed their e-mail address to:

pcms@pcmswa.org

Please make a note in your directory.

Thank you.

PCMS/WSMA Trustees get energized at Board Retreat

On Saturday, January 22nd, the PCMS Board of Trustees Retreat started out with lots of "YAH HOO'S" as President **Patrick Hogan** asked Board of Trustee members **Mike Kelly, Laurel Harris, Sumner Schoenike, Joe Jasper, Joe Regimbal, Ken Feucht, Jeff Nacht, Carl Wulfestieg, David Bales** and **Loren Finley** and WSMA board members **Ron Morris, Len Alenick, Nick Rajacich** and **Don Russell** to share what gets them excited about life and moves them to an unbridled "yah hoo" experience. The exercise was prefaced by the showing of a clip from the movie *I.Q.* where Tim Robbins' character takes Einstein (played by Walter Matthau) on a motorcycle ride. His niece (played by Meg Ryan) takes issue that Tim Robbins has taken Einstein on a motorcycle ride because it is dangerous. Robbins retorts that "he loved it and he went yah hoo" then he asks her when was the last time she had said "yah hoo," and she couldn't quite recall. (See the movie!)

After a rousing round of sharing, Dr. Hogan introduced WSMA President Dr. Ken Isaacs and CEO Tom Curry to discuss the priority issues of WSMA which are to enact tort reform; to improve the quality of medicine, promote safety and error reduction; to promote medical practice viability and administrative simplification, and to build the strength and viability of WSMA. Initiative 330 was discussed in detail and they are looking to a budget of almost $7 million for the campaign. Much of this will be media purchasing as they will work to craft the message that most resonates with the public.

The WSMA Legislative Agenda was also reviewed. Priorities for the year include liability reforms, access to care and taxes, patient safety and error reduction measures, medical discipline, public health funding, mental health parity, scope of practice issues and prescription drugs.

Hospital representatives **Drs. Don Mott, Mike Newcomb** and **J.D. Fitz** each gave a brief update of issues on their hospital system's agenda for 2005.

Dr. Mott reported that the Good Samaritan Cancer Center has opened and invited everyone to the open house in February. They are in aggressive recruitment mode and continue working on staff retention and training and physician behavior.

Dr. Newcomb, reported on employment vs. recruiting, noting that the Franciscan Health System will employ physicians in varying capacities specifically to keep them in the area and in practice, but it is not their priority to do so. He spoke of their commitment to their computerized Patient Record System and of the need for continued advocacy for medical professionals. "We have to find our common ground" and work together, he noted.

Dr. Fitz, the new Medical Director of MultiCare Medical Group reviewed MultiCare's building and expansion plans including the new surgery wing at Tacoma General and the

See "Board of Trustees" page 18

From left, Drs. Mike Newcomb, Don Mott and J.D. Fitz represented Franciscan Health System, Good Samaritan and MultiCare respectively

PCMS and WSMA Board members visit with one another in the "comfortable" meeting room at Shenanigan's Restaurant

From left, Drs. Sumner Schoenike, Len Alenick, Ron Morris, Joe Jasper and Carl Wulfestieg (front) participate in the discussion

The First *Kimi & George Tanbara, MD Humanitarian Award* to Honor Dr. Gordon Klatt

Community Health Care's Annual Dinner will be the setting to honor **Gordon Klatt, MD** for his work as the founder of Relay for Life. Dr. Klatt will also be the guest speaker at the dinner. The Pierce County Medical Society, the American Cancer Society and Northwest Physicians Network are partners with Community Health Care in honoring Dr. Klatt who started Relay for Life in May of 1985. During one 24 hour period, he walked/ran 83 miles alone around the University of Puget Sound track to raise money and awareness for cancer research and treatment. From this beginning, Relay for Life has grown to over 4,000 cities in the U.S. and ten foreign countries and has raised millions of dollars for cancer research and treatment.

Gordon Klatt, MD

Dr. Klatt is a General/ Colon/Rectal surgeon with K-Y Surgical Associates in Tacoma. He attended medical school at the University of Minnesota and competed his Internship at Fitzsimons Army Medical Center and his Residency at Madigan Army Medical Center. Dr. Klatt's work experience includes Chief of Surgery, U.S. Army Hospital, Okinawa, Japan and Staff General Surgeon, Madigan Army Medical Center. In the Army Reserves he was the Commander of the 6250th U.S. Army Hospital in Tacoma and Commander of the 50th General Hospital in Seattle.

The Kimi & George Tanbara, MD Humanitarian Award was established by Community Health Care as a part of the 2004 Annual Dinner which honored Dr. Tanbara and his wife Kimi for their long dedication to health care for low-income and uninsured individuals.

Community Health Care's Annual Dinner will be held on March 30, 2005 at the new Tacoma Convention Center. Tickets for the dinner are $40.00 per person. Tickets may be purchased online at http://commhealthdinner. kintera.org/. Proceeds from the dinner are used to provide medical care to those who cannot afford care. In 2003, Community Health Care served 34,801 low-income Pierce County residents through 131,981 patient visits. Since services are offered to all individuals regardless of their ability to pay, a total of $5,191,314 in uncompensated health care was provided. Services are provided through eight medical clinics and three dental clinics.

Dinner sponsorship opportunities are also available. If you have questions about the dinner please call the Community Health Care Marketing & Development Department at (253) 597-4550. ■

Next stop November for smoke ban initiative

Last year's Initiative 890 failed for lack of money; this year's Initiative 901 won't have that problem

You can't keep a good idea down. Especially an idea that promises to save lives.

Last year, Breathe Easy Washington - a group of public health advocates, many from Pierce County - launched an initiative drive to enact a workplace smoking ban in this state. Initiative 890 would have been a *real* ban, as opposed to the Legislature's 1985 Clean Air Act, which purported to protect workers from tobacco smoke but in fact was riddled with exemptions for restaurants, taverns, bowling alleys and the like.

Opponents tried to confuse the issue with a decoy initiative, but I-890 ultimately ran out of steam because its backers just didn't have enough money to finance a successful signature drive.

They're back now. The revived measure, Initiative 901, would also require that all employers under the state's jurisdiction provide smoke-free environments for their workers.

I-901 is part of what has become a national and international movement. Eight states and many cities outside those states have enacted comprehensive or nearly comprehensive bans on smoking in workplaces and establishments frequented by the public. The American Heart Association estimates that nearly a third of all Americans live in jurisdictions covered by these laws.

Breathe Easy Washington now has the wholehearted support of the American Lung Association, the Cancer Society and Heart Association - which have become frustrated with the Legislature's lack of movement on this issue. The initiative now has financial support and a professional campaign staff and now appears to have the means to secure a spot on the November ballot.

If the employers who run smoke-filled workplaces aren't worried, they should be. It's hard to imagine that the voters - the vast majority of them nonsmokers - will want to perpetuate a status quo that forces wage-earners to breathe dangerous concentrations of secondhand smoke for long hours every shift.

It's telling that the backer of I-901 include bartenders, waiters and waitresses - jobs that presently entail heightened risks of dying from heart disease and lung cancer. Nobody in Washington state should be expected to unnecessarily risk lungs and life for the sake of a paycheck. This initiative, if successful, will help ensure that nobody does. ■

(Reprinted from TNT 1/31/05)

The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

Committed Involvement

Federico Cruz, MD

With the start of a new year, we face many issues in medicine. The legislature needs to address tort reform and health care access. The funding of health care is up in the air as many legislators want to expand eligibility for the poor and uninsured, but each year the state-subsidized programs generate huge deficits for the state budget. There are no easy answers in sight.

Looking closer to home, we've seen a flurry of activity in Pierce County around emergency preparedness. The threat of pandemic flu, SARS, smallpox, earthquakes and tsunamis has heightened our efforts to make sure we are ready. The first responder agencies (fire, police and the ambulance systems) initially took the lead in developing emergency response plans. But they only involve the first part of what needs to happen as a community wrestles with a disaster or emergency situation. Now we are looking at the role of the hospitals, clinics, health department and community health care providers.

The Department of Homeland Security has committed funds to our state and local area to develop emergency preparedness plans for any contingency, from bioterrorism to dirty bombs to chemical releases and the natural disasters of flooding and mudslides. Everything starts with an early warning or surveillance system. What patterns show something is happening in the community? What will it take to identify the agent early enough so that a timely response can be instituted? Several scientists recognized the Tsunami that occurred after the earthquake in South Asia early but no organized system was in place that could take that information and actually warn people. Many people could actually have survived the huge waves that came ashore in Thailand, India, Indonesia and Sri Lanka, if only multiple jurisdictions had worked with each other and put response systems together.

This is a powerful lesson for us in Pierce County. We do have a surveillance system in place and now we are making sure that we have a system in place that can respond to any of the critical early warning information that we collect.

"Physicians play very important roles in the organized medical response to a disaster: both in surveillance and response."

Physicians play very important roles in the organized medical response to a disaster: both in surveillance and response.

First, active involvement in disease reporting is incredibly important. Early clusters of cases of epidemic disease are almost always seen in a physician's office. But this does the community no good unless it is reported to the health department. The system is in place but it requires you as the provider to take the time to report (via computer, phone or fax). Whether it is a naturally occurring disease outbreak or an international one because of terrorism, every hour of early warning we can get will mean saved lives.

The second critical role that physicians play involves the medical response to an emergency. Whether it is trauma related or infectious disease related, organized medicine is right in the middle of the community response. As we look at large community emergencies (a flu pandemic or a SARS outbreak), clinical sites become the center of the community response. The federal government has tried to organize a Physician Reserve Corp that would be available to staff clinical sites in the affected areas. This has not really developed widely. In a community the size of Pierce County it is clear that we need an organized disaster response with active involvement of the broad mass of current medical providers. But this doesn't just mean "let's get a list around to all the docs and see if we can get them to sign up." We need a real system of committed involvement from all parts of the medical community, from the primary

See "Involvement" page 12

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.*

Tenncare Lite

"It is the nature of desire not to be satisfied, and most men live only for the gratification of it. The beginning of reform is not so much to equalize property as to train the noble sort of natures not to desire more, and to prevent the lower from getting more."
Aristotle

Andrew Statson, MD

On 1-10-05, Tennessee governor Phil Bredesen presented his latest effort to salvage whatever he could of Tenncare, while averting the bankruptcy of the state. The threat to revert to straight Medicaid is off for now.

The new program, called Basic Tenncare, will preserve full coverage for the currently enrolled 612,000 children, but will eliminate 323,000 adults from the rolls. The remaining 396,000 adults, who are eligible for Medicaid, will have restricted benefits.

When Tenncare began in January 1994, it was the most comprehensive program in the nation. The then governor Ned McWherter introduced it as "Tennessee without limits." In 1993, the cost of Medicaid in Tennessee had risen so much, that it threatened the solvency of the state. The governor found a solution in the allure of managed care.

Tenncare was launched as an experiment to deliver care to a larger number of people for the same amount of money. Managed care was going to keep the costs down. To make the idea more attractive, the governor presented it as an expansion of the program, to solve the problem of the uninsured and to cover those who were not insurable because of medical problems.

All that for the same amount of money. Does that sound like magic to you? Well, behind the smoke and mirrors was a little political tidbit. It is called Federal Matching Funds.

Let me explain. For every state dollar Tenncare spends, it receives about two dollars in federal matching funds. The trick was to spend more, so they could get more from the feds. They did that, at least to a degree, by raising taxes for the hospitals in the state. Of course, increased hospital costs called for increased reimbursements from Tenncare and more federal dollars to match. So far, so good.

Recently, the federal government caught on to their trick and changed the formula for matching funds. Suddenly Tennessee found itself having to spend more state money. Even before that happened, Tenncare was already beset by rapidly rising costs, just like all other Medicaid programs.

Another problem arose as early as the mid-1990's. Since Tenncare had promised care without limits, it could not cut benefits. Over the years, a public interest law firm, the Tennessee Justice Center, filed many lawsuits and obtained a number of consent decrees, which tied the hands of the state.

For instance, due to legal constraints, prescription drug expenses rose 26% per year in Tennessee, compared to an average of 17% in neighboring states. This fiscal year, the pharmacy benefits alone will cost $2.11 billion. Compare that with the state budget for higher education, which will be $1.89 billion.

Tenncare started having problems almost since the beginning, but by 2000 its fiscal condition had become worse than that of the previous Medicaid program in 1993. Managed care did not produce the expected savings. To aggravate the problem, the costs of health care rose faster than the growth of tax revenue and the general rate of inflation.

In the Bulletin of the Vanderbilt University Medical Center from 5-14-99, Doug Campbell wrote that Tenncare's river of red ink was reaching flood stage. It was underfunded by over $200 million, and the payments from the HMOs didn't cover the actual cost of care.

As of May 1999, VUMC had spent $80 million of reserves to cover losses attributable to Tenncare. Doctor Harry R. Jacobson, Vice-Chairman for Health Affairs, said that VUMC could not afford to subsidize the Tenncare program at the level of approximately $20 million per year.

By early 1999, one of the HMO plans was already bankrupt and taken over by the state and another one was on the brink of failure. In early 2000, the governor asked the legislature for additional $264 million in funding to improve payments and to stop the exodus of physicians and hospitals from participation in the program. Perhaps even more important, Blue Cross, whose HMO covered 600,000 people, had also threatened to withdraw.

See "Tenncare" page 12

Tenncare from page 11

That extra money kept the system going for another two years. In 2002, the HMOs collapsed and the state had to take over.

An audit of Tenncare, released 3-28-02, reported that Tenncare spent $48 million during the previous year providing health care to thousands of people who apparently don't live in Tennessee, or in some cases, in the U.S. Of that money, $16 million came from state funds and $32 million from the feds.

According to the Nashville Business Journal, 11-22-04, Tenncare did not solve the problem of the uninsured, either. In 2002, Tennessee still had 12% uninsured, versus 16% nationally and 25% in Texas. The program covered 19% of the population, fourth highest in the country.

What is the outlook for Tenncare Lite. If you have hoped that the state has learned from its experience and no longer believes in magic, I hate to disappoint you. Governor Bredesen plans to return to the managed care model and will ask the HMOs to assume even more financial risk in the delivery of Tenncare benefits. Read that to mean that they will go bankrupt faster, provided he can convince any of them to bid for the plan.

The state considers putting significant restrictions on benefits, such as limited number of office visits and prescriptions, mandated generic drugs and a formulary list, but it looks like that will apply only to the adults, who represent one third of the enrolled. The children will have no limit on their expenses.

In its plan to help cut costs, the state pulled another rabbit out of the hat, disease management. After reading the recent report of the Congressional Budget Office on the potential of cost savings from disease management, I am afraid the expected benefits Tenncare might derive from that will turn out to be just as illusory as those from managed care. I wonder whether socialists can ever learn, even when the system is crumbling around their ears. ■

Involvement

from page 9

care docs (with a critical need for pediatricians) to trauma docs (chest surgeons and orthopedists) to specialists (psychiatrists and infectious disease docs). There are many challenges to putting together the plans for this community response system. How do we get people signed up? How do we contact them and coordinate them during an emergency? How do we train and support them in the field?

When a disaster strikes our community, we all need to do our part. Organized medicine has a long history of direct involvement. Now as we design our community plans we need to get physicians to the table to help ensure an effective blueprint. **Over the next six months we will be pulling together a broad coalition of community players to plan the medical response to a local disaster. Please get involved. The Pierce County Medical Society needs to be right in the middle of developing these plans. We have much to offer and there are glaring needs that have to be filled. Let's work together to make sure that our community is truly prepared.**

Thank you. ■

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) 717 Hart 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) 227 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 Christine Gregoire 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 Tom Campbell (R) 786-7912; campbell_to@leg.wa.gov
Rep Jim McCune (R) 786-7824; mccune_ji@leg.wa.gov

25th District, (Puyallup, Sumner, Milton)
Sen Jim Kastama (D) 786-7648; kastama_ji@leg.wa.gov
Rep Dawn Morrell (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 Derek Kilmer (D) 786-7802; kilmer_de@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 Mike Carrell (R) 786-7654; carrell_mi@leg.wa.gov
Rep Tami Green (D) 786-7958; green_ta@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 2005 Guide to the Washington State Legislature which includes listings for elected state and federal officials, please call PCMS 572-3667.

David BeMiller, MD, retired Ob/Gyn, loses wife unexpectedly

On January 17, 2005, retired member **David BeMiller, MD**, lost his wife Linda unexpectedly. Linda was horseback riding when she had a massive heart attack.

Linda and David were married in 1963 and resided in Tacoma for most of their married life. They raised three sons.

Linda was very active in community affairs and philanthropy. She worked for the Greater Tacoma Community Foundation and Grantmakers, Inc., was a past-president of City Club and was named Tacoma-Pierce County Municipal League Person of the Year.

A service was held for Linda on February 5th in Lagerquist Hall on the Pacific Lutheran University campus. Remembrances can be made to your favorite charity.

Dr. BeMiller can be reached by email at knothead@pacifier.com or by phone, 253-720-2783.

PCMS extends condolences to Dr. BeMiller and his family. ■

Medical Quality Assurance Commission's Newsletters

The Department of Health has determined to provide the Medical Quality Assurance Commission's Update Newsletters via email with a link to the newsletter. This will be a significant cost savings and an opportunity to provide more frequent updates to physicians and physician assistants.

An electronic emailing list has been created to notify you when the most recent newsletter is available. To add your name to the list, please go to http://listserv.wa.gov/archives/mqac-update.html, select participation on listserv and click on "m," and follow the directions. Or you may contact Beverly Thomas, Program Manager by fax to 360-236-4768 or by email to beverly.thomas@doh.wa.gov and request you name be added to the list.

For those who do not have access to the Internet and would like to automatically receive a hard copy of the Update Newsletter, please contact Beverly Thomas, Program Manager at 360-236-4788 or by fax to 360-23604768. ■

IN MEMORIAM

G. MARSHALL WHITACRE, MD

1918 - 2004

G. Marshall Whitacre, MD

Dr. G. Marshall Whitacre died December 24, 2004 at his home in Tacoma after a lengthy illness.

Dr. Whitacre was born November 18, 1918 at Tacoma General Hospital and graduated with honors from Stadium High School in 1936.

He received his medical degree from Northwestern University, graduating fourth in his class, in 1943. He completed his internship at Cook County Hospital and his residency at Hines VA Hospital. In 1952, after serving in the Army, he returned to Tacoma and opened his internal medicine practice, where he practiced until his retirement in 1979.

PCMS extends condolences to Dr. Whitacre's family.

American Heart Association Community Heart & Stroke Initiatives

The American Heart Association is currently working on several Community Heart & Stroke Initiatives/Programs in which you can get involved. The first being the "Search Your Heart" program. This faith-based series is aimed towards minority churches, encouraging church lay people to implement heart healthy and stroke prevention activities within their congregation. The program features six modules, including exercise, nutrition, health screenings, stroke, stress reduction and advocacy. As an American Heart Volunteer, you could assist this effort in lending your time, expertise and presenting on topics which increase awareness of risk factors associated with heart disease and stroke.

"Get With the Guidelines" program is a secondary prevention program for hospitals and serves as a quality improvement tool. It features an online web-based system to track specific patient data from hospital admission to patient discharge. Get With the Guidelines satisfies a key requirement for hospitals who desire Primary Stroke Certification. As an advocate for this endeavor your assistance could help in getting local hospitals stroke certified.

The American Heart/American Stroke Association and the National Committee for Quality Assurance (NCQA) have developed the Heart/Stroke Recognition Program. This program recognizes physicians for the high quality cardiovascular and stroke care they provide for their patients. Assistance is needed in becoming NCQA certified, showing support for this program and encouraging fellow colleagues to do the same. Physicians receiving this certification are not only rewarded financially, but are acknowledged for providing a certain standard of care to their cardiovascular patients.

To learn more about any of these programs or to get volunteer information, please contact, Tiffany Farr, Community Heart & Stroke Director at 253.272.7854 ext. 15. ■

Applicants for Membership

Peter P. Hu, MD
Radiology
222 - 15th Ave SE, Puyallup
253-841-4353
Med School: The University of Utah
Internship: MeritCare Hospital
Residency: Medical College of Wisconsin
Fellowship: Mallinckrodt Institute of Radiology

Personal Problems of Physicians Committee

Medical problems, drugs, alcohol, retirement, emotional,

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

Confidentiality Assured

COLLEGE OF MEDICAL EDUCATION

Radiology program just around the corner

April 22 at Fircrest Golf Club

This popular CME program is returning to Fircrest Golf Club on April 22. *Radiology for the Non-Radiologist* is a one-day program designed to update primary care physicians on advances in radiology.

The course directors are **Drs. Rick Robin** and **Andy Levine**.

Greater Pierce County's two radiology physician groups - TRA Medical Imaging and Medical Imaging Northwest - offer this highly focused program with expert faculty to discuss the latest advances in imaging and interventional radiology. ■

Get ready for *Internal Medicine Review 2005*

Covering recent advances in internal medicine, this two-day program will be in the Lagerquist Conference Center at St. Joseph Hospital on May 5 and 6. **Dr. Art Knodel** returns as the course director.

Faculty from all over the country are scheduled to present on a variety of cutting-edge issues, ranging from bioterrorism to metabolic syndrome to advances in insulin treatment, and much, much more.

Register now by calling 253-627-7137. ■

Continuing Medical Education

Dates	Program	Director(s)
Thursday-Friday May 5-6	Internal Medicine Review 2005	Art Knodel, MD
Friday, April 22	Radiology for the Non-Radiologist	Rick Tobin, MD Andy Levine, MD
Friday, May 20	Primary Care 2005	Steve Duncan, MD

ADDRESS CHANGES

Please note the following address changes:

Marvin Brooke, MD
11711 101st Ave E #4, Puyallup 98373
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253-841-3169 fax
7707 SE 27th St #104, Mercer Island 98040
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206-275-2073 fax

Glen Deyo, MD
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Ronald Goldberg, MD
400 - 15th Avenue SE #D, Puyallup 98372

Robert Gore, MD
1901 S Union #B5003, Tacoma 98405

Deborah Hickey, DO
5612 - 20th St Ct W #C, Fircrest 98466

Sharon Metcalf, MD
St. Francis Women's Healthcare
710 S 348th St Suite A, Federal Way 98003
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Richard Ostenson, MD
400 - 15th Avenue SE #D, Puyallup 98372

Philip Perkins, DO
6512 - 20th St Ct W #C, Fircrest 98466

Lawrence Majovski, PhD
6512 - 20th St Ct W #C, Fircrest 98466

Glee Lyon, ARNP
6512 - 20th St Ct W #C, Fircrest 98466

Retired Doctors' Wives Luncheon

There will be a no-host luncheon Wednesday, February 23, 2005 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 Marlyn Baer (564-6374) by Friday, February 18.
Come and renew friendships!

Board of Trustees from page 7

opening of the new Mary Bridge Children's Health Center in March. He noted that they will be starting a $25 million office space project on the north side of the Allenmore parking lot which will be completed in 2007, and a $40 million multi-specialty office in Gig Harbor. He discussed MultiCare's electronic medical record system EPIC noting that they will be working on the inpatient component over the next three years.

Kyle Unland, Nutrition and Physical Activity Coordinator for the State Department of Health gave an overview of the magnitude of the obesity problem and some thoughts about what can be done and what the state is doing in this arena. He referenced a Washington State Nutrition and Physical Activity Plan that outlines policy and environmental approaches for communities. The state is targeting schools, city planners, local program administrators, legislators, state agencies and many others for assistance in making policy changes to increase activity and improve nutrition.

Rick Porso, Public Health Manager with the Tacoma Pierce County Health Department reported on his department's focus on policy, particularly school based. He noted that policies are being designed to give schools latitude to develop individual policies, but they are encouraging schools to all work toward a standard policy. He noted that the Health Department would be excited to work with PCMS on this issue.

There was great interest and enthusiasm from board members around the fitness/nutrition issue and many ideas were brought forward and discussed. There were numerous ideas of how PCMS could motivate members and their staffs to improve their choices around exercise and nutrition.

Dr. Hogan introduced CHAMP, a newly formed Coalition for Health, Active Medical Professionals, that will work to create a healthy Pierce County medical community to serve as role models for patients and the community and to work to change societal attitudes about the importance of fitness and nutrition in the health of individuals.

Continuing along the prevention theme, Dr. Hogan reported on the Initiative 901 campaign, which is the initiative to the people for protecting all workers from cigarette smoke. Noting that this initiative is exactly like the one attempted last year, he explained the difference of a solid funding base behind it and organization clout from the American Lung, Cancer and Heart Associations. Petitions will soon be distributed and he hopes physicians offices will assist.

Other actions included formation of a tort committee, activation of a Bylaws committee, the recommendation that PCMS move toward a "paperless" Society, and that PCMS Trustees identify important issues and work toward county sponsored resolutions to be submitted for WSMA consideration at the House of Delegates meeting in September. ■

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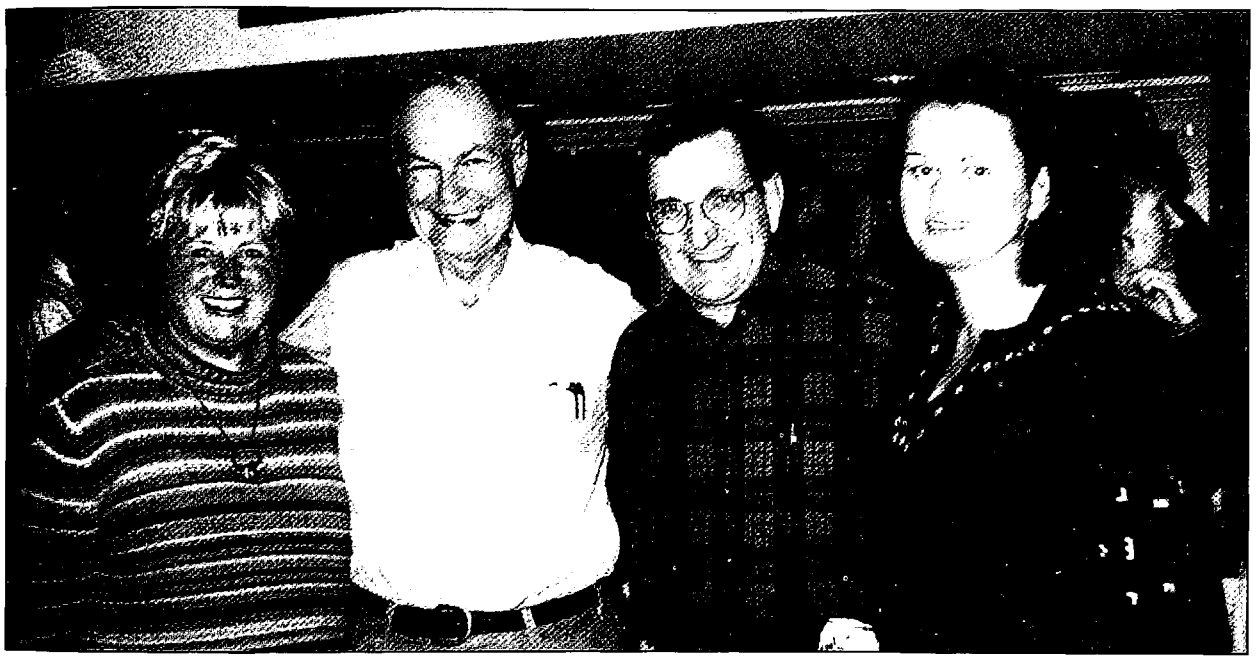
Pierce County Medical Society

BULLETIN

March, 2005

"Fun in Whistler"



Dr. Matt White and his wife Kris (left) and Dr. Ken Feucht and his wife Betsy enjoy themselves at the Whistler CME conference reception and look forward to great meetings and fun times in Whistler

more photos page 15

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.

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Pierce County Medical Society
BULLETIN

March, 2005

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President's Page

by Patrick J. Hogan, DO

Patrick J. Hogan, DO

Exercise as Medicine

CHAMP (Coalition for Healthy, Active Medical Professionals) has now been established in Pierce County as the inaugural chapter in the nation

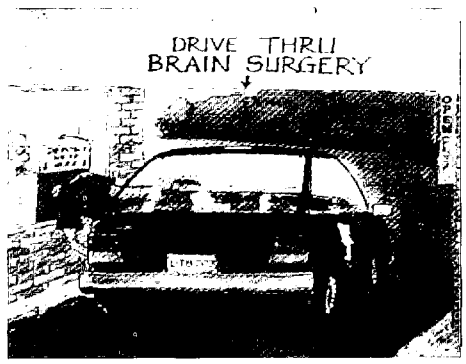
We are developing a model for fitness in the medical community that will be used as a template across the nation. Besides the improved fitness and wellness in our own ranks, the goals of CHAMP are to serve as an example to all Pierce County residents young and old and facilitate awareness of fitness options and education for patients and staff. Many of you heard Dr. Charles Schulman, President of the American Medical Athletic Association speak at the March General Membership Meeting on "Exercise as Medicine." He will present our CHAMP model to the AMAA convention before the Boston Marathon in April. (Watch for the summary of his discussion in the April issue of the *Bulletin*.) If you have any additional ideas for this model or would be willing to volunteer for the CHAMP coordination committee, please contact Sue Asher or myself.

BMI is Vital

The Body Mass Index (BMI) is considered to be as vital as the other vital signs as a predictor of underlying disease and should be equal emphasis in discussions. Making the BMI part of the vital signs at each visit is being utilized in many clinics nationwide. It is a better way to monitor a person's weight and fitness and highlights the need to address the issue at each office visit. BMI guidelines and the means of calculating it or measuring it will be distributed to PCMS member offices and BMI charts will be available through the PCMS office.

We can change our "drive-thru society" and fitness by how we practice

We have the power to change the path that our American society is taking with 60% overweight and only 15% doing adequate exercise. It is up to the medical profession to change the "less muscular activity is better" mentality that our society has steadily developed over the past four decades. The key is to ignore our culture's obsession with being as sedentary as possible that is driving the supersizing of Americans such as a **drive-thru at every business** and a remote control for every device. We have to reframe people's **thinking about fitness as a part of daily life**.



A written **Prescription for Exercise** can be the greatest medicine recommended. We have made RX pads for exercise available for your patients and staff. These have been modeled by progressive programs in New Hampshire and Canada and personalized for our use for PCMS members. Call PCMS staff for your prescription pad.

Just as people are compelled to be compliant with their daily medication, everyone must make **exercise an unbreakable obligation** that is as important as any other medication or appointment that a person may have through the day. Fitness trainers have recognized that making exercise a **routine commitment to daily life** is what predicts if a person will benefit on a long term basis from a fitness program.

As highlighted in Jean Borst's article in this month's *Bulletin* (see page 7), this commitment is as important at any time throughout a person's life. We are **inspired by our retired members** who continue to serve as inspiration for physical activity to our community. **Persistent activity maintains vitality into older age.** Exercise is a life-long way of life and it is never too late to start. As an example, a study was done in which 90-plus year old women in care centers were started on a carefully guided weight training

See "Blending" page 4

Blending from page 3

program. All these women made large gains in their strength that transmitted to improvements in their independence in daily activities.

Pedometers are now available as a benefit for members of the Pierce County Medical Society as a means of motivation and tracking the 10,000 steps per day recommended guideline and being an example to the community. (See PCMS *FitNews #3*). Taking 10,000 steps per day is a crucial first step although not an end in itself. The body rapidly adapts to an exercise level and we to need to **continually challenge the body** in order to achieve cardiovascular fitness, diabetes prevention and bone health. We need to **Huff and Puff to be Buff**. However, **a long journey can not begin without these first steps** and this program will start people along the way.

Breaking News: Recent studies related to fitness

In a Mayo Clinic study reported in January, the one main difference between groups of overweight people who did not routinely exercise compared to normal weight non-exercisers was just the level of movement in daily life. The overweight people sat an average of three hours more per day and the other group maintained a higher level of movement throughout their daily activities. The message is to **promote more movement in daily life activities**.

Many of you observed the *New England Journal of Medicine* article in December that demonstrated that even if physically fit, an overweight physically fit person still does have a higher risk than a fit person in the recommended weight range of development of diseases of obesity such as diabetes and cardiovascular disease. However, it is still held true that **it is healthier to be overweight and fit rather than thin and sedentary**. Although exercise is the key to effective long term weight loss, it must be tied to the proper nutritional program. **(See this month's editions of PCMS *FitTips* and *NutriTips* that can be copied from the *Bulletin* or copied from the PCMS website for your staff and patients).**

The importance of fitness was emphasized in an excellent review in January from University of Triest, Italy demonstrating the **metabolic consequences of physical inactivity** separate from the weight issue. This demonstrated that **muscle metabolism adapts to inactivity** with resultant negative consequences in the body leading to resistance to the glucoregulatory effect of insulin and the development of the metabolic syndrome. The abdominal obesity that follows becomes a harmful organ in itself secreting chemicals that promote vascular disease and diabetes. The good news is that **exercise reverses these effects**; programs the muscle to again become a healthy organ and diminishes the effect and presence of the abdominal fat organ.

Smoke Out for Washington: Healthy Indoor Air for all of Washington

We have now had the formal kick off of the I-901 initiative campaign to bring healthy **smoke-free air to all public places in Washington**. There is now the major emphasis on getting petitions in all physician offices to accomplish the required signature number as soon as possible. We can then get to the business of counteracting any tobacco industry smoke screen tactics before the next election and insure that this crucial measure is passed on next November's ballot. **Please contact PCMS or myself to get petitions for your office or for your personal efforts.**

Legislative Action

While the Legislative Day in January brought reassurance that passage of an additional B & O tax on physicians is unlikely, it remains a major concern in light of a proposed $2.2 billion state deficit and warrants calls/emails to your legislators. Tax increases on our services will make our state the very least attractive for physicians.

The strategy of properly framing the Tort reform initiative I-330 was emphasized. It was shown that the Washington public favors I-330 if it is understood that this is a **"caring physician vs. personal injury lawyer"** issue and that I-336 is totally funded by the trial lawyer group for their own profit preservation. The PCMS Tort Reform Committee is busy preparing the stage for the upcoming battle to improve the medical climate in which we practice in Washington State. ■

Pierce County Medical Society has a new e-mail address

PCMS has changed their e-mail address to:

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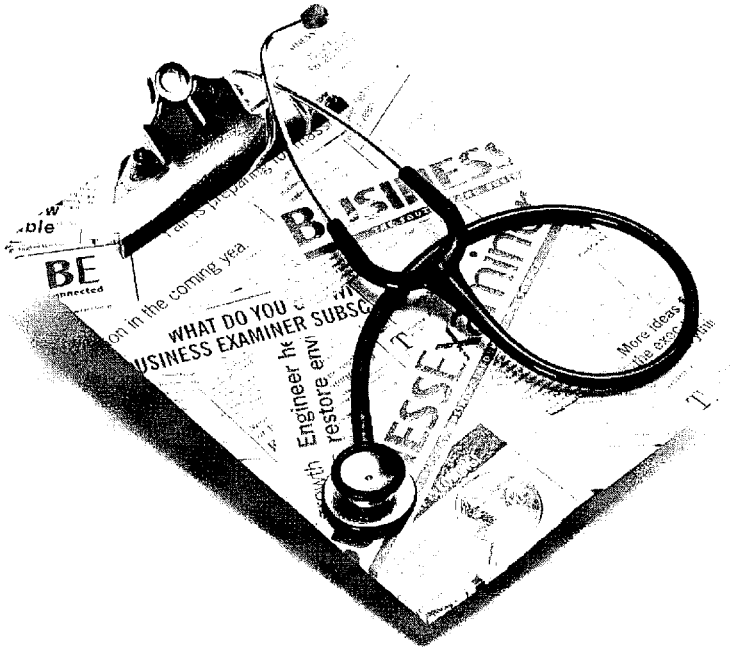

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FitTips #3

by Patrick Hogan, DO

Exercise for Weight Loss

1. Although it is true that fit and overweight is better than thin and unfit, it has been demonstrated that overweight fit people still have twice the risk of diabetes and vascular disease than the normal weight fit person.
2. **Abdominal fat** is not just fat lying there. It is **active, harmful tissue** that secretes at least 30 chemicals that increase risk of vascular disease to the heart and brain, greatly increases the risk of diabetes and may contribute up to 20% of all cancers.
3. **A hormone called Leptin** is over-produced in fat tissue and leads to metabolic changes leading to further fat accumulation, bone loss, and decrease in sex hormones. **With regular exercise, Leptin decreases** in production leading to enhanced fat burning and other health benefits.
4. A 3,500 calorie loss is needed for one pound of fat loss. That would require a 500 calorie deficit per day for a one pound per week loss. However, people are often eating in excess of their requirements and slowly gaining weight. So, decreasing calorie intake may only be to that of the daily requirement and not result in weight loss. It is much easier to lose weight **by exercising the extra calories away** and decreasing calories to a more comfortable and sustainable level. (See 8 & 17 below)
5. A fitness program has the best effect on the body if done five or six days per week with alternating types of exercise as noted below with one or two rest days per week.
6. The ideal exercise program mixes an **aerobic program and a weight training** program. This diversity helps prevent injury and prevents boredom.
7. **Weight training has multiple benefits** for everyone. It increases the calorie consumption of the body for about four days after a weight training session, replaces fat with muscle that continually burns more calories, and increases the load on the body required for bone health that will be discussed in a later edition. Remember: **Strength does not increase during exercise**. Exercise puts a demand on the body that causes it to increase strength **in the days after strength training**. It is ideal to allow a few days between strength training sessions or to exercise different muscles on different days to achieve the maximal benefit without injury.
8. **Aerobic exercise** is exercise that causes a person to huff and puff and increase the heart rate. Exercise at this level is needed for optimal benefit and weight loss although exercise at this level is something **that should be worked up to**.
9. Each **10 minutes of aerobic exercise** at 70-80 % of your maximum heart rate (see #10 below) burns about **100 calories for men and about 75 calories for women**. If you exercise below 70 % of your maximum heart rate then you will need to exercise approximately 15 minutes to burn the same amount of calories. Although lower intensity exercise will utilize more fat for fuel, the higher intensity exercise will rev up the metabolism to **burn more calories for hours after the exercise**. Varying the exercise intensities in different workouts will further insure weight loss and greater fitness.
10. **Heart rate monitors** are now inexpensive and will help motivate and measure your exertion level at a point that is adequate for weight loss and fitness. A general estimate of what you heart rate should be is to calculate you maximal heart rate by subtracting your age from 220. Your heart rate should be between 60 to 80% of that number for optimal fat burning and long term conditioning effect. (For example, at age 45, maximal heart rate is about 175 and 60 – 80% of that is about 110 to 140 heart beats per minute. Higher heart rates are used in training for optimal performance for athletic events.)
11. Walking or running **10,000 steps each day** is a good guideline for fitness. This can be monitored with an inexpensive pedometer. In a recent study, people who were overweight sat an average of three hours per day more than those who stayed active even just by puttering and **moving about more throughout the day**.
12. For other exercise types other than walking or running, substitute 2,500 steps for every 15 minutes of vigorous exercise toward your 10,000 steps per day goal.
13. Our society promotes inactivity and energy conservation with drive-up's, remotes, elevators and escalators. Instead, look for ways in your **daily life** to **increase your daily steps and muscular movement**. Fitness and better health will follow.
14. **Persistence is the key to achieving fitness and weight control**. Make exercise a near **daily way of life and as important as any other appointment** that you may have. Once the habit is established it is much easier to maintain. The exercise that is enjoyable and will be sustained long term will vary with personality types. For some, a competitive activity is a better fit. For others, an individual activity is more comfortable. For everyone, any exercise is more sustainable if done with a buddy or part of a group that will get you going when the going isn't the most convenient. Getting going on exercise some days is difficult for even the most conditioned athletes but **not making excuses is the secret to successful fitness**.
15. Weight loss may not occur early after starting an exercise program. The brain initially may react to fat loss by releasing a chemical that holds onto fat. However, as fitness occurs and metabolism changes, this fat level is reset and weight loss will steadily occur.
16. Even before weight loss occurs, the **benefits of fitness** will be realized early such as improved energy level, sense of well being, improved sexual function, improved heart function and improved moods (see PCMS *FitTips #1*).
17. **Stress alone increases the deposits of fat in the body**. This is especially common in our stressful, modern life. **Exercise** is

See "Weight Loss" page 6

NutriTips #3

by Joan Brookhyser, RD, CSRCD

Exercise and Nutrition

Exercise and Nutrition

There are several answers to the question of what to eat when you exercise depending on your exercise goal: 1) weight loss and fitness management, 2) heart disease prevention, 3) to enhance performance in a given exercise or sport, or a combination of these goals.

This edition will cover the topic of exercise and weight loss management which is the most common motivation for maintaining a fitness program. In order to succeed it is important to know what and how much to eat so that you do not sabotage your weight goals.

It is estimated that a 3,500 calorie deficit will equal a one pound body fat loss. So in order to lose one pound of body fat per week you would need to eat 500 calories less per day. However, because of adaptations in the body there are factors that can impede this weight loss. Exercise offers the bridge to connect the optimal weight loss program so that you can lose weight easier and maintain your desired weight long term. See further information on this in PCMS *FitTips #3*.

How To Eat

The average calories burned for a non-active person is about 10-12 calories per pound of body weight in a 24 hours period. So, for example, if you are a 200 pound man you will burn between 2,000 and 2,400 calories per day by relaxing during the day and/or sitting at your desk at work. Now if you add in 30 minutes of aerobic exercise you will burn another 300 calories, bringing the total calories burned to 2,300-2,700 for the day. The 300 calories from exercise may not seem like much, which is why exercising for 30 minutes per day does not justify an extra slice of pizza (400 calories) or that chocolate sundae (500 calories). The key will be not to replace all of the calories you just burned during exercise with excess food. At the same time, it is not recommended to starve yourself since receiving valuable nutrients are needed to prevent muscle breakdown.

Start with the food pyramid to get your basics:

Per day:

2*-3 milk servings (100-150 calories/serving)

2-3 3 oz servings of protein (210 calories/serving)

5-8 servings of fruits and vegetables (50-100 calories/serving)

6-8 servings of bread and or nuts (100 calories/serving)

*Lower number recommended for women or if you are having trouble losing weight at the higher number of servings

You should not lose more than two pounds of body weight per week with your exercise and weight loss program. If you are, you are not losing at a healthy rate that will be maintained. If needed, add foods to prevent this rapid weight loss.

If you are not losing weight, use less servings of the bread and grain group and try increasing your exercise duration and intensity. You should also evaluate your diet to avoid too many processed breads and grains, such as pastries, white bread, bagels or other refined sugar products that are called high glycemic index foods. These foods can often increase insulin secretion making weight loss more difficult.

Curbing Hunger

When you start to exercise you may feel very hungry and feel you need food when in reality you may just be fluid depleted. Make sure you replace your fluid losses before responding to your hunger. Also try not to over exert yourself with exercising (heart rate over 80 % maximum) for long periods of time. When you exercise this hard your body uses only glucose for energy, sometimes leaving you more glycogen depleted and with low blood sugars that may make you want to overeat.

Pre-plan a snack after your workout. This will prevent you from eating foods or snacks impulsively that are high in empty calories or not of nutrient quality. Good nutritious snacks can be such things as a sports bar like Luna, Balance, Clif, or any sports bar containing approximately 10-15 g protein and 30-40 g carbohydrate, a slice of cheese, a few crackers and a piece of fruit, yogurt, cereal and milk, or ½ peanut butter and jelly sandwich.

You do not need to eat extra food or carbohydrate drinks during exercise unless you exercise more than 60 minutes at a time. In the next PCMS *NutriTips* I will cover the kinds of foods you should eat for these longer workouts and exercising for enhanced performance. ■

Weight Loss from page 5

the best way to counteract the chemical responses that are responsible for this and prevent these abdominal fat deposits. Exercise also helps us to cope with stress better psychologically.

18. Although exercise is the key to weight loss and health, it must be combined with a **good nutritional program** (see *NutriTips #3*).
19. Summary: Eating 100 calories per day less than your body needs (equal to one cookie or an 8 ounce soft drink) and averaging only an extra 100 calories extra output from exercise per day will result in a 2 pound per month or 24 pounds per year weight loss. **Steady and consistent healthy life style change is the key factor to long term fitness and prevention of the diseases due to obesity and inactivity.**

Coming soon in *FitTips*: Exercise in the treatment and prevention of diabetes; Exercise and bone health; Exercise and sexual function; and Exercise in the prevention of heart disease. ■

Special Feature

by Jean Borst

Fit for Life: No Rocking Chairs for These Guys

"You don't stop playing when you get old. You get old when you stop playing."
George Bernard Shaw

Throughout their medical careers, they were each making a smart and valuable investment for the future – the investment of fitness. And now, as others may be slowing down and taking it easy in their 60s, 70s and 80s, they are still running, hitting, swimming, biking and hiking their way through life. Inspirational to say the least, these four individuals are giving a whole new meaning to the term "active seniors."

Ken Graham: Diversity is the Key

At age 74, **Dr. Ken Graham** has made physical fitness a lifelong commitment. From biking to tennis to swimming to gym workouts, the retired family practice physician feels very strongly that diversity is the key to keeping exercise fresh and enjoyable.


Ken Graham, MD

"I grew up always busy hunting, fishing, and enjoying other outdoor activities," he recalls. He started running when he was in his late 30s, and has participated in 20 Sound to Narrows races. But the impact of all those years of running took a toll on his knees. He hung up his running shoes about three years ago, but certainly didn't throw in the towel.

Today, Dr. Graham logs his miles on the tennis court, on his bike and in the pool.

Dr. Graham is one of a group of about 20-30 local men and some women, ages 40-80, who play tennis on a regular basis at Tacoma's Pac West. "It's a great way to exercise, and a nice social activity, too," he says. As a warm-up to his tennis workouts, he spends time in the gym stretching, lifting weights and working out on the cardio machines.

When the weather cooperates, Dr. Graham heads outdoors on his bike. He credits Doug Jackman, former PCMS executive director, for getting him wheeling. "Doug took me under his wing," he recalls. In addition to weekly organized rides, Dr. Graham also participated twice in the annual Seattle to Portland bike event. Up until just a few years ago, he was still joining a group of about six physicians who rode regularly. "It got to the point where I was working too hard and it wasn't as much fun," he says. "I didn't want to hold them up, so I started riding solo. But that's ok, too."

In addition to his regular fitness routine, Dr. Graham still hunts and takes daily walks with his chocolate lab. He suggests walking as a great form of exercise for those who might not have the time, desire or ability to fit in a demanding exercise regimen. "This area is a great place for walking, and there are so many options," he says, suggesting some of his favorites — Pt. Defiance Park, Titlow Beach, and China Lake, a gem of a park in Fircrest. And in the summer months, Dr. Graham suggests hiking as a great exercise option. "There is no end to the hiking options in this area," he notes.

Most of all, he suggests variety. "Exercise gets boring if you do the same thing all the time."

Cordell Bahn: Retired, but Still on the Run

It's that time again. As June approaches, more and more runners are out on the road, logging miles, training on hills, and getting ready for a Tacoma classic — Sound To Narrows. And **Dr. Cordell Bahn** is one of them.


Cordell Bahn, MD

This will be No. 33 for Dr. Bahn, 69, along with a handful of individuals who call themselves "The Every-timers," those who have run the 12k course each year since its inception in 1972.

For Dr. Bahn, a retired surgeon, running is just about as natural as breathing.

"I used to be overweight as a teenager," he recalls. "Even though I grew out of that, I think deep down, there's a little fat guy inside of me, so I've always been aware of that. I think that motivates me."

For Dr. Bahn, who started running after medical school, the convenience of running was very conducive to his hectic practice. "It was a wonderful fitness program to have while I was working," he says. "I could always fit a run into my schedule."

Dr. Bahn runs two to three miles, four times a week. He also runs scenic 5-Mile Drive in Pt. Defiance Park weekly. "Running keeps my life on an

See "Fit for Life" page 8

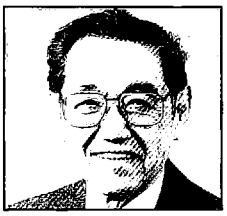
Fit for Life from page 7

even keel," he explains. "It's good for my spirits and my wellbeing. It's not that I'm a dark or gloomy person, but I always feel better after a run." And it also keeps his Labrador retriever in shape.

In addition to running, Dr. Bahn also hits the ice at Sprinker Recreation Center in Spanaway. He took up ice hockey in the 1990s, but getting knocked to the ice a few times by a 220-pound kid was enough for him to retire his stick. "I'm definitely a pleasure skater now," he says.

Dr. George Tanbara and Vern Larson: In a League of Their Own

While they say it's all fun and games, **Dr. George Tanbara**, 82, and **Dr. Vern Larson**, 77, aren't exactly your average recreational tennis players. Between them, they have competed locally, regionally, nationally and internationally, and still participate in multiple tournaments each year. And for five consecutive years, the pair was ranked No. 1 in doubles in the Northwest in the over-55 age group.


George Tanbara, MD

Tacoma pediatrician George Tanbara, MD — still practicing today — was just 12 years old when he picked up his first tennis racquet. "I just happened to find a racquet," he says, "and it became my lifelong sport." With the exception of the time he spent in a Japanese internment camp in Southern California during World War II, he has played the game ever since.

While living and playing tennis in Los Angeles, Tanbara had the opportunity to meet many top-seeded players, including Bobby Riggs, former Wimbeldon and U.S. Open champion, well known for his "battle of the sexes" tennis match at age 55 with Billie Jean King. "We used to go to the same tennis shop," he recalls, "and we also met at different age-group national tennis tournaments through the years. We had some very interesting conversations."

A regionally and nationally ranked player over the years, Tanbara says that his game has slowed down a bit, although he continues to play on a regular basis and participates in tournaments. He plays at least three times a week at the Tacoma Lawn and Racquet Club. "We have a diverse group of individuals, some 10 to 30 years younger than me," he says. "We all play at about the same caliber, although some are better than others. I mainly do it for the fun of it."

He might be doing it for the fun of it, but he's still playing some serious tennis. He and his doubles partner from South Carolina participate in four national age-group events each year, playing a game on each of the four court surfaces – indoor, hard court, grass and clay. "I go east for two tournaments, and he comes west for two," he says. He admits that indoor play is probably most conducive for the older players. "There's no sun, no wind, and it's warm! But I'll play on any surface, just as long as it's fun."

Through the years, Dr. Tanbara has had his share of injuries – tennis elbow, a separated shoulder, ruptured Achilles tendon. "I was younger then, and could hardly wait to get back out on the court," he says. "But I knew that to do that, I had to follow the right steps. I probably went overboard on the physical therapy, but it was important to me to get healthy as soon as possible."

For Dr. Tanbara, tennis has given him the opportunity to play with other people who want to have a good time. And for him, that's what it's all about. "It's vital that everyone on the court is having fun," he says. "Yes, you should play for yourself, but it's just as important that the people you're playing with are enjoying themselves."

For Dr. Vern Larson, the tennis racquet ended up in his hands a little later in life. At age 40, he decided to take lessons along with his children. And today, he's still going strong.


Vern Larson, MD

A retired radiologist, Dr. Larson recalls the challenges of making time for tennis while running a busy practice. "I made the best of it," he says, "I played on days off, weekends and late in the evening. That's the great thing about indoor courts."

Dr. Larson plays tennis three to four times a week at Lakewood Racquet Club. He participates in about 15 tournaments a year, primarily in the Northwest and California, and has won several titles. He has also played in national and international tournaments, including the World Medical Tennis Championships, in which he placed second one year. "I played well over the years, and I had a good time," he says.

While others have been plagued by knee, hip and shoulder problems, Dr. Larson has only dealt with the occasional sprained ankle. "I attribute that to the regular, steady practice of exercise," he says. "It's very important to exercise on a regular basis to avoid injury."

Obviously, Dr. Larson says, most people his age are not going to take up the game of tennis. "For me to start playing as late as I did, and to play well, is kind of surprising. I've been able to play reasonably good tennis with some of the best players in the northwest, country and world."

Regardless of age, he encourages everyone to find a fitness outlet and stick with it." People who don't exercise on a regular basis are losing out on a whole lot," he says. "I know that it's tough when you're busy, especially if you're a physician working 16-hour days. But it is possible to make the time."

And worth every minute of it. ■

In My Opinion

by William H. Martin, 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.*

Retirement Means Time for Family and Travel

The most difficult choice we physicians must make is to retire from the active practice of medicine. Those of us who provide surgical care find this particularly distressing, not only for the years it has taken to develop our skills, but also for the continuous feedback we receive in the performance of surgery. This is a time - and emotion - demanding specialty that not only takes many years to develop the skills necessary for successful practice, but also extracts considerable cost to family relationships. I personally feel considerable pride in my adult children and their successes. I am in need at this point in my life to restore my relationships with my children as well as to know my five grandchildren.

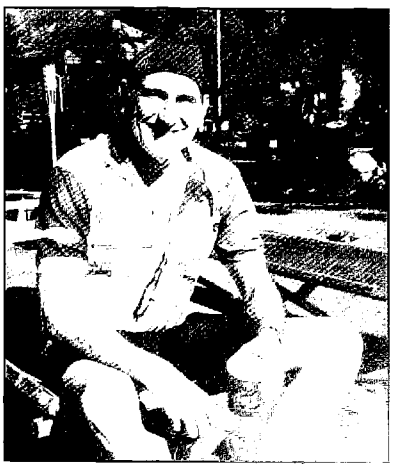
I intend to remain in this community, which I have grown to love over my 28 years of residence. I will assist other surgeons for as long as I can remain upright but will have the flexibility for travel and lengthy stays at various destinations in this country and abroad.

"I am in need at this point in my life to restore my relationships with my children as well as to know my five grandchildren."

I take particular pride in the surgical practice I founded in 1978, Mt. Rainier Surgical Associates. I am confident that the practice will continue to serve this community with skilled and dedicated surgical care. There is no greater legacy than the confidence that my own level of dedication remains with my associates, **Dr. Theresa Terem, Dr. Mark Ludvigson, Dr. Clifford Porter** and our newest associate, **Dr. Kathy Toosie**.

I will continue to live in the Tacoma community with the confidence that my family will receive the skilled and dedicated medical care that I have observed from both the medical community and the hospitals in Tacoma. ■

Dr. Bill Martin and wife Karyl after completing the 2002 Seattle-to-Portland



Bill Martin, MD on the way up Stevens Pass at the 2002 Courage Classic bicycle ride benefiting Mary Bridge

Applicants for Membership

Garry L. Gregory, PA-C
South Sound Neurosurgery
1519 - 3rd St SE #101, Puyallup
253-841-8939
Training: UC Davis School of Medicine

Christina P. Hitchcock, MD
Ob/Gyn
MultiCare Ob/Gyn
521 Martin L King Jr Way, Tacoma
253-403-4747
Med School: Chicago Medical School
Internship: Kern Medical Center
Residency: Kern Medical Center

Directory Changes

Please make the following address and/ or phone/fax number changes to your 2005 Physician Directory:

Lee Bergman, PA-C
Add as primary office address/phone:
1708 S Yakima #105, Tacoma 98405
Phone: 426-4420
FAX: 426-4383

Jay Iyengar, MD
Change office address to:
1818 S Union #1A, Tacoma 98405

Daniel Nehls, MD
Change Tacoma phone to: 426-4420
Change FAX to: 426-4383
Omit Physicians only number

Hugo Van Dooren, MD
Change office address to:
6411 N 48th St, Tacoma 98407

Personal Problems of Physicians Committee

Medical problems, drugs, alcohol, retirement, emotional,

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

Confidentiality Assured

The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

Do the right thing

Federico Cruz, MD

Ireland's bars go smoke free! I have to admit that I never thought that I would see the day that cigarettes would be extinguished in the pubs in the old country, but the entire nation of Ireland has gone smoke-free. Times are changing. Public perceptions have begun to catch up to the science of smoking. There is no doubt in most people's minds that smoke - whether directly because you are a smoker or indirectly because you are around smokers - is unhealthy. Because the public accepts that smoking is basically an unhealthy activity, it means that policy-setters (e.g., politicians) can move forward with new laws governing cigarette use. Outright bans are becoming more and more common.

If we look back during our lives, we have gone from a period where physicians had prominent places in tobacco ads (the Chesterfields' ads where it was the most popular cigarette among physicians) and the U.S. military gave out cigarettes to enlisted men free as part of their c-rations, to a time now where every physician knows the deadly health impacts of smoking and screening for tobacco use is a regular part of general medical care.

The tobacco industry has been discredited as a result of years of lies and misrepresentations around the health effects of tobacco and nicotine on those exposed to tobacco smoke. A huge settlement was accomplished with the industry and the attorneys general from states across the country. This resulted in restrictions in advertising and a large payout in damages that totaled many billions of dollars. These were very important steps forward. But the battle is not over. We still have a large and very successful tobacco industry that still effectively markets their wares. Tens of thousands of teens still begin smoking every year. Tobacco related diseases are still the number one cause of preventable death each year in our country.

"Change is often led by local actions started by local citizens, groups and agencies that are rooted in their communities."

If we are going to change this, there are some concrete steps that we need to take in our community, in our state and in our nation. Change is often led by local actions started by local citizens, groups and agencies that are rooted in their communities. A perfect example of this is here in Pierce County. The local Board of Health supported by local anti-smoking coalitions put in place a comprehensive smoking ban that governed almost all public places. Though it was challenged in court and eventually discontinued by court ruling, the action of the Board and their allies changes things here in Pierce County. After the ban was suspended, many bars and restaurants went smoke free anyway. They had learned during the time when the ban was in effect that it was both good business and was the right thing to do for their employees.

Since the original ban by the Board, Pierce County has become the most smoke free place in the state. Of new business licenses granted in 2004 for new bars and restaurants, close to 95% were smoke free. All done because it was the right thing to do.

The rest of the state needs to catch up. Normally we would look to the legislature to pass a state law that would put into place a statewide ban. Unfortunately this has not happened in the past and is unlikely to happen this year. The industry has successfully gotten several bills to move forward that push back the standards for clean air.

This has set the stage for a new effort to get an initiative in front of the voters to establish once and for all some public policy on smoking in public

See "Right Thing" page 20

HIPAA Security Rule Basics: Q & A

Q: What is the compliance date?
A: All covered entities, except for small health plans, must comply with the Security Rule by April 20, 2005. Small health plans have until no later than April 20, 2006.

Q: Who is covered?
A: All HIPAA-covered entities must comply with the Security Rule for all protected health information created, received, maintained, or transmitted electronically. If you are uncertain whether you are a covered entity, please see the Centers for Medicare and Medicaid Services' Covered Entity Decision Tools at http://www.cms.hhs.gov/hipaa/hipaa2/support/tools/decisionsupport/default.asp.

Q: What does the Security Rule do?
A: The security standards were developed to protect electronic health care information while permitting appropriate access and use of that information. The Security Rule adopts national standards for safeguards to protect the confidentiality, integrity, and availability of electronic protected health information.

There are 18 security standards—divided into the categories of administrative, physical, and technical safeguards—that covered entities must implement. Additionally, there are 42 implementation specifications that provide detailed instruction for satisfying the security standards. These implementation specifications are either required or addressable. If an implementation specification is required, the covered entity must comply as specified. If an implementation specification is addressable, the covered entity has more flexibility because it must do one of the following:

- Implement the specification if reasonable and appropriate; or
- If implementing the specification is not reasonable and appropriate:
  - Document why, and
  - Implement an equivalent alternative measure that is reasonable and appropriate, or
  - Do not implement the specification or an alternative if it would not be reasonable or appropriate and the standard could still be met.

Q: How does the Security Rule differ from the Privacy Rule?
A: The Security Rule is closely linked with the Privacy Rule, with security enabling privacy. The Security Rule has a broader scope than the Privacy Rule in that it addresses confidentiality, integrity, and availability while it has a narrower scope in that it addresses only electronic protected health information.

Q: Does the Security Rule require specific technology?
A: No, the Security Rule standards were designed to be technology-neutral and do not require the use of specific technologies. Each covered entity has the flexibility to choose technologies appropriate for its practice. Compliance with the Security Rule does not have to be expensive.

Q: How can a small provider comply with the Security Rule?
A: In determining what security measures to use, all covered entities may consider size, capabilities, and cost. The Centers for Medicare and Medicaid Services states: "A small provider who is a covered entity would first assess their security risks and vulnerabilities and the mechanisms currently in place to mitigate those risks and vulnerabilities. Following this assessment, they would determine what additional measures, if any, need to be taken to meet the standards; taking into account their capabilities and the cost of those measures."

Q: What should I do first?
A: Appoint a security individual who is responsible for the security of the covered entity's electronic protected health information and identify ways in which your organization can work towards compliance. The basic approach should include, at a minimum, assessing current security risks, developing an implementation plan, implementing solutions, documenting decisions, and reassessing periodically. See the Centers for Medicare and Medicaid Services' Web site, http://www.cms.hhs.gov/hipaa/hipaa2/default.asp, for information, regulations, educational materials, and HIPAA-related links.

Q: Is there any good news?
A: Yes, in developing the Security Rule, the Department of Health and Human Services closely reflected the requirements of the Privacy Rule. The Privacy Rule requires covered entities to have in place appropriate administrative, physical, and technical safeguards. Thus, covered entities that have implemented the Privacy Rule may have already taken some of the steps necessary to satisfy the Security Rule.■

Reprinted from Physicians Risk Management Update, Volume XVI, Number 1

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.*

More Magic

Andrew Statson, MD

"MAGIC, n. An art of converting superstition into coin. There are other arts serving the same high purpose, but the lexicographer does not name them."
Ambrose Bierce

A report on the connection between medical care and bankruptcy recently made a splash in the news. Doctor Quentin Young, national coordinator of the PNHP (Physicians for a National Health Program) said the following:

"The paradox is that the costliest health system in the world performs so poorly. We waste one-third of every health care dollar on insurance bureaucracy and profits while two million people go bankrupt annually and we leave 45 million uninsured. With national health insurance ('Medicare for All'), we could provide comprehensive, lifelong coverage to all Americans for the same amount we are spending now and end the cruelty of ruining families financially when they get sick."

For the same amount we are spending now? Really? Do you know of any program that the government has implemented, in which the cost of the bureaucracy was eliminated or reduced? Do you know of any government program that can provide goods or services to the public at a lower cost than private enterprise, without getting tax subsidies? Public transportation, perhaps? Amtrak? Bonneville?

Medicare proclaims that its administrative costs are only 5%. Perhaps, but what does that mean? They don't collect taxes or premiums. The IRS and the Social Security Administration do that. They don't process claims or make payments. The intermediaries do that. So 5% of the Medicare budget goes to pay for the top layer of bureaucracy at the CMS central office. Add to that the overhead of the intermediaries, at perhaps 35%, the cost of collecting the money, the cost to us to prepare and submit the claims, and you can easily come up with an overall administrative cost of close to 50% of the collected taxes and premiums.

So how is Medicare-for-All going to provide more coverage to more people for the same amount of money? By magic?

The authors selected and studied five cluster samples. The debtors filled out questionnaires asking them whether medical expenses were a factor in their bankruptcy and if so, to what extent.

"So how is Medicare-for-All going to provide more coverage to more people for the same amount of money? By magic?"

The study put into the category of Major Medical Bankruptcy those who reported illness or injury as a specific reason for bankruptcy, or had medical bills of more than one thousand dollars in the past two years that were not covered by insurance, or lost two weeks of work income due to illness, or mortgaged their home to pay medical bills.

This seems to be a very broad category. The authors claim that most of the bankrupt were middle class Americans. It makes no sense that one thousand dollars in out-of-pocket expenses or two weeks off work without pay in a two year span would bring them down to their knees. Something is wrong with the assumptions or the statements.

The category of Any Medical Bankruptcy included all of the above, and added those who reported addiction, or gambling, or birth or death of a family member. So losses due to addiction and gambling, or to change in family situation were considered causes of medical bankruptcy.

There is no mention how many debtors in the major category may have had losses related to addiction or gambling. There is no mention of even an attempt to estimate how many American families had more than one thousand dollars in uncovered medical expenses during the past two years, or lost two weeks of work income due to illness, or mortgaged their home to pay medical bills, but who did not declare bankruptcy.

See "Magic" page 11

Magic from page 13

Of all debtors in their sample, 46.2% met the criteria for major medical bankruptcy and 54.5% for any medical bankruptcy. Of the medical debtors, 15.6% had government insurance (Medicare, Medicaid or VA). Another 60.1% had private insurance. Only one third of the latter lost their insurance during the course of their illness.

Overall, 24% of the medical debtors were not insured to begin with, and an additional 20% subsequently lost their insurance. Of all medical debtors, 56% had insurance throughout their illness.

So how would a National Health Program help? Do the authors claim that Medicare-for-All will cover all expenses, without any deductibles and copays? Do they really believe that will ever happen? Do they have any idea what the federal deficit would be like if it should happen?

The authors admit that their study has limitations. They used a questionnaire and relied on the truthfulness of the respondents. They had no way of knowing how much money the debtors spent on cigarettes and alcohol, or for that matter, on gambling and drugs. They could only say that the debtors denied such expenses.

One can blame high deductibles and copays as a cause of bankruptcy, but that is the reality of life for most Americans. Loss of two weeks of work income, or one thousand dollars in out-of-pocket medical expenses in two years is a common occurrence for most of us, yet very few are unable to meet such life contingencies. I am not saying it is easy, but it is something most of us can handle. There must be another, a more likely reason for these bankruptcies.

Their criteria for counting a bankruptcy as due to medical expenses are much too broad. The authors have cast a wide net to include in the category of major medical bankruptcy many people who don't belong there.

I suspect that even a slightly narrower net would have brought a much smaller number of people into their sample and they would have had to admit that medical costs are not such a big factor in personal bankruptcy. That, however, would not have served PNHP, whose goal is Medicare-for-All.

In conclusion, I have two quotes:

First, for a word from a psychiatrist, here is Thomas Szasz: "Men are rewarded and punished not for what they do, but rather for how their acts are defined. This is why men are more interested in better justifying themselves than in better behaving themselves."

Second, a word from an economist, Friedrich Hayek: "There is a delusion that macro-economics is both viable and useful (a delusion encouraged by its extensive use of mathematics, which must always impress politicians lacking any mathematical education, and which is really the nearest thing to the practice of magic that occurs among professional economists)."

I have been told that someone did feed a multitude of people with five fishes and two loaves of bread, but that happened two thousand years ago and so far, to my knowledge, nobody has been able to duplicate that feat. ■

In My Opinion

by Patty Kulpa, MD

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Doctor Scorecards - Good or Bad?

Call for physicians from small same-specialty medical groups

The pay-for-performance model is being introduced in the U.S. as an alternative way to improve uniformity in delivering quality healthcare and cost effectiveness. This model uses evidence-based medicine (EBM) to establish national standards and guidelines for the healthcare industry. EBM and practice guidelines are supposed to provide a stronger scientific foundation for clinical work, to achieve consistency, efficiency, effectiveness, quality and safety in medical care. These guidelines became performance indicators for the various health plans for the practicing physicians.

Patty Kulpa, MD

Over the last several years, health plans and private stakeholders in the healthcare industry have introduced various pilot studies using this model in hopes to meet customer satisfaction and customer needs. For the practicing physicians and healthcare providers in our community, local health plans like Regence Blue Shield and Premera Blue Cross conducted pilot studies with several local large medical clinics in Washington using this model. They were using physician quality scorecards to gain insights into how their practices compared to peers and to focus on areas for medical group improvement of their healthcare quality. They encouraged best performance with financial incentives.

As they expand this model to small same-specialty medical groups, unintended and intended consequences may occur. Noneconomic and economic impacts on these medical physicians may be of concern.

Dr. Patty Kulpa, a graduate level MBA student at UW Tacoma is conducting this as her student culminating research project. She is asking for all medical physicians who practice in a small specialty medical group (solo to 5 doctors) in Pierce County to complete a fax survey questionnaire. Please complete the survey if you or your group meets these criteria. Please do NOT let your nurse or other office staff fill this out for you unless they are your thoughts.

The research objective is to identify the factors that may be most salient in physicians' decision to accept or reject the pay-for-performance model concept. The research may benefit you in understanding the potential outcomes (sacrifices +/or benefits) with the use of this model to your medical practice. You may

See "Scorecards" page 22

Whistler CME program - education AND vacation

Course director Dr. Rick Tobin (left) and his son on their way to the slopes

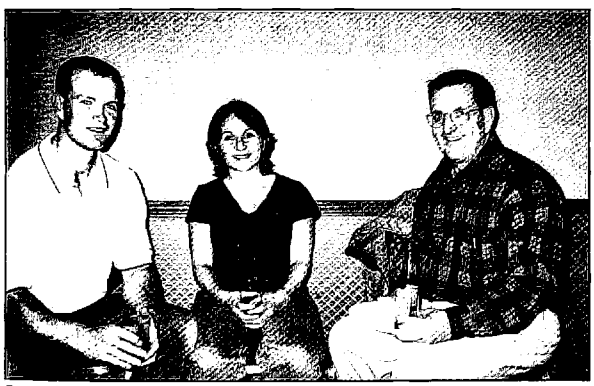
The CME at Whistler course, the College of Medical Education's winter resort program, was a big hit this year, providing excellent medical education, great skiing and great vacationing.

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. ■



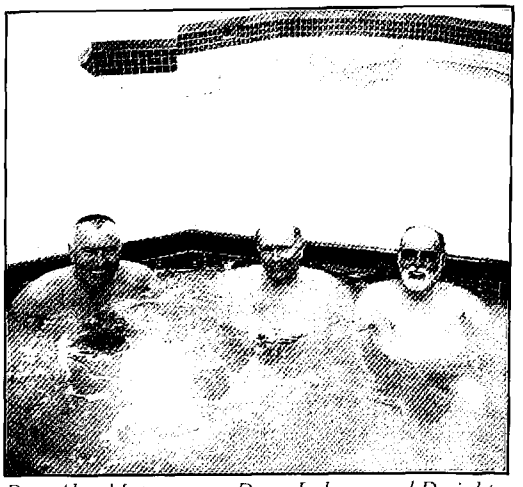
Dr. John Steedman (left) and his wife Cindy visit with Dr. Ken Feucht. The Puyallup physicians practice orthopedic & general surgery, respectfully

Dr. Steven Dagg with his wife Mary Beth and sons Ben and Sam. Dr. Dagg is a family practitioner with CHC

Dr. Peter Krumins, his wife Christine and their children ready for great family fun and vacation

Drs. Dwight Williamson and Dave Lukens (front left) [illegible] themselves with Dr. Barbara Echo and her husband Eric Pla[illegible]

Dr. Mark Craddock and his wife Jinny visit with gastroenterologist Dr. Harald Schoeppner at the opening reception



Drs. Ales Matzenauer, Dave Lukens and Dwight Williamson take the chill off and enjoy themselves apres-ski

Dr. Ralph Katsman, gastroenterologist with his family, including wife Lisa and daughters Danielle and Marisa

From left, Drs. Mark Craddock, Dale Overfield and Rick Tobin enjoy visiting as they look forward to education and vacation

Dr. David law, Tacoma internist with his daughter Hilary get ready to find the snow

Dr. Peter Krumins, orthopedic surgeon gets ready to hit the slopes with his children Benjamin, left and Stuart, right

COLLEGE OF MEDICAL EDUCATION

Surveys on the way

The College of Medical Education is currently preparing a survey to be distributed to Pierce County physicians to assess CME need in the county. Please look for it in the mail.

The results of this survey will be used to determine future COME course offerings, as well as types of presenters, venues, specific topics and more. The more doctors who complete the survey the better information we have to make decisions. Your help is very much appreciated. ■

Internal Medicine Review 2005

Covering recent advances in internal medicine, this two-day program will be in the Lagerquist Conference Center at St. Joseph Hospital on May 5th and 6th. **Dr. Art Knodel** returns as the Course Director.

Faculty from all over the country are scheduled to present on a variety of current issues important to the family practice and internal medicine doctor.

Scheduled topics include:

- A physicians response to bioterrorism
- Metabolic syndrome: emerging trends
- Advances in insulin treatment
- Surgical techniques for cardiac disease
- MQAC: Common Perils in Private Practice
- And much, much more ■

Continuing Medical Education

Radiology program just around the corner

April 22 at the popular Fircrest Golf Club

This popular CME program is returning to the Fircrest Golf Club on April 22. "Radiology for the Non-Radiologist" is a one-day program designed to update primary care physicians on advances in radiology.

The course directors are **Dr. Gordon Benjamin** and **Dr. Andy Levine**.

Greater Pierce County's two radiology physician groups – TRA Medical Imaging and Medical Imaging Northwest – offer this highly-focused program with expert faculty to discuss the latest advances in imaging and interventional radiology.

This day-long program will provide cutting-edge information useful to family practice and internal medicine physicians, as well as ob/gyn and geriatrics specialists.

Topics for the program are scheduled to include …

- a case-based analysis of abdominal and pelvic pain
- Acute Neurological Episodes — brain attack
- Alzheimer's/PET
- Vertebroplasty/Osteoporosis
- UFE or Vascular/Vein Ablation
- MSK/Arthritis
- Breast MR

Register early! This is a popular program. Call 253-627-7137. ■

Dates	Program	Director(s)
Friday, April 22	Radiology for the Non-Radiologist	Rick Tobin, MD Andy Levine, MD
Thursday-Friday May 5-6	Internal Medicine Review 2005	Art Knodel, MD
Friday, May 20	Primary Care 2005	Steve Duncan, MD

Right Thing from page 11

places. Initiative 901 (Healthy Indoor Air for all Washington) has been filed and a formal campaign team has been set up. The effort is being run by staff hired by the American Cancer Society, the Lung Association and the Heart Association. The campaign manager has successfully run other initiatives. They have also hired a full-time fundraiser.

The goal is to organize volunteers all over the state who will collect 165,000 signatures. The rest will be gotten by paid signature gatherers. Many physicians' offices participated in the last initiative effort for tort reform. It is time to step forward again and help out with this effort. The goal of getting the initiative on the ballot is very doable. The public is solidly behind the effort. Physicians can and need to be right in the middle of this effort to establish good public policy. This fits on every level with your role in the community as healers. The public needs to see us not just advocating for issues involving care but also on health and wellness. The time for pushing smoking out of public places is now. Please join in the effort. Expect a call from campaign staff for your involvement. Setting up a place for petitions to be signed by your patients is an easy thing to do. And it is the right thing to do.■

Editor's Note: Call PCMS at 572-3667 to get petitions for your office.

Pierce County Medical Society

invites you and your spouse/guest to the

Retired Physician Luncheon

PIERCE COUNTY ATTRACTIONS

featuring

Raymond Barnett

Washington State Historical Society, Exhibit Manager

- ⇨ Learn about self guided tours available in Pierce County
- ⇨ Updates and tips on coming attractions
- ⇨ Questions, answers and more information about:

- **Chihuly Glass Display at Union Station**
- **Crystal Mountain Recreation Area**
- **Karpeles Manuscript Museum**
- **Northwest Trek Wildlife Park**
- **Commencement Bay Maritime Center**
- **Fort Nisqually Historic Site**
- **Mount Rainier National Park**
- **Tacoma Art Museum**

FIRCREST GOLF CLUB
1500 REGENTS BLVD.

FRIDAY, MARCH 18TH, 2005
12:00 (NOON)

Please return in the enclosed envelope or call PCMS at 572-3667 no later that Monday, March 14th, 2005

YES, I (we) have reserved Friday, March 18th to join retired members (including spouses/guests, and widows) of the Medical Society for lunch.

Name (please print) _____

Please reserve _____ lunch(es) at $18.00 per person (includes tax & tip). My check is attached.

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

Thank you.

Hanford Community Health Project

In January 2005, the Hanford Community Health Project (sponsored by the Agency for Toxic Substances and Disease Registry- ATSDR) will be launching a major public awareness campaign to educate people concerned about past exposure to radioactive iodine (I-131) released from the Hanford Nuclear Reservation. **As a health care provider in Washington state you should expect a marked increase in inquiries about exposure to I-131.**

Between 1944 and 1972, I-131 was released from the Hanford Nuclear Reservation. The majority of these releases occurred between 1944 and 1951. The releases were related to the production of plutonium for use in nuclear weapons.

It's estimated that children, who were up to five years old and lived in Adams, Benton or Franklin counties in Washington state at the time of the releases, received the highest doses of I-131. Today, these are adults between the ages of 54 and 65. Much of this exposure came through consumption of contaminated milk produced by cows (and goats) grazing on contaminated pastures downwind of Hanford.

Public health researchers have conducted extensive epidemiological research around the releases of I-131 at Hanford and the potential link to thyroid disease. The Hanford Thyroid Disease Study, published in June 2002, did not show any association between Hanford's I-131 releases and the occurrence of thyroid disease. Results of the study were published in the December 1, 2004 issue of the *Journal of the American Medical Association.*

Other epidemiological studies, including investigations at Chernobyl and the Marshall Islands, have shown that exposure to radioactive iodine is associated with an increased risk of developing thyroid cancer and other thyroid related diseases. Despite the findings of the Hanford Thyroid Disease Study, downwinders remain concerned about the releases and there is a demonstrated need in the community for more educational resources.

Physicians and other health care providers should be prepared to respond to inquiries about exposure to I-131 and any potential health risks involved. The Hanford Community Health Project (HCHP) offers a wide range of educational materials that will assist you in educating and evaluating patients who inquire about exposure to I-131. These materials can be accessed at www.hanfordhealth.info. They include:

· *A Guide For Physicians: Thyroid Evaluation of Patients Who are Concerned About Hanford Iodine-131 Releases* (Also available soon in PDA format on www.hanfordhealth.info)

· A summary of the 2002 survey conducted on the communities' knowledge of the releases at Hanford, health care utilization, access to care issues related to thyroid disease, and health education needs

There is also an opportunity for free **Continuing Medical Education (CME) credit**. Health care providers can download the ATSDR Case Study in Environmental Medicine (CSEM) *Radiation Exposure From Iodine 131.* This is a self-instructional publication that qualifies for Continuing Medical Education (CME) credit. The case study can be downloaded on the HCHP Web site.

The HCHP Web site, www.hanfordhealth.info, contains educational materials and links around exposure to I-131 for both patients and health care providers. This includes a new streaming video that addresses the psychological aspects of exposure and how to help patients cope. ■

Scorecards from page 15

find this survey very interesting. Results of the study will be posted in the PCMS *Bulletin* in June 2005.

Your participation and all of the study's aggregated data will be kept *confidential* by the researcher. Sole purpose of this survey is to collect and to analyze aggregate data. Returning this survey affirms your informed consent to participate in this research. With help of PCMS and NPN, surveys will be faxed the week of March 7, 2005. Tentative deadline for completion is the end of March 2005. Your participation will be greatly appreciated. If you have any questions about this survey, please contact me, Dr. Kulpa at 253- 851-2922. THANK YOU in advance. ■

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Pierce County Medical Society

BULLETIN

April, 2005

"Defiance Runners"

PCMS members, Drs. Mark Craddock, John Hautala, Pat Hogan, Jim Komorous, David Law and Craig Rone join with member spouses Ginny Craddock, Sonya Hawkins, Donna Jasper and Belinda Rone and friends to walk or run every Saturday or Sunday morning at Pt. Defiance Park

They invite YOU to join them

see story page 9

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.

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Pierce County Medical Society
BULLETIN

April, 2005

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President's Page

by Patrick J. Hogan, DO

Physicians Leading Us to a Healthier Community

Patrick J. Hogan, DO

Tobacco use as well as exposure and poor fitness as well as obesity are the first and second leading causes of illness in our society. The success of the measures now at our doorstep to control these epidemics will **depend upon the leadership of each of us in the medical profession**.

Role of PCMS for Health Advocacy

Some will argue that the role of the PCMS is only to focus on the administrative and financial dilemmas that threaten the health of our practices and thus leave public health measures to the Health Department. The Health Department does establish health priorities and give us guidance on the means of accomplishing health improvement programs. However, the fact is that the implementation and success of these measures is the role of PCMS and the medical community. Because of the governmental and budgetary restraints of the health department, they depend on our direct work with our patients and the public to enhance the health of our community. It is *our* personal responsibility, not that of a governmental body, to improve both our own personal health and the health of the people in our region.

Issues of Unity for PCMS

One of the greatest motivations for working on these tobacco and fitness public health issues is that they are not divisive or partisan as some business issues are and instead are unifying programs that highlight **our passion for caring for patients**. In a time when today's administrative and financial issues are eroding our satisfaction level, making a difference in our world with activism toward community health measures provides a great deal of **personal satisfaction**. Despite all the adversity that we are subjected to these days, health activism emphasizes what we remember as our **ultimate reasons for entering the medical vocation** along with bringing us a great sense of gratification and exhilaration by making such a **positive impact in our patients' lives**.

Great Opportunity for Tobacco Control

The current initiative 901 for Clean Air for All Washington State will play a huge role in controlling tobacco use that is the **leading cause of suffering in our society**. Not only will it accomplish the overt purpose of protecting workers and eliminating the short and long term consequences of our exposure to tobacco smoke, it will play a major role toward eliminating the previous illusion that tobacco smoking is normal human behavior. This measure has been a major force **in decreasing the use of tobacco** in other states where freedom from smoke in public places is the current policy. We must take the leadership role in this State in getting I-901 on the ballot as well as being a counterforce to the inevitable tobacco industry propaganda against its passage. **This opportunity, if lost, will not come again soon** in our lifetimes. Passage will also be a great boost to passage in other states toward the goal of freedom from tobacco smoke in America.

"It is our personal responsibility, not that of a governmental body, to improve both our own personal health and the health of the people in our region."

What can you, your staff and patients do to help?

All PCMS members have been sent a fax asking for your support to have petitions signed in waiting rooms and for financial support. ***Please do not assume that this will be done by the other guy***. This is an issue that will depend on each of you for it to be successful. We can get the necessary signatures if everyone **gets just 10 to 20 signatures a week** in their waiting rooms through June. *Almost all people are very happy to sign the petition for their personal reasons and for the good of Washington State.* Every signature and every message of support from you will count.

See "Physicians" page 4

Physicians from page 3

Our New Fitness Coalition

Involvement in **CHAMP (Coalition for Healthy, Active Medical Professionals)** is the ultimate opportunity for leadership. It will require a personal effort that is already part of many of your lives. The most effective means of making fitness a natural lifestyle for your patients and the overall community is by **leading by the example of fitness** for ourselves and all medical staff. Improving fitness in itself will produce life saving results but is also the ultimate long term weapon in the battle against the epidemic of diseases associated with obesity. As was noted in a March *NEJM*, because of the progressive trends toward an inactive life style in our society, the diseases associated with obesity and lack of fitness are predicted to begin earlier in life. As a result, life spans are projected to be dropping and the current generation of children eventually will be dying at a younger age than their parents' generation.

As with any life style change, we also need to keep in mind that **the major benefit of fitness is the vast improvement in the quality of life that occurs rather than only prolonging life**.

Becoming a CHAMP Champion

You have now received your CHAMP packet appealing for your leadership with this measure. We can have fun with this while changing attitudes toward fitness with the use and promotion of the pedometers provided, fitness club memberships, and participation in CHAMP athletics events.

RX for Fitness

The necessary next step then is prescribing exercise formally for patients. Since this has been successful in other areas of the U.S. and Canada, exercise prescription pads have been sent to you to make it easier to formally recommend exercise to patients and provide them with options on how to begin. It is even more ideal to help a patient tailor their selected exercise type to their personality type. A guideline for this from the December 2004 *Physician and Sports Medicine Journal* has been provided to you.

Viability of Medical Practices

Dedicated PCMS staff and members will continue to work to maintain the financial health of your medical practices. See the updates and talking points in the **I-330 Corner** in your monthly PCMS *Bulletin*.

Kudos To You!!

Congratulations on maintaining your passion for living and caring for your patients. By working as well as playing together we can maintain a healthy balance in life and optimism for continued happiness in our personal and professional lives. ■

Initiative 330 Corner

- The pros and cons of tort reform, as debated by **Mike Kelly, MD** and Stephen Bulzomi, JD were published in the March 7 edition of the *Pierce County Business Examiner*. For a copy of the 20 questions posed to both, and their respective answers, call the PCMS office and a copy will be faxed to you.

- **Dr. Peter Marsh** has been appointed "General" of the I-330 fundraising division in Pierce County. **Drs. Mike Kelly, Joe Jasper** and **Nick Rajacich** will assist Dr. Marsh in raising $316,000 in Pierce County for the campaign. To date, Pierce County has met 16% of their $316,000 goal.

- "How to Fix the Tort System" was the feature article of the March 14 edition of *Business Week*. The cover story chronicled tort issues from the Pitiless Era 1900-1945, the Liability Explosion 1945-1980, and the Backlash 1981-2005. They also compare the European system with the U.S. system in terms of expenses, damages, awards, fees, lawyer population and publicity. For a very interesting read, call PCMS to obtain a copy of the article.

- Seattle Superior Court Judge Steven Gonzalez recently threw out an audacious attempt by WSTLA leaders to remove from I-300 the provisions relating to caps on non-economic damages and attorney fees. Judge Gonzalez agreed with the Attorney General's office - and the *Yes on I-300/No on I-336 Campaign* - that the initiative should go to a vote of the people in November and that the personal injury lawyers had no legal ground for their argument. And, he ruled in favor of the request by the AG and the campaign that the challenge be summarily dismissed.

  However, the personal injury attorneys have appealed Judge Gonzalez's decision to dismiss the case. Their goal is an expedited appeal to the State Supreme Court, which will likely take 60-90 days (but could be sooner). The Attorney General's office and WSMA will fight them all the way and expect to, once again, prevail.

- At press time, 1330 opponents were pushing "Plan B" in the House and Senate Democratic Caucuses. Plan B fails the test of real reform and serves to confuse voters. Please urge your senator to not take action on Plan B.

FitTips #4

by Patrick Hogan, DO

Running As Part of Your Exercise Program

Why run?

1. The Human form is ideal for running. As reviewed in *Nature 2004*, vol 432, Nov 18 pp 345-352, the human body is ideally adapted physically and physiologically to running. Running is a natural thing to do but many people have just stopped doing it. The potential to start running again is always there and gets easier as the body adapts.
2. Running can be done at any time or any place with minimal equipment.
3. Running provides excellent cardiovascular conditioning for heart disease prevention.
4. Running is excellent for weight control. It utilizes 100 calories for every mile run and increases calorie output throughout the day after the run.
5. Running improves moods. It is an excellent way of boosting the chemicals in the brain that relieves depression and increases the ability to cope with stressors.
6. Running improves sexual function. Libido and erectile dysfunction is improved with a running program as well as improving self esteem, energy levels and stamina.
7. Running is excellent for bone strength. It has been shown to NOT promote arthritis formation and in fact improves joint function.
8. Running enhances all the physical, psychological and spiritual benefits of exercise.

How to start running

See ***Fit Facts: Ready to Run*** (insert) describing the basics on how to start training for running.

1. Start slowly to adapt the body to the new movements. It is a commonly heard story of people who initially could not run a block who eventually built up to running a marathon. Beginning with a walking program is often helpful - **see *Fit Facts - A Walk a Day*** (insert).
2. Starting a running program is usually not enjoyable in the first month but becomes exhilarating as conditioning occurs. Stay with it and you will be rewarded.
3. Having good quality well cushioned shoes is crucial to prevention of injury. These can ideally be fitted though one of the local running stores.

How to run

The key to success is running efficiently and in a manner to avoid injury.

1. Running tall with the head and shoulders upright rather than hunched forward enhances the body parts working together.
2. Run with the whole body. Running will be done with greater ease if the arms are swinging and shoulders and hips are rotating.
3. Decrease the impact of running. Although most people land on their heal first, this is a bone that transmits forces throughout the body when impacted. It is better to land on the elastic forefoot and with the foot landing directly underneath the body instead of out in front of the body.
4. Further decrease the impact of running by the foot already coming backward along the ground rather than landing directly down and then pushing off.
5. Wear a heart rate monitor to check your exertion level. (see *FitTips #3*)
6. Many people run more consistently if done with a buddy or group. Even the best runners often have difficulty with motivation to start a run especially in inclement weather or if stiff. Consistency of a running schedule is the key to a successful, life long, pleasurable running program.
7. Mix your running with other exercise and take at least one day off per week.

NutriTips #4

by Joan Brookhyser, RD, CSR, CD

Performance Nutrition

When eating for performance, nutrition changes from basic sustenance, or a means to lose weight, to fuel and a means to gain advantage. Whether you are an elite athlete or wanting to try longer workouts or running your first 10K or marathon or first century bike ride, nutrition will make a difference in not only performance but also enjoyment of the exercise.

You may spend one or more hours per day training, the rest of the time you are recovering, rebuilding and becoming stronger from that training. Nutrition serves as your base for building a stronger body: carbohydrates will replenish your energy reserves, protein will rebuild body tissue, fats will further aid your body in energy and body rebuilding. This is no time for high protein diets or other fad diets. Your plan will need to take into consideration **base eating, pre-race eating, eating during your event and for recovery**.

Base Eating: Day-to-day while in an exercise or training program

Your base eating pattern should be 60% carbohydrate, 20% protein and 20-30% fat. Or another way to visualize your eating is to visualize your plate with 60% with fruits, vegetables and whole grains, 20% with meat, fish, poultry, tofu or dried cooked beans and 20-30% topped off with nuts, healthy oils or avocados.

During Exercise

After 90 minutes of exercise, glycogen stores may become low, so replenishing these stores before depletion is needed. **A good rule of thumb is 15-25 grams of carbohydrate per 30 minutes after 45 minutes of exercise**. This may include sports drinks, gels or even a baked potato.

Fluid needs will also need monitoring. Depending on weather conditions you should consume ½ to ¾ cup fluid for every 10-20 minutes of your workout. Avoid high protein bars during exercise.

Pre-Race Eating

Pre race eating is something that needs practice. A few tips to keep in mind: Try different food combinations prior to your actual race. Never try a new food or beverage on the day of a race. **This pre-race meal should contain 50-200 grams of carbohydrate**. Low glycemic load foods are best during this time such as a peanut butter and jelly sandwich, yogurt or a bagel with cream cheese. Ideally eat your pre race meal 2-4 hours before your event. If this is not possible due to nervousness or time of the race, eat most of the carbohydrate the night before, topping it off in the morning with a carbohydrate drink. A little protein in the meal can usually be tolerated. But again this is individual. With fluid, try to get in two cups of fluid two hours before your event and approximately one cup 15 minutes before your event. Cool liquids are best, for these are absorbed the best.

After Your Event Eating

Within 20 minutes of completing your event replenish your carbohydrate stores. By replenishing your glycogen stores quickly you prevent tissue breakdown and feel less run down following your workout. **A good rule of thumb for post event eating is 50–100 grams of carbohydrate. Some protein with this carbohydrate is also recommended**. The ratio recommended is 4:1 or 4 grams of carbohydrate to 1 grams of protein. Chocolate milk (yes chocolate) is an example of that perfect ratio. Fluid should be replaced quickly. Two cups of fluid for every 1 pound of weight loss. Again you should experiment on training days by weighing yourself pre and post workout to see how much fluid you lose.

Further Reading for Eating for Exercise Performance

If you desire more reading on this subject, the following are good references:

- www.dietsite.com/sportsnutrition
- www.runnersworld.com/nutrition/training
- Eating for Endurance and Ultimate Sports Nutrition, Ellen Coleman
- Food guide for Marathoners, Nancy Clark ■

Special Feature

by Jean Borst

Exercise as Medicine

Patient: "Doctor, the problem with me is that obesity runs in my family."
Doctor: "No, the problem with you is that no one runs in your family."

No one disputes that exercise is good for you. And while most individuals have heard the message to get up and get moving, many still have not acted on it. In fact, the majority of American adults get no regular exercise. And for physicians trying to convince their patients to take on a more active, less sedentary lifestyle, saying "just do it" sometimes just isn't enough.

When a show of hands indicated that most individuals attending the March 8 PCMS General Membership Meeting exercised regularly, Dr. Charles Schulman admitted, "I'm preaching to the converted, but we all need to get other people in the same place we're at."

The noted Boston-based cardiologist is not only a medical expert, Dr. Schulman also understands firsthand the benefits of exercise and fitness. An avid runner, he is president of the American Medical Athletic Association and past president of the American Running Association. "Many of my patients know I run," he said. "If they don't, I tell them." Since many of his patients are facing life-threatening illnesses or have had heart bypass surgery, it means more to them to know their physician follows his own advice. "It makes the message more powerful than, 'Do as I say, not as I do.'"

Appearing before a record number of attendees including physicians, spouses and office staff, Dr. Schulman offered helpful and insightful information on the benefits, as well as the risks, of exercise, how to get started on an exercise program, and the value of writing an exercise prescription for patients.

In addition to emphasizing the importance of increasing the fitness and health of our medical community, Dr. Schulman offered methods on influencing patients to be healthier by improving their fitness and nutrition practices.

"We owe it to ourselves and our patients to be physically active and to encourage them to be physically active, as well."

Charles Schulman, MD

Benefits and Risks

"The first thing we have to do is to get our patients not to be sedentary," Dr. Schulman explained. "There is a tremendous amount of difference between sedentary and something, and moving your patient from a non-active lifestyle to a moderately active one significantly increases health benefits."

Dr. Schulman discussed the many physiological and clinical benefits of exercise. In a nutshell, and perhaps his most persuasive message of all, is that the higher your level of activity, the lower your chances of death.

While the benefits of exercise far exceed the dangers, Dr. Schulman explained that there are some risks to consider. "But they should not be considered barriers," he added.

"A lot of people worry about cardiovascular risks," Dr.

See "Exercise" page 8

From left, Drs. Debby Ayars, Christine Puig, Elena Gleyzer. Also pictured is Phil Upchurch, Dr. Gleyzer's husband

Attendees were eager to sign Initiative 901, calling for smoke-free public places in Washington State

Exercise from page 7

Schulman explained, although only 5 to 10 percent of acute MIs are associated with vigorous exercise. The most common exercise-associated risk is muscle and joint injuries, although the number of occurrences is greatly diminished the higher an individual's fitness level. Proper supervision of an exercise program, stretching, wearing appropriate gear, and exercising in the proper environment also reduces the chance of injury.

While extremely rare, Dr. Schulman noted the occurrences of exercise-induced rhabdomyolysis, primarily in ultramarathoners and military recruits in basic training. These extreme instances typically occur among untrained individuals, in hot, humid weather, when an individual is unable to reduce heat loss through sweating, or in individuals with hypokalemia or those with sickle cell traits exercising at high altitudes.

Overcoming the Barriers

One of the most challenging aspects of becoming more active, and encouraging your patients to do the same, is overcoming the barriers that prevent individuals from exercising, including:

Environment: Neighborhood safety can be a concern, as well as the lack of convenient or accessible facilities.

Psychosocial milieu: One of the biggest issues people have with exercising regularly is time, or more accurately, the perceived lack of time. But as Dr. Schulman offered, "What fits into your schedule better — exercising one hour a day, or being dead 24 hours a day?" It's important to make people realize that they have to work exercise into their schedules, and that they should do something they like to do."

Self-efficacy: If you were ever active, you're more likely to become active. "If you're sedentary now, but you were active in the past, at least you know what it feels like."

Personal reasons: Lack of interest or the "I'm not a jock" syndrome.

Health factors: There are individuals who can't exercise because of health issues. "Even individuals with a variety of illnesses can exercise more than they realize," Dr. Schulman noted.

Program accessibility: "What is the right program for me?"

An additional, and significant, barrier to becoming more active is physicians' lack of emphasis on the importance of being physically active. To remedy this problem, Dr. Schulman offered the "exercise prescription."

Writing the Exercise Prescription

The pressures of a busy practice leave many doctors little time to discuss fitness and exercise with their patients. Dr. Schulman suggested that physicians offer their patients sensible, practical methods to guide them to more active lifestyles. PCMS "prescription pads" were distributed that can be used to write patients an "exercise prescription." Components to consider include:

- Frequency: Individuals should exercise at least three times a week. ("Five is better; seven is not necessary.")
- Intensity: The level of intensity associated with exercise should be moderately hard, or brisk, but comfortable.
- Duration: 30-45 minutes

Not only does an exercise prescription assist in a person's taking more ownership of his or her own health, it also provides concrete guidelines and goals for patients.

So, How Do I Do It?

So, the "just do it" approach might not work for everyone. Dr. Schulman offers this formula for getting your patients moving:

- Bring up the issue with your patient.
- Assess the situation.
  - What is the individual's current level of physical activity?
  - What is the patient's stage of motivational readiness?
- Advise: Give your patient specific feedback.
- Assist: Provide support and encouragement to your patient and help him or her set small goals and intermediate steps.
- Arrange a follow-up phone call or visit: "Show you're interested in what people are doing," he advises. "Encourage your patients to be more physically active. Let them know that doing something is better than doing nothing. Help them understand that accumulating 30 minutes of moderate intensity exercise most days is preferable, but everything counts."

Most important, Dr. Schulman explains, employ the KISS - "Keep it simple, stupid" - method when helping your patient develop successful strategies for exercising. "People need to understand that they can fit exercise into their lives in small chunks and tweak their schedules to stay on track. Remember, exercise doesn't need to be a job. Walking is the most common form of exercise, and easy to do."

Further encourage your patients to stick to it by suggesting they exercise at a convenient time and place, with someone else, outdoors, with their dog, at a gym, or while watching television or listening to music.

And for those physicians who need to follow these same steps to become more physically fit and active, take these suggestions to heart.

"We owe it to ourselves and our patients to be physically active and to encourage them to be physically active, as well," Dr. Schulman noted. "Your example will be an inspiration to others – your friends, family and patients."

For more information, or to get an exercise prescription pad for your practice, please contact the PCMS office at (253) 572-3667. ■

Special Feature

by Jean Borst

Defiance Runners

A commitment to fitness, the opportunity to run with friends, and the lure of beautiful Pt. Defiance Park bring this group together every weekend

"I think running does breed very nice people and I've noticed that the more they run, the nicer they get."
Sir Roger Banister, May 2004, on the 50th anniversary of the 1st sub-four-minute mile

Talk to any serious runner, and you'll hear an endless list of the benefits of the sport. There's little preparation beyond buying a good pair of shoes; you can do it anywhere; and the physical, mental and psychological benefits are unmatched. But for many runners, one of the greatest benefits is social.

Every Saturday or Sunday morning, you can find a group of friends gathered at Pt. Defiance Park on the road between the rose garden and tennis courts. They might be there for a serene jog through the park, a fast-paced endurance run to prepare for an upcoming race, or just to catch up with friends while getting in their exercise. Regardless, they are there — weekend after weekend. They run through rain, sun and snow. They've experienced together the triumphs of marriages, births, graduations and promotions. They've been there through divorce, death and disappointment. Through it all, the Defiance Runners have endured.

Formed in the 1980s by a group of local physicians, the Defiance Runners is now made up of a diverse group of individuals from a variety of professions and backgrounds, and includes runners at all levels. In addition to providing a great social outlet, the group provides friendly support and encouragement, great motivation for improvement, the opportunity to meet new people with similar interests, and good conversation to help the miles go by.

Three "start times" are scheduled on Saturday and Sunday mornings. Runners who want to get an early start on the day can begin at 7 a.m. Faster runners who want to run the nearly five-mile course twice begin at 7:45 a.m., and the last group takes off at 8:30 a.m. Most people wait at the end of the course for everyone to finish, then it's off to the Antique Sandwich Company for post-run socializing, along with coffee and cinnamon rolls. "It's one of the few places you can go into dressed in running clothes and dirty shoes and not get looked at twice," **Dr. Craig Rone** said.

Caught up in the Phenomenon

A Tacoma ENT and a runner for over 30 years, Dr. Rone was part of a generation swept up in the running phenomenon of the 1970s. "Everyone was talking about running – in school and at work," he recalls.

Fueled by American victories in the Olympic and Boston marathons, the cult of the long-distance runner captured the nation's imagination, and the five-minute mile became legend. Steve Prefontaine, Frank Shorter, Mary Decker and Bill Rodgers were not just runners — they were celebrities, and provided inspiration to the country's growing group of runners.

See "Runners" page 10

Defiance Runners prepare for a five mile jaunt through the park with their favorite running partner "Lucy." Lucy is pictured here with her owner Dr. David Law, flanked by Joan Brookhyser and Dr. Pat Hogan

Defiance Runners gather at the Antique Sandwich Company after their run. PCMS members include Drs. David Law, John Hautala, Craig Rone and Pat Hogan. Dr. Mark Craddock snapped the photo

Runners from page 9

Rone began running in 1972 and continued through college, medical school and during his residency. After relocating from Seattle to Tacoma in the early 1980s, Dr. Rone was at a Medical Society function when he overheard **Dr. Jim Komorous** mention the Pt. Defiance running group. His interest was piqued, and Dr. Rone, along with his friend and frequent running partner **Dr. John Hautala**, joined the group. Since that time, he rarely misses the weekend outings at Pt. Defiance. Other PCMS members and Defiance Runners include Drs. **Pat Hogan, David Law, Andy Loomis**, and **Mark Craddock**.

"For me, the social contact is key," Dr. Rone explains. "I look forward to seeing my friends each week—regardless of the weather or how I'm feeling. I want to catch up with everyone, hear about their families, their travels, and the ups and downs of their lives."

PCMS President Dr. Pat Hogan, who joined the group in 1990, concurs. "Being part of this group is great motivation," Dr. Hogan says. "It's not only a great excuse to go out and exercise, it's a great social outlet as well. Participating in an organized running group is what gets me there. I've made it an important part of my schedule."

"Being with others draws you more easily into a dedicated routine," Dr. Rone added. "It's a lot of fun, and I continually look forward to it."

The Most Fantastic Place in the World to Run

Three miles of perhaps the wildest shore in any American city, the 700 green acres of Pt. Defiance Park feature some of the last of the magnificent native old-growth forests in the Puget Sound. For anyone who might think that running is boring, a run through this beautiful urban wilderness might change their minds.

"Pt. Defiance Park is a gem," Dr. Rone says. The Rones live virtually minutes from the park and spend a great deal of time there – mostly on foot. "It's like running at Longmire in Mt. Rainier National Park. And it's right in our backyard."

"It's a beautiful course," Dr. Hogan added. "You have the woods, padded trails, views of the water. Even when it's raining, the trees shelter you. It's really one of the ideal spots for running."

In the mid-1980s, four-time Boston Marathon winner Bill Rodgers came to the area to participate in St. Joseph's annual heart run. To promote the event, a lunch and run with Rodgers was auctioned at an event. Dr. Hautala won the auction item and took Rodgers on a run at Pt. Defiance. "Rodgers thought it was the most fantastic place in the world to run," Rone recalls.

Team CHAMP

As part of the recently created Coalition for Healthy, Active Medical Professionals (CHAMP), Dr. Hogan is hoping to develop a CHAMP running team as an offshoot of the Defiance Runners. The team would participate in local races, such as Sound to Narrows and the Heart Run. "We'd like to develop a cohesive group to represent the medical profession," he said. "It would be a great way to lead by example and promote the benefits of running."

If you are interested in joining the Defiance Runners – whether it's for a quick-paced 10-mile run or a leisurely jog – you're welcome to join the group at the lower park drive between the tennis courts and the rose garden. All Medical Society members are welcomed and encouraged to join. "Don't be intimidated," Dr. Hogan stresses. "We welcome all levels. We even have some walkers."

If you have any questions, feel free to contact Dr. Rone at 272-7114 or Dr. Hogan at 284-4488.■

Kent Holder Going the Distance

For those who think running a marathon is an imposing feat, consider that 65-year-old Kent Holder participates in the 26-mile runs just for training. The retired firefighter is a competitive ultramarathoner. At this writing, in fact, Holder is on his way to Southern California to run his 24th consecutive Avalon 50, a 50-mile race on Catalina Island.

A fitness runner until his early 30s, Holder became interested in competitive running when he was participating in the California Fireman's Olympics. Although he initially started running marathons, he discovered that his amazing endurance enabled him to be competitive at ultra long distances. Since that time, Holder has run 131 ultras, 86 marathons, and hundreds of other races.

Perhaps even more impressive, Holder has run in 31 additional marathons as a guide runner for 67-year-old Harry Cordellos, who is not only an internationally known motivational speaker, author and competitive multi-sport athlete, he is also blind.

"I love running, and I've enjoyed being involved with Harry. It's been a gratifying opportunity to help someone compete at the best of their ability."

Holder moved from Huntington Beach, California to Fox Island three years ago and can often be seen running through Pt. Defiance Park. "Pt. Defiance is great, and has wonderful trails. I really enjoy having it so close to home."

So, next Saturday when the rain is coming down, the bed is feeling especially warm, and you are considering skipping that five-mile run, think of Kent.

The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

A New Approach to Death Certificates

Federico Cruz, MD

Love them or hate them, it appears that computerized records are an integral part of medical practice and the use of electronic records is going to expand steadily. For the last 10 years there has been a movement across the United States to do away with all paper medical records. Much of this discussion has been hype but there has been significant progress on the understanding, affordability and technological capacity to accomplish this vision. Some of the larger practices here in Pierce County are moving forward and are already utilizing electronic records. We all need to become more versatile in our use of computerized systems.

An opportunity to work with one form of electronic record is here: The state of Washington is proposing a new approach to their death certificate system.

Several years ago, Washington State *birth* certificates went from paper to an electronic system. In a few months, *death* certificates will be processed in Pierce County with the new Electronic Death Registration (EDRS) using a computer and the Internet. **EDRS is a web-based system that lets physicians and other certifiers complete and file death records with local and state registrars electronically.**

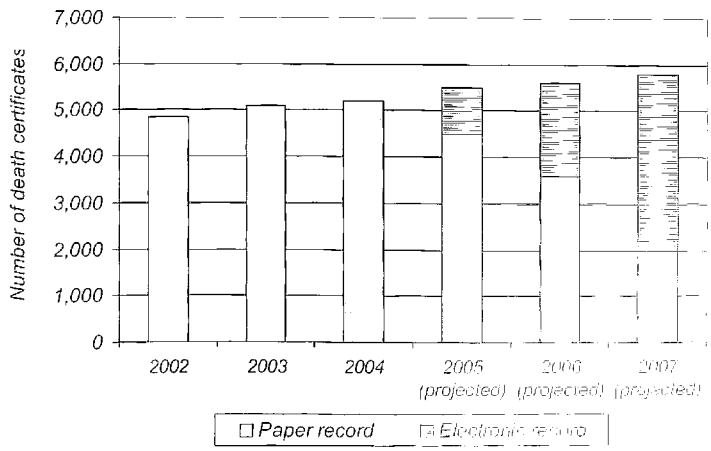
With EDRS, physicians will be "signing" death certificates electronically using a digital signature from any computer with an Internet connection. User-friendly screens will guide physicians to enter cause-of-death information and then certify that information. Online prompts will provide feedback if you enter an unacceptable cause of death. With a few clicks of a mouse, a death certificate can be accurately completed any time of the day or night. The system will be available 24 hours a day, 7 days a week.

EDRS is a good thing. Families will be able to get burial permits and copies of death certificates faster and with fewer errors. Less fraud will occur because social security numbers will be quickly and automatically matched with files at the Social Security Administration, giving thieves less time to steal identities. Cause-of-death data will be more accurate due to enhanced quality control checks.

Tacoma-Pierce County Health Department will begin implementing this new system starting in June 2005. We will include more and more physicians in the system throughout the year, providing lots of training and information along the way. Eventually, we're expecting Washington State Department of Health to mandate that all physicians use EDRS - probably not until 2009, but it's coming.

You'll be hearing more about EDRS throughout the year and may be invited to be a part of the first stages of implementation. I hope you will participate in this project. If you are interested in receiving more information about EDRS, you can call our Vital Records office at 253-798-6480 or e-mail crim@tpchd.org. ■

Projection of Electronic Death Certificates Filed in Pierce County



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Internship: Tacoma Family Medicine
Residency: Tacoma Family Medicine

Amol J. Shah, MD
Emergency Medicine
Mt. Rainier Emergency Physicians
407 14th Ave SE, Puyallup
253-697-4200
Med School: Med College of PA
Internship: LSU Earl K. Long Med Ctr
Residency: LSU Earl K. Long Med Ctr

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.

It's All in Our Head

Andrew Statson, MD

"In this best of all possible worlds...everything is for the best."
Voltaire (1759)

We have it on good authority. The insurance commissioner said so. There is no malpractice crisis. I don't know what ever gave us that idea.

A review of claims and awards during the past ten years showed a small increase, and not even every year at that. In some years there was a drop.

On average, the number of claims increased only by 5% per year, the amount paid to patients, by 4%, and the costs for defense, by 6%. That's it.

Wait. There is more. Of the ten thousand malpractice claims filed during the past ten years, 73% were dropped or dismissed. Those patients and lawyers got nothing. Imagine that.

When there was a payment, 65% of the time it was of less than one hundred thousand dollars. Payouts of one million dollars or more were 1.7% of the total number of awards during the first half of the decade and only 1.6% during the second half.

Unfortunately, the study did not report on a cutoff equal to the proposed cap, namely $250,000, to see whether the number of those awards went up and how many people would have been affected by such a cap.

The commissioner admitted that the data does not say we don't need to do something about the liability problem, but there is no crisis, and no urgency to act. Everything should be done in good time, with all deliberate speed.

Let me analyze the data. One thousand claims were filed every year. Assuming that two physicians are named in the average lawsuit, that means that two thousand are sued per year. With about eight thousand physicians practicing in the state of Washington, one quarter of us must have a claim every year.

The number of claims rose 5% per year over ten years, for a total compound growth of 63%. The total payout increased by 4% per year, or 48% in ten years. The costs for the defense went up by 6% per year, or 79% in ten years. Mere peanuts, you'll agree.

One study the insurance commissioner did not do, but should have, was on the growth of insurance reimbursements for physician services.

"So how is Medicare-for-All going to provide more coverage to more people for the same amount of money? By magic?"

Did I say growth? I'll venture to make a wild guess and say that for most private practice physicians in this state, their gross practice income remained steady during the past ten years, but their total expenses went up, so that their net income declined. This is not about our state only. I hear the same thing from colleagues across the country.

Forty years ago office overhead was typically 30% of gross. Forty percent was high. Now I suspect that office overhead is 70% of gross and 60% is low.

The insurance commission report did not challenge the fact that our liability insurance premiums had risen sharply in recent years. But hey, don't blame the lawyers. They are as innocent as newborn lambs.

Blame Osama. If he hadn't sent his goons to blow up the World Trade Center, why, our insurance rates would have been much lower than what they are now. It's all because of 9/11. Yes. Of course.

Still, our premiums went up. For some specialties, they more than doubled during the past five years. At the same time, our net income shrank, even more so if we accounted for inflation.

According to the commission report, 2,720 awards were paid during the past ten years, of which barely 950 were for more than one hundred thousand dollars and only [illegible] for a million or more.

Coalition for a Healthy Active Medical Community - CHAMP -

Please share your exercise routines with your colleagues. The *Bulletin* will be featuring:

- Bike Riding in May
- Swimming in June

and other sports in future editions. Please call PCMS and let us know about your favorite methods of exercise.

Also - call PCMS (572-3667) if you would like to form a "CHAMP" team for your favorite sports event

Join the Celebration... May is Arthritis Month

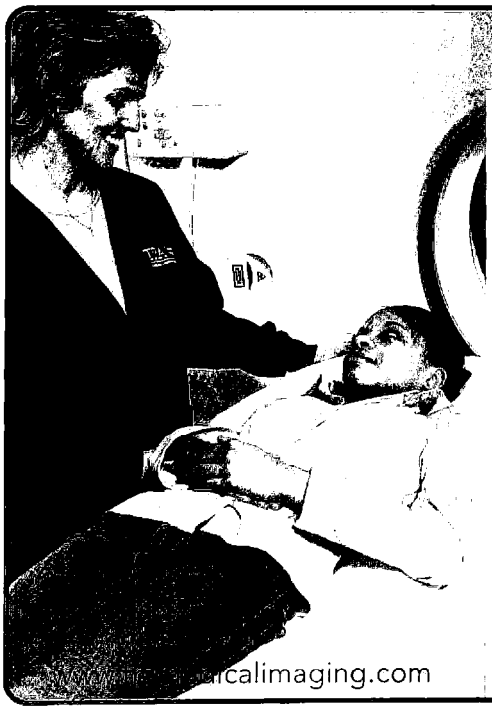
Participate in the Arthritis Walk on June 4 at Owens Beach in Point Defiance Park and show your support for the 1.6 million people in Washington and Alaska who have arthritis.

Arthritis is our nation's #1 cause of disability and affects 66 million people, including over 300,000 children.

The Arthritis Walks in Washington are presented locally by Proliance Surgeons, with 135 physicians specializing in orthopedic and general surgery.

Invite your friends, colleagues and family members to join you and form a team. You'll have fun, help raise awareness and support research to find a cure. And, dogs get arthritis too, so bring your four-footed best friend along to walk with you.

For information about the Arthritis Walk, call 1-877-232-2898 or visit the Arthritis Foundation website at www.arthritis.org.■



Retired Members Learn About History Museum

The Exhibit Manager from the Washington State Historical Society, Mr. Raymond Barnett, spoke at the March meeting of retired PCMS physicians at Fircrest Golf Club.

After much socializing and a lunch buffet, Mr. Barnett talked about the vision and mission of the History Museum noting that they aim to make the study of history illuminating and inspiring. He explained that they try to tell a story through objects as opposed to many museums that just display objects. Their stories are both local and national in scope.

He spoke at length about how the museum chooses exhibits. And, there are many ways that exhibits come to be. One is museum management determination, another by lender scheduling. The current 911 exhibit came to Washington with a call from the Smithsonian. Being the only museum west of the Mississippi to be asked, the show has been a highlight for our state. Lenders also invite museums to compete for exhibits, which was the route of the African American Movies show. Volunteers make suggestions, as has been done by Dr. Hallet, suggesting a display of the history of the American Lung Association which will begin in August, 2006.

Mr. Barnett spoke of the tremendous growth of cultural riches in our state partnered with the growth of cultural facilities in Pierce County. The History Museum is always interested in partnering with the Art, Glass, and other museums for events and activities and looks forward to a new LeMay Museum for future collaborations.

Retired members meet three times annually to keep in touch with colleagues as well as enjoy a short program on topics of human interest. At the June meeting, Dr. James Blankenship will talk to the group about self-directed investing using the internet. ■

Julia Mueller (right) visits with Emmalou Lyle and Dr. Marcus Stuen, retired psychiatrist

Dr. Mian Anwar (center) and his wife Patty visit with Dr. Stan Mueller

COLLEGE OF MEDICAL EDUCATION

Continuing Medical Education

Last Chance for the Radiology Program

Using radiology to improve patient care

Register now! This popular CME program is returning to the Fircrest Golf Club on April 22. *Radiology for the Non-Radiologist* is a one day program designed to update primary care physicians on advances in radiology.

The course directors are **Dr. Gordon Benjamin** and **Dr. Andy Levine**.

Greater Pierce County's two radiology physician groups – TRA Medical Imaging and Medical Imaging Northwest – offer this highly-focused program with expert faculty to discuss the latest advances in imaging and interventional radiology.

This day long program will provide cutting edge information useful to family practice and internal medicine physicians, as well as ob/gyn and geriatrics specialists. Topics for this six credit program are scheduled to include a case-based analysis of abdominal and pelvic pain, acute Neurological Episodes — brain attack, UFE or Vascular/ Vein Ablation, MSK/Arthritis, and much more.

Register by calling 253-627-7137. ■

Internal Medicine Review 2005

Coming soon...

Faculty from all over the country are scheduled to present on a variety of current and issues important to the family practice and internal medicine doctor.

Covering recent advances in internal medicine, this two day program will be in the Lagerquist Conference Center at St. Joseph Hospital on May 5th and 6th. **Dr. Art Knodel** returns as the Course Director.

Scheduled topics include:

- A physician's response to bioterrorism
- Metabolic syndrome: emerging trends
- Advances in insulin treatment
- Surgical techniques for cardiac disease
- MQAC: common perils in private practice
- And more. ■

Colorectal Cancer Prevention and Detection: A Learning Opportunity

Colon cancer is the second leading cause of cancer death in the State of Washington. It is also the MOST preventable cancer. The American Cancer Society has designated this education activity for one Category One credit toward the AMA Physician Recognition Award.

Upon completion of the program, you will be able to identify individuals who are at average or increased risk for developing colorectal cancer; recommend appropriate screening strategies and intervals based on patient risk profiles; appreciate the benefits and limitation to the various screening methodologies; incorporate into your practice proven strategies and systems that enhance patient participation in colorectal screening and follow up.

This is not a College of Medical Education program, but you are encouraged to take advantage of this excellent (and free) educational opportunity. For more information you can visit the web site: **www.cancer.org/cme.** ■

Primary Care 2005 Conference

Primary Care 2005 is a new multi-specialty course, similar to our Common Office Problems program offered in the fall. The course director is **Steve Duncan, MD**, family practitioner from Puyallup.

Primary Care 2005 will be held in the Lagerquist Conference Center at St. Joseph Hospital on Friday, May 20. This one day course for six credits will focus on recent developments and updates in a wide range of topics in primary care medicine. ■

Dates	Program	Director(s)
Friday, April 22	Radiology for the Non-Radiologist	Rick Tobin, MD Andy Levine, MD
Thursday-Friday May 5-6	Internal Medicine Review 2005	Art Knodel, MD
Friday, May 20	Primary Care 2005	Steve Duncan, MD

Head from page 13

If only 95 patients a year were awarded more than one hundred thousand and only nine received more than a million, why are the lawyers so strongly against caps? If, as the lawyers say, caps would not make a big difference in the total payout, why are they so active in their opposition to caps? Why make it such a big issue?

The editorial of *The News Tribune* on this subject was gratifying. There may not be a crisis, it said, but something needs to be done because reimbursements have not kept up with the increase in costs. How true.

The conclusion reached by the insurance commissioner did not surprise me. The people in Olympia (in the legislative, executive and judicial branches of our state government) don't perceive that the current situation is a crisis.

They see us still going to work every day. We are in our offices, in the Operating Rooms, in the Emergency Rooms. We still take care of our patients. As long as we continue to do that, they will not believe that there can be a crisis.

Certainly, there are long waits in our Emergency Rooms. Our hospitals and offices are short on staff. The care the patients receive is not as prompt, as personal and as attentive as it once was. Yet the patients are taken care of, and if they have to wait a long time, why, blame it on the doctors.

As long as we respond to the call of our profession and report for work, there will be no acknowledgment of the crisis. It's only in our heads. The people in Olympia count on our sense of responsibility, on our commitment to serve our patients, and they keep turning the screws a little tighter day after day.

Why shouldn't they? They know that we will continue to take care of our patients, no matter what they do to us.

This year we had a respite on our liability premiums. We also have something to look forward to, our initiative on the ballot. Perhaps that will make a difference. At least, we can hope. The future will tell whether that hope is justified. ■

Personal Problems of Physicians Committee

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

Your colleagues want to help

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

Confidentiality Assured

Directory Changes

Please make the following address and/or phone/fax number changes to your 2005 Physician Directory:

Kenneth Kirkwood, MD
Change office address and phone to:
502 54th Ave E, Fife 98424
459-7500
459-7527 FAX

Wendel Smith, MD
Change office address to:
1802 S Yakima #102, Tacoma 98405

Gail Venuto, MD
Change office phone to: 207-4890
Change FAX to: 207-4871
Change E-mail address to:
gailvenuto@fhshealth.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 looking for P/T to F/T Board Certified or Board Eligible Physician to join a group practice. Work 3-4 days a week with a great support staff. Base salary plus incentive. Fax your CV to 253-847-9630.

OFFICE SPACE

Medical Office Space. Deluxe medical office space for lease. 2,500 to 17,000 square feet available. Excellent location, walking distance to Good Samaritan Hospital in the Master plan campus. Full generator back up and ample parking. Custom tenant improvements built to suit your needs. For more information please contact Roger Mayer, Crescent Realty, Inc. at 253-370-0286 or e-mail rammayer@comcast.net.

GENERAL

Lower Sound Beach Cabin for Rent. Three bdrm, 2 bath cabin with large deck and large sandy beach. $1,300 week. Email beadqueen54@msn.com or call 253-848-3801.

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Pierce County Medical Society

BULLETIN

May, 2005

From left, Drs. Pat Hogan, Harald Schoeppner, Henry Retailliau and Nick Iverson at the Daffodil Classic in April. See story page 7

From the Daffodil Classic in Orting to Dr. Peter Marsh's home in Lakewood, Pierce County physicians are "moving and shaking"

From left, Drs. Bill Roes, George Tanbara, Matt Rice, Ray Pliskow, Charles Weatherby, Vita Pliskow, Gordy Klatt, Barry Weled, Sandra Reilley, Jim Komorous, John Huddlestone, Kari Vitikainen, Peter Marsh, Randy Otto, Bob Sands and Nick Rajacich gathered at the home of Peter Marsh for I330 marching orders. See story page 15

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.

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Pierce County Medical Society
BULLETIN

May, 2005

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President's Page

by Patrick J. Hogan, DO

Patrick J. Hogan, DO

Our Roots Keep Us Standing

I was recently asked what keeps physicians energized for the practice of medicine amidst all the adversity. For me, it is the same ideal that motivated my dream for becoming a physician when I was a teenager 40 years ago. The ability to positively impact the quality of life of so many people on each and every day is a joy that physicians are gifted with more than any other profession.

When I make that eye-to-eye connection with that inner person inside the patient, all the detractions of staying in practice fall aside and the magic of that patient-doctor relationship emerges. It is that art of being a healer that enhances the outcome of our treatments. It is that interaction that energizes physicians to bring the healing energy to the next patient. What keeps us going year after year and keeps us young is the sense of purpose and the rewards from that purpose.

I was once told by a sage old physician in northern Minnesota decades ago when I was just entering medicine, "Give your best care to your patients and you will never have to worry about money, it will come along with many other rewards." Unfortunately in today's world we often do have to battle with the forces that threaten our monetary rewards but the rewards that we receive from what we give to mankind will never change. It's not what we get that makes us successful, it is what we give and who we become in the getting.

The greatest sense of personal reward and gratification that I have received has been from helping people establish a routine fitness program and permanently breaking the tobacco addiction.

It is a real opportunity to produce real life-long benefits in the patient's quality of life rather than solely treating the condition that they present with. It is toward this end of helping people with life style changes that Initiative 901 (Tobacco free air for all Washington) and CHAMPS (Coalition for Healthy Active Medical Professionals) have been established.

I have received feedback from many PCMS members that our current CHAMP campaign is refreshing and highlights the positive role that we have as health care providers.

Enhancing our own fitness will not only serve as the necessary role model for our patients and increase the effectiveness of our advice, it will also physically energize us, provide a stress outlet for our complicated lives and prevent the consequences of sedentary lifestyles that we are subjected to as well as anyone else.

Instead of this campaign detracting from our commitment to other issues, it actually gives our brains the rejuvenation needed to maintain enthusiasm for other matters such as tort reform. "In order to continue carrying a weight, it has to be put down at times." Our resolve for passage of I-330 and I-901 will get stronger as we pace ourselves.

Each month in the *Bulletin* we will highlight various exercise options for PCMS members to include running, biking, swimming, paddling, yoga, skiing, fencing, tennis and more.

We appreciate the feedback that we have received on various exercise options that people are doing. Please send an e-mail highlighting what you or your colleagues are doing for fitness.

As always, we are continuing to appeal for offices to put the I-901 petitions into their waiting rooms. These have been HIPPA authorized.

We only have until the end of June to get the signatures needed to get this on the ballot and make Washington's public places smoke free. Montana just beat us as the 8th state to be smoke free. By working together for the signatures and the campaign, we can become the 9th smoke free state come next November and will be a spearhead for the rest of the country. We will all be rewarded that we were part of that history.

So remember our roots for entering medicine. Our roots will keep us strong despite the winds of adversity [illegible] be wiping at our branches.

FitTips #5

by Patrick Hogan, DO

Exercise For Your Whole Life for a Longer and Healthier Life

1. Starting an exercise program any time in life, even into the 90s, has been shown to be beneficial for improving balance, flexibility and the ability to do daily activities with less energy expenditure. At any age it will help prevent or improve diseases of blood vessels to the brain, heart and the rest of the body (prevention of heart attack and stroke). Improvement in bone strength is a big benefit (watch for *FitTips #7* in the July issue of the PCMS *Bulletin* for more on this benefit).

2. Prevention of stroke and heart attacks requires **life style choices** for everyone as well as medication options for each individual. Medications will not be as effective without the **proper diet** (see *NutriTips #5*, this issue page 6) and the **proper exercise program**. If a person is using tobacco, the benefits of most medications for stroke and heart attack prevention are reversed so **tobacco cessation** is an absolute must.

3. Having a stroke is three times more likely in people who do not exercise. Not exercising is as much a risk factor for stroke as high blood pressure or cholesterol.

4. More Americans die from heart disease than from any other ailment. **Exercise decreases the risk of heart disease** by lowering blood pressure, lowering cholesterol, reducing obesity, improving the blood supply to the heart and strengthening power of the heart.

5. For older individuals and those with risk factors for heart disease, start the exercise program slowly after clearance by your physician. For those who have already had a heart attack or cardiac bypass operation, what you learned in the cardiac rehab course should be maintained in a **life long exercise program** specifically designed for you. Only 5% of heart attacks occur during heavy exercise. **Exercise is a prevention of heart attacks not the cause of them**.

6. A study reported in 2004 in *Circulation* demonstrated that those with **stable** coronary artery disease had a greater survival rate without heart attacks after treatment with an exercise program compared to stent placement in the coronary arteries. **Exercise improves the blood supply to the heart tissues.**

7. **Heart rate monitors** are the best way to determine if you are not exercising hard enough (heart rate less than 60% maximum) or exercising too hard (heart rate over 80% maximum). The most accurate and easiest heart rate monitors use a chest strap and a watch. They can be inexpensive and an important investment into your fitness program. The basic models are what most people need such as the Polar F1 or Nike C3 that have easy to read numbers and are simple to use. Heart rate monitors can be purchased at athletic stores or on line such as at HDO Sport, www.store.hdosport.com or Road Runner, www.roadrunnersports.com.

8. Exercise 4-5 times each week to bring your heart rate up to point of strengthening your heart, brain and blood vessels as well as your muscles. This should be at between 60-80% of your maximum heart rate. To determine your heart rate goals see the ***Fit Facts* insert in this month's *Bulletin*): Monitoring Exercise Intensity Using Heart Rate** or refer to *FitTips #3* item #10 from the March 2005 *Bulletin* on heart rate monitoring.

9. **Use a pedometer** as a fun and motivating way of achieving the 10,000 steps per day that is recommended for any individual (add a 2500 step adjustment for every 15 minutes of swimming , biking or other non-stepping exercise). Get a pedometer at most drug stores, athletic stores or on line at www.pedometersusa.com. Have the goal of at least 30 minutes of some type of exercise per day either all at once or in chunks of time during the day.

10. **Cross training** is the principle of doing different types of exercises on different days. It is the ideal way to prevent exercise injury especially as we get older, exercise all muscle groups of the body, maintain your long term interest in exercise and improve the overall level of fitness. This results in greater disease prevention results. Alternate your running/walking program with weight training and with other active exercise such as biking that varies the emphasis to different body parts.

11. **All the other benefits of exercise become all the more important as we grow older**. Other than the benefits noted above, is a decreased rate of developing diabetes and better control of diabetes if you have it (see next month's *FitTips #6*). People who exercise also have lower rates of developing Parkinson's disease or Alzheimer's disease, decreased cancer rates, better sexual function, better mood control, better balance to prevent falls and less fractures if a fall does occur (see *FitTips #1* in the January 2005 issue of the PCMS *Bulletin*).■

NutriTips #5

by Joan Brookhyser, RD, CSR, CD

Is Fat Bad For You?

Fat is a major source of calories or energy. Fat improves the taste and odor of foods and gives a feeling of fullness. Fats form the structures in our bodies, including muscles, nerves, membranes and blood vessels and are essential for the absorption of fat-soluble vitamins A, D, E and K in the body. Although some fat in the diet is necessary, too much fat can lead to heart disease, obesity and other health problems. In addition, keeping the right balance of *good* fats to *bad* fats is the key to fitness, optimum health and helping maintain a healthy body weight. The following is a summary of the primary types of fats we eat:

THE BAD FATS

Saturated fats: This fat is found in most animal products such as beef, pork, milk products and poultry. It is also found in the plant oils; coconut oil and palm oil. Another way to identify a saturated fat is that these fats become solid or almost solid at room temperature. Saturated fats stimulate the production of LDL cholesterol ("bad" cholesterol) and therefore increase blood cholesterol levels and the risk of heart disease. ***Saturated fats can raise cholesterol levels and LDL-cholesterol levels more than dietary cholesterol itself.*** In addition these fats are thought to contribute to other chronic disorders and possibly cancers.

Hydrogenated or trans fatty acids (partially hydrogenated): These types of fats were introduced into the food industry when palm oils (saturated fats) were known to contribute to high lipid levels. However these fats were soon found to create the same havoc with chronic illness as saturated fats. Hydrogenated fats are polyunsaturated fats such as corn or safflower oil that have had extra hydrogen atoms added to them to make them more stable in processed foods and in cooking fast foods. These types of fats are found in many commercially baked cookies, cakes, chips, crackers, in addition to fried fast foods.

GOOD FATS

Polyunsaturated fats: Polyunsaturated fats are found in vegetable oils such as corn oil, safflower oil, soybean oil, and sunflower oil. Polyunsaturated fats are also present in fish and fish oils, which help to decrease triglyceride levels. Polyunsaturated fats lower LDL cholesterol and total cholesterol but they also lower HDL cholesterol (remember HDL cholesterol is the good stuff). Therefore, this fat should be limited to a certain degree.

Monosaturated fats: These fats are also found in vegetable oils such as olive oil, peanut oil, canola oil, and foods such as avocados, olives, almonds, hazelnuts and pecans. Monounsaturated fat lowers total blood cholesterol by lowering LDL cholesterol without lowering HDL cholesterol. *Research has shown that substituting monounsaturated fat for saturated fats (and polyunsaturated fats) reduces blood cholesterol levels without affecting the HDL levels.*

Omega 3 Fatty Acids: Some foods contain unique polyunsaturated fats called Omega-3 fatty acids. These fatty acids seem to make blood platelets less likely to clot, thus decreasing risk of artery blockage and heart attacks. Since many of the foods high in these fats are not eaten on a regular basis, research also suggests this fat may contribute to other chronic diseases such as arthritis, skin problems, asthma and certain auto immune disorders. High amounts of Omega-3 fatty acids can be found in fatty fish like salmon, albacore, tuna, mackerel, sardines, herring and rainbow trout. Omega 3 fatty acids can also be found in certain plant products such as walnuts, pumpkins seeds, full fatted soy milk or tofu and flaxseed oil. *One percent of your calories per day should come from these fats.* Some people may want to take higher doses of Omega 3 fatty acids to reduce complications of other diseases. In this case a supplement of Omega 3 fatty acid is recommended in the amount of 2-6 grams per day. The only side effect from this is that Omega 3 fatty acids can act as a blood thinner, therefore, these supplements should be avoided prior to an upcoming surgery or if you are on blood thinning medication.

HOW DO YOU GET THE RIGHT FAT BALANCE

It is very difficult to avoid all bad fats. The key is to keep them to a minimum as much as possible. Labeling laws now require food companies to list the type of fats in their product. When reading these labels try to keep the ratio of polyunsaturated to saturated fats high, and keep trans fats to no more than 2 g per day. Overall try to keep your fats to no more than 30% of your total calories per day, and less if you have heart disease. ■

Special Feature

by Jean Borst

The Wheel Deal...PCMS Members Hit the Road

May is National Bike Month, but for many Pierce County Medical Society members, biking is something to celebrate year round. Whether they are taking a scenic ride through Pt. Defiance Park, commuting across town to the office, or taking on the Cascade Mountains, these Pierce County Medical Society members have made bicycling an important part of their fitness regimens...and their lives.

Dr. Patty Kulpa

"I've always liked biking," says Dr. Patty Kulpa, a Gig Harbor Ob/Gyn. "I guess I'm just a tomboy at heart."

Dr. Kulpa took up biking as her primary fitness activity a few years ago, transitioning from running. "It took a while to get used to the idea that you could take breaks when you go on a long bike ride," she recalls. "When you run, you run until you're done. At first, I thought I couldn't stop until the ride was over."

For the last decade, Dr. Kulpa has ridden in the Courage Classic, an annual three-day ride that covers 172 miles and goes over Snoqualmie, Blewitt and Stevens passes. Last year, she took part in the Century Ride, a 100-mile trek from Seattle to Vancouver, BC. Closer to home, Dr. Kulpa rides in hilly Gig Harbor, Pt. Defiance Park, or the Orting Trail. Due to a full work and school schedule, however, she is taking most of her rides indoors these days.

"Most of my bike time is in spin class," she explains. Spin, or indoor cycling, simulates terrain and situations encountered in actual bicycle rides, including hill climbs, sprints and interval training.

"It's great interval training," she explains, "and it really makes you a more efficient bike rider." She notes that a 45-minute spin workout is the equivalent of 30 to 40 miles of biking.

Dr. Kulpa finds biking is a great fitness option for nearly everyone. "It's an excellent sport for women," she notes. "It provides muscle toning, and it's great aerobic exercise." It's also something for people of all ages, and is also a great family activity. She notes that Pierce County offers many family rides, including the Tour de Pierce, a fun summer ride through Pierce County for fitness and fun that promotes bicycle safety and awareness. (This year's event is scheduled for June 26. Go to www.co.pierce.wa for more information.)

"There are many bike events that are not competitive races," she says. "It's such a great sport and recreational activity."

For those considering biking as a fitness or recreational option, she offers these suggestions:

• **Rent a bike first** before buying.

• **Buy from a reputable bike shop**. "Fitting is very important, especially for women," she explains. "Avoid the temptation to buy a bike from Sears or Costco," she cautions. "It's true that you get what you pay for," she says.

• **Wear the right clothes**. "What you wear makes a world of difference," she notes. She encourages riders, particularly women, to wear pants with no seams. "The seams can cause pressure points," she explains. "After a long ride, you can experience pretty severe soreness. I'm a gynecologist. I see it."

• **Start slowly**. "Get comfortable with your bike first," Dr. Kulpa advises. "Start slowly and gain confidence. There is a learning curve with biking, especially with the gears."

• **Join a bike group**. "There are many local clubs that welcome riders of all levels," she says, "and that's a great way to get going." Or, check with your friends who bike. Ask if you can join them, or see if they have suggestions for other groups. "Although it can be a solo sport, I don't recommend biking alone," Dr. Kulpa explains. "Not only is it more fun and social biking with others, you really do need someone there

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Drs. Henry Retailliau, Don Shrewsbury, Mark Craddock and Pat Hogan are joined by John Loesch and Joan Brookhyser after their Wednesday morning ride at Pt. Defiance Park followed by breakfast at the Antique

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to back you up if something goes wrong."

And yes, things do go wrong – from chains falling off to a flat tire to significantly more dire mishaps. "It can be dangerous, and accidents do happen," Dr. Kulpa says, who was the victim of an accident herself when she sheered off the mirror of a Chevy Blazer. "The woman just wasn't paying attention," she recalls. "It didn't stop me from biking. I've just become more aware of what's around me."

Dr. Henry Retailliau

For Dr. Henry Retailliau, biking is both practical and challenging. From a three-mile commute to the office, to a 200-mile annual ride to Portland, biking plays a prominent role in this internal medicine physician's life.

It was 1996 when **Dr. Steve Hammer** suggested Dr. Retailliau join him for the 200-mile Seattle-to-Portland Bicycle Classic. "I've ridden it every year since," he says. In 1998, he took on the Courage Classic for the first time and has ridden in the popular and challenging event for the last six years.

But not all of Dr. Retailliau's rides are quite so intensive. Nearly five years ago, when his office converted to the electronic medical record system, "I found it really draining to be so inactive, sitting in front of the computer for such long periods of time," he recalls. "I started bicyce commuting and found it was an excellent way for me to get the cobwebs out of my brain and make time for physical fitness."

Dr. Retailliau continues a biking tradition started by former PCMS Executive Director Doug Jackman. He and a group of other Society members meet at 6 a.m. every Wednesday morning at the Antique Sandwich Company in Ruston to ride a couple of loops through Pt. Defiance Park. "What better way to face the middle of the week than with an invigorating, scenic ride with good friends?"

His daily commuting, Wednesday rides, and longer weekend outings make preparation for STP and Courage Classic relatively easy.

Dr. Retailliau cautions that biking is not without risks. He recalls Dr. Lawrence Bingham, a Tacoma pediatrician and former PCMS member, who was killed while riding his bike in Tacoma in 1976. He was trying to spray repellant on a dog that was chasing him. He also notes that other PCMS members have broken hips in bicycling mishaps. "The dangers shouldn't be minimized," he cautions.

Dr. Nichol Iverson

A serious bicyclist since 1971, internal medicine physician Dr. Nichol Iverson maneuvered his way on two wheels through the streets of Boston and New York during his internship and residency. Although he also ran, skied, and played baseball and basketball — "the things normal kids do" — biking became his passion after a 1995 skiing accident on Crystal Mountain. "Once I could use my leg again, I rehabbed my knee by bicycling," he recalls. "My first ride was about 10 feet, or one revolution of the pedals. Two days later, I tried again and managed a half-mile. After three days, I made it about three miles, and two weeks later, I was up to 20 miles." The rest is history, so to speak. Dr. Iverson eventually completed the 206-mile Seattle-to-Portland Bicycle Classic in just one day.

He's since ridden in the STP five times with other PCMS members, and has participated in various other organized rides including the Chilly Hilly, Daffodil Festival, Peninsula Century, and Tour de Blast. Dr. Iverson has also taken part in the 154-mile Ride Around Mt. Rainier in One Day (RAMROD) seven times, and I plans to "crank it up again" this year at the age of 60. "Except for the 10,000 feet of gain climbing to Paradise and going over Cayuse Pass, it's my favorite ride," he jokes.

Like other PCMS members, Dr. Iverson notes that there is no shortage of great bike routes in the area. "Try trail riding, such as the Orting Trail or the Interurban Trail that runs from Algona to Renton. Rides around the Tacoma waterfront and Pt. Defiance Park are other great, scenic options."

For individuals who think they might be too busy to bike or take part in other physical activities, Dr. Iverson offers this: "Even when I was doing critical care and was Critical Care Director at Good Samaritan Hospital, I made time to exercise," he says. "When I broke my ankle 15 years ago, I did four miles on crutches four day a week to keep in shape. After rotator cuff surgery, I rode a recumbent bicycle to keep pressure off my surgically treated arm while still pedaling around eastern Pierce County."

But you don't need to ride hundreds of miles on a bike to get fit. Dr. Iverson suggests that people turn off the television, eat less (unless you're exercising a lot), and lift weights at home between running, cycling or swimming. "Play with your children or grandchildren. Coach baseball, football, basketball and play with the kids and do all their warm-ups with them," he advises. "Take the stairs. Walk in the woods. Your lunch hour can be a great time to get in a few minutes of walking, running or any other activity."

All in all, Dr. Iverson firmly be-

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Pierce County Bicycle Guide Map

The Pierce County Bicycle Guide Map shows a comprehensive route system throughout Pierce County from the Key Peninsula to Mt. Rainier National Park. The 24" by 36" map is double-sided, full-color, attractive to view, easy to use, and full of helpful information for the visiting or local bicyclist.

These free maps are available at the Public Works counter at the Pierce County Annex, 2401 S. 35th Street in Tacoma, Pierce County Library Branches, bicycle shops, and visitor information centers. You can also have a map(s) mailed to you by making out a check to Pierce County for $1 (postage and handling) for each map requested. Mail the check and request to Pierce County Public Works, 2401 S. 35th Street, Rm. 150, Tacoma, WA 98409 or go to http://www.co.pierce.wa.us/text/services/recreate/bike.htm.

The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

End of Life Care

Federico Cruz, MD

The media overwhelmed us recently with images of Terry Schiavo. Her tragically shortened life and the struggles of her family continued up to and after her death. Politicization of this family issue was an ugly process, one that none of us should even have to imagine going through.

I will admit that it pushed several buttons within me. I have written before on end of life care and shared experiences within my own family. The depth of anguish that family members experience when a loved one enters the final days of life can be severe. All those elements that make relationships so special become excruciating: commitment, love, devotion, promises made, the determination to be responsible, discomfort and then the unwillingness to see a loved one suffering, and, lastly, the vow to provide the best care possible. Bringing in outside agencies and authorities to dictate care is the last thing that most of us would want to handle. The decision-making is difficult and trying. Courts and others brought into the situation just complicate the process even more.

We want to do the right thing. Why is it then, with all the right intentions, we find ourselves all too often in awkward situations when it comes to care of the dying?

We are often undone by our feelings of discomfort with death and dying. Some years back a neighbor of mine talked to me about concerns he had with the precarious health of his father. He asked my advice on end of life care and I suggested that he get the immediate family together to talk directly with his dad about how everyone felt. His father was amenable and they did meet. They even included their pastor in the meeting. It was one of those intense gatherings where many feelings of apprehension were voiced. The dad was appreciative of their concerns but also clear that he had had a long life and his health was failing. He did not want heroic efforts done if he should suffer a catastrophic event (he had serious heart disease among other chronic diseases). He was especially adamant about not being on a respirator if he should go into heart failure. Everyone was in agreement and promises were made.

Fast forward several months later. The father has a massive stroke and goes into respiratory failure. The family, consulted about levels of care, did not hesitate to voice their desire that everything possible should be done for their father. Their father went into the ICU and was promptly put on a respirator. Three weeks of intensive care later he died.

"A written statement about end-of-life desires will allow the physician to play a much more active role in guiding the family in the right direction."

As an outsider looking in it is easy to look at this and ask what happened. The pledge of no heroic efforts to prolong life resulted in a stay in the ICU. A pledge of no respirator gave way to three weeks of mechanical ventilation. The family got caught up in the situation, truly wanting the best for their dad. They did not want to see him suffer. They did not want to lose him. And they forgot that the best care does not necessarily mean more care. That more care does not necessarily lead to less pain, especially if the person had strong feelings and trusted that his family would honor those feelings. Fear of death does not change the realities of the situation.

And of course physicians get caught in the middle.

The Terry Schiavo case gives us in the medical profession a wonderful opportunity to trigger discussions with families about end of life care. We cannot stop difficult situations from arising but we can lessen the chaos of feelings running amok.

There are some things that we cannot avoid in medicine. Death is one of those 'things.'

The norm is to avoid the issue unless pressed into it. We all know that we need to discuss end of life care with all of our chronic disease patients and educate them to discuss their care with their families.

But it doesn't stop there. The family discussions have to be part of a process that includes the medical provider

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and something gets written down. This is critical. It can serve as guidance that can be referred to in the heat of the moment after an acute health event occurs.

This will not eliminate misunderstandings or intra-familial conflict but it will frame the discussion of what care is delivered to a loved one. A written statement about end of life desires will allow the physician to play a much more active role in guiding the family in the right direction. Our society spends a huge part of our health care budget – more than we can really afford – on end of life care. And in many situations that care does not lead to less suffering or reflect the desires of the patient. I urge the Pierce County Medical Society to lead a communitywide process, one that starts with in-depth discussions among physicians on end of life care. From that dialogue will flow clear guidelines that will lead to systematic training of physicians. And only then can it lead to the more difficult process of training our patients. ■

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.*

Over the Hill

Andrew Statson, MD

"This review should provoke careful study of the relationship of physician experience and the quality of care. It also raises concerns about the adequacy of continuing professional education in medicine."
The Editors, *Annals of Internal Medicine*, 15 February 2005

"My name is Andrew, and I am an incompetent."

"Hello, Andrew."

Thus began a recent meeting of Incompetents Anonymous, Over-The-Hill Chapter.

On February 15, 2005, *The Boston Globe* carried a headline, "Greater Risk Seen with Older Doctors." Scott Allen, from the staff of the paper, wrote the following: "A provocative study from Harvard Medical School suggests that, as a group, older doctors know less, provide lower-quality care, and may expose patients to greater risks than physicians recently out of medical school, a conclusion that an accompanying editorial declares should be a wake-up call to the medical profession."

The study mentioned above is a meta-analysis of 62 papers, published between 1-1-1966 and 6-30-2004. Of these, 32 (52%) reported decreased performance with increasing years of practice for all outcomes, 13 (21%), for some outcomes, 13 reported no association, 1 reported an increased performance for some outcomes and 2 reported an initial increase in performance, followed by a decrease.

Because of the many different approaches to the topic by the various studies, the authors could not apply strict meta-analytic techniques to their material.

The assessment of knowledge was based mostly on results from board examinations. Twelve studies looked at that and all reported a negative association between knowledge and length of practice.

How is that possible?

My board certification was for life. I know, I am an old fogey. By the late 1970s, the boards came up with the idea of voluntary recertification. At the time, I overheard a Gyn oncologist say that he wouldn't be able to pass it. The reason was obvious. He had committed himself to a limited scope of practice and did not keep up with developments outside his field. Since then the boards came up with subspecialty tests, but that is another story.

"Medical practice is in constant flux. However, before we declare something to be progress, we must make sure it is based on reality, not on wishful thinking or on political correctness."

Personally, I am more interested in the procedural part of practice than in the cognitive part. I like surgery and obstetrics and don't care for endocrinology and infertility. I would rather let someone else handle that. I suspect most of us have individual preferences for certain aspects of our practice, and a lack of interest, or even dislike for other aspects, even in our chosen field.

Then, there is the issue of training. I took a rotating internship, but soon afterwards, internships disappeared. The powers that be decided that the residents needed more specialty training and rotating through fields outside the specialty was a waste of time.

As most truths in medicine, that turned out to be a temporary one. When our specialty decided to promote itself as a primary care field, suddenly general medical training became not only advisable, but required. Of course, that changed the board questions. Now that the trend is again away from general practice, the test questions will change in the opposite direction.

Follow the standard, we are told. Is that good or bad? How do I dare ask such a question? Well, during the more than forty years that I have been on the scene, the standards of care on some important points have gone back and forth a few times. I'll list hormone replacement.

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lieves doctors should be models for their patients. "If a physician is overweight and out of shape, telling a patient to eat right and exercise is going to fall on deaf ears," he says. "Do anything that gets you active, and share your experiences with your friends and patients. The only excuse for not exercising is some horrible medical condition that absolutely prevents exercise. Apart from that, there is only lack of discipline and laziness."

Dr. Don Shrewsbury

"I started because my friends were bike riders, "recalls Dr. Don Shrewsbury, a Tacoma otolarynologist/head and neck surgeon, who has been biking for over 20 years. He was also drawn to biking because of a particular race – the 200-mile Seattle to Portland Bicycle Classic, a favorite of avid cyclists and the largest multi-day bicycle event in the Northwest. To date, Dr. Shrewsbury has since participated in five STPs.

He has also ridden eight times in the Courage Classic. "It's not only a great weekend of riding," he notes, "it also supports a great cause — the Rotary Endowment for the Intervention and Prevention of Child Abuse and Neglect."

Dr. Shrewsbury rides two to three times a week during the summer and once a week during the winter. He joins friends for a weekly 30-mile ride from University Place to Dupont and back, which includes a much-enjoyed coffee break at the Dupont Starbucks. "During the summer, the group is much larger and the rides more frequent," he says.

During the winter months, Dr. Shrewsbury supplements his training by taking part in spin classes at the local YMCA. "It's a great workout," he says, "and provides good interval training." But, he adds, "nothing beats riding outside."

For Dr. Shrewsbury, the benefits of biking are seemingly endless." It's an excellent aerobic activity. It's not only a great way to strengthen your legs, but biking also offers a great upper-body work out."

He also enjoys the social aspects of biking and finds that biking with friends is a great motivator. "The social part of biking really makes it appealing and interesting. Not only do you have a chance to spend time with friends, but they really do motivate you to show up and participate."

And if your friends aren't motivation enough, the scenery will certainly get you on your bike. "It's important to take a scenic route when you're riding," Dr. Shrewsbury advises. "After all, we have the benefit of living in a wonderful area. From the Puget Sound to the Cascades to the wooded route through Pt. Defiance Park, you can't beat the scenery when you're on a bike. "

The Many Benefits of Biking

From improving fitness to enhancing your social life, biking is a great exercise option for individuals of all ages. Here are a few of the benefits.

A Wheel Good Whole-Body Workout. Bicycling is an excellent way to exercise 20 to 60 minutes a day, three to five days a week for achieving good health and fitness. Cycling is as effective as walking and running for toning large muscles of the lower body. It provides the needed aerobic activity to stimulate the cardiovascular system but with less stress on your joints.

In biking, the impact on the joints is slight, so that even

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In My Opinion

by Nichol 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.

Blind Justice

Nichol Iverson, MD

"A Seeing Eye dog came in with the Judge, and
I knew it was another case of Blind Justice."
Arlo Guthrie singing *Alice's Restaurant*

When in the course of human events, we occasionally find a little story that seems to defy reality. One of my patients under my astute care for eighteen years came to me this week with a rather disturbing problem. At age seven, he was riding on a small motorcycle in the back, sans helmet, and had the unfortunate consequence of flying through the air after a collision with an automobile, and his occiput dared to go head to head with the pavement. The pavement won the battle. My poor patient spent years of rehabilitation, had significant mentation problems, and had cortical blindness. In spite of the terrible tragedy, he was able to care for himself, has worked from time to time as a dishwasher, and at the Goodwill Industries. He had at one time a seizure disorder, but fortunately, he has been off medication for eight years without any more seizures.

In spite of this poor chaps physical and mental problems, he always has a smile on his face until this week. He received a letter from the DIVISION OF DISABILITY DETERMINATION SERVICES, which stated, "After reviewing all of the information carefully, we have decided that you are no longer blind." I have no recollection of combining spittle with mud, and placing it on this man's eyes. I sent a letter to this DIVISION, stating that this man was blind. BLIND. My patient has, of course, 60 days to appeal this decision in writing; however, he can neither read nor write. Fortunately, this fellow's mother read the letter, and brought it to me. I suspect the bureaucrats who sent this letter have found a clever loophole in their system: deny blind people their disability, knowing that they cannot read the

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Directory Changes

Please make the following changes to your 2005 Physician Directory:

Diane Combs, MD
Change office suite number to #208

Hui Hong, MD
Change office address and phone to:
11311 Bridgeport Way SW #100
Lakewood, WA 98499
581-6688 phone/512-2894 fax
588-2481 physicians only

Donald Lee, MD
Change fax number to: 512-2894

Johnette Maehren, DO
Change office address and phone to:
314 ML King Jr Way #400
627-0666 phone/627-2879 fax

Kenneth Meckler, MD
Change fax number to: 426-6115

John Sashko, MD
Change office address and phone to:
11311 Bridgeport Way SW #100
Lakewood, WA 98499
581-6688 phone/512-2894 fax

David Wilhyde, MD
Change fax number to: 426-6115

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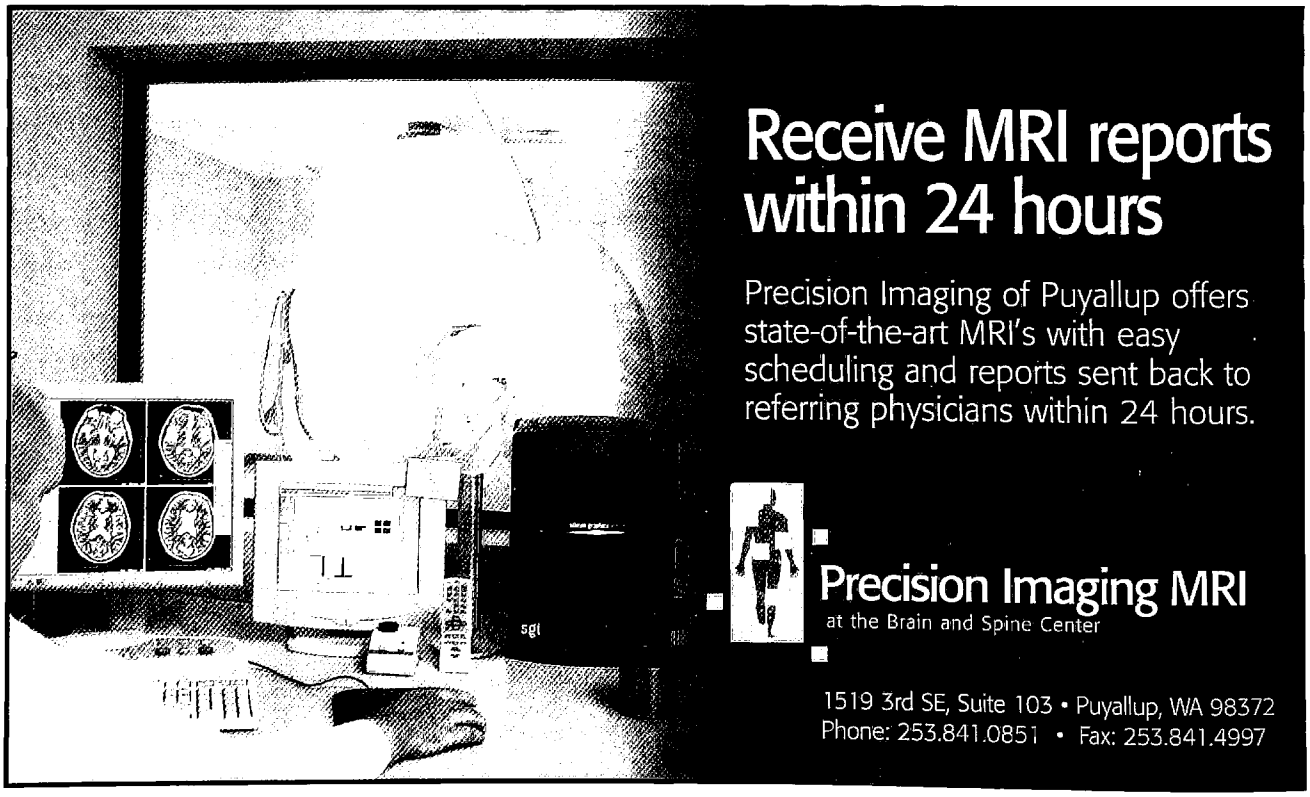
letter, and will toss it "somewhere," as they may not know where the trash is. I can just see them cavorting about, with high fives for all concerned.

As you might expect, the DIVISION OF DISABILITY DETERMINATION SERVICES received a blistering letter from me. My fingers are toast. I have seen many people who know how to work the system, and have SSI patients with less back problems than I have had for the last 29 years since I yanked on a rhododendron in 1976, but they can see the letters coming. I have a quadriplegic patient who went through a similar process. I have better things to do than write scathing letters to salaried people who have no common sense and impose on my patient-doctor relationship time. Maybe I need to go to some more continuing education to find out how the blind can suddenly see after 35 years, or a quadriplegic of eighteen years pick up her bed and toss it on her back, and walk out the door. God only knows I would love to perform these kinds of miracles. ■



Let's Get Ready to RUMBL-L-L-E

As the battle lines are clearly drawn, physicians across the state are preparing for a very public, very contentious initiative battle

On April 24th, the last day of this year's legislative session, Plan B (HB2292) died when the legislature adjourned....fortunately. A proposal that wasn't so destructive in what it would do but useless because of what it wouldn't have done....placed caps on attorney fees and damages, and allowed no provisions for periodic payments or collateral source rules. Not real reform.

So, without an alternative from the legislature, the ballot in November will have two tort reform Initiatives. Initiative 330 and Initiative 336. The doctors' initiative and the personal injury lawyers' initiative respectively. Initiative 330 will maximize patient recovery of damages with a sliding scale cap on attorneys' fees, fully compensate patient injury without limits except for pain and suffering which would be capped from $350,000- $1,050. guarantee payments over time, encourage voluntary arbitration and mandatory mediation of disputes and make juries aware of other payments that the injured patient has or will receive.

Initiative 336 requires public hearings for liability insurance companies' proposed rate increases, establishes a state-run insurance company to provide excess liability insurance to physicians and institutions and will revoke the license of a physician who has had three or more judgments entered in court in a ten year period.

This campaign can be won. Doctors for Sensible Lawsuit Reform campaign advisors have conducted studies in Washington State that have shown that the public stands behind physicians when they learn that personal injury attorneys are solely behind the opposing initiative. The first thing that physicians must do is stay on message.

The other thing that is required to get the message out to the public is money. Each physician in Washington State is being asked to contribute $1,000 to the DSLR Campaign. WSMA is tracking donations by county and Pierce County is being challenged to raise $290,000. We can do better than this!!

Dr. Peter Marsh has agreed to lead the fundraising campaign in Pierce County and has assembled a team to assist him. Please expect a call, letter or any other means of contact from Dr. Marsh or one of his team members. They include: **Drs. Bill Roes, Ken Feucht, Ron Morris, Vern Nessan, John Huddlestone, Sandra Reilley, Barry Weled, Jim Komorous, Vita Pliskow, Ray Pliskow, Kari Vitikainen, Matt Rice, Mike Kelly, Charles Weatherby, Paul Lester, John Lenihan Dick Bowe, Frank Senecal, Nick Rajacich, Joe Jasper, George Tanbara, Don Russell, Bob Sands, Ray Pliskow, Randy Otto, John Vaccaro, Gordy Klatt and Jim Buttorff.**

Dr. Marsh's 'Let's Get Ready to Rumble' attitude combined with his "money talks" mantra will help WSMA build their campaign war chest to fight the smoke and mirrors that the personal injury attorneys will throw at the public. (ie: at a recent tort reform debate in Gig Harbor, the attorney's message was loud and clear...by supporting I330 you are giving up your rights and more specifically your right to your day in court. Resonating with the public, unless their claims are disputed, they may be effective.

For a donation pledge form, please call the PCMS office, 253-572-3667. ■

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people with bad knees can pedal with relatively little pain. There are many other benefits of biking, he says, including making friends, becoming more athletic, and getting to enjoy the outdoors.

Cycling is an excellent aerobic conditioner, if you do it long enough, often enough, and with enough intensity. It also builds strength, boosts endurance, reduces stress and burns 350-450 calories an hour or more, depending on the speed, terrain, type of bike, and other factors. Like most exercise, you get out of biking what you put into it. If you pedal too slowly and just coast through your ride, the fitness benefits can be greatly reduced, but that certainly doesn't mean it can't be enjoyable. It's really all up to you.

And don't forget the mental and emotional benefits. Biking is a great way to connect with other people, and the pleasure of riding outdoors through the unmatched scenic beauty of the Pacific Northwest is unparalleled.

Less Body Stress Than Running. If you're overweight, or experience orthopedic problems that are aggravated by weight-bearing exercises, cycling is a great fitness option. And while there are always some risks with any fitness program, biking can be fairly low-risk if your bike fits properly, you wear a custom-fit helmet, and avoid accidents. If you ignore the rules of the road, including the one that says don't overdo it, injuries can occur.

But What About our Weather? There's probably nothing better than riding a bike on a beautiful Northwest day. But what about the other weather we experience here in our region? Keep up your biking fitness by riding an indoor stationary bike, taking spin classes, or consider putting your own bike on a wind trainer. Check with any bike shop.

Excellent for Cross-Training. So, you're a runner, swimmer or skater? Consider biking as a great low-body-stress sport to round out your fitness program. Many runners, walkers, swimmers, skaters and other sports enthusiasts use a low-body-stress sport like cycling to round out their fitness program.

Great for the Environment. While a great fitness option, biking is also great for the environment. Individuals, like Dr. Retailliau, regularly commute to the office on two wheels – fitting in an extra workout, alleviating the headache of parking, and eliminating car emissions. ■

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repeat cesareans, desirable weight gain during pregnancy and desirable cesarean section rates as a few of the parameters that changed significantly over time. There are others.

So, after we have been in practice for a number of years and seen the guidelines sway back and forth, it is normal to wait before we accept new ones, to make sure they will stay around for a while. Those who want us to follow the seesaw of the guidelines should remember what President Truman said: "Fool me once, shame on you. Fool me twice, shame on me."

Medical science continues to progress and most of the changes are beneficial and should be accepted. I hope we agree on that. Medical practice is in constant flux. However, before we declare something to be progress, we must make sure it is based on reality, not on wishful thinking or on political correctness.

Now back to the Harvard study.

The final point in that paper is the review of outcomes. One large study, done in Pennsylvania in 2000 covered 39,000 patients with myocardial infarction, treated by 4,000 physicians. The researchers controlled for many factors and found a 0.5% increase in mortality for every year the treating physician had been out of medical school. According to the study, a physician who graduated twenty years ago would have a ten percent higher mortality rate in his practice, compared to a recent graduate.

Perhaps they controlled for the age of the patients and for the duration of their illness, but the paper does not say that they did. Older physicians tend to have older patients, whose illnesses they have treated for years, and I suspect such patients are more likely to die.

One surprising observation about the Harvard paper is that out of the sixty-two studies only two noted that performance increased with years of practice, leveled and then went down. That is the most logical curve and probably the closest to reality.

That observation underscores the difficulty in measuring quality of care and in comparing outcomes, even when the measure is mortality or length of hospitalization. Human beings are complex structures. No two are alike. What works for one does not necessarily work for others.

Among the studies the authors reviewed, 24 looked at the application of standards for diagnosis, screening and prevention. Of these, 15 showed that physicians in practice for more years were less likely to follow the standards. Nineteen studies assessed adherence to standards of treatment and 14 of them showed negative correlation with physician age.

The problem here is that some guidelines might be wrong and waiting for more proof before adopting them may not be a bad thing. I'll mention only the recommendation to give stilbestrol to patients with bleeding in early pregnancy to prevent miscarriage as an example of guidelines that were wrong. Fortunately, that recommendation came out of Harvard and was followed locally, but did not reach countrywide acceptance. I shudder to think what would have happened if it had.

The paper raises one important question about the value of CME. Mandatory CME has been around for over thirty years. It came about in the hope of reducing the liability risk by forcing physicians to keep up-to-date. I don't know whether it helped us keep up-to-date, but I know it didn't reduce the liability risk.

To remedy the situation, Harvard now proposes periodic sabbaticals, perhaps a month every three years, during which physicians would take intensive courses in new procedures and treatments. Good idea.

The question is why and why now? Last year, Harvard fired the manager of its endowment fund. Government grants are down. Private donations are low. So what is a university to do? ■

COLLEGE OF MEDICAL EDUCATION

Get Ready for Hawaii 2006

Every two years the College goes to Hawaii – and plans have already been made for the College's 2006 CME program on the Island of Hawaii.

This popular conference will be held the week of April 2nd in 2006 at the world-renowned Hapuna Beach Prince Hotel. CME courses will run from Sunday April 2nd to Friday April 7th, 2006.

The Hapuna Beach Prince Hotel is located on the large island, Hawaii, on Hapuna Beach. Hapuna's beach has been rated "the number one beach in America" with a long stretch of white, pristine sand. A perfect place for swimming, snorkeling, scuba diving, sailing, windsurfing, kayaking and whale watching and more.

A block of rooms at greatly discounted rates have been reserved. Additional details about the conference, including information about a block of airplane seats, will come to you in a future letter and future *Bulletin* updates.

The course brochure with CME content and other registration details will be available in early June. The course director is **Dr. Mark Craddock**.

Travel arrangements will be handled by Jeanette at All Wanderlands Travel in Tacoma. Her phone number is 253-572-6271. ■

Continuing Medical Education

Primary Care 2005 Conference

Primary Care 2005 is a new multi-specialty course, similar to our Common Office Problems program we offer in the fall. The course director is **Dr. Steve Duncan** from Puyallup.

Primary Care 2005 will be held in the Lagerquist Conference Center at St. Joseph Hospital is offered Friday, May 20. This one day course for six credits will focus on recent developments and updates in a wide range of topics in primary care medicine.

Topics for this conference include:

- Depression – Trends, Treatment
- Is Migraine a Progressive Brain Disease?
- Hypertension: New Treatment Paradigms
- Current Concepts in Dementia
- Women's Health: Menopausal Symptoms and Protection from Osteoporosis
- A Multi-Disciplinary Response to Childhood Obesity

Call the College of Medical Education at 627-7137 to register. ■

Surveys on the Way

The College of Medical Education is currently preparing a CME survey that will be distributed to Pierce County Medical Society members to assess local CME needs. Please watch for it in the mail.

The results of this survey will be used to determine future COME course offerings, as well as types of presenters, venues, specific topics and more.

The College of Medical Education Board of Directors will appreciate your feedback in planning local CME courses for physicians. The College Board sets the agenda for courses that will be offered each year.

Your participation will be appreciated. ■

Dates	Program	Director(s)
Friday, May 20	Primary Care 2005	Steve Duncan, MD

Applicants for Membership

Leslie J. Ballard, MD
Ob/Gyn
MultiCare Ob/Gyn Associates
521 Martin L King Jr Way, Tacoma
253-403-4747
Med School: University of New Mexico
Internship: University of Florida
Residency: University of Florida

Katayoun Toosie, MD
General Surgery
Mt. Rainier Surgical Associates
419 South L Street, Tacoma
253-383-5949
Med School: New York University
Internship: Harbor - UCLA Med Ctr
Residency: Harbor - UCLA Med Ctr

Classified Advertising

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GENERAL

Lower Sound Beach Cabin for Rent. Three bdrm, 2 bath cabin with large deck and large sandy beach. $1,300 week. Email beadqueen54@msn.com or call 253-848-3801.

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Pierce County Medical Society

BULLETIN

June, 2005

(From left) Drs. Kirk Harmon, Willie Shields, Pat Hogan, Sumner Schoenike and Jane Moore, (front right) Joan Brookhyser and Dr. Lilly Koblenz meet at 7:00 am at the YMCA for an energizing start to their Saturday morning

These CHAMP (Coalition for Healthy Active Medical Professionals) members find swimming an excellent form of exercise and tout mental recharging, stress relief, relaxation and diversion as significant benefits

(From left) Drs. Frank Senecal, Kirk Harmon and Willie Shields get set for a rigorous session in the pool

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.

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Pierce County Medical Society
BULLETIN

June, 2005

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President's Page

by Patrick J. Hogan, DO

Patrick J. Hogan, DO

Our Life is About Caring

Caring for our selves
Caring for our patients
Caring for our profession
Caring for our community

Our ability to continue to provide this level of caring depends on **maintaining our energy for caring about caring**.

With all our daily life stressors, fatigue and overload hammering away at our stamina, it can be a challenge to stay strong and avoid loss of caring about caring for ourselves or our profession or even to some extent the quality of patient care.

Giving some caring energy to this four legged structure of care as a whole is integral to achieving the optimal caring energy capacity that we can give to any of its parts.

Caring for Ourselves

We know that to best care for our patients we must first care for ourselves and we must also care for ourselves in order for our patients to best follow our advice for optimal healthy living.

Caring for our personal selves is the integral core behind the CHAMP initiative of the PCMS. The **C**oalition for **H**ealthy **A**ctive **M**edical **P**rofessionals emphasizes the physical and psychological well being of those of us caring for patients and our profession.

By increasing our fitness, we will enhance our physical and psychological stamina for maintaining our enthusiasm for caring. The most important step in this process is that first step in **establishing the habit** of the fitness program. As our local world-known swim coach and fitness icon Dick Hannula recently said to me after a swim at the YMCA, *"A person first gets in the habit of exercise and then gets into the feeling of exercise."* The feeling of the benefits of fitness pervades all dimensions of life and becomes as important to the sense of well being and health as food and water.

One of our major barriers that we have to overcome is that our society is immersed in an epidemic of **health apathy** which is the antithesis of caring. The medical community has not been spared from this epidemic, especially the nursing and paraprofessional staff to which we have to be role models for as well as for our patients. Just caring about our own fitness is a big first step. Woody Allen said, *"80% of success is just showing up."*

The success of **reversing the trend of obesity as the norm in our society** first depends on fitness just showing up on both our personal and clinical radar screens. This will then lead to the steps needed to elevate us to the level of the role models from which behavior changes in our patients and the community will follow. Our recommendations for fitness will have much greater credibility if coming from professionals actively engaged in a fitness program.

It has been enlightening to hear about all the fitness options that PCMS members are involved in. These options will continue to be highlighted each month for motivation and for awareness of all fitness opportunities available. I truly would like to hear about your personal fitness programs whether it be tennis, mountain climbing, surfing, or lacrosse that may be an inspiration for other members.

It is time to begin your office preparation for the CHAMP participation in Run/Walk across Washington Event. This will occur on the 15th of October in Point Defiance Park, one of America's most beautiful places to run and walk. This 5K route will be a great opportunity for motivation for offices to build fitness toward a goal, as a demonstration to the community on fitness for health, and to come together as a group to participate in a state wide effort.

Care of Our Patients/Combat HEALTH APATHY

It was recently reported that 40% of prescriptions are now written for metabolic syndrome consequences. It could be said that this is related to life style *choices* but is more accurate that it is related to life style unawareness or **health apathy**. Most people are just not thinking about fitness or healthy dietary choices as part of their daily lives.

It will be by the actions of physicians, not only by our words, that we can build the force needed to swing the national momentum of obesity and un-

See "Caring" page 4

Caring from page 3

fitness toward the opposite direction. However, the current unhealthy momentum has built up over many years and it will take many more to reverse the trend. It will take a tenacious, organized effort to develop a change in the collective consciousness of society before consequences of catastrophic proportions occur, if this trend continues.

It will require patients to **first be aware** that what they do and eat day to day will make a huge difference in how their bodies work and feel. The next step will be to **motivate them to care** to make the right life style choices. This month's *FitTips* and *NutriTips* assists with some information on preventing and treating the metabolic syndrome and diabetes with fitness and nutrition.

No Magic to Weight Loss

Please read the summary in this month's PCMS *Bulletin* about Dr. Kanter's lecture from our May PCMS General Membership Meeting, New Wrinkles in the Weight Loss Game (page 11). As he emphasized, none of the diets that have been recently marketed have produced magical physiologic body changes by any scientific study. All successful long term sustained weight control depends on maintaining a decreased caloric intake from the previous overweight level and an increase degree of exercise from the previous level. Once the person adjusts to this pattern, weight control no longer becomes a burden but rather a healthier way of life.

Caring for Our Profession

Everyone has now seen the appeals for your financial support of the I-330 Tort Reform campaign. Although any contribution is recognized as a sacrifice in today's financial climate, what is being requested is relatively very small compared to what the trial lawyers are contributing to their countermeasure and is certainly a good investment toward improving the health of our health care system. We will need to emphasize to the public during this campaign that Initiative 330 will not take away patients' rights for their day in court as the lawyers are saying. We need to frame the message of the initiative as an issue of doctors and their patients against the profiteering lawyers.

Caring for Our Community

The signature gathering for Initiative 901 for Clean Air for All Washington to prevent tobacco smoke exposure in all public places is progressing very well. There is still time through June to gather as many signatures as possible to assure that the measure will be on the ballot next November. This is a tremendous community care effort, not just locally but for the national effort for continued protection of the public and workers from tobacco smoke exposure as well as to strengthen the collective consciousness of society against the use of tobacco. It was originally thought that we would become the 8th smoke-free state, but now Montana and Vermont have become smoke free in public places so we are currently poised to become the 10th smoke-free state. However, your help is crucial over the next month to make this happen.

THANK YOU FOR ALL YOUR CARING. ■

FitTips #6

by Patrick Hogan, DO

Exercise and Diabetes

Type I Diabetes is characterized as absolute insulin deficiency or lack of insulin production. Although exercise alone will not control the blood glucose, optimal health and blood glucose control requires a combination of exercise, diet and insulin.

Type II Diabetes affects about 90% of those diagnosed with diabetes. Although enough insulin is being produced in this disorder, the body does not properly respond to the insulin and the blood glucose rises. Serious consequences in other systems throughout the body then occur over time that can lead to heart attacks, strokes or neuropathy.

Obesity and sedentary life style are the major causative factors in the development of this type of diabetes.

Exercise improves the movement of glucose into the cells for use as fuel. Exercise improves the sensitivity of the body to insulin also improving the movement of glucose into the cells from the blood. **Thus, exercise can cause the elevated blood glucose to fall.**

For some people with type II diabetes, exercise alone will control the blood glucose levels.

For others the dosage requirement of insulin or an oral medication will be less when exercise becomes a routine part of the treatment program.

Exercise reduces body fat, especially the abdominal fat that plays a major role in the development of diabetes. Abdominal fat acts like an organ that secretes chemicals that contributes to diabetes and heart diseases.

Exercise promotes muscles development that uses glucose for energy rather than fat storage.

Exercise has tremendous benefits for the cardiovascular system. Since 2 out of 3 diabetics die from heart disease or stroke, it is very important that exercise be done for especially this reason.

Exercise strengthens the heart, lowers blood pressure, lowers the cholesterol – LDL (bad type) and raises the HDL (good cholesterol type) all leading to a decreased rate of heart attacks and stroke.

Exercise reduces the effects of stress that have negative consequences to an even greater extent for the person with diabetes. Stress increases hormones such as cortisol and glucogon that can elevate blood glucose. Stress also has further negative effects on the heart and brain that are reversed by the effects of exercise. Exercise enhances the state of well being.

Exercise in itself has been shown to prevent diabetes. Those at highest risk of diabetes such as those with a family history or obesity have a lower rate of diabetes if they are involved in an exercise program. The best way to treat any disorder is to prevent it from first occurring.

Guidelines for Exercise for Diabetes

If you have diabetes, medical clearance for an exercise program should be obtained by your physician and an exercise program should be started under the guidance of a professional aware of your situation (physician, diabetes educator, exercise specialist).

Exercise should be a combination of aerobic and resistance training throughout each week. Aerobic exercise is exercise that involves moving your whole body in a rhythmical activity at whatever level of intensity is suitable for your level of fitness. This can be done at one time for 20-60 minutes or broken up throughout a day in 10 minute segments 3 to 5 times each week. (See *FitTips #5* on Staying Fit throughout your whole life.)

Resistance training involves strengthening of muscles through various weights or resistance machine options for 8 to 15 repetitions for about 10 exercises twice per week.

Be sure that the exercise includes a warm up and cool down period.

See *NutriTips #6* in this issue of *Bulletin* about **checking pre- and post-exercise blood glucose levels** and managing nutrition when exercising with diabetes.

Drink plenty of fluids before, during and after exercise and avoid extremes in temperature to prevent excess loss of fluids.

Shoes need to be well cushioned and well fitted to minimize foot trauma. Be observant for and treat any skin breakdowns or blisters.

Report unusual symptoms to medical personnel; such as chest pain, headache or lightheadedness.

It has happened that heart attacks can occasionally occur during exercise but remember that this number is small compared to the number of **heart attacks and strokes that are prevented by a regular exercise program.**

Be sure to wear a clearly visible diabetes identification bracelet or shoe tag while exercising.

NutriTips #6

by Joan Brookhyser, RD, CSR, CD

Making Food Adjustments for Exercise and Diabetes

Exercise is one of the best things you can do for yourself when you have diabetes. However if you are on insulin or oral medication for your diabetes you may need to keep a few guidelines in mind.

If you are on insulin:

- Check your blood glucose prior to and after exercise training
- If you are exercising less than 30 minutes at a low intensity you probably do not need to adjust your insulin
- If your blood glucose is < 70 mg/dL don't exercise
- If your blood glucose is < 100 mg/dL, then eat 15-20 grams of carbohydrate 15-30 minutes prior to training
- Re-check blood glucose levels 30 minutes after training or sooner if you have symptoms of low blood sugar
- If exercising at a high intensity a carbohydrate replacement of up to 30-50 grams may be needed per hour of training
- Avoid exercise during insulin peak times
- Inject your insulin over a less active or inactive muscle site
- Have fast acting carbohydrate available at all times (i.e. lifesavers, glucose tabs, Gatorade)
- Check glucose levels immediately after exercise is completed. If glucose levels are <70 mg/dL treat with 15-20 g carbohydrate
- Do not exercise if your blood sugar is above 300 mg/dl with ketones
  NOTE: A low blood sugar can occur up to 24 hours after exercise so monitor blood sugars carefully and make sure and have a bedtime snack
- Inject exercise insulin in less active muscles such as the stomach

If you are on medication:

- If your blood sugar is less than 100 mg/dL have one carbohydrate choice before exercising, such as a piece of fruit or glass of milk

If you are diet controlled:

- There is no need for supplementary food except when exercise is exceptionally vigorous or of long duration

Other Tips:

- Try to exercise at the same time everyday. This will help lessen food adjustments
- Alcohol, aspirin and beta blockers may increase the chance of low blood sugars
- Stay hydrated
- If you are losing weight you may need adjustments in your medication or insulin dosing
- Frequent interaction with your Diabetes Educator or other provider to adjust meds or insulin may also help with more weight loss ■

Special Feature

by Jean Borst

PCMS Swimmers Making a Splash

Do you remember as a child going to the local pool? There was nothing quite like the combination of exhaustion and exhilaration that came with spending a day in the water. While most of us have graduated from Marco Polo and splash attacks, swimming for exercise and fitness as an adult can bring back those nostalgic feelings – and provide a great mental and physical workout to boot.

Swimming is possibly a nearly perfect form of exercise. It is non-weight bearing and imposes no stress on the bones and joints; it improves cardiovascular conditioning; it is an effective weight-control exercise — one hour of swimming burns about as many calories as running six miles in one hour; and it is a form of meditation that helps calm the nerves. Swimming also uses most of the major muscle groups, and strengthens both the upper and lower body.

Two PCMS physicians talked recently about their life-long attachment to the water. **Drs. Jane Moore** and **Sumner Schoenike** both began swimming in medical school and continue to make swimming their primary form of fitness and exercise today.

From Stress Control to Competitive Swimming

"I've always enjoyed swimming and the feel of water," says Dr. Jane Moore, a general practice physician in Tacoma. Dr. Moore began swimming in medical school and discovered Masters swimming during her residency. She's been swimming regularly – and competitively — ever since.

Dr. Moore has competed in local, regional, national and international Masters Competitions since 1979 and has been active in United States Masters Swimming (USMS) at the state and national levels since the early 80s. Comprised of more than 40,000 members nationwide and the sponsor of two national championship meets each year, USMS encourages and promotes physical fitness and health in adults; offers the opportunity to participate in a lifelong fitness and/or competitive swimming program; encourages organizations and communities to establish and sponsor Masters swimming programs; enhances fellowship and camaraderie among Masters swimmers; and stimulates research in the sociology, psychology and physiology of Masters swimming.

Dr. Moore served as chair of the USMS Sports Medicine Committee for 10 years and remains a member of that committee today. Former president of the Pacific Northwest Association of Masters Swimmers (PNA), Dr. Moore is currently on PNA's board of directors. With her husband, she has organized several swim meets including three USMS National Championship meets at the King County Aquatic Center. In 2002, the Moores were awarded the USMS Ransom J. Arthur Award given annually to the person who has done the most to further the objectives of Masters swimming. The Moores are also recipients of the PNA Distinguished Service Award and the USMS National Championships Meet Award.

Dr. Moore swims four to five times a week for 60 to 90 minutes. She swims at the Morgan Family YMCA, as well as the King County Aquatic Center and Federal Way Kenneth Jones Pool. In addition to swimming, she walks on a regular basis and recently added jogging to her fitness regimen. She and her husband also do Pilates at home, as well as weight training and stretching. "On a seasonal basis, we also hike, cross-country ski, and snowshoe," she says. In their spare time, they also plan to do more bicycling!

Obviously, fitness is a vital component of the couple's lives, but swimming is at the forefront for Dr. Moore. "Being in the water is very relaxing for a swimmer," she explains. "It's quiet and soothing, and the repetitive action lets your brain shift into automatic so

See "Swimmers" page 8

Benefits of Swimming

According to the U.S. Water Fitness Association (USWFA), water exercise offers many physical, social and mental benefits:

- *Improved strength and flexibility*
- *Better muscular endurance and balance (many professional and amateur athletes cross-train in the water)*
- *A stronger heart*
- *Enhanced physique or figure*
- *Improved circulation*
- *Rehabilitation therapy for used or healing muscles and recovery from accidents and injuries*
- *Weight control*
- *Relief from stress and tension*
- *Increased energy*

Swimmers from page 7

you can stop thinking about the problems or difficulties of your day. You are able to concentrate on your technique, how your arms and legs are moving, how you are breathing, how you hit the wall and turn at the end of each length. That concentration drives other thoughts away and gives you a chance to recover from the stress of the day. Sometimes, a great mental benefit is just being in the water and not having to talk or listen to another person for a while!"

Dr. Moore recommends swimming for anyone who is looking for a good, overall fitness outlet. As with all exercise programs, she advises that individuals start out slowly. "Lessons and coached workouts are an excellent way to go," she says. "Working out with a group of people in a class can also provide support and camaraderie, and it's also harder to take it easy or be lazy if you're swimming with a group of people."

She also adds that there are other water-exercise options in addition to swimming. "Water jogging belts are good tools for non-swimmers," she says. "They are particularly helpful for injured runners and walkers, and deep-water aerobic exercise classes can also be enjoyable and beneficial."

One thing is certain, Dr. Moore explains, there is no shortage of places to learn to swim, improve your swimming technique, swim competitively, or take part in a water-exercise program. However, you do need to find a place that meets your needs. "Swimmers have a harder time arranging workouts than walkers or runners. They can't just go out the door and start." She advises individuals to find a pool that is convenient in location, has times available for lap swimming, and isn't too crowded. "It's hard to do a workout if you are sharing a lane with someone who swims half a lap then stands up, who can't swim straight, or who changes speeds erratically," she says.

While she most highly recommends the King County Aquatic Center, Dr. Moore says any of the Y facilities are good choices for year-round use, as well as Eastside Pool, People's Pool and the Center at Norpoint. In the summer, check out the pools at Titlow and Stewart Heights. There are also pools open for public swims at PLU and UPS, as well as Foss, Stadium, Clover Park, Mt. Tahoma, Lakes, Gig Harbor, Peninsula, Puyallup and Rogers high schools. If you're interested in taking your stroke to a higher level, a list of pools with Masters swimming programs is available on the Pacific Northwest Association of Master Swimmers website at www.swimpna.org.

Dr. Schoenike

A swimmer for over 30 years, Dr. Sumner Schoenike began swimming laps at the Rice University pool while attending medical school at Baylor University. He began slowly and eventually increased his distance to between a mile and a mile and a half. Rather than swimming what is known as a swimmer's mile – 1,650 yards or 1,500 meters – Dr. Schoenike set his sights on swimming a statute mile, which is 1,760 yards or 1,609 meters.

Today, Dr. Schoenike is still in the water, typically swimming 72 laps, three times a week. He swims at the Lakewood Y pool, located just minutes from his pediatric practice. "Having my office so close to the pool is very helpful," he says.

While his swimming up to now has been purely recreational, he is currently

See "Swimmers" page 20

Tips to Improve Your Swimming

- *As you swim, think about a straight line from head to hips to legs. All parts of the stroke are integrally linked. Head position and kick determine how high you ride in the water. The timing of your breathing affects your alignment and also, to some extent, the path of your arms.*
- *Keep your head straight down as you swim; roll your body both ways, even if you only breathe on one side; don't over kick or you will tire out your legs.*
- *Alternate different strokes within the same workout to reduce boredom and work different muscle groups.*
- *Warm up and stretch before swimming hard. A few minutes of stretching before and after swimming will make your stroke smoother and more efficient, and will help relieve muscle soreness.*
- *After warming up and stretching, swim continuously for 10 minutes. Once you can do that comfortably, increase your swim time by 2 minutes every third session. Then add in a set of 10 sprints of about 50 yards each. Rest for about 30 seconds in between sprints.*
- *Do a total-body conditioning program. It is extremely important to strengthen the rotator cuff muscles to keep the shoulder joint tight, so make shoulder-strengthening exercises part of your regular workout routine. Free weights allow you to isolate the rotator cuff muscles better than exercise machines.*
- *Drink plenty of fluids before and after your workout. It's easy to become dehydrated, even during water workouts.*

Source: www.sportsinjuryhandbook.com

The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

MRSA

Federico Cruz, MD

The incidence of community-associated methicillin-resistant *S. aureus* (CA-MRSA) continues to increase and there is new evidence that certain strains of CA-MRSA have acquired novel virulence genes. These virulent strains can cause primary skin and soft tissue infections (SSTI's) in persons without traditional risk factors for MRSA, including severe and even fatal infections. The changing epidemiology of CA-MRSA requires a more aggressive approach to SSTI's, including incision and drainage as well as culture and susceptibility testing, where appropriate.

In response to this new reality, the Tacoma-Pierce County Health Department added a new section to your Communicable Disease manual. Materials in this section are intended to provide interim clinical guidance for management of *S. aureus* skin and soft tissue infections in outpatient settings, until more definitive guidelines are available from the Centers for Disease Control and Prevention and/or medical professional organizations.

The new section in the manual contains the following:

- "Interim Guidelines for Evaluation and Management of Community-Associated Methiciliin-Resistant *Staphylococcus aureus* Skin and Soft Tissue Infections in Outpatient Settings" for providers. These guidelines were developed collaboratively by the Infectious Diseases Society of Washington, Washington State Department of Health, Tacoma-Pierce County Health Department, and Public Health-Seattle and King County. Key points in the document are highlighted in bold. They are also available electronically at:
  - **http://www.tpchd.org**
  - **http://www.doh.wa.gove/Topics/Antibiotics/providersMRSA.htm**

- An algorithm (extracted from pages 11-12 of the above guidelines) for reference in the clinical setting.

- Educational card with important infection control practices for your office staff, with photographic examples of MRSA skin infections.

- A booklet entitled "Living with MRSA" to assist you in the education of your patients and their families when MRSA is diagnosed.

You should have received this information. If you haven't and would like the materials or have questions, please call (253) 798-6410 and request this. ■

New Law Protects Employers from Liability for Giving Good Faith Job References

By Jane H. Graham and Nichole Chiappini

Increasingly, employers are frustrated by the fact that when they try to check references on an applicant, former employers are unwilling to provide substantive information. Yet they themselves fear liability for giving such information to prospective employers of their former employees. This leads to a vicious cycle of employers passing on undesirable employees. Fortunately, the Washington Legislature **recently passed legislation (HB 1625) that protects employers from job reference liability** and Governor Gregoire has signed it into law. This Note discusses the new law and provides practical tips to help employers benefit from its protections.

THE NEW LAW

When the new law takes effect on July 24, 2005, Washington will join the nearly 80% of states that have statutes protecting employers from liability for giving references. Employers that disclose information about former or current employees to prospective employers or employment agencies will be presumed to have acted in good faith, and will be immune from liability for such disclosures if certain conditions are met. The conditions include:

- The disclosure cannot be unsolicited. The law's good faith presumption does not apply if an employer discloses information without having been asked for it. Thus, to be protected, a disclosure must be made in response to a specific request by a prospective employer or employment agency. In practical terms, this means that a manager should not contact a friend at another company and say, "I heard you were considering hiring Jane Doe. Let me tell you about her."
- The disclosed information must be related to the employee's job ability, job performance, or job duties. The law only protects employers if the information they disclose is related to: (1) the employee's ability to perform her/his job; (2) the diligence, skill, or reliability with which the employee carried out her/his job duties; or (3) any illegal or wrongful acts that the employee committed, which relate to her/his job duties. These limitations on the types of disclosures that are protected should not come as a surprise to employers. Just as employers should only ask job related questions during the hiring process, they should likewise only disclose job related information when giving references. Personal opinions about the employee's personality, honesty, character, and the like usually will not be protected.
- Employers should retain a record of the disclosures. Although the law uses the word "should" regarding record keeping, following its suggested approach will enable employers to take full advantage of the law's protections. The record should indicate: (1) the person to whom the disclosure was made, as well as the entity with which that person is associated; (2) the person making the disclosure and their position; (3) the date the disclosure was made; and (4) the information that was

See "References" page 16

General Membership Meeting, "New Wrinkles in the Weight Loss Game," interesting and informative

Dr. Robert Kanter, internist and endocrinologist from Bellevue, provided an excellent overview of dieting and weight loss at the General Membership Meeting in May. In keeping with the PCMS CHAMP (Coalition for Healthy, Active, Medical, Professionals) Initiative, his information fit nicely with the focus on better fitness and nutrition, and consequently better health.

Before the crowd of 70, Dr. Kanter focused primarily on low carbohydrate diets, noting that they can work but there is lots of hype, and many people profiteering from the concept. People must be careful to avoid magical thinking and think about the reality of what is being sold to them.

The premise of the low carbohydrate diet is that carbohydrates are the culprit and if they are restricted, then one can eat unlimited fat and protein. The mechanism is decreased blood sugar and insulin and increased protein and ketone production, all which seem to decrease appetite. The diets that espouse this concept include Atkins, Protein Power, Sugar Busters and the Zone, to name a few. They call for carbohydrate counts of less that 20 to less than 60 per day.

Dr. Kanter believes the correct question one should ask before undertaking such a nutrition plan is not what diet will produce the greatest weight loss, but what diet will reduce morbidity and mortality and which is the easiest to follow? The initial weight loss is loss of glycogen and water combined with further solute diuresis caused by ketone production.

In clinical trials it was shown that people on low carbohydrate diets did experience

- a rapid initial weight loss
- reduced caloric intake of 400-500 calories per day
- weight loss consistent with reduced intake
- better adherence and weight loss than those on low fat diet
- improved lipids, blood pressure and blood sugar
- increased urine calcium and uric acid excretion

The trials have given researchers the green light to do further studies, and after the analysis of almost 100 studies, they determined there was no greater efficiency of weight loss, but perhaps improved adherence made the difference.

In summary, Dr. Kanter noted that the low carbohydrate diet shows no accelerated fat loss, that weight loss is dependent on caloric intake, compliance is easier due to fat satiation and the feeling of being full, there are no serious adverse effects, that there are adverse effects on the kidney and bones long term, exercise needs to be incorporated into the diet plan, and there has been no long term follow up of these diet plans. Other cautions are for gout, kidney stones, osteoporosis, renal insufficiency, microalbuminuria and unstable vascular disease.

See "Wrinkles" page 22

Lessons I Learned in the Courtroom

by Peter Nelson, MD

I believe I am the only member of my 13-doctor group to endure a two-week medical malpractice trial down to the verdict and aftermath. It is a life-changing experience, and I could easily write a book about it. The most important chapter of the book would be titled "Professional Deportment."

If you are ever involved in a malpractice lawsuit, the outcome may well hinge on your integrity. That's because a vital piece of documentation will inevitably be lacking in the chart. Your testimony and recollections will have to fill in the gaps in documentation. It will be your word against the plaintiff's. Accordingly comes the role of character. Here are some ways to preserve your good character as a physician, which will help you to prevail in the event of a medical malpractice lawsuit:

• **Be sure your character is unblemished**. Character cannot be directly observed; it is inferred from its products. Of these, kindness is of singular value as a lens through which people make judgments of character. Everyone understands kindness! Your respectful speech, your eye contact, your adherence to etiquette - such as knocking on the door prior to entering the exam room - all this is being evaluated by the patient and the patient's family. The message received should shout "KINDNESS." The medical record might reinforce that message with a documented telephone follow-up.

• **Never make belittling comments about patients to your staff**. You may have heard the story of a physician who had a code for patients he deemed "slow cerebrators." That code came to light in the course of depositions, and his case became indefensible.

• **Treat nurses, technicians, and secretaries with kindness and consideration** - and they will return that back to the patients. The court cares about a physician's IQ, training, and credentials only in a peripheral way. What the court really wants to know about is your character. How you treat staff speaks eloquently thereof.

• **Never discuss money or reimbursement in the workplace**. The plaintiff may later try to paint you as a greedy physician who wouldn't take time to do the right thing. Don't provide ammo.

• **Be on your best behavior at deposition and in vicinity of the courtroom** - that is, five or six blocks from the courthouse. Be cordial with the plaintiff's counsel. Be kindly and solicitous of the plaintiff and plaintiff's family, whom you will necessarily encounter face-to-face numerous times in court. Trials are time-intensive, and everybody except the judge uses the same two restrooms during breaks.

• **There should be no jokes or frivolities in the courtroom**. You should always confer quietly with your own counsel, and you should listen attentively and considerately to witnesses on each side, taking notes where appropriate.

• **Never alter anything in the chart**. Altering a chart destroys the defense because it impugns the physician's integrity. A physician who alters the chart can no longer say anything under oath that will be believed. If you haven't read the Physicians Insurance article on altering charts (at http://www.phyins.com/pi/risk/updates/julaug04.htm.), please read it.

• Rather than alter a chart, I recommend a very factual and non-defensive dictation of a "bad-outcome note." Such a dictation could begin, "I became aware through a telephone call from [name of caller] at [time] that [name of patient] expired at home and that efforts by EMS toward resuscitation were unavailing." You could then go on to state your pertinent recollections about the case, which likely will add information over and above your previously dictated note.

Acknowledging the bad outcome in the chart actually helped my case. In this verdict, the judge mentioned my dictated bad-outcome note and said, "We can be sure Dr. Nelson's memory was not faulty because he dictated this note when everything was still fresh in his mind."

To defend myself in court was a momentous decision, one that I don't regret. The time commitment was prodigious. The emotional toll was significant but manageable. If I was able to do this, I believe most physicians reading this can and should do likewise, depending on advice of counsel. But be advised that the bedrock of your defense rests upon your unwavering kindness to your patients. ■

Physicians Risk Management Update
Volume XVI, Number 2
Physicians Insurance A Mutual Company

PCMS Foundation Awards 2005 Grants

At their April meeting, the PCMS Foundation Board of Directors selected grant recipients for 2005. Nine agencies were selected to receive grant awards.

Thanks to the generosity of PCMS members, the Foundation raised $20,308 during the 2004-05, fund raising season. This is an increase of $1,688 over last year and $3,701 over the 2002-03 year. THANK YOU for your generosity and compassion for those less fortunate!

Foundation Board members, **Drs. Charles Weatherby** and **Lawrence A. Larson**; Nicole Crowley (**James Crowley, MD**), and Mona Baghdadi (**Tarek Baghdadi, MD**) elected to contribute $20,000 to local non-profit agencies this year. Agencies receiving funding and the amounts they were awarded include:

NEIGHBORHOOD CLINIC	$5,000
CCS/PHOENIX HOUSE	$3,000
TRINITY NEIGHBORHOOD CLINIC	$3,000
NEW PHOEBE HOUSE	$3,000
FAMILY RENEWAL SHELTER	$2,000
COMMUNITY HEALTH CARE	$1,000
AMERICAN LUNG ASSOCIATION	$1,000
PIERCE COUNTY AIDS FOUNDATION	$1,000
HOSPITALITY KITCHEN	$1,000

The Foundation is very specific about how the contributed funds are donated and spent. Monies will only be granted to Pierce County non-profit agencies and preference is given to health related organizations and programs. All agencies are screened and must supply documentation that the money was spent as intended and utilized in our county for those most in need.

This year both the Neighborhood Clinic and the Trinity Clinic sought funding for prescription medicine for patients. While local physicians volunteer to see patients at both clinics, prescription medication poses a problem financially. This is a big boost to their small budgets and is a significant help for successful treatment of patients in dire need. The funding in total will significantly help those in need of food, shelter, and health care in Pierce County.

The Holiday Sharing Card project is the primary fund raiser for the Foundation. This project was originally administered by the PCMS Alliance, formerly known as the PCMS Auxiliary. When the Alliance disbanded in 2000, the PCMS Board of Directors voted to form a foundation to continue the philanthropic work in the community.

The Foundation is looking into additional ways to raise funds to contribute to our community. If you have any ideas, please contact Sue Asher at the Society office, 572-3667. ■

Applicants for Membership

Shane S. Anderson, MD
Pathology
Puget Sound Institute of Pathology
1001 Klickitat Way SW #205, Seattle
206-622-7747
Med School: University of Minnesota
Residency: University of Washington
Fellowship: NY Presbyterian Hospital

Christopher Hager, MD
Pathology
Puget Sound Institute of Pathology
1001 Klickitat Way SW #205, Seattle
206-622-7747
Med School: Med Univ of South Carolina
Internship: SUNY Health Science Center
Residency: Emory University Hospital

Shaista Quddusi, MD
Endocrinology
St. Francis Medical Clinic
34503 9th Ave S #100, Federal Way
253-874-2227
Med School: Dow Medical College
Internship: Civil Hospital, Karach
Residency: Cook County Hospital
Fellowship: University of Washington

H. Lester Reed, MD
Internal Medicine
MultiCare Health System
315 Martin L King Jr Way, Tacoma
253-403-1251
Med School: University of Kentucky
Internship: Natl. Naval Medical Center
Residency: Natl. Naval Medical Center
Fellowship: Natl. Naval Medical Center

Myong J. Roe, MD
Ob/Gyn
St. Francis Women's Healthcare
710 S 348th St #A, Federal Way
253-944-6950
Med School: Yonsei University
Internship: Bridgeport Hospital
Residency: Maimonides Medical Center
Residency: Naval Regional Medical Center

Robert J. Snyder, MD
Ob/Gyn
St. Francis Women's Healthcare
710 S 348th St #A, Federal Way
253-944-6950
Med School: Jefferson Med College
Internship: Lehigh Valley Hospital
Residency: Lehigh Valley Hospital

Ilya Stone, MD
Pathology
Puget Sound Institute of Pathology
PO Box 34245, Seattle
206-622-7747
Med School: University of Mississippi
Internship: University of Arkansas
Residency: University of Arkansas
Fellowship: Akron City Hospital

Sylvia S. Thomas, MD
Family Practice
5920 100th St SW #31, Lakewood
253-584-3023
Med School: Loma Linda University
Internship: Kaiser Permanente Med Ctr
Residency: Kaiser Permanente Med Ctr

Thao Huynh Tran, MD
Ob/Gyn
St. Francis Women's Healthcare
710 S 348th St #A, Federal Way
253-944-6950
Med School: Albert Einstein
Internship: Hartford Hospital
Residency: Hartford Hospital

Bryan D. Whitemarsh, MD
Family Practice
Good Sam Family Med at South Hill
16515 Meridian E #104A, Puyallup
253-697-3030
Med School: University of Washington
Internship: Tacoma Family Medicine
Residency: Tacoma Family Medicine

Liability Initiative Update

Doctors, Nurses, and Patients for a Healthy Washington is the name of the new campaign committee replacing Doctors for Sensible Lawsuit Reform (DSLR). The change was required because of the transition of filing with the Public Disclosure Commission (PDC).

This name more accurately reflects the broad nature of the campaign and will be more effective at communicating how I-330 will improve access to needed medical services while I-336 would further erode access. Committee members include Ken Isaacs, MD, WSMA President and Chair of the Committee; Mariann Tefft, an expectant mother from Olympia who will lose her OB/GYN after the birth of her child; Dana Wallace, RN, an emergency room nurse from Everett; and Scott Bond, chair of the WSHA (Washington State Hospital Association). While this committee is a Political Action Committee (PAC) it will deal with this campaign only – and will have no association whatsoever with political candidates and their campaigns for office.

Pierce County's fund raising goal for the campaign is **$316,000** with just over $90,000 being raised through Mid-May. Each physician is being asked to donate $1,000 to the campaign – a small price compared to the $25,000 being asked from each trial attorney. All contributions will be gratefully accepted, however.

Dr. Peter Marsh has assembled a team of "assistants" to help in fund raising efforts. They include **Drs. Dick Bowe, Jim Buttorff, Ken Feucht, John Huddlestone, Joe Jasper, Mike Kelly, Gordy Klatt, Jim Komorous, John Lenihan, Paul Lester, Ron Morris, Vern Nessan, Randy Otto, Ray Pliskow, Vita Pliskow, Nick Rajacich, Sandra Reilley, Matt Rice, Bill Roes, Don Russell, Bob Sands, Frank Senecal, George Tanbara, John Vaccaro, Kari Vitikainen, Needham Ward, Charles Weatherby** and **Barry Weled**. Expect a letter or phone call from one or more of these physicians in the very near future.

The pieces are falling into place for passing I-330 and defeating I-336 in November. The polling data looks very positive. The professional campaign team is in place and there is a sound plan. The campaign needs money to be successful. Send in your contribution today by going online at www.yesoni330.org or calling the PCMS, 572-3667 for a contribution form.

Thank you for your support - this is our one opportunity to enact medical liability reform in our state!! □

References from page 10

disclosed. The record should be retained in the employee's personnel files for at least two years from the date of the disclosure. Former and current employees have a right, upon request, to inspect disclosure records—along with the rest of their individual personnel file.

• Higher standard of proof. Employers won't be protected if they disclose information that is knowingly false, deliberately misleading, or made with reckless disregard for the truth. If there is a lawsuit, however, the employee has the burden of establishing, by "clear and convincing evidence," that a disclosure was false, misleading, or reckless. This is a tougher burden to meet than the usual "preponderance of the evidence" standard.

PRACTICAL TIPS

What should employers do in light of the new law when giving and seeking references?

Create a centralized system for giving references. Create a centralized system so that all references flow through a "gatekeeper" (*e.g.*, the human resource department or, in the case of small employers, a specific individual). Having such a gatekeeper simplifies compliance with the requirements of the law and increases the likelihood that only job-related references will be given. Inform all employees of the centralized system.

Train managers, supervisors, and other employees who may be asked for references. Welltrained managers and supervisors are an employer's first line of defense in protecting itself from job reference liability. Managers and supervisors should know the company's centralized system for giving references, understand that only job-related information should be disclosed, and know not to provide unsolicited information.

Develop a standardized form. Create a form that managers and supervisors can complete as they give references. The form should contain prompts for the statutorily-required information (discussed above), information regarding permissible and impermissible disclosures, and instructions on what managers should do with the completed form. Employers seeking references may improve the quality of the information they receive by sending a form to former employers, which would simplify the former employer's record keeping.

Recognize special circumstances. The new law does not protect employers from liability for breaches of employment-related agreements. Therefore, be sure specific references comply with the terms of any applicable agreements. For example, if a severance agreement exists in which an employer agreed to modify a terminated employee's personnel file to reflect a resignation rather than a termination, then a reference giver should not state that the employee was terminated.

The protection provided by the new law should go a long way toward easing employer concerns over job reference liability. Cautious employers, however, may still wish to obtain releases from departing employees that release them from liability for giving information to prospective employers. ■

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.*

Andrew Statson, MD

Taxes Versus Premiums

"For years I thought what was good for our country was good for General Motors, and vice versa. The difference did not exist. Our company is too big. It goes with the welfare of the country."

To the Senate Committee on Armed Services
Charles Erwin Wilson (1952)
President of General Motors
Secretary of Defense

Unfortunately, GM of today is very different from GM of 1952. Then it was a dynamic enterprise, which controlled one half of the domestic automotive market and held a commanding presence in the world. Today GM has a 25% share of the domestic market, and that keeps shrinking further. As for a world presence, I better not say anything.

GM is in trouble. Its share price is half of what it was a year ago and its bonds were recently downgraded to junk status. GM claims its financial troubles are largely due to the high cost of health care.

With the generous health benefits that it pays for workers, retirees and their dependents, GM says that its expenses for health care amount to $1,525 per car produced. The company provides full health care coverage. The employees pay no premiums or deductibles. They only have a small co-pay for office visits and prescriptions. Added to that are generous retirement benefits, at the additional cost of about $700 per car.

The truth is that GM caved in to its unions and they are running it into the ground. Watching its sagging fortunes, GM casts a wistful look at its competitors and claims that they have an advantage because in Japan taxes pay for health care. So to save the company from bankruptcy, GM is searching for a deeper pocket, and who else but Uncle Sugar.

Thus GM, Ford, and probably many other businesses have joined the universities in the push for a National Health Plan.

The universities have led the charge for a NHP for a number of years. They have had financial problems, too. Vanderbilt University Medical Center reported a few years ago that they were subsidizing the care of their Medicaid patients to the tune of twenty million dollars per year.

I suspect that most other university medical centers are in the same situation. They treat the most complex and therefore the most expensive conditions. They cannot turn away patients, even those who cannot pay. What the Medicaid programs pay them is not enough to cover their costs and the universities have to absorb the loss.

At the same time, government grants are harder to get, private companies have cut their budget for research, and endowment donations are down. The universities are looking at reducing their staffing and some have already started. No wonder they are searching for a deeper pocket, too.

As *Fortune* magazine reported in a recent article on the prospects for a National Health Plan, there is another sector in financial trouble, which also would be delighted to get federal help. Those are the state and local governments.

The states are saddled with the rapidly rising costs of Medicaid, which already are eating a quarter to a third of their budget and threatening to consume half. That is happening at a time of considerable resistance among the population to a tax increase.

At the same time, just like GM, the states have their own workers, retirees and dependents, for whom they pay generous retirement and health care benefits. These benefits are now paid out of current revenue, meaning taxes, without provision for the future costs of the retiree benefits. As these obligations pile up, the cost may overwhelm the taxing ability of the sector. A national retiree and health care program can save the municipalities from financial disaster, or worse, from popular unrest.

The prescription benefit for Medicare is already a step in the direction of federalizing the pension obligations of the private and public sector. It will be interesting to watch what other steps will be taken during the next few years.

I think there is a general agreement

See "Taxes," page 12

Taxes from page 11

that the costs of both health insurance and health care are too high. Those costs are not going to disappear if the federal government were to take over. On the contrary, they will go up.

The only difference is that people will pay the price in taxes, rather than in premiums. Costs will be controlled through rationing, instead of ability to pay, and only the federal government has the amount of power that will be necessary to impose rationing. The unions may sink GM and Ford, but they will not be allowed to strike against the federal government.

Is there an alternative to government takeover, and if so, what? In the army we were told that there are two ways of doing things, our way and the government's way. In the army, we had to do things the government's way. In reference to health care, that means rationing in one shape or another. It also means that people who have the necessary political pull or rank will always get more care or more expensive care than those who don't.

Our way means that we decide for ourselves what health care to get, according to the assessment of our needs and of our ability to afford the price. That means that people who can and want to pay for it, will get more care or more expensive care than others.

The question here is whether more care or more expensive care produces a more desirable result. That, however is a value judgment and will vary with the individual. I will never forget the report about Generalissimo Francisco Franco, who spent a full month dying in the intensive care unit of a Madrid hospital, had cardiac arrest and was resuscitated five times, before they finally let him die. He was quoted as having said, "Why is it so difficult to die?" Perhaps that was his punishment for being a dictator.

Health care is an economic good, and as such, it has a cost. It uses resources and those resources are limited. There is just so much of them to go around. In the market, the decision to consume resources belongs to the buyer.

In an opinion piece, entitled "Wanna Fix Health Care? Stop Hiding the Cost!" published in the *Wall Street Journal* on October 13, 2004, Holman W. Jenkins Jr. wrote that removing the price tag of health care doesn't make it free.

He quoted Clark Havighurst from Duke University, who said that the systematic hiding of health care costs from those who pay them allows politicians to spend the public money on health care in ways the public would never choose for itself, either in the marketplace or in the voting booth. "The consequence of the shell game in which costs are moved wherever employees/consumers/voters are not looking" is that health care is regulated in ways "that make sense only because the price tags have been generally removed. Several whole percentage points of the nation's gross domestic product are thus diverted wastefully to health care from other uses."

President Calvin Coolidge, in an address to the American Society of Newspapers Editors on January 17, 1925, said, "The chief business of the American people is business."

Health care is a significant portion of the economy. As such, it is a business and therefore, it is the business of the American people. Even though frequently misquoted on that point, President Coolidge did not say that business is the business of the federal government. He was right in making that distinction. ■

In My Opinion

by Mohammad Saeed, 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.*

Mobile Electrodiagnostic Laboratories

Mohammad Saeed, MD

I have recently come to find out that mobile electrodiagnostic laboratories are operating in our area. I have had the opportunity to review some of the studies done by these mobile labs and find that they are of poor quality, testing more nerves than necessary, and billing the patient, and ultimately the health care system excessive fees.

While NCS is very important in evaluating peripheral nerve problems, it is universally accepted and supported by the American Association of Neuromuscular and Electrodiagnostic Medicine (AANEM), that Electrodiagnosis is of value only when nerve conduction studies are completed in combination with needle EMG, particularly for proximal peripheral nerve problems such as root and plexus lesions, but also for many other neuromuscular disorders.

Many mobile diagnostic centers tend to have the following characteristics: Typically an out-of-state entity leases space in an office suite (generally a chiropractor's or family practice physician's office). A technician performs a variety of NCS, sometimes utilizing other techniques to include somatosensory/dermaiomal evoked potentials and spinal ultrasound usually absent any trained physician assessment, and no EMG study is ever performed. The technician generally employs a "shot-gun" approach as per the mobile labs protocol - testing every nerve and limb rather than tailoring the study to the individual patient, as a properly trained electrodiagnostic physician would do. The tabular data is then sent to a physician, generally out-of-state, for interpretation (and usually not someone formally trained in Electrodiagnostic Medicine or Board Certified by AANEM). The physician interprets the studies and then sends the results back to the ordering physician. The ordering physician then sends the insurance company a bill that usually exceeds normal pricing for these studies, or course, absent one of the critical components of electrodiagnosis, EMG study.

Electrodiagnostic examination is different than MRI or EEG, which can be interpreted by the physician without seeing the patient once the data is acquired. Electrodiangostic evaluation requires the physician to be on site taking a history and physical, because NCS and EMG examinations are often modified and expanded as the findings unfold.

I would recommend great caution before any one is involved in this type of arrangement. If you have any questions please feel free to contact me at 253-272-9994. ■

Swimmers from page 8

biking and running as part of his training for his first-ever triathalon (with PCMS President **Pat Hogan**). "Biking and running have really complemented my exercise routine," he said. "And while I enjoy having the variety, I don't find swimming monotonous in the least. I love it, in fact! In the pool, I go into a meditative space. I can reflect about my day and plan ahead. It's a perfect opportunity to take a mental break."

Swimming has become such an integral part of his life, that, he says, "I get very grumpy if I'm unable to go." His staff has noticed that as well, he laughs. "They do a good job of getting me out the door so I don't miss my swim."

Of course, Dr. Schoenike explains, the mental benefits are equally matched by the physical benefits of swimming. As a non-weight-bearing activity, swimming puts little stress on the joints. While a great upper and lower body workout, adding flip turns to your workout also strengthens abdominal muscles. "I love the fact that it's such a complete body workout," he says.

Dr. Schoenike's love of swimming has been passed along to his daughter. After learning to swim at an early age, she swam competitively through school. "It was a great activity for us to enjoy together when she was growing up," he recalls. "I started off being able to swim circles around her, but now she swims circles around me." When she goes to Whitman College this fall, she plans to continue swimming recreationally. "It's definitely in her blood," he said.

For individuals who perhaps have never learned to swim, or never learned to swim properly, he encourages them

See "Swimmers" page 21

Swimmers from page 20

to take up the sport. 'It's never too late to learn," he says. "I know a woman who didn't learn to swim until she was in her 40s. Now, she's one of the premier swimmers at the Lakewood YMCA."

For those who would like to become better swimmers, Dr. Schoenike recommends working with a coach. "There are a lot of bad habits that can cause you to be less efficient. But you can overcome those to become a better swimmer," he says. He also highly recommends the book "Total Immersion Swimming: A Revolutionary Way to Swim Better and Faster" by Terry Laughlin and John Delves. "It really breaks down the component of swimming and is a great resource for someone learning to swim or trying to become a more efficient swimmer," he explains.

Dr. Schoenike recommends any of the YMCA pools for individuals looking for someplace to take the plunge. "And if you travel at all, you can always find a Y. Your card will get you into any facility."

And for those of you who think you don't have time in your busy schedules for exercise, Dr. Schoenike offers this. "It takes a half hour to swim a mile, and then you're done. If your time is limited, then swimming is definitely a good exercise choice."

If you are interested in getting into a swimming routine, remember – as with all exercise – start out slowly. "Start by swimming two to four laps," he advises. "Eventually, you will reach a plateau of swimming where you feel as if you can go on forever. And that's a wonderful place. Then it becomes your sport." ■

Wrinkles from page 17

Looking at the big picture, one needs to remember that diet is only one component of a weight loss plan. Exercise, portion control and social support all play significant roles in the successful weight loss plan.

"Any diet will work if you follow it and the diet that works the best is the one you believe in," said Dr. Kanter. Many make sense on the surface, South Beach, Atkins, etc., but there is no published data on these diets to show the success of decreasing morbidity and mortality.

Dr. Kanter said he liked Dr. Phil's diet plan which identifies seven skills that help people stick to a diet plan. It is focused on behavior and nicely done as it prepares people when they face tough choices. The book is titled, "The Ultimate Weight Solution – The 7 Keys to Weight Loss Freedom."

Dr. Kanter reminded everyone to not forget exercise which is a significant factor to weight loss. However, for those without significant amounts of weight to lose, it can take up to 80 minutes of daily exercise if used as a single strategy. "Exercise alone is not the magic bullet," he noted. An "empowered attitude" and "study of the Mediterranean Diet" were two additional parting suggestions he made for successful weight control. ■

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Washington State Division of Disability Determination Services. Medical Consultant Position Available. The State of Washington Division of Disability Determination Services seeks physicians to perform contract services in the Olympia and downtown Seattle offices. Contract services include the evaluation of mental or physical 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: Competitive rates. Interested physicians should contact Gene Profant, MD, Chief Medical Consultant at (360) 664-7454; Mary Gabriel, Regional Manager, Olympia North at (360) 664-7362; or Randy White, Regional Manager, Seattle at (206) 654-7216.

Personal Problems of Physicians Committee

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

Your colleagues want to help

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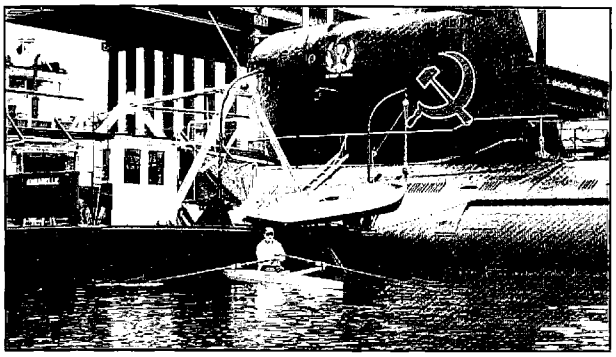
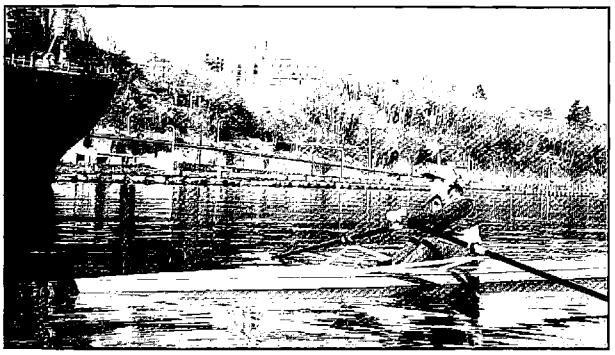
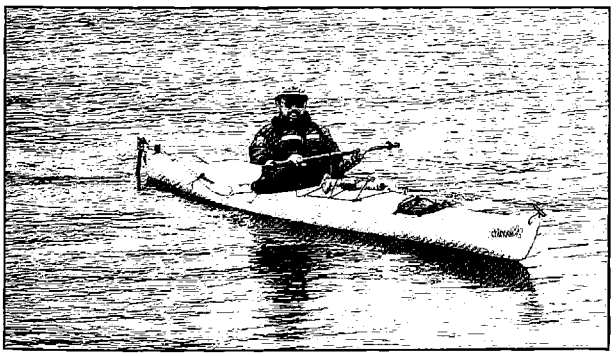
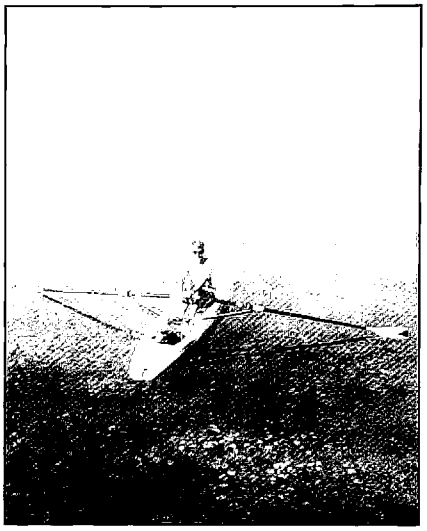
July, 2005









Rowing and Kayaking - connecting with nature AND fitness

Top Right: Andy Loomis, MD in Puget Sound
Top Left: Sid Whaley, MD below 11th Street Bridge
Center: Jan Whaley enjoys the scenery along Ruston Way
Bottom: David Munoz, MD ready to go....

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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.

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Pierce County Medical Society
BULLETIN

July, 2005

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President's Page

by Patrick J. Hogan, DO

Patrick J. Hogan, DO

Power of Positive Words and Thoughts in Medicine and Life

"Change your thoughts and change your world."
Norman Vincent Peal

In our world of highly technical treatments and medications, it is often forgotten how much the efficacy of treatment is dependent upon the positive thoughts and words of the treating physician. We have a healing power that adds to the direct effect of the treatment prescribed or the recovery after a surgery. We now all understand that placebo responses are neurophysiologic processes rather than a psychological phenomena. These benefits only add onto the effect of the medication or treatment. By promoting positive thought and belief in a treatment we are producing synaptic neurophysiologic changes that enhances all our treatments. Although this can be a difficult concept to accept for those of us grounded in solid scientific principle, medical science is making strides in understanding the physiology behind the synaptic changes of positive thought. It is part of the art of medicine that utilizes the positive patient interaction in order to optimize the desired therapeutic result.

Positive Thought to Change Behavior:
Behavior change for addictions

The Freedom from Tobacco support group at St. Joseph's Hospital recently celebrated it's 13 year anniversary. This is a group in which people are essentially guaranteed to stop smoking and control this lifelong addiction if they consistently come to the group for assistance with information, pharmacology and support in all stages of the process but most of all from the **positive power that the words and feelings from the group have on the addicted brain**. At the anniversary celebration people stood with testimonials from the last ten years. All had tried multiple other stop smoking options. The overriding message from them all was that it was the **"magic" of the collective, positive thoughts** from myself and especially every other member of the group that could override the power of nicotine and pull them through week to week until tobacco use was a thing of their past. **Synaptic connections are promoted in the brain that are used for a healthy behavior**. These synapses are strengthened by continued use while the old pattern withers and dies away.

Behavior change for fitness

All people know that a fitness program is healthy and will lead to a better and longer life. However, only 10% of people exercise to the level that they should. Reprogramming of the brain is needed to change the behavior of previous life style activity levels.

Old established synaptic pathways need to be extinguished and new pathways need to be established. It is through repetitive **positive reminders and encouragement** that the synaptic connections form that make exercise a natural part of daily life rather than a chore. I stated last month that initially establishing an exercise program requires frequent self positive talk to establish the habit (synaptic circuit) and eventually feel the positive energy of fitness. Fitness in itself leads to further positive energy toward positive attitudes and an upward spiral of overall health.

The *FitTips* and *NutriTips* will be of assistance with your patients. Hopefully, CHAMP will offer some incentive to each of us to be positive role models.

(See the ad on page 21 about plans for the CHAMP Walk/Run across Washington.)

Positive Thinking to Keep us Healthy, Happy and Fit

"Happiness cannot come from without, it must come from within. What makes us happy is that which we think, feel and do first for the other fellow and then for ourselves."
Helen Keller

"It is not what happens to you it is how you react to it."
Reverend Robert Shuler

Things happen in life but the extent of suffering is a choice. It takes conscious effort to spin a positive thought pattern to a health problem, pain or personal adversity. On a recent personal level, while running the Sound to Narrows race, a thief broke my car

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Positive from page 3

window and stole Joan's purse with credit cards, camera, phone and PDA. We were mostly disheartened by the loss of pictures and lack of meaningful response by the legal system but were able to spin it all to work out with positive replacements and a positive lesson.

In medicine we encounter patients daily with similar disorders but it is remarkable how some people **suffer so much less** from the pain or consequences of their illness because of their positive spin of their attitude.

Sometimes the self-induced discomfort that comes with strenuous exercise can dissuade a person from maintaining an exercise program or excelling in fitness to their potential. However, it is much easier to maintain our fitness program if we spin it positively by accepting that the pain or discomforts will be there but it is **our choice how much we suffer from them**. The discomfort will pass and the fitness program will be progressively more enjoyable as our remarkable human body adapts to the challenges it is presented with. **The benefits of this adaptation carry over to all other aspects of life**.

Pain may come along as a passenger but it is not who you are or part of you. You have the control to maintain your inner strength and choice to experience as little suffering from the pain as possible. Eventually the unwanted guest of pain will leave and you will be stronger. Positive thought attitudes will develop the necessary synaptic connection in your brain that will minimize the suffering from pain or adversity.

Other Positive Notes

Initiative 901 for Clean Air for all Washington is waiting for certification of signatures to successfully make it to the November ballot. Thank you for everyone's positive efforts who helped collect signatures for this first phase of victory toward a Smoke Free Washington.

We are gathering momentum to **continually spin Initiative 330 as positive for patients and doctors** and Initiative 336 as positive only for lawyers and negative for everyone else.

Thank you for your contributions and work toward this.

Dr. Matt Rice gave the Board of Trustees and excellent **presentation on patient safety**. The results of his work will have great positive effects on the safety of our patient population. See a summary of his presentation on page 9 of this issue of the *Bulletin*.

SPIN IT POSITIVE. Choose not to suffer. HAPPINESS COMES FROM WITHIN. We can change the world by positively working with our community, our patients and our personal selves. Chose to be happy. Develop positive brain synaptic connections. ■

FitTips #7

by Adrienne McNamara, MS

Exercise and Bone Health

1. **Osteoporosis Facts**

Osteoporosis is a condition characterized by low bone mass and an increased susceptibility to fracture. Currently 14 million Americans are osteoporotic with 18 million more at risk due to low bone mass. The most detrimental consequence of osteoporosis is fractures, with over 750,000 vertebral fractures occurring each year. The incidence of hip fractures is expected to double to 2.6 million per year by the year 2025 with an associated mortality of 15-20% in the one year period following a hip fracture. These fractures and other osteoporosis related outcomes place an estimated financial burden on the U.S. of over $14 billion annually, indicating a clear need for strategies to maintain proper bone health. (NIH consensus panel, 2001: ACSM position stand: Physical Activity and bone health, 2004)

2. **Exercise and Bone Health: Principles of Training**

Like all exercise training, there are specific principles of training that apply to exercising for bone health. The first is the principle of **specificity**: You need to **specifically stress** the skeletal area of interest in order to produce a bone adaptation. Equally important is the principle of **progressive overload**. Bones must be stressed beyond their "lazy zone" in order to have an exercise effect. As the exercise activities become routine, bones will no longer need to adapt, so either activity type or intensity must be progressed to stimulate further bone adaptations. Bones are stressed by moderate to high impact weight bearing activity and by resistance training. Lastly is the principle of **reversibility** — exercise-induced bone adaptations will be reversed if the exercise is stopped.

3. **What This Means**

Our normal everyday activities are often not adequate to increase or maintain bone mass in order to prevent osteoporosis. **Walking is generally not enough of a weight bearing activity for bone health**. More needs to be done! We need to consciously do activities to help our bones.

4. **What To Do: Kids**

Osteoporosis is considered a "pediatric disease with geriatric consequences." Encouraging children to be active for their bones during growth is essential for achieving a healthy peak bone mass to help prevent osteoporosis later in life. The American College of Sports Medicine recommends the following: Impact activities such as gymnastics, plyometrics, jumping and moderate resistance training (for safety less than 60% of the amount that could be lifted once). Also participating in running sports such as soccer or basketball is likely to be of benefit. Intensity should be high, done at least three days a week for 10-20 minutes.

5. **What To Do: Adults**

The primary purpose of physical activity during adulthood, in regards to bone, is to preserve bone mass. There is a 0.5% loss in bone mass per year after age 40, with even greater losses for women in the years surrounding menopause (up to 5% per year). Therefore maintenance, not necessarily increases, of bone mineral density (BMD) is essential for bone health of the mature skeleton. The ACSM recommends the following for adults: Weight bearing endurance activities (running, tennis, stair climbing), activities that involve jumping (basketball, volleyball) and resistance training. Intensity should be moderate to high, depending on tolerance and safety. Perform weight bearing activities 3-5 times per week and resistance training 2-3 times per week. Duration should be 30-60 minutes combined each day.

6. **What To Do: Older Adults**

Even older adults should maintain as high level of physical activity as possible for bone health. Additionally, any exercise that improves balance and strength may also decrease the risk of falls, which are major contributors to fractures. Thus, if you can decrease falls, you can decreases fractures, even if there is no change in BMD. **According to the ACSM position stand, the incidence of hip fractures is up to 40% lower for active individuals when compared to sedentary individuals**. Thus, any exercise can help! Specifically, older adults should also weight train to their capacity to improve bone strength, BMD and balance.

7. **Other Exercises: Rowing**

Rowing has been found to have a positive impact on bone in young men and women with rowers having higher spine BMD than controls and with rowers increasing spine BMD over training seasons compared to non-rowers. **My own research has shown that postmenopausal women might also benefit from rowing exercise since a sample of postmenopausal rowers had higher spine BMD than non-rowers**. However, other exercises to improve BMD of the hip must also be done in conjunction with rowing for overall bone health.

8. **Examples of Good Resistance Exercises**

Anything that specifically stresses the spine and hip — the following are good examples: Squats, lunges, lat pull-downs, upright or seated row, back extensions.

You should perform exercises at an intensity of less than 60% of the amount that you could lift or push on one repetition.

9. **Other Factors**

Many other factors contribute to good bone health such as adequate calcium and hormonal status. Calcium supplementation as well as medication therapy may also be necessary in some cases, along with exercise, to maximize bone health. (See *NutriTips* on page 6 for more on bone health.)

Bottom Line: Move Those Bones!!!!!! □

Adrienne McNamara, MS is in her PhD program in Exercise Physiology at Oregon State University. She is doing her research work in the bone response to exercise. She is the daughter of Dr. Patrick Hogan.

NutriTips #7

by Joan Brookhyser, RD, CSR, CD

Nutrition and Your Bones

Over 99% of the calcium in your body is found in your bones and teeth. For this reason, calcium is a key component, though not the only component to your bone health.

Factors Contributing to Positive Calcium Balance and Your Bone Health

Most important is getting calcium in your diet everyday. Men and women (premenopausal) need approximately 1000-1200 mg of calcium per day and post menopausal women at least 1500 mg per day. The following is a list of common sources of calcium from dairy and non-dairy foods to help meet your needs.

FOOD SOURCES OF CALCIUM	AMOUNT	CALCIUM (MG)
Milk	1 cup	150 – 200
Yogurt	1 cup	150 – 225
Natural cheeses	1 oz	150 – 200
Calcium fortified orange juice	½ cup	125 – 150
Blackstrap molasses	1 Tb	140 – 150
Tofu	½ cup	100 – 300
Almonds	1/3 cup	120 – 170
Broccoli, Okra, Chinese Cabbage – cooked*	1 cup	150 – 175*

*Note: Calcium absorption in these vegetables is 30-40% higher than other sources listed

Other Nutrients of Importance

- Vitamin D-fortified food sources, egg yolks, sweet potatoes and sunlight
- Magnesium – dark leafy vegetables, nuts, seeds and whole grains
- Isoflavones – soy (milk, tofu, tempeh, soy meat substitutes) and all dried beans, red clover, flax seeds
- Boron – apples, dried fruits, nuts and honey

Factors Contributing to *Negative* Calcium Balance and Bone Health

- Excess protein, salt and alcohol
- **Smoking**
- Caffeinated beverages
- Dark sodas

Supplements

As much as possible try to get your calcium from foods, as there is nothing better for the optimum absorption of calcium. Many of these foods work together with a balance of nutrients to help your bone health. If you do feel you need a calcium supplement, good supplements are those such as calcium citrate, calcium malate or a mixture. Also make sure they contain at least 400 IU of vitamin D to help your calcium be absorbed. Magnesium in the amount of 300-600 mg is also good to take with your supplement since it has been shown to help prevent bone loss. A general multivitamin and mineral supplement is also recommended since other nutrients also play a role in bone health.■

Special Feature

by Jean Borst

Rowing and Kayaking: Get fit, have fun and enjoy the ride!

"It's a great art, is rowing. It's the finest art there is. It's a symphony of motion. And when you're rowing well, why it's nearing perfection. And when you reach perfection you're touching the divine. It touches the you of you's, which is your soul."

— George Pocock

What better way to experience the Pacific Northwest than from the water? From beautiful Puget Sound, to expansive and pristine lakes, to the white- water of our rivers, this is a great place to make water sports a part of your life…and your fitness plan.

Dr. Sid Whaley, a Tacoma dermatologist, took up rowing a decade ago. "My wife introduced me to the sport," he said. "She became involved as a Berkeley undergraduate, although women weren't allowed to row competitively at that time."

The Whaleys row five to six days a week year round in singles on Commencement Bay and in singles or a pair on American Lake. "Rowing in a single is like flying across the water," he says.

Dr. Whaley said that he is often asked for advice by individuals trying to decide between kayaking and rowing. "I tell novices that if the destination they are trying to reach is important, then kayaking is easy to learn and very straight forward. If the means by which you want to get there is paramount, then rowing is a much purer sport. You are still aware of your surroundings – the eagles, seals, mountains – but your main concentration is on your rowing strokes. In that sense, it means you have to leave personal problems on the shore until you return."

While it may look like an upper body sport, rowing actually provides a full body workout and is one of the few athletic activities that involve all of the body's major muscle groups. "Rowing is very easy on the body when done correctly," Dr. Whaley said. "It does demand strength. Upper body strength is important, but the power of the rowing stroke comes from the legs."

Dr. Pat Hogan opts for kayaking as a "perfect way to round out my fitness program of biking and running." But it goes far beyond simple fitness, he explains. "Here in the Northwest, there are so many wonderful, beautiful opportunities for exploring our waterways – lakes, rivers, Puget Sound. I really feel that most people don't take advantage of our surroundings. Kayaking and/or rowing are excellent ways to make the connection with this amazing area we live in."

Rowing and kayaking also offer a good fitness option for individuals concerned about their bone health. According to Dr. Hogan, "studies have shown that a rowing workout puts an extra load on the whole system to prevent bone weakening in the spine. We need to be sure our overall fitness programs include all systems."

The Benefits

In addition to the supreme fitness benefits of the sport, rowing and kayaking are also great for:

• **Cross Training:** If skiing is your winter sport, make rowing your spring, summer, and fall one.

See "Rowing" page 8

The Mechanics of Rowing

The motion of each stroke is made up of four parts that flow into one another: the catch, drive, finish, and recovery. The catch is the start of each stroke when you place your oar into water. As you begin to push with your legs, you are entering the drive of the stroke. When the legs are fully extended, you begin to pull the oar in with your arms and swing your shoulders backward, bringing yourself to the finish position. As you roll your hands back away from your body and bring yourself forward on the slide, you complete the stroke with the recovery. The entire process is repeated, each movement flowing into the next, forming another stroke.

The same technique is used whether you're in the water or in the gym. While they certainly don't offer the scenery and exhilaration of being in a boat, rowing machines provide the same fitness benefits.

Rowing from page 7

• **Weight Loss:** Combined with healthy eating, rowing will help quickly shed pounds as it builds muscle and increases metabolism.

• **Rehab:** Rowing is a low-impact workout, so people recovering from knee injuries can often row even though they can't do other sports. It's a great way to work your lungs for recovering smokers. Or rowing can help you get in shape after a long recess from exercise.

• **Connecting with other people:** To get involved in rowing, contact a local club. Whatever level of participation you're looking for, there is a club out there to meet your needs. Dr. Whaley suggests contacting the Commencement Bay Rowing Club www.combay row.org for more information. "There are also some excellent rowing camps offered during the summer that may help you get over the initial hump of learning." The internet is a great resource for programs in the Puget Sound area.

Dr. Sid Whaley in his single, enjoying the peaceful calm waters of American Lake in early fall

• **Local Competitions:** Not surprisingly, the Pacific Northwest offers a multitude of competitive opportunities for rowers. Local clubs often host Masters' Regattas. The events are fun, low-key and offer a great opportunity to meet other rowers.

• **Regional, National and International Competitions:** You can always take your competitive drive to the next level. There are Masters' Regional, National, and World regattas each year and Boston hosts the annual World Indoor Rowing Championship.

Whether you're looking for a great way to get fit, wanting to complement your workouts with a great cross-training option, or simply want to make a connection with this beautiful area we live in, rowing and kayaking are perfect options. But beware, says Dr. Whaley: "Rowing is an addictive sport, but a wonderful way to stay fit while enjoying yourself." ■

Great Kayaking Trips in the South Puget Sound

- *South Sound Triple Crown (Fox, McNeil and Anderson Islands in a day)*
- *Vashon Island Circumnavigation*
- *Cutts Island*
- *Budd Inlet*
- *Upper Henderson Bay*
- *Henderson Inlet*
- *Maury Island Circumnavigation*
- *Hartstene Island Circumnavigation*
- *Tacoma Narrows Exploration*
- *Shelton Shuttle (Hammersley)*
- *Southworth to Blake Island*
- *Commencement Bay*
- *Steilacoom to Titlow Beach*
- *Longbranch, Pitt Passage & Penrose SP*
- *Grapeview to Jarrell Cove*
- *Squaxin Island Circumnavigation*
- *Dash Point to Alki Beach*
- *Arcadia to Little Skookum Inlet*
- *Pickering Push (Hartstene to McMicken)*
- *Home to Heron*
- *Steilacoom to Luhr Beach*
- *Fox Island Circumnavigation*
- *Owen Beach to Titlow Beach*
- *Eld Inlet*
- *Lake Kapowsin*
- *Olympia to Seattle in One Day*
- *Anderson Island Overnight*
- *Dash Point to Seola Beach and Back*
- *Nisqually Delta Classic*

Patient Safety Foundation board member Matt Rice, MD discusses Patient Safety with PCMS Board of Trustees

Emergency Medicine physician **Dr. Matt Rice** discussed patient safety with the PCMS Board of Trustees at their June 7 board meeting. Dr. Rice is a member of the Board of Directors of the National Patient Safety Foundation and has served as the foundation's former chair and program director.

Five years after the Institute of Medicine (IOM) report "To Err is Human: Building a Safer Health System," Dr. Rice commented on its impact. "I believe that the report leveraged the medical profession into making changes - even if they did not want to, and the level of conversation and concern about medical errors, injuries and safety, has dramatically expanded," he said. While specific data on the impact doesn't exist - due to little data prior to the release of the report and no nationally organized method to determine change - he outlined his beliefs about what the safety movement has accomplished to date.

Matt Rice, MD

• The safety movement has given us a new idea of errors – it is well known that errors occur, but people do get hurt and we, as a profession, need to do better. Some think it doesn't apply to them while others think there but for the grace of God go I.

• Errors should be focused on the system. We think we practice safe medicine, and we actually do, but the systems are complex and often bad outcomes are not the fault of the physician.

• Institutions now know they have to have plans in place and focus on safety as a priority issue. They, too, need to focus on the "systems" approach.

• While quality and safety may be administered from the same office, they are separate. And, while they go hand in hand, they need to be separated out and studied for us to learn.

• Everyone has come to the table on safety and all stakeholders are involved. From Congress and the CDC to JCAHO and the AMA – many organizations, political agencies, etc. are seeing the issue from their perspective. And, it broadens the scope, such as realizing the hazards of stress and fatigue on patient safety.

While Dr. Rice reviewed the accomplishments, he was quick to point out that barriers remain including the complexity of medicine being a major one. "Medicine is more complex than any other profession," he noted. There are more than 50 different types of medical specialties and subspecialties interacting with each other and with other allied health professionals. And, "the more complex any system is, the more chance there is that it might fail," he added.

There are many pressures on the system to change, noted Dr. Rice. "Big systems will be pushing us in this direction whether we want to go or not and the business community has jumped on board in a major way. Training institutions and medical schools are participating and there is huge public demand. The press likes the issue as well and payers will likely force the issue in time."

"Lots of people have the wrong answers and are looking for an easy fix," warned Dr. Rice. "Be careful. Often times we can focus too intently on technology and forget the patient," he warned. There are no quick and easy fixes.

From experience, Dr. Rice has found that bouncing between what's right and what's workable is a viable solution. Speaking from his emergency department routine, it's a balancing act of spending more time with the patient and less time with the patient's record.

For a copy of "Five Years After To Err Is Human – What Have We Learned?," from *JAMA*, May 18, 2005 please call PCMS, 572-3667. ■

Five Years After To Err Is Human – What Have We Learned??

Five years ago, the Institute of Medicine (IOM) called for a national effort to make health care safe. Although progress since then has been slow, the IOM report truly "changed the conversation" to a focus on changing systems, stimulated a broad array of stakeholders to engage in patient safety, and motivated hospitals to adopt new safe practices. The pace of change is likely to accelerate, particularly in implementation of electronic health records, diffusion of safe practices, team training, and full disclosure to patients following injury. If directed toward hospitals that actually achieve high levels of safety, pay for performance could provide additional incentives. But improvement of the magnitude envisioned by the IOM requires a national commitment to strict, ambitious, quantitative, and well-tracked national goals. The Agency for Healthcare Research and Quality should bring together all stakeholders, including payers, to agree on a set of explicit and ambitious goals for patient safety to be reached by 2010.

JAMA. 2005; 293:2384-2390

Retired Members Luncheon Recap

Jim Blankenship, MD Shares Knowledge of Internet Investing

Retired member **Jim Blankenship, MD** spoke at the Retired Physicians Luncheon at Fircrest Golf Club on June 23rd about self directed investing using the internet. His qualifications quickly surfaced as he admitted spending at least an hour and a half EVERY day studying financials on line, and he extended his disclaimer that if his opinions don't serve people well, he isn't to blame, but if his advice brings success, he will take credit.

His fascination and enjoyment of computers started early with an Apple being his initial machine in the early 70s. Combined with the necessity and interest in investing, and the discovery of the world wide web after retirement, he has the tools and time to really enjoy and benefit from his hobby.

He believes that to be successful you must have discipline and not be emotional about investments. He also feels strongly that asset allocation and balancing a portfolio are vitally important. His opinion is that the international market is very important and emerging markets should be included. He doesn't buy the theory that the percentage of bonds in your portfolio should equal your age but thinks stocks should be 60-80% and bonds 20-40% depending upon your comfort level. He is comfortable with international making up 20-40% and emerging markets only ten percent, as they are volatile. He is comfortable with an equal split between small and large caps even though small caps have outdone large over time.

Asking the audience about their access to internet investing, there was a definite split in the room. "You can't do self directed investing without the internet," he cautioned. But he reviewed all the necessary players such as a discount broker (AmeriTrade, Fidelity, Schwab, etc.) and a tracker (Quicken or Microsoft Money), which you can get through a Mutual Fund Company such as Fidelity, Vanguard or T. Rowe Price. His favorite search engine is Google and he highly recommended it for those not familiar with it.

He reviewed Individual Retirement Accounts, both traditional and Roth as well as educational. "My grandson is 4 and he already has $10,000 saved toward his college education," he said proudly.

After reviewing suggested web sites and good books, he shared his hot tip for the day – consider index funds. Since you can't beat the market, in his opinion, index funds are a very solid way to go.■

IN MEMORIAM

WILLIAM BURROWS, MD

1917 - 2005

Dr. William Burrows died March 26, 2005 after a short struggle with cancer.

Dr. Burrows received his medical degree from the University of Minnesota School of Medicine in 1943. After graduation he interned in the U.S. Navy where he served as a doctor on the troop transport ship, USS Barnstable in the South Pacific. He helped found the Good Samaritan Hospital in the 1950s and is said to have stopped counting after he delivered 1400 babies.

Dr. Burrows practiced general medicine in Puyallup from 1947 until his retirement in 1985.

PCMS extends condolences to Dr. Burrows' family.

William Burrows, MD

The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

West Nile Virus

Federico Cruz, MD

As of the writing of this article, Washington continues to be the only state in the contiguous U.S. where West Nile Virus (WNV) has not infected a human. Public Health experts predict 2005 is the year we'll see cases in our state and probably our own community.

There is not much new to report about the illness. Carried by birds and spread to humans via mosquitoes, the clinical features of West Nile Fever include: fever, headache, fatigue, and occasionally skin rash on the trunk of the body, swollen lymph glands, and eye pain. When the central nervous system is impacted by WNV, syndromes range from febrile headache to aseptic meningitis to encephalitis.

Before 1999, the virus was found only in the Eastern Hemisphere including Africa, Asia, the Middle East and Europe. Since the mid-1990s, outbreaks of West Nile Virus have increased and the virus first appeared in New York City in 1999. Since that time, it has spread rapidly throughout the country. West Nile Virus appears to be firmly established in the United States; researchers expect its continued spread in the future.

The West Nile Virus is spread to people and animals by infected mosquitoes. There is no evidence that West Nile Virus is spread directly from person to person, animal to person or animal-to-animal. In areas where the virus is found, less than one percent of the mosquitoes carry the virus. When bitten by an infected mosquito, less than one percent of people become seriously ill.

Some people can experience mild symptoms about 3-15 days after a mosquito bite. Most don't experience any symptoms and recover with no medical treatment. There is no specific treatment for the virus and no vaccine available for humans.

The most important strategy for WNV is to prevent mosquito bites by reducing mosquito habitat around your home by:

- Making sure window and door screens are "bug tight."
- Staying indoors at dawn and dusk when mosquitoes are the most active.
- Wearing clothes to protect skin when going into mosquito-infested areas.
- Using mosquito repellant.
- Emptying anything that holds standing water.
- Changing water in birdbaths, fountains, wading pools and animal troughs weekly.
- Making sure roof gutters drain properly.

To check the presence of the West Nile Virus, local county and city agencies have begun surveillance activities, sampling birds, mosquitoes and keeping track of reported cases of WNV. To report a dead bird or mosquito infestation, or to ask other questions, please call health department staff at: 253 798-6578.

In My Opinion

by Alan Tice, 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 Point Defiance Runners

Alan Tice, MD

It was great to see the Point Defiance Runners featured on the front of the Pierce County Medical Society *Bulletin* in the April issue.

As one of the founders of the group, it is also great to see the number of people involved and the dedication to physical fitness and camaraderie. It is a pleasure to run through the park and its pristine environment and tasty blackberries along the paths and to envision the Indians who must have approached the fort a century ago.

I miss running with the group on Saturdays and Sundays although I do get back occasionally and find they have stayed in better shape than I.

In return for the good times with the runners in the park, I would like to offer an invitation, if not a challenge to the members of PCMS to join me over here in Hawaii to run the Hawaii marathon. It is shaping up for December 10 - plenty of time to train. See website at: http://www.honolulumarathon.org.

Let me know if you are interested.■

Dr. Tice can be reached by e-mail: alantice@idlinks.com
or home address: 5641 Kalanialaole Highway, Honolulu HI 96821

Members Complete Sound To Narrows 2005

Dr. Tom Herron, Gig Harbor pediatrician was the **56th person of nearly 6,000 to cross the finish line** in the 32nd annual Sound to Narrows Run on June 11. Dr. Herron finished second in his age division with a time of 47:47. Congratulations, Dr. Herron!!!

Special recognition also goes to **Dr. Cordell Bahn**, retired cardiovascular surgeon who has run in EVERY Sound to Narrows event for 32 years. He almost missed one year due to a family wedding, but fortunately was able to make arrangements at the last minute. Dr. Bahn completed his 32nd running in 1:21:02.

Several physicians completed the 12k (7.46 mile) challenging run in **UNDER ONE HOUR!**

Tom Herron, MD, Gig Harbor Pediatrician: **47:47**

Steve Pace, MD, Tacoma Emergency Physician: **55:37**

Harald Schoeppner, MD, Tacoma Gastroenterologist: **55:39**

Stephen Elder, MD, Tacoma Anesthesiologist: **57:26**

Patrick Hogan, DO, Tacoma Neurologist: **58:01**

Loren Betteridge, MD, Tacoma Family Physician: **58:12**

James Schopp, MD, Tacoma General Surgeon: **59:20**

Other finishers include:

Robert Ettlinger, MD, Tacoma Rheumatologist
William Hirota, MD, Lakewood Gastroenterologist
Bill Jackson, MD, Tacoma Radiologist
David Law, MD, Tacoma Internist
Michael Priebe, MD, Tacoma Gastroenterologist
Jim Rooks, MD, Lakewood Otolaryngologist
Sumner Schoenike, MD, Lakewood Pediatrician

PCMS congratulates all members and their families on accomplishing such a physically challenging event.

Unfortunately, the results of the run were not published in the newspaper for review, making it difficult to track members who participated. Results were available on line but only by entering a person's name. There were not lists that you could access for review. Consequently, many members that did participate may not be included in this report.

IF YOU WERE A PARTICIPANT IN THE SOUND TO NARROWS, BUT ARE NOT LISTED IN THIS REPORT, PLEASE CALL THE MEDICAL SOCIETY OFFICE AND WE WILL RUN ADDITIONAL NAMES NEXT MONTH.

Apologies are extended to those members we missed, and again, congratulations to all finishers. ■

Court Declines Managed Care Suit

The U.S. Supreme Court said it would not take a case in which several HMOs wanted justices to rule that physician's lawsuits against the insurers must go to arbitration in lieu of a class-action lawsuit.

The ruling means that lawsuits against Humana, PacifiCare Health Systems, United Health Care and others will go forward, with a trial scheduled for September in federal court in Miami. Anthem and WellPoint have merged since the lawsuits were initially filed.

Physicians and some medical societies sued the nation's largest health plans in federal courts, accusing the HMOs of systematically denying or downcoding claims. ■

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.*

To MOC or not to MOC

Andrew Statson, MD

"If a little knowledge is dangerous, where is the man who has so much as to be out of danger?"
Thomas Henry Huxley (1877)

In case you need to be reminded, MOC stands for Maintenance of Certification. Usually, it refers to the new annual recertification process. With their latest project, the Boards strive to keep us from wallowing in our errant ways. They aim to take us to the land of divine perfection, where no doctor shall ever make a mistake, and where no patient shall ever have a complication. After all, we are expected to walk on water, aren't we?

To reinforce its stand and to subdue any opposition to the new method of recertification, should there be any, the American Board of Internal Medicine commissioned a poll by the Gallup Organization, which was carried out in July 2003. The results of that poll are reported in full on the web site of ABIM (www.abim.org).

Among the usual questions about their age, sex, and contact with the health care system, people were asked a few questions that stand out because of the assumption that the general public has any idea what they mean.

One of them was: Out of the 160 hours a month (40 hours per week) that doctors work, how many hours should they spend keeping up with new developments in their field? 1-2? 3-5? 6-10? The answers to this question are irrelevant. I found amazing the following assumptions: that people could know how much reading we should do, that doctors worked forty hours per week, and that the time for education came out of those hours.

In real life, a physician who works forty hours per week is a part-timer. Our usual work week is sixty hours, day in and day out, and another twenty hours, perhaps, for being on call. Any reading we do is on top of that.

In my field, we have the Green Journal and the Gray Journal. Just going through them every month and critically analyzing only a few of the articles, would take more than ten hours.

We listen to medical tapes when we drive. We read every chance we get. We read at the dinner table, we read sitting on the john, we read in bed, we even tuck a journal under our pillow and read in our sleep. How could people who are not in medicine understand the amount of time we spend reading about medicine?

The key question in that poll, however, the one the ABIM needed to justify its procedures and even its existence, had to do with board certification. When the people were asked whether their doctors should be board certified, that is, be examined by an independent organization to ascertain their knowledge and fitness to practice, 98% of the responders said yes.

Wow! 98%! That is how many of the Iraqis agreed that Saddam should be their president, but I am sure the Gallup pollsters did not use his methods of persuasion to obtain this result.

I don't remember the last time 98% of Americans agreed on anything. That beats motherhood and apple pie. Unless given the option of apple pie or no pie at all, at least 5% would go for cherry. I suspect pecan and pumpkin would gather another 10% each. As for motherhood, well, why do so many people use birth control?

If the purpose of board certification is to test our fitness to practice, what then is state licensing for?

To return to the issue of certification, during my forty years in practice I don't ever remember a patient asking whether I was board certified, let alone wanting to know what that was. Some of us have it on our letterhead, but I wonder how many patients understand what it means or even pay attention to it.

This answer, assuming it reflects the thinking of people who understood the question, suggests that the trial lawyers have succeeded in convincing the public that doctors, left to themselves, are

See "MOC" page 18

Applicants for Membership

John B. Bak, MD
Urology
Northwest Urology Center
1624 South I Street #204, Tacoma
253-272-8441
Med School: Georgetown Medical School
Internship: Upstate Medical University
Residency: Upstate Medical University

Klaus Mergener, MD PhD
Internal Medicine/Gastroenterology
Digestive Health Specialists
1901 S Union #B4006, Tacoma
253-272-5127
Med School: Heidelberg University
Internship: Duke University
Residency: Duke University
Fellowship: Duke University

Filiz Millik, MD
Pediatrics/Allergy/Immunology
Allergy & Immunology Specialty Service
3909 10th Street SE #2, Puyallup
253-848-9484
Med School: Hacettepe School of Med
Internship: Columbia & St. John Hospital
Residency: Columbia & St. John Hospital
Fellowship: Rush University

Ambre L. Olsen, MD
Urogynecology
Northwest Urogynecology (FHS)
11311 Bridgeport Wy SW #311, Lakewood
253-512-2733
Med School: University of Washington
Internship: Oregon Health Sciences Univ
Residency: Oregon Health Sciences Univ
Fellowship: Oregon Health Sciences Univ

Steven A. Pace, MD
Emergency Medicine
Tacoma Emergency Care Physicians
315 Martin L King Jr Way, Tacoma
253-403-1050
Med School: University of Washington
Internship: Gorgas Hospital
Residency: Kern Medical Center

Megan Struthers, MD
Pediatrics
University Place Pediatric Clinic
1033 Regents Blvd #102, Fircrest
253-564-1115
Med School: UC San Diego
Internship: UW/Children's Hospital/MC
Residency: UW/Children's Hospital/MC

Patrick J. Vaughan, MD
Orthopaedic Surgery
Tacoma Orthopaedic Surgeons
2420 South Union #300, Tacoma
253-756-0888
Med School: Georgetown University
Internship: Virginia Commonwealth Univ
Residency: Virginia Commonwealth Univ

In My Opinion

by Thomas Bageant, 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.

Opinions for Improving Medical Care and Lowering Costs

(Emphasis on Washington State)

Thomas Bageant, MD

Insurance Claim Forms

One common claim form should suffice for all third parties. This would reduce clerical expenses and save money for patient care.

Procedural Codes

There should be one set of procedural codes used by all third parties. It is a clerical nightmare to provide different codes for Medicare, State Industrial Disability, private insurances, and DSHS (welfare). Medicare has even threatened physicians with fines and jail time if they use an incorrect code. A common set of acceptable codes would simplify office work and save money.

Tort Reform

Effective tort reform is needed. Proper reform will improve the availability of health care and lower the inflation of costs. It will also protect all small businesses from frivolous suits and excessive jury awards. There should be caps for "pain and suffering." There should be caps for lawyer's fees. Medical care funds should be used for patient care and not be drained off by lawyers, insurance companies, or drug companies. Some lawyers believe that any physician who has lost three court decisions should be punished. Should not lawyers be held to the same standard? If a lawyer loses three or more legal decisions should he/she not also be punished?

CMEs (Continuing Medical Education credits)

Washington State, and many other states, require continuing education credits for licensed professionals within the state. The efforts of this program seem politically correct but, in fact, these efforts do not insure adequate education for licensed professionals. This program has supported a growing industry of educational courses that drain even more funds away from patient care. Physicians can acquire credits in fields that have nothing to do with their specialty. This program has never been adequately audited and I believe it should be terminated. It has not been cost effective. Is it improving patient care?

"Any Willing Provider Law"

In Washington State, this law has allowed virtually anyone to claim themselves as a provider of health care and receive compensation from insurance companies. Many insurance companies have abandoned Washington State and those companies that have remained have been forced to raise their rates. This law has been a "special interest windfall" for providers of alternative care. Alternative care providers are not held to the standards of physicians. Once again funds have been diverted from conventional care and alternative care has not improved the health status of our citizens. This law should be repealed.

Health Insurance Policies

Insurance companies should be allowed to offer basic care policies for conventional care, along with psychiatric care, only. Even a-la-carte policies should be allowed and offered. Many citizens no longer need obstetric or pediatric coverage and men have never needed gynecologic coverage.

JCAHO (Joint Commission)

This independent commission started as a well intended effort to improve care and documentation in hospitals within the United States. It has become a huge, expensive, bureaucratic bully. The "cost benefit ratio" derived from Commission reviews can not justify its existence. The hospitals within our community should no longer seek the services of JCAHO. This course of action would save large sums of money that could provide more and better patient care.

Drug Costs

Large cooperatives should be formed and allowed to import FDA approved drugs from reputable companies through out the world. The exclusive copyrights to new drugs held by drug companies, should have a shorter life span. A broad spectrum formulary of inexpensive drugs should be made available to all citizens.

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drooling ignoramuses, and if they learned anything in medical school, they promptly forgot it upon graduation, so that they need to be continually reeducated, then tested to make sure they got it, whatever "it" is.

The attorneys, however, could not have accomplished that feat without the help of our faculty physicians. There was a time when physicians went into academic medicine for the prestige of becoming professors. They wanted to teach, to do research and to write for publication. Those who wanted to make money went into private practice.

Faculty physicians were notoriously underpaid and mandatory CME gave them the opportunity to catch up in income with the private practitioners. Now they have overtaken us. Not that they shouldn't earn more than we do, but it shouldn't be under false pretenses.

The official reason for mandatory CME was to assure the public that doctors keep up with advances in their field, and by doing so, they would avoid making mistakes. The goal of mandatory CME was to reduce our liability exposure by improving medical practice.

Unfortunately, CME did not achieve its goal. If we were to compare liability premiums, number and incidence of lawsuits, expenses for their defense, awards to plaintiffs, or any other parameter, even adjusted for inflation and population growth, between now and the early 1970's, when CME became mandatory, the conclusion can only be that the program failed horribly.

Improving medical practice did not require a mandate. Lifelong learning has been the hallmark of our profession since before Hippocrates. We learn from our experience and from the experience of others. We learn from experimentation. We learn by trial and error. Here comes that dreaded word again, error.

Humans are not mechanical models where we can know in advance how they will perform. In reality, all our treatments are trials. We learn from them by the result they produce.

Electronic chips are more complex than mechanical structures and frequently do unexpected things. However, once we have designed them, we can run multiple routines to test their performance. Then we can mass produce them and expect from every one of them a performance similar to that seen in the lab. But even then, there is a large number of rejects, and we can never be sure how the chips would perform on routines not tested.

Humans are much more complex than chips, but also, every one of us is an individual, different from everyone else. We don't come stamped out from a template. That is why the result of a treatment may be different from what we expect, and frequently is.

There was a time when board certification was a distinction, not a requirement for staff appointments or insurance contracts. As it became universal, its meaning cheapened. Now it is the equivalent of what a medical diploma was in the past.

This is another example of what educators call grade inflation. A college degree today is about equivalent to a high school diploma a generation or two ago. When nobody is left behind, nobody can get ahead. We all are in a pack.

That is only one part of our problem. Another part is the choice and the formulation of the questions on board examinations and the proper answers to them. I overheard a few family physicians who had to take the certification before the end of last year. They said that some of the questions allowed two or more correct answers, while others called for answers that were demonstrably wrong.

To go back to the quote by Huxley at the beginning of this article, where are the examiners who know so much as to be out of danger? ■

COLLEGE OF MEDICAL EDUCATION

Hawaii 2006... Make Plans Now!

Arrangements for the very popular Hawaii CME program have been finalized for the 2006 program which will be held Sunday April 2 to Friday April 7, 2006.

Upon request of previous physician attendees, we will return to the very popular **Hapuna Beach Prince Hotel on the Island of Hawaii**. Hapuna's beach has been rated the number one beach in America featuring a long stretch of white, pristine sand.

Both lodging and air travel arrangements have been secured at greatly discounted prices, but you MUST REGISTER EARLY to lock in the discounted rates.

To make travel arrangements, please call Jeanette at All Wanderlands Travel in Tacoma. Jeanette will be happy to assist you in arranging your travel plans. Her phone number is 253-572-6271. DO IT TODAY! Plan early and make it easy.

The course agenda and brochure is in production and will be mailed in the next few weeks.

Call the College, 627-7137 for more information. ■

The Results Are In!

The College of Medical Education (COME) has received and tallied 179 responses to its survey asking medical society members about the College, its venues, program topics, etc.

The College programs are well utilized by the membership with 73 percent of responders indicating they attend College courses. The vast majority (64 percent) also prefer the most used format of one-day courses offering six hours of credit. Preferred days: 40 percent picked Friday, 23 percent picked Thursday, and 19 percent each chose Saturday and Wednesday.

With occasional requests for programs to be held in cities other than Tacoma, members were asked their preferences for Fircrest, Gig Harbor, Lakewood, Puyallup and Tacoma. Tacoma was clearly favored with 140 responses (78%), Fircrest followed with 118 responses (66%), then Lakewood (45%), Gig Harbor (31%) and Puyallup (25%). This clearly supports programs in the Tacoma/Fircrest corridor where most are currently held at St. Joseph Medical Center and Fircrest Golf Club.

The College has enjoyed years of great support and sponsorships from pharmaceutical companies which has enabled the College to offer most of their high quality CME programs at no cost to participants. With future support uncertain, implementation of course fees is a real possibility and it is reassuring to learn that 67% of respondents indicated that having to pay a nominal fee would not prevent them from attending. Twenty percent indicated a fee would prevent them from participating. The majority of support indicated that $100 would be the maximum fee they would be willing to pay for a full day course.

PCMS members were also asked to rank their level of interest in specific topics for future COME courses. The top 10 topics include:

• Infectious Diseases	26 percent
• Dermatology	19 percent
• Cardiology	18 percent
• Pain Management	16 percent
• Geriatrics	16 percent
• Orthopedics	15 percent
• Mental Health	15 percent
• Endocrinology	14 percent
• Neurology	13 percent
• Sports Medicine	13 percent

The College Board of Directors is working on setting the course calendar for 2006. Watch the PCMS *Bulletin* as well as your mail for the soon to be released annual calendar.

To receive a copy of the survey results, call the College at 253-627-7137. ■

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Patient's Privacy Rights

Current law has increased office expenses, wastes time, seems to be politically correct, and has impaired necessary communication needed for efficient patient care. The efforts to protect patient's rights should not be aimed at the innocent, it should be punitive for the guilty. Any person, or institution, who releases a patient's medical information that leads to the patient losing a job, failure to be employed, slanders the patient, prevents insurance coverage, or in any way harms that patient, should be held liable. The current law should be replaced.

B & O Tax (Business and Occupation Tax)

In Washington State there is currently no income tax but there is a tax on gross receipts, even if that business fails to make a profit. This tax is applied at both the state and city level thus providing a horrible environment for businesses in Washington State. This includes the practice of medicine. I believe this tax should be eliminated.

I firmly believe the use of all tobacco products should be banned in public places. I believe "junk food" should be defined, banned in all schools, and heavily taxed. Fluoride should be in all municipal water systems. Uninhibited stem cell research, supported by our government, should be allowed without political restrictions. These suggestions would decrease tobacco related disease, help decrease obesity related disease, improve dental health, and support the future of our healthcare system. Public health would improve.

These are just a few of my thoughts and opinions that I believe would decrease the cost of medical care, improve the environment for small businesses, increase the competition between companies offering health care insurance, lower the cost of liability insurance for businesses, improve public health, and vastly increase the percentage of health care dollars used for patient care. ■

C H A M P

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Bill Roes, MD	884-9221
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Doctors Statewide Contributing to Yes on I330/No on I336

Statewide, physicians are contributing to the Initiative 330 campaign, the Health Care Access Initiative for tort reform for Washington State. Financial support will not only help ensure passage of I330 but will help DEFEAT Initiative 336, the retribution initiative being sponsored by personal injury attorneys.

Peter Marsh, MD is the WSMA Field Marshall leading the charge to raise funds in Pierce County. Assisted by many colleagues and PCMS staff, he is inching toward the Pierce County goal of $316,000. At press time, 41% of this goal has been met, with $130,140 having been received from Pierce County physicians. Other counties are moving forward with their goals as follows:

Benton Franklin, 41% of goal
Clark, 27% of goal
King, 30% of goal
Pierce, 41% of goal
Spokane, 89% of goal
Thurston, 67% of goal
Mason, 99% of goal
Lewis, 62% of goal
Grays Harbor, 23% of goal
Yakima, 127% of goal
Whatcom, 65% of goal

For a complete listing of contributors to the campaign designated into gold, silver or bronze categories, please see the insert ***Tort Reform, Yes on I330/No on I336*** in this month's *Bulletin*. ■

Classified Advertising

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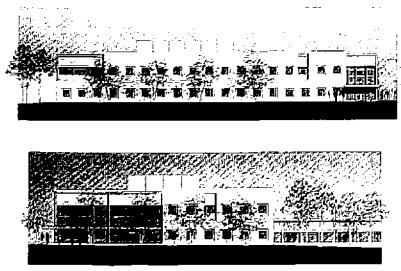

architect rendering

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*As of 1/05, these specialties have received space in St. Clare Pavilion

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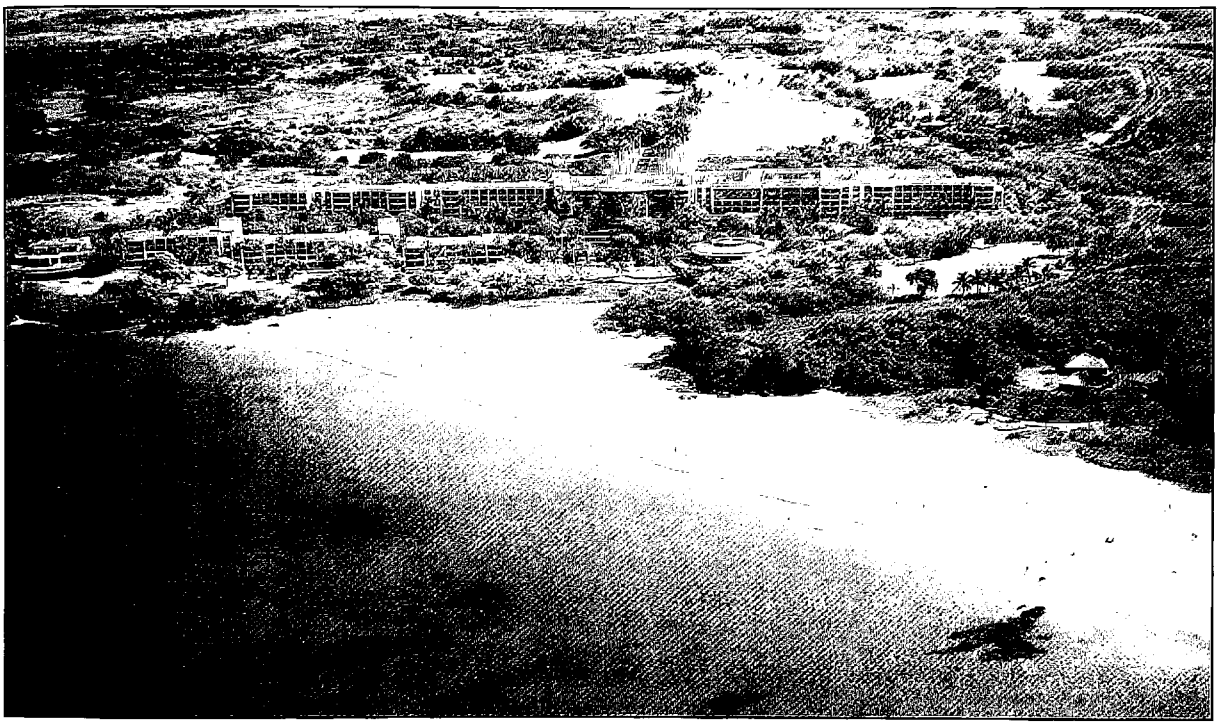
Pierce County Medical Society

BULLETIN

August, 2005



Hapuna Beach Prince Hotel

To view in real time, with your friends, family and colleagues, make your reservations today for Hawaii and CME 2006 (more info page 21)

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.

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Pierce County Medical Society
BULLETIN

August, 2005

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President's Page

by Patrick J. Hogan, DO

Patrick J. Hogan, DO

Adaptation to Change: A Key to Lifelong Health and Happiness

We have to continually adapt to change. Change can be stressful if resisted without adaptability. Change is inevitable but our human condition has the remarkably fortunate ability to adapt in order to maintain our happiness and function. Some of the many examples of change that affect all of us are noted below.

Adaptation to the changes of aging is a continuous process. Those that are most successful with this process are aging with fewer consequences and without losing the zest for life. A large part of facilitating this adaptation is maintaining an adequate exercise program for both the mind and body. **The body and mind will respond to a challenge that is presented to it.** Exercise will prevent the weight gain of older years and stimulate the brain's synaptic connection needed to maintain balance and strength. This is best accomplished by a comprehensive program of aerobic exercise, strength training, as well as **Yoga and Pilates as discussed in this month's *FitTips*.**

CHAMP (Coalition for Healthy Active Medical Professionals) has been formed to assist medical personnel and patients towards adapting with a regular exercise program.

Maintaining active, challenging thought will also forestall the cognitive changes of aging by exercising the synaptic connections needed for memory and integrated thinking.

We are fortunate to have the human system that will adapt to progressive physical activity and be healthier for it. It just takes a slow, steady progression in exercise levels to allow the body to assimilate the benefits without overstressing the system.

As an example in case, I had been training for the Oregon Pacific Trail 50 mile run that I did on July 30 in part as an experiment in the adaptation of the human body and in part as a fund raiser for CHAMP. As of one year ago I would consider a long run to be 10 miles. With the process of slow adaptation with longer runs over the months, my body can now accept a 30 mile run as a training run and can tolerate a 50 mile run. No one needs to run a 50 miler for conditioning unless you want to raise money for CHAMP. However, it demonstrates that anyone who is now sedentary can adapt to 30 minutes of exercise in a day or a person used to 2000 steps per day can adapt to 10,000 steps per day. **So whether the goal of exercise is to forestall aging effects, weight loss or conditioning for overall health, steady perseverance and consequent adaptation will successfully achieve the exercise intensity necessary to achieve your goals.**

Not only are we adapting to our own aging, there is also the psychological adapting process to the **changes of aging occurring in our loved ones** whether they are teenagers going through a revolting stage or a parent suffering the hardships of older age. The psychological adaptation to these changes can be one of the most stressful times in person's life. Adaptation skills will make these transition times healthier for our minds to handle.

Adapting to alterations in our bodies from disorders or injury: In our daily interactions with patients, we see a wide spectrum of levels of adaptation to illness or disorders of the body. There are some that are devastated psychologically by their loss of functions and there are **those that remarkably adapt** to continue to be happy and productive in spite of their limitations.

Those that are injured also can either become disabled by the limitations from the changes of the injury or have the attitude to adapt and excel in the rehab process to return rapidly to their previous capabilities.

One of the most remarkable examples of adaptation to a disorder is that of Harry Cordellos. He was born near blind at birth and was totally blind by later teenage years. His book *"No Limits"* describes how he became an accomplished photographer, wood power tool craftsman, high board diver, champion trick water-skier, rock climber, and the world's greatest blind athlete in marathons, ultramarathons and triathalons. **We are extremely fortunate to have the once-in-a-lifetime opportunity to hear his entertaining and motivational speech at our October General Membership Meeting. Please mark the date now. It is a talk no one will ever forget.**

Adapting attitudes to [illegible]

See "Adaptation" page 4

Adaptation from page 3

public health issues: At times we have to fight to accomplish a change for the good of our world. **Tobacco use in public places** had been a part of our society until the process was started 20 years ago to change that society norm. We are now on the verge of all public places in Washington being smoke free come its passage in the November election. Many thanks to those that helped with this process over the decades and with the signature gathering for initiative 901. There will be those that resist this change as being an infringement on smokers' rights when in fact **the greater good of enhancement of the right of smoke free air will prevail.** Those that resist this change will ultimately adapt and our society will be a better place to live.

Adapting to medical economics changes have been very traumatic for many physicians. This has required continual adaptation to maintain our happiness in our profession. **Our work over the next few months to accomplish the passage of I-330** in November will produce a positive change in the litigation system. The dark side lawyers will initially battle against these changes but they too will eventually adapt to what is best for our world. See *I-330 Corner* (page 13) for the update on what we can do to accomplish this change in November.

Despite all the changes in our medical economic climate, physicians will continue to **adapt to provide excellent care for our patients** and provide for those that depend on us financially. There are others in the insurance and legal professions that suggest that physicians need a Pay for Performance system or threats of litigation in order to compel us to do excellent work. However, each of us knows that what keeps us providing excellent care for our patients is our own integrity as professionals knowing that we must provide the best care possible despite the hurdles the insurance and legal profession puts in front of us.

As Steve Prefontaine said of his running, "to give anything less than my best is to sacrifice the gift." **As medical professionals we will adapt to do our best no matter what the circumstances.**

By the way, thank you to all that contributed with donations toward my 50 mile run to the cause of fitness in our community. The money raised will be effectively used for the CHAMP goals. Further contributions through PCMS of $5 or more are still greatly appreciated toward the planned fitness projects in the upcoming months. ■

FitTips #8

by Lois Zoltani, MS and Patrick Hogan, DO

A Lifelong Guide to Wellness: Yoga, Pilates and Health

Getting Started

1) It is always sensible to check with your physician before embarking on any exercise program, especially if you have any medical conditions or are convalescing or recovering from an injury.

2) The techniques will be clarified in a class or video. Generally speaking begin each session with relaxation postures, then do some warming-up, relax between poses (asanas), practice balancing poses, and end with more relaxation postures.

3) Do not force your body into positions that it is not ready to perform.

4) Proper controlled breathing is an important part of many poses.

5) To permit freedom of movement, clothing should be loose and comfortable.

6) The best way to approach your Yoga and/or Pilates practice is "open, empty, and bare." That means, come with an open mind, an empty stomach, and bare feet.

Benefits of Yoga and Pilates

1) Anyone can do Yoga and it is a good gateway activity to developing an exercise program if a person has not otherwise been physically active.

2) Yoga and Pilates are dynamic mind and body exercises. These have now merged into the mainstream of exercise programs in our culture because of the recognized improvement in balance, core strength, breathing patterns and posture as well as definite stress release.

3) Yoga produces a centering and increased body awareness and body confidence that has far reaching benefits. People lose weight just by doing weekly Yoga.

4) Physical benefits: It is often said that "You are as young as your spine." The poses initially focus on increasing and maintaining flexibility of the spine. Practicing the poses on a regular basis will build stamina and invigorate the body.

5) The gentle stretching, twisting, and bending movements bring flexibility to the other joints and muscles of the body, as well as suggested benefits to internal organs. Bad posture that has been linked to backaches and knee problems is improved with Yoga and Pilates. Each time you practice yoga, you take your joints through their full range of motion enhancing flexibility that is helpful in all other sports and daily life.

6) With normal aging and with many disorders, proprioception is impaired (the ability to feel what your body is doing and where it is in space). This greatly decreased balance and the ability to perform daily life activities or sport activities. Eventually this leads to falling and is one of the greatest causes for loss of independence and nursing home admissions. Yoga and Pilates are the best means of improving proprioception, strengthening the core muscles and preventing loss of balance or improving balance already lost. The improved posture and balance will benefit all aspects of daily life and the ability to do other exercise or sport activities.

7) Yoga promotes relaxation and consciously slows breathing forcing focus on the present. This encourages shifting the balance from the sympathetic nervous system (or the fight-or-flight response) to the parasympathetic nervous system. The later is calming, it lowers breathing and heart rates, decreases blood pressure, and increases blood flow to internal organs. Herbert Benson, MD refers to this as the "relaxation response." **Most current relaxation techniques are based on the principles of yoga.**

8) Studies have found that regular Yoga and Pilates practice lowers the resting heart rate, increases endurance, and can improve your maximum uptake of oxygen during exercise – all reflection of improved aerobic conditioning.

9) There are many ways Yoga and Pilates exercises improve your health. When you improve your posture, you improve your breathing. Changing your breathing and movement patterns lead positive synaptic changes in your nervous system. Every system in the body is connected. Yoga and Pilates improves your sense of well-being physically, mentally and spiritually. This improves your outlook on life and your interactions with other people.

10) Yoga and Pilates gets your blood flowing, ensuring a rich supply of nutrients and oxygen, especially in your hands and feet. Yoga can help with a wide range of problems, such as PMS, arthritis, insomnia, backache, and help with poor posture.

11) It's well proven that weight-bearing exercise strengthens bones and may help prevent osteoporosis. Many postures in Yoga and Pilates require that you lift your own weight.

12) Those who practice Yoga inverted poses have noted improved digestive functions.

13) When you move in and out of the different postures, you contract and stretch muscle and compress organs, enhancing lymphatic drainage.

14) Yoga and Pilates gives you the tools to help you change, and you usually start to feel better the first time you practice some of these exercises. You may also notice that the more you commit to practice, the more you benefit. This makes it possible for you to get involved in your own care, which leads to power to effect change, and this can lead to hope. Hope in itself is part of the healing process.

15) There are many branches of Yoga practice each with a different focus. Hatha yoga emphasizes concentration and more gentle stretching and strengthening. Power Yoga (Ashtanga) emphasizes more constant movement to promote flexibility, stamina and strength. Bikram yoga enhances flexibility but the heated room that it is usually conducted in can be dangerous and is without clear benefit. Many other Yoga forms are available that can be individualized to a person's preferences.

NutriTips #8

by Joan Brookhyser, RD, CSR, CD

Vegetarianism Myths and Facts

Are you thinking of going vegetarian? Or is a loved one thinking of making this change? If so, you are joining the ranks of over 5% of the American population who choose only plant based eating and a much higher percentage choosing a greater amount of plant based eating than they were previously. The reasons vary from environmental issues, animal rights concerns and many more for health reasons to slow down the progression of "diseases of affluence," aka cancer, heart disease and arthritis, to name a few. There are still many myths regarding this diet choice. Here are a few of those myths and facts to get them straight:

MYTH: *You cannot get enough protein on a vegetarian diet.*
FACT: You *can* get enough protein with a plant based diet. Good sources of plant based protein are: tofu, dried cooked beans, nuts and seeds and whole grains.

MYTH: *You cannot get enough calcium without using milk products.*
FACT: There are many ways to get calcium without dairy products; the easiest is with fortified foods such as calcium fortified juices and soy milk. In addition, foods such as almonds, black strap molasses and cooked greens can also provide good sources of calcium.

MYTH: *A diet with animal products is just as healthy as one without animal products.*
FACT: A vegetarian diet can provide added protection against several types of cancer, in addition to heart disease, and digestive problems. In addition, a vegetarian diet may provide added protection against kidney disease progression and diabetes management.

MYTH: *You will become iron deficient on a vegetarian diet.*
FACT: It is just as easy to become deficient in iron on a poorly planned diet with animal protein foods as one with plant based protein foods. Good sources of iron to include every day are black strap molasses, iron fortified cereals, firm tofu, nuts, seeds and dried cooked beans.

MYTH: *Children and teens should not follow a vegetarian diet.*
FACT: Children and teens can follow a vegetarian diet as long as they are following a well balanced vegetarian diet. In fact, picky children often do not like meat; and vegetarian foods offer a great alternative to meat. With teens, again the key is balance, and making sure they are getting the appropriate servings of nutrients from each food group. For example if they are not drinking milk are they getting enough servings of alternative sources for calcium. If they are not eating meat are they eating enough other protein foods (i.e. not just a bagel for lunch). ■

Next *NutriTips*: A Vegetarian Food Guide for Balanced Eating.

References: *Child of Mine* – Ellen Sater
Becoming Vegetarian – Vesanto Melina

In My Opinion

by Lois Zoltani, MS

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Success with Exercise Adherence: The Benefits of Adding Yoga and Pilates To Your Exercise Program

"What a shame it is to grow old without knowing the beauty of which the body is capable."
Socrates

Exercise adherence is a hard "sell." We so often hear "exercise and eat right." The fact of the matter is most media reports and research studies regarding exercise adherence indicate it is hard for many individuals to establish maintenance. As Americans, we've all heard about the number of people who are inactive, over-weight and obese, and have seen the data about the severe costs of this epidemiological problem. The Center for Disease Control presents numerous facts of several health disorders resulting from a sedentary lifestyle. Enough already! Despite all the warnings, the bottom line is if you are not ready for change toward a healthy lifestyle, it is not going to happen. **This is why it is important to examine the patterns of behavior change toward a better lifestyle and greater fitness.**

There are five basic stages that one must go through before change of behavior occurs. The findings reflect patterns for stages of adopting and maintaining the new behavior.

1) Precontemplation – not exercising (sedentary)
2) Contemplation – not exercising but thinking of starting
3) Preparation- exercising occasionally, intending to do so regularly
4) Action – exercising regularly for less than 6 months
5) Maintenance – exercising regularly.

The research suggests people initiate change by moving through these stages representing their readiness to change. As people move through the stages, they come to realize that the advantages of the behavior change outweigh any perceived disadvantages. This information acts as positive reinforcement while you train yourself to behave in a new way. Individuals initiating change also need to increase their self-efficacy. Self-efficacy is a **person's belief in their ability** to be successful at exercise. Motivational techniques assist the individual in self-efficacy for overcoming barriers and their previous lifestyle and will contribute to establishing the maintenance stage of life long regular exercise.

Barriers: Why People Do Not Exercise

1. Not enough time. Commuting, work, kids, activities, church, family, eating, & relaxation and sleep. Many people can't organize their day to fit in exercise.

2. Don't like to exercise. Exercise has been used as punishment.

3. Fear and Embarrassment. Fear of being seen if you are fat or obese. Fear of being embarrassed or intimidated when starting an exercise program.

See "Success" page 8

Lois Zoltani in excellent form

Pat Hogan and Joan Brookhyser practicing

Success from page 7

4. Fear for safety such in the inner city or parks.
5. Not knowing how to exercise.
6. Lack of support from spouse.
7. Perceived poor health...not in shape to get into shape, or fear of having a heart attack. It is good to check in with your doctor but one might say it is a good recommendation to **"check in with you doctor if you are NOT going to start an exercise program."**
8. Cultural barriers.
9. Money barriers.
10. Some people think the only way to exercise is at a health club.

Motivating People to Change and Break Barriers to Exercise

Several consequences of people who do not exercise were investigated by the World Health Organization (WHO). They found the relationship to an unhealthy lifestyle resulted in high medical care costs. The (WHO) estimated that approximately half of all health costs can be attributed to the unhealthy behaviors of poor diet and physical inactivity. A yearlong study regarding obesity research (2002) compared the relationship between waist circumference, body mass index, and medical care costs. The study indicated visceral obesity generated 85% more in-patient charges than those with the lowest level of visceral obesity. Increase in BMI (Body Mass Index) and/or WC (Waist Circumference) contributes to many chronic diseases. It is not only the total amount of excessive body fat that creates the diseases but the location of the fat. According to an article, *"Treatment of Obesity"* by Dr. Despres, "Excess visceral adipose tissue (>88 cm in women; >102 cm in men) is the culprit, rather than simply being overweight." In other words, a high WC is closely related to high risk for developing Type 2 diabetes, metabolic syndrome, and subsequent cardiovascular complications, including retinopathy, nephropathy, neuropathy, macular degeneration, and cardiovascular disease.

If you have been reading Dr. Hogan's "FitTips" you already know a lot of the advantages of regular exercise. The "PRESCRIPTION For Better Health" pads are great in motivating people to make the lifestyle change to initiate their exercise program.

Dr. Hogan's *FitTips #1*, "Exercise: The prescription for prevention and treatment of all disorders," makes a lot of good sense. Prescribing cardiovascular exercise, weight resistance exercise and flexibility exercise, along with proper nutrition, contribute to establishing a healthy body composition. Appropriate exercise and nutrition leads to better waist circumference, which leads to better health and fitness, and better weight management.

The perceived intensity of exercise is inversely related to exercise adherence in middle-aged adults. For example, in a recent study (2005), J. Wilbur stated when an average, middle-aged, formerly sedentary individual selected an exercise intensity, they were more likely to continue regular exercise if they perceived the intensity to not feel too hard or unpleasant. This means that one of the most important factors to consider when starting an exercise program, in the first 4 – 6 weeks, is to keep the intensity at a level that is comfortable.

Advantages of Using Yoga to Implement an Exercise Program

Maintaining a Yoga or Pilates exercise practice along with a cardiovascular exercise program such as walking briskly can be a comfortable way to start an exercise program.

For example, Yoga offers physical activity to your lifestyle with a complete approach to developing proper posture, body awareness, improved balance, muscular strength, endurance and flexibility, along with stress release. The poses (asanas) are performed in a repertoire of a series of essential sequential

See "Success" page 20

Yoga Class Opportunities:

1. Apothecary Spa 582-1329
2. Bikram Yoga Center 761-9007
3. Smurro's Wellness Center 381-2794
4. Pure Fitness 253-565-5155
5. YMCA: call individual branches

Yoga/Pilates Videos:

PILATES:
AM Pilates, Jillian Hessel: mat workout

YOGA:
1. ***Yoga Peak Performance***, Rod Stryker: for strength, stamina, creative energy, balance, stress release and concentration
2. ***AM Yoga for Beginners***, Rodney Yee: awaken, stretch, energize
3. ***PM Yoga for Beginners***, Patricia Walden: focus, vitalize, define
4. ***Power Yoga***, Rodney Yee: stamina, flow, strengthen, energize
5. ***AM/PM Yoga for Weight Loss***, Suzane Deason
6. ***Yoga for Conditioning for Athletes***, Rodney Yee
7. ***Yoga for Beginners***, Rodney Yee: awaken, stretch, energize
8. ***Vinyasa Flow Yoga***, Seane Corn

Resources:

1. Amazon.com - search yoga or Rodney Yee, Rod Stryker, Seane Corn
2. Living Arts 1-800-2-living or www.livingarts.com for catalog, audio, books, yoga accessories
3. www.gaiam.com

coalition for Healthy Active Medical Professionals

CHAMP

GET READY FOR THE FUN, MARK YOUR CALENDAR:

CHAMP 5K (3.2 mile) FUN WALK/RUN

SATURDAY, OCTOBER 15, 2005; 9:00 A.M.

PT. DEFIANCE PARK, OWEN BEACH

Please join us this fall as thousands of walkers WALK ACROSS WASHINGTON to begin, renew or continue their commitment to physical activity

Sponsored by: Pierce County Medical Society and Metro Parks
in cooperation with Association of Washington Cities

Running Workout

by Lucy Smith

Whatever your body type, you can succeed at running.

Running has taken me many places: to parks small and large, along city streets, and through forests around the world. I even met my husband during a race, and I've pushed a Baby Jogger over the sand in Australia with my 2-year-old daughter, Maia, in it.

Running makes me feel strong and powerful, and I love the calm focus it provides as I concentrate on the action of my arms, legs and lungs. But most of all, I love its simplicity and accessibility. Whatever your body type, you can succeed at running. Because you need little more than a good pair of running shoes, you can do it anywhere, anytime.

This training plan (please see insert "Running Workout") prepares you for a 5k race — a popular charity-race distance — in six weeks. You'll ease in slowly by alternating running and walking, which will prepare your body for the longer periods of running to come. If you build up slowly and go at your own pace, you'll cross the finish line in no time.

Carmichael Training Systems coach Lucy Smith is a six-time Canadian Duathlete of the Year, most recently in 2002. She holds 12 Canadian national championship titles.

In My Opinion

by Michael 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.*

Thank You, Mike

Earlier this year, Norman Corwin, 95-year-old member of the Radio Hall of Fame and once called "Radio's Poet Laureate," said in an editorial to NPR, "The blood brothers of common courtesy are kindness, sympathy and consideration." Recognition of events related to these principles serves the public. However, most circulated news is bad news. A calm sea and prosperous voyage do not make news but a shipwreck does. The negative publicity attracts more of the same through repetition and imitation.

I'm not suggesting we fool ourselves into believing that kindness, consideration and compassion will right wrongs, keep the peace and heal wounds. I believe it comes down to the value of examples, which can be positive or negative. This is about a positive event, which may lead to similar repetition and imitation.

Let me begin by taking this opportunity to thank Mike.

His first name is all I remember about him. At the time, I was distracted, focusing instead on processing the intense pain coming from the right side of my body. An accident is not the ideal time for formal introductions.

This was my first incident in 4 years of cycling. The volume of traffic was much higher than usual on the afternoon of July 29 as I rode along Chambers Creek road near the dam at the bottom of the hill. Suddenly, a truck forced me from the asphalt onto a narrow strip of unstable dirt. I lost control immediately, came back upon the asphalt, flipped, became airborne and landed in the middle of the street. The landing was both violent and painful - enough to bruise my shoulder, hip and fracture both my helmet and a few ribs.

Michael Kelly, MD

Although other Good Samaritans gathered, Mike took charge and performed a very reasonable cursory examination of head, neck, shoulder, clavicle and chest. He explained he had

See "Thank You" page 19

Bicycling, Mountain Climbing and Running... PCMS Members Keep Fit

PCMS members are staying fit and active this summer whether participating in organized events or organizing their own.

The ever popular Sound to Narrows run, and Seattle to Portland bicycle ride are two events that many members enjoy. Mountain climbing also provides satisfying physical challenges while offering scenic rewards.

What is your favorite physical activity? Please capture your favorite sport or physical challenge on camera and forward it to PCMS. Be sure and stay tuned as the *Bulletin* continues to feature a different sport or exercise each month in efforts to help motivate readers to continue quests for increased fitness levels.

And, mark your calendar for our 3 mile walk/run on Saturday, October 15 at Pt. Defiance Park. This CHAMP (Coalition for Healthy, Active Medical Professionals) event is open to all medical professionals and is being sponsored to help those that are just beginning to exercise get started. (See ad page 9)■

Sumner Schoenike, MD completes the Sound to Narrows

David Law, PCMS Past President, finishes Sound to Narrows strong

Jim Rooks, MD PCMS Past President, approaches Sound to Narrows finish

L to R: Dr. Mark Craddock, Joan Brookhyser, Drs. Pat Hogan and Dave Law, wearing CHAMP t-shirts, scale Mt. Adams

Dr. Gary Taubman and Tracy Gage complete the Seattle to Portland bicycle ride

Trauma Center Update

The Tacoma Trauma Center, now nearing its fifth year, has released their 2004 Report to the Community. The Trauma Center is jointly operated by St. Joseph Medical Center and Tacoma General Hospital. The Center successfully operates under the medical direction of **Lori Morgan, MD.**

In 2004, trauma incidents totaled 1,320 - led by motor vehicle crashes (including motorcycles) responsible for 44% or 579 of those incidents. Falls accounted for 21% at 284, stabbing/gun shot wounds accounted for 155 cases (12%); 100 assaults made up 8% of the caseload, pedestrian vs. auto were 4% (47 cases); bicycles were responsible for 29 cases (2%) leaving 126 cases (9%) in the other or miscellaneous category. So, while trauma numbers are increasing in Pierce County, fewer than 20 percent of traumatic injuries are assault related. The very clear majority of injuries in 2004 were caused by motor vehicle accidents or falls, combined totaling 65%.

Having a Level II Trauma Center in Pierce County can make the difference between life and death for a patient, as they will be cared for at either St. Joseph Medical Center or Tacoma General Hospital, no longer requiring a 30-mile air transport to Harborview in Seattle. This incredible collaboration of healthcare systems is working well and the numbers continue to grow. In 2002 the trauma center admitted 1,042 patients; in 2003 admits increased 11 percent to 1,158 and in 2004 they treated 1,320 patients, an increase of 14 percent.

This year, a Trauma Educator/Outreach Coordinator staff person was added to raise awareness of trauma and educate the community about prevention. The trauma educator/outreach coordinator works closely with community organizations and area school districts to offer a variety of prevention programs and can be reached by calling 253-403-8667.■

Old Cell Phone(s) On Hand?

The YWCA Pierce County will be happy to accept any and all old cell phones.

They activate them for client use and/or recycle them and receive funds for their children's programs.

They may be taken to the YWCA at 405 Broadway in Tacoma between 8 and 5 Monday thru Friday, or you may call Kristy at 272-4181 Ext. 222 for more information.

In My Opinion

by Peter Marsh, 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.*

An Open Letter from Peter Marsh, MD

Peter Marsh, MD

Dear Colleague:

In less than four months, citizens in our state will head to the polls where they will vote on Initiatives 330 and 336, as both will appear on the November ballot. I know you are well aware of Initiative 330, the physician, nurse and patient sponsored solution to tort reform.

Are you familiar with Initiative 336 - the initiative written and sponsored by personal injury attorneys, in retribution? If not, you may want to have a closer look because if this initiative passes, we all need to understand the impact it will have on our profession.

For example, I336 will:

- establish a state-run insurance company to provide excess liability insurance to physicians and institutions – **we will have to pay TWO premiums** – one to our own insurance company and one to the state-run insurance company
- revoke the license of any physician who has had three or more judgments of medical malpractice entered in court in a ten year period. This is unnecessary as no physician insured by Physicians Insurance has had three judgments against them in the last ten years. This will close the door to any chance we had of recruiting physicians in high-risk specialties to our state
- make it easier for personal injury attorneys to troll for cases, will kill peer review and will extort earlier and more lucrative settlements from good doctors

The I336 campaign is well funded by personal injury attorneys, and finds great support from injured patients willing to share their tragic stories that garner sympathy from an uninformed public. Ironically, the No on I330 group has raised $584,727 while the Yes on I336 has raised only $7,826 – proving the point that personal injury attorneys are not interested in passing their initiative, but only want to defeat real reform.

We need to do everything in our power to make sure that I330 passes in November but we will go from bad to worse if we allow I336 to become law. (For a copy of the I336 campaign brochure call PCMS, 572-3667)

We need your financial support today, and your personal commitment to educate your patients from now until November. For a contribution form or to order brochures, posters and other campaign materials for your office, call the Pierce County Medical Society, 572-3667 or visit www.yesoni330.org

Please join your colleagues and let us add your name to the list of supporters.■

I330 Campaign Corner

Pierce County's goal for I330 is $315,908 and we are fast approaching the $200,000 mark. Inserted in this issue of the Bulletin is a listing for all contributors to date. Thank you for your support and generosity. The campaign appreciates early contributions as it is necessary to purchase air and print media in advance for fall coverage.

Please mark your calendar for the September General Membership Meeting, Tuesday, September 13, at the Landmark Convention Center for a full campaign review and update including how to talk to your patients about supporting I330 and not supporting I336.■

Order Your *Yes on I-330/No on I-336* Campaign Materials Today

Be sure to post information up about the *Yes on I-330/No on I-336 Campaign* in your practice. Brochures, 5x7 easel-back cards, buttons, bumper stickers, 8½ x 11 fliers (three different styles), and 11 x 17 posters outline why voters should vote yes on I-330 and no on I-336 in the November 8 election.

Help us get the word out to patients by ordering your copies today! To order copies, go to www.yesoni330.org (click on "Order Materials Here") or call the campaign office at 1 (877) 740-0177.■

IN MEMORIAM

JOHN V. MERRICK, MD

1929 - 2005

Dr. John Merrick died July 13, 2005 at his home in Puyallup.

Dr. Merrick received his medical degree from the University of Pennsylvania School of Medicine in 1956. He completed his internship at Presbyterian Hospital in Philadelphia, PA and his residency at Mountain View General and Tacoma General hospitals. He held numerous membership, both medical and non-medical, and was President of Medical Staff at Good Samaritan Hospital in 1978. He is quoted as saying, "My greatest achievement was the practice of medicine."

Dr. Merrick practiced general medicine in Puyallup from 1973 until his retirement in 1994.

PCMS extends condolences to Dr. Merrick's family.

In My Opinion.... The Invisible Hand

by Andrew Statson, MD

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California Dreaming

Andrew Statson, MD

"The gates of hell are open night and day;
Smooth is the descent, and easy is the way;
But to return, and view the cheerful skies,
In this the task and mighty labor lies."

The Aenead
Virgil (18 BC)

Coming soon, to a state near you, the Single Payer System.

In early April, a single-payer bill (SB 840) came out of the Banking and Insurance Committee of the California Senate with a do-pass recommendation by a vote of seven to four. The bill will establish a California Health Insurance System (CHIS), which will provide health insurance to every resident of the state. At the same time, it will prohibit the sale of any private policies that cover benefits provided by the CHIS.

Physical presence in the state with intent to reside will determine residence. Californians temporarily out of state will be covered by the program. CHIS will bill nonresidents for care received while visiting California.

However, if the Commissioner of CHIS determines that people are immigrating to the state for the purpose of obtaining health care, he may impose a waiting period for eligibility.

The plan will cover all medical care deemed appropriate by the consumer's health care provider. Sounds good, doesn't it?

Yes, but the Commissioner and the Chief Medical Officer will exclude services with no medical indication. The Chief Medical Officer will establish evidence based standards of care and implement systems to measure quality and correct quality of care problems.

The budget of CHIS will provide support for research and for the training of providers.

All licensed or accredited health care providers may participate in the CHIS. The participants may choose to receive a salary, or be paid on a fee-for-service basis.

The fee-for-service providers must elect representatives to negotiate rates with the CHIS. If an agreement on provider reimbursement is not reached before a deadline set by the CHIS, the CHIS shall set binding rates.

If I understand this correctly, we can negotiate, but if we don't agree with their proposal by a certain date, they will tell us how much they are going to pay us, period. In Newspeak that is called fair negotiating practices.

To fund the program, the bill will levy new taxes, including employer and employee payroll tax, self-employed business income tax, a tax on unearned income, and a surcharge on all incomes over $200,000.

The bill will require CHIS to attempt to get waivers and permits to incorporate Medicare and Medicaid into the system, and to enroll all federal, state and local government employees. I wonder how readily these employees will accept health benefits equal to those of Medicaid.

What happens when they run out of money?

Well, when (the bill says "if") the Commissioner determines that revenue trends indicate the need for cost controls, he shall convene the Health Insurance Policy Board to decide what measures to take. These measures may include delayed introduction of benefit improvements; adjustment of the health care providers' budget to correct for inappropriate utilization; limitation on the reimbursement to managers, health care providers, and suppliers of medical equipment and pharmaceuticals; imposition of copays and deductibles; and increase in premiums and taxes.

To help achieve these goals, the Commissioner will establish an Office of Health Care Planning, an Office of Health Care Quality, a Health Insurance Policy Board, an Office of Consumer Advocacy, a Health Insurance Fund, a Payment Board, a Public Advisory Committee, and an Office of the Inspector General. The latter will have broad powers to investigate, audit and review financial and business records of individuals and entities that provide services and products to the system and are paid by the system. That office will be within and under the direction of the Office of the Attorney General.

The Commissioner will set up ten

See "Dreaming" page 16

Dreaming from page 15

health insurance regions, each with a planning director and a medical officer. A regional health planning board, made of thirteen members appointed by the planning director, will advise him and recommend regional health planning policy measures.

If you are not impressed by now, the bill also plans to save money by limiting administrative costs to ten percent of total system costs within five years of completing the transition to CHIS and to five percent of system costs within ten years. These administrative cost savings (I am not making this up) will be achieved by administrative simplification and bulk purchasing of prescription drugs and medical equipment.

In case you are wondering where these numbers came from, the CMS claims that its administrative costs are five percent of its budget. Yes, of course. That is the cost to maintain the office of the CMS. It does not include the cost of collecting the premiums, which is done by the Social Security Administration; the cost of collecting the Medicare taxes, which is done by the IRS; or the cost of processing claims and paying for services, which is done by the intermediaries.

The overhead cost of the intermediaries probably runs at thirty-five percent of budget. Add to that our cost to comply with the record-keeping, coding and billing requirements, which probably amount to ten percent of budget, and we get close to fifty percent administrative costs for the Medicare program as a whole. So how is California going to do it for less than ten percent, after creating all those agencies for the state and the projected ten regions, with all the administrative personnel that it will need to implement the program?

Twenty percent of Californians have no insurance. Employers cannot keep up with the rise in premiums and either drop the coverage for their employees and retirees, or choose policies with higher deductibles and copays. Many people have to forgo needed care. True enough. I heard the same arguments in the 1960's, during the debates on Medicare and Medicaid. These programs promised to take care of that problem.

Our health care system is broken, more so than it was forty years ago. Something must be done. What else but having the state take over the health insurance business and raise taxes?

If the problem is the uninsured and the underinsured, why not expand the existing programs? Because they are already in trouble. They promised too much and couldn't deliver. Now they are out of money and the people are opposed to more taxes.

The proponents believe that if they presented the issue as universal coverage and the taxes as insurance premiums, the people will accept them more readily. Perhaps.

Yet even this bill provides for waiting periods, during which people will be without coverage. It calls for deductibles, copays, and restrictions, delays or denials of service. The program will cost more, not less. The money to pay for the bureaucracy and for the promised services will have to come from somewhere. Will Californians swallow the needed level of taxation? Will even more businesses pick up their stakes and move out of state?

I suspect the secret hope of the proponents is that, when the state goes broke, the Federal government will come to their rescue. They ignore the lesson from Tenncare. Even worse, they ignore the deficits and the growing debt of the Federal government. Who is going to bail it out when it goes bankrupt? Japan? China? India? For how long will they continue to buy its promissory notes? ■

In My Opinion

by George Tanbara, MD

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Invitation to Tour CHC Clinics

George Tanbara, MD

Thank you to all my colleagues for your help and advice since I started my practice in August 1954 – 51 years ago. I practiced solo until January 1980 (25 ½ years) and have been in a group since then – another 25 ½ years. It has been an honor to serve on almost every committee at one time or another, to serve as secretary for five years which meant setting the budget, helping with the Library which served all the members, recruiting 20 members to join the newly formed Tacoma Urban League, serving as a WSMA delegate annually, and a being a constant author of resolutions that were either initially passed, subsequently passed, or never seriously considered by the House of Delegates!

In 1967 the medical society organized an all morning meeting, attended by 50 physicians (20% out of 250) at the Tacoma Community House to discuss the issue of patients who did not have access to medical care. With involvement from Tacoma Urban Coalition, chaired by Dr. Eugene Wiegman (then president of PLU) and administered by Jim Walton (former Tacoma city manager) and Bob Pfotenhsuer (Group Health D.C. lobbyist), weekly meetings were held for two years prior to initiating the first Eastside Clinic, which opened weekly in the community room of Lister School. The success of the clinic saw growth to a Quonset hut supplied by the Tacoma Housing Authority and then to the Eastside Community Center. The success also expanded to the downtown area where a clinic was initially housed in the basement of the St. Joseph Hospital Nursing School subsequently ending up in the hilltop area.

Society physicians, including subspecialists contributed time as well as patient care to both clinics and eventually sponsored a shift in operations to the Urban Health Initiative administered through the Tacoma Pierce County Health Department. The agency ultimately became Community Health Care Delivery System (CHCDS) and eventually just Community Health Care (CHC). Many community members, society members, hospitals and health care providers supported the efforts of providing care to those that did not have medical access over the years and deserve much credit for their work and dedication. Little did they know they would be a part of what is today, Community Health Care, a county wide system that provides medical and dental care for those in need.

My writing serves as invitation to all members to learn more about CHC by taking a tour of one (or more) of the eight medical and three dental clinics in Pierce County. The clinics offer a medical, dental and pharmacy "home" to each patient, regardless of income. If you have patients that you are unable to offer services to, they will be able to go to CHC, regardless of income or if they are uninsured, underinsured, unable to be insured, don't want to be insured, or want to go someplace other than the emergency room. I will be happy to accompany you on a tour of any CHC clinic if you just let me know.

CHC has served as an excellent health safety net for 36 years in our community, but there are also other community clinics with varying capabilities that may be best for those in need, so consider them as well. Any practice unable to serve certain patients for whatever the reason, please consider CHC with clinics in Parkland, Downtown Tacoma, Soundview, Eastside, Sumner, Lakewood and Tillicum.

Thank you for letting me serve. ■

Applicants for Membership

Kevin E. Braun, MD
Family Medicine
5920 100th Street SW #31, Lakewood
253-584-3023
Med School: Tufts University
Internship: University of Minnesota
Residency: University of Minnesota

Peter M. Lux, MD
Physical Medicine & Rehab
Rainier Rehabilitation Associates
8012 112th St Ct E #120, Puyallup
253-841-5849
Med School: Rush Medical College
Internship: St. Vincent Hospital
Residency: University of Washington

Thao N. Tran, MD
Int Med/Allergy/Asthma
Puget Sound Allergy, Asthma & Immun.
1901 S Union #B6010, Tacoma
253-383-4721
Med School: University of Maryland
Internship: Pennsylvania State Univ
Residency: Milton S. Hershey Med Ctr
Fellowship: Stony Brook Univ Hospital

PCMS Extends Condolences to Roger Lee, MD

Sylvia Lee, wife of **Roger Lee, MD** died Sunday, July 17 from complications of pneumonia. She was born in November, 1944, the youngest of six children of Dr. & Mrs. King T. Kwong.

Sylvia was the first teacher to teach Spanish to grammar school students in Philadelphia, PA and she was the first woman inducted into the Elks Club of Washington. Sylvia served as President of the Tacoma Opera Guild and enjoyed teaching country western line dancing in Tacoma and on cruise ships. She loved life, people and travel.

A wonderful wife, mother and friend to all, Sylvia will be deeply missed by her immediate family, including her husband, Roger Lee, MD, her daughter Marisa and son Ryan and three grandsons.

Memorial contributions may be made to the Gynecologic Oncology Group, 1600 JFK Blvd #1020, Philadelphia, PA 19103 or a charity of choice.

PCMS extends sympathies to Dr. Lee and his family. ■

Thank You from page 10

military training and expertise, which he applied during his recent deployment in Iraq. He was reassuring and professional.

Although he could have called 911 and left me, stable as I was, along the side of the road, he offered to drive me home. He was on his way to Point Defiance Zoo with his 4-year-old daughter. Distance to my home was not an issue - he just wanted to help, even if it meant a delay in his plans. He dropped me at home a few minutes later and left for the Zoo when he was sure I remained stable.

In a world in which we feel impotent grappling with the inhumanity of human beings, something to which Mike has had first hand experience, a gesture such as Mike's represents something quite big. Ultimately, it's related to compassion, a quality in short supply these days.

I believe, as Norman Corwin, that good can be as communicable as evil, and that's where kindness and compassion come into play. Contagions of the right stuff have a chance to occur so long as conscionable and caring people, such as Mike, are around and appropriate retelling of their deeds occur.

So, thank you, Mike and those of you who practice such common courtesy. Thanks for refusing to be a silent witness. Thanks for infecting us with your example. Perhaps recognition, such as this, will help spread those principles to which you already ascribe: kindness, sympathy and consideration. ■

Success from page 8

exercises modified to the needs of the individual along with proper breathing techniques. The vertebra and the major muscles of the body are involved. Many of the major muscles of your shoulders, arms, and legs are attached to the spine and/or pelvic bones called the "core." For example, if the core muscles are well conditioned, you will enjoy optimal transfer of energy from large to small muscles when you walk, sit, twist, lift, and perform other movements in your daily activity. Moreover, if the core is well trained, you are less likely to be injured, or suffer from back pain. Included in the practice should be relaxation techniques in the beginning and the end to aid in relieving stress.

By practicing relaxation techniques, we are able to lower stress levels, which decrease the levels of the hormone cortisol. In response to too much stress, levels of the hormone cortisol rise; for many people who continue to worry, those levels can stay high. Elevated cortisol levels not only stimulate eating, they ensure that any additional calories are efficiently converted to fat. Worse, under the influence of increased cortisol, that fat tends to get deposited in the abdomen. As we already know, large abdominal fat levels are linked to insulin resistance – a precursor to Type 2 (adult-onset) diabetes and heart disease. By combating stress, these exercises help normalize cortisol levels.

As a structured exercise program, Pilates and Yoga are non-competitive, an asset in a fiercely combative society. The stretches and poses improve your posture and also encourages healthy sleep. Yoga can be a form of gentle exercise and a way of relieving stress.

Young and old, fit and unfit, can all benefit from this type of exercise. Exercise is essential for good health although it is not always the most exciting part of life.

It should be seen as part of your routine, like brushing your teeth – not the most fun, but we all have to do it. Once it becomes routine, it will become a very pleasurable part of each day. ■

Lois A. Zoltani, MS, holds a master's degree in Health/Fitness Promotion and Physical Education from PLU and is a Certified Pilates and Yoga Instructor.

COLLEGE OF MEDICAL EDUCATION

2005-2006 Schedule Planned

The College's course schedule for the 2005-2006 year is almost finalized. Review of the recent CME survey results once again confirmed the focus on primary care with specialty updates as a focus.

Scheduled in 2005, *Common Office Problems* will be held on Friday, October 14 and the ever popular *Infectious Diseases Update* is scheduled for Friday, November 11. Both will be held at Fircrest Golf Club and are all day programs.

In 2006, the popular evening program *Cardiology for Primary Care* will be on two Tuesday evenings, January 10 and January 17 at St. Joseph Hospital.

For resort travelers, *CME at Whistler* will be January 25-28 at Whistler Resort in British Columbia and *CME at Hawaii* will be on the big Island of Hawaii at the Hapuna Beach Resort, our most popular Hawaii venue that is requested over and over.

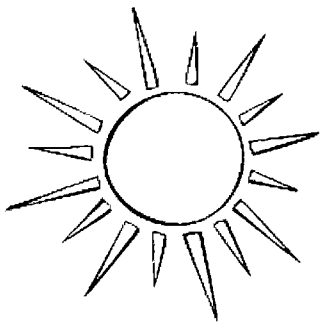
The year will conclude with *Internal Medicine Review* on May 5-6 and *Primary Care 2006* on Friday, June 2. Both will be all day sessions at St. Joseph Hospital.

Added to this year's schedule will be *Mental Health Review*, a course focusing on the diagnosis, treatment and management of mental health concerns faced in the primary care and internal medicine setting.

Watch for the annual course calendar which will be mailed soon and printed in subsequent issues of the *Bulletin*.■

Hawaii 2006...Fun and Sun

Plans are set for the Hawaii CME program in April 2006. Both hotel and air arrangements have been made and the agenda for the four days of CME has been set, according to course director, **Mark Craddock, MD**. The dates are April 2 to 7, 2006.



Focus on infectious diseases, neurology and gastroenterology will be paramount with some rheumatology, endocrinology and dermatology included. The CME schedule will be Monday, Tuesday, Thursday and Friday, from 7:45 a.m. until 12:00 noon, with no meetings scheduled on Wednesday: ideal for extra time to spend with friends and family.

This year the course will be held on the big island of Hawaii, at the beautiful Hapuna Beach Resort. Hapuna Beach has been rated the 'number one beach in America' – a long stretch of pristine white sand viewed by most of the resort's first class guest rooms.

The College has negotiated exceptional rates for all room categories at nearly 50 percent off offered by local travel agents. Connecting rooms for children 18 and under are also offered for those that want to bring families. Airline rates have also been negotiated to offer outstanding bargains.

Make plans now. Call Jeanette Paul at All Wanderlands Travel 572-6271, or email her at jeanette@awtvl.com. Watch your mail for the program brochure which will arrive shortly.

And, do yourself a favor and call Jeanette. You will be very glad next April that you made that call today. ■

Bill for Reporting Medical Errors Cleared

By Kevin Freking, Associated Press Writer

WASHINGTON - A national system designed to increase reporting of medical errors won final congressional approval July 27 and was sent to President Bush.

It is estimated that more than 250 Americans die every day as a result of preventable medical errors. Health care officials say increased reporting of such errors would make it easier to spot harmful trends and find solutions, but the current environment punishes openness because reporting such errors could lead to the loss of credentials or a lawsuit.

Under the legislation approved overwhelmingly by the House, health care officials would voluntarily report medical errors to patient safety organizations, which would use a network of computer databases to analyze the information and make recommendations on ways to improve health care. The information would be treated as privileged and confidential.

The Congressional Budget Office estimates that the operation of the data collection system will cost about $58 million over the next five years.

"I believe this bill will be the first assault on the culture of fear that has permeated medicine for many years now," said Rep. Michael Burgess (news, bio, voting record), R-Texas.

Similar legislation passed both chambers of Congress last year, but the session ended before a final agreement could be reached. This time, the House and Senate bills are identical, so the bill only needs the signature of President Bush before becoming law. The Senate approved the measure last week.

The bill had the support of Republicans and Democrats.

The American Medical Association and the American Hospital Association supported the legislation, as did consumer groups such as the AARP. Dr. J. Edward Hill, president of the AMA, said the legislation would not harm consumers' rights to access the legal system if they are harmed by medical error.

"I think employees and physicians will be excited about the ability to make positive suggestions about how to improve systems so errors won't occur," said Hill, a family physician from Tupelo, Miss. "This way, we learn from our mistakes."

The Bush administration said the legislation would reduce the number of lawsuits resulting from medical error.

"Information from medical records and existing data sources will continue to be made available for injured plaintiffs to pursue their claims in court, just as that information is available today," said a statement released by the Office of Management and Budget.

While some health care analysts believe the number of deaths due to medical error has been exaggerated, that sentiment does not mean they oppose the establishment of a national reporting system. ■

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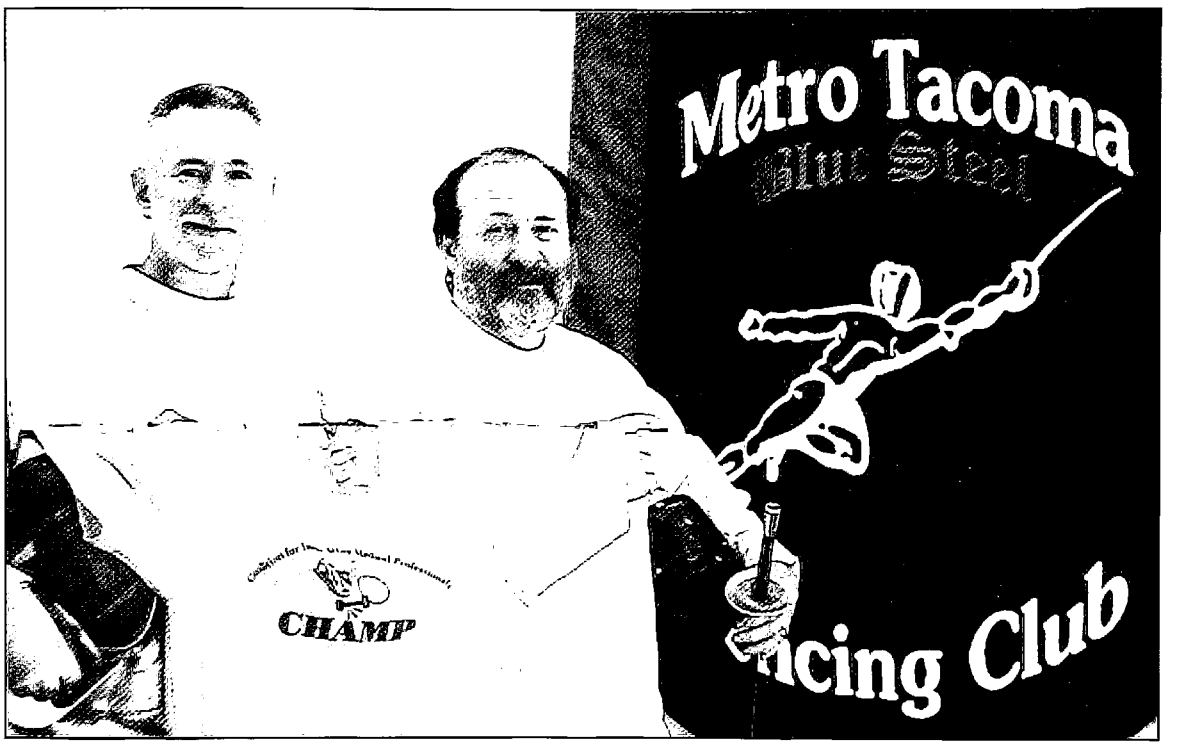
BULLETIN

September, 2005



Drs. Joe Jasper (left) and Glenn Deyo fencing enthusiasts and CHAMP supporters

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.

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Pierce County Medical Society
BULLETIN

September, 2005

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President's Page

by Patrick J. Hogan, DO

Patrick J. Hogan, DO

The Action Step

Taking the Step to Action- no excuses- Just do it

There are many notable steps that a person can take, such as that final step onto the summit of a mountain, the first and last step in a marathon, the step of an astronaut onto the moon. However, the most important step that any individual can take is **the step to action that will improve the person's life or the world in some small way**. These steps add up one at a time to great changes in the world or our lives.

When we hear of something that is good for our lives or the lives of others, what is it that holds us back from taking the step to action that makes that happen? Sometimes it is a time factor or a perceived physical or psychological limitation. It is a matter of getting through those initial stages toward that step to action and just getting it done. Whatever the "it" is in Just Do It , we all need some help in getting to that stage of action as noted below.

Stages of change toward the Action Step:

1. **Precontemplative** (*don't bother me I don't give a rip*)
2. **Contemplative** (*HMMM - maybe I should do this; it could make a difference in my life or the world*)
3. **Preparation** (*okay okay - I do need to do this. Now what do I do to make it happen?)*
4. **Action Step** (*Wow, I am actually doing this but this sure takes effort)* This step often takes about 6 months of encouraging yourself before the action becomes routine
5. **Maintenance** (*I feel so good with what I have done. It is not so hard anymore and now it is just a matter of keeping it going*)

Many people seem to get stuck at the contemplative or preparation phase with very good intensions toward doing "it" whether it be making that donation, volunteering time, or starting an exercise program. Once we realize that we are stuck, it just takes that psychological jump to the next stage to get us on our way to really making a difference in the world or our lives.

We have imminent wonderful opportunities upon us now to positively change the world. Their success is dependent upon many people getting unstuck and making that action step jump without delay.

The I-901 Clean Air for All Washington will be on the ballot in November and is an **opportunity that will not come again** to prevent the suffering of people of all ages from being exposed to tobacco smoke. This will have immense implications not only for the health of our community members but also for the entire country. Many other states are poised to take action with their smoke free initiatives depending on our success.

We have been working steadily since the 1980's building the momentum toward the success of this initiative and building the **collective consciousness** toward a smoke free society. Until this collective consciousness developed to the critical mass needed for action, a change to public air free of tobacco smoke here and world wide would not have been possible. It would have been hard to imagine just a few years ago that Canada, Ireland, Scotland, Norway, New Zealand, India, Italy and amazingly soon to be France would have smoke free air regulations in work, restaurant and bar places. The United States must join these ranks but it will have to be a state by state process that is very much dependent on if Washington becomes the 10th smoke free state.

We are in the leadership roles to take the Action step to be sure that voters know the truth about this measure and are not emotionally swayed by faulty messages that they will be hearing from the tobacco industry or other disillusioned minds about "smoker's rights" infringements and unrealistic threats about economic damages.

The fallacy of smoker's rights: The comment that a person has the right to kill themselves with smoke does not apply to any space occupied by another person. In public places where workers of all ages, including teenagers who are employed and non-smokers, with or without medical conditions can be exposed to the harmful effects of tobacco, the right of everyone to clean air far outreaches any suggestion of a right of a few to smoke in public air spaces.

The science related to fatal illnesses from SHS (second-hand smoke) is irrefutable. However, even if the opposition throws in a smoke screen questioning the validity of second hand smoke diseases, there can be absolutely no argument to the immediate illnesses caused by SHS. Whether it's nausea, headache, severe migraine pain, nasal congestion or asthma from SHS exposure, it happens instantly from the smoke exposure. [illegible]

Action from page 3

search is not needed to prove what people suffer from immediately. It is not anyone's right to cause suffering of another especially for something as unnecessary as putting tobacco smoke into the air we depend on. People don't have a choice to breath; Smokers do have a choice to limit their smoke to areas without children or non-smokers.

I-330 campaign is now in full swing. This is a great opportunity for all of us to take the **action step to improve our medical climate** by helping everyone understand that this initiative will benefit the people of our state even more so than the medical profession by assuring access to affordable medical care. It will only be the excessive wealth of trial lawyers that will be negatively impacted by this initiative.

Action step toward personal Fitness: The step toward fitness is one of the most important steps a person will ever take in a lifetime. It will lead to stress reduction, rejuvenation of daily energy levels, reduction of the aging effects with improved bone and joint function, muscle strength, balance and all the benefits discussed in previous *FitTips*. However, this is the major activity that people become stuck in at the contemplative and preparation stages. Often the action step does not occur because of concerns about personal physical or psychological limitations for exercise or countless other poor excuses. It is just a matter of doing "it" and the rewards will be bountiful. Our October 4 General Membership meeting will be tremendously motivating to all of us to maintain our fitness life long or any endeavor we desire despite any limitations. **We will hear a remarkably entertaining and inspirational talk by Harry Cordellos. Besides being acclaimed as the worlds greatest blind athlete, his accomplishments are much more broad**. He will demonstrate that limitations don't have to get in the way of what we feel needs to be done. The theme of his life is **taking that Action step despite limitations**. We all have physical , mental and time limitations but despite these restraints, it is amazing how much we can do if we allow the "it" in *Just Do It* to happen by taking that step to action. As each person takes that step to action of fitness another extremely important phenomena will occur by adding to **the collective consciousness about the crucial importance of fitness.** As this develops, we will eventually reach the critical mass in society needed to change the current direction and finally **control the current epidemic of diseases related to obesity and unfitness in this country.** See this month's *FitTips* on how to start a walking program for fitness in itself or as a step to other activities as highlighted in the monthly *Bulletin*. **We have an excellent opportunity for individuals and clinics to begin a walking program and to support the fitness revolution by joining the Walk Across Washington event on October 15 sponsored by your PCMS and CHAMP (see the flyer coming your way and in the *Bulletin*).** ■

FitTips #9

by Patrick Hogan, DO and Adrienne McNamara MS

Walking for Health, Weight Loss and Fitness

1. No excuses: Walking is the most accessible form of exercise available. No expensive equipment is needed, nor much skill as we are a species that up until recently has relied on walking as our primary mode of transportation.

2. Walking for weight control: One thing that many people do not realize is that you burn approximately the same amount of calories per mile while walking as you would while running—walking just takes longer. Consequently walking can be an effective mode of weight control. This is encouraging as many people feel that running is either too strenuous, too hard on the joints, or just plain un-enjoyable. When walking for weight control, aim to burn approximately 200-300 calories a session (2-3 miles) and try to walk most days of the week.

3. Walking for cardiovascular benefits: Although walking any speed will burn calories, for optimal cardio-respiratory health you must walk between 55-85% of your heart rate maximum. This is your target heart rate range. (To calculate your THR see *FitTips #3.*) Anything below this range will not adequately stress your system to provide the numerous health-related benefits to the cardiovascular system. A simple heart rate monitor can help ensure that you are exercising hard enough. These can be purchased at any sporting goods store and can range from $30-200. Alternatively, you can stop mid-walk and take your heart rate for 10 seconds and multiply by 6.

4. Proper shoe selection: Although little gear is required for walking, a proper pair of shoes can increase your comfort and help prevent injuries. Before starting a walking program, examine your shoes. If the soles of your shoes are showing signs of wear, replace them, as the mid-sole (the part of the shoe that provides cushioning and absorbs shock) will already be worn out by this point. A basic rule of thumb is to replace your walking shoes every 300 miles or every 6 months, whichever comes sooner. Although it may seem harmless, repetitive walking in worn out shoes can lead to a plethora of injuries as your joints will have to absorb the shock that otherwise would be absorbed by your shoes. Be sure your heals don't slip and your toes don't touch the end of the shoes.

5. True to form: Everyone knows how to walk, but there are some points to consider that will maximize your workouts while preventing injuries. Walk tall with your shoulders back and eyes forward, not down. A common mistake made while trying to increase speed is to excessively lengthen the stride length (how far you walk with each step). Stride-length is most determined by leg length as well as your body's natural walking mechanics. Excessive stride length increases the impact on the joints and spine. Instead, to increase speed choose a comfortable stride length and increase your turnover (the quickness of your steps). Another way to increase the intensity of your workout is to increase the movement of your arms. **However, make sure that your arms do not cross the midline** of your body as this will waste energy and increase injury rate. While walking fast try "pumping" your arms back and forth (forearms parallel to the ground moving back toward your hips. Note: usually this will naturally occur while walking fast—just make an effort to not walk with hands in pockets or straight down by your side. The more of your body that you are moving the better for your fitness level and weight loss potential.

6. Make it fun: One of the greatest benefits of walking is that it can be done anywhere. To increase enjoyment and prevent injuries, try to vary the routes that you walk. Exploring trails or the beach can give both your mind and your joints a break from the doldrums of walking on pavement and roads. Finding a partner or a group to walk with will also help your motivation and the effectiveness of your walking program.

7. Make a goal: One way to stay excited about your walking program is to sign up for a walking event, such as the Avon Breast Cancer walk or the Walk across Washington or a Volksmarch. This will both add some meaning to your training, as well as give you something to work for. See web sites noted below for more information on these types of events that will also help motivate you toward your walking goals.

8. Supplement your program with other activities: Contrary to popular belief, walking by itself is not adequate to prevent osteoporosis (see *FitTips #8*). Therefore be sure to supplement your program with **resistance training (weights)** or other higher impact exercises (jumping, etc) in order to maintain the health of your bones to ensure that you can enjoy a life time of walking. See *Fit Facts* on jump roping for guidelines on this safe impact exercise (inserted in this issue).

9. Week by week training guidelines for building a walking exercise program as a health walker (17 minutes per mile), fitness walker (14:30 minutes per mile) or athletic walker (12 minutes per mile) are available through the Pierce County Medical Society.

10. Resources: Web sites: www.coolrunning.com (for listings of walking and running events), www.ava.org (American Volkssport Association). Local contact for information: Pierce County Medical Society. Book: *The Complete Guide to Walking for Health* –Mark Fenton

Happy Trails!!!! ■

NutriTips #9

by Joan Brookhyser, RD, CSR, CD

Almost Vegetarian Food Guide

Here is a healthy guideline for anyone wanting a more plant based diet

	ANYTIME	SOMETIMES*	SELDOM*
GRAIN GROUP 6 or more servings a day serving size: 1oz. bread or cereal ½ cup rice, pasta 3 cups air popcorn	Whole grain breads, tortillas Whole grain cereals: (fiber 3-5g. minimum) Brown rice, bulgur, barley, oats Pasta – Whole wheat Whole grain crackers (2 grams fat or less per ½ oz.) Air popped popcorn	Muffins, bagels Granola Cereals Waffles, Pancakes Pretzels Popcorn microwave – light Oil popped popcorn w/o fat	Heavily sweetened cereals Biscuits, donuts, croissants Fried Rice Pasta & rice in fatty sauces Snack crackers > 2g fat per ½ oz Bread stuffing from mix Microwave popcorn Popcorn with added fat
FRUITS & VEGETABLES 5 – 9 servings a day Serving size: 1 piece fruit 1 cup vegetables 8 oz. potato = 2 servings	All fruits & vegetables – except those at right Potatoes: sweet, white	Dried fruit Fruit juice Avocado	Coconut Olives French Fries Vegetables with fat Fried vegetables Scalloped or au gratin potatoes
DAIRY GROUP Adults: 2-3 servings daily Children: 3-4 servings Serving Size: 8oz./1 cup milk or 1 cup yogurt ½ c. cottage cheese	Skim milk, ½%, 1% milk Nonfat yogurt 1% cottage cheese Evaporated skim milk Buttermilk Soymilk, soy cheese, soy yogurt	2% milk 2% cottage cheese Low fat cheeses<5 g fat/oz. Fruit yogurt – high sugar Ice milk, frozen yogurt, sherbet Soy based ice cream	Whole milk, cream Whole milk yogurt Hard, processed or cream cheese Sour milk Milkshakes, ice cream Regular cottage cheese Evaporated or condensed milk
PROTEIN GROUP Eggs, beans, nuts, soy and seeds Meat, fish or poultry Serving Size: 2 servings a day	1 c. cooked beans, lentils, split peas, chestnuts Soy products – tofu, texturized vegetable protein (TVP), tempeh, soybeans	Whole egg Nuts, seeds, peanut butter Vegetarian entrees high in fat Fresh meat, fish or poultry	Canned or cured meats
FATS, OILS & SAUCES	Catsup, mustard, vinegar, cocktail sauces, barbecue sauce, salsa, horseradish, pickle relish, herbs, spices, low fat or fat-free salad dressings	Steak sauce, soy sauce, bouillon, reduced calorie margarine Reduced calorie mayonnaise Unsaturated vegetable oils (olive, canola)	Butter, coconut oil, lard Regular margarine, mayonnaise Regular salad dressings Cream sauces Gravy
SWEETS & SNACKS	Fruit Jam, jelly or apple butter	Lowfat cakes & cookies, angel food, gingersnaps, graham crackers, fig bars	Cookies, cakes, pies, soft drinks, candy bars, "chips" (potato, corn, or taco)

* Amounts will vary based upon your nutritional goals, age, weight and level of physical activity. Sometimes means 2 to 3 times a week. Seldom means one or fewer times a week.

Prepared by the Nutrition and Wellness Center, Lewis Gale Clinic, 540/772-3750. 07/02

Special Feature

by Jean Borst

The Path to Fitness is Not Always Conventional Part I: Fencing

Fitness takes many forms. It's not always about crossing the finish line at Sound to Narrows or putting in laps at the local Y. This month, and the next two months to follow, our fitness feature spotlights some more unique activities.

Fencing

"The shining blue reflections of the blade impress you still more ominously than its point. Suddenly you look up and see a pair of eyes glaring at you with defiance. They shine even more than the blade. They are bluer than the ***blue steel***. The effective stare of the veteran..."
Aldo Nadi, On Fencing, The Sword - Yesterday and Today

For **Dr. Joe Jasper**, fencing has always been a part of his life. Even when he took a 25-year respite from the sport, his interest in fencing never really waned.

Dr. Jasper became intrigued by fencing in high school, but was unable to get any formal training until college. He quickly made up for lost time, participating on the junior varsity teams at New York University and Case Western Reserve University in the early 70s. After giving up the sport for nearly 25 years, he renewed his interest in hopes of getting his kids involved in fencing. At present, he teaches fencing to teens and adults on a regular basis and trains three times a week. "I've been to only a couple of competitions in my middle-age years," he says. "My mind seems more willing than my body," he jokes. Dr. Jasper spends a great deal for time officiating and coaching, but still competes every week at Metro Tacoma Fencing Club.

"Fencing is an interesting combination of athletic skill and fun," he notes. "One must apply agility, fine and gross motor skills, fast-paced analytic tactics, speed, both respect and use of rules, footwork, bladework and adaptability. Endurance can also come into play, but strength is less important than general fitness and skill. Fencing appeals to me more than running or weights. And it's a terrific distraction from work."

If you think you might be interested in fencing, the Metro Tacoma Fencing Club is a great place to start. The not-for-profit teaching and training club offers instruction in foil, épée and sabre fencing weapons. Located at 401 South Tacoma Way, you can get more information by visiting their website at www.tacomafencing.com. Beginners' courses normally start each first week of the month. There is a Saturday session and a Wednesday evening session. The course consists of a 90-minute class, once a week for eight weeks. The cost is $80 for the eight-week consecutive period.

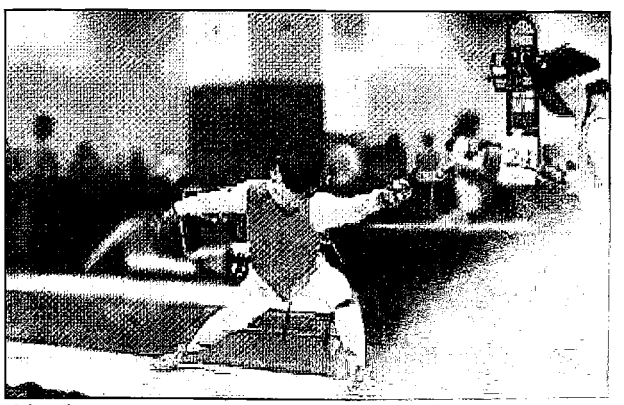
Even if you're not quite ready to sign up for instruction, Dr. Jasper encourages anyone interested to visit the club to observe classes and competitions.

A little about Fencing...

Foil, épée and sabre are the three weapons used in the sport of fencing. While it is not unusual for fencers to compete in all three events, they generally choose to develop their skills in one weapon. Until recently, women were permit-

See "Fencing" page 8

Left, Max Jasper, son of Dr. Joe Jasper, ready to break the distance from his adversary



Max Jasper competes nationally, and has the attention of many colleges, including Stanford

GET READY FOR THE FUN, MARK YOUR CALENDAR:

CHAMP 5K (3.2 mile) FUN WALK/RUN

SATURDAY, OCTOBER 15, 2005; 9:00 A.M.

PT. DEFIANCE PARK, OWEN BEACH

Please join us this fall as thousands of walkers WALK ACROSS WASHINGTON to begin, renew or continue their commitment to physical activity

Sponsored by: Pierce County Medical Society and Metro Parks
in cooperation with Association of Washington Cities

Fencing from page 7

ted to compete only in foil, but now the USFA & FIE offer national competitions for women in épée and sabre. Women's épée was added to the World Championships in 1989 and was held for the first time at the Olympic Games in 1996.

Foil and épée are point-thrusting weapons. Sabre is a point-thrusting as well as a cutting weapon. The target areas differ for the three weapons, though all three are scored electrically.

The main object of a fencing bout (what an individual "game" is called) is to effectively score 15 points (in direct elimination play) or five points (in preliminary pool play) on your opponent before he scores that number on you. Each time a fencer scores a touch, she receives a point. Direct elimination matches consist of three three-minute periods.

For those new to fencing, it is difficult to follow the lightning speed of the fencers' actions. To become more comfortable in watching a fencing bout, focus on one fencer. The fencer being attacked defends himself by use of a *parry*, a motion used to deflect the opponent's blade, after which the defender can make a *riposte*, an answering attack. Thus, the two adversaries keep changing between offense and defense. Whenever a hit is made, the referee will stop the bout, describe the actions, and decide whether or not to award a touch.

Fencers seek to maintain a safe distance from each other, that is, out of range of the other's attack. Then, one will try to break this distance to gain the advantage for an attack. At times, a fencer will make a false attack to gauge the types of reactions by the opponent that can be deceived in the real attack.

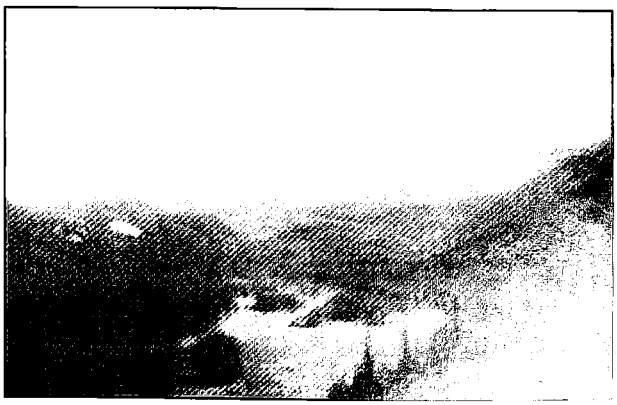
As you become accustomed to the speed of the game, the tactics and strategies become more apparent, and you will gain a better understanding for the finesse and fascination of fencing. ■

Doing it for the CHAMP

- *Patrick Hogan's Ode to the Ultramarathon* -

July 30 - the day arrives after months of training
Pacific Crest Trail 50 mile run looms ahead
Veteran Ultramarathoners advise running to finish not for time
My hope is to do both
6:30 am start is cool and in the shade along the Pacific Trail
Veterans advise to start slow and then slow down
Rational rationing of energy for the last 15 miles is the art of the Ultra
Running over rocks and roots trying to maintain a good pace
Focus on just running to the next 5 mile aid station rather than 50 miles ahead
Stunning scenery of crystal clear lakes and Mt. Hood overlooking the valley
Seems like a long way to the mountain at the 12 mile viewpoint (see picture)
Concentrating on footing and body awareness to prevent chafing and blisters
To the half way point 18 trips on roots and rocks and just two falls
Last two miles to the 25 mile point are steep, soft sand and not runnable
Time at top to rehydrate, empty sand from shoes and change socks and CHAMP shirt
Temperature at 80 degrees at the summit is still tolerable
Fast exhilarating run down the next 5 mile hill followed by rolling steep up hills
Temperature rapidly rising making adequate hydration not possible between aid stations
Awareness of adequate electrolyte tablets and fluid, carbohydrate replacement
My body is trained for 30 miles but in the heat by 35 I start the Ultramarathon shuffle
Encouraging words from friends and donations to CHAMP before the race push me along
At the 44 mile aid/water station it is 93 degrees in the shade
Last six miles seem to last forever with carried water quickly used
Dodging thousands of roots and rock on mostly nice trail
Total of 33 trips along the 50 miles but only 3 falls to the ground
Feeling pain but not suffering since I know this is what I want to do and I will succeed
After 172,000 steps only 3500 steps remain to go but these seem to last an eternity
Hopes that each hill is the last is only met with another and another
Finally cheers from the Ranger station can be heard in the distance
Last 400 yards bring a surge of energy
Running backwards across the finish as a memorial to Scott McQueen's death
Slowly rehydrating as my stomach accepts fluids. Great feeling to be done and walking
After a shower and camaraderie with the other runners I am ready for the next Ultra ■

Mt. Hood - the 25 mile mark



Mt. Hood from the 12 mile mark

PCMS Extends Condolences to James Blankenship, MD for Loss of His Wife, Ann

Ann C. Blankenship, wife of **James Blankenship, MD**, died at home in her sleep August 18, 2005. She was born in May 1931 and graduated from Stadium High School and attended the University of Puget Sound.

Mrs. Blankenship was a committed classical musician and teacher, having been a principal member of several local symphonies, including the Tacoma Symphony. She taught the flute for nearly fifty years and was an alumna of Sigma Alpha Iota, an honor society of classical musicians. Illness, taking her strength and touch gradually, forced her to quit playing and teaching nearly fifteen years ago. In her last years, though she was unable to walk and easily exhausted, she remained a devoted concert-goer with her husband and lifelong musical friends.

After her retirement she was involved with several local groups supporting persons with multiple sclerosis and other disabilities.

In lieu of flowers, donations may be made to the Multiple Sclerosis Society.

PCMS extends sympathies to Dr. Blankenship and his family. ■

Old Cell Phone(s) On Hand?

The YWCA Pierce County will be happy to accept any and all old cell phones. They activate them for client use and/or recycle them and receive funds for their children's programs.
They may be taken to the YWCA at 405 Broadway in Tacoma between 8 and 5, Monday thru Friday, or you may call Kristy at 272-4181 Ext. 222 for more information

Yoga hazard...

The August, 2005 *Bulletin* coverage on Yoga noted that Bikram Yoga enhances flexibility but the heated room that it is usually conducted in can be dangerous and is without clear benefit. The caution should extend in that it is a really difficult (physically demanding and mentally challenging) yoga practice. The environment of a highly heated room (105 degrees) could pose a risk for people with unknown silent conditions such as cardiovascular disease, hypertension and/or lymphatic swelling.

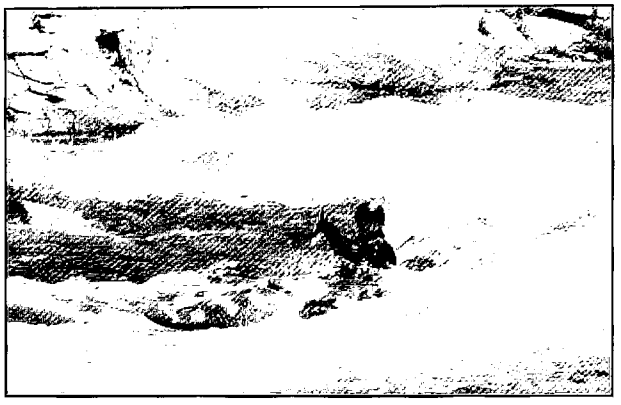
Rick Schoen, MD Finds Kayaking and Canoeing Fun and Exciting

Rick Schoen, MD, family practitioner in Gig Harbor, has experienced the beauty and serenity as well as the fun and excitement of kayaking and river canoeing. "It's a wonderful sport that not only gives exercise, but happens in amazing surroundings. Lots of fun, too," he noted.

Although experienced at kayaking and canoeing, Dr. Schoen is very safety oriented. "We practice rescue and safety techniques and we never hesitate to say, no we'll walk this rapid," he said. ■

Dr. Schoen (in bow) navigating the San Juan River, SE Utah

Dr. Schoen kayaking Cooper River near Salmon La Sac, WA



Dr. Schoen kayak-surfing the Wenatchee River, Eastern WA

The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

Important Changes in Vaccine Delivery Coming in 2006 for Vaccine for Children Program Providers

The Centers for Disease Control and Prevention is undertaking an effort to centralize vaccine inventory and distribution for the Vaccine for Children (VFC) Program at the national level. CDC will contract with national distributors to ship vaccine directly to providers to consolidate inventories and reduce the number of times vaccine is handled during the delivery process.

In order to continue participating in the VFC Program, the State Department of Health (DOH), along with all counties and providers in Washington, will be required to adopt this new way of doing business. We are working with DOH to establish guidelines to ensure a smooth and successful transition. The change to direct distribution is expected to begin the first or second quarter of 2006.

Some things won't change for providers:

- Tacoma Pierce County Health Department will still be your point of contact for participating in the VFC Program and receiving publicly purchased vaccine free of charge.
- Providers will continue to place vaccine orders with Tacoma Pierce County Health Department.
- Providers will still submit monthly vaccine accountability reports to Tacoma Pierce County Health Department.

We will continue to work with you on various aspects of vaccine quality assurance, including VFC Site Visits, CASA/AFIX assessments and vaccine storage and handling quality assurance. Our efforts to continue to provide quality outreach and education for immunization promotion, influenza planning and other immunization related topics will continue.

Some things will change for providers:

- Once your order has been processed by Tacoma Pierce County Health Department, vaccines will be delivered directly to your office from the distributor.
- Providers will no longer have to, **or be able to**, stop in to pick-up vaccines.
- Provider office staff will have to be fully trained in handling vaccines so that when deliveries arrive, vaccines are properly stored to avoid vaccine loss.
- Providers will have to plan ahead with ordering, allowing time for delivery.
- A good rule of thumb for ordering will be to place orders when you still have a 10 to 15 day supply of vaccine in inventory.

We can assist you by training your office staff, assessing your ordering and storage needs and providing helpful reference materials. As we learn more about timing and the new processes, we will contact you to help you and your office staff prepare for these changes. Please take time to share this and future information with all staff.

Should you have any questions or concerns, please contact us at 253.798.2987. Thank you for your continued efforts to assure that Pierce County children are appropriately immunized. ■

The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

Avian Flu

Federico Cruz, MD

There has been a steady stream of images coming from the Far East: Pictures of thousands of civilians wearing masks, and of huge funeral pyres of birds and other farm animals. We are watching the potential development of a new strain of Influenza A (H5N1). This strain of avian flu has all the markings of a huge public health threat.

We judge all flu outbreaks against the standard of the great pandemic of 1918. That outbreak left over 20 million dead worldwide. Many people react with some indifference to an outbreak that occurred in the distant past. After all, this was before antibiotics, before effective vaccines, before any anti-viral drugs were available and of course before all the high-tech medical advances that are available now to deal with the desperately ill.

Yes, those statements are true but in many ways not completely relevant to our situation now.

• Yes. . . we do have sophisticated vaccine technology. BUT, we do not have a vaccine specific for the new virus that is evolving. And it takes at a minimum of 4-5 months to produce any significant number of doses of vaccine.

• Yes . . . we do have antibiotics for the secondary pneumonias that can be so devastating. BUT, bacterial infections were one cause of the huge mortality for that the flu of 1918. The virus itself was highly virulent and caused massive respiratory shock in patients that had nothing to do with a secondary bacterial infection.

• Yes . . . we do have anti-virals that may be effective against an avian flu. BUT, we have stockpiles that currently cover only 1-2% of our population. Remember, in a pandemic 25-30% of the entire population will be infected.

• Yes . . . we have intensive care units and respiratory support systems that could save many lives. BUT, they all depend on a healthy workforce in place 24 hours a day. In 1918 close to 50% of the health care workforce came down with the disease.

So, the bottom line is pretty grim. We are better off than the people of 1918, but we will face the pandemic without a vaccine, without adequate anti-virals to cover those most in need. We will have a health care system that may or may not have the staff to provide the basic life supporting services that are going to be needed by tens of thousands of patients.

However, it is not all gloom and doom. We have an enormous advantage over 1918. We know it is coming and we can get ready. We can work on preparing the way for rapid vaccine production at massive levels. We can stockpile adequate supplies of anti-virals, we can organize and prepare our health care work force to keep essential services going.

What else have we learned?

• In 1918 the best and worse happened in our health care system. In some communities, hospitals stood unstaffed and patients unattended as doctors and nurses didn't show up, or reported instead for military duty. In other communities substantial numbers of health care professionals showed up and fought the infection at substantial risk. Dentists, medical students, pharmacists, and retired professionals were recruited to staff the many hospitals and emergency facilities that went up overnight to manage the hundreds of thousands of acutely ill patients that deluged the system.

• Avian flu has affected humans in Asia for several years, providing us with a wealth of experience in caring for patients. Good hygiene and communicable disease control measures (gowns and gloves and N95 masks) have prevented hospital-acquired infections from happening. Anti-virals, if started early enough, do impact the course of the infection.

• Public health has a huge responsibility during an outbreak to work with the public at large. How do we maintain public trust, and effectively communicate disease prevention strategies? How do we keep up public morale? Learning from 1918 we have to tell the truth about the disease and the risks to the community. We have to be active, not passive, in approaching the epidemic. Organize, organize, organize, getting everyone involved in facing this threat. Panic will only lead to the collapse of essential services and can be minimized by being focused and getting the word out about concrete things the public can do to safeguard their community and themselves and family members. This may involve the use of masks with the general public level. Respiratory etiquette practices will need to become second nature to everyone in the community. The closure of public gatherings, schools, restaurants, bars, and theatres may occur to try to slow the spread of the virus into the community.

For you, the physicians of our

See "Flu" page 20

IN MEMORIAM

MAX S. THOMAS, MD

1914 - 2005

Dr. Max Thomas died August 16, 2005. He practiced internal medicine in Tacoma from 1946 until his retirement in 1983.

Dr. Thomas received his medical degree from the University of Iowa School of Medicine in 1939. He completed his internship at City Hospital in Akron, OH and residencies at Schofield General Hospital, Thomasville General Hospital and Mason Clinic.

Avid interests included tennis, bridge and maintaining his manicured yard. He was a nationally ranked tennis player in his mid-eighties and continued to enjoy bridge until shortly before his death.

Dr. Thomas lost his wife of 66 years in July.

PCMS extends condolences to Dr. Thomas' family.

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.

Pay for Performance

Andrew Statson, MD

"You need three things in the theater - the play, the actors and the audience, and each must give something."
In *Theater Arts* (July 1958)
Kenneth Haigh

Performance. Think of Hamlet following the ghost on the platform in front of Elsinore Castle. Think of Petruchio taming Katharina. Think of Professor Higgins tutoring Liza Doolittle.

That is performance. Most of us know the stories from the films, rather than from the plays, but the theater has more. It has the audience.

Viola Spolin, theatrical director and producer, said, "The audience is the most revered member of the theater. Without an audience, there is no theater...They are our guests, our evaluators." She could have added that the reaction of the audience affects the performance of the actors and can make or break the show.

Yes, but what does that have to do with medicine? Well, Reuters Health reported that in late July Mark Miller, executive director of the Medicare Payment Advisory Commission (MedPAC), testified before the Senate Finance Committee. He said that his commission had enough measures to start paying physicians and others based on the quality of care given to the patients in the Medicare program. These measures look at processes, such as giving aspirin after a heart attack; at safe practices, such as checking medications and dosages; and at some outcomes of treatment.

For physicians, Mark Miller suggested to start by setting aside 2% of the Medicare payments, to be redistributed when the doctors meet preset targets or show improvement in their practices.

Herb Kuhn of CMS said that current demonstration projects have shown improved performance in patients with heart attacks, congestive heart failure, pneumonia, coronary artery bypass grafts, or hip or knee replacements. I don't know whether these improvements had to do with processes of treatment or with outcomes.

Senator Charles Grassley, chairman of the Finance Committee, joined by the committee's top democrat, Senator Max Baucus, has already introduced pay-for-performance legislation. According to Senator Grassley, "Something is wrong when delivering low quality care leads to more revenue for providers."

We used to be physicians. Then we became providers. Now it looks like we'll be performers. I'm not sure whether that is a promotion or a demotion. Our performance will be judged not by the audience, that is, our patients, but by people from the outside, who will never witness a play.

They will judge on the roominess of the stage and its visibility from the seats, on the appropriateness of the decor, on the realism of the costumes and the makeup of the actors, on their adherence to the script, but not on their interaction with the audience. Perhaps most important of all, they will judge on the cost of the performance.

So how are they going to do that? They'll review patient records to see that all the bullets are there. They'll look at the algorithms we have followed according to what they call evidence based practice. They'll give us the protocols for disease management. As long as we do as told, we will have performed to their satisfaction. Does that mean that the patients are getting the medical care that is best for them? That is what MedPAC seems to think. Evidence based practice equals best medical care. There should be no question.

Well, Doctor Michael Mennuti, the newly installed president of ACOG, is also a professor of human genetics. In his inaugural address he said, "We already know that variations in a patient's genome can increase the chance of developing certain diseases and can affect the severity of common disorders, such as hypertension and heart disease. We also know that an environmental exposure will cause disease in some patients; yet, in other people, the same exposure is not a problem, because they have a different genome. And we know that a drug might be very effective to treat a disease in one patient, but ineffective in someone else with the same disease - based on differences in their genome."

How was that again? We must conclude that, according to the evidence, there is no single way to treat a disease. The best treatment must vary from pa-

See "Performance" page 16

Performance from page 15

tient to patient, according to their genetic makeup. What does that say about evidence based practice? Perhaps I misunderstood. I thought evidence based practitioners maintained that there was only one best treatment for every condition, the same for everybody.

Doctor Mennuti opened the door to a new field, pharmacogenetics, which will give us designer drugs to fit the patients' genomes. I see a problem there, too. If I remember anything about genetics, it is that just because some genes are there doesn't mean that they are expressed. Even if we knew the entire genome of all our patients, we still wouldn't know when, how often, and for how long any one gene is active. On what basis, then, will we treat our patients?

There is more. The lessons from the side-effects of the NSAID should have taught us that. If we turn off a gene in a certain organ where its effect is deleterious, can we avoid turning it off in other organs where its effect is beneficial? Can we give NSAID to relieve the pain and inflammation of arthritis without at the same time adversely affecting the renal, gastrointestinal, cardiovascular or nervous system?

Someone had said that to err is human, but to really foul things up, we need a computer. I'll add that we need regulators with computers. The long-term effects of pay-for-performance will be interesting to watch. Unfortunately, when disasters begin to happen, the regulators will not accept the blame and will point their finger at us.

To return to the analogy with the theater, the script is the text, which the actors are expected to deliver. I don't know how strictly they adhere to it. Assuming that they always do, the way they say the words may make them sound as a curse, or as a blessing; as hatred, or as love.

To us, the text is the medical literature. How we apply it makes a difference. There is so much in it, that if we looked long enough, we could find justification for just about anything, from repeat section to vaginal birth, from high dose Pitocin to low dose, from low weight gain during pregnancy to high, from low protein diet to high, from hormone replacement forever to no hormone replacement at all, . . . someone stop me, please.

Finally, the brilliance of the script and the delightfulness of the performance are not enough for the success of the play. If it does not enchant the audience, it will be a flop. I suspect that live performances vary from day to day, according to the reaction of the audience.

If a medical treatment does not help the patients, it will be wasted, whether it conformed to the protocols or not. The patients are our evaluators, the best placed to assess the quality of the treatment, because they are involved in it as much as we are, and they have to live with its result. No one else can be a better judge. ■

Pierce County Medical Society

Public Health/School Health Committee

invites you to join them for breakfast and

New Vaccines and Immunization Recommendations

featuring

— David Estroff, MD —

Deputy Chief, Department of Pediatrics, Madigan Army Medical Center
Clinical Professor of Pediatrics, U of W — Colonel Medical Corps USAR
Assoc Professor of Pediatrics, USUHS — Fellow, American Academy of Pediatrics

Please join us as we bring together pediatricians, public health representatives, school nurses and others to learn about new immunization recommendations and schedules including regional state and local program reviews and updates. In light of the many changes that are happening this year, we encourage your participation and look forward to robust discussions. Please bring your questions.

including panel members:

Tom Charbonnel, MD; Pediatrician, Tacoma; Chair, Pierce County Immunization Coalition
Ruth McDougall, RN, BSN; Public Health Nurse Consultant, WA State Department of Health, Immunization Program
Cindy Smith, RN, BSN; Immunization Program Coordinator, Tacoma Pierce County Health Department

- Vaccination update a comprehensive review
- New/revised schedule recommendations
- Review of changes including Varicella, Meningococcal and TdaP
- Pierce County Immunization Coalition, TPCHD and State Dept of Health updates
- Your questions and topics for discussion

Wednesday, September 28th
7:00 8:15 a.m.

Jackson Hall; 314 ML King Jr Way

Buffet breakfast available

RSVP helpful. Please call PCMS, 572-3667 and confirm your attendance

Applicants for Membership

David W. Dempster, MD
Internal Medicine
1624 South I Street #303, Tacoma
253-272-1231
Med School: University of Washington
Internship: Virginia Mason
Residency: Virginia Mason
Fellowship: Lenox Hill

Jon F. Geffen, DO
Physical Medicine & Rehab
Puget Sound Spine Institute
1515 ML King Jr Way, Tacoma
253-572-2663
Med School: Kirksville College
Internship: Capital Region Med Ctr
Residency: University of Missouri
Fellowship: Alabama Orth & Spine Ctr

Karkal Shwetha S. Hegde, MD
Internal Medicine
Good Samaritan Family Medicine
16515 Meridian E #A104, Puyallup
253-697-3030
Med School: Jawaharlal Neru
Internship: Englewood Hospital
Residency: Englewood Hospital

Jessica D. Lee, MD
Neurology
Madigan Army Medical Center
253-968-1440
Med School: University of Mississippi
Internship: Madigan AMC
Residency: Madigan AMC

Sangik Oh, MD
Int Med/Gastro
Tacoma Digestive Disease Center
1112 - 6th Ave #200, Tacoma
253-272-8664
Med School: Tufts University
Internship: Rhode Island Hospital
Residency: Rhode Island Hospital
Fellowship: Beth Israel Deaconess

Rosemary P. Peterson, MD
Cardiology
Cardiac Health Specialists
1802 South Yakima #307, Tacoma
253-627-1244
Med School: Uniformed Services Univ
Internship: Wilford Hall Med Ctr
Residency: Walter Reed Army Med Ctr
Fellowship: Walter Reed Army Med Ctr
Fellowship: Madigan Army Med Ctr

WSMA Annual Meeting in Tacoma - Health Care at the Crossroads

September 30 – October 2 is the date for the WSMA Annual Meeting which will be held in Tacoma at the Sheraton Hotel. The theme of this year's meeting is "Health Care at the Crossroads," a fitting theme according to President Ken Isaacs, MD. Because we are approaching the November elections and a vote on I330 and I336, and also for the unknowns physicians face in regard to Medicare reimbursement, pay for performance and the increasingly blurred line between physicians and other health care providers, we stand at an interesting juncture.

The Keynote speaker will be Governor Mike Huckabee of Arkansas, addressing America's Greatest Terror – Chronic Disease. He will focus on the impact of a nation that has focused on treating diseases rather than preventing them and the physical and fiscal disaster we face in healthcare. He is recognized as a national leader in the area of health care reform and has improved health care for Arkansans with many creative initiatives.

The Memorial Lecture on Physicians Health will feature F. Daniel Duffy, Ph.D., discussing "Doctoring the Respectable Addiction." He will explore the similarities between burnout and "unmanageability" of medical practice and addiction. The metaphor provides some useful ideas about the process of recovery that may be applicable to physicians burnout and growth toward balance in profession and personhood.

In addition to the plenary sessions, many scientific programs will coincide with the annual meeting including: Addiction Medicine 101; Allergy, Asthma and Immunology Symposium; Physician-Facilitated Community Health Projects; Pulling Together: Managing Handoffs, Conflicts, and Coordination of Care; Ophthalmology: What's New in Today's Environment; Advances in Women's Health; Common Legal Issues of a Medical Practice; Lessons from Terry Schiavo – Are Advance Directives the Solution or Part of the Problem?; and Quality Care, Information Technology and Payment Incentives.

For more information about the WSMA Annual Meeting in Tacoma, please call the WSMA at 1-800-552-0612 or PCMS at 572-3667. ■

Personal Problems of Physicians Committee

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

Your colleagues want to help

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

Confidentiality Assured

Flu from page 13

community, get ready to play an incredibly important role. You will be at the heart of the care effort that will be needed to keep thousands of infected individuals alive. But in order for you to be effective, you need to prepare. This starts with looking deeply within yourselves, asking how to be effective when this crisis hits our community. Ask: What supports will I need? How can I protect myself and my family and still show up for work? What training and orientation do I need to function in a system not run through your private offices?

In the coming months you will be asked to step forward and participate in our community's preparations. Please step forward. Everyone is looking to you to be there and to be ready. It truly is your role. ■

COLLEGE OF MEDICAL EDUCATION

Hawaii 2006... Fun and Sun

Plans are set for the Hawaii CME program in April 2006. Both hotel and air arrangements have been made and the agenda for the four days of CME has been set, according to course director, **Mark Craddock, MD**. The dates are April 2 to 7, 2006.

Focus on infectious diseases, neurology and gastroenterology will be paramount with some rheumatology, endocrinology and dermatology included. The CME schedule will be Monday, Tuesday, Thursday and Friday, from 7:45 a.m. until 12:00 noon, with no meetings scheduled on Wednesday; ideal for extra time to spend with friends and family.

This year the course will be held on the big island of Hawaii, at the beautiful Hapuna Beach Resort. Hapuna Beach has been rated the 'number one beach in America' – a long stretch of pristine white sand viewed by most of the resort's first class guest rooms.

The College has negotiated exceptional rates for all room categories at nearly 50 percent off offered by local travel agents. Connecting rooms for children 18 and under are also offered for those that want to bring families. Airline rates have also been negotiated to offer outstanding bargains.

Make plans now. Call Jeanette Paul at All Wanderlands Travel 572-6271, or email her at jeanette@awtvl.com. Watch your mail for the program brochure which will arrive shortly.

And, do yourself a favor and call Jeanette. You will be very glad next April that you made that call today. ■

Continuing Medical Education

Common Office Problems CME features timely primary care topics

Registration is set for the College's *Common Office Problems* CME scheduled for Friday, October 14, 2005. The conference will be held at St. Joseph Medical Center, Rooms 1A & B.

The program will offer 6 Category I CME credits and is again directed by **Mark Craddock, MD**.

This year's course will offer:

- Treatment of Common Skin Disorders
- MRSA: Trends in the Community and Guidelines for Treatment
- Is Polycystic Ovarian Syndrome a Cardiovascular Disease?
- Latest Trends and Treatments for Gynecological Infections
- Management of Common Rhythm Disorders: Focus on Atrial Fibrillation and Atrial Flutter
- Parkinsons: What's New?

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. Those attending the program will be able to:

- Apply recent developments for diagnosing and treating common skin disorders.
- Explain the metabolic implications and different treatment modalities of polycystic ovarian disease.
- Describe the latest information for diagnosing and treating gynecological infections.
- Identify the most recent community MRSA trends and treatment guidelines.
- Use the management of common rhythm disorders in the office setting, including specifically atrial fibrillation and atrial flutter.
- Apply the recent developments relevant to primary care physicians for diagnosing and treating Parkinson's Disease.

Look for the registration brochure in the mail just after Labor Day.

For more information, please call the College of Medical Education, 627-7137. ■

Dates	Program	Director(s)
Friday, October 14	Common Office Problems	Mark Craddock, MD
Friday, November 11	Infectious Diseases Update	Philip Craven, MD
Tuesday (evenings) January 10 & 17	Cardiology for Primary Care	Gregg Ostergren, DO
Wednesday-Saturday January 25-28	CME at Whistler	John Jiganti, MD
Friday, March 10	Mental Health Review	David Law, MD
Sunday-Friday April 2-7	CME at Hawaii	Mark Craddock, MD
Friday-Saturday May 5-6	Internal Medicine Review 2006	John Hurst, MD
Friday, June 2	Primary Care 2006	Steve Duncan, MD

Retired Doctors' Wives Luncheon

There will be a no-host luncheon Wednesday, September 28, 2005 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 Marlyn Baer (564-6374) by Friday, September 23.

Come and renew friendships!

Compliance Programs for Physicians' Practices

The WSMA and the Washington State Medical Group Management Association are offering a half day program that will provide, in very practical terms, the "rules of the game" and specific actions that physicians' practices must implement in order to achieve compliance. All practice staff need to cooperate in performing the necessary "due diligence" to guarantee that your practice is complying with the law.

Topics covered include compliance programs, audit activities by government and commercial insurers, risk areas for physician practices and improving practice revenue through an effective compliance program.

Offered in Tacoma at the LaQuinta Inn on Friday, September 16, 12:30 to 4:30 pm. Cost is $189 per person. Call 1-800-552-0612 for registration information. ■

Classified Advertising

POSITIONS AVAILABLE

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East Sumner, WA. Three buildings facing Main Street and the new Fred Meyer retail outlet, currently the Sumner Animal Vet. Building #1 - 5,000 sq. ft. including a 1,000 sq. ft. three-bedroom apartment. Building #2 - 1,500 sq. ft. and building #3 - 3,000 sq. ft. Any one or all $1.50/sq. ft. NNN. 253-863-7761

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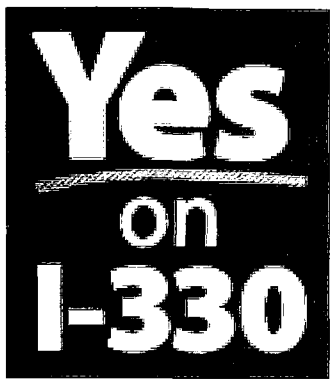
BULLETIN

October, 2005



Join doctors, nurses and patients and vote for a healthy Washington on November 8

See I-330 Update page 19

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.

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Pierce County Medical Society
BULLETIN

October, 2005

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President's Page

by Patrick J. Hogan, DO

Patrick J. Hogan, DO

Living Healthy with Stress

We are all so stressed! Whether it is from our own problems or seeing tragedies of hurricanes or a distant war, stress can weigh heavily on our minds and bodies. Even when serious problems are not present in a person's life, most patients we talk to and most medical professionals have a perception of stress in their lives. Worrying about things that could, but probably won't happen is one of the most pervasive self-imposed unnecessary stressors. **It is no wonder that so many diseases are impacted by stress in our American culture.**

In an emergency situation, stress produces a beneficial protective response for the body. However, these effects from cortisol and adrenaline released continually day in and day out due to persistent unresolved stress produce damaging consequences in our bodies. Chronic unresolved stress produces blood pressure elevation and cholesterol elevation. It produces accumulation of abdominal "toxic" fat in place of muscle that lowers the metabolic rate. It produces neurotransmitter changes resulting in sleep disturbance, depression and further lowered coping ability. Instead of the emergency "flight or fight" response from stress that was originally programmed in our bodies, a "stew and chew" response has developed in our society in which stresses are suppressed and appetite for fatty food is increased. **Along with the American sedentary life style, these stress responses on the body have resulted in our epidemic of metabolic syndrome and escalated cardiac disease** in those with less than adequate stress coping skills. Stress effects are as important of a cause of heart disease as the effects of smoking.

The good news is that damage from stress is preventable. A recent study from Ohio State University has confirmed that stress does impair the immune system responses. However, the negative effect of stress on the immune system did not occur in those who had an active means of coping with stress.

It is now recognized that all the adverse consequences of stress on our systems can be averted if we have adequate coping mechanisms and an adequate outlet for the stress.

CHAMP is dedicated to keeping medical professionals healthy in both body and mind through physical activity and good diet. Our patients will then benefit as a result. The best way of coping with stress for us and our patients is by making exercise a near daily routine in life. Exercise has been documented to decrease the excessive tension energy in the nervous system and muscles. Exercise leads to an elevated endorphin relaxation response for nearly two hours after the exercise session. Exercise counteracts the stress related loss of muscle tissue and eliminates the toxic abdominal stress fat that has accumulated. Exercise improves sleep, depression, self worth and confidence. Exercise promotes better nutrition that helps the body better manage stress.

The exercise to release stress responses can be done through 30 minutes or more a few times a week of **aerobic exercise** (such as running, biking, or swimming) or many **recreational exercises** (such as dancing, racket sports, kayaking, fencing and even meaningful sexual activity). **Yoga** is also an excellent means of releasing the effects of stress on the body and as noted in the August PCMS *Bulletin*, should be part of every complete exercise program.

The proper attitude toward stress is also important by not amplifying stressors to more than they are and not stressing about things that can not be changed. A "don't worry be happy" attitude is ideal but at least prevent worry from pervading the day-long consciousness that would then lead to self imposed stress damage.

Spirituality can be an important aspect of stress release whether or not a person is religiously inclined, especially if done in balance with other stress release techniques noted above. An exaggerated focus on religiosity alone actually increases stress rather than decreasing it. Similar physiologic benefits can be derived from meditation sessions of any content. It is just doing meditation regularly that matters, not the duration it is done. Spirituality is an experience unique to each individual. The Dali Lama has said "My religion is kindness." The satisfaction and joy from helping others in our human family is a stress release in itself.

And don't forget laughter. People who laugh regularly have less stress perception and less incidence of heart disease according to a University of Maryland study. Lighten up!

See "Stress" page 4

Stress from page 3

Release stress just for the health of it. Consciously let go of stress that is not necessary and go ahead and experience the stress that must come to us all. Develop coping techniques so your mind and body will remain healthy despite the stress of stress. Send in your ideas for coping with stress while surviving in our complicated medical world that we can compile for the PCMS membership.

Yes on 901 and 330 Addendum:

The initiative to prohibit tobacco smoke in public places in Washington is likely the most important public health vote we may ever take. It won't happen unless we get to the polls and get our patients to the polls. It is certain that the tobacco industry could defeat this initiative if they mobilize to vote the 20% opposed to it and we do not adequately counter those votes. **Getting people out to vote for 330 and 901 is the perfect union toward a healthier Washington.** Let's get people thinking yes on 330 and 901 and no on 336. ■

CHAMP Activities/Updates

Digestive Health Specialists bicycle team at the Mary Bridge Courage Classic. From left: Gonzallo Tello, Tracy Gage RN, Gary Taubman MD and Harald Schoeppner MD

In addition to the yoga studios listed in the August *Bulletin*, a new studio in south Federal Way with a wide range of classes and experienced instructors has been recommended by a PCMS member. It is Three Trees Yoga, 204 South 348th Street, 253-815-9642.

FitTips #10

by Patrick Hogan, DO and Adrienne McNamara MS

Resistance Strength Training for Everyone

Why to do weight training:

1. Weight lifting is not just for body builders. Resistance strength training whether with free weights or weight machines should be a part of everyone's exercise program. It provides multiple benefits at all ages and no matter what the motivation is for the exercise program.

2. People lose about ½ pound of muscle mass through aging every year after age 25. This results in a lower metabolic rate and resultant weight gain from fat deposition. Weight training prevents and **restores this muscle mass** and replaces the fat tissue with muscle tissue.

3. **Weight training increases the metabolic rate** well after the exercise session even during sleep that results in increased calories being burned. Weight training is an essential part of any weight loss program.

4. Strengthening muscle improves the ability to do daily activities easier and more safely. Most back injuries and strained muscles occur because of deconditioned weak muscles.

5. **In older people** strength training especially improves walking and balance. Even at ages over 90, the strength and flexibility achieved improves the ability to do daily activities, prevents falls and helps people get back up without injury if they do fall.

6. As fat is replaced by muscle people feel better about themselves with **greater self-esteem and self-confidence**. Strength training is a good stress and depression reliever.

7. Women who weight train will not develop big muscles but will develop good muscle tone with good muscle definition.

8. Weight training increases the **strength of bones** and prevents osteoporosis better than almost any other exercise option.

9. Weight training **improves tendon and ligament strength** as well as muscle allowing any sport to be done better with less chance of injury.

10. Muscle strength training also **improves heart strength** improving cardiac function.

How to do resistance strength training with weights or machines:

1. It is ideal to receive instruction provided by a trainer at the YMCA or fitness facilities.

2. Machine weights are safer to use, require less time and better isolate the muscle targeted. Free weights do provide greater dynamic strengthening of supporting muscles.

3. Greater strength is achieved in the recovery (essentric) part of the muscle contraction rather than the concentric part of the contraction. Thus, bring the weight back to the starting position more slowly. Typically a count of 2 seconds pushing the weight and 4 seconds recovering back to the baseline is ideal.

4. Breath freely during the entire motion without breath holding. ■

NutriTips #10

by Joan Brookhyser, RD, CSR, CD

Fiber and Your Health

Fiber (a.k.a. roughage) is the non-digestible part of food that is not cable of breakdown and absorption by the human gut. As a result, during transit of this non-digestible food these fibers have ample opportunity to interact with products of digestion. These physiological effects we now know to be very beneficial to prevention of disease and maintenance of our daily health.

WHAT KIND OF FIBER SHOULD YOU EAT?

There are two kinds of fiber in our diet: soluble and insoluble. Insoluble fiber is what is often recommended for bowel irregularity and constipation. In addition, insoluble fiber can delay stomach emptying and slow the rate of digestion and absorption of important nutrients. Insoluble fibers may also play a role in cancer prevention.

Soluble fiber has a more unique role in colon and cardiac health. Soluble fiber tends to hold water and form gels thus becoming a substrate in colonic fermentation that is important in colon health. The other benefit of this mechanism is ability to lower cholesterol levels. For Type II Diabetes this type of fiber can help regular blood sugars as well.

HOW MUCH FIBER DO YOU NEED?

Adults should try to get 25-35 g fiber per day. At least six grams should come from soluble sources. Children and young adults need fiber as well. From age 2 up to the age of 20 it is recommended for children to get in 5 grams per day plus their age. For example a 5 year old would need 10 g of fiber per day (5 + 5 age = 10). Fiber intake above these recommendations is not advised as excess fiber can result in malabsorption of important nutrients.

WHERE DO YOU GET FIBER?

Below is a small list of sources of fiber and average fiber content of these foods:

INSOLUBLE FIBER

Whole grain bread (1 slice) = 2-3 g
Bran cereals (½ -1 cup) = 3-4 g
Vegetables (½ cup raw) = 2-3 g
Fruit with edible seeds such as strawberries (whole or ½ cup) = 3-4 g
Pastas (whole grain ½ c) = 3-4 g (white grain) = < 1 g
Shredded wheat (2 biscuits) = 5 g

SOLUBLE

Oats (3/4 cup cooked) = 3 g
Legumes or dried cooked beans (½ cup) = 4-7 g
Barley (½ cup) = 3 g
Apples (with skin) = 3-4 g
Carrots (½ cup) = 2 g
Citrus fruits (1 whole) = 2-3 g ■

Special Feature

by Jean Borst

The Path to Fitness is not Always Conventional Part II: Ballroom Dancing

"To dance, above all, is to enter into the motions of life. It is an action, a movement, a process. The dance of life is not so much a metaphor as a fact; to dance is to know oneself alone and to celebrate it."
—Sherman Paul

When Diana Dean took up ballroom dancing five years ago, it was more to keep her daughter company than to seek out a new activity. "She was back home, between colleges, and bored," she recalls. "She looked in the yellow pages and found a ballroom studio in Tacoma. I just went along as her partner to offer moral support. Three months later, my daughter was off to Bastyr, and I was totally hooked on ballroom dancing. I loved everything about it."

At that point, she managed to get her husband, **Dr. Bill Dean**, Tacoma urologist, involved. "I just felt it wouldn't look right if I went out dancing without him," she says. "He was a great sport." They attended lessons together at a studio in Tacoma, and he even performed in a studio showcase dressed as John Travolta in Saturday Night Fever – white suit and all. Diana donned a Cruella DeVille costume and performed a mean west coast swing at the same event.

"It was at that point I realized ballroom dancing was about more than just movement – it's about music, acting, costuming, role playing."

When the Tacoma studio closed, Bill hung up his dancing shoes, along with his white suit. But Diana sought out a studio in Kirkland where she attends classes twice a week. Some students at the studio specialize in certain dances. Others, like Diana, want to learn them all. She studies all three American ballroom dances, which includes Smooth (waltz, fox trot and tango), Rhythm or Latin (cha-cha, rumba, meringue, salsa), and East and West Coast Swing.

"Some people are there just for the exercise and social contact, while others are more serious," Diana explains. "I'm somewhere in the middle. I'm interested in learning all I can." Diana has participated in a number of local competitions, as well as a few national contests. "Some people are just not inclined to compete, but I like it," she says. "And besides, it gives me an excuse to dance for two solid days. I love it."

Dancing has provided more than exercise and a fun hobby for Diana. It's been somewhat of a lifesaver. "I was suffering from severe anxiety and depression, and at one point had to give up my job as a speech pathologist as well as my dancing. I felt like I wasn't present in my body. It was a very difficult time." Recognizing how important dance was to her, Diana's psychologist encouraged her to return to it. "Dancing really is good for my mental health. It's one thing that truly relieved my anxiety and depression. The dancing, movement and music put me at ease. I've come to realize that both the physical exercise and the joy that comes from dancing is what my soul needs. I almost reach a meditative level – especially when I'm dancing a beautiful waltz. I feel like I'm flying around the floor."

Dr. Bill Dean (aka John Travolta) and wife Diana in perfect form

And that feeling remains with her, even when she's not on the dance floor. "Since I began dancing, I must carry myself differently. So often, strangers approach me and ask if I'm a dancer. And once they find out I am, they are

See "Dancing" page 8

Pierce County Dance Resources

Ballroom dancing venues for Waltz, Foxtrot, Tango, Swing, Salsa, Cha Cha, Rumba, Hustle, Lindy Hop, etc.:

1) **Abbey Ballroom** - www.abbeyballrrom.com
Friday night dances and private and group classes

2) **U.S.A. Dance - Tacoma Chapter** - www.dancetacoma.org or 307-1499
Dances fourth Saturday of each month

3) **Yahoo** - http://calendar.yahoo.com/dancetacoma
Has extensive monthly calendar of dancing possibilities in area

4) **South Park Community Center** - Saturday October 8 - $50
Twenty five workshops and professional shows

Dancing from page 7

always interested in hearing about it. So many people tell me they have wanted to try it," including PCMS President **Pat Hogan**, an avid fitness buff who is trying to fit dance into his regular exercise routine. She and her husband also know of other couples within the Medical Society who dance regularly.

Diana highly recommends dance to anyone who has an inclination to try it out. "It's great exercise, you can lose weight, and it's a wonderful way to meet people. I come across all sorts of people in my classes. Some are there because they want to learn to dance for their wedding or their child's wedding. There are also a lot of young people taking lessons and dancing in studios and clubs." Swing and salsa are particularly popular with the young crowd, she says. Despite past stereotypes, ballroom dancing isn't just for older adults anymore.

If you think you're interested in ballroom dancing, there really isn't much preparation involved to get you out on the floor. "To get started, you just need yourself and a little money," Diana says. At some point, Diana suggests purchasing ballroom dancing shoes, especially if you're planning to take six or more classes.

Diana offers these suggestions to get you going:

• Check the Internet. It's a great resource for information on classes, studios, ballrooms and dance shoes.

• If you're interested in taking classes, call and find out about fees. Do they offer a series of classes? Can you attend classes on a drop-in basis? Be aware that private lessons can cost up to $76 an hour.

• Go to a ballroom or club first. Most locations charge only a nominal fee and often provide instruction. Seattle is your best bet. From the seductive salsa at Beso Del Sol to the fluidity of the Viennese waltz at the Century Ballroom, there are many options to choose from. Weekly dances are also held at the Seattle Center's Center House. Again, check the Internet for locations, hours and cost.

And remember, you don't have to be a couple to dance. "Actually, there are advantages to being single," Diana says. "You get to dance with a lot of different people, and there's always someone to dance with. It's fun, and you get a lot of practice."■

The Physical Benefits of Ballroom Dancing

It's no secret that moderate exercise and sensible eating habits are the key to remaining trim and fit. However, the thought of spending thirty minutes on a treadmill, or jogging around the block five times is out of the question for many of us. Dancing works like a stress and tension reducer. For people on a hectic schedule it can become a passion that helps you improve your attitude and increase your confidence in both social and business situations. That's what makes dance the ideal exercise! After all, dancing is a mild aerobic workout, minus the boring part! When you take dance lessons, you make exercise a fun and enjoyable social event, every night of the week. Your dance "work out" takes place with pleasant music and everyone's in a good mood. It's fun.

Consider these dance facts:

- Dance contributes to increased personal confidence
- Olympic athletes often include dance in their training to sharpen their control, agility, speed and balance
- Dance is considered to be one of the top five physical activities, out of 60 studied
- Dance contributes to good posture and body alignment
- Dancing encourages gentle stretching
- Dance increases your flexibility and stamina
- As an aerobic exercise, dance benefits your cardiovascular system as you swing and sway from hips to shoulders
- Some doctors recommend 30 minutes of dance, three times per week

Ever since the International Olympic Committee gave ballroom dancing provisional recognition, it has been getting a lot of attention as a true athletic activity. One look at the fitness level and physiques of professional ballroom competitors, trainers and dance teachers is proof of its virtues.

"Ballroom dance is a rigorous activity that uses the larger muscle groups, and is usually done over the course of an hour, or an entire evening," said George B. Theiss, President of Arthur Murray International. "It's most frequently compared to ice dancing, and no one would question the athletic ability of an ice skater. Since we work without gliding across ice, it's possible that a competitive ballroom dancer might even be in better shape than a figure skater.

Many people turn to ballroom dance when more traditional exercise programs fall by the wayside, either because of injuries or sheer boredom. Ballroom dance is a low impact activity. This makes it accessible to people of at any age or fitness level. With less emphasis on "going for the burn" and more on having fun; the weight loss, improved circulation and aerobic conditioning emerges as a wonderful side effect.

Source: Arthur Murray Southern California *www.dancestudios.com/Exercise.html*

In My Opinion....

by Nichol 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.

How to Turn Yourself Into An Aerobic Monster: Part 17 in a series of one Take the RAMROD Challenge at age 60

A fellow cyclist nearing Cayuse Pass in 90° temperatures: "We paid to do this?"

First, take your expensive U.S. Postal Service bike to have it tuned to perfection, place it lovingly on your roof bike rack on your Volvo, and drive home. A great day of riding is ahead! As you arrive home, mess with your cell phone to change it to speaker phone as you drive near your garage until..... crunch. Yep, the bike does not fit. Remember, every disaster is an opportunity. Knowing that every ounce counts, and realizing that I had bloated up to a jiggly 168 lbs in 2004, then lost weight down to 159 lbs, I knew there was only one way to decrease my weight for hill climbing. The Ride Around Mt. Rainier in One Day, the RAMROD, is a beautiful one-day, 154 mile pleasure ride with a couple of hills that accumulate a mere 10,000 feet of gain. Everybody should ride this route at least once in a lifetime. I called around frantically to see if I could replace the crushed frame that I had ridden 15,000 miles over the last three years.

Secondly, in this year of fitness expressed by our esteemed PCMS President **Pat Hogan**, I dashed to a cycle shop in Seattle, where I found an identical frame and geometry to the one I had been riding. There were a few upgrades. The carbon fiber bike had better and lighter components, and I added Titanium pedals, carbon fiber aero bars, lightweight wheels, a wireless computer (saves weight), super light tires and tubes, but retained my 57 lb seat to protect certain body parts. I then bought Rocket 7 carbon fiber racing shoes, (made in Puyallup, U.S.A!) molded to my feet. My bike was a whopping 18 lbs, owing to the 57lb seat, and in order to compete with Lance Armstrong, I would have to pay $3,000 per pound to have a cycle like his. Lance is not sixty years old. I considered replacing all my amalgam fillings with plastic, and having carbon fiber bone replacements to save weight. Shaving my legs and hair can help a little, and riding buck-naked could also save a little weight, but may not be allowed in a National Park. Furthermore, the added sunscreen necessary for one of the whitest guys on the planet may offset any weight in the clothing, and could create some problems riding in pace lines with both men and women.

Thirdly, ride on specified days some short rides of 35 to 40 miles, and occasionally a few longer rides of 80 to 90 miles. This spring, once the drought was declared, we endured rain mixed with downpours and wind, from March to July. I rode up a little hill June 10th, from the entrance of Mt Rainier National Park to Paradise, and almost went to the *REAL* Paradise on the ride down. Mountains have no mercy. In spite of having all of my winter gear on, the ride down in the snow, then pouring rain and wind, kept me shuddering for 30 minutes when I got back to my car. I think my core temperature was around 17 degrees Centigrade at the end of the ride in JUNE! The general rule is to try to work up to about 300 miles per week. Commute on your bike!

Fourthly, plan your year. I rode the Chilly Hilly in February, the Daffodil Classic in April, The Peninsula Metric Century plus 12 non metric miles, I got lost (ask **Dr. Henry Retailliau**.) Later in June, the Tour de Blast takes riders up the west overlook to Mt. St. Helens in an easy 84 miles jaunt with a few hills. I think there is less than 7,000 feet of vertical on this ride. In July, there is a final tune up for the RAMROD, the Seattle to Portland Classic, a.k.a. the STP. Although this is a relatively long ride of 206 miles, it is mostly flat. This ride is a good place for beginners, but I would suggest riding at least for a week or two before attempting this ride.

Nichol Iverson, MD, Puyallup internist, geared for the RAMROD

Fifffffthhhly, or is it filthy? Get up at 04:00 on the last Thursday in July, drive to Enumclaw, et, voila, ride around Mount Rainier! Il est très simple! The ride only took eleven hours and twenty-one minutes. I tarried at the first rest stop when I talked with friends whom I have met on other short rides.

Actually, riding these difficult rides is easy. Yes, you heard it first here.

See "RAMROD" page 10

RAMROD from page 9

There is a secret, however. Discipline. When I sit across from a patient who is three feet two inches tall and weighs four hundred and thirty seven pounds, I feel that I have a responsibility to keep myself in shape. I competed in nothing in school after playing little league in grade school. I was too skinny, too slow, too uncoordinated and just plain non-athletic. As I have gotten older, I refuse to sit "sur mon derrière" and complain about my lack of God-given physical talent. Walking an hour daily, or biking an hour daily or exercising in some other venue on a daily basis is within the grasp of anybody. For virtually anybody, there is some form of exercise that can be adapted to help maintain vitality, proper weight and cardiovascular conditioning. There are, of course, a few unfortunate individuals, such as quadriplegic patients, who are limited in their ability to exercise. For the rest of us, there is a very simple and safe formula. Do more, and eat less. Anybody want to ride the RAMROD with me next year? I'm already training. ■

In My Opinion....

by Patty Kulpa, 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.*

PCMS - Pay for Performance Survey Results

Patty Kulpa, MD

Intended and Unintended Consequences of Using Pay for Performance Incentive Programs in Improving Quality Patient Care in Small Specialty Medical Groups: Pilot Study

Pay-for-performance programs (P4P) have grown recently in response to government pressures for establishment of national healthcare guidelines, growth in demands by purchasers (employers) for improvements in quality of care, rise in consumer-directed healthcare, resurgence of double-digit medical cost inflation, chronic medical conditions and healthcare utilization from the aging. P4P programs in healthcare differentiate payment among healthcare providers based on quality and efficiency measures. P4P programs are in their infancy developmental phase with primary focus on primary care physicians. They differ with the quality measurement, incentive payment structure and incentive size. Large primary medical practices are adopting these P4Ps.

For the small medical specialty groups, the P4P's performance measures may not be totally applicable and/or affordable due to their size and specialized medical care to the patient. They are a unique group of motivated physicians who made a conscious choice for their medical practice style.

In a pilot study, 225 Pierce County physicians from specialty groups received a fax survey questionnaire. Forty-five qualified physicians, who came from same specialty groups with less than five members, responded to a faxed survey.

Attitudes, Beliefs & Specialist' Profile

Prior knowledge of P4P did not influence the respondents' attitudes and beliefs of P4P program. There was no significant relationship between awareness of P4P and the attitude/beliefs and unique characteristics of this specialist group.

The unique profile of these specialists described them as being autonomous physicians, who practiced the art of medicine along with the science of medicine, and are the achievement motivators. They chose their practice style because they are less comfortable in a rigid structure of large hospital owned medical clinics. They met certain patient needs in a different setting and provided quality of medical service.

Unintended and Intended Consequences

This paper looked at the intended and unintended consequences of using P4P incentive program in improving quality patient care in small specialty medical groups

The intended consequences of using P4P were to provide uniformity in quality and efficiency by the healthcare providers in U.S. healthcare system via financial incentives. Healthcare consumers would benefit with the healthcare providers using evidence-based medicine to improve their medical decision-making.

In the research study, the unintended consequences for these Pierce County medical specialists to become involved in P4P were their loss of self-esteem with the threat to their competence of the new changes with P4P program, their loss of autonomy, their fear of doing cookbook medicine, the loss of their perceived quality delivery, their loss of future job security their loss of practicing the art of medicine, the upfront financial risk and lack of financial resources to meet the required office technological updates.

The small group medical specialists shared with the primary physicians from previous studies the unintended consequences: government pressures, pressures from the other stakeholders comprising of quality care advocates, employers, insurance companies, and consumers for P4P usage.

With P4P usage, confusion with the various quality measurements of the various P4P programs, inappropriate usage of the EBM healthcare guidelines in certain areas of medicine, and the misuse of the P4P program can occur. Potential misuses would include some physicians avoiding sick or "high risk" patients to improve their quality ranking, encouraging physicians to achieve "target rates" for healthcare interventions even when it may be inappropriate for some patients, and discounting patient preferences and clinical judgment.

Acceptance of P4P

Many of the specialists in the pilot study believed in theory the benefits of P4P but uncertainty of its acceptance prevailed (46.7%). Most respondents were unsure or did not want to accept the P4P as a way to deliver quality of

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their patients. Respondents perceived they are already delivering quality to their patients. They questioned the validity of quality measurements.

In this study, 31.1% would change their behavior to adapt to P4P if they were given education. Only 8.8% respondents could intellectually understand the need to change but could not fully accept it. 15.6% respondents would stay status quo and 22.2% outright resisted the change.

Doctors practicing in small groups in their own right are not conformist. That is a given. They will be more resistant to change if they do not understand it, if the change occurs suddenly, the change does not agree with their values, the change process excludes their input and does meet their needs. They basically will behave in ways that make sense to them, based on their values, and how they believe the proposed change will alter their current situation. The intellectual basis for change does not guarantee its acceptance.

Limitations of the Study

The small sample size, the type of sampling and the constructs of the questionnaire design limited my study. As a pilot study it only provided insights of the attitudes/beliefs of small group medical specialist, of their unique characteristics and of their financial obstacles. Future studies should use a randomized group of specialists stratified by the type of specialty, size and gender distribution in order to undertake a descriptive analysis of this subject. Tailoring the construct of the design survey to fit to a multivariate discriminant analysis would give more rigors to the analysis.

Conclusion

Their unique personal characteristics and their financial barriers prevented them from totally accepting P4P. P4P would have economic and noneconomic impact on these physicians. Overall, the survey results showed most specialists either rejected or were unsure whether they wanted to become a participant in the P4P programs.

My Opinion

For the small group medical specialist to accept this concept, their practice style and their perceived quality delivery for their specialty need to be addressed and be met in a collaborative manner. Keeping the providers in the loop with actionable information for change in behavior given to them on a frequent basis will promote provider acceptance.

There is no perfect health system anywhere in the world. For the P4P program to work in the healthcare industry, critical mass of physician participation is needed along with altered physician behavior that would promote system-wide quality improvement. This new approach will impact the overall future delivery of patient healthcare quality in United States. Let's get it right!

(Thank you for all of your support with this research study!)■

The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

Post Katrina

Federico Cruz, MD

Post Katrina...will things ever be the same? This seems to be a time of second-guessing, where the clarity of hindsight tells us what we should have done to avoid part of this awful tragedy. I don't want to jump on the finger pointing bandwagon – even though there was much that could have been avoided – there is blame enough.

For me, as Director of the local health department, this has been a time of sober reflection. How well prepared are we for a disaster occurring in the Puget Sound area? I have the real concerns of an anxious and needy community approaching me to ask: What are you doing to protect us? How will you respond if disaster strikes?

Our health department is part of the emergency response system for Pierce County, the state of Washington, and the national (Department of Homeland Security) system. National plans, state plans and local plans, all coming together, all developed in cooperation with a huge set of agencies at multiple levels across our country and state and local region. It is an invitation for confusion and chaos.

At least we continue to test ourselves, to be prepared.

As part of the Katrina response system, the state mobilized emergency workers (Urban Search and Rescue, law enforcement, medical and environmental volunteers) and dispatched them to the Gulf area as part of the national disaster response system. The Governor of Louisiana called our governor to ask if we would take in several hundred evacuees from the Hurricane-ravaged area. Governor Gregoire agreed and initiated "Operation Evergreen." Statewide, an alert went out over Labor Day weekend and staff of our health department met with the County EOC (Emergency Operations Center) staff to plan out how we would respond locally. Since the evacuees were scheduled to fly into Madigan Air Force base, our department was tasked with completing health screens and arranging any needed health care.

We scrambled over the next three days to put together a detailed plan of how to greet, screen, refer and house 2000 guests from Louisiana. This sparked passionate discussions and negotiations with our partners in public health departments, emergency preparedness and social service agencies across the state to be ready when the first plane touched down. As happens in most disasters, plans changed. The planes didn't come. Mass evacuations were halted. Instead, families began to trickle in as Gulf coast evacuees sought out family members and friends living in this area.

The event was very intense for us as we were on the spot to provide a complex set of services in a short period of time. Coordinating everything with a very large set of private and public agencies and large numbers of volunteers. How did we do? The short answer is: We were ready. It was not a pretty process but a real plan was in place and resources mobilized.

Part of the long answer to the question of how we did goes back to mobilizing our community resources. It was painfully apparent to us that there was much more preparation that should have been done before the event happened. In particular, working with medical care providers. Even more specifically with PHYSICIANS. We needed a number of family practice, internists, and specialists who could assess patients over a short period of time. Trying to round up volunteers over Labor Day weekend was not the time to do this.

We were fortunate the planes didn't land here. We have been given a space to get ready for future events that will require obtaining medical services with little notice. Now – before the disaster button is pushed again – is when we need to dialogue. Who is willing to help out in times of emergencies? What skill sets can we as a community put on the table when the call for help comes? I ask each of us to consider stepping forward. Sign up with the Pierce County Medical Society to be part of a pool of volunteers that can be contacted when need arises. By registering in advance, credentials and applicable skills can be checked ahead of time and malpractice insurance for the duration of volunteer time will be established. And, registration should be straightforward. A group of Medical Society members and emergency response staff will create a short, pain-free process for signing up.

What more could you ask for? Contact the Medical Society office for more details (572-3667). Please sign up today. Your community needs you! ▫

Ron Morris, MD Seeks Pierce County Charter Review Seat

Ron Morris, MD, family practitioner in Puyallup is seeking election to the Pierce County Charter Review Board, District 2, Position 3. Without an opponent in the primary election, he advanced directly to the general election, November 8.

The Charter Review Board is concerned with issues such as controlling property taxes and can have influence by ensuring that the charter requires developers to pay their share of infrastructure costs through impact fees for roads, sewers and public safety; term limit reforms which impacts the total number of years of county service, monitoring groups that want to gain and hold power indefinitely; campaign finance reform, auditing of tax exemptions, planning commission reform, and other important issues.

Tell friends and family in the 25th District, Puyallup, to vote for Ron Morris - Charter Review Board. To volunteer for his campaign, call him at 253-841-0523. ■

Pharmacy Directory Correction/Addition

An incorrect fax number was printed in the 2006 Pharmacy Directory. Please make the following change:

Kirk's Pharmacy (Eatonville)
Change fax number to: 832-4520

Also add second location:

Kirk's Pharmacy at Sunrise (Puyallup)
11212 Sunrise Blvd E #204
Phone: 770-3408 FX: 770-3511

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 Function of Price

Andrew Statson, MD

"We are only beginning to understand on how subtle a communication system the functioning of an advanced industrial society is based - a communication system which we call the market, and which turns out to be a more efficient mechanism for digesting dispersed information than any that man has deliberately designed."

Friedrich von Hayak (1978)

Picture a herd of deer grazing on a slope. Something stirs in the brush not far away. The lookout sounds the alarm and the herd runs, followed by a few coyotes. While the deer fed, blood filled their splanchnic bed. When they began running, the flow of blood had to be redirected to the legs, where it would do the most good. The gut was shut out. That is the function of epinephrine.

Money is the lifeblood of the economy, and price is its epinephrine. When the price goes up, it reduces the flow of money in that direction and sends it to where you can get the most for the amount you spend.

Imagine for a moment that our cattle herds were sick and most of them must be destroyed. The price of beef climbs to fifty dollars a pound. What are we going to do? We'll switch to chicken, pork, turkey, lamb, or even eggs, fish and tofu for our source of protein. On rare occasions, when we really crave beef, we may buy a small amount, but until the supply returns to normal, a steak will remain a luxury.

Should the government freeze the price of beef, long lines would form and the stores would be sold out within hours. If you asked the clerk to put you down on their waiting list, he'll gladly do that, for two years from now. If, instead, you slipped him a twenty dollar bill and promised him the same when he got your pound of beef, he'll set it aside for you from their next shipment. That is how regulated markets work.

The rise in the price is a signal of scarcity. It tells us we may buy the product if we must, but only by depriving ourselves of other things we also want. We would be better off to use another product instead, although the choice always remains ours. How many other things are we willing to give up to get a pound of beef?

On the opposite, a low price is a signal of abundance. Come and get it, it yells. If the price of hamburger went down to twenty cents a pound, it would be cheaper to feed our dogs with it than to buy dog food.

The above examples are one aspect of the function of price, as a signal to the consumers. A high price is also a signal to the producers. It tells them to increase their output, so they can profit from the opportunity. In so doing, they rapidly bring up the supply to match the demand, thus alleviating the scarcity.

Any political intervention in the economy that affects prices, also disrupts the regulatory mechanism of the market. Subsidies, price controls, quotas, and rationing of any sort interfere with the redistribution of economic blood and prolong the imbalance between supply and demand.

If you have read this far, you may be asking, "Fine, but what does that have to do with medicine?" A lot, actually.

For many years, the health sector of the economy has functioned without a pricing mechanism. Our prices are arbitrary, and the payments we get, even more so. The demand for our services is not regulated by the pricing mechanism of the market, and neither is the supply.

Only the uninsured patients are asked to pay what we charge, which, by the way, is based on the whim of the institution, and is not subject to any market discipline. Recently a New York reporter asked several institutions what they charged for MRIs, mammograms and other tests. For the same service, a three-fold difference existed between the highest and the lowest of the quoted fees. Of course, those quotes were not what the institutions received from insured patients.

The only pricing where the market imposes its discipline is in the area of uncovered services, mostly for elective cosmetic procedures.

While the subsidies to the consumers removed the market discipline for the demand of services, they also affected the supply side. Faced with that, the payors introduced a discipline of their own making, by setting a list of regulatory requirements, such as restrictions

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on the frequency of visits, tests, and prescription refills; prior authorization for various services; gatekeeper referrals; and many others. That led to a large increase in the hassle and the cost of doing business, thus raising the general cost of health care. The system is a nightmare.

The overall cost of the health care system already is horrendous, and is headed higher. Administration expenses consume at least 40% of the total. Their share is bound to increase with all the additional regulations controlling our practices, which, it seems, are piled on top of the existing ones almost daily.

Businesses, especially the small ones, are reducing the health care coverage for their employees, or dropping it altogether. Several states project that in ten years Medicaid will consume more than 60% of their budget. They probably are wrong, but that gives you an idea of how much pressure there is to do something, pressure coming both from business and from government.

To many, that something is to transfer the costs to the Federal government, with its deep, though empty, pockets. If we are going to go under, we might as well do it in style.

So how do we discipline the health care field? Medicare is leaning toward more management with its pay-for-performance program. It will push protocols and algorithms for disease management. Its goal seems to be the control of the treatment process.

Another approach relies on market forces. The current name for that is consumer-driven health care. Many companies have offered such programs to their employees and several million people already are enrolled in them. UnitedHealth and Aetna, among others, write such policies. These plans allow the patients to choose their physicians and treatments, and even to negotiate prices.

Some states also are moving in that direction. South Carolina has introduced such a program for its Medicaid patients. It allows the patients to manage their own health care purchases; it frees physicians, hospitals and others to design innovative programs for care; and it helps patients make decisions by giving them information and support.

Several other states—Florida, Vermont, Arkansas, and Colorado—have started pilot programs in consumer-driven health care. It is too early to know how these will work out over time. So far, they seem to have reduced costs while improving patient satisfaction.

The major cause of dissatisfaction with managed care was the restriction it imposed on patient choices. This program doesn't have that disadvantage.

This is not a true market approach. Patient care still is subsidized. Yet it makes patients aware of the cost of their treatments and has built-in incentives for them to choose appropriate care and to look for favorable pricing. At the same time, it lifts many of the regulations strangling physicians and hospitals. This is a small step toward the discipline of the market, the first we have seen in a long time. ■

7 Key Points About the New Medicare Drug Benefit: What Doctors Need to Know

Enrollment starts in a few weeks. How are your going to answer your patients' questions?

By David Glendinning, *AMNews* staff. Oct. 3, 2005.

Fall has arrived, and that means the Medicare prescription drug plans are off and running.

Starting now with the help of their families and the physicians that take care of them, beneficiaries will work to decide how — or whether — to sign up for what many are calling the biggest change to hit the health program since its inception. Seniors and people with disabilities face a variety of economic and practical considerations as they prepare to enter a new era of Medicare outpatient drugs.

Here are seven points that may help doctors determine what role they can — or wish — to play in this process. Still, no matter what level of involvement physicians decide to take, it's a given that all doctors should decide how they will handle patients' questions.

1. You're first on the list

In a recent Kaiser Family Foundation poll, most seniors said they first would ask for their physicians' counsel in deciding whether to enroll in a Medicare drug plan. Federal officials overseeing the rollout of the new benefit say doctors need to prepare accordingly.

The Centers for Medicare & Medicaid Services is asking doctors and their staffs to bone up on the basics of the benefit in advance of this fall's initial enrollment period. The more physicians know about what the government is offering seniors, the better off everybody will be when the inevitable first questions start coming up in the exam room, the agency said in a recent article to doctors.

"As a trusted source, your patients may turn to you for information about this new coverage," the agency said. "Because of this, we're looking to you and your staff to take advantage of this 'teachable moment' and help your Medicare patients."

Educational materials that the government has been offering physicians to distribute to colleagues and staff have stressed their role as the gatekeepers to enrollment information.

The main message that CMS is trying to impart: First learn, then teach.

2. Your audience is diverse

Every Medicare enrollee is eligible to sign up for drug coverage regardless of income and health status, but not ev-

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ery one will necessarily want to.

With doctors' help, federal officials say, most beneficiaries will decide early on whether the program is right for them. The Dept. of Health and Human Services recently estimated that as many as 30 million out of the 41 million eligible enrollees will sign up for drug coverage in the first year of the benefit's operation.

Legitimate reasons exist as to why certain patients might not be eager to sign up for the new benefit. Some already have coverage for their medications through a former employer and are not sure if they want to give it up in favor of a Medicare plan, beneficiary groups say. Yet others spend little on prescriptions right now and wonder if it makes sense to pay monthly premiums for unneeded drugs.

The situation becomes more complex with the addition to the mix of Medicaid, state pharmacy assistance programs and Medigap plans. Depending on how generous the existing coverage is, beneficiaries might be able to wrap the new Medicare benefits around holes in their current coverage rather than choose one program over another.

The moral of this particular story is that not all beneficiaries are facing the same set of circumstances, experts say.

3. Your patient's bottom line matters

The decision patients need to make in the coming months is essentially an economic one. For some low-income seniors, the government might be putting too much money on the table for beneficiaries to pass it up — and for their doctors to let them.

Many people with low incomes already should have gotten wind of the federal subsidies for which they could be eligible. The Social Security Administration this summer mailed out millions of letters alerting seniors that they could qualify for extra help under the Medicare drug benefit.

Individuals who make less than $14,355 annually and couples who earn less than $19,245 are eligible for extra financial help, assuming that their assets do not exceed certain limits. Beneficiaries at the lowest end of the income spectrum would be required to pay only $1 to $5 for each of their prescriptions, with no premiums or deductibles.

The prospect of such federal assistance has prompted seniors' groups such as AARP to urge their members to fill out any application forms that they receive from Social Security — or risk throwing away free money. Beneficiaries already receiving certain forms of government help won't need to bother; enrollment will be automatic for them.

Those who would receive the standard drug benefit would, after paying a monthly premium, then pay a $250 deductible to trigger the coverage. The government would bankroll 75% of the next $2,000 in drug costs, after which the initial subsidies would cease. A catastrophic benefit, under which Medicare pays for 95% of drugs, would kick in only after the beneficiary has spent $3,600 of his or her own money.

The bottom line, according to CMS — know your patients' bottom line.

4. Tell patients to act quickly

Drug benefit open enrollment for 2006 launches on Nov. 15 and continues for six months, until May 15. Physicians should know that any of their Medicare patients who have not signed up by the spring will need to cool their heels before they can do so again — after the beneficiaries contemplate a new set of fiduciary issues.

Unless seniors have drug coverage from another source that is at least as generous as what Medicare is offering, they will pay a premium penalty for signing up late. For every month beyond May that a beneficiary delays enrolling in a drug plan, his or her monthly premium offer will permanently increase by 1% of the national average premium.

With that economic sword of Damocles hanging over seniors' heads, AARP and other groups are urging every Medicare beneficiary to strongly consider joining a drug plan before mid-May. Even the healthiest of patients likely will need more expensive drug regimens later in life, and some could develop sudden illnesses during the vulnerable interim months when they have no access to catastrophic protections, the groups say.

Part of a physician's medical advice to elderly and disabled patients therefore may be that they should make a reasoned decision — but within a reasonable amount of time.

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Yes on I330 - No on I336 Campaign Information/Update

Order Campaign Materials

The November 8 election is fast approaching and it is critical that we take advantage of the voter contact your have very day with patients. Please make sure your waiting rooms and lobbies are stocked with information about the *Yes on I-330/No on I-336 Campaign*.

Order brochures, 5 x 7 easel-back cards, buttons, bumper stickers, 8 1/2 x 11 fliers (three different styles) and 11 x 17 posters.

Also, please take advantage of the latest voter-education aid: The campaign's waiting-room video. This will provide your patients with a short overview of I-330 and I-336 and also rebut some of the untruths our opponents are spreading. **REMEMBER: Lawyers have their own video that they are showing in the lobbies of law offices across our sate**. We must do everything we can to make sure our patients have access to the truth!

Place the fliers in your elevators and public areas, have brochures available in your waiting areas so patients can be informed about the two initiatives, ask your staff to wear the campaign buttons, and put a bumper sticker on your car.

Lawn signs are available upon request by calling PCMS, 572-3667. Please post a lawn sign at your office and home and help the campaign by posting additional signs throughout your community.

Finance Update

Pierce County continues to contribute to the campaign - reaching $234,000 at press time. Thanks to the continued fund-raising efforts of **Peter Marsh, MD**, Pierce County physicians are continuing financial contributions. Pierce County's goal is $315,908.

Opposition's Premise

The No on I-330 campaign ads totally distort the truth by claiming people will be forced to give up their right to a jury trial. NOTHING in I-330 would force a person to give up their right to a jury trial. It allows both physicians and patients to voluntarily agree to arbitration as an alternative dispute resolution.

For more information about the *Yes on I-330/No on I-336 Campaign*, go to www.yesoni330.org or call the campaign office at 1-877-740-0177.

Applicants for Membership

Omma G. Vaidya, MD
Ob/Gyn
521 Martin L King Jr Way, Tacoma
253-403-2900
Med School: Michigan State University
Internship: Lutheran General Hospital
Residency: Lutheran General Hospital

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5. Patients' choices will abound

Regardless of how complex their physicians' advice ends up being, those who embrace the Medicare drug benefit in the coming months will find no shortage of plan options.

Before releasing the full list of private plans Medicare approved to participate in the program, CMS announced that beneficiaries in every region of the country would be able to choose from a list of more than 10 stand-alone prescription drug plans, with the tally exceeding 20 in some areas. Those figures do not even include any Medicare Advantage managed care plans that have applied to administer drug benefits.

Federal officials treated the news as evidence that private plans have a great interest in getting into the nascent Medicare drug market. Healthy competition among insurers will translate into robust health benefits and lowered costs for both beneficiaries and the government, they said.

At the beginning of the year, CMS estimated that average monthly premiums would run seniors close to $40 per month. But the plethora of competitive bids allowed the agency to lower its estimate closer to $30 per month.

Seniors and the physicians who treat them also are bound to hear a great deal from insurers themselves. Some of the larger firms that are offering national drug plans are each planning to spend tens of millions of dollars on marketing their benefits directly to beneficiaries, industry experts said.

So doctors helping their patients navigate the drug benefit decision process should be aware that the choices will not end just because the beneficiaries decide to go for it.

6. You may be asked to fight

Many seniors will want to research which plans will cover most or all of the drugs that they are likely to need over the course of the year. To that end, CMS offers reference forms to doctors that their patients can use to record their medication regimens for side-by-side comparison to plan offerings.

For many seniors, the drugs that they need will be somewhere on the formularies of drug plans in their area, according to CMS.

For those who don't find their particular drug listed, in many cases a comparable alternative within the same clinical category will be available, agency officials said.

But even those who are the new program's fiercest supporters concede that cases will arise in which a needed drug has no covered alternatives and cannot be found on the approved lists of any plan in the area. In those cases, doctors could find themselves recruited into action during the enrollment period.

Physicians knowledgeable and weary of long, protracted battles with managed care companies might not relish the thought of taking on yet another insurer. But some patient advocates say medical professionals would play a vital role in prompting reversals of formulary decisions — in some cases even before a beneficiary has taken advantage of any drug benefit.

Drug plans must have an appeals process in place from the start that is designed to take expert clinical assessments into account when drug formularies receive a challenge based on medical necessity.

Some patients might find that the process of getting the drugs they need is not simply a matter of signing up. It's a matter of getting their doctors to help them fight to ensure that the plans they sign up for cover the drugs they need.

7. You can pass the baton

If these details sound overwhelming to some practices, they very well might be. CMS and physician groups such as the American Medical Association are working to make sure that doctors don't get distracted from what they do best by getting bogged down in minutia.

In one flyer the agency and the AMA produced for doctors, the groups urge physicians to keep their "teachable moment" minimal if need be.

"We understand the pressure on your clinical time with your patients, which is why we would just ask that you inform your patients who have Medicare that the new prescription drug coverage could be valuable to them and worth exploring," the document states.

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COLLEGE OF MEDICAL EDUCATION

Welcome... Lori Carr

Lori Carr is the new program administrator for the College. Lori spent the last five years as Senior Speech Coordinator and Contract Manager for Phoenix Partners Limited, dba locally as John Nance Productions. She was responsible for coordination of promotion of Mr. Nance's national speaking business. Fortunately, Lori also has a medical background, serving as an office manager for Phoenix Cardiac and Thoracic Surgeons from 1980-1989.

She brings an abundance of enthusiasm, the highest level of professionalism, and an exceptional ability to get the job done. Welcome Lori. ■

Whistler CME January 25-28

Everyone interested in attending the CME at Whistler, British Columbia is encouraged to make plans now for travel and lodging. This popular event is scheduled for Wednesday through Saturday, January 25th to the 28th, 2006.

Reservations for the program's 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. You are encouraged to make your reservations soon to ensure space - at least by December 1, 2005 when any remaining condos in the block will be released.

The Whistler course is under the medical direction of **John Jiganti, MD.** ■

Continuing Medical Education

Annual Infectious Diseases Update Friday, November 11, Fircrest

The annual Infectious Diseases Update is set for Friday, November 11, 2005 at the Fircrest Golf Club. The food, facilities and setting are perfect for continuing medical education.

The program is directed by **Dr. Philip Craven** and is hosted by the physicians of Infections Limited and offers reviews and updates on a variety of clinical topics.

Speakers and topics include:

• AIDS Past, Present and Future	Elizabeth Lien, MD
• Immunization Update	Larry Schwartz, MD
• Wisdom of the Ages In Infectious Disease Practice	Philip Craven, MD
• Sepsis	Richard Root, MD
• Hepatitis C - The Slow, Quiet Virus	Ann Hyder, MD
• Infectious Diarrhea: Before and After the Flood	Marina Arbuck, MD

This is a popular program, please register early by calling the College at 627-7137. ■

Hawaii CME - April 2-7...Make Plans Today

The Hawaii CME course will be held at the Hapuna Prince Hotel on Hapuna Beach on the island of Hawaii, April 2-7, 2006.

Reservations must be made early for both travel and hotel. Call Jeanette Paul at All Wanderlands Travel, 572-6271 or email her at jeanette@awtvl.com.

Watch your mail for the program brochure which will arrive shortly. ■

Dates	Program	Director(s)
Friday, October 14	Common Office Problems	Mark Craddock, MD
Friday, November 11	Infectious Diseases Update	Philip Craven, MD
Tuesday (evenings) January 10 & 17	Cardiology for Primary Care	Gregg Ostergren, DO
Wednesday-Saturday January 25-28	CME at Whistler	John Jiganti, MD
Friday, March 10	Mental Health Review	David Law, MD
Sunday-Friday April 2-7	CME at Hawaii	Mark Craddock, MD
Friday-Saturday May 5-6	Internal Medicine Review 2006	John Hurst, MD
Friday, June 2	Primary Care 2006	Steve Duncan, MD

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 – Family Practice Family Practice and Internal Medicine group seeks BE/BC family practice and/or internal medicine physician to join a thriving practice in a congenial setting. Located in Gig Harbor, just minutes from Tacoma. As a MultiCare Medical Group physician, you will enjoy excellent compensation and system-wide support, while practicing your own patient care values. Take a look at one of the Northwest's most progressive health systems. Three year FP or IM residency in accredited U.S. program required. Email your CV to *MultiCare Health System Provider Services at providerservices@ multicare.org or fax your CV to 866-264-2818. Website: www.multicare. org.* "MultiCare Health System is proud to be a drug free workplace"

Established Auburn Family Practice looking for P/T to F/T Board Certified or Board Eligible Physician to join a group practice. Work 3-4 days a week with a great support staff. Base salary plus incentive. Fax your CV to 253-847-9630.

Seattle, Washington. Multi-specialty medical group seeks B/C FP, IM/Peds or ER physician for a f/t urgent care position. All urgent cares are located within 40 minutes of downtown Seattle. As a MultiCare Medical Group physician, you will enjoy excellent compensation and benefits, flexible shifts and system-wide support, while practicing your own patient care values. Take a look at one of the Northwest's most progressive health systems. You'll live the Northwest lifestyle and experience the best of Northwest living, from big city amenities to the pristine beauty and recreational opportunities of the great outdoors. Please email your CV to *MultiCare Health System Provider Services at providerservices@ multicare.org or fax your CV to 866-264-2818. Website: www.multicare. org.* "MultiCare Health System is a drug free workplace"

LPN - We currently have openings for full-time LPNs - Phone Consulting Nurses. Proven skills and friendly manner with patients and peers. Self-starter, computer knowledge, good phone etiquette, organizational skills and flexibility required. Triage experience preferred. Shift: Must be flexible with schedule, position typically scheduled 10-7 and/or 11-8, and must be available to work weekends. Why work for Sound Family Medicine? Ask our staff! It's a friendly environment, a place where you're respected as a professional, and a place that welcomes innovations—like digital medical records—that enhance patient care and improve the workplace. If you're looking for a great place to work, take a look at us. Check out our website at www.soundfamilymedicine.com. Fax resume and cover letter to: 253-845-7073 Email to: recruitment@soundfamilymedicine.com

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Passing beneficiaries off to experts who have more time and resources to walk them through the more all-consuming details of the drug benefit enrollment process may be as simple as knowing a phone number or Web site. Assistance from Medicare itself can cover everything from determining low-income subsidy eligibility to comparing drug offerings of competing plans. Regional organizations known as Senior Health Insurance Assistance Programs, or SHIPs, and Area Agencies on Aging also will provide assistance and counseling that physicians may not have the time to offer.

Above all else, physicians need to be available to diagnose medical conditions and prescribe the necessary drugs to treat them, CMS said. Just because doctors are the first stop for help in figuring out what happens in the meantime doesn't necessarily mean that they need to be the last stop. ■

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POSITIONS AVAILABLE

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Pierce County Medical Society
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Pierce County Medical Society
BULLETIN

November, 2005

CHAMP/Walk Across Washington Inaugural Walk/Run Meets with Success!

Physicians, nurse practitioners, therapists, spouses, friends and colleagues participated in the first walk/run at Owen Beach in Pt. Defiance Park in support of the Coalition for Healthy Active Medical Professionals (CHAMP)

More photos, story page 9

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.

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Pierce County Medical Society
BULLETIN

November, 2005

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President's Page

by Patrick J. Hogan, DO

Don't Worry Be Healthy - Humor and Fitness in Medicine FIT HAPPENS

We had an exceptionally inspiring and captivating lecture by Harry Cordellos at the October General Membership Meeting. At age 68 he remains the world's most accomplished and motivating blind athlete. He brought us to a greater understanding of what it is like to be blind and to make most of any life limitation. He also is the perfect example of how **not to let any excuse prevent us from exercising or being involved**. We all have excuses but we heard from Harry how to work through those excuses and continue to take care of ourselves with fitness as well as caring for our fellow mankind by being involved.

PCMS President Pat Hogan is honored by the opportunity to run with Harry Cordellos, America's Greatest Blind Athlete

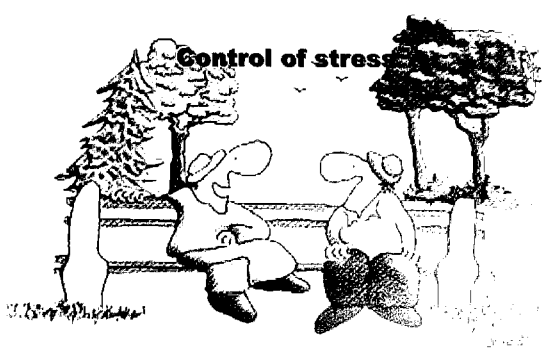
He blended his lecture with great insights into living with a limitation and humorous perspectives that we can use in our care of patients. We all know the value of humor in medicine. Humor provides great benefits for our brains; the comedy relief that we experience is actually a release of the neurotransmitter effects of stress on our brains.

In December we will have further opportunity to enhance humor in our medical practices and our own lives with a visit by the **amazing and legendary Warren Miller**. With his usual genius wit that has become famous from his ski films for the past 50 years, he will provide a humorous view point on staying physically and mentally active throughout life. This is an opportunity that will not come again to experience his passion for life in person.

All of us in the medical field are in a time of being demanded to work longer hours for less financial rewards while paying more for overhead and malpractice insurance along with expanding bureaucratic demands. It will continue to be the goal of your Pierce County Medical Society to improve the quality of our work life through the PCMS dedicated staff and many ongoing programs. At the same time, we must continually provide a life style example to the public in order to improve their quality of life and health. To that end I want to heap great kudos upon those of you who participated in our first annual **CHAMP Walk/Run Across Washington** event at Pt. Defiance on October 15. It was a successful inaugural event celebrating what is positive about medicine today as we provided an example to the community on the benefits of fitness. It was great to emphasize the disease prevention and stress release benefits of exercise if people just get out and do it. Just as medication doesn't help anyone who doesn't take it, exercise doesn't help anyone who doesn't do it.

It was at this event that I coined the phrase "Fit Happens." Watch for **FIT HAPPENS** bumper stickers coming soon from our CHAMP coalition as our motto. If we work and play together, it will not take much effort from each person to turn around our current epidemic of inactivity, obesity and the associated diseases that will be consuming so much of our recourses.

SURGEON GENERAL'S WARNING: THE SURGEON GENERAL HAS DETERMINED THAT THE LACK OF PHYSICAL ACTIVITY IS DETRIMENTAL TO YOUR HEALTH.■



"My doctor told me to avoid any [illegible] stress, so I didn't open his bill."

What Are You Doing with the Rest of Your Life???

The legendary Warren Miller will highlight PCMS Annual Meeting

You won't want to miss this unique opportunity to hear the world famous, 80 year old skiing filmmaker, author and artist at the PCMS Annual Meeting on Tuesday, December 13. Warren Miller has been skiing since 1936 and drawing cartoons since 1939, which was a good start to building the most respected name in action sports cinematography. He has produced feature length, snow-sports films every year that he takes on tour around the world. His most recent movie "Higher Ground" just opened in October to rave reviews. Part action/adventure and part documentary, the film crisscrosses the globe - hitting the steeps of Alaska terrain, parks in Colorado, deep powder in British Columbia and cliffs in Switzerland. "Higher Ground" captures a select group of individuals in amazing locations, pushing their athletic boundaries.

During his talk, titled "What Are You Doing With the Rest of Your Life?", **he will share his life story and lessons from around the world on how to have a successful life, how to live long and healthful, and how to have a good attitude and eliminate stress.**

Also featured on the docket for the evening is the presentation of the Community Service Award and introduction of the 2006 officers. The evening will feature raffle drawings that will benefit the PCMS Foundation. Attendees are asked to bring an unwrapped toy for a child and/or a wrapped gift for a woman that will be taken to the YWCA Shelter for their residents.

The evening will see the passing of the PCMS gavel from President **Patrick Hogan, DO**, neurologist to President-Elect **Joseph Jasper, MD**. **Dr. Michael J. Kelly**, Past President will have an opportunity to bid farewell as a PCMS trustee having served on the board since 1999.

Watch your mail for the Annual Meeting flyer, or call the Society office, 572-3667 for registration information.■

FitTips #11

by Patrick Hogan, DO

Exercise for Control of Stress and Moods

Why Exercise for Stress Control

Stress results in consequences of increased blood pressure and cholesterol
Stress produces increase in abdominal fat that secretes harmful chemicals into the system
Stress has a tendency to increase the appetite for fatty unhealthy foods
Stress can cause a loss of muscle tissue that is replaced by fat
Stress causes a lowered metabolic rate that causes further fat accumulation
These effects all result in increased rates of heart disease, strokes and diabetes
Stress has been proven to impair the immune system leading to increased infections
Stress produces a chemical change in our brains that increases depression and anxiety
Stress interferes with normal sleep that further increases levels of depression
Stress decreases the tolerance to pain by interfering with brain endorphin levels

Benefits of Exercise for Stress Control and Mood Control

Stress is expected in life but adequate coping with stress prevents the stress damage
Stress controls include coping techniques, humor, spirituality, meditation, and especially exercise. These measures may prevent the need for medications or enhance their benefits
Exercise reverses or prevents each of the harmful stress consequences noted above
Exercise lowers blood pressure, lowers cholesterol, decreases abdominal fat, prevents the loss of muscle tissue, and decreases the rate of heart disease, stroke and diabetes
Exercise prevents the immune system impairment that is otherwise caused by stress
Exercise improves moods and sleep quality by enhancing the positive brain chemicals
Exercise improves pain control by enhancing the brain's natural pain relieving chemicals
Exercise gives a person a better self- image, self-confidence and a positive outlook on life

How to Exercise for Stress and Mood Control

1. Do it now rather than waiting for life to settle down. Make a daily appointment for exercise that is of a high priority that you must keep
2. The exercise program is most effective if well rounded with aerobic exercise, weight training and mobility training such as with Yoga and Pilates
3. Any level of exercise is helpful. Aerobic exercise is most effective if it can be built up to the level that will produce chemical changes in the brain and metabolism changes in the body that is at least 30 minutes in a day about 4 days per week. This again should be built up to over time and doesn't have to be done all at one time in the day. The exercise level that is optimal is at 60-80% of the maximal heart rate. (See *FitTips #3* for how to calculate the maximal heart rate and best exercise levels. As a guideline, you should exercise hard enough to be able to talk but not sing while exercising)
4. Weight training is an excellent stress outlet as well as producing positive benefits that counter the negative effects of stress. (See *FitTips # 10*)
5. Yoga, Pilates and meditation are excellent means of producing stress release, improving stress coping and countering the negative effects of stress. This can be done later in the same day as aerobic exercise or on alternate days of other exercise. It is not adequate to make this the only means of exercise since a cardiovascular program is also needed. (See *FitTips #9*)
6. Recreational sports exercise can produce further stress benefits if enjoyable and fun ■

NutriTips #11

by Joan Brookhyser, RD, CSR, CD

What to Eat as You Go Through "The Change"

Probably no area of nutrition gets more attention these days than menopause. What do you eat to avoid menopausal symptoms? What do you do about weight gain? How about osteoporosis? Books have been written on each of these topics so here we will try to summarize key points.

LIFESTYLE - It is hard not to talk about lifestyle in general when summarizing nutrition during the middle to golden years, however, at no other time does lifestyle have more of an impact on your overall health.

· Avoid excess calories. Your metabolism is slowing down therefore you need less food to keep your weight in check. It is a time to focus more on a quality diet and to make sure your energy expenditure is balanced out by this decrease in metabolism. When evaluating the results of the Women's Healthy Lifestyle Project, those pre-menopausal women who were guided in diet and exercise maintained their weight or lost weight during the 5 year intervention and in turn gained less abdominal fat.

· Reduce stress. What does this have to do with nutrition. Well, as estrogen levels decrease there is an increase in cytokine in response to stress contributing to abdominal fat deposition.

· Keep a balanced diet. Follow the Pyramid for the basics and add in lots of fruits and vegetables. Eat whole grains and use more plant proteins in place of animal proteins. Health risks increase over the age of 50, a lot of which can be decreased by a high fiber, plant based diet.

· Limit alcohol. There is some suggestions that excess alcohol consumption post menopause increases your risk of breast cancer and increases the risk of B-12 deficiency. Researchers from Brigham and Women's Health Hospital showed that women who drink more 1.5 drinks per day and on hormonal medication were at a 30 % higher risk for developing breast cancer. On the other hand, total abstinence from alcohol may not be good either. Studies still seem to show a cardiac protective effect of alcohol in post menopausal women, when consumed in moderation, approximately one glass of wine or one beer per day.

BONE HEALTH - Continue to obtain 1500 mg of calcium in your diet per day. This can either be from 3 to 4 calcium food servings per day or with a combination of foods and supplements. See *NutriTips #7*. Make sure your calcium supplement has vitamin D, which is needed more now than before your menopausal years. Also, moderate alcohol use that may further contribute to bone loss.

SOY - The verdict is still out on whether soy is of help during the menopausal years. Because the isoflavones in soy work like a weak estrogen it is thought that eating soy may help lesson some of the symptoms of estrogen deficiency such as hot flashes, vaginal dryness and increased risk of cardiac disease. Trying to include one serving of soy per day such as a ¼ block of tofu, 1 cup of soy milk, or ½ cup of soy nuts may be of help. Other sources of phytoestrogens are red clover and flaxseeds (ground). Avoid soy supplements for some are very concentrated in isoflavones and may be more of a health hazard than benefit, especially if you are a breast cancer survivor or at risk for breast cancer.

OMEGA 3 FATTY ACIDS - Rapid drops of estrogen production create an increase in insulin production. This increase in insulin in turn creates an increase in Arachadonic acid (aka PGE 2 series) production, inflammatory hormones that further increase hot flashes and other discomforts of menopause. Increasing your use of omega 3 fatty acids either from supplements or by eating fatty fish 2-3 times per week (i.e. salmon, tuna or mackerel), may help decrease this discomfort. Flaxseed works as well however more may be needed to get the same effect.

USE HERBS CAUTIOUSLY

As for herbal remedies, there are no general recommendations. Some women try black cohosh for relief of hot flashes, but the research is still doubtful. However if you choose to take it, it is recommended not to take it longer than six months. Some women take valerian to thwart insomnia. Kava kava has been used for anxiety but certain brands have been associated with liver damage. Vitamin E also has been thought to be helpful in hot flashes. But data is still questionable. It may be of more help for prevention of cardiac disease or Alzheimer's. If you try vitamin E, make sure the type of vitamin you take is natural (d-Alpha) not synthetic (dl). Some herbs can interfere with or intensify the action of blood thinners and others drugs, so patients should always ask a health practitioner before taking any herbal products. Patients facing surgery must quit taking certain herbal medications two weeks before the operation.

The bottom line recommendations for women's nutritional supplement requirements through menopause: 1) A general multivitamin for post menopausal women, 2) Omega 3 fatty acid supplement 1000-2000 mg per day - if you do not eat fish, 3) Calcium supplement 1500 mg if you are not able to take in enough good sources of calcium with vitamin D. ■

Pierce County Medical Society

Public Health/School Health Committee

presents

AUTISM

Understanding the Challenges and Confusion

featuring

Gary Tart, MD

Pediatrician; Pediatrics Northwest
Advisory Board, Autism Society of WA
Board Member, Tacoma Autism Society

Allison Brooks, PhD

Clinical Director, Autism Center
University of Washington
Tacoma

- Dr. Tart will give a personal as well as professional perspective in the role of the family and the autistic child
- Dr. Brooks will discuss the difficulties in regard to autism diagnosis and the University of Washington Autism program

Please join us as we bring together pediatricians, family practitioners and other interested physicians, public health representatives, school nurses and others to learn about this central nervous system disorder that can cause such frustration and misunderstanding for care takers
-Please bring your questions-

Friday, November 18

7:00—8:15 a.m.

Jackson Hall; 314 ML King Jr Way

Buffet breakfast available

RSVP helpful, but not required. Please call PCMS, 572-3667 and confirm your attendance
There is no charge to attend

CMS Announces Payment Update and Policy Changes for Medicare Physician Fee Schedule

The Centers for Medicare & Medicaid Services (CMS) expects to pay approximately $57.6 billion to 875,000 physicians and other health care professionals in 2006, according to a final rule released today that will update payment rates and revise payment policies under the Medicare Physician Fee Schedule. The final rule expands Medicare coverage of glaucoma screening; expands access for rural beneficiaries enrolled in Medicare Advantage plans to services of federally qualified health centers (FQHCs); adopts a modified approach to reforming payment for multiple imaging procedures performed on a beneficiary at one session; and revises payment for inhalation therapy and end stage renal disease (ESRD) treatment.

The physician fee schedule specifies payment rates to physicians and other providers for more than 7,000 health care services and procedures, ranging from simple office visits to complex surgery. The fee schedule is updated on an annual basis according to a formula specified by statute that takes into account the rate of growth in overall Medicare spending for physicians' services in recent years.

The final rule indicates that, based on the update formula, payment rates per service for physicians' services will be reduced by 4.4 percent for 2006. "The existing law calls for a decrease in payment rates for physicians in response to continued rapid increases in use of services and spending growth, and Medicare does not have the authority to change this", said CMS Administrator Mark B. McClellan, M.D., Ph.D. "The current system is not sustainable, and the payment reduction offers further proof that we must move to a payment system that ensures ad-

See "Medicare" page 10

Inaugural CHAMP Walk/Run Participants Show Commitment to Good Health

One hundred and thirty five people completed the inaugural CHAMP/Walk Across Washington walk/run on Saturday, October 15th at Pt. Defiance Park's Owen Beach.

Displaying commitment to fitness and good health in spite of not the most favorable weather conditions is exemplary. Particularly given that almost 75 people that were registered to participate did not show up! Congratulations to all finishers.

The event, organized with the co-sponsorship of the Association of Washington Cities, Metro Parks and the City of Tacoma was organized to encourage people to begin a new program of walking to improve their health, by increasing activity, and to encourage those that exercise regularly to continue. The event was a celebration of healthy lifestyles and was part of CHAMP's initiative to promote healthy people, families, workplaces and communities.

CHAMP, Coolmax t-shirts are available at a fantastic price of just $10 in small, medium, large or extra large by calling the PCMS office 572-3667. Join the fun!■

Tom Herron, left, pediatrician and Martin Goldsmith, radiologist, finalists #1 and #2 respectively

PCMS President Pat Hogan and Past President David Law, with Lucy, at the beautiful Owen Beach finish line

Donna and Joe Jasper showing their support for 330 and opposition for 336

Drs. Jane Moore, second from left in back row and Pat Hogan, third from left join spouses, friends and colleagues

Dr. David Judish made the CHAMP walk a family affair bringing his wife Karen and daughter Sophia

Medicare from page 8

equate payments to physicians, but also supports high quality and efficient health care services. We want to continue to work with Congress toward a payment system that is more sustainable. In this rule, we continue to refine payment rates to reflect current medical practice, while doing all we can under current law to support physicians' efforts to provide greater quality and efficiency of care for Medicare beneficiaries."

In addition to updating the Medicare physician fee schedule, the final rule revises a number of other policies affecting Medicare Part B services. The final rule extends the glaucoma screening benefit to include Hispanic-Americans age 65 and older because they are identified as an ethnic group at high risk for the disease. Currently, this benefit is limited to individuals with diabetes, those with a family history of glaucoma, and African-Americans age 50 and over, who are another group with a propensity to develop glaucoma.

Additionally, as required by the Medicare Modernization Act (MMA), the final rule provides for supplemental payments to federally qualified health centers (FQHCs) that contract with Medicare Advantage (MA) plans. The payments are designed to equalize the payments received by the health center for treating Medicare Advantage enrollees with the center's payment rate for beneficiaries in the traditional fee-for-service program. These supplemental payments will encourage health centers to participate in the new MA program.

The rule makes several changes to Medicare payment for separately billable drugs and biologicals furnished by ESRD facilities. The cumulative impact of these changes will be a 1.2 percent increase in payment per treatment.

Under the new methodology, the payment rate will be set at average sales price (ASP) plus 6 percent, consistent with payment rates for most other drugs under Medicare Part B. This approach will apply for all sepa-

See "Medicare" page 18

In My Opinion....

by W. Pierre Andrade, 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 Letter to My Colleagues

W. Pierre Andrade, MD

This summer many of you received a note from me requesting donations for the Nephcure Foundation. This organization was started by a father who's son had nephrotic syndrome. He had found that there was no organization, in this country, dedicated to raising money for research into this disease. So he started one himself. He also ran a racing school that taught incipient motorcycle road racers faster ways around the track. His organization, 2 Fast, also provide mere mortals like me track day instruction hoping to improve riding skills and consequently improving safety. He used his access to Pacific Raceways to have his friends get pledges per lap then rode the track all day and raised $15,000.00 that first year. Last year the event raised $70,000.00.

This year the format changed to eliminate the pledge per lap and relied instead on straight pledges. This year in excess of $90,000.00 was raised.

The event is supported by many luminaries in the motorcycling world, pro racers attend the event to ride and demonstrate their speed and skill. Hollywood personalities that are involved in motorcycling also donate their time and presence. This year David Allen Grier and Mark Gosselar pledged their time. The event has been profiled on Speed TV. This year the crew from Speed TV was back filming the event and highlighting the contribution that motorcyclists make to raising money for the Nephcure Foundation.

My intent in writing this today is to thank everyone of you who responded to my plea and sent money in for donation to Nephcure. I am well aware of the repeated requests that we all have each year to donate money to many very different causes. I was gratified to see that many of you have been able to overcome your "donation/compassion fatigue" and provided me with enough cash to make the Pierce County Medical Society proud. I am proud of all of you and the continuing good work that you all do as well as the extra lengths you all go to to make this community a better place to live in. Thank you from Nephcure and the children this foundation will help, and thank you from me personally for all that you do, not just for your donations. ■

House Approves Healthcare Overhaul

Tax at odds with plans by Romney, Travaglini

By Scott S. Greenberger, *Globe* Staff, November 4, 2005

Recently, the Massachusetts House of Representatives overwhelmingly approved a sweeping healthcare bill that promises to cover nearly all the state's 500,000 uninsured residents within three years.

The House voted 131-22 for the legislation just a few hours after rejecting a Republican-led effort to scuttle the bill's proposed payroll tax on businesses.

The vote formally launched a long-awaited debate with Governor Mitt Romney and the state Senate over healthcare for the uninsured, a goal that has eluded politicians in Washington and Massachusetts for decades.

The House plan, which also includes an expansion of Medicaid coverage and a requirement that people buy insurance if they can afford it, is designed to cover 95 percent of the state's uninsured. Romney says his plan would accomplish the same goal, while Senate President Robert E. Travaglini says his proposal would cover about half of those without insurance. The Senate has yet to vote on Travaglini's proposal.

At the core of the House plan is the controversial payroll tax, which would be levied on businesses with more than 10 employees if they do not provide insurance to their workers. Romney and Travaglini oppose the tax. But the 129 to 24 House vote on the payroll tax would be enough to overrule a Romney veto, and House Speaker Salvatore F. DiMasi has suggested that many senators support the idea, despite Travaglini's reservations.

DiMasi began the debate with an emotional plea to lawmakers, imploring them to demonstrate "bold and courageous leadership" and make Massachusetts the first state to provide healthcare coverage to all its citizens. DiMasi emphasized that nearly all businesses that provide healthcare coverage would be exempt from the new payroll tax.

"Massachusetts has been known, throughout its history, throughout this country's history, for being the first in many things," he said. "What we are proposing is a bold proposal. It takes bold and courageous leadership to pass this for our citizens, to control the healthcare costs in our Commonwealth, provide healthcare for everyone, to help our hospitals. Our system is broken, and it needs to be fixed."

The beginning of the House debate was delayed for more than four hours, as House leaders met behind closed doors to make last-minute corrections to the measure, which DiMasi unveiled, and to consolidate some 150 amendments into manageable chunks. House Republican leader Bradley H. Jones Jr. said the delay was evidence that the proposal had been hastily prepared and that the outcome of the floor debate was predetermined. Other lawmakers, and lobbyists, grumbled that four days was not nearly enough time to digest the roughly 80-page measure.

Jones praised the overall bill, but urged lawmakers not to "add a huge new tax to an already struggling economy." Other Republicans and a handful of Democrats echoed that theme, reflecting widespread opposition to the payroll tax among leading business organizations.

"The reality is our job growth is anemic, and the business community is struggling," said Representative Vinny M. deMacedo, a Plymouth Republican. "Is this the time we should be taking on such a broad-based tax to the business community that provides the jobs for our constituents?"

DeMacedo backed Romney's contention that revenue from the new tax is not needed to cover everyone. DiMasi said that, with the changes made yesterday, the new tax would bring in about $350 million annually, not the $650 million he originally estimated. He was sanguine about the loss of $300 million, saying that in three years, when the healthcare plan is fully phased in, the state won't need the extra money.

In addition to revenue from the payroll tax, the House plan relies on $255 million annually from the Bay State's tobacco settlement fund. Massachusetts spends more than $1 billion a year on medical care for the uninsured through its uncompensated care pool, but DiMasi said that within three years that expenditure will drop to roughly $210 million as people purchase their own coverage. The federal government

See "Overhaul" page 20

The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

Pandemic Flu

Federico Cruz, MD

RCW 38.52.110...in the event of a disaster...( ) shall have the power to command the service and equipment of as many citizens as considered necessary in light of the disaster proclaimed.

I recently gave a talk to some of my public health colleagues on the need to prepare for a potential pandemic flu outbreak. There has been a tremendous amount of media attention recently on the progression of the avian flu virus through Asia and now into Europe.

With much fanfare and sensationalism, the media has bombarded us with images of contagion. Workers with masks pushing mounds of dead birds into ditches for disposal, a stream of photos of patients on respirators as they struggle to survive infection with the avian flu virus.

Part of me is appalled by the scare tactics of the media but another part, the public health part says, no, this is a reality we have to face. Pandemic flu is on the horizon. It is not if, but when, that we can argue about. Because of the enormous potential for massive human suffering, we have to be prepared. I have talked to you in previous articles on the important role that physicians play in emergency preparedness. I have asked you to look at yourselves personally and to ask yourselves what do you need to do in order to be available to your community during an emergency. I will ask the same question now but in the context of pandemic flu.

When a novel strain of influenza strikes our community, many 1000's of people will get infected. The baseline predictions from the CDC are that between 25-30% of the population will come down with the infection. In Pierce County, there are 750,000 people. You do the math. Twenty-five percent of this number is huge. There will be many thousands of acutely ill patients needing your help.

One of my jobs as public health director is to see that those sick patients and you, the provider, intersect in a planned and coordinated manner. We are working on plans for special clinical sites across Pierce County where basic services for the acutely ill can be provided. I have talked to you on several occasions to alert you to the fact that much planning is going on to be prepared for emergencies, and how to best focus and utilize the needed local resources. You are one of the local resources. So, do not be surprised during an emergency should I approach you and direct you to a clinical site and connect you to a care team and a long line of sick patients.

So who am I to tell you what to do? I am your public health director and my position was actually created for these very situations. Public health got started to control contagion, and to stop the spread of epidemic disease. The state constitution and state laws very clearly lay out my roles and responsibilities for dealing with epidemic disease. The authority is very broad - extraordinary powers to utilize public and private properties and to impress the citizenry. We are given these tremendous powers and, quite frankly, I have never used them on a broad scale. But, I want you to know that I will utilize them if a pandemic situation occurs. Your community will desperately need your skills, energy, passion, and your commitment. I bring this all up now because, if there is concern about my role and authority, now is the time for the discussion not during a future crisis.

I am committed to protecting our community from the ravages of epidemic disease. I need your wholehearted support. Please think about this and, if you have questions or concerns, please do not hesitate to give me a call at (253) 798-2899 or e-mail me at fcruz@tpchd.org.

If the need should arise, I look forward to working with you.■

Franciscan Health System establishes Fellowship in Advanced Laparoscopic Surgery

Franciscan Health System has established one of the nation's few Advanced Laparoscopic Surgery Fellowship programs, in partnership with community physicians.

Located at St. Joseph Medical Center in Tacoma, the elite program has been developed under the auspices of the Minimally Invasive Surgery Fellowship Council to provide teaching opportunities to surgeons who are seeking advanced qualifications in laparoscopic surgical procedures. The Fellowship at St. Joseph is one of only about 65 officially sanctioned training programs of its kind in the United States, and one of only 15 available on the West Coast.

Tacoma surgeon **Eugene Cho, MD**, serves as the program's medical director. He previously was director of the Fellowship in Surgical Endoscopy and Advanced Laparoscopy at the University of Maryland School of Medicine in Baltimore.

The one-year program at St. Joseph Medical Center allows the surgical Fellow to receive instruction in minimally invasive techniques from expert, local surgeons. Surgeons serving as core faculty for the Fellowship are **C. Stevens Hammer, MD**; **James Rifenbery, MD**, **Kathy Toosie, MD**, and James Yamashita, MD.

Kelly Nolan, MD, is the first Fellow participating in this inaugural year of the program. She recently completed a surgical residency at the University of Utah. While participating in the Fellowship at St. Joseph, Dr. Nolan also will assist in providing general-surgery call coverage.

For more information about the Advanced Laparoscopic Surgery Fellowship at St. Joseph Medical Center, or to apply for a faculty position, contact Dr. Cho via email at eschomd@ gmail.com.■

Dr. Saeed Receives Award

On September 24, 2005 the American Association of Neuromuscular and Electrodiagnostic Medicine (AANEM) presented **Mohammad Saeed, MD** with their first Outstanding Advocate Award. The award was presented to Dr. Saeed at the AANEM's 52nd Annual Scientific Meeting in Monteray, California.

The Outstanding Advocate Award recognized extraordinary contributions by a member or nonmember toward increasing public awareness or advocating to government entities or insurance companies about the role of electrodiagnostic medicine in the diagnosis and treatment of muscle and nerve disorders.

Congratulations Dr. Saeed!■

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 Complexity of Life

Andrew Statson, MD

"The more human beings proceed by plan, the more effectively they may be hit by accident."
Friedrich Dürrenmatt (1962)

Complexity and authority don't mix well. Unfortunately for the people in authority, life is complex. So how can they rule? By trying to make life simple; by forcing it to fit a mold.

The great attraction of socialism is its simplicity. Those in power, presumably also in the know, devise a plan. The rest of us are ordered to follow it. The idea is simple, logical, and wrong.

Have you practiced shooting baskets? You throw the ball. If you miss, you modify the force and the direction of your throw. You aim at the goal, get feedback, and adjust your shot.

Perhaps I could give you a physical formula, telling you the amount of force you need to apply and the angle of the throw. That may be a way to make a machine throw balls, but for a human, it wouldn't work. You have to practice and learn from experience.

Since our earliest childhood, we have been learning through feedback. We act, we miss, and we correct our aim accordingly. Such is life, every step of the way.

Medical practice is more complicated than that. We deal with living beings, not with inert balls. Imagine throwing a cat or a bird and hoping that it would go through the ring?

So how can a ruler control the practice of medicine? The short of it is that he can't. It's not possible. And it wouldn't be for lack of trying.

Stalin approached the problem in his usual style. A few months before he died, he executed several of his personal physicians. The charge was incompetence, and conspiracy to commit treason. I guess they failed to make him immortal.

Closer to home, Medicare plans to penalize physicians who do not follow their algorithms by reducing their compensation and possibly dropping them from the program. Even though the stated goal may be to improve care, the main reason is to control costs.

A common argument, repeated during the past thirty years at least, is that the Medicare costs per patient in Florida are more than double what they are in Minnesota. The implied conclusion is that the people in Florida, and specifically the physicians, are abusing the system.

The study does not mention the quality of the Floridians' health to begin with, or the results of the treatments. Perhaps the retirees in Florida are happier because of that. Perhaps the people in Minnesota have a different lifestyle, and reach Medicare age healthier. Perhaps they don't run to their doctors for every cold. Perhaps they mistrust us and use folk remedies instead. Perhaps the Minnesotans who move to Florida are sicker than those who stay back home.

Most medical studies have the same problem. Life is too complex to be studied as it is, so the researchers have to simplify it somehow and make it fit a mold. That is the only way they can ask questions of interest and gather data. Once they have the numbers, they can play with them and derive their conclusions.

Please don't misunderstand me. I have great respect for the medical research that advances our knowledge of diseases and of their treatments. I have little regard for the research with preconceived ideas that caters to the politically correct trend of the day. Insurance companies use the conclusions of such papers to influence our practice, to the detriment of our patients.

I have two examples in mind from my own field. One was a study reporting that patients with previous cesarean sections who delivered vaginally had fewer uterine dehiscences than those who delivered by elective repeat section prior to labor. That study did not dare proclaim the obvious conclusion, that labor closes uterine dehiscences.

The other study reported that patients who received epidural analgesia early in labor were more likely to require delivery by section. Its conclusion was that epidurals increased the incidence of dystocia. Analgesia causes dystocia? How? By what mechanism?

Both studies are out of favor now, but at the time their conclusions led to putting many patients through unnecessary suffering.

See "Complexity," page 16

Complexity from page 15

I wonder whether the recent reports, stating that the medical treatment of coronary occlusion is better than intervention, are based on science, rather than on political correctness. These doubts about the integrity of our medical research may seem strange, but they are the result of the socialistic transformation of medical practice. It is as if the shadow of Lysenko is poisoning the atmosphere in our universities.

Let me explain. The essence of socialism is centralized decision making. The people in authority decide what is good for all of us, and that is what we get, whether we want it or not. If scientific proof is needed to show their plans are correct, they will manufacture it.

The opposite is true of capitalism. It requires the diffusion of both information and decision making across the system. The best placed people are those in the field, closest to the problem. They see the situation develop, they act, and they get immediate feedback. They are the first to get the information, to assess the extent of the problem, and to determine how to solve it. They are *there*. Given the authority to act, they respond the fastest, thus limiting the damage.

These same people in a socialistic system are hampered by regulations and unable to act on their own initiative. They have to wait for someone else, far away up the ladder, to give them permission. While they are waiting, they watch helplessly while the problem gets worse.

If they are competent, but the rigidity of the system ties their hands so they cannot apply their skills to the fullest, they become frustrated and unhappy. They will get out and find a job where they can be fulfilled. If they cannot leave, they will shut their mind and act as robots. Either way, the system breeds incompetence.

History gave our generation the opportunity to carry out a unique experiment. In 1945, the Iron Curtain divided Europe into two. The socialist model ran the eastern part. The ruling class made the plans, gave the orders, and established rigid procedures. The western part adopted the capitalist principles of individual initiative and decision making, motivated by the goal of personal enrichment and growth. The socialist model failed. Today there are more Marxists in our universities than in the whole of Eastern Europe.

So what is it going to be for American medicine, socialism or capitalism? Probably Medicare will continue to strangle medical practice with more and more rules, although it might reverse course. Politically that would be difficult, but not impossible.

The Canadians are becoming more vocal in expressing disenchantment with their system. I suspect that our politicians, no matter what their stripes and regardless of what they say, are aware of the problems besetting our northern neighbors. Some of them may even be looking for ways to swing public opinion against socialism.

Medicare and Medicaid will probably continue as programs for the indigent, expensive, clumsy, more and more restrictive. The demonstration projects of patient-directed health care will probably show the way for new insurance policies and new models of medical practice. Perhaps we'll need to repeat the European experiment, to learn from personal experience which model is better. It would be nice if we could let California do that and just watch.

Let me end with a quote from Will Rogers: "Plans get you into things, but you got to work your way out." ■

100,000 Lives Campaign: Hospitals join patient safety plan

Editor's Note: The WSMA endorses the 100,000 Lives Campaign

Aggregate mortality data collected through the project could give a big boost to evidence-based medicine, campaign supporters say

More than half of America's hospital beds are now enrolled in the Institute for Healthcare Improvement's 100,000 Lives Campaign, a patient-safety initiative aimed at helping participating hospitals prevent some of the most fatal and costly medical errors.

IHI President and CEO Donald M. Berwick, MD, said the now 2,800 participating hospitals exceeded the campaign's original goal of 2,000.

The program, in which the AMA is a partner, focuses on six initiatives. IHI estimates that, if implemented reliably by at least 1,600 hospitals, the campaign would save 100,000 lives over 18 months.

The program, launched in January, is scheduled to issue a report in June 2006 detailing the aggregate mortality data for the hospitals that have joined the effort. Dr. Berwick called the early numbers very promising.

"We, as a nation, will be able to have a big party in June 2006 when the results are released," Dr. Berwick said at the Chicago stop in the campaign's promotional 16-city fall bus tour from Boston to Seattle.

Dr. Berwick said he would urge participating hospitals to report their mortality data publicly at an individual or systemwide level once the results are in next June. Such disclosure is not required to participate in the campaign, which will only report aggregate national data.

Participating hospitals pledge to develop rapid-response teams, administer appropriate drugs for heart attack patients, prevent adverse drug events, reduce surgical site and central line infections, and reduce ventilator-related pneumonia. The campaign is organized regionally into geographic nodes — usually quality improvement organizations, medical societies, hospital associations and ad hoc outfits — to help support participating hospitals at the local level.

The initiative came in response to a 1999 Institute of Medicine report estimating that as many as 98,000 people die each year due to medical errors — a figure the AMA has said is "flawed." A study published in the July 25, 2001, *Journal of the American Medical Association* estimated that medical errors contribute to 5,000 to 15,000 patient deaths annually. Regardless of the numbers dispute, experts say most of these deaths are due to systemic failures rather than individual mistakes.

Since publication of the IOM report, efforts such as the Surgical Care Improvement Project and the Leapfrog Group's quality initiatives have been undertaken to address the problem. What makes the 100,000 Lives Campaign different, Dr. Berwick said, is that hospitals are trusting the public to see how well they do.

Hospital leaders participating in the campaign are "courageous," Dr. Berwick said. "They're working hard every day to do the best for patients, and now they're coming forward to say, 'We can do better. We have defects and we can improve.' They trust the public to hear the bad news but take as a promise that they'll improve. That's a total change in the attitude."

The cultural change

Physician resistance to systemic changes and hospitals' unwillingness to spend money on fixes with an unclear track record have been overwhelmed by emerging scientific evidence, said Charles Watts, MD, chief medical officer at Chicago's Northwestern Memorial Hospital.

"What's changed is the increasing level of evidence for these interventions and many others that can predictably decrease mortality, decrease complications and provide patients a safer journey through the health care system," Dr. Watts said at a campaign news briefing at Northwestern, which is participating in the program. "It's that increasing rigor of evidence that's stimulating us to go through this process."

Dr. Watts said the evidence base and the practical advice provided by Boston-based IHI have helped Northwestern improve. "The way they organize data and give us methods and approaches to get all of the caregivers within the institution to take part in this is incredibly effective for day-to-day care."

Supporters of the 100,000 Lives Campaign contrasted the initiative's focus on evidence-based medicine with a more traditional idea of medicine that revolves around the individual doctor's or nurse's autonomy and creativity. Changing the culture in a hospital and making sure physicians don't feel new systems are being forced upon them is crucial, Dr. Watts said.

"If you don't respect, don't educate, don't inform and don't try to level the playing field before putting the initiative in place," he said, "you'll have guerrilla warfare."

Dr. Watts said Northwestern's decision to join the campaign also has given him leverage when it comes to capital requests that can improve patient safety. "In decisions where two capital requests are relatively even in terms of perceived need, the one that has the best demonstration of improved quality of care and patient care will win every single time," he said. "That's the effect it's had."

The AMA has partnered with the campaign by educating physicians in how to make strides in safety at their hospitals.

"This isn't just about the 100,000 lives we can save," said John Nelson, MD, MPH, immediate past president of the AMA. "This is about the obligation to improve health care for all 294 million Americans by having a better health care system.

"Patients are not widgets," Dr. Nelson added. "If you mess up, you can't throw them away. And sometimes to fix them costs tons of money and an amazing amount of time. We need to get it right the first time." ■

Reprinted from AMNews, Nov. 7, 2005

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rately billed drugs in both independent and hospital based facilities. At the same time, the rule increases the drug add-on adjustment to the composite rate. This adjustment was established to offset payment cuts that occurred when the payment for drugs and biologicals was reduced as a result of the ASP plus 6 percent methodology. The rule also revises geographic designations and wage index adjustments with respect to ESRD payment, but provides for a four-year transition.

In response to comments on the proposed rule, the final rule revises in several ways the proposal to reduce payments for certain diagnostic imaging procedures to reflect their limited additional costs when they are performed on contiguous body parts in the same session with the patient. Specifically, CMS will not apply this reduction to transvaginal ultrasound and ultrasound of the breasts, pending further study. In addition, the 50 percent payment reduction to procedures after the first procedure will be phased in over two years, so that the reduction in 2006 will be 25 percent, and 50 percent in 2007. Finally, the rule will apply the budget neutrality adjustment to the practice expense component of the services only.

In response to comments expressing concern about beneficiary access to intravenous immune globulin (IVIG), CMS is establishing a temporary add-on payment to cover the additional preadministration-related services required to locate and acquire adequate IVIG product and prepare for an infusion of IVIG during this current period of market instability. CMS has determined that the pricing for IVIG is accurate, and that there is no overall product shortage.

However, in the face of such factors as increasing IVIG demand and manufacturer allocation of many formulations, physician office staff has to expend extra resources on locating and obtaining appropriate IVIG products and scheduling patient infusions.

For calendar year 2006 only, physicians and hospitals will be permitted to bill this add-on code to compensate for the administrative burdens associated with IVIG administration during this time of some volatility in IVIG product availability. During the upcoming year, CMS and other agencies in the Department of Health and Human Services intend to work with the IVIG patient community, product manufacturers, distributors, physicians and hospitals to develop a common understanding of the evolving IVIG marketplace, assure continued collection of accurate ASP data, and focus attention on the medical necessity of the utilization of IVIG. We anticipate that these steps and other ongoing corrections in the marketplace will help to ensure that supply volatility stabilizes in the next year.

Building on the CMS experience in 2005 with a demonstration project measuring quality of care for cancer patients undergoing chemotherapy, CMS is also establishing a new cancer quality demonstration that focuses on treat-

See "Medicare" page 22

Applicants for Membership

Marina Arbuck, MD
Infectious Disease
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1624 South I Street #405, Tacoma 98405
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Moacyr R. Oliveira, MD
Oncology/Hematology
Northwest Medical Specialties
1624 South I Street #102, Tacoma 98405
253-428-8700
Med School: Federal Univ of Minasgeais
Internship: University of Iowa
Residency: University of Iowa
Fellowship: University of Iowa

Annette P. Peck, MD
Pathology
Puget Sound Institute of Pathlogy
PO Box 34245, Seattle 98124
206-467-1470
Med School: Oregon Health Science Univ
Internship: Virginia Mason Med Ctr
Residency: University of Washington
Fellowship: Harborview Med Ctr

Ramona V. Popa, MD
Infectious Disease
Infections Limited
1624 South I Street #405, Tacoma 98405
253-428-8700
Med School: Univ of Medicine & Pharm
Internship: Mountainside Hospital
Residency: Mountainside Hospital
Fellowship: SUNY at Stony Brook

Belinda S. Rone, MD
Pediatrics
University Place Pediatric Clinic
1033 Regents Blvd #102, Fircrest 98466
253-564-1115
Med School: University of Washington
Internship: UW/COHMC
Residency: UW/COHMC

Swati D. Vora, MD
Pediatric Neurology
Pediatric Neurology Associates
2201 South 19th St, Tacoma 98405
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Confidentiality Assured

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will help pay for the Medicaid expansion.

The proposed payroll tax would be 5 percent on companies with 11 to 100 employees and 7 percent on businesses with 100 or more workers. Companies with 10 or fewer workers would be exempt.

Currently, businesses that offer health coverage to their workers chip in extra money, either through a surcharge built into their premiums or in a payment made directly to the state, to help cover the cost of care for the state's uninsured. Employers that don't provide insurance don't have to contribute.

To provide an incentive for employers to offer coverage, the House measure would allow them to deduct their healthcare costs from the new payroll levy. DiMasi initially said that because healthcare costs for the average company are between 12 percent and 15 percent of payroll and the new levy is either 5 percent or 7 percent, employers that offer coverage now would not have to make any payment at all.

DiMasi acknowledged on Tuesday, however, that certain firms with highly paid employees or many part-time workers might be exposed to the tax, even though they cover some or all of their workers. He said that situation was unintended and that his staff would come up with a way to fix it.

Yesterday House leaders amended the bill so that the salaries of highly paid employees would count only up to $94,200 in calculating overall payroll costs. They also exempted from the calculation employees getting healthcare coverage through their spouses. Together, those changes accounted for the $300 million reduction in revenue, DiMasi said.

Part-time workers would count as full-time employees in calculating the payroll tax, a detail designed to persuade employers to offer them coverage.

In addition to pushing employers to cover their workers, the House plan would also require people who can afford health insurance to buy it, provide subsidies to lower-income people to help them pay premiums, and raise the income limits for MassHealth, the state's Medicaid program, so an additional 130,000 people can enroll.

Massachusetts would be the first state to force its citizens to purchase health insurance. A study released recently by the Urban Institute argues that it would be impossible to cover the Bay State's uninsured without that requirement, called an individual mandate, either by itself or in combination with a separate requirement that employers cover their workers.

Romney's plan also includes a requirement that individuals purchase insurance. He would combine the requirement with rule changes that would allow insurance companies to offer limited, low-cost policies and state subsidies to help people buy them.

The House plan would also provide subsidies, and it envisions policies that many more people will be able to afford.

The House requirement on individuals would be less strict than Romney's. Some people would be exempt if the state determines that they cannot afford coverage, under an income-based formula. For those who can afford insurance but don't purchase it, there would be a financial penalty equal to half of the premiums they would have paid. ■

Physical Medicine and Rehabilitation Conference

Physical Medicine and Rehabilitation Service, Madigan Army Medical Center will be hosting the 21st Annual Physical Medicine and Rehabilitation Conference on March 14th-17th 2006 at Sheraton Hotel, Tacoma, Washington. Several nationally renowned speakers will lecture on Technological and Therapeutic Advances in the Management of Chronic Spine and Musculoskeletal Pain, Electrodiagnosis, Stroke, Peripheral Neuropathy, Pediatrics, Osteoporosis, Prosthetics & Orthotics, War Time Injuries and Rehabilitation, and Evidence Based Medicine.

The conference is designed for Physiatrists, Physicians in related Specialties and Allied Health Care Professionals interested in updating their knowledge in Pain management and Neuromuscular Medicine. The course curriculum and registration details will be available on the web at www.thegeneva foundation.org/events in December 2005. Approximately twenty-five (25) category I CME will be provided. For information, please contact COL Shashi Kumar, MD or Cauleen Harper at 253-968-2020 or email cauleen.harper@amedd.army.mil

COLLEGE OF MEDICAL EDUCATION

Cardiology for Primary Care course postponed

The Cardiology for Primary Care CME course scheduled for Tuesday evenings, January 10 and 17 in early 2006 has been postponed and will be rescheduled on the course calendar for 2006-2007. We apologize for any inconvenience. If you have questions, call the College of 253-627-7137. ■

Hawaii CME - April 2-7... Make Plans Today

The Hawaii CME course will be held at the Hapuna Prince Hotel on Hapuna Beach on the island of Hawaii, Sunday - Friday, April 2-7, 2006.

Offering 16 Category I credits, the Hawaii program is designed for PCMS and other physicians and features addresses on a variety of topics.

Reservations must be made early for both travel and hotel. Call Jeanette Paul at All Wanderlands Travel, 572-6271 or email her at jeanette@awtvl.com.

DON'T DELAY, MAKE YOUR RESERVATIONS NOW! ■

Continuing Medical Education

CME at Whistler...Snow is Looking Good!

Agenda set for Whistler....Register Soon

The annual Whistler and CME course will be held Wednesday through Saturday, January 25th to 28th, 2006. Make your reservations now as everyone is anticipating a busy, busy ski season.

This year's course has a dynamite line up of speakers discussing a variety of topics of interest to all physicians. **John Jiganti, MD,** course director, has done an outstanding job of scheduling speakers and topics, including:

• Modern Update for the Treatment of Alzheimer's	Allen Bott, MD
• Primary Prevention of Sudden Cardiac Death	Michael Rome, MD
• From Top to Bottom: The Latest in GI	W. Mark Hassig, MD
• Depression: The Old and the New	Patrick Donley, MD
• Updates in Min. Invasive Therapies for Abnormal Bleeding	John Lenihan, MD
• New Treatments for COPD: Hype or Hope?	Arthur Knodel, MD
• Managing Diabetes and Hyperglycemia in the Hosp. Patient	Ronald Graf, MD
• "The GAP:" Weight Control in a Super-Sized Environment	David Bales, MD
• Cardiac Imaging: New CT, MRI, PET and Nuclear Options	Daniel Heller, MD
• Innovations in Orthopedic Surgery	John Jiganti, MD

The program has been accredited for 10 hours of AMA Category I Continuing Medical Education Credits. After the course the participant will be able to:

Cite the most recent updates and treatments for Alzheimer's Disease; Discuss recent developments in preventing cardiac events; Recognize the appropriate indications and use of the upper endoscopic ultrasound, small bowel capsule endoscopy and virtual colonoscopy; Review past and present treatments for depression; Understand new developments in invasive therapies for abnormal bleeding; Identify and discuss the most current recommendations for COPD; Learn to recognize the importance of managing hyperglycemia in the hospital patient and how to treat it; Identify teaching strategies for patients' weight control; Identify and discuss new ways to help patients navigate an increasingly complex array of diagnostic options and treatments; Identify and discuss innovations in implant and material changes in orthopedic surgery.

Reservations for the program's condos can be made by calling **Aspens on Blackcomb**, toll free, at 1-877-676-6767, booking code #362871. You must identify yourself as part of the College of Medical Education group. Likewise, you are encouraged to make your reservations soon to ensure space - at least by November 25, 2005, when any remaining condos in the block will be released. ■

Dates	Program	Director(s)
Wednesday-Saturday January 25-28	CME at Whistler	John Jiganti, MD
Friday, March 10	Mental Health Review	David Law, MD
Sunday-Friday April 2-7	CME at Hawaii	Mark Craddock, MD
Friday-Saturday May 5-6	Internal Medicine Review 2006	John Hurst, MD
Friday, June 2	Primary Care 2006	Steve Duncan, MD

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ment provided to beneficiaries for any of 13 cancers listed as a primary diagnosis.

This demonstration, which will be conducted throughout calendar year 2006, will use the CMS billing system to generate information on coordination of care, treatment design, and patient monitoring.

The final rule modifies Medicare payment for a dispensing fee for inhalation therapy drugs provided using nebulizers, which are covered by Medicare Part B. In 2005, CMS established an interim dispensing fee of $57 for a 30-day supply and $80 for a 90-day supply of these inhalation drugs. On further review of the available information and comments, CMS has concluded that the industry cost data on which the 2005 dispensing fee was based includes care management activities (such as in-home visits, patient education, caregiver training, and care coordination) that do not fall within the scope of a dispensing fee, and that do not have a Medicare benefit category. Furthermore, a September 2005 OIG report found little evidence that such care management services are widely provided to beneficiaries in actual practice. Therefore, for 2006, CMS is establishing a dispensing fee of $57 for a 30-day prescription for the first time a Medicare beneficiary uses inhalation drugs and a $33 fee for other months. In addition, Medicare will pay a 90-day dispensing fee of $66.

CMS is also developing a demonstration program for care management and care coordination for users of inhalation therapy, with the involvement of physicians, product suppliers, and other health professionals, in order to determine whether such services have a positive impact on outcomes and reduce overall Medicare spending. This demonstration will focus on obtaining the most effective care for Medicare beneficiaries with relatively severe or complex respiratory conditions, including beneficiaries who need both nebulizer treatments and drugs dispensed through metered dose inhalers (MDIs) that will now be covered as part of the new Medicare drug benefit.

The final rule revises the definitions of two categories of designated health services (DHS) subject to the physician self-referral ban to include diagnostic and therapeutic nuclear medicine services and supplies. Under the physician self-referral statute and regulations, a physician is prohibited from making referrals for DHS to an entity with which he or she (or an immediate family member) has a financial relationship, unless an exception applies. CMS recognizes that the inclusion of nuclear medicine as DHS may have an impact on some current arrangements under which patients are receiving medical care, and that some financial arrangements may have to be restructured. Therefore, CMS is delaying the effective date for this regulatory change until January 1, 2007.

Other provisions in the final rule include:

- Expanding the list of Medicare telehealth services to include certain medical nutrition therapy services, which will enable greater access to these services for beneficiaries in rural areas.
- Discussing the methodology used by Medicare to determine the costs of running a physician's practice, which together with work and malpractice expense, form the basis for setting the payment rates for the individual physician services included in the Medicare Physician Fee Schedule.
- Changing the supplying fee for Medicare Part B immunosuppressive, oral anticancer and oral anti-emetic drugs.

The final rule will be effective for services provided on or after January 1, 2006.

NOTE: You may see the Final Rule at: http://www.cms.hhs.gov/physicians/pfs/CMS-1502-FC.pdf ■

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East Sumner, WA. Three buildings facing Main Street and the new Fred Meyer retail outlet, currently the Sumner Animal Vet. Building #1 - 5,000 sq. ft. including a 1,000 sq. ft. three-bedroom apartment. Building #2 - 1,500 sq. ft. and building #3 - 3,000 sq. ft. Any one or all $1.50/sq. ft. NNN. 253-863-7761.

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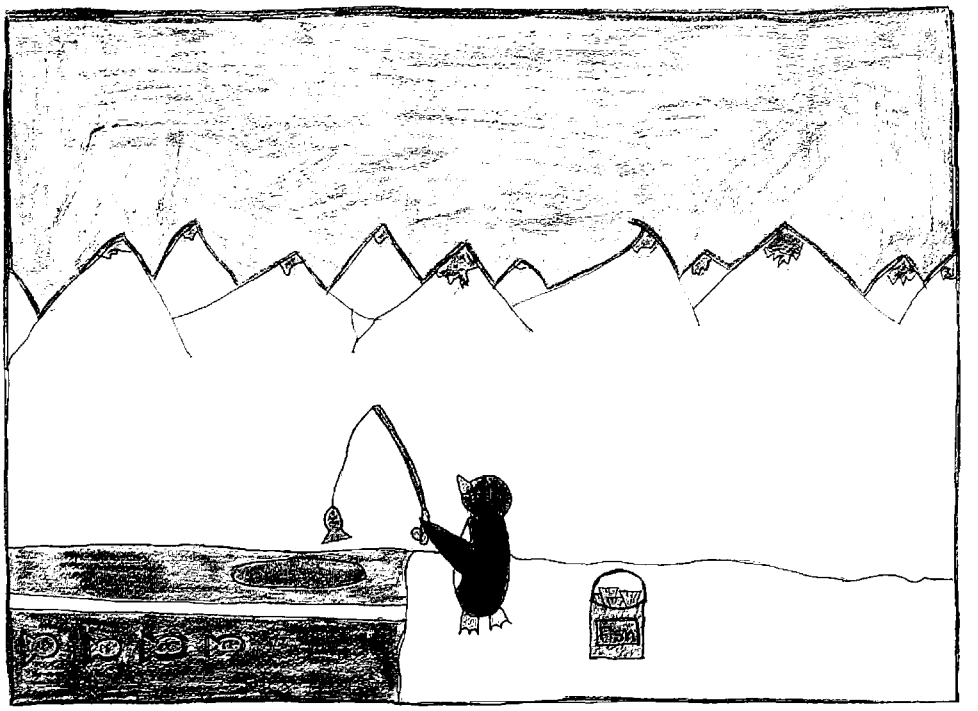
BULLETIN

December, 2005

Happy Holidays



2005 Holiday Sharing Card
Artist, Jason Lee Middle School Student, Jahira Teague

The 2005 Annual Meeting to feature
the legendary Warren Miller - see 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.

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Pierce County Medical Society
BULLETIN

December, 2005

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President's Page

by Patrick J. Hogan, DO

Patrick J. Hogan, DO

Steps Toward a Healthier World

Congratulations to everyone who contributed over the years toward Washington becoming the **10th state to be free of tobacco smoke** in all public places and work places. This can only be attributed to our unrelenting work at steadily changing societal attitudes toward making tobacco use and especially tobacco smoke exposure unacceptable behavior. This has been a long time coming since 1906 when the cigarette mass production machine was invented and the mass marketing campaign of deception began. ***Exactly 100 years later we have finally turned the tide toward winning the war that has claimed millions of lives of addicted smokers who were led to believe by the Tobacco Cartel that tobacco use was sexy, a stress reliever or macho. At long last the American public have become fed up with these lies and have begun to fight back.*** Now that the collective thought of the American people has reached the threshold of awareness of the destructive effects of tobacco, sweeping positive health changes will occur rapidly across North America. Already, six Canadian Provinces have passed public smoke-free laws and six additional states are poised ready to begin their smoke-free processes now that Washington's initiative was overwhelmingly successful. It will only be a matter of time that all of the U.S. and Canada will be added to the other countries where all of their citizens are protected from second hand smoke. It is, after all, simply a matter of public health, just as protecting the public from other preventable diseases.

Taking It a Step Farther

On January 1, 2006, the **entire campuses** of all Pierce County hospital systems will be free of tobacco smoke. This was also a long fought battle that will become a model throughout the state. **All staff and visitors will not be allowed to smoke on any Franciscan Health System, MultiCare Health System or Good Samaritan Hospital property.** A nurse can **no longer accept any order to allow any patient to leave the hospital to smoke** with the exception of the mental health units where, because of archaic thinking, these patients will not yet be given the life saving health benefits being provided for other mental health patients throughout the country. However, this can be accepted for now since the whole tobacco free battle is an ongoing process and some dinosaurs become extinct more slowly.

Our own great wise master icon of public health, **Dr. George Tanbara,** told me over ten years ago when I was disappointed by the defeat of a ordinance in the Pierce County Council to make restaurants smoke free in 1994, *"These things just take time. Be patient and it will happen."* **He was right that with perseverance our dream of totally smoke free public places in Washington has become a reality and with further perseverance other dinosaurs of resistance to public health will also fall.**

CHAMP (Coalition for Healthy Active Medical Professionals) Forever

An 85 year old man was asked in October after he completed the New York marathon how he tapered before the run. He answered by saying he also ran the Portland marathon one week earlier. It is amazing what the human body can continue to do with maintaining the right attitude and activity level. On the contrary, it is also remarkable how much the body will deteriorate in an untimely manner with lack of self care. With public health measures, to include CHAMP, we can help prevent this untimely deterioration and accomplish the greatest good to the greatest number of people and to our society. Through the efforts of CHAMP in the upcoming years, we will work to promote a healthy life style attitude that includes fitness, obesity prevention, as well as freedom from tobacco for all ages. We will do this, in part, by example and with interventional programs. Other medical professions, to include nurses, PT's , OT's, and Pharmacists are urged to become involved with this effort along with retired members, family and staff. This will have the greatest impact to improve the fitness of all people, no matter what their age or condition.

The success of this **will again take a change in the collective thought of the country**, which must be done if we are to stem the incredible toll that the lack of fitness and obesity is having on our society.

Never doubt that a small group of people dedicated to a cause can change the world. Indeed it is the only thing that ever has.

Pierce County Medical Society

invites you and your spouse/guest to experience

the legendary

WARREN MILLER

as he presents

WHAT ARE YOU DOING WITH THE REST OF YOUR LIFE?

at the

2005 ANNUAL MEETING

Tuesday, December 13, 2005
Sheraton Tacoma Hotel, Ballroom
1320 Broadway Plaza, Tacoma

Social Hour: 6:30 p.m.
Dinner: 7:00 p.m.
Program: 8:00 p.m.

Don't miss this unique opportunity to hear the world famous, 80 year old skiing filmmaker, author and artist! Warren Miller has been skiing since 1936 and drawing cartoons since 1939 when he was delivering newspapers in Hollywood. He went on to build the most respected name in action sports cinematography as he produced and toured feature length, snow-sports films each year. Today he happily shares his life stories and lessons with audiences across the world including how to have a successful life, how to live long and healthful, how to have a good attitude, and how to eliminate stress in your life. An inspiring, entertaining, and humorous evening is promised.

Introduction of the 2006 Officers
Presentation of the Community Service Award
Raffle Drawings and Holiday card sales to benefit the PCMS Foundation
Please bring an unwrapped toy (child) and/or a wrapped gift (woman) for YWCA Shelter residents

Please return by Friday, December 9 to PCMS, 223 Tacoma Avenue South, Tacoma WA 98402
You may fax to 253-572-2470 or call 253-572-3667 for more information

Please reserve _____ dinner(s) at $40 per person. Enclosed is my check for $ _____

Or, charge my credit card # _____ Expiration date _____

☐ Visa ☐ MC ☐ AM Signature _____

My name for nametag (please print or stamp) _____

My spouse/guest name for name tag _____

We look forward to seeing you!

FitTips #12

by Patrick Hogan, DO/Brigitte Colby, RN, BSN

Exercise for Your Heart

Prevent heart disease, make your heart work stronger, recover from heart disorders

Benefits of exercise for your heart: Prevents blood vessel disease; reduces vascular damage that is already present • Lowers bad (LDL) cholesterol and raises good (HDL) cholesterol • Lowers elevated blood pressure and reduces need for medication • Reduces the harmful effects of stress on the heart (see *FitTips #11*) • Reduces the abdominal fat that secretes chemicals that are harmful to the heart arteries. Improves heart rhythms and improves heart failure with a stronger heart • Improves the ability to do daily activities with less strain on the system • Improves other disorders that can cause heart disease (see *FitTips #5* on Diabetes) • Enhances smoking cessation success that is of utmost importance for heart health.

Precautions before you begin: People over 50 who have not exercised regularly or who have risk factors for vascular disease (family history, smoking, obesity, elevated cholesterol) should be cleared by their physician before beginning their exercise program. A treadmill stress test or other tests may be needed for clearance for exercise on your own. If you have had a heart attack or have heart disease, your exercise program will be best initially monitored and guided by a cardiac rehab program that may be insurance covered.

How to exercise for your heart and the rest of your body and mind: It is important to start with low intensity and build up slowly in order to avoid injury, maintain motivation and steadily increase strength. The ideal is to build up to a comprehensive exercise program utilizing the four facets of the program listed below:

1. **Conditioning exercise 3-4 times per week:** Conditioning exercise can be anything that moves the body in a smooth rhythmical manner and increases the heart rate such as walking (see *FitTips #9*), running (see *FitTips #4*), biking, swimming, cross country skiing, elliptical training, rowing and others. Remember to warm up for a few minutes to adjust your body from rest to an active state. If stretching is done, it is best done after the warm up period or after the exercise session.
2. **Strength/resistance training twice per week:** Strength training has multiple benefits for heart health, blood pressure, weight control, stress control, injury prevention and bone health (see *FitTips #10*). It is best to do 8-10 strength exercises utilizing various muscle groups for one or two sets at 8 to 14 repetitions each. Avoid sustained straining (isometric) exercise. For the best results, practice pushing/pulling the weight over a count of two and returning to the starting position over a count of four.
3. **Yoga, Pilates or other flexibility exercises:** Keeps joints mobile, improves core strength, good stress release, prevents injury during other exercise and enhances balance (see *FitTips #9* - Yoga-Pilates). Do this at least once or twice per week.
4. **A day off each week:** This will assimilate the benefits of the exercise and promote recovery of both mind and body in order to make exercise a life long part of your life.

More on how much exercise is needed: A further guide on how much to exercise to achieve optimal benefits for the heart is to expend **2000 calories per week** in a moderate to brisk dynamic exercise program. Ideally five 60-minute sessions of moderate intensity exercise would burn about 2000 calories. There is a 65% lower rate of heart disease when someone exercises to this level compared to a sedentary person. A general guideline is to maintain an active life style every day. Look for ways in daily life to be **more active** rather than trying to save energy that has become such a part of the American life style. Look for ways to add steps to your day such as taking the stairs, parking farther away, walking in instead of going to the drive-through. Doing 10 minutes of exercise three times a day instead of 30 minutes at once is almost as beneficial if it works better into your life style.

How hard to exercise: The Talk test is a good guideline if you don't have a heart rate monitor. You should be able to **talk during the fitness exercise** session but not sing. If you can't speak a phrase at a time, you need to slow down. If you can sing, you need to speed up. Being able to recite the Pledge of Allegiance without gasping between phrases is a good guideline. Ideally, a heart rate monitor is the best guide to maintain the heart rate in the 60-80% range of maximum during the conditioning exercise part of your exercise program. These are now inexpensive and easy to use. A general guide on your maximum heart rate is 220 minus your age. Then take 65-80% of that number for your conditioning exercise range. (Example 220 - age 60 = 160; 65-80% of that is 104-128). **It is important to have fun while exercising** and best to exercise with a buddy to enhance the enjoyment and motivation to maintain the exercise program for life.

Who should not exercise: There is **no chronic condition** that would not benefit from an exercise program at the safe level and the right type of exercise for that disorder. This includes people with arthritis, lung disease, kidney disease, diabetes, brain disease, and heart disease. For conditions such as stable angina, post heart attack or post-bypass surgery, a cardiac rehabilitation program is best suited to guide a person through the acute recovery phase and prepare for a daily life long exercise program.□

NutriTips #12

by Joan Brookhyser, RD, CSR, CD

What to Eat: For Men Only

There is so much focus on women and nutrition. But about men? They have needs, too. Right? Actually many of the concerns that catch the attention of women are just as important for men, with a few hormonal variations. Here is a rundown of key points.

YOUR PROSTATE WOULD RATHER BE VEGETARIAN

Daily meat consumption triples the risk of prostate enlargement. Regular milk consumption doubles the risk, and failing to consume vegetables regularly nearly quadruples the risk. Try to eat five to nine servings of fruits and vegetables per day. Add a non meat dish to your weekly meals two or more times per week. This can include a bean casserole or soup, bean burritos, stirfries with tofu and or nuts, or swapping your hamburger for a garden burger at dinner.

In addition, **add *cooked* tomato products** to your meals at least three or more times per week. This can include a tomato sauce on pasta, veggie pizza or a tomato based soup or stew. Tomato products contain a very powerful antioxidant Lycopene that is a cousin to betacarotene. If you do not like tomato products, watermelon and pink grapefruit are also good sources of Lycopene.

BONE HEALTH

One in four men over age 50 will have an osteoporosis related fracture in his lifetime. Adequate calcium and vitamin D is important in decreasing this risk. 1000 mg of calcium is needed for adult men. See *NutriTips # 7* "Diet and Your Bones" for more details on how to obtain prevent osteoporosis. If you take a calcium supplement make sure it has vitamin D added to it.

OTHER IMPORTANT NUTRITIONAL TIPS FOR MEN

· Avoid excess calories. Just like women, your metabolism is slowing down as you age, therefore you need less food to keep your weight in check. It is a time to focus more on a quality diet and to make sure your energy expenditure is balanced out by this decrease in metabolism.

· Reduce stress. What does this have to do with nutrition? As we age, stress hormones (adrenaline and cortisol) increase and this is one factor that contributes to mid-life abdominal fat deposition despite good nutrition otherwise.

· Keep a balanced diet. Follow the Pyramid for the basics and add in lots of fruits and vegetables. Eat whole grains and use more plant proteins in place of animal proteins. Health risks increase over the age of 50, a lot of which can be decreased by a high fiber, plant based diet.

· Limit alcohol. Moderate alcohol drinkers may have better health and live longer than those that do no drink or drink heavily. However, this is still controversial and depends on health concerns and your medical history. Limiting alcohol to one drink per day is suggested. One alcoholic drink per day can be a 5 oz glass of wine, a 12 oz beer or a 1.5 oz jigger of hard liquor.

· Soy. Soy may provide added protection against cancer and cardiac disease. Try to include one serving of soy per day such as a ¼ block of tofu, 1 cup of soy milk, or ½ cup of soy nuts.

· Omega 3 Fatty Acids. Increasing your use of omega 3 fatty acids either from supplements or by eating fatty fish 2-3 times per week (i.e., salmon, tuna or mackerel) may help decrease coronary risk, elevated triglycerides levels and risk of a stroke.

HERBALS AND OTHER SUPPLEMENTS

There are many nutritional products on the market and it may be tempting to get on the band wagon of using these products. However, be careful, several herbs can interfere with medications you are taking, and in addition can be contraindicated with other health concerns you might have. In addition, nutritional supplements are poorly regulated. It is estimated that 70% of nutritional supplements do not contain what they say they do! When buying supplements make sure they contain the USP (United States Pharmocopeia) code or have the GMP (Good Manufacturing Practices) code on the product. This can help assure you are receiving a good product.

If you would like to add supplements to your health program, the following would be suggested:

- A general multivitamin for men
- Omega 3 fatty acid supplement 1000-2000 mg per day- if you do not eat fish
- Calcium supplement 1000 mg if you are not able to take in enough good sources of calcium with vitamin D
- Saw Palmetto, a natural plant extract taken in a dose of 160 mg 2 times per day to further help prevent prostrate enlargement. ■

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.*

Long Haul Optimism

Michael J. Kelly, MD

"The point of living and of being an optimist, is to be foolish enough to believe the best is yet to come."
- Peter Ustinov

In the weeks following the November balloting, not a day passed without a colleague or patient inquiring about my reaction to the defeat of I-330 and the future of reform. While it's true I went through a time of grief, just like most of you, I have now become that fool to whom Peter Ustinov refers. I believe most of us must become convinced of the need to become just as foolish if we are to continue reform efforts.

The pessimism voiced during many of those conversations prompted this article. Let me begin by being somewhat contrary. I say, "Bring on the pessimism!" It has a role to play, although temporary. Its perspective is valuable. We must be willing to use pessimism's keen sense of reality without dwelling too long in its dark shadows. Once we've learned its lessons, get rid of it.

There is no doubt that the seemingly endless, vicious attack ads, outright lies and obfuscations by the personal injury lawyers knocked the psychological wind out of many of us. Disillusioned and fatigued, we licked our wounds and wondered if it was really worth it.

In addition, we find ourselves hammered with the daily demands of our work, intertwined as it is with the commitments to family and friends. However, both our patients and the political leadership of this state still expect us to solve this medical liability conundrum, so long ignored by the legislature. This is a challenge that will not go away.

It is important to realize all is not gloom and despair. There is a very large oasis of hope in this political desert. Hundreds of thousands of Washingtonians agreed with our message of the need for medical liability reform. Approximately five percent more votes would have secured the passage of I-330. We won 26 out of 39 counties. The public also saw through the self-serving hypocrisy of the personal injury attorneys to defeat I-336 despite early polling showing very strong support for their initiative.

In "*The Impossible Will Take a Little While,*" Paul Loeb writes, "History shows that the proverbial rock can be rolled, if not to the top of the mountain, then at least to successive plateaus...History also shows that even seemingly miraculous advances are in fact the result of many people taking small steps together over a long period of time." Through such incremental steps, we will change the present tort system. We must continually remind ourselves that change comes only when we continue for the long haul.

Taking the long view is essential because our culture promotes despair if desired results are not immediately obtained – that if we aren't certain of success, we shouldn't even begin.

Physicians are perfectionists. We often set such high standards that we convince ourselves unless we know every conceivable fact, figure and statistic about medical liability reform, and can argue it with eloquence; we have no right to take it on. Nevertheless, those who make the greatest impact know that change comes when we act despite our doubts and hesitations, learning as we go and persisting despite failures and frustrations.

The leadership of both the PCMS and WSMA are in this for the long haul. They realize reform is essential, but perhaps by another direction – one that includes options that move the issue out of the traditional tort law system. Stay tuned to the bulletins from both organizations as these approaches and concepts are described.

Long-term thinkers savor the journey of engagement – exhibiting defiance, resilience and persistence. We need to act no matter what the seeming odds, both to be true to our deepest moral values, and to open up new possibilities. With trust in one another's pragmatism, abiding fairness and devotion to the cause of reform, we will succeed in changing the present system. As Mr. Ustinov suggests, let's all be foolish enough to believe the best is yet to come and use the energy of that belief to rekindle the flame of our political activism. ❑

WSMA Looking to 2006 Legislative Priorities

The 2006 legislative session will be short – just 60 days - and will convene on January 9. The 56-43 Democratic majority in the House and the 26-23 Democratic majority in the Senate remain unchanged. It is anticipated that the session will not go beyond 60 days because there is no motivation for legislators to stay any longer given it is an election year and they cannot raise money until 30 days beyond the session's end.

WSMA's priorities for the session include Liability Reform and Patient Safety, Medical Discipline, Medical Practice Issues and Scope of Practice.

Medical practice issues will include but not be limited to:

- Cosmetic surgery sales tax
- B&O tax relief
- Regulation of office based surgery
- Development of specialty hospitals
- Electronic imaging self referral
- Evidence based care/Pay for performance
- Regulation of prepaid medical practices and access fees

Scope of practice bills will include licensing of genetic counselors and licensing of athletic trainers.

This is just an initial sampling of bills that are expected to be discussed during the session that are of priority to WSMA.

Plan to attend WSMA's Legislative Day on Monday January 23 at the Red Lion Hotel, 2300 Evergreen Park Drive in Olympia.

If you are interested in attending and would like carpool information, please call Sue at PCMS, 253-572-3667. ■

Linking Nutrition, Physical Activity and Learning

Jane Moore, MD, President of the Washington Coalition for Promoting Physical Activity and member of the PCMS Public Health/School Health Committee gave a presentation in October to physicians, school nurses and public health professionals regarding the role of physicians in improving physical fitness and health and preventing obesity in children. Dr. Moore has lobbied extensively on this topic and serves as a member of the Action for Healthy Kids, Washington State Team.

Jane Moore, MD

Her presentation, "The Role of Physicians, What Can We Do to Help?" fits nicely with this year's CHAMP initiative and is specifically targeted to physicians and gives practical guidelines and tips on what to do and how to get involved.

Be a source of information

Physicians are respected by patients as a good source of information, particularly on health topics. Take advantage of this. Patients will listen; other people will listen, so be sure and speak up and provide information. A recent public health poll conducted in Grays Harbor County found that when people were asked where they prefer to get information about the health benefits of physical activity, almost 50% of them said their doctor, while the second place source was the newspaper at 25%. These were followed by television at 23% and the internet at 18%. Patients overwhelmingly said they would follow the recommendation of their physician to increase physical activity if their physician advised them to do so. So, speak up.

While half of physicians report being comfortable discussing inactivity and it's health consequences with patients, most admit that the comfort level drops in providing a specific "exercise prescription" to patients. Of no surprise to physicians, however, is the overriding barrier of time constraints which over 90% of physicians indicated as a major detriment to working with patients to improve physical activity.

Be a role model

Let your patients know that you do as you say. Tell your own experiences. Wear a pedometer in your office and talk to others about increasing their daily steps. Help them be aware. Increase your physically activity and move more, even if it is just parking further away from each door you enter!

Be a "CHAMP"

The PCMS better health initiative, Coalition for Healthy, Active Medical Professionals, produces *FitFacts* and *FitTips* and can provide you with prescription pads to write scripts for exercise for your patients. The *FitFacts* and *FitTips* are published monthly in this publication and back copies are available.

Become an activist

There are many organizations both locally and nationally that support this issue. By joining organizations you can learn more, be better informed and increase your resource files. This is a great way to stay up to date with the most current information. By becoming active, you can share information and resources with others and lobby for change.

Step up. Get involved. Feel free to call Dr. Moore at 759-9902 to get connected.

Remember, it can be as simple as eating healthier and moving more!

Internet Resources:

Washington Coalition for Promoting Physical Activity
www.beactive.org

Action for Healthy Kids
www.actionforhealthykids.org

Centers for Disease Control
www.cdc.gov/nccdphp/dnpa/physical/index.htm

Active Living Network
www.activeliving.org ■

Applicants for Membership

Christian H. Nguyen, MD
Diagnostic Radiology
Medical Imaging Northwest
7424 Bridgeport Way W #103, Lakewood
253-841-4353
Med School: University of Minnesota
Internship: University of Minnesota
Residency: University of Minnesota
Fellowship: Mayo Clinic

Helen H. Shigemitsu, MD
Diagnostic Radiology
Medical Imaging Northwest
7424 Bridgeport Way W #103, Lakewood
253-841-4353
Med School: New York University
Internship: University of California, SF
Residency: Montefiore Medical Center
Residency: Loma Linda University
Fellowship: University of California, SD

Spencer E. Wang, MD
Diagnostic Radiology
Medical Imaging Northwest
7424 Bridgeport Way W #103, Lakewood
253-841-4353
Med School: Tufts University
Internship: Kaiser Medical Center
Residency: University of Florida
Fellowship: University of Florida

Physical Medicine and Rehabilitation Conference

Physical Medicine and Rehabilitation Service, Madigan Army Medical Center will be hosting the 21st Annual Physical Medicine and Rehabilitation Conference on March 14th-17th 2006 at Sheraton Hotel, Tacoma, Washington. Several nationally renowned speakers will lecture on Technological and Therapeutic Advances in the Management of Chronic Spine and Musculoskeletal Pain, Electrodiagnosis, Stroke, Peripheral Neuropathy, Pediatrics, Osteoporosis, Prosthetics & Orthotics, War Time Injuries and Rehabilitation, and Evidence Based Medicine.

The conference is designed for Physiatrists, Physicians in related Specialties and Allied Health Care Professionals interested in updating their knowledge in Pain management and Neuromuscular Medicine. The course curriculum and registration details will be available on the web at www.thegeneva foundation.org/events in December 2005. Approximately twenty-five (25) category I CME will be provided. For information, please contact COL Shashi Kumar, MD or Cauleen Harper at 253-968-2020 or email cauleen.harper@amedd.army.mil

Old Cell Phone(s) On Hand?

The YWCA Pierce County will be happy to accept any and all old cell phones. They activate them for client use and/or recycle them and receive funds for their children's programs.

They may be taken to the YWCA at 405 Broadway in Tacoma between 8 and 5, Monday thru Friday, or you may call Kristy at 272-4181 Ext. 222 for more information

The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

With Planning, Openness, We'll Weather Bird Flu

Federico Cruz, MD

Recently, I had one of those humbling and unnerving discussions with my son. You've been there: Your child comes to you and puts you on the spot. He or she has a problem and wants you to solve it.

The issue is bigger than you, but you do your best, and then leave worrying that your best is not enough.

This call started with my son asking about avian flu – a natural question for a public health director. I gave him a speech about the risks. So far in this conversation I am on safe ground.

Then he lowers the boom: "Pop, you're going to help me out, aren't you? You are going to protect your grandkids, right?"

I didn't miss a step. I was positive and assured him what we could do. Yes, I said, he could protect his kids. And I could help protect my grandkids.

He hung up feeling better, but the night had just begun for me. I was anything but reassured. I didn't sleep that night because the truth is that we've got some problems in the fight against pandemic flu.

As a father and grandfather, I can't magically create a protective shell around my loved ones just because that's what I want. If the world is faced with a pandemic flu this winter, a lot of people, including those I love, will get very sick and may die.

In Pierce County, and across the country, we have serious holes in our community influenza plan. The plan is very thin in several important areas, starting with prevention. The cornerstone of any flu control plan is having adequate vaccine so people don't get sick. We do not have any vaccine. It's not that we are missing half of what we need; we do not have any protective medication, or vaccine, sitting in a stockpile somewhere that we can reliably get our hands on when we need it.

Partly, this gap is unavoidable. Until the virus becomes one that can easily pass from person to person, we can only guess the viral characteristics. Without that information, we can't create a vaccine.

But once the outbreak starts and we have identified the virus, can we make it rapidly so that we can get it out to our communities to protect our loved ones? Sadly, the answer is no.

Right now, we cannot make the vaccine quickly in large amounts because we haven't put in all the work that has to be done first to allow for vaccine development. We didn't think it was important back in 1997, when this avian flu was first recognized, that we put together the infrastructure (the factories and labs) needed to quickly produce large amounts of vaccine.

We didn't make the investment, a bad decision from the past that we have to live with today.

If we do not have a vaccine readily available, how do we protect ourselves and give the federal government time to make the needed vaccine? The answer is straightforward. We have to slow the spread of the virus as it moves through our community.

This means using old-fashioned approaches that we have used in public health for hundreds of years: isolation and quarantine. We call these approaches "social distancing." It means simply that we keep people at risk away from other folks at risk. We close schools, ban public and group gatherings (movies, concerts, bars, restaurants, church meetings), and increase telecommuting for as many work activities as possible.

These are not easy things to do, and many people will resist. But the bottom line is this: Despite the fact that they will have a major impact on the economy of our community, they will work to slow the spread of the virus and limit the number of people who come down with the disease.

From a public health viewpoint, the decision to call for isolation and quarantine is easy: it works to slow the spread of the virus. However, they will only work if the public – you and your family and friends – cooperate, accepting limitations on movement.

There are several other systems that need to be in place, even as up to one-third of the work force call in sick for a month or more. The health care system has to operate efficiently so that those who get sick can be transported to where they can receive the needed care.

Utilities in this county have to function. Food and medical supplies must get where they are needed. Police and firefighters have to be able to respond to emergency calls.

Basically, local government has to

See "Bird Flu" page 12

Bird Flu from page 11

keep running to deal with all the many issues that will surface when large numbers of people have their lives disrupted. Every service-delivery system will have to prioritize its work and cross-train personnel to cope with a greatly reduced labor force.

We can plan for this and train staff to be ready; in county government, this has already begun.

In addition, there are concrete things that need to be in place from the start: necessary protective equipment (e.g., masks, gloves and hand-washing supplies). We need a local stockpile of antiviral agents. Vaccines can prevent someone from getting infected with a virus. An antiviral agent can prevent disease and be the treatment for someone who is already infected.

Again the federal government does not currently have a large-enough supply to protect our community in an influenza pandemic. We can only hope that the virus evolves slowly enough to give pharmaceutical companies time to create the needed amounts of vaccines and antiviral medications.

We will also have to hope that sufficient funds are provided for public health and medical systems so that we can purchase the antivirals once they have been produced.

In previous pandemics, information was often filtered, with honesty left at the door. This will not work today. We will be asking many people in our community to make sacrifices and to restrict greatly their activities.

Public compliance is all predicated on trust. People need to believe in their public health system, to believe in their local elected officials. That starts with honesty, pure and simple.

So it all comes back to my promise to my son and to my grandkids. Will I be able to protect them when the pandemic comes?

We will – if we do our jobs now, getting our control plan in place and addressing the weak spots in it right away. ■

Reprinted from the TNT, 11/27/05

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.*

Time to Shrug?

Andrew Statson, MD

"'Mr. Rearden,' said Francisco, his voice solemnly calm, 'if you saw Atlas, the giant who holds the world on his shoulders, if you saw that he stood, blood running down his chest, his knees buckling, his arms trembling, but still trying to hold the world aloft with the last of his strength, and the greater his effort, the heavier the world bore down upon his shoulders—what would you tell him to do?'
'I . . . don't know. What . . . could he do? What would you tell him?'
'To shrug.'"

Ayn Rand (1957)

The people have spoken. We lost.

Our opponents have maintained that no malpractice crisis exists. They have said that we are just whining. Once slapped on the wrist, we'll settle down and go back to work, like the good little boys and girls that we are. One of the options we have is to do just that, as we have always done before, and as they expect us to, and in so doing, to prove them right.

Perhaps many people saw this campaign as a squabble about money between the lawyers and the doctors. In a sense, they are right. The squabble was about money, and as far as the lawyers are concerned, it probably was just about money. Once they bleed us dry, they'll move on to someone else.

To us, though, it was not just about money. It was also about our professional survival, as individuals and as a group. We are at the wall. We cannot retreat any further.

One reporter suggested that we negotiate with the lawyers, reach an agreement, and seal it into law in the legislature. Isn't that what we have been trying to do for years? Our people have been in Olympia every session, speaking to legislators, pleading for relief. The answer they gave us has always been the same: the people have a right to their day in court. So now we should go back and ask them to change their tune? How much of a chance do we have?

It is as if we are riding a bus that is going in the wrong direction. We asked the driver (meaning the legislature) to turn around and take us to where we want to go. He refused. We turned to the other passengers (meaning the people) to intercede on our behalf. They refused. The only real options we now have is to ride to wherever the bus will take us, or to get off, if we dare.

I don't know of any other field where people work longer and harder than we do, year after year. The owners of some new businesses may do that at the beginning, to get themselves established, but once their business is going, they usually cut down. We don't. We love what we do. It is interesting, challenging, and very rewarding.

So now we keep going, hoping that we'll get relief, thinking that this nonsensical way to practice medicine cannot last. We hope that if we could just hang in there a little longer, everything would be fine again.

I am reminded of a Ukrainian refugee I met in Paris in 1958. He had escaped from his country back in 1919. The situation was so bad that he thought such an impossible system couldn't last, that soon it would break down, and he would be able to go back home. When he told me that story, the system had already lasted forty years. It crumbled eventually, but he was long dead when that happened.

Thirty years ago, comedians joked that if you needed a doctor on Wednesdays, you had to go to the golf course. It was good for a laugh, but it ignored the fact that if we had a day off during the week, it was because we worked 10-12 hours a day the rest of the time, and took night call in addition. Of course, nobody mentioned that, and most people probably didn't think about it.

Today you don't hear that joke any more. We work five days a week, twelve hours a day, and most of us also take night and weekend call. We frequently steal additional hours from what ought to be our leisure time to keep up with the medical literature. I suppose we should consider that pleasure, not work.

We increased our working hours during the past ten years, attempting to maintain our income, because the payments for our services went down. Yet the powers that control our payments decided that we were providing too many services and making too much money. As a result, they are squeezing us more.

Medicare is a good example. According to their formula, the more we do,

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the less they'll pay us per service. They have threatened to cut our payments by 4.5% per year for the next several years, because we are working too much and making all that money. Last year, they relented and gave us a 1% increase, and that in the face of a 2.5% official inflation rate. Was that an increase? Well, they said it was.

In any event, our overhead expenses go up at the rate of 5-10% per year. We are falling further and further behind. So far we could make it up in volume, at least to some degree, but most of us can no longer expand our work schedule to compensate for the loss. We have reached our limit. The pace at which we currently work is not sustainable. Something will have to give.

What chance do we have of getting relief? Well, the President has talked about reform for several years. The bills submitted to Congress didn't get anywhere. In the meantime, Congress passed laws limiting the liability exposure of restaurants, firearm manufacturers, and pharmaceutical companies.

What does that tell you? They certainly can act when they want to, but we are not high on their list of priorities. They fully expect us to continue to work, because we can't help ourselves. We love so much what we are doing that we'll keep going even if we had to pay to do it.

"Common Good" is doing a good job in publicizing the idea of health courts. They have stirred some talk, but no action. Perhaps health courts may become a reality one day, but that is in the distant future. Politicians don't act until faced with a crisis. So far, health care has remained generally available. Unless we quit in large numbers, it will remain so.

The ball is now in our court.

We could go to the legislature, again, hat in hand. Do many of you hope that they'll give us what we want? Remember, they passed a cap a number of years ago, and the State Supreme Court struck it down as unconstitutional.

We could ask for better reimbursements, but the governments at all levels are running out of taxing power. They have to contend with their unions, with the pension and health benefits for their retirees, with many other groups clamoring for free money. We are too low on their list to expect that we'll get anything.

So what options do we have? We cannot do much as a group, that is obvious. We can do a lot as individuals, one by one.

We have to ask ourselves how we are doing now, where we are headed, and whether we are compensated properly for the work we do. We must consider that things are more likely to get worse, rather than better. We must decide whether to stay on the bus no matter where it will take us, or get off as soon as we have a chance. When a significant number among us get off, things will change. ■

State Medical Board Bans Dating of Patients, Gray Areas of Conduct

Despite objections from lawyers and a doctors' group, the state medical board Friday adopted a sexual misconduct policy that includes a ban on doctors dating patients.

Supporters say the new policy will help target misconduct that falls short of obvious sexual contact. Opponents contend it could be used to unfairly strip the licenses of good doctors.

The Medical Quality Assurance Commission unanimously passed the measure at its meeting in Renton, said Donn Moyers, spokesman for the state Department of Health. The commission has considered such a rule for about six years.

Every doctor and physician assistant in the state will be subject to the measure once it takes effect in about two months.

The policy lists 11 prohibited acts, and those who violate the rules could lose their licenses. The list includes sexual contact, but also says providers can't kiss patients in a romantic way, ask them for dates or fail to allow privacy while patients undress.

"This would create a bright line," board member Hampton Irwin said. "If they step over it, they know there will be consequences."

The Washington State Medical Association and some doctors' lawyers say the rule isn't needed. The state already has the power to prosecute valid sexual misconduct allegations, said John Arveson, the medical association's professional affairs director.

Opponents also say the rules could allow innocent medical providers to be accused of wrongdoing.

The ban on dating patients could be unfair because, in a small town, "the doctor may not have anyone else to date," attorney Thomas Fain wrote in a March letter to the board.

The medical board has received at least 160 complaints of sexual misconduct by doctors and physician assistants since 1998.

About 20 percent resulted in disciplinary action. The other complaints weren't necessarily invalid, but the board had limited ways to act, said Mike Farrell, a medical board attorney.

Before the new policy, there was a ban on sexual contact and a prohibition of "moral turpitude."

Other health professionals already operate under sexual misconduct rules similar to the new policy for doctors and physician assistants.

The Medical Quality Assurance Commission's Web site has information about the new policy at https://fortress.wa.gov/doh/hpqa1/HPS5/Medical/default.htm Examples of sexual misconduct prohibited under new policy:

- All types of sex and sexual contact
- Kissing "in a romantic or sexual manner"
- Examining or touching genitals without wearing gloves
- Touching "any sexualized body part" for purposes not related to treatment or examination
- Failing to provide patients with privacy as they dress or undress
- Offering drugs or other medical services in exchange for sex
- Soliciting a date
- Discussing the physician's sexual history, preferences or fantasies ■

AP, Reprinted from The News Tribune, 11/19/05

Patience Wearing Thin Over Flu Shot Distribution Woes

Public health officials say more vaccine doses are coming, but doctors wonder about the window of opportunity to use them

By Victoria Stagg Elliott, reprinted from *AMNews* staff. Dec. 5, 2005

When it became clear to Brian Bachelder, MD, a family physician in Mt. Gilead, Ohio, that none of the 250 doses of influenza vaccine he had ordered were going to get to his office through the usual channels, he hatched a plan. He made a deal with the pharmacist from the local grocery store, which had an ample supply, to hold two clinics at his office.

"It's not ideal, but we're getting some service for the patients," he said.

Dr. Bachelder is one of many physicians across the country dealing with a flu vaccination season characterized by maldistribution.

High on the list of physician complaints: Many retail outlets appear to have plenty, while some medical practices seem to have none.

According to the Centers for Disease Control and Prevention, more than 80 million doses are expected to be delivered before this season is done. Several surveys suggest, however, that so far the vaccine may not be reaching physicians. One conducted by the Medical Society of the State of New York found that as of the beginning of November about 60% of physicians had received less than 25% of what they ordered and many had received none. Another by the California Medical Association found that 46% had not received a single shot.

"We should have vaccine in the hands of doctors," said Jack Lewin, MD, CMA chief executive officer. "This is a terrible mess. All of the big box stores have vaccine. Something stinks in the way vaccine is distributed."

But experts say these rapidly carried out surveys may not offer a completely accurate picture because physicians who are having difficulties may be more likely to respond, thereby skewing results. The CDC and the AMA are currently conducting their own randomized, scientific survey to gain a better understanding. The data are expected to be presented at the National Influenza Vaccine Summit in January 2006.

But while the distribution picture is murky, what is clear is that some physicians are angry about what they have experienced.

"It is time for the federal and state governments to consider stepping in and taking over the vaccine distribution system to assure that those most in need actually get their shots," said MSSNY President Robert A. Scher, MD. "Why should the flu shot be a loss leader for an enterprise like a discount store?"

Community vaccinators counter, though, that the impression that clinics in retail settings have adequate supplies is not entirely accurate. Companies in these venues report that they, too, have cancelled many of their clinics. They also say it's not true that they only reach healthy individuals.

"There are a variety of issues here, and it's a legitimate concern," said Stephen Allred, clinical director of Getaflushot.com, the largest provider of flu vaccines in Washington and Oregon. "But we do service the high risk and work with the [CDC] guidelines. We get a lot of referrals from medical practices, and we have contracts with hospitals for both their patients and for their staff."

The company has received less than half of what it ordered, but this total amount is regarded as proprietary information.

More on the way? Public health officials are calling for doctors to be patient because more supplies are on the way, and an increasing number of physicians will be receiving at least some of what they ordered. At press time, millions more doses were expected from Chiron, one of the three manufacturers of the injectable version this season. The CDC also expects to receive 800,000 doses at the end of November to distribute to areas with shortfalls.

"In those locations where the clinics have been closed and the doctors don't have vaccine, CDC will be able to offer a little bit of help and potentially even more help in December," said CDC Director Julie Gerberding, MD, MPH.

Still, doctors say their patience is wearing thin and the logistics of providing flu shots are becoming a nightmare. "All we have heard for the past few months is be patient and wait," said James Cunnar, MD, a family physician in Naperville, Ill., who has not received

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COLLEGE OF MEDICAL EDUCATION

Continuing Medical Education

Cardiology for Primary Care Course Postponed

The Cardiology for Primary Care CME course scheduled for Tuesday evenings, January 10 and 17 in early 2006 has been postponed and will be rescheduled on the course calendar for 2006-2007. We apologize for any inconvenience. If you have questions, call the College of 253-627-7137. ■

Snow is Calling - Make your Whistler Reservations Today

Snow is great and everyone is anticipating a busy, fun ski season so plan now for the College's January 25-28 CME program at Whistler.

Reservations for the program's condos can be made by calling **Aspens on Blackcomb**, toll free, at 1-877-676-6767, booking code #362871. You must identify yourself as part of the College of Medical Education group. Likewise, you are encouraged to make your reservations soon to ensure space. ■

Dates	Program	Director(s)
Wednesday-Saturday January 25-28	CME at Whistler	John Jiganti, MD
Friday, March 10	Mental Health Review	David Law, MD
Sunday-Friday April 2-7	CME at Hawaii	Mark Craddock, MD
Friday-Saturday May 5-6	Internal Medicine Review 2006	John Hurst, MD
Friday, June 2	Primary Care 2006	Steve Duncan, MD

Hawaii CME - April 2-7... Make Plans Today

The Hawaii CME course will be held at the Hapuna Prince Hotel on Hapuna Beach on the island of Hawaii, Sunday - Friday, April 2-7, 2006.

Offering 16 Category I credits, the Hawaii program is designed for PCMS and other physicians and features addresses on a variety of topics.

Reservations must be made early for both travel and hotel. Call Jeanette Paul at All Wanderlands Travel, 572-6271 or email her at jeanette@awtvl.com.

DON'T DELAY, MAKE YOUR RESERVATIONS NOW! ■

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any of the 300 doses he ordered. "Influenza is going to be here, and we're not going to have any more time."

Many had scheduled regular appointments in October and November for their high-risk patients so they could get the shot in conjunction with their routine care. Calling those patients back is an enormous burden. Caretakers may be less willing to take more time off work for an extra office visit. Snowy winter sidewalks may make elderly patients less willing to risk going outside.

"It's not always easy to get them in to just come back for their flu shot. It's a massive headache for us, massive work for my office staff and an additional visit for the patient," said Ellen Brull, MD, a family physician in Niles, Ill. She ordered 400 shots for her practice but had received just over 100 as of mid-November. Those have been used, and she has been told she will receive no more.

Although some physicians are concerned that they are more likely to get stuck with shots that arrive in December and beyond, many agree that late-season shots are a good idea, and 70% of those surveyed in California said they planned to continue to vaccinate into January.

But doctors also say that late-season shots are a high-risk business proposition. Patients may have gotten shots elsewhere, be unwilling to come in to get them, or may not see the sense in getting a late-season shot.

"I understand that it can be given in January," said Dr. Bachelder. "But if I was offered another 100 doses, I'd have to turn it down. I can't spend several hundred dollars on vaccine I may not be able to use." ■

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